Case Nos. 85525 & 85656

In the Supreme Court of Nevada

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

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230	Response to Plaintiffs' Trial Brief Regarding Specific Price Term	11/16/21	41	10,153–10,169
424	Response to Sur-Reply Arguments in Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment (Filed Under Seal)	10/21/21	109	26,931–26,952
148	Second Amended Complaint	10/07/21	21 22	5246–5250 5251–5264
458	Second Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits (Filed Under Seal)	01/05/22	126 127	31,309–31,393 31,394–31,500
231	Special Verdict Form	11/16/21	41	10,169–10,197
257	Special Verdict Form	11/29/21	49	12,035–12,046
265	Special Verdict Form	12/07/21	49	12,150–12,152
6	Summons – Health Plan of Nevada, Inc.	04/30/19	1	29–31
9	Summons – Oxford Health Plans, Inc.	05/06/19	1	38–41
8	Summons – Sierra Health and Life Insurance Company, Inc.	04/30/19	1	35–37
7	Summons – Sierra Health-Care Options, Inc.	04/30/19	1	32–34
3	Summons - UMR, Inc. dba United Medical Resources	04/25/19	1	20–22
4	Summons – United Health Care Services Inc. dba UnitedHealthcare	04/25/19	1	23–25
5	Summons – United Healthcare Insurance Company	04/25/19	1	26–28
433	Supplement to Defendants' Motion to Seal Certain Confidential Trial Exhibits (Filed	12/08/21	110 111	27,383–27,393 27,394–27,400

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

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

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

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

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

CERTIFICATE OF SERVICE

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

Electronic notification will be sent to the following:

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Attorneys for Amicus Curiae (case no. 85656)

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

The Honorable Nancy L. Allf
DISTRICT COURT JUDGE – DEPT. 27
200 Lewis Avenue
Las Vegas, Nevada 89155

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/s/ Jessie M. Helm
An Employee of Lewis Roca Rothgerber Christie LLP

being paid by the patient or simply due to error. Indeed, for most of these 5 claims, the allowed amount corresponds exactly to the amount of the patient deductible noted in your spreadsheet.
You also identified 2 claims with an ED CPT code that were not denied. We agree that these were not denied in full, but they were partially denied. You noted in row 11,508 that the 99291 claim line was still at issue, which is correct, but the 99292 claim line on that same claim was denied. Likewise, you noted in row 11,083 that the 99291 claim line was still at issue. Again, that is correct, but the 99292 claim line on that same claim was denied. So, these 2 claims are just like all of the other partially denied claims about which we have been conferring – there is a line on the claim that was paid and a line on the claim that was denied. The ERISA defense and issue we are raising does not turn on whether the denied claim line was an ER service or a non-ER service. It turns on whether the claim was fully approved and payable or whether the claim contains some claim lines that were denied as not covered and not payable. These two claims fall into that category. Let me know if you all see the data differently.
Finally, there are still 9 CollectRx resolved claims on this list (rows 11585 to 11594) which should be removed based on our prior discussion. Please let me know if you all see those 9 Collect Rx claims differently.
If we can reach agreement on these last group of claims, then I think we have a final list of disputed claims for trial and we can have our respective experts update their analysis based on this final list. Thanks. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Thursday, October 28, 2021 4:42 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

017251

[EXTERNAL MESSAGE]

Couple of issues with a few, but I think we are very close. Please review and let me know.
K

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Monday, October 25, 2021 8:07 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

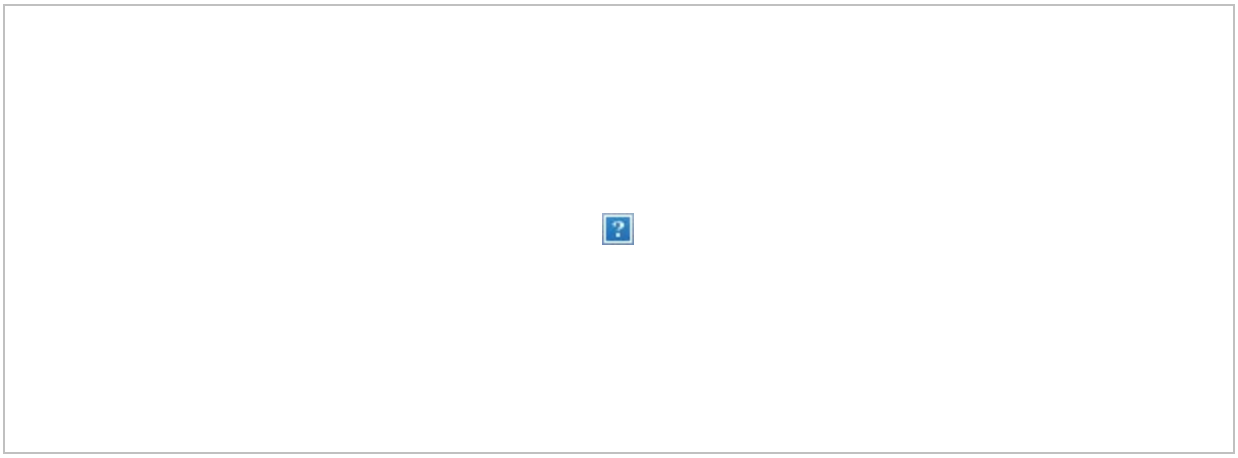
Kevin,
Per your request, we have added a column (AD) to the spreadsheet showing the CPT codes for the denied charges. Please see attached.
Regarding the 18 account numbers in Bruce Deal's work papers: We have removed those from the list. In the initial spreadsheet, these claims were marked as denied but with denied charges of $0. It appears that either TeamHealth is not disputing the billed charges associated with the denied lines, or those line items were re-adjudicated later and United allowed some amount.
Regarding the 17 claims which appear to be denied in full: These claims are recorded as

denied in full in Defendants' claims data. We have reviewed the denial reasons for these claims and they were indeed denied in full. While TeamHealth recorded an allowed amount for these claims, there is no corresponding allowed amount in Defendants' claims data. It is possible that the allowed amount recorded by TeamHealth was paid by the patient or a different payor; was recorded in error; or was the result of a claim initially being allowed but later reversed and denied.
Please let me know if you have further questions. Thanks. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Sunday, October 24, 2021 2:18 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Also, I note that the following 17 records, using your denied charges, suggest that the claim was denied in full, but if every one of them has an allowed amount, so that doesn't make sense to me.



017252

017252

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Sunday, October 24, 2021 11:42 AM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>
Subject: RE: Partially Denied Claim Issue

Kevin,
We have now had the opportunity to review the spreadsheet that you sent on Thursday to address our objections to the disputed claims that contain coverage denials. Thanks to you all for taking a crack at solving this problem but, unfortunately, your proposed method of removing the denied claim lines doesn't solve the problem. Your approach assumes that all the primary ED CPT codes on these claims were allowed and paid, while all the secondary CPT codes were denied. This creates two problems: First, this approach excludes claim lines with secondary CPT codes that were allowed and paid. Second, this approach includes claim lines with ED CPT codes which were denied. It is therefore both over- and under-inclusive.
I want to propose an alternative way to solve the problem. We have prepared a

spreadsheet that flags the denied claims (see attached spreadsheet column AB) and lists the amount of charges that were denied for each claim (see column AC). This spreadsheet accurately captures the charges actually denied for each claim. This method thus targets narrowly the issue of partial denials. It does not remove any claim lines that were paid and it removes all claim lines that were denied. Please share this analysis with Mr. Leathers and your broader team and let me know if they have any questions and, if they do, we would be willing to put our experts together with your experts to get aligned on this problem. If you all are willing to remove the denied claim lines from your damages analysis, which would be consistent with the position that your colleague communicated to Judge Allf at the hearing on our summary judgment motion last week, then I think this will resolve our objection about the partially denied claims on the disputed claims list.
By the way, please note that this spreadsheet already removes the claims conceded in Plaintiffs' opposition to Defendants' motion for partial summary judgment (i.e., UHC and UMR claims with a Jan 2020 DOS, claims resolved through negotiated agreements with DiS, the non-ER claims identified by Mr. Leathers for removal, and the 10 additional Data iSight claims about which we corresponded previously).
Best. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Thursday, October 21, 2021 5:56 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

017253

Lee, see enclosed. Per my text, I've added three columns to FESM 20911 (B) for the purpose of isolating the partially denied claims and once identified, extracting the core EM cpt so that when assessed for damages, column M (CPT FOR TRIAL (KL)) and column O (CHARGES FOR TRIAL (KL)) , will result in the same damage number regardless of whether that claim is measured against a bundled or unbundled cpt source file.
Also, I'm waiting to hear back from Louis as to the other 10 iSight claims. If we agree, those will come out to.
Expert will have to do math as well to see if they get same result and will also have to set the data in the "charge for trial column.
Let me know what you (Deal) thinks of this approach to resolving your concern that we are seeking damages for the denied claim lines associated with the bills that had a denied claim line.
K

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Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: 2:19-cv-00832-JAD-VCF **PLAINTIFF FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.'S FRCP 26(a)(1) INITIAL DISCLOSURES**

Pursuant to FRCP[1] 26(a)(1), plaintiff Fremont Emergency Services (Mandavia), Ltd., ("Plaintiff" or "Fremont"), hereby submits its initial disclosures.

[1] While Plaintiff submits these initial disclosures under the Federal Rules of Civil Procedure, Plaintiff reserves all rights with respect to its arguments asserted in the Motion to Remand (ECF No. 5). Plaintiff does not submit to the jurisdiction of the Federal Court and intends to continue to pursue the arguments raised in its Motion to Remand.

017256

017256

I. INDIVIDUALS LIKELY TO HAVE DISCOVERABLE INFORMATION.

1. Based on information to date, Plaintiff identifies the individuals listed below as likely to have discoverable information under FRCP 26(b).

Name	Contact Information	General Subject Matter
Kent Bristow	265 Brookview Centre Way Suite 400 Knoxville, TN 37919 This witness may only be contacted through counsel of record: Pat Lundvall Kristen T. Gallagher McDonald Carano LLP 2300 W. Sahara Ave., Suite 1200 Las Vegas, NV 89102	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendant's[2] underpayment of covered emergency medicine services provided by Plaintiff to Defendant's insureds; the course of conduct that existed between Plaintiff and Defendant prior to Defendant's decision to unilaterally reduce payments due to Plaintiff; Plaintiff's damages; and Defendant's conduct in its negotiations with Plaintiff.
Paula Dearolf	265 Brookview Centre Way Suite 400 Knoxville, TN 37919 This witness may only be contacted through counsel of record: Pat Lundvall Kristen T. Gallagher McDonald Carano LLP 2300 W. Sahara Ave., Suite 1200 Las Vegas, NV 89102	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendant's underpayment of covered emergency medicine services provided by Plaintiff to Defendant's insureds; the course of conduct that existed between Plaintiff and Defendant prior to Defendant's decision to unilaterally reduce payments due to Plaintiff; and Plaintiff's damages.
Greg Dosedel	c/o D. Lee Roberts, Jr. Colby L. Balkenbush Josephine E. Groh Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC 6385 South Rainbow Blvd. Suite 400 Las Vegas, NV 89118	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendant's underpayment of covered emergency medicine services provided by Plaintiff to Defendant's insureds; the course of conduct that existed between Plaintiff and Defendant prior to Defendant's decision to unilaterally

[2] United Healthcare Insurance Company, United Health Care Services Inc., d/b/a Unitedhealthcare, UMR, Inc., d/b/a United Medical Resources, Oxford Health Plans, Inc., Sierra Health and Life Insurance Company, Inc., Sierra Health-Care Options, Inc. and Health Plan of Nevada, Inc. shall collectively be referred to herein as the "Defendant."

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

Name	Contact Information	General Subject Matter
		reduce payments due to Plaintiff; Plaintiff's damages; and Defendant's conduct in its negotiations with Plaintiff.
David Greenberg	1643 NW 136th Ave. Building H, Suite 100 Sunrise, FL 33323 This witness may only be contacted through counsel of record: Pat Lundvall Kristen T. Gallagher McDonald Carano LLP 2300 W. Sahara Ave., Suite 1200 Las Vegas, NV 89102	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendant's underpayment of covered emergency medicine services provided by Plaintiff to Defendant's insureds; the course of conduct that existed between Plaintiff and Defendant prior to Defendant's decision to unilaterally reduce payments due to Plaintiff; Plaintiff's damages; Defendant's conduct in its negotiations with Plaintiff; and Data iSight's representations made to Plaintiff with respect to the amount to be paid for covered emergency medicine services provided by Plaintiff to Defendant's insureds.
John Haben	c/o D. Lee Roberts, Jr. Colby L. Balkenbush Josephine E. Groh Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC 6385 South Rainbow Blvd. Suite 400 Las Vegas, NV 89118	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendant's underpayment of covered emergency medicine services provided by Plaintiff to Defendant's insureds; the course of conduct that existed between Plaintiff and Defendant prior to Defendant's decision to unilaterally reduce payments due to Plaintiff; Plaintiff's damages; and Defendant's conduct in its negotiations with Plaintiff.
Rena Harris	8511 Fallbrook Ave. Suite 120 West Hills, CA 91304 This witness may only be contacted through counsel of record: Pat Lundvall Kristen T. Gallagher McDonald Carano LLP 2300 W. Sahara Ave.,	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendant's underpayment of covered emergency medicine services provided by Plaintiff to Defendant's insureds; the course of conduct that existed between Plaintiff and Defendant prior to

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Name	Contact Information	General Subject Matter
	Suite 1200 Las Vegas, NV 89102	Defendant's decision to unilaterally reduce payments due to Plaintiff; Plaintiff's damages; and Defendant's conduct in its negotiations with Plaintiff.
Jacy Jefferson	c/o D. Lee Roberts, Jr. Colby L. Balkenbush Josephine E. Groh Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC 6385 South Rainbow Blvd. Suite 400 Las Vegas, NV 89118	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendant's underpayment of covered emergency medicine services provided by Plaintiff to Defendant's insureds; the course of conduct that existed between Plaintiff and Defendant prior to Defendant's decision to unilaterally reduce payments due to Plaintiff; Plaintiff's damages; and Defendant's conduct in its negotiations with Plaintiff.
Custodian of Records for National Care Network, LLC	211 E. 7th Street, Suite 620 Austin, TX 78701	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendant's underpayment of covered emergency medicine services provided by Plaintiff to Defendant's insureds; Defendant's decision to unilaterally reduce payments due to Plaintiff; Plaintiff's damages; and the method for determining the payment made by Defendant to Plaintiff.
Angie Nierman	c/o D. Lee Roberts, Jr. Colby L. Balkenbush Josephine E. Groh Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC 6385 South Rainbow Blvd. Suite 400 Las Vegas, NV 89118	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendant's underpayment of covered emergency medicine services provided by Plaintiff to Defendant's insureds; the course of conduct that existed between Plaintiff and Defendant prior to Defendant's decision to unilaterally reduce payments due to Plaintiff; Plaintiff's damages; and Defendant's conduct in its negotiations with Plaintiff.

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Name	Contact Information	General Subject Matter
Dan Rosenthal	c/o D. Lee Roberts, Jr. Colby L. Balkenbush Josephine E. Groh Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC 6385 South Rainbow Blvd. Suite 400 Las Vegas, NV 89118	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendant's underpayment of covered emergency medicine services provided by Plaintiff to Defendant's insureds; the course of conduct that existed between Plaintiff and Defendant prior to Defendant's decision to unilaterally reduce payments due to Plaintiff; Plaintiff's damages; and Defendant's conduct in its negotiations with Plaintiff.
Dan Schumacher	c/o D. Lee Roberts, Jr. Colby L. Balkenbush Josephine E. Groh Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC 6385 South Rainbow Blvd. Suite 400 Las Vegas, NV 89118	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendant's underpayment of covered emergency medicine services provided by Plaintiff to Defendant's insureds; the course of conduct that existed between Plaintiff and Defendant prior to Defendant's decision to unilaterally reduce payments due to Plaintiff; Plaintiff's damages; and Defendant's conduct in its negotiations with Plaintiff.
Jennifer Shrader	265 Brookview Centre Way, Suite 400 Knoxville, TN 37919 This witness may only be contacted through counsel of record: Pat Lundvall Kristen T. Gallagher. McDonald Carano LLP 2300 W. Sahara Ave., Suite 1200 Las Vegas, NV 89102	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendant's underpayment of covered emergency medicine services provided by Plaintiff to Defendant's insureds; the course of conduct that existed between Plaintiff and Defendant prior to Defendant's decision to unilaterally reduce payments due to Plaintiff; Plaintiff's damages; and Defendant's conduct in its negotiations with Plaintiff.

2. Any and all persons and entities identified by Defendant regarding this matter.

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II. DOCUMENTS.

1. Fremont discloses the following documents[3] in support of its claims, defenses, and denials asserted in the Complaint:

Bates Start	Bates End	Document Description
FESM00001	FESM00003	July 2, 2019 letter re Provider Dispute Reconsideration/Appeal for the Physician Practices
FESM00004	FESM00004	Confidential and withheld pending entry of a protective order
FESM00005	FESM00007	July 2, 2019 letter re Provider Dispute Reconsideration/Appeal for the Physician Practices
FESM00008	FESM00008	Confidential and withheld pending entry of a protective order
FESM00009	FESM00009	Confidential and withheld pending entry of a protective order
FESM00010	FESM00010	Confidential and withheld pending entry of a protective order
FESM00011	FESM00011	Confidential and withheld pending entry of a protective order
FESM00012	FESM00018	March 19, 2019 letter re UHG Surprise Billing Chairmen Letter
FESM00019	FESM00104	Health Plan of Nevada, Inc. – Medicaid/Nevada Check-up Consulting Provider Agreement
FESM00105	FESM00107	Health Plan of Nevada, Inc. Consulting Provider Amendment
FESM00108	FESM00108	March 1, 2019 letter re Health Plan of Nevada and Fremont Emergency Services Termination Confirmation
FESM00109	FESM00117	September 10, 2018 letter re Request to Renegotiate or Terminate Intention
FESM00118	FESM00120	Sierra Health & Life Insurance Company, Inc. Amendment to Individual/Group Provider Agreement
FESM00121	FESM00200	Sierra Health & Life Insurance Company, Inc. Individual/Group Provider Agreement
FESM00201	FESM00203	Sierra Health & Life Insurance Company, Inc. Amendment to Individual/Group Provider Agreement
FESM00204	FESM00219	Sierra Health & Life Insurance Company, Inc. Individual/Group Provider Agreement
FESM00220	FESM00220	March 1, 2019 letter re Sierra Healthcare Options (Sierra Health and Life) and Fremont Emergency Services Termination Confirmation

[3] Documents bates-labeled FESM00001-FESM00341 (other than those withheld as confidential) were previously produced in Fremont's Response to Defendants' First Set of Requests for Production of Documents to Fremont dated July 29, 2019.

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Bates Start	Bates End	Document Description
FESM00221	FESM00223	Amendment to Medical Group Participation Agreement MGA Commercial Rate Increase
FESM00224	FESM00224	June 30, 2017 letter re United Healthcare and Fremont Emergency Services Termination Notification
FESM00225	FESM00255	December 19, 2014 letter re Executed Participation Agreement/Notice of Effective Date
FESM00256	FESM00256	March 9, 2017 letter
FESM00257	FESM00287	December 19, 2014 letter re Executed Participation Agreement/Notice of Effective Date
FESM00288	FESM00334	Complaint filed in Middle District of Pennsylvania against United Healthcare
FESM00256	FESM00341	Information on Payment of Out-of-Network Benefits

2. All documents or other evidence identified in any pleadings or papers filed by any party in this matter or during discovery.

III. DAMAGES COMPUTATION.

Fremont provides the following calculation of damages:

Plaintiff seeks damages described in the Complaint. Specifically, Plaintiff's damages for its claims for relief are to be determined as (i) the difference between the lesser of (a) amounts Plaintiff charged and (b) the reasonable value or usual and customary rate for its professional emergency medicine services and the amount Defendant unilaterally allowed as payable for the claims at issue in the litigation plus (ii) the Plaintiff's loss of use of those funds. In addition, Plaintiff seeks damages based on the statutory penalties for late-paid and partially paid claims as set forth in the Nevada Insurance Code under its claim for violation of Nevada's prompt pay statutes. Plaintiff also seeks to recover treble damages and all profits derived from Defendant's knowing and willful violation of Nevada's consumer fraud and deceptive trade practices statutes.

The reasonable value of and/or usual and customary rate for Plaintiff's emergency medicine services in the marketplace will be determined by the finder of fact at trial. Plaintiff will continue to gather information concerning those calculations and their total amount of damages, which will also be the subject of expert testimony. Plaintiff's damages continue to accrue and will be amended, adjusted and supplemented as necessary during the course of this litigation as additional claims are adjudicated and paid by Defendant. Plaintiff also seeks punitive damages, attorneys' fees, costs and

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interest under each of the claims asserted in this action. Plaintiff seeks equitable relief for which a calculation of damages is not required by the Nevada Rules of Civil Procedure; however, Plaintiff seeks special damages under this claim.

Subject to the foregoing, Plaintiff will provide Defendant with a spreadsheet providing the details for each of the claims at issue in this litigation regarding the services provided, the billed charges for the services provided and the amount Defendant adjudicated as payable, among other information. For the claims with dates of services through April 30, 2019, the difference between the Plaintiff's billed charges and the amounts allowed by Defendant as payable is approximately $11,037,700.25 prior to any calculation of interest due thereon.

IV. INSURANCE AGREEMENTS.

Plaintiff is not currently aware of any relevant insurance agreements.

Plaintiff's investigation and discovery concerning this case is continuing, and, if additional information is obtained after the date of these disclosures, Plaintiff will supplement these disclosures.

DATED this 2nd day of October, 2019.

McDONALD CARANO LLP

By: /s/*Amanda Perach*

Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 2nd day of October, 2019, I caused a true and correct copy of the foregoing **PLAINTIFF FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.'S FED. R. CIV. P. 26(a) INITIAL DISCLOSURES** to be served via U.S. Mail, postage prepaid upon the following:

D. Lee Roberts, Jr.
Colby L. Balkenbush
Josephine E. Groh
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
lroberts@wwhgd.corn
cbalkenbush@wwhgd.corn
jgroh@wwhgdcorn

Attorneys for Defendants UnitedHealthcare Insurance Company, United HealthCare Services, Inc., UMR, Inc., Oxford Health Plans Inc., Sierra Health and Life Insurance Co., Inc. Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc.

/s/ *Kimberly Kirn*
An employee of McDonald Carano LLP

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Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: 2:19-cv-00832-JAD-VCF **FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS**

Pursuant to Rules 26 and 34 of the Federal Rules of Civil Procedure plaintiff Fremont Emergency Services (Mandavia), Ltd. ("Fremont") serves the following First Set of Requests for Production of Documents ("Document Requests") to defendants United HealthCare Insurance Company ("UHCIC"), United HealthCare Services, Inc. ("UHC Services"), UMR, Inc. ("UMR"), Oxford Health Plans, Inc. ("Oxford" and collectively the "UH Parties"), Sierra Health and Life

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Insurance Company, Inc. ("Sierra"), Sierra Health-Care Options, Inc. ("Sierra Options") and Health Plan of Nevada, Inc. ("HPN" and with "Sierra and Sierra Options, the "Sierra Affiliates" and collectively with the UH Parties, "United HealthCare") and asks that United HealthCare respond in writing within thirty (30) days of the date of service, to McDonald Carano LLP, 2300 West Sahara Avenue, Suite 1200, Las Vegas, Nevada 89102. These Document Requests are continuing in nature and Defendant must timely supplement the answers to them under Fed. R. Civ. P. 26(e) whenever a response is in some material respect incomplete or incorrect.

DEFINITIONS

1. "Communicate" means every manner or means of disclosure or transfer or exchange of information whether orally, by document or otherwise, and whether face to face, in a meeting, by telephone or other electronic media, mail, personal delivery or otherwise.

2. "Communication" means the transfer of information from a person or entity, place, location, format, or medium to another person or entity, place, location, format, or medium, without regard to the means employed to accomplish such transfer of information, but including without limitation oral, written and electronic information transfers. Each such information transfer, if interrupted or otherwise separated in time, is a separate communication.

3. "Document" is defined to be synonymous in meaning and equal or exceeding in scope to the usage of this term in Fed. R. Civ. P. 34(a). It includes images, words and symbols that are electronically stored and which, if printed on paper, would be the text of a document, as well as metadata contained within particular electronic files. It also means all written or graphic matter of every kind or description however produced or reproduced whether in draft, in final, original or reproduction, signed or unsigned, whether or not now in existence, and regardless of whether approved, sent, received, redrafted or executed, and includes without limiting the generality of its meaning all correspondence, telegrams, notes, e-mail, video or sound recordings of any type of communication(s), conversation(s), meeting(s), or conference(s), minutes of meetings, memoranda, interoffice communications, intra office communications, notations, correspondence, diaries, desk calendars, appointment books, reports, studies, analyses, summaries, results of investigations or tests, reviews, contracts, agreements, working papers, tax

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returns, statistical records, ledgers, books of account, vouchers, bank checks, bank statements, invoices, receipts, records, business records, photographs, tape or sound recordings, maps, charts, photographs, plats, drawings or other graphic representations, logs, investigators' reports, stenographers' notebooks, manuals, directives, bulletins, computer data, computer records, or data compilations of any type or kind of material similar to any of the foregoing however denominated and to whomever addressed. "Document" shall include but is not limited to any electronically stored data on magnetic or optical storage media as an "active" file (readily readable by one or more computer applications or forensic software); any "deleted" but recoverable electronic files on said media; any electronic file fragments (files that have been deleted and partially overwritten with new data); and slack (data fragments stored randomly from random access memory on a hard drive during the normal operation of a computer [RAM slack] or residual data left on the hard drive after new data has overwritten some but not all of the previously stored data. "Document" shall exclude exact duplicates when originals are available but shall include all copies made different from originals by virtue of any writings, notations, symbols, characters, impressions or any marks thereon.

4. Data iSight is the trademark of an analytics service owned by National Care Network, LLC. Data iSight and National Care Network, LLC are collectively referred to as "Data iSight."

5. "Fremont" shall mean and refer to Fremont Emergency Services (Mandavia), Ltd. and/or any past or present agents, representatives, employees, partners, principals, members, assigns, predecessors-in-interest, successors-in-interest, affiliates and every person acting or purporting to act, or who has ever acted or purported to act, on its behalf.

6. "Defendants," "You," or "Your" shall mean and refer to Defendants United HealthCare Insurance Company, United HealthCare Services, Inc., UMR, Inc., Oxford Health Plans, Inc., Sierra Health and Life Insurance Company, Inc., Sierra Health-Care Options, Inc. and Health Plan of Nevada, Inc. and/or any past or present agents, representatives, employees, partners, principals, members, assigns, predecessors-in-interest, successors-in-interest, and every person acting or purporting to act, or who has ever acted or purported to act, on their behalf.

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7. "UH Parties" means and refers to defendants United HealthCare Insurance Company, United HealthCare Services, Inc., UMR, Inc. and Oxford Health Plans, Inc.

8. "Sierra Affiliates" means and refers to defendants Sierra Health and Life Insurance Company, Inc., Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc.

9. "Lawsuit" shall mean and refer to the lawsuit styled *Fremont Emergency Services (Mandavia), Ltd. v. United HealthCare Insurance Company, et al.* filed in the Eighth Judicial District Court, Clark County, Nevada, Case No. A-19-792978-B and removed to the United States District Court, D. Nevada, Case No. 2:19-cv-00832-JAD-VCF.

10. A "claim" means any billing instrument or request for reimbursement by a Provider for medical services provided.

11. "CLAIM" or "CLAIMS" means those claims for reimbursement for Emergency Services and Care or Nonemergency Services and Care provided by Fremont to Your Plan Members for dates of service on or after July 1, 2017 (UH Parties) and on or after March 1, 2019 (Sierra Affiliates).

12. "Emergency Services and Care" means medical screening, examination, and evaluation by a physician or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists, and if the physician or personnel determines that it does exist, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition within the service capability of a hospital.

13. "Emergency Medicine Services" shall mean and refer to evaluation and management services (described by CPT codes 99281-99285), critical care services (described by CPT codes 99291-92) and the associated procedures performed by Fremont in the State of Nevada.

14. "Emergency Medicine Group" shall mean and refer to any or all groups of physicians, mid-level practitioners and other healthcare providers that staff hospital emergency departments, observations units and urgent care clinics in the State of Nevada, whether the group is structured as a professional corporation, a limited liability corporation, partnership, or otherwise.

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15. "Emergency Department Services" shall mean all services performed in the emergency department of a hospital in the State of Nevada by a hospital, physicians of any specialty (not limited to emergency medicine physicians), nurses or any healthcare providers.

16. "Nonemergency Services and Care" means medical services and care which are not Emergency Services and Care.

17. "Non-Participating Provider" or "Non-Network Provider" means a healthcare provider who has not been designated by You as a "participating" or "network" provider.

18. "Participating Provider" or "Network Provider" means a healthcare provider who has an agreement with You as an independent contractor or otherwise, or who has been designated by You, to provide services to Plan Members.

19. "Plan" means any health benefit product or program, including but not limited to an HMO, an Exclusive Provider Organization ("EPO") or Preferred Provider Organization ("PPO") product or program, issued, administered, or serviced by You.

20. "Plan Member" means an individual covered by or enrolled in a Plan.

21. "Provider" means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed to do so in the state where those services are furnished.

INSTRUCTIONS

1. These Document Requests seek all requested documents that are in Defendant's possession, custody, and/or control, including without limitation, any records depositories or archives.

2. Copies of requested documents that differ from other copies of the document by reason of alterations, margin notes, comments, attached materials, or otherwise shall be considered separate documents and shall be produced separately.

3. Documents that are physically attached to, segregated and/or separated from other documents, whether by inclusion in binders, files, sub files, or by use of dividers, tabs, or any other method, shall be left so attached, segregated, and/or separated when produced, and shall be retained in the order in which they are maintained, in the file where they are found.

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4. If you contend that any document requested to be produced, or any part thereof, is protected from discovery by the attorney-client privilege, work product doctrine, or some other ground or privilege or immunity, as required under Rule 26(b)(5) of the Federal Rules of Civil Procedure, produce a log that identifies each document withheld and provides at a minimum the following information:

a. the place, date, and manner of preparation or other recording of the document;

b. the title and subject matter of the document;

c. the identity and position of the author, the addressee, and all recipients of the document; and

d. a statement of (i) the nature of the legal privilege claimed or other reason for withholding the document and (ii) the factual basis for that claim of privilege or other reason for withholding, including the facts establishing any claim of privilege, the facts showing that the privilege has not been waived, the status of the person claiming the privilege, and a statement as to whether the contents of the document are limited to legal advice or contain other subject matter.

5. For each document from which portions were withheld pursuant to instruction 4, identify and produce all other portions of the document not so withheld.

6. Scope of Answers. In answering these Document Requests, you are requested to furnish all information available to you, however obtained, including hearsay, information known by you or in your possession or appearing in your records, information in the possession of your attorneys, your investigators, and all persons acting on your behalf, and not merely the information known of your own personal knowledge.

7. Qualification of Answers. If your answer is in any way qualified, please state the exact nature and extent of the qualification.

8. If additional information or documents become known to Defendant regarding any of these Document Requests following the initial response and submission to Plaintiff, supplementation of the response with such information is required.

9. For each document produced, identify the specific document request number or numbers to which the document is responsive.

10. All documents are to be produced as they are kept in the usual course of business including any labels, file markings, or similar identifying features, or shall be organized and

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labeled to correspond to the categories requested herein. If there are no documents in response to a particular request, or if you withhold any responsive documents or categories of documents based on any objections, You shall state so in writing.

11. Where a request seeks the production of electronically stored information ("ESI"), that information must be produced in its native format with corresponding load files containing the document's text and all available metadata. For purposes of these discovery requests, "native format" means a file saved in the format designated by the original application used to create it.

12. If you object to any Request in part, you shall respond fully to the extent not objected to, and set forth specifically the grounds upon which the objection is based.

13. If you cannot answer a Request fully after exercising due diligence to secure the documents requested, so state and respond to the extent possible, specifying your inability to respond to the remainder, the reasons therefore, the steps taken to secure the documents that were not produced, and stating whatever information or knowledge you have concerning the missing documents. Please also identify the person you believe to have possession of the missing documents, and the facts upon which you base your response.

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RULES OF CONSTRUCTION

1. The terms “relate to,” “related to,” “relating to,” “relative to,” and “in relation to,” include without limitation “refer to,” “summarize,” “reflect,’ “constitute,” “concern,” “contain,” “embody,” “mention,” “show,” “comprise,” “evidence,” “discuss,” “describe,” or “pertaining to.”

2. The term “concerning” means and includes without limitation “regarding,” “pertaining to,” “reflecting,” “referring to,” “relating to,” “containing,” “embodying,” “mentioning,” “evidencing,” “constituting,” or “describing.”

3. The use of the masculine gender, as used herein, also means the feminine, or neuter, whichever makes a discovery interrogatory more inclusive.

4. The words “and” and “or” shall be construed conjunctively or disjunctively, whichever makes a discovery interrogatory more inclusive.

5. The use of the singular form of any word includes the plural and vice versa.

6. The terms “person or entity” and “persons or entities” mean any individual, firm,

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corporation, joint venture, partnership, association, fund, other organization, or any collection or combination thereof.

REQUESTS FOR PRODUCTION OF DOCUMENTS

REQUEST FOR PRODUCTION NO. 1:

Produce all Documents and/or Communications with the Nevada Division of Insurance and/or Nevada Insurance Commissioner relating to or concerning NRS 679B.152.

REQUEST FOR PRODUCTION NO. 2:

Produce any and all Documents and/or Communications regarding, discussing, or referring to NRS 679B.152

REQUEST FOR PRODUCTION NO. 3:

Produce any and all Documents and/or Communications between You and Fremont regarding any of the CLAIMS.

REQUEST FOR PRODUCTION NO. 4:

Produce all Documents and/or Communications regarding Your adjudication and/or payment of each CLAIMS that Fremont submitted to You for payment between July 1, 2017, and the present.

REQUEST FOR PRODUCTION NO. 5:

Produce any and all Documents and/or Communications relating to Your determination and/or calculation of the allowed amount and reimbursement for any of the CLAIMS, including the following: (i) the method by which the allowed amount and reimbursement for the Claim was calculated; (ii) the total amount You allowed and agreed to pay; (iii) any contractual or other allowance taken; and (iv) the method, date, and final amount of payment.

REQUEST FOR PRODUCTION NO. 6:

Produce any and all Documents and/or Communications relating to Your decision to reduce payment for any CLAIM.

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REQUEST FOR PRODUCTION NO. 7:

Produce any and all Documents and/or Communications supporting or relating to Your contention or belief that You are entitled to pay or allow less than Fremont's full billed charges for any of the CLAIMS.

REQUEST FOR PRODUCTION NO. 8:

If you contend that any course of prior business dealing(s) by and between You and Fremont entitle(s) You to pay less than Fremont's full billed charges for any of the CLAIMS, or is otherwise relevant to the amounts paid for any of the CLAIMS, produce any Documents and/or Communications relating to any such prior course of business dealing(s).

REQUEST FOR PRODUCTION NO. 9:

If you contend that any agreement(s) by and between You and Fremont entitles You to pay less than Fremont's full billed charges for any of the CLAIMS, or is otherwise relevant to the amounts paid for any of the CLAIMS, produce any Documents and/or Communications relating to any such agreement(s).

REQUEST FOR PRODUCTION NO. 10:

Produce any and all Documents and/or Communications relating to the methodology You currently use, or used during calendar or Plan years 2016, 2017, 2018 and/or 2019 to determine and/or calculate Your reimbursement of Non-Participating Providers in Nevada for Emergency Medicine Services.

REQUEST FOR PRODUCTION NO. 11:

Produce all Documents and/or Communications between You and any third-party, including but not limited to Data iSight, relating to (a) any claim for payment for medical services rendered by Fremont to any Plan Member, or (b) any medical services rendered by Fremont to any Plan Member.

REQUEST FOR PRODUCTION NO. 12:

Produce all Documents identifying and describing all products or services Data iSight, provides to You with respect to Your Health Plans issued in Nevada or any other state, including without limitation repricing services provided to You, whether You adjudicated and paid any

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claims in accordance with re-pricing information recommended by Data iSight, and the appeals administration services provided to You.

REQUEST FOR PRODUCTION NO. 13:

Produce all Documents and/or Communications concerning, evidencing, or relating to any negotiations or discussions concerning Non-Participating Provider reimbursement rates between You and Fremont, including, without limitation, documents and/or communications relating to the meeting in or around December 2017 between You, including, but not limited to, Dan Rosenthal, John Haben, and Greg Dosedel, and Fremont, where Defendants proposed new benchmark pricing program and new contractual rates.

REQUEST FOR PRODUCTION NO. 14:

Produce all Documents regarding rates insurers and/or payors other than You have paid for Emergency Services and Care in Nevada to either or both Participating or Non-Participating Providers from July 1, 2016, to the present.

REQUEST FOR PRODUCTION NO. 15:

Produce all Documents and/or Communications, reflecting, analyzing, or discussing the methodology you used to calculate or determine Non-Participating Provider reimbursement rates for Emergency Services in Nevada, including, but not limited to, any documents and/or communications you used or created in the process of calculating and/or determining the prevailing charges, the reasonable and customary charges, the usual and customary charges, the average area charges, the reasonable value, and/or the fair market value for Emergency Services in Clark County.

REQUEST FOR PRODUCTION NO. 16:

Produce all Documents that refer, relate or otherwise reflect shared savings programs in Nevada for Fremont's out-of-network claims from July 1, 2017 to present. This request includes, without limitation, contracts with third parties regarding Your shared savings program, amounts invoiced by You to third parties for the shared savings program for Fremont's out-of-network claims, amount You were compensated for the shared savings program for Fremont's out-of-network claims.

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REQUEST FOR PRODUCTION NO. 17:

All Communications between You and any third-party, relating to (a) any CLAIM for payment for medical services rendered by Fremont to any Plan Member, or (b) any medical services rendered by Fremont to any Plan Member.

REQUEST FOR PRODUCTION NO. 18:

All documents and/or communications regarding the rational, basis, or justification for the reduced rates for emergency services proposed to Fremont in or around 2017 to Present.

REQUEST FOR PRODUCTION NO. 19:

All documents regarding the Provider charges and/or reimbursement rates that You have paid to Participating or Non-Participating Providers from July 1, 2017, to the present in Nevada. Without waiving any right to seek further categories of documentation, at this juncture, Fremont is willing to accept, in lieu of contractual documents, data which is blinded or redacted and/or aggregated or summarized form.

REQUEST FOR PRODUCTION NO. 20:

All Documents relied on for the determination of the recommended rate of reimbursement for any CLAIM by Fremont for payment for services rendered to any Plan Member. This request includes, without limitation, all cost data, reimbursement data, and other data and Documents upon which such recommended rates are based.

REQUEST FOR PRODUCTION NO. 21:

All Documents relating to Your relationship Data iSight, including any and all agreements between You and Data iSight, and any and all documents that explain the scope and extent of the relationship, Your permitted uses of the data provided by Data iSight, and the services performed by Data iSight.

REQUEST FOR PRODUCTION NO. 22:

Produce any and all Documents and/or Communications relating to any analysis of the usual and customary provider charges for similar services in Nevada for Emergency Medicine Services.

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REQUEST FOR PRODUCTION NO. 23:

Produce any and all Documents and/or Communications relating to any analysis of any Nevada statutes or guidelines You currently use, or used during calendar or Plan years 2016, 2017, 2018 and/or 2019, to determine and/or calculate Your reimbursement of Non-Participating Providers in Nevada for Emergency Medicine Services.

REQUEST FOR PRODUCTION NO. 24:

Produce any and all Documents and/or Communications relating to any analysis of Nevada statutes with regard to the payment of the CLAIMS.

REQUEST FOR PRODUCTION NO. 25:

Produce all agreements between You and any Participating Providers in Nevada relating to the provision of Emergency Medicine Services to Plan Members.

REQUEST FOR PRODUCTION NO. 26:

Produce any and all Documents and/or Communications regarding the provider charges and/or reimbursement rates that other insurers and/or payors have paid for Emergency Medicine Services in Nevada to either or both participating or non-participating providers from January 1, 2016, to the present, including Documents and/or Communications containing any such data or information produced in a blinded or redacted form and/or aggregated or summarized form.

REQUEST FOR PRODUCTION NO. 27:

Produce any and All Documents and/or Communications concerning, evidencing, or relating to any negotiations or discussions concerning non-participating provider reimbursement rates between the UH Parties and Fremont, including negotiations or discussions leading up to any participation agreements or contracts with Fremont in effect prior to July 1, 2017.

REQUEST FOR PRODUCTION NO. 28:

Produce any and All Documents and/or Communications concerning, evidencing, or relating to any negotiations or discussions concerning non-participating provider reimbursement rates between the Sierra Affiliates and Fremont, including negotiations or discussions leading up to any participation agreements or contracts with Fremont in effect prior to March 1, 2019.

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REQUEST FOR PRODUCTION NO. 29:

Produce any and all contracts and participation agreements that You have or had with any Emergency Medicine Groups and/or any hospitals or other providers of Emergency Department Services other than Fremont that were in effect at any point from January 1, 2016, through the present, including all fee or rate schedules and amendments and addendums, and all other documents reflecting the agreed-upon terms for reimbursement for any product or service.

REQUEST FOR PRODUCTION NO. 30:

Produce any and all Documents and/or Communications between You and any Emergency Medicine Groups and/or any hospitals or other providers of Emergency Department Services other than Fremont occurring at any point from January 1, 2016, through the present relating to negotiations of any reimbursement rates and/or fee schedules for Emergency Medicine Services and/or Emergency Department Services.

REQUEST FOR PRODUCTION NO. 31:

Produce any and all Documents and/or Communications regarding Your goals, thoughts, discussions, considerations, and/or strategy regarding reimbursement rates and/or fee schedules for participating Emergency Medicine Groups and/or any hospitals or other providers of Emergency Department Services from January 1, 2015, through the present.

REQUEST FOR PRODUCTION NO. 32:

Produce any and all Documents and/or Communications regarding Your goals, thoughts, discussions, considerations, and/or strategy regarding reimbursement rates and/or fee schedules for non-participating Emergency Medicine Groups and/or any hospitals or other providers of Emergency Department Services from January 1, 2016, through the present.

REQUEST FOR PRODUCTION NO. 33:

Produce any and all Documents and/or Communications regarding Your reimbursement rates paid or to be paid to out-of-network Emergency Medicine Groups and/or complaints about Your level of payment for Emergency Medicine Services and/or Emergency Department Services received from out-of-network providers.

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REQUEST FOR PRODUCTION NO. 34:

Produce any and all Documents and/or Communications regarding the impact, if any, that reimbursement rates paid by You to non-participating providers have had on profits You earned and/or premiums You charged with respect to one or more of Your commercial health plans offered in the State of Nevada from 2016 to the present.

REQUEST FOR PRODUCTION NO. 35:

Produce any and all Documents and/or Communications regarding Your reimbursement policies for non-participating providers considered or adopted, effective January 1, 2016, to the present.

REQUEST FOR PRODUCTION NO. 36:

Produce any and all Documents and/or Communications regarding or reflecting the average or typical rate of payment, or an aggregation, summary or synopsis of those payments, that You allowed from January 1, 2016, to the present for all or any portion of the Emergency Medicine Services and/or Emergency Department Services rendered to Your Plan Members covered under any plan You offer in Nevada.

REQUEST FOR PRODUCTION NO. 37:

Produce any and all Documents and/or Communications concerning Emergency Medicine Services and/or Emergency Department Services You published, provided or made available to either Emergency Medicine Groups or Your Plan Members in Nevada from 2016 to the present concerning Your reimbursement of out-of-network services.

REQUEST FOR PRODUCTION NO. 38:

Produce any and all Documents and/or Communications concerning Your adjudication and/or payment of each claim for Emergency Medicine Services and/or Emergency Department Services that either participating or non-participating Emergency Medical Groups and/or any hospitals or other providers of Emergency Department Services other than Fremont submitted to You for payment between January 1, 2016, and the present.

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REQUEST FOR PRODUCTION NO. 39:

Produce any and all Documents and/or Communications reflecting any policies, procedures, and/or protocols that You contend governs the appeal of Your adjudication and/or payment decision with respect to one or more of the CLAIMS.

REQUEST FOR PRODUCTION NO. 40:

Produce any and all Documents and/or Communications regarding any appeals of adverse determinations, disputes of payment, or any submission of clinical information concerning the CLAIMS.

REQUEST FOR PRODUCTION NO. 41:

Produce any and all Documents and/or Communications regarding any challenges by any other non-participating Emergency Medicine Group and/or any non-participating hospital or other non-participating provider of Emergency Department Services of the appropriateness of the reimbursement rates paid by You for Emergency Medicine Services and/or Emergency Department Services rendered to Your Plan Members from January 1, 2016, to the present.

REQUEST FOR PRODUCTION NO. 42:

Produce any and all Documents and/or Communications regarding, discussing, or referring to any failure by You to attempt to effectuate a prompt, fair, and/or equitable settlement of any CLAIMS.

REQUEST FOR PRODUCTION NO. 43:

Produce any and all Documents and/or Communications suggesting that Medicare reimbursement rate for any Emergency Medicine Services is not a measure of either fair market value or the usual and customary rate for such services.

REQUEST FOR PRODUCTION NO. 44:

Produce all Documents You reviewed or relied upon in preparing Your responses to Fremont's First Set of Interrogatories.

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REQUEST FOR PRODUCTION NO. 45:

Produce any and all Documents and/or Communications supporting, refuting, or relating to Your affirmative defenses identified in Your Answers to Fremont's First Set of Interrogatories to Defendants.

DATED this 9th day of December, 2019.

McDONALD CARANO LLP

By: /s/ *Kristen T. Gallagher*

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 9th day of December, 2019, I caused a true and correct copy of the foregoing **FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS** to be served via hand delivery as follows:

D. Lee Roberts, Jr., Esq.
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Attorneys for Defendants UnitedHealthcare Insurance Company, United HealthCare Services, Inc., UMR, Inc., Oxford Health Plans, Inc., Sierra Health and Life Insurance Co., Inc., Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc.

/s/ *Marianne Carter*
An employee of McDonald Carano LLP

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Attorneys for Defendants

DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

Case No.: A-19-792978-B
Dept. No.: 27

DEFENDANTS' NINTH SUPPLEMENTAL RESPONSES TO FREMONT EMERGENCY SERVICES (MANDAVIA) LTD.'S FIRST SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS

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Defendants UnitedHealth Group, Inc., UnitedHealthcare Insurance Company, United HealthCare Services Inc., UMR, Inc., Oxford Health Plans, Inc., Sierra Health and Life Insurance Co., Inc., Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc. ("United HealthCare"), by and through their attorneys of the law firm of Weinberg Wheeler Hudgins Gunn & Dial, LLC, hereby submit these supplemental responses to Plaintiff's ("Plaintiff" or "Fremont") First Set of Requests for Production of Documents ("Requests") as follows (**supplemental responses in bold**):

PRELIMINARY STATEMENT

Defendants have made diligent efforts to respond to the Requests, but reserve the right to change, amend, or supplement their responses and objections. Defendants also reserve the right to use discovered documents and documents now known, but whose relevance, significance, or applicability has not yet been ascertained. Additionally, Defendants do not waive their right to assert any and all applicable privileges, doctrines, and protections, and hereby expressly state their intent and reserve their right to withhold responsive information on the basis of any and all applicable privileges, doctrines, and protections.

Defendants' responses are made without in any way waiving or intending to waive, but on the contrary, intending to preserve and preserving, their right, in this litigation or any subsequent proceeding, to object on any grounds to the use of documents produced in response to the Request, including objecting on the basis of authenticity, foundation, relevancy, materiality, privilege, and admissibility of any documents produced in response to the Requests.

The documents produced in conjunction with these supplemental responses are being produced subject to the confidentiality and attorneys' eyes only protections permitted pursuant to Section 3(f) of the Stipulation and Order Re: Pending Matters that was entered on May 15, 2020 and pursuant to the terms of Confidentiality and Protective Order that the Parties are currently in the process of negotiating.

Defendants are limiting their responses to the Requests to the reasonable time-frame of July 1, 2017 to present ("Relevant Period") and object to the Requests to the extent that Plaintiff fails to limit the Requests to a specific time period.

SPECIFIC OBJECTIONS TO PLAINTIFF'S DEFINITIONS, INSTRUCTIONS, AND RULES OF CONSTRUCTION

1. Defendants object to the "Instructions," "Definitions," and "Rules of Construction" accompanying the Requests to the extent they purport to impose any obligation on Defendants different from or greater than those imposed by the Nevada Rules of Civil Procedure.

2. Defendants object to the "Instructions," "Definitions," and "Rules of Construction" to the extent they purport to require the production of Protected Health Information or other confidential or proprietary information without confidentiality protections sufficient to protect such information from disclosure, such as those found in the Confidentiality and Protective Order entered on June 24, 2020.

3. Defendants object to the definition of "Claim" or "Claims" as vague, not described with reasonable particularity, overbroad, unduly burdensome, not relevant to the claims or defenses in this case, and not proportional to the needs of this case to the extent they (1) include claims not specifically identified by Plaintiff in FESM000011, or (2) relate to claims, patients, or health benefits plans for which Defendants are not responsible for the at-issue claims administration.

4. Defendants object to the definition of "Data iSight" as vague, not described with reasonable particularity, overbroad, unduly burdensome, not relevant to the claims or defenses in this case, and not proportional to the needs of this case. Defendants contend that Plaintiff does not fully or accurately describe Data iSight, which is a service offered by MultiPlan, Inc. that provides pricing information concerning medical claims.

5. Defendants object to the definition of "Document," "Communication," and "Communicate" to the extent those terms include within their scope materials, at to the Requests, to the extent they seek documents or information protected by the attorney-client privilege, the attorney work product doctrine, the settlement privilege, or any other applicable privilege, including, but not limited to: information that was prepared for, or in anticipation of, litigation; that contains or reflects the analysis, mental impressions, or work of counsel; that

contains or reflects attorney-client communications; or that is otherwise privileged.

6. Defendants object to the definition of the terms "Defendants," as used in the context of the Requests, and "You," and/or "Your" as vague, not described with reasonable particularity, overbroad, unduly burdensome, not proportional to the needs of the case, and seeking information that is not relevant to the outcome of any claims or defenses in this litigation. Plaintiff's definition includes, for example, "predecessors-in-interest," "partners," "any past or present agents," and "every person acting or purporting to act, or who has ever acted or purported to act, on their behalf," which suggests that Plaintiff seeks materials beyond Defendants' possession, custody, or control. Defendants will not search for or produce materials beyond their possession, custody, or control. Defendants have answered the Requests on behalf of Defendants, *as defined herein,* only based upon Defendants' knowledge, materials and information in Defendants' possession, and belief formed after reasonable inquiry.

7. Defendants object to the definition of "Fremont" as vague, not described with reasonable particularity, overbroad, unduly burdensome, not proportional to the needs of the case, and seeking information that is not relevant to the outcome of any claims or defenses in this litigation Plaintiff's definition includes, for example, "any past or present agents," "representatives," " partners," "predecessors-in-interest," "affiliates," and "every person acting or purporting to act, or who has ever acted or purported to act, on [its] behalf' without identifying these entities or persons with reasonable particularity, and creating an undue burden by requiring Defendants to identify them. In responding to the Requests, Defendants will construe "Fremont" to refer to those parties who were known to have been affiliated with Fremont Emergency Services (Mandavia), Ltd. during the Relevant Period.

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8. Defendants object to the definition of "Emergency Services and Care," "Emergency Medicine Services," and "Emergency Department Services" as vague, not described with reasonable particularity, overbroad, unduly burdensome, not relevant to the claims or defenses in this case, and not proportional to the needs of this case to the extent they (1) include any medical services not related to the at-issue claims, or (2) relate to any medical

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services for claims, patients, or health benefits plans for which Defendants are not responsible for the at-issue claims administration.

9. Defendants object to the definition of "Nonemergency Services and Care" as vague, not described with reasonable particularity, overbroad, unduly burdensome, not relevant to the claims or defenses in this case, and not proportional to the needs of this case to the extent it (1) includes services by not related to the at-issue claims, or (2) relates to the services for claims, patients, or health benefits plans for which Defendants are not responsible for the at-issue claims administration.

10. Defendants object to the definition of "Non-Participating Provider," "Non-Network Provider," "Participating Provider," and "Network Provider" as vague, not described with reasonable particularity, overbroad, unduly burdensome, not relevant to the claims or defenses in this case, and not proportional to the needs of this case to the extent they (1) include persons or entities that are not parties to this case, or (2) concern persons or entities unrelated to the at-issue claims.

11. Defendants object to the definition of "Plans" and "Plan Members" as vague, not described with reasonable particularity, overbroad, unduly burdensome, not relevant to the claims or defenses in this case, and not proportional to the needs of this case to the extent they (1) include health benefits plans and members of such plans not specifically identified by Plaintiff, (2) include health benefits plans that are not related to the at-issue claims, or (3) are referring to health benefits plans for which Defendants are not responsible for the at-issue claims administration.

12. Defendants object to the definition of "Provider" as vague, not described with reasonable particularity, overbroad, unduly burdensome, not relevant to the claims or defenses in this case, and not proportional to the needs of this case to the extent it (1) includes persons or entities that are not parties to this case, or (2) concern persons or entities unrelated to the at-issue claims.

13. Defendants object to Instruction No. 1 as vague and not described with reasonable particularity, as it uses the term Defendant, in the singular, without defining which of the

Defendants it is referring to. Defendants also object to Instruction No. 1 to the extent it seeks to impose obligations and/or penalties on Defendants beyond what is contemplated by the Nevada Rules of Civil Procedure or applicable local rules.

14. Defendants object to Instruction Nos. 2, 3, 4, 5, 6, 7, and 8 to the extent they seek to impose obligations and/or penalties on Defendants beyond what is contemplated by the Nevada Rules of Civil Procedure.

15. Defendants object to Instruction No. 9 as unduly burdensome and not proportional to the needs of the case insofar as it asks Defendants to provide "[for each document produced, identify the specific document request number or numbers to which the document is responsive." Defendants also object to Instruction No. 9 to the extent it seeks to impose obligations and/or penalties on Defendants beyond what is contemplated by the Nevada Rules of Civil Procedure.

16. Defendants object to Instruction Nos. 10, 11, and 12 to the extent they seek to impose obligations and/or penalties on Defendants beyond what is contemplated by the Nevada Rules of Civil Procedure.

17. Defendants object to Instruction No. 13 as unduly burdensome and not proportional to the needs of the case insofar as it asks Defendants to provide the name of "the person you believe to have possession of the missing documents, and the facts upon which you base your response." Defendants also object to Instruction No. 13 to the extent it seeks to impose obligations and/or penalties on Defendants beyond what is contemplated by the Nevada Rules of Civil Procedure.

RESPONSES TO REQUESTS FOR PRODUCTION OF DOCUMENTS

REQUEST FOR PRODUCTION NO. 5:

Produce any and all Documents and/or Communications relating to Your determination and/or calculation of the allowed amount and reimbursement for any of the CLAIMS, including the following: (i) the method by which the allowed amount and reimbursement for the Claim was calculated; (ii) the total amount You allowed and agreed to pay; (iii) any contractual or other allowance taken; and (iv) the method, date, and final amount of payment.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that the term "CLAIM" is vague, as noted in Defendants' objections to Plaintiff's Definitions, as the definition does not identify what specific list of claims it is referring to. However, Defendants interpret this Request as referring to the claims listed in FESM000011. Assuming those are the claims Fremont intended to refer to, Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents and communications related to the four categories set forth in this Request (i.e. (i) the reimbursement methodology, (ii) the total amount allowed and agreed to pay, (iii) any contractual or other allowance taken and (iv) the method, date and final amount of payment), Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Defendants further object to categories (ii), (iii) and (iv) of this Request as they seek information that is equally, if not more accessible, to Fremont. There is no justification for imposing the burden on Defendants to identify, collect, review, and produce such documents when Fremont already possesses the same.

Moreover, the request is overbroad, unduly burdensome, not reasonably particular, and not proportional to the needs of the case as it essentially requests all documents related to the parties' claims and defenses. It would be essentially impossible for Defendants to perform the investigation necessary to identify all documents and communications that in someway relate to the determination and calculation of the allowed amounts for all of the 15,210 CLAIMS.

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Defendants request that Fremont meet and confer to narrow the scope of this request and provide some semblance of reasonable particularity with respect to the type of documents they are seeking so as to reduce the burden imposed on Defendants.

Responding further, subject to and without waiving Defendants' objections: please see documents previously produced as DEF001536–DEF010454, and documents forthcoming, beginning at DEF011481. Defendants have made diligent efforts to respond to the Requests, but reserve the right to supplement their responses and objections.

REQUEST FOR PRODUCTION NO. 6:

Produce any and all Documents and/or Communications relating to Your decision to reduce payment for any CLAIM.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that the term "CLAIM" as vague, as noted in Defendants' objections to Plaintiff's Definitions, as the definition does not identify what specific list of claims it is referring to. However, Defendants interpret this Request as referring to the claims listed in FESM000011. Assuming those are the claims Fremont intended to refer to, Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents and communications related to any decision to reduce payment on a CLAIM, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor..

Moreover, the request is overbroad, unduly burdensome, not reasonably particular, and not proportional to the needs of the case as it essentially requests all documents related to the

parties' claims and defenses. It would be essentially impossible for Defendants to perform the investigation necessary to identify all documents and communications that in someway relate to the decision to not pay the full billed charges on all of the 15,210 CLAIMS.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF010455-DEF010554.

Responding further, subject to and without waiving Defendants' objections: please see documents previously produced as DEF001536–DEF010454, and documents forthcoming, beginning at DEF011481. Defendants have made diligent efforts to respond to the Requests, but reserve the right to supplement their responses and objections.

REQUEST FOR PRODUCTION NO. 7:

Produce any and all Documents and/or Communications supporting or relating to Your contention or belief that You are entitled to pay or allow less than Fremont's full billed charges for any of the CLAIMS.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that the term "CLAIM" is vague, as noted in Defendants' objections to Plaintiff's Definitions, as the definition does not identify what specific list of claims it is referring to. However, Defendants interpret this Request as referring to the claims listed in FESM000011. Assuming those are the claims Plaintiff intended to refer to, Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Plaintiff has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Plaintiff for the full amount billed. To produce the documents and communications related to any decision to pay or allow less than Plaintiff's full billed charges on a CLAIM, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual

claim file for a total of 30,420 hours of employee labor.

Moreover, the request is overbroad, unduly burdensome, not reasonably particular, and not proportional to the needs of the case as it essentially requests all documents related to the parties' claims and defenses. It would be essentially impossible for Defendants to perform the investigation necessary to identify all documents and communications that in someway relate to the decision to not pay the full billed charges on all of the 15,210 CLAIMS.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF010455-DEF010554.

Responding further, subject to and without waiving Defendants' objections: please see documents previously produced as DEF000722–DEF000854, and documents produced concurrently herewith as DEF011090–DEF011210, DEF011295–DEF011382, DEF011384–DEF011396, and DEF011411–DEF011446. Defendants have made diligent efforts to respond to the Requests, but reserve the right to supplement their responses and objections.

REQUEST FOR PRODUCTION NO. 8:

If you contend that any course of prior business dealing(s) by and between You and Fremont entitle(s) You to pay less than Fremont's full billed charges for any of the CLAIMS, or is otherwise relevant to the amounts paid for any of the CLAIMS, produce any Documents and/or Communications relating to any such prior course of business dealing(s)

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that the phrase "prior business dealing(s)" is vague. Defendants are not certain what is intended by this phrase and are thus unable to determine whether or not they would make the contention referenced in this Request (i.e. is Fremont referring to prior payments by Defendants to Fremont, prior contracts between Defendants and Fremont, etc.). Defendants request clarification as what is meant by this phrase and Defendants will then supplement their response to this Request, if supplementation is warranted.

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Defendants further object that documentation of prior business dealings between Defendants and Fremont would necessarily be possessed by Fremont. There is no justification for imposing the burden on Defendants to identify, collect, review, and produce such documents when Fremont already possesses the same.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF10559–DEF011089. Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.

REQUEST FOR PRODUCTION NO. 9:

If you contend that any agreement(s) by and between You and Fremont entitles You to pay less than Fremont's full billed charges for any of the CLAIMS, or is otherwise relevant to the amounts paid for any of the CLAIMS, produce any Documents and/or Communications relating to any agreements(s).

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows: During the time period after which Fremont became a non-participating, out-of-network provider, Defendants are not currently aware of any direct written participation agreement between Defendants and Fremont that would govern the amount of reimbursement (if any) for the CLAIMS. However, there may be other contracts/agreements that governed the amount of reimbursement for each CLAIM, including, but not limited to, the applicable health benefits plan documents. Defendants are continuing to attempt to determine whether any such contracts/agreements exist and will supplement this response, if any such contracts or agreements are found.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF11295–DEF011382, DEF011384–DEF011396, and DEF011411–DEF011446. Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and

objections.

REQUEST FOR PRODUCTION NO. 10:

Produce any and all Documents and/or Communications relating to the methodology You currently use, or used during calendar or Plan years 2016, 2017, 2018 and/or 2019 to determine and/or calculate Your reimbursement of Non-Participating Providers in Nevada for Emergency Medicine Services.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant and not proportional to the needs of the case. This Request is overbroad as it seeks information on methodologies used prior to July 1, 2017 (the date of the first claim Fremont is asserting). This Request is also overbroad as it seeks information on the methodologies used to calculate reimbursement rates for all non-participating emergency services providers in Nevada, as opposed to being limited to information related to methodologies used to calculate the rate of reimbursement on the claims Fremont is asserting in this litigation. The information sought in this Request is also not relevant as Defendants often use different reimbursement methodologies depending on, for example, the particular claim, provider, and/or the applicable health benefits plan documents.

Defendants request that Fremont meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants and that Fremont is able to get the information it is seeking.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF011212–DEF011273. Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.

REQUEST FOR PRODUCTION NO. 13:

Produce all Documents and/or Communications concerning, evidencing, or relating to

any negotiations or discussions concerning Non-Participating Provider reimbursement rates between You and Fremont, including, without limitation, documents and/or communications relating to the meeting in or around December 2017 between You, including, but not limited to, Dan Rosenthal, John Haben, and Greg Dosedel, and Fremont, where Defendants proposed new benchmark pricing program and new contractual rates.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that this Request is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 claims where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents and communications that relate to any discussions or negotiations over the reimbursement rates on those claims, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual claims, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Moreover, all documents and communications exchanged between Defendants and Fremont would necessarily be possessed by Fremont. There is no justification for imposing the burden on Defendants to identify, collect, review, and produce such documents when Fremont already possesses the same.

Defendants further respond by referring Fremont to the following bates numbered documents produced with these responses that relate to negotiations between Fremont and the Sierra Defendants: DEF000114 – DEF000156. For the other aspects of this Request that were objected to, Defendants request that Plaintiff meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants, seeks relevant information and that Plaintiff is able to get the information it is seeking.

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Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF010559–DEF011089. Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.

REQUEST FOR PRODUCTION NO. 14:

Produce all Documents regarding rates insurers and/or payors other than You have paid for Emergency Services and Care in Nevada to either or both Participating or Non-Participating Providers from July 1, 2016, to the present.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that this Request seeks information that is not within its possession, custody or control. To the extent Plaintiff believes this information would be within Defendants' possession, custody or control, Defendants request that Plaintiff clarify this Request. Defendants further object that this Request is overbroad and unduly burdensome as it appears to seek documents on all emergency medical services claims that have ever been paid by any insurer or payor in Nevada during the specified time frame. Thus, the Request likely covers hundreds of thousands of claims for payment and seeks information that is not proportional to the needs of this litigation. Defendants further object that this Request is overbroad as it seeks information starting on July 1, 2016, but the earliest claim Fremont has asserted is dated July 1, 2017. Defendants further state that to the extent Defendants do have any responsive documents these document would likely be publicly available to Plaintiff as well.

By way of further response, subject to and without waiving Defendants' objections, United does not receive rate information from other insurers and/or payors. However, United refers Plaintiffs to DEF011072, produced concurrently herewith.

REQUEST FOR PRODUCTION NO. 15:

Produce all Documents and/or Communications, reflecting, analyzing, or discussing the methodology you used to calculate or determine Non-Participating Provider reimbursement rates

for Emergency Services in Nevada, including, but not limited to, any documents and/or communications you used or created in the process of calculating and/or determining the prevailing charges, the reasonable and customary charges, the usual and customary charges, the average area charges, the reasonable value, and/or the fair market value for Emergency Services in Clark County.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant and not proportional to the needs of the case since it is not limited to a specific time frame and/or not limited to the methodology used to calculate reimbursement rates for emergency services provided by Fremont, as opposed to other non-party emergency services providers. Rather, this improper Request appears to seek documents and communications relating to rates of reimbursement to providers other than Fremont.

A portion of this Request does seek relevant information as Fremont is a non-participating provider that provides emergency services in Nevada. However, that portion of this Request, as currently framed, is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 claims where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents and communications that relate to the methodology used to calculate the amount of reimbursement paid on Fremont's claims, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual claims, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1 to, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Responding further, subject to and without waiving Defendants' objections: please see document produced concurrently herewith as DEF010558.

Responding further, subject to and without waiving Defendants' objections: please

see documents produced concurrently herewith as DEF011212–DEF011273. Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.

REQUEST FOR PRODUCTION NO. 16:

Produce all Documents that refer, relate or otherwise reflect shared savings programs in Nevada for Fremont's out-of-network claims from July 1, 2017 to present. This request includes, without limitation, contracts with third parties regarding Your shared savings program, amounts invoiced by You to third parties for the shared savings program for Fremont's out-of-network claims, amount You were compensated for the shared savings program for Fremont's out-of-network claims.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that this Request seeks information that is not relevant to Plaintiff's claims and not proportional to the needs of the case. Defendants further object that this Request is vague in regard to what is meant by "shared savings programs." Defendants request that Plaintiff clarify what is meant by this term so that Defendants can determine whether they have responsive documents in their possession.

Defendants further object that this Request is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 claims where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents that relate to amounts invoiced to third parties for those claims and amounts received by Defendants, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual claims, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Defendants request that Plaintiff meet and confer to narrow the scope of this Request to

ensure that it is not unduly burdensome to Defendants and that Plaintiff is able to get the information it is seeking.

Responding further, subject to and without waiving Defendants' objections: please see documents previously produced as DEF000722–DEF000854, and documents produced concurrently herewith as DEF011090–DEF011210. Defendants have made diligent efforts to respond to the Requests, but reserve the right to supplement their responses and objections.

REQUEST FOR PRODUCTION NO. 17:

All Communications between You and any third-party, relating to (a) any CLAIM for payment for medical services rendered by Fremont to any Plan Member, or (b) any medical services rendered by Fremont to any Plan member.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that the term "CLAIM" is vague, as noted in Defendants' objections to Plaintiff's Definitions, as the definition does not identify what specific list of claims it is referring to. However, Defendants interpret this Request as referring to the claims listed in FESM000011. Assuming those are the claims Fremont intended to refer to, Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the communications between Defendants and third parties related to those CLAIMS, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Defendants request that Plaintiff meet and confer to narrow the scope of this Request to

ensure that it is not unduly burdensome to Defendants and that Plaintiff is able to get the information it is seeking.

Responding further, subject to and without waiving Defendants' objections: please see documents previously produced as DEF001536–DEF010454, and DEF010555 and documents forthcoming, beginning at DEF011481. Defendants have made diligent efforts to respond to the Requests, but reserve the right to supplement their responses and objections.

REQUEST FOR PRODUCTION NO. 18:

All documents and/or communications regarding the rational, basis, or justification for the reduced rates for emergency services proposed to Fremont in or around 2017 to Present.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 claims where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents related to why those claims were paid at a particulate rate, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Moreover, the request is overbroad, unduly burdensome, not reasonably particular, and not proportional to the needs of the case as it essentially requests all documents related to the parties' claims and defenses. It would be essentially impossible for Defendants to perform the investigation necessary to identify all documents and communications that in someway relate to the justification for the payments made on all of the 15,210 CLAIMS.

Responding further, subject to and without waiving Defendants' objections: please see

documents produced concurrently herewith as DEF010455-DEF010554.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF011276–DEF011279, DEF011295–DEF011410.

Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.

REQUEST FOR PRODUCTION NO. 19:

All documents regarding the Provider charges and/or reimbursement rates that You have paid to Participating or Non-Participating Providers from July 1, 2017, to the present in Nevada. Without waiving any right to seek further categories of documentation, at this juncture, Fremont is willing to accept, in lieu of contractual documents, data which is blinded or redacted and/or aggregated or summarized form.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that, even with the limitation proposed by Fremont, this Request is overbroad, unduly burdensome and seeks irrelevant information that is not proportional to the needs of the case. It is unclear what the relevance is of documents showing what the amounts Defendants paid to providers other than Fremont. Depending on, for example, the provider, the claim at issue, and/or the applicable health benefits plan documents, Defendants use different methodologies to calculate the allowed amount of reimbursement. The documents sought in this Request are therefore not relevant to determining the usual and customary rate of reimbursement for the claims Fremont is asserting in this litigation.

To the extent this Request is also seeking documents related to the reimbursement rates for claims of Fremont as a Non-Participating Provider, Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 claims where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents relating to the reimbursement

rates on those claims, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Responding further, subject to and without waiving Defendants' objections: please see document produced concurrently herewith as DEF010558.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF011274–DEF011275.

Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.

REQUEST FOR PRODUCTION NO. 20:

All Documents relied on for the determination of the recommended rate of reimbursement for any CLAIM by Fremont for payment for services rendered to any Plan Member. This request includes, without limitation, all cost data, reimbursement data, and other data and Documents upon which such recommended rates are based.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that the term "CLAIM" is vague, as noted in Defendants' objections to Plaintiff's Definitions, as the definition does not identify what specific list of claims it is referring to. However, Defendants interpret this Request as referring to the claims listed in FESM000011. Assuming those are the claims Fremont intended to refer to, Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents relied on to determine the amount of reimbursement to be issued on a CLAIM, Defendants would, among other things, have to pull the administrative record for each of the 15,210

individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Moreover, the request is overbroad, unduly burdensome, not reasonably particular, and not proportional to the needs of the case as it essentially requests all documents related to the parties' claims and defenses. It would be essentially impossible for Defendants to perform the investigation necessary to identify all documents and communications that in someway relate to the reimbursement issued to Fremont on all of the 15,210 CLAIMS.

Defendants request that Fremont meet and confer to narrow the scope of this request and provide some semblance of reasonable particularity with respect to the type of documents they are seeking so as to reduce the burden imposed on Defendants.

Responding further, subject to and without waiving Defendants' objections: please see all contracts and evidence of contracts that Defendants believe were in place during the relevant period, including documents produced concurrently herewith as DEF011280–DEF011382, and DEF011411–DEF011479.

Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.

REQUEST FOR PRODUCTION NO. 22:

Produce any and all Documents and/or Communications relating to any analysis of the usual and customary provider charges for similar services in Nevada for Emergency Medicine Services.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is vague in regard to what type of "analysis" it is referring to and vague in regard to what "similar services" it is referring to. Defendants are thus

unable to determine whether they have documents that are responsive to this Request. Defendants further object that this Request appears to be overbroad, unduly burdensome and seeks information that is not relevant to Plaintiff's claims and not proportional to the needs of the case.

Defendants request that Plaintiff meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants and that Plaintiff is able to get the information it is seeking.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF011274–DEF011279.

Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.

REQUEST FOR PRODUCTION NO. 23:

Produce any and all Documents and/or Communications relating to any analysis of any Nevada statutes or guidelines You currently use, or used during calendar or Plan years 2016, 2017, 2018 and/or 2019, to determine and/or calculate Your reimbursement of Non-Participating Providers in Nevada for Emergency Medicine Services.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant to Plaintiff's claims and not proportional to the needs of the case. This improper Request seeks documents and communications relating to reimbursement calculations for all non-participating providers in Nevada rather than just Fremont. Defendants further object that this Request is vague in referring to "any Nevada statutes or guidelines" rather than to specific statutes. This vagueness, in turn, makes it unduly burdensome for Defendants to find responsive documents. Further, this Request appears to potentially call for information that is subject to the attorney-client and/or work product privileges as it is seeking analysis of Nevada statutes and guidelines. Defendants further object to the extend this Request seeks information

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from prior to July 1, 2017, the date of the earliest claim submitted by Fremont, as such information is not relevant to Plaintiff's claims.

To the extent that Fremont intended this Request to refer to NRS 679B.152, Defendants incorporate by reference their responses to requests for production nos. 1 and 2.

Defendants request that Plaintiff meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants and that Plaintiff is able to get the information it is seeking.

By way of further response, to date, United has not identified any non-privileged documents responsive to this request. Responding further, United states that, for fully-insured plans, United typically must file its plan language with the Nevada Division of Insurance and receive approval for its out-of-network reimbursement methodologies. United is undertaking efforts to locate documents reflective of these filings.

REQUEST FOR PRODUCTION NO. 24:

Produce any and all Documents and/or Communications relating to any analysis of Nevada statutes with regard to the payment of the CLAIMS.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows: Defendants object that the term "CLAIM" is vague, as noted in Defendants' objections to Plaintiff's Definitions, as the definition does not identify what specific list of claims it is referring to. However, Defendants interpret this Request as referring to the claims listed in FESM000011. Assuming those are the claims Plaintiff intended to refer to, Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Plaintiff has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents and communications relating to any legal analysis that impacted the amount paid on those CLAIMS (assuming such documents even exist), Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for

privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Defendants further object that this Request is vague in referring to "Nevada statutes" rather than to specific statutes. This vagueness, in turn, makes the Request unduly burdensome for Defendants to find responsive documents. Further, this Request appears to potentially call for information that is subject to the attorney-client and/or work product privileges as it is seeking analysis of Nevada statutes.

Defendants request that Plaintiff meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants and that Plaintiff is able to get the information it is seeking.

By way of further response, to date, United has not identified any non-privileged documents responsive to this request. Responding further, United states that, for fully-insured plans, United typically must file its plan language with the Nevada Division of Insurance and receive approval for its out-of-network reimbursement methodologies. United is undertaking efforts to locate documents reflective of these filings.

REQUEST FOR PRODUCTION NO. 25:

Produce all agreements between You and any Participating Providers in Nevada relating to the provision of Emergency Medicine Services to Plan Members.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request seeks information that is not relevant to Plaintiff's claims and not proportional to the needs of the case. Fremont is a non-participating provider and thus Defendants' contracts with participating providers are not relevant. Defendants further object that this Request is not limited to any specific time period.

Defendants also object that this Request improperly asks that they reveal information

about their agreements with other providers. Defendants' agreements with other providers typically contain confidentiality clauses such that producing these agreements could force Defendants to breach their obligations to these third parties. Moreover, the information sought is proprietary and subject to protection as a trade secret pursuant to NRS 600A.030(5) as this information has independent value due to, among other things, the fact that it is not known to other providers like Fremont.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF011280–DEF011382, and DEF011411–DEF011446. Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.

REQUEST FOR PRODUCTION NO. 26:

Produce any and all Documents and/or Communications regarding the provider charges and/or reimbursement rates that other insurers and/or payors have paid for Emergency Medicine Services in Nevada to either or both participating or non-participating providers from January 1, 2016, to the present, including Documents and/or Communications containing any such data or information produced in a blinded or redacted form and/or aggregated or summarized form.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request seeks information that is not within its possession, custody or control. To the extent Plaintiff believes this information would be within Defendants' possession, custody or control, Defendants request that Plaintiff clarify its Request. Defendants further object that this Request is overbroad and unduly burdensome as it appears to seek documents on all emergency medical services claims that have ever been paid by any insurer or payor in Nevada during the specified time frame. Thus, the Request likely covers hundreds of thousands of claims for payment and seeks information that is not proportional to the needs of this litigation. Defendants further object that this Request is overbroad and seeks

irrelevant information as it seeks information starting on July 1, 2016 but the earliest claim Plaintiff has asserted is dated July 1, 2017. Defendants further state that to the extent Defendants do have any responsive documents these document would likely be publicly available to Fremont as well.

By way of further response, subject to and without waiving Defendants' objections, United does not receive rate information from other insurers and/or payors. However, United refers Plaintiffs to DEF011072, produced concurrently herewith.

REQUEST FOR PRODUCTION NO. 27:

Produce any and All Documents and/or Communications concerning, evidencing, or relating to any negotiations or discussions concerning non-participating provider reimbursement rates between the UH Parties and Fremont, including negotiations or discussions leading up to any participation agreements or contracts with Fremont in effect prior to July 1, 2017.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object to this Request to the extent that it seeks documents and communications from prior to July 1, 2017 as this portion of the Request seeks information that is not relevant to Fremont's claims and that is not proportional to the needs of the case. Defendants will not be providing documents that are responsive to this portion of the Request.

Moreover, all documents and communications exchanged between Defendants and Fremont would necessarily be possessed by Fremont. There is no justification for imposing the burden on Defendants to identify, collect, review, and produce such documents when Fremont already possesses the same.

Defendants have been unable to locate documents relating to rate negotiations between Fremont Emergency Services (MANDAVIA) Ltd. and the other Defendants but will supplement this response and produce same if any such documents are located.

Responding further, subject to and without waiving Defendants' objections: please

see documents produced concurrently herewith as DEF011447–DEF011479. Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.

REQUEST FOR PRODUCTION NO. 28:

Produce any and All Documents and/or Communications concerning, evidencing, or relating to any negotiations or discussions concerning non-participating provider reimbursement rates between the Sierra Affiliates and Fremont, including negotiations or discussions leading up to any participation agreements or contracts with Fremont in effect prior to March 1, 2019.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object to this Request to the extent that it seeks documents and communications from prior to March 1, 2019 as this portion of the Request seeks information that is not relevant to Plaintiff's claims and that is not proportional to the needs of the case. Defendants will not be providing documents that are responsive to this portion of the Request.

Moreover, all documents and communications exchanged between Defendants and Fremont would necessarily be possessed by Fremont. There is no justification for imposing the burden on Defendants to identify, collect, review, and produce such documents when Fremont already possesses the same.

Defendants further respond by referring Plaintiff to the following bates numbered documents produced with these responses: DEF000114 – DEF000156.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF011276–DEF011279, DEF011295–DEF11410. Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.

REQUEST FOR PRODUCTION NO. 31:

Produce any and all documents and/or Communications regarding Your goals, thoughts,

discussions, considerations, and/or strategy regarding reimbursement rates and/or fee schedules for participating Emergency Medicine Groups and/or any hospitals or other providers of Emergency Department Services from January 1, 2015, through the present.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant to Plaintiff's claims and not proportional to the needs of the case. This Request seeks a substantial amount of information regarding Defendants' negotiations, strategy, relationship, and rates of reimbursement to numerous non-parties which has no relevance to Plaintiff's claims. Defendants further object that this Request seeks irrelevant information to the extent this Request seeks information from prior to July 1, 2017 as Plaintiff is not asserting any claims for services prior to that date. Defendants further object that, as written, this Request is vague and it is unclear exactly what documents would be responsive to this Request. Defendants further object that, since this Request refers to Defendants' "goals." "thoughts," and "strategy," it may be seeking information that is protected by the attorney-client and/or attorney work product privileges.

Defendants also object that this Request improperly asks that they reveal information about their agreements with other providers. Defendants' agreements with other providers typically contain confidentiality clauses such that producing these agreements could force Defendants to breach their obligations to these third parties. Moreover, the information sought is proprietary and subject to protection as a trade secret pursuant to NRS 600A.030(5) as this information has independent value due to, among other things, the fact that it is not known to other providers like Fremont.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF010455-DEF010554.

Responding further, subject to and without waiving Defendants' objections: please

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see documents produced concurrently herewith as DEF10559–DEF011089. Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.

REQUEST FOR PRODUCTION NO. 32:

Produce any and all Documents and/or Communications regarding Your goals, thoughts, discussions, considerations, and/or strategy regarding reimbursement rates and/or fee schedules for non-participating Emergency Medicine Groups and/or any hospitals or other providers of Emergency Department Services from January 1, 2016, through the present.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant to Plaintiff's claims and not proportional to the needs of the case. This Request seeks a substantial amount of information regarding Defendants' negotiations, strategy, relationship, and rates of reimbursement to numerous non-parties which has no relevance to Plaintiff's claims. Defendants further object that this Request seeks irrelevant information to the extent this Request seeks information from prior to July 1, 2017 as Fremont is not asserting any claims for services prior to that date. Defendants further object that, as written, this Request is vague and it is unclear exactly what documents would be responsive to this Request. Defendants further object that, since this Request refers to Defendants' "goals." "thoughts," and "strategy," it may be seeking information that is protected by the attorney-client and/or attorney work product privileges.

Defendants also object that this Request improperly asks that they reveal information about their agreements with other providers. Defendants' agreements with other providers typically contain confidentiality clauses such that producing these agreements could force Defendants to breach their obligations to these third parties. Moreover, the information sought is proprietary and subject to protection as a trade secret pursuant to NRS 600A.030(5) as this

information has independent value due to, among other things, the fact that it is not known to other providers like Fremont.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF010455-DEF010554.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF10559–DEF011089. Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.

REQUEST FOR PRODUCTION NO. 33:

Produce any and all Documents and/or Communications regarding Your reimbursement rates paid or to be paid to out-of-network Emergency Medicine Groups and/or Complaints about Your level of payment for Emergency Medicine Services and/or Emergency Department Services received from out-of-network providers.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant to Plaintiff's claims and not proportional to the needs of the case. This Request seeks a substantial amount of information regarding Defendants' rates of reimbursement to numerous non-parties which has no relevance to Plaintiff's claims. Defendants further object that this Request is overbroad since it is not limited to any specific time period. The term "Complaints" is also vague and overbroad, as noted in Defendants' objections to Plaintiff's Definitions. Indeed, as written, this Request appears to call for Defendants to produce any communication from any out of network provider to Defendants where the provider complains in any way about payment, regardless of when that communication was sent. There are likely hundreds of thousands if not millions of documents that could be responsive to this Request.

Defendants also object that this Request improperly asks that they reveal information about their agreements with other providers. Defendants' agreements with other providers typically contain confidentiality clauses such that producing these agreements could force Defendants to breach their obligations to these third parties. Moreover, the information sought is proprietary and subject to protection as a trade secret pursuant to NRS 600A.030(5) as this information has independent value due to, among other things, the fact that it is not known to other providers like Fremont.

Responding further, subject to and without waiving Defendants' objections: please see document produced concurrently herewith as DEF010558.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF011211, and DEF011274–DEF011275. Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.

REQUEST FOR PRODUCTION NO. 34:

Produce any and all Documents and/or Communications regarding the impact, if any, that reimbursement rates paid by You to non-participating providers have had on profits You earned and/or premiums You charged with respect to one or more of Your commercial heath plans offered in the State of Nevada from 2016 to the present.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant to Plaintiff's claims and not proportional to the needs of the case. This Request is overbroad in that it is not limited to the impact of reimbursement rates paid to Fremont on Defendants profits but rather includes numerous non-party non-participating providers. This Request also seeks irrelevant information as the impact of reimbursement rates to numerous non-parties (or to Plaintiff for that matter) on Defendants' profits has no bearing on

whether or not Fremont was reimbursed at the appropriate rate for the services it provided to Defendants' plan members. This Request is also overbroad and seeks irrelevant information to the extent it seeks information from prior to July 1, 2017, which is the date of the earliest claim asserted by Plaintiff in this litigation.

In addition, this Request is objectionable as it infringes on Defendants' privacy interests and seeks proprietary and confidential business information that the Defendants are entitled to shield from disclosure. *Ranney-Brown Distributors, Inc. v. E. T. Barwick Indus., Inc*., 75 F.R.D. 3, 5 (S.D. Ohio 1977) ("Ordinarily, Rule 26 will not permit the discovery of facts concerning a defendant's financial status, or ability to satisfy a judgment, since such matters are not relevant, and cannot lead to the discovery of admissible evidence."); *U.S. for the Use and Benefit of P.W. Berry Co. v. Gen. Elec. Co*., 158 F.R.D. 161, 164 (D.Or.1994) (granting motion for protective order in a breach of contract action, precluding discovery of corporate and individual financial information including tax returns and financial statements, because that information was not relevant within the meaning of Rule 26(b)(1)) when the core of the parties' dispute was over whether or not the plaintiff had been adequately compensated for the work it performed).

Moreover, this information is subject to protection as a trade secret pursuant to NRS 600A.030(5) as this information has independent value due to, among other things, the fact that it is not known to other providers like Fremont.

Responding further, to date, United has not located documents responsive to this request. United's efforts to identify such documents, if any exist, are continuing.

REQUEST FOR PRODUCTION NO. 35:

Produce any and all Documents and/or Communications regarding Your reimbursement policies for non-participating providers considered or adopted, effective January 1, 2016, to the present.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is overbroad and seeks information that is not relevant and not proportional to the needs of the case. This Request is overbroad in that it seeks reimbursement policies for all non-participating providers rather than just those that would apply to Plaintiff. It is also overbroad in that it seeks documents from prior to July 1, 2017, which is the date of the earliest claim asserted by Plaintiff.

Defendants also object that the term "reimbursement policies" is unreasonably vague and could arguably apply to numerous irrelevant documents. In general, the amounts paid to non-participating providers are based on the terms of the applicable health benefits plan documents. It is unclear if these are the documents Fremont is seeking or if Fremont is seeking something else. Defendants request that Plaintiff meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants and that Plaintiff is able to get the information it is seeking.

Responding further, subject to and without waiving Defendants' objections: please see documents previously produced as DEF001536–DEF010454, and documents forthcoming, beginning at DEF011481. Defendants have made diligent efforts to respond to the Requests, but reserve the right to supplement their responses and objections.

REQUEST FOR PRODUCTION NO. 36:

Produce any and all Documents and/or Communications regarding or reflecting the average or typical rate of payment, or an aggregation, summary or synopsis of those payments, that You allowed from January 1, 2016, to the present for all or any portion of the Emergency Medicine Services and/or Emergency Department Services rendered to Your Plan Members covered under any plan You offer in Nevada.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant to Plaintiff's claims and not proportional to the needs of the case.

This Request seeks a substantial amount of information regarding Defendants' rates of payment to numerous non-parties which has no relevance to Plaintiff's claims. Defendants further object that this Request is overbroad since it seeks documents from prior to July 1, 2017, which is the date of the earliest claim asserted by Plaintiff. Indeed, as written, this Request calls for the production of documents and communications relating to "any plan" the Defendants have offered in Nevada in the last four years, regardless of whether Fremont ever treated any of those plan members. There are likely hundreds of thousands if not millions of documents that could be responsive to this Request.

Defendants also object that this Request improperly asks that they reveal information about their payments to other providers. Defendants' agreements with other providers typically contain confidentiality clauses such that producing this information could force Defendants to breach their obligations to these third parties. Moreover, the information sought is proprietary and subject to protection as a trade secret pursuant to NRS 600A.030(5) as this information has independent value due to, among other things, the fact that it is not known to other providers like Fremont.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF011274–DEF011275.

Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.

REQUEST FOR PRODUCTION NO. 38:

Produce any and all Documents and/or Communications concerning Your adjudication and/or payment of each claim for Emergency Medicine Services and/or Emergency Department Services that either participating or non-participating Emergency Medical Groups and/or any hospitals or other providers of Emergency Department Services other than Fremont submitted to You for payment between January 1, 2016, and the present.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as

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follows:

Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant to Plaintiff's claims and not proportional to the needs of the case. This Request seeks a substantial amount of information regarding Defendants' payments on non-party claims which have no relevance to Plaintiff's claims. Defendants further object that this Request is overbroad since it seeks documents from prior to July 1, 2017, which is the date of the earliest claim asserted by Plaintiff. There are likely hundreds of thousands of documents that could be responsive to this Request.

Defendants also object that this Request improperly asks that they reveal information about their payments to other providers. Defendants' agreements with other providers typically contain confidentiality clauses such that producing this information could force Defendants to breach their obligations to these third parties. Moreover, the information sought is proprietary and subject to protection as a trade secret pursuant to NRS 600A.030(5) as this information has independent value due to, among other things, the fact that it is not known to other providers like Fremont.

Responding further, subject to and without waiving Defendants' objections: please see document produced concurrently herewith as DEF010558.

Responding further, subject to and without waiving Defendants' objections: please see documents produced concurrently herewith as DEF011274–DEF011275.

Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.

REQUEST FOR PRODUCTION NO. 41:

Produce any and all Documents and/or Communications regarding any challenges by any other non-participating Emergency Medicine Group and/or any non-participating hospital or other non-participating provider of Emergency Department Services of the appropriateness of the reimbursement rates paid by You for Emergency Medicine Services and/or Emergency Department Services rendered to Your Plan Members from January 1, 2016, to the present.

/ / /

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that this Request is overbroad, unduly burdensome and seeks information that is not relevant to Plaintiff's claims and not proportional to the needs of the case. This Request seeks "all documents and/or communications" relating to challenges by non-parties to Defendants' rates of reimbursement. Such information has no relevance to Plaintiff's claims. Defendants further object that this Request is overbroad since it seeks information from prior to July 1, 2017, the date of the earliest claim asserted by Plaintiff. The term "challenges" is also vague and overbroad in that it is unclear what type of challenges are intended to be encompassed by it (i.e. legal complaint, administrative appeals, other types of "challenges," etc.). Indeed, as written, this Request could be read to call for Defendants to produce any communication from any out of network provider to Defendants where the provider complains in any way about payment.

Responding further, subject to and without waiving Defendants' objections: please see document produced concurrently herewith as DEF011211.

Defendants have made diligent efforts to respond to this Request, but reserve the right to supplement their response and objections.

REQUEST FOR PRODUCTION NO. 42:

Produce any and all Documents and/or Communications regarding, discussing, or referring to any failure by You to attempt to effectuate a prompt, fair, and/or equitable settlement of any CLAIMS.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as follows:

Defendants object that the phrase "attempt to effectuate a prompt, fair, and/or equitable

settlement of any CLAIMS" is vague as it is unclear exactly what type of failure by Defendants would make a document and/or communication responsive.

Defendants further object that the term "CLAIM" is vague, as noted in Defendants' objections to Plaintiff's Definitions, as the definition does not identify what specific list of claims it is referring to. However, Defendants interpret this Request as referring to the claims listed in FESM000011. Assuming those are the claims Plaintiff intended to refer to, Defendants object to this Request on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Plaintiff has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full amount billed. To produce the documents and communications relating to any legal analysis that impacted the amount paid on those CLAIMS (assuming such documents even exist), Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

Defendants request that Plaintiff meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants and that Plaintiff is able to get the information it is seeking.

Responding further, United does not agree that it has failed to effectuate a prompt, fair, and/or equitable settlement of the at-issue claims, and thus has no documents responsive to this Request.

REQUEST FOR PRODUCTION NO. 43:

Produce any and all Documents and/or Communications suggesting that Medicare reimbursement rate for any Emergency Medicine Services is not a measure of either fair market value or the usual and customary rate for such services.

RESPONSE:

Subject to and without waiving Defendants' objections, including Defendants' specific objections to Plaintiff's Definitions, Instructions and Rules of Construction, Defendants state as

follows:

Defendants object that this Request is vague, overbroad, and, by extension, unduly burdensome. Defendants are uncertain what is meant by the phrase "suggesting that Medicare reimbursement rate . . . is not a measure of either fair market value or the usual and customary rate for such services" and request that Plaintiff clarify exactly what type of documents and communications it is seeking.

This Request is overbroad and unduly burdensome in that it is not limited to communications from any particular person or entity and is not limited in time frame. As written, the Request would require the Defendants to essentially search all their records and databases all over the country for any comments relating to "Medicare," "fair market value" and "usual and customary."

Defendants request that Plaintiff meet and confer to narrow the scope of this Request to ensure that it is not unduly burdensome to Defendants and that Plaintiff is able to get the information it is seeking.

By way of further response, United does not agree with Plaintiffs' argumentative statement that "Medicare reimbursement rate for any Emergency Medicine Services is not a measure of either fair market value of the usual and customary rate for services." Furthermore, to date United has found no documents establishing that United holds that view that "Medicare reimbursement rate for any Emergency Medicine Services is not a measure of either fair market value of the usual and customary rate for services."

Dated this 30th day of October, 2020.

/s/ Brittany M. Llewellyn,
D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Brittany M. Llewellyn, Esq.
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
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Telephone: (702) 938-3838
Facsimile: (702) 938-3864
Attorneys for Defendants

CERTIFICATE OF SERVICE

I hereby certify that on the 30th day of October, 2020, a true and correct copy of the foregoing **DEFENDANTS' NINTH SUPPLEMENTAL RESPONSES TO FREMONT EMERGENCY SERVICES (MANDAVIA) LTD.'S FIRST SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS** was electronically served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

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Attorneys for Plaintiffs

/s/ Audra R. Bonney
An employee of WEINBERG, WHEELER, HUDGINS GUNN & DIAL, LLC

From:	Kevin Leyendecker
To:	Balkenbush, Colby; lblalack@omm.com; TMH010; Pat Lundvall; Kristen T. Gallagher; Amanda Perach
Cc:	Blalack II, K. Lee; Gordon, Jeffrey E.; Pat Lundvall; Portnoi, Dimitri D.; Levine, Adam; Roberts, Lee; Llewellyn, Brittany M.
Subject:	2d Amended Expert Designation
Date:	Saturday, September 4, 2021 12:55:53 PM
Attachments:	Ps 2d Amended Expert Disclosures.docx

Please see enclosed, which I expect to be served through the court's system on Tuesday.

Lee/Colby, I'm not sure I've got all United counsel copied here, so I would appreciate y'all forwarding to anyone I've missed.

Thanks

Kevin

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OST

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Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
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Emily L. Pincow (admitted *pro hac vice*)
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asingrossi@lashgoldberg.com

Joseph Y. Ahmad (*pro hac vice* forthcoming)
John Zavitsanos (*pro hac vice* forthcoming)
P. Kevin Leyendecker (*pro hac vice forthcoming*)
Jane L. Robinson (*pro hac vice forthcoming*)
Jason S. McManis (*pro hac vice* forthcoming)
Michael Killingsworth (*pro hac vice* forthcoming)
Louis Liao (pro hac vice *forthcoming*)
Joshua H. Harris *(pro hac vice forthcoming*)
Ahmad, Zavitsanos, Anaipakos, Alavi & Mensing, P.C
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Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITEDHEALTH GROUP, INC., a Delaware	Case No.: A-19-792978-B Dept. No.: XXVII

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corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

Plaintiffs Fremont Emergency Services (Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest") (collectively, "Plaintiffs" or "Health Care Providers"), hereby submit their second amended expert witness disclosure pursuant to and in accordance with Rule 16.1(a)(2) of the Nevada Rules of Civil Procedure (as amended).

1. **Scott Phillips**
   c/o Counsel for Plaintiffs

Mr. Phillips is the founding shareholder of the healthcare consulting and management firm Healthcare Management Partners, LLC. He has been retained by Plaintiffs to provide expert testimony in this action. A copy of his reports have previously been produced. He is expected to offer opinions as set forth in those reports as well as opinions related to the original and/or rebuttal reports produced by the other retained experts designated by the parties (Bruce Deal, Alex Mizenko and David Leathers).

2. **David Leathers**
   c/o Counsel for Plaintiffs

Mr. Leathers is a Managing Director at Alvarez and Marsal, a global professional services firm specializing in turnaround and interim management, performance improvement, and business advisory services. He has been retained by Plaintiffs to provide expert testimony in this action. A copy of his report has previously been produced. He is expected to offer opinions as set forth in that report as well as opinions related to the original and/or rebuttal reports produced by

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the other retained experts designated by the parties (Bruce Deal, Alex Mizenko and Scott Phillips).

3. Dr. Joseph Crane
c/o Counsel for Plaintiffs

Dr. Crane is the Chief Medical Officer of TeamHealth and a practicing emergency medicine physician. He has over twenty years of clinical experience in emergency rooms across different states. He has also overseen the operations of several emergency departments by working in administrative positions throughout his career. Dr. Crane has formal education in both medicine and business. He graduated from the Executive Physician MBA program at the University of Tennessee, where he has taught healthcare operations as an adjunct professor since 2005. His curriculum vitae was previously produced.

Dr. Crane is expected to offer opinions as reflected and discussed in his September 3, 2021 deposition. At this time, no fee has been set for Dr. Frantz to provide testimony at trial or during a deposition in this case

4. Dr. Robert Frantz
c/o Counsel for Plaintiffs

Dr. Frantz is a Board Certified Emergency Physician and Group President of TeamHealth West Group. His curriculum vitae was previously produced. Dr. Frantz has first-hand knowledge of emergency medicine departments and has expertise related thereto as discussed in his deposition. He may offer fact testimony, lay opinion testimony and/or expert opinion testimony at trial on those same matters. Any such testimony will rely on his training, experience, and personal observations from working in affiliation with the Health Care Providers and other emergency medicine physicians. At this time, no fee has been set for Dr. Frantz to provide testimony at trial or during a deposition in this case.

Plaintiffs reserve their rights to disclose additional individuals, that should be permitted to provide testimony in accord with NRS 50.275, 50.285 and 50.305, if appropriate based on the expert disclosures made by Defendants.

Dated this 4th day of September, 2021.

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By: */s/* _____
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CERTIFICATE OF SERVICE

I certify that I am an employee of McDonald Carano LLP, and that on this 24th day of August, 2021, I caused a true and correct copy of the foregoing to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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Attorneys for Defendants

Judge David Wall, Special Master
Attention: Mara Satterthwaite & Michelle Samaniego
JAMS
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/s/ Beau Nelson
An employee of McDonald Carano LLP

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From: Kevin Leyendecker
To: Balkenbush, Colby
Cc: Louis Liao; Jason McManis
Subject: Disputed Claims
Date: Thursday, September 9, 2021 12:33:06 PM
Attachments: 08_24_Disputed_Claims.xlsx

Colby,

Although I don't have Phillips workpapers yet, I am sending you the updated claim file we sent him and Leathers.

We took about 500 more claims so new total is 12,081. With this, I don't anticipate the target will move anymore.

Let me know if you have any questions. Also, I don't think it's reasonable to expect Deal to update his analysis bf the depo since he will be seeing this for first time today, but that's your/his call.

Kevin

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EXHIBIT 3

From:	Kevin Leyendecker
To:	Balkenbush, Colby; Blalack II, K. Lee
Cc:	Pat Lundvall; Kristen T. Gallagher; Amanda Perach; Jason McManis; Angela Keniston
Subject:	SUPPLEMENTAL REPORT
Date:	Thursday, September 9, 2021 2:44:11 PM
Attachments:	Supplemental Expert Report of David Leathers 9.8.2021.pdf Workpapers.zip

Colby and Lee,

Enclosed you will find a supplemental report from David Leathers, along with his workpapers.

I've asked Pat's office to do the formal service through the court's portal, but I wanted to send you a courtesy copy since I just received it.

Kevin

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From: Evans, Craig <cwevans@alvarezandmarsal.com>
Sent: Thursday, September 9, 2021 2:39 PM
To: Leathers, David <dleathers@alvarezandmarsal.com>; Pat Lundvall <plundvall@mcdonaldcarano.com>; Kevin Leyendecker <kleyendecker@AZALAW.COM>
Subject: SUPPLEMENTAL REPORT

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Kevin,

Please find attached David's supplemental report. Also attached are our workpapers including SQL scripts.

Regards,

Craig W. Evans
Senior Director
Alvarez & Marsal Disputes and Investigations, LLC
2100 Ross Avenue, 21st Floor
Dallas, TX 75201
Direct: +1 214.438.1093
Mobile: +1 214.235.3965
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From:	Balkenbush, Colby
To:	Louis Liao
Cc:	Kevin Leyendecker; Jason McManis; plundvall@mcdonaldcarano.com; kgallagher@mcdonaldcarano.com; Amanda Perach
Subject:	RE: Disputed Claims
Date:	Friday, September 10, 2021 6:17:09 PM
Attachments:	image002.png REVISEE-sig2020_5801a862-4942-4e3a-94ab-425c0ea8e329.png

Thank you. Please see the below link to access Deal's and Mizenko's rebuttal work files.

https://wwhgd.sharefile.com/d-s410f5b4a67f948519d290e2c76ea655b

From: Louis Liao [mailto:lliao@AZALAW.COM]
Sent: Friday, September 10, 2021 3:41 PM
To: Balkenbush, Colby
Cc: Kevin Leyendecker; Jason McManis
Subject: RE: Disputed Claims

This Message originated outside your organization.

Colby,

Please see Sharefile link below for Phillips' workpapers.

https://azalaw.sharefile.com/share/getinfo/s354cff4d8a6c4028be1bcf48009b2d4e

Best regards,
Louis

AHMAD ZAVITSANOS ANAIPAKOS ALAVI MENSING
AZA

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From: Balkenbush, Colby <CBalkenbush@wwhgd.com>
Sent: Thursday, September 9, 2021 1:12 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Cc: Louis Liao <lliao@AZALAW.COM>; Jason McManis <jmcmanis@AZALAW.COM>
Subject: RE: Disputed Claims

Received. Thank you Kevin.

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WEINBERG WHEELER HUDGINS GUNN & DIAL
TRIAL LAWYERS

LITIGATION DEPARTMENT OF THE YEAR ALM'S DAILY REPORT
2020 - 2019 - 2018 - 2017 - 2016 - 2014

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From: Kevin Leyendecker [mailto:kleyendecker@AZALAW.COM]
Sent: Thursday, September 9, 2021 10:33 AM
To: Balkenbush, Colby
Cc: Louis Liao; Jason McManis
Subject: Disputed Claims

This Message originated outside your organization.

Colby,

Although I don't have Phillips workpapers yet, I am sending you the updated claim file we sent him and Leathers.

We took about 500 more claims so new total is 12,081. With this, I don't anticipate the target will move anymore.

Let me know if you have any questions. Also, I don't think it's reasonable to expect Deal to update his analysis bf the depo since he will be seeing this for first time today, but that's your/his call.

Kevin

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The information contained in this message may contain privileged client confidential information. If you have received this message in error, please delete it and any copies immediately.

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DISTRICT COURT
CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	CASE NO.: A-19-792978-B DEPT. NO.: 27 ORAL AND VIDEOTAPED DEPOSITION OF BRUCE DEAL MONDAY, SEPTEMBER 13, 2021 AT 11:06 A.M. CST WITNESS LOCATED AT 1010 EL CAMINO REAL MENLO PARK, CALIFORNIA REPORTED REMOTELY DUE TO THE COVID-19 STATE OF DISASTER

REPORTED BY: MICHELLE R. FERREYRA, CCR No. 876

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From: Kevin Leyendecker
To: Blalack II, K. Lee; Balkenbush, Colby; Jason McManis
Subject: Additional materials to experts
Date: Monday, September 13, 2021 8:03:33 PM

Lee and Colby

Please be advised that after the depo today I sent Mr Phillips and Mr Leathers the exhibits I marked in the depo of Mr Deal

If you didn't download them from the chat, let me know and I'll forward them.

Kevin

Get Outlook for iOS

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From:	Kevin Leyendecker
To:	Blalack II, K. Lee; Balkenbush, Colby
Subject:	FW: Additional work product
Date:	Tuesday, September 14, 2021 3:29:21 PM
Attachments:	Claims at Issue - Allowed Amt Comparisons - with FAIR Health.xlsx DML Claims at Issue - Allowed Amt Comparisons.xlsx

Lee and Colby,

Enclosed is an additional workpaper I just received from Mr. Leathers.

From: Leathers, David <dleathers@alvarezandmarsal.com>
Sent: Tuesday, September 14, 2021 3:28 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Cc: Leathers, David <dleathers@alvarezandmarsal.com>; Evans, Craig <cwevans@alvarezandmarsal.com>
Subject: Additional work product

Kevin,

Attached additional work product.

DL

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Managing Director
Alvarez & Marsal
700 Louisiana Street, Suite 3300
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(M) 713-505-5022

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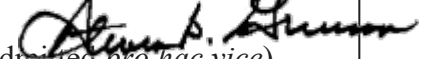
Electronically Filed
5/5/2022 11:47 AM
Steven D. Grierson
CLERK OF THE COURT



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Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

Defendants.

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

PLAINTIFFS' OPPOSITION TO DEFENDANTS' RENEWED MOTION FOR JUDGMENT AS A MATTER OF LAW

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Fremont Emergency Services (Mandavia), Ltd.; Team Physicians of Nevada-Mandavia, P.C.; Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine (collectively the "Health Care Providers") submit this response in opposition to Defendants' renewed motion for judgment as a matter of law. This opposition is based upon the record in this matter, the points and authorities that follow, the pleadings and papers on file in this action, and any argument of counsel entertained by the Court.

Points and Authorities

United's motion mischaracterizes the Health Care Providers' positions and overlooks the standard of review. The jury has already found in favor of the Health Care Providers on every claim, and its findings are supported by the evidence. This Court should overrule United's motion to undo the jury's verdict.

I. Background

The evidence at trial proved that United artificially slashed its rates of payment and developed a scheme to reap profits at the expense of Plaintiffs, as well as other healthcare providers. For many years, before this scheme began to unfold, United recognized an obligation to pay reasonable rates to physicians who did not participate in United's network of healthcare providers. PX014 at 3; PX025 at 2; PX363 at 3. United knew the industry standard, as shown in internal documents, of calculating "reasonable and customary" rates using a database maintained by the independent nonprofit FAIR Health Inc. PX014 at 3; PX025 at 2; PX363 at 3. Using this "traditional" reimbursement approach, United paid a healthcare provider's billed charge if it did not exceed the 80th percentile of charges in the FAIR Health database. PX025 at 2 *and* PX014 at 3; 11/10/21 Trial Tr. at 99:6–9.

In 2016, most of United's clients used this FAIR Health benchmark to determine reimbursements for out-of-network services. PX025 at 2; *see also* 11/3/21 Tr. at 36:23–37:14; 11/2/21 Tr. at 142:14–21, 148:10–20; 11/10/21 Tr. at 99:6–9; 11/12/21 Tr. at 212:16–21. United enjoyed industry-leading margins during this time. PX066 at 2. It knew that lower reimbursements would not only affect healthcare providers, but also increase financial burdens on patients who received a balance bill. PX477 at 3 (more protection for United's members

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when reimbursement is based on "R&C"—i.e., reasonable and customary rates).

United nevertheless began a campaign to abolish the industry-standard approach and "get clients off R&C/Fair Health." PX368 at 7; 11/3/21 Tr. at 50:21–51:1. It sought to use alternatives that allowed United to charge clients for additional "shared savings" fees that were unavailable if clients used FAIR Health. 11/3/21 Tr. at 49:5–9, 50:21–51:1; 11/15/21 Tr. at 190:8–12. The revenue United generated from shared savings fees for a given claim was calculated as up to 50% of the difference between a provider's billed charge and the amount United paid. PX010 at 60; PX256; 11/12/21 Tr. at 201:14–17. In other words, the less United paid to healthcare providers, the more shared savings revenue United received from the client. *Id.*; *see also* 11/8/21 Tr. at 149:17–150:24; 11/15/21 Tr. at 190:8–12.

To create an impression that lower rates were reasonable, United enlisted MultiPlan's Data iSight service to calculate out-of-network reimbursement using a purported "legally sound process" rather than United's "random calculated amounts." PX043. Data iSight was marketed as an objective and geographically adjusted determination of fair reimbursement rates. PX506 at 3. But internal documents revealed that Data iSight simply used the rate **United** secretly dictated to MultiPlan. PX34 at 10. PX293 at 1; 11/10/21 Tr. at 82:21–25. When United first deployed Data iSight in 2016, the rate of payment United chose was 350% of the Medicare rate for emergency services. 11/10/21 Tr. at 80:3–5; 11/15/21 Tr. at 16:6–17:6. United told MultiPlan to reduce this rate even further to 250% by 2019. 11/10/21 Tr. at 80:3–5; PX288 at 176.

United grew rich from this scheme at the expense of its own members and healthcare providers in Nevada. In one business plan, United depicted its "migration to high reduction programs" that offered less member protection between 2017 and 2019. PX477 at 3. Shared savings revenues generated through Data iSight using the Outlier Cost Management (OCM) program did not exist in 2017 but soared to $1.3 billion a year. *Id.*; *see also* 11/2/21 Tr. at 158:19–23. These are stark results for the work United performed to earn these revenues. 11/8/21 Tr. at 151:4–9. United's 2019 financial results for the West Region describe Nevada as one of two "outperforming markets" and show that per-member-per-month margins also

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skyrocketed at unprecedented levels. PX462 at 33; PX426 at 12.

Meanwhile, during the same period, United's payments to Plaintiffs were in freefall and declined each year. 11/17/21 Tr. at 36:23–7. For the claims disputed at trial, United paid an average of $246 a claim and discounted the Plaintiffs' total billed charges by $10,399,341. PX473G; 11/17/21 Tr. at 39:8–16. As a result, United unilaterally paid only **20%** of Plaintiffs' billed charges, even though these charges closely tracked the 80th percentile of FAIR Health benchmark. *Id.*; 11/16/21 Tr. at 84:8–14; 11/17/21 Tr. at 114:4–9. Evidence at trial also showed that the calculation of rates for individual claims was devoid of rhyme or reason, reflecting United's admission that it used "random calculated amounts." *See, e.g.*, 11/16/21 Tr. 214:24–216:1; 246:20–247:1; PX043.

United tried to justify its underpayments by citing an illusory concern: egregious billing practices and rising costs for out-of-network services. PX012. But Plaintiffs' billed charges increased minimally from year to year. 11/17/21 Tr. at 49:11–50:1. In fact, United was aware internally that the average billed charges for out-of-network services continued to reduce every year from 2016 to 2019. 11/3/21 Tr. at 16:17–19. Plaintiffs' billed charges were notably far lower than the rates billed by Sound Physicians, an emergency physician practice that United owned in Nevada. 11/18/21 Tr. at 225:9–17, 277:15–20; PX473. Moreover, Plaintiffs' policy against balance billing was demonstrated through documentation, communications with United, and trial testimony. PX424 at 2; 11/16/21 Tr. at 67:12–19, 68:6–13, 69:14–70:5. Substantial evidence also showed that United started a covert campaign to manipulate public opinion about the billing practices of emergency room physicians, including by exercising editorial control over an academic study authored by Zack Cooper, an economics professor at Yale University. PX509 at 2–6; PX012; PX239 at 2; PX100.

United's real motive was to maximize profit and shared savings revenue. It acknowledged internally that it "generate[d] additional savings by not running the claims through U&C but rather driving all [out-of-network] claims to a more aggressive pricing . . . ." PX243. In 2019, United forecasted cutting out-of-network reimbursement by another $3 billion through 2023. PX477 at 3–4; 11/2/21 Tr. at 161:6–8. United even devised a plan to cut

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MultiPlan out of the equation to "eliminate vendor fees" but use its own company, Naviguard, to carry out Data iSight's function of determining "fair" and geographically adjusted reimbursement rates. PX342 at 16, 20; PX478 at 14.

After hearing this evidence at trial, the jury found against United on every count of liability and awarded $2,450,182.29 in actual damages and $60,000,000.00 in punitive damages.

II. Standard of review

Under Rule 50, United must show that a reasonable jury would not have a legally sufficient evidentiary basis to find for the Health Care Providers. NRCP 50(a), (b). The court's power to grant judgment as a matter of law should be cautiously exercised. *Dudley v. Prima*, 84 Nev. 549, 551, 445 P.2d 31, 32 (1968). Conflicting evidence alone is not grounds to reverse a jury's verdict; if a reasonable jury could draw inferences from the evidence to support the verdict, the verdict must not be reversed. *See Reyburn Lawn & Landscape Designers, Inc. v. Plaster Dev. Co.*, 127 Nev. 331, 344, 255 P.3d 268, 277 (2011) ("Judgment as a matter of law should not be granted when there is conflicting evidence on material issues.").

III. Record evidence supported the verdicts against SHL, HPN, and UMR

Defendants' motion appears to be based on the idea that the only evidence supporting the judgment was the existence of UHIC and UHS outlier cost management programs. Mtn. at 5. Defendants conclude that to the extent SHL, HPN, and UMR calculated reimbursements differently from United HealthCare Insurance Company and United HealthCare Services, then no further relevant evidence remains in the case. This position ignores the testimony of both Ms. Hare and Mr. Ziemer, as well as many exhibits, all of which support the judgment against these three Defendants.

Defendants' argument that there was no evidence of any interactions between the Plaintiffs and defendants SHL, HPN, and UMR is puzzling. The claim files demonstrated thousands of instances in which the Health Care Providers cared for SHL, HPN, and UMR's insureds, including the charges that were billed for those visits and the amount that defendants paid. *See, e.g.*, PX473 at Rows 6269–11594 (Columns V and AB identifying SHL, HPN, and UMR as the parties that adjudicated claim); *see also* 11/18/21 Tr. at 225:18–226:13 (testimony

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of Bruce Deal that United produced claims data across five defendants). These thousands of visits are themselves evidence of a course of dealing between the parties.

The evidence shows that SHL and HPN paid far less than the already low rates paid by UHIC and UHS. Ms. Hare testified that SHL and HPN paid the same reimbursement for all emergency-care visits, regardless of severity. 11/16/21 Tr. at 156: And documentary evidence showed this universal payment was extraordinarily low. *See, e.g.*, PX473B-1; PX473C; PX473 at Rows 6418, 6472, 6491, 6562, 6777, 9314, 9320, 10771, 11121, 11126; 11/16/21 Tr. at 157:10–18.

Moreover, Mr. Ziemer testified about UMR's own cost-savings programs, which resulted in irrational and unjustifiably low payments to the Health Care Providers. 11/15/21 Tr. at 207:20–208:19, 231:20–232:19. The documentary evidence supported the unfair and random effect of UMR's cost-savings approach. PX256, PX473A, PX473B.

Despite their bottom-of-the-barrel payments, both Mr. Ziemer and Ms. Hare testified that they understood that SHL, HPN, and UMR were obligated to reimburse the Health Care Providers at a reasonable rate. 11/15/21 Tr. at 203:8–12; 11/16/21 Tr. at 203:19–24.

This evidence provided ample support for all of the Health Care Providers' claims against SHL, HPN, and UMR. The evidence established that the Health Care Providers provided services to these defendants' members, the defendants understood that they had an obligation to reimburse the Health Care Providers, that the defendants were benefitted by the Health Care Providers' actions, and that without justification, the defendants failed to reimburse the Health Care Providers a reasonable amount for their services. The evidence supports the jury's verdict.

IV. Unfair Claims Practices Act

A. The Health Care Providers have standing under the Unfair Claims Practices Act.

NRS 686A.020 broadly prohibits any "person" from engaging in unfair claims practices:

> A person shall not engage in this state in any practice which is defined in NRS 686A.010 to 686A.310, inclusive, as, or determined pursuant to NRS 686A.170 to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

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NRS 686A.020. The language of the statute does not limit who may bring a claim.

Neither *Gunny v. Allstate Ins. Co.*, 108 Nev. 344, 830 P.2d 1335 (1992) nor *Fulbrook v. Allstate Ins. Co.*, 61567, 2015 WL 439598 (Nev. Jan. 30, 2015) (unpublished disposition) holds that the Unfair Claims Practices Act does not create a private right of action against insurers in favor of third-party claimants like the Health Care Providers. Both cases involved family members of the insureds, who had no direct harm arising from the alleged violation of the Unfair Claims Practices Act. It was the lack of a legally redressable harm, not the lack of a contractual relationship, that doomed standing for the family-member plaintiffs in those cases. Indeed, after this Court rejected the same argument in United's motion to dismiss, the Nevada Supreme Court denied United's Petition for Writ of Prohibition challenging that order. Order Denying Petition for Writ of Prohibition or, Alternatively, Mandamus (Case No. 81680). In addition, while a contractual relationship is not necessary to establish standing, the finding of an implied contract between the plaintiffs and defendants also supports plaintiffs' standing here.

Moreover, the plain language of NRS 686A.310 does not prohibit a third party, such as the Health Care Providers, from raising claims under the Act, but instead provides permissively that claims may be asserted by the Commissioner or the insured. NRS 686A.310(2) ("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 subsection 1 as an unfair practice."). Notwithstanding the language of NRS 686A.310(2), the Nevada Supreme Court has expressly recognized the potential availability of claims asserted by third parties who are not insureds when standing can otherwise be established. *Torres v. Nev. Direct Ins. Co.*, 131 Nev. 531, 541, 353 P.3d 1203, 1211 (Nev. 2015) (citing *Gunny*, 830 P.3d at 1336) (noting that it has "intimated in dicta in *Gunny* that a third-party who is a specific intended beneficiary of an insurance policy might have a sufficient relationship to support a bad faith claim [under NRS 686A.310].").

B. All Defendants are subject to liability under the Unfair Claims Practices Act.

As discussed above, NRS 686A.020 plainly establishes that *all persons* are prohibited

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from engaging in "any practice which is defined in NRS 686A.010 to 686A.310, inclusive, as, or determined pursuant to NRS 686A.170 to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance." The statute does not carve out liability for TPAs. United's motion asks the Court to rewrite the statute's language.

Further, carving out TPAs from liability under the Unfair Claims Practices Act contravenes common sense. NRS 686A.310 prohibits the failure "to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear." It is the administrator, not the self-funding employer, responsible for effectuating the prompt, fair and equitable settlement of claims. This fact is evidenced by the implementation of "shared saving"-type programs by UHS, UHIC, and UMR. PX010 at 60; PX256; 11/10/21 Tr. at 71:7–9; 11/12/21 Tr. at 188:22–189:19. Such programs rely on the administrator, not the self-insured employer, to determine the amount actually paid. United's request that this Court arbitrarily exclude TPAs from the reach of the Unfair Claims Practices Act would lead to an absurd result, eliminating protection from those harmed by unfair claims settlement practices when the claims are handled by a TPA.

Nevada has patterned NRS 686A.310 after the National Association of Insurance Commissioners ("NAIC") model Unfair Claim Settlement Practices Act ("UCSPA"),[1] but

[1] NAIC's Model 900-1, Section 4, provides:

> Any of the following acts by an insurer, if committed in violation of Section 3, constitutes an unfair claims practice:
>
> D. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

Exh. 1. Similarly, NRS 686A.310 provides:

> 1. Engaging in any of the following activities is considered to be an unfair practice:
>
> ***
>
> (e) Failing to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear.
>
> 2. In addition to any rights or remedies available to the Commissioner, an

(continued)

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modified the model rule in an important distinction to permit a private right of action under Nevada law. *See* Nevada Lawyer, *Nevada's Unfair Claims Settlement Practices Act NRS 686A.310*, Michael C. Mills, Esq. (March 2013) at p.1. The NAIC Model Act identifies an insurer as any "person…and any other legal entity engaged in the business of insurance, ***including*** agents, brokers, adjusters and ***third party administrators***."[2] This same conclusion about including third party administrators as liable for unfair claims settlement practices can be gleaned from Nevada's insurance statutes. This makes sense because such companies are the ones who actually *settle* claims, going to the very purpose of NRS 686A.310(e)'s provisions that expressly address "[u]nfair practices in settling claims."

In turn, NRS 679A.130 makes it clear that third party administrators engage in the business of insurance, subjecting them to liability under NRS 686A.310:

> **"Transacting insurance" defined.** In addition to other aspects of insurance operations to which provisions of this Code by their terms apply, "transact" with respect to ***a business of insurance includes*** any of the following, by mail or otherwise or whether or not for the purpose of profit:
>
> 1. Solicitation or inducement.
> 2. ***Negotiations.***
> 3. Effectuation of a contract of insurance.
> 4. ***Transaction of matters subsequent to effectuation and arising out of such a contract.***

NRS 679A.130 (emphasis added). To exclude third party administrators from liability under

---

> insurer is liable to its insured for any damages sustained by the insured as a result of the commission of any act set forth in subsection 1 as an unfair practice.

[2] NAIC's Model 900-1 provides:

> "Insurer" means ***a person***, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society, and any other legal entity ***engaged in the business of insurance***, including agents, brokers, adjusters and third party administrators. Insurer shall also mean medical service plans, hospital service plans, health maintenance organizations, prepaid limited health care service plans, dental, optometric and other similar health service plans as defined in Section [insert applicable section]. For purposes of this Act, ***these foregoing entities shall be deemed to be engaged in the business of insurance***;

Exhibit 1, NAIC Model Rule 900-1 (1997).

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686A.310, as United is asking this Court to do, would contradict the purposes of the Nevada insurance statute, which provides:

> 1. The purposes of this Code are to:
>
> ***
>
> (b) Implement the public interest in the business of insurance;
>
> ***
>
> (e) Insure that policyholders, claimants and insurers are treated fairly and equitably;
>
> ***
>
> (h) Prevent misleading, unfair and monopolistic practices in insurance operations.

NRS 679A.140.

Albert H. Wohlers & Co. v. Bartgis, 114 Nev. 1249, 969 P.2d 949 (1998) does not support United's arguments. Wohlers was "engaged in a joint venture ***with an insurer***," Allianz Life Insurance Company of North America. *Id*. at 959. The jury found both the insurer (Allianz) and Wohlers violated 686A.310. *Id*. at 960–61. But Allianz was the party that issued the policy and made the coverage determinations,[3] not Wohlers. *Id*. at 954–55 ("[t]he detailed listing of charges from the hospital also revealed that Allianz had deemed all medical expenses beyond basic room and board as 'ancillary charges' … [a]ccordingly, Allianz agreed to cover only ten percent of these 'ancillary charges.'"). Under those facts, and after affirming the jury's verdict against the insurer (Allianz), the Nevada Supreme Court found that Wohlers was not also an insurer and therefore reversed the 686A.310 unfair claims finding against Wohlers. *Id*. at 959. Those facts are not analogous to the facts here and for that reason, the *Wohlers* holding cited by Defendants is inapplicable. In short, none of United's authorities establish why the responsible party—the administrator—should be shielded from liability. United is not entitled to judgment on this claim.

C. The jury's finding that Defendants' liability was reasonably clear is supported by the evidence.

United argues that it could not have known that its liability was reasonably clear until the

[3] As the evidence at trial made clear, when acting as third party administrators, Defendants are still making coverage determinations and processing claims. 11/10/21 Tr. at 75:10–21; 11/16/21 Tr. at 22:18–21. In other words, they are acting as insurers.

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jury returned its verdict. If this argument had merit, then no insurer would ever face liability under the statute. Similarly, if disagreement among expert witnesses about the exact dollar amount owed were sufficient to evade liability, no insurer would be liable.

The question the jury faced was whether United's liability was reasonably clear, and whether, at that time, United failed to effectuate a prompt, fair, and equitable settlement. *See* NRS 686A.310(1)(e). United never disputed that it was liable for the claims at issue; it paid *something* for every single claim. Brief at 13. Therefore, the relevant question was not whether United hit a "sum certain" target, but whether the amount United paid was "fair and equitable."

In United's view, the argument is whether a specific dollar value could be assigned to every claim without reasonable dispute; and if not, United could not be liable under the statute. If that were true, the statutory language would not include the words "fair and equitable." The statutory language recognizes that there may be disputes about the exact dollar amount that should be paid. The standard is not whether United can be held to an exact number, but whether United's settlements were "fair and equitable." The jury had ample evidence to find that they were not.

D. The jury's finding that Defendants failed to effectuate a prompt, fair, and equitable settlement is supported by the evidence.

For each of the disputed claims, the evidence showed that the plaintiffs submitted a claim for payment, and Defendants paid the claim at a lower amount of Defendants' choosing. Defendants' suggestion that the Health Care Providers were required to show further evidence of negotiation for every claim to prevail under NRS 686A.310 finds no support either in the law or in common sense. Defendants themselves admitted that the volume of claims they manage is so large that they rely on automation to administer them. 11/15/21 Tr. at 20:7–19; *see also id.* at 217:3–17. Requiring further negotiation of every claim—a requirement that has no basis in the statute—would create an unreasonable burden on claimants like the Health Care Providers who must submit large volumes of relatively small claims.

Defendants' cases, which involve good-faith disputes, are not to the contrary. The jury found—based on ample evidence—that the defendants' dispute of the amount owed was not in

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good faith. *See infra* at Section VC. The jury's findings on this issue are supported by the evidence.

E. Plaintiffs offered evidence sufficient for the jury to find that an officer, director, or department head knowingly permitted the violations.

Defendants rely on the false premise that an officer, director, or department head must personally administer each disputed claim in order to satisfy the requirement that they knowingly permitted the failure to settle the claims fairly and equitably. This argument also finds no support either in the law or in common sense. What is sufficient—and what happened here—is for an officer, director, or department head to be aware of and permit the policies that systematically resulted in unfair and inequitable settlement of claims. *See* NRS 686A.270 (sufficient for officer, director or department head to knowingly permit the act or have prior knowledge thereof); *My Left Foot Children's Therapy LLC v. Certain Underwriters at Lloyd's London Subscribing to Policy No. HAH15-0632*, 2021 WL 1093094, at *5 (D. Nev. March 22, 2021) (where claims handler was following policies, procedures, and authority implemented by the chief underwriting officer and department head, the insurance company effectively approved the claims mishandling at issue).

Here, Mr. Haben, Mr. Ziemer, and Ms. Hare were all aware of the policies at issue. Mr. Haben testified that he was in charge of out-of-network payments for UHS and UHIC. 11/10/21 Tr. 13:5–7. Mr. Ziemer was vice president of customer solutions and in charge of setting reimbursement strategies for UMR. 11/15/21 Tr. at 182:24–10. And Ms. Hare testified that she was in charge of claim reimbursement for SHL and HPN. 11/16/21 Tr. at 133:1–7. While Ms. Hare resisted characterizing herself as a department head, the jury could conclude that her position over claim reimbursement qualified her as a department head for purposes of the statute. Not only were all three in charge of the relevant reimbursement programs, their testimony showed that they were familiar with the manner in which their respective companies set reimbursements. 11/12/21 Tr. at 20:3–17; 11/15/21 Tr. at 250:15–252:19.

The purpose of the requirement is to ensure that responsible defendants with fair policies aren't punished for the acts of rogue low-level employees. The evidence at trial more than

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satisfied that requirement. United cannot show that this court should reverse the jury's verdict on these claims.

F. The Health Care Providers introduced evidence that their injuries were caused by United's claims handling processes.

United simultaneously argues that the Unfair Claims Practices Act will only allow a plaintiff to recover consequential damages arising from the defendant's claims-handling practices, and that the Unfair Claims Practices Act allows no recovery of consequential damages. Setting that aside, and even accepting United's representation that the plaintiffs must show harm from "the claims process itself," Brief at 18–19, plaintiffs submitted evidence of exactly that.

As already discussed herein, the Health Care Providers presented evidence that each of the defendants developed reimbursement methodologies that were calculated to systematically underpay the Health Care Providers' claims. This is a harm from the claims process itself.

Yusko v. Horace Mann Servs. Corp., 2012 WL 458471 (D. Nev. Feb. 10, 2012) does not support United's argument. In that casualty insurance case, the defendant insurance company had already paid the policy limits to the insured. Therefore, the court found that no wrongful processing or other bad conduct by the defendant could have harmed the plaintiff, because she was not entitled to anything else under the policy. The reasoning of that case does not apply here.

Here, the statutory language is plain. Defendants are liable if they fail to "effectuate prompt, fair and equitable settlements of claims in which [their liability] has become reasonably clear." NRS 686A.310(1)(e). Defendants' failure to meet that standard of conduct harmed the Health Care Providers, as the jury found. Defendants' argument merely amounts to a restatement of their unfounded claim that underpayment of a claim cannot be the basis of liability. That premise is wrong. The Court should not reverse the jury's findings on this issue.

V. Punitive damages

A. UHS and UMR are subject to punitive damages

For the reasons set out above, UHS and UMR are subject to the Unfair Claims Practices Act and therefore are not exempt from punitive damages on this cause of action.

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B. Punitive damages are available for the Unfair Claims Practices Act claims.

Although the Nevada Supreme Court has held that punitive damages are not available for breach of contract claims, it has not imposed that restriction on the Unfair Claims Practices Act. See *Ins. Co. of the West v. Gibson Title Co., Inc.,* 122 Nev. 455, 464, 134 P.3d 698, 703 (2006) ("[T]he award of punitive damages cannot be based upon a cause of action sounding *solely* in contract.") (emphasis added). The gravamen of unfair claims practices is not just the breach of an obligation, but the failure to treat the plaintiff fairly. *See* NRS 686A.310. That is particularly true in the context of a relationship with unequal bargaining power, as is shown here, where plaintiffs must treat defendants' members and have no ability to bargain in advance. This unequal power distinguishes this situation from ordinary contracting scenarios.

United mischaracterizes this Court's order denying the Motion to Dismiss the First Amended Complaint. The Court observed that if the Nevada Supreme Court were to determine that a contractual relationship would be required to have standing to assert a claim for Unfair Claims Practices, such a claim had been asserted in this case through the implied-contract claim. Order Denying Motion to Dismiss FAC ¶68. That is not the same thing as holding that a claim under the Unfair Claims Practices Act sounds solely in contract. Moreover, as already discussed herein, the critical question for standing under *Gunny* is not the existence of a contract, but whether the plaintiffs suffered cognizable harm. *Gunny v. Allstate Ins. Co.*, 108 Nev. 344, 345–346, 830 P.2d 1335, 1335–1336 (1992). Here, that requirement is met.

For the first time in its "renewed" motion, Defendants also raise the argument that the "ordinary way" an insurer may be held liable for punitive damages is through tortious breach of the implied covenant of good faith and fair dealing in the insurance contract. As has already been extensively briefed before this Court, that is not the only method whereby insurers may be found liable for punitive damages. The Health Care Providers incorporate their previous briefing and argument on this subject by reference herein.

C. Ample evidence supports the jury's finding of fraud, oppression, and malice.

United's representatives testified that United has a duty to pay a reasonable reimbursement amount. 11/15/21 Tr. at 36:17–22; *id.* at 203:8–12; 11/16/21 Tr. at 203:19–23.

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Despite that obligation, UHIC, UHS, and UMR implemented MultiPlan's Data iSight service and moved clients away from paying reasonable and customary rates. PX368 at 7; 11/3/21 Tr. at 50:21–51:1; *see also* PX243 (correspondence from Paradise to Haben evaluating UMR out-of-network reimbursement); 11/15/2021 Tr. at 208:7–19 (testimony of Ziemer describing UMR's use of Data iSight). They knew that Plaintiffs and other healthcare providers did not agree to this, "proposing a move over time towards non-secured (i.e. not a contracted discount) reductions . . . ." PX244 at 1.

While SHL and HPN did not use the same cost reduction programs, the rates they paid were even lower. *See* PX473C. Moreover, documentary evidence showed that SHL and HPN were on notice that they had not paid a reasonable value in accordance with the Affordable Care Act. PX348; PX 325. The ACA sets a minimum based on usual and customary rates that SHL and HPN conceded at trial was not part of their analysis to set reimbursement rates. 11/15/21 Tr. at 160:20–10; PX314. The evidence further showed that the defendants' motivation for reducing out-of-network reimbursement rates was to increase United's profits. PX243; PX477 at 3–4; 11/2/21 Tr. at 161:6–8; PX342 at 16, 20; PX478 at 14.

The evidence showed that United's profit-seeking, wrongful conduct harms the plaintiffs, emergency-care providers on whom the community depends, and thus risks the quality of care available to the public. 11/19/21 Tr. at 32:17–33:4. In fact, the evidence showed that United targeted the plaintiffs, who (unlike medical practice groups without a national affiliation) have the ability to push back against United's unfair policies. 11/17/21 Trial Tr. at 38:20–24 (testimony of Deal that the defendants reimbursed Plaintiffs $245 per claim on average and $528 to other providers in Nevada). It also showed that United claimed to treat emergency-care providers fairly, when that was not true. PX163 at 82 ("SHL recognizes that claim problems occur from time to time. We appreciate our physicians and providers bringing them to our attention. We handle these claims as expeditiously as we can. Reasonable procedural guidelines are established to manage them."); PX322 (advising Congress about adequate levels of reimbursement for out-of-network emergency services); *see also id.* at 80; PX165 at 180, 182. The evidence showed United blamed doctors—and specifically practices affiliated with

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TeamHealth—for driving up medical costs, while at the same time United's own physician-staffing group charged rates far in excess of the plaintiffs' billed charges. PX079 at (authorizing identification of TeamHealth in media publication about surprise medical bill study); 11/18/21 Tr. at 225:9–17 (Plaintiffs' billed charge of $1,428 for 99285 CPT code); *id.* at 277:15–20 (Sound Physicians charge of $1,761 for 99285 CPT code).

In short, the evidence supported the jury's conclusion that United deliberately placed its own interests over the providers who form the safety net of the community. There is no basis to overturn the jury's finding of fraudulent, oppressive, and malicious conduct here.

1. The jury's finding that the defendants engaged in fraudulent conduct is amply supported by the evidence.

Defendants argue that "the jury must find that Defendants acted fraudulently ***in their failure to negotiate*** equitable, fair, and prompt settlements in violation of the Unfair Claims Practices Act." The evidence showed just that. United held itself out as performing fair and objective reimbursement determinations. PX142 at 42 (UHIC certificate of coverage); PX120 at 86 (UHS summary plan description); PX296 at 81 (UMR summary plan description); PX163 at 80 (SHL provider manual) PX165 at 180 (HPN provider manual); PX444 at 2 (UHS explanation of benefits). But the evidence at trial showed that United's real reimbursement decisions were driven primarily by profits rather than objectivity or fairness. *See* Section I, above, detailing the ways in which all five defendants relentlessly drove down reimbursement rates and targeted the Plaintiffs in particular.

United's unfair practices have directly harmed providers. While United has driven down its reimbursement rates, it has also deployed policies designed to discourage provider resistance and unfairly deny appeals. *See, e.g.,* PX243 ("We also **generate additional savings by not running the claims through U&C but rather driving all OON claims to a more aggressive pricing and managing appeals** to try to hold the member harmless) (emphasis added); PX375 at 2 (representing to providers that claim was processed using Data iSight, "which utilizes cost data if available (facilities) or paid data (professionals)"); PX170A (showing the profits United could make by using Data iSight instead of UCR, taking into consideration a low number of

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expected appeals); P470 (United rejecting an appeal because "this claim has been reviewed and reimbursed using Data iSight"); PX163 at 82 ("SHL recognizes that claim problems occur from time to time. We appreciate our physicians and providers bringing them to our attention. We handle these claims as expeditiously as we can. Reasonable procedural guidelines are established to manage them."). This harm is compounded by United's massive market share in Nevada. P089 at 58 ("Sierra/United membership totaling 80% of the Clark County, Nevada market share"). Following the appropriate standard of review, this Court should assume the jury believed all the evidence favorable to Plaintiffs, as the prevailing party, and drew all reasonable inferences in Plaintiffs' favor. *See Bongiovi v. Sullivan*, 122 Nev. 556, 581, 138 P.3d 433, 451 (2006). There is ample evidence to support the verdict.

2. The jury's finding of oppression and malice is supported by the evidence.

Similarly, the evidence supported the jury's conclusion that United knew of the probable harmful consequences of its wrongful act, and willfully and deliberately failed to act to avoid those consequences. As detailed above, Plaintiffs offered evidence that United deliberately drove down reimbursement rates so it could rake in massive profits—without regard to the harm its policies caused to emergency-care providers or the public who depends on them. Plaintiffs further offered evidence that United deliberately targeted the plaintiffs for harm because of their association with TeamHealth. 11/17/21 Trial Tr. at 38:20–24. This evidence supports the jury's verdict.

United's claim that "no malice or oppression as a matter of law because Defendants ***paid*** the insurance claims at issue" is absurd on its face. United can provide no support for the idea that any amount of payment—no matter how low and inadequate—eliminates oppression or fraud as a matter of law.

D. Punitive damages are available for the unjust enrichment claim.

In a footnote, United argues that the Court should reverse the jury's award of punitive damages on the Health Care Provider's unjust-enrichment claim. The Court's decision to allow the Health Care Provider's claim to proceed was within its discretion, and United has not

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provided any authorities to show that this Court abused its discretion. The Health Care Providers incorporate the briefing on this issue in their response to United's motion for new trial, filed simultaneously with this brief.

United also cannot show that the unjust enrichment claim in this case does not support a punitive damages award.[4] Although punitive damages are not available for breach of contract claims, the same restriction does not apply to an unjust enrichment claim, because unjust enrichment only applies in the absence of a contract. See *Ins. Co. of the West,* 122 Nev. at 464, 134 P.3d at 703 ("[T]he award of punitive damages cannot be based upon a cause of action sounding *solely* in contract.") (emphasis added); *Leasepartners Corp. v. Robert L. Brooks Tr. Dated Nov. 12, 1975*, 113 Nev. 747, 755–56, 942 P.2d 182, 187 (1997) ("[a]n action based on a theory of unjust enrichment is not available when there is an express, written contract, because no agreement can be implied when there is an express agreement.").

Unlike a claim for breach of contract, unjust enrichment "is grounded in the theory of restitution, not in contract theory." *Schirmer v. Souza*, 126 Conn. App. 759, 765, 12 A.3d 1048 (2011). Therefore, punitive damages may be available when appropriate based on the defendant's conduct. *See, e.g.*, *Hester v. Vision Airlines, Inc*., 687 F.3d 1162 (9th Cir. 2012); *Bavelis v. Doukas*, No. 2:17-CV-00327, 2021 WL 1979078, at *3 (S.D. Ohio May 18, 2021) (affirming punitive damages award based on a theory of unjust enrichment).

The same evidence that shows United's fraudulent, malicious, and oppressive conduct with respect to unfair claims practices also supports punitive damages for plaintiffs' unjust-enrichment claim. This Court should reject United's fly-by argument about punitive damages on this ground as well.

VI. Implied-in-fact contract

United's arguments regarding the implied-in-fact contract rest on a fatal straw-man premise: that the implied contract requires an agreement between the parties that United would pay the Health Care Providers' full billed charges. As this Court is aware, plaintiffs' position

[4] The parties have already briefed and argued this issue. The Health Care Providers incorporate their previous briefing and argument by reference herein.

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was materially different: the parties formed a contract through their conduct, in which plaintiffs provided services to United's members and United acknowledged its obligation to pay for those services. As the law recognizes, the Health Care Providers could succeed on this claim either by showing that United acknowledged its obligation to pay a reasonable price, or the if the jury found the parties did not agree on a price, the jury could infer that United was obligated to pay a reasonable price. *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 381, 283 P.3d 250, 257 (2012). In fact, although United did not pay a reasonable price for plaintiffs' services, its witnesses acknowledged that it had an obligation to do so. 11/15/21 Tr. at 36:17–22; *id.* at 203:8–12; 11/16/21 Tr. at 203:19–23. The jury's verdict is supported both by the evidence and the law.

A. The jury had sufficient evidence to find the required elements of an implied contract.

"[T]o find a contract implied-in-fact, the fact-finder must conclude that the parties intended to contract and promises were exchanged, the general obligations for which must be sufficiently clear. It is at that point that a party may invoke quantum meruit as a gap-filler to supply the absent term." *Certified Fire*, 128 Nev. at 379–80, 283 P.3d at 256.

As discussed above, the evidence showed that United acknowledged that the Health Care Providers has provided valuable services to United's members and that United owed an obligation to reimburse the Health Care Providers a reasonable price. 11/15/21 Tr. at 132:23–133:33, 203:8–12. Under *Certified Fire*, this evidence is sufficient to support the jury's finding of an implied contract.

B. The evidence supported the jury's finding of an intent to contract.

The United defendants acknowledged not only that the Health Care Providers provided services to their members, but also that United was obligated to pay the Health Care Providers for those services. These facts distinguish this case from *Steele v. EMC Mortg. Corp.*, No. 59490, 129 Nev. 1154, 2013 WL 5423081 (Sept. 20, 2013) (unpublished disposition). In *Steele*, defendant's contract was with plaintiff's father; the plaintiff herself did not provide any additional goods or services, and there was no evidence that defendant understood it had any

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contractual obligation to plaintiff. By contrast, here United acknowledged and understood that Plaintiffs regularly provided services to United's members, and that United had an obligation to pay Plaintiffs for those services. The evidence supports the jury's finding of an intent to contract.

C. The evidence supported the jury's finding of exchanged promises.

Again, United tries to avoid the jury's verdict by inventing a requirement that the Health Care Providers prove that United specifically agreed to pay the providers' billed charges. This is a straw-man argument. The evidence showed that the Health Care Providers agreed to treat United's members and that United agreed to pay the Health Care Providers for that service. In addition, the Health Care Providers agreed not to balance bill United's members and to submit claims in the format United requested. 11/16/21 Tr. at 67:2–19, 68:6–13, 69:14–70:5 *and* (agreement not to balance bill); 11/22/21 Tr. at 115:1–117:25 (Plaintiffs' claims submissions process using Form 1500); PX168 at 58 (requirements to submit claim using CMS 1500 forms); PX163 at 90–91 (same for SHL); PX165 at 192–93 (same for HPN). United also acknowledged that it had an obligation to pay a reasonable value for the Health Care Providers' services. This evidence was sufficient to support the jury's finding that the parties had an exchange of promises that was implied through their conduct.

D. The evidence supported the jury's finding that the parties agreed on material terms.

Although "[a] valid contract cannot exist when material terms are lacking or are insufficiently certain and definite[,] [a] contract can be formed, however, when the parties have agreed to the material terms, even though the contract's exact language is not finalized until later." *May v. Anderson*, 121 Nev. 668, 672, 119 P.3d 1254, 1257 (2005); *see also Brinkerhoff v. Foote*, 132 Nev. 950, 387 P.3d 880 (2016). "Which terms are essential 'depends on the agreement and its context and also on the subsequent conduct of the parties, including the dispute which arises and the remedy sought." *Certified Fire*, 128 Nev. at 378, 283 P.3d at 255 (quoting RESTATEMENT (SECOND) OF CONTRACTS § 131, cmt. g (1981)); *see also Aliya Medcare Fin., LLC v. Nickell*, No. CV1407806MMMSHX, 2015 WL 11089594, at *9 (C.D. Cal. May 28, 2015) (interpreting Nevada law).

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As already mentioned, the Nevada Supreme Court has explicitly acknowledged that "quantum meruit [for an implied in fact contract] fills the price term when it is appropriate to imply the parties agreed to a reasonable price" and "[w]here such a contract exists, then, quantum meruit ensures the laborer receives the reasonable value, usually market price, for his services." *Certified Fire*, 128 Nev. at 379–80, 283 P.3d at 256 (citing 1 Dan B. Dobbs, *Dobbs Law of Remedies* § 4.2(3) (2d ed. 1993)); *see Sierra Development Co. v. Chartwell Advisory Group, Ltd.*, 325 F. Supp. 3d 1102, 1106 (D. Nev. 2018) ("quantum meruit may be employed as a gap-filler to supply absent terms"); *Mielke v. Standard Metals Processing, Inc.*, 2015 WL 1889709, *5 (D. Nev. April 24, 2015) (same); *Risinger v. SOC LLC*, 936 F. Supp. 2d 1235, 1246-47 (D. Nev. 2013) (same); *see also Commonwealth Land Title Ins. Co. v. Iota Indigo, LLC*, 2015 WL 4647863, *4 (D. Nev. Aug. 5, 2015). Indeed, United's representatives testified that they understood they had an obligation to pay the Health Care Providers a reasonable value for their services. 11/15/21 Tr. at 36:17–22; *id.* at 203:8–12; 11/16/21 Tr. at 203:19–23.

As stated repeatedly above, United's arguments that plaintiffs must show an agreement that United would pay plaintiffs' full billed charges are without merit. And the question of which terms are essential is a question of fact. *See Certified Fire*, 128 Nev. at 378, 283 P.3d at 255. Assuming the jury determined duration to be an essential term, the evidence supported its conclusion that United understood its obligation to reimburse providers for the providers' services to United's members to be a continuing obligation.

VII. Unjust enrichment

Defendants' argument about the unjust-enrichment claim is a red herring. The doctrine of election of remedies prevents a plaintiff from obtaining inconsistent *remedies*, or from recovering twice for the same injury. *J.A. Jones Const. Co. v. Lehrer McGovern Bovis, Inc.*, 120 Nev. 277, 288–89, 89 P.3d 1009, 1017 (2004) (The "doctrine of election of remedies applies only to *inconsistent* remedies. . . . . [T]he district court can determine, after trial, if a duplicate recovery has been obtained on two theories of recovery . . . .") (emphasis in original). The judgment in this case does not award the Health Care Providers recovery for both unjust enrichment and the implied-contract claim. Therefore, there is no conflict in remedies.

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VIII. Prompt-Pay Act

A. The plaintiffs have a private right of action under the Prompt-Pay Act.

The Health Care Providers' Prompt-Pay claim is based on the NV Healthcare Prompt-Pay Statutes set forth in NRS 683A.0879 (third party administrator), NRS 689A.410 (Individual Health Insurance), NRS 689B.255 (Group and Blanket Health Insurance), NRS 689C.485 (Health Insurance for Small Employers), and NRS 695C.185 (HMO). Each statute provides as follows:

> NRS 683A.0879 Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements. [Effective through December 31, 2019.]
>
> 1. Except as otherwise provided in subsection 2, an administrator shall approve or deny a claim relating to health insurance coverage within 30 days after the administrator receives the claim. If the claim is approved, the administrator shall pay the claim within 30 days after it is approved. Except as otherwise provided in this section, if the approved claim is not paid within that period, the administrator shall pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.
>
> ***
>
> 4. An administrator shall not pay only part of a claim that has been approved and is fully payable.
>
> 5. ***A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section***.

Subsections 4 and 5 appear in each NV Healthcare Prompt-Pay Statute.[5]

[5] **NRS 689A.410 Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements. [Effective through December 31, 2019.]**

***

4. An insurer shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section

NRS 689B.255 Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with

(continued)

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United relies on an inapplicable prompt-pay statute, NRS 690B.012 (the "Casualty Prompt-Pay Statute"), only applicable to casualty insurance, that does not provide for a private right of action. United's reliance on *Allstate Ins. Co. v. Thorpe*, 123 Nev. 565, 571, 170 P.3d 989, 993 (2007) in an effort to support its motion is misplaced because *Allstate's* ruling is limited to NRS 690B.012 and is wholly inapplicable to the Health Care Providers' claims.

The Casualty Prompt-Pay Statute is categorically different than the NV Health Care Prompt-Pay Statutes, which provide: "***A court*** shall award costs and reasonable attorney's fees to the prevailing party ***in an action brought pursuant to this section.***" *See Arora v. Eldorado Resorts Corp.*, No. 2:15-cv-00751-RFB-PAL, 2016 WL 5867415, at *8 (D. Nev. Oct. 5, 2016) ("the provision within the [wage] statute for the payment of 'attorney fee[s]' further supports an implied private right of action. There would be no need for such allowance within the language of the statute if a private right of action were not implied."); *see Neville v. Eighth Judicial Dist. Court*, 133 Nev. 777, 783, 406 P.3d 499, 504 (2017) (stating it would be absurd to think that the Legislature intended a private cause of action to obtain attorney fees for an unpaid wages suit

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requirements. [Effective through December 31, 2019.]

***

4. An insurer shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

NRS 689C.485 Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements. [Effective through December 31, 2019.]

***

4. A carrier shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

NRS 695C.185 Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements. [Effective through December 31, 2019.]

***

4. A health maintenance organization shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

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but no private cause of action to bring the suit itself). Because United relies on inapplicable authority, the Court should deny its motion on this point.

For the first time in its "renewed" motion for judgment as a matter of law, Defendants argue that this Court should reverse the jury's verdict on this cause of action because United "paid" the claims within thirty days. However, as detailed above, the relevant statutes provide that an insurer or administrator "shall not pay only part of a claim that has been approved and is fully payable." *See* NRS 683A.0879(4); NRS 689A.410(4); NRS 689B.255(4); NRS 689C.485(4); and NRS 695C.185(4). The jury was instructed accordingly; jury instruction 38 required the jury to find that defendants "failed to fully pay, within 30 days of submission of the claim, a claim that was approved and fully payable." The jury properly found that United had failed to do so.

B. The Prompt-Pay Act does not require administrative exhaustion.

United's arguments regarding administrative exhaustion rely on statutes of general applicability;[6] however, NRS 679A.170 provides that specific provisions relative to a particular type of insurance prevail over generalized provisions.[7] Under the instruction of NRS 679A.170, the Court should decline to apply generalized statutes about administrative procedures when the NV Health Care Prompt-Pay Statutes expressly contemplate court action for violation of their provisions. Therefore, United's arguments regarding administrative exhaustion do not form a basis to reverse the jury's verdict.

IX. ERISA

This Court has previously rejected United's ERISA preemption arguments. *See* June 24, 2020 Order Denying Defendants' Motion to Dismiss First Amended Complaint. The United States Supreme Court has also addressed this issue and concluded that there is no conflict

[6] NRS 679B.310 (administrative procedures; hearings in general); NRS 679B.370 (appeal from Commissioner); NRS 233B.130 (judicial review); NRS 233B.133 (deadlines in petition for judicial review).

[7] "**Particular provisions prevail**. Provisions of this Code relative to a particular kind of insurance or type of insurer or particular matter shall prevail over provisions relating to insurance in general or insurers in general or to such matter in general." NRS 679A.170.

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preemption when it is the **rate of payment** that is at issue. *See Rutledge v. Pharmaceutical Care Mgmt. Assoc.*, 141 S. Ct. 474, 478, 208 L. Ed. 2d 327 (2020) (Arkansas statute regulating the price of drugs covered under pharmacy benefit plans "has neither an impermissible connection with nor reference to ERISA and is therefore not pre-empted"). Critically, *Rutledge* makes clear that "not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan. **That is especially so if a law merely affects costs**." *Id.* at 480 (emphasis added). Costs in this context refers to an expense that an insurer like United will incur, and in this case, an amount that United will pay a provider. The Court went on to hold: "ERISA does not pre-empt state rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage." *Id.* (citing *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 668, 115 S. Ct. 1671 (1995)). *See also De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806, 816, 117 S. Ct. 1747 (1997) (concluding that ERISA didn't pre-empt a state tax on gross receipts for patient services that simply increased the cost of providing benefits). The exact same reasoning applies here.

Furthermore, in addressing conflict preemption under ERISA, the "starting presumption" is that "Congress does not intend to supplant state law," and "that the historic police powers of the States were not to be superseded by [ERISA] unless that was the clear and manifest purpose of Congress." *Viad Corp. v. MoneyGram Int'l, Inc.*, No. 1 CA-CV 15-0053, 2016 WL 6436827, at *2 (Ariz. Ct. App. Nov. 1, 2016) (quoting *New York State Conference of Blue Cross & Blue Shield Plans*, 514 U.S. at 654–55). Therefore, the proper analysis under Section 514(a) starts with the presumption that ERISA does not supplant state-law claims.

Section 514 saves from preemption "any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A). The savings clause functions to preserve a state's traditional regulatory power over insurance, banking, and securities. *Rudel v. Hawai'i Management Alliance Ass'n*, 937 F.3d 1262, 1269–70 (9th Cir. 2019); *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 325, 136 S. Ct. 936, 946 (2016).

A common-law claim "relates to" an employee benefit plan governed by ERISA "if it

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has a connection with or reference to such a plan." *Providence Health Plan v. McDowell*, 385 F.3d 1168, 1172 (9th Cir. 2004); *see also Blue Cross of Cal. v. Anesthesia Care Assoc. Med. Group, Inc.*, 187 F.3d 1045, 1052 (9th Cir. 1999). The Supreme Court has limited the parameters of § 514(a) preemption to two categories of state laws. *Gobeille*, 136 S. Ct. at 943. Those categories are: (1) laws "with a reference to ERISA plans," which include laws which "act[ ] immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation," and (2) laws with "an impermissible connection with ERISA plans, meaning a state law that governs a central matter of plan administration or interferes with nationally uniform plan administration." *Id.* Here, the Health Care Providers provided evidence that they had an implied-in-fact contract with United, which obligated United to pay them reasonable compensation, and that alternatively, the law of unjust enrichment obligated United to pay the Health Care Providers the reasonable value for their services.

The Ninth Circuit has also made it clear that § 514(a) does not apply to claims brought by third-party healthcare providers, like the Health Care Providers here. *See Morris B. Silver M.D., Inc. v. Int'l Longshore & Warehouse etc.*, 2 Cal. App. 5th 793, 799, 206 Cal. Rptr. 3d 461, 466 (Ct. App. 2016); *Providence Health Plan*, 385 F.3d at 1172; *Abraham v. Norcal Waste Sys., Inc.*, 265 F.3d 811, 820–21 (9th Cir. 2001); *Blue Cross of Cal.*, 187 F.3d at 1052–53; *see also The Meadows v. Employers Health Ins.*, 47 F.3d 1006, 1008 (9th Cir. 1995) (stating that § 1144(a) does not preempt "claims by a third-party who sues an ERISA plan not as an assignee of a purported ERISA beneficiary, but as an independent entity claiming damages.").

Other jurisdictions have also made it clear that § 514(a) claims by third-party providers arising out of analogous circumstances to those asserted by Health Care Providers here are not preempted. *See*, e.g., *Memorial Hosp. System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 243–46 (5th Cir. 1990) (holding hospital's claim for deceptive and unfair practices arising from representations regarding coverage not preempted and articulating two-factor test); *see also Access Mediquip LLC v. UnitedHealthcare Ins. Co.*, 662 F.3d 376, 385 (5th Cir. 2011) ("The state law underlying Access's misrepresentation claims does not purport to regulate what benefits United provides to the beneficiaries of its ERISA plans, but rather what representations

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it makes to third parties about the extent to which it will pay for their services."); *Depot, Inc. v. Caring for Montanans, Inc.*, 915 F.3d 643, 667 (9th Cir. 2019), *cert. denied*, 140 S. Ct. 223 (2019) ("State-law claims are based on other independent legal duties when they are in no way based on an obligation under an ERISA plan and would exist whether or not an ERISA plan existed.") (citing *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 950 (9th Cir. 2009)) (internal alteration omitted).

In short, the relationship between the Health Care Providers and United—*i.e.*, provider/insurer—is not a relationship that is intended to be governed by Section 514(a). Therefore, none of the Health Care Providers' claims are subject to conflict preemption.

Moreover, disputes concerning rates of payment do not fall within ERISA's scope and are not subject to complete preemption. *Marin Gen. Hosp.*, 581 F.3d at 948; *see also California Spine & Neurosurgery Inst. v. Boston Scientific Corp.*, No. 18-CV-07610-LHK, 2019 WL 1974901, at *3 (N.D. Cal. May 3, 2019) ("Under Ninth Circuit law, ERISA does not preempt claims by a third party [medical provider] who sues an ERISA plan not as an assignee of a purported ERISA beneficiary, but as an independent entity claiming damages.").

The Health Care Providers refer the Court to its June 24, 2020 order denying the same arguments United makes here. The Health Care Providers' claims are not preempted and the Court should decline to reverse the jury's verdict on this ground.

X. Conclusion

United has failed to show that a reasonable jury would not have a legally sufficient evidentiary basis to find as it did. *See* NRCP 50. For the reasons set forth herein, the Health Care Providers respectfully request this Court to deny United's motion.

[Signature block follows]

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DATED this 4th day of May, 2022.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of Ahmad Zavitsanos & Mensing, PC, and on this 4th day of May, 2022, I caused a true and correct copy of the foregoing **PLAINTIFFS' OPPOSITION TO DEFENDANTS' RENEWED MOTION FOR JUDGMENT AS A MATTER OF LAW** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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UNFAIR CLAIMS SETTLEMENT PRACTICES ACT

Table of Contents

Prefatory Note: By adopting this model act in June 1990, the NAIC separated issues regarding unfair claims settlement practices into a free-standing act apart from the NAIC Model Unfair Trade Practices Act. This change focuses more attention on unfair claims as a function of market conduct surveillance separate and apart from general unfair trade practices. By doing so, the NAIC is not recommending that states repeal their existing acts, but states may modify them for the purpose of capturing the substantive changes. However, for those states wishing to completely rewrite their comprehensive approach to unfair claims practices, this separation of unfair claims from unfair trade practices is recommended.

Section 1. Purpose

The purpose of this Act is to set forth standards for the investigation and disposition of claims arising under policies or certificates of insurance issued to residents of [insert state]. It is not intended to cover claims involving workers' compensation, fidelity, suretyship or boiler and machinery insurance. Nothing herein shall be construed to create or imply a private cause of action for violation of this Act.

Drafting Note: A jurisdiction choosing to provide for a private cause of action should consider a different statutory scheme. This Act is inherently inconsistent with a private cause of action. This is merely a clarification of original intent and not indicative of any change of position. The NAIC has promulgated the Unfair Property/Casualty Claims Settlement Practices and the Unfair Life, Accident and Health Claims Settlement Practices Model Regulations pursuant to this Act.

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Section 2. Definitions

When used in this Act:

A. "Commissioner" means the Commissioner of Insurance of this state;

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

B. "Insured" means the party named on a policy or certificate as the individual with legal rights to the benefits provided by the policy;

C. "Insurer" means a person, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers, adjusters and third party administrators. Insurer shall also mean medical service plans, hospital service plans, health maintenance organizations, prepaid limited health care service plans, dental, optometric and other similar health service plans as defined in Section [insert applicable section]. For purposes of this Act, these foregoing entities shall be deemed to be engaged in the business of insurance;

D. "Person" means a natural or artificial entity, including, but not limited to, individuals, partnerships, associations, trusts or corporations;

E. "Policy" or "certificate" means a contract of insurance, indemnity, medical, health or hospital service, or annuity issued. "Policy" or "certificate" for purposes of this Act, shall not mean contracts of workers' compensation, fidelity, suretyship or boiler and machinery insurance.

Drafting Note: The term "policy" is intended to cover the product issued by medical, health or hospital service plans and should be changed to conform to the laws of each state.

The Federal Employee Retirement Income Security Act (ERISA) preempts certain entities and some activities of those entities from the application of state laws. The purpose of these definitions is to include within this Act and regulations issued pursuant to it, all entities and activities to the extent not preempted by ERISA.

Section 3. Unfair Claims Settlement Practices Prohibited

It is an improper claims practice for a domestic, foreign or alien insurer transacting business in this state to commit an act defined in Section 4 of this Act if:

A. It is committed flagrantly and in conscious disregard of this Act or any rules promulgated hereunder; or

B. It has been committed with such frequency to indicate a general business practice to engage in that type of conduct.

Section 4. Unfair Claims Practices Defined

Any of the following acts by an insurer, if committed in violation of Section 3, constitutes an unfair claims practice:

A. Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

B. Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;

C. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

D. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

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E. Compelling insureds or beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;

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F. Refusing to pay claims without conducting a reasonable investigation;

G. Failing to affirm or deny coverage of claims within a reasonable time after having completed its investigation related to such claim or claims;

H. Attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application;

I. Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured;

J. Making claims payments to an insured or beneficiary without indicating the coverage under which each payment is being made;

K. Unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof of loss form;

L. Failing in the case of claims denials or offers of compromise settlement to promptly provide a reasonable and accurate explanation of the basis for such actions;

M. Failing to provide forms necessary to present claims within fifteen (15) calendar days of a request with reasonable explanations regarding their use;

N. Failing to adopt and implement reasonable standards to assure that the repairs of a repairer owned by or required to be used by the insurer are performed in a workmanlike manner.

Section 5. Statement of Charges

Whenever the commissioner has reasonable cause to believe that an insurer doing business in this state is engaging in any unfair claims practice and that a proceeding in respect thereto would be in the public interest, the commissioner shall issue and serve upon the insurer a statement of the charges in that respect and a notice of hearing, which shall set a hearing date not less than thirty (30) days from the date of the notice.

Drafting Note: If a formal hearing procedure exists, states may wish to incorporate the timeframes from that existing procedure.

Section 6. Cease and Desist and Penalty Orders

If, after hearing, the commissioner finds an insurer has engaged in an unfair claims practice, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the insurer charged with the violation a copy of the findings and an order requiring the insurer to cease and desist from engaging in the act or practice and the commissioner may, at the commissioner's discretion, order:

A. Payment of a monetary penalty of not more than $1,000 for each violation but not to exceed an aggregate penalty of $100,000, unless the violation was committed flagrantly and in conscious disregard of this Act, in which case the penalty shall not be more than $25,000 for each violation, but not to exceed an aggregate penalty of $250,000 pursuant to hearing; and/or

B. Suspension or revocation of the insurer's license if the insurer knew or reasonably should have known it was in violation of this Act.

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Section 7. Penalty for Violation of Cease and Desist Orders

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An insurer that violates a cease and desist order of the commissioner and, while the order is in effect, may, after notice and hearing and upon order of the commissioner, be subject, at the discretion of the commissioner, to:

A. A monetary penalty of not more than $25,000 for each and every act or violation not to exceed an aggregate of $250,000 pursuant to hearing; and/or

B. Suspension or revocation of the insurer's license.

Section 8. Regulations

The commissioner may, after notice and hearing, promulgate reasonable rules, regulations and orders as are necessary or proper to carry out and effectuate the provisions of this Act. The regulations shall be subject to review in accordance with Section [insert applicable section].

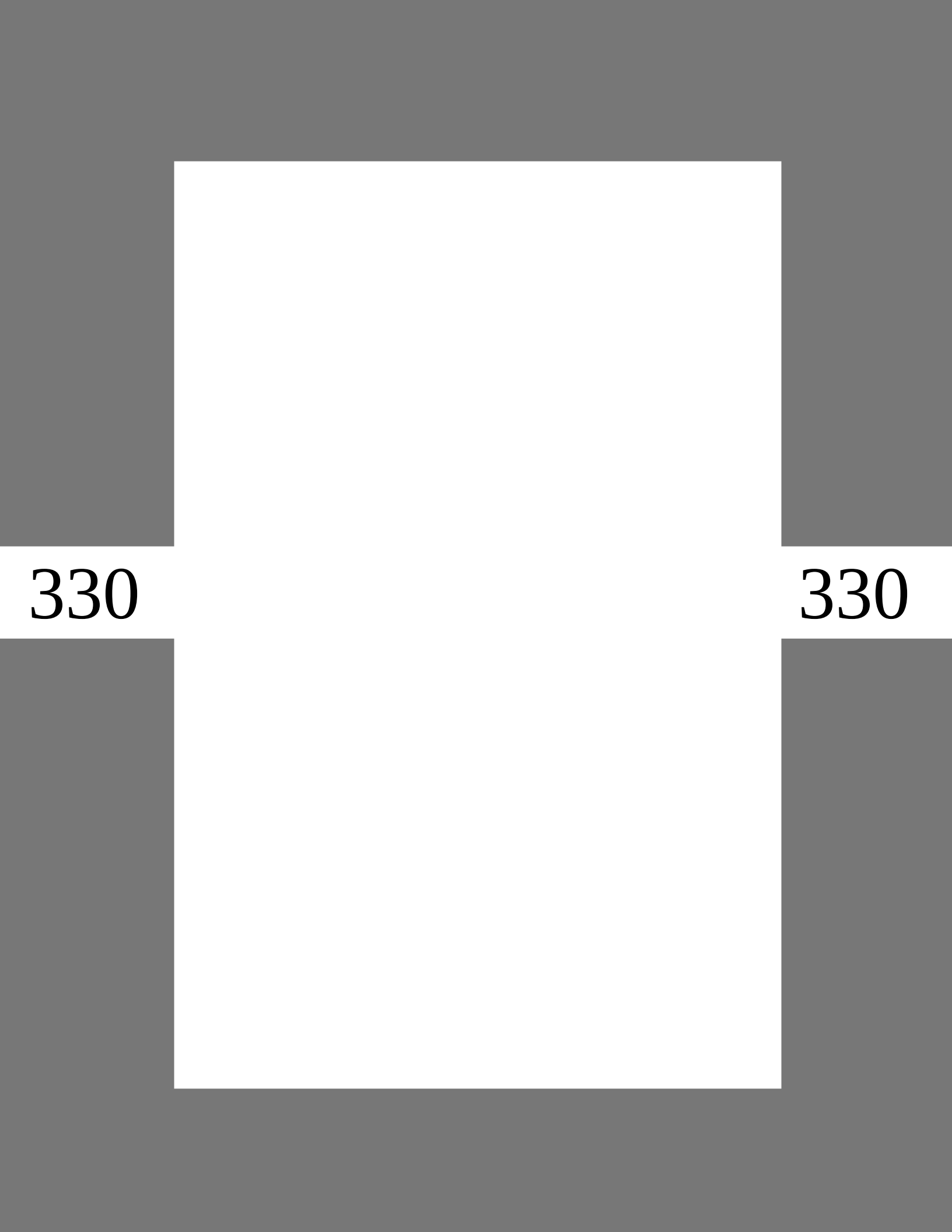
Drafting Note: Insert section number providing for review of administrative orders.

Section 9. Severability

If any provision of this Act, or the application of the provision to any person or circumstances, shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1972 Proc. I 15, 16, 443-444, 491, 495-496 (claims settlement practices made part of Unfair Trade Practices Act).
1990 Proc. II 7, 13-14, 160, 177-179 (adopted free-standing claims settlement practices act).
1991 Proc. I 9, 16, 192-193, 203-206 (amended and reprinted).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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

Case No.: A-19-792978-B
Dept. No.: 27

REPLY IN SUPPORT OF DEFENDANTS' MOTION FOR REMITTITUR AND TO ALTER OR AMEND THE JUDGMENT

Hearing Date: June 29, 2022
Hearing Time: 10:00 a.m.

017374

vs.

UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

Defendants UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services Inc. ("UHS"), which does business as UnitedHealthcare or "UHC" and through UHIC), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Company ("SHL"), and Health Plan of Nevada, Inc. ("HPN") (collectively, "Defendants"), by and through their attorneys, hereby submit this Reply in support of their Motion Remittitur and to Alter or Amend the Judgment ("Motion").

Simply put, there is simply no justification for the colossal $60 million punitive damages award. Here the punitive damages award blew past both procedural and substantive due process limitations. Defendants' conduct was not sufficiently reprehensible to justify an award of punitive damages that was, on average, *twenty-three times greater* than the compensatory damages award. This Court should vacate, or at the very least significantly reduce, the punitive damages award.

I.

THE PUNITIVE DAMAGES ARE UNCONSTITUTIONALLY EXCESSIVE

Every award of punitive damages must pass the due process standards espoused by the United States Supreme Court, including that "few awards exceeding a single-digit ratio between punitive and compensatory damages . . . will satisfy due process." *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408, 425 (2003). Indeed, the "relevance of the ratio between compensatory and punitive damages is indisputable, being a central feature" of the "due process analysis." *Exxon Shipping Co. v. Baker*, 554 U.S. 471, 507 (2008) (citing *State Farm*). There is no denying that the

punitive damages in this case concerning economic injury are astronomical compared to the compensatory damages. Accordingly, the judgment should be remitted or amended.

TeamHealth Plaintiffs oppose that necessary outcome by advancing a litany of arguments for why the Court need not concern itself with the ratio between punitive and compensatory damages—*i.e.*, the "central feature" of punitive damages due process analysis. All fail for numerous reasons. First, TeamHealth Plaintiffs implore the Court to supplant the jury's findings with its own by going beyond the evidence presented to the jury. This is not permitted. Indeed, TeamHealth Plaintiffs provide the Court with no authority that it has the power to do so. Second, TeamHealth Plaintiffs need the Court to go beyond the record and evaluate unproven "facts" because this case does not exhibit the reprehensibility necessary to justify $60 million in punitive damages. But Nevada law precludes the Court from imputing the sufficient reprehensibility to justify the award. Moreover, this case only concerns an economic injury. Namely, TeamHealth Plaintiffs and its corporate family did not receive their desired profits. There is no risk of any other harm. Third, because there is no potential risk of other harm, the disparity between the compensatory and punitive damages awards is unjustifiable. Fourth, the need to reduce the punitive damages is supported by civil and statutory penalties. Because TeamHealth Plaintiffs' arguments do not overcome the fact that the punishment—*i.e.*, punitive damages—must fit the crime—*i.e.*, compensatory damages and the basis thereof—this Court must remit or amend the punitive damages judgment.

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A. <u>The Court May Only Consider Evidence Presented To The Jury</u>

Amazingly, TeamHealth Plaintiffs assert that the Court can deprive Defendants of due process in analyzing whether the punitive damages award violates the United States Constitution's Due Process clause. Namely, the Court is free to go beyond the evidence presented to the jury in its due process analysis. (Opp. at 3, n.1.) TeamHealth Plaintiffs provide no support for this argument. Instead, they contend that their ignorance of any such bar means that verdicts may be supported without regard to the trial record. *Id.* *But see Morgan v. Woessner*, 997 F.2d 1244, 1257 (9th Cir. 1993) ("The task of the court is a comparison between the amount of punitive damages actually assessed and a figure derived from the facts of the case at hand."); *Jernigan v.*

Sheriff, 86 Nev. 387, 389, 469 P.2d 64, 65 (1970) (holding courts may not consider purported "facts" outside the record, such as those in a party's papers, when assessing a verdict). TeamHealth Plaintiffs' untenable position is the basis for their argument that the Court may consider allegations never presented to the jury – and thus, never able to be countered by Defendants – and allegations and related evidence that TeamHealth Plaintiffs *successfully moved to exclude from trial*. *Compare* First Amend. Compl. ¶ 209 *to* Second Amend. Compl; *see* 11/1/2021 Order Granting Plfs' Mot. *in Limine* to Exclude Evidence re Dismissed Claims; *see also* Opp. at 10 n.2 (providing no support in their attempt to mislead the Court into believing attorneys' fees may be considered "in evaluating . . . the ratio of punitive to compensatory damages"). Logically, the Court cannot consider allegations that TeamHealth Plaintiffs dropped and that Defendants had no opportunity to defend against at trial in a *due process* analysis.[1]

To be sure, the Supreme Court has held that trial courts have a "somewhat superior advantage" in their analysis of the first *Gore* factor. *Cooper Indus., Inc. v. Leatherman Tool Grp., Inc.*, 532 U.S. 424, 440 (2001); *Bongiovi v. Sullivan*, 122 Nev. 556, 583, 138 P.3d 433, 452 (2006) (holding this Court must review the "excessiveness of a punitive damages award" using "the federal standard's three guideposts:" "(1) the degree of reprehensibility of the defendant's misconduct; (2) the disparity between the actual or potential harm suffered by the plaintiff and the punitive damages award; and (3) the difference between the punitive damages awarded by the jury and the civil penalties authorized or imposed in comparable cases."). The district court has the advantage "with respect to issues turning on witness credibility and demeanor," indicating that the issues and facts presented to the jury are critical components when determining the reprehensibility

[1] Further, the Court should yet again rebuke TeamHealth Plaintiffs' insatiable quest to rely on *Ingenix*. In tilting at the windmill this go around, TeamHealth Plaintiffs provide no authority that permits the Court to supplant the trial record with extraneous, unproven conspiracy theory. Indeed, doing so would be worse than relying on prior bad acts because the alleged conduct related to the *Ingenix* settlement was never determined to be reprehensible, let alone unlawful. But if the Court were to look at evidence not presented to the jury, it should turn to Defendants' offer of proof because it contains a plethora of information that contextualizes Defendants' conduct and shows that it was not reprehensible. This includes the actual relationship of the parties and the fact that Defendants reimbursed TeamHealth Plaintiffs at amounts commensurate to what TeamHealth Plaintiffs accept from other commercial payers.

of a defendant's conduct. *Cooper Indus., Inc.*, 532 U.S. at 440. The Supreme Court noted further that while it determined that the an appeals court must review the application of the *Gore* test de novo, "it of course remains true that the Court of Appeals should defer to the District Court's findings of fact unless they are clearly erroneous." *Id.* at 440, n.14. This Court, however, cannot replace the jury's findings of fact regarding Defendants' conduct with its own based on TeamHealth Plaintiffs' allegations that were neither presented to nor considered by the jury. *See Jernigan*, 86 Nev. at 389, 469 P.2d at 65. Thus, the Court's due process analysis is confined to the trial record.

B. This Case Does Not Exhibit Reprehensibility Necessary to Justify $60 Million in Punitive Damages

1. Nevada Law Establishes that the Court Cannot Impute Sufficient Reprehensibility to Justify the Award

This is a case based solely on economic harm between two sophisticated businesses. Opp. at 6:28 ("This case involves economic, not physical harm."); 10/22/2021 Tr. 65:3-4 ("This is big business against big business."). TeamHealth Plaintiffs are private equity backed business-savvy physician-staffing companies, Opp. at 2; 12/7/2021 Tr. 110:2-3, that attempt to create a sense of moral outrage in a case relating to alleged underpayment for services.[2] This distraction hides the fact that they make no effort to distinguish *Ace Truck v. Kahn* or *Evans v. Dean Witter Reynolds* – Nevada cases demonstrating the necessary degree of reprehensibility necessary to support a large punitive damages award.

In *Ace Truck*, plaintiffs were awarded punitive damages for defendants' fraud relating to the sale of a business. *Ace Truck & Equip. Rentals, Inc. v. Kahn*, 103 Nev. 503, 511, 746 P.2d

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[2] For example, TeamHealth Plaintiffs assert Defendants' conduct was reprehensible because the reimbursement that TeamHealth Plaintiffs received "*could*" result in *doctors* being inadequately paid. Opp. at 2 (citing 11/17/21 Tr. 256:8-18) (emphasis added). However, the Court prohibited Defendants from exploring whether any additional reimbursement would result in *any provider* receiving more pay from TeamHealth Plaintiffs. Indeed, TeamHealth Plaintiffs told the jury that the jury was "not going to find . . . what happens to this money . . . [and] what the consequences are" if they rule in TeamHealth Plaintiffs' favor. 11/23/2021 Tr. 173:4-10. But if Defendants' conduct is reprehensible because it could result in doctors being inadequately paid, then the reprehensibility analysis must compare the reimbursement at-issue in this case against the reimbursement that TeamHealth Plaintiffs received from in-network payers. Those in-network payments would effect doctor pay, too. But the Court excised those facts from the case.

132, 137 (1987), *abrogated on other grounds by Bongiovi v. Sullivan*, 122 Nev. 556, 138 P.3d 433 (2006). The Nevada Supreme Court noted that although plaintiffs suffered economic harm, as well as "considerable inconvenience and annoyance as a result of appellants' fraud, . . . this is not high on the scale of severity of harm done when compared to the general run of malicious and oppressive acts which make up the bulk of punitive damage cases." *Id.* Similar to TeamHealth Plaintiffs, the *Ace Truck* plaintiffs' business remained "in operation and appears to have survived the defendants' misdeeds." *Id.* And just like the plaintiffs in *Ace Truck*, TeamHealth Plaintiffs are not "vulnerable" victims. *Id.* ("From our view of the record [plaintiffs] appear to be business people of normal and expected wisdom and sophistication in making this transaction."). The court accordingly reduced the punitive damages award to a roughly one-to-one ratio. *Id.*

In contrast, the Nevada Supreme Court has found larger punitive damages awards appropriate, but only where defendants reprehensibility was *much* higher than that supported by the jury's verdict. In *Evans v. Dean Witter Reynolds*, which supported a punitive damages award of only ***2.4*** times compensatory damages (compared to the 23:1 ratio here), the defendants assisted a fiduciary with looting millions of dollars from a mentally and physically incompetent widow; funds on which she relied for sustenance. 116 Nev. 598, 602-04, 5 P.3d 1043, 1045-47 (2000). The reprehensibility of the *Evans* defendants was two-fold: (1) the particular vulnerability of an incompetent client; and (2) the fiduciary relationship that was violated. No comparable concern exists here.

Moreover, in *Exposure Graphics v. Rapid Mounting Display*, 128 Nev. 895 (2012), the Nevada Supreme Court found that a punitive damages award equaling 2.1 times the compensatory damages was improper. The court observed that the reprehensibility of the defendant's conduct was fairly limited given that the case stemmed from a business transaction, and that a ratio of 2.1 "should be limited to instances in which the injured party demonstrates a higher degree of reprehensibility than that which was present" in that case. *Id.* Such is the case here. TeamHealth Plaintiffs cannot establish the required reprehensibility to support the ratios of punitive damages to compensatory damages awarded.

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2. The Type of Harm Suffered Weighs Against a Large Award

As "[i]t should be presumed that a plaintiff has been made whole for his injuries by compensatory damages," a defendant's conduct must be "so reprehensible as to warrant the imposition of further sanctions to achieve punishment or deterrence." *State Farm*, 538 U.S. at 419. The only harm alleged by TeamHealth Plaintiffs is economic: they received less payment than they demanded as reimbursement for certain out-of-network emergency medicine services. TeamHealth Plaintiffs have been made whole through compensatory damages, at a notably lower rate than they argued was appropriate.[3]

To get around this recovery obstacle, TeamHealth Plaintiffs conflate analysis of the *type* of harm suffered with the analysis of whether the conduct was intentional and/or malicious. It is undisputed that the only harm suffered by TeamHealth Plaintiffs was lower profits, making their argument that *Gore* supports an award of punitive damages at a 23:1 ratio unavailing. Opp. at 7:2-5. The full passage from *Gore* states:

> In this case, none of the aggravating factors associated with particularly reprehensible conduct is present. The harm BMW inflicted on Dr. Gore was purely economic in nature. The presale refinishing of the car had no effect on its performance or safety features, or even its appearance for at least nine months after his purchase. BMW's conduct evinced no indifference to or reckless disregard for the health and safety of others. To be sure, infliction of economic injury, especially when done intentionally through affirmative acts of misconduct, or when the target is financially vulnerable, can warrant a substantial penalty. *But this observation does not convert all acts that cause economic harm into torts that are sufficiently reprehensible to justify a significant sanction in addition to compensatory damages*.

BMW of N. Am. v. Gore, 517 U.S. 559, 575 (1996) (emphasis added) (citation omitted). The *Gore* Court cited *TXO Prod. Corp. v. All. Res. Corp.*, 509 U.S. 443, 453 (1993) in support of its contention that, under the right circumstances, economic harm *might* justify a substantial punitive

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[3] The jury found that the appropriate reimbursement rate was, on average ~319% of Medicare, compared to the ~760% of Medicare TeamHealth Plaintiffs demanded, on average, for the At-Issue Claims, *see* 12/7/2021 Tr. 81:7-13, 116:19-25; 11/29/2021 Verdict at Interrogatory Nos. 2-4, 7-9, further underscoring the comparative reasonableness of Defendants' reimbursement at, on average, ~164% of Medicare. *See also* Opp. at 5:25-26 (noting $2,450,182.29 award was less than the $10.5 million sought).

damages award. In *TXO*, an oil company "knowingly and intentionally brought a frivolous declaratory judgment action." *Id.* at 449. The company's fraud in that case was perpetuated by its abuse of the court system, which merited a substantial punitive damages award. *Id.* at 453. This is a dramatically distinct degree of conduct than that alleged here.

The "record in this case discloses no deliberate false statements, acts of affirmative misconduct, or concealment of evidence of improper motive, such as were present in *Haslip* and *TXO*." *Gore*, 517 U.S. at 579. The verdict does not include any determinations of intentional, deliberate, or affirmative acts to harm TeamHealth Plaintiffs, because imposing liability under the actual causes of action did not entail such findings. Likewise, TeamHealth Plaintiffs presented no evidence that Defendants' motive in paying less than TeamHealth Plaintiffs' full billed charges was "evil," fraudulent, or that it served no legitimate purpose – the only testimony on this subject consistently affirmed that Defendants intended to control skyrocketing healthcare costs for their clients and members. *E.g.*, 11/3/2021 Tr. 49:18-20; 11/8/2021 Tr. 20:9-14. And while TeamHealth Plaintiffs argue that the jury found Defendants liable for underpaying a large number of claims, it cannot be said that Defendants did so as part of a plan to drive TeamHealth Plaintiffs out of business. Opp. at 9. Defendants refused to pay the full amounts of TeamHealth Plaintiffs' invoices because they were unreasonable – and the jury agreed. *See* 11/29/2021 Verdict at Interrogatory Nos. 2-4, 7-9 (refusing to award TeamHealth Plaintiffs' billed charges).

C. The Extreme Disparity between the Compensatory and Punitive Damages Awards is Unjustifiable

TeamHealth Plaintiffs attempt to justify the wildly disproportionate punitive damages award by conjuring the threat of an alleged harm that never happened and is now, thanks to the No Surprises Act, unlikely to happen in the future. TeamHealth Plaintiffs argue that the award is justified because of the "harm to public health and safety that was likely to have resulted from the conduct at issue but for the intervention of the Plaintiffs' lawsuit." Opp. at 10:7-8. TeamHealth Plaintiffs are correct that "the proper inquiry is whether there is a reasonable relationship between the punitive damages award and *the harm likely to result* from the defendant's conduct as well as the harm that actually has occurred." *Gore*, 517 U.S. at 581 (emphasis in original) (internal

quotations omitted). It is incorrect, however, to find that such a reasonable relationship exists here. TeamHealth Plaintiffs' argument is incorrect for several reasons: (1) harm to public health and safety did not occur; (2) given the timeframe and amount of underpayments, it is not reasonable to infer such harm would occur; and (3) the passage of the No Surprises Act makes the harm even less likely to occur.

The Supreme Court has observed that "[p]unitive damages should bear a reasonable relationship to the harm *that is likely to occur from the defendant's conduct* as well as to the harm that actually has occurred. If the defendant's actions caused *or would likely cause* in a similar situation only slight harm, the damages should be relatively small." *TXO*, 509 U.S. at 460 (emphasis in original). Here, TeamHealth Plaintiffs did not present and cannot now point to *any* evidence that establishes that the conduct resulted in any physical harm or that these "underpayments" threatened anyone's health or physical safety – rather, TeamHealth Plaintiffs and its corporate family, including its publicly traded owner, did not receive the pecuniary gain that they desired. There was similarly no evidence presented that doctors' compensation was reduced; that any emergency room in Nevada was forced to close; or that patient care was impacted by the alleged underpayments.

In *TXO*, the Supreme Court held it was "appropriate to consider the magnitude of the *potential harm* that the defendant's conduct would have caused to its intended victim if the wrongful plan had succeeded, as well as the possible harm to other victims that might have resulted if similar future behavior were not deterred." *TXO*, 509 U.S. at 460 (emphasis in original). Here, the Court need not guess as to the level of magnitude of any potential harm. In a case involving more than 11,000 claims over three years, TeamHealth Plaintiffs could show no harm to the alleged public safety net . Instead, TeamHealth Plaintiffs' witnesses merely posited that the federal government established a public safety net by prohibiting their providers from turning any patient away, including those that will never pay for the services rendered. 11/15/2021 Tr. 154:14-21 (Dr. Scherr: "by law, the EMTALA law, we have to provide" medical treatment); 11/17/2021 Tr. 257:8-14 (Dr. Frantz: "we have a federal mandate, . . . EMTALA, whereby emergency physicians have

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to take care of . . . all patients . . . whether they can pay or not"). Therefore, it would be unreasonable to assume that the public safety net would continue to be harmed if Defendants continued to remit reimbursement for services rendered. The argument that it could possibly have happened is implausible. It is also insufficient due to the substantial evidence – based on tens of thousands of claims over several years – that it did not happen.

Additionally, the No Surprises Act makes it unreasonable to accept TeamHealth Plaintiffs' speculative version of the potential future harm that could be suffered. NRS 439B.160; NRS 439B.751(2); NRS 439.754; *see also* H.R. 133, § 103 (effective January 1, 2022). The Legislature has largely removed the threat that underpayments "could undermine, and therefore jeopardize, the emergency rooms that comprise the healthcare safety net for Nevada's citizens." Opp. at 8:5-6. This threat has not materialized in the past, and it is not reasonable to assume it will in the future. The massive ratio between compensatory and punitive damages is not warranted on this ground.

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D. Civil and Statutory Penalties, Including the Prompt Pay Act, Support that No Further Punitive Damages are Appropriate

TeamHealth Plaintiffs assert that the Ninth Circuit has effectively abandoned the third *Gore* factor for violations of common law tort duties. If true, then they could cite to a Ninth Circuit case. But no such case exists and TeamHealth Plaintiffs resort to Tenth and Third Circuit precedent that common law tort duties "do not lend themselves to a comparison with statutory penalties." Opp. at 12 (citing *Lompe v. Sunridge Partners, LLC*, 818 F.3d 1041, 1070 (10th Cir. 2016)). However, the *Lompe* court held that "[a]lthough the lack of robust comparisons renders this guidepost less helpful in the overall analysis," it would nonetheless "include what information is available to comport with the Supreme Court's direction." *Id.* at 1070, n.30. Moreover, Ninth Circuit precedent directly contradicts TeamHealth Plaintiffs' contention: "An exacting *Gore* review, *applying the three guideposts rigorously*, may be appropriate when reviewing a common law punitive damages award." *Arizona v. ASARCO LLC*, 773 F.3d 1050, 1056 (9th Cir. 2014) (emphasis added).

II.

TEAMHEALTH PLAINTIFFS CONCEDE THAT PROMPT PAY ACT INTEREST NO LONGER ACCRUES

Defendants argued in their Motion that the judgment must not be read to impose Prompt Pay Act interest on top of post-judgment interest. TeamHealth Plaintiffs concede that Prompt Pay Act interest stopped accruing the day judgment was entered. Opp. at 12 n.5; *see also* EDCR 2.20(e) ("Failure of the opposing party to serve and file written opposition may be construed as an admission that the motion . . . is meritorious and a consent to granting the same.").

CONCLUSION

For the foregoing reasons, this Court should eliminate the award of punitive damages. Alternatively, it should reduce the ratio of punitive damages to be equal to the compensatory damages.

Dated this 22nd day of June, 2022.

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CERTIFICATE OF SERVICE

I hereby certify that on the 22nd day of June, 2022, a true and correct copy of the foregoing **"REPLY IN SUPPORT OF DEFENDANTS' MOTION FOR REMITTITUR AND TO ALTER OR AMEND THE JUDGMENT"** was electronically filed and served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

Case No.: A-19-792978-B
Dept. No.: 27

REPLY IN SUPPORT OF DEFENDANTS' RENEWED MOTION FOR JUDGMENT AS A MATTER OF LAW

Hearing Date: June 29, 2022
Hearing Time:10:00 a.m.

vs.

UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

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I. INTRODUCTION

TeamHealth Plaintiffs do not engage with the substantive arguments in Defendants' motion. As the motion established, TeamHealth Plaintiffs have not presented evidence to support any of their claims against any defendant. Indeed, those claims are legally foreclosed. Nor are TeamHealth Plaintiffs entitled to punitive damages: they established no predicate tort to support the claim, and the jury's own verdict rejecting the billed charges that TeamHealth Plaintiffs claimed were "clear[ly]" owed eliminates the necessary state of mind.[1] This Court should vacate the judgment and grant the motion.

II. TEAMHEALTH PLAINTIFFS HAVE NOT PRESENTED OR PROVEN CLAIMS AGAINST SHL, HPN, AND UMR

TeamHealth Plaintiffs employ an interesting rhetorical device in arguing against the JMOL motion for failing to prove a case against SHL, HPN and UMR ("the secondary defendants"). First, TeamHealth Plaintiffs preface the arguments with a nearly four-page "Background" section, arguing the theory of the overall case, especially against UHI and UHS ("the primary defendants"). Then they argue the specifics of the cases against SHL, HPN, and UMR—for barely over a single page.

But the case against UHI and UHS cannot as a matter of law make out a presentation against SHL, HPN, and UMR. And TeamHealth Plaintiffs' argument on the actual cases against these three secondary defendants simply glosses over the particulars of their case, trying to create an impression that they presented adequate evidence. They did not.

Truly, TeamHealth Plaintiffs conflate the need to present and prove a prima facie case at trial with the substantially less stringent (especially in Nevada) standard for stating a cause of action in a complaint under NRCP 12(b)(5). While a plaintiff can avoid dismissal or demurrer simply by alleging certain circumstances, one must actually prove facts to present a case to the jury. *See, e.g.*, *Goodrich v. Garrison Prop. & Cas. Ins. Co., Inc.*, 526 F. Supp. 3d 789, 801 (D. Nev. 2021) (holding plaintiff is required to present evidence of a prima facie case to proceed to a

[1] The excessiveness of those awards are discussed in the concurrently filed reply brief on remittitur and to alter and amend the judgment, incorporated here.

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jury).

It is indisputable that TeamHealth Plaintiffs did not present the same case against SHL, HPN, and UMR as they did against UHI and UHS. These three secondary defendants "calculated reimbursements differently," as TeamHealth Plaintiffs admit. (Opp. at 4:18-19.) The evidence against UHI and UHS, such as it is, cannot be demonstrative against the secondary defendants.

But that is what TeamHealth Plaintiffs attempt to do. They argue that there were "thousands of instances" where TeamHealth Plaintiffs' providers cared for insureds of the secondary defendants, for which TeamHealth Plaintiffs billed and were paid. (Opp. at 4:24-27.) That does not prove a prima facie case on any of these claims against the secondary defendants, however. TeamHealth Plaintiffs' causes of action require proof of something more than a disparity between their billed charges and the amounts they received in reimbursement.

Then TeamHealth Plaintiffs argue that "SHL and HPN" paid "less than" the rates paid by UHI and UHS. (Opp. at 5:3-4.) That does not carry the day, either. As to UMR, TeamHealth Plaintiffs put forward that it had cost-savings programs. (Opp. at 5:9.) TeamHealth Plaintiffs' argument is that, simply because they demonstrated that the secondary defendants paid an amount less than they were billed, TeamHealth Plaintiffs have made out a case. That is insufficient to present a claim to the jury. Without specific evidence apart from the list of claims itself (which purports to show the amounts billed and amounts allowed, and little else, *see* P473), TeamHealth Plaintiffs have not proved their causes of action against these secondary defendants—mostly glaringly as to SHL and HPN. This complete failure of proof makes any verdict against these secondary defendants contrary to law.

Moreover, while they contend that witnesses appreciated some obligation to reimburse providers at a reasonable rate (Opp. at 5:13-15), that assertion does not amount to proof of a specific duty and certainly not a breach of the duty simply because reimbursement was less than the billed amount in these circumstances.[2] Thus, the Court must vacate the verdicts rendered

[2] As discussed in Part V.B below, any acknowledgment by Defendants to reimburse at a reasonable rate is not confirmation of a *contractual* duty with TeamHealth Plaintiffs but simply the obligations imposed under

against SHL, HPN, and UMR and enter judgment those defendants' favor.

III. PLAINTIFFS HAVE NOT MADE OUT ANY CLAIM UNDER THE UNFAIR CLAIMS PRACTICES ACT

A. Only Insureds have a UCPA Right of Action, and Plaintiffs are not Insureds

The issue of standing is clear: The Nevada Unfair Claims Practices Act ("UCPA") does not allow a claim by a third-party, that is, someone other than an *insured*. NRS 686A.310(2). Originally, the UCPA did not allow for a private right of action at all. *Tweet v. Webster*, 610 F. Supp. 104, 106 (D. Nev. 1985). Then, in 1987, the Legislature amended NRS 686A.310 to allow for such a claim but it was expressly limited to claims by an "insured."

The UCPA grants certain specific rights to insureds and to claimants. While a non-insured claimant, such as an injured third-party making a claim against the insured, is protected by some of the statute's provisions, the remedy for such a claimant is not a right of action, but administrative recourse through the Insurance Commissioner.

TeamHealth Plaintiffs attempt to obfuscate the controlling standard by citing the wrong statute. They call on NRS 686A.020, which simply states that acts prohibited in certain sections of the Chapter constitute "an unfair method of competition or an unfair or deceptive act or practice . . . ." But it was the 1987 amendment to NRS 686A.310(2) that conferred a private right of action, and that provision limits the action to an insured: "In addition to any rights or remedies available to the Commissioner, ***an insured is liable to its insured*** for any damages sustained by the insured as a result of the commission of any act set forth in subsection 1 as an unfair practice." NRS 686A.310(2) (emphasis added),

Here, TeamHealth Plaintiffs are concededly not insureds. In fact, they are not even traditional third-party claimants, such as an injured party seeking recovery under bodily-injury coverage where the circumstances of an automobile-injury accident are clear. TeamHealth Plaintiffs are simple service "providers" seeking recovery for the services provided. They are vendors, not claimants. They are not the entities contemplated by the UCPA.

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preexisting statutes and the benefit plans with members—claims that TeamHealth Plaintiffs pointedly elected not to pursue.

TeamHealth Plaintiffs maintain that the Nevada Supreme Court has not said that the UCPA cause of action is limited to insureds, citing *Gunny v. Allstate Ins. Co.*, 830 P.2d 1335 (Nev. 1992) and *Fulbrook v. Allstate Ins. Co.*, 2015 WL 439598 (Nev. Jan. 30, 2015). (Opp. at 6). But TeamHealth Plaintiffs are wrong. Citing with approval leading federal decisions on the statute, the Nevada Supreme Court in *Gunny* held that a third-party claimant had no right of action under the UCPA:

> [W]e conclude that Greg has ***no private right of action as a third-party claimant under NRS 686A.310***. *See Crystal Bay General Imp. Dist. v. Aetna Cas. & Sur.*, 713 F. Supp. 1371, 1377 (D. Nev. 1989) (NRS 686A.310 creates no private right of action in favor of third-party claimants against an insurer); *Tweet v. Webster*, 610 F. Supp. 104 (D. Nev. 1985) (a third-party claimant has no contractual relationship with an insurance company).

830 P.2d at 1336 (emphasis added).[3] The court was equally clear in *Fulbrook*: "This statute, however, does not provide a private right of action to third-party claimants." 2015 WL 439598 at *4; *see also Wilson v. Bristol W. Ins. Grp.*, No. 209-CV-00006-KJD-GWF, 2009 WL 3105602, at *2 (D. Nev. Sept. 21, 2009) ("No private right of action as a third-party claimant is created under NRS 686A.310."). Plaintiffs are not insureds. They cannot maintain a claim under the UCPA.

B. Only an "Insurer" can be Liable under the UCPA

Plaintiffs *again* want to rely on NRS 686A.020 to create the impression that the UCPA's right of action applies to all prohibited acts by "all persons." (Opp. at 6:28-7:4.) But *again*, the right of action is created by NRS 686A.310(2), which expressly states that "***an insurer is liable to its insured***[.]" (emphasis added).

As explained in the Motion, UHS, UMR, and in some instances UHIC are third-party administrators, not insurers. The Nevada Supreme Court has made clear that a plan administrator is not an insurer so as to face a UCPA right of action. *Albert H. Wohlers & Co. v. Bartgis*, 114 Nev. 1249, 1264, 969 P.2d 949, 960 (1998) ("[W]e conclude that NRS 686A.310 does not apply to Wohlers because it is not an insurer or company within the meaning of the applicable statutory

[3] In discussing *Gunny* and *Torres*, TeamHealth Plaintiffs conflate the statutory limits of a UCPA right of action with the different issue of standing to bring a third-party bad-faith action. While a bad-faith cause of action is a matter for the courts, it is not illuminating on the statutory claim.

law. Therefore, the district court erred in applying the provisions of NRS 686A.310 to Wohlers.").[4] In fact, the court in *Bartgis* expressly rejected the same argument that under NRS 686A.020 a UCPA action could be brought against "all persons." *Id.*, at 1264, 969 P.2d at 960.

TeamHealth Plaintiffs seem to argue that this Court should look to the definition of an insurer in the National Association of Insurance Commissioners model rule, which would include a third-party administrator. (Opp. at 7:16-8:9.) But the Nevada Legislature did not include this definition, and the model rule does not provide for a private right of action. Where the Legislature has so clearly diverged from the approach of the model rule, the courts should honor that intent. Differing from the NAIC model, the Legislature created a private right of action, but limited it to be against insurers, only.[5] The text of the Unfair Claims Practices Act is conclusive on this subject.

C. TeamHealth Plaintiffs did not make out a Claim under NRS 686A.310(1)(e)

This case is different from typical insurance cases. In an insurance claim, a claimant will make a demand on an insurer, which will not make any payment on the claim until it is finally resolved. That is why the statute seeks to encourage settlement efforts once liability of the insurer is reasonably clear.

This case is distinct from that scenario in several ways. Defendants did pay reimbursement on the bills submitted, just not on the entire amount requested. While the provision of services might entitle a vendor to some reimbursement, liability would only be "*clear*" as to the fact of recovery, not the amount. And the *amount* of payment, rather than *liability* for reimbursement, is the dispute in this case. A provider cannot establish that liability for a particular amount is "clear" when there is a dispute as to the amount of reimbursement. Under TeamHealth Plaintiffs' argument, any carrier would violate NRS 686A.310 every time there was a disagreement as to the

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[4] TeamHealth Plaintiffs again conflate bad-faith principles with this statutory right of action. They argue that the administrator in *Bartgis* was more than just that because it was involved in a joint venture with the insurer. (Opp. at 9.) That was relevant to the appellate court's analysis of the administrator's liability in bad faith. Even with the administrator's more fulsome involvement, however, the Nevada Supreme Court still held that it was not an insurer under the UCPA.

[5] Plaintiffs ask the court to look to definitions of broader terms, such as "in the business of insurance" or "[t]ransacting insurance." But the term in the title and text of NRS 686A.310 is narrower; it is "insurer." That is defined as a "person engaged as a principal and as indemnitor, surety or contractor in the business of entering into contracts of insurance." NRS 679A.100. This definition does not apply to administrators.

amount of the claim. And here, moreover, the jury did not even award TeamHealth Plaintiffs the amount they requested.[6] This verdict further demonstrates that *no* Defendant's liability was reasonably clear because the jury *rejected* the amount TeamHealth Plaintiffs billed for each of the At-Issue claims, instead determining that a reasonable value was far less than what TeamHealth Plaintiffs requested. 11/29/21 Special Verdict Form; *see also* 12/6/2022 Tr. 51:10-13. And the jury clearly disagreed with both experts, instead awarding $2.65 million in liability—an amount neither party offered as a proposed amount of damages. *Id*.

Here, the parties disputed the amount to be paid. That was not resolved before the jury presented its verdict. Where the specific amount owed is in dispute, the extent of liability is not reasonably clear, and the claim fails. *See, e.g., Clifford v. Geico Cas. Co*., 428 F. Supp. 3d 317, 325 (D. Nev. 2019). Disagreement among experts on the amount of damages is enough to establish that "liability has not become reasonably clear." *Lubritz v. AIG Claims, Inc.*, No. 217CV02310APGNJK, 2018 WL 7360623, at *7 (D. Nev. Dec. 18, 2018); *Big-D Const. Corp. v. Take it for Granite Too*, 917 F. Supp. 2d 1096, 1118-19 (D. Nev. 2013).

In addition, TeamHealth Plaintiffs never presented evidence of a refusal to negotiate. TeamHealth Plaintiffs presented no evidence that, where an individual claim was appealed and negotiated, Defendants were unreasonable in negotiating a fair settlement. TeamHealth Plaintiffs offered no evidence that they communicated with Defendants and sought to negotiate a higher reimbursement on the disputed claims, and that Defendants rejected their reasonable demands for additional payment. The Court cannot allow the imposition of statutory liability for Defendants alleged failure to "effectuate a prompt, equitable, and fair settlement." Under TeamHealth Plaintiffs' approach, the mere tender of any amount less than billed charges would create strict

[6] "Liability" is different from the amount of recovery. The UCPA is geared toward cases different from this, and the cases adjudicating UCPA claims have focused on the denial of benefits where a first-party claim is allegedly meritorious but is improperly denied on its face. *Bartgis*, 114 Nev. 1249, 969 P.2d 949 (denial of aspect of claim as legally not covered); *Powers v. United Services Auto. Ass'n*, 114 Nev. 690, 962 P.2d 596 (1998) (denial of claim as intentional act), *opinion modified on denial of reh'g*, 115 Nev. 38, 979 P.2d 1286 (1999); *Fed. Ins. Co. v. Coast Converters*, 130 Nev. 960, 339 P.3d 1281 (2014) (dispute over which coverage applied where there were different limits). Perhaps conceivably, a minimum policy claim might be improperly denied on the amount. But first- and third-party coverage issues are different, in that they are resolved—or denied—in a single transaction, settling all or nothing. Here, an amount was paid.

liability under the statute. That is insufficient.

The Unfair Claims Practices Act does not prohibit good faith disagreements over the valuation of claims in the course of settling those claims. The UCPA targets delays in settlement where liability has become reasonably clear. Because the parties' experts disagreed about the amount damages TeamHealth Plaintiffs suffered, liability never became reasonably clear until the jury rendered its verdict. And the jury's award of an amount significantly lower than TeamHealth Plaintiffs' billed charges necessarily means that there was no sum certain that was reasonably clear before trial. Based on the statutory text and the case law, liability for these At-Issue claims is by definition not reasonably clear.

D. TeamHealth Plaintiffs did not Establish Knowledge of an Officer or Director

To prevail, TeamHealth Plaintiffs must prove that an "officer, director, or department head of the insurer has knowingly permitted such an act or has had prior knowledge thereof." NRS 686A.270; *Yusko v. Horace Mann Servs. Corp.*, No. 2:11–cv–00278–RLH–GWF, 2012 WL 458471, at *4 (D. Nev. Feb. 10, 2012) (granting summary judgment where plaintiff had not presented any evidence that an officer, director, or department head was aware of the conduct in question). Without evidence that an officer, director, or department head permitted the unfair insurance practices, TeamHealth Plaintiffs' claim fails as a matter of law. *Hackler v. State Farm Mut. Auto. Ins. Co.*, 210 F. Supp. 3d 1250, 1255 (D. Nev. 2016) (finding "Claims Teams Managers" did not qualify under the statutory requirements of NRS § 686A.270).[7]

[7] In *My Left Foot Children's Therapy, LLC v. Certain Underwriters at Lloyd's London subscribing to Policy No. HAH15-0632*, the plaintiffs sought relief under both NRS 686A.310(1)(e) ("[f]ailing to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear") and (1)(f) (forcing the insured to sue recover amounts due under the policy where the insured made claims for "amounts reasonably similar to the amounts ultimately recovered"). 2:15-CV-01746-MMD-VCF, 2021 WL 1093094, at *3 (D. Nev. Mar. 22, 2021). As evidence that "an officer, director or department head of the insurer has knowingly permitted" these violations as required under NRS 686A.270, plaintiffs provided authority letters and specific evidence that claims handlers followed the insurer's policies and procedures.

Here, non-insured TeamHealth Plaintiffs are relying solely on subsection (1)(e), yet they presented no evidence that Defendants' policies and procedures expressly authorized employees to violate the law or provided employees express authority to deny a settlement where Defendants' liability for full billed charges was "reasonably clear." As discussed above, the jury's verdict conclusively establishes that it was not. And even if TeamHealth Plaintiffs had shown that individual billed charges were inappropriately denied (which they did not), the aggregate findings in the jury's verdict undermine any suggestion that there

In sum, TeamHealth Plaintiffs presented no evidence that demonstrates that any officer, director, or department head permitted a unfair insurance practice.

IV. TEAMHEALTH PLAINTIFFS ARE NOT ENTITLED TO PUNITIVE DAMAGES

A. As TeamHealth Plaintiffs Cannot Establish a UCPA Case, There can be no Punitive Damages

Earlier on the Motion and in this Reply, Defendants set out the reasons TeamHealth Plaintiffs cannot bring a UCPA claim under these circumstances, including that TeamHealth Plaintiffs are not insureds and that UHS and UMR, and in some instances UHIC, are not insurers. Without a right of action, there cannot be a punitive recovery based on that claim. Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' claim for punitive damages under the Unfair Claims Practices Act.[8]

B. There can be no Punitive Damages Based on a Contract-Based UCPA Case

It is express in the punitive damages statute that such a recovery cannot be had in an obligation arising out of contract. NRS 42.005 permits punitive damages only "in an action for breach of an obligation not arising from contract," and the Nevada Supreme Court has ruled that

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was a top-down endeavor to deny TeamHealth Plaintiffs' billed charges even when those charges "clearly" reflected the reasonable value of services. Tellingly, unlike the *My Left Foot* plaintiffs, TeamHealth Plaintiffs here would have been unable to sustain a claim under (1)(f) because they manifestly did *not* recover amounts similar to what they had claimed they were owed from Defendants.

This case is instead like the *McCall* case (distinguished in *My Left Foot*) and *Hackler*. *See McCall v. State Farm Mut. Auto. Ins. Co.*, 2018 U.S. Dist. LEXIS 126616, at *10, 2018 WL 3620486, at *4-5 (as described in *My Left Foot*, rejecting the argument that because "claims adjusters were following procedures developed by State Farm's officers and department heads, management was effectively approving claims mishandling" because there were "no policies, procedures or depositions from management to support her conjecture...[and] without evidence that State Farm's upper management knew of and permitted allegedly unfair practices, McCall cannot prove her claim"). While Defendants maintain that *Hackler* and not *My Left Foot* sets forth the appropriate standard for the "officer, director or department head" requirement of NRS 686A.270, TeamHealth Plaintiffs cannot even prevail under the looser standard in *My Left Foot*.

[8] TeamHealth Plaintiffs did not seek punitive damages in connection with any other cause of action. JPTO at 5–6; *see also* SAC ¶¶ 80–89 (no allegation of entitlement to punitive damages in Second Claim for Relief for unjust enrichment). Because TeamHealth Plaintiffs did not request punitive damages in connection with the unjust enrichment cause of action, they have waived the right to seek those damages on that cause of action. "As a general proposition a pretrial order does control the subsequent course of the trial and supersedes the pleadings." *Walters v. Nev. Title Guar. Co.*, 81 Nev. 231, 234, 401 P.2d 251, 253 (1965); *see also* EDCR 2.67(b)(2) (pretrial memorandum must present "a list of all claims for relief … with each category of damage requested").

punitive damages cannot be awarded under NRS 42.005 where an action "sounds in contract, and not in tort." *Rd. Highway Builders, LLC v. N. Nev. Rebar, Inc.*, 284 P.3d 377, 384 (Nev. 2012); *see also Sprouse v. Wentz*, 105 Nev. 597, 602, 781 P.2d 1136, 1140 (1989) ("[P]unitive damages must be based on an underlying cause of action ***not based on a contract theory***.") (emphasis added). This prohibition applies not just to breach of contract claims, but broadly to any cause of action that "arises from" or "sounds in" contract. And a UCPA claim is based on a contractual relationship, here arising from the implied contract claim. *See* Ps' Opp. to Mot. to Dismiss at 25–26 (May 29, 2020); Order Denying Mot. to Dismiss FAC ¶ 68.

TeamHealth Plaintiffs cite *Ins. Co. of the West v. Gibson Title Co., Inc.*, 122 Nev. 455, 464, 134 P.3d 698, 703 (2006) to argue that punitive damages are recoverable under the UCPA, but that case does not even mention the UCPA. In fact, the holding in that case was that, as the plaintiff did not have a tort action against a surety for the tort of bad faith, there could be no punitive damages. *Id.* The *Gibson* court observed further that the "award of expected profits is adequate to compensate the aggrieved principal . . . because it made the principal whole. Therefore, as a matter of law, there was no basis for the jury's award of punitive damages." *Id.*

Furthermore, TeamHealth Plaintiffs again mischaracterize the holding of *Gunny*, this time by ignoring direct quotes from the opinion. First, the *Gunny* Court held that a plaintiff "lack[ed] standing to sue" under the UCPA because "he had no contractual relationship with" the insurer. 108 Nev. at 345, 830 P.2d at 1335-36. Second, the Court held that third-party claimants do not have a "private right of action . . . under NRS 686A.310." *Id.* at 346. Nonetheless, TeamHealth Plaintiffs contend that a contract is irrelevant to UCPA analysis because any person can sue so long as he or she has suffered some nondescript "cognizable harm." (Opp. at 13:16-19). . TeamHealth Plaintiffs untenable argument does not survive the fact that a contract is needed to bring a UCPA claim and, thus, making such causes of action sound in contract. Either there is a contract and punitive damages are unavailable or there is no contract and the UCPA cause of action cannot be maintained.

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Finally, neither the UCPA claim nor the unjust enrichment claim is based on the type of special relationship that gives rise to the tort of insurance bad faith. Under the circumstances, TeamHealth Plaintiffs cannot recover punitive damages.

C. TeamHealth Plaintiffs did not make the Requisite Showing for Punitive Damages

TeamHealth Plaintiffs' argument on their proof of malice, oppression, and fraud is more of the same type of conclusory presentation, glossing over the rigid requirements of the punitive damage statues. NRS 42.005 requires "*clear and convincing evidence*" of "oppression, fraud or malice." NRS 42.005(1) (emphasis added); *see also United Fire Ins. Co. v. McClelland*, 105 Nev. 504, 512, 780 P.2d 193, 198 (1989).

And those statutory requirements are intentional. In the 1989 reforms to the punitive damages statutes, amid controversies around the country that such damages should be repealed, the Nevada Legislature put in a number of protections for defendants. Among these was the requirement that punitive damages must be proven by clear and convincing evidence, not a mere preponderance. 1989 Statutes of Nevada 486. The sufficiency of the evidence must be judged against that high standard.

Here, TeamHealth Plaintiffs' conclusory showing does not suffice.

1. Fraud

TeamHealth Plaintiffs' argument that they proved a fraud case is more confusing than clarifying. Fraud is not simply making misrepresentations. "'Fraud' means an intentional misrepresentation, deception or concealment of a material fact known to the person *with the intent to deprive another person of his or her rights* or property or to otherwise injure another person." NRS 41.001(2) (emphasis added). The intentionally false representation must be made to induce reliance and must actually cause the damages at issue.

TeamHealth Plaintiffs cannot prove any of these elements. At most, TeamHealth Plaintiffs presented evidence that Defendants made some representations about FAIR Health and Data iSight. But there is no evidence showing these representations were false, no evidence that

TeamHealth Plaintiffs justifiably relied on these representations, and no evidence that these representations caused them to be harmed in any way.

Similarly, the suggestion that "United held itself out as performing fair and objective reimbursement[s]" (Opp. at 15:13-14) is not enough without proof that TeamHealth Plaintiffs relied to their detriment in forming a course of action or that the representation somehow caused their harm. Indeed, TeamHealth Plaintiffs repeatedly argued to the jury that they had no choice but to treat Defendants' members by virtue of their legal obligations under EMTALA. *See, e.g.*, 11/2/2021 Tr. 30:7-31:10, 35:8-36:1 (opening argument discussing ER doctors' legal obligations under EMTALA); 11/15/2021 Tr. 154:14-21 (Dr. Scherr testifying to the same); 11/23/2021 Tr. 81:19-82:2 (Dr. Scherr disagreeing with Defendants' expert that ER providers are willing sellers because of EMTALA). Thus, representations about reimbursement criteria plainly could not have induced TeamHealth Plaintiffs to treat Defendants' members – by their own admission they had no such discretion.

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It is not enough that TeamHealth Plaintiffs argue that "United's unfair practices have directly harmed" them. (Opp. at 15:21.) It must be the *fraud* that caused the harm, and TeamHealth Plaintiffs cannot show that as a matter of law. And that fraud must be in the context of violating NRS 686A.310(1)(e), failing to effectuate settlement once liability is clear in violation of the Unfair Claims Practices Act. TeamHealth Plaintiffs did not even attempt to demonstrate that connection. Thus, they are not entitled to punitive damages on this ground.

2. Oppression and Malice

There are two types of malice, express and implied. Express malice requires a deliberate attempt to injure a person. NRS 42.001(3). There is no evidence of that here.

Implied malice and oppression both require "despicable conduct" engaged in with a conscious disregard of the rights of others. NRS 42.001(3) and (4). "'Conscious disregard' means the knowledge of the probable harmful consequences of a wrongful act and a willful and deliberate failure to act to avoid those consequences." NRS 42.001(1).

The business decisions made here were concerned with cost control for clients and members. This is not the type of despicable conduct contemplated by punitive damages. *E.g.*,

11/3/2021 Tr. 49:18-20; 11/8/2021 Tr. 20:9-14. The resultant alleged economic harm is not "reprehensible" to justify a punitive award, especially where TeamHealth Plaintiffs tout their national connections in being able to assert their claims in this case. Defendants made payment on the bills, moreover, rather than denying or refusing to pay. *See Pioneer Chlor Alkali Co. v. Nat'l Union Fire Ins. Co.*, 863 F. Supp. 1237, 1250–51 (D. Nev. 1994) (acknowledging "difficulty constructing a factual situation where an insurer who violated [NRS 686A.310] could have done so with an oppressive or malicious intent yet not denied, or refused to pay, the claim"). TeamHealth Plaintiffs simply made smaller profits.

Punitive damages focus on a defendant's state of mind in engaging in particular conduct. TeamHealth Plaintiffs seem to intend that the Court and the jury infer that *mens rea* from the conduct itself. That cannot be done under these circumstances, and such an inference would not be clear and convincing evidence. Defendants cannot have had the "evil" state of mind required to prove malice or oppression—the only evidence concerning the states of mind of Defendants' executives shows that they were concerned about controlling costs for their clients and members, and this evidence concerns Defendants' out-of-network programs generally rather than the settlement of any particular At-Issue Claim. TeamHealth Plaintiffs failed to establish entitlement to punitive damages on this ground.

V. IMPLIED IN FACT CONTRACT IS AN INAPPROPRIATE CAUSE OF ACTION

TeamHealth Plaintiffs take pieces of their argument from several inconsistent positions to contend that there is a contract here, even though the parties—far from agreeing on all the elements of a contract—agreed on little or nothing at all. This is not an implied-in-fact contract.

A. The Parties Did Not Mutually Assent to Material Terms

The parties here did not intend to contract, did not exchange promises, and did not agree on terms. *Magnum Opes Constr. v. Sanpete Steel Corp.*, 129 Nev. 1135 (2013) (citing *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 379, 283 P.3d 250, 256 (2012)). Defendants certainly did not agree to pay TeamHealth Plaintiffs their full billed charges for all out-of-network services indefinitely into the future.

Defendants did not manifest *any* intent to contract with TeamHealth Plaintiffs. There is no proof. Instead, TeamHealth Plaintiffs rely on an acknowledgement that they provided services to insureds and an "obligation" of the health carriers and self-funded plans to make a reimbursement to TeamHealth Plaintiffs. Such an obligation is not the same as an intent to contract. Without this evidence, a contract was simply not formed. *Certified Fire Prot. Inc.*, 128 Nev. at 379, 283 P.3d at 256; *Steele v. EMC Mortg. Corp.*, 129 Nev. 1154 (2013).

B. The Purported Contract Lacks Consideration Because It Arises from the Parties' Preexisting Statutory Duties

Moreover, both the obligation to treat patients and this payment obligation result from preexisting statutory duties of the parties, not a detriment freely undertaken.

"A party's affirmation of a preexisting duty is generally not adequate consideration to support a new agreement." *Cain v. Price*, 134 Nev. 193, 195, 415 P.3d 25, 28 (2018) (citing *Cty. of Clark v. Bonanza No. 1*, 96 Nev. 643, 650, 615 P.2d 939, 943 (1980)); *Thomas v. Palmer*, 49 Nev. 438, 446, 248 P. 887, 889 (1926) ("[A]s a general rule, the performance of, or the promise to perform, an existing legal obligation is not a valid consideration. This is a well-recognized rule, needing no citation of authorities to sustain it." (internal quotation mark omitted)). This includes duties imposed by statute or other law. 3 WILLISTON ON CONTRACTS § 7:42 (4th ed. May 2022 update).[9] Williston provides the example of common carriers, who already bear a duty to carry passengers without discrimination:

> Thus, an agreement by a common carrier to fulfill obligations imposed on it by law such as carrying passengers . . . is not sufficient consideration for a promise to the carrier, when the existing law requires the carrier to do or permit these things.

Id. Likewise, because a hospital is statutorily obligated to promulgate by-laws and develop procedures for reviewing a doctor's competency, those by-laws as such cannot constitute an enforceable *contract* with the doctor, even though they describe duties that both parties owe to one

[9] WILLISTON is quoted and cited approvingly in *Zhang v. Eighth Judicial District Court*, 120 Nev. 1037, 1040–41, 103 P.3d 20, 22–23 (2004) (quoting 3 RICHARD A. LORD, WILLISTON ON CONTRACTS 569–73 (4th ed. 1992), the section on preexisting duty), *abrogated on other grounds by Buzz Stew, LLC v. City of N. Las Vegas*, 124 Nev. 224, 181 P.3d 670 (2008).

another. *Robles v. Humana Hosp. Cartersville*, 785 F. Supp. 989, 1001 (N.D. Ga. 1992). This principle applies, too, when "each party's act was undertaken pursuant to statute, based upon an existing legal obligation," such that "[n]either party's act induced the other's action." *Prows v. State*, 822 P.2d 764, 767–68 (Utah 1991) (refusing to enforce a contract to pay statutorily required assessments in exchange for an agreement to guarantee deposits at statutorily mandated levels); *see also Temple Univ. Hosp., Inc. v. Philla.*, No. 1794, 2006 WL 51206, at *3 (Pa. Ct. Com. Pl. Jan. 3, 2006) (holding "there was no exchange of consideration" because the provider "was legally bound to provide emergency care services" pursuant to EMTALA).

Such illusory promises to do what the law purportedly already requires the parties to do is contrary to the existence of *any* contract, express or implied in fact. *See Certified Fire Prot. Inc.*, 128 Nev. at 379-80, 283 P.3d at 256 ("To find a contract implied-in-fact, the fact-finder must conclude that the parties intended to contract and promises were exchanged").

Here, the contract that TeamHealth Plaintiffs have alleged rests entirely not on a *voluntary* exchange of mutually agreeable promises—the acrimony and allegations of bad faith undermine that—but on both parties' supposed obligations under existing law. TeamHealth Plaintiffs must provide services to all patients, regardless of insurance status or ability to pay, or be open to civil actions and monetary penalties. 42 U.S.C.A. § 1395dd(d). TeamHealth Plaintiffs repeatedly argued and presented testimony that they *had no choice* but to treat Defendants' members by virtue of their legal obligations under EMTALA – this is hardly evidence of an intent to contract with Defendants.[10] *Temple Univ. Hosp.*, 2006 WL 51206, at *3.

In turn, Defendants' obligation to reimburse those services was not arrived at through contract with TeamHealth Plaintiffs, but through the member benefit plans. The parties certainly did not agree on price, let alone to pay whatever rate TeamHealth Plaintiffs set, as even the jury

[10] This differs from the textbook example of the off-duty doctor who, happening upon an injured individual on the street, obtains consent to administer aid *without* a preexisting legal obligation to do so. The contract there is indeed a voluntary meeting of the minds, the only exigency banging at the bargaining table a medical one, not a legal one.

found here. TeamHealth Plaintiffs were legally obligated to provide emergency service to patients, and the rates of reimbursement were established by the benefit plan.

Tellingly, in a bid to avoid removal or ERISA preemption, TeamHealth Plaintiffs elected *not* to pursue a claim to enforce any federal statutory obligation or (so they argue) based on the benefit plans. Yet in their workaround to couch this as an implied-in-fact contract, they have ignored the invalidity of the consideration. Whatever rights TeamHealth Plaintiffs might have been able to pursue to enforce the preexisting statutory or benefit-plan duties, they do not create rights of contract or unjust enrichment.

C. Missing Material Terms Show the Absence of a Contract, Not a License for Plaintiffs or the Jury to Impose those Terms

The absence of consideration under the preexisting duty rule reinforces that there was no agreement to pay TeamHealth Plaintiffs' billed charges or any reimbursement rate other than that set by the benefit plan. Because price was such a material term, this court should not find contract formation without an agreement on that point. *See, e.g.*, *Certified Fire Prot. Inc.*, 128 Nev. at 379-80, 283 P.3d at 256.

TeamHealth Plaintiffs attempt to use quantum meruit to supply this missing essential term, but that is only appropriate where the parties agreed to pay a reasonable price. *Id.*; Dan B. Dobbs, *Dobbs Law of Remedies* § 4.2(3) (2d ed. 1993) (quantum meruit fills price term when it is appropriate to imply the parties agreed to a pay reasonable price). There was no such agreement here, express or implied-in-fact. Defendants had established rates of reimbursement and did not agree to TeamHealth Plaintiffs' billed rates or any other alternative. The parties' experts provided several options of reasonable rates, and the jury awarded a completely different amount. There is just not enough here to impose either a contract or quantum meruit.

TeamHealth Plaintiffs have also not established the duration or term of this implied-in-fact contract. Nor have TeamHealth Plaintiffs submitted any evidence of the duration or term of the implied-in-fact contract. In fact, TeamHealth Plaintiffs objected to Defendants questioning witnesses on this topic. *See* 11/10/2021 Tr. 168:22-169:4. TeamHealth Plaintiffs' position appears to be that the duration is indefinite—that Defendants somehow agreed to pay them at their full

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rates forever into the future. Yet it is clear from this litigation that Defendants reject and repudiate the notion of any such an agreement. But under TeamHealth Plaintiffs' position, they may attempt to continue to enforce it indefinitely into the future. To the contrary, Defendants' witnesses have denied having agreed to any such term. 11/10/2021 Tr. 168:16–21; Joint Submission of Dep. Clips for Trial Record as Played on Nov. 12, 2021 39:21–41:23. Without a meeting of the minds on that term, there can be no implied contract. *See Matter of Est. of Kern*, 107 Nev. 988, 991, 823 P.2d 275 (1991).

For all these missing elements, this Court should grant judgment as a matter of law for defendants of the implied-in-fact contract claim.

VI. UNJUST ENRICHMENT IS UNAVAILABLE TO TEAMHEALTH PLAINTIFFS

If the Court sustains the implied-in-fact contract claim, it must enter judgment for Defendants on the unjust enrichment claim. "[U]njust enrichment is unavailable when there is an enforceable contract between the parties." *Richey v. Axon Enters., Inc.*, 437 F. Supp. 3d 835, 849 (D. Nev. 2020). The causes of action are simply incompatible.

In reply, TeamHealth Plaintiffs argue that inconsistent remedies are allowable, so long as there is not a duplicative recovery. (Opp. at 20). *But see* 11/23/2021 Tr. 10:9-12:22 (agreeing to elect a remedy on the judgment). But here, only one cause of action can exist, and that is the contract claim.

This is especially important, where near the end of trial, TeamHealth Plaintiffs successfully attempted to base their punitive damage request on the unjust enrichment cause of action. Where a contract claim invalidates an unjust enrichment cause, the case should be treated as contract matter, and no punitive damages allowed.

In the pleadings and the Pre-Trial Order in effect as trial begin, TeamHealth Plaintiffs' claims for punitive damages were based only on the UCPA. TeamHealth Plaintiffs are now attempting to justify them also on the unjust enrichment claim. That is improper and a violation of Defendants' rights, especially as they relate to a quasi-criminal claim for punitive damages. It was unfair and an abuse of discretion to allow that change in the case so late in the proceedings.

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VII. THE PROMPT PAY ACT DOES NOT APPLY

TeamHealth Plaintiffs are attempting to recover fees and interest under the various similar versions of the Prompt Pay Act. Those statutes do not apply. Neither the Insurance Code nor the Prompt Pay Act itself affords TeamHealth Plaintiffs a private right of action against Defendants. *Joseph v. Hartford Fire Ins. Co.*, No. 2:12–CV–798 JCM (CWH), 2014 WL 2741063, at *2 (D. Nev. June 17, 2014); *Allstate Ins. Co. v. Thorpe*, 123 Nev. 565, 572, 170 P.3d 989, 994 (2007).

Indeed, even the colloquial nickname of these statutes is misleading.[11] Based on an earlier insurance regulation, the statute is intended to compel insurance companies to pay the policyholder's covered medical bills promptly by imposing an interest penalty if an insurance company has determined that payment is owed, and failed to pay within thirty days. The Nevada Legislature specifically geared the statute toward encouraging attention to insurance claims. Under it, an administrator has thirty days to "approve or deny a claim relating to health insurance coverage." NRS 683A0879(1). Even so, the administrator does not have to approve the claim or even to deny it within that time, as the administrator can request additional information within twenty days of receiving the claim. NRS 683A.0879(2). If and when the claim is approved, the administrator shall pay the claim within thirty days after it is approved. NRS 683A0879(1).

It is clear from the statue's use of the phrase "a claim relating to health insurance coverage" that it is dealing with coverage benefits on a claim by an insured, and not bills from vendors. In this sense the Prompt Pay Act is very much like the UCPA.

But unlike the UCPA, these statutes are not regulating or imposing any liability for decision-making relating to claims decisions. The Prompt Pay Act provisions do not require a certain determination on the coverage issues. They say simply that "if" the claim is approved, it must be paid within a certain time. The statutes do not require the claim to be approved, do not prohibit the claim from being denied, and do not mandate the claim must be paid in full.[12] If "the

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[11] "In construing an ambiguous statute, evidence of the legislature's intent may be gleaned from the title of the act by which the statute was enacted." *Thompson v. First Judicial Dist. Court, Storey Cnty.*, 100 Nev. 352, 354, 683 P.2d 17, 19 (1984). But here, the words "Prompt Pay" appear nowhere in the enacted title or body of the relevant statutes.

[12] TeamHealth Plaintiffs set out subsection 4 of each statute, which states that "[a]n administrator shall not pay only part of a claim that has been approved and is fully payable." This provision does not, however,

approved claim" is not paid within that period, the administrator shall pay interest. NRS 683A0879(1).

Here, TeamHealth Plaintiffs do not have the type of "claim relating to health insurance coverage" contemplated by the statues. They are vendors, not insurance claimants like insureds. And Defendants did not approve the entire amount of the bills, so "the approved claim" is only to the extent of Defendants' approval. The provisions regarding interest and fees do not come into play, as Defendants paid the claims.

There is also no clear establishment of a private right of action before the exhaustion of administrative remedies, as there is with the UCPA. Just as with NRS 690B.012, these statutes do not expressly create a cause of action. *Cf. Allstate Ins. Co. v. Thorpe*, 123 Nev. 565, 572, 170 P.3d 989, 994 (2007). While they allow fees to the prevailing party "in an action brought pursuant to this section," that falls short of the clarity required to create a private right of action that exists without having to first pursue relief with the insurance commissioner. NRS 683A0879(5). Just as in *Thorpe*,[13] it would make sense to have TeamHealth Plaintiffs initially adjudicate the timeliness of payment in the administrative arena.[14]

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VIII. THE CLAIMS ARE PREEMPTED BY ERISA

Under ERISA § 514, a state-law claim conflicts with ERISA and is expressly preempted if it "relates to" an employee benefit plan governed by ERISA. 29 U.S.C. § 1144(a). This action is undoubtedly related to employee benefit claims, and all of TeamHealth Plaintiffs' causes of action are preempted by ERISA.

Contrary to TeamHealth Plaintiffs' arguments, ERISA preempts any state law that would rewrite the terms of the governing health plans to require payment for out-of-network ER services

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require an administrator or insurer to approve every claim in full, so a partial approval would not be fully payable.

[13] Incorporate by reference MNT and Reply arguments re Thorpe and PPA. Grab pin cites when finalized.

[14] Indeed, amendments to the Prompt Pay statutes in 2019, following the enactment of Nevada's No Surprises Act at NRS 439B.754 (*see* NRS 439B.700-.760), make clear that those statutes are no longer available to prosecute claims for out-of-network emergency services. *See* AB 469, §§ 21-27, 2019 Nev. Stat. 328-34.

at amounts higher than permitted by the plans. Indeed, it is well established that ERISA preempts implied-in-fact contract claims such as TeamHealth Plaintiffs. *Aetna Life Ins. Co. v. Bayona*, 223 F.3d 1030, 1034 (9th Cir. 2000); *Parlanti v. MGM Mirage*, 2:05-CV-1259-ECR-RJJ, 2006 WL 8442532, at *6 (D. Nev. Feb. 15, 2006).

The benefit plans here were a central issue at trial, to the point that plaintiffs prevailed in getting a rebuttable presumption of spoliation for Defendants' failure to timely produce these plans, despite their purported irrelevance to the claims.[15] And there is no question that the only reason TeamHealth Plaintiffs are looking to Defendants for reimbursement at all is because of Defendants' agreement to their members, as stated in the plans. This case does not merely "have a connection to" or "relate to" an ERISA plan; it *arises from* these plans.

IX. CONCLUSION

For the foregoing reasons, this Court should grant Defendants judgment as a matter of law on all causes of action.

Dated this 22nd day of June, 2022.

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[15] The reversible error created by that rebuttable-presumption instruction is discussed in the Defendants' motion for new trial and concurrently filed reply.

CERTIFICATE OF SERVICE

I hereby certify that on the 22nd day of June, 2022, a true and correct copy of the foregoing "**REPLY IN SUPPORT OF DEFENDANTS' RENEWED MOTION FOR JUDGMENT AS A MATTER OF LAW"** was electronically filed and served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

Case No.: A-19-792978-B
Dep't 27

REPLY IN SUPPORT OF MOTION FOR NEW TRIAL

Hearing Date: June 29, 2022
Hearing Time: 10:00 a.m.

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LEWIS ROCA

017412

vs.

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

Defendants.

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LEWIS ROCA

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Defendants UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services Inc. ("UHS", which does business as UnitedHealthcare or "UHC" and through UHIC), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Company ("SHL"), and Health Plan of Nevada, Inc. ("HPN") (collectively, "Defendants"), by and through their attorneys, hereby submit this Reply in support of their Motion for New Trial ("Motion").

INTRODUCTION

As the Court is well aware, Defendants and TeamHealth Plaintiffs[1] have vigorously litigated this case. In the interest of judicial economy, this Reply does not refute TeamHealth Plaintiffs' Opposition point-by-point but clarifies and highlights misrepresentations and erroneous arguments advanced in the Opposition. Defendants do not waive any argument raised in the Motion, which demonstrates why the Opposition is wrong. If the Court would like further briefing on any issue, Defendants are happy to oblige.

I. TEAMHEALTH PLAINTIFFS' OPPOSITION MISSTATES THE RECORD AND DOES NOT REFUTE THAT DEFENDANTS WERE PRECLUDED FROM OBTAINING CRITICAL EVIDENCE DURING DISCOVERY.

A. Defendants Were Prejudiced By Being Barred from Obtaining Discovery on Reimbursement Rates That Inform What a Willing Buyer and Seller Would Consider Reasonable and How TeamHealth Plaintiffs Set Their Billed Charges.

As Defendants made clear in their Motion, Nevada law is consistent with the law in other jurisdictions that all contemplate a broad presentation of evidence touching on reasonable value. Mot. at 9-10. Ultimately, the standard is market-based: the "reasonable value" of medical services is "the price that would be agreed upon by a willing buyer and a willing seller negotiating at arm's length" in the relevant market, *Children's Hosp. Central Cal. v. Blue Cross of Cal.*, 226 Cal. App. 4th 1260, 1275, 172 Cal. Rptr. 3d 861, 872 (Cal. Ct. App. 2014), or "what the services are ordinarily worth in the community," *see Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc.*, 832 A.2d 501, 508–10 (Pa. Super. Ct. 2003)—not the healthcare providers' unilaterally-set billed charges. Indeed, in another currently-pending litigation against United initiated by affiliates of TeamHealth Plaintiffs,

[1] "TeamHealth Plaintiffs" collectively refers to the three Plaintiffs in this action, each of which is owned by and affiliated with TeamHealth Holdings, Inc. ("TeamHealth"): Fremont Emergency Services (Mandavia), Ltd. ("Fremont"), Team Physicians of Nevada-Mandavia, P.C. ("TPN"), and Crum, Stefanko and Jones, Ltd., d/b/a Ruby Crest Emergency Medicine ("Ruby Crest").

counsel for TeamHealth Plaintiffs' affiliates ***conceded*** that the "reasonable value" of those TeamHealth Plaintiffs' emergency medicine services is "based on what is paid in the market," or "[w]hat a willing buyer will pay or what a willing seller will sell … based on a market transaction between those two parties." *See Emergency Care Servs. of Pa., P.C., et al. v. UnitedHealthcare of Pa., Inc., et al.*, No. 00598, Sept. Term 2020, Tr. Mar. 15, 2022 at 20:6-8, 22:1-7.

Evidence that is probative of the value of the emergency medicine services rendered by TeamHealth Plaintiffs in Nevada, the relationship of that reasonable value to the amounts that TeamHealth Plaintiffs unilaterally decided to charge for those services, and whether TeamHealth Plaintiffs are actually entitled to "reasonable value" for whatever services they rendered *all* would have been relevant to the claims and defenses presented in this case. Yet, as Defendants explained in their Motion, the Court ruled first through discovery orders and again through its motions in limine orders that virtually all evidence or argumentation that Medicare informs what a willing buyer and seller would consider reasonable reimbursement, that Medicare functions as a prime rate in the health care industry, and that Defendants' official corporate position was that reasonable value is Medicare plus a small margin. *See* Nov. 9, 2020 Order ¶ 4, 10/19/21 Tr. 208:21-209:2. Likewise, the Court ruled that in-network reimbursement data and rates that Defendants themselves produced with health insurers other than the Defendants was irrelevant and inadmissible (10/19/21 Tr. 214:2-9), despite their *clear* relevance to what constitutes the "reasonable value" of the emergency medicine services that Team Health Plaintiffs' contracted health care providers rendered to Defendants' insureds.

TeamHealth Plaintiffs' Opposition does not contest the relevance of Medicare and other rates that would inform the "reasonable value" evidence in this case that Defendants were prevented from obtaining. Rather, TeamHealth Plaintiffs assert three main arguments in their Opposition, none of which are availing.

First, TeamHealth Plaintiffs rely erroneously on *Cox v. Copperfield*, 2022 WL 1132225, at *7-8 (Nev. Apr. 14, 2022),[2] to support their flawed argument that the Court did not err in preventing

[2] In *Cox*, an appeal from a judgment on a defense verdict in a personal injury case, the plaintiffs had sought at trial to call a medical expert to rebut surveillance video introduced by the defendants of one of the plaintiffs that contradicted the appellant's in-court testimony. The trial court denied that request, and the plaintiffs contended on appeal that that decision was an abuse of discretion. 2022 WL 1132225, at *7. The Nevada Supreme Court refused to review the trial court's exclusion of the medical expert because the appellants "did

discovery on evidence that informs "reasonable value" because, according to them, Defendants waived their right to raise the Court's discovery errors because those errors were not included in Defendants' omnibus offer of proof. Boiled down to its core and put into context, TeamHealth Plaintiffs' argument is that Defendants should have included evidence in their offer of proof that they were *never allowed or able to collect*. TeamHealth Plaintiffs *Cox* argument misses the mark: the entire point of Defendants' arguments and explanations in its Motion concerning the Court's discovery errors was just that—a focus on the Court's *discovery* errors, which resulted in Defendants being prohibited from collecting vast amounts of evidence on topics of discovery that Defendants required to put on an adequate defense to TeamHealth Plaintiffs' lawsuit. Simple logic dictates that Defendants could not have included in their offer of proof evidence it was never permitted to collect, thus prejudicing them substantially from receiving a fair trial.

TeamHealth Plaintiffs' *Cox* argument is a contorted view on what is required in Nevada for offers of proof: that the offer of proof itself did not contain every single evidentiary example that Defendants could have included does not waive Defendants' arguments to seek a new trial. In Nevada, "[o]ffers of proof are intended to (1) fully disclose to the court and opposing counsel the nature of evidence offered for admission, but rejected, and (2) preserve the record for appellate review." *Las Vegas Convention & Visitors Auth. v. Miller*, 124 Nev. 669, 688, 191 P.3d 1138, 1150–51 (2008) (citing *Morrison v. Air Cal.*, 101 Nev. 233, 237, 699 P.2d 600, 603 (1985)). Importantly, it is well established in Nevada that when the parties fully briefed the issue in a *pretrial motion*, the district court held a hearing, and the district court made a dispositive ruling *before trial*, an offer of proof is ***unnecessary*** to preserve an issue on appeal. *See Bronneke v. Rutherford*, 120 Nev. 230, 236, 89 P.3d 40, 44 (2004); *Richmond v. State*, 118 Nev. 924, 931, 59 P.3d 1249, 1254 (2002).

TeamHealth Plaintiffs also take issue with testimony that was obtained live at trial that was not included in Defendants' omnibus offer of proof. Opp. at 9. Their attempt to cry foul here is a

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not proffer the identity of their requested medical expert or what she or he might testify to" in an offer of proof. *Id.* But, as explained in this brief, *Cox* is inapposite to Defendants' Motion with respect to the Court's discovery errors that substantially prejudiced Defendants from receiving a fair trial because, unlike the medical expert that the plaintiffs in *Cox* sought to admit, Defendants provided in their Motion numerous categories of evidence that they would have introduced at trial but never had the opportunity to provide in an offer of proof because they were precluded in the first instance from obtaining that discovery.

disingenuous sideshow—counsel for both parties agreed at trial that Defendants could simply obtain testimony for their offer of proof from certain witnesses live at trial, outside the presence of the jury, rather than have to repeat it in the omnibus offer of proof. This was sensible—rather than forcing Defendants to unnecessarily conduct a repeat examination to go into an offer of proof, opposing counsel and the Court agreed that it would be more efficient to forego obtaining individual offers of proof and instead simply read it into the record and put what was left into Defendants' omnibus offer of proof. Now, in an about-face, TeamHealth Plaintiffs appear to contest the propriety of this process they themselves agreed to, arguing that Defendants failed to adequately include this evidence in their offer of proof.

For example, with respect to Defendants' argument that they were prejudiced by being prevented from offering evidence about Defendants' state of mind with respect to Medicare rates, which TeamHealth Plaintiffs' counsel acknowledged "is always relevant with respect to punitive damages," Tr. 10/22/2021 119:15–17 (argument of K. Gallagher), TeamHealth Plaintiffs argue that Defendants did not include in their offer of proof the evidence from its witnesses Scott Ziemer and John Haben concerning the reasonableness of Defendants' benchmark pricing program that relied on Medicare rates, which constitutes evidence of Defendants' state of mind regarding the reasonableness of their rates. *See* 11/3/2021 Tr. at 150:17-152:18; 11/16/2021 Tr. at 39:9-24. Indeed, their *Cox* argument is misaligned because, in fact, Defendants obtained testimony from Leif Murphy—that the parties agreed could be read as "live" offer of proof evidence—in which Mr. Murphy testified about TeamHealth Plaintiffs' costs being far below the amount of profits that TeamHealth Plaintiffs reaped from their billed charges to Defendants. *See* 11/16/21 Tr. 117:7-17 (Murphy communicated to Schumacher in an April 2019 meeting that costs per encounter were $150); *id.* 123:1-12 (Murphy communicated to Schumacher in an April 2019 meeting that costs per encounter were $150 and that average collection per encounter was $350). It would simply have been a waste of judicial economy to have required Defendants to separately elicit offers of proof on these witnesses, and in any event, TeamHealth Plaintiffs' attempt to distract from the Court's discovery errors should not be permitted.

Likewise, TeamHealth Plaintiffs attempt to avoid the prejudicial effect that the Court's rulings on the relevance of TeamHealth Plaintiffs' processes for setting their billed charges by artificially

narrowing the issue, arguing that Defendants were not prejudiced because the Court's motions in limine ruling allowed evidence about FairHealth and TeamHealth Plaintiffs' price increases. Opp. at 2. But this is beside the point—as Defendants made clear in their Motion, the Court erred by preventing Defendants from ever collecting discovery on this topic in the first place. This had the effect, at trial, of preventing Defendants from impeaching or testing TeamHealth Plaintiffs' arguments that their full billed charges were reasonable. Mot. at 30. And in event, TeamHealth Plaintiffs' *Cox* argument is thus irrelevant: regardless of the evidence that Defendants included in their offer of proof, Defendants provided numerous examples in its Motion of TeamHealth Plaintiffs opening the door to evidence that it would have introduced to impeach TeamHealth Plaintiffs' arguments but were hampered from doing so because of the Court's erroneous discovery rulings.

TeamHealth Plaintiffs' *Cox* argument impermissibly seeks to reset the goalposts for what is necessary for an offer of proof in Nevada. The Court should reject this argument in each instance that TeamHealth Plaintiffs assert it in their Opposition.

Second, TeamHealth Plaintiffs attempt to reframe the Medicare issue by asserting that the parties agreed that Medicare would only be limited in two ways.[3] Opp. at 8. This reframing misses the mark by ignoring the entire context for where the parties came from prior to that "agreement." As Defendants explained in their Motion, the Court's November 9, 2020 Order found that TeamHealth Plaintiffs were not required to produce claims data related to Medicare and Medicaid reimbursement. Already, then, by the time trial began and Defendants agreed to the limitations that TeamHealth Plaintiffs identify, Defendants were agreeing from a place of disadvantage, already saddled with being barred from collecting discovery on rates that inform what a willing buyer-willing

[3] TeamHealth Plaintiffs also assert in their Opposition that Defendants "suggest[] certain evidence was excluded simply because it referenced Medicare rates." Opp. at 8. Not so. Each document cited in Defendants' Motion was excluded at trial *solely* on the basis of mentioning Medicare *alone*, nor did Defendants "suggest" as much. As Defendants noted in their Motion, the Court precluded Defendants from introducing these and many other documents discussing Medicare on the basis of its Nov. 9, 2020 Order, which rejected Defendants' arguments that Medicare rates inform what a willing buyer and seller would consider reasonable reimbursement, that Medicare functions as a prime rate in the health care industry, and that Defendants' official corporate position was that reasonable value is Medicare plus a small margin. In any event, TeamHealth Plaintiffs appear to agree that these documents should not be excluded for Medicare alone; to the extent that the Court *did* prohibit introduction of these documents on the basis that TeamHealth Plaintiffs are suggesting, Defendants would agree that that, too, would be improper.

seller would pay in the relevant geographic market. That Defendants agreed on any limitations on the small amount of evidence they *did* obtain is beside the point: Defendants were prevented from obtaining evidence in the first place that would have allowed Defendants to support numerous of their key defense themes at trial, including their defense that "[s]ome or all of TeamHealth Plaintiffs' billed charges are excessive under the applicable standards." JPTO at 8 (Sixth Affirmative Defense). And more importantly, by the time Defendants negotiated these limitations, they were already facing the prospect through the Court's motions in limine rulings of having *no* ability to introduce *any* evidence that even referenced Medicare.

The effect of the Court's decisions greatly affected Defendants' ability to cogently rebut before the jury TeamHealth Plaintiffs' argument that the at-issue emergency medicine services represented "reasonable value" under Nevada law. For example, as Defendants explained in their Motion, Defendants' expert witness Bruce Deal was precluded from explaining why and how Medicare reimbursement rates are probative of the reasonableness of TeamHealth Plaintiffs' billed charges and Defendants' reimbursement rates in the relevant Nevada market. *See Certified Fire Protection Inc. v. Precision Construction*, 128 Nev. 371, 283 P.3d 250 (2012); *Children's Hosp.*, 226 Cal. App. 4th at 1275, 172 Cal. Rptr. 3d at 872; *Temple Univ. Hosp., Inc. v. Philla.*, No. 1794, 2006 WL 51206, at *3 (Pa. Ct. Com. Pl. (Phila. Cty.) (Jan. 3, 2006) (Commerce Program, J. Jones). TeamHealth Plaintiffs misleadingly state that Deal was permitted to testify about Medicare rates, but as Defendants pointed out, that testimony was superficial: Deal was prevented from explaining important findings from his expert report about why Medicare is a good comparator for "reasonable value," and why commercial insurers pay a premium to Medicare.

Third, TeamHealth Plaintiffs fail to address Defendants' nearly seven pages of arguments and evidence that they were prejudiced, and deserve a new trial, based on the Court's erroneous discovery and motions in limine rulings about TeamHealth Plaintiffs' provider participation agreements with Defendants and other payors. Mot. at 20-26. Instead, TeamHealth Plaintiffs attempt to wave away these arguments and evidence by incorrectly stating that its arguments about the agreements are "essentially the same" as its arguments and evidence about the parties' in-network rates. Opp. at 10. This ignores that Defendants cited different law and provided different evidence in support of their

argument. And besides, as to those in-network rates, TeamHealth Plaintiffs similarly address the relevance of those rates in perfunctory fashion, simply repeating that the Court found out-of-network rates to be relevant and in-network rates irrelevant. *Id.* at 10-11. But as Defendants noted extensively in their Motion (at 9-20), the Court's ruling was erroneous because, as a matter of law, in-network rates are probative of the value that a willing buyer would pay for similar services in the marketplace. TeamHealth Plaintiffs do not dispute the law, instead relying only on the Court's erroneous discovery ruling.

B. Defendants Were Prejudiced By Being Barred from Obtaining Discovery on TeamHealth Plaintiffs' Corporate Flow of Funds.

TeamHealth Plaintiffs' Opposition fails to meaningfully address Defendants' arguments in their Motion that the Court's erroneous discovery rulings about TeamHealth Plaintiffs' corporate flow of funds prejudiced Defendants. Mot. at 33-36. Instead of addressing these arguments, TeamHealth Plaintiffs assert perfunctory arguments on one page of their Opposition that are unavailing.

First, TeamHealth Plaintiffs re-assert their failed *Cox* argument with respect to "specific profits to TH or Blackstone" in Defendants' offer of proof. Opp. at 14-15. As already noted, this argument fails under Nevada law. *See supra* at X. Further, TeamHealth Plaintiffs concede that Defendants obtained this information from Mr. Murphy at trial, *id.*, which is sufficient for Defendants to have preserved their argument that evidence concerning TeamHealth Plaintiffs' corporate flow of funds would have made a material difference for the jury in considering the reasonable value of TeamHealth Plaintiffs' emergency medicine services.

Second, TeamHealth Plaintiffs assert that it would have been prejudicial to allow Defendants to present any evidence of TeamHealth Plaintiffs' flow of corporate funds because "United fails to consider whether its underpayments affected physician salary or contract payments." Opp. at 15. This vague assertion lacks any citation or support and ignores the simple fact that Defendants were hamstringed from collecting *any* evidence on TeamHealth Plaintiffs' corporate flow of funds that would have been probative of the underpayments that TeamHealth Plaintiffs suggest. Indeed, TeamHealth Plaintiffs' suggestion that "the Court did not exclude all evidence about Plaintiffs' relationship with TeamHealth or Blackstone" once again misses the point: whatever limited evidence

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the Court allowed in on this point, it paled in comparison to what Defendants were never permitted to collect during discovery.

Third, TeamHealth Plaintiffs argue that "[w]hether physicians get a share of the verdict is immaterial to Plaintiffs' reasonable and customary charges." Opp. at 15. This is a total non-sequitur—Defendants' argument concerning the prejudice that the Court's erroneous evidentiary rulings about TeamHealth Plaintiffs' corporate flow of profits is dependent on whether physicians received a share of the verdict—rather, it is whether the profits that TeamHealth Plaintiffs, and the corporate executives that concededly set TeamHealth Plaintiffs' charges, obtained *after* their contracted physicians were paid factored into the determinations of the full billed charges that became the basis of the damages that the jury awarded TeamHealth Plaintiffs here.

TeamHealth Plaintiffs' Opposition is wholly unresponsive to the arguments Defendants explained in their Motion concerning the discovery that it was precluded from obtaining and using in support of its defenses at trial. The Court's erroneous February 4 Order prevented Defendants from rebutting TeamHealth Plaintiffs' evidence admitted throughout trial suggesting that Defendants' conduct resulted in underpayment of physicians or reduced payment to physicians or firing of physicians. This resulted in substantial prejudice to Defendants' ability to receive a fair trial, so a new trial is clearly warranted.

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C. Defendants Were Prejudiced By Being Barred from Obtaining Discovery on TeamHealth Plaintiffs' Costs of Doing Business.

TeamHealth Plaintiffs' Opposition essentially concedes that costs are relevant to the determination of what constitutes the "reasonable value" of the emergency medicine services rendered in this case by arguing that courts are not *required* to consider costs in determining the reasonableness of a healthcare provider's charges. Instead of rebutting the clear relevance of this datapoint, TeamHealth Plaintiffs simply argue that the Court did not err in excluding this relevant data and focus on the "[t]estimony at trial [that] demonstrated that Plaintiffs determine charges not based on costs, but on FAIR Health data." Opp. at 13. That very testimony makes the point clearly why Defendants should have been allowed to introduce the evidence outlined in their offer of proof: the setting of billed charges based on FAIR Health data begs the question of what the underlying data is based on. In other words, presenting to the jury testimony about FAIR Health's mere aggregation

of the data it receives does not provide the jury any explanation whatsoever as to whether and how TeamHealth Plaintiffs built their cost of doing business into the FAIR Health data they used to set their billed charges.

Even less convincing is TeamHealth Plaintiffs' assertion that "Because United's offer of proof provides no baseline to compare the Plaintiffs' profits vis-à-vis other emergency services providers, it fails to show that the excluded evidence of costs is material." *Id.* at 13-14. Not once throughout this litigation, including at trial, have Defendants argued that the relevance of TeamHealth Plaintiffs' profits hinges on how those profits compare to other emergency medicine services providers matters. Rather, as Defendants obtained from Mr. Bristow's live testimony at trial, such profit-evidence is relevant because TeamHealth Plaintiffs' costs of doing business are exceedingly low compared to their full billed charges. *See* 11/16/21 Tr. 117:7-17 (Murphy communicated to Schumacher in an April 2019 meeting that costs per encounter were $150); *id.* 123:1-12 (Murphy communicated to Schumacher in an April 2019 meeting that costs per encounter were $150 and that average collection was $350 per encounter). Such a consideration is, as TeamHealth Plaintiffs concede, relevant to the reasonable value of their emergency medicine services and their associated charges billed to Defendants.

In any event, TeamHealth Plaintiffs' attempt to sidestep the clear relevance of their cost evidence misses the forest through the trees at the heart of Defendants' Motion: the Court's February 4 Order preventing Defendants from fulsome discovery on TeamHealth Plaintiffs' profits prevented Defendants from impeaching TeamHealth Plaintiffs' assertions about the reasonable value of their emergency medicine services and the need for their physicians to be adequately compensated.

D. Defendants Were Prejudiced By Being Barred from Obtaining Discovery on TeamHealth Plaintiffs' Policies Regarding Balance Billing.

Defendants were entirely precluded from obtaining evidence of TeamHealth Plaintiffs' balance billing policy documents. Yet, as Defendants explained in their Motion (at 37-39), TeamHealth Plaintiffs were allowed to point to the absence of evidence from the record of instances in which they balance billed as evidence that they did not balance bill. This significantly prejudiced Defendants by allowing TeamHealth Plaintiffs to induce sympathy in the jury and offer unimpeached testimony that their billing practices were above board in all instances.

TeamHealth Plaintiffs' assertion in their Opposition that they produced and offered at trial evidence "to show that they did not balance bill United's members in Nevada" (Opp. at 15-16) is unavailing. That evidence—a single balance billing policy, from one year—is entirely self-serving, particularly when TeamHealth Plaintiffs refused to produce any other discovery that would allow Defendants to prove that one policy or determine whether TeamHealth Plaintiffs in fact followed that policy. TeamHealth Plaintiffs' position simply begs the question: if TeamHealth Plaintiffs did not in fact balance bill, then why did they oppose discovery that would have confirmed that "fact"? Defendants were precluded from obtaining any evidence that may have shown that, in fact, TeamHealth Plaintiffs *did* systemically balance bill patients, at least far more than they have led on. Once again, TeamHealth Plaintiffs used the balance billing issue, on the one hand, as a shield to preclude Defendants from obtaining any evidence on these balance-billing policies, and on the other hand, as a sword take the position at trial that Defendants have introduced no evidence that TeamHealth Plaintiffs have a policy to balance bill.

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TeamHealth Plaintiffs' hollow contention that TeamHealth Plaintiffs should be absolved from their sword-and-shield approach because "United deposed witnesses to develop evidence that it alleges was undiscoverable" (Opp. at 15) ignores completely the fact that Defendant lacked document discovery on TeamHealth Plaintiffs' balance billing conduct and other policies that would have allowed for more fulsome examination. In fact, TeamHealth Plaintiffs' counsel even instructed at least one of their key witnesses *not to answer* questions about these policies and practices. *See, e.g.*, Deposition of J. Carmen (4/29/21) at 52:20-53:25, 185:11-188:7 (attached as Exhibit 2 to Defendants' Renewed Motion to Compel Further Testimony from Deponents Instructed Not to Answer Questions, filed on 6/8/21). This prejudiced Defendants materially and merits a new trial.

E. Defendants Were Prejudiced By Being Barred from Introducing Evidence About TeamHealth Plaintiffs' Improper Coding.

Finally, as Defendants explained in their Motion (at 4-9), Defendants were significantly prejudiced by the Court's prohibition of evidence about TeamHealth Plaintiffs' improper coding and claims submissions. In their Opposition, TeamHealth Plaintiffs make numerous mischaracterizations about the record and Defendants' arguments and evidence about TeamHealth Plaintiffs' "upcoding"

and how the Court's refusal to allow Defendants to introduce this evidence substantially prejudiced Defendants through the effect it had on the damages awarded to TeamHealth Plaintiffs.

For example, TeamHealth Plaintiffs mischaracterize Defendants' argument about TeamHealth Plaintiffs' claims that were not for emergency medicine services. They assert that they "agreed to remove those claims from the disputed claims spreadsheet after United moved for summary judgment on this issue." Opp. at 7. But TeamHealth Plaintiffs *only* agreed to remove claims that had *solely* non-emergency room codes—they did *not* agree to remove claims that had *both* emergency room codes *and* non-emergency room codes. TeamHealth Plaintiffs own expert, David Leathers, included this analysis in his supplemental report. *See, e.g.*, Leathers Supp. Rep. 9.8.21 at 2 ("Exhibit 3 summarizes the UHC out-of-network claim data by CPT code and separates the weighted average and median reimbursement amounts between claims with one CPT code and claims with multiple (or bundled) CPT codes for one emergency room visit."); *id.* Ex. 1 n.1 (analyzing bundled claims using the ED code on those claims); *id.* Ex. 5 (separating analysis by core claims with only ED CPT codes and bundled claims including non-ED CPT codes). And at trial, Leather testified that, with respect to the five CPT codes at issue, TeamHealth Plaintiffs submitted "CPT codes bundled with other sorts of services . . . . In other words, where the doctor performed an emergency service within one of those top [codes], but also did another service." 11/16/21 Tr. at 234:16-24; *see also id.* at 239:10-13 ("Q. When you say core plus bundled other CPTs, does that -- is that a reference to the bundles meaning having one of these four CPTs plus some other CPT codes? A. Yes."); 11/17/21 Tr. at 33:20-25 (discussing Leather's reasoning for separate analysis and comparisons for bundled versus unbundled claims in the disputed claims spreadsheet).

Defendants were substantially prejudiced by this outcome because TeamHealth Plaintiffs ultimately obtained damages for such "bundled" claims. As Defendants noted in their Motion, this was manifestly erroneous: in a case purely about the emergency medicine services rendered by TeamHealth Plaintiffs' physicians, Defendants should have been permitted to introduce evidence and explanation from TeamHealth Plaintiffs' *own* expert witnesses that would demonstrate that the damage the jury ultimately awarded TeamHealth Plaintiffs almost certainly included damages for

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disputed claims that included non-emergency services. Such error is squarely grounds for a new trial under Nevada law. *See* NRCP 59(a)(1)(F).

II.
TEAMHEALTH PLAINTIFFS' OPPOSITION FAILS TO ADEQUATELY REFUTE THAT DEFENDANTS WERE PREJUDICED BY THE COURT'S MOTION IN LIMINE RULINGS BASED ON ISSUES THAT AROSE AT THE START OF TRIAL.

Defendants in their Motion explained the Court's errors of law in deciding Defendants' motions in limine that substantially affected Defendants' right to a fair trial. Mot. at 43-46. Regarding the Court's error in admitting evidence that is beyond the scope of this lawsuit, Defendants explained that they were prejudiced by the Court's determination that evidence of conduct related to TeamHealth Plaintiffs' submission of health benefit claims after January 1, 2020 (MIL No. 32) and evidence related to Defendants' consideration of Naviguard (MIL No. 29) was relevant. That determination was clearly erroneous: not *one* disputed claim is relevant after January 1, 2020, and Naviguard played *no* role whatsoever in pricing or processing any of the disputed claims in this lawsuit. Mot. at 44-45.

TeamHealth Plaintiffs do not meaningfully dispute these facts. Instead, they assert three primary arguments, all of which are unavailing.

First, TeamHealth Plaintiffs argue that Defendants somehow "waived" this argument for two supposed reasons. They first assert that Defendants "waived" their argument that post-2020 and Naviguard-related evidence is irrelevant because Defendants "cannot obtain dispositive relief on a portion of Plaintiffs' damages through a motion in limine." Opp. at 17. This assertion is completely unsupported and should be granted zero weight because it is a mischaracterization of Defendants' argument, which goes to the relevant scope of admissible evidence at trial (as is the purpose of motions in limine), not an attempt to obtain "dispositive relief." They then assert that Defendants "did not move to compel arbitration," citing *Principal Investments v. Harrison*, 132 Nev. 9, 20-21, 366 P.3d 688, 697-98 (2016), for the proposition that a party waives an arbitration clause by initiating court proceedings. Opp. at 17. This assertion is a complete non-sequitur and should be summarily rejected: there is no relevant arbitration clause to the disputed claims during the relevant time period, and in any event, it was *TeamHealth Plaintiffs*, not Defendants, who initiated court proceedings in this lawsuit.

Second, TeamHealth Plaintiffs rely on the repeated and boilerplate assertion made throughout their Opposition that "substantial evidence supports the jury's verdict." Opp. at 17. They specifically identify here that "because the jury awarded only one-fourth of the requested actual damages, United has no basis to conclude that the jury awarded relief for the claims from January 1, 2020 to January 20, 2020 in the claims file." *Id.* But of course, TeamHealth Plaintiffs have no way of concluding that the jury did *not* award such relief or that claims submitted post-January 1, 2020 factored into the ultimate damages that TeamHealth Plaintiffs received. And this argument fundamentally misses the point: be it evidence of post-January 1, 2020 conduct generally, or Naviguard specifically, such evidence should have never been presented in the first place. Its admission provided the jury with the incorrect and unfair impression that Defendants were perpetuating a scheme that they did not perpetuate, during a time period that has no legal or factual bearing on any of the health benefit claims actually in dispute in this case. *Regardless* of whether the parties can point definitively to how this evidence manifested in the jury's specific damages determination, there can be no dispute that TeamHealth Plaintiffs' mountains of evidence and testimony presented at trial about these irrelevant topics greatly prejudiced Defendants by influencing the jury, including its consideration of whether to award punitive damages. *See* Mot. at 44-46.

Third, the closest TeamHealth Plaintiffs come to engaging with Defendants' argument that any remote probative value of this evidence is far outweighed by its prejudicial effect on Defendants is TeamHealth Plaintiffs' one-sentence statement that "the Court did not err in admitting Naviguard evidence because this evidence was probative of United's intent to improperly underpay billed charges for out-of-network services during the claims period." Opp. at 17. But TeamHealth Plaintiffs' support for this assertion is to cite a large chunk of trial testimony from John Haben that TeamHealth Plaintiffs argue demonstrates that Haben "agreed" that Naviguard discussions impacted Defendants' decisions in 2019 to seek more profits. But TeamHealth Plaintiffs do not point to any specific testimony in support of that interpretation. In fact, Haben specifically testified that Defendants' considerations for providing equal benefits and protections to their ASO and fully-insured clients were *not* actioned in 2019. 11/9/21 Tr. 158:3-17.

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The fact remains that TeamHealth Plaintiffs do not—because they *cannot*—point to any evidence that Defendants' implementation of Naviguard is probative of the pricing or processing of any of the disputed claims in this case. In other words, Defendants' considerations in 2019 that were not implemented until 2020 have no bearing on the disputed claims in this case. For all these reasons, Defendants are entitled to a new trial based on the Court's erroneous determinations that evidence post-dating January 1, 2020, including Defendants' implementation of Naviguard, had any probative value on the disputed claims in this case.

Separately, Defendants also explained in their Motion that they were prejudiced by being prevented from informing the jury that TeamHealth Plaintiffs removed from their operative complaint Paragraph 209's allegation that "A special element of reliance or trust between the Health Care Providers and the Defendants [existed], such that, Defendants were in a superior or entrusted position of knowledge." Mot. at 39. TeamHealth Plaintiffs' only meaningful response to Defendants' argument[4] is to invoke their *Cox* argument yet again. Opp. at 16-17. But like TeamHealth Plaintiffs' failed arguments relying on *Cox* noted above, TeamHealth Plaintiffs' assertion that Defendants failed to include Paragraph 209 in their offer of proof is a misaligned interpretation of the purpose and requirements of offers of proof in Nevada. That "offer of proof" already existed—in the form of the First Amended Complaint itself. TeamHealth Plaintiffs' overly formalistic interpretation of *Cox* boils down to an argument that Defendants should have included evidence related to Paragraph 209 in its offer of proof, but the existence of TeamHealth Plaintiffs' First Amended Complaint that includes Paragraph 209 is sufficient to preserve Defendants' ability to raise their argument related to it. And that Defendants *did* raise that argument before the Court (10/20/2021 Tr. at 93:12-15) is sufficient for the Court now to grant a new trial on this basis.

[4] TeamHealth Plaintiffs also assert (Opp. at 16) that "whether a statement is a party admission goes to hearsay, not relevance and Rule 403," but that argument should be rejected because TeamHealth Plaintiffs provide no meaningful explanation or support for this assertion, in contrast to Defendants' Motion that explains the legal relevance of this evidence (Mot. at 39-42).

III.
THE VERDICTS WERE SPOILED BY OPPOSING COUNSELS' MISCONDUCT

A. TeamHealth Plaintiffs' Counsel Conceded That the Jury Rendered the Verdicts Based on Attorney Misconduct.

On April 8, 2022, after Defendants filed their Motion, Law360 published an article about this trial based on its interview of TeamHealth Plaintiffs' lead trial counsel, John Zavitsanos. **Exhibit 1**. In it, Mr. Zavitsanos confirmed that *Lioce* was violated. As such, a new trial is required.

As explained in Defendants' Motion, counsel "cannot attempt to have the jury 'send a message about some social issue that is larger than the case itself'" and must avoid "'[a]ny inclination . . . to inflame the passions of the jury,'" including through "'an appeal to the emotional . . . tendencies of a jury.'" Mot. at 54-55 (quoting *Lioce v. Cohen*, 124 Nev. 1, 174 P.3d 970 (2008); *Shannon v. State*, 105 Nev. 782, 789 (1989); *State v. Eighth Jud. Dist. Ct. (Armstrong)*, 127 Nev. 927, 933, 267 P.3d 777, 781 (2011)). Mr. Zavitsanos admitted that the verdict was obtained by violating these fair trial mandates:

> ***the jury*** in Las Vegas[] just ***felt the weight, the kind of societal obligation that was on them for this trial***. . . . And I say that because we spoke with a few of the jurors afterwards, and ***they understood that this was much more than just the verdict in this case***.

Exhibit 1 at 4 (emphasis added). How could they not? As explained in the Motion, TeamHealth Plaintiffs' counsel purposefully placed the weight of society's obligations on the jury to make the jury believe that the case was about much more than the verdict. For example, in opening the case, opposing counsel immediately engaged in misconduct by telling the jury that "Nevadans," including the jury, receive the worst medical care in the country but "deserve . . . to be treated the same as others . . . when it comes to reimbursement for emergency medical care." Mot. at 59. So, opposing counsel urged the jury "'to pull Nevada up from the bottom . . . and say enough is enough.'" *Id.*; *Rudin v. State*, 120 Nev. 121, 147, 86 P.3d 572, 589 (2004) (Rose, J., dissenting) ("The opening statement of a . . . case is extremely important in asserting a successful defense . . . [because] the impression a juror has after opening statements usually carries . . . to . . . the verdict . . . . [Thus,] by the end of opening statements, [defendant] was already at a great disadvantage[.]"). TeamHealth Plaintiffs do not dispute that the "enough is enough" argument in their opening statement was misconduct. Opp.

at 17-27; Mot. at 59-60. As detailed in the Motion, opposing counsels' misconduct pervaded the case. That pervasion served to build upon, and reinforce, the improper impression that was foisted upon the jury by the opening statement misconduct. Then, in closing argument, opposing counsel bookended the trial with more misconduct, telling the jury that "the world is watching" and the case is "about so much more than just this 10 and half million dollars that [TeamHealth Plaintiffs] are owed." *Id*. at 62.

Because opposing counsel admitted that they succeeded in manipulating the jury to decide the case based on social issues that are larger than the case itself, there is no merit to the argument that the verdict was not irreparably and fundamentally tainted by misconduct. *Lioce*, 124 Nev. at 20-21, 172 P.3d at 982-83 ("irreparable and fundamental error is error that results in a substantial impairment of justice or denial of fundamental rights").

B. Opposing Counsels' Misconduct Was Preserved Because It Was Profuse and Inescapable.

TeamHealth Plaintiffs erroneously assert that their counsels' inescapable misconduct was waived, so the Court should deprive Defendants of a new and fair trial. If the waiver argument is true, which it is not, then the only consequence is that the easiest to satisfy standard of review for a new trial based on attorney misconduct—*i.e.*, review of object-to misconduct—is not applicable. Opp. at 18-21. Waiver does not affect the other standards of review, discussed below, which also require a new trial based on opposing counsels' misconduct. But, TeamHealth Plaintiffs' argument does not hold water. They misapply *Lioce* and ignore the record to claim that Defendants did not object to opposing counsels' misconduct that plagued trial. *Id*. Thus, the easiest standard of review is applicable. And like the more stringent standards of review, it requires a new trial.

1. Pursuant to *Lioce*, Rampant Attorney Misconduct Is Preserved.

In *Lioce*, the Nevada Supreme Court explained that the rationale for requiring contemporaneous objections "is to provide the [trial] court with an opportunity to instruct counsel, admonish the jury, and prevent additional prejudice through repeated misconduct." 124 Nev. at 15, 174 P.3d at 979. However, when counsel is forced to "continuously object to repeated or persistent misconduct" and those objections are sustained, "the nonoffending attorney is placed in the difficult

position of . . . emphasizing the point" and having the jury draw a "negative impression [about] the attorney and the party the attorney represents." *Id*. at 19.

In TeamHealth Plaintiffs' view, the Court can only consider cumulative misconduct if an objection is sustained. Opp. at 18. But the problem attendant to cumulative misconduct and constant objections is ***worse*** when the trial court overrules objections or fails to admonish the attorney engaging in misconduct. In those instances, the jury sees an obstructionist attorney desperate to hide information. As such, the rationale underpinning the contemporaneous objection requirement is obviated by cumulative misconduct and reviewed as if there was an objection. *See id.* at 23 (***Regarding the . . . failure to object***, we conclude that, ***because of the persistent nature of [opposing counsel]'s misconduct, the . . . objections to [the] other [misconduct] sufficiently preserved this issue***" (emphasis added)). Thus, TeamHealth Plaintiffs argument that the cumulative misconduct exception does not apply to unobjected-to misconduct is meritless.

2. Defendants Objected to Opposing Counsels' Improper Tactics and Preserved the Issue.

TeamHealth Plaintiffs contend that Defendants waived whether the shocking amount of attorney misconduct spoiled the verdicts. Opp. at 18-21. They do so by arguing that Defendants did not object and, if Defendants did, those objections do not count. *Id.*

Defendants lodged objections in accordance with *Lioce* to preserve the issue. As demonstrated in the Motion, TeamHealth Plaintiffs' counsel engaged in an extraordinary amount of misconduct. Mot. at 55-85, 90-93. From the outset of trial, opposing counsel resorted to misconduct: conditioning the jury during opening statement that a verdict in TeamHealth Plaintiffs' favor will remedy a social ill that will benefit jury. *Id.* at 59. The Court denied Defendants' objection to this misconduct, which opened the flood-gates upon the rest of trial. *See id.* at 55-85, 90-93. As defense counsel explained to the Court, this left Defendants in the untenable "position of having to object constantly before the jury" even though similar objections were denied. *See id*. at n.7 (quoting 11/23/2021 Tr. 271:13-16). Indeed, TeamHealth Plaintiffs concede that the Court denied numerous objections. Opp. at 20-21. Thus, Defendants are within the ambit of *Lioce's* objected-to misconduct review and TeamHealth Plaintiffs' "**zero**" objection argument is meritless. Opp. at 18-19 (bolding in original).

TeamHealth Plaintiffs know this to be true, too. That is why they contend that Defendants' objections were not sufficient to preserve the issue and it is not the Court's job to review the record for attorney-misconduct. Opp. at 18. Both arguments strain credulity.

First, the Motion provides a plethora of misconduct examples with citations, so the Court does not have to wade through the mud on its own. Mot. at 55-85, 90-93. As such, the Court will be able to satisfy its duty to "make specific findings, both on the record and in its order" by reviewing those examples and the record cites. *Lioce*, 124 Nev. at 19-20, 174 P.3d at 982. Tellingly, TeamHealth Plaintiffs want the Court to play ostrich to the record. That is because upon review of the Motion and its citations to the record, the Court will see that Defendants raised numerous objections to opposing counsels' misconduct.

Second, Defendants' numerous objections to opposing counsels' misconduct preserved *Lioce's* objected-to standard of review. For example, Defendants objected to opposing counsel's misconduct during opening statement. Mot. at 59, 62 (conditioning the jury to rule in TeamHealth Plaintiffs' favor by remedying a social ill larger than the case). While TeamHealth Plaintiffs concede that Defendants informed the court that the opening statement constituted misconduct, they erroneously argue that the error was waived because Defendants did not object until after opening statements were finished. Opp. at 21. This is false and misrepresents the law. Defendants objected while opening statements were delivered. Mot. at 59. And, as TeamHealth Plaintiffs know because they cite *Cox v. Copperfield*, 138 Nev. Adv. Op. 27 (April 14, 2022), in their Opposition, objections made after attorney presentation satisfy the requirement to object "during trial." *Cox*, 138 Nev. Adv. Op. at *8 (observing that objection made "after . . . closing argument" is contemporaneous).

Moreover, TeamHealth Plaintiffs concede that Defendants raised numerous objections during opposing counsels' inappropriate witness examinations. Opp. at 20-21. In doing so, TeamHealth Plaintiffs assert that attorney misconduct objections are only preserved if a litigant says "objection, attorney misconduct" or "objection, *Lioce*." Opp. at 18, 20-21. Otherwise, the Court has no idea that an attorney is engaging in misconduct. For example, they contend, *inter alia*, that "form" and "argumentative" objections are insufficient. *Id*. However, a "form" objection broadly encompasses all manner of inappropriate questions. And, argumentative questions encompass attorney

misconduct. Indeed, in *Grosjean*, the Nevada Supreme Court found attorney misconduct based on an argumentative objection. 125 Nev. at 356-57, 363-66 & n.3, 212 P.3d at 1074, 1079-80 & n.3 ("[defendant] objected to the [misconduct] as being argumentative"). Therefore, TeamHealth Plaintiffs' argument that Defendants' objections did not preserve attorney misconduct is baseless. In short, attorney misconduct is captured by varying objections because an attorney can engage in misconduct is differing ways.

Because Defendants lodged numerous objections during trial concerning opposing counsels' persistent misconduct, which were largely denied, they were placed in the position of having to constantly object. Thus, Defendants objections preserved *Lioce's* objected-to standard of review for assessing opposing counsels' misconduct. Alternatively, as discussed below, the objected-to standard is satisfied by the misconduct that Defendants did object to and the misconduct that purportedly was not objected to meets the unobjected-to standard.

C. What TeamHealth Plaintiffs Claim Is "Permitted Advocacy" Was Attorney Misconduct Under Any *Lioce* Standard.

TeamHealth Plaintiffs contend that Defendants failed to demonstrate that that the verdicts are unreliable based on the attorney misconduct depicted in the Motion. Specifically, they argue that: (1) the verdicts are supported by substantial evidence; (2) Defendants did not meet any of *Lioce's* standards for a new trial; and (3) the conduct complained about was permitted advocacy. Opp. at 21-25. Defendants' Motion, however, establishes that opposing counsel engaged in rampant misconduct, and not "permitted advocacy," which rendered the verdicts unreliable under any *Lioce* standard. Moreover, an attorney misconduct argument attacks the validity of the verdict, so the evidence supporting the verdict is called into question. *See generally Lioce*, 124 Nev. 1. As such, the taint of opposing counsels' misconduct defeats TeamHealth Plaintiffs' substantial evidence argument.

1. The Profuse Attorney Misconduct Rendered the Verdicts Unreliable Under Any *Lioce* Standard.

The Motion demonstrates the scope, nature, and quantity of opposing counsels' misconduct, including that the misconduct was persistent. Mot. 47-85 (detailing liability and punitive damages phase misconduct); *id.* at 90-93 (detailing misconduct related to Defendants' immunized First Amendment Activities). TeamHealth Plaintiffs, however, contend that the persistent attorney

misconduct detailed in the Motion does not meet any *Lioce* standard for obtaining a new trial. To do so, TeamHealth Plaintiffs gloss over, or fail to address, the aspects of *Lioce* that confirm a new trial is required due to their counsels' misconduct.

The central tenet that guides *Lioce* review is whether the evidence is offset by attorney misconduct. *See Lioce*, 124 Nev. at 16-17, 174 P.3d at 980; *see also* Opp. at 22-23. Indeed, a court's review of whether a verdict is unreliable is always based on the "scope, nature, and quantity of the misconduct." *Lioce*, 124 Nev. at 17, 174 P.3d at 980; *Grosjean*, 125 Nev. at 365, 212 P.3d at 1079. This is true regardless of the particular standard of review being utilized—*i.e.*, whether the specific attorney misconduct being assigned error was preserved, whether the court sustained or denied an objection, or whether the court admonished the attorney that engaged in misconduct. *Lioce*, 124 Nev. at 17, 174 P.3d at 980; *Grosjean*, 125 Nev. at 365, 212 P.3d at 1079. Moreover, when an attorney engages in persistent misconduct, "the offending attorney has accepted the risk that ***the jury will be influenced*** by [the] misconduct." *Lioce*, 124 Nev. at 19, 174 P.3d at 981 (emphasis added). Because the jury ***will*** be influenced by persistent misconduct, plain error is practically presumed. *See Lioce*, 124 Nev. at 19, 174 P.3d at 981 ("the district court shall give great weight to the fact that single instances of improper conduct that could have been cured by objection and admonishment might not be curable when that improper conduct is repeated"); *Grosjean*, 125 Nev. at 369, 212 P.3d at 1082.

The plethora of attorney misconduct marshalled in the Motion demonstrates that persistent misconduct influenced the jury's verdicts. The examples provided in the Motion show that the scope of the misconduct included, *inter alia*, injection of personal opinion as to the justness of TeamHealth Plaintiffs' lawsuit, the credibility of witnesses, and the culpability of Defendants. The nature of the misconduct was also revealed by the examples: inflame the passions of the jury, including, *inter alia*, by having the jury decide the case based on the weight of societal obligations. And, the numerous examples show the sheer quantity of misconduct that placed Defendants in the untenable position of having to constantly object. Some of those examples include:

- Prohibited injection of personal opinion that a witness was a liar. Mot. at 72 (explaining Court's instruction for jury to disregard opposing counsel's "Pinocchio" and "bald-faced lie" statements had no deterring effect).

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- Prohibited send-a-message requests by asking the jury to say "enough is enough" in order to remedy a social ill befalling every Nevadan, including the jury. Mot. at 59-58; *see also Rudin*, 120 Nev. at 147, 86 P.3d at 589 (Rose, J., dissenting) ("the impression a juror has after opening statements usually carries . . . to . . . the verdict . . . [, so defendant] was already at a great disadvantage").
- Prohibited *ad hominem* attacks of witnesses designed to inflame the jury's passions, such as asking whether a witness "fe[lt] good inside" and "proud" that he made more than doctors that save lives. Mot. at 35-36, 57, 68.
- Prohibited placement of the jury into the verdict by telling them that "anybody living in [Nevada] ought to be embarrassed about" the reimbursement level that was remitted for the emergency medicine services that Nevadans receive. Mot. at 62.
- Prohibited golden rule argument by injecting the jury into the verdict by telling them that they were manipulated by Defendants. Mot. at 92-93 ("'[L]et me tell you something, they got to you all [the jury]" with "this nonsense [of] educating the public' . . . that the Country 'had this huge problem with balance billing.'" (quoting 11/23/2021 Tr. 144:6-16)); *id*. at 93 ("'[Defendants] have spent an enormous amount of resources in brainwashing . . . the people of this state,'" including the jury (quoting 12/7/2021 Tr. 98:19-23)).[5]
- Prohibited "the jury has wasted its time" argument by not ruling in a party's favor. Mot. at 84-85. TeamHealth Plaintiffs attempt to distract from the prohibited "wasted its time" misconduct by contending that their counsel was allowed to tell the jury they should not speak in a "whisper" because of the evidence. Opp. at 25. Tellingly, they do not address the fact that opposing counsel engaged in prohibited misconduct by making the punitive damages verdict about the jury.

[5] TeamHealth Plaintiffs do not oppose that their attorneys engaged in misconduct related to their use Defendants' petitioning related activities. *Compare* Opp. at 18, 22-23 (opposing Mot. at 47-85) *and id.* at 21 (making clear that they only opposed "thirty-eight pages" of Defendants' Motion), *with* Mot. at 47-85, 90-93 (arguing forty-two pages worth of attorney misconduct) *and id.* at 90-93 (presenting unopposed argument that opposing counsel engaged in misconduct). As such, TeamHealth Plaintiffs have waived their ability to challenge that misconduct and have conceded the merits of the argument. *See* E.D.C.R. 2.20(e) ("Failure of the opposing party to serve and file written opposition may be construed as an admission that the motion . . . is meritorious and a consent to granting the same.").

Because opposing counsel engaged in persistent misconduct, they accepted the risk that the verdicts would be rendered unreliable due to the jury being influenced by the misconduct. As such, TeamHealth Plaintiffs cannot claim that substantial evidence supports an unreliable verdict. Alternatively, the examples marshalled in the Motion establish that: (1) the misconduct's effect was so extreme that the taint to the verdict could not be removed by objection with or without admonishment;[6] (2) the Court erred in constantly overruling Defendants' objections and admonishment would likely have affected the verdict in their favor;[7] and (3) the misconduct resulted in "irreparable and fundamental error . . . such that, but for the misconduct, the verdict would have been different."[8] Indeed, it is enough to show that the misconduct affects what the jury would have otherwise awarded. *See id*. Therefore, a new trial is required.

2. TeamHealth Plaintiffs' Counsels' Misconduct Was Not Permitted Advocacy.

TeamHealth Plaintiffs contend that their misconduct is permitted advocacy because: (1) the Nevada Supreme Court has denied relief when an attorney injects his or her personal beliefs into a case, including by calling witnesses lairs, Opp. at 23 (citing *Grosjean v. Imperial Palace*, 125 Nev. 349, 363-65, 212 P.3d 1068, 1078-80 (2009); (2) they "did not direct the jury to rule **contrary to the evidence**," *id*. 23-24 (emphasis in original); and (3) they can "'disparag[e]' a witness or [an] 'opponent[],'" *id*. at 24 (citing *Pizarro-Ortega v. Cervantes-Lopez*, 133 Nev. 261, 269 n.12, 396 P.3d 783, 790 n.12 (2017)). They are wrong.

First, TeamHealth Plaintiffs errantly assert that the Nevada Supreme Court denied relief when it found that an attorney engaged in misconduct by injecting his own emotions into the case, disparaging his opponent's case, and declaring that witnesses and his opponent were liars. *Id*. TeamHealth Health Plaintiffs do so by relying on *Grosjean*. *Id*. However, in *Grosjean* the Nevada Supreme Court unequivocally held that the attorney engaged in misconduct and "conclude[d] that the

[6] New trial standard for sustained objections that concern attorney misconduct where the court did or did not admonish the offending attorney in front of the jury. *Lioce*, 124 Nev. at 18, 174 P.3d at 981.

[7] New trial standard for overruled objection that concerns attorney misconduct. *Lioce*, 124 Nev. at 18, 174 P.3d at 981.

[8] New trial standard for unobjected-to attorney misconduct. *Lioce*, 124 Nev. at 19, 174 P.3d at 981-82.

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misconduct . . . warrant[ed] a new trial[.]" *Grosjean*, 125 Nev. at 368-69. A such, TeamHealth Plaintiffs are wrong that the *Grosjean* court denied relief based on attorney misconduct.

Second, TeamHealth Plaintiffs advance the erroneous argument that a verdict can only be set aside when misconduct is coupled with an express request to the jury to rule contrary to the evidence. Opp. at 23. TeamHealth Plaintiffs cite *Pizarro-Ortgeo* as support. However, that case only authorized "send a message" arguments if the attorney asks the jury to do so based on the evidence. 133 Nev. at 269. It did not hold that a verdict can only be set aside based on an express request to disregard evidence. *See id*. To be sure, *Lioce* and *Grosjean* explain that a verdict can be set aside when the attorney's misconduct could ***suggest*** or ***encourage*** the jury to render a verdict based on forbidden rationale, such as societal obligations. *See Lioce*, 124 Nev. at 21, 172 P.3d at 983 (faulting "[attorney]'s arguments [that] ***suggested*** to the jurors . . . that jury could remedy [a] social ill[]" (emphasis added)); *Grosjean*, 125 Nev. at 365, 212 P.3d at 1079 (faulting "attorney's comments during witness examination, during closing argument, and later during the punitive damages portion of the trial [that] ***encouraged*** the jurors to look beyond the law and the relevant facts" (emphasis added)). That is precisely what TeamHealth Plaintiffs did throughout both phases of trial. *E.g.*, Mot. at 59 (urging the jury "'to pull Nevada up from the bottom . . . and say enough is enough'"); *id*. at 64 (encouraging the jury to rule in TeamHealth Plaintiffs' favor because the "world is watching" and the case is "about so much more than just this 10 and half million dollars that [TeamHealth Plaintiffs] are owed"); *id*. at 84-85 (suggesting that a large punitive damages verdict is required or else the jury would "have wasted a month and a half of [their] lives"). Thus, there is no merit to TeamHealth Plaintiffs' argument that a verdict is impervious to the taint of misconduct if the jury is not expressly asked to disregard the evidence.

Third, TeamHealth Plaintiffs claim that their attorneys are allowed to disparage opposing witnesses and Defendants. Opp. at 24 (citing *Pizarro-Ortega*). However, *Pizarro-Ortega* does not support that argument. In that case, the appellant contended that opposing counsel engaged in misconduct by disparaging a witness. 133 Nev. 269 n.12, 396 P.3d at 790 n.12. In a footnote, without recanting the purported misconduct, the Nevada Supreme Court informed that it "considered the . . . record" and was "not persuaded that . . . counsel engaged in misconduct." *Id*. This terse

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statement does not stand for the proposition that counsel can disparage a witness or an opponent. Instead, it means that opposing counsel did not engage in misconduct because counsel did not disparage a witness.

* * *

Due to the overwhelming amount of attorney misconduct that took place during this trial, the verdicts were spoiled and must be set aside.

IV.
TEAMHEALTH PLAINTIFFS URGE THIS COURT TO ALLOW DEFENDANTS TO BE HELD LIABLE FOR FIRST AMENDMENT ACTIVITIES IMMUNE FROM LIABILITY

The right to petition is "among the most precious of the liberties safeguarded by the Bill of Rights" and is "intimately connected, both in origin and in purpose, with the other First Amendment rights of free speech and free press." *United Mine Workers of Am., Dist. 12 v. Illinois State Bar Ass'n*, 389 U.S. 217, 222 (1967). When a party asserts that its First Amendment rights will be infringed, the party "is in essence asserting a First Amendment ***privilege***." *Perry v. Schwarzenegger*, 591 F.3d 1147, 1160 (9th Cir. 2010) (emphasis in original). Yet, TeamHealth Plaintiffs ignore precedent to implore an unsupported argument that there is no First Amendment privilege and request that the Court ignore their persistent infringement of Defendants' First Amendment activities that should have been immune from liability. Opp. at 25-26.

TeamHealth Plaintiffs agree that Defendants' conduct incidental to the Yale Study, the Brookings Report, and the *New York Times* article are protected First Amendment Activities. Opp. at 25-27. And, they concede that their unsupported argument in opposition to Defendants' motion in limine number 20—that Defendants' activities were not immune to liability and off limits because *Noerr-Pennington* only applies in the antitrust context—was erroneous. *Compare id.*, *with* Mot. at 86-88 (demonstrating TeamHealth Plaintiffs persuaded the Court to allow use of the evidence based on meritless, unsupported opposition). Nonetheless, they believe that it was proper to admit and use immunized activity to convince the jury to find liability and award $60 million dollars in punitive damages. Opp. at 26.

To let those verdicts stand, however, would ignore clear constitutional jurisprudence that First Amendment rights should not be burdened. *E.g.*, *Evans Hotel, LLC v. Unite Here Local 30*, 433 F.

Supp. 3d 1130, 1144 (S.D. Cal. 2020) ("the court [must] determine whether the plaintiff's lawsuit burdens the defendant's petitioning activities" (citing *Sosa v. DirectTV, Inc.*, 437 F.3d 923, 930, 932 (9th Cir. 2006))). If those rights are burdened, they are not immune and will be chilled. *See White v. Lee*, 227 F.3d 1214, 1231 (9th Cir. 2000) ("[T]o say that one does not have *Noerr-Pennington* immunity is to conclude that one's petitioning activity is unprotected by the First Amendment."). Indeed, activity immune from liability cannot be both immune from liability and used to establish liability and punitive damages. *See id.* Unsurprisingly, TeamHealth Plaintiffs' argument is meritless.

TeamHealth Plaintiffs argue without support that activity immune from First Amendment activity can be used to prove liability and punitive damages so long as that activity does not "underl[ie] the causes of action" of a lawsuit. Opp. at 26. This argument is nonsensical. TeamHealth Plaintiffs contradictorily assert that Defendants' immunized First Amendment activities did not "underl[ie] [their] causes of action" but also "provided important context." Opp. at 26-27. But how can something not underlie a cause of action and also provide important context at the same time? By allowing activity immune from liability to be used to establish liability and obtain punitive damages, the Court would chill a litigant from engaging in future protected activity. Thus, when activity is immune from liability, that activity is unavailable as evidence for proving liability or obtaining punitive damages.

However, in an unsupported hail mary, TeamHealth Plaintiffs argue that their persistent, successful use of Defendants' immunized activities is of no concern because the verdicts are supported by substantial evidence. Opp. at 27. In essence, the argument means that courts can turn a blind eye to the infringement, and future chilling, of First Amendment rights by disregarding the full record. *Id.* Any court that reviews the trial record, however, will see that Defendants' immunized activities were a critical component of TeamHealth Plaintiffs' case. Mot. at 88-93. Indeed, TeamHealth Plaintiffs utilized Defendants' immunized activity during opening statement, throughout their case-in-chief, and during closing arguments of both phases of trial. *Id*. For example, during the liability phase of trial, opposing counsel told the jury that they should find Defendants liable because Defendants manipulated the jury. Mot. at 92-93 ("'[L]et me tell you something, they got to you all [the jury]' with 'this nonsense [of] educating the public . . . that the Country had this huge problem

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with balance billing.'" (quoting 11/23/2021 Tr. 144:6-16)). Then, during the punitive damages phase, opposing counsel implored the jury to punish Defendants for engaging in First Amendment activity because Defendants "brainwashed" the jury. *See id*. at 93 ("'[Defendants] have spent an enormous amount of resources in brainwashing . . . the people of this state,'" including the jury (quoting 12/7/2021 Tr. 98:19-23)). In other words, both the liability verdict and punitive damages verdict are entangled with conduct that is supposed to be immunized by the First Amendment.[9] As such, the jury's verdicts punish Defendants for exercising their protected First Amendment rights that should have been immune from liability. To prevent the verdict from chilling future First Amendment activity, the Court must order a new trial that is devoid of this evidence.

Finally, TeamHealth Plaintiffs misrepresent caselaw to support their argument that activity immune from lability can be used as evidence to prove liability. TeamHealth Plaintiffs attempt to convince the Court that *Theme Promotions, Inc. v. News America Mktg. FSI*, 546 F.3d 992, 1007 (9th Cir. 2008), can be read for the proposition that *Noerr-Pennington* and the First Amendment do not embody "an evidentiary privilege." *See* Opp. at 26 ("*Theme Promotions* rejected the plaintiff's attempt to characterize the *Noerr-Pennington* doctrine as an evidentiary privilege"); *White*, 227 F.3d at 1231 ("*Noerr-Pennington* is a label for a form of First Amendment protection"). But *Theme Promotions* held otherwise, explicitly.

In that case, the trial court vacated the jury's verdict because plaintiff presented the jury with evidence of defendant's activities that were protected by the First Amendment. 546 F.3d at 997-999, 1006-07. The plaintiff argued that it was error for the district court to vacate the jury's verdict on *Noerr-Pennington* grounds because activity immune from liability is not privileged and can be used as evidence. *Id*. 1006-07. Specifically, the plaintiff argued that *Noerr-Pennington* did not apply because a state evidentiary privilege that purportedly permitted admission of the immunized evidence should have governed. *See id*. at 1007. However, the court explained that because *Noerr-Pennington* "has been articulated as a principle of statutory construction rather than as a privilege . . . , ***it applies***

[9] Even assuming arguendo that the liability verdict could be found to be supported by substantial evidence, the jury's punitive damages verdict punishes Defendants for conduct that is immune from punishment. Thus, the jury's punitive damages verdict must be set aside. Alternatively, it is excessive because it punishes First Amendment conduct. Therefore, at the very least, there must be a massive reduction to the award.

in all contexts." *Id*. (emphasis added). Thus, the court held that immune activity is privileged and cannot be used as evidence. *Id.* at 1006 ("[Plaintiff . . . argue[d] that [defendant's] conduct was not privileged under [*Noerr-Pennington*]. We disagree."). As such, TeamHealth Plaintiffs' argument that activity immune from liability is not privileged is disingenuous and meritless.

In sum, TeamHealth Plaintiffs did not attempt to meet their burden to show that Defendants' petitioning activities are not protected by the First Amendment and *Noerr-Pennington*. Mot. at 87-88; *see also Boone v. Redevelopment Agency of San Jose*, 841 F.2d 886, 894 (9th Cir. 1988) ("In order not to chill [First Amendment] activities, it is important that a plaintiff's complaint contain specific allegations demonstrative that *Noerr-Pennington* protections do not apply."). Indeed, they do not dispute that Defendants' activities are protected under the First Amendment. As such, the verdicts obtained using immunized activity will chill Defendants' petitioning activities. Therefore, the verdict cannot stand and the Court must order a new trial.

V.
IRREGULARITY IN THE PROCEEDINGS, ABUSE OF DISCRETION, AND ERRORS OF LAW THAT REQUIRE A NEW TRIAL

A. TeamHealth Plaintiffs Did Not Always Seek to Recover Punitive Damages Under a Theory of Unjust Enrichment.

To contend that they have always clearly sought to recover punitive damages under a theory of unjust enrichment, TeamHealth Plaintiffs resort to vague statements that they generally sought an award of punitive damages. Opp. at 28-29 ("'Through this lawsuit, [TeamHealth Plaintiffs] seek . . . punitive damages'" and TeamHealth Plaintiffs "'request the following relief: . . . [a]n award of punitive damages'" (quoting Joint Pre-Trial Memo. at Section II, TeamHealth Plaintiffs' Statement of the Facts of the Case,[10] and Second Am. Compl. Request for Relief). General statements, however, do not overcome TeamHealth Plaintiffs' specific, limiting representations that they did not seek punitive damages under a theory of unjust enrichment. *Shelton v. Shelton*, 119 Nev. 492, 497, 78

[10] TeamHealth Plaintiffs attempt to recharacterize the Joint Pre-Trial Memorandum's Section II, which is titled "Statement of the Facts of the Case," by calling Section II "Plaintiffs' Statement of the Case." Opp. at 28. This mischaracterization is an apparent attempt to argue that Defendants relied on that generic "'statement of the . . . case.'" Opp. at 29 (quoting Mot. at 97). The Joint Pre-Trial Memorandum and Defendants' Motion and incorporated filing, however, make obvious that Defendants were referring to TeamHealth Plaintiffs' specific statement that they were only seeking punitive damages pursuant to their bad faith theory contained in the Unfair Claims Practices Act cause of action. Mot. at 97.

P.3d 507, 510 (2003) ("a specific provision will qualify the meaning of a general provision"). Moreover, those vague statements do not overcome Nevada Supreme Court precedent.

First, TeamHealth Plaintiffs contend that Defendants "should have known that [TeamHealth] Plaintiffs sought punitive damages under any . . . legal theory . . . because [TeamHealth] Plaintiffs did not limit the request of punitive damages to any single claim." *Id*. at 29 (citing Joint Pre-Trial Memo. at Section II). This is false, and TeamHealth Plaintiffs cannot escape reality through contrived reliance on vague, generalized statements by ignoring specific representations. As noted in the Motion, on October 4, 2021, TeamHealth Plaintiffs represented that they would only be seeking punitive damages with regard to their bad faith theory contained in their Unfair Claims Practices Act ("UCPA") cause of action. Mot. at 96-97. After TeamHealth Plaintiffs attempted to remove all references to the categories of damages that they were seeking with regard to specific causes of action in violation of EDCR 2.67(b)(2), Defendants demanded that TeamHealth Plaintiffs comply with the law. *Id.* TeamHealth Plaintiffs acceded and specifically represented that they were only seeking punitive damages with regard to their bad faith theory contained in their UCPA cause of action. *Id.*; *compare* Joint Pre-Trial Memorandum at 5-6 (representing that TeamHealth Plaintiffs sought "actual damages" and "punitive damages" for UCPA cause of action), *with id*. at 5 (representing that TeamHealth Plaintiffs only sought "actual damages" and "pre- and post-judgment interest" for unjust enrichment cause of action).

Second, TeamHealth Plaintiffs argue that Defendants were aware of TeamHealth Plaintiffs' intent to seek punitive damages based on any cause of action because the Joint Pre-Trial Memorandum contained Defendants' position that an issue at trial will be "[***w]hether*** TeamHealth Plaintiffs can present evidence sufficient to establish . . . ***punitive damages are available*** to TeamHealth Plaintiffs on any claim ***for which that category of damages is asserted***." Opp. at 29 (emphasis added). However, TeamHealth Plaintiffs' argument ignores the plain meaning of the very words that they quote from Defendants' Joint Pre-Trial Memorandum position. That position is unambiguously limited to the "category of damages" for which punitive damages have been "asserted." *Id*. Section III of the Joint Pre-Trial Memorandum contains the "Categories of Damages" that TeamHealth Plaintiffs asserted. Punitive damages are not asserted under the unjust enrichment

cause of action. Joint Pre-Trial Memorandum at 5-6. It is only asserted under the UCPA cause of action. *Id*. Thus, Defendants' position that "whether . . . punitive damages are available . . . on any claim for which that category of damages is asserted" was limited to the UCPA cause of action. TeamHealth Plaintiffs cannot distort that position, especially to Defendants' prejudice.

Third, TeamHealth Plaintiffs' mischaracterization of *Sprouse v. Wentz*, 105 Nev. 597, 781 P.2d 1136 (1989), does not enable their vague, general statements to supersede their specific, limiting representations. TeamHealth Plaintiffs misrepresent *Sprouse* by claiming that "the party seeking punitive damages did not allege . . . actions arising to the level of fraud, oppression, or malice," and TeamHealth Plaintiffs did so in their complaint. Opp. at 30. So, they assert *Sprouse* is inapposite. *Id.* However, the plaintiff in *Sprouse* "alleg[ed] . . . fraud necessary for punitive damages." 105 Nev. at 601, 781 P.2d at 1138. Thus, TeamHealth Plaintiffs' argument that *Sprouse* is inapposite is predicated on misrepresentation and has no merit. Moreover, the *Sprouse* plaintiff's pre-trial statements led defendant to believe that punitive damages were only sought for one cause of action. *Id*. at 604. TeamHealth Plaintiffs did exactly that, too. Meaning, TeamHealth Plaintiffs' specific representations led Defendants to believe that punitive damages were not sought for unjust enrichment. Therefore, just as it was error to allow the *Sprouse* plaintiff to seek punitive damages for a cause of action beyond the specific representations there, TeamHealth Plaintiffs' request for punitive damages were supposed to be limited to their specific representations. As such, it was error for the Court to permit TeamHealth Plaintiffs to expand their pursuit of punitive damages beyond the UCPA cause of action and a new trial is required.

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B. A New Trial Is Required Due to the Improper Admission of Evidence During the Liability Phase of Trial.

1. The Court Improperly Pre-Admitted or Conditionally Admitted Numerous Exhibits.

TeamHealth Plaintiffs advance three arguments as to why the Court did not err in pre-admitting or conditionally admitting exhibits before the start of trial: (1) Defendants "waived any objection to conditionally admitted exhibits because [they] did not move to strike those exhibits from the record before the close of evidence"; (2) "the Court did not err by not holding a . . . [Federal] Rule [of Evidence] 104(b)" hearing; and (3) "the standard for conditional relevancy under [NRS]

47.040 . . . is minimal." Opp. at 32. These arguments are meritless. Indeed, TeamHealth Plaintiffs do not rely on any Nevada precedent regarding state procedure. Instead, they distract with federal procedure.

First, TeamHealth Plaintiffs fault Defendants for not moving to strike conditionally admitted exhibits. *Id.* This argument is a red herring. Defendants objected to the full admission of numerous exhibits that were conditionally admitted because there was no foundation. *See, e.g.*, Mot. at 104, 106-110. Defendants, thus, could not have waived the admission of the exhibits by objecting to their conditional admission and then objecting to their full admission. Defendants were under no obligation to move to strike a fully admitted exhibit to preserve the issue. Nonetheless, TeamHealth Plaintiffs contend this overkill is required because of federal procedure. Opp. at 32 (citing United States Supreme Court precedent interpreting federal procedure). However, TeamHealth Plaintiffs provide no explanation for why federal procedure would apply in Nevada state court. In any event, there was no requirement to move to strike.

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Second, TeamHealth Plaintiffs assert there was no error because the Court was not required to hold a Federal Rule of Evidence 104(b) hearing. Again, it is unclear from TeamHealth Plaintiffs' brief why this state Court would have to abide by federal procedure and its related precedent. Regardless, the Court was required to hold a NRS 47.080 hearing, which is what Defendants requested pre-trial and discussed in their Motion. Mot. at 102-03. Pursuant to Nevada state procedure and jurisprudence, the Court was required to hold a hearing for TeamHealth Plaintiffs to "state the proper purpose" of each objected-to document. *Id.* That hearing never happened, but TeamHealth Plaintiffs were allowed to use those documents in their opening statement. *Id.* The use of those documents, including Defendants' First Amendment activities immune from lability, in opening statement was error because opening statements "are not evidence . . . of anything[] and cannot be so considered by the jury." *Rodriguez v. State* 273 P.3d 845, 848 n.3 (2012) (alterations in original omitted) (quoting *State v. Olivieri*, 49 Nev. 75, 77-78, 236 P. 1100, 1101 (1925)); *see also Rudin*, 120 Nev. at 147, 86 P.3d at 589 (Rose, J., dissenting) ("the impression a juror has after opening statements usually carries . . . to . . . the verdict . . . . For that reason, by the end of opening statements, [defendant] was already at a great disadvantage even though no evidence had been presented.").

Third, TeamHealth Plaintiffs argue that "the standard for conditional relevancy under [NRS] 47.040 . . . is minimal." However, the minimal standard that they insist upon is no standard at all. They offer no guiding principle aside from relegating the Court to an empty set of robes. Opp. at 32-33. Moreover, even though TeamHealth Plaintiffs do not provide any citations to state procedural law, the federal support that they rely upon makes clear that the judge must be a gatekeeper. As such, the Court was required to properly satisfy itself that the objected-to documents could be conditionally admitted. In any event, it was improper for any evidence to have been used in opening statement.

2. The Court Improperly Admitted Numerous Exhibits That Lacked Foundation.

TeamHealth Plaintiffs present two arguments as to why exhibits were properly admitted without foundation: (1) the authenticity of the documents is not in question; and (2) witnesses had personal knowledge of documents they had never seen before. Opp. at 33-34. Neither argument overcomes the requirement that an exhibit can only be admitted after proper foundation has been laid.

TeamHealth Plaintiffs assert that Defendants "do[] not claim that the exhibits lack authenticity" even though the Motion argues that there was no foundation for authenticity to be established. Opp. at 33. But putting the cart before the horse begs the question of how authenticity can be established without foundation. To get around that conundrum, TeamHealth Plaintiffs argued that documents are admissible when there is evidence or another showing sufficient to authenticate. Opp. at 33. Particularly, they argued that a witness with knowledge of a document was not needed to lay ***foundation*** because one of the other methods to prove ***authenticity*** filled the void. *Id*. (citing NRS 52.025-52.105). Noticeably absent from their Opposition, however, is any explanation of how those other authenticity methods are applicable. *Id*. That is because authenticity is not the same as foundation. And, TeamHealth Plaintiffs cannot even satisfy those other authenticity methods. For example, TeamHealth Plaintiffs cite to the "[a]ncient documents" standard, but none of the exhibits in this trial were "at least 20 years old." *Id*. (citing NRS 52.095). Likewise, they do not explain how the "process or system" standard is applicable. *Id*. (citing NRS 52.105). Because none of the other authentication methods were applicable in this case, an appropriate foundational witness was required to testify regarding the document before that document's admission into evidence. Otherwise, evidence could be admitted without a witness on the stand.

TeamHealth Plaintiffs also claim that Defendants have waived any objection regarding TeamHealth Plaintiffs' failure to lay proper foundation to authenticate purported business records. Opp. at 33. Specifically, that Defendants did not raise a NRS 51.135 objection. This argument is misguided. Before a business record is admitted into evidence, NRS 52.260 requires foundation that the record be "made in the course of a regularly conducted activity in accordance with NRS 51.135 . . . by a custodian of the record or another qualified person in a signed affidavit." Defendants objected to the admission of many exhibits, which, as detailed in their Motion, was because TeamHealth Plaintiffs failed to lay a foundation through "a custodian of the record or another qualified person." Mot. 105-110. Thus, the issue is not waived.

Relatedly, TeamHealth Plaintiffs request that the Court abrogate the rules of evidence because all of Defendants' and MultiPlan's documents that were entered into evidence were self-authenticating. Opp. at 33-34. But again, they fail to explain what "self-authenticating" standard they are invoking. Instead, they hide behind a high-level, misrepresented quote from a federal case. *Id*. (quoting *Ideal Electric Company v. Flowserve Corp.*, 2006 WL 8441868, at *1-2 (D. Nev. Sept. 21, 2006)). To be sure, the court in *Ideal Electric* explained that some documents are self-authenticating while others need to be "authenticated through circumstantial evidence." *Ideal Electric*, 2006 WL 8441868, at *1. A document is only self-authenticating if a party has "establish[ed] . . . facts sufficient to constitute self-authentication under [FRE] 902." *Id*. A "document's own distinctive characteristics," however, do not establish self-authentication under FRE 902. *Id*. (citing FRE 901, not 902, for why a document "may be authentic[]" based on it characteristics). Thus, TeamHealth Plaintiffs' federal case does not support their argument that the contested exhibits were self-authenticated under Nevada's rules of evidence.

In Nevada, a document may be self-authenticated if it meets the requirements of one of the statutes found in NRS 52.115-52.175. These are the only types of documents that are presumed authentic. *Id*. TeamHealth Plaintiffs, however, failed to establish facts sufficient to show that any of these statutes apply. Thus, there is no merit to TeamHealth Plaintiffs' argument that Defendants' and MultiPlan's documents were self-authenticating.

Finally, TeamHealth Plaintiffs contend that the jury could infer that witnesses had personal knowledge of documents despite those witnesses testifying that they had ***never*** seen the document before. *Compare* Opp. at 34 ("[TeamHealth] Plaintiffs in fact laid the foundation for personal knowledge of Haben and Paradise"), *with e.g.,* Mot. at 107 (citing 11/3/2021 Tr. 128:25-129:2 (Haben: "I am not familiar with [PX 92]. So I don't know.")), *id*. at 108 (citing 11/9/2021 Tr. 192:15-17 (Haben: "I don't know what [PX 426] is. I've never seen it before.")), *and* Mot. at 112 (citing 12/7/2021 Tr. 43:15-17 (Paradise: "I have not [seen PX 519 or PX 1001-04 before]")). TeamHealth Plaintiffs again hide behind high-level quotes from federal case law to distract from their failings. Opp. at 34. All of TeamHealth Plaintiffs' sources, however, reach two conclusions that negate their argument: (1) the jury must be able to conclude that a witness has personal knowledge; and (2) courts serve as gatekeepers of evidence. *Id*. No reasonable juror could conclude that a witness has personal knowledge about a document when the witness's sworn testimony is that he or she has never seen the document before. As such, the Court was required to exercise its gatekeeper reasonability and not admit the evidence.

In sum, TeamHealth Plaintiffs would have the Court break new ground by ruling that a witness is never needed for the admission of evidence. Their position ignores Nevada's rules of evidence to the contrary. Because many documents were admitted without proper foundation, including documents described as critical to the case, *e.g.,* Mot. at 106 (citing opposing counsel's personal opinion as to the importance of PX 25, which evinces Defendants' protected First Amendment activities), a new trial is required.

C. The Improper Admission of Evidence During the Punitive Damages Phase Requires a New Trial.

Defendants' Motion lays out the reasons why TeamHealth Plaintiffs' Opposition is incorrect. However, two points from the Opposition warrant reply: (1) the documents admitted into evidence were not responsive to a discovery request; and (2) the documents were admitted without proper foundation.

1. The Certified Financial Statements Admitted Into Evidence Were Not Responsive to TeamHealth Plaintiffs' Request for Production No. 34.

TeamHealth Plaintiffs' Opposition advances no reason for why PX 1001-04 were responsive to Request for Production No. 34. Opp. at 35. Instead, they assert that those certified financial statements were relevant and admissible because "Defendants did not offer to produce a different set of documents that demonstrated the profit impact of out-of-network reimbursements." *Id*. That is not the standard for responsiveness or admissibility. As explained in the Motion, those certified financial statements did not show that there was any impact to profits as a result of the reimbursement rates paid by Defendants. Mot. at 111. This is apparent from TeamHealth Plaintiffs' concession that the documents noted nothing more than "accurate reflections of the profits" and not reflections of any impact to profits.

2. No Witness at Trial Had Personal Knowledge of the Admitted Financial Documents.

TeamHealth Plaintiffs assert that Rebecca Paradise had personal knowledge of the financial performance of the out-of-network programs that impacted Nevada because she had "oversight over the entire nation." Opp. at 37. So, she necessarily must have personal knowledge of PX 519 and PX 1001-04, including the financial figures and statements contained in those exhibits. *See id.* As such, the evidence was admissible and Defendants "could have cured any potential confusion on re-direct examination by breaking down the financial information." Opp. at 35-36.

TeamHealth Plaintiffs' assumption that Ms. Paradise had personal knowledge of the exhibits due to her job is contradicted by her sworn testimony. As explained in the Motion, Ms. Paradise had "[n]ever seen a balance sheet in [her] time . . . at United," so she had never seen the exhibits before taking the stand. Mot. at 112. Therefore, the only testimony that Defendants could elicit on re-direct was that Ms. Paradise had no personal knowledge to competently testify to the matters she was being asked to testify about. *See id*. There is nothing Defendants could have done on re-direct, or in the very limited amount of time that the Court allotted for the second phase of trial, that would have cured the error of admitting those exhibits and any confusion about the financial figures shown to the jury.

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D. The Use of Deposition Testimony in This Case Was Fraught with Irregularity, Abuse of Discretion, and Unfair Surprise.

1. Defendants Properly Explained That a New Trial is Required Due to Deposition Testimony Being Presented at Trial in the Same Manner As Live Witness Testimony.

TeamHealth Plaintiffs tersely contend that Defendants did not satisfy their burden of explaining why a new trial is required due to deposition testimony being disjointly presented similar to a live witness. Opp. at 39-40. Particularly, TeamHealth Plaintiffs take issue with not knowing "whose testimony [was] presented by deposition," what "misleading impression" was created, whether Defendants invoked the rule of completeness, and what testimony would have been offered. *Id*. Their argument strains credulity because both they and the Court are aware of this information.

First, TeamHealth Plaintiffs and the Court know that Daniel Rosenthal and Dan Schumacher testified at trial via deposition. Second, TeamHealth Plaintiffs and the Court know that Defendants objected to all deposition witnesses being treated the same as live witnesses and wanted the rule of completeness to be enforced because disjointed deposition testimony will result in an answer being "give[n] . . . and then . . . skip[ping] to a different topic. The answers won't be in sequence to questions." *See* Mot. at 116-17 (explaining how TeamHealth Plaintiffs convinced the Court allow Defendants to be prejudiced by providing incomplete deposition testimony (citing 11/1/2021 Tr. 170-172)); 11/1/2021 Tr. 170:11-16; 11/1/2021 Tr. 172:13-18 ("by cutting [deposition testimony] up . . . we're going to sacrifice clarity and understanding of the jury . . . they might not hear . . . answers that naturally follow . . . until [Defendants]" designated testimony is presented). Third, TeamHealth Plaintiffs and the Court know what testimony would have been offered because the parties exchanged designations, the Court ruled on objections to the proposed deposition testimony, and disjointed deposition testimony was presented.

For example, TeamHealth Plaintiffs were errantly allowed to present Mr. Rosenthal's deposition testimony concerning the Yale Study. Mot. at 85-93; Daniel Rosenthal Deposition (Nov. 12, 2021), Tr. 77:12-106:15. As part of that presentment, the jury was left to believe that it Mr. Rosenthal's opinion that TeamHealth did not need to be named in the study was predicated solely on his "feel[ing]" that it was "a less is more situation." Rosenthal Dep. Tr. 93:15-93:19. However, the important context of that statement did not come until Defendants were allowed to play their portion

of the deposition testimony, explaining that "if the [study's] findings weren't going to be different, then . . . why name them." *Id.* 93:20-94:5. Thus, the jury was misled into believing that TeamHealth was not named in the study for nefarious purposes as opposed to there being no need to name them because doing so had no effect on the study's findings. Therefore, TeamHealth Plaintiffs' terse argument has no merit.

* * *

Due to the chorus of trial errors, Defendants were deprived of a fair trial. Therefore, a new trial is required.

VI.
JURY INSTRUCTIONS

A. Condition Precedent

Under TeamHealth Plaintiffs' theory of lability for an implied-in-fact contract, they needed to submit an emergency medicine services claim to Defendants in order to be reimbursed. Indeed, TeamHealth Plaintiffs crafted the following statement about their implied-in-fact contract theory, which was read to the jury:

> Plaintiffs claim that they entered into an implied contract with defendants. The ***plaintiffs contend that they agreed to*** provide emergency care to patients . . . [and] ***submit claims in the manner required*** by the defendants. . . . ***[I]n exchange***, defendants agreed to reimburse plaintiffs ***for the reasonable value of plaintiffs' services***.

11/23/2021 Tr. 127:15-21 (emphasis added); 11/21/2021 Tr. 6:5-7:14. The proper submission of claims is ***an event*** that must occur ***before*** the covenant to reimburse is effective. The authority cited by TeamHealth Plaintiffs in their Opposition prove this is true. Opp. at 49-50 (citing Restatement (Second) of Contracts § 224 (1981); *McCorquodale v. Holiday, Inc.*, 90 Nev. 67, 69, 518 P.2d 1097, 1098 (1974)). As TeamHealth Plaintiffs explain, a "condition precedent . . . is ***an event*** that must occur ***before*** the contractual covenant[] . . . [is] effective." *Id*. (emphasis added). As such, any obligation to reimburse TeamHealth Plaintiffs was conditioned on their submitting claims in the manner required by Defendants.

TeamHealth Plaintiffs contend that Defendants' condition precedent instruction could not have been given because "it was confusing." This is a remarkable assertion because Defendants' proposed instruction is the 2018 Model Instruction. TeamHealth Plaintiffs have provided no reason

why this Model Instruction was confusing. Therefore, the instruction was an accurate statement of the law.

Defendants proposed instruction was also supported by the evidence. During Defendants' case, they demonstrated that TeamHealth Plaintiffs did not submit at least 491 claims for reimbursement as required. Mot. at 130-32. TeamHealth Plaintiffs only counter argument is baseless: that no evidence was presented at trial to support a condition precedent jury instruction. Opp. at 50. Because there was evidence supporting Defendants' proposed instruction, which was an accurate statement of the law, the Court should have given the requested instruction to the jury. That instruction was not provided, so a new trial is required.

B. Definition of Insurer Under the Unfair Claims Practices Act.

Defendants agree that this issue has been extensively briefed by the parties. Those papers provide the Court with nearly everything that it needs to decide the issue. All that remains is correcting one factual error and one legal error in TeamHealth Plaintiffs' Opposition.

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TeamHealth Plaintiffs assert that the term "insurer" as used in the UCPA, NRS 686A.310, means "all persons" engaged in the business of insurance. Opp. at 51. TeamHealth Plaintiffs argue this must be true because a different statute, NRS 686A.020, "establishes that all persons are prohibited from engaging in . . . 'an unfair method of competition or an unfair or deceptive act or practice in the business of insurance,'" which includes a violation of the UCPA. *Id*. However, the jury was not asked to decide, and was not instructed on, whether Defendants violated NRS 686A.020. 11/23/2021 Tr. 130:18-131:9; 11/29/2021 Special Verdict Form Interrogatory No. 10. That means the relevant inquiry is not whether a third-party administrator can be held liable under NRS 686A.020 as "a person . . . in the business of insurance" but whether a third-party administrator is "an insurer" that can be held liable under the UCPA.

To that end, NRS 686A.020 establishes that a third-party administrator is not "an insurer" under the UCPA due to the differing, plain language used by the Nevada Legislature in those statutes. Whereas subsection two of the UCPA states that "***an insurer is liable to its insured*** . . . as a result of the commission of an[] unfair practice," NRS 686A.020 is violated by "***a person . . . in the business of insurance***," such as an insurer or a third-party administrator, that "engage[d] in . . . an unfair . . .

practice." (emphasis added). Clearly, the Nevada Legislature could have used the broader NRS 686A.020 language that includes third-party administrators in the UCPA but instead chose to only include insurers. *Nationstar Mortg., LLC v. Saticoy Bay LLC Series 2227 Shadow Canyon*, 133 Nev. 740, 745, 405 P.3d 641, 646 (Nev. 2017) ("Where a legislature includes particular language in one section of a statute but omits it in another section of the same act, it is generally presumed the legislature acts intentionally and purposely in the disparate inclusion or exclusion." (alterations in original omitted)). Thus, third-party administrators are not subject to the UCPA. As such, the Court erred in refusing to provide Defendants' instruction.

C. Failure to Exhaust Administrative Remedies Under the Prompt Pay Act.

TeamHealth Plaintiffs attempt to fault Defendants for not presenting evidence regarding administrative exhaustion. Opp. at 52. However, as explained in prior papers, including the Motion, administrative exhaustion was an essential element of TeamHealth Plaintiffs' cause of action. As such, TeamHealth Plaintiffs had to carry the burden of proving that they satisfied that element. If they did not, then their cause of action fails. Because that cause of action was submitted to the jury, the Court was required to instruct the jury on the administrative exhaustion element and permit Defendants to argue that TeamHealth Plaintiffs did not meet their burden.

TeamHealth Plaintiffs errantly argue that a litigant does not need to exhaust administrative remedies whenever a statute does nothing more than include language providing that a "prevailing party" is entitled to "costs and reasonable attorney's fees." Opp. at 51. Thus, a failure to exhaust administrative remedies instruction was not required.

To support their argument, they assert that the Court should not look to Nevada Supreme Court decisions interpreting Nevada's Insurance Code. *Id*. at 52 (citing *Allstate Ins. Co. v. Thorpe*, 123 Nev. 565, 571, 170 P.3d 989, 993 (2007)). Instead, they would have the Court believe that the issue of whether Nevada's Insurance Code requires the exhaustion of administrative remedies should be decided by looking to Nevada's wage protection statutes and related jurisprudence. *Id*. at 51-52 (arguing that *Thorpe* should not be relied upon because it deals with a "statute . . . which does not apply here," so the Court should look to wage statute cases).

TeamHealth Plaintiffs lead the Court astray in arguing that the Nevada Supreme Court's jurisprudence concerning the Insurance Code is inapposite when deciding an Insurance Code issue. TeamHealth Plaintiffs only argument for why *Thorpe* should be disregarded is that the statute at issue in that case did not "contemplat[e] court action." Opp. at 52. But, in holding that exhaustion of administrative remedies was required for claims arising under the Insurance Code, *Thorpe* relied on *City of Henderson v. Kilgore*. 123 Nev. at 993 & n.14 (citing *City of Henderson v. Kilgore*, 122 Nev. 331, 131 P.3d 11 (2006)). In *City of Henderson*, the Nevada Supreme Court examined a statute that contemplated judicial remedies in the dispute and ruled that failure to exhaust administrative remedies precluded judicial remedies. 122 Nev. at 335-36, 131 P.3d at 14-15 (interpreting NRS 288.110(3) ("[a]ny party aggrieved . . . may apply to a court of competent jurisdiction" for certain relief) and holding that "fail[ure] to exhaust . . . administrative remedies . . ." precludes justiciability in the court). Therefore, the failure to exhaust administrative remedies is required under all sections of the Insurance Code regardless of whether limited judicial involvement is contemplated.

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Additionally, TeamHealth Plaintiffs ignore *Thorpe's* holding that the "Nevada Insurance Commissioner has express authority to 'enforce the provisions of the Nevada Insurance Code,' NRS Title 57" and can "hold hearings for any purpose within the scope of Title 57." 123 Nev. at 572, 170 P.3d at 994 (alterations in original omitted). If a party is "aggrieved by [the Commissioner's] ruling," then the party has "the right to seek judicial review 'in the manner provided by . . . the Nevada Administrative Procedure Act.'" *Id*. (alteration in original omitted).

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TeamHealth Plaintiffs' suit relies on Prompt Pay Act statutes that are all found in the Insurance Code, *i.e.*, Title 57. Accordingly, TeamHealth Plaintiffs suit is within the scope of Title 57. Thus, to obtain relief for a violation of those statutes, a party must bring an administrative action before the Insurance Commissioner.

Indeed, each Prompt Pay Act statute relied upon by TeamHealth Plaintiffs expressly provides that "[t]he Commissioner may require an [administrator/HMO/insurer/carrier] to provide evidence that [it] has complied with the requirements set forth in th[e] [applicable statute]." NRS 683A.0879(7); NRS 689A.410(7); NRS 689B.255(7); NRS 689C.485(7); NRS 695C.185(7). And each Prompt Pay Act statute expressly requires that "the Commissioner determine[] [whether] an

[administrator/HMO/insurer/carrier] is not in substantial compliance with the requirements in th[e] [applicable statute]." NRS 683A.0879(8); NRS 689A.410(8); NRS 689B.255(8); NRS 689C.485(8); NRS 695C.185(8). These provisions would be superfluous by not requiring TeamHealth Plaintiffs to prove they exhausted administrative remedies. Accordingly, the inclusion of that language in the statutes and the Nevada Supreme Court's Insurance Code jurisprudence make clear that a party must avail itself of a hearing before the Insurance Commissioner. As such, TeamHealth Plaintiffs' argument that *Thorpe* is inapposite is meritless.

Because the failure to exhaust administrative remedies is an essential element, TeamHealth Plaintiffs were required satisfy it before obtaining relief. Thus, the Court erred in refusing to give Defendants' proposed instruction and a new trial is required.

D. The Spoliation Instruction.

1. The Rebuttable Presumption Instruction Was Not Warranted.

TeamHealth Plaintiffs assert two arguments for why the rebuttable presumption was warranted. First, Defendants did not produce client demand documents—*i.e.*, documents demonstrating that Defendants' clients wanted out-of-network programs to constrain rising health care costs—that TeamHealth Plaintiffs could use to contradict the testimony that TeamHealth Plaintiffs elicited from witnesses during their own case-in-chief. *See* Opp. at 52-54. Second, TeamHealth Plaintiffs assert that Defendants' production of over 200,000 pages of administrative records in response to an ever-changing at-issue claims list was deficient. Opp. at 54-55. Both arguments fail.

TeamHealth Plaintiffs concede that Defendants produced documents concerning customer demand. Opp. at 52. So, TeamHealth Plaintiffs were in possession of documents that they could have used against Defendants' witnesses. TeamHealth Plaintiffs decided not to explore those documents. Defendants do not know why TeamHealth Plaintiffs made this decision, but perhaps it was because those document substantiated the client demand testimony that TeamHealth Plaintiffs elicited. What Defendants and the Court do know, however, is that instead of trying to challenge those documents and the testimony, TeamHealth Plaintiffs complained that they did not have the documents that they wanted—*i.e.*, documents that could impeach Defendants' witnesses that were

called during TeamHealth Plaintiffs' case-in-chief. Their decision not to challenge the documents should not have been rewarded with a rebuttable presumption instruction.

TeamHealth Plaintiffs also take issue with the 200,000+ pages of administrative records that Defendants produced. Opp. at 54-55. In other words, they take issue with the fact that Defendants produced 7,000+ plan documents and explanation of benefits that covered approximately 16,446 unique claims. Mot. at 140. That is far greater than the 11,563 at-issue claims presented to the jury. Mot. at 140. Tellingly, absent from the Opposition is any explanation for why Defendants should be penalized for TeamHealth Plaintiffs' ever-changing at-issue claims list that caused the production covering 16,446 claims to not cover every 11,563 at-issue claims presented to the jury. Opp. at 54-55. That is because it is undeniable that TeamHealth Plaintiffs' ever-changing at-issue claims list made it impossible to produce every document associated with the at-issue claims that were presented to the jury. *See* Mot. at 139 (explaining how Defendants were required to search and collect the administrative records for 23,000 at-issue claims even though half that amount would be presented to the jury). Had TeamHealth Plaintiffs dutifully presented their at-issue claims list to Defendants in the first place, this mess could have been avoided. TeamHealth Plaintiffs' failure to adequately prosecute their case, whether gamesmanship or through lack of diligence, should not be rewarded.

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Additionally, TeamHealth Plaintiffs contend that the rebuttable presumption was warranted because the focus is not on what was produced, but on the plan documents that were not produced. However, plan documents are a subset of the administrative records and Defendants had to conduct discovery as efficiently as possible. That did not require producing every plan document before producing the other documents included in the administrative record. Indeed, TeamHealth Plaintiffs attempted to elicit harmful testimony from John Haben by focusing on other administrative record documents, such as explanation of benefits and appeals records. Thus, there is no merit in separating the administrative record into discrete aspects and penalizing Defendants for not being able to produce every plan document for the at-issue claims.

2. The Jury Was Not Correctly Instructed on the Rebuttable Presumption.

TeamHealth Plaintiffs advance three erroneous arguments in their Opposition. First, that a rebuttable presumption can be given if evidence was merely suppressed as opposed to destroyed with

the intent to harm another party. Opp. at 55-56. Second, that they satisfied their burden to receive a rebuttable presumption based on the Court's order that did not find any intent to harm TeamHealth Plaintiffs. Third, the jury plays no role in determining whether a party has intended to harm its opponent.

TeamHealth Plaintiffs ignore the fact that the Nevada Supreme Court held NRS 47.250(3)'s rebuttable presumption to only be applicable if evidence was destroyed with the intent to harm. Opp. at 55-56. In *Bass-Davis v. Davis*, 122 Nev. 442, 445, 134 P.3d 103, 105 (Nev. 2006), the Nevada Supreme Court ruled that the "NRS 47.250(3) [rebuttable] presumption . . . ***applies only in cases*** involving willful suppression of evidence, ***in which the party destroying evidence intends to harm another party****, i.e.*, to obtain a competitive advantage in the matter." TeamHealth Plaintiffs know this to be true, as demonstrated by this cribbed *Bass-Davis* quote from the Opposition : "in *Bass-Davis* the Nevada Supreme Court discussed 'willful suppression **or** destruction, which triggers the rebuttable presumption under NRS 47.250(3) . . .' *Bass-Davis* 122 Nev. at 452, 134 P.3d at 109." Opp. at 55-56 (alterations in original). TeamHealth Plaintiffs provided a cribbed quote because the rest of the quoted *Bass-Davis* sentence clarifies that NRS 47.250(3) "requires more than simple destruction of evidence and instead requires that evidence be destroyed with the intent to harm another party." *Bass-Davis*, 122 Nev. at 452, 134 P.3d at 109. Meaning, that when the *Bass-Davis* Court referred to "willful suppression or destruction," it used those terms as synonyms. *Id*. Indeed, the Court "conclude[d] that an NRS 47.250(3) rebuttable *presumption* only applies in cases involving *willfully* **destroyed evidence**." *Id*. at 454 (italics in original; bolding added). As such, there is no merit to TeamHealth Plaintiffs' argument that mere suppression, as opposed to destruction of evidence with the intent to harm, satisfies NRS 47.250(3).

Next, TeamHealth Plaintiffs erroneously assert that they satisfied their burden that evidence was willfully suppressed—*i.e.*, destroyed with the intent to harm—because the Court's August 3, 2021 Order found Defendants' conduct to be willful. Opp. at 56. They also claim that Defendants' only counter to the Court's order is to an inapplicable case, *MDB Trucking, LLC v. Versa Prods. Co., Inc.*, 136 Nev. 626, 632, 475 P.3d 397, 404 (Nev. 2020). First, TeamHealth Plaintiffs ignore that Defendants quoted *MDB Trucking* to the extent that it was relying on *Bass-Davis's* interpretation of

NRS 42.250(3). So, the case is applicable as relied upon. Second, TeamHealth Plaintiffs ignore that Defendants relied on multiple sources in the Motion, not just *MDB Trucking*. Mot. at 144. (citing *Bass-Davis*). *Id.* Third, Defendants demonstrated that TeamHealth Plaintiffs did not meet their burden for the rebuttable presumption because they failed to demonstrate the required intent to harm element. *Id.* TeamHealth Plaintiffs ignored that argument. Thus, they concede that the Court's August 3, 2021 Order did not find that Defendants acted with any intent to harm. *See id*. ("the Court does not believe there has been any destruction . . . of evidence"). As such, because TeamHealth Plaintiffs solely relied on the Court's order, they did not meet their burden.

Finally, TeamHealth Plaintiffs contend that willfulness can be determined by a judge and not the jury. Opp. at 56-57. TeamHealth Plaintiffs' only argument, however, concerns whether an instruction can be given and not whether a judge can take a factual determination required by that instruction out of the hands of the jury. *Id*. That sole argument is supported by just one quote from *Bass-Davis*: "if the district court, in rendering its discretionary ruling ***on whether to give an adverse inference instruction*** . . . ." *Id*. (emphasis added). That quote says nothing about whether a judge can take a factual determination required by the instruction out of the hands of the jury. All it indicates is that a judge decides whether an instruction should be given. Thus, TeamHealth Plaintiffs have advanced no reason to abrogate *Bass-Davis's* requirement that the party seeking a rebuttable presumption must present "evidence" to the jury that evidence was destroyed with the intent to harm. *Bass-Davis*, 122 Nev. at 448, 134 P.3d at 107 ("When such evidence is produced, the presumption that the evidence was adverse applies, and the burden of proof shifts . . . ."). Therefore, it was error to take the willfulness decision away from the jury. *Boland v. Nev. Rock & Sand Co.*, 111 Nev. 608, 613, 894 P.2d 988, 991 (1995) ("willfulness is generally a question of fact").

* * *

Because of the above errors related to the rebuttable presumption instruction, the verdicts were irreparably tainted and a new trial is required.

CONCLUSION

TeamHealth Plaintiffs' Opposition is filled with misrepresentations and meritless arguments. It does not dispel the fact that an overwhelming number of errors occurred in this litigation that

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prevented Defendants from receiving a fair trial. It also does not refute the fact that the verdicts cannot be salvaged. Therefore, the Court must set-aside the spoiled verdicts and order a new trial.

Dated this 22 day of June, 2022.

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CERTIFICATE OF SERVICE

I hereby certify that on the 22nd day of June, 2022, a true and correct copy of the foregoing **"REPLY IN SUPPORT OF NEW TRIAL"** was electronically filed and served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

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EXHIBIT 1

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EXHIBIT 1

Titan Of The Plaintiffs Bar: AZA Law's John Zavitsanos

By ***Ben Zigterman*** · *Listen to article*

Law360 (April 8, 2022, 12:03 PM EDT) -- After spending seven weeks in Las Vegas late last year, Ahmad Zavitsanos & Mensing partner John Zavitsanos returned with $63 million.

John Zavitsanos

AZA Law

On his firm's culture:
"We are very street, with high IQ. There's nobody here whose ancestors came over on the Mayflower. ... And there are a lot of people here kind of like me, where the starting line for them was much further back."

In a grueling trial against one of the nation's largest insurers, Zavitsanos and his team convinced a jury to side with emergency room staffing company TeamHealth in a decision that could also have significant ramifications for the health care industry, landing Zavitsanos a spot among Law360's 2022 Titans of the Plaintiffs Bar.

"We worked very hard, and we didn't get a whole lot of sleep during that time, but it was just great," Zavitsanos said.

"Nobody's gonna ever outwork us," he added. "If I need to, I'll stay up for four days straight without sleeping because winning; it's everything."

The team also had a chance to sample a bit of Las Vegas nightlife during the seven weeks.

"We'd have our trial and then in the evening, we'd all go to dinner together. A bunch of us would then go gamble at the casino a little bit and then come back, get ready for the next day," he said.

The victory marked the third in about 18 months that Zavitsanos has racked up for TeamHealth and its affiliates, which help hospitals staff their emergency rooms.

TeamHealth has accused insurance companies of not properly reimbursing the ER doctors, while the insurers have argued that emergency room staffing companies have been seeking reimbursement windfalls.

"This is really, I would say, vital to the health care system of the United States," TeamHealth's chief counsel for revenue payment integrity, Carol Owen, said.

The cases have to do with how much emergency-care doctors are paid for out-of-network care.

"The problem is there is no statute that identifies how much you are supposed to pay in terms of an absolute

dollar and cents," Zavitsanos said. "What they say is that these insurance companies, out of network, are required to pay the 'usual and customary rate,' and that's not defined."

Zavitsanos first got involved with TeamHealth in February 2020, about a month before a trial was originally set to begin in Texas.

TeamHealth held a mock trial, "and the result was not good at all," Owen said.

"I really respect the lawyers who were representing us, but they were clearly unlikely to connect successfully with a Houston jury," Owen said.

TeamHealth's trial consultant suggested some lawyers, and Owen happened to call Zavitsanos first.

"John was immediately lively and engaged and smart and talking to me meaningfully about the judge we were in front of, what her trials were like," Owen said. "He'd tried, I think, two trials with her, even though she was quite new on the bench, and so after 10 minutes of discussion, I could tell that this was the guy for the case. He was fantastic."

When Zavitsanos joined the case, he said his firm completely changed the strategy.

"We basically make a U-turn on the case. Literally a U-turn, going the exact opposite direction of the way it had been developed," he said.

That trial was eventually delayed until June of last year, when a jury awarded two affiliates of TeamHealth about $19.1 million in damages from insurer Molina Healthcare of Texas Inc. for routinely underpaying claims.

While that case was continued, TeamHealth was also seeking new attorneys six days before a similar trial in Arkansas after Owen said the legal team wasn't going to be able to handle it.

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"In I guess a moment of panic, they called us a week before the Arkansas case, which was a couple of months later, and asked if we could jump on that," Zavitsanos said. "We got ready in six days. We were actually getting ready for trial during trial. ... We were making massive adjustments on that case as well. We started the trial with something like 20 exhibits; we finished the trial with close to 400 exhibits. And it was really because we changed the theory of the case."

In August 2020, the Arkansas jury awarded a TeamHealth affiliate $9.4 million in a verdict against Centene Corp.

"We won every penny we were asking for," Owen said.

After every trial, Zavitsanos makes a habit of meeting with jurors to get to know what drives them.

"We got to talk to the jurors after the first two trials, and we made some pretty substantial adjustments in this last one based on the feedback we got from the first two, and frankly now the next one that we have, which is going to be in Philadelphia in November, we're going to make even more adjustments based on the feedback we got from the Las Vegas jury," Zavitsanos said.

He said the jurors don't necessarily care about which company employs or supervises the doctors, but rather they care about the patients and the doctors themselves.

"They care about two things: access to quality care for patients, and they care about the doctors," he said.

While not explicitly referencing the 2017 mass shooting in Las Vegas, Zavitsanos said his team emphasized what would happen if emergency rooms disappeared.

"We have the largest mass shooting in U.S. history from the Mandalay Bay. And all of the emergency room doctors that handled those people were all our doctors, they were all TeamHealth doctors," he said.

The arguments worked, with the jury awarding TeamHealth more than $62 million in December, including $60 million in punitive damages against UnitedHealthcare.

After taking some jurors out to dinner, sending questionnaires and having phone calls with some others, Zavitsanos found that the jurors had taken the trial seriously.

"I think the jury, particularly the jury in Las Vegas, just felt the weight, the kind of societal obligation that was on them for this trial," he said. "And I say that because we spoke with a few of the jurors afterwards, and they understood that this was much more than just the verdict in this case."

TeamHealth CEO Leif Murphy said he's been impressed with Zavitsanos' work, both in the courtroom and in helping him prepare as a witness in the trials.

"Everything that we've done on the litigation front has been extremely complex, had to be distilled down into digestible and manageable bites for a jury, and he's done a fantastic job at that," Murphy said. "There are a lot of acronyms. There are complex economics behind the health care equation. ... You can lose the jury really quickly in this stuff."

In preparing him as a witness, Murphy said Zavitsanos was always prepared.

"The countless documents that he had reviewed personally and that he could draw my attention to and that we could have a discussion about their context and how they fit into the case, it's pretty darn impressive," Murphy added.

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Zavitsanos was quick to credit his team for their success, particularly in Nevada, where he said the team was in sync during the lengthy trial.

"It was a combination of just being around each other the whole time, and second of all, I just think the personality of the various team members just fit like a jigsaw puzzle," he said. "We had cerebral types. We had extroverted types. We had people that were thinking about appellate issues. We had people that were focused on the exhibits. We had people focused on getting witnesses lined up, and it just all came together better than any trial team I've ever been on."

He also said the firm's emphasis on trial experience has been key.

"We are in trial often. And that helps," Zavitsanos said.

The firm's extensive trial work is what attracted partner Jason McManis to the firm; he joined AZA four years ago.

"The perception that I had was that John has worked hard along with the other partners to create a firm that tries cases as trial lawyers, even though they're big commercial cases," McManis said. "And since I've been here, that has been absolutely my experience."

Zavitsanos started AZA in the mid-1990s with his law school friend Joe Ahmad. During their first year, Zavitsanos said they had an agreement not to settle any cases.

"We were going to try every case that came in because we wanted to establish ourselves," he said. "My partner and I, we had 15 jury trials that year."

Since then, the firm, which was named a Texas Powerhouse by Law360 in 2014, has grown to more than 50 attorneys, which Zavitsanos said is a diverse group that is "very street, with high IQ."

"There's nobody here whose ancestors came over on the Mayflower. We're also very ethnic. I think we speak like 11 or 12 languages here. We have a lot of people that are first generation," he said. "And there are a lot of people here kind of like me, where the starting line for them was much further back."

Born in Greece, Zavitsanos grew up in Chicago and became the first person in his family to graduate from grade school. After graduating from the University of Michigan Law School in 1987, Zavitsanos moved to Houston to be in what he called the "trial lawyers' Mecca" and eventually co-founded AZA.

That love of litigation carries through to today, with a strong emphasis on trial work.

"I love it. I could not imagine doing anything else," he said. "There's nothing more glorious than just being in trial."

--Additional reporting by Cara Salvatore and Michelle Casady. Editing by Alyssa Miller.

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- Ahmad Zavitsanos

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- Centene Corp.
- Mandalay Bay Hotel & Casino
- Molina Healthcare Inc.

Law360 Names 2022's Top Attorneys Under 40

Law360 is pleased to announce the Rising Stars of 2022, our list of 176 attorneys under 40 whose legal accomplishments belie their age.

Top 10 trending in Health

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

Defendants.

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

NOTICE OF SUPPLEMENTAL ATTORNEYS FEES INCURRED AFTER SUBMISSION OF HEALTH CARE PROVIDERS' MOTION FOR ATTORNEYS FEES

Please take notice that the Health Care Providers update and supplement their Motion for

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Attorneys' Fees filed March 30, 2022 with the information attached hereto.

Dated this 24th day of June, 2022.

McDONALD CARANO LLP

By: */s/ Pat Lundvall*

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and on this 24th day of June, 2022, I caused a true and correct copy of the foregoing **NOTICE OF SUPPLEMENTAL ATTORNEYS FEES INCURRED AFTER SUBMISSION OF HEALTH CARE PROVIDERS' MOTION FOR ATTORNEYS FEES** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

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

AFFIDAVIT VERIFYING SUPPLEMENTAL ATTORNEYS' FEES INCURRED AFTER SUBMISSION OF HEALTH CARE PROVIDERS' MOTION FOR ATTORNEYS' FEES

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corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

STATE OF NEVADA)
) SS
COUNTY OF CLARK)

Pat Lundvall, being first sworn under penalty of perjury pursuant to the laws of the State of Nevada, states that:

1. I am an attorney with the law firm of McDonald Carano LLP ("McDonald Carano") and counsel of record for Plaintiffs Fremont Emergency Services (Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest" and collectively the "Health Care Providers").

2. I am over the age of 18 years. I submit this affidavit verifying the additional attorneys fees incurred after submission of Health Care Providers' Motion for Attorneys' Fees filed March 30, 2022. This affidavit is based upon my own personal knowledge unless otherwise stated.

3. Attached to this affidavit as Exhibit 1 are various documents offered in support. Those documents are true and correct copies of law firm invoices submitted for payment to the Health Care Providers.

4. The supplemental amount of attorneys' fees reflected by this affidavit is $835,041.00. That sum breaks down as follows for the four law firms who were counsel of record:

McDonald Carano LLP	$251,118.50
Lash & Goldberg LLP	$12,321.50
Ahmad, Zavitsanos & Mensing, P.C.	$571,601.00

5. This amount of supplemental attorneys' fees was actually and necessarily incurred, and is believed to be reasonable.

6. The time entries associated with this supplemental request fall into the following categories.

. . .

. . .

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Category:	Total:
Defendants' Motion to Apply the Statutory Cap on Punitive Damages; Defendants' Motion for Judgment as a Matter of Law	$209,615.00
Defendants' Motion for New Trial	$131,772.00
Defendants' and Non-Party MultiPlan's Sealing Issues • Defendants' Motion to Seal Certain Confidential Trial Exhibits • MultiPlan, Inc.'s Motion to Seal Certain Confidential Trial Exhibits • MultiPlan, Inc.'s Motion to Seal Courtroom During January 20, 2022 Hearing on Motion to Seal Certain Confidential Exhibits on Order Shortening Time • Defendants' Motion to Seal Defendants' Status Report and Summary of Revised Redactions to Trial Exhibits • Defendants' Motion to Seal Courtroom and Motion for Evidentiary Hearing in Support of Motion to Seal Certain Confidential Trial Exhibits on Order Shortening Time • Defendants' Motion to Seal Defendants' Index of Trial Exhibit Redactions in Dispute • Defendants' Motion to Seal Joint Status Report and Table Identifying the Redactions to Trial Exhibits That Remain in Dispute	$159,953.50
Defendants' Miscellaneous Post-Trial Issues • Defendants' Motion to Apply Statutory Cap on Punitive Damages • Defendants' Renewed Motion for Judgment as a Matter of Law • Defendants' Motion for Remittitur and to Alter or Amend the Judgment • Defendants' Rule 62(b) Motion for Stay Pending Resolution of Post-Trial Motions on Order Shortening Time • Defendants' Motion to Retax Costs • Defendants' Notice Posting *Supersedeas* Bond	$157,083.00
Health Care Providers' Motion for Attorneys' Fees; Health Care Providers' Verified Memorandum of Costs	$176,617.00
Grand Total:	**$835,041.00**

7. As originally detailed, each law firm retained by the Health Care Providers worked on an agreed-upon hourly basis. That agreement was reached in advance of the engagement and held steady - - and in one instance was agreed-to-be-discounted - - throughout the course of the engagement. The Health Care Providers continue to employ CounselLink to review all law firm invoices before they are submitted to client representatives for review and payment. Generally,

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CounselLink ensures there are no duplicative or redundant billing entries, all invoices were submitted in accord with agreed-upon rates for agreed-upon timekeepers, and all invoices fell within the scope of the Health Care Providers' Outside Counsel Guidelines. Once CounselLink submitted its comments to a designated in-house counsel, that counsel reviewed all comments and each invoice for accuracy and reasonableness. Thereafter, if the total amount of the invoice was $75,000 or less, (later increased to $100,000 or less), the invoice was submitted for payment (as adjusted after reviews) and paid. If the invoice exceeded those amounts, then a third-level of review was conducted by another in-house counsel before being submitted for payment (as adjusted after reviews) and paid.

8. The total amount of requested attorneys fees via the Health Care Providers' Motion for Attorneys' Fees is $13,518,085.41 ($12,683,044.41 original plus $835,041.00 supplemental).

9. I make these statements under penalty of perjury. If called as a witness. I am competent and would testify to these facts.

Dated this 24th day of June, 2022.

Pat Lundvall

Pat Lundvall

SUBSCRIBED AND SWORN to before me this 24th day of June, 2022.

NOTARY PUBLIC in and for the County of Clark, State of Nevada

TUBOU NELSON
Notary Public, State of Nevada
No. 93-1487-1
My Appt. Exp. May 14, 2026

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EXHIBIT 1

Invoice Overview Report - Law Firm Invoice ID: 12440568

McDonald Carano Wilson, Las Vegas
Please Remit Payment to:
P.O Box 2670
Reno, NV 89505
UNITED STATES

Tax ID: 88-0074283

Invoice Information

TH Matter Number:	2019-CRP-1948	**Invoice Currency:**	US Dollar
CounselLink Invoice ID:	72877603	**NET TO PAY (USD):**	$61,466.17
Law Firm Matter ID:	19438-3		
CounselLink Upload Date:	03/02/2022		
Final Invoice:	No	**Invoice Date:**	03/02/2022
Submitted By:	N/A	**Service Period:**	09/10/2021 - 01/31/2022
Attention:	Phil McSween	**Matter Contact:**	Owen, Carol
Corporate Customer:	TEAMHealth Legal	**Contact Office:**	Corporate
Billing Office Address:		**Contact Office Address:**	265 Brookview Centre Way Suite 400 Knoxville, TN 37919
Matter Title:	Case 34 - United NV		
Invoice Description:			

Invoice Additional Information

Lawson Vendor ID: 78149	**Accounting Unit:** 10300
GL Account #: 83220	**Lawson Vendor ID-AP Points:**

Matter Spend Performance

Matter	Actual (USD)
Life of Matter:	$15,355,922.66

Invoice Summary

Type	Amount	Client Adjustment	Invoice Adjustment	Tax	Cost Share	Net	Prompt Pay Discount	Approved to Date	Net to Pay
Fees (USD):	$47,139.00	($333.00)	$0.00	$0.00	$0.00	$46,806.00	$0.00	$0.00	$46,806.00
Expenses (USD):	$14,660.17	$0.00	$0.00	$0.00	$0.00	$14,660.17	$0.00	$0.00	$14,660.17
Total (USD):	$61,799.17	($333.00)	$0.00	$0.00	$0.00	$61,466.17	$0.00	$0.00	$61,466.17

Allocation Summary

Contact Charge Type	Allocated Amount (USD)	Cost Share (USD)	Net (USD)	Prompt Pay Discount (USD)	Net To Pay (USD)

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DEFAULT ALLOCATION					
Fees - 100.000000% - Balance Remaining	$46,806.00	$0.00	$46,806.00	$0.00	$46,806.00
Expenses - 100.000000% - Balance Remaining	$14,660.17	$0.00	$14,660.17	$0.00	$14,660.17
Sub-Total:	$61,466.17	$0.00	$61,466.17	$0.00	$61,466.17
†Cost Sharing; ‡ Track Limit Overage **Total:**	$61,466.17	$0.00	$61,466.17	$0.00	$61,466.17

Approval Summary

Date	User	Amount (USD)
03/03/2022	Owen, Carol	$61,466.17
	Total:	$61,466.17

Timekeeper Summary

Timekeeper	Timekeeper ID	Level	Rate	Units	Fees Billed (USD)	Fees Recommended (USD)
Armendariz, Julia	JLA	Associate	$275.00	3.7	$1,017.50	$684.50
Surowiec, Karen	KAS	Paralegal	$185.00	20.9	$3,866.50	$3,866.50
Gallagher, Kristen	KTG	Partner	$450.00	1.6	$720.00	$720.00
Lundvall, Pat	PL	Partner	$650.00	63.9	$41,535.00	$41,535.00

Charges Summary

Fees

#	Date	Timekeeper	Description	Units	Rate (USD)	Adj. (USD)	Inv. Adj. (USD)	Tax (USD)	Net (USD)
9	01/01/2022	Lundvall, Pat	Emails with Kevin Leyendecker and team re [redacted]	1.3	$650.00	$0.00	$0.00	$0.00 (0%)	$845.00
10	01/03/2022	Lundvall, Pat	Email with Marianne Carter and team re Clerk's Notice of Hearing on defendants' motion to apply the statutory cap on punitive damages; emails with Jason McManis and all counsel re [redacted]; emails with Terrance White and all counsel re order denying defendants' motion for judgment as a matter of law; review and analyze [redacted]	1	$650.00	$0.00	$0.00	$0.00 (0%)	$650.00
11	01/03/2022	Gallagher, Kristen	Attention to post-trial matters (memo of costs, request from law clerk re order on motion for judgment as a matter of law, Multiplan request for further extension re motion to seal trial exhibits)	0.9	$450.00	$0.00	$0.00	$0.00 (0%)	$405.00
12	01/03/2022	Surowiec, Karen	Continue to compile documents for Memo of Costs	1.5	$185.00	$0.00	$0.00	$0.00 (0%)	$277.50
13	01/04/2022	Lundvall, Pat	Emails with Colby Balkenbush, Terrance White and all counsel re defendants' objection to proposed order denying defendants' motion for judgment as a matter of law; review and analyze [redacted]; review research	2.5	$650.00	$0.00	$0.00	$0.00 (0%)	$1,625.00

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			re [redacted]						
14	01/04/2022	Surowiec, Karen	Continue to compile documents for Memo of Costs	2.5	$185.00	$0.00	$0.00	$0.00 (0%)	$462.50
15	01/05/2022	Lundvall, Pat	Emails with Jane Robinson and team re [redacted]; emails with Colby Balkenbush, Terrance White and all counsel re hearing transcript for defendants' objection; email with Marianne Carter re Order Denying Defendants' Motion for Judgment as a Matter of Law; review and analyze [redacted]	2.2	$650.00	$0.00	$0.00	$0.00 (0%)	$1,430.00
16	01/05/2022	Gallagher, Kristen	Attention to post-trial matters (United's objection to order denying motion for judgment as a matter of law; exchange emails with AZA re [redacted]; review court's order re [redacted])	0.5	$450.00	$0.00	$0.00	$0.00 (0%)	$225.00
17	01/06/2022	Lundvall, Pat	Email with Marianne Carter and team re Order and Notice of Entry of Order Denying Defendants' Motion for Judgment as a Matter of Law; review and analyze [redacted]; email with Marianne Carter and team re Defendants' Reply in Support of Motion to Seal Certain Confidential Exhibits and sharelink for Defendants' Supplemental Appendix of Exhibits; review and analyze [redacted]	1.1	$650.00	$0.00	$0.00	$0.00 (0%)	$715.00
19	01/10/2022	Lundvall, Pat	Emails with Jason McManis and team re [redacted] emails with Marianne Carter and team re Motion to Seal Defendants' Second Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits, Motion to Seal Defendants' Reply in Support of Motion to Seal Certain Confidential Trial Exhibits and Notices of Hearing re same; review and analyze [redacted] emails with Kevin Leyendecker and team re [redacted]; review and analyze [redacted]	3.7	$650.00	$0.00	$0.00	$0.00 (0%)	$2,405.00
20	01/11/2022	Lundvall, Pat	Emails with Kevin Leyendecker and team re [redacted]; review and revise [redacted] emails with Karen Lawrence and all counsel re scheduling of motions to redact	4.5	$650.00	$0.00	$0.00	$0.00 (0%)	$2,925.00

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			and case management regarding agenda; emails with Jason McManis and team re [redacted]; emails with Jason McManis and all counsel re [redacted] emails with Kevin Leyendecker and team re [redacted]; review and analyze [redacted] prepare for tomorrow's hearings on Defendants' Motion for Judgment as a Matter of Law and Defendants' Motion for Leave to Exceed Page Limits, Defendants' Motion to File Omnibus Offer of Proof Under Seal, Motion in Limine 40 to Prohibit Plaintiffs from Introducing New Evidence During the Punitive Damages Phase of Trial, United's Preliminary Motion to Seal Attorneys' Eyes Only Documents Used At Trial, Multiplan, Inc.'s Motion to Seal Certain Confidential Trial Exhibits, Motion to Seal Defendants' Supplement to Motion to Seal Certain Confidential Trial Exhibits, Motion to Seal Defendants' Motion to Seal Certain Confidential Trial Exhibits, Defendant's Motion to Seal Defendants' Opposition to Plaintiffs' Supplemental Jury Instruction (Contested) and Motion to Seal Courtroom for January 12 Hearing on Motion to Seal Certain Trial Exhibits on Order Shortening Time						
21	01/11/2022	Gallagher, Kristen	Attention to post-trial matters (hearing on motion to seal trial exhibits, form of judgment)	0.2	$450.00	$0.00	$0.00	$0.00 (0%)	$90.00
22	01/12/2022	Lundvall, Pat	Email with Marianne Carter and team re Plaintiffs' Opposition to Defendants' Motion to Seal Courtroom During January 12, 2022 Hearing; review and analyze [redacted]; emails with Karen Lawrence and all counsel re agenda for today's hearings; review and analyze [redacted]; prepare and appear for hearings on Defendants' Motion for Judgment as a Matter of Law and Defendants' Motion for Leave to Exceed Page Limits, Defendants' Motion to File Omnibus Offer of Proof Under Seal, Motion in Limine 40 to Prohibit Plaintiffs from Introducing New Evidence During the Punitive Damages Phase of Trial, United's Preliminary Motion to Seal Attorneys' Eyes Only Documents Used At Trial, Multiplan, Inc.'s Motion to Seal Certain Confidential Trial Exhibits, Motion to Seal Defendants' Supplement to Motion to Seal Certain Confidential Trial Exhibits, Motion to Seal Defendants' Motion to Seal Certain Confidential Trial Exhibits, Defendant's Motion to Seal Defendants' Opposition to	5.4	$650.00	$0.00	$0.00	$0.00 (0%)	$3,510.00

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			Plaintiffs' Supplemental Jury Instruction (Contested) and Motion to Seal Courtroom for January 12 Hearing on Motion to Seal Certain Trial Exhibits on Order Shortening Time; emails with team re [redacted]; multiple emails with Jane Robinson and team re [redacted] and case management regarding [redacted] review and analyze [redacted] emails with Justin Fineberg and team re [redacted]; review and analyze [redacted]							
25	01/13/2022	Lundvall, Pat	Email with Beau Nelson and team re 1/12/22 hearing transcript; review and analyze [redacted]; multiple emails with team re [redacted] teleconference with team to discuss [redacted]; email with Marianne Carter and team re Multiplan's Reply Memorandum in Support to Seal Certain Confidential Trial Exhibits; review and analyze [redacted]; multiple emails with John Zavitsanos and team re [redacted]; emails with team re [redacted]; emails with Julia Armendariz, Kristen Gallagher and Amanda Perach re [redacted]	4.7	$650.00	$0.00	$0.00	$0.00 (0%)	$3,055.00	
26	01/13/2022	Armendariz, Julia	Conduct research re [redacted] Email exchange with Pat Lundvall re [redacted]	3.6	$275.00	($324.00)	$0.00	$0.00 (0%)	$666.00	
28	01/14/2022	Lundvall, Pat	Multiple emails with Justin Fineberg and team re [redacted]; review and analyze [redacted]; research regarding [redacted]; emails with team re [redacted] multiple emails with Jason McManis and all counsel re	6.5	$650.00	$0.00	$0.00	$0.00 (0%)	$4,225.00	

			[redacted] email with Marianne Carter and team re Multiplan's Motion to Associate Counsel and Motion for Leave to File Appendix of Selected Exhibits Under Seal; review and analyze [redacted] emails with Carol Owen and team re [redacted]; emails with Brittany Llewellyn and all counsel re letter to John Zavitsanos and Jason McManis regarding procedure set forth at hearing on motion to seal; review and analyze [redacted]						
29	01/14/2022	Armendariz, Julia	Email exchange with Pat Lundvall re [redacted]	0.1	$275.00	($9.00)	$0.00	$0.00 (0%)	$18.50
30	01/15/2022	Lundvall, Pat	Research re [redacted]	4.5	$650.00	$0.00	$0.00	$0.00 (0%)	$2,925.00
31	01/17/2022	Lundvall, Pat	Emails with Kevin Leyendecker and team re [redacted]	3.4	$650.00	$0.00	$0.00	$0.00 (0%)	$2,210.00
32	01/18/2022	Lundvall, Pat	Emails with Kevin Leyendecker and team re [redacted]; review and revise [redacted]; emails with Brian Grubb re [redacted]; review and analyze [redacted]; email with Marianne Carter and team re Multiplan's Motion to Seal Courtroom During January 20, 2022 Hearing on Motion to Seal Certain Confidential Trial Exhibits on Order Shortening Time, Notice of Hearing re Multiplan's Motion for Leave to File Appendix of Selected Exhibits Under Seal, Notice of Hearing and Supplement to Multiplan's Motion to Associate Counsel; review and analyze [redacted] emails with Karen Lawrence and all counsel re virtual hearing on Multiplan's motion to seal	4.2	$650.00	$0.00	$0.00	$0.00 (0%)	$2,730.00
33	01/19/2022	Lundvall, Pat	Substantial edits to draft plaintiffs' opposition to defendants' motion to apply statutory cap on punitive damages and plaintiffs' cross motion for entry of judgment; emails with Kevin Leyendecker and team re [redacted]; emails with Marianne Carter and team re 2/23/22 hearing re Final Judgment and case and case	6	$650.00	$0.00	$0.00	$0.00 (0%)	$3,900.00

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			management; email with Terrance White and all Counsel re Administrative Order 22-02 re no in-person hearing appearances; review and analyze [redacted]; email with Marianne Carter and team re Plaintiffs' Opposition to Multiplan's Motion to Seal Courtroom During January 20, 2022 Hearing; review and analyze [redacted]; emails with team re [redacted] prepare for tomorrow's hearings on Multiplan, Inc.'s Motion to Seal Courtroom During 1/20/22 Hearing on Motion to Seal Certain Confidential Trial Exhibits on Order Shortening Time, Multiplan, Inc.'s Motion for Leave to File Appendix of Selected Exhibits Covered by its Motion to Seal Same on Order Shortening Time and Multiplan, Inc.'s Motion to Associate Counsel on Order Shortening Time						
34	01/20/2022	Lundvall, Pat	Multiple emails with Colby Balkenbush and all counsel re exhibits to Multiplan's motion to file certain exhibits under seal and case management; review and analyze [redacted]; prepare and appear for hearings on Multiplan, Inc.'s Motion to Seal Courtroom During 1/20/22 Hearing on Motion to Seal Certain Confidential Trial Exhibits on Order Shortening Time, Multiplan, Inc.'s Motion for Leave to File Appendix of Selected Exhibits Covered by its Motion to Seal Same on Order Shortening Time and Multiplan, Inc.'s Motion to Associate Counsel on Order Shortening Time; multiple emails with Kevin Leyendecker and team re draft plaintiffs' opposition to defendants' motion to apply statutory cap on punitive damages and plaintiffs' cross motion for entry of judgment, strategy and case management re exhibits, appendix and judgment; review, analyze, revise same; multiple emails with Louis Liao and team re final proposed judgment and case management; review and analyze [redacted]; multiple emails with Jane Robinson and team re [redacted]; review, finalize, file and serve same; email with Beau Nelson and team re same	5.7	$650.00	$0.00	$0.00	$0.00 (0%)	$3,705.00
37	01/21/2022	Lundvall, Pat	Email with Beau Nelson and team re 1/20/22 hearing transcript; review and analyze [redacted] multiple emails with Brittany Llewellyn and all counsel re	0.2	$650.00	$0.00	$0.00	$0.00 (0%)	$130.00

			proposal regarding redactions to exhibits to motion to seal trial exhibits and case management; multiple emails with Jason McManis and team re [redacted] strategy regarding response and case management; email with Marianne Carter and team re Notice of Entry of Order Admitting to Practice Craig L. Caesar; review and analyze [redacted]							
39	01/24/2022	Lundvall, Pat	Emails with Claudia Aguayo, Micaela Moore, Steve Silva and Daniel Aquino re analysis of reply to answer to petition for writ of mandamus, update re in-person hearing appearances, strategy and case management	3	$650.00	$0.00	$0.00	$0.00 (0%)	$1,950.00
40	01/24/2022	Surowiec, Karen	Continue to compile backup for memo of costs	4.1	$185.00	$0.00	$0.00	$0.00 (0%)	$758.50
41	01/25/2022	Lundvall, Pat	Emails with Brittany Llewellyn and all counsel re update regarding redactions to exhibits to motion to seal trial exhibits and case management	0.1	$650.00	$0.00	$0.00	$0.00 (0%)	$65.00
42	01/25/2022	Surowiec, Karen	Continue to compile backup for memo of costs	4.5	$185.00	$0.00	$0.00	$0.00 (0%)	$832.50
43	01/26/2022	Lundvall, Pat	Email with Marianne Carter and team re Plaintiffs' Notice of United's and MultiPlan's Non-Compliance and Request for Deadlines to Comply with Court's Sealing Orders and Minute Order re Status Check; review and analyze [redacted] emails with Jason McManis and team re [redacted]	0.6	$650.00	$0.00	$0.00	$0.00 (0%)	$390.00
44	01/26/2022	Surowiec, Karen	Continue to compile backup for memo of costs	4.8	$185.00	$0.00	$0.00	$0.00 (0%)	$888.00
45	01/27/2022	Lundvall, Pat	Email with Marianne Carter and team re Defendants' Status Report on Redactions to Certain Trial Exhibits; review and analyze [redacted]; prepare and appear for Status Check hearing; email with Kristen Gallagher and Amanda Perach re [redacted]; email with Beau Nelson and team re transcript of proceedings 1/27/22; review and analyze [redacted]; emails with Jason McManis and team re [redacted]; review and analyze [redacted]; emails with Jason McManis and all counsel re same	2.7	$650.00	$0.00	$0.00	$0.00 (0%)	$1,755.00
47	01/28/2022	Lundvall, Pat	Multiple emails with Jason McManis, Colby Balkenbush and all counsel re draft order re motion to seal trial exhibits and case management re edits/approval; review and analyze [redacted]	0.2	$650.00	$0.00	$0.00	$0.00 (0%)	$130.00
48	01/28/2022	Surowiec, Karen	Continue to compile backup for memo of costs	3.5	$185.00	$0.00	$0.00	$0.00 (0%)	$647.50
50	01/31/2022	Lundvall, Pat	Emails with Marianne Carter and team re Order Granting Plaintiffs' Proposed Schedule for	0.4	$650.00	$0.00	$0.00	$0.00 (0%)	$260.00

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			Submission of Final Redactions; review and analyze [redacted] emails with Brittany Llewellyn and all counsel re defendants' log of revised redactions to trial exhibits and case management; review and analyze [redacted]; emails with Ellie Phillips and all counsel re sharelink for production of redacted trial exhibits; review and analyze [redacted]						
					Sub Total:	($333.00)	$0.00	$0.00	$46,806.00

Expenses

#	Date	Timekeeper	Description	Units	Rate (USD)	Adj. (USD)	Inv. Adj. (USD)	Tax (USD)	Net (USD)
1	09/10/2021	None	Service, Junes Legal Service, Inc.	1	$30.00	$0.00	$0.00	$0.00 (0%)	$30.00
2	11/05/2021	None	Other, AT&T TeleConference Services	1	$4.51	$0.00	$0.00	$0.00 (0%)	$4.51
3	12/06/2021	None	Business Meals, Bankcard Center	1	$2,725.83	$0.00	$0.00	$0.00 (0%)	$2,725.83
4	12/06/2021	None	Parking, Bankcard Center	1	$18.00	$0.00	$0.00	$0.00 (0%)	$18.00
5	12/07/2021	None	Parking, Bankcard Center	1	$24.00	$0.00	$0.00	$0.00 (0%)	$24.00
6	12/07/2021	None	Parking, Bankcard Center	1	$12.00	$0.00	$0.00	$0.00 (0%)	$12.00
7	12/22/2021	None	Filing Fee-Court, Bankcard Center	1	$2,440.00	$0.00	$0.00	$0.00 (0%)	$2,440.00
8	12/22/2021	None	Filing Fee-Court, Bankcard Center	1	$3.50	$0.00	$0.00	$0.00 (0%)	$3.50
18	01/06/2022	None	Filing Fee-Court, Bankcard Center	1	$3.50	$0.00	$0.00	$0.00 (0%)	$3.50
23	01/12/2022	None	Business Meals, Bankcard Center	1	$20.81	$0.00	$0.00	$0.00 (0%)	$20.81
24	01/12/2022	None	Parking, Bankcard Center	1	$24.00	$0.00	$0.00	$0.00 (0%)	$24.00
27	01/13/2022	None	Transcripts, Bankcard Center	1	$398.93	$0.00	$0.00	$0.00 (0%)	$398.93
35	01/20/2022	None	Filing Fee-Court, Bankcard Center	1	$3.50	$0.00	$0.00	$0.00 (0%)	$3.50
36	01/20/2022	None	Filing Fee-Court, Bankcard Center	1	$2,440.00	$0.00	$0.00	$0.00 (0%)	$2,440.00
38	01/21/2022	None	Transcripts, Bankcard Center	1	$220.24	$0.00	$0.00	$0.00 (0%)	$220.24
46	01/27/2022	None	Transcripts, Bankcard Center	1	$41.55	$0.00	$0.00	$0.00 (0%)	$41.55
49	01/28/2022	None	Transcripts, Bankcard Center	1	$20.00	$0.00	$0.00	$0.00 (0%)	$20.00
51	01/31/2022	None	EDiscovery Fees	1	$6,229.80	$0.00	$0.00	$0.00 (0%)	$6,229.80
					Sub Total:	$0.00	$0.00	$0.00	$14,660.17
					Grand Total:	($333.00)	$0.00	$0.00	$61,466.17

Client Adjusted Charges Summary

#	Date	Biller	Units	Adj. Amount (USD)	Details
L37 - Rate Rule: This rate exceeds the approved rate.					

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26	01/13/2022	JLA	3.6	($324.00)	Conduct research re Judge Allf ruling tendencies on punitive damage caps; Email exchange with Pat Lundvall re research
29	01/14/2022	JLA	0.1	($9.00)	Email exchange with Pat Lundvall re Judge Allf research
		Sub-Total:		($333.00)	
		Grand Total:		($333.00)	

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Invoice Overview Report - Law Firm Invoice ID: 12440568S

McDonald Carano Wilson, Las Vegas
Please Remit Payment to:
P.O Box 2670
Reno, NV 89505
UNITED STATES

Tax ID: 88-0074283

Invoice Information

TH Matter Number:	2019-CRP-1948	**Invoice Currency:**	US Dollar
CounselLink Invoice ID:	72923541	**NET TO PAY (USD):**	$333.00
Law Firm Matter ID:	19438-3		
CounselLink Upload Date:	03/09/2022		
Final Invoice:	No	**Invoice Date:**	03/02/2022
Submitted By:	N/A	**Service Period:**	01/31/2022 - 01/31/2022
Attention:	Phil McSween	**Matter Contact:**	Owen, Carol
Corporate Customer:	TEAMHealth Legal	**Contact Office:**	Corporate
Billing Office Address:		**Contact Office Address:**	265 Brookview Centre Way Suite 400 Knoxville, TN 37919
Matter Title:	Case 34 - United NV		
Invoice Description:			

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Invoice Additional Information

Lawson Vendor ID: 78149 **Accounting Unit:** 10300

GL Account #: 83220 **Lawson Vendor ID-AP Points:**

Matter Spend Performance

Matter	Actual (USD)
Life of Matter:	$15,355,922.66

Invoice Summary

Type	Amount	Client Adjustment	Invoice Adjustment	Tax	Cost Share	Net	Prompt Pay Discount	Approved to Date	Net to Pay
Fees (USD):	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Expenses (USD):	$333.00	$0.00	$0.00	$0.00	$0.00	$333.00	$0.00	$0.00	$333.00
Total (USD):	$333.00	$0.00	$0.00	$0.00	$0.00	$333.00	$0.00	$0.00	$333.00

Allocation Summary

Contact Charge Type	Allocated Amount (USD)	Cost Share (USD)	Net (USD)	Prompt Pay Discount (USD)	Net To Pay (USD)

DEFAULT ALLOCATION						
Fees - 100.000000% - Balance Remaining		$0.00	$0.00	$0.00	$0.00	$0.00
Expenses - 100.000000% - Balance Remaining		$333.00	$0.00	$333.00	$0.00	$333.00
	Sub-Total:	$333.00	$0.00	$333.00	$0.00	$333.00
†Cost Sharing; ‡ Track Limit Overage	**Total:**	$333.00	$0.00	$333.00	$0.00	$333.00

Approval Summary

Date	User	Amount (USD)
03/14/2022	Owen, Carol	$333.00
	Total:	$333.00

Timekeeper Summary

Timekeeper	Timekeeper ID	Level	Rate	Units	Fees Billed (USD)	Fees Recommended (USD)

Charges Summary

Expenses

#	Date	Timekeeper	Description	Units	Rate (USD)	Adj. (USD)	Inv. Adj. (USD)	Tax (USD)	Net (USD)
1	01/31/2022	None	to recoup the reduction in fees related to a rate for timekeeper Julia Armendariz, the proper rate for JLA is $275 and it is now approved in Fee ID #4667	1	$333.00	$0.00	$0.00	$0.00 (0%)	$333.00
					Sub Total:	$0.00	$0.00	$0.00	$333.00
					Grand Total:	$0.00	$0.00	$0.00	$333.00

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Invoice Overview Report - Law Firm Invoice ID: 12441997

McDonald Carano Wilson, Las Vegas
Please Remit Payment to:
P.O Box 2670
Reno, NV 89505
UNITED STATES

Tax ID: 88-0074283

Invoice Information

TH Matter Number:	2019-CRP-1948	**Invoice Currency:**	US Dollar
CounselLink Invoice ID:	72949239	**NET TO PAY (USD):**	$61,436.30
Law Firm Matter ID:	19438-3		
CounselLink Upload Date:	03/14/2022		
Final Invoice:	No	**Invoice Date:**	03/11/2022
Submitted By:	N/A	**Service Period:**	12/15/2021 - 02/28/2022
Attention:	Phil McSween	**Matter Contact:**	Owen, Carol
Corporate Customer:	TEAMHealth Legal	**Contact Office:**	Corporate
Billing Office Address:		**Contact Office Address:**	265 Brookview Centre Way Suite 400 Knoxville, TN 37919
Matter Title:	Case 34 - United NV		
Invoice Description:			

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Invoice Additional Information

Lawson Vendor ID: 78149	**Accounting Unit:** 10300
GL Account #: 83220	**Lawson Vendor ID-AP Points:**

Matter Spend Performance

Matter	Actual (USD)
Life of Matter:	$15,355,922.66

Invoice Summary

Type	Amount	Client Adjustment	Invoice Adjustment	Tax	Cost Share	Net	Prompt Pay Discount	Approved to Date	Net to Pay
Fees (USD):	$48,342.50	$0.00	$0.00	$0.00	$0.00	$48,342.50	$0.00	$0.00	$48,342.50
Expenses (USD):	$13,093.80	$0.00	$0.00	$0.00	$0.00	$13,093.80	$0.00	$0.00	$13,093.80
Total (USD):	$61,436.30	$0.00	$0.00	$0.00	$0.00	$61,436.30	$0.00	$0.00	$61,436.30

Allocation Summary

Contact Charge Type	Allocated Amount (USD)	Cost Share (USD)	Net (USD)	Prompt Pay Discount (USD)	Net To Pay (USD)

DEFAULT ALLOCATION					
Fees - 100.000000% - Balance Remaining	$48,342.50	$0.00	$48,342.50	$0.00	$48,342.50
Expenses - 100.000000% - Balance Remaining	$13,093.80	$0.00	$13,093.80	$0.00	$13,093.80
Sub-Total:	$61,436.30	$0.00	$61,436.30	$0.00	$61,436.30
†Cost Sharing; ‡ Track Limit Overage **Total:**	$61,436.30	$0.00	$61,436.30	$0.00	$61,436.30

Approval Summary

Date	User	Amount (USD)
03/14/2022	Owen, Carol	$61,436.30
	Total:	$61,436.30

Timekeeper Summary

Timekeeper	Timekeeper ID	Level	Rate	Units	Fees Billed (USD)	Fees Recommended (USD)
Perach, Amanda	AMP	Partner	$400.00	4.7	$1,880.00	$1,880.00
Surowiec, Karen	KAS	Paralegal	$185.00	4.5	$832.50	$832.50
Lundvall, Pat	PL	Partner	$650.00	70.2	$45,630.00	$45,630.00

Charges Summary

Fees

#	Date	Timekeeper	Description	Units	Rate (USD)	Adj. (USD)	Inv. Adj. (USD)	Tax (USD)	Net (USD)
2	02/01/2022	Lundvall, Pat	Multiple emails with Karen Lawrence and all counsel re update regarding hearing calendar and case management re plaintiffs' cross-motion for entry of judgment; emails with Jason McManis re [redacted]; multiple emails with Brittany Llewellyn, Jason McManis and all counsel re updated redactions to trial exhibits, plaintiffs' proposed redactions revisions log and case management; review and analyze [redacted]	3	$650.00	$0.00	$0.00	$0.00 (0%)	$1,950.00
3	02/02/2022	Lundvall, Pat	Zoom conference with team re [redacted]; emails with Marianne Carter, Karen Lawrence and all counsel re courtesy copy of Plaintiff's opposition and cross-motion for entry of judgment and case management regarding hearing; emails with Jason McManis and team re [redacted]	2.6	$650.00	$0.00	$0.00	$0.00 (0%)	$1,690.00
4	02/03/2022	Lundvall, Pat	Emails with Jason McManis, Jeffrey Fowler and all counsel re follow-up regarding meet/confer and draft stipulation and order identifying exhibits not subject to any party's motion to seal and case management; review and analyze [redacted]; emails with Jason McManis and all counsel re additional updated redactions to trial exhibits and case management; begin review on bill of costs	2.5	$650.00	$0.00	$0.00	$0.00 (0%)	$1,625.00
5	02/04/2022	Lundvall, Pat	Multiple emails with Brittany Llewellyn and all counsel re	1	$650.00	$0.00	$0.00	$0.00 (0%)	$650.00

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			proposed stipulation and order setting forth new deadlines regarding redactions to trial exhibits and case management; review and analyze [redacted] email with Marianne Carter and team re Stipulation and Order Regarding Schedule for Submission of Redactions; review and analyze [redacted]						
6	02/05/2022	Lundvall, Pat	Emails with Craig Caesar and all counsel re current United/MPLN motion to seal status and case management	0.2	$650.00	$0.00	$0.00	$0.00 (0%)	$130.00
7	02/07/2022	Lundvall, Pat	Email with Marianne Carter and team re Multiplan Inc Proposed Redactions to Items Listed in Exhibits A, B and C to Multiplan's Motion to Seal; review and analyze [redacted]; multiple emails with Brittany Llewellyn and all counsel re sharelink file for defendants' proposed revised redactions to trial exhibits and case management re list of revisions to redactions; review and analyze [redacted]	0.2	$650.00	$0.00	$0.00	$0.00 (0%)	$130.00
8	02/08/2022	Lundvall, Pat	Email with Marianne Carter and team re Defendants' Motion to Seal Courtroom and Motion for Evidentiary Hearing in Support of Motion to Seal Certain Confidential Trial Exhibits on Order Shortening Time, Defendants' Status Report and Summary of Revised Redactions to Trial Exhibits, Motion To Seal Defendants' Status Report And Summary Of Revised Redactions To Trial Exhibits, Motion for Leave to Exceed Page Limits Regarding Defendants' Status Report and Summary of Revised Redactions to Trial Exhibits and Notice of Hearing re same; review and analyze [redacted] emails with Jeffrey Fowler and all counsel re follow-up regarding list of revisions to redacted trial exhibits and case management	1	$650.00	$0.00	$0.00	$0.00 (0%)	$650.00
9	02/09/2022	Lundvall, Pat	Email with Marianne Carter and team re Plaintiffs' Status Report and Response to United's and MultiPlan's Submissions for February 10, 2022 Hearing; review and analyze [redacted]; emails with Jeffrey Fowler and all counsel re list of revisions to redacted trial exhibits and case management; review and analyze [redacted] emails with Jason McManis, Terrance White and all counsel re Plaintiffs' Status Report and Plaintiffs' Supplemental Ex. 1; review and analyze [redacted]; prepare for tomorrow's status check hearing re Multiplan's motion to seal and motion to seal courtroom	4	$650.00	$0.00	$0.00	$0.00 (0%)	$2,600.00
10	02/10/2022	Lundvall, Pat	Email with Marianne Carter and team re Defendants' Index Of Trial Exhibit Redactions In Dispute, Defendants' Supplement to Motion to Seal Courtroom and Motion for Evidentiary Hearing, Appendix of Exhibit to Plaintiffs' Status Report and Response to United's and MultiPlan's Submissions for February 10, 2022 and Plaintiffs' Opposition	4.1	$650.00	$0.00	$0.00	$0.00 (0%)	$2,665.00

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			to Defendants' Motion to Seal Courtroom and Motion for Evidentiary Hearing; review and analyze [redacted]; multiple emails with Terrance White and all counsel re 2/16/22 hearing appearances on defendants' motion to apply the statutory cap on punitive damages and plaintiffs' cross-motion for entry of judgment; emails with Jason McManis and team re same, strategy and case management; prepare and appear for status check hearing re Multiplan's motion to seal and motion to seal courtroom; emails with Amanda Perach and Kristen Gallagher re [redacted]					
11	02/10/2022	Perach, Amanda	Attend hearing on motion to seal, redactions and MPI motion to seal; prepare summary of [redacted]	4.1	$400.00	$0.00	$0.00	$0.00 (0%)	$1,640.00
12	02/11/2022	Lundvall, Pat	Emails with Marianne Carter re Defendants' Opposition to Plaintiffs' Cross-Motion for Entry of Judgment, Defendants' Reply in Support of Their Motion to Apply the Statutory Cap on Punitive Damages, Order Granting Defendants' Motion To Seal Defendants' Second Supplemental Appendix Of Exhibits To Motion To Seal Certain Confidential Trial Exhibits, Motion To Seal Defendants' Reply In Support Of Motion To Seal Certain Confidential Trial Exhibits, Motion To Seal Defendants' Index Of Trial Exhibit Redactions In Dispute and Notice of Hearing re same; review and analyze [redacted]; multiple emails with Terrance White and all counsel re continued motion to seal hearing and case management regarding availability; email with Beau Nelson and team re transcript of proceedings 2/10/22; review and analyze [redacted]	4	$650.00	$0.00	$0.00	$0.00 (0%)	$2,600.00
13	02/12/2022	Lundvall, Pat	Emails with Terrance White and all counsel re availability for continued motion to seal hearing	0.2	$650.00	$0.00	$0.00	$0.00 (0%)	$130.00
14	02/14/2022	Lundvall, Pat	Telephone conference with Kevin Leyendecker re [redacted]; multiple emails with Justin Fineberg and team re [redacted]t; review and analyze [redacted]; emails with Karen Lawrence and all counsel re rescheduling of continued motion to seal hearing; email with Marianne Carter and team re Plaintiffs' Motion to Unlock Certain Admitted Trial Exhibits on Order Shortening Time and Notice Of Withdrawal Of Motion To Seal Defendants' Index Of Trial Exhibit Redactions In Dispute; review and analyze [redacted]; emails with Kevin Leyendecker, Jason McManis, Kristen Gallagher and Amanda Perach re [redacted]	3.2	$650.00	$0.00	$0.00	$0.00 (0%)	$2,080.00

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15	02/15/2022	Lundvall, Pat	Emails with Michael Killingsworth and team re [redacted] s; review and analyze [redacted] emails with Brittany Llewellyn and all counsel re redacted trial exhibits and case management; emails with Karen Lawrence and all counsel re tomorrow's hearings; prepare for tomorrow's hearings on Plaintiffs' Motion to Unlock Certain Admitted Trial Exhibits on Order Shortening Time, Final Judgment, Defendants' Motion to Apply the Statutory Cap on Punitive Damages and Plaintiffs' Cross-Motion for Entry of Judgment	6	$650.00	$0.00	$0.00	$0.00 (0%)	$3,900.00
16	02/16/2022	Lundvall, Pat	Review and analyze [redacted]; emails with Dan Polsenberg and all counsel re same and request to strike; email with Marianne Carter and team re Defendants' Response to Plaintiffs' Motion to Unlock Certain Admitted Trial Exhibits, Plaintiffs' Reply in Support of Cross Motion for Entry of Judgment and Defendants' Index of Trial Exhibit Redactions in Dispute; review and analyze [redacted] emails with Brittany Llewellyn and all counsel re proposed stipulation and order regarding certain admitted trial exhibits and case management re edits/approval; review and analyze [redacted]; emails with Kevin Leyendecker and team re [redacted]; review and analyze [redacted]; prepare and appear for hearings on Plaintiffs' Motion to Unlock Certain Admitted Trial Exhibits on Order Shortening Time, Final Judgment, Defendants' Motion to Apply the Statutory Cap on Punitive Damages and Plaintiffs' Cross-Motion for Entry of Judgment	6.4	$650.00	$0.00	$0.00	$0.00 (0%)	$4,160.00
17	02/16/2022	Perach, Amanda	Attend portion of hearing on motion for final judgment, motion to apply statutory cap on punitive damages and countermotion and motion to unlock certain admitted trial exhibits	0.6	$400.00	$0.00	$0.00	$0.00 (0%)	$240.00
18	02/17/2022	Lundvall, Pat	Multiple emails with Kevin Leyendecker and team re [redacted]; email with Beau Nelson and team re Notice of Entry of Stipulation and Order Regarding Certain Admitted Trial Exhibits; review and analyze [redacted]; multiple emails with Michael Infuso and all counsel re proposed order on Multiplan's motion to seal certain confidential trial exhibits and case management re edits/approval; review and analyze [redacted] email with Beau Nelson and team re remote appearance link for today's continued hearing; prepare and	8	$650.00	$0.00	$0.00	$0.00 (0%)	$5,200.00

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			appear for continued hearing on Defendants' Motion to Apply the Statutory Cap on Punitive Damages/Plaintiffs' Cross Motion and pending matters; email with Beau Nelson and team re transcript of proceedings 2/16/22; review and analyze [redacted]						
19	02/18/2022	Lundvall, Pat	Email with Beau Nelson and team re transcript of proceedings 2/17/22; review and analyze [redacted]	0.4	$650.00	$0.00	$0.00	$0.00 (0%)	$260.00
20	02/22/2022	Lundvall, Pat	Emails with Carol Owen, Kristen Gallagher and Amanda Perach re [redacted]; emails with Brittany Llewellyn and all counsel re MultiPlan's proposed order on motion to seal trial exhibits and case management; review and analyze [redacted]	3.2	$650.00	$0.00	$0.00	$0.00 (0%)	$2,080.00
21	02/23/2022	Lundvall, Pat	Prepare draft order denying defendants' motion for cap on punitive damages; email with Marianne Carter and team re Plaintiffs' Objection to Multiplan's Proposed Order on Multiplan's Motion to Seal Certain Confidential Trial Exhibits; review and analyze [redacted]; emails with Michael Infuso, Terrance White and all counsel re proposed order relating to MultiPlan's Motion to Seal Certain Confidential Trial Exhibits and plaintiffs' objection; review and analyze	4.8	$650.00	$0.00	$0.00	$0.00 (0%)	$3,120.00
22	02/24/2022	Lundvall, Pat	Review and revise draft order denying defendants' motion for cap on punitive damages; email with Kevin Leyendecker re [redacted]; review and revise proposed Judgment; emails with Kevin Leyendecker re [redacted]; multiple emails with Jason McManis and team re [redacted]	5.2	$650.00	$0.00	$0.00	$0.00 (0%)	$3,380.00
23	02/25/2022	Lundvall, Pat	Multiple emails with Kevin Leyendecker and team re [redacted]; review and analyze [redacted] multiple emails with Karen Surowiec, Kristen Gallagher and Amanda Perach re [redacted] review and revise draft order denying defendants' motion for cap on punitive damages; emails with Carol Owen and team re [redacted]; emails with Carol Owen and team re [redacted]	4.9	$650.00	$0.00	$0.00	$0.00 (0%)	$3,185.00
24	02/25/2022	Surowiec, Karen	Revise cost backup for Memo of Costs	4	$185.00	$0.00	$0.00	$0.00 (0%)	$740.00
25	02/28/2022	Lundvall, Pat	Multiple emails with Kevin Leyendecker and team re [redacted]; review and analyze [redacted]; multiple emails with Karen Surowiec and Brandon Morgan re [redacted]	5.3	$650.00	$0.00	$0.00	$0.00 (0%)	$3,445.00

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			[redacted]; multiple emails with Carol Owen and team re [redacted] emails with Terrance White and all counsel re redline objections to draft Multiplan order on motion to seal certain trial exhibits; review and analyze [redacted]; multiple emails with Kevin Leyendecker and all counsel re revised proposed judgment and case management re edits/approval; review and analyze [redacted]; research re [redacted]s						
26	02/28/2022	Surowiec, Karen	Review costs received from AZA, Lash & Goldberg and Napoli; exchange emails with Pat Lundvall re [redacted]	0.5	$185.00	$0.00	$0.00	$0.00 (0%)	$92.50
					Sub Total:	$0.00	$0.00	$0.00	$48,342.50

Expenses

#	Date	Timekeeper	Description	Units	Rate (USD)	Adj. (USD)	Inv. Adj. (USD)	Tax (USD)	Net (USD)
1	12/15/2021	None	Jury Fees, CC Eighth Judicial District Ct.	1	$6,864.00	$0.00	$0.00	$0.00 (0%)	$6,864.00
27	02/28/2022	None	EDiscovery Fees	1	$6,229.80	$0.00	$0.00	$0.00 (0%)	$6,229.80
					Sub Total:	$0.00	$0.00	$0.00	$13,093.80
					Grand Total:	$0.00	$0.00	$0.00	$61,436.30

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Invoice Overview Report - Law Firm Invoice ID: 12443497

McDonald Carano Wilson, Las Vegas
Please Remit Payment to:
P.O Box 2670
Reno, NV 89505
UNITED STATES

Tax ID: 88-0074283

Invoice Information

TH Matter Number:	2019-CRP-1948	**Invoice Currency:**	US Dollar
CounselLink Invoice ID:	73148487	**NET TO PAY (USD):**	$113,116.34
Law Firm Matter ID:	19438-3		
CounselLink Upload Date:	04/18/2022		
Final Invoice:	No	**Invoice Date:**	04/15/2022
Submitted By:	N/A	**Service Period:**	02/11/2022 - 03/31/2022
Attention:	Phil McSween	**Matter Contact:**	Owen, Carol
Corporate Customer:	TEAMHealth Legal	**Contact Office:**	Corporate
Billing Office Address:		**Contact Office Address:**	265 Brookview Centre Way Suite 400 Knoxville, TN 37919
Matter Title:	Case 34 - United NV		
Invoice Description:			

Invoice Additional Information

Lawson Vendor ID: 78149	**Accounting Unit:** 10300
GL Account #: 83220	**Lawson Vendor ID-AP Points:**

Matter Spend Performance

Matter	Actual (USD)
Life of Matter:	$15,355,922.66

Invoice Summary

Type	Amount	Client Adjustment	Invoice Adjustment	Tax	Cost Share	Net	Prompt Pay Discount	Approved to Date	Net to Pay
Fees (USD):	$106,524.50	$0.00	$0.00	$0.00	$0.00	$106,524.50	$0.00	$0.00	$106,524.50
Expenses (USD):	$7,752.84	$0.00	($1,161.00)	$0.00	$0.00	$6,591.84	$0.00	$0.00	$6,591.84
Total (USD):	$114,277.34	$0.00	($1,161.00)	$0.00	$0.00	$113,116.34	$0.00	$0.00	$113,116.34

Discount/Premium Information

Adjustment Type	Description	Discount %	Adjustment Amount (USD)
Expense Discount	Witness Fees, Rebecca	0.45%	($35.00)

	Paradise Void Check # - 000029112		
Expense Discount	Witness Fees, Dan Rosenthal Void Check # - 000029111	0.45%	($35.00)
Expense Discount	Witness Fees, Angela (Angie) Nieman Void Check # - 000029110	0.45%	($35.00)
Expense Discount	Witness Fees, Jolene Bradley Void Check # - 000029179	0.36%	($28.00)
Expense Discount	Witness Fees, John Haben Void Check # - 000029178	0.36%	($28.00)
Expense Discount	Witness Fees, Jacy Jefferson Void Check # - 000029176	0.36%	($28.00)
Expense Discount	Witness Fees, Dan Schumacher Void Check # - 000029174	0.36%	($28.00)
Expense Discount	Witness Fees, Angela Nierman Void Check # - 000029173	0.36%	($28.00)
Expense Discount	Witness Fees, Vince Zucarello Void Check # - 000029184	0.36%	($28.00)
Expense Discount	Witness Fees, Scott Ziemer Void Check # - 000029182	0.36%	($28.00)
Expense Discount	Witness Fees, Rebecca Paradise Void Check # - 000029181	0.36%	($28.00)
Expense Discount	Witness Fees, Lisa Dealy Void Check # - 000029180	0.36%	($28.00)
Expense Discount	Witness Fees, Vince Zucarello Void Check # - 000029306	0.86%	($67.00)
Expense Discount	Witness Fees, Scott Ziemer Void Check # - 000029305	0.86%	($67.00)
Expense Discount	Witness Fees, Rebecca Paradise Void Check # - 000029304	0.86%	($67.00)
Expense Discount	Witness Fees, Marty Millerliele Void Check # - 000029303	0.86%	($67.00)
Expense Discount	Witness Fees, Leslie Hare Void Check # - 000029302	0.86%	($67.00)
Expense Discount	Witness Fees, Kevin Ericson Void Check # - 000029301	0.86%	($67.00)
Expense Discount	Witness Fees, Jolene Bradley Void Check # - 000029300	0.86%	($67.00)
Expense Discount	Witness Fees, John Haben Void Check # - 000029299	0.86%	($67.00)
Expense Discount	Witness Fees, Jason Schoonover Void Check # - 000029298	0.86%	($67.00)
Expense Discount	Witness Fees, Jacy Jefferson Void Check # - 000029297	0.86%	($67.00)

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Expense Discount	Witness Fees, Angela Nierman Void Check # - 000029295	0.86%	($67.00)
Expense Discount	Witness Fees, Lisa Dealy Void Check # - 000029308	0.86%	($67.00)
		Total:	($1,161.00)

Allocation Summary

Contact Charge Type	Allocated Amount (USD)	Cost Share (USD)	Net (USD)	Prompt Pay Discount (USD)	Net To Pay (USD)
DEFAULT ALLOCATION					
Fees - 100.000000% - Balance Remaining	$106,524.50	$0.00	$106,524.50	$0.00	$106,524.50
Expenses - 100.000000% - Balance Remaining	$6,591.84	$0.00	$6,591.84	$0.00	$6,591.84
Sub-Total:	$113,116.34	$0.00	$113,116.34	$0.00	$113,116.34
†Cost Sharing; ‡ Track Limit Overage **Total:**	$113,116.34	$0.00	$113,116.34	$0.00	$113,116.34

Approval Summary

Date	User	Amount (USD)
04/20/2022	McSween, Phil	$113,116.34
	Total:	$113,116.34

Timekeeper Summary

Timekeeper	Timekeeper ID	Level	Rate	Units	Fees Billed (USD)	Fees Recommended (USD)
Surowiec, Karen	KAS	Paralegal	$185.00	119.7	$22,144.50	$22,144.50
Gallagher, Kristen	KTG	Partner	$450.00	4.5	$2,025.00	$2,025.00
Lundvall, Pat	PL	Partner	$650.00	126.7	$82,355.00	$82,355.00

Charges Summary

Fees

#	Date	Timekeeper	Description	Units	Rate (USD)	Adj. (USD)	Inv. Adj. (USD)	Tax (USD)	Net (USD)
10	03/01/2022	Lundvall, Pat	Multiple emails with Carol Owen and team re [redacted]; emails with Kevin Leyendecker and team re [redacted]; review and analyze [redacted] emails with Carol Owen, Nicole Kinnard and Karen Surowiec re [redacted]; emails with Kevin Leyendecker and all counsel	6	$650.00	$0.00	$0.00	$0.00 (0%)	$3,900.00

			re [redacted] review, revise and analyze [redacted]; emails with Nicole Kinnard and Karen Surowiec re [redacted]; review and analyze [redacted]						
11	03/01/2022	Surowiec, Karen	Continue to review and compile backup for costs received from AZA, Lash & Goldberg and Napoli; revise costs breakdown spreadsheets	4.8	$185.00	$0.00	$0.00	$0.00 (0%)	$888.00
12	03/02/2022	Lundvall, Pat	Multiple emails with Karen Surowiec and team re [redacted], review and analyze [redacted] multiple emails with Carol Owen and team re [redacted]; teleconference with Karen Surowiec re [redacted]	4.7	$650.00	$0.00	$0.00	$0.00 (0%)	$3,055.00
13	03/02/2022	Surowiec, Karen	Continue to compile back re Memo of Costs	1.9	$185.00	$0.00	$0.00	$0.00 (0%)	$351.50
14	03/03/2022	Lundvall, Pat	Multiple emails with Carol Owen and team re [redacted] review and analyze [redacted]; emails with Michael Infuso and all counsel re draft order on Multiplan's motion to seal certain confidential trial exhibits; review and analyze [redacted]; emails with Kevin Leyendecker and team re [redacted]; review and analyze [redacted]; emails with Marianne Carter and team re same and case management; multiple emails with Abraham Smith and all counsel re redline revised draft order denying defendants' motion to apply statutory cap on punitive damages, plaintiffs' objection and case management; review and analyze [redacted]; emails with team re [redacted]; emails with Karen Surowiec re [redacted]; review and analyze [redacted]	5.2	$650.00	$0.00	$0.00	$0.00 (0%)	$3,380.00
15	03/03/2022	Surowiec,	Continue to compile back re	5.7	$185.00	$0.00	$0.00	$0.00	$1,054.50

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