KAREN SIBALICH and MARGARET OWENS, Individually, and as Class representatives on behalf of other similarly situated,	:	SUPERIOR COURT OF NEW JERSEY APPELLATE DIVISION
	:	DOCKET NO. A-002879-23
Plaintiffs-Appellants,	:	CIVIL ACTION
and	:	
SPINE SURGERY ASSOCIATES and AMBULATORY SURGICAL CENTER OF SOMERSET, individually and as class representatives on behalf of others similarly situated,	:	ON APPEAL FROM ORDER FILED ON MAY 16, 2024, IN THE SUPERIOR COURT OF NEW JERSEY, LAW DIVISION, IN SUSSEX COUNTY, UNDER DOCKET NO. SSX-L-124-18.
	:	SAT BELOW:
Plaintiffs,	:	HON. WILLIAM J. MCGOVERN, III, J.S.C.
v.	:	
NATIONWIDE MUTUAL INSURANCE COMPANY, NATIONWIDE AFFINITY INSURANCE COMPANY OF AMERICA, and NATIONWIDE PROPERTY AND CASUALTY INSURANCE COMPANY.	:	
Defendants-Respondents.	:	

AMENDED BRIEF OF PLAINTIFFS-APPELLANTS KAREN SIBALICH AND MARGARET OWENS REDACTED

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INTRODUCTION

This putative class action arises from the systematic underpayment of claims for first party medical benefits by Defendant Nationwide Mutual Insurance Company and its subsidiary underwriting companies (collectively "Nationwide") under standardized insurance policies it issued in Pennsylvania. Nationwide promised its Pennsylvania insureds that it would pay "all reasonable expenses for necessary medical treatment," which Nationwide has internally defined as the 80th percentile the usual, customary and reasonable fees. But deviating from that standard, Nationwide applied state fee schedules to reduce what it would pay even though the out-of-state fee schedules do not apply to insurance policies issued in Pennsylvania. As a result, Nationwide paid less than it should have on the putative class members' medical bills, leaving them to pay the balance due for their treatment. Nationwide thus breached the terms of its standardized insurance policies in a uniform, systematic manner that makes this case well-suited for class treatment.

Nationwide processes claims for medical benefits using a computerized system that applies hierarchical rules to automatically set the allowed amounts on claims. This case concerns a misapplication of those rules and a failure to properly implement that system consistent with state law.

As the trial court has found, under the "reasonable fee" rule, "Nationwide has defined the standard for reasonable expenses by its internal procedures as the" 80th percentile of the usual, customary, and reasonable fees. Pa75-76. But in breach of the terms of its form insurance policies and its own internal operating rules, Nationwide's automated claims processing system calculated the claims of its Pennsylvania insureds for medical treatment and services received outside Pennsylvania at far less than the 80th percentile by applying state fee schedules to their claims. It should have paid the claims at the 80th percentile under its "reasonable fee" rule, [redacted] CPa112, T314:17-22.

Because Nationwide uniformly applied state fee schedules for medical treatment and services rendered in states whose fee schedules do not apply to policies issued in Pennsylvania, the putative class members all share a common grievance that demands a common remedy—the reprocessing and payment of their claims at the 80th percentile. Using Nationwide's electronic files, the putative class members can be readily identified. Their claims can also be proven with common evidence along with their damages, which reflect the difference between the 80th percentile and what Nationwide paid. And that

calculation can be easily performed as it involves just three variables: (1) the percentile to use; (2) the procedure or diagnostic code; and (3) the zip code of the area in which the treatment or services were rendered. Nationwide's defense here is also common to all class members and supports class certification, as a result.

In denying Plaintiffs' Motion for Class Certification, the trial court did not consider any of this evidence and thus failed to conduct a "rigorous analysis" of the evidence, as it must. That alone is enough to warrant reversal. The trial court's decision should also be reversed as the trial court improperly speculated that the factfinder must consider potentially dozens of variables in determining reasonableness despite evidence that Nationwide has never considered any of those variables in determining what to pay. The fact that neither of the experts opined that such variables are relevant confirms that the trial court did not view the evidence in the light most favorable to class certification. The trial court also misunderstood the central issue here. This case turns on the meaning of the "all reasonable expenses" requirement. Yet rather than address that provision as written, the trial court focused instead on whether the state fee schedules were "reasonable."

This Court can and should therefore find that the trial court abused its discretion in denying class certification under Rules 4:32-1(a)(3) and (b)(3).

PROCEDURAL HISTORY

Plaintiffs filed the Class Action Complaint against Nationwide on March 12, 2018. Pa114-56. After Nationwide removed this matter to federal court, the district court remanded it on September 27, 2018.[1]

After Plaintiffs amended the complaint, Pa157-90, Nationwide moved to dismiss the action on May 15, 2019. Just one day later, Plaintiffs moved for partial summary judgment. On August 22, 2019, the Court granted Nationwide's motion to dismiss in part, denied it in substantial part, and denied Plaintiffs' motion for partial summary judgment. Pa3-4. The trial court held that "the fee schedules authorized by N.J.S.A. 39:6A-4.6 are inapplicable to policies issued outside the State of New Jersey." Pa58. The trial court however denied Plaintiffs' motion for partial summary judgment, reasoning that "[w]hether application of the New Jersey fee schedule resulted in reasonable rates of compensation is a matter of fact that can only be established through further discovery." Pa28.

Following two more motions to dismiss, discovery began in earnest in mid-2020, with both parties exchanging paper discovery and depositions of the

[1] 1T refers to the January 28, 2022 Transcript of Motion Hearing;
2T refers to the August 12, 2022 Transcript of Motion Hearing;
3T refers to the April 10, 2024 Transcript of Motion Hearing.

individual Plaintiffs, the parties' corporate designees, several of Nationwide's employees, and the corporate designee of Auto Injury Solutions, Inc. ("AIS"). During discovery, Plaintiffs obtained evidence and testimony showing that Nationwide pays claims at the 80th percentile rate whenever there is neither a PPO agreement nor an applicable state fee schedule. *See infra* Pb9-10.

Much more could be said about the discovery here. Just three events merit mentioning though. First, the trial court precluded Plaintiffs' from obtaining class discovery. Pa61. Second, in ruling on Nationwide's motion to strike the report of Plaintiffs' expert, Dr. Ron Luke, the trial court observed that "Nationwide concedes that the central question in this litigation is whether Nationwide satisfied its obligation as set forth in its policies that requires it to pay 'all reasonable expenses for necessary medical treatment'" and that "Nationwide has defined the standard for reasonable expenses by its internal procedures as the UCR charge at the 80th percentile." Pa75-76. Third, in denying a motion to compel discovery from Plaintiffs' healthcare providers, the trial court found that because Nationwide "does not consider" the collection rates, expense accounting, or profit and loss statements of its insureds' healthcare providers in adjusting claims, discovery on those issues would not lead to evidence relevant to whether Nationwide paid all reasonable expenses. Pa97-98.

On October 15, 2021, Plaintiffs moved for class certification.[2] Plaintiffs defined the Class as:

> [a]ll Persons insured under a Nationwide® or a Nationwide® corporate affiliate motor vehicle insurance policy issued by Nationwide Mutual Insurance Company and/or its Underwriting Affiliates in the Commonwealth of Pennsylvania who following a motor vehicle accident occurring in Pennsylvania filed, or had claims filed on their behalf, for first-party personal injury protection ("PIP Claim") benefits for medical treatment, services, or products rendered or provided by healthcare providers outside of Pennsylvania ("Out of State Treatment") for injuries sustained in a motor vehicle accident, which PIP Claim Nationwide Mutual Insurance Company and/or its underwriting affiliates paid according to a state fee schedule.

Pa12.

During the class certification proceedings, the trial court directed the parties to write to the Insurance Commissioners of the State of New Jersey and the Commonwealth of Pennsylvania to whether they or their agencies are interesting in participating "in this case as *amici curiae*" or "direct parties[.]"[3]

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[2] At the time Plaintiffs moved for class certification, Plaintiffs' healthcare providers—Spiney Surgery Associates and the Ambulatory Surgical Center of Somerset—were parties to this Action. On December 21, 2021, the trial court granted Nationwide's motion for summary judgment dismissing these healthcare providers' claims. Pa35**.**

[3] While Plaintiffs' motion for class certification was pending, the Hon. Jennifer P. Wilson, U.S.D.J., granted final approval of a class action settlement in *Banks v. Allstate Fire & Casualty Insurance Company*, No. 19-1617. Pa1847. That case involved substantially the same allegations. In particular, Ms. Banks alleged that Allstate applied inapplicable out-of-state fee schedules to the PIP claims of its Pennsylvania insureds. In an October 23, 2023, Final

Pa99-101. Neither state's regulators expressed any interest in participating in this litigation or pursuing separate enforcement proceedings.

On May 16, 2024, the trial court denied Plaintiffs' motion for class certification. Pa1-2.

Pursuant to Rule 2:2-3(b)(9), this appeal follows "as of right."

STATEMENT OF FACTS

A. Nationwide paid Plaintiffs' medical claims according to New Jersey's state fee schedule.

Plaintiffs Karen Sibalich and Margaret Owens experienced first-hand how the programming error in Nationwide's automated claims processing system could wreak havoc on their lives. After sustaining substantial injuries in car accidents in Pennsylvania, they sought medical care just over the border in New Jersey. Pa257. Their providers thereafter submitted claims to Nationwide for reimbursement. Pa258. On receiving those claims, Nationwide ran them through its computerized claims processing system, which automatically priced the claims according to the New Jersey fee schedule. Pa258-60. And without considering whether the New Jersey state fee schedule actually applied or the payments would satisfy the "all reasonable expenses" requirement, [redacted]

Approval Order, Judge Wilson found that the requirements of Rule 23(a) and (b) of the Federal Rules of Civil Procedure had been satisfied. Pa1855, ¶ 4.

[redacted] CPa1580-1703.

That left them subject to balance billing, with Plaintiff Sibalich owing $13,782.15 to her medical providers and Plaintiff Owens $38,197.40. Pa6.

B. Nationwide uses an automated, computerized system to review and process auto PIP claims.

1. The claims adjustment process begins with AIS processing the claim using automated rules.

[redacted] CPa275, T285:15-19. [redacted] CPa1199, T68:8-10. [redacted] CPa1200-01, T69:14 to T70:24.

[redacted], CPa1201, T71:5-6, [redacted] CPa549; CPa424. [redacted]

[redacted] CPa1201, T71:16-22.

2. When neither a PPO agreement nor a state fee schedule applies, Nationwide's automated rules default the payment to its "reasonable fee" rule.

[redacted]. CPa437. If there is no applicable PPO agreement, Nationwide will next apply any state fee schedules that apply. Because Nationwide's form insurance policies "make[] no reference to fee schedules imposed by state law," Pa47, Nationwide can only apply a state fee schedule if specifically authorized by state law. This means that if there is neither a PPO agreement nor an applicable state fee schedule—either because no state fee schedule applies or the procedure does not have a fee schedule value—Nationwide must satisfy the "all reasonable expenses" requirement. To do that, [redacted].[4] CPa1207-08, T76:15 to T77:9. [redacted]

[4] *See also* CPa437; CPa41, T156:7-10 [redacted]

[redacted]

[redacted]

3. Nationwide pays medical claims at the 80th percentile of Fair Health's UCR Benchmark data.

[redacted] CPa436. The calculation of UCR fees is a straightforward, mechanical process, [redacted] *Id.* AIS performs the entire process electronically and automatically for Nationwide using the 80th percentile of Fair Health's UCR Benchmark data.[5] AIS's computer system considers no other factors in calculating what Nationwide pays under the "reasonable fee" rule.

[redacted] CPa43, T162:3-12 [redacted]; CPa50, T193:16-22 [redacted]; CPa51, T194:4-5 [redacted]; CPa43, T162:1-2 [redacted]

[5] *Compare* CPa1688-89 [redacted] with Pa1393 (admitting that the Fair Health value at the 80th percentile for procedure code 62321 is **$4,654.38**).

4. Nationwide's claims adjusters first receive claims only after AIS runs the "Automated Rules" to process and price them.

[redacted] CPa276, T289:5-17. [redacted]. CPa292, T353:24 to T354:11. [redacted] CPa282, T314:1-3. Nationwide's adjusters are only responsible for confirming the accuracy of the information in a claim, speaking with the injured party, verifying coverage, and reviewing claims for causation and necessity of the treatment.[6]

5. Nationwide issues EORs to document all bases for reducing the healthcare providers' reimbursements.

[redacted] CPa280, T305:5-9; *see also* CPa1615-

[6] [redacted] CPa279, T303:6-22. [redacted] *Id.*, T303:23 to T304:2. [redacted] CPa280, T304:2-8; JA562. [redacted] CPa280, T304:19.

1703; CPa280, 9T305:5-9. [redacted]

[redacted] CPa1615-1703; CPa280, T305:15-18. [redacted]

[redacted] CPa284, T321:12-19. [redacted]

[redacted]

CPa280, T304:14-25; CPa281, T309:17 to T310:12.

6. Nationwide routinely reprocesses claims after adjusters issue EORs.

[redacted]

[redacted]" CPa297, T373:6-15. [redacted]

[7] Procedure codes relating to medical treatment are standardized. "Practitioners and facilities bill for their services using standard code sets including Healthcare Common Procedure Coding Systems (HCPCS), Current Procedure Terminology (CPT) codes, International Classification of Diseases (ICD) diagnosis and procedure codes, Diagnosis-Related Groups (DRGs), Ambulatory Payment Groups (APGs), and National Drug Codes (NDCs)." Those coding systems all "tie back to a fee schedule or a UCR database which contains the fee for each medical procedure. Pa1430-31, ¶ 75. As Dr. Luke has explained, "each medical procedure, whether setting a fractured femur or performing discectomy with fusion neck surgery, all have medical procedure codes (27236 and 22551) that tie to a fee schedule or UCR database which contains the fee for that procedure." *Id.*

[redacted] CPa301, T389:3-8; CPa37, T138:4-14.

C. The parties' experts have testified how this case can be resolved on a class-wide basis.

While the parties' experts—Dr. Ron Luke and Mr. Lamar Blount—disagree on Nationwide's liability, their opinions both support class certification, which the trial court overlooked in its analysis.

1. Plaintiff's expert, Dr. Ron Luke.

According to Dr. Ron Luke, the usual, customary, and reasonable ("UCR") charge method "is a reasonable and generally accepted method used by Nationwide, by other property/casualty insurers, and by health plans to calculate the allowed amount for medical services, absent a negotiated rate or an applicable government fee schedule." Pa1407, ¶ 6. Dr. Luke opined that when using the "UCR charge method to calculate an allowable amount, the 80th percentile is reasonable, generally accepted, and the proper percentile to use." *Id.*, ¶ 7. As he explained, the UCR80 rate is a "reasonable basis for setting the allowed amount for medical bills." *Id.*, ¶ 8.

Dr. Luke further explained that "[t]he best indication of the proper percentile to be applied is the percentile that the payor actually uses, absent a PPO or state fee schedule." Pa1416-17, ¶ 33 (emphasis added). Dr. Luke thus concluded that because Nationwide uses the 80th percentile, "it is the percentile

that should be used in determining what the allowed amount should have been for the claims of the putative class members." *Id.*

Dr. Luke also explained that all the "data necessary to calculate the correct allowable amount is already in electronic form[,] [t]here is nothing in the dispute that requires review of medical records or the manual review of medical bills." Pa1427, ¶ 65. Dr. Luke added that because Nationwide approved and paid the claims albeit under inapplicable state fee schedules, the allowed amounts can be recalculated at the 80th percentile. Pa1428, ¶ 70. He explained that "there is no need to reconsider coding" or for a "clinical review, as Nationwide sent none of the bills for peer review or IME." *Id.* So, while the medical services rendered to Plaintiffs Sibalich and Owens differed, Dr. Luke concluded that Nationwide's underpayment can be identified and corrected to reflect to the UCR80 rate for the claims at issue here." Pa1429, ¶¶ 71-73. Dr. Luke explained that the underpayments can be identified and corrected by Nationwide and AIS through reprocessing of the relevant claims or, alternatively, by him if he is provided with the claims data. *Id.*, ¶ 74.

2. Nationwide's expert, Lamar Blount.

Nationwide's expert, Lamar Blount, [redacted] CPa778, T103:9-13. [redacted]

[redacted] CPa778, T103:23-24. And demonstrating how the claims here can be resolved on a class-wide basis, Mr. Blount repriced the claims of Plaintiffs Sibalich and Owens using a simple Excel spreadsheet, albeit using a goal-directed methodology he created for this litigation that is starkly different from the one Nationwide uses day in and out:

[redacted]

CPa527-29; *see also* CPa750, T75:6-16. [redacted]

[redacted] CPa697-98, T22:9 to T23:6. But like Nationwide, Plaintiffs, and Plaintiffs' expert, Mr. Blount considered none of the factors that the trial court found should be evaluated in determining whether Nationwide's payments were reasonable. So, while Plaintiffs' dispute the merits of Mr. Blount's methodology, it nonetheless remains that even his methodology can be applied class-wide without the need for the individualized claim-by-claim process envisioned by the trial court.

STANDARD OF REVIEW

Plaintiffs seek class certification to ensure that the members of the putative Class "have access to the courthouse" and can obtain redress for their injuries. *See Baskin v. P.C. Richard & Son, LLC*, 246 N.J. 157, 172 (2021) (quoting *Lee v. Carter Reed Co.*, 203 N.J. 496, 518 (2010)). Considering the "class action's 'historic mission of taking care of the smaller guy[,]" New Jersey's class action rule is "liberally construed." *Id.* at 103-04. A class action should therefore "lie unless it is clearly infeasible." *Riley v. New Rapids Carpet Ctr.*, 61 N.J. 218, 225 (1972)).

At the class certification stage, a court "must accept as true all of the allegations in the complaint" and "consider the remaining pleadings, discovery (including interrogatory answers, relevant documents, and depositions)[.]" *Lee*, 203 N.J. at 506. While the court must conduct "a 'rigorous analysis' to assess whether the requirements for class certification have been met[,]" *id.* (quoting *Iliadis v. Wal-Mart Stores, Inc.*, 191 N.J. 88, 106-07 (2007)), the evidence must be viewed "in a light favorable to" class certification. *Id.*

Due to its failure to follow the "class action set forth in Rule 4:32-1," *Dugan v. TGI Fridays, Inc.*, 231 N.J. 24, 50 (2017), the trial court abused its discretion in denying class certification.

SUMMARY OF THE ARGUMENT

The trial court abused its discretion in denying class certification.

1. As the typicality requirement is not a demanding inquiry, *Laufer v. U.S. Life Ins. Co. in the City of N.Y.*, 385 N.J. Super. 172, 180 (App. Div. 2006), the trial court should have found that Plaintiffs Sibalich and Owens' claims are typical of those of the putative class members. Like all other putative class members, Plaintiffs Sibalich and Owens were insured under insurance policies Nationwide issued in Pennsylvania and had sustained injuries in motor vehicle accidents in Pennsylvania. Then after receiving claims for the medical treatment that the putative class members received outside of Pennsylvania, Nationwide paid their claims under state fee schedules that do not apply to insurance policies issued in Pennsylvania. Their claims for breach of conduct based on Nationwide's failure to pay "all reasonable expenses" are therefore typical as they arise from the same practice and course of conduct.

2. Common issues predominate because this case involves the "interpretation of standard form contracts." *See Gillis v. Respond Power, LLC*, 677 Fed. Appx. 752, 756 (3d Cir. 2017). Evidencing its abuse of discretion, the trial court failed to appreciate how that makes this case "particularly well-suited for class-treatment." *Id.* And making matters worse, the trial court did

not even consider the terms of Nationwide's policies as written: it focused on whether Nationwide's payments were "reasonable," and not whether they satisfied the "all reasonable expenses" requirement.

3. This case also involves common proof. Such proof includes evidence that Nationwide uses a computerized, claims processing system that sets the allowed amounts on clams according to a set of hierarchical rules:

a) When there is a PPO agreement, the system will pay the claim at the contracted-for PPO rate.

b) If there is no PPO agreement, the system will pay the claim according to any applicable state fee schedules.

c) If there is neither a PPO agreement nor an applicable state fee schedule, the system will default to paying claims under the "reasonable fee" rule, which pays claims at the 80th percentile.

Such proof also includes testimony from Nationwide's corporate designee that [redacted] CPa112, T314:17-22. Despite an obligation to view such evidence in the light most favorable to class certification, the trial court considered none of this evidence. It rather surmised that individual issues must exist as claims must be reviewed on a claim-by-claim basis even though Nationwide uses a computerized claims processing system to automate the review and pricing of claims without the need to

consider on an individual basis whether its payments satisfy the "all reasonable expenses" requirement.

4. The trial court also abused its discretion here by failing to consider the comparative efficiencies of any alternative methods of adjudication and that this class action is perhaps the only practical vehicle to resolve the putative class members' claims against Nationwide, as it must in considering Rule 4:32-1(b)(3)'s superiority requirement. *See Dugan*, 231 N.J. at 49.

ARGUMENT

A. Plaintiffs' claims are typical of those of the putative Class Members as they all involve Nationwide's payment of first-party benefit claims using inapplicable out-of-state fee schedules. (Pa22-25)

Typicality is satisfied if "the claims or defenses of the representative parties are typical of the claims or defenses of the class[.]" R. 4:32-1(a)(3). This is not a demanding inquiry. *Laufer*, 385 N.J. Super. 172, 180 (App. Div. 2006). The typicality requirement is satisfied "[i]f the class representative's claims arise from the same events, practice, or conduct, and are based on the same legal theory, as those of other class members[.]" *Id.*

Because Plaintiffs Sibalich and Owens bring the same claims as every other member of the proposed class based on the same alleged misconduct—Nationwide's payment of their claims according to inapplicable out-of-state fee schedules—their claims satisfy the typicality requirement. The trial court

nonetheless held that Plaintiffs Sibalich and Owens's claims are insufficiently typical because they "are more different, unique, and complex to evaluate than they are alike." Pa24. According to the trial court, "[e]very claimant's accidents and injuries are different and distinct; every health care provider is different and distinct; most of the provider's billing practices are individualized and distinct; [and] each claimant/patient's medical history [is] unique." *Id.* The trial court's view that no insured could ever possibly serve as a representative plaintiff because every insured's experience is unique misperceives this case; while each PIP claim is as unique as the medical care involved, Nationwide systematically underpaid them all by unlawfully applying an out-of-state fee schedules to claims which should have been paid at the 80th percentile under the "reasonable fee" rule.

"Factual differences between the proposed representative[s] and other members of the class do not render the representative[s] atypical "if the claim arises from the same event or practice or course of conduct that gives rise to the claims of the class members.'" *In re Schering Plough Corp. ERISA Litig.*, 589 F.3d 585, 598 (3d Cir. 2009) (quoting *Hoxworth v. Blinder, Robinson & Co.*, 980 F.2d 912, 923 (3d Cir. 1992)). "Even relatively pronounced factual differences will generally not preclude a finding of typicality where there is a strong similarity of legal theories or where the claim arises from the same

practice or course of conduct." *In re Nat'l Football Players Concussion Injury Litig.*, 821 F.3d 410, 428 (3d Cir. 2016) (quoting *In re Prudential Ins. Co. Am. Sales Prac. Litig. Agent Actions*, 148 F.3d 283, 311 (3d Cir. 1998)). Typicality demands only that the claims "share the same essential characteristics"; it does not require the claims to "be identical." *Laufer*, 385 N.J. Super. at 180 (quoting Moore's Fed. Prac. § 23.24 (3d ed. 1997)).

Even if the treatment and medical histories of each putative class member are regarded as being unique, each putative class member has more in common than they do not with respect to their claims. After processing their claims for first-party medical benefits under insurance policies Nationwide issued in Pennsylvania, Nationwide paid less than it should have because of a systematic error in its automated claims processing system, which applied state fee schedules to their claims.[8] Plaintiffs allege that Nationwide failed to satisfy the "all reasonable expenses" requirement as a result of its reliance on the state fee schedules in paying the putative class members' claims.

[8] The proposed class definition pre-supposes insurance under a Pennsylvania issued Nationwide policy and medical treatment deemed by Nationwide's adjusters to be necessary and causally related to a motor vehicle accident. Having reviewed, processed, and approved the putative class members' claims for payment, Nationwide has already found that each class member is insured under a Pennsylvania policy and that their medical treatment and services were necessary and causally related to their covered motor vehicle accidents.

The plaintiffs and the class's claims here thus arise from the same course of conduct and proceed on the same legal theories. That is more than enough to clear the "low threshold" for typicality. *See NFL*, 821 F.3d at 428. There is moreover no evidentiary basis supporting any claimed factual variations as the trial court prohibited Plaintiffs from obtaining class discovery. Pa61. That alone necessitates reversal of the trial court's decision denying class certification. *See Riley*, 61 N.J. at 229. The trial court's speculation about there being factual variations is also incompatible with its duty to rigorously analyze and ground its decision in evidence. *See Marcus v. BMW of N. Am., LLC*, 687 F.3d 583, 596 (3d Cir. 2012).

The trial court's speculation constitutes an abuse of discretion for another reason: it does not matter to the claims or defenses here. Consider the trial court's observations that "every health care provider is different and distinct" and that "most of the provider's billing practices are individualized and distinct." Pa24. The trial court made no effort to determine whether these supposed factual variations would support "a unique defense that is likely to become a major focus of the litigation." *Schering Plough Corp.*, 589 F.3d at 598. And it is hard to see how they could. *See Schiff v. Liberty Mut. Fire Ins.,* 542 P.3d 1002, 1007 (Wash. 2024) (*en banc*) (rejecting argument that the PIP statute's "all reasonable and necessary expenses" requirement compels a

claim-by-claim review rather than a "formulaic approach"), *id.* at 1008 (finding argument that "specific factors about providers must be incorporated into the review process" meritless as "Fair Health incorporates certain factors inherently," such as "a doctor's experience by including all bills submitted to insurance providers in a given area").

The trial court's reasoning is also inconsistent with its prior rulings. Earlier in the case, Nationwide had moved to compel production of documents relating to the Plaintiffs' health care providers' collection rates, expense accounting, and profit and loss statements. Nationwide argued that this information is relevant to whether the health care providers' charges constitute "reasonable expenses." The trial court rightly denied Nationwide's motion. Pa80-81. It noted that in determining what to pay, Nationwide "would look at the UCR value of the procedure as listed in its Fair Health 80th percentile data, remit payment in that amount and reject any demands by the doctor for higher reimbursement." Pa97-98. The trial court added that "Nationwide itself does not consider or refer to any of the aforementioned information in determining what is a reasonable fee under the policy." *Id.* And so, the trial court held that Nationwide's requests would not likely lead to relevant evidence. *Id.*

Other supposed factual variations—the putative Class Members' specific individual injuries and their medical histories—are similarly immaterial. The

evidence shows that in deciding what it would pay under the "reasonable fee" rule—which applies whenever there is neither a PPO agreement nor applicable state fee schedule—Nationwide pays the claims at the 80th percentile with no consideration given to the claimant's specific injuries or medical history.

While the specific treatment or medical service rendered is relevant, it does not, as the trial court wrongfully concluded, frustrate the typicality element of this case. It is obvious that the members of the putative class will have received different treatment and medical services. Such differences do not, however, render Plaintiffs Siablich and Owens' claims atypical. Nationwide paid their claims at less the 80th percentile because they received treatment in a state with a fee schedule, and did so without any consideration given to the specific treatment they received. *See DeMaria v. Horizon Healthcare Servs, Inc.*, No. 11-7298, 2015 WL 3460997, *6 (D.N.J. June 1, 2015) (finding typicality because "the Plaintiffs submitted Form 1500s for CMT, PT, and E/M and were paid for CMT but denied payment for PT and E/M on the grounds that chiropractors were not eligible for E/M and PT claims"). [redacted]. *See* CPa1445. The process for calculating the allowed amount for each claim is therefore the same. Pa1428 (Dr. Luke: "the

correct allowable amount can be calculated by applying the FAIR Health UCR80 amount for each CPT or other standard code for the correct geozip").

The trial court's typicality analysis also disregards the mandate that it view the record in the light most favorable to class certification. *See Iliadis*, 191 N.J. at 96. Contrary to this foundational principle, the trial court observed that "Nationwide used and relied on the New Jersey auto fee schedules, as alleged, to gauge or determine the reasonable reimbursement rate to be paid[.]" Pa24. Plaintiffs alleged nothing of the sort. The record moreover contains no support for the claim that Nationwide relied on New Jersey's state fee schedules in determining whether its payments to Plaintiff Sibalich and Owens' health care providers were "reasonable." According to Nationwide's corporate designee, [redacted]. CPa44.

Nationwide's EORs similarly confirm that Nationwide does not use the state fee schedules to gauge reasonableness. When Nationwide applies a state fee schedule such as the New Jersey fee schedule, it issues an EOR that bears the code: "FS_NJ." [redacted] CPa1633-34. [redacted]

[redacted] *Id.* [redacted] CPa1692-93. [redacted] *Id.* Given the differences in these explanations, there is no evidence that Nationwide relied on the state fee schedules as an input to gauge or determine the reasonable reimbursement rate to be paid. Nationwide's arguments to the contrary are no more than a *post hoc* rationalization to justify its underpayments.

The trial court's reasoning that "there is no authority that precludes or bars Nationwide from using those fee schedules as a barometer or measure of reasonableness, or as a factor among other factors to determine reasonable–ness" is similarly misplaced. *See Lee*, 203 N.J. at 525. In coming to that conclusion, the trial court overlooked that "the entire contract should be read as a whole." *Pritchard v. Wick*, 178 A.2d 725, 727 (Pa. 1962). Had it done that, it would have recognized that the issue here is not whether the amounts prescribed in the fee schedules are "reasonable" but whether Nationwide's

payments satisfied the "all reasonable expenses" requirement. By not addressing the contract as a whole, the trial court failed to conduct the rigorous analysis required.[9] It also abused its discretion in failing to recognize that the interpretation of the "all reasonable expenses" requirement is itself a common question that supports class class certification.

B. Plaintiffs can establish the claims here on a class-wide basis. (Pa25-30).

The predominance element requires a "'pragmatic assessment' of various factors." *Lee*, 203 N.J. at 519 (quoting *Iliadis*, 191 N.J. at 108). The first inquiry involves a "qualitative assessment of the common and individual questions," which focuses not on the number of common and individual issues but on the significance of the common questions. *Id.* The second inquiry asks "whether the 'benefit' of resolving common and presumably some individual questions through a class action outweighs doing so through 'individual actions.'" *Id.* at 519-20 (quoting *Iliadis*, 191 N.J. at 108). The third inquiry "is

[9] Nationwide argues that *any* "reasonable" payment satisfies its contractual obligations. That is, if there is some basis to find the payment is "reasonable," that suffices and satisfies Nationwide's obligations. Nationwide ignores that the word "*all*" (and not the words "a" or "any") modifies the phrase "reasonable expenses." And when those three words are read together, as Pennsylvania law requires, the "all reasonable expenses" provision requires Nationwide to pay 100% of possible reasonable expenses. A payment may therefore be "reasonable" yet not satisfy the "all reasonable expenses" requirement if a higher reasonable charge amount also exists.

whether a class action presents a 'common nucleus of operative facts.'" *Id.* at 520 (quoting *Iliadis*, 191 N.J. at 108).

Rather than conduct the "pragmatic assessment" required, the trial court found that a claim-by-claim analysis is needed because in other cases, other courts hearing different claims from insureds based on different insurance policies and laws found that individual issues predominated. In grounding its decision on the rulings in other cases without regard to the claims and facts here, the trial court failed to conduct an "independent examination of the facts, claims, and defenses" here. *See Iliadis*, 191 N.J. at 114.

In particular, the trial court should have considered (1) the "all reasonable expenses" provision in Nationwide's form insurance policies; (2) the testimony and evidence that Nationwide had determined that claims should be paid at the 80th percentile whenever neither a PPO agreement nor an applicable state fee schedule applies; and (3) that the parties' respective experts each offered opinions demonstrating how this case can be resolved on a class-wide basis. By considering none of this, the trial court rested its decision on a distorted view of the record and thereby abused its discretion.

1. The trial court overlooked the benefits of resolving classwide whether Nationwide's use out-of-state fee schedules violates the "all reasonable expenses" requirement. (Pa25-30).

In reimbursing Plaintiff Sibalich and Owens' claims, Nationwide represented that it was doing so [redacted] CPa1633-34. In moving to dismiss the claims here, Nationwide argued that it was authorized under New Jersey law to pay Plaintiff Sibalich and Owens' claims according to the New Jersey state fee schedule. The trial court ruled against Nationwide, holding that the New Jersey fee schedule does not apply to the claims of Plaintiffs Sibalich and Owens as "the fee schedules authorized by N.J.S.A. 39:6A-4.6 are inapplicable to policies issued outside the State of New Jersey." Pa58. Because a class has not been certified, that ruling applies only to the claims of Plaintiffs Sibalich and Owens and not the other members of the putative class. Yet in denying class certification, the trial court seemingly overlooked its ruling on this common—and for that matter—central question of law in its analysis. It therefore could not assess whether the benefit of resolving this issue on a class-wide basis outweighs doing so through individual actions. *Cf. Lee*, 203 N.J. at 519.

Though decided before certification, the holding that the New Jersey fee schedule does not apply to the Plaintiffs' claims is no less important to the putative class members and should have been a compelling factor in the class

certification analysis. *See In re Nassau Cnty. Strip Search Cases*, 461 F.3d 219, 228 (2d Cir. 2006); *Waste Mgmt. Holdings, Inc. v. Mowbray*, 208 F.3d 288, 299 (1st Cir. 2000). When a cohort of plaintiffs are "aggrieved by a single policy of defendants," such as Nationwide's improper use of out-of-state fee schedules, "the case presents 'precisely the type of situation for which the class action device is suited' since many nearly identical litigations can be adjudicated in unison." *Nassau Cnty.*, 461 F.3d at 228 (quoting *In re Visa Check/MasterMoney Antitrust Litig.*, 280 F.3d 124, 146 (2d Cir. 2001)).

This Court's decision in *Laufer v. The U.S. Life Insurance Company*, 385 N.J. Super. 172 (App. Div. 2006), is instructive. The plaintiff there filed a class action under the Consumer Fraud Act alleging that the insurance company misrepresented to its insureds that they had nursing home coverage when in fact they did not. *Id.* at 178. This Court reasoned that "[i]f Laufer proves that the notice Wohlers sent to U.S. Life policyholders violates the Consumer Fraud Act, and all class members are informed of this violation, some of them may make individual decisions to discontinue the coverage or to seek monetary relief against U.S. Life based on their own individual circumstances." *Id.* at 184. According to this Court, that "would clearly 'benefit the entire class.'" *Id.*

A declaration that the non-Pennsylvania state fee schedules do not apply and an injunction barring Nationwide from applying such fee schedules would benefit the entire class much the same. It would also resolve once and for all whether Nationwide can pay claims according to state fee schedules in lieu of having to pay "all reasonable expenses." *See Young v. Nationwide Mut. Ins.,* 693 F.3d 532, 543 (6th Cir. 2012) (whether the use of geocoding software could have prevented Nationwide from overcharging its insureds was "central to all of the class members' claims and would advance the interests of the class as a whole"). And lest there be any doubt that such relief would benefit the entire class, Nationwide's mischief here is not just that it used the state fee schedules in paying the claims at issue, but also that it misrepresented to the putative class members and their providers that the fee schedules apply. If a class action is not allowed, Nationwide could "continue with impunity." *Cf. Matter of Cadillac V8-6-4 Class Action*, 93 N.J. 412, 435 (1983).

2. The trial court overlooked the uniformity of the "all reasonable expenses" requirement and its significance. (Pa25-30).

As this Court and others have recognized, "the interpretation of standard form contracts are particularly well-suited for class treatment." *Gillis v. Respond Power, LLC*, 677 Fed. Appx. 752, 756 (3d Cir. 2017) (collecting cases); *Lusky v. Capasso Bros.*, 118 N.J. Super. 369, 372 (App. Div. 1972).

Yet in ruling on class certification, the trial court ignored Nationwide's form insurance contracts and in particular, the policies' "all reasonable expenses" clause. That failure is fundamental and inconsistent with the trial court's duty to conduct a rigorous analysis.

Throughout its decision, the trial court framed the central question here as whether Nationwide paid a "reasonable" fee in paying Plaintiff Sibalich and Owens' claims according to the New Jersey fee schedule. That framing misses the point because under Pennsylvania law, "the entire contract should be read as a whole . . . to give effect to its true purpose." *Pritchard*, 178 A.2d at 727. "Pennsylvania's rules of construction do not permit words in a contract to be treated as surplusage[.]" *Nationwide Prop. & Cas. Ins. v. Ismakovic*, 531 F. Supp. 3d 926, 932 (E.D. Pa. 2021). "[E]very word" in the contract must therefore be given effect. *Id.* To do that here, the trial court was bound to consider the "all reasonable expenses" clause as written, rather than the truncated version it considered in denying certification.

Had the trial court correctly followed these canons of contract construction, a different result would have followed. According to the trial court, the fact finder here would have "to determine reasonableness on a case-by-case, claim-by-claim basis, and then assess whether Nationwide's evaluation was reasonable or unreasonable." Pa32. Again, the issue here is not

whether the rates set forth in the state fee schedules are reasonable; it is whether Nationwide paid "all reasonable expenses."

The trial court also ignored Nationwide's performance under its form insurance policies—specifically its failure to implement its "reasonable fee" rule, under which, Nationwide pays claims at the 80th percentile. That is compelling evidence on the meaning of the "all reasonable expenses" clause "entitled to great weight." *Smith v. Life Investors Ins. of Am.*, Civil Action No. 07-681, 2009 WL 3756911, *7 (W.D. Pa. Nov. 6, 2009).

As Nationwide's insurance policies are "standard form contracts," they "should be interpreted uniformly as to all similarly situated signatories[.]" *Gillis*, 677 Fed. Appx. at 756 (citing *Kolbe v. BAC Home Loans Servs., LP*, 738 F.3d 432, 440-41 (1st Cir. 2013); Restatement (Second) of Contracts §211(2) & Cmt. e (1981)). This requires consideration of Nationwide's course of performance outside this litigation, which according to Dr. Luke, is the "best indication" of the meaning of the "all reasonable expenses" clause. Pa1416-17, ¶ 33. Under Pennsylvania law, this is true regardless of whether the "all reasonable expenses" clause is considered ambiguous or not. *See Atl. Richfield v. Razumic*, 390 A.2d 736, 741 n.6 (Pa. 1978).

In *Brooks v. Educators Mutual Life Insurance Company*, 206 F.R.D. 96 (E.D. Pa. 2002), a federal district court considered "course of performance"

evidence. The defendant insurer argued, much like Nationwide here, that because it has the discretion under its policies to determine the amount to be paid for medical services, individualized determination would be necessary to determine liability for each class member. *Id.* at 105. The district court disagreed, finding that the plaintiffs had produced evidence "to undermine Educator's contention that its determination of the reasonable and customary charge is, in fact, made on a case-by-case, individualized basis." *Id.* This evidence included testimony that (1) "Educators paid for anesthesia services at a rate of '20% of what the surgeon's reasonable and customary allowance was'"; and (2) that "Educators used the Medicode software program, whose data incorporate the amounts that a provider has accepted in the past as reimbursement[.]" *Id.* Recognizing that the insurer used a "standardized calculation or formula[,]" *id.* n.8, the district court found that the defendant insurer's "assertion that its determination of what to pay as the reasonable and customary charge is made on a case-by-case, discretionary basis, is belied by … the factual record to date." *Id.* at 105.

As in *Brooks*, the evidence here establishes that Nationwide never decides what to pay under the "all reasonable expenses" clause on a claim-by-claim basis when the default rule applies. Rather, the evidence shows that Nationwide pays claims at the 80th percentile whenever there is neither a PPO

agreement nor an applicable fee schedule. Because Nationwide sets the allowed amount for claims without a claim-by-claim, individualized review, an individualized, claim-by-claim review is neither necessary nor appropriate here as Nationwide's form insurance policies "should be interpreted uniformly as to all similarly situated signatories[.]" *See Gillis*, 677 Fed. Appx. at 756.

Nationwide nonetheless argues that it uses the 80th percentile as the measure of what satisfies the "all reasonable expenses" provision only outside of New Jersey and for medical treatment not otherwise subject to a fee schedule. That argument need not be credited at the class certification stage though as the evidence must be viewed in the light most favorable to class certification. *See Lee*, 203 N.J. at 505. It is also only an argument. To be sure, Plaintiff Owens received treatment from Dr. Choi in New Jersey on February 13, 2017, for which Nationwide paid the claim under its "reasonable fee" rule at the 80th percentile. *Compare* CPa1688 [redacted] with Pa1393 (interrogatory response that UCR80 rate for procedure code 62321 is $4,654.38).

As for Nationwide's argument that 80th percentile applies only if the medical treatment is one not listed in a fee schedule, that too is unfounded and one that has been rejected. *See, e.g.*, *Smith*, 2009 WL 3756911, at *6-8 (W.D. Pa. Nov. 6, 2009) (rejecting insurer's argument that its course of performance

in interpreting "actual charges" only applies to "prescription drugs""). When Nationwide pays claims under the "all reasonable expenses" clause, [redacted] CPa1692-93. [redacted] CPa1633-34. When juxtaposed, those EORs show that when Nationwide pays a claim according to a state fee schedule, Nationwide has not determined that the fee is "reasonable" as it would if it were paying the claim under the "all reasonable expenses" clause.

Nationwide's argument here is also contrary to the testimony of its corporate designee. [redacted] *See* CPa112, T314:17-22. By disregarding this evidence of Nationwide's course of performance and how the claims should be priced if no state fee schedule applies, the trial court abused its discretion.

3. The trial court overlooked the opinions of the parties' experts which support class certification. (Pa25-30).

"The court's obligation to consider all relevant evidence and arguments extends to expert testimony." *In re Hydrogen Peroxide Antitrust Litig.*, 552 F.3d 305, 307 (3d Cir. 2008). In many cases, this requires the trial court to weigh "conflicting expert testimony at the certification stage[.]" *Id.* at 323. Even when the parties have offered conflicting expert testimony, the "reliability, admissibility, and credibility" of those expert reports can still involve questions that "apply uniformly" to all members of the proposed class, which justify class certification. *See Iliadis v. Wal-Mart Stores, Inc.*, 191 N.J. 88, 111-12 (2007). While the parties' experts here have offered conflicting testimony on Nationwide's liability, the experts for both sides have offered opinions that demonstrate that this case can be resolved on a class-wide basis.

Plaintiffs' expert, Dr. Luke opined that "the best indication of the proper percentile to be applied is the percentile that the payor actually uses, absent a PPO or state fee schedule." Pa1416-17, ¶ 33. And so, Dr. Luke concluded that because Nationwide uses the 80th percentile, "it is the percentile that should be used in determining what the allowed amount should have been for the claims of the putative class members." *Id.*

[redacted]

CPa778, T103:9-13, [redacted]

[redacted]. CPa527-29. While Plaintiffs disagree with the particulars of his methodology and the conclusions he ultimately reached, Mr. Blount's spreadsheet and his testimony confirm that the claims here can be proven on a class-wide basis.

In short, there is no competing expert testimony on the issue and elements of class certification. Both sides' experts have offered ways to resolve this case on a class-wide basis without the need for a claim-by-claim adjudication. Yet the trial court considered none of that. It rather found that there are a litany of factors that must be considered in assessing the reasonableness of Nationwide's payments contrary to the testimony and opinions of both parties' experts. Pa24; Pa26.

4. The trial court failed to conduct an independent examination of the facts, claims, and defenses here by relying on decisions in other cases, none of which involved the "all reasonable expenses" requirement, course of performance evidence, or expert testimony like that here. (Pa25-30).

Rather than examine the "all reasonable expenses" clause," Nationwide's course of performance under that clause, or the expert evidence, the trial court looked to other cases, which involved challenges to the reasonableness of payments made by insurers. Pa27-30. None of those cases, however, involved the "all reasonable expenses" clause. Nor did any examine

the defendant insurer's course of performance or expert testimony like that here. They instead addressed challenges by insureds to the way the defendant insurers determined what constitutes a reasonable fee. Yet this case does not involve a challenge to Nationwide's use of the 80th percentile in determining what satisfies the "all reasonable expenses" requirement. It rather trains on Nationwide's failure to follow price the claims using its own "reasonable fee" rule for setting the allowed amounts for claims.

While relying on cases bearing no resemblance to the matter at hand, the trial court gave no consideration to any of the decisions Plaintiffs cited, which much more closely resemble the instant action. *See Brooks*, 206 F.R.D. at 105-07 (certifying (b)(3) class because evidence showed that the insurer "paid anesthesia bills . . . not on an individualized basis, but through the use of a standardized calculation or formula); *DeMaria*, 2015 WL 3460997, at *7 (finding that individual issues did not predominate because "the fairest and most efficient way for the court to address the class members' claims is to consider the legality of the bundling policy on a class-wide basis and, if illegal, to order reprocess of claims"); *Generation Changers Church v. Church Mut. Ins. Co.*, 693 F. Supp. 3d 795, 818 (M.D. Tenn. 2023) (granting class certification where alleged overpayments of insurance claims could be identified and resolved use "nothing more than a mathematical calculation").

Unlike *Brooks*, *DeMaria*, and *Generation Changers*, the decisions cited by the trial court have little in common with the claims here.

In discussing *Atlantic Ambulance Corp. v. Cullum*, 451 N.J. Super. 247 (App. Div. 2017), the trial court noted that this Court found a decision denying certification of the "Cullum class of claimants" proper because they "challenged the reasonableness of the fees charged by Atlantic." Pa28. Because "[i]ndividuals requiring ambulance services do not 'contract' with Atlantic[,]" the plaintiffs there did not claim that Atlantic breached a contract; they argued that there was an implied contract or quasi-contract. *Atlantic Ambulance*, 451 N.J. Super. at 261.

Atlantic Ambulance is an inapt comparison. Lacking a form insurance policy like that here, which requires the payment of "all reasonable expenses," the Cullum plaintiffs could only argue that the "uniform flat rates" charged by Atlantic for ambulance services "were excessive and disproportionate to the reimbursement rates assessed by insurance providers for similar services." *Id.* at 251. In other words, the plaintiffs argued that Atlantic's rates were unreasonable in comparison to what insurers paid; not what other *ambulance* providers charged. Nor did the Cullum plaintiffs offer the sort of course of performance and expert evidence Plaintiffs present here.

While *Atlantic Ambulance* is distinguishable as to the case's Cullum plaintiffs, its treatment of a distinct "Hitti" class is instructive. The Hitti class's claims concerned Atlantic's charge of a $14 mileage fee for patients not transported to a hospital. *Id.* at 252. As this Court noted, during the litigation, "Atlantic conceded that it was improper to charge a $14 mileage fee for individuals who were not transported to a hospital." *Id.* at 251 n.5. This Court then explained that consideration of Atlantic's failure to refund the $14 mileage fee did not raise a concern that the fact finder would have to make a free-ranging reasonableness determination given that the issue was "limited to a charge Atlantic admits was billed in error and does not implicate Atlantic's rate-setting decisions for ambulance services." *Id.* at 261. The same could be said here given that Plaintiffs are not challenging the underlying hierarchal rules Nationwide uses to pay claims under its "reasonable fee" rule, but rather its failure to use the appropriate "rule when paying the claims at issue here which results in its underpaying "all reasonable expenses" resulting from an insured's medical treatment. As in *Cullum*, [redacted] CPa112, T314:17-22.

The trial court reliance on *DiCarlo v. St. Mary Hospital*, 530 F.3d 255 (3d Cir. 2008), fares no better. The plaintiff there contended that the charges he was required to pay were unreasonable because St. Mary's charged other patients—uninsured, Medicare, Medicaid, and charity patients—less. *Id.* at 263. In rejecting that argument, the Third Circuit noted that "St. Mary's has a uniform set of charges (casually known as the 'Chargemaster') that it applies to allow patients"—and that St. Mary's "accepts[—]discounted payments if the patient is covered by a government program that legislative imposes discounts." *Id.* And recognizing that the plaintiff agreed to pay "all charges" and no legislatively imposed discount applied, he was bound to pay the prices set on St. Mary's Chargemaster. *Id.* at 264. Much like the plaintiff did in *DiCarlo*, Nationwide claims that it should not have to pay what its Pennsylvania form insurance policies require because New Jersey's Legislature has seen fit to discount health care provider payments under its state auto fee schedules for insurance policies issued in New Jersey. Nationwide cannot claim the benefit of a discount the Legislature did not grant it. *Cf. DiCarlo*, 530 F.3d at 266 (quoting *Kolari v. New York-Presbyterion Hosp.*, 382 F. Supp. 2d 362 (S.D.N.Y. 2005)). It must satisfy the "all reasonable expenses" requirement according to its "reasonable fee" rule.

The trial court's reliance on *Innovative Physical Therapy, Inc. v. MetLife Auto & Home*, No. 07-5446, 2008 WL 4067316 (D.N.J. Aug. 26, 2008) and *State Farm Mut. Auto Ins. Co. v. Sestile*, 821 So. 2d 1244 (Fla. Dist. Ct. App. 2002), are likewise misplaced. There, the plaintiffs argued that the insurers' use of such computerized systems and percentile benchmark data violated state law and the insurance policies. *See Innovativ*, 2008 WL 4067316 at *10; *Sestile*, 821 So. 2d at *1246. In both cases, the courts found that "[i]f the legislature has chosen not to determine the term "reasonable," it is not a court's function to determine, across the board, that an insurer's internal method of gauging reasonableness does or does not comply with the statute." *Innovative*, 2008 WL 2067316 at *10 (quoting *Sestile*, 821 So. 2d at 1248). Again, in this case, Plaintiffs are not challenging Nationwide's "internal method of gauging reasonableness" but Nationwide's failure to properly implement its own rules due to its use of inapplicable state fee schedules.

Given the claims here and the evidence that Nationwide pays claims at the 80th percentile when neither a PPO agreement nor state fee schedule apply, this matter much more closely resembles *Brooks*. The defendant insurer in *Brooks* argued that individual issues predominated because the amount it paid for anesthesia services was made on a "discretionary, case-by-case basis." *Brooks*, 206 F.R.D. at 105. In granting class certification, the district court

noted that that the plaintiffs had presented evidence that undermined the insurer's argument that it determines what is reasonable on a claim-by-claim basis. That evidence included testimony that it paid claims at "20% of what the surgeon's reasonable and customary allowance was" and that it also used a software program to calculate what it would pay. *Id.* Similar evidence exists here: Nationwide uses a software program to calculate what it pays, which it does at the 80th percentile whenever its "reasonable fee" rule applies.

As Nationwide has already processed, approved and paid the claims of the putative class members, there should be no remaining individual issues. That notwithstanding, the trial court speculated that there may be individual issues that necessitate a claim-by-claim review. During discovery, Nationwide sought evidence that would support the need for such a review. Those efforts however fell flat. [redacted] CPa1305, T174:6-13. [redacted] CPa1306-07, T175:16-19, T175:20 to T176:1, T176:2-6. The trial court overlooked this evidence, contrary to its duty to conduct a rigorous analysis of the evidence.

But even if there were some residual individual issues, that is not a bar to class certification as individual issues "may remain following resolution of common questions." *Iliadis*, 191 N.J. at 108. As the Supreme Court has stressed, trial courts have a variety of tools available to resolve any individual issues, which should be used "to ensure that as many class members as possible receive[] full and fair consideration of their claims." *Little v. Kia Motors Am., Inc.*, 242 N.J. 557 (2020); *Lee*, 203 N.J. at 530-31.

In denying class certification the trial court considered none and failed to appreciate the consequences that its decision would have on the absent class members. For example, the trial court could have certified a class for reprocessing the insurance claims like the district court did in *DeMaria*. Like Nationwide here, the defendant insurer in *DeMaria* argued that an order requiring the reprocessing of claims would be inappropriate given certain individual issues, such as whether the claims included certain code modifiers and the information in the patients' medical records. *DeMaria*, 2015 WL 3460997, at *9. The district court found these "possibilities do not dissuade the Court from finding that certifying a class for the remedy of reprocessing is the most fair and efficient method of adjudicating the legality of the bundling policy." *Id.* The district court continued that "[a]ny reason for denial [of the underlying claims] other than the bundling policy is subordinate to the

question of the bundling policy's legality because the claims were automatically denied under the bundling policy, without any consideration of whether other legitimate reasons for denial might exist." *Id.*

Any individual issues here would be subordinate just the same and perhaps more so. Unlike in *DeMaria*, where the defendant insurer did not determine whether other reasons for claim denial might exist, [redacted]. *See* CPa284, T321:12-19, T326:1-10; CPa22, T81:8-12. The record thus contains no evidence that there are any remaining individual issues. But even if there were, those issues would be subordinate to the common questions focusing on the "all reasonable expenses" requirement, Nationwide's course of conduct, and the testimony of the parties' experts. Because these common issues predominate, the trial court abused its discretion in denying class certification.

C. A class action is superior to any alternative means of adjudication. (Pa31-32)

The trial court also erred by considering Rule 4:32-1(b)(3)'s superiority requirement in a vacuum without consideration of the comparative efficiencies of any alternative methods of adjudication. The superiority requirement—the final prerequisite for class certification—requires that the class action 'be superior to other available methods for the fair and efficient adjudication of the

controversy." *In re Cadillac*, 93 N.J. at 435 (quoting R. 4:32-1(b)(3)). It requires consideration of (1) the available alternative methods of adjudication of each issue, "(2) a comparison of the fairness to all whose interests may be involved between such alternative methods and a class action, and (3) a comparison of the efficiency of adjudication of each method." *Id.* at 436. The superiority requirement thus mandates "a comparison with alternative procedures[.]" *Dugan*, 231 N.J. at 49 (quoting *Int'l Union of Operating Engineers Local No. 68 Welfare Fund v. Merck & Co., Inc.*, 192 N.J. 372, 383 (2007)); *see also Mullins v. Direct Digital, LLC*, 795 F.3d 654, 664 (7th Cir. 2015) (describing superiority requirement as "comparative," requiring courts to "assess efficiency with an eye toward 'other available methods'").

To explore whether there were any alternative methods of adjudication, the trial court ordered the parties to write to the insurance regulators of New Jersey and Pennsylvania to invite their participation. Neither states' regulators showed any interest in intervening or taking any administrative action against Nationwide. This shows that administrative litigation is not a realistic alternative to this putative class action. *See Iliadis*, 191 N.J. at 116 (finding the administrative framework under the Wage and Hour Law, N.J.S.A. 34:11-56a to -56a30, inferior to the class action).

Individual litigation is similarly inferior. While the trial court observed that mini-trials or plenary hearings may be required to resolve individual issues, that finding rests on a view of the record that is inconsistent with the requirement that the evidence be viewed in the light most favorable to class certification. In any event, the existence of individual issues does not bar class certification. *Iliadis*, 191 N.J. at 113 (citing *In re Cadillac*, 93 N.J. at 438). Nor should it. Class actions are "greatly preferred" even if "many individual inquiries are necessary" when there are threshold issues common to all class members, such as contract interpretation, *Young*, 693 F.3d at 545 (quoting *Pipefitters Loc. 636 Ins. Fund. v. Blue Cross Blue Shield*, 654 F.3d 618, 631 (6th Cir. 2011); *Daffin v. Ford Motor Co.*, 458 F.3d 549, 554 (6th Cir. 2006)).

The trial court also erred by not comparing the advantages and disadvantages of the class action in relation to individual litigation. The trial court indeed overlooked that many class members will have claims with a negative value, meaning that considering litigation costs, their claims would have a negative expected return. According to the Supreme Court, that is the "most compelling rationale for finding superiority in a class action." *See Iliadis*, 191 N.J. at 115 (quoting *Castano v. Am. Tobacco Co.*, 84 F.3d 734, 744 (5th Cir. 1996)). Nor did it appreciate how due to the intricacies of Nationwide's form insurance policies, the complexities of state law, and

Nationwide's conduct, few putative class members are likely to have discovered that Nationwide had no basis under state law to pay their claims according to state fee schedules in lieu of having to satisfy the "all reasonable expenses" requirement.

When faced with similar technical violations of state law and negative value claims, courts have found individual litigation inferior to class actions. *See Young*, 693 F.3d 545-46 (finding class action involving claims that Nationwide overcharged its insureds superior given the negative value of the claims and the "unlikelihood that many injured policyholders will discover, let alone attempt to vindicate their individual injur[ies]"); *Kinder v. Nw. Bank*, 278 F.R.D. 176, 183 (W.D. Mich. 2011) (noting "[m]ost members of the class are likely not aware of the technical violation of the statute" and "likelihood that many members of the class will choose to bring individual lawsuits is remote.").

If a class action is not allowed here, Nationwide would moreover be effectively "immune from liability." *See Iliadis*, 191 N.J. at 105. This is because "the ***realistic*** alternative to a class action is not . . . million[s of] individual suits, but zero individual suits." *Id.* at 116-17 (quoting *Carnegie v. Household Int'l, Inc.*, 376 F.3d 656, 661 (7th Cir. 2004)) (emphasis in original). Because a class action is "perhaps the only practical vehicle" to

resolve the claims here for Nationwide's Pennsylvania insureds, the class-wide resolution of the present controversy is superior to any other methods of adjudication. *See Lee*, 203 N.J. at 517-18. After all, the denial of class status due to the manageability concerns expressed by the trial court is "disfavored" given the "public interest involved in class actions." *Iliadis*, 191 N.J. at 117 (internal citations omitted).

By failing to perform the comparative analysis required under Rule 4:32, the trial court abused its discretion. Its decision denying class certification should therefore be reversed.

CONCLUSION

For all these reasons, the trial court's decision to deny class certification should be reversed.

Respectfully,

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Appellate Division

Docket No. A-002879-23

KAREN SIBALICH and MARGARET OWENS, Individually and as Class Representatives on behalf of others similarly situated, *Plaintiffs-Appellants,* -and- SPINE SURGERY ASSOCIATES and AMBULATORY SURGICAL CENTER OF SOMERSET, Individually, and as Class Representatives on behalf of others similarly situated, *Plaintiffs,* vs. NATIONWIDE MUTUAL INSURANCE COMPANY, NATIONWIDE AFFINITY INSURANCE COMPANY OF AMERICA and NATIONWIDE PROPERTY AND CASUALTY INSURANCE COMPANY, *Defendants-Respondents.*	CIVIL ACTION ON APPEAL FROM AN ORDER FILED ON MAY 16, 2024 IN THE SUPERIOR COURT OF NEW JERSEY, LAW DIVISION, SUSSEX COUNTY Docket No.: SSX-L-124-18 Sat Below: HON. WILLIAM J. MCGOVERN, III, J.S.C.

REDACTED BRIEF ON BEHALF OF DEFENDANTS-RESPONDENTS

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PRELIMINARY STATEMENT

After conducting a thorough analysis spanning nearly three years, reviewing over ten briefs, convening multiple hearings running more than seven hours in total, and soliciting commentary from the insurance departments of New Jersey and Pennsylvania, Judge William McGovern, J.S.C. (ret.) of Sussex County issued a 31-page order denying Plaintiffs' motion for class certification. Judge McGovern correctly found that the typicality, predominance, and superiority prerequisites were not satisfied when a putative class of insurance policyholders attempted to challenge whether the amounts they were paid satisfied the contractual obligation to pay for all "reasonable expenses" for necessary medical treatment. Judge McGovern's well-reasoned opinion overwhelmingly satisfies the "rigorous analysis" standard by comprehensively considering an extensive record of facts, exhibits, testimony, and expert reports submitted by both parties. The Court should affirm Judge McGovern's ruling by holding that Plaintiffs failed to meet their burden to satisfy all class certification prerequisites under New Jersey law.

Judge McGovern's opinion rests on the fact that, when Nationwide adjusts automobile insurance claims for First Party Benefits (also known as PIP Benefits) relating to medical treatment provided in New Jersey, Nationwide considers, among other factors discussed below, the New Jersey Auto PIP Fee Schedule

(the "Fee Schedule") as an indication of whether the expenses are "reasonable." This is consistent with the New Jersey Department of Banking & Insurance (DOBI) having designed the Fee Schedule to reflect "*reasonable* and prevailing fees". To maintain consistent adjusting, Nationwide follows the same procedures for assessing the "reasonableness" of medical expenses related to New Jersey providers, *regardless* of whether the underlying PIP claim is submitted under a policy that was issued in New Jersey or in Pennsylvania.

The applicable language in the Plaintiffs' PIP policies obligates Nationwide to pay "all reasonable expenses for necessary medical treatment and rehabilitative services." Plaintiffs argue that, because the Fee Schedule is legally binding on New Jersey policies, but is not legally binding on Pennsylvania policies, then Nationwide is somehow precluded from considering the Fee Schedule when a PIP claim is submitted under a Pennsylvania policy—*even if the treatment is rendered in New Jersey by a New Jersey provider*. Plaintiffs have never explained why medical expenses deemed "reasonable" by DOBI are somehow "*not* reasonable" for Pennsylvania policyholders. For Pennsylvania policyholders, Plaintiffs contend that Nationwide's payment is inherently too low as a matter of law, even though it may be the same amount paid under policies issued in New Jersey, *for the same medical treatment*, provided by *the same New Jersey provider*. According to Plaintiffs, any

payment applying the Fee Schedule under a Pennsylvania policy *automatically* constitutes breach of contract, *without the need for any other considerations*.

Plaintiffs' position is backwards. New Jersey courts faced with similar arguments have explained that if the amounts healthcare plaintiffs received from insurer defendants are "reasonable," *regardless of how the reimbursements were calculated*, then there is no breach of the insurance policy. Importantly, in the context of a putative class action, the amount published in the Fee Schedule is not legally binding on policies issued in Pennsylvania with respect to reasonableness, and therefore, as the trial court correctly recognized, it would have to consider myriad factors to assess reasonableness on a claim-by-claim basis. Judge McGovern recognized that, *even if* the Fee Schedule is not legally binding as to reasonable expenses under Pennsylvania PIP policies, then the Fee Schedule is at least *relevant* to reasonableness. If the Fee Schedule is not legally binding, the trial court would have to consider myriad factors to assess reasonableness on a claim-by-claim basis and would be faced with many questions of individualized proof. These challenges, documented in the robust trial court record, demonstrate why the class certification prerequisites of predominance, typicality, and superiority are not satisfied.

PROCEDURAL HISTORY

1. Plaintiffs' Complaints And Partial Summary Judgment Motion

Plaintiffs filed their original Complaint in March 2018, followed by three subsequent amendments. Pa114-156, Pa157-190, Pa191-225, Pa246-359. Nationwide moved to dismiss, and Plaintiffs moved for partial summary judgment. Pa36. Judge Weaver denied both motions at the preliminary pleading stage, but offered important insight to guide further proceedings. *See* Pa34-59.

First, Judge Weaver found that the Provider Plaintiffs Spine Surgery Associates (SSA) and Ambulatory Surgical Center (ASCS)—who were the proposed representatives of a competing class of plaintiff medical providers who sought the same recovery as Insured Plaintiffs Karen Sibalich and Margaret Owens and whose claims the trial court dismissed with prejudice earlier in the case—could not somehow recover for "payment of bills," which is not a cause of action recognized in New Jersey. Pa47-48. In commenting on the lack of contractual privity between Nationwide and Provider Plaintiffs, Judge Weaver said that *D'Ascoli v. Stieh* supports the "right to collect *from the Insured Plaintiffs*, but not the contention that either putative class of Plaintiffs may collect from [Nationwide]." *Id.* (emphasis added).

Second, Judge Weaver found that, even if Nationwide allegedly applied the New Jersey Fee Schedule uniformly to the PIP claims of Pennsylvania

policyholders, that does not constitute an inherent underpayment or breach of the contract, and Nationwide has a right to demonstrate, on a claim by claim basis, why its payment satisfied the contractual obligation to pay "reasonable expenses for necessary medical treatment[.]" Pa49-50.

Third, Judge Weaver recognized that "[T]here may be a gap between a provider's usual and customary fee and what constitutes a reasonable expense." *Id.* And that, therefore, Nationwide "may be able to demonstrate that application of New Jersey's fee schedule, which ordinarily reflects 'the reasonable and prevailing fees of 75% of practitioners within the region,' N.J.S.A. 39:6A-4.6(a) provided reasonable compensation to the Provider Plaintiffs." *Id.*

In addition to breach of contract, Plaintiffs attempt to prosecute claims for bad faith and unjust enrichment. Pa272-75, Pa295-309, Pa277-79. The trial court dismissed *with prejudice* the count for Consumer Fraud, and Plaintiffs did not seek interlocutory appeal. Pa8.

2. Nationwide's Successful Motion For Partial Summary Judgment

On December 21, 2021, the trial court granted Nationwide's motion to dismiss all claims alleged by the Provider Plaintiffs. Da21. The trial court found that the purported "assignments" Sibalich and Owens issued to SSA and ASCS were revocable, incomplete, lacking in requisite intent, or altogether non-

existent—rendering them invalid as a matter of law.[1] *Id.* SSA claimed to have an assignment of benefits from Sibalich and Owens, which purportedly allowed them to proceed directly against Nationwide. *Id.* ASCS had no assignments. *Id.* But those facts were not necessarily representative of *other* healthcare providers and *their* assignment procedures. Pa24. In fact, in denying class certification, Judge McGovern pointed out how every healthcare provider and its billing practices could be different and distinct. Pa24.

[redacted] *See* CDa41-49. Nationwide contends that the validity or invalidity of any assignments must be adjudicated on a case-by-case basis, which raises further issues that preclude certification. *See* Da30-33.

Provider Plaintiffs did not seek interlocutory appeal of the summary judgment decision, but their counsel *continue to represent them in this litigation* (while simultaneously representing the Insured Plaintiffs) and counsel has

[1] In granting summary judgment to Nationwide, the trial court held that valid assignments of benefits were *required* for Provider Plaintiffs to pursue their claims against Nationwide. Da21-22. In the absence of properly executed assignments, there was no basis for Providers' claims. *Id.*

announced an intention to (eventually) attempt an appeal on behalf of the Provider Plaintiffs. Pls.' Br., 1T at p.77, 2T at p.44.

3. Plaintiffs' Belated Motion for Class Certification

Nearly four years after they first filed their Complaint, Plaintiffs moved for class certification on October 15, 2021. Pa8. With the dismissal of the Provider Plaintiffs two months later, *see supra*, only the class of Insured Plaintiffs remained as potentially-viable. Pa13-14.

4. Over The Course Of Two-And-A-Half Years, The Trial Court Undertook A Rigorous Analysis Of Whether Plaintiffs Met The Class Certification Requirements

From the filing of Plaintiffs' motion for class certification in October 2021 through the court's issuance of its ruling in May 2024, the court conducted a rigorous inquiry into whether Plaintiffs had met the class certification requirements in New Jersey, including three separate oral arguments; multiple rounds of briefing in 2021, 2022, 2023, and 2024[2]; and written inquiries to

[2] The trial court invited plentiful class certification briefing beyond the moving, opposition, and reply papers. *See* Da24-42, CDa25-50, Da48, Da60-64, Da74-126. Indeed, Judge McGovern left no stone unturned in determining whether Plaintiffs had met their burden under the New Jersey rules governing class certification. Pursuant to Rule 2:6-1(a)(2), those additional briefs and related submissions are included in Nationwide's appendix because the question of whether the issues raised therein were considered by the trial court in the course of its indisputable "rigorous analysis" over the course of the nearly two-and-a-half years Plaintiffs' motion was pending is germane to the appeal. *See Goasdone v. Am. Cyanamid Corp*., 354 N.J. Super. 519, 527 (Law Div. 2002) (citation omitted) (stating that when adjudicating a motion for class certification,

multiple regulatory bodies. *See* 1T, 2T, 3T; Pa3-4; Da60-62, Da65-70.[3] In addition to the three oral arguments specifically dedicated to class certification on January 28, 2022, August 12, 2022, and April 10, 2024, the court repeatedly raised certification issues *sua sponte* at other hearings.[4]

5. In A Well-Reasoned Opinion Reflective Of Rigorous Analysis, Judge McGovern *Denied* Plaintiffs' Motion For Class Certification

Following the rigorous process recounted *supra*, Judge McGovern issued a 31-page order denying Plaintiffs' motion for class certification. Pa1-33. Judge McGovern correctly found that the typicality, predominance, and superiority

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"the [trial] court must undertake a 'rigorous analysis' to ascertain whether the requirements for certification have been met").

[3] The trial court directed the parties to solicit the views of DOBI and the Pennsylvania Commissioner for the Department of Insurance (PA-DOI) on the legal and factual issues presented by the class certification motion. Da42, Da43-47, Pa100-01, Da60-62, Da65-68. On May 25, 2023, the New Jersey Attorney General's Office responded on behalf of DOBI, advising that: (a) it would decline to participate in this case; (b) it was not aware of any cases raising the same or similar issues; and (c) "[a]lthough N.J.A.C. 11:3-39 governs the PIP fee schedules, it does not address the use of New Jersey's fee schedules by insurance companies that are regulated by jurisdictions other than New Jersey." Da70.

[4] Additionally, while the class certification motion was pending, counsel for Plaintiffs informed the trial court that they negotiated a class action settlement in a similar case pending in the Middle District of Pennsylvania, *Banks v. Allstate*, No. 19-cv-1617-JPW (M.D. Pa.), which was approved. While counsel for Plaintiffs asserted that the settlement supports certification here, Nationwide explained that no certification is possible *in a litigation context* because, among other reasons, Nationwide did not waive individual defenses (thus rendering certification unmanageable) and counsel for Plaintiffs had an inherent conflict of interest in attempting to simultaneously represent Insured Plaintiffs and Provider Plaintiffs. *See* Da49-57, Da71-73.

prerequisites were not satisfied when a putative class of insurance policyholders attempted to challenge whether the amounts they were paid satisfied the contractual obligation to pay for all "reasonable expenses" for necessary medical treatment:

> Every claimant's accidents and injuries are different and distinct; every health care provider is different and distinct; most of the provider's billing practices are individualized and distinct; each claimant/patient's medical history in unique. The fact that Nationwide's insureds are all allegedly paid at a reduced rate that plaintiffs contend is unreasonably low across the board is not enough to establish typicality: the claims involved are more different, unique, and complex to evaluate than they are alike. The fact that Nationwide used and relied on the New Jersey auto fee schedules, as alleged, to gauge or determine the reasonable reimbursement rate to be paid, is not per se illegal. While there is no legal or enforceable requirement that Nationwide must apply the New Jersey auto fee schedules for health care services provided to out-of-state policy holders, there is no authority that precludes or bars Nationwide from using those schedules as a barometer or measure of reasonableness, or as a factor among other factors to determine reasonableness….
>
> [T]here exist a host of individual issues that relate uniquely to each claimant and his/her individual personal and medical situation and medical history, and treatment regimen. Added to this are the potential dozens of variables that apply without question to the many health care treatment providers involved.
>
> When the issue is to determine what reasonable health costs are or may be, there are a host of factors at play that must be evaluated when considering whether a health care provider's bill is reasonable. Not only factors and variables that apply to the specific health care provider … but also factors that apply to the individual plaintiff/insured: what were the particular circumstances of the patient … such as for example, age, degree of pain or distress, was the patient treated in an emergency setting or a regular follow up

> appointment, was a consult with another provider involved, did the patient have a an agreement or long-standing arrangement or relationship with the health care provider that resulted in discounting the bill and if so to what degree? ….
>
> The claims presented by Plaintiffs and putative plaintiffs in this case are unique and varied; each claim has its own "DNA" and these claims will not be more justly and effectively resolved by using the class action vehicle; to allow these claims to go forward in a class action modality is either to invite a broad-brush one-size-fits-all approach (some would say "sledgehammer" mentality) where—while some claims may be amenable to resolution as a result—it is impossible to visualize how the majority of claims could be reviewed and resolved short of having mini-trials or plenary hearings as to each claim. This probability derails the class action train.

Pa24-25, Pa26, Pa28, Pa31. Judge McGovern's well-reasoned opinion overwhelmingly satisfies the "rigorous analysis" standard by comprehensively considering an extensive record of facts, exhibits, testimony, and expert reports submitted by both parties. Pa24-25, Pa26, Pa28, Pa31.

STATEMENT OF FACTS

1. Plaintiffs Karen Sibalich And Margaret Owens

Sibalich and Owens were insured under PIP policies underwritten respectively by Nationwide Affinity Insurance Company of America and Nationwide Property and Casualty Insurance Company. Pa470-520; Pa413-68. They were injured in separate car accidents. Pa257. Both sought treatment from the now-dismissed Provider Plaintiffs. Pa126-127. Only some of the treatment rendered to Sibalich was the same as that rendered to Owens. *See* Pa1689.

Their medical providers billed Nationwide for various treatments. *See* Pa1740. Nationwide's payments for the treatments ran the gamut of possibilities: some were paid according to recommendations in the Fee Schedule; some were paid more than the Fee Schedule, but not the full billed amount; and some were paid less than the Fee Schedule. *See* Pa1740. Additionally, Nationwide paid for some of the treatments at the full billed amounts.[5]

2. The Dismissed Provider Plaintiffs: Spine Surgery Associates And Ambulatory Surgical Center Of Somerset

Provider Plaintiffs SSA and ASCS were originally co-Plaintiffs in this case along with Sibalich and Owens (*i.e.,* the Insured Plaintiffs). *See* Da6-23. All claims prosecuted by the Insured Plaintiffs Sibalich and Owens arose out of the medical bills that SSA and ASCS issued to them. Pa261, 265. Nationwide successfully moved to dismiss all claims asserted by SSA and ASCS. Da7.

a. The Providers Used An Array Of Vendors And Bespoke Methodologies To Set Pricing, And Contend Their Services Were Priced Reasonably, Despite Being *Higher Than FH80*

Provider Plaintiffs SSA and ASCS used different third-party vendors, who relied on different data sources and methodologies, to set pricing for medical services. *See, e.g.*, Pa1650; Pa1653; Pa1681-83. SSA relied upon data from

[5] *See, e.g.,* Pa1721-22 (provider charged and Nationwide paid $4,043 for Sibalich treatment); Pa1712-13 (provider charged and Nationwide paid $166 for Owens treatment).

third-party vendor Optum360 to arrive at its prices. Pa1650. Optum360 used data obtained from Fair Health, Inc. Pa1653. [redacted] CPa1381-82, CPa1384; *see also* Pa1232; Pa1657. ASCS used four separate vendors to assist with its pricing. *See* Pa1681-83. ASCS also reviews, on an *ad hoc* basis, Explanations of Benefits (EOBs) generated by other surgical centers and area hospitals, such as Robert Wood Johnson and Morristown Medical Center. Pa1211-16; Pa1679.

Regardless of pricing vendor, both Provider Plaintiffs testified that pricing decisions ultimately come from the owners of the practices, Drs. James Dwyer and Paul Vessa. Pa1650. Currently, the Provider Plaintiffs set their prices at the 95th percentile of usual, customary, and reasonable (UCR) rates as determined by Fair Health—but that has not always been the case. Pa1651; Pa1666. The providers decided to increase their pricing to the 95th percentile due to "the physician's reputation, experience and skill set, and their length of time in the profession" but admitted that no one at their organizations had ever

done any systematic research to support the selection of the 95th percentile. Pa1651-52; Pa1678-79. The Provider Plaintiffs *do not contend* that all of their competitors can justify charges at the 95th percentile—or even the 80th percentile. *See* Pa1670; Pa1139. On the contrary, the Provider Plaintiffs believe they are uniquely qualified to charge at the 95th percentile based on their expertise and skill, but other providers who are less-qualified might have to charge "reasonable prices" at a much lower percentile (even as low as the 25th percentile). *Id*. The Provider Plaintiffs acknowledged there exists a "range of reasonableness" spanning from the 80th to the 95th percentile. Pa1139-41.

b. The Provider Plaintiffs Have Materially-Different Assignment Forms

Prior to Sibalich and Owens receiving medical treatment, [redacted] *See* CDa1-24. By contrast, ASCS has an entirely different set of forms, which were never even signed. Da14. At SSA, the trial court found, neither Sibalich nor Owens executed a *valid* assignment of benefits, nor otherwise conveyed the right to sue. *Id.* At ASCS, the trial court found, neither Sibalich nor Owens executed *any* assignment of benefits or right to sue. *Id*. Accordingly, the trial court ruled that the "assignment of benefit" forms were materially deficient, and did not legally amount to an assignment of rights from Plaintiffs to their medical providers. Da22.

c. The Provider Plaintiffs Follow Different Practices In Collecting Payment Balances From Patients, And Deciding Whether To "Balance Bill"

If an insurer does not pay the medical bill at the amount set by the provider, the provider determines whether to bill the patient for the difference, otherwise known as "balance billing." *See* Pa1667. ASCS makes balance billing decisions on a "case-by-case basis," dependent on various factors such as patient hardship, individual installment or partial-pay arrangements, or familial relationships with the doctors in the practice. Pa1667. SSA regularly issues balance bills to patients, and did so in this case. Pa1756-58; Pa1760-61. SSA and ASCS also engage in collection practices, sometimes hiring attorneys to collect full unpaid balances. Pa1658; Pa1680. Plaintiffs' expert *conceded* that fee collection data is relevant to reasonableness in certain circumstances. Pa1469-71.

3. The Policies Issued to Sibalich and Owens

Sibalich purchased policy number 5837E 222653 from Nationwide Affinity Insurance Company of America, insuring four motor vehicles, for the policy period November 25, 2015 to January 25, 2016; and Plaintiff Margaret Owens purchased policy number 5837E 443009 from Nationwide Property and Casualty Insurance Company, insuring a motor vehicle for the policy period August 2, 2016 to January 15, 2017. Pa470-520; Pa413-68. The Sibalich and Owens insurance policies (collectively, the "Policies") both explicitly specify

that they are issued pursuant to the Pennsylvania Motor Vehicle Financial Responsibility Law ("MVFRL"). Pa438; Pa497. The relevant language of the First Party Benefits provision of the Policies provides in part, "**Option 1—Medical Benefit We** will pay all reasonable expenses for **necessary medical treatment and rehabilitative services**." Pa438; Pa497-98.

4. Nationwide Has An Individualized Claims Adjustment Process That *Does Not Entail* Uniform Payments According To The Fee Schedule, As Reflected By The Payments On The Sibalich And Owens Claims.

Nationwide contracts with a third-party vendor called [redacted] CPa1574. [redacted] CPa1575. When a medical provider generates a bill for treatment rendered to a Nationwide policyholder or other potentially covered claimant, the provider mails its bill and [redacted] CPa1576.

Nationwide's adjusters have access to the data regarding individual policyholders and other potentially covered claimants and their respective claims via [redacted] CPa1577. [redacted] *Id.* [redacted] *Id.* [redacted] *Id.* [redacted] *Id.* [redacted] *Id.* [redacted] *Id.* [redacted] *Id.*

The payment of the Sibalich and Owens medical bills demonstrates Nationwide's individualized claim adjustment process. *See* Pa1740; Pa1712-13; Pa1721-22. Nationwide paid some of the bills using the recommended payment amounts in the Fee Schedule, some at amounts *greater than* the Fee Schedule,

and some less than the Fee Schedule. *See* Pa1740. Sometimes, Nationwide paid *at the full billed amounts*, which was set at the 95th percentile. *See* Pa1712-13; Pa1721-22 (provider charged $4,043; Nationwide paid $4,043). [redacted] CPa327; CPa362 CPa278.

LEGAL ARGUMENT

1. STANDARD OF REVIEW

"Class certification decisions rest [o]n the sound discretion of the trial court." *Myska v. New Jersey Mfrs. Ins. Co.*, 440 N.J. Super. 458, 474 (App. Div. 2015) (citation omitted). "[T]he [trial] court must undertake a 'rigorous analysis' to ascertain whether the requirements for certification have been met." *Goasdone*, 354 N.J. Super. at 527 (citation omitted). In reviewing a denial of class certification, the appellate court need simply "ascertain whether the trial court has followed [Rule 4:32-1(b)(3)'s] standards and properly exercised its discretion." *Id.* (citation omitted). An abuse of discretion arises only "when a decision is made without a rational explanation, inexplicably departed from established policies, or rested on an impermissible basis." *Id.*(citation omitted).[6]

[6] Additionally, Plaintiffs bear the burden to establish all class certification prerequisites in the trial court. *Beegal v. Park West Gallery*, 394 N.J. Super. 98, 109 (App. Div. 2007). Plaintiffs must show *facts* that establish each of the class

Here, the record is clear that the trial court performed the requisite "rigorous analysis," and reached a sound conclusion supported by the facts and record. For all the reasons stated more fully herein, this Court should affirm the trial court's denial of class certification.

2. THE TRIAL COURT PROPERLY FOUND THAT THE PROPOSED CLASS DID NOT SATISFY THE REQUIREMENTS FOR A RULE 4:32-1 (b)(3)[7] CLASS SEEKING MONETARY RELIEF.

Plaintiffs attempted to certify the following class:

> **Insured Class:** All persons insured under motor vehicle insurance policies issued by Nationwide and its underwriting affiliates in the Commonwealth of Pennsylvania who filed or had claims filed on their behalf for first-party PIP benefits for injuries sustained in a motor vehicle accident, whose medical treatment was provided in whole or in part by health care providers located outside of Pennsylvania, and whose first-party PIP benefits for medical treatment or rehabilitative services were paid by Nationwide, directly or through a subsidiary or affiliate, according to a state fee schedule.

Pa12; Pls. Br., p. 6.

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certification requirements by a preponderance of the evidence. *See Dugan v. TGI Fridays, Inc.*, 231 N.J. 24, 49 (2017) (internal citations and quotations omitted) ("a court deciding class certification must undertake a 'rigorous analysis' to determine if the Rule's requirements have been satisfied. That scrutiny requires courts to look beyond the pleadings [to] ... understand the claims, defenses, relevant facts, and applicable substantive law").

[7] Under Rule 4:32-1(b)(3) plaintiffs must satisfy two requirements for a monetary relief class. First, any "questions of law or fact common to the members of the class [must] predominate over any questions affecting only individual members." *Id.* at 539. Second, class adjudication must be "superior to other available methods for the fair and efficient adjudication of the controversy." *Id.*

a. The Trial Court Correctly Found That The Proposed Class Does Not Satisfy Rule 4:32-1(b)(3)'s Predominance Requirement

The predominance inquiry requires a "rigorous analysis" to determine whether questions of law or fact common to the members of the class predominate over any questions affecting only individual members. *Iliadis v. Wal-Mart Stores, Inc.*, 191 N.J. 88, 106 (2007). This entails an examination "beyond the pleadings" to "understand the claims, defenses, relevant facts, and applicable substantive law." *Id.* at 106-07 (citation omitted). The analysis "involves a qualitative assessment of the common and individual questions rather than a mere mathematical quantification of whether there are more of one than the other." *Lee v. Carter-Reed Co.*, 203 N.J. 496, 519-20 (2010). The predominance requirement is "far more demanding" than the requirement in Rule 4:32-l(a)(2) that there be common questions of law or fact. *Castro v. NYT Television,* 384 N.J. Super. 601, 608 (App. Div. 2006) (citation omitted). It is not enough to find common issues—they must *predominate*.

i. The Trial Court Correctly Found That Adjudicating The Claim Of Each Putative Class Member Would Require An Individual Inquiry Into Whether Nationwide's Payment Satisfied The Contractual Obligation To Pay For All "Reasonable Expenses For Necessary Medical Treatment[,]" Which Precludes Any Finding Of Predominance.

The need to adjudicate the "reasonableness" of medical expenses on an

individual basis reflects the *antithesis* of any predominating common issue.[8]

In *Innovative Physical Therapy,* the plaintiffs raised a challenge to an insurer's use of fee review software when adjusting PIP claims. 2008 WL 4067316 at *2. Plaintiffs attempted to define a putative class of insureds who sustained injuries in a covered occurrence, and who: (a) submitted first-party claims for payment of medical expenses; (b) had their claim submitted to computer fee review; (c) received payment in an amount less than the submitted medical charge, but greater than zero, based on a fee review reduction code (such as 41 or X41); and (d) at time of payment, policy limits were not exhausted. *Id.* Like Plaintiffs in the present case, the plaintiffs in *Innovative Physical Therapy* argued that a class could be certified because they were supposedly "not challenging the individual determinations of reasonableness for the claims of individual class members, but the *uniform process* that Defendants apply to all

[8] *See, e.g.*, *Atlantic Ambulance Corp. v. Cullum*, 451 N.J. Super. 247, 261 (App. Div. 2017) ("[D]enial of class certification for the breach of contract claim on behalf of the Cullum class, challenging the reasonableness of fees charged by Atlantic, was proper."); *Innovative Physical Therapy, Inc. v. Metlife Auto & Home*, No. 07-5446, 2008 WL 4067316, at *10 (D.N.J. Aug. 26, 2008), *aff'd on other grounds, St. Louis Park Chiropractic, P.A. v. Fed. Ins. Co.*, 342 Fed. App'x 809 (3d Cir. 2009). Because Rule 4:32-1 was "modeled after its federal counterpart Rule 23(a) and (b), federal case law can lend important guidance on the interpretation and application of Rule 4:32-1. *Varacallo v. Massachusetts Mut. Life Ins. Co.*, 332 N.J. Super. 31, 41 (App. Div. 2000); *Goasdone*, 354 N.J. Super. at 528. *See also* Pressler & Verniero, Comment to R. 4:32 (noting that New Jersey class action rules "conform, in significant part, to Rule 23 of the Federal Rules of Civil Procedure.").

claims." *Id.* at *9 (emphasis added) (citation omitted). The court rejected plaintiffs' position, explaining that no class could be certified based on the need for individual reasonableness determinations:

> [A]lthough some courts have held that medical review tools may be questioned, *they cannot be addressed in a class-based proceeding because an individualized evaluation must be conducted in determining the reasonableness and necessity of medical bills*…. Additionally, the Court considers that because class membership could potentially include individual insureds, solo practitioners, group practitioners, or other types of medical providers, individual inquiries into what is *"reasonable" for each type of insured or medical provider seeking reimbursement would be necessary*.

Id. at 10, fn.10 (emphasis added).

The same logic of *Innovative Physical Therapy* applies here. Just as the court found that individual reasonableness inquiries would be necessary based on the nature of the provider's practice, so too would such inquiries be necessary here, which defeats predominance. *See also Advanced Acupuncture*, 2008 WL 4056244, at *13 (dismissing class allegations on same grounds as *Innovative Physical Therapy*). The reasoning employed in *Innovative Physical Therapy* and *Advanced Acupuncture* has been repeatedly followed in similar cases throughout the country, and case-after-case has denied certification based on similar lack of predominance where individual issues of reasonable medical

expenses are at issue.[9]

These cases reflect just a few examples where courts found class treatment to be improper in suits challenging reasonableness of medical expenses.[10]

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[9] *See, e.g., DWFII Corp. v. State Farm Mut. Auto. Ins. Co.*, 271 F.R.D. 676, 683-84 (S.D. Fla. 2010), *aff'd*, 469 Fed. App'x 762 (11th Cir. 2012) (internal citations omitted) (each plaintiff would have to individually prove "that the insured had valid insurance coverage and his benefits were unexhausted, that the provider actually performed the services for which it billed; that the treatment(s) the provider performed was medically necessary…, that the provider billed for reasonable amount[s] …, and that the bill the provider submitted was properly completed."); *Gloria v. Allstate Cnty. Mut. Ins. Co.*, C/A SA-99-CA-676-PM, 2000 WL 35754563, at *9 (W.D. Tex. Sept. 29, 2000) (whether a provider's charge is "reasonable and/or necessary for a particular treatment for a particular injury in a particular location must be determined on an individualized basis" and that "even if plaintiffs prove the computerized evaluation of the PIP claims was flawed the parties and the Court still will need to analyze each charge on every claim for reasonableness and necessity"); *MRI Associates of St. Pete, Inc. v. State Farm Mut. Auto. Ins. Co.*, 755 F. Supp. 2d 1205, 1208 (M.D. Fla. 2010) (because the calculation of a reasonable amount would vary "based on many factors specific to the individual claim," the court found "[t]he evaluation of a reasonable amount rests on an examination of the various factors on a case-by-case basis and can only be determined by a factfinder…. [And] different fact-finders may reach different conclusions from the same facts"); *Premier Open MRI v. Allstate Ins. Co*., No. 16-2003-CA-004498, 2005 WL 6058681, at *1 (Cir. Ct. Duval Cty. Fla. Jan. 7, 2005) (where plaintiffs raised a challenge to the defendant insurers' alleged refusal to pay for certain PIP benefits involving magnetic resonance imaging services ("MRIs"), the court denied certification based on the need for individual adjudication of reasonableness, because "the trier of fact would need to review the particular facts and circumstances associated with the rendering and billing of each MRI service by the class members," and the "need for these individualized evidentiary inquiries … will predominate over any issues common to the class as a whole.").

[10] *See also, e.g., Halvorson v. Auto-Owners Ins. Co.*, 718 F.3d 773, 779 (8th Cir. 2013) ("Here, the individual questions necessary to determine breach of contract and bad faith include whether a provider's charge was usual and customary and, thus, whether the claim payment was reasonable. These individual inquiries

Plaintiffs offered no basis to deviate from this expansive body of cases. Plaintiffs also did not dispute the factors relevant to assessing reasonableness, including: the expertise, skill level, and years of practice experience of the medical provider;[11] the average amounts actually collected by the medical provider;[12] and patient expectations, the value of services provided, typical

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regarding what is 'usual and customary' for each class member will predominate over whether Auto–Owners's process was reasonable and 'overwhelm questions common to the class.'"); *Ross-Randolph v. Allstate Ins. Co.*, No. DKC-99-3344, 2001 WL 36042162, at *6 (D. Md. May 11, 2001) (dismissing class allegations based upon conclusion that any inquiry into denial of PIP benefits necessarily required a fact finder to make individualized determinations on a number of issues as to each purported class member); *Johnson v. GEICO Cas. Co*., 310 F.R.D. 246, 255 (D. Del. 2015), *aff'd*, 672 Fed, App'x 150 (3d Cir. Nov. 29, 2016) (finding class treatment unworkable where each individualized determination "would include, at a minimum, whether the PIP claim was for reasonable and necessary medical expenses."); *Ostrof v. State Farm Mut. Auto. Ins. Co*., 200 F.R.D. 521, 531 (D. Md. 2001) (same; further noting "[c]onsistently in such cases courts have found individualized inquiries to predominate and have declined certification.").

[11] Provider Plaintiffs testified that they justified the supposed reasonableness of their fees by their skill and expertise. *See, e.g*., Pa1238-39 ("[W]hen a surgeon sets their cost, or sets their fees, they incorporate the difficulty of the work that's done, the risk that's taken on.… Every doctor sort of determines what his fee is going to be[.]"); Pa1670 (testifying that some medical providers should charge at a lower rate based on comparatively-lower complexity or experience); *see also* Pa1653-65; Pa1654.

[12] Plaintiffs' expert *conceded* that fee collection data is relevant to reasonableness in certain circumstances. *See, e.g.* Pa1469-71 (Deposition of Plaintiffs' expert Dr. Ronald Luke) (Q. Have you ever considered payment or collection data in your assessment of reasonableness? … A. I thought it was a reasonable approach [.]"). *See also,* Pa1690-91 (Nationwide's Expert Report of Lamar Blount at 3-4, ¶ 11 ("Nationwide paid [Sibalich and Owens] 100% and 113%, respectively of the expected average collection amounts" for their claims).

payor practices, local market competition, administration expenses, practice costs, and equitable profit[13].

Apart from the threshold adjudication of reasonableness, the trial court would additionally need to address ancillary considerations for every claim, such as: whether Nationwide implemented adjustments beyond the Fee Schedule (*e.g.*, NCCI edits, PPO agreements, or guidelines from the Centers for Medicare and Medicaid Services (CMS)); whether payment under the Fee Schedule reflects payment-as-billed; whether policy limits were reached; and whether the claim was submitted to a Peer Review Organization to determine whether all or a portion of the medical treatment was necessary. Other ancillary considerations the trial court would need to address include whether the insured executed an

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The New Jersey Appellate Division has repeatedly held that bill collections are relevant to "reasonableness." *See, e.g., In re Adoption of N.J.A.C. 11:3-29*, 410 N.J. Super. at 39 ("We found that paid fees have diverged significantly from billed fees, making paid fees *a much more accurate measure of 'reasonable and prevailing fees.*'") (citations and quotation marks omitted, emphasis added).

[13] Nationwide submitted, and the trial court considered, evidence regarding the relevance of all these factors. [redacted] CPa1381-82, CPa1384.

assignment of benefits in favor of the provider, and if so, whether that assignment is legally binding; whether the provider, after receiving payment from Nationwide at less than billed, issued a deficiency bill to the insured for the remaining amount allegedly owed (*i.e.* whether the provider "balance billed" the insured)—and whether the patient paid any additional amounts in response to the balance bill; whether the provider, after receiving payment from Nationwide, wrote-off the balance, or pursued third party collection; and whether the provider and the patient reached any negotiated compromises to resolve the bill for less than its face value.

Further ancillary considerations include whether there is a conflict of interest between the insured and the provider in the event of an adjudication that additional amounts are owed under a PIP claim—especially where direct payment to the provider may erode or exhaust the insured's PIP coverage limit, leaving the insured with less coverage (or no coverage) for additional medical expenses;[14] and whether Plaintiffs' attempt to certify a multistate class *beyond New Jersey*, extending to medical treatments in unidentified states with fee

[14] This consideration is especially relevant where the current counsel for all original Plaintiffs (*i.e.*, Insured Plaintiffs *and* Provider Plaintiffs) purport to somehow simultaneously represent *both* insureds *and* providers who are competing to seek collection of the same funds from Nationwide.

schedules, would raise variations among state laws that would be unmanageable to adjudicate on a class basis.

The trial court correctly recognized that all of these considerations call for individual inquiries that destroy predominance.

ii. The Trial Court Properly Found That Adjudicating The Claim Of Each Putative Class Member Would Additionally Require An Individual Inquiry Into The Status Of The Provider-Insured Transaction.

The trial court also correctly recognized that, after resolving who has the right to prosecute a claim for payment of each medical bill for every PIP claim at issue,[15] then the trial court would need to assess whether each medical provider "balance billed" its patients, *i.e.*, issued a deficiency bill for any remaining amounts allegedly owed, or whether the provider instead discounted or wrote-off the bill in some manner. *See* Pa28. Here, the Provider Plaintiffs acknowledged that they do balance bill—but only in some circumstances.[16]

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[15] The trial court correctly recognized that adjudicating the claim of each class member would require the court to consider the status of the transaction between the policyholders and their medical providers with respect to each bill. *See* Pa30. This necessarily includes the potential *existence* of an assignment of benefits, and the *validity* of any such assignment. *See* Da22 ("[T]here appears to be no basis for claims by the Provider Plaintiffs *in the absence of an executed Assignment of Benefits*.") (emphasis added).

[16] One provider testified that it balanced billed on a "case-by-case" basis, with many factors influencing the decision, including familial relationships, patient hardship, and prior financial arrangements. Pa1667. The other provider also balance billed, based on "individualized circumstances for each claim," including financial hardship, pre-determined payment plans, and whether any

The status of any balance billing is integral to determining which party (if any) has the right to pursue and receive any additional amounts that might be determined to be owed on each PIP claim. If a provider accepted the amount paid on the PIP claim, and never issued a balance bill to the policyholder for a particular treatment, then is either the policyholder or the provider entitled to any further amounts? How would the trial court adjudicate circumstances where the provider accepted payment on the PIP claim, issued a balance bill to the policyholder, and then the patient paid *some* but not *all* of the balance? How would the results be affected by third party collection activity, negotiated compromises, write-offs, and assignments of benefits?

In sum, even if Plaintiffs theory of uniform "reasonableness" at the 80th percentile (*i.e.*, FH80) were otherwise workable, Plaintiffs never identified any method for the trial court to determine, on a systematic or class-wide basis, the

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available insurer appeals have been exhausted. Pa1655-56. SSA balance billed both Sibalich and Owens. *See* Pa1756-58 (showing "balance" of $22,025.40); Pa1760-61 (showing "balance" of $13,782.15). The particular facts concerning the Insured Plaintiffs and the Provider Plaintiffs illustrate the complexities of assignments, balance billing, and collections. *See* Pa1658 ("We found it better to utilize attorneys, to assist us in making the appropriate collections"); *see also* Pa1680 (regarding ASCS's collection efforts). ASCS admitted that, when negotiating with insured plaintiffs, *it sometimes waives the right to sue the insurer* in exchange for an agreement by the insured patient to pay a specific amount. Pa1684 ("Q. And in return for the carrier agreeing to pay a negotiated amount, Ambulatory gives up its right to further pursue that insurance carrier, right? A. Yeah, I believe so.").

amount purportedly owed under the policy, and the party to whom it is allegedly owed. This reflects a telling concession that the task is not possible in light of balance-billing, negotiated compromises between medical providers and insured patients, third party collection activity, write-offs, and assignments of benefits. Moreover, most of the relevant information—if not all of it—*would not even be contained in Nationwide's claim files*,[17] and thus would necessitate extrinsic claim-by-claim investigations. *See* Pa1667; Pa1655-56. The trial court acknowledged that these inherent problems destroy any finding of predominance and preclude certification. *See* Pa31.

b. Plaintiffs Cannot Overcome Inherent Problems With Predominance By Requesting The Court To Impose An Across-The-Board Standard For "Reasonable Expenses" Based On Extrinsic Evidence or "Course Of Performance."

Plaintiffs argue that the Court should ignore any individual issues, and should instead impose a uniform "reasonableness" standard of FH80, because Nationwide has sometimes applied that standard in some states with *no applicable fee schedule* (*i.e.*, outside of New Jersey); and for some medical procedures that are *not covered by any fee schedule*. Notably, the FH80 standard

[17] *See* Pa1685 (describing Pa1763 as a communication between dual pricing/collection vendor and provider "inquiring about specific action to take on a particularly large accounts receivable, and how each individual doctor wants to instruct the staff to proceed" but making no reference to insurer involvement).

advocated by Plaintiffs *does not appear in any of Nationwide's policy documents or correspondence with claimants or medical providers*. Nevertheless, Plaintiffs dwell at length on the PIP claims adjustment practices that Nationwide allegedly applies to those claims that are *not included in the class definition. See, e.g.* Pls. Br., p. 9 ("When neither a PPO agreement *nor a state fee scheduled applies*, Nationwide's automated rules default the payment to its 'reasonable fee' rule") (emphasis added). Thus, Plaintiffs assertion that "reasonable expenses" must *always* mean FH80, and *any* payment below that threshold supposedly constitutes breach of contract, relies on extrinsic evidence. However, Plaintiffs' position on extrinsic evidence is plainly wrong under Pennsylvania law.

i. There Is No Ambiguity In The Nationwide Policies That Would Give Rise To Consideration Of Extrinsic Evidence.

The Policies at issue here were issued in Pennsylvania to Pennsylvania policyholders, and Pennsylvania law governs their interpretation. Pls. Br., pp. 1-2. The "primary goal in interpreting a policy, as with interpreting any contract, is to ascertain the parties' intentions as manifested by the policy's terms." *Kvaerner Metals Div. of Kvaerner U.S., Inc. v. Com. Union Ins. Co.*, 589 Pa. 317, 331 (2006) (citation omitted). "When the language of a contract is unambiguous, [the court] must interpret its meaning solely from the contents within its four corners, consistent with its plainly expressed intent." *Seven Springs Farm, Inc. v. Croker*, 748 A.2d 740, 744 (Pa. Super. 2000) (*en banc*),

aff'd, 801 A.2d 1212 (2002) (citation omitted). When language is unambiguous, the court "may not consider extrinsic evidence." *Id.* "A contract is not ambiguous merely because the parties do not agree on its construction." *Id*. "An insurance policy provision is ambiguous only if it is 'reasonably' susceptible of more than one meaning." *Riccio v. Am. Republic Ins. Co.*, 453 Pa. Super. 364, 377 (1996), *aff'd*, 550 Pa. 254 (1997) (citation omitted). "Courts should read policy provisions to avoid ambiguities, if possible, and not torture language to create them." *Id.* (citation and quotations omitted).

To the extent Plaintiffs argue that the phrase "reasonable expenses" invites consideration of extrinsic evidence because it is undefined, Pennsylvania law holds that, "[w]ords of common usage in an insurance policy are construed according to their natural, plain, and ordinary sense." *Kvaerner*, 589 Pa. at 332–33. [18] Under its plain meaning, the term "reasonable" is clear and unambiguous—indeed, courts interpreting *the New Jersey Fee Schedule* use the term "reasonable" to characterize the fees therein.[19]

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[18] Further, the court "may consult the dictionary definition of a word to determine its ordinary usage." *Id.* at 333. Black's Law Dictionary defines "reasonable" as "fair, proper, or moderate under the circumstances; sensible." *Black's Law Dictionary* (11th ed. 2019).

[19] *See New Jersey Healthcare Coal.*, 440 N.J. Super. at 134 (Fee Schedule reflects "reasonable and prevailing fees"); *In re Adoption of N.J.A.C. 11:3-29*, 410 N.J. Super. at 25-37 (same); *Univ. Physicians Assocs. v. Transp. Drivers, Inc.*, No. A-3350-15T2, 2017 WL 3597249, at *1-*4 (App. Div. Aug. 22, 2017) (where insurer allegedly paid providers at the 75th percentile as the industry

Thus, Plaintiffs' contention that extrinsic evidence from other states renders Nationwide automatically liable for breach of contract whenever Nationwide uses the New Jersey Fee Schedule as an indicator of "reasonable expenses" for medical treatment provided by New Jersey providers simply makes no sense. *See* Pa25. In absence of any ambiguity, Plaintiffs identify no basis to consider practices on PIP claims that are *not included within the putative class*, of which the Plaintiffs would not even have any knowledge.[20]

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standard in New Jersey, and plaintiffs insureds sought payment at the 95th percentile as "usual, customary, and reasonable (UCR)," the Appellate Division held that *actually paid fees* in the New Jersey Fee Schedule—rather than the *billed* fees—represented a more accurate measure of "reasonable and prevailing fees.") (citing N.J.S.A. 39:6A–4.6).

[20] Under Pennsylvania law, Plaintiffs also cannot argue that consideration of extrinsic evidence is permissible to determine *whether* a policy term is ambiguous. Pennsylvania law permits use of extrinsic evidence only in two limited circumstances—(i) trade usage in a commercial contract, and (ii) latent ambiguities. *Artesian Water Co. v. Chester Water Auth.*, No. CIV.A. 10-7453, 2012 WL 3029689, at *4 (E.D. Pa. July 24, 2012). Neither situation applies here. First, the Nationwide Policies are not commercial contracts for the sale of goods. *See Call v. Czaplicki*, No. CIV. 09-6561, 2010 WL 3724275, at *12 (D.N.J. Sept. 16, 2010). Second, there is no latent ambiguity in the Policy. Under Pennsylvania law, "[a] latent ambiguity in a contract 'arises from extraneous or collateral facts which make the meaning of a written agreement uncertain although the language thereof, on its face, appears clear and unambiguous.'" *Artesian Water Co.*, 2012 WL 3029689, at *4. Pennsylvania courts apply a narrow interpretation of "latent ambiguity"—the inquiry "must be about the parties' 'linguistic reference' rather than about their expectations." *Selective Way Ins. Co. v. RHJ Med. Ctr., Inc*., No. CIV.A. 06-1211, 2008 WL 5156078, at *6 (W.D. Pa. Dec. 8, 2008) (citations omitted). As used in the Nationwide Policies, the term "reasonable" is not ambiguous, and indeed respects the interpretation of the Fee Schedule by New Jersey courts, as well as the applicable fee schedule of the states where policies are issued. *See New*

ii. "Course Of Performance" Evidence Is Limited To The *Specific Contract At Issue*.

Plaintiffs assert that the trial court should have considered Nationwide's "course of performance"—*but not* with respect to the Sibalich and Owens PIP claims, and *not* with respect to any other PIP claims that Nationwide adjusted for medical treatment provided in New Jersey and covered by the Fee Schedule. Rather, Plaintiffs assert that the trial court should have instead focused on Nationwide's alleged "course of performance" *outside of* New Jersey, and for medical treatments that are *not* otherwise subject to the Fee Schedule. *See* Pls. Br., p. 33. This directly conflicts with Pennsylvania law, which allows courts to consider a party's course of performance only in connection with parties to the specific contract at issue, to better understand a contract term.[21] The three

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Jersey Healthcare Coal., 440 N.J. Super. at 134 (Fee Schedule reflects "reasonable and prevailing fees"); *In re Adoption of N.J.A.C. 11:3-29*, 410 N.J. Super. at 25-37 (same); Pennsylvania Motor Vehicle Financial Responsibility Law ("MVFRL") § 1712(1) (addressing "coverage to provide for *reasonable* and necessary medical treatment and rehabilitative services").

[21] *See Com. ex rel. Kane v. UPMC*, 634 Pa. 97, 135 (Pa. 2015) ("a party's *performance under the terms of a contract* is evidence of the meaning of those terms") (emphasis added); *see also Matthews v. Unisource Worldwide, Inc.*, 748 A.2d 219, 222 (2000) ("[T]he course of the parties' performance *under a contract* is always relevant in interpreting that contract.") (emphasis added). Secondary sources confirm this governing principle. *See* 5 Corbin on Contracts §§ 24.16, 24.17 (2021) ("In the process of interpreting a contract, the court can receive great assistance from the interpreting statements made by the parties themselves or *from their conduct in rendering or in receiving performance under it*…. The parties' conduct *under similar, prior contracts with each other* can be of great assistance to a court which must determine the parties' intended

Pennsylvania cases cited by Plaintiffs (Pls. Br., pp. 33-36) *do not* support the notion that, in the face of unambiguous terms, courts nevertheless examine a general "course of dealing" with respect to third parties outside the contract (*i.e.*, persons falling outside the putative class).[22] Moreover, if the language of the contract is clear—as in the present case—then Pennsylvania law directs courts to eschew "course of conduct" evidence completely.[23]

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meaning when they formed the contract currently being interpreted.") (emphasis added).

[22] *See Brooks v. Educators Mut. Life Ins. Co.*, 206 F.R.D. 96, 104 (E.D. Pa. 2002) (court *did not consider* "course of performance evidence," and instead found a common question of law or fact based on historical practices limited to the putative class and their own insurance policies); *Smith v. Life Investors Ins. Co. of Am.*, 2009 WL 3756911, at *6-8 (W.D. Pa. Nov. 6, 2009) (consideration of "trade usage" and "course of performance" arose only due to ambiguous policy language); *Atl. Richfield v. Razumic*, 390 A.2d 736, 741 n.6 (Pa. 1978) (Pls. Br., p. 33) (court considered course of performance *between the two parties to the contract*) (quoting Restatement (Second) of Contracts, § 228 cmt. g).

[23] *See Connelly Constr. Corp. v. Travelers Cas. & Sur. Co. of Am.,* No. CV 16-555, 2018 WL 2091417, at *4 (E.D. Pa. May 3, 2018) (citations omitted) (course of conduct evidence not considered when plain language of contract was clear); *see also Gior G.P., Inc. v. Waterfront Square Reef, LLC*, 202 A.3d 845, 857 (Pa. Commw. Ct. 2019) (contract language was "clear as a bell" so the court need not have considered the course of conduct to ascertain the intention of the parties). Even if it were appropriate to consider the "course of conduct," that would support Nationwide's position, to the extent Nationwide paid medical expenses charged by New Jersey providers according to the Fee Schedule. In other words, Nationwide's conduct *with respect to the putative class that Plaintiffs attempted to certify* would demonstrate Nationwide's belief that the Fee Schedule reflects "reasonableness" for medical treatment in New Jersey.

For all the reasons set forth above, Plaintiffs presented no viable grounds for the Court to uniformly equate "reasonable expenses" at FH80 based on purported ambiguity, extrinsic evidence, or "course of conduct." Rather, the adjudication of "reasonable expenses" would need to consider all the factors referenced earlier, and this precludes any finding of predominance, as recognized by the trial court.

c. A Class Action Is Not A Superior Method Of Resolution Here

The trial court correctly recognized that attempting to resolve the claims here would not only fail the superiority prerequisite, but would be impossible from a practical standpoint.[24]

3. THE TRIAL COURT PROPERLY HELD THAT PLAINTIFFS DO NOT SATISFY THE REQUIREMENTS OF A RULE 4:32-1 (b)(2)[25] CLASS FOR INJUNCTIVE RELIEF

a. Plaintiffs Cannot Certify A Rule 4:32-1(b)(2) Class For Injunctive Relief Because Individualized Issues Predominate

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[24] *See* Pa31; *see also, Johnston v. HBO Film Mgmt., Inc.*, 265 F.3d 178, 194 (3d Cir. 2001) (superiority not established where trial could involve 'countless mini-trials … establishing proof of each of these elements and defenses," and would "present severe manageability problems"); *Kings Choice Neckwear, Inc. v. FedEx Corp*., 2009 WL 689718, at *4 (D.N.J. Mar. 11, 2009).

[25] Class certification under Rule 4:32-1(b)(2) has two requirements. First, the relief sought must be injunctive. Second, the defendant must have acted in a consistent manner towards members of the class so that its actions may be viewed as a pattern of activity. *Goasdone,* 354 N.J. Super. at 531 (citations omitted). The requirement of "cohesiveness" is considered implicit in the second prong of the (b)(2) class. *Id.* at 531.

Under New Jersey law, courts deny (b)(2) requests for class certification when individualized issues predominate over common ones—which the trial court found here. For example, in *Goasdone*, the court explained:

> Courts are reluctant to certify (b)(2) class actions where individual issues are present for two reasons. The first reason is that, unlike (b)(3) class actions, class members cannot opt out of a (b)(2) class; they are bound by the litigation…. Thus, the court must ensure that significant individual issues do not pervade the entire action because it would be unjust to bind absent class members to a negative decision where the class representative's claims present different individual issues than the claims of the absent members present…. The second reason is that the class action would serve little purpose and would become unmanageable if significant individual issues were to arise consistently.

354 N.J. Super. at 533-34.

Accordingly, the same types of individualized issues discussed above that preclude class action treatment under Rule 4:32-1(b)(3) also defeat class action treatment under Rule 4:32-1(b)(2).[26]

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[26] *See e.g., In re Managerial, Prof'l & Tech. Employees*, No. 02-CV-2924 (GEB), 2006 WL 38937, at *6 (D.N.J. Jan. 5, 2006) ("The Court finds that the Proposed Class is not cohesive and therefore fails to satisfy the requirements of subdivision (b)(2). *Plaintiffs' claims raise a number of individualized issues*.") (emphasis added); *Jamie S. v. Milwaukee Pub. Sch*., 668 F.3d 481, 499 (7th Cir. 2012) ("That the plaintiffs have superficially structured their case around a claim for class-wide injunctive and declaratory relief does not satisfy Rule 23(b)(2) if as a substantive matter the relief sought would merely initiate a process through which highly individualized determinations of liability and remedy are made; this kind of relief would be class-wide in name only[.]"); *Ebert v. Gen. Mills, Inc*., 823 F.3d 472, 480-81 (8th Cir. 2016) (finding Rule 23(b)(2) certification improper based on the existence of highly individualized issues).

b. Plaintiffs Also Cannot Certify A Rule 4:32-1(b)(2) Class For Injunctive Relief Because They Primarily Seek Money Damages.

Where the relief sought is entirely or predominately money damages—which is certainly the Plaintiffs' goal in this case[27]—then Rule 4:32-1(b)(2) certification is inappropriate.[28] Moreover, even Plaintiffs' claim for declaratory relief is actually a disguised claim for money. For example, Plaintiffs say they want "Declaratory relief determining Insured Plaintiffs' and Insured Class members' *current and future rights to prompt payments for amounts properly billed* by their health care providers relating to covered motor vehicle accidents and prohibiting Defendant from applying inapplicable fee schedules when determining and paying Insured Class members' claims submitted by them or by members of the Health Care Provider Class." Pa209-11, Count I, "Wherefore" clause (emphasis added).) In other words, the "declaratory relief" that Plaintiffs seek is merely a judicial statement that they are entitled to money

[27] The Third Amended Complaint refers only in passing to declaratory relief, and all the causes of action Plaintiffs seek money damages. *See, e.g.,* Pa209-10, Count I ("Wherefore" clause); Pa215-17, III ("Wherefore" clause); Pa217-19, IV ("Wherefore" clause); Pa211-15, II ("Wherefore" clause).

[28] *See Goasdone*, 354 N.J. Super. at 531-32; *see also Novak v. Home Depot U.S.A., Inc.*, 259 F.R.D. 106, 118 (D.N.J. 2009) (denying class for injunctive relief because the record indicated that plaintiff's main intention was to obtain money damages); *Reap v. Cont'l Cas. Co.*, 199 F.R.D. 536, 548 (D.N.J. 2001) ("monetary relief predominates and precludes certification under 23(b)(2)").

under their preferred standard of FH80. On this basis alone, Plaintiffs' request to certify a (b)(2) class should be denied.

The depositions of proposed class representatives Sibalich and Owens also reveal that the core relief they seek is monetary.[29] Likewise, the depositions of the now-dismissed Provider Plaintiffs also revealed that the core relief sought in the case is monetary. *See* Pa1653; Pa1668.

c. Any Proposed Injunction Regarding The Application Of The Fee Schedule To Insurance Claims Could Not Possibly Satisfy The Prerequisites For Issuing An Injunction

Yet another reason why Plaintiffs cannot satisfy the requirements of a (b)(2) class for injunctive or declaratory relief is that their requested relief is fatally deficient under applicable New Jersey law. Plaintiffs seek a declaration that state fee schedules do not apply to the claims of the members of the putative class, and they seek to enjoin Nationwide from continuing to apply such fee schedules. But Plaintiffs have not sufficiently described the acts it seeks to

[29] *See* Pa838-39 ("A. I would like for my doctors to be paid what is owed them …"); Pa866 ("A. [The case is] for all the people that didn't get their bills paid to the amount that should be paid."); Pa867 ("A. The doctors have not been paid what is owed to them in full."); Pa655 ("Q. So why are you suing Nationwide? A. For my medical bills."); Pa743 at 98:8-11 ("Q. Can you describe for me the class that you are trying to represent? A. All the people who haven't had their medical bills paid by Nationwide."); Pa746 at 101:14-18 (Q. I'm just asking if you can think of any other responsibilities or obligations you have, besides sitting here, as a proposed representative? A. Well, to get my bills paid that Nationwide didn't pay.").

restrain, both from a practical standpoint and under the law.

In New Jersey, Rule 4:52-4 requires that all injunctions must "be specific in terms" and "describe in reasonable detail, and not by reference to the complaint or other document, the act or acts sought to be restrained." Injunctions must therefore be specific and cannot be vague.[30] Here, Plaintiffs have not set forth the specific terms, nor described in reasonable detail, the acts it seeks to restrain Nationwide from doing—nor could Plaintiffs succeed in doing so. Plaintiffs have asked that Nationwide be enjoined from "applying" the Fee Schedule. Does this mean Nationwide would be prohibited from *considering* the Fee Schedule in any way whatsoever? Does this mean Nationwide can never pay the exact amount of the Fee Schedule? Would Nationwide comply with the requested injunction if it were to pay one penny more or less than the Fee Schedule? What if a fee charged for a particular procedure happens to match the amount set forth in the Fee Schedule—would Nationwide violate the injunction by paying it? Due to the vagueness of the

[30] *See State ex rel. Bd. of Health of Saddle Brook Twp. v. Sommers Rendering Co.*, 66 N.J. Super. 334, 342 (App. Div. 1961) (An "injunction should be plain and certain on its face. It should not be vague and uncertain, but should be reasonably specific, so that the person enjoined *may readily know what he must do or refrain from doing*") (emphasis added); *Bituminous Concrete Co. v. Manzo Contracting Co.*, 70 N.J. Super. 102, 107 (App. Div. 1961) ("It is fundamental that an order imposing a restraint should be so clear, definite and certain in its terms that the person to whom it is directed may readily know what he is restrained from doing.").

proposed relief, Nationwide cannot reasonably ascertain what it is being requested to do or refrain from doing. [redacted] *See* CPa1577.

Plaintiffs' request for the trial court to enjoin Nationwide from *even considering* the New Jersey Fee Schedule as *one relevant factor* in adjusting claims of Pennsylvania policyholders who seek treatment in New Jersey is unworkable as both a legal and practical matter. Such an injunction: (a) would conflict with Judge Weaver's ruling that Nationwide "may be able to demonstrate that application of New Jersey's fee schedule … provided reasonable compensation to the Provider Plaintiffs;" (b) would conflict with New Jersey cases holding that the Fee Schedule reflects reasonable fees[31]; (c) would be superfluous, to the extent Plaintiffs are asking the trial court to rule that the Fee Schedule is not legally binding on Pennsylvania policyholders—which is already the law; and (d) would be unsupported by any Nationwide policy language or other legal authority, to the extent Plaintiffs were asking the trial court to mandate that Nationwide reprocess bills at FH80.[32]

[31] *See, e.g.*, *New Jersey Healthcare Coal.*, 440 N.J. Super. at 134; *In re Adoption of N.J.A.C. 11:3-29*, 410 N.J. Super. at 25-37.

[32] Judge McGovern's denial of class certification also highlights why no injunction is appropriate: *See* Pa24-25 ("The fact that Nationwide used and

Simply put, Plaintiffs offered no justification to the trial court—and have failed to do so on appeal—for requesting declaratory relief through a (b)(2) class that would improperly limit Nationwide's performance of its policy obligations, and that would effectively prohibit Nationwide from ever changing its practices in determining reasonableness of medical expenses. For all of these reasons, the trial court properly denied Plaintiffs' Motion to Certify a (b)(2) class.

d. Plaintiffs' Requested "Reprocessing Injunction" Is A Request For Monetary Damages In Disguise; Any "Reprocessing" Raises The Same Individualized Concerns.

Plaintiffs' characterization of their proposed (b)(2) class as simply requesting a "reprocessing" of claims is disingenuous and raises insurmountable obstacles to certification. Under similar facts, courts in New Jersey have *specifically held* that a reprocessing injunction is not appropriate, because it is simply a request for money damages in disguise.[33]

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relied on the New Jersey auto fee schedules, as alleged, to gauge or determine the reasonable reimbursement rate to be paid, is not *per se* illegal.")

[33] *See, e.g.*, *In re Aetna UCR Litig.*, No. 07CV3541KSHCLW, 2018 WL 10419839 at *23 - *25 (D.N.J. June 30, 2018) (where a putative class of policyholder plaintiffs sought to certify a class under Fed. R. Civ. P. 23(b)(2), and requested an injunction that the insurer "reprocess all of the out of network claims in accordance with an actual UCR calculation," the court denied class certification because the "lawsuit was quite evidently about money damages, which can best be viewed through the prism of [plaintiffs'] claim for benefits and breach of contract claim, as well as the complained-of-injuries (underpayments);" and "an injunction would not provide indivisible relief to all class members")*; Lipstein v. UnitedHealth Grp*., 296 F.R.D. 279, 292 (D.N.J. 2013) (denying certification of (b)(2) class and rejecting reprocessing injunction

The cases Plaintiffs cite in support of a (b)(2) reprocessing injunction class are readily distinguishable. Indeed, neither *Brooks v. Educators Mut. Life Ins. Co.*, 206 F.R.D. 96, 105-07 (E.D. Pa. 2002) nor *Generation Changers Church v. Church Mut. Ins. Co.*, 693 F. Supp. 3d 795, 818 (M.D. Tenn. 2023) even involved a reprocessing injunction.[34] And Plaintiffs' reliance on *DeMaria v. Horizon Healthcare Servs., Inc*., No. 11-7298 (WJM), 2015 WL 3460997, at *9 (D.N.J. June 1, 2015) is also misplaced. (Pls. Br., pp. 45-46.) *DeMaria* dealt with the "binary question" of whether chiropractic claims were covered or not, and addressed the reprocessing of those claims which had been *completely denied* by the insurer for lack of coverage. 2015 WL 3460997, at *1. Here, there is no "binary question" of coverage as in *DeMaria.* The logic of *DeMaria* is inapplicable where Plaintiffs argue that all putative class claims are already

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because dispute over policy language was "at its heart, a contract dispute" raising highly individualized results).

[34] *See Brooks*, 206 F.R.D. at 104-07 (E.D. Pa. 2002) (plaintiffs sought only a *forward-looking* injunction "requiring [the insurer] to pay for all *future* anesthesia services based on the reasonable and customary charge as defined in its policies[;]" and the court found that monetary damages *would not need to be calculated on an individualized basis*); *Generation Changers Church v. Church Mut. Ins. Co.*, 693 F. Supp. 3d 795, 818 (M.D. Tenn. 2023) ("[i]f a proposed class action *did* call on an insurer to perform a complete do-over on thousands of claims, then the expense of doing so might pose real workability and predominance problems") (citing *Kartman v. State Farm Mut. Auto. Ins. Co.*, 634 F.3d 883, 893 (7th Cir. 2011)). The *Generation Changers Church* decision is currently on appeal to the United States Court of Appeals for the Sixth Circuit. *See* No. 24-5700 (6th Cir.).

covered, and they seek a reprocessing to pay additional amounts based on a different consideration of "reasonable expenses." Such an exercise would require a determination of which line items on each claim were priced according to the Fee Schedule, whether such adjustments were otherwise "reasonable" under Plaintiffs' proposed alternative, whether the adjuster considered additional factors during payment and pricing of the claim, and whether the adjuster made any changes to the recommended reimbursement amounts. The trial court cannot possibly undertake this exercise on a putative class basis.

Rather than mirror the "binary question" at issue in *DeMaria*, the dispute here is more akin to *In re Aetna UCR Litig.*, which concerned the *amount of payment*, and the individualized issues related to such payments. 2018 WL 10419839 at *25. Like *In re Aetna UCR Litig.*, where the Court denied certification of the (b)(2) reprocessing injunction, the trial court properly denied Plaintiffs demand for reprocessing of all Nationwide PIP claims according to FH80. As Plaintiffs' own expert opined, "reasonableness" is a flexible concept that demands individual consideration.[35]

[35] Pa1486 ("I think there are different data points that the finder of fact could consider in arriving at an opinion on what charge was reasonable. The UCR 80 values is a data point. [The fact finder] could conceivably look at the negotiated rates for a specific provider. They could look at a number of different factors. *There's no one of those factors [that] has to be definitive,* and, ultimately, *the finder of fact would have to synthesize those in their head* and determine what number they wanted to award.") (emphasis added).

With respect to Nationwide's purported *actual ability* to reprocess claims at "FH80," Plaintiffs have not demonstrated that such an exercise would be possible, nor have they cited any policy language, case law, or statutory authority to support such mandate. Plaintiffs point to third party AIS software as purported "proof" that Nationwide could, if it wanted to, supposedly reprocess claims. Pls. Br., pp. 12-13. But Plaintiffs ignore the evidence reflecting that this cannot be achieved other than through an intensely manual effort insusceptible to scaling on a putative class basis.[36] Any suggestion otherwise completely ignores the deposition testimony and exaggerates the discovery sought and obtained—all of which was before the trial court through a robust record. Moreover, even if Nationwide's prior payment amounts at the Fee Schedule level could be somehow scaled upwards to FH80, this would not resolve any of the issues discussed above concerning the *actual amounts allegedly legally owed,* and the entity that may be allegedly entitled to further payment. For all of the above reasons, Plaintiffs cannot satisfy the requirements

[36] For example, when Nationwide responded to Plaintiffs' interrogatories by providing certain percentile values for line items on Plaintiffs' bills, Nationwide explained: "obtaining the requested information would require Nationwide to employ a time-consuming and burdensome manual process, inconsistent with applicable payment rules, policy limits, and other applicable parameters." Pa1393. [redacted] CPa362, CPa1576-79.

for (b)(2) injunctive relief for a "reprocessing injunction" and the trial court correctly declined to certify any such class.

4. THE TRIAL COURT CORRECTLY DETERMINED THAT PLAINTIFFS CANNOT SATISFY THE TYPICALITY REQUIREMENT OF RULE 4:32-1(a).[37]

Under the "typicality" requirement of Rule 4:32-1(a)(3), the "claims of the representative must have the essential characteristics common to the claims of the class." *In re Cadillac V8-6-4 Class Action*, 93 N.J. 412, 425 (1983) (citation omitted). The named representative must be able to establish "the bulk of the elements of each class member's claims when they prove their own claims." *In re Merrill Lynch*, 191 F.R.D. 391, 397–98 (D.N.J. 1999), *aff'd sub nom. Newton v. Merrill Lynch*, 259 F.3d 154 (3d Cir. 2001), *as am.* (Oct. 16, 2001) (citation omitted). "If proof of the representatives' claims could not necessarily prove all of the proposed class members' claims, the representatives are not typical of the proposed members' claims." *Id.* (citations omitted). "The premise of the typicality requirement is simply stated: as goes the claim of the

[37] Before a New Jersey court can certify a class under Rule 4:32-1, the plaintiff must satisfy the four "general prerequisites". First, the class must be "so numerous that joinder of all members is impracticable." (a)(l). Second, there must be "questions of law or fact common to the class." (a)(2). Third, the representative party's claims or defenses must be "typical of the claims or defenses of the class." (a)(3). And, fourth, the representative party must "fairly and adequately protect the interests of the class." (a)(4). The trial court found Plaintiffs' proposed class met commonality and adequacy but not typicality. Pa24.

named plaintiff, so go the claims of the class." *Broussard v. Meineke Disc. Muffler Shops, Inc.*, 155 F.3d 331, 340 (4th Cir. 1998) (citation omitted). As the District of New Jersey held specifically in the context of entitlement to insurance benefits, "proof of a right to recovery under one contract does not necessarily establish a classwide right to recovery." *Agostino v. Quest Diagnostics*, 256 F.R.D. 437, 467 (D.N.J. 2009), *ovrld on o.g., Maniscalco v. Brother Intern. (USA) Corp.*, 709 F.3d 202, 207–08 (3d Cir. 2013).[38]

Plaintiffs assert the typicality prong is satisfied because Sibalich and Owens allegedly have essential characteristics common to the claims of other putative class members. But even if the Court were to find that the amounts paid by Nationwide on Plaintiffs' claims fell less than the standard of

[38] With respect to typicality, Plaintiffs inexplicably cite *Schiff v. Liberty Mutual Fire Insurance Co.*, 542 P.3d 1002 (Wash. 2024) (*see* Pls. Br., pp. 22-23), which offers no support. As a threshold matter, the court in *Schiff* held that the insurer's practice of determining reasonableness by using a third-party database to ascertain whether medical bills fell below the 80th percentile *was not an unfair practice*, and *did not violate* the "all reasonable and necessary" requirement under Washington's PIP statutes. *Schiff*, 542 P.3d at 1004. Second, the *Schiff* court *did not hold* that a "formulaic approach" could serve as the proper means for determining reasonableness. *See id.* at 1007. Instead, the Washington Supreme Court held that the insurer's formulaic approach *did not violate* the Washington Consumer Protection Act, though the court declined to opine on whether such an approach was the *only* appropriate method to determine reasonableness. *See id.* Moreover, the court rejected a lower court decision mandating a claim-by-claim review in lieu of a formulaic review process. *Id.* at 1007-08. Thus, *Schiff* has nothing to do with typicality.

"reasonable expenses for necessary medical treatment" due to the facts and circumstances unique to their injury, treatment, and medical provider—that does not mean that *any other* putative class member would recover. The trial court would still need to adjudicate reasonableness and entitlement to recovery on an individual claim-by-claim basis, which defeats typicality.

This lack of typicality was amply reflected in the extensive record before the trial court, which correctly held that class certification should also be denied because the Plaintiffs' claims are not typical of the putative class, Pa24:

- Nationwide did not apply the Fee Schedule to all of Plaintiffs' medical claims. Some claims were paid at amounts *higher than the Fee Schedule*, and some were paid as billed. *See* Pa1740; Pa1721-22.

- SSA and ASCS relied on third-party pricing data vendor Optum360. Optum360 uses pricing data from Fair Health, Inc. Other providers might use different pricing data vendors and different methodologies to arrive at different price-points, which is relevant to reasonableness. Pa1650; 1653; 1670. *See also* Pa1139-41.

- ASCS relied on several third-party vendors, among them a "Mr. Johnson of Seattle," Murphy Healthcare Group, National Medical Billing, Surgical Notes, and other sources such as their own patients' hospital bills, to arrive at their prices for services. Pa1666, Pa1681-83.

- During the putative class period, SSA and ASCS did not charge for their own services at any single percentile, but rather they *continuously increased* their charges relative to a Fair Health percentile, which further complicates any reasonableness assessment. Pa1651-52; Pa1678-79.

- Provider Plaintiffs (a) sometimes balance-billed; (b) sometimes did not balance bill "unpaid" portions of claims; (c) sometimes negotiated reduced payment, or unilaterally took a write-off; (d) sometimes pursued collections through an attorney or collection agency; and (e) sometimes

issued an aggregate "superbill" telling a patient what it could possibly owe. *See* Pa1658; Pa1680.

- Nationwide submitted a portion of the Sibalich bill to a Peer Review Organization (PRO), contesting the necessity of treatment. Pa1748-54.

Based on the above considerations, regardless of how claims may be adjudicated for Plaintiffs, the outcome cannot be determinative for any other member of the putative classes—and therefore the typicality requirement is fatally lacking under Rule 4:32-1(a)(3). *See* Pa24. For the above reasons, Plaintiffs failed to meet the requirements of Rule 4:32, and the trial court was correct to deny their motion for class certification.[39]

5. EVEN IF A PUTATIVE CLASS COULD BE CERTIFIED, THERE IS NO BASIS TO INCLUDE POLICY HOLDERS WHOSE CLAIMS WERE ADJUSTED *OUTSIDE NEW JERSEY*.[40]

[39] Nationwide respectfully disagrees with the trial court that commonality or adequacy have been satisfied. Plaintiffs argue—incorrectly—that commonality is satisfied because the operative Policy language and Nationwide's practice of applying the Fee Schedule is common to all putative class members. But even if it were true that Nationwide paid all putative class members using the Fee Schedule (*which is controverted by the record*) that does not inform the question of whether the amount paid meets the contractual standard of "all reasonable expenses for necessary medical treatment." For Rule 4:32-1(a)(4)'s adequacy requirement, a putative class representative cannot simply lend her name to the complaint and then place unfettered reliance on class counsel. *See, e.g., Kelley v. Mid-Am. Racing Stables*, 139 F.R.D. 405, 410 (W.D. Okla. 1990); *In re Gold Chip Funding, Co.*, 61 F.R.D. 592, 594 (M.D. Pa. 1974). Here, the proposed class representatives utterly failed the adequacy test. Pa847-48 (Owens could not articulate basis for class action complaint); Pa746 (Sibalich could not explain class representative obligations).

[40] Plaintiffs never bothered to enumerate the states that purportedly fall within their putative class. Plaintiffs merely referenced "a state fee schedule," in their

a. No Evidence Reflects Nationwide's Practices In Any Specific State Beyond New Jersey.

The only evidence presented to the trial court in support of certification concerned Nationwide's alleged conduct with respect to Pennsylvania policyholders who seek medical treatment in New Jersey, and Plaintiffs utterly failed to satisfy their burden to demonstrate why such certification could extend beyond claims involving treatment from New Jersey medical providers.[41]

b. Any Attempt To Certify On A Multi-State Basis Fails The Prerequisites For Predominance And Superiority.[42]

Plaintiffs' putative multi-state classes rested on the unsupported assumption that Nationwide purportedly applied non-applicable "fee schedules"

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putative class definition and left the trial court to divine what those states were.

[41] *See* Rule 4:32-1(a)-(b); *see also Korrow v. Aaron's Inc.*, No. 10-cv-6317 MAS, 2013 WL 5811496, at *5 (D.N.J. July 31, 2013) ("advancing mere threshold pleading requirements" insufficient for class certification); *Ochsner v. Cranbury Twp.*, 8 N.J. Tax 330, 333-34 (App. Div. 1986) (affirming denial of class certification, finding, *inter alia,* lack of evidence about putative class members).

[42] To certify a multi-state class, Plaintiffs must affirmatively "demonstrate, through an extensive analysis of state law variances, th[at] class certification does not present insuperable obstacles." *Advanced Acupuncture Clinic, Inc.*, 2008 WL 4056244, at *14 (internal citations and quotation omitted); *see also Beegal,* 394 N.J. Super. at 114 (affirming denial of class certification, noting "[i]n multi-state class actions, variations in state law may swamp common issues and defeat predominance"). Moreover, Plaintiffs must affirmatively "demonstrate a suitable and realistic plan for trial" for their putative multi-state classes. *Ford Motor Co. Ignition Switch Prod. Liab. Litig., In re*, 174 F.R.D. 332, 341-42 (D.N.J. 1997).

from "some" unidentified states outside of New Jersey. Plaintiffs' failure to identify any states beyond New Jersey is particularly telling, as the "fee schedules" from other states differ materially from New Jersey—and from each other.[43] Moreover, Plaintiffs could not plausibly allege that, outside of New Jersey, use of any "fee schedule" as a measure of "reasonableness" constitutes *per se* breach of contract, regardless of the amount that allegedly may be payable under the local "fee schedule." *See Advanced Acupuncture Clinic, Inc.*, 2008 WL 4056244, at *12 ("If the amounts Plaintiffs received from Defendants are 'reasonable,' *regardless of how the reimbursements were calculated*, then there is no breach of the policy.") (emphasis added).

For any putative class member whose treatment was provided outside of New Jersey, the trial court would have to scrutinize the amount allegedly paid under the fee schedule of that state, and adjudicate whether the amount published in the schedule satisfies the standard of "reasonable expenses" based on the facts and circumstances. This inquiry will vary from state to state, to the extent the fee schedules themselves (and the methodology by which they were

[43] For example, unlike New Jersey, the Florida "fee schedule" limits reimbursement for many medical charges to 80% of 200% of Medicare. *See* Fla. Stat. Ann. § 627.736(5)(a). And unlike either New Jersey or Florida, the Hawai'i "fee schedule" limits reimbursement for many medical charges to 110% of Medicare of participating fees prescribed in the Medicare Resource Based Relative Value Scale System. *See* Haw. Admin. R. § 12-15-90; HRS § 431:10C-308.5. These schemes are markedly different from New Jersey.

compiled) vary materially from New Jersey. Thus, liability would need to be adjudicated *not only* claim-by-claim, *but also* state-by-state, which inherently defeats predominance and renders class treatment unmanageable.[44]

Accordingly, the trial court's denial of class certification was appropriate not only with respect to PIP claims involving treatment in New Jersey, but also as to treatment provided outside of New Jersey.

CONCLUSION

For all the foregoing reasons, Nationwide respectfully requests that this Court affirm the trial court's denial of Plaintiffs' Motion for Class Certification.

Respectfully submitted,

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Attorneys for Defendants/Respondents

Dated: April 2, 2025

[44] New Jersey courts agree. *See Advanced Acupuncture Clinic, Inc.*, 2008 WL 4056244, at *12 ("Determining whether the reimbursements were 'reasonable' or 'unreasonable,' in light of the states' varying statutes, would be unmanageable as a class action."); *see also Fenwick v. Ranbaxy Pharms., Inc.*, 353 F. Supp. 3d 315, 331 (D.N.J. 2018) (denying class certification because plaintiff did not provide analysis of state law variances for the claims and related impact on predominance).

KAREN SIBALICH and MARGARET OWENS, Individually, and as Class representatives on behalf of other similarly situated,	:	SUPERIOR COURT OF NEW JERSEY APPELLATE DIVISION
	:	DOCKET NO. A-002879-23
Plaintiffs-Appellants,	:	CIVIL ACTION
and	:	
SPINE SURGERY ASSOCIATES and AMBULATORY SURGICAL CENTER OF SOMERSET, individually and as class representatives on behalf of others similarly situated,	:	ON APPEAL FROM ORDER FILED ON MAY 16, 2024, IN THE SUPERIOR COURT OF NEW JERSEY, LAW DIVISION, IN SUSSEX COUNTY, UNDER DOCKET NO. SSX-L-124-18.
	:	SAT BELOW:
Plaintiffs,	:	HON. WILLIAM J. MCGOVERN, III, J.S.C.
v.	:	
NATIONWIDE MUTUAL INSURANCE COMPANY, NATIONWIDE AFFINITY INSURANCE COMPANY OF AMERICA, and NATIONWIDE PROPERTY AND CASUALTY INSURANCE COMPANY.	:	
Defendants-Respondents.	:	

REDACTED REPLY BRIEF OF PLAINTIFFS-APPELLANTS KAREN SIBALICH AND MARGARET OWENS

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INTRODUCTION

Nationwide Mutual Insurance Company and its subsidiaries (collectively, "Nationwide") systematically underpaid the claims of Plaintiffs and the putative Class Members by applying out-of-state fee schedules to their claims rather than paying "all reasonable expenses" as required under Nationwide's form insurance policies. Because this case involves the interpretation of a single contractual provision common to all putative Class Members and Nationwide's systematic underpayment of their claims using state fee schedules, this case is well-suited for class treatment.

The provision in Nationwide's insurance policies at issue here requires Nationwide to pay "all reasonable expense***s*** for necessary medical treatment and rehabilitative services." The overarching question on liability is thus whether Nationwide violated this provision when it paid the first-party insurance claims of Plaintiffs and the putative Class Members under state fee schedules in lieu of paying "all reasonable expenses." That question predominates over all others and is common to all putative Class Members. The question of damages is also common: what should have Nationwide paid?

Unable to dispute the predominating nature of these questions, Nationwide argues that it need only pay a "reasonable" expense rather than address the "all reasonable expenses" provision as written. Db1-2. By making

that argument the focus of its opposition, Nationwide has confirmed what Plaintiffs have argued all along, which is that that the interpretation of the "all reasonable expenses" provision is the predominating issue here and that it can be answered on a common basis.

Nationwide also fails to offer any substantive response to Plaintiffs' argument that the trial court failed to perform the required rigorous analysis, viewing the record in the light most favorable to class certification as it must. And Nationwide cannot given that the trial court's decision lacks any discussion of the documents, testimony, or expert opinions Plaintiffs submitted to show how Nationwide's liability can be proven on a class-wide basis. The trial court instead impermissibly based its decision on (1) the same misreading of the "all reasonable expenses" requirement that Nationwide makes in its opposition; (2) Nationwide's allegations that it relied on the state fee schedules in gauging reasonableness; and (3) speculation that the "claims involved are more different, unique, and complex to evaluate than they are alike." Pa24-25.

The trial court should not have relied on Nationwide's allegations and speculation. It also need not have. Plaintiffs sought class discovery to test that proposition. But contrary to Supreme Court precedent, the trial court barred Plaintiffs from obtaining class discovery and thus decided the class certification motion prematurely. Pa26, Pa60-61.

The trial court thus abused its discretion and its decision denying class certification should be reversed.

ARGUMENT

A. The interpretation of the "all reasonable expenses" provision is a common issue that predominates over all others.

As this and other courts have recognized, "claims involving the interpretation of standard form contracts are particularly well-suited for class treatment." *Gillis v. Respond Power, LLC*, 677 Fed. Appx. 752, 756 (3d Cir. 2017); *Lusky v. Capasso Bros.*, 118 N.J. Super. 369, 372 (App. Div. 1972).[1]

Perhaps the surest sign that the trial court erred in denying class certification is thus Nationwide's decision to begin its opposition by focusing on the interpretation of its form insurance policies. Db1-2. Rather than dispute the outsized importance that the interpretation of Nationwide's form insurance policies has on Plaintiffs' claims, Nationwide eschews discussing how that issue fits into the "pragmatic assessment" that the trial court must conduct. *Cf. Lee v. Carter-Reed Co., L.L.C.*, 203 N.J. 496, 519-20 (2010). It instead simply claims Plaintiffs are wrong and that "reasonable expenses" provision in its form insurance policies is "clear and unambiguous." Db30-31. Such arguments

[1] *See also Zehentbauer Family Land, LP v. Chesapeake Expl., L.L.C.*, 935 F.3d 496, 506 (6th Cir. 2019) (quoting 1 McLaughlin on Class Actions § 5:56 (15th ed. 2018)); *Smilow v. Southwestern Bell Mobile Sys.*, 323 F.3d 32, 39 (1st Cir. 2003); *Janicik v. Prudential Ins. Co.*, 451 A.2d 451, 461-62 (Pa. Super. 1982).

are however irrelevant at the class certification stage. *See Iliadis v. Wal-Mart Stores, Inc.*, 191 N.J. 88, 107 (2007). This is because "class certification does not occasion an examination of the dispute's merits." *Id.* (quoting *Olive v. Graceland Sales Corp.*, 61 N.J. 182, 189 (1972)).

Nationwide also happens to be wrong on the merits. Under Pennsylvania law, the language of form insurance policies "must be construed in its plain and ordinary sense" and "must be read in its entirety." *See Pa. Nat'l Mut. Cas. Ins. Co. v. St. John*, 106 A.3d 1, 14 (Pa. 2014) (citing *Riccio v. Am. Republic Ins. Co.*, 705 A.2d 422, 426 (Pa. 1997)); *see also Commonwealth v. UPMC*, 129 A.3d 441, 464 (Pa. 2015); *Cypress Point Condo Ass'n v. Adria Towers, L.L.C.*, 226 N.J. 403, 416 (2016).

Nationwide's form insurance policies require it to pay "all reasonable expenses for necessary medical treatment and rehabilitative services." But rather than address this provision as written, Nationwide focuses on just two of the three operative words: "reasonable expenses." Db2-3, 7-8, 19, 28-34, 41-42, 49. Eliding the word "all" from the "all reasonable expenses" provision has predictably led Nationwide (and the trial court) astray here.

As Appellants explained in their opening brief, "A payment may … be 'reasonable' yet not satisfy the 'all reasonable expenses' requirement if a higher reasonable charge amount also exists." Pb27. Nationwide tellingly

offers no response to this argument and has waived any argument to the contrary. *See State v. Watson*, 254 N.J. 558, 609 (2023).

Nationwide instead argues that "the term 'reasonable' is clear and unambiguous" based decisions by this Court using "the term 'reasonable' to characterize the fees therein." Db30 n.19. None of the decisions Nationwide cites however address the "all reasonable expenses" provision. Nationwide is therefore wrong on the merits. But for now, at the class certification stage, what matters is that the interpretation of the "all reasonable expenses" provision in Nationwide's uniform insurance policies is a common question and one that predominates over all others, as Nationwide has made evident with its refusal to address the provision as written.[2]

B. The trial court overlooked the evidence that Nationwide pays claims under the "all reasonable expenses" provision at the 80th percentile.

The trial court also abused its discretion by finding that individual issues predominate without considering the evidence [redacted]. CPa16; CPa109; CPa966; CPa980-81; CPa997-98; CPa1207-08. The trial court likewise failed to

[2] Showing how the common issues here predominate, [redacted] CPa303.

consider the opinion of Plaintiffs' expert, Dr. Luke, who opined that "[t]he best indication of the proper percentile to be applied is the percentile that the payor actually uses, absent a PPO or state fee schedule." Pa1416-17, ¶ 33. Having considered none of this, the trial court could not—and thus did not—properly assess whether the requirements for class certification have been satisfied. *See Lee*, 203 N.J. at 505.[3]

In its attempt to defend the trial court's decision, Nationwide notably does not claim that the trial court considered such evidence, let alone that it viewed the evidence in the light most favorable to Plaintiffs as it must. *Cf. Lee*, 203 N.J. at 505. Nationwide instead argues that the "trial court invited plentiful class certification briefing[.]" Db7 n.2. The trial courts' requests that the parties submit supplemental briefing does not however satisfy its obligation to conduct a rigorous analysis. After all, the trial court's opinion "speaks for itself." *See, e.g.*, *Ippolito v. Ippolito*, 465 N.J. Super. 428, 431 (App. Div. 2020). And because the trial court addressed none of this evidence in its decision, this Court is without any assurance that the trial court rigorously analyzed the record in the manner that it must.

[3] *See also In re Hydrogen Peroxide Antitrust Litig.*, 552 F.3d 305, 307 (3d Cir. 2008); *Iliadis*, 191 N.J. at 111-12.

Nationwide also attempts to defend the trial court's decision on the basis that so-called course of performance evidence should not be considered. There are however three reasons why that argument is wrong and misses the point.

The first and perhaps most significant reason is that at the class certification stage, whether the factfinder may consider course of performance evidence is itself common question and a significant one at that.

The second is that Nationwide paints with too broad of a brush in labeling all the evidence submitted by Plaintiffs as course of performance evidence. For example, [redacted]. CPa112. That testimony is not course of performance evidence; it is an admission by Nationwide's corporate designee that if the state fee schedules do not apply, the claims should be paid at the 80th percentile. Given that testimony, no individual issues remain as Nationwide has reviewed, approved and paid each claim, albeit using an inapplicable state fee schedule.

The third is that Nationwide is wrong on the merits. According to the Pennsylvania Supreme Court, course of performance evidence may be considered regardless of whether a contract is ambiguous or not. *See Atl.*

Richfield Co. v. Razumic, 390 A.2d 736, 741 n.6 (Pa. 1978); *see also UPMC*, 129 A.3d at 464 ("a party's performance under the terms of a contract is evidence of the meaning of those terms"). In seeming recognition that its argument that such evidence should not be considered runs contrary to black letter law, Nationwide claims that its course of performance outside of New Jersey and for medical treatments that are not otherwise subject to a fee schedule should not be considered because a party's course of performance should only be considered in connection with the "parties to the specific contract at issue." Db32. But "[t]o properly interpret an insurance policy, it is necessary to discern how that contract has been interpreted in the past" and to that end, "documents regarding similar claims of other insureds" are relevant. *See Mariner's Cove Site B Assocs. v. Travelers Indem. Co.*, No. 04-1913, 2005 U.S. Dist. LEXIS 8352, at *3 (S.D.N.Y. Apr. 29, 2005) (collecting cases).

Nationwide also ignores that this case involves form insurance policies issued in Pennsylvania to its Pennsylvania insureds and, so, does not involve different contracts. The argument that no consideration should be given to Nationwide's course of performance with respect to medical treatments that are not subject to a fee schedule likewise makes little sense as no fee schedule applied to the claims of Plaintiffs Sibalich and Owens (and the other members of the putative class) for treatment outside of Pennsylvania as New Jersey's

state fee schedules only apply to policies issued (or deemed to be issued) in New Jersey. Pa58 (citing N.J.S.A. 39:6A-4.6 and N.J.A.C. 11:3-29.1(a)).

Nationwide's argument also reflects a profound misapprehension of how state fee schedules operate, which underscores the need for this issue to be resolved on a class-wide basis. Under N.J.S.A. 39:6A-4.6, balance billing is prohibited when the fee schedule legally applies: "[n]o health care provider may demand or request any payment from any person in excess of those permitted by the medical fee schedules established pursuant to this section, nor shall any person be liable to any health care provider for any amount of money which results from the charging of fees in excess of those permitted by the medical fee schedules established pursuant to this section." When an insurance policy subject to this statute conflicts with it, the statute controls. *See Est. of Leeman v. Eagle Ins. Co.*, 309 N.J. Super. 525, 533 (App. Div. 1998). Thus, when New Jersey's PIP statute applies, Nationwide need not satisfy its "all reasonable expenses" provision in its policies because the fee schedule controls. But when there is no applicable fee schedule, Nationwide must pay "all reasonable expenses." That Nationwide fails to understand the interplay between the "all reasonable expenses" provision and the New Jersey state fee schedule is one more reason it is so important that this issue be decided on a class-wide basis and the trial court should have granted class certification.

C. The trial court improperly based its decision on Nationwide's allegations that it used the state fee schedules to gauge reasonableness.

Nationwide's opposition brief confirms that there is another common issue that predominates, which the trial court abused its discretion by overlooking. As a corollary of its argument that its insurance policy forms only require it to pay "reasonable expenses," Nationwide contends "Judge McGovern's opinion rests on the fact that, when Nationwide adjusts automobile insurance claims for First Party Benefits (also known as PIP Benefits) relating to medical treatment provided in New Jersey, Nationwide considers . . . the New Jersey Auto PIP Fee Schedule (the "Fee Schedule") as an indication of whether the expenses are 'reasonable.'" Db1-2. This argument is not a reason to affirm the trial court's opinion; it is proof that the trial court failed to undertake the "rigorous analysis" required under Rule 4:32.

While Nationwide strenuously argues it considered New Jersey's fee schedule as an indication of what is "reasonable" in making the disputed payments at issue here, Nationwide notably has presented no evidence to that effect. Db1-2. It indeed has presented no testimony or documents to the trial court showing that it did so. And even now, while Nationwide claims that it relied on the state fee schedules in assessing whether its payments were reasonable, it cites no evidence in the record to support that claim.

In contrast, Plaintiffs presented considerable evidence to the contrary. [redacted] percentile." CPa966. [redacted] CPa950-60. [redacted] CPa111, [redacted] CPa28; CPa44; CPa302.

As Nationwide's documents and witnesses confirm, [redacted] CPa437, CPA106. The Explanations of Review that Nationwide issued to Plaintiffs Sibalich and Owens also confirm that when Nationwide pays a claim according to a state fee schedule, it is not paying a "reasonable fee" but one it (falsely) states is prescribed by law. Pb25-26.

So, on the one hand, Nationwide has presented no evidence that it uses the state fee schedules as a gauge of reasonableness, and, on the other hand, Plaintiffs provided testimony and documents that refute Nationwide's claim it did. In thus finding that "Nationwide used and relied on the New Jersey auto

fee schedules, ***as alleged***, to gauge or determine the reasonable reimbursement rate to be paid[,]" Pa24-25 (emphasis added), the trial court abused its discretion by failing to review the evidence in the light most favorable to Plaintiffs. *Cf. Lee*, 203 N.J. at 505. And making this abuse of discretion even worse, the trial court based its decision Nationwide's allegations with no consideration given to any of the evidence that Plaintiffs presented.

D. The trial court's contradictory decisions confirm that it abused its discretion in denying class certification.

This Court can find that the trial court failed to properly apply the standards for class certification given that the decision to deny class certification cannot be reconciled with two of the trial court's earlier decisions.

First, earlier in this case, Nationwide moved to compel discovery from Plaintiffs Spine Surgery Associates and Ambulatory Surgical Center of Somerset about their "collection rates, expense accounting, [and] profit and loss statements," arguing that such discovery is "relevant to the issue [of] whether the charges by Provider Plaintiffs for medical services constitute 'reasonable expenses' that may be covered by the Nationwide policy." Pa97. The trial court disagreed. It explained that such discovery would likely not lead to relevant evidence because Nationwide "does not consider or refer to any of the aforementioned information in determining what is a reasonable fee under the policy." *Id.* Yet in denying class certification, the trial court did an

about-face. It held that the typicality requirement is not satisfied because "every health care provider is different and distinct" and "most of the provider's billing practices are individualized and distinct." Pa24. That 180-degree turn is incompatible with the trial court's duty to "understand and analyze the 'claims, defenses, relevant facts, and applicable substantive law" in ruling on class certification. *Lee*, 203 N.J. at 506 (quoting *Iliadis*, 191 N.J. at 107).

Second, the trial court altogether overlooked the opinions and testimony of Plaintiff's expert, Dr. Ron Luke, thereby abusing its discretion. As the trial court recognized in its December 24, 2021, decision on Nationwide's motion to strike Dr. Luke's expert report and to bar his testimony, Dr. Luke has opined that the "the utilization of the UCR method at the 80th percentile rate to set the allowed amount, by [Nationwide], for medical services is a reasonably and generally accepted method[.]" Pa76. In denying that motion, the trial court found that "Dr. Luke may assist the trier of fact in understanding insurance company policies and practices and may assist the trier of fact in addressing the ultimate issue or issues in this case." Pa77. Given that recognition, Dr. Luke's opinions and testimony should have factored into the trial court's rigorous analysis. That it did not was another abuse of discretion.

E. The trial court abused its discretion by denying Plaintiffs the opportunity to obtain class discovery.

The trial court also abused its discretion by ruling on the motion for class certification before "any class discovery has been conducted," Pa26, Pa60-61. *Cf. Riley v. New Rapids Carpet Ctr.*, 61 N.J. 218, 228-29 (1972). Compounding that error, the trial court filled the voids in the record created by its decision to bar Plaintiffs from obtaining class discovery by accepting as true Nationwide's various allegations that the claims of the putative Class Members are "unique and varied," *see* Pa24-25, -31, contrary to its obligation to perform a rigorous analysis and view the record in the light most favorable to class certification. *Cf. Lee*, 203 N.J. at 505.[4]

The trial court, for instance, found that "Defendants have argued, persuasively, that their affirmative defenses and ability to produce evidence to

[4] Nationwide also argues that there is a possibility that its Pennsylvania insureds have assigned their claims to their medical providers without providing any evidence that this is an individual issue. In any event, to the extent assignments may be an issue at all, it is not a significant one. When an insured assign his or her claim to his or her healthcare provider, the healthcare provider steps into the shoes of the insured. *See James Talcott, Inc.*, 76 N.J. 305, 309 (1978). In such cases, the healthcare provider becomes the Insured Class Member and can "seek funds directly from" any common fund established here. *Cf. Nat'l Football League Players' Concussion Injury Litig.*, 923 F.3d 96, 110 (3d Cir. 2019). If a dispute arises over whether there is a valid assignment, the dispute is between the insured and his or her healthcare provider. Nationwide has no interest in the outcome of any such dispute. It remains liable regardless of whether there has been an assignment.

contest or challenge these claims on an individual basis will be impaired or abridged in the class action mode, and that they are entitled to the full scope of due process in defending their positions, including the ***full range of individualized discovery*** . . . ." Pa31 (emphasis added). The trial court thus recognized the importance of discovery and based its decision on Nationwide's arguments and not the evidential record. What makes this abuse of discretion so egregious is that Plaintiffs had presented evidence rebutting this position, including the testimony of [redacted]. CPa1306-07. Because the trial court disregarded this and other evidence, this Court should reverse.

CONCLUSION

For all these reasons, the trial court's decision to deny class certification should be reversed.

Respectfully,

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