IN THE SUPREME COURT OF THE STATE OF NEVADA

STATE OF NEVADA, EX. REL. COMMISSIONER OF INSURANCE, BARBARA D. RICHARDSON, in her official capacity as Receiver for Nevada Health Co-Op,

Petitioner,

v.

THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF CLARK, AND THE HONORABLE KATHLEEN DELANEY, DISTRICT JUDGE, DEPT. 25,

Respondents,

MILLIMAN, INC., a Washington Corporation; Jonathan L. Shreve, an individual; and Mary Van Der Heijde, and individual,

Real Parties in Interest,

Supreme Court Case No.: 77682

Dist. Court Case No.: A-17-760558-C

PETITIONER'S APPENDIX

VOLUME I of III

Part 2

Tami D. Cowden, Esq., NBN 8994
Mark E. Ferrario, Esq., NBN 1625
Donald L. Prunty, Esq., NBN 8230
GREENBERG TRAURIG, LLP
10845 Griffith Peak Drive, Ste. 600
Las Vegas, Nevada 89135
Telephone (702) 792-3773
Facsimile (702) 792-9002
Attorneys for Petitioner

CHRONOLOGICAL INDEX OF APPELLANT'S APPENDIX

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II	APP00230-266	12/18/17	Plaintiff's Opposition to Defendant Millennium Consulting Services, LLC's Motion to Dismiss
I	APP00180-229	12/11/17	Plaintiff's Opposition to Milliman's Motion to Compel Arbitration

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II	APP00296-339	1/9/18	Reporter's Transcript of Motion to Compel Arbitration Hearing
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CERTIFICATE OF SERVICE

Pursuant to NRAP 25,1 certify that I am an employee of GREENBERG TRAURIG, LLP, that in accordance therewith, I caused a copy of ***Petitioner's Appendix Volumes I – III*** to be served to the Real Parties Interest via the Supreme Court's e-filing system on December 17, 2018, and upon:

Patrick G. Byrne, Esq. (NV Bar No. 7636)
Alex L. Fugazzi, Esq. (NV Bar No. 9022)
Aleem A. Dhalla, Esq. (NV Bar No. 14188)
Snell & Wilmir
3883 Howard Hughes Parkway, # 1100
Las Vegas, NV 89169
pbyrne@swlaw.com;
afugazzi@swlaw.com;
adhalla@Wswlaw.com
Attorneys for Real Parties in Interest

Justin N. Kattan, Esq. (Pro Hac Vice)
Dentons US, LLP
1221 Avenue of the Americas
New York, NY 10020
Justin.kattan@dentons.com
Attorneys for Real Parties in Interest

With a courtesy copy to:

Judge Kathleen Delaney
Eighth Judicial District Court
Clark County, Nevada
Regional Justice Center
200 Lewis Avenue
Las Vegas, NV 89155

Judge Timothy C. Williams
Eighth Judicial District Court
Clark County, Nevada
Regional Justice Center
200 Lewis Avenue
Las Vegas, NV 89155
(As the Judge to which this matter is currently assigned)

via hand delivery on December 18, 2018.

/s/ Andrea Lee Rosehill
An Employee of Greenberg Traurig LLP

OPPS

MARK E. FERRARIO, ESQ.
Nevada Bar No. 1625
ERIC W. SWANIS, ESQ.
Nevada Bar No. 6840
DONALD L. PRUNTY, ESQ.
Nevada Bar No. 8230
GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway, Suite 400 N
Las Vegas, NV 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002
Email: ferrariom@gtlaw.com
swanise@gtlaw.com
pruntyd@gtlaw.com
Counsel for Plaintiff

DISTRICT COURT
CLARK COUNTY, NEVADA

STATE OF NEVADA, EX REL. COMMISSIONER OF INSURANCE, BARBARA D. RICHARDSON, IN HER OFFICIAL CAPACITY AS RECEIVER FOR NEVADA HEALTH CO-OP,

Plaintiff,

v.

MILLIMAN, INC., a Washington Corporation; JONATHAN L. SHREVE, an Individual; MARY VAN DER HEIJDE, an Individual; MILLENNIUM CONSULTING SERVICES, LLC, a North Carolina Corporation; LARSON & COMPANY P.C., a Utah Professional Corporation; DENNIS T. LARSON, an Individual; MARTHA HAYES, an Individual; INSUREMONKEY, INC., a Nevada Corporation; ALEX RIVLIN, an Individual; NEVADA HEALTH SOLUTIONS, LLC, a Nevada Limited Liability Company; PAMELA EGAN, an Individual; BASIL C. DIBSIE, an Individual; LINDA MATTOON, an Individual; TOM ZUMTOBEL, an Individual; BOBBETTE BOND, an Individual; KATHLEEN SILVER, an Individual; DOES I through X inclusive; and ROE CORPORATIONS I-X, inclusive,

Defendants.

Case No.: A-17-760558-C
Dept. No.: 25

PLAINTIFF'S OPPOSITION TO MILLIMAN'S MOTION TO COMPEL ARBITRATION

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

Plaintiff, Commissioner of Insurance BARBARA D. RICHARDSON ("Commissioner"), in her capacity as Receiver of Nevada Health CO-OP ("NHC" or "CO-OP"), by and through her undersigned counsel, hereby submits this Opposition to Defendant Milliman's Motion to Compel Arbitration. This Opposition is based on the pleadings and papers on file herein, the attached memorandum of points and authorities, and any exhibits attached hereto, and any oral argument this Court should choose to entertain.

DATED this 11th day of December, 2017.

GREENBERG TRAURIG, LLP

/s/ Donald L. Prunty, Esq.
MARK E. FERRARIO, ESQ.
Nevada Bar No. 1625
ERIC W. SWANIS, ESQ.
Nevada Bar No. 6840
DONALD L. PRUNTY, ESQ.
Nevada Bar No. 8230
3773 Howard Hughes Parkway, Suite 400 N
Las Vegas, NV 89169
Counsel for Plaintiff

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Milliman seeks to have this Court relinquish its exclusive jurisdiction over proceedings relating to the receivership of NHC in favor of private, confidential, arbitration. However, relinquishing this jurisdiction would be contrary to the complex statutory scheme for winding down of insurance companies as laid out in Nevada's Liquidation Act, NRS 696B, and the Receivership Court's[1] prior Permanent Injunction and Order Appointing Commissioner as Permanent Receiver of Nevada Health Co-Op (the "Receivership Order"). This statutory scheme – and the Receivership Order issued under that statutory authority – have one purpose: maximizing the value of the estate of the defunct insurance company for the benefit of policyholders and creditors. The Commissioner, having been appointed receiver, must carry out that goal. To that end, she has asserted claims against numerous entities, including Milliman, in the instant lawsuit. Wresting

[1] The Hon. Judge Kenneth Cory, Clark County Nevada Eight Judicial District, Dept. 1.

various fragments of this lawsuit into piecemeal private tribunals for confidential proceedings outside public view is not in line with the purposes of the statute. Mere months ago, another court considering Milliman's ability to compel arbitration under an identical contract provision and similar circumstances denied Milliman's motion.[2]

Further, Milliman's view is not in line with the law; Milliman's legal arguments are meritless. Milliman argues that the general policy favoring arbitration mandates arbitration here, but the Federal Arbitration Act (the "FAA") is reverse-preempted by the McCarran-Ferguson Act, which expressly leaves insurance regulation to the states. The Nevada Arbitration Act (the "NAA") conflicts with the specific statutory scheme laid out in Nevada's Liquidation Act, and as the specific takes precedence over the general under Nevada law, the exclusive jurisdiction of the district court provided for in the statute and the Receivership Order entered under the statute prevails.

Moreover, the Receiver is not a signatory to the contract containing the arbitration clause, and therefore Milliman must show that an exception applies to the rule that arbitration only binds signatories. Milliman's attempts to invoke an exception fall flat.

Finally, even if this Court were inclined to enforce the arbitration clause, under applicable law it could only do so with respect to the claims arising out of the contract at issue. Many of the claims here do not arise out of the contract. Likewise, many of the claims are not brought on behalf of NHC, but instead on behalf of its creditors or policyholders. In both of these situations, arbitration is inappropriate. As such, only a narrow subset of claims could be arbitrated. Under those circumstances it would be wasteful, duplicative, and create the possibility of inconsistent results to bifurcate the claims against Milliman. In sum, this Court should deny Milliman's motion to compel arbitration for the reasons that follow.

II. FACTUAL BACKGROUND

When NHC's predecessor, the Culinary Health Fund, considered the possibility of establishing a CO-OP under the ACA, it sought out an actuarial expert. The Culinary Health Fund entered into a contract with Milliman, dated October 20, 2011 (the "2011 Agreement"). The 2011

[2] *See* Judgment on Exceptions, 19th Judicial District Court, Parish of East Baton Rouge, State of Louisiana, September 19, 2017, attached hereto as **Exhibit A**. Although couched as a motion related to subject matter jurisdiction, the nature of the motion was to compel arbitration.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

Agreement contained an arbitration clause requiring arbitration of "any dispute arising out of or relating to the engagement of Milliman…" *See* Motion to Compel Arbitration, Exhibit A, at 5. As more specifically laid out in the Complaint, the Culinary Health Fund's assets were assigned to NHC.

Unfortunately, Milliman's services as a consulting actuary failed to meet applicable statutory, professional, and contractual standards. Among other issues, Milliman produced deficient forecasts and studies for loan applications, recommended inadequate insurance premium levels, provided faulty actuarial guidance to NHC management, promoted and incorporated in its assumptions accounting entries that were neither proper nor authorized without appropriate disclosure, participated in financial misreporting, and improperly calculated and certified NHC's projections and reserves to regulators.

Further, as more specifically described in the Complaint, Milliman was not merely a contractor performing outsourced tasks, but an "interactive partner" of NHC; it served as the key partner providing budget forecasts, planning, premium pricing, opinions, and judgments that were justifiably relied on by the new CO-OP. In fact, the CO-OP relied on the superior knowledge and expertise of its self-proclaimed "interactive partner" Milliman and Milliman's actuaries - Shreve and Heijde - to establish and run the enterprise.

As a result of Milliman's failures, as well as the failures of other named defendants in this action, NHC was incapable of continuing, and the Nevada Department of Insurance was forced to step in. Amy L. Parks (the then acting Nevada Commissioner of Insurance) commenced the receivership action against NHC by filing a petition to appoint herself as the receiver of NHC under NRS 696B. Thereafter, on October 14, 2015, the Receivership Court issued the Receivership Order naming the Commissioner as permanent receiver of NHC. *See* Receivership Order, attached hereto as **Exhibit B**. Cantilo & Bennett, L.L.P. was named as Special Deputy Receiver ("SDR").

Pursuant to the Court's Receivership Order and subsequent Final Order of Liquidation, the Commissioner as Receiver and the SDR are authorized to liquidate the business of NHC and wind up its ceased operations, including prosecuting suits on behalf of the thousands of injured people and entities associated with NHC's liquidation, including NHC's members, its formerly insured patients, unpaid hospitals, doctors, other creditors, and the public at large. *See generally id.*

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

As relevant here, the Receivership Order provides the following:

> (1) ... The Receiver and the SDR are hereby directed to ***conserve and preserve the affairs*** of CO-OP and are vested, in addition to the powers set forth herein, with all the powers and authority expressed or implied under the provisions of chapter 696B of the Nevada Revised Statute ("NRS"), and any other applicable law. The Receiver and Special Deputy Receiver are hereby authorized to rehabilitate or liquidate CO-OP's business and affairs ***as and when they deem appropriate under the circumstances and for that purpose may do all acts necessary or appropriate for the conservation, rehabilitation, or liquidation*** of CO-OP....
>
> (2) Pursuant to NRS 696B.290, the Receiver is hereby authorized with ***exclusive title to all of CO-OP's property*** (referred to hereafter as the "Property") and ***consisting of all…[c]auses of action***, defenses, and rights to participate in legal proceedings…
>
> (3) The Receiver is hereby directed to take immediate and exclusive possession and control of the Property except as she may deem in the best interest of the Receivership Estate. In addition to vesting title to all of the Property in the Receiver or her successors, the said ***Property is hereby placed in custodia legis of this Court and the Receiver***, and the Court hereby assumes and ***exercises sole and exclusive jurisdiction over all the Property and any claims or rights respecting the Property to the exclusion of any other court or tribunal***, such exercise of sole and exclusive jurisdiction being hereby found to be central to the safety of the public and of the claimants against CO-OP.
>
> …
>
> (5) All persons, corporations, partnerships, associations and all other entities wherever located, are hereby ***enjoined and restrained from interfering in any manner*** with the Receiver's possession of the Property or her title to her right therein and from interfering in any manner with the conduct of the receivership of CO-OP.
>
> …
>
> (8) All claims against CO-OP its assets or the Property must be submitted to the Receiver as specified herein ***to the exclusion of any other method of submitting or adjudicating such claims in any forum, court, or tribunal subject to the further Order of this Court***.[3] The Receiver is hereby authorized to establish a Receivership Claims and Appeal Procedure, for all receivership claims. The Receivership Claims and Appeal Procedures shall be used to facilitate the orderly disposition or resolution of claims or controversies involving the receivership or the receivership estate.
>
> …
>
> 11) The officers, directors, trustees, partners, affiliates, brokers, agents, creditors, insureds, employees, members, and enrollees of CO-OP, and all of the persons or entities of any nature including, but not limited to, claimants,

[3] Milliman submitted a Proof of Claim on January 16, 2016.

> plaintiffs, petitioners, and any governmental agencies who have claims of any nature against CO-OP, including cross-claims, counterclaims and third party claims, are ***hereby permanently enjoined and restrained from doing or attempting to do any of the following***, except in accordance with the express instructions of the Receiver or by Order of this Court:
> …
>
> b. Commencing, bringing, maintaining or further prosecuting any action at law, suit in equity, ***arbitration***, or special or other proceeding against CO-OP or its estate, or the Receiver and her successors in office, or any person appointed pursuant to Paragraph (4) hereinabove;
>
> …
> (14) The Receiver shall have the power and is hereby authorized to:
> a. Collect all debts and monies due in claims belonging to CO-OP, wherever located, and for this purpose:(i) institute and maintain actions in other jurisdictions, in order to forestall garnishment and attachment proceedings against such debts; (ii) ***do such other acts as are necessary or expedient to marshal, collect, conserve or protect its assets or property***, including the power to sell, compound, compromise or assign debts for purposes of collection upon such terms and conditions as she deems appropriate, and the ***power to initiate and maintain actions at law or equity or any other type of action or proceeding of any nature, in this and other jurisdictions***; (iii) to pursue any creditors remedies available to enforce her claims;
> …
> h. Institute and to prosecute, in the name of CO-OP or in her own name, any and all suits and of the legal proceedings, to defend suits in which CO-OP or the Receiver is a party in this state or elsewhere, whether or not such suits are pending as of the date of this Order…
> …
> (19) No judgment, order, attachment, garnishment sale, assignment, transfer, hypothecation, lien, security interest or other legal process of any kind with respect to or affecting CO-OP or the Property shall be effective or enforceable or form the basis for a claim against CO-OP or the Property ***unless entered by the court, or unless the Court has issued its specific order***, upon good cause shown and after due notice and hearing, permitting same.
> …
> (24) The Court shall ***retain jurisdiction for all purposes necessary to effectuate and enforce this Order***.

See Receivership Order, **Exhibit B** (emphasis added).

Accordingly, on August 25, 2017, the Receiver instituted a contract and tort action on behalf of NHC and the thousands of people and entities who were injured by NHC's liquidation, asserting 63 causes of action against sixteen defendants, including Milliman and its actuaries. *See generally*

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

Complaint. Pursuant to the Receivership Order, the Receiver initiated this action in the Eighth Judicial District Court, the situs of the receivership proceedings and the only courts with jurisdiction over the Property of NHC. As relevant here, the Receiver asserted numerous claims solely against Milliman, including: (1) negligence per se – Violation of NRS 681B; (2) professional malpractice; (3) intentional misrepresentation; (4) constructive fraud; (5) negligent misrepresentation; (6) breach of fiduciary duty; (7) negligence; (8) breach of contract; (9) tortious breach of the implied covenant of good faith and fair dealing; (10) breach of the implied covenant of good faith and fair dealing; (11) negligent performance of an undertaking; (12) unjust enrichment; (13) civil conspiracy; and (14) concert of action.

Additionally, the Receiver brought two additional causes of action against Milliman and all other defendants, asserting that all defendants acted jointly as part of a civil conspiracy and in concert of action, and thus, are jointly and severally liable for the damages described in the complaint.

III. LEGAL ARGUMENT

As noted above, the Eighth Judicial District Court has exclusive jurisdiction over this litigation, as the Receivership Order held that for the safety of the public and the claimants against NHC, all Property – including claims and defenses of NHC – is within the sole and exclusive jurisdiction of the Eighth Judicial District Court, to the exclusion of all other tribunals.[4] *See* **Exhibit B**, Receivership Order ("the Court hereby assumes and exercises sole and exclusive jurisdiction over all the Property and any claims or rights respecting the Property to the exclusion of any other court or tribunal, such exercise of sole and exclusive jurisdiction being hereby found to be essential to the safety of the public and of the claimants against [NHC].") This exercise of jurisdiction is consistent with Nevada law. *See* NRS 696B.190 (court may make all necessary or proper orders to carry out the purposes of the delinquency proceedings); NRS 696B.200 (providing for jurisdiction over persons obligated to the insurer due to transactions between themselves and the insurer). Although Milliman argues that this Court should compel arbitration despite this clear grant of exclusive jurisdiction, Milliman's arguments are meritless, as outlined below.

[4] The Receivership Court has declined without prejudice to coordinate this case with the Receivership Case. Jurisdiction remains appropriate within the Eighth Judicial District pursuant to NRS 696B.190. References to exclusive jurisdiction relate to the Eighth Judicial District courts unless otherwise indicated by the context.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

A. The General Policy in Favor of Arbitration Does Not Apply, and None of the Claims Should be Arbitrated.

Milliman makes much of the state and federal policies in favor of arbitration; however, the general policy in favor of arbitration does not apply here, for several reasons. First, the FAA and NAA's policy in favor of arbitration are inapplicable here, where Nevada's Liquidation Act reverse-preempts the FAA and precludes any contrary application of the NAA. Second, the presumption in favor of arbitration does not apply where the Receiver was not a signatory to the Agreement at issue, and does not simply "step into the shoes" of NHC. Because there is no applicable policy in favor of arbitration, this Court should retain the Receiver's claims against Milliman in this Court to effectuate the purposes of the Liquidation Act.

1. The General Policy in Favor of Arbitration Does Not Apply Where Nevada's Insurers Liquidation Law Reverse-Preempts the FAA and Precludes Contrary Application of the NAA.

Milliman contends that the general policy in favor of arbitration under the FAA and NAA should apply to mandate arbitration here. However, the FAA is reverse-preempted by the McCarran-Ferguson Act, and the NAA does not apply where any general policy in favor of arbitration evidenced by the NAA conflicts with the more specific statute governing insurance receivership proceedings. As such, arbitration is not required.

a. Nevada's Insurer's Liquidation Law Reverse-Preempts the FAA

The Court should refuse to compel arbitration under the FAA as the controlling Liquidation Act[5] reverse-preempts the FAA under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 ("McCarran-Ferguson").

In the McCarran-Ferguson Act, Congress declared that the continued regulation by the states of the business of insurance is in the public interest. *See* 15 U.S.C. § 1011. Congress concluded that "[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the . . . States which relate to the regulation . . . of such business." *Id*. at §1012(a). No

[5] Nevada's Liquidation Act may be cited as the Uniform Insurers Liquidation Act. NRS 696B.280. The Act is set forth at NRS 696B.030 to 696B.180 and 696B 290 to 696B.340. *Id.*

federal law "shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the Business of insurance. . . unless such Act specifically relates to the business of insurance." *Id*. at §1012(b). Thus, McCarran-Ferguson exempts state laws regulating the business of insurance from preemption by federal statutes that do not specifically relate to the business of insurance, such as the FAA. 15 U.S.C. § 1012(b). The Supreme Court has created a three-part test to determine whether reverse-preemption of federal law through McCarran-Ferguson occurs. Specifically, a court is to examine whether: 1) the state statute was enacted for the purpose of regulating the business of insurance; 2) the federal statute involved "does not specifically relat[e] to the business of insurance"; and 3) the application of the federal statute would "invalidate, impair, or supersede" the state statute regulating insurance. *Humana Inc. v. Forsyth*, 525 U.S. 299, 307, 119 S.Ct. 710, 142 L.Ed.2d 753 (1999). Here, each of these criteria is met, and accordingly, Nevada's Liquidation Act reverse-preempts the FAA under McCarran-Ferguson.

First, there can be no real dispute that Nevada's statute was enacted for the purpose of regulating the business of insurance. The Liquidation Act provides that "upon taking possession of the assets of an insurer, the domiciliary receiver shall immediately proceed *to conduct the business of the insurer* or to take such steps as are authorized by this chapter for the purpose of rehabilitating, liquidating, or conserving the affairs or assets of the insurer. NRS 696B.290(3); *see Ernst & Young, LLP v. Clark,* 323 S.W.3d 682 (Ky. 2010) (holding that this prong was "clearly satisfied" and noting that "[w]e can hardly overstate the degree to which the regulation of insurance permeates this controversy. The very claims which [the defendant] would take to arbitration arise directly out of Kentucky's intense interest in the regulation of worker's compensation insurance... The [liquidation act at issue] is itself the ultimate measure of the state's regulation of the insurance business: the take-over of a failing insurance company.").

Second, courts have determined that the FAA is not a federal statute that specifically relates to the business of insurance. *See, e.g. Munich Am Reinsurance Co. v. Crawford*, 141 F.3d 585, 590 (5th Cir. 1998) (there is no question that the FAA does not relate specifically to the business of insurance."); *Stephens v. Am. Int'l Ins. Co.*, 66 F.3d 41, 44 (2d Cir. 1995) ("No one disputes the fact that the FAA does not specifically relate to insurance.")

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

Third, the application of the FAA would "invalidate, impair, or supersede" Nevada's Liquidation Act. Nevada's Liquidation Act incorporates the Uniform Insurers Liquidation Act ("UILA"). *See* NRS 696B.280. The general purpose of the UILA is to "centraliz[e] insurance rehabilitation and liquidation proceedings in one state's court so as to protect all creditors equally." *Frontier Ins. Serv. V. State*, 109 Nev. 231,236, 849 P.2d 328, 331 (1992), *quoting Dardar v. Ins. Guaranty Ass'n*, 556 So. 2d 272, 274 (La. Ct. App. 1990). Similarly, the UILA's overall purpose is to protect the interests of policyholders, creditors and the public. *See, e.g*. NRS 696B.210, 696B.530, 696B540; *see also* Joint Meeting of the Assembly and Senate Standing Committees on Commerce, March 25, 1977 (summarizing statements by Richard Rottman, Insurance Commissioner, and Dr. Tom White, Director of Commerce Department) (Nevada's insurance law was "designed to help the Insurance Division regulate the industry on behalf and primarily in the interests of the public of the State of Nevada"). Applying the law of the domiciliary state, as well as centralized proceedings in one state's court, advances these purposes. *See Frontier Ins. Serv*., 109 Nev. at 236, 849 P.2d at 3341; *In re Freestone Ins. Co.*, 143 A.3d 1234, 1260-61 (Del. Ch. 2016); *see also Benjamin v. Pipoly*, 2003-Ohio-5666, ¶45, 155 Ohio App. 3d 171, 184, 800 N.E.2d 50, 60 ([C]ompelling arbitration against the will of the liquidator will always interfere with the liquidator's powers and will always adversely affect the insurer's assets."). Indeed, Nevada's Liquidation Act recognizes the need for consolidation in one court via various statutory provisions. *See, e.g*., NRS 696B.190(1) (District court has original jurisdiction over delinquency proceedings under NRS 696B.010 to 696B.565, inclusive, and any court with jurisdiction may make all necessary or proper orders to carry out the purposes of those sections); NRS 696B.190(4) ("No court has jurisdiction to entertain, hear or determine any petition or complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation or receivership of any insurer…or other relief …relating to such proceedings, other than in accordance with NRS 696B.010 to 696B.565, inclusive."); NRS 696B.270 ("The court may at any time during a proceeding...issue such other injunctions or orders as may be deemed necessary to prevent interference with the Commissioner or the proceeding, or waste of the assets of the insurer, or the commencement or prosecution of any actions…"). Likewise, the Court, acting within its statutory

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

authority, ordered that it would exercise "sole and exclusive jurisdiction" over all Property (including lawsuits), "to the exclusion of any other court or tribunal."

The Kentucky Supreme Court held that "the third part of the *Forsyth* test is satisfied because the Federal Arbitration Act's preference for arbitration conflicts with, and impairs, the [liquidation act's] grant of broad and exclusive jurisdiction to the Franklin Circuit Court… the federal policy favoring arbitration is subordinated to the state's superior interest in having matters relating to the rehabilitation of an insurance company adjudicated in the Franklin Circuit Court." *See Clark*, 323 S.W.3d 682, 692. Likewise, Nevada's Liquidation Act relates directly to the business of insurance and thus reverse-preempts the FAA. As the Court in *Taylor v. Ernst & Young* held when interpreting that states statutes which were also based on the Uniform Insurers Liquidation Act, "when allowed, forum selection ***belongs to the liquidator*** and the liquidator ***alone***." 958 N.E.2d at 1209 (emphasis added). Accordingly, the cases cited by Milliman based on the FAA are inapposite, and the Receiver's chosen forum – this Court – has jurisdiction over the claims.

b. Nevada's Insurance Liquidation Law and the Receivership Order Precludes Contrary Application of the NAA.

Milliman also argues that the general policy in favor of arbitration implicit in the ***Nevada*** Arbitration Act ("NAA") governs. *See* Motion, at 8. However, it is well-settled that where a general statute conflicts with a specific one, the specific one governs. *See, e.g.*, *State Dep't of Taxation v. Masco Builder*, 129 Nev. Adv. Op. 83, 312 P.3d 475, 478 (2013) ("A specific statute controls over a general statute"). "Under the general/specific canon, the more specific statute will take precedence, and is construed as an exception to the more general statute, so that, when read together, the two provisions are not in conflict and can exist in harmony." *Williams v. State Dep't of Corr.*, 402 P.3d 1260, 1265 (Nev. 2017) (internal citations and quotations omitted).

Here, although the NAA provides a general policy in favor of arbitration, the Liquidation Act creates a specific and detailed statutory scheme for winding down insolvent insurance companies for the benefit of NHC's members, its formerly insured patients, unpaid hospitals, doctors, other creditors, and the public at large. *See* NRS 696B. Under this scheme, the district court has original jurisdiction over delinquency proceedings (including liquidation), and may make

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

all necessary or proper orders to carry out the purposes of the Liquidation Act. *See* NRS 696B.190. Likewise, the statute provides that "[n]o court has jurisdiction to entertain, hear or determine any petition or complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation or receivership of any insurer…or other relief preliminary, incidental or relating to such proceedings, other than in accordance with NRS 696B.010 to 696B.565, inclusive. *Id*. The Court may issue injunctions or orders as may be deemed necessary to prevent interference with the Commissioner or the proceeding, or waste of the assets of the insurer, or the commencement or prosecution of any actions, or the obtaining of preferences, judgments, attachments or other liens, or the making of any levy against the insurer or against its assets or any part thereof. *See* NRS 696B.270.

Pursuant to its statutory authority, the district court entered an order – the Receivership Order – that comprehensively addresses the receivership of NHC. It states that the Court has exclusive jurisdiction. Milliman now argues that this exclusive jurisdiction is not exclusive, but subject to an arbitration clause due to the general policy in favor of arbitration that arises by virtue of the NAA. This general policy in favor of arbitration cannot trump the specific statutory scheme laid out in the Liquidation Act, and this Court should not apply the policy in favor of arbitration.

2. The Presumption in Favor of Arbitration Does Not Apply to the Non-Signatory Commissioner and Should Not be Applied Here.

Even assuming that the Court considered the policy in favor of arbitration laid out in the FAA and the NAA applicable here, the policy in favor of arbitration could not apply on these facts where the Receiver is not a signatory to the Agreement. It is fundamental that "arbitration is a matter of contract and a party cannot be required to submit to arbitration any dispute which he has not agreed so to submit." *AT&T Techs., Inc. v. Commc'ns Workers of Am.*, 475 U.S. 643, 648 (1986) (citation omitted); *EEOC v. Waffle House, Inc.*, 534 U.S. 279, 294 (2002) ("Arbitration under the [FAA] is a matter of consent, not coercion. . . . It goes without saying that a contract cannot bind a nonparty."); *First Options of Chi., Inc. v. Kaplan*, 514 U.S. 938, 943 (1995) ("[A]rbitration is simply a matter of contract between the parties; it is a way to resolve those disputes—but only those disputes—that the parties have agreed to submit to arbitration.").

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

Here, the Receiver is not a signatory to the Agreement at issue – in reality or in legal effect – and as such, this Court should not compel arbitration. Milliman makes three arguments to the contrary, none of which are persuasive. First, Milliman argues that because a receiver "steps into the shoes" of its predecessor, the Receiver here is bound. Second, Milliman argues that equitable estoppel prevents the Receiver from seeking to enforce some parts of the agreement but not others. Finally, Milliman argues that the Receivership Order does not require consolidation of all claims in this Court. None of these arguments has merit.

a. The Receiver Does Not Simply "Step Into the Shoes" of NHC.

Milliman argues that the Receiver is bound by the arbitration clause because she has simply stepped into the shoes of NHC by virtue of the receivership. There is no dispute that the Receiver is not ***actually*** a signatory to the Agreement that contains the arbitration clause. However, Milliman seeks to get around this by arguing that the Receiver is ***effectively*** a signatory to the Agreement because she has "stepped into the shoes" of NHC. This is not accurate.

Milliman cites a number of cases supposedly standing for the proposition that a receiver simply steps into the shoes of the insolvent entity and must therefore be bound as the insolvent entity would have been. However, Milliman's cases are not on point, as they do not involve receivership under a state insurance code where the FAA is reverse preempted by the McCarran-Ferguson Act or under circumstances like these. *See O'Melveny & Myers v. F.D.I.C*, 512 U.S. 79, 82 (1994) (FDIC as receiver for a savings and loan); *Anes v. Crown P'ship, Inc.*, 113 Nev. 195, 199 (1997) (private company as receiver for property owner/lessor); *First Fin. Bank v. Lane*, 130 Nev. Adv. Op. 96, 339 P.3d 1289, 1290, 1293 (2014) (assignee steps into shoes of assignor); *Wuliger v. Manufacturers Life Ins. Co.*, 567 F.3d 787 (6th Cir. 2009) (individual receiver for private investment company).[6]

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[6] Although Milliman's citation to *Texas Commerce Bank v. Garamendi* does involve a receiver for an insolvent insurer, in making the cited statement, the court was drawing a distinction between an insurance commissioner acting as a public official versus acting as a receiver, and was not commenting on the issue before the Court here. 28 Cal. App. 4th 1234, 1245 (Cal Ct. App. 1994) (defendant receiver was not acting as a public official, but as a receiver, when he made determination affecting payment priority).

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

On the contrary, a liquidator or receiver of a defunct insurance company does not simply "stand in the shoes" of an insolvent insurer, because he or she also represents the insureds, policyholders, and creditors of that entity. *See Taylor v. Ernst & Young*, 130 Ohio St. 3d 411, 419 (Ohio 2011) ("[t]he fact that any judgments in favor of the liquidator accrue to the benefit of insureds, policyholders, and creditors means that the liquidator's unique role is one of public protection…"); *see generally Cordial v. Ernst & Young*, 199 W. Va. 119, 128 (W.Va. 1996) (insurance commissioner as receiver for an insurer "acts as the representative of interested parties, such as the defunct insurer, its policyholders, creditors, shareholders, and other affected members of the public," not simply as the defunct insurer). In *Arthur Andersen v. Superior Court*, a California court rejected the defendant's argument that an insurance liquidator acts as a typical receiver, holding:

> No authority is offered for the proposition that the Insurance Commissioner acts merely as an ordinary receiver. Ordinary receivers do not become involved until control of a business is taken away from its officers or owners due to insolvency, deadlock or other causes. Ordinary receivers do not monitor the solvency of an entity on behalf of persons, such as policyholders, who do business with the entity. The Insurance Code, by contrast, assigns such pre-conservatorship duties to the Insurance Commissioner. (See, e.g., Ins. Code, § 730, subd. (b).) In carrying out these duties, the Insurance Commissioner acts not in the interests of the equity owners of the insurance company, but rather in the interests of policyholders. Thus the Insurance Commissioner in this case is not seeking merely to prosecute claims of an entity under receivership. To the contrary, the essence of the Insurance Commissioner's claim is that AA damaged the policyholders. Thus even though a receivership may bear some points of analogy to a statutory insurance company liquidation (primarily in that each can involve the marshalling of the assets of an estate), an ordinary receivership is a different procedure for a different situation.

67 Cal. App. 4th at 1495.

This fact is important to courts when determining whether or not to enforce an arbitration clause. For example, the *Taylor* court called the defendant's attempt at compelling arbitration "a garden-variety attempt to enforce an arbitration clause against a nonsignatory" and applied a presumption ***against*** arbitration. 130 Ohio St. 3d 411, 420; *see generally Covington v. Am. Chambers Life Ins. Co*, 779 N.E.2d 833, 838 (Ohio Ct. App. 2002) (holding liquidator not bound by arbitration agreement because the dispute involved setoff and proof of claims, which impacted the

rights of creditors); *Jaime Torres Int'l Sports Mgmt., Inc. v. Kapila*, 2016 WL 8585339, at *7 (S.D. Fla. May 11, 2016) (in bankruptcy context, because the trustee stood in the shoes of both the debtor and the creditors, and the creditors were not parties to the agreement containing the arbitration clause, the claims were not subject to the arbitration clause).

Such is the case here. Nevada's statutory framework was not designed to primarily protect insurance companies, but rather their insureds and their creditors. For example, violations of statutory requirements concerning certifications of Milliman to the Department of Insurance, and other claims as alleged, damaged persons other than just NHC. The Receiver is suing not only on behalf of NHC, but "on behalf of…NHC's members, insured enrollees, and creditors." *See* Complaint, at ¶ 1. She has not simply "stepped into the shoes" of NHC. While Milliman may argue it is fair to bind ***NHC*** to an arbitration clause in an agreement that its predecessor signed, it is not fair to bind those that had no say in that agreement – e.g., creditors and policyholders – to those terms. That is especially true here, where the arbitration clause limits discovery and precludes punitive damages. *See* Motion to Compel Arbitration, Exhibit A, at ¶ 5. Because the Receiver is not merely acting on behalf of NHC here, it would be unjust to force application of the arbitration clause. Courts have held similarly with regard to those claims that do not arise out of the agreement itself. *See Taylor*, 130 Ohio St. 3d 411 (malpractice claim and fraudulent transfer claim were not subject to arbitration, as malpractice claim did not arise from engagement letter and fraudulent transfer claim sprung to life upon the issuance of the liquidation order).[7]

[7] Milliman offers *Rich v. Cantilo & Bennett* for the proposition that receivers are bound by arbitration provisions in the agreements that they assume to enforce. *See* Motion, at 11; 492 S.W.3d 755 (Tex. Ct. App. 2016). This case is not binding and is factually distinguishable; for example, the Texas receivership statute specifically states that "nothing in this chapter deprives a party of any contractual right to pursue arbitration." *See id*., at 762, citing Tex. Ins. Code § 443.005(e). However, even in *Rich*, the court acknowledged that arbitration was warranted ***only*** for those claims "accruing independently of the Receiver's appointment and arising under the…agreement."). Many of the Receiver's claims here either accrued as a result of the Receiver's appointment, or are unrelated to the Agreement. As such, a finding in Milliman's favor would not result in the entirety of the claims against Milliman being arbitrated, but would at most result in bifurcation of the case (some claims to arbitration and some claims litigated here). This is an unnecessary waste of the resources of the NHC estate, would be duplicative, and could potentially result in inconsistent findings. Likewise, *Bennett v. Liberty Nat. Fire Ins. Co*., also cited by Milliman, is inapposite where the liquidator in that case "presented no evidence that enforcing the arbitration clauses here will disrupt the orderly liquidation of the insolvent insurer." *See* 968 F.2d 969, 972 (9th Cir. 1992). As explained herein, sending some claims to arbitration will undoubtedly disrupt the orderly liquidation of NHC and be an unnecessary drain on the NHC estate, to the detriment of policyholders, creditors, and the public. Further, according to the arbitration clause, the arbitrator would not have the ability to award punitive damages and would only be able to conduct limited discovery (unlike this Court). In any event, neither of these cases is binding on this Court.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

b. Equitable Estoppel Does Not Mandate Arbitration Here.

Milliman's next argument is that the doctrine of equitable estoppel mandates arbitration. Again, the general rule is that a party ***cannot*** be bound to an arbitration provision in an agreement that it did not sign. *See, e.g. Truck Ins. Exch. v. Swanson*, 124 Nev. 629, 635, 189 P.3d 656, 659-60 (2008). However, equitable estoppel is an exception to this general rule: it provides that a non-signatory may be bound if it seeks to enforce rights under an agreement, as it cannot disavow portions of that same agreement. *See* Motion, at 11; *Truck Ins. Exch*., 124 Nev. 629, 636, 189 P.3d 656, 661.[8]

However, estoppel has its limits. Courts have found that while certain contractual provisions may be enforced against a non-signatory where the non-signatory "receives a direct benefit from the contract containing an arbitration clause," this exception ***does not apply*** to non-signatories whose interests might be related to, but do not flow from, the contractual interest of a signatory to the agreement. *See, e.g. Truck Ins. Exch.*, 124 Nev. 629, 637, 189 P.3d 656, 661-62 (finding that a party who was not a signatory to the written agreements, and who did not directly benefit from those agreements in initiating its cause of action, was not estopped from repudiating the arbitration agreement). Where any benefit to the non-signatory is indirect, even where the claims are "intertwined with the underlying contract," only the signatory is estopped from avoiding the clause. *See Javitch v. First Union Sec., Inc*., 315 F.3d 619, 629 (6th Cir. 2003), citing *Thomson-CSF v. Am. Arbitration Ass'n*, 64 F.3d 773, 779 (2d Cir. 1995) ("When only an indirect benefit is sought…it is only the signatory that may be estopped from avoiding arbitration with a non-signatory when the issues the non-signatory is seeking to resolve are intertwined with the underlying contract," and vacating the lower court's decision for further consideration of this issue).

Here, this logic applies. The Receiver is not the direct beneficiary of the Agreement. The Receiver represents a number of other interests and does not herself receive a "direct benefit" from the Agreement. The Receiver did not have a business plan drafted for her that obtained federal funding. The Receiver did not have its reserves calculated and certified. Milliman did not calculate rates for the Receiver's insurance company. As such, equitable estoppel does not apply here.

[8] The *Ahlers* case cited by Milliman is inapposite. In addition to being unpublished and therefore noncitable as precedent, it involves a situation where a plaintiff ***signatory*** to a contract with an arbitration clause attempts to avoid an arbitration clause. Here, the plaintiff, the Receiver, is a ***non-signatory***.

Finally, equitable estoppel is by its nature a creature of equity: it is an exception that seeks to do what is fair. Here, it would not be fair to send the claims against Milliman to arbitration with limited discovery and limited damages further expanding litigation costs and reducing the amount remaining for distribution to claimants; the policyholders and creditors never agreed to such an arrangement.

c. Nevada's Statutory Scheme and the Receivership Court's Order Mandate that the Receiver's Decision to Litigate in the Eighth Judicial District Court be Respected.

Milliman's final argument also fails. Milliman argues that "there is no statutory provision that requires the Receiver to litigate contract and tort claims against a third-party in any particular forum or jurisdiction." *See* Motion, at 12. Milliman goes on to argue that section 14(a) of the Receivership Order permits the Receiver to litigate anywhere, and that the portion of the Receivership Order that gives exclusive jurisdiction to the Eighth Judicial District Court is not applicable. This strained reading of the Receivership Order is not tenable.

i. The Receivership Order Provides for Exclusive Jurisdiction.

The parties agree that the Receivership Order governs this action. A review of the Receivership Order reveals that, consistent with the Nevada law, the Order provides the Receiver with broad power to "conserve and preserve the affairs of" NHC, including performing "all acts necessary or appropriate for the conservation, rehabilitation, or liquidation" of NHC. In other words, the Receiver is tasked with maximizing the value of the estate of NHC for the purposes of those with claims against the estate. It gives the Receiver legal and equitable title to all NHC "Property," which explicitly includes causes of action, defenses, and rights to participate in legal proceedings. *See* **Exhibit B**, Receivership Order, at (2)(b). It also places all Property, and any claims or rights respecting the Property in the "sole and exclusive jurisdiction" of the Court, ***to the exclusion of any other court or tribunal***. *See id*., at (3). The fact that later in the order, the Receiver is "authorized" to "collect all debts and monies due and claims belonging to [NHC], and for this purpose:…to do such other acts as are necessary or expedient to marshal, collect, conserve, or protect its assets or property, including the power…to initiate and maintain actions at law or

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

equity or any other type of action or proceeding of any nature, in this, and other jurisdictions…" *id*., at (14)(a), does not negate the Court's exclusive jurisdiction. By authorizing the Receiver to litigate in other jurisdictions when necessary, the Receivership Order simply provides the Receiver the ability to marshal assets when she can only do so in another court for jurisdictional reasons (such as exclusive federal jurisdiction or out-of-state proceedings).

A similar situation arose in Ohio in *Taylor*, 130 Ohio St.3d 411. There, the Ohio statute provided that all liquidation actions were to be brought in the court of common pleas of Franklin County, and other statutory provisions were in accord, but still other provisions stated that as part of the liquidator's power to collect debts, the liquidator may institute actions in other jurisdictions, litigate "elsewhere," and submit the value of a security to arbitration. *See Taylor*, 130 Ohio St.3d. 411, 415-16. The Ohio Supreme Court explained the arguably conflicting provisions by noting that "***when allowed***, ***forum selection belongs to the liquidator and the liquidator alone***." *Id*. at 416 (emphasis added). Here, the complementary provisions in the Receivership Order are similar: they simply provide that where there is ***discretion*** to choose a forum, that discretion belongs to the Receiver. Here, the Receiver has initiated litigation in the Eighth Judicial District Court, and (14) does not come into play. [9]

ii. Milliman's Arguments to the Contrary Fail.

Perhaps recognizing that the Receivership Order's statement of exclusive jurisdiction is fatal to its motion to compel arbitration, Milliman attempts to argue that it does not apply because (1) the Receiver's claims against Milliman do not affect the administration, allocation, or ownership of NHC's property or assets, and (2) Milliman is bringing no claims "against" NHC.

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[9] To the extent that Milliman argues that New York law may apply, under New York law, an insurer's agreement to arbitrate is unenforceable against a statutory liquidator, even in those actions wither the same contract terms are in dispute. *See, e.g. Corcoran v. Ardra Insurance Co.*, 567 N.E.2d 969 (N.Y. 1990) (refusing to compel arbitration in an action by the liquidator to recover reinsurance proceeds); *In re: Allcity Ins. Co.*, 66 A.D.2d 531, 535 (N.Y. App. Div. 1979) (refusing to enforce arbitration agreement in an insurance rehabilitation proceeding because "nowhere in [the New York liquidation statute] is there any indication that the Legislature intended to have rehabilitation effected in any forum but a *court* of law") (emphasis added); *Skandia Am. Reinsurance Corp. v. Schenck*, 441 F. Supp. 715, 723 n. 11 (S.D.N.Y., 1977) ("These arbitration clauses do not deprive this court of jurisdiction. Once a New York insurer is placed in liquidation, it may not be compelled to arbitrate . . . Indeed, the order of liquidation terminates the company's existence."); *Ideal Mut. Ins. Co. v. Phoenix Greek Gen. Ins. Co.*, No. 83-CV-4687, 1987 WL 28636, at *2 (S.D.N.Y. Dec. 11, 1987) ("The liquidators of insurance companies are simply not bound to arbitrate claims involving the companies."); *Washburn v. Corcoran*, 643 F. Supp. 554, 557 (S.D.N.Y. 1986).

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

Milliman's first argument is nonsensical. Put simply, money damages are property of the NHC estate, as are causes of action (claims for money damages). *See* **Exhibit B**, Receivership Order, at (2)(a) and (b) ("assets" are Property; "causes of action" are Property). Whatever money damages are recovered will go directly into the NHC estate and be paid out as appropriate. Further, the Receivership Order specifically provides that no judgment, order or legal process of any kind affecting NHC or the Property shall be effective or enforceable unless entered by the Court, or unless the Court permits the same. *See id.*, at (19). Any money damages awarded by an arbitrator would certainly be Property of the NHC estate.

Second, whether or not Milliman is bringing any claims ***"against"*** NHC (emphasis in original) is irrelevant to the plain fact that the Court has sole and exclusive jurisdiction over claims or rights respecting the NHC estate Property. In any event, however, Milliman ***is*** bringing a claim against NHC: it filed a proof of claim recognizing the jurisdiction of Nevada courts. *See* Proof of Claim dated January 16, 2016, attached hereto as **Exhibit C**.

Finally, Milliman's analogy to the bankruptcy context is unavailing. Whether or not bankruptcy courts have discretion to deny arbitration of non-core pre-petition common law claims is irrelevant here. McCarran-Ferguson preempts insurance-related claims rather than the bankruptcy claims cited by Milliman, and Nevada's Liquidation Act governs these proceedings, not the Bankruptcy Code. Further, as noted above, the Receiver here is not simply acting on behalf of NHC, but on behalf of creditors and policyholders. Bankruptcy cases have not forced arbitration in that context. *See Hays & Co. v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 885 F.2d 1149, 1154 (3d Cir. 1989) (holding bankruptcy trustee's claims under § 541 of the Bankruptcy Code were subject to arbitration only to the extent that the trustee stands in the shoes of the debtor, but the trustee is not bound to arbitrate claims brought on behalf of creditors); *Javitch v. First Union Secs., Inc.*, 315 F.3d 619, 625–27 (6th Cir. 2003) (holding that a receiver was bound to arbitrate because the court order appointing him as receiver only authorized him to assert actions on behalf of the receivership entities (and not creditors) and the actions were, in fact, on behalf of the entities rather than creditors); *see also In re EPD Inv. Co., LLC*, 821 F.3d 1146, 1152 (9th Cir. 2016) (holding that where a bankruptcy trustee asserts claims on behalf of a creditor he is not bound by the debtor's

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

agreement to arbitrate); *In re Salander-O'Reilly Galleries, LLC*, 475 B.R. 9 (S.D.N.Y. 2012) ("a trustee's claims asserted as a lien creditor under §544…are not subject to a pre-petition agreement between the debtor and another party to arbitrate"); *Boedeker v. Rogers*, 736 N.E.2d 955 (Ohio Ct. App. 1999) (holding a class action by and on behalf of policyholders against the former directors and officers of an insurer was not subject to an arbitration clause in their employment agreement); *Jaime Torres Int'l Sports Mgmt., Inc. v. Kapila*, 2016 WL 8585339, at* 7 (S.D. Fla. May 11, 2016) (holding that where a trustee brings claims on behalf of the debtor and creditors, the trustee is not bound to arbitrate because the creditors were not parties to the arbitration agreement).

Even Milliman's primary case citation for this proposition did not compel arbitration; the Fifth Circuit held that where the underlying nature of the case derives exclusively from the provisions of the Bankruptcy Code, a bankruptcy court *does* have discretion to refuse to enforce an arbitration agreement if it conflicts with the purposes of the Code. *See In re Gandy*, 299 F.3d 489, 495 (5th Cir. 2002). The court in *Gandy* determined that where the "heart" of the debtor's complaint concerns bankruptcy issues, as opposed to pre-petition contract or tort issues, where the equitable and expeditious distribution of assets would be better served by litigation in one tribunal, where a proof of claim had been filed, thus invoking the powers of the bankruptcy court, and the debtor had requested a bankruptcy-specific remedy that the arbitrator may not be able to provide, the court would not order arbitration. *Id*. at 496-99. The court held that "[p]arallel proceedings would be wasteful and inefficient, and potentially could yield different results and subject the parties to dichotomous obligations." *Id*. at 499.

The same is true here. Even if there is a hard-and-fast rule that would permit arbitration in the bankruptcy context, Milliman has pointed to no such rule under Nevada law. Furthermore, unlike in a bankruptcy action, McCarran-Ferguson reverse-preempts the FAA, upon which these cases are based. However, the considerations of waste, inefficiency, and different results are very real. Further, Milliman has already subjected itself to the jurisdiction of the Court by filing a proof of claim.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

3. The AAA is Not an Adequate Forum to Resolve This Dispute.

Milliman cites *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.* for the proposition that pre-dispute agreements to arbitrate are enforceable if the party may effectively vindicate its rights in the arbitral forum. *See* 473 U.S. 614 (1985). The "effective vindication" doctrine "provides courts with a means to invalidate, on public policy grounds, arbitration agreements that operate as a prospective waiver of a party's right to pursue statutory remedies." *See Mohamed v. Uber Techs., Inc.*, 848 F.3d 1201, 1212 (9th Cir. 2016), *quoting Am. Exp. Co. v. Italian Colors Rest.*, ––U.S. ––, 133 S.Ct. 2304, 2310, 186 L.Ed.2d 417 (2013). In other words, where rights ***cannot*** be effectively vindicated, arbitration is inappropriate.

However, the AAA would not be an adequate forum for effectively vindicating the Receiver's rights here. The arbitration clause provides for only limited discovery and no punitive damages; this Court has the power both to order full discovery and to award punitive damages if appropriate. This Court acts in the public interest, whereas an arbitrator's role is to act in the interests of the parties. Further, as some of the claims involve joint and several liability of all defendants – e.g., conspiracy and concert of action – none of whom are parties to the Agreement. These joint claims would be impossible for an arbitrator to adjudicate and the parties would risk inconsistent judgments.

IV. CONCLUSION

In light of the foregoing, NHC respectfully requests that this Court DENY Milliman's Motion to Compel Arbitration.

DATED this 11th day of December, 2017.

GREENBERG TRAURIG, LLP

/s/ Donald L. Prunty, Esq.
MARK E. FERRARIO, ESQ.
Nevada Bar No. 1625
ERIC W. SWANIS, ESQ.
Nevada Bar No. 6840
DONALD L. PRUNTY, ESQ.
Nevada Bar No. 8230
3773 Howard Hughes Parkway, Suite 400 N
Las Vegas, NV 89169
Counsel for Plaintiff

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

CERTIFICATE OF SERVICE

I hereby certify that on this 11th day of December, 2017, a true and correct copy of the foregoing **PLAINTIFF'S OPPOSITION TO MILLIMAN'S MOTION TO COMPEL ARBITRATION** was filed with the Clerk of the Court using the Odyssey eFileNV Electronic Service system and served on all parties with an email address on record, pursuant to Administrative Order 14-2 and Rule 9 of the N.E.F.C.R.

The date and time of the electronic proof of service is in place of the date and place of deposit in the U.S. Mail.

/s/ Shayna Noyce
An employee of Greenberg Traurig, LLP

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

DECL

MARK E. FERRARIO, ESQ.
Nevada Bar No. 1625
ERIC W. SWANIS, ESQ.
Nevada Bar No. 6840
DONALD L. PRUNTY, ESQ.
Nevada Bar No. 8230
GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway, Suite 400 N
Las Vegas, NV 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002
Email: ferrariom@gtlaw.com
swanise@gtlaw.com
pruntyd@gtlaw.com
Counsel for Plaintiff

DISTRICT COURT
CLARK COUNTY, NEVADA

STATE OF NEVADA, EX REL. COMMISSIONER OF INSURANCE, BARBARA D. RICHARDSON, IN HER OFFICIAL CAPACITY AS RECEIVER FOR NEVADA HEALTH CO-OP,

Plaintiff,

v.

MILLIMAN, INC., a Washington Corporation; JONATHAN L. SHREVE, an Individual; MARY VAN DER HEIJDE, an Individual; MILLENNIUM CONSULTING SERVICES, LLC, a North Carolina Corporation; LARSON & COMPANY P.C., a Utah Professional Corporation; DENNIS T. LARSON, an Individual; MARTHA HAYES, an Individual; INSUREMONKEY, INC., a Nevada Corporation; ALEX RIVLIN, an Individual; NEVADA HEALTH SOLUTIONS, LLC, a Nevada Limited Liability Company; PAMELA EGAN, an Individual; BASIL C. DIBSIE, an Individual; LINDA MATTOON, an Individual; TOM ZUMTOBEL, an Individual; BOBBETTE BOND, an Individual; KATHLEEN SILVER, an Individual; DOES I through X inclusive; and ROE CORPORATIONS I-X, inclusive,

Defendants.

Case No.: A-17-760558-C
Dept. No.: 25

DECLARATION IN SUPPORT OF PLAINTIFF'S OPPOSITION TO MILLIMAN'S MOTION TO COMPEL ARBITRATION

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

I, Donald L. Prunty, declare under penalty of perjury under the laws of the United States and the State of Nevada that the facts contained herein are true to the best of my personal knowledge and belief, and if called upon, I could and would competently testify to them.

1. I am an attorney duly licensed to practice law in the State of Nevada with the law firm of Greenberg Traurig, LLP, counsel for Plaintiff Barbara D. Richardson, Commissioner of Insurance, as the Permanent Receiver for Nevada Health CO-OP ("Plaintiff").

2. Except as otherwise indicated, all facts set forth in this Declaration are based on my personal knowledge and belief, and, if called as a witness, I could and would competently testify to the facts set forth in this Declaration.

3. This Declaration is submitted in support of Plaintiff's Opposition to Defendant Milliman's Motion to Compel Arbitration.

4. Exhibit A to the Opposition is a true and correct copy of the Judgment on Exceptions, 19th Judicial District Court, Parish of East Baton Rouge, State of Louisiana, dated September 19, 2017.

5. Exhibit B to the Opposition is a true and correct copy of the Receivership Court's Permanent Injunction and Order Appointing Commissioner as Permanent Receiver of Nevada Health Co-Op ("Receivership Order"), dated October 14, 2015.

6. Exhibit C to the Opposition is a true and correct copy of Milliman's Proof of Claim (redacted).

7. I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct.

DATED this 11th day of December, 2017.

/s/ Donald L. Prunty, Esq.
DONALD L. PRUNTY, ESQ.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

EXHIBIT A

19TH JUDICIAL DISTRICT COURT
PARISH OF EAST BATON ROUGE
STATE OF LOUISIANA

22-SEP-2017

TO: J E CULLENS JR
WALTERS PAPILLION THOMAS
12345 PERKINS RD BLDG 1
BATON ROUGE, LA 70810

JAMES J DONELON VS TERRY S SHILLING ETAL

CASE NUMBER: C651069

JUDGE: TIMOTHY E KELLEY

DIVISION: SECTION 22

YOU ARE HEREBY NOTIFIED OF THE FOLLOWING ACTION FOR THE

AFOREMENTIONED CASE: SEE ENCLOSED COPY OF JUDGMENT SIGNED 9/19/17
REGARDING HEARING OF 8/25/17

PAULA DENNIS
JUDICIAL ASSISTANT TO JUDGE
TIMOTHY E KELLEY

NOTIFIED:

Form 4522

JAMES J. DONELON, COMMISSIONER OF INSURANCE FOR THE STATE OF LOUISIANA, IN HIS CAPACITY AS REHABILITATOR OF LOUISIANA HEALTH COOPERATIVE, INC.	:	SUIT NO.: 651,069 SECTION: 22
versus	:	19TH JUDICIAL DISTRICT COURT
TERRY S. SHILLING, GEORGE G. CROMER, WARNER L. THOMAS, IV, WILLIAM A. OLIVER, CHARLES D. CALVI, PATRICK C. POWERS, CGI TECHNOLOGIES AND SOLUTIONS, INC., GROUP RESOURCES INCORPORATED, BEAM PARTNERS, LLC, MILLIMAN, INC., BUCK CONSULTANTS, LLC. AND TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA	:	PARISH OF EAST BATON ROUGE
	:	STATE OF LOUISIANA

STATE
SEP 15 2017
DEPUTY CLERK OF COURT

JUDGMENT

A contradictory hearing regarding the following matters:

1. **DECLINATORY EXCEPTION OF LACK OF SUBJECT MATTER JURISDICTION**, filed herein by defendant, Milliman, Inc. ("Milliman");

2. **DECLINATORY EXCEPTION OF IMPROPER VENUE**, filed herein by defendant, Buck Consultants, LLC ("Buck");

3. **PEREMPTORY EXCEPTION OF PRESCRIPTION**, filed herein by defendant, Group Resources Incorporated ("GRI"); and

4. **CGI'S MOTION FOR SUMMARY JUDGMENT**, filed herein by defendant, CGI Technologies and Solutions, Inc. ("CGI").

was held pursuant to applicable law on August 25, 2017, in Baton Rouge, Louisiana, before the Honorable Timothy Kelley; present at the hearing were:

J. E. Cullens, Jr., attorney for plaintiff, James J. Donelon, Commissioner of Insurance for the State of Louisiana, in his capacity as Rehabilitator of Louisiana Health Cooperative, Inc.

James A. Brown, attorney for defendant, Buck Consultants, LLC

W. Brett Mason, attorney for defendant, Group Resources Incorporated

V. Thomas Clark, Jr., attorney for defendant, Milliman, Inc.

Frederick Theodore Le Clercq, attorney for defendant, Beam Partners, LLC

Harry J. Philips, Jr., attorney for defendant, CGI Technologies and Solutions, Inc.

Considering the evidence and exhibits admitted at this hearing, the pleadings and memoranda filed by the parties, applicable law, the argument of counsel, and for the reasons stated in open court at the hearing of this matter:

IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that MILLIMAN INC.'S DECLINATORY EXCEPTION OF LACK OF SUBJECT MATTER JURISDICTION is **DENIED.**

IT IS FURTHER HEREBY ORDERED, ADJUDGED, AND DECREED that BUCK CONSULTANTS, LLC'S DECLINATORY EXCEPTION OF IMPROPER VENUE is **DENIED.**

IT IS FURTHER HEREBY ORDERED, ADJUDGED, AND DECREED that GROUP RESOURCES INCORPORATED'S PEREMPTORY EXCEPTION OF PRESCRIPTION is **DENIED.**

IT IS FURTHER HEREBY ORDERED, ADJUDGED, AND DECREED that CGI TECHNOLOGIES AND SOLUTIONS, INC.'S MOTION FOR SUMMARY JUDGMENT is **DENIED, WITHOUT PREJUDICE.**

IT IS FURTHER HEREBY ORDERED, ADJUDGED, AND DECREED that this Court's previous order staying general discovery regarding the merits of this litigation dated April 26, 2017, is hereby **LIFTED**; furthermore, it is contemplated that all parties will timely confer and propose a **CASE SCHEDULING ORDER** it is contemplated that all parties will timely confer and propose and acceptable case scheduling order to be adopted by this Court.

IT IS FURTHER HEREBY ORDERED, ADJUDGED, AND DECREED that each defendant shall have 30 days from the date of the mailing of the signed judgment to file a notice of intent to seek supervisory writs.

SIGNED this 19 day of September, 2017, at Baton Rouge, Louisiana.

HON. JUDGE TIMOTHY KELLEY, 19th JDC

PLEASE PROVIDE NOTICE OF JUDGMENT
PURSUANT TO LSA–CCP ART. 1913

I HEREBY CERTIFY THAT ON THIS DAY A COPY OF THE WRITTEN REASONS FOR JUDGMENT / JUDGMENT / ORDER / WAS MAILED BY ME, WITH SUFFICIENT POSTAGE AFFIXED TO: Robert Bickford, V. E. Cullens, Matthew Farley, James Brom, V. Thomas Clark, Jr., Henry Olinde, Jr., Robert David, Jr.
DONE AND SIGNED ON 9-25-17
DEPUTY CLERK OF COURT
W. Britt Mann, Robert Barton, Frederic Le Clercq, Thomas McEachin, Richard Boudreaux, Ryan French, Justin Marocco, Mirais Hodder, Alexander Breckinridge V

FILED
EAST BATON ROUGE PARISH, LA
2017 SEP 15 PM 12:35
DEPUTY CLERK OF COURT

RULE 9.5 CERTIFICATION

Pursuant to Uniform Local Rule 9.5, I certify that I first circulated this proposed JUDGMENT to counsel for all parties via email on August 30, 2017, and then circulated a revised version on September 7, 2017, and that:

X No opposition was received; or

__ The following opposition was received:

I have allowed at least five (5) working days before presentation to the court.

Certified this 15th day of September, 2017.

J. E. Cullens, Jr.

Respectfully submitted,

J. E. Cullens, Jr., T.A., La. Bar #23011
Edward J. Walters, Jr., La. Bar #13214
Jennifer Wise Moroux, La. Bar #31368
WALTERS, PAPILLION,
THOMAS, CULLENS, LLC
12345 Perkins Road, Bldg One
Baton Rouge, LA 70810
Phone: (225) 236-3636
Facsimile: (225) 236-3650
Email: cullens@lawbr.net

CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing has been furnished via U.S. Mail, postage prepaid, and via e-mail, to all counsel of record as follows:

I hereby certify that a true copy of the foregoing has been furnished via via e-mail to all counsel of record as follows:

Thomas McEachin
Schonekas, Evans, McGoey & McEachin, LLC
909 Poydras Street, Suite 1600
New Orleans, Louisiana 70112

Robert J. David, Jr.
Juneau David, APLC
Post Office Drawer 51268
Lafayette, LA 70505

Robert B. Bieck, Jr.
Jones Walker
201 St. Charles Avenue, 49th Floor
New Orleans, LA 70170

Henry D.H. Olinde, Jr.
Olinde & Mercer, LLC
8562 Jefferson Highway, Suite B
Baton Rouge, LA 70809

Harry (Skip) J. Philips, Jr.
Taylor Porter
Post Office Box 2471
Baton Rouge, LA 70821

W. Brett Mason
Stone Pigman
301 Main Street, #1150
Baton Rouge, LA 70825
225-490-5812

Frederic Theodore 'Ted' Le Clercq
Deutsch Kerrigan, LLP
755 Magazine Street
New Orleans, LA 70130

V. Thomas Clark, Jr.
Adams and Reese, LLP
450 Laurel Street
Suite 1900
Baton Rouge, LA 70801

James A. Brown
Liskow & Lewis
One Shell Square
701 Poydras Street, #5000
New Orleans, LA 70139

Matt J. Farley
Krebs Farley
400 Poydras Street, #2500
New Orleans, LA 70130

Baton Rouge, Louisiana this 15th day of SEPTEMBER, 2017.

J. E. Cullens, Jr.

FILED
EAST BATON ROUGE PARISH, LA
2017 SEP 15 PM 12:34
DEPUTY CLERK OF COURT

EXHIBIT B

Electronically Filed
10/14/2015 03:52:52 PM

CLERK OF THE COURT

ORD
ADAM PAUL LAXALT
Attorney General
JOANNA N. GRIGORIEV
Senior Deputy Attorney General
Nevada Bar No. 5649
555 E. Washington Avenue, Suite 3900
Las Vegas, NV 89101
P: (702) 486-3101
Email: jgrigoriev@ag.nv.gov
Attorney for the Division of Insurance

IN THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA

CLARK COUNTY, NEVADA

STATE OF NEVADA, EX REL. COMMISSIONER OF INSURANCE, IN HER OFFICIAL CAPACITY AS STATUTORY RECEIVER FOR DELINQUENT DOMESTIC INSURER, Plaintiff, vs. NEVADA HEALTH CO-OP, Defendant.	Case No. A-15-725244-C Dept. No. 1

PERMANENT INJUNCTION AND ORDER APPOINTING COMMISSIONER AS PERMANENT RECEIVER OF NEVADA HEALTH CO-OP

A Petition For Appointment Of Commissioner as Receiver and Other Permanent Relief; Request for Injunction Pursuant to NRS 696B.270(1) by the Commissioner of Insurance, Amy L. Parks, in her official capacity as Temporary Receiver of NEVADA HEALTH CO-OP ("CO-OP") was filed with the consent of CO-OP's board of directors on September 25, 2015; a Non Opposition to Petition For Appointment Of Commissioner as Receiver and Other Permanent Relief and a waiver of the opportunity to appear at a show cause hearing was filed by CO-OP through its counsel on September 29, 2015; an Order Appointing the Acting Commissioner of

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Insurance, Amy L. Parks, as Temporary Receiver Pending Further Orders of the Court, Granting Temporary Injunctive Relief Pursuant to NRS 696B.270, and authorizing the Temporary Receiver to appoint a special deputy receiver was filed on October 1, 2015; the Commissioner, as Temporary Receiver, appointed the firm of Cantilo & Bennett, L.L.P. ("C&B"), as Special Deputy Receiver ("SDR") of CO-OP on October 1, 2015 .

The Court having reviewed the points and authorities submitted by counsel and exhibits in support thereof, and for good cause,

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

(1) Acting Commissioner of Insurance, Amy L. Parks, is hereby appointed Permanent Receiver ("Receiver"), and C&B is appointed Permanent SDR of CO-OP. The SDR shall have all the responsibilities, rights, powers, and authority of the Receiver subject to supervision and removal by the Receiver and the further Orders of this Court. The Receiver and the SDR are hereby directed to conserve and preserve the affairs of CO-OP and are vested, in addition to the powers set forth herein, with all the powers and authority expressed or implied under the provisions of chapter 696B of the Nevada Revised Statute ("NRS"), and any other applicable law. The Receiver and Special Deputy Receiver are hereby authorized to rehabilitate or liquidate CO-OP's business and affairs as and when they deem appropriate under the circumstances and for that purpose may do all acts necessary or appropriate for the conservation, rehabilitation, or liquidation of CO-OP. Whenever this Order refers to the Receiver, it will equally apply to the Special Deputy Receiver.

(2) Pursuant to NRS 696B.290, the Receiver is hereby vested with exclusive title both legal and equitable to all of CO-OP's property (referred to hereafter as the "Property") and consisting of all:

a. Assets, books, records, property, real and personal, including all property or ownership rights, choate or inchoate, whether legal or equitable of any kind or nature;

b. Causes of action, defenses, and rights to participate in legal proceedings;

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c. Letters of credit, contingent rights, stocks, bonds, cash, cash equivalents, contract rights, reinsurance contracts and reinsurance recoverables, in force insurance contracts and business, deeds, mortgages, leases, book entry deposits, bank deposits, certificates of deposit, evidences of indebtedness, bank accounts, securities of any kind or nature, both tangible and intangible, including but without being limited to any special, statutory or other deposits or accounts made by or for CO-OP with any officer or agency of any state government or the federal government or with any banks, savings and loan associations, or other depositories;

d. All of such rights and property of CO-OP described herein now known or which may be discovered hereafter, wherever the same may be located and in whatever name or capacity they may be held.

(3) The Receiver is hereby directed to take immediate and exclusive possession and control of the Property except as she may deem in the best interest of the Receivership Estate. In addition to vesting title to all of the Property in the Receiver or her successors, the said Property is hereby placed in the *custodia legis* of this Court and the Receiver, and the Court hereby assumes and exercises sole and exclusive jurisdiction over all the Property and any claims or rights respecting the Property to the exclusion of any other court or tribunal, such exercise of sole and exclusive jurisdiction being hereby found to be essential to the safety of the public and of the claimants against CO-OP.

(4) The Receiver is authorized to employ and to fix the compensation of such deputies, counsel, employees, accountants, actuaries, investment counselors, asset managers, consultants, assistants and other personnel as she considers necessary. Any Special Deputy Receiver appointed by the Receiver pursuant to this Order shall exercise all of the authority of the Receiver pursuant hereto subject only to oversight by the Receiver and the Court. All compensation and expenses of such persons and of taking possession of CO-OP and conducting this proceeding shall be paid out of the funds and assets of CO-OP in accordance with NRS 696B.290.

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(5) All persons, corporations, partnerships, associations and all other entities wherever located, are hereby enjoined and restrained from interfering in any manner with the Receiver's possession of the Property or her title to or right therein and from interfering in any manner with the conduct of the receivership of CO-OP. Said persons, corporations, partnerships, associations and all other entities are hereby enjoined and restrained from wasting, transferring, selling, disbursing, disposing of, or assigning the Property and from attempting to do so except as provided herein.

(6) All providers of health care services, including but not limited to physicians hospitals, other licensed medical practitioners, patient care facilities, diagnostic and therapeutic facilities, pharmaceutical companies or managers, and any other entity which has provided or agreed to provide health care services to members or enrollees of CO-OP, directly or indirectly, pursuant to any contract, agreement or arrangement to do so directly with CO-OP or with any other organization that had entered into a contract, agreement, or arrangement for that purpose with CO-OP are hereby permanently enjoined and restrained from:

a. Seeking payment from any such member or enrollee for amount owed by CO-OP;

b. Interrupting or discontinuing the delivery of health care services to such members or enrollees during the period for which they have paid (or because of a grace period have the right to pay) the required premium to CO-OP except as authorized by the Receiver or as expressly provided in any such contract or agreement with CO-OP that does not violate applicable law;

c. Seeking additional or unauthorized payment from such CO-OP members or enrollees for health care services required to be provided by such agreements, arrangements, or contracts beyond the payments authorized by the agreements, arrangements, or contracts to be collected from such members or enrollees; and

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d. Interfering in any manner with the efforts of the Receiver to assure that CO-OP's members and enrollees in good standing receive the health care services to which they are contractually entitled.

(7) All landlords, vendors and parties to executory contracts with CO-OP are hereby enjoined and restrained from discontinuing services to, or disturbing the possession of premises and leaseholds, including of equipment and other personal property, by CO-OP or the Receiver on account of amounts owed prior to October 1, 2015, or as a result of the institution of this proceeding and the causes therefor, provided that CO-OP or the Receiver pays within a reasonable time for premises, goods, or services delivered or provided by such persons on and after October 1, 2015, at the request of the Receiver and provided further that all such persons shall have claims against the estate of CO-OP for all amounts owed by CO-OP prior to October 1, 2015.

(8) All claims against CO-OP its assets or the Property must be submitted to the Receiver as specified herein to the exclusion of any other method of submitting or adjudicating such claims in any forum, court, or tribunal subject to the further Order of this Court. The Receiver is hereby authorized to establish a Receivership Claims and Appeal Procedure, for all receivership claims. The Receivership Claims and Appeal Procedures shall be used to facilitate the orderly disposition or resolution of claims or controversies involving the receivership or the receivership estate.

(9) The Receiver may change to her own name the name of any of CO-OP' accounts, funds or other property or assets, held with any bank, savings and loan association, other financial institution, or any other person, wherever located, and may withdraw such funds, accounts and other assets from such institutions or take any lesser action necessary for the proper conduct of the receivership.

(10) All secured creditors or parties, pledge holders, lien holders, collateral holders or other persons claiming secured, priority or preferred interest in any property or assets of CO-OP, including any governmental entity, are hereby enjoined from taking any steps whatsoever

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to transfer, sell, encumber, attach, dispose of or exercise purported rights in or against the Property.

(11) The officers, directors, trustees, partners, affiliates, brokers, agents, creditors, insureds, employees, members, and enrollees of CO-OP, and all other persons or entities of any nature including, but not limited to, claimants, plaintiffs, petitioners, and any governmental agencies who have claims of any nature against CO-OP, including cross-claims, counterclaims and third party claims, are hereby permanently enjoined and restrained from doing or attempting to do any of the following, except in accordance with the express instructions of the Receiver or by Order of this Court:

a. Conducting any portion or phase of the business of CO-OP;

b. Commencing, bringing, maintaining or further prosecuting any action at law, suit in equity, arbitration, or special or other proceeding against CO-OP or its estate, or the Receiver and her successors in office, or any person appointed pursuant to Paragraph (4) hereinabove;

c. Making or executing any levy upon, selling, hypothecating, mortgaging, wasting, conveying, dissipating, or asserting control or dominion over the Property or the estate of CO-OP;

d. Seeking or obtaining any preferences, judgments, foreclosures, attachments, levies, or liens of any kind against the Property;

e. Interfering in any way with these proceedings or with the Receiver, any successor in office, or any person appointed pursuant to Paragraph (4) hereinabove in their acquisition of possession of, the exercise of dominion or control over, or their title to the Property, or in the discharge of their duties as Receiver thereof; or

f. Commencing, maintaining or further prosecuting any direct or indirect actions, arbitrations, or other proceedings against any insurer of CO-OP for proceeds of any policy issued to CO-OP.

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(12) However, notwithstanding any other provision of this Order, the commencement of conservatorship, receivership, or liquidation proceedings against CO-OP in another state by an official lawfully authorized by such state to commence such proceeding shall not constitute a violation of this Order.

(13) No bank, savings and loan association or other financial institution shall, without first obtaining permission of the Receiver, exercise any form of set-off, alleged set-off, lien, or other form of self-help whatsoever or refuse to transfer the Property to the Receiver's control.

(14) The Receiver shall have the power and is hereby authorized to:

a. Collect all debts and monies due and claims belonging to CO-OP, wherever located, and for this purpose: (i) to institute and maintain actions in other jurisdictions, in order to forestall garnishment and attachment proceedings against such debts; (ii) to do such other acts as are necessary or expedient to marshal, collect, conserve or protect its assets or property, including the power to sell, compound, compromise or assign debts for purposes of collection upon such terms and conditions as she deems appropriate, and the power to initiate and maintain actions at law or equity or any other type of action or proceeding of any nature, in this and other jurisdictions; (iii) to pursue any creditor's remedies available to enforce her claims;

b. Conduct public and private sales of the assets and property of CO-OP, including any real property;

c. Acquire, invest, deposit, hypothecate, encumber, lease, improve, sell, transfer, abandon, or otherwise dispose of or deal with any asset or property of CO-OP, and to sell, reinvest, trade or otherwise dispose of any securities or bonds presently held by, or belonging to, CO-OP upon such terms and conditions as she deems to be fair and reasonable, irrespective of the value at which such property was last carried on the books of CO-OP. She shall also have the power to execute, acknowledge and deliver any and all deeds, assignments, releases and other instruments necessary or proper to

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effectuate any sale of property or other transaction in connection with the receivership;

d. Borrow money on the security of CO-OP' assets, with or without security, and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the receivership;

e. Enter into such contracts as are necessary to carry out this Order, and to affirm or disavow as more fully provided in subparagraph p., below, any contracts to which CO-OP is a party;

f. Designate, from time to time, individuals to act as her representatives with respect to affairs of CO-OP for all purposes, including, but not limited to, signing checks and other documents required to effectuate the performance of the powers of the Receiver.

g. Establish employment policies for CO-OP employees, including retention, severance and termination policies as she deems necessary to effectuate the provisions of this Order;

h. Institute and to prosecute, in the name of CO-OP or in her own name, any and all suits and other legal proceedings, to defend suits in which CO-OP or the Receiver is a party in this state or elsewhere, whether or not such suits are pending as of the date of this Order, to abandon the prosecution or defense of such suits, legal proceedings and claims which she deems inappropriate, to pursue further and to compromise suits, legal proceedings or claims on such terms and conditions as she deems appropriate;

i. Prosecute any action which may exist on behalf of the members, enrollees, insureds or creditors, of CO-OP against any officer or director of CO-OP, or any other person;

j. Remove any or all records and other property of CO-OP to the offices of the Receiver or to such other place as may be convenient for the purposes of the efficient and orderly execution of the receivership; and to dispose of or

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destroy, in the usual and ordinary course, such of those records and property as the Receiver may deem or determine to be unnecessary for the receivership;

k. File any necessary documents for recording in the office of any recorder of deeds or record office in this County or wherever the Property of CO-OP is located;

l. Intervene in any proceeding wherever instituted that might lead to the appointment of a conservator, receiver or trustee of CO-OP or its subsidiaries, and to act as the receiver or trustee whenever the appointment is offered;

m. Enter into agreements with any ancillary receiver of any other state as she may deem to be necessary or appropriate;

n. Perform such further and additional acts as she may deem necessary or appropriate for the accomplishment of or in aid of the purpose of the receivership, it being the intention of this Order that the aforestated enumeration of powers shall not be construed as a limitation upon the Receiver;

o. Terminate and disavow the authority previously granted CO-OP' agents, brokers, or marketing representatives to represent CO-OP in any respect, including the underlying agreements, and any continuing payment obligations created therein, as of the receivership date, with reasonable notice to be provided and agent compensation accrued prior to any such termination or disavowal to be deemed a general creditor expense of the receivership; and

p. Affirm, reject, or disavow part or all of any leases or executory contracts to which CO-OP is a party. The Receiver is authorized to reject, or disavow any leases or executory contracts at such times as she deems appropriate under the circumstances, provided that payment due for any goods or services received after appointment of the Receiver, with her consent, will be

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deemed to be an administrative expense of the receivership, and provided further that other unsecured amounts properly due under the disavowed contract, and unpaid solely because of such disavowal, will give rise to a general unsecured creditor claim in the Receivership proceeding.

(15) CO-OP, its officers, directors, partners, agents, brokers and employees, any person acting in concert with them, and all other persons, having any property or records belonging to CO-OP, including data processing information and records of any kind such as, by way of example only, source documents and electronically stored information, are hereby ordered and directed to surrender custody and to assign, transfer and deliver to the Receiver all of such property in whatever name the same may be held, and any persons, firms or corporations having any books, papers or records relating to the business of CO-OP shall preserve the same and submit these to the Receiver for examination at all reasonable times. Any property, books, or records asserted to be simultaneously the property of CO-OP and other parties, or alleged to be necessary to the conduct of the business of other parties though belonging in part or entirely to CO-OP, shall nonetheless be delivered immediately to the Receiver who shall make reasonable arrangements for copies or access for such other parties without compromising the interests of the Receiver or CO-OP.

(16) Nothing in this Order may be construed as to prevent the Nevada Life and Health Insurance Guaranty Association and the Nevada Insurance Guaranty Association from exercising their respective powers under Title 57 of the NRS.

(17) In addition to that provided by statute or by CO-OP's policies or contracts of insurance, and to the extent not in conflict with the other provisions of this Paragraph (17), the Receiver may, at such time she deems appropriate, without prior notice, subject to the following provisions, impose such full or partial moratoria or suspension upon disbursements owed by CO-OP, provided that

a. Any such suspension or moratorium shall apply in the same manner or to the same extent to all persons similarly situated. However, the Receiver may, in

Office of the Attorney General
555 East Washington Avenue, Suite 3900
Las Vegas, Nevada 89101

her sole discretion, impose the same upon only certain types, but not all, of the payments due under any particular type of contract; and

b. Notwithstanding any other provision of this Order, the Receiver may implement a procedure for the exemption from any such moratorium or suspension, those hardship claims, as she may define them, that she, in her sole discretion, deems proper under the circumstances.

c. The Receiver shall only impose such moratorium or suspension when the same is not specifically provided for by contract or statute:

i. As part, or in anticipation, of a plan for the partial or complete rehabilitation of CO-OP;

ii. When necessary to assure the delivery of health care services to covered persons pending the replacement of underlying coverage; or

iii. When necessary to determine whether partial or complete rehabilitation is reasonably feasible.

d. Under no circumstances shall the Receiver be liable to any person or entity for her good faith decision to impose, or to refrain from imposing, such moratorium or suspension.

e. Notice of such moratorium or suspension, which may be by publication, shall be provided to the holders of all policies or contracts affected thereby.

(18) It is hereby ordered that all evidences of coverage, insurance policies and contracts of insurance of CO-OP are hereby terminated effective on December 31, 2015, unless the Receiver determines that any such contracts should be cancelled as of an earlier date.

(19) No judgment, order, attachment, garnishment sale, assignment, transfer, hypothecation, lien, security interest or other legal process of any kind with respect to or affecting CO-OP or the Property shall be effective or enforceable or form the basis for a claim against CO-OP or the Property unless entered by the Court, or unless the Court has issued its specific order, upon good cause shown and after due notice and hearing, permitting same.

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555 East Washington Avenue, Suite 3900
Las Vegas, Nevada 89101

(20) All costs, expenses, fees or any other charges of the Receivership, including but not limited to fees and expenses of accountants, peace officers, actuaries, investment counselors, asset managers, attorneys, special deputies, and other assistants employed by the Receiver, the giving of the Notice required herein, and other expenses incurred in connection herewith shall be paid from the assets of CO-OP. Provided, further, that the Receiver may, in her sole discretion, require third parties, if any, who propose rehabilitation plans with respect to CO-OP to reimburse the estate of CO-OP for the expenses, consulting or attorney's fees and other costs of evaluating and/or implementing any such plan.

(21) The Commissioner is part of the government of the State of Nevada, acting in her official capacity, and as such, should be exempt from any bond requirements that might otherwise be required when seeking the relief sought in this proceeding. Accordingly, it is Ordered that no bond shall be required from the Commissioner as Receiver.

(22) If any provision of this Order or the application thereof is for any reason held to be invalid, the remainder of this Order and the application thereof to other persons or circumstances shall not be affected thereby.

(23) The Receiver may at any time make further application for such further and different relief as she sees fit.

(24) The Court shall retain jurisdiction for all purposes necessary to effectuate and enforce this Order.

(25) The Receiver is authorized to deliver to any person or entity a copy or certified copy of this Order, or of any subsequent order of the Court, such copy, when so delivered, being deemed sufficient notice to such person or entity of the terms of such Order. But nothing herein shall relieve from liability, nor exempt from punishment by contempt, any person or entity that, having actual notice of the terms of any such Order, shall be found to have violated the same.

Office of the Attorney General
555 East Washington Avenue, Suite 3900
Las Vegas, Nevada 89101

(26) Notice of any filings in this proceeding shall additionally be provided by electronic delivery to the email addresses provided by the Special Deputy Receiver and counsel for the Receiver.

IT IS SO ORDERED

DATED this 14 day of October, 2015.

DISTRICT COURT JUDGE

Respectfully submitted by:

ADAM PAUL LAXALT
Attorney General

By: _____
JOANNA N. GRIGORIEV
Senior Deputy Attorney General
Attorneys for the Division of Insurance

Office of the Attorney General
555 East Washington Avenue, Suite 3900
Las Vegas, Nevada 89101

NOTICE TO BE PROVIDED TO:

Cantilo & Bennett, L.L.P.
Special Deputy Receiver
Nevada Health CO-OP
3900 Meadows Lane
Las Vegas, NV 89107

Copy to:
11401 Century Oaks Terrace
Suite 300
Austin, TX 78758

EXHIBIT C

Nevada Health CO-OP

JAN 16 2016

Received

PROOF OF CLAIM FORM

For Internal Office Use Only: POC # _____, Claim Type: _____, Date Received: By _____

Claimant Name & Address	Policy Information (if applicable)
Name	Insured Name
Date of Birth SSN	Insured DOB
Company Name and Tax ID (if applicable) Milliman, Inc. [redacted]	Member ID
Street Address 1400 Wewatta St. Ste 300	Coverage Date(s)
City/State/Zip Denver CO 80202	**Alternate Contact Name & Telephone No.**
Phone 303 299 9400 E-Mail heather.irias@milliman.com	
If Claimant is represented by an attorney, please complete this section and attach copy of Power of Attorney	
Name of Attorney & Attorney's Firm	Bar Card No.
Street Address	Tax ID No.
City/State/Zip	Ph.
E-mail Address	Fax

All claims submitted to the Special Deputy Receiver ("SDR") shall set forth in reasonable detail: (1) the amount of each of the claims; (2) the facts and basis upon which each of the claims and claim amounts is based; and (3) the priority level for the claims being submitted to the SDR (i.e. "priorities" mean a secured creditor claim, a policyholder claim, an unsecured general creditor claim, etc.). All such claims must be verified by the claimant's affidavit, or someone authorized to act on behalf of the claimant and having knowledge of the facts (and must include adequate documentation). All claims and documentation supportive of each of the claims should be submitted to the SDR. The SDR reserves the right to request additional documentation, as needed, to make a determination of your claim. Health Care Providers ("Providers"), such as physicians or hospitals, are exempt from using this POC form for existing claims that they have already filed with NHC or new claims that they may file. Providers should not submit the POC form for their claims, but should closely review the POC Instructions for detailed guidance regarding deadlines and submission requirements for Provider claims. See the pages that follow for the POC Instructions to use when completing this POC form and for information about Provider claims.

Explanation of Claim: **(Attach additional pages if necessary)**

Milliman served as the COOP's actuaries. The work in question included a lot of analysis requested by the Nevada DOI.

JERI ALLSUP
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20034004450
MY COMMISSION EXPIRES NOVEMBER 29, 2019

State of Colorado §
§
County of Denver §

Unless otherwise expressly noted in this Proof of Claim Form, I alone am entitled to file this Proof of Claim Form, no others have an interest in the claims being submitted through this Proof of Claim Form, no payments have been made on the claim or claims herein submitted, no third party is liable on this debt, the sums claimed in this Proof of Claim Form are justly owing, and there is no set-off or other defense to the payment of this claim. I declare, under penalty of perjury, that all of the statements made in this Proof of Claim Form and all the documents attached to this form are true, complete, and correct.

Jill Van Den Bos
Signature of Claimant or Authorized Agent

Jill Van Den Bos
Printed Name

Sworn to and subscribed before me this 6 day of December 2016

Jeri Allsup
Notary Public Signature

NOTE: ATTACH DOCUMENTATION TO SUPPORT YOUR CLAIM.

Milliman

1400 Wewatta Street, Suite 300
Denver, CO 80202-5549
Tel+1 303 299 9400 Fax+1 303 299 9018
milliman.com

September 11, 2015

Basil Dibsie
Chief Financial Officer
Nevada Health CO-OP
3900 Meadows Lane, Suite 214
Las Vegas, NV 89107

Invoice No. 0154NVH 09 0915

Nevada Health CO-OP August 1-31, 2015 Consulting Services Details				
Project	**Staff**	**Hours**	**Rate**	**Charges**
2015 Operational Support	Mary van der Heijde	26.25	510.00	13,387.50
	Jill Van Den Bos	41.75	475.00	19,831.25
	Daniel Perlman	2.50	365.00	912.50
	TJ Gray	56.75	360.00	20,430.00
	Colleen Norris	18.00	330.00	5,940.00
	Jordan Paulus	0.25	315.00	78.75
	Katie Matthews	40.50	205.00	8,302.50
	Amy Baldor	0.75	180.00	135.00
	Charles Kaminer	1.00	160.00	160.00
Subtotal				$ 69,177.50
2016 Rate Filing Objection Responses	Jill Van Den Bos	2.00	475.00	950.00
	Katie Matthews	3.75	205.00	768.75
	Charles Kaminer	5.25	160.00	840.00
Subtotal				$ 2,558.75
Individual and Small Group Pricing	Jill Van Den Bos	4.75	475.00	2,256.25
	Ksenia Whittal	4.75	375.00	1,781.25
	TJ Gray	12.75	360.00	4,590.00
	Scott Katterman	1.25	325.00	406.25
	Jorge Torres	13.50	260.00	3,510.00
	Blaine Miller	7.25	220.00	1,595.00
	Jason McEwen	8.50	215.00	1,827.50
	Katie Matthews	11.50	205.00	2,357.50
	Charles Kaminer	1.00	160.00	160.00
Subtotal				$ 18,483.75
IBNR and Reserving	Jill Van Den Bos	1.00	475.00	475.00
Subtotal				$ 475.00
Large Group	Jill Van Den Bos	0.75	475.00	356.25
	TJ Gray	0.50	360.00	180.00
	Jordan Paulus	0.25	315.00	78.75
	Katie Matthews	1.50	205.00	307.50
	Charles Kaminer	2.25	160.00	360.00
Subtotal				$ 1,282.50
Total Due				$ 91,977.50

Milliman

Task Details for this invoice:

August

Assistance with with PartnerRe discussions, including:
Excess of loss analysis (delivered August 6th)
2016 Scenario testing (delivered August 7th)
PartnerRE excess of loss proposal (delivered August 13th)

PDR work, including:
PDR analysis (delivered August 5th)

IBNR work, including:
Estimated IBNR and RC projections for internal planning (delivered August 21st)
Projections in response to DOI request (delivered August 27th)
Projections in response to DOI request (delivered August 28th)

2016 Rate Refiling
2016 rate refiling reflecting 20% rate increase (delivered August 13th)

Minimum Value Work
Minimum value testing (delivered August 5th)

Planned September Tasks
Assistance with plan wind-down, CO-OP, DOI, and CMS requests.

Estimated September Charges: $25,000 - $40,000

Terms: Due within 30 days of invoice date.
Please make checks payable to: Milliman
Please contact Heather Irias at (303) 672-9085 with any questions.

Milliman

1400 Wewatta Street, Suite 300
Denver, CO 80202-5549
Tel+1 303 299 9400 Fax+1 303 299 9018
milliman.com

October 7, 2015

Basil Dibsie
Chief Financial Officer
Nevada Health CO-OP
3900 Meadows Lane, Suite 214
Las Vegas, NV 89107

Invoice No. 0154NVH 10 1015

Nevada Health CO-OP September 1-30, 2015 Consulting Services Details				
Project	**Staff**	**Hours**	**Rate**	**Charges**
2015 Operational Support	Tom Snook	1.00	550.00	550.00
	Mary van der Heijde	9.00	510.00	4,590.00
	Jill Van Den Bos	16.75	475.00	7,956.25
	Ksenia Whittal	1.75	375.00	656.25
	Colleen Norris	57.50	330.00	18,975.00
	Katie Matthews	19.75	205.00	4,048.75
	Ally Weaver	0.25	180.00	45.00
2016 ACA Model Research Fee				12,500.00
Total Due				$ 49,321.25

Task Details for this invoice:

September

IBNR, PDR, and Claims analysis support.
Various discussions with the DOI and CMS.

Planned October Tasks

Ad hoc support, as needed.

Estimated October Charges: $1,000 - $4,000

Terms: Due within 30 days of invoice date.
Please make checks payable to: Milliman
Please contact Heather Irias at (303) 672-9085 with any questions.

Milliman

1400 Wewatta Street, Suite 300
Denver, CO 80202-5549
Tel+1 303 299 9400 Fax+1 303 299 9018
milliman.com

November 10, 2015

Basil Dibsie
Chief Financial Officer
Nevada Health CO-OP
3900 Meadows Lane, Suite 214
Las Vegas, NV 89107

Invoice No. 0154NVH 11 1115

Nevada Health CO-OP October 1-31, 2015 Consulting Services Details				
Project	**Staff**	**Hours**	**Rate**	**Charges**
2015 Operational Support	Jill Van Den Bos	0.25	475.00	118.75
	Colleen Norris	0.50	330.00	165.00
	Abigail Caldwell	0.50	275.00	137.50
	Katie Matthews	0.25	205.00	51.25
Total Due				$ 472.50

Task Details for this invoice:

October

Responses to CO-OP and DOI requests regarding solvency and reserves.

Planned November Tasks

Responses to ad hoc requests.

Estimated November Charges: N/A

Terms: Due within 30 days of invoice date.
Please make checks payable to: Milliman
Please contact Heather Irias at (303) 672-9085 with any questions.

IN THE SUPREME COURT OF THE STATE OF NEVADA

STATE OF NEVADA, EX. REL. COMMISSIONER OF INSURANCE, BARBARA D. RICHARDSON, in her official capacity as Receiver for Nevada Health Co-Op,

Petitioner,

v.

THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF CLARK, AND THE HONORABLE KATHLEEN DELANEY, DISTRICT JUDGE, DEPT. 25,

Respondents,

MILLIMAN, INC., a Washington Corporation; Jonathan L. Shreve, an individual; and Mary Van Der Heijde, and individual,

Real Parties in Interest,

Supreme Court Case No.: 77682

Dist. Court Case No.: A-17-760558-C

PETITIONER'S APPENDIX

VOLUME I of III

Part 1

Tami D. Cowden, Esq., NBN 8994
Mark E. Ferrario, Esq., NBN 1625
Donald L. Prunty, Esq., NBN 8230
GREENBERG TRAURIG, LLP
10845 Griffith Peak Drive, Ste. 600
Las Vegas, Nevada 89135
Telephone (702) 792-3773
Facsimile (702) 792-9002
Attorneys for Petitioner

CHRONOLOGICAL INDEX OF APPELLANT'S APPENDIX

VOL.	PAGES	DATE FILED	DESCRIPTION
I	APP00001-2	10/20/11	Consulting Services Agreement between Milliman, Inc. and the Culinary Health Fund
I	APP00003-4	9/10/12	Consulting Services Agreement between Milliman, Inc. and Hospitality Health
I	APP00005-17	10/14/15	Permanent Injunction and Order Appointing Commissioner as Permanent Receiver of Nevada Health Co-Op
I	APP00018-22	12/6/16	Proof of Claim by Milliman, Inc.
I	APP00023-118	8/25/17	Complaint
I	APP00119-145	10/26/17	Millennium Consulting Services, LLC's Motion to Dismiss
I	APP00146-179	11/6/17	Motion to Compel Arbitration
I	APP00180-229	12/11/17	Plaintiff's Opposition to Milliman's Motion to Compel Arbitration
II	APP00230-266	12/18/17	Plaintiff's Opposition to Defendant Millennium Consulting Services, LLC's Motion to Dismiss
II	APP00267-295	1/3/18	Milliman's Reply in Support of Motion to Compel Arbitration
II	APP00296-339	1/9/18	Reporter's Transcript of Motion to Compel Arbitration Hearing
II	APP00340-383	1/9/18	Amended Reporter's Transcript of Motion to Compel Arbitration hearing
II	APP00384-395	1/9/18	Millennium Consulting Services, LLC's Reply in Support of its Motion to Dismiss
II	APP00396-405	3/12/18	Order Granting Milliman's Motion to Compel Arbitration
II	APP00406-411	3/28/18	Order Denying Millennium Consulting Services, LLC's Motion to Dismiss
II	APP00412-431	3/29/18	Plaintiff's Motion for Reconsideration
II	APP00432-446	4/16/18	Milliman's Opposition to Plaintiff's Motion for Reconsideration

III	APP00447-464	4/24/18	Plaintiff's Reply in Support of Motion for Reconsideration
III	APP00465-505	5/1/18	Reporter's Transcript of Plaintiff's Motion for Reconsideration
III	APP00506-517	6/1/18	Milliman's Supplemental Brief in Opposition to Plaintiff's Motion for Reconsideration
III	APP00518-542	6/29/18	Plaintiff's Sur-Reply in Support of Motion for Reconsideration
III	APP00543-551	8/8/18	Notice of Entry of Order Denying Plaintiff's Motion for Reconsideration

ALPHABETICAL INDEX OF APPELLANT'S APPENDIX

VOL.	PAGES	DATE FILED	DESCRIPTION
II	APP00340-383	1/9/18	Amended Reporter's Transcript of Motion to Compel Arbitration hearing
I	APP00023-118	8/25/17	Complaint
I	APP00003-4	9/10/12	Consulting Services Agreement between Milliman, Inc. and Hospitality Health
I	APP00001-2	10/20/11	Consulting Services Agreement between Milliman, Inc. and the Culinary Health Fund
I	APP00119-145	10/26/17	Millennium Consulting Services, LLC's Motion to Dismiss
II	APP00384-395	1/9/18	Millennium Consulting Services, LLC's Reply in Support of its Motion to Dismiss
II	APP00432-446	4/16/18	Milliman's Opposition to Plaintiff's Motion for Reconsideration
II	APP00267-295	1/3/18	Milliman's Reply in Support of Motion to Compel Arbitration
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II	APP00412-431	3/29/18	Plaintiff's Motion for Reconsideration
II	APP00230-266	12/18/17	Plaintiff's Opposition to Defendant Millennium Consulting Services, LLC's Motion to Dismiss
I	APP00180-229	12/11/17	Plaintiff's Opposition to Milliman's Motion to Compel Arbitration

III	APP00447-464	4/24/18	Plaintiff's Reply in Support of Motion for Reconsideration
III	APP00518-542	6/29/18	Plaintiff's Sur-Reply in Support of Motion for Reconsideration
I	APP00018-22	12/6/16	Proof of Claim by Milliman, Inc.
II	APP00296-339	1/9/18	Reporter's Transcript of Motion to Compel Arbitration Hearing
III	APP00465-505	5/1/18	Reporter's Transcript of Plaintiff's Motion for Reconsideration

CERTIFICATE OF SERVICE

Pursuant to NRAP 25,1 certify that I am an employee of GREENBERG TRAURIG, LLP, that in accordance therewith, I caused a copy of ***Petitioner's Appendix Volumes I – III*** to be served to the Real Parties Interest via the Supreme Court's e-filing system on December 17, 2018, and upon:

Patrick G. Byrne, Esq. (NV Bar No. 7636)
Alex L. Fugazzi, Esq. (NV Bar No. 9022)
Aleem A. Dhalla, Esq. (NV Bar No. 14188)
Snell & Wilmir
3883 Howard Hughes Parkway, # 1100
Las Vegas, NV 89169
pbyrne@swlaw.com;
afugazzi@swlaw.com;
adhalla@Wswlaw.com
Attorneys for Real Parties in Interest

Justin N. Kattan, Esq. (Pro Hac Vice)
Dentons US, LLP
1221 Avenue of the Americas
New York, NY 10020
Justin.kattan@dentons.com
Attorneys for Real Parties in Interest

With a courtesy copy to:

Judge Kathleen Delaney
Eighth Judicial District Court
Clark County, Nevada
Regional Justice Center
200 Lewis Avenue
Las Vegas, NV 89155

Judge Timothy C. Williams
Eighth Judicial District Court
Clark County, Nevada
Regional Justice Center
200 Lewis Avenue
Las Vegas, NV 89155
(As the Judge to which this matter is currently assigned)

via hand delivery on December 18, 2018.

/s/ Andrea Lee Rosehill
An Employee of Greenberg Traurig LLP

Milliman

Consulting Services Agreement

This Agreement is entered into between Milliman, Inc. (Milliman) and the **Culinary Health Fund** (Company) as of **October 20, 2011**. Company has engaged Milliman to perform consulting services as described in the letter dated **October 20, 2011** and attached hereto. Such services may be modified from time to time and may also include other general actuarial consulting services. These terms and conditions will apply to all subsequent engagements of Milliman by Company unless specifically disclaimed in writing by both parties prior to the beginning of the engagement. In consideration for Milliman agreeing to perform these services, Company agrees as follows.

1. Billing Terms Initial 6 Months. Company acknowledges the obligation to pay Milliman for services rendered, whether arising from Company's request or otherwise necessary as a result of this engagement, at Milliman's fixed fee arrangement for the personnel utilized plus all out-of-pocket expenses incurred. Milliman understands that the initial funding may not be immediately available but expects prompt payment once they become available. In the event that the health cooperative is dissolved and does not receive funds to become a going concern, Milliman will not pursue payment from individuals associated with the dissolved health cooperative for the work done for feasibility studies and business plans.

2. Billing Terms After 6 Months. Company acknowledges the obligation to pay Milliman for services rendered, whether arising from Company's request or otherwise necessary as a result of this engagement, at Milliman's normal billing rate for the personnel utilized plus all out-of-pocket expenses incurred. Milliman will bill Company periodically for services rendered and expenses incurred. All invoices are payable upon receipt. Milliman reserves the right to stop all work if any bill goes unpaid for 60 days. In the event of such termination, Milliman shall be entitled to collect the outstanding balance, as well as charges for all services and expenses incurred up to the date of termination.

3. Tool Development. Milliman shall retain all rights, title and interest (including, without limitation, all copyrights, patents, service marks, trademarks, trade secret and other intellectual property rights) in and to all technical or internal designs, methods, ideas, concepts, know-how, techniques, generic documents and templates that have been previously developed by Milliman or developed during the course of the provision of the Services provided such generic documents or templates do not contain any Company Confidential Information or proprietary data. Rights and ownership by Milliman of original technical designs, methods, ideas, concepts, know-how, and techniques shall not extend to or include all or any part of Company's proprietary data or Company Confidential Information. To the extent that Milliman may include in the materials any pre-existing Milliman proprietary information or other protected Milliman materials, Milliman agrees that Company shall be deemed to have a fully paid up license to make copies of the Milliman owned materials as part of this engagement for its internal business purposes and provided that such materials cannot be modified or distributed outside the Company without the written permission of Milliman or except as otherwise permitted hereunder.

4. Limitation of Liability. Milliman will perform all services in accordance with applicable professional standards. The parties agree that Milliman, its officers, directors, agents and employees, shall not be liable to Company, under any theory of law including negligence, tort, breach of contract or otherwise, for any damages in excess of three (3) times the professional fees paid to Milliman with respect to the work in question. In no event shall Milliman be liable for lost profits of Company or any other type of incidental or consequential damages. The foregoing limitations shall not apply in the event of the intentional fraud or willful misconduct of Milliman.

5. Disputes. In the event of any dispute arising out of or relating to the engagement of Milliman by Company, the parties agree that the dispute will be resolved by final and binding arbitration under the

Milliman

Commercial Arbitration Rules of the American Arbitration Association. The arbitration shall take place before a panel of three arbitrators. Within 30 days of the commencement of the arbitration, each party shall designate in writing a single neutral and independent arbitrator. The two arbitrators designated by the parties shall then select a third arbitrator. The arbitrators shall have a background in either insurance, actuarial science or law. The arbitrators shall have the authority to permit limited discovery, including depositions, prior to the arbitration hearing, and such discovery shall be conducted consistent with the Federal Rules of Civil Procedure. The arbitrators shall have no power or authority to award punitive or exemplary damages. The arbitrators may, in their discretion, award the cost of the arbitration, including reasonable attorney fees, to the prevailing party. Any award made may be confirmed in any court having jurisdiction. Any arbitration shall be confidential, and except as required by law, neither party may disclose the content or results of any arbitration hereunder without the prior written consent of the other parties, except that disclosure is permitted to a party's auditors and legal advisors.

6. Choice of Law. The construction, interpretation, and enforcement of this Agreement shall be governed by the substantive contract law of the State of New York without regard to its conflict of laws provisions. In the event any provision of this agreement is unenforceable as a matter of law, the remaining provisions will stay in full force and effect.

7. No Third Party Distribution. Milliman's work is prepared solely for the internal business use of Company. Milliman's work may not be provided to third parties without Milliman's prior written consent. Milliman does not intend to benefit any third party recipient of its work product, even if Milliman consents to the release of its work product to such third party.

8. Confidentiality. Any information received from Company will be considered "Confidential Information." However, information received from Company will not be considered Confidential Information if (a) the information is or comes to be generally available to the public through no fault of Milliman, (b) the information was independently developed by Milliman without resort to information from the Company, or (c) Milliman appropriately receives the information from another source who is not under an obligation of confidentiality to Company. Milliman agrees that Confidential Information shall not be disclosed to any third party.

9. Use of Milliman's Name. Company agrees that it shall not use Milliman's name, trademarks or service marks, or refer to Milliman directly or indirectly in any media release, public announcement or public disclosure, including in any promotional or marketing materials, customer lists, referral lists, websites or business presentations without Milliman's prior written consent for each such use or release, which consent shall be given in Milliman's sole discretion.

Milliman, Inc.

By: Mary van der Heyde 11/7/11
Signature and Date

Mary van der Heyde, Principal & Consulting Actuary
Print Name and Title

Culinary Health Fund

By: Bobbette Bond
Signature and Date

Bobbette Bond
Print Name and Title

Milliman

Consulting Services Agreement

This Agreement is entered into between Milliman, Inc. ("Milliman") and **Hospitality Health** ("Company") as of **September 10, 2012.** Company has engaged Milliman to perform consulting services as described in the letter dated **April 24, 2012** and attached hereto. Such services may be modified from time to time and may also include general actuarial consulting services. These terms and conditions will apply to all subsequent engagements of Milliman by Company unless specifically disclaimed in writing by both parties prior to the beginning of the engagement. In consideration for Milliman agreeing to perform these services, Company agrees as follows.

1. **BILLING TERMS.** Company acknowledges the obligation to pay Milliman for services rendered, whether arising from Company's request or otherwise necessary as a result of this engagement, at Milliman's standard hourly billing rates for the personnel utilized plus all out-of-pocket expenses incurred. Milliman will bill Company periodically for services rendered and expenses incurred. All invoices are payable upon receipt. Milliman reserves the right to stop all work if any bill goes unpaid for 60 days. In the event of such termination, Milliman shall be entitled to collect the outstanding balance, as well as charges for all services and expenses incurred up to the date of termination.

2. **TOOL DEVELOPMENT.** Milliman shall retain all rights, title and interest (including, without limitation, all copyrights, patents, service marks, trademarks, trade secret and other intellectual property rights) in and to all technical or internal designs, methods, ideas, concepts, know-how, techniques, generic documents and templates that have been previously developed by Milliman or developed during the course of the provision of the Services provided such generic documents or templates do not contain any Company Confidential Information or proprietary data. Rights and ownership by Milliman of original technical designs, methods, ideas, concepts, know-how, and techniques shall not extend to or include all or any part of Company's proprietary data or Company Confidential Information. To the extent that Milliman may include in the materials any pre-existing Milliman proprietary information or other protected Milliman materials, Milliman agrees that Company shall be deemed to have a fully paid up license to make copies of the Milliman owned materials as part of this engagement for its internal business purposes and provided that such materials cannot be modified or distributed outside the Company without the written permission of Milliman or except as otherwise permitted hereunder.

3. **LIMITATION OF LIABILITY.** Milliman will perform all services in accordance with applicable professional standards. The parties agree that Milliman, its officers, directors, agents and employees, shall not be liable to Company, under any theory of law including negligence, tort, breach of contract or otherwise, for any damages in excess of three (3) times the professional fees paid to Milliman with respect to the work in question. In no event shall Milliman be liable for lost profits of Company or any other type of incidental or consequential damages. The foregoing limitations shall not apply in the event of the intentional fraud or willful misconduct of Milliman.

4. **DISPUTES.** In the event of any dispute arising out of or relating to the engagement of Milliman by Company, the parties agree that the dispute will be resolved by final and binding arbitration under the Commercial Arbitration Rules of the American Arbitration Association. The arbitration shall take place before a panel of three arbitrators. Within 30 days of the commencement of the arbitration, each party shall designate in writing a single neutral and independent arbitrator. The two arbitrators designated by the parties shall then select a third arbitrator. The arbitrators shall have a background in either insurance, actuarial science or law. The arbitrators shall have the authority to permit limited discovery, including depositions, prior to the arbitration hearing, and such discovery shall be conducted consistent with the Federal Rules of Civil Procedure. The arbitrators shall have no power or authority to award punitive or exemplary damages. The arbitrators may, in their discretion, award the cost of the arbitration, including

APP00003

reasonable attorney fees, to the prevailing party. Any award made may be confirmed in any court having jurisdiction. Any arbitration shall be confidential, and except as required by law, neither party may disclose the content or results of any arbitration hereunder without the prior written consent of the other parties, except that disclosure is permitted to a party's auditors and legal advisors.

5. **CHOICE OF LAW.** The construction, interpretation, and enforcement of this Agreement shall be governed by the substantive contract law of the State of New York without regard to its conflict of laws provisions. In the event any provision of this agreement is unenforceable as a matter of law, the remaining provisions will stay in full force and effect.

6. **NO THIRD PARTY DISTRIBUTION.** Milliman's work is prepared solely for the internal business use of Company. Milliman's work may not be provided to third parties without Milliman's prior written consent. Milliman does not intend to benefit any third party recipient of its work product, even if Milliman consents to the release of its work product to such third party.

7. **USE OF MILLIMAN'S NAME.** Company agrees that it shall not use Milliman's name, trademarks or service marks, or refer to Milliman directly or indirectly in any media release, public announcement or public disclosure, including in any promotional or marketing materials, customer lists, referral lists, websites or business presentations without Milliman's prior written consent for each such use or release, which consent shall be given in Milliman's sole discretion.

8. **CONFIDENTIALITY.** Any information received from Company will be considered "Confidential Information." However, information received from Company will not be considered Confidential Information if (a) the information is or comes to be generally available to the public through no fault of Milliman, (b) the information was independently developed by Milliman without resort to information from the Company, or (c) Milliman appropriately receives the information from another source who is not under an obligation of confidentiality to Company. Milliman agrees that Confidential Information shall not be disclosed to any third party.

Milliman, Inc.

By: Mary van der Heijde 10/12/12
Signature and Date

Mary van der Heijde, Principal & Consulting Actuary
Print Name and Title

Hospitality Health

By: Bobbette Bond
Signature and Date

Bobbette Bond, Director of Public Policy
Print Name and Title

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CLERK OF THE COURT

ORD
ADAM PAUL LAXALT
Attorney General
JOANNA N. GRIGORIEV
Senior Deputy Attorney General
Nevada Bar No. 5649
555 E. Washington Avenue, Suite 3900
Las Vegas, NV 89101
P: (702) 486-3101
Email: jgrigoriev@ag.nv.gov
Attorney for the Division of Insurance

IN THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA

CLARK COUNTY, NEVADA

STATE OF NEVADA, EX REL. COMMISSIONER OF INSURANCE, IN HER OFFICIAL CAPACITY AS STATUTORY RECEIVER FOR DELINQUENT DOMESTIC INSURER, Plaintiff, vs. NEVADA HEALTH CO-OP, Defendant.	Case No. A-15-725244-C Dept. No. 1

PERMANENT INJUNCTION AND ORDER APPOINTING COMMISSIONER AS PERMANENT RECEIVER OF NEVADA HEALTH CO-OP

A Petition For Appointment Of Commissioner as Receiver and Other Permanent Relief; Request for Injunction Pursuant to NRS 696B.270(1) by the Commissioner of Insurance, Amy L. Parks, in her official capacity as Temporary Receiver of NEVADA HEALTH CO-OP ("CO-OP") was filed with the consent of CO-OP's board of directors on September 25, 2015; a Non Opposition to Petition For Appointment Of Commissioner as Receiver and Other Permanent Relief and a waiver of the opportunity to appear at a show cause hearing was filed by CO-OP through its counsel on September 29, 2015; an Order Appointing the Acting Commissioner of

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Insurance, Amy L. Parks, as Temporary Receiver Pending Further Orders of the Court, Granting Temporary Injunctive Relief Pursuant to NRS 696B.270, and authorizing the Temporary Receiver to appoint a special deputy receiver was filed on October 1, 2015; the Commissioner, as Temporary Receiver, appointed the firm of Cantilo & Bennett, L.L.P. ("C&B"), as Special Deputy Receiver ("SDR") of CO-OP on October 1, 2015 .

The Court having reviewed the points and authorities submitted by counsel and exhibits in support thereof, and for good cause,

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

(1) Acting Commissioner of Insurance, Amy L. Parks, is hereby appointed Permanent Receiver ("Receiver"), and C&B is appointed Permanent SDR of CO-OP. The SDR shall have all the responsibilities, rights, powers, and authority of the Receiver subject to supervision and removal by the Receiver and the further Orders of this Court. The Receiver and the SDR are hereby directed to conserve and preserve the affairs of CO-OP and are vested, in addition to the powers set forth herein, with all the powers and authority expressed or implied under the provisions of chapter 696B of the Nevada Revised Statute ("NRS"), and any other applicable law. The Receiver and Special Deputy Receiver are hereby authorized to rehabilitate or liquidate CO-OP's business and affairs as and when they deem appropriate under the circumstances and for that purpose may do all acts necessary or appropriate for the conservation, rehabilitation, or liquidation of CO-OP. Whenever this Order refers to the Receiver, it will equally apply to the Special Deputy Receiver.

(2) Pursuant to NRS 696B.290, the Receiver is hereby vested with exclusive title both legal and equitable to all of CO-OP's property (referred to hereafter as the "Property") and consisting of all:

a. Assets, books, records, property, real and personal, including all property or ownership rights, choate or inchoate, whether legal or equitable of any kind or nature;

b. Causes of action, defenses, and rights to participate in legal proceedings;

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c. Letters of credit, contingent rights, stocks, bonds, cash, cash equivalents, contract rights, reinsurance contracts and reinsurance recoverables, in force insurance contracts and business, deeds, mortgages, leases, book entry deposits, bank deposits, certificates of deposit, evidences of indebtedness, bank accounts, securities of any kind or nature, both tangible and intangible, including but without being limited to any special, statutory or other deposits or accounts made by or for CO-OP with any officer or agency of any state government or the federal government or with any banks, savings and loan associations, or other depositories;

d. All of such rights and property of CO-OP described herein now known or which may be discovered hereafter, wherever the same may be located and in whatever name or capacity they may be held.

(3) The Receiver is hereby directed to take immediate and exclusive possession and control of the Property except as she may deem in the best interest of the Receivership Estate. In addition to vesting title to all of the Property in the Receiver or her successors, the said Property is hereby placed in the *custodia legis* of this Court and the Receiver, and the Court hereby assumes and exercises sole and exclusive jurisdiction over all the Property and any claims or rights respecting the Property to the exclusion of any other court or tribunal, such exercise of sole and exclusive jurisdiction being hereby found to be essential to the safety of the public and of the claimants against CO-OP.

(4) The Receiver is authorized to employ and to fix the compensation of such deputies, counsel, employees, accountants, actuaries, investment counselors, asset managers, consultants, assistants and other personnel as she considers necessary. Any Special Deputy Receiver appointed by the Receiver pursuant to this Order shall exercise all of the authority of the Receiver pursuant hereto subject only to oversight by the Receiver and the Court. All compensation and expenses of such persons and of taking possession of CO-OP and conducting this proceeding shall be paid out of the funds and assets of CO-OP in accordance with NRS 696B.290.

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(5) All persons, corporations, partnerships, associations and all other entities wherever located, are hereby enjoined and restrained from interfering in any manner with the Receiver's possession of the Property or her title to or right therein and from interfering in any manner with the conduct of the receivership of CO-OP. Said persons, corporations, partnerships, associations and all other entities are hereby enjoined and restrained from wasting, transferring, selling, disbursing, disposing of, or assigning the Property and from attempting to do so except as provided herein.

(6) All providers of health care services, including but not limited to physicians hospitals, other licensed medical practitioners, patient care facilities, diagnostic and therapeutic facilities, pharmaceutical companies or managers, and any other entity which has provided or agreed to provide health care services to members or enrollees of CO-OP, directly or indirectly, pursuant to any contract, agreement or arrangement to do so directly with CO-OP or with any other organization that had entered into a contract, agreement, or arrangement for that purpose with CO-OP are hereby permanently enjoined and restrained from:

a. Seeking payment from any such member or enrollee for amount owed by CO-OP;

b. Interrupting or discontinuing the delivery of health care services to such members or enrollees during the period for which they have paid (or because of a grace period have the right to pay) the required premium to CO-OP except as authorized by the Receiver or as expressly provided in any such contract or agreement with CO-OP that does not violate applicable law;

c. Seeking additional or unauthorized payment from such CO-OP members or enrollees for health care services required to be provided by such agreements, arrangements, or contracts beyond the payments authorized by the agreements, arrangements, or contracts to be collected from such members or enrollees; and

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d. Interfering in any manner with the efforts of the Receiver to assure that CO-OP's members and enrollees in good standing receive the health care services to which they are contractually entitled.

(7) All landlords, vendors and parties to executory contracts with CO-OP are hereby enjoined and restrained from discontinuing services to, or disturbing the possession of premises and leaseholds, including of equipment and other personal property, by CO-OP or the Receiver on account of amounts owed prior to October 1, 2015, or as a result of the institution of this proceeding and the causes therefor, provided that CO-OP or the Receiver pays within a reasonable time for premises, goods, or services delivered or provided by such persons on and after October 1, 2015, at the request of the Receiver and provided further that all such persons shall have claims against the estate of CO-OP for all amounts owed by CO-OP prior to October 1, 2015.

(8) All claims against CO-OP its assets or the Property must be submitted to the Receiver as specified herein to the exclusion of any other method of submitting or adjudicating such claims in any forum, court, or tribunal subject to the further Order of this Court. The Receiver is hereby authorized to establish a Receivership Claims and Appeal Procedure, for all receivership claims. The Receivership Claims and Appeal Procedures shall be used to facilitate the orderly disposition or resolution of claims or controversies involving the receivership or the receivership estate.

(9) The Receiver may change to her own name the name of any of CO-OP' accounts, funds or other property or assets, held with any bank, savings and loan association, other financial institution, or any other person, wherever located, and may withdraw such funds, accounts and other assets from such institutions or take any lesser action necessary for the proper conduct of the receivership.

(10) All secured creditors or parties, pledge holders, lien holders, collateral holders or other persons claiming secured, priority or preferred interest in any property or assets of CO-OP, including any governmental entity, are hereby enjoined from taking any steps whatsoever

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to transfer, sell, encumber, attach, dispose of or exercise purported rights in or against the Property.

(11) The officers, directors, trustees, partners, affiliates, brokers, agents, creditors, insureds, employees, members, and enrollees of CO-OP, and all other persons or entities of any nature including, but not limited to, claimants, plaintiffs, petitioners, and any governmental agencies who have claims of any nature against CO-OP, including cross-claims, counterclaims and third party claims, are hereby permanently enjoined and restrained from doing or attempting to do any of the following, except in accordance with the express instructions of the Receiver or by Order of this Court:

a. Conducting any portion or phase of the business of CO-OP;

b. Commencing, bringing, maintaining or further prosecuting any action at law, suit in equity, arbitration, or special or other proceeding against CO-OP or its estate, or the Receiver and her successors in office, or any person appointed pursuant to Paragraph (4) hereinabove;

c. Making or executing any levy upon, selling, hypothecating, mortgaging, wasting, conveying, dissipating, or asserting control or dominion over the Property or the estate of CO-OP;

d. Seeking or obtaining any preferences, judgments, foreclosures, attachments, levies, or liens of any kind against the Property;

e. Interfering in any way with these proceedings or with the Receiver, any successor in office, or any person appointed pursuant to Paragraph (4) hereinabove in their acquisition of possession of, the exercise of dominion or control over, or their title to the Property, or in the discharge of their duties as Receiver thereof; or

f. Commencing, maintaining or further prosecuting any direct or indirect actions, arbitrations, or other proceedings against any insurer of CO-OP for proceeds of any policy issued to CO-OP.

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(12) However, notwithstanding any other provision of this Order, the commencement of conservatorship, receivership, or liquidation proceedings against CO-OP in another state by an official lawfully authorized by such state to commence such proceeding shall not constitute a violation of this Order.

(13) No bank, savings and loan association or other financial institution shall, without first obtaining permission of the Receiver, exercise any form of set-off, alleged set-off, lien, or other form of self-help whatsoever or refuse to transfer the Property to the Receiver's control.

(14) The Receiver shall have the power and is hereby authorized to:

a. Collect all debts and monies due and claims belonging to CO-OP, wherever located, and for this purpose: (i) to institute and maintain actions in other jurisdictions, in order to forestall garnishment and attachment proceedings against such debts; (ii) to do such other acts as are necessary or expedient to marshal, collect, conserve or protect its assets or property, including the power to sell, compound, compromise or assign debts for purposes of collection upon such terms and conditions as she deems appropriate, and the power to initiate and maintain actions at law or equity or any other type of action or proceeding of any nature, in this and other jurisdictions; (iii) to pursue any creditor's remedies available to enforce her claims;

b. Conduct public and private sales of the assets and property of CO-OP, including any real property;

c. Acquire, invest, deposit, hypothecate, encumber, lease, improve, sell, transfer, abandon, or otherwise dispose of or deal with any asset or property of CO-OP, and to sell, reinvest, trade or otherwise dispose of any securities or bonds presently held by, or belonging to, CO-OP upon such terms and conditions as she deems to be fair and reasonable, irrespective of the value at which such property was last carried on the books of CO-OP. She shall also have the power to execute, acknowledge and deliver any and all deeds, assignments, releases and other instruments necessary or proper to

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effectuate any sale of property or other transaction in connection with the receivership;

d. Borrow money on the security of CO-OP' assets, with or without security, and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the receivership;

e. Enter into such contracts as are necessary to carry out this Order, and to affirm or disavow as more fully provided in subparagraph p., below, any contracts to which CO-OP is a party;

f. Designate, from time to time, individuals to act as her representatives with respect to affairs of CO-OP for all purposes, including, but not limited to, signing checks and other documents required to effectuate the performance of the powers of the Receiver.

g. Establish employment policies for CO-OP employees, including retention, severance and termination policies as she deems necessary to effectuate the provisions of this Order;

h. Institute and to prosecute, in the name of CO-OP or in her own name, any and all suits and other legal proceedings, to defend suits in which CO-OP or the Receiver is a party in this state or elsewhere, whether or not such suits are pending as of the date of this Order, to abandon the prosecution or defense of such suits, legal proceedings and claims which she deems inappropriate, to pursue further and to compromise suits, legal proceedings or claims on such terms and conditions as she deems appropriate;

i. Prosecute any action which may exist on behalf of the members, enrollees, insureds or creditors, of CO-OP against any officer or director of CO-OP, or any other person;

j. Remove any or all records and other property of CO-OP to the offices of the Receiver or to such other place as may be convenient for the purposes of the efficient and orderly execution of the receivership; and to dispose of or

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destroy, in the usual and ordinary course, such of those records and property as the Receiver may deem or determine to be unnecessary for the receivership;

k. File any necessary documents for recording in the office of any recorder of deeds or record office in this County or wherever the Property of CO-OP is located;

l. Intervene in any proceeding wherever instituted that might lead to the appointment of a conservator, receiver or trustee of CO-OP or its subsidiaries, and to act as the receiver or trustee whenever the appointment is offered;

m. Enter into agreements with any ancillary receiver of any other state as she may deem to be necessary or appropriate;

n. Perform such further and additional acts as she may deem necessary or appropriate for the accomplishment of or in aid of the purpose of the receivership, it being the intention of this Order that the aforestated enumeration of powers shall not be construed as a limitation upon the Receiver;

o. Terminate and disavow the authority previously granted CO-OP' agents, brokers, or marketing representatives to represent CO-OP in any respect, including the underlying agreements, and any continuing payment obligations created therein, as of the receivership date, with reasonable notice to be provided and agent compensation accrued prior to any such termination or disavowal to be deemed a general creditor expense of the receivership; and

p. Affirm, reject, or disavow part or all of any leases or executory contracts to which CO-OP is a party. The Receiver is authorized to reject, or disavow any leases or executory contracts at such times as she deems appropriate under the circumstances, provided that payment due for any goods or services received after appointment of the Receiver, with her consent, will be

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deemed to be an administrative expense of the receivership, and provided further that other unsecured amounts properly due under the disavowed contract, and unpaid solely because of such disavowal, will give rise to a general unsecured creditor claim in the Receivership proceeding.

(15) CO-OP, its officers, directors, partners, agents, brokers and employees, any person acting in concert with them, and all other persons, having any property or records belonging to CO-OP, including data processing information and records of any kind such as, by way of example only, source documents and electronically stored information, are hereby ordered and directed to surrender custody and to assign, transfer and deliver to the Receiver all of such property in whatever name the same may be held, and any persons, firms or corporations having any books, papers or records relating to the business of CO-OP shall preserve the same and submit these to the Receiver for examination at all reasonable times. Any property, books, or records asserted to be simultaneously the property of CO-OP and other parties, or alleged to be necessary to the conduct of the business of other parties though belonging in part or entirely to CO-OP, shall nonetheless be delivered immediately to the Receiver who shall make reasonable arrangements for copies or access for such other parties without compromising the interests of the Receiver or CO-OP.

(16) Nothing in this Order may be construed as to prevent the Nevada Life and Health Insurance Guaranty Association and the Nevada Insurance Guaranty Association from exercising their respective powers under Title 57 of the NRS.

(17) In addition to that provided by statute or by CO-OP's policies or contracts of insurance, and to the extent not in conflict with the other provisions of this Paragraph (17), the Receiver may, at such time she deems appropriate, without prior notice, subject to the following provisions, impose such full or partial moratoria or suspension upon disbursements owed by CO-OP, provided that

a. Any such suspension or moratorium shall apply in the same manner or to the same extent to all persons similarly situated. However, the Receiver may, in

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her sole discretion, impose the same upon only certain types, but not all, of the payments due under any particular type of contract; and

b. Notwithstanding any other provision of this Order, the Receiver may implement a procedure for the exemption from any such moratorium or suspension, those hardship claims, as she may define them, that she, in her sole discretion, deems proper under the circumstances.

c. The Receiver shall only impose such moratorium or suspension when the same is not specifically provided for by contract or statute:

i. As part, or in anticipation, of a plan for the partial or complete rehabilitation of CO-OP;

ii. When necessary to assure the delivery of health care services to covered persons pending the replacement of underlying coverage; or

iii. When necessary to determine whether partial or complete rehabilitation is reasonably feasible.

d. Under no circumstances shall the Receiver be liable to any person or entity for her good faith decision to impose, or to refrain from imposing, such moratorium or suspension.

e. Notice of such moratorium or suspension, which may be by publication, shall be provided to the holders of all policies or contracts affected thereby.

(18) It is hereby ordered that all evidences of coverage, insurance policies and contracts of insurance of CO-OP are hereby terminated effective on December 31, 2015, unless the Receiver determines that any such contracts should be cancelled as of an earlier date.

(19) No judgment, order, attachment, garnishment sale, assignment, transfer, hypothecation, lien, security interest or other legal process of any kind with respect to or affecting CO-OP or the Property shall be effective or enforceable or form the basis for a claim against CO-OP or the Property unless entered by the Court, or unless the Court has issued its specific order, upon good cause shown and after due notice and hearing, permitting same.

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(20) All costs, expenses, fees or any other charges of the Receivership, including but not limited to fees and expenses of accountants, peace officers, actuaries, investment counselors, asset managers, attorneys, special deputies, and other assistants employed by the Receiver, the giving of the Notice required herein, and other expenses incurred in connection herewith shall be paid from the assets of CO-OP. Provided, further, that the Receiver may, in her sole discretion, require third parties, if any, who propose rehabilitation plans with respect to CO-OP to reimburse the estate of CO-OP for the expenses, consulting or attorney's fees and other costs of evaluating and/or implementing any such plan.

(21) The Commissioner is part of the government of the State of Nevada, acting in her official capacity, and as such, should be exempt from any bond requirements that might otherwise be required when seeking the relief sought in this proceeding. Accordingly, it is Ordered that no bond shall be required from the Commissioner as Receiver.

(22) If any provision of this Order or the application thereof is for any reason held to be invalid, the remainder of this Order and the application thereof to other persons or circumstances shall not be affected thereby.

(23) The Receiver may at any time make further application for such further and different relief as she sees fit.

(24) The Court shall retain jurisdiction for all purposes necessary to effectuate and enforce this Order.

(25) The Receiver is authorized to deliver to any person or entity a copy or certified copy of this Order, or of any subsequent order of the Court, such copy, when so delivered, being deemed sufficient notice to such person or entity of the terms of such Order. But nothing herein shall relieve from liability, nor exempt from punishment by contempt, any person or entity that, having actual notice of the terms of any such Order, shall be found to have violated the same.

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(26) Notice of any filings in this proceeding shall additionally be provided by electronic delivery to the email addresses provided by the Special Deputy Receiver and counsel for the Receiver.

IT IS SO ORDERED

DATED this 14 day of October, 2015.

DISTRICT COURT JUDGE

Respectfully submitted by:

ADAM PAUL LAXALT
Attorney General

By: _____
JOANNA N. GRIGORIEV
Senior Deputy Attorney General
Attorneys for the Division of Insurance

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555 East Washington Avenue, Suite 3900
Las Vegas, Nevada 89101

NOTICE TO BE PROVIDED TO:

Cantilo & Bennett, L.L.P.
Special Deputy Receiver
Nevada Health CO-OP
3900 Meadows Lane
Las Vegas, NV 89107

Copy to:
11401 Century Oaks Terrace
Suite 300
Austin, TX 78758

Nevada Health CO-OP

JAN 16 2016

Received

PROOF OF CLAIM FORM

For Internal Office Use Only: POC # _____, Claim Type: _____, Date Received: By _____

Claimant Name & Address	Policy Information (If applicable)
Name	Insured Name
Date of Birth SSN	Insured DOB
Company Name and Tax ID (if applicable) Milliman, Inc 91-0675641	Member ID
Street Address 1400 Wewatta St. Ste 300	Coverage Date(s)
City/State/Zip Denver CO 80202	Alternate Contact Name & Telephone No.
Phone 303 299 9400 E-Mail heather.irias@milliman.com	
If Claimant is represented by an attorney, please complete this section and attach copy of Power of Attorney	
Name of Attorney & Attorney's Firm	Bar Card No.
Street Address	Tax ID No.
City/State/Zip	Ph.
E-mail Address	Fax

All claims submitted to the Special Deputy Receiver ("SDR") shall set forth in reasonable detail: (1) the amount of each of the claims; (2) the facts and basis upon which each of the claims and claim amounts is based; and (3) the priority level for the claims being submitted to the SDR (*i.e.* "priorities" mean a secured creditor claim, a policyholder claim, an unsecured general creditor claim, etc.). All such claims must be verified by the claimant's affidavit, or someone authorized to act on behalf of the claimant and having knowledge of the facts (and must include adequate documentation). All claims and documentation supportive of each of the claims should be submitted to the SDR. The SDR reserves the right to request additional documentation, as needed, to make a determination of your claim. Health Care Providers ("Providers"), such as physicians or hospitals, are exempt from using this POC form for existing claims that they have already filed with NHC or new claims that they may file. Providers should not submit the POC form for their claims, but should closely review the POC Instructions for detailed guidance regarding deadlines and submission requirements for Provider claims. See the pages that follow for the POC Instructions to use when completing this POC form and for information about Provider claims.

Explanation of Claim: **(Attach additional pages if necessary)**

Milliman served as the coop's actuaries. The work in question included a lot of analysis requested by the Nevada DOI.

JERI ALLSUP
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20034004450
MY COMMISSION EXPIRES NOVEMBER 29, 2019

State of Colorado §
§
County of Denver §

Unless otherwise expressly noted in this Proof of Claim Form, I alone am entitled to file this Proof of Claim Form, no others have an interest in the claims being submitted through this Proof of Claim Form, no payments have been made on the claim or claims herein submitted, no third party is liable on this debt, the sums claimed in this Proof of Claim Form are justly owing, and there is no set-off or other defense to the payment of this claim. I declare, under penalty of perjury, that all of the statements made in this Proof of Claim Form and all the documents attached to this form are true, complete, and correct.

Jill Van Den Bos
Signature of Claimant or Authorized Agent

Jill Van Den Bos
Printed Name

Sworn to and subscribed before me this 6 day of December 2016

Jeri Allsup
Notary Public Signature

NOTE: ATTACH DOCUMENTATION TO SUPPORT YOUR CLAIM.

Milliman

1400 Wewatta Street, Suite 300
Denver, CO 80202-5549
Tel+1 303 299 9400 Fax+1 303 299 9018
milliman.com

September 11, 2015

Basil Dibsie
Chief Financial Officer
Nevada Health CO-OP
3900 Meadows Lane, Suite 214
Las Vegas, NV 89107

Invoice No. 0154NVH 09 0915

Nevada Health CO-OP August 1-31, 2015 Consulting Services Details				
Project	**Staff**	**Hours**	**Rate**	**Charges**
2015 Operational Support	Mary van der Heijde	26.25	510.00	13,387.50
	Jill Van Den Bos	41.75	475.00	19,831.25
	Daniel Perlman	2.50	365.00	912.50
	TJ Gray	56.75	360.00	20,430.00
	Colleen Norris	18.00	330.00	5,940.00
	Jordan Paulus	0.25	315.00	78.75
	Katie Matthews	40.50	205.00	8,302.50
	Amy Baldor	0.75	180.00	135.00
	Charles Kaminer	1.00	160.00	160.00
Subtotal				$ 69,177.50
2016 Rate Filing Objection Responses	Jill Van Den Bos	2.00	475.00	950.00
	Katie Matthews	3.75	205.00	768.75
	Charles Kaminer	5.25	160.00	840.00
Subtotal				$ 2,558.75
Individual and Small Group Pricing	Jill Van Den Bos	4.75	475.00	2,256.25
	Ksenia Whittal	4.75	375.00	1,781.25
	TJ Gray	12.75	360.00	4,590.00
	Scott Katterman	1.25	325.00	406.25
	Jorge Torres	13.50	260.00	3,510.00
	Blaine Miller	7.25	220.00	1,595.00
	Jason McEwen	8.50	215.00	1,827.50
	Katie Matthews	11.50	205.00	2,357.50
	Charles Kaminer	1.00	160.00	160.00
Subtotal				$ 18,483.75
IBNR and Reserving	Jill Van Den Bos	1.00	475.00	475.00
Subtotal				$ 475.00
Large Group	Jill Van Den Bos	0.75	475.00	356.25
	TJ Gray	0.50	360.00	180.00
	Jordan Paulus	0.25	315.00	78.75
	Katie Matthews	1.50	205.00	307.50
	Charles Kaminer	2.25	160.00	360.00
Subtotal				$ 1,282.50
Total Due				$ 91,977.50

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Task Details for this invoice:

August

Assistance with with PartnerRe discussions, including:
- Excess of loss analysis (delivered August 6th)
- 2016 Scenario testing (delivered August 7th)
- PartnerRE excess of loss proposal (delivered August 13th)

PDR work, including:
- PDR analysis (delivered August 5th)

IBNR work, including:
- Estimated IBNR and RC projections for internal planning (delivered August 21st)
- Projections in response to DOI request (delivered August 27th)
- Projections in response to DOI request (delivered August 28th)

2016 Rate Refiling
- 2016 rate refiling reflecting 20% rate increase (delivered August 13th)

Minimum Value Work
- Minimum value testing (delivered August 5th)

Planned September Tasks
- Assistance with plan wind-down, CO-OP, DOI, and CMS requests.

Estimated September Charges: $25,000 - $40,000

Terms: Due within 30 days of invoice date.
Please make checks payable to: Milliman
Please contact Heather Irias at (303) 672-9085 with any questions.

Milliman

1400 Wewatta Street, Suite 300
Denver, CO 80202-5549
Tel+1 303 299 9400 Fax+1 303 299 9018
milliman.com

October 7, 2015

Basil Dibsie
Chief Financial Officer
Nevada Health CO-OP
3900 Meadows Lane, Suite 214
Las Vegas, NV 89107

Invoice No. 0154NVH 10 1015

Nevada Health CO-OP September 1-30, 2015 Consulting Services Details				
Project	**Staff**	**Hours**	**Rate**	**Charges**
2015 Operational Support	Tom Snook	1.00	550.00	550.00
	Mary van der Heijde	9.00	510.00	4,590.00
	Jill Van Den Bos	16.75	475.00	7,956.25
	Ksenia Whittal	1.75	375.00	656.25
	Colleen Norris	57.50	330.00	18,975.00
	Katie Matthews	19.75	205.00	4,048.75
	Ally Weaver	0.25	180.00	45.00
2016 ACA Model Research Fee				12,500.00
Total Due				$ 49,321.25

Task Details for this invoice:

September

IBNR, PDR, and Claims analysis support.
Various discussions with the DOI and CMS.

Planned October Tasks

Ad hoc support, as needed.

Estimated October Charges: $1,000 - $4,000

Terms: Due within 30 days of invoice date.
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Milliman

1400 Wewatta Street, Suite 300
Denver, CO 80202-5549
Tel+1 303 299 9400 Fax+1 303 299 9018
milliman.com

November 10, 2015

Basil Dibsie
Chief Financial Officer
Nevada Health CO-OP
3900 Meadows Lane, Suite 214
Las Vegas, NV 89107

Invoice No. 0154NVH 11 1115

Nevada Health CO-OP October 1-31, 2015 Consulting Services Details				
Project	**Staff**	**Hours**	**Rate**	**Charges**
2015 Operational Support	Jill Van Den Bos	0.25	475.00	118.75
	Colleen Norris	0.50	330.00	165.00
	Abigail Caldwell	0.50	275.00	137.50
	Katie Matthews	0.25	205.00	51.25
Total Due				$ 472.50

Task Details for this invoice:

October

Responses to CO-OP and DOI requests regarding solvency and reserves.

Planned November Tasks

Responses to ad hoc requests.

Estimated November Charges: N/A

Terms: Due within 30 days of invoice date.
Please make checks payable to: Milliman
Please contact Heather Irias at (303) 672-9085 with any questions.

COMP
MARK E. FERRARIO, ESQ.
Nevada Bar No. 1625
ERIC W. SWANIS, ESQ.
Nevada Bar No. 6840
DONALD L. PRUNTY, ESQ.
Nevada Bar No. 8230
GREENBERG TRAURIG, LLP
3773 Howard Hughes Pkwy., Suite 400 N
Las Vegas, NV 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002
Email: ferrariom@gtlaw.com
swanise@gtlaw.com
pruntyd@gtlaw.com

Counsel for Plaintiff

DISTRICT COURT
CLARK COUNTY, NEVADA

STATE OF NEVADA, EX REL. COMMISSIONER OF INSURANCE, BARBARA D. RICHARDSON, IN HER OFFICIAL CAPACITY AS RECEIVER FOR NEVADA HEALTH CO-OP, Plaintiff, v. MILLIMAN, INC., a Washington Corporation; JONATHAN L. SHREVE, an Individual; MARY VAN DER HEIJDE, an Individual; MILLENNIUM CONSULTING SERVICES, LLC, a North Carolina Corporation; LARSON & COMPANY P.C., a Utah Professional Corporation; DENNIS T. LARSON, an Individual; MARTHA HAYES, an Individual; INSUREMONKEY, INC., a Nevada Corporation; ALEX RIVLIN, an Individual; NEVADA HEALTH SOLUTIONS, LLC, a Nevada Limited Liability Company; PAMELA EGAN, an Individual; BASIL C. DIBSIE, an Individual; LINDA MATTOON, an Individual; TOM ZUMTOBEL, an Individual; BOBBETTE BOND, an Individual; KATHLEEN SILVER, an Individual; DOES I through X inclusive; and ROE CORPORATIONS I-X, inclusive, Defendants.	CASE NO. A-17-760558-C DEPT. NO. Department 18 **COMPLAINT** Exempt from Arbitration: Amount in excess of $50,000

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

COMES NOW, Plaintiff, Barbara D. Richardson, Commissioner of Insurance in the State of Nevada, in her official capacity as Permanent Receiver of Nevada Health Co-Op ("Plaintiff" or "Commissioner"), with the Commissioner appointed in that official capacity on October 14, 2015 by the Eighth Judicial District Court, Clark County Nevada,[1] to serve as the permanent receiver ("Receiver") of the NEVADA HEALTH CO-OP ("NHC"), for the benefit of NHC's members, enrolled insureds, creditors, and the Receiver, by and through her attorneys, GREENBERG TRAURIG, LLP, and for her cause of action against Defendants MILLIMAN, INC. ("Milliman"), JONATHAN L. SHREVE ("Shreve"), and MARY VAN DER HEIJDE ("Heijde") (collectively the "Milliman Defendants"); MILLENNIUM CONSULTING SERVICES, LLC ("Millennium"); LARSON & COMPANY, P.C. ("Larson"), DENNIS T. LARSON ("D. Larson"), MARTHA HAYES ("Hayes") ("Larson," together with "D. Larson" and "Hayes," collectively the "Larson Defendants"); INSUREMONKEY, INC. ("InsureMonkey") and ALEX RIVLIN ("Rivlin," together with InsureMonkey, collectively the "InsureMonkey Defendants"); NEVADA HEALTH SOLUTIONS, LLC ("NHS"); PAMELA EGAN ("Egan"), BASIL C. DIBSIE ("Dibsie"), LINDA MATTOON ("Mattoon"), TOM ZUMTOBEL ("Zumtobel," together with Egan, Dibsie, and Mattoon, the "Officer Defendants"); BOBBETTE BOND ("Bond"), and KATHLEEN SILVER ("Silver," together with "Bond, the "Director Defendants") (the Officer Defendants and the Director Defendants collectively the "Management Defendants") (each a "Defendant," and collectively, all defendants are referred to as "Defendants") alleges as follows:

INTRODUCTION

1. Plaintiff, as Commissioner of the Nevada Division of Insurance (the "Nevada DOI") and NHC's Receiver, has brought this action on behalf of NHC, NHC's members, insured enrollees, and creditors.

2. NHC and its predecessors-in-interest were formed to provide health insurance to individuals and small businesses under the federal Affordable Care Act (the "ACA").

/ / /

[1] Commissioner Barbara D Richardson has succeeded Amy L. Parks, the former Commissioner of Insurance, who was initially appointed as Receiver by the Eight Judicial District Court.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
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Telephone: (702) 792-3773
Facsimile: (702) 792-9002

3. This complaint concerns certain providers of services to, and management of, NHC, and how their conduct, including their failure to perform applicable fiduciary, contractual, professional, and statutory standards, caused substantial losses to NHC and, ultimately, the other parties represented by the Commissioner.

4. InsureMonkey was contracted to provide software and related services, and to administer NHC's call center to enroll insureds, bill the insureds and the federal government for premiums, collect the premiums, confirm eligibility and, when necessary, terminate the coverage of insureds who failed to pay premiums due.

5. InsureMonkey failed on each account, causing losses to NHC. Additionally, without limitation, as some of InsureMonkey's compensation was paid based on the number of insureds it calculated, InsureMonkey was overpaid for its services due to its over reporting of the number of insureds. The faulty data provided by InsureMonkey also led to inaccurate reporting to regulatory authorities. Defendant Rivlin, InsureMonkey's Chief Executive Officer, mislead NHC concerning the capabilities and efforts of InsureMonkey to obtain lucrative contracts with NHC.

6. Milliman was NHC's consulting actuary, that, among other issues, produced deficient forecasts and studies for loan applications, set inadequate insurance premium levels, provided faulty actuarial guidance to NHC management, promoted and incorporated in its assumptions accounting entries that were neither proper nor authorized without appropriate disclosure, participated in financial misreporting, and improperly calculated and certified NHC's projections and reserves to regulators. Defendants Shreve and Heijde were individual actuaries of Milliman who certified actuarial data to the Nevada DOI in their individual names.

7. Millennium, an expert in statutory accounting and a consultant for insurance companies, was engaged by NHC to prepare and file NHC's financial statements and supplemental reports with the Nevada DOI and the National Association of Insurance Commissioners (the "NAIC"), assist in review and preparation of responses to insurance regulators and the NAIC regarding financials, respond to auditor inquiries, and provide statutory accounting and report support as needed. Millennium failed in its responsibilities, which included, without limitation, ensuring that statutory accounting and reporting principles had been followed, and its work resulted

in financial misreporting to the Nevada DOI insurance regulators, and the prolongation of NHC's business at great loss beyond the point at which it would have been halted but for Defendant Millennium's acts and conduct.

8. Larson served as NHC's independent auditor that, among other issues, performed deficient audits, failed to adequately inspect and value reserves and receivables, failed to properly disclose related party transactions, and failed to disclose the existence of substantial doubts about NHC's inability to continue as a going concern. Defendants D. Larson and Hayes were the individual CPAs identified by contract as directly responsible for NHC's audits.

9. NHS is a company that was engaged by NHC to perform medical utilization management services. NHS failed in its position as a medical gatekeeper for NHC by among other concerns, failing to verify the eligibility of members for medical services during their utilization reviews, resulting in over $1 million in overpayments to medical services providers. In addition, NHS and Management Defendant Kathleen Silver engaged in self-dealing in which NHS and/or Kathleen Silver were unjustly paid substantial amounts by NHC for so-called utilization management and member eligibility review services. Upon information and belief, little work was provided under this utilization management arrangement by NHS for NHC, and NHS compensation was unfairly based on a mechanical fee of how many total members existed at NHC each month; a fee that bore little to no relation to services being provided by NHS. NHS's president was Management Defendant Kathleen Silver, and upon information and belief, the owner of NHS was Unite Here Health ("UHH"). Upon information and belief, UHH was an entity with financial ties and/or direct or indirect business links with Management Defendants Bobbette Bond, Thomas Zumtobel, and Kathleen Silver. UHH was being paid to process and adjudicate claims of NHC, and then it was being paid again through NHS to do a quality control review check of the very claims that UHH processed. NHS also had a conflict of interest, or the appearance of a conflict of interest, by being engaged to provide a quality control review of claim services provided by its parent company, UHH. The NHS and NHC medical utilization management review arrangement was unfair, unreasonable, and just another way to siphon more money out of NHC to the detriment of its members, policyholders, and creditors.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

10. This complaint also concerns the management of NHC who intentionally, fraudulently, in knowing violation of the law, and without reasonable belief that their actions were in the interests of NHC, directed, allowed, and/or concealed the internal control weaknesses of NHC, the wrongdoing of NHC's service providers, the squandering of funds to unjustly enrich themselves, the acts of self-dealing at the expense of NHC, the wrongful payment of claims and wrongful member enrollments, the loss of reinsurance recoveries, the continuation of NHC in business that led to substantial losses, and the misreporting of financial and operating results to regulators.

11. Each of the Defendants had a fundamental duty not to mislead government regulators and to perform their work in accordance with applicable fiduciary, statutory, professional, and contractual standards.

12. Defendants' acts and conduct concealed, for a time, NHC's approaching insolvency and its inability to continue as a going concern from regulators, and ultimately increased the losses suffered by NHC and the others represented by the Receiver.

13. Defendants' actions caused significant losses to NHC, its members, insured enrollees, and creditors, among others, until NHC ultimately failed, and the State of Nevada was forced to protect the public, seek appointment as a receiver, recoup losses caused by Defendants, and liquidate NHC's assets for the benefit of the public.

PARTIES

14. Plaintiff Commissioner Barbara D. Richardson, in her capacity as Commissioner of Insurance and as Permanent Receiver of Nevada Health Co-Op, is authorized to liquidate the business of NHC and to wind up its ceased operations pursuant to NRS 696B.220.2 and an order entered on October 14, 2015 by the Eighth Judicial District Court, Clark County, Nevada. This authority includes authorization to institute and to prosecute, in the name of NHC or in the Receiver's own name, any and all suits and other legal proceedings, and to prosecute any action that may exist on behalf of the members, insured enrollees, or creditors of NHC against any person. The Nevada DOI is and was at all relevant times a Department of the State of Nevada.

/ / /

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

15. NHC is and was at all relevant times a non-profit Nevada corporation.

16. Upon information and belief, Defendant Milliman is and was at all relevant times a Washington state corporation.

17. Upon information and belief, Defendant Shreve is and was at all relevant times a Consulting Actuary and Principal of Milliman residing in Denver, Colorado. He issued the Feasibility Study described later herein.

18. Upon information and belief, Defendant Heijde is and was at all relevant times a Consulting Actuary and Principal of Milliman residing in Denver, Colorado, and served as NHC's first "Appointed Actuary."

19. Upon information and belief, Defendant Millennium is and was at all relevant times a North Carolina limited liability company, with its principal place of business located in Raleigh, North Carolina.

20. Upon information and belief, Defendant Larson is and was at all relevant times a Utah professional corporation and Certified Public Accounting firm with its principal place of business located in Salt Lake City, Utah. Larson is registered to provide accounting services to Nevada entities with the Nevada State Board of Accountancy.

21. Upon information and belief, Defendant D. Larson is a CPA. He was the engagement partner who was responsible for supervising the 2013 audit of NHC. Upon information and belief, he is an individual residing in Utah. D. Larson is registered to provide accounting services to Nevada entities with the Nevada State Board of Accountancy.

22. Upon information and belief, Defendant Hayes is a CPA. She was the Larson engagement partner who was responsible for supervising the 2014 audit of NHC.

23. Upon information and belief, Defendant InsureMonkey is and was at all relevant times a Nevada corporation with its headquarters located in Clark County, Nevada.

24. Upon information and belief, Defendant Rivlin is and was at all relevant time an individual residing in Clark County, Nevada, and the Chief Executive Officer of InsureMonkey.

25. Upon information and belief, Defendant NHS is and was at all relevant times a Nevada limited liability company, with its headquarters located in Clark County, Nevada.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
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26. Upon information and belief, Defendant Egan is and was at all relevant times an individual residing in Clark County, Nevada. Egan was NHC's Chief Development Officer from its inception through approximately April 2014. In or around April 2014, Egan became NHC's Chief Executive Officer, and she remained in that position through NHC's placement into receivership.

27. Upon information and belief, Defendant Dibsie is and was at all relevant times an individual residing in Clark County, Nevada. Dibsie was NHC's Chief Financial Officer from its inception through its placement into receivership.

28. Upon information and belief, Defendant Mattoon is and was at all relevant times an individual residing in Clark County, Nevada. Mattoon was NHC's Chief Operating Officer from approximately November 2014 through NHC's placement into receivership.

29. Upon information and belief, Defendant Zumtobel is and was at all relevant times an individual residing in Clark County, Nevada. Zumtobel was NHC's Chief Executive Officer from its inception through approximately April 2014. Zumtobel served on NHC's Board of Directors from May 4, 2012 through November 14, 2014. Zumtobel served on NHC's Budget and Audit and Consumer Advisory Committees.

30. Upon information and belief, Defendant Bond is and was at all relevant times an individual residing in Clark County, Nevada. Bond was a member of NHC's Board of Directors from May 4, 2012 through NHC's placement into receivership. Bond served on NHC's Budget and Audit and Consumer Advisory Committees.

31. Upon information and belief, Defendant Silver is and was at all relevant times an individual residing in Clark County, Nevada. Silver was a member of NHC's Board of Directors from May 4, 2012 through January 1, 2015, President of the Culinary Health Fund and President of Defendant NHS.

FACTUAL ALLEGATIONS

A. The Affordable Care Act

32. Congress enacted the Affordable Care Act (the "ACA") in March of 2010. The ACA included a series of interlocking reforms designed to expand coverage in the individual health insurance market.

33. The ACA bars insurers from taking a person's health into account when deciding whether to sell health insurance, generally requires each person to maintain insurance coverage or make a payment to the Internal Revenue Service, and gives tax credits to certain people to make insurance more affordable.

34. The ACA also established a Consumer Operated and Oriented Plan ("CO-OP") program which was intended to foster the creation of qualified non-profit health insurance issuers to facilitate the purchase of health plans by individuals and small businesses.

35. Under the CO-OP program, qualifying insurers were eligible for federal loans to establish and provide stability to insurers. Applicants were required to submit a feasibility study and a business plan as part of the loan application process.

36. Recognizing risks associated with the uncertainty of the reforms initiated by the ACA, Congress also established programs known as the "Federal Transitional Reinsurance," "Risk Corridors," and "Risk Adjustment" (known collectively as the "3Rs") to help mitigate some of the insurers' risks during their first few years of operation.

37. In addition to conforming to the ACA, health insurance providers, including those in Nevada, are required to adhere to state law and are regulated by state commissioners of insurance.

38. Without limitation, under Nevada law, NHC is required to have its reserves valued and certified by an actuary, file statutory financial statements, enroll members and pay claims according to guidelines, file independently audited financial statements, and submit other operational and financial data as determined by statute and by the Nevada DOI.

FACTUAL ALLEGATIONS RELATING TO THE MILLIMAN DEFENDANTS

B. Milliman is Engaged by and Establishes a Fiduciary Relationship with NHC and its Predecessors in Interest.

39. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

40. Recognizing the possible benefits to some of its members, the Culinary Health Fund (the health insurance affiliate of the Culinary Union), considered the possibility of establishing a qualifying CO-OP under the ACA.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

41. Due to the need to set insurance rates, establish appropriate reserves, apply for government loans, obtain required certifications, and forecast future results, the Culinary Health Fund sought out an actuarial expert.

42. The Culinary Health Fund entered into a contract with Milliman, dated October 20, 2011 (the "2011 Agreement").

43. Upon information and belief, the initial compensation for Milliman was contingent on the Culinary Health Fund obtaining federal loans for the CO-OP project.

44. Because the CO-OP program required separation from an established insurer, the Culinary Health Fund established Hospitality Health, Ltd., a Delaware non-profit corporation ("Hospitality Health").

45. On information and belief, the Culinary Health Fund assigned and transferred all rights, title, and interest in the 2011 Agreement to Hospitality Health.

46. Milliman continued to perform work under the 2011 Agreement for Hospitality Health after the assignment.

47. On or about September 10, 2012, Milliman also directly entered into a Consulting Services Agreement (the "Consulting Services Agreement") with Hospitality Health.

48. The Consulting Services Agreement provides that "Milliman will perform all services in accordance with applicable professional standards."

49. NHC was formed in October, 2012, and all assets and agreements of Hospitality Health, including the Consulting Services Agreement, were assigned to NHC.

50. Milliman holds itself and its employees out as experts in providing actuarial opinions and other services to third parties.

51. Milliman represented itself to the Culinary Health Fund, Hospitality Health, and NHC, as much more than a simple service provider.

52. In its proposal dated April 12, 2012, Milliman described the CO-OP development as "an interactive partnership in order to ensure the viability of the CO-OP in a short timeframe."

53. As an "interactive partnership," Milliman proclaimed joint responsibility for the success of the CO-OP.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
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54. Furthermore, Milliman committed that its work would be done in a manner "to ensure the viability of the CO-OP."

55. The proposal further boasted that Milliman could provide "significant assistance" to the CO-OP in areas of standard actuarial tasks within an insurer, as well as development, strategy, and training.

56. Milliman, by framing itself as an interactive partner with Hospitality Health and its successor, NHC, in developing strategy, and in training its staff, Milliman did not perform a mere set of outsourced tasks, but rather served as the key partner providing budget forecasts, planning, premium pricing, opinions, and judgments that were justifiably relied on by the new CO-OP.

57. As newly formed non-profit companies, Hospitality Health, and later NHC, relied on the superior knowledge and expertise of its self-proclaimed "interactive partner" Milliman and Milliman's actuaries - Shreve and Heijde - to establish and run the enterprise.

58. In its position as an "interactive partner," the Milliman Defendants enjoyed a special relationship and position of trust with the Culinary Health Fund, Hospitality Health, and NHC.

59. Services ultimately to be provided by the Milliman Defendants included preparing a feasibility study to be included in loan applications and statutory filings, projecting future profits, valuing reserves, setting premiums, participation in financial reporting, and serving as the CO-OP's statutorily required appointed actuary to provide certifications to the state and other entities.

C. Milliman Provides a Defective Feasibility Study, $66 Million in Federal Loans are Obtained, and Hospitality Health's Assets and Loans are Assigned to and Assumed by NHC.

60. On or about December 21, 2011, Milliman issued a document entitled "Hospitality Health Feasibility Study and Business Support for Consumer Operated and Oriented Plan (CO-OP) Application" (the "Feasibility Study"), which was to be used for the application for federal loans under the CO-OP program and for other purposes.

61. The Feasibility Study included financial projections of what Milliman labeled as its "Best Estimate Scenario" and "Alternative Scenarios." Milliman also included an analysis of the CO-OP's ability to repay loans applied for under the application.

62. The results of Milliman's analysis concluded that regardless of each scenario it tested, the CO-OP would:

- Achieve sufficient market penetration to support its expenses;
- Meet statutory minimum loss ratio requirements;
- Maintain a surplus level in excess of the minimum required to avoid Nevada DOI oversight; and
- Generate enough surplus to repay its federal loans.

63. In fact, Milliman projected that under its "Best Estimate Scenario," the CO-OP would generate an accumulated surplus in excess of $27 million by the end of 2014, $64 million by the end of 2017, and $144 million by the end of 2033.

64. Indeed, under each and every scenario presented in its report, Milliman stated that the CO-OP would generate a positive accumulated surplus.

65. Based at least in part on the Milliman projections, the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS") and Hospitality Health, entered into a loan agreement with a closing date of May 17, 2012 (the "CMS Loan Agreement").

66. The CMS Loan Agreement provided for a total of $65,925,394 in loans, including a Series A Start-up Loan with a maximum amount of $17,105,047 (the "Start-up Loan"), and a Series B Solvency Loan in the maximum amount of $48,820,347 (the "Solvency Loan," collectively, the "CMS Loans").

67. On or about December 21, 2012, by a Joint Resolution of the Boards of Directors of Hospitality Health and of NHC, the assets and liabilities of Hospitality Health, including the CMS Loans and the Consulting Services Agreement with Milliman, were assigned to and assumed by NHC.

68. During the transaction, the Boards of Directors of Hospitality Health and of NHC were identical and included many of the Management Defendants.

69. On December 21, 2012, CMS amended the CMS Loan Agreement to substitute NHC for Hospitality Health.

70. NHC was funded by the CMS Loans. Without the CMS Loans, NHC would not have had sufficient funds to qualify for licensing or to begin selling insurance.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
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Telephone: (702) 792-3773
Facsimile: (702) 792-9002

71. Based on the conclusions of the Feasibility Study and on the availability of the CMS Loans obtained through its use, in 2013 the Nevada DOI licensed NHC to begin selling insurance as of January 1, 2014.

D. Milliman's Work Does Not Meet Applicable Professional and Statutory Standards.

72. Throughout its relationships with the Culinary Health Fund, Hospitality Health, and NHC, the Milliman Defendants' work failed to meet applicable professional and statutory standards.

73. Without limitation, these deficiencies manifested themselves in the work Milliman performed relating to premium rate development, financial projections and reserve calculations, and financial misreporting. Moreover, Milliman improperly utilized financial information that it knew to be incorrect and that had not been adequately disclosed.

1. Premium Rate Development.

74. Premium rate development is a critical process for the viability of an insurer. If rates are set too low, the insurer cannot pay the medical and administrative costs, and the company will eventually fail. Conversely, if rates are set too high, the insurer will not achieve the necessary or desired market share because its products will be more expensive than those of its competitors. As a result, revenue will be inadequate.

75. As a start-up company, NHC relied heavily on its expert, actuary, and "interactive partner" Milliman, to identify appropriate assumptions and to perform the necessary actuarial calculations to establish NHC's premiums at a level that could support NHC's continued existence.

76. When developing premium rates, actuaries must comply with applicable statutory and professional standards, including those published by the NAIC and the Actuarial Standards of Practice ("ASOPs") of the U.S. Actuarial Standards Board. Such standards require the use of appropriate assumptions when developing premium rates.

77. The Milliman Defendants intentionally or negligently failed to comply with such standards.

78. In the development of NHC's 2014 and 2015 premium rates, the Milliman Defendants made a series of unjustified and inappropriate assumptions that adversely impacted NHC's premium rates.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
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Telephone: (702) 792-3773
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79. The use of these unjustified and inappropriate assumptions ultimately impacted NHC's financial viability, as mispriced premiums were unable to cover actual expenses and costs.

80. Inappropriate assumptions used by the Milliman Defendants in the premium development process that NHC ultimately relied on for its financial viability included, but were not necessarily limited to:

i. Milliman's estimates of premium rates were based on Milliman's Health Cost Guidelines (HCGs). The HCGs are based on data collected from large-group, employer-based health plans, a population with characteristics that are inherently different from those present in the individual and small-group market. As such, Milliman knew or should have known that the claim costs it projected based on data underlying the HCGs were not appropriate for the individual and small group customers that plans under the Affordable Care Act were designed to serve, unless substantial adjustments were made. Milliman failed to make such appropriate adjustments.

ii. Contrary to the ASOPs applicable to its work, Milliman did not adequately account for adverse selection - the concept that those with the greatest need and likely to generate the highest cost would be the most likely to seek apply for their most beneficial plans. Adverse selection was a critical, material, obvious, and foreseeable consideration from an actuarial perspective. The upper tier plans proved so unprofitable that all Platinum and most Gold plans were cancelled in NHC's second year of operations.

iii. Inflation adjustments used by Milliman were too low, based on commonly known data and Milliman's own firm views. Had Milliman appropriately applied a higher inflation factor, premiums would have been higher, reducing NHC's financial losses.

iv. Milliman underestimated pent-up demand for medical insurance at a lower price point. The ACA subsidized lower income insureds. Once funded, individuals with conditions that had remained untreated were suddenly able to receive the health care they needed, and understandably and predictably, these individuals tended to make use of medical services en masse.

v. Milliman's projections, even in its "low enrollment" scenario did not sufficiently consider the adverse effects of low enrollment or slow enrollment. As a result, the provision for administrative expenses in Milliman's pricing analysis that the NHC relied upon was

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

also deficient. The anticipated administrative expenses of NHC were spread over a smaller enrollment population than Milliman had projected, leading to a greater loss on each insured.

vi. Milliman failed to account for the high administrative costs necessary for a startup company, such as NHC. Despite the fact that the Feasibility Study showed administrative cost of $6.8 million in 2014 for far fewer enrollees, actual 2014 expenses were $23.6 million, flagging the disastrous financial impact of improper budgeting based on Milliman's faulty projections.

vii. Finally, proper consideration of NHC's target market was essential to estimating appropriate premiums and understanding potential risks. Milliman intentionally or negligently failed to assess NHC's target market by attempting to position NHC as the low-cost provider and in effect, "buy" participation.

81. While Milliman was aware of the challenges in the market, Milliman intentionally or negligently failed to adequately explain to NHC or to its regulators the inherent risks and uncertainty in the underlying rate development, the interaction of coverage levels in product offerings, and the dangers of competitive positioning as the low-cost provider in the market. This failure contributed significantly to the mispricing of premiums, and ultimately, the demise of NHC.

2. Financial Projections.

82. In developing NHC's financial projections, such as the Feasibility Study and other pro formas or financial reports, Milliman and Shreve made a series of inappropriate and unjustified assumptions that caused the financial projections they presented to management, the Nevada DOI, and CMS to be unrealistic and unachievable in practice.

83. When preparing financial projections such as those prepared by Milliman, an actuary's work is subject to professional and statutory standards, including those published by the NAIC, and the American Academy of Actuaries, including but not limited to ASOP No. 7 – "Analysis of Life, Health, or Property-Casualty Insurer Cash Flows," among other professional guidance.

84. The Feasibility Study included a certification by Milliman Consulting Actuary and Principal, Shreve, that stated, in part, that the projections were prepared under his supervision, were "accurate and complete," and were "prepared in accordance with generally recognized and accepted

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

principles and practices which are consistent with Actuarial Standards of Practice, the Code of Professional Conduct and Qualification Standards for Public Statements of Actuarial Opinion of the American Academy of Actuaries."

85. The inappropriate and unrealistic assumptions used by Milliman in its financial projections include, but are not limited to, those set forth in the Premium Rate Development section above.

86. The use of such inappropriate and unjustified assumptions violated applicable statutory and actuarial standards.

87. In the feasibility study dated December 21, 2011, prepared by Milliman and used in support of the loan application to CMS, Milliman concluded, "Our financial projections indicate [the CO-OP] will be able to repay its startup loans within five years of their specific drawdown dates. Further, we project [the CO-OP] will have sufficient capital to repay its solvency loans within fifteen years of their specific drawdown dates while meeting state reserve requirements and solvency regulations. These projections are based on best estimate assumptions but also hold true for the alternate scenarios tested."

88. None of the enrollment scenarios considered the possibility that NHC would have trouble attracting an adequate level of enrollment, and every economic scenario assumed that the loss ratio in nearly every modeled year would contribute to a surplus. These assumptions completely disregarded the obvious possibility that there would be significant volatility in enrollment and/or the medical loss ratio. In fact, for example, NHC's medical payments in 2014 alone exceeded the premiums received, even before administrative costs.

89. With all of the uncertainty surrounding implementation of the ACA, a competent actuary should have understood that it was a very realistic possibility that NHC would fail to be viable. Some of the modeled scenarios should have identified this possibility so as to inform NHC management and regulators. Possible scenarios, such as low enrollment, very high medical costs, and high administration expense, were not presented in the Feasibility Study, while in actuality, these possibilities should have been anticipated by Milliman actuaries when they prepared the Feasibility Study.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

90. Milliman's intentional or negligent failure to consider the possibility of these adverse enrollment and/or medical loss ratio scenarios resulted in every single scenario of the Feasibility Study showing that NHC would generate significant positive cash flows over the mid to long-term time period.

91. Milliman had a financial incentive to paint such a rosy outlook, even if it was in contradiction to actuarial standards. Upon information and belief, Milliman conditioned payment for its preparation of NHC's Feasibility Study upon NHC being awarded a loan by CMS. That is, Milliman would only receive payment for its services if NHC's efforts to secure a loan from CMS were successful.

92. By conditioning payment upon a successful result, Milliman compromised its independence as an actuary and thereby breached its duty to NHC.

93. As the certifying actuary for the Feasibility Study, Shreve is jointly and severally responsible with Milliman, his employer, for the work performed on the Feasibility Study.

94. Milliman failed to include and properly calculate actuarial reserves when preparing liability information that would later be relied upon and used by NHC in its financial reporting to Nevada DOI insurance regulators for year 2014 and the first calendar quarter of year 2015. Milliman would also certify to these improper actuarial reserves in separate reports submitted to the Nevada DOI regulators.

3. Reporting of Reserves.

95. Milliman and Heijde intentionally or negligently underreported actuarial items used in NHC's financial reports and which were submitted to the Nevada DOI. The under accrual of the December 31, 2014 reserves, including but not limited to premium deficiency reserves ("PDR") and incurred but not reported ("IBNR") reserves, caused NHC to appear financially stronger and solvent. On information and belief, they also intentionally or negligently used sources containing improper financial information that tended to artificially maintain surplus levels reported to the Nevada DOI without proper authorization or adequate disclosure.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

96. The understated PDR and IBNR reserves overstated the surplus levels and risk based capital ("RBC") ratios that the Nevada DOI used to assess the solvency of insurers. An insufficient RBC ratio would have been a red flag to the Nevada DOI and would have required NHC to take corrective steps, limiting acceptability to consumers, creditors, and regulators.

97. NHC management and the Milliman Defendants understood that the higher the IBNR reserves and PDR were, the lower the surplus and the worse the RBC ratio would be. Keeping the IBNR reserves and PDR artificially low and the surplus high masked NHC's insolvency and allowed NHC to continue to take on risk and lose money.

98. When developing and certifying reserves, actuaries must comply with statutory and professional requirements and standards.

99. NRS 681B requires, in part, that the opinions of an "appointed actuary" as to whether the reserves and related actuarial items held in support of the policies and contracts of an insurer are computed appropriately, be based on conditions that satisfy contractual provisions, be consistent with prior reported amounts, and comply with applicable laws of the State of Nevada.

100. NRS 681B also provides minimum statutory requirements for actuarial opinions on reserves, including compliance with the Valuation Manual adopted by the NAIC.

101. Actuaries are also required to comply with relevant standards set forth by the American Academy of Actuaries and the Actuarial Standards Board when setting reserves, including but not limited to ASOP 42 – "Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims" and ASOP 5 – "Incurred Health and Disability Claims."

102. For the typical health entity offering comprehensive medical insurance coverage, the size of the PDR reported in a company's annual financial statement should be consistent with the expected underwriting loss for the following year.

103. On March 13, 2015, and subsequently on May 14, 2015, Heijde and Milliman issued their Actuarial Memorandum and Statement of Opinion for the NHC (the "2014 Opinion"). In the 2014 Opinion, Heijde described that their role was to "certify that all required reserves have been established, at good and sufficient levels."

104. For the 2014 Opinion, Heijde and Milliman calculated a PDR of $0 for NHC.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

105. The PDR calculation produced a positive value of $197,162, where a negative number implies a reserve is to be held.

106. This calculation was not credible or in accordance with professional or statutory standards, as evidenced by the substantial prior and continuing losses of NHC.

107. Heijde and Milliman also grossly underestimated NHC's year-end 2014 IBNR reserves, overstating NHC's surplus position.

108. That calculation, based on known facts concerning unprocessed claims, was inconsistent with statutory and professional standards.

109. Heijde served as the appointed actuary for NHC and personally executed the 2014 Opinion.

110. The 2014 Opinion contained the opinion of Heijde and Milliman that the amounts carried on NHC's balance sheet on account of inadequately disclosed information were in accordance with accepted actuarial standards, that they were based on relevant and appropriate actuarial assumptions, that they met the requirements of the insurance laws and regulations of the State of Nevada, and that they were at least as great as the minimum amounts required to make full and sufficient provision for all unpaid claims and other actuarial liabilities of the organization.

111. The 2014 Opinion stated that Heijde's review indicated that the parties were in a financial position to meet all liabilities resulting from its relevant contracts, that she performed calculations to determine the need for a PDR, and that she determined that such a PDR was not necessary.

112. The 2014 Opinion confirmed that it was prepared for NHC's filings with the State of Nevada, NHC's auditors, the NAIC, CMS, and the Nevada DOI.

113. The 2014 Opinion raised concerns with the Nevada DOI when it noticed the apparent discrepancies between the report filed by Heijde and the actual results of NHC. It held telephonic conferences and issued written correspondence in an effort to investigate the issue.

114. On February 10, 2015, the Nevada DOI held a call to discuss the estimation of actuarial items relating to the financial statements with the Milliman team. In an e-mail dated February 14, 2015, at 8:00 p.m. on a Saturday, the Nevada DOI sent extensive and specific

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

recommendations to Milliman and NHC on the methodology to calculate the year-end PDR. The Nevada DOI expressed concerns about unrealistic expense levels and the importance of projecting PDR through the end of 2015 using reasonable and supportable assumptions.

115. The Nevada DOI included an excerpt of the then-current draft of applicable guidance to address the calculation and communication of the PDR, and it highlighted in bold italics detailed notes specific to NHC. In particular, the DOI questioned NHC's financial position and its elevated combined ratio stating, specifically:

> "In particular, based on the high level of expenses, and the level of underwriting losses projected for 2015, along with the premium increase limitations built into the ACA, we do not believe that it is reasonable for NHC's PDR to reflect a projection to the end of the contract period. In other words, without providing significant evidence to support the adequacy of renewal premiums, NHC should be projecting all groups through the end of the projection period (to 12/31/2015) using reasonable and supportable projection assumptions."

116. Milliman's calculated PDR of zero is even more alarming, given the detailed instructions provided to Milliman by the Nevada DOI in an e-mail from Annette James to Colleen Norris, dated February 14, 2015:

> "The size of the PDR reported in a company's annual financial statement should be consistent with the expected underwriting loss for the following year."

117. A week later, on February 18, 2015, the Nevada DOI followed up with a conference call with Milliman regarding the calculation of actuarial items. In a February 26, 2015 e-mail from Annette James to Basil Dibsie, the DOI stated the following:

> "***We are concerned that the preliminary December 31, 2014 premium deficiency reserve (PDR) of zero which was discussed during that call appears to be understated***. While the projected premiums and claims appear to be in line with our expectation, the level of projected expenses, combined with the expected risk corridor receipts appear to be optimistic, resulting in a PDR that appears to be understated. From a big picture perspective, it appears to be optimistic for the CO-OP to go from $21 million deficit as of 12/31/14 to a surplus position within a year. ***We therefore urge you and your actuaries to review the estimates and ensure that the appropriate level of conservatism is incorporated into the year-end estimates.*** Once the requested spreadsheets and back-up information are provided to us, we will review the calculations and may be in a position to provide specific feedback at that time." ***[emphasis added]***

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

118. The Nevada DOI went to extraordinary lengths to communicate clear guidelines for the calculation of PDR so as to produce "fairly stated year-end financials with information that is consistently applied." The then acting Insurance Commissioner made herself available for multiple calls and initiated and responded to numerous e-mails, including during non-traditional business hours. Despite the Nevada DOI's clear instructions, Milliman, Heijde, and certain members of NHC management, including but not limited to Egan and Dibsie conspired to conceal the true financial position of NHC and refused to follow the Nevada DOI's guidance.

119. In addition, in its e-mails dated February 14, 2015 and February 26, 2015, the Nevada DOI stated it expected the PDR to be reevaluated on a quarterly basis and adjusted as necessary if the emerging experience was substantially different from the projected experience. These steps were not taken and, in fact, the PDR calculation appears to have been skipped at the end of the first quarter, contrary to the Nevada DOI's explicit request.

120. By July 31, 2015, Milliman issued a document titled "Premium Deficiency Reserve as of June 30, 2015." This time, Milliman calculated that NHC would be required to hold a significant PDR.

121. The July 31 PDR calculation produced a value of ($15,928,707), where a negative number implies a reserve to be held, a roughly $16,000,000 swing from the March 14 calculation.

122. On December 31, 2014, Milliman had first calculated an IBNR reserve of $5.8 million, but then in May restated that number to be $11.0 million. By June 30, 2015, Milliman calculated the balance as $15,027,286, while still not establishing a PDR. This was a significant and unfavorable swing in NHC's financial position from year-end.

123. Still, Milliman did not restate the 2014 financial statement information. The continuing avalanche of negative claims should have provided ample reason to revisit the 2014 reserves, but Milliman failed to do so.

124. In total, the reported reserves shifted tens of millions of dollars in a few short months.

125. As the certifying actuary for the 2014 Opinion, actuarial memorandum, and subsequent communications with the Nevada DOI, Heijde is jointly and severally responsible with her employer, Milliman, for the work performed for the 2014 Opinion, actuarial memorandum, and NHC's reserve calculations.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

4. Use of Improper and Unauthorized Financial Information.

126. In addition to the understatement of reserves, on information and belief, Milliman, Heijde, and NHC management intentionally or negligently used financial information, recording loan proceeds as a receivable in the year prior to that in which a formal application for the draw was made, and participated in misreporting 2014 financial information to the Nevada DOI without adequate and proper disclosures of operating results and NHC's viability. Milliman, Heijde, and NHC management knew or should have known that these practices would tend to artificially maintain surplus levels, avoid the level that would trigger Nevada DOI supervision, misreport financials, and extend the continued and unjustified existence of NHC as an operating insurance business enabling it to write more insurance risks and undertake more financial obligations.

127. The practice of prematurely booking potential CMS loan draws as receivables without adequate disclosure was used to bolster risk-based capital levels to help meet statutory requirements.

128. The outstanding balance on the Solvency Loan as of December 31, 2014, was $42,965,683. The maximum principal available under the loan was $48,820,349. Although a draw in the amount of $3,152,275 was formally requested in January 2015 and obtained in February 2015, the transaction was recorded as if it had occurred as of December 2014, which Milliman knew was inaccurate and misleading without additional disclosure.

129. Milliman set IBNR reserves too low and no PDR reserves until July 31, 2015, in violation of actuarial standards and practices and without due regard to NHC's operating results and information, which was inaccurate and misleading.

130. Given the other issues noted above, had the CMS loan final draw been correctly recorded in 2015, it would have negatively impacted the critical ratio testing requirement with the Nevada DOI.

131. The clear pattern of reduced and understated actuarial items on the balance sheet for IBNR reserves and PDR, along with the use of inappropriate and inadequately disclosed financial information to meet statutory requirements, indicates that Milliman's estimates were arrived at in an effort to falsely inflate NHC's surplus levels and RBC ratio position, as well as to misreport the 2014 financial information of the company, so as to avoid or postpone inevitable Nevada DOI intervention.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

FACTUAL ALLEGATIONS RELATING TO MILLENNIUM

E. Millennium Represents Itself as an Accounting and Consulting Firm with Insurance Industry Expertise and is Engaged by NHC to Prepare and File Statutory Statements.

132. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

133. Financial reporting for insurance companies is complex and involves issues not frequently encountered by those in other industries.

134. NHC was required to file statutory basis financial statements and compliance reports related to the audit of federal awards.

135. The Nevada DOI recognizes only statutory accounting practices prescribed or permitted by the State of Nevada. The NAIC's Accounting Practices and Procedures Manual ("SAP") has been adopted as a component of prescribed or permitted practices by the State of Nevada.

136. On information and belief, during late 2014, NHC sought out an accounting firm that was an expert in insurance accounting, reporting, and consulting.

137. Millennium reports on its website that it provides educational training, regulatory consulting, and administrative services to insurance companies, insurance regulators, and other insurance-related entities throughout the United States and Puerto Rico.

138. Millennium's website also states that "Millennium Consulting's portfolio of services provides a variety of solutions to meet the demanding obligations of statutory accounting and reporting regulations."

139. On information and belief, NHC identified and engaged Millennium after NHC's employee attended a statutory accounting seminar put on by Millennium and because of Millennium's self-proclaimed expertise in statutory accounting and reporting regulations for the insurance industry.

140. On or about January 7, 2015, NHC entered into a service agreement (the "Service Agreement") with Millennium to provide accounting and consulting services. Under the terms of the Service Agreement, Millennium was to:

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

- Prepare and file NHC's Annual Statement, including all NAIC Supplemental Exhibits and Schedules for filing with the Nevada DOI and the NAIC;

- Prepare and file NHC's Quarterly Statement, including all NAIC Supplemental Exhibits and Schedules for filing with the Nevada DOI and the NAIC;

- Assist in the review and prepare responses to any regulatory letter from the Nevada DOI and the NAIC related to the Annual and/or Quarterly Statement filings;

- Respond to any independent auditor inquiries regarding the preparation and filing of NHC's Audited Statement Supplemental filings, as needed; and

- Acquire, on behalf of NHC, Annual and Quarterly RBC software.

141. Schedule A to the Millennium Service Agreement specified that the contracted work would include preparation of schedules "in accordance with statutory accounting and reporting rules prescribed and permitted by the State of Nevada" and "entail evaluating general ledger accounting entries, ensuring that statutory accounting and reporting principles have been followed, recommending any adjustments to adhere to statutory accounting and reporting rules prescribed by the state of [Nevada] and preparing any supporting worksheets that may be needed in arriving at appropriate allocations of financial amounts within some of the schedules."

142. By undertaking the contractual duties specified in the Service Agreement, Millennium agreed to perform the duties of an internal financial controller. In this position, NHC relied on the superior knowledge and expertise that Millennium touted to run NHC. In this position, Millennium enjoyed a special relationship and position of trust with NHC.

F. Millennium Fails to Live Up to its Contractual Obligations to Prepare Financial Statements in Accordance with Applicable Standards.

143. Despite the fact that Millennium was to evaluate general ledger entries, to ensure that statutory accounting and reporting principles had been followed, and to recommend any adjustments so as to adhere to statutory accounting and reporting rules prescribed by the State of Nevada, the reports prepared and filed by Millennium under the Service Agreement failed to meet applicable statutory, professional, and contractual standards.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

144. NHC's 2014 Annual Statement (the "2014 Annual Statement") was not prepared in accordance with statutory accounting and reporting rules, and it had to be subsequently amended.

145. Millennium did not properly disclose the reliance on extraordinary state prescribed or permitted practices, whether such prescribed or permitted practices were approved, or whether the reporting entity's risk based capital ratios would have triggered a regulatory event had it not used a prescribed or permitted practice.

146. Inappropriate and unapproved wording was used in the notes to the 2014 Annual Statement.

147. Data presented between schedules was inconsistent.

148. The 2014 Annual Statement disclosure regarding the CMS Loans was not in conformity with applicable standards, including SSAP 15, because there was no disclosure regarding the covenants associated with these loans.

149. The 2014 Annual Statement did not disclose material related party transactions.

150. The 2014 Annual Statement did not disclose significant internal control weaknesses that materially impacted operations and the financial statement.

151. The 2014 Annual Statement reflected without adequate disclosure, a receivable amount of $3.2 million as of December 31, 2014, with an offsetting entry to surplus in the form of the CMS Solvency Loan, despite the fact that NHC did not submit a formal loan request to CMS until the subsequent year.

152. NHC incurred significant losses for the year ending December 31, 2014 that exceeded the financial projections included in its CMS application and in NHC's licensing application with the Nevada DOI. Additionally, enrollments were substantially below target, and cash flow was a problem, with credit lines becoming rapidly exhausted.

153. Millennium failed to adequately disclose required reserves, projected future losses for 2015, the impact on NHC's RBC results, the impact on NHC's CMS loan covenant requirements, projected future shortfalls in enrollments, the exhaustion of NHC's available lines of credit, the growing concern regarding NHC's ability to continue as a going concern, and NHC's plan to mitigate these negative trends.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

154. For the first quarter of 2015, many of these issues, including without limitation the understatement of reserves, remained unaddressed, and the first quarter 2015 statutory statements prepared and filed by Millennium were not in conformance with required contractual, statutory, or professional standards.

155. Millennium further participated in the drafting of NHC's Management's Discussion & Analysis (the "MD&A") report for 2014 as required under the Service Agreement.

156. Nevada has adopted NAIC reporting rules by statute and order of the Nevada DOI. Pursuant to NAIC rules, the MD&A requirements are intended to provide, in one section, material historical and prospective textual disclosure enabling regulators to assess the financial condition and results of operations of the reporting entity. Under NAIC rules, reporting entities should identify any known trends or any known demands, commitments, events or uncertainties that will result in or that are reasonably likely to result in the reporting entities' liquidity increasing or decreasing in any material way.

157. The 2014 MD&A prepared by Millennium did not explain or discuss the severity of NHC's financial position nor did it provide the MD&A's users with relevant and required information regarding extraordinary accounting practices in use, the inadequacy of reserves, liquidity and borrowing concerns, or other challenges faced by NHC. As such, Millennium failed to perform its work in accordance with the NAIC rules prescribed and permitted by the State of Nevada, as required by the Service Agreement.

FACTUAL ALLEGATIONS RELATING TO THE LARSON DEFENDANTS

G. Larson Represents Itself as a CPA Firm with Insurance Industry Expertise and is Engaged by NHC to Audit the Company.

158. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

159. The audits of insurance companies may be complex and involve issues not frequently encountered by companies not specializing in such audits.

160. On information and belief, during late 2013 and early 2014, NHC sought out a CPA firm that was an expert in auditing and advising insurance companies.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

161. Larson is a Certified Public Accounting firm that asserts in its website that it "began practice in 1975 with the central purpose of serving the insurance industry. We have grown to become one of the premier insurance audit firms in the nation . . ."

162. Its website continues by saying that, "while many insurance companies prepare GAAP [Generally Accepted Accounting Practices] statements for internal use, statutory filings are required by all licensed insurance companies. These regulations are very different from GAAP regulations. Because of this, only individual with industry specific expertise can fully comprehend the impact of different transactions. And without this understanding, it is difficult for an insurance company to operate successfully long term. . . . When choosing professional advisors to help you navigate the rapidly shifting waters of the insurance industry, you need experienced, knowledgeable professionals. Our insurance group is an integrated team of audit, tax, and advisory professionals delivering sophisticated business solutions to help our clients minimize their growth potential and remain competitive."

163. On information and belief, NHC identified and engaged Larson because of its self-proclaimed expertise in insurance company audits.

164. On or about February 19, 2014, NHC and Larson entered into an engagement letter under which Larson would provide professional services to NHC.

165. The February 19, 2014 engagement letter drafted by Larson included the following statements:

- "We will audit the statutory financial statements of Nevada Health Co-Op (the Company) which comprise the statutory statements of admitted assets, liabilities, and capital and surplus as of December 31, 2013, and the related statutory statements of income, changes in capital and surplus, and cash flows for the year then ended. Also the following supplementary information accompanying the statutory financial statements will be subjected to the auditing procedures . . . . :
  - The National Association of Insurance Commissioners' (NIAC) required supplementary information
  - Schedule of Expenditures of Federal Awards

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

- The objective of our audit is the expression of opinions as to whether your statutory financial statements are fairly presented, in all material respects, in conformity with statutory accounting principles and to report on the fairness of the supplementary information referred to in the [above] paragraph.

- Our audit will be conducted in accordance with the auditing standards generally accepted in the United States of America; the standards for financial audits contained in Government Auditing Standard, issued by the Comptroller General of the United States; the Single Audit Act Amendments of 1996; and the provisions of OMB Circular A-133, and will include test of accounting records, a determination of major programs(s) in accordance with OMB Circular A-133, and other procedures we consider necessary to enable us to express such opinions and to render the required reports.

- Dennis T. Larson, CPA, is the engagement partner and is responsible for supervising the engagement and signing the report or authorizing another individual to sign it."

166. A subsequent engagement letter with similar terms, dated September 30, 2014 (collectively, with the February 19, 2014 engagement letter, "Engagement Letters"), was also entered into by NHC and Larson for the year ended on December 31, 2014, with Martha Hayes as the responsible CPA.

H. Larson Defendants Ignore Glaring Warning Signs, Perform Only a Cursory Review of Material Items, and Issue Opinions on NHC's 2013 and 2014 Financial Statements without Adequate Justification, Disclosure, or Qualifications.

167. During 2014 and into 2015, the Larson Defendants performed an audit on the books and records of NHC and completed other work concerning supplemental information to be presented regarding NHC.

168. In early 2015, NHC and its actuary, Milliman, filed preliminary financial reports with the Nevada DOI for the year ended December 31, 2014.

169. These reports included analysis of NHC's actuarial reserves.

170. These reports showed no PDR and only $5.8 million in IBNR reserves as of December 31, 2014.

171. NHC's reserve levels raised concerns.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

172. As set forth above, throughout early 2015, the Nevada DOI went to extraordinary lengths to communicate clear guidance for the proper calculation of reserves.

173. Given the guidance delivered by the Nevada DOI and additional guidance given by the NAIC, the balances of the reserves should have been questioned and audited both from a year-end perspective and as part of Larson's subsequent event testing. Yet there is no evidence in the audit work papers that anything more than a cursory review took place.

174. Even without adjusting reserve balances, NHC had reported losses of over $8 million in 2013 and over $16 million in 2014.

175. Up until Larson issued its reports on June 1, 2015, NHC continued to hemorrhage losses.

176. NHC had all but exhausted its remaining capital by that time.

177. NHC exhausted what remained of its almost $66 million in CMS Loans in early 2015, and had no borrowing capacity remaining, given its huge losses.

178. These should all have been "red flags" to the Larson Defendants that NHC would be unable to continue as a going concern.

179. Alarmingly, a receivable related to a CMS loan request was recorded in 2014, although it was not even formally applied for in that year, but rather in the following year. Adequate disclosure of this transaction was not included in the 2014 audited financial statements.

180. As auditors specializing in insurance companies, Larson knew or should have known that recording of a receivable concerning proceeds of the loan in the year before it was formally applied for, without adequate authorization or disclosure, was misleading, could artificially inflate NHC's reported surplus levels, and could make NHC appear more solvent than it actually was.

181. NHC's officers and directors were relatively inexperienced in insurance matters and were unable to establish sufficient internal controls over its business.

182. NHC also relied on outside service providers to perform critical processes for NHC, creating another set of internal control concerns.

183. Contractors handling enrollment, claims processing, billing, receipt of premiums, premium rate setting, actuarial services, and other issues did not perform their work in accordance with industry and professional standards, resulting in significant internal control issues and losses for NHC.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

184. Larson should have planned its audit procedures, taking into account the internal control weaknesses evident at NHC.

185. However, Larson did not adequately plan for, search for, identify, or disclose these internal control weaknesses.

186. Both the 2013 and 2014 financial reports submitted to the Nevada DOI attached supplemental information, including respective MD&A's, which were subject to Larson's auditing procedures.

187. The MD&A's however, were at best deficient prohibited boilerplate that did not conform to statutory, industry or NAIC requirements and neither discussed nor disclosed significant issues concerning, without limitation, NHC's extraordinary accounting practices, insufficient reserves, liquidity concerns, lack of borrowing capacity or its inability to continue as a going concern, as set forth herein.

188. On or about May 29, 2014, Larson issued its audit report for the year ended December 31, 2013 (the "2013 Opinion"). The 2013 Opinion contained no information concerning NHC's ability to continue as a going concern, despite the fact that by the time the report was issued, NHC was incurring substantial unanticipated losses. Neither did the 2013 audit report disclose the significant internal control weaknesses that existed or recognize adequate reserves for the contracts on which NHC was already incurring substantial losses.

189. On or about June 1, 2015, Larson issued its Statutory Financial Statements and Independent Auditor's Report and other Legal and Regulatory Information (the "2014 Audit Opinion") regarding NHC's 2013 and 2014 financial statements.

190. The 2014 Audit Opinion contained one emphasis of matter paragraph noting only issues with the Risk Adjustment, the Federal Transitional Reinsurance, and the Risk Corridor programs. Despite the materiality of receivables from the federal government, and the issues raised concerning their calculation, the 2014 Audit Opinion stated that, "[Larson's] opinion is not modified with respect to this matter."

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

191. The 2014 Audit Opinion was without any qualification as to the reported reserves, the recording of loan receipts in the year prior to actual receipts, internal control weaknesses, or NHC's ability to continue as a going concern.

192. On or about June 1, 2015, Larson issued its Reports of Independent Certified Public Accountants Required by OMB Circular A-133 for the Year Ended December 31, 2014 (the "2014 OMB Report"), which included its analysis of internal controls for the purpose of expressing its opinion on the financial statements.

193. In the 2014 OMB Report, Larson stated that during its audit, it did not identify any deficiencies in internal control that it considered to be material weaknesses.

194. Additionally, in the 2014 OMB Report, Larson represented that, as part of obtaining reasonable assurance about whether NHC's financial statements were free from material misstatements, it performed tests of NHC's compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have had a direct and material effect on the determination of financial statement amounts.

195. In the 2014 OMB Report, Larson further stated the results of its tests disclosed no instances of noncompliance or other matters that were required to be reported under government auditing standards.

196. As part of the 2014 OMB Report, Larson also included an Independent Auditor's Report on Compliance for Each Major Program; Report on Internal Control over Compliance; and Report on Schedule of Expenditures of Federal Awards Required by OMB Circular A-133 ("the 2014 Major Program Report").

197. In the 2014 Major Program Report, Larson reported that, in its opinion, NHC complied in all material respects with the types of compliance requirements referred to in the report that could have had a direct and material effect on each of its major federal programs for the year ended December 31, 2014; that it did not identify any deficiencies in internal control over compliance that it considered to be material weaknesses; and that, in its opinion, the schedule of expenditures of federal awards was fairly stated in all material respects in relation to the statutory financial statements taken as a whole.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

I. The Larson Defendants' Work Failed to Meet Statutory and Professional Standards Required of CPAs.

198. In performing its audits of NHC and in providing other accounting services to NHC, Larson failed to meet statutory and professional standards, including, but not limited to those set forth herein.

199. Larson did not properly identify or disclose the reliance of NHC on extraordinary state prescribed or permitted practices, whether such prescribed or permitted practices were approved, or whether the reporting entity's risk based capital ratios would have triggered a regulatory event had it not used a prescribed or permitted practice.

200. Larson failed to identify and adequately disclose that material transactions, including the posting of a multi-million dollar receivable from a loan that had not even been formally applied for, were recorded in the year prior to formal application and receipt.

201. Larson failed to identify and disclose that as of December 31, 2013, and 2014, NHC's ability to continue as a going concern was in doubt.

202. Larson failed to adequately identify and disclose that NHC's insurance reserves including its PDR as of December 31, 2013, and 2014, and IBNR reserves as of December 31, 2014, were materially misstated.

203. Larson failed to adequately analyze and test work performed by NHC's actuary.

204. Larson failed to identify and disclose related party transactions.

205. Larson failed to identify and disclose internal control deficiencies, including but not limited to financial reporting controls, as well as internal controls relating to claims, enrollment, member termination, premium tracking, and provider arrangements.

206. Larson failed to identify and disclose violations of loan covenants and NHC's inability to repay existing debt.

207. Larson failed to identify or properly assess business risks, including but not limited to insufficient premium rates to support the policies issued, inadequate information technology systems and vendors, problems with processing and paying claims, issues with billings for premiums, issues with processing premium payments, and a lack of additional borrowing capacity.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

208. Larson failed to identify, plan for, or disclose NHC management's lack of experience and competence to produce financial statements that were in conformance with applicable reporting standards and free from material misstatements.

209. Larson failed to adequately test, disclose and report the collectability and reserves for material receivables.

210. Larson failed to prepare an adequate audit plan or to even follow the inadequate audit plan that it prepared.

211. Larson failed to perform proper subsequent events testing and did not identify or disclose numerous subsequent events that should have been considered in analyzing year-end account balances and that should have been disclosed in the financial statements.

212. Larson failed to identify or disclose deficient MD&A information and disclosures contained in the supplemental information provided with NHC's 2013 and 2014 financial statements.

213. Larson also failed to properly document and maintain appropriate audit evidence in support of any audit work it performed.

FACTUAL ALLEGATIONS RELATING TO THE INSUREMONKEY DEFENDANTS

J. InsureMonkey is Engaged by NHC Based on its Claimed Expertise.

214. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

215. In 2013, NHC sought a qualified contractor to provide software and services, including a customer portal to enroll and to service NHC's customers. The software and services would also collect and provide to NHC data necessary for making operational decisions and reporting to regulators.

216. Defendants Rivlin and InsureMonkey represented to NHC that InsureMonkey was qualified and capable of providing the software and services.

217. On or about April 13, 2013, NHC and InsureMonkey entered into a Memorandum of Understanding for InsureMonkey to provide the technology and software services. NHC and InsureMonkey subsequently entered into a Master Services Agreement relating to technology and

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

services, making the agreement effective as of the date of the earlier Memorandum of Understanding (the "2013 Master Services Agreement"). Rivlin largely negotiated and executed the 2013 Master Services Agreement on behalf of InsureMonkey.

218. As part of the 2013 Master Services Agreement, InsureMonkey expressly acknowledged that it was required to "comply with [NHC's] obligations" under NHC's CMS Loan Agreement as part of performing InsureMonkey's services. Similarly, InsureMonkey acknowledged that it had to maintain certain records and provide NHC, CMS, and others with access to certain information relating to InsureMonkey's performance under the 2013 Master Services Agreement.

219. In a similar timeframe, NHC was also searching for a contractor to perform additional customer service functions, including establishing a call center and providing support to consumers involved in the enrollment process.

220. During this April-May 2013 time period, InsureMonkey's representatives, especially its CEO Rivlin, expressly represented that InsureMonkey was capable of providing all of the additional customer service support functions that NHC was seeking, in addition to its technological and software support.

221. From June through August 2013, NHC and InsureMonkey continued to negotiate terms of a customer services contract to handle both on-exchange and off-exchange support services. Again, during this time, InsureMonkey's representatives, including Rivlin, repeatedly touted InsureMonkey's capabilities in the customer service space relating to the insurance business.

222. On or about August 1, 2013, NHC and InsureMonkey entered into another Memorandum of Understanding governing InsureMonkey's provision of customer service functions to NHC (the "August 2013 Customer Service MOU"). Rivlin negotiated and executed the August 2013 Customer Service MOU on behalf of InsureMonkey.

223. The August 2013 Customer Service MOU required InsureMonkey to deliver "contact center service…for new and renewing member enrollments" on behalf of NHC. This included providing, staffing, and operating both a call center and a walk-in center for consumers.

224. The August 2013 Customer Service MOU represented that InsureMonkey would provide "professionally licensed and trained Contact Center Agents" and that InsureMonkey would

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

"train all Agents on NHC products and enrollment processes as well as enrollment processes" through the exchange, "including determining subsidy eligible populations and providing eligibility" through the exchange.

225. Upon information and belief, when Rivlin and other representatives of InsureMonkey made representations regarding the services they could and would perform, they either had no intention of fulfilling those obligations and/or should have reasonably understood that InsureMonkey was unable to adequately perform the critical services they were contracting to perform on behalf of NHC. As a result, InsureMonkey knew or should have known that its failure necessarily would have impacted NHC's status with CMS and the loan proceeds NHC was to obtain under the CMS Loans Agreement.

226. On or about September 3, 2013, InsureMonkey and NHC entered into an additional Memorandum of Understanding further expanding InsureMonkey's responsibilities and obligations with respect to customer and member services (the "September 2013 Customer Service MOU"). Yet again, this agreement was predicated upon the express representations of Rivlin regarding InsureMonkey's capabilities with respect to these types of services.

227. Among other things, the September 2013 Customer Service MOU detailed NHC's obligations with respect to developing "a comprehensive model of member services that addresses all aspects of stakeholder management." In addition to providing a member services center on behalf of NHC, InsureMonkey agreed that it would track certain information regarding members, their eligibility status, and other contacts relating to information and data that needed to be reported to CMS.

228. InsureMonkey performed services under its agreements with NHC relating to the 2013 enrollment period for 2014 coverage.

229. During this time, NHC relied upon InsureMonkey's ability to perform its services and on the reporting and tracking data provided to it by InsureMonkey in submitting reports and information to CMS.

230. On or about August 1, 2014, NHC and InsureMonkey entered into a Master Services Agreement "to consolidate the terms of their continuing business relationship under the terms of

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

this Agreement" and to set forth the scope of the parties' relationship moving forward (the "Master Agreement"). Rivlin again negotiated and executed the Master Agreement on behalf of InsureMonkey.

231. Like the prior agreements, InsureMonkey expressly represented in the Master Agreement that it would "comply with the terms of the [CMS] Loan Agreement" in performing its obligations to NHC.

232. InsureMonkey represented in the Master Agreement that the "[s]ervices contemplated hereunder will be performed by adequately trained, competent personnel, in a professional manner, with such personnel having the requisite skill and expertise necessary to perform and complete the Services in accordance with industry standards[.]"

233. InsureMonkey also represented in the Master Agreement that the "[s]ervices will substantially conform to the applicable specifications and acceptance criteria (if any) agreed to by the parties in the applicable Statement of Work[.]"

234. Throughout the relationship between InsureMonkey and NHC, because of the inexperience of NHC management and the representations of InsureMonkey as to its superior knowledge and expertise, NHC trusted, relied on, and depended on InsureMonkey as a key component of its operation in its business of insuring and servicing NHC's Members.

235. At the time Rivlin executed the Master Agreement, he and InsureMonkey knew or reasonably should have known that that they had no intention or ability to honor the terms of the Master Agreement, that InsureMonkey would not and could not perform the services contemplated by the Master Agreement in accordance with industry standards, and that InsureMonkey did not have adequately trained and competent personnel to perform such service.

K. InsureMonkey Fails to Perform Under its Agreement and Misrepresents Key Data that NHC Relied upon in Reporting to CMS.

236. Under the parties' agreements, NHC was largely left to the mercy of InsureMonkey. InsureMonkey was responsible for reporting current, complete, and accurate enrollment, billing, and eligibility data, upon which NHC was to rely in servicing its members and in making its reports to CMS, the Nevada DOI, and others.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

237. InsureMonkey failed to follow industry standards relating to tracking and reporting basic enrollment, billing, and eligibility data, including without limitation the failures set forth herein.

238. At critical times during the open enrollment process, InsureMonkey was unable to make the broker portal it had created work properly and allow agents to sign up individuals for insurance policies. These portal issues impacted and depressed enrollment numbers in both 2014 and 2015, leading to fewer members being insured under the plan and lower premium income for NHC.

239. InsureMonkey failed to attend regular CMS information calls on NHC's behalf, which it was contractually required to do, leading to NHC failing to receive necessary information from CMS that InsureMonkey was obligated to obtain and transmit.

240. InsureMonkey failed to submit monthly reconciliation files to CMS for many months as required, impacting the receipt of premium subsidies from CMS.

241. InsureMonkey failed to hire qualified individuals to provide the customer and member services as contemplated by the parties' agreements.

242. InsureMonkey failed to properly train individuals to provide the customer and member services contemplated by the parties' agreements.

243. InsureMonkey failed to properly supervise individuals providing the customer and member services contemplated by the parties' agreements.

244. InsureMonkey failed to properly log eligibility data for individuals during the enrollment process.

245. InsureMonkey failed to obtain premium payments from new and renewing members or to transmit that information in a timely manner.

246. InsureMonkey failed to timely terminate members' eligibility when they became ineligible for benefits under the plan.

247. InsureMonkey failed to timely transmit information regarding premiums received, causing the improper suspension of insureds' coverage and terminating or negatively affecting premium subsidies that NHC would otherwise have received from CMS.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

248. InsureMonkey even failed at the most basic level in reporting the total number of enrollees in the plan.

249. When the incompetency of InsureMonkey's employees was brought to InsureMonkey's attention, InsureMonkey failed to retrain or replace those individuals, and it allowed them to continue to provide deficient customer and member services.

250. As a result of InsureMonkey's incompetency despite its representations to the contrary, as well as its deficient hiring, training, supervision, and retention of employees, InsureMonkey's performance under the agreements was woefully deficient.

251. InsureMonkey had an incentive to over report the number of members enrolled in the plan at any given time and to not terminate a member's eligibility in NHC's books and records.

252. Notably, several of the parties' agreements, including the Master Agreement, calculated the payment due to InsureMonkey from NHC based on a certain price per member, per month that the member was enrolled in the plan.

253. Upon information and belief, InsureMonkey, at the direction of its CEO Rivlin, intentionally misrepresented the membership enrollment numbers in order to procure larger payments to InsureMonkey under their agreements.

254. At the time, NHC had no reason to know or suspect the extent of InsureMonkey's failure to properly report enrollment, billing, and eligibility data or its deliberate misreporting of enrollment, billing, and eligibility data. NHC only learned of the extent of InsureMonkey's misreporting after the appointment of a receiver over NHC.

255. Despite its woefully deficient performance, InsureMonkey was paid approximately $4.4 million for contracted services in 2014 and over $5 million in 2015.

256. InsureMonkey's actions and conduct addressed herein resulted in grave consequences to NHC. Without limitation, InsureMonkey's actions led to the following: (a) underpayment to NHC for advanced premium tax credits that NHC would have been entitled to had InsureMonkey properly performed its services and provided reliable data concerning enrollment to NHC and CMS; (b) NHC paying out additional claims as a proximate result of InsureMonkey's reporting of faulty eligibility data; (c) NHC overpaying into the transitional reinsurance program as

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

the proximate result of InsureMonkey's reporting of faulty eligibility data; (d) NHC overpaying InsureMonkey and other contractors in payments calculated on faulty enrollment data provided by InsureMonkey; and (e) decreased risk corridor payments to NHC as the proximate result of InsureMonkey providing faulty and unreliable enrollment data.

FACTUAL ALLEGATIONS RELATING TO NEVADA HEALTH SOLUTIONS

L. NHS Engages with Kathleen Silver in Self-Dealing, Receiving Substantial Sums for Deficient Utilization Management Services.

257. Plaintiff realleges and incorporates all of the allegations contained in the proceeding paragraphs as is fully set forth herein.

258. Utilization management is the evaluation of appropriateness and medical necessity of health care services, procedures and facilities according to evidence-based criteria or guidelines, and under the provisions of an applicable health insurance plan.

259. NHS represented itself to be a capable utilization management services company.

260. Pursuant to a Utilization Management Services Agreement (the "Utilization Agreement"), NHS contracted with NHC to perform evaluations of appropriateness and medical necessity of heath care services, procedures and facilities; perform precertification of hospital admissions and outpatient procedures; process information related to in-hospital observations; provide concurrent reviews for inpatient acute care, rehabilitation and long term acute care; provide discharge planning; and perform provider appeal reviews, along with other services. NHS was also engaged to perform member eligibility review services for NHC, a process through which the enrollment of NHC's members must be verified for medical benefits to be allowed by NHC.

261. Throughout the relationship between NHS and NHC, because of the relative inexperience of NHC management (well known to NHS) and the representations of NHS as to its superior knowledge and expertise, NHC trusted, relied on, and depended on NHS as its gatekeeper to ensure the appropriateness and medical necessity of medical services incurred by NHC's members and their eligibility for such services.

262. NHS breached the Utilization Agreement by failing to perform contracted work and by failing to perform to applicable contractual, professional and industry standards. Without

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

limitation, NHS failed to perform to the standards set forth in the Utilization Management Program that was incorporated into the Utilization Agreement.

263. Under the Utilization Agreement, NHS was to perform its services utilizing appropriate medical staff including accredited physicians. On information and belief, NHS did not employ qualified personnel to perform the contracted services, and at most subcontracted such services to others, to the extent they were performed at all.

264. Initial compensation was mechanically calculated based on the total persons enrolled as NHC members each month, a fee that bore little to no relation to services being provided by NHS. Upon information and belief, little work was actually performed by NHS for NHC.

265. Fees under the Utilization Agreement were charged by NHS on a per member per month basis, but NHS required a minimum monthly fee to be paid based on an enrolled membership of 10,000 members. NHC did not have 10,000 enrolled members for the first four months of 2014 and was substantially short of 10,000 enrolled members in those months; thus, NHC paid the minimum monthly fee to NHS in each of those first four months of 2014. Additionally, NHC was to be charged by NHS for all direct and indirect provider costs incurred by NHS for performing its services. However, since NHS provided little services to NHC in 2014, there were no other direct or indirect costs charged by NHS to NHC other than the per member per month flat monthly fee stated above. On information and belief, NHS failed to adjust for the actual cost of the limited work performed.

266. NHS and Management Defendant Kathleen Silver engaged in self-dealing in which NHS was unjustly paid substantial amounts by NHC for the so-called utilization management services. NHS's president was Management Defendant Kathleen Silver, and upon information and belief, the owner of NHS was UHH. Upon information and belief, UHH was an entity with financial ties and/or direct or indirect business links with Management Defendants Bobbette Bond, Thomas Zumtobel, and Kathleen Silver. UHH was being paid to process and adjudicate claims of NHC, and then it was being paid again through NHS to do a quality control review check of the very claims that UHH processed. The NHS and NHC medical utilization management review arrangement was unfair, unreasonable, and just another way to siphon more money out of NHC to the detriment of its members, policyholders, and creditors.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

267. NHS's actions and conduct resulted in substantial losses to NHC. Without limitation, in excess of $1 million in claims were paid outside of enrollment when NHS failed to properly perform eligibility checks during utilization reviews. NHS was paid fees and expenses totaling $382,968 under this utilization management and enrollment eligibility review arrangement. Costs which should not have been incurred under the Utilization Management Program were incurred, contracted assistance to members for managing health care decisions was not received, and inappropriate financial benefits were paid from this arrangement to the detriment of NHC's members, policyholders, and creditors.

FACTUAL ALLEGATIONS RELATING TO THE MANAGEMENT DEFENDANTS

M. The Management Defendants Fail to Uphold Their Fiduciary Duties to NHC.

268. Plaintiff realleges and incorporates all of the allegations contained in the proceeding paragraphs as is fully set forth herein.

269. As officers and directors of NHC, each of the Management Defendants owed duties of good faith and loyalty to NHC and was charged with exercising his or her powers, authority, and discretion in the best interests of NHC.

270. Additionally, the Management Defendants executed employment agreements and ethics and conflicts of interest documents which contractually specified such duties.

271. The duties owed by the Management Defendants included, without limitation, not misleading regulatory authorities, instituting adequate internal controls to protect company assets and operations, adequately selecting and supervising employees and contractors, avoiding self-dealing, fully and adequately disclosing related party transactions, avoiding the squandering of NHC's assets, and reviewing and ensuring the accuracy of loan applications, financial statements, and regulatory filings submitted by NHC.

272. From NHC's inception through its being put in receivership in October 2015, as outlined below, each of the Management Defendants failed to uphold his or her duties owed to NHC when exercising his or her powers and authority with respect to the business decisions, operations, reporting and management of NHC.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

N. Management Defendants Unreasonably Fail to Establish Internal Controls, Exercise Oversight, Ensure Accurate Reporting, or Adequately Disclose Related Party Transactions.

273. A primary responsibility of Management Defendants was to institute sufficient internal controls to ensure the protection of assets, to establish and enforce procedures to run NHC, and to conform with statutory requirements, including providing accurate reporting to regulators and the public.

274. The Management Defendants failed to establish sufficient internal controls over its business.

275. Initially, the Management Defendants failed to hire or train adequate personnel to run its business. As a result, NHC relied on contractors to perform critical processes for NHC, creating another set of internal control concerns, ones that were likewise overlooked and ignored by the Management Defendants.

276. Rather than prudently limiting the scope of business until such time as adequate internal controls had been established, the Management Defendants appear to have adopted an "even if we lose money on each customer we will make it up in volume" approach.

277. Contractors handling enrollment, claims processing, billing, receipt of premiums, premium rate setting, actuarial services, and other issues did not perform their work in accordance with industry and professional standards, resulting in significant internal control issues and losses for NHC, issues that should have been caught and remedied by the Management Defendants, but were not.

278. Additionally, the total breakdown in internal controls caused misleading reports to be issued in violation of applicable statutes and standards.

279. The Management Defendants knew or should have known of the dearth of internal controls to protect NHC and the public. The Management Defendants' refusal to institute such controls involved and/or constituted negligence, intentional misconduct, fraud, and/or knowing violations of the law.

280. The Management Defendants similarly failed or refused to exercise the necessary required oversight of NHC and its contractors.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

281. Employees without the expertise or experience to run such a large undertaking were negligently hired and retained, or were simply allowed to keep positions given to them by the Culinary Health Fund.

282. As discussed herein, rather than replacing or obtaining sufficient training for its employees, the Management Defendants engaged contractors whose work was not properly performed or appropriately overseen.

283. Even when significant problems arose, the Management Defendants failed to exercise their oversight function and remedy them.

284. Contractors created overly optimistic feasibility studies, on information and belief, in order to receive compensation that would only be paid if loans were received.

285. Early in the process, NHC's officers and directors, including each of the Management Defendants, authorized and/or ratified financial transactions and assumed financial obligations that they knew or should have known NHC could not meet or otherwise satisfy.

286. Customers had difficulty signing up for services, premiums went unbilled or unpaid, failures in reporting data to CMS caused government subsidies to be lost, and vendors were paid despite failing to perform under contracts. Insureds failed to receive coverage because of bad data, and costs were paid because NHC could not confirm whether coverage was or was not in effect. Still, the Management Defendants failed to exercise appropriate oversight to remedy the situation.

287. Despite horrendous losses, the Management Defendants authorized NHC to continue to draw down on government loans, knowing there was no reasonable way that such loans could be repaid.

288. As further discussed herein, the Management Defendants, including the audit committee members, the chief financial officer, and NHC's president, also failed to exercise oversight to ensure accurate, truthful, and non-misleading dissemination of financial information to regulatory authorities and the public with respect to NHC's affairs.

289. The Management Defendants knew or should have known that their intentional decision not to exercise appropriate oversight would cause significant damages and would involve and/or constitute negligence, intentional misconduct, fraud, and/or knowing violations of the law.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

290. The Management Defendants' actions or inactions similarly caused misleading reporting of financial and operational results to the Nevada DOI and others.

291. From 2012 through 2015, the Management Defendants retained and/or approved the retention of certain third party entities to perform financial reporting and/or auditing on behalf of NHC, including, but not limited to Milliman, Millennium, and Larson.

292. In early 2015, a preliminary report was filed with the Nevada DOI for the year ended December 31, 2014.

293. As discussed above, NHC's reserve levels raised concerns with the Nevada DOI, and throughout early 2015 the Nevada DOI went to extraordinary lengths to communicate clear guidance for the proper calculation of reserves. Nevada DOI guidance went directly to NHC management.

294. Additionally, the NAIC pointed out deficiencies in NHC's statutory reporting directly to NHC's management.

295. The Nevada DOI stated they expected the PDR to be re-evaluated on a quarterly basis and adjusted as necessary if the emerging experience was substantially different from the projected experience. These steps were not taken and, in fact, the PDR calculation appears to have been skipped at the end of the first quarter, contrary to the Nevada DOI's explicit request and prior to the issuance of certain audits and financial reports adopted, ratified, and/or disseminated by the Management Defendants.

296. The balances of the reserves should have been questioned and audited by the Management Defendants, both from a year-end review perspective and as part of NHC's management, audit committee, and overall oversight responsibilities, yet there is no evidence that any such actions were taken, and the Management Defendants issued later reports without adjustment.

297. Even without adjusting reserve balances, NHC had reported losses of over $8 million in 2013 and over $16 million in 2014.

298. Up until NHC issued reports on June 1, 2015, NHC continued to hemorrhage losses under the direction, guidance, and management of the Management Defendants.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

299. NHC had all but exhausted its remaining capital by that time.

300. NHC exhausted what remained of its almost $66 million in CMS loans in early 2015, and had no borrowing capacity remaining given its huge losses.

301. As previously mentioned, the amount of a draw on the CMS Loans, that had not been formally applied for in 2014, was recorded as a receivable in the 2014 annual financial reports without adequate disclosure.

302. At a minimum, NHC's Audit Committee members, including Defendant Bond, knew, or should have known that recording of a receivable for a loan in the year before it was formally applied for, without disclosure, was misleading, could artificially inflate NHC's reported surplus levels, and could make NHC appear more solvent than it actually was.

303. These issues should all have been obvious "red flags" to the Management Defendants, and they should have been disclosed, along with the fact that NHC would be unable to continue as a going concern. They should also have resulted in appropriate remedial measures.

304. The Management Defendants knew or should have known that their intentional decision not to properly address red flags raised by regulators, as well as the obvious deficiencies of NHC's financial reports, would cause significant damages and involve and/or constitute negligence, intentional misconduct, fraud, and/or knowing violations of the law.

305. Additionally, the Management Defendants drafted or ratified and approved of the release of the 2013 and 2014 MD&A's. These documents, which are intended to disclose and serve as management's discussion and analysis of important issues facing NHC, failed to disclose or analyze important issues, including without limitation, NHC's extraordinary accounting practices, insufficient reserves, liquidity concerns, lack of borrowing capacity or its inability to continue as a going concern. The failure of management to adequately disclose or analyze these and other issues was in violation of statutory and industry requirements, including those set forth by the NAIC, the Nevada DOI and incorporated into Nevada law.

306. The Management Defendants did not ensure proper reporting of related party transactions.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

307. NHC management had extensive connections with the Culinary Union and its UHH administrator. Many of the Director Defendants had served on the Board of the Culinary Health Fund, and some Directors also had positions with the Culinary Union. NHC hired UHH to administer the medical side of NHC's business. As a result, UHH was paid significant fees that, on information and belief, provided a windfall for UHH.

308. Defendant Kathy Silver served as a director of NHC and was president of two Culinary Union related entities, NHS and the Culinary Health Fund.

309. As discussed above, NHC management engaged NHS to perform utilization management and member eligibility review services for NHC in 2014. NHC paid substantial fees to NHS for this service, receiving limited and deficient services in return. NHS also had a conflict of interest, or the appearance of a conflict of interest, by being engaged to provide a quality control review of claim services provided by its parent company, UHH.

310. Despite requirements to disclose these related party transactions in financial statements and other filings to the Nevada DOI, CMS and others, NHC management failed to adequately provide such disclosure.

311. NHC management also paid themselves exorbitant compensation without justification and despite the fact that NHC was losing millions of dollars each financial report period.

312. Due to the material amounts of funds flowing from NHC to UHH and NHS, the Management Defendants were under an obligation to report the related party transactions in NHC's financial statements, and they were under a further obligation to assure that these related party transactions were fair and reasonable to NHC. The Management Defendants, however, failed to do so.

313. Management Defendants, including but not limited to Egan, Dibsie and Mattoon, authorized or caused to be paid claims outside of eligibility, in violation to their fiduciary duties to NHC, resulting in substantial losses to NHC.

314. Such acts and omissions with respect to NHC's failure to adequately disclose related party transactions and to assure their fairness, paying claims outside of eligibility, along with paying themselves unreasonable compensation, by the Management Defendants involved and/or constituted intentional misconduct, fraud, self-dealing, and/or the knowing violation of the law.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

O. The Financial Collapse of NHC and the Resulting State Rehabilitation and Liquidation Proceedings.

315. Ultimately, no one could deny that NHC was incapable of continuing as a going concern, and the Nevada DOI was required to step in. On August 17, 2015, NHC's board of directors voted to cease writing new business and to suspend voluntarily its certificate of authority, effectively "throwing in the towel" and ending any prospect of recovery.

316. On September 25, 2015, and with the consent of NHC's board of directors, a petition for appointment of Commissioner as Receiver and Other Permanent Relief; Request for Injunction Pursuant to NRS 696 B.270(1) was filed by the then acting Nevada Commissioner of Insurance, Amy L. Parks, in her official capacity as Temporary Receiver of the Nevada Health CO-OP.

317. An Order Appointing the Acting Commissioner of Insurance, Amy L. Parks, as Temporary Receiver Pending Further Orders of the Court, Granting Temporary Relief Pursuant to NRS 696B.270, and authorizing the Temporary Receiver to appoint a special deputy receiver was filed on October 1, 2015. The Commissioner, as Temporary Receiver, appointed the firm of Cantilo & Bennett, L.L.P. as Special Deputy Receiver on October 1, 2015.

318. On October 14, 2015, the Court issued a Permanent Injunction and Order Appointing Commissioner as Permanent Receiver of Nevada Health CO-OP. On September 21, 2016, the Court issued a Final Order Finding and Declaring Nevada CO-OP to be insolvent and placing Nevada Health CO-OP into Liquidation.

319. Under these orders the Commissioner of Insurance (as the Permanent Receiver) and Cantilo & Bennett (as the Special Deputy Receiver) are authorized to liquidate the business of NHC and wind up its ceased operations pursuant to NRS 696B.220.2. This authority includes authorization to institute and to prosecute, in the name of the CO-OP or in the receiver's own name, any and all suits and other legal proceedings, and to prosecute any action which may exist on behalf of the members, enrollees insured, or creditors, of CO-OP against any person.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

320. The consequences of Defendants' actions were not simply academic. Over $65 million in federal loans are in default. Medical insurance for tens of thousands of people was disrupted; doctors and hospitals went unpaid; and insured patients were left concerned about receiving needed care and whether they would be able to pay medical bills.

321. The Receiver is now tasked with liquidating the failed insurer to protect members, insured enrollees, and creditors of NHC and the public.

CAUSES OF ACTION RELATED TO MILLIMAN DEFENDANTS

FIRST CAUSE OF ACTION

(Negligence Per Se - Violation of NRS 681B Against Milliman and Heijde)

322. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

323. NRS 681B requires, in part, the opinion of an appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of the State of Nevada.

324. NRS 681B also prescribes minimum standards of form and substance for the opinion, including those set forth in the Valuation Manual adopted by the NAIC.

325. Plaintiff and those represented by Plaintiff, including the members of NHC, NHC's insured enrollees, NHC's creditors, NHC, and the State of Nevada belong to a class of persons that NRS 681B was designed to protect.

326. Milliman and Heijde accepted appointment as NHC's appointed actuary, and provided opinions under NRS 681B.

327. As a result, Milliman and Heijde were subject to the minimum standards as set forth in NRS 681B.

328. As set forth above, Defendants Milliman and Heijde violated NRS 681B by failing to perform their duties as the appointed actuary in accordance with the applicable minimum statutory and applicable professional standards.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

329. Plaintiff's injury was the type against which NRS 681B was intended to protect.

330. As a direct and proximate result of Defendants Milliman and Heijde's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

331. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

SECOND CAUSE OF ACTION

(Professional Malpractice Against Milliman Defendants)

332. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

333. The Milliman Defendants were engaged by NHC and its predecessors in interest to provide professional actuarial services to NHC.

334. Such services included but were not limited to providing certification required pursuant to NRS 681B, conducting a feasibility study, providing business plan support, assisting NHC in setting premium rates, participating in the preparation of financial reports and information to regulators, and establishing policies of insurance as set forth herein.

335. The Milliman Defendants had a duty to use such skill, prudence, and diligence as other members of the profession commonly possess and exercise.

336. As detailed above, the Milliman Defendants breached that duty by failing to comply with applicable statutory and professional standards including those set forth in NRS 681B, the Valuation Manual adopted by the NAIC, the ASOPs as adopted by the Actuarial Standards Board of the American Academy of Actuaries, and by taking actions that caused the misreporting of the 2014 financial results without reasonable basis.

337. As a direct and proximate result of the Milliman Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

338. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

THIRD CAUSE OF ACTION

(Intentional Misrepresentation (Fraud) Against Milliman Defendants)

339. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

340. On or about December 21, 2011 Milliman and Shreve issued a document entitled "Hospitality Health Feasibility Study and Business Support for Consumer Operated and Oriented Plan (CO-OP) Application."

341. On or about March 1, 2015 and on or about May 14, 2015, Milliman and Heijde issued the valuation and certification of NHC's reserves pursuant to NRS 681B.

342. In each of these documents, the respective Milliman Defendants certified that the statements contained therein were, to the best of their knowledge and belief, accurate, complete, and prepared in accordance with generally recognized and accepted actuarial principles and practices consistent with ASOPs, the Code of Professional Conduct and Qualification Standards for Public Statements of Actuarial Opinion of the American Academy of Actuaries.

343. The Milliman Defendants knew or believed that these representations were false, or that they had an insufficient basis of information for making them.

344. Milliman also participated in the preparation of 2014 financial information to the Nevada DOI insurance regulators for 2014 that presented and represented NHC's financial condition, and this information was misleading, false, without sufficient basis, and misreported the financial information of NHC.

345. Plaintiff justifiably relied upon the Milliman Defendant's representations.

346. As a direct and proximate result of the Milliman Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

347. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

FOURTH CAUSE OF ACTION

(Constructive Fraud Against Milliman Defendants)

348. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

349. At all relevant times, the Milliman Defendants had a fiduciary and/or confidential relationship with NHC.

350. The Milliman Defendants owed a legal or equitable duty to Plaintiff arising from a fiduciary or confidential relationship.

351. The Milliman Defendants breached that duty by misrepresenting or concealing a material fact, i.e. that the Milliman Defendants had not performed their services in accordance with applicable statutory and professional standards as set forth herein and that as a result NHC should not have relied on their conclusions, advice and opinions.

352. As a direct and proximate result of the Milliman Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

353. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FIFTH CAUSE OF ACTION

(Negligent Misrepresentation Against Milliman Defendants)

354. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

355. The Milliman Defendants, in a course of action in which they had a pecuniary interest, failed to exercise reasonable care or competence in obtaining or communicating information to Plaintiff as set forth above.

356. Such information included, without limitation, the information set forth in the Feasibility Study, the calculation of premiums, the calculation of financial projections, the calculation of required reserves, and the communication of financial information to the Nevada DOI insurance regulators.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

357. Plaintiff justifiably relied on this information it received.

358. As a direct and proximate result of the Milliman Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

359. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

SIXTH CAUSE OF ACTION

(Breach of Fiduciary Duty Against Milliman Defendants)

360. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

361. A fiduciary duty existed between Plaintiff and the Milliman Defendants where Milliman was in a superior or trusted position as set forth herein.

362. The Milliman Defendants breached that duty by failing to perform to statutory and professional standards as set forth above.

363. As a direct and proximate result of the Milliman Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

364. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

SEVENTH CAUSE OF ACTION

(Negligence Against Milliman Defendants)

365. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

366. The Milliman Defendants owed a duty of care to Plaintiff, including the duty to perform its work in accordance with applicable statutory and professional standards.

367. As detailed above, by failing to perform to applicable statutory and professional standards, the Milliman Defendants breached that duty.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

368. The breach was the legal cause of Plaintiff's injuries.

369. As a direct and proximate result of the Milliman Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

370. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

EIGHTH CAUSE OF ACTION

(Breach of Contract Against Milliman)

371. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

372. Milliman and Hospitality Health entered into a valid and enforceable contract - the Consulting Services Agreement - that required Milliman to perform professional actuarial services.

373. A provision of the Consulting Services Agreement states, "Milliman will perform all services in accordance with applicable professional standards."

374. Plaintiff was assigned all rights benefits and interests in the Consulting Services Agreement by Hospitality Health.

375. Milliman failed to perform under the Consulting Services Agreement by failing to perform actuarial services as required under applicable professional and statutory standards, as detailed above.

376. Plaintiff performed or was excused from performance under the Consulting Services Agreement.

377. As a direct and proximate result of Milliman's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

378. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

NINTH CAUSE OF ACTION

(Tortious Breach of the Implied Covenant Against Milliman)

379. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

380. Milliman and Hospitality Health entered into a valid and enforceable contract - the Consulting Services Agreement - that required Milliman to perform professional actuarial services.

381. Plaintiff was assigned all rights benefits and interests in the Consulting Services Agreement by Hospitality Health.

382. Milliman owed a duty of good faith to Plaintiff arising from the contract.

383. A special element of reliance or fiduciary duty existed between Plaintiff and Milliman where Milliman was in a superior or trusted position.

384. Milliman breached the duty of good faith by engaging in misconduct in a manner that was unfaithful to the purpose of the Consulting Services Agreement, by failing to perform in accordance with statutory and professional standards as set forth herein.

385. As a direct and proximate result of Milliman's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

386. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

TENTH CAUSE OF ACTION

(Breach of the Implied Covenant of Good Faith and Fair Dealing Against Milliman)

387. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

388. Milliman and Hospitality Health entered into a valid and enforceable contract - the Consulting Services Agreement - which required Milliman to perform professional actuarial services.

389. Plaintiff was assigned all rights benefits and interests in the Consulting Services Agreement by Hospitality Health.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

390. Under applicable law, the Consulting Services Agreement contains an implied covenant of good faith and fair dealing among all parties.

391. Milliman, by failing to follow applicable professional and statutory standards as set forth herein, breached that duty by performing in a manner that was unfaithful to the purpose of the Consulting Services Agreement.

392. As a direct and proximate result of Milliman's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

393. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

ELEVENTH CAUSE OF ACTION

(Negligent Performance of an Undertaking Against Milliman Defendants)

394. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

395. The Milliman Defendants undertook to provide actuarial services, including but not limited to providing a feasibility study, calculating insurance premiums, performing other forecasts, calculating and certifying required reserves and other actuarial items, and participating in the preparation of financial information and reports that would be submitted to the Nevada DOI insurance regulators.

396. The Milliman Defendants knew or should have recognized these undertakings as necessary for the protection of NHC's members, NHC's enrolled insured, NHC's creditors, and the State of Nevada.

397. By performing the actuarial services detailed above, the Milliman Defendants undertook to perform a duty owed by NHC to its members, enrolled insureds, creditors and regulators to act in accordance with statutory and professional standards, to properly compute premiums, to properly perform feasibility studies and forecasts, to properly value the reserves and other actuarial items of NHC, and to submit proper and reasonable reports of financial condition.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

398. The Milliman Defendants' failure to exercise reasonable care in performing its services, including their failure to perform actuarial services in accordance with applicable standards as detailed herein, increased the risk of harm to NHC, NHC's customers and vendors, and the State of Nevada, and it unnecessarily prolonged, and it led to, the continued and unjustified existence of NHC.

399. As a direct and proximate result of the Milliman Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

400. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

TWELFTH CAUSE OF ACTION

(Unjust Enrichment Against Milliman)

401. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

402. Milliman was paid over $1 million for actuarial services that were to be performed in accordance with statutory and professional standards.

403. Despite failure to provide such services in accordance with statutory and professional standards, Milliman unjustly retained the fees paid to it for such services against fundamental principles of justice, equity, and good conscience.

404. As a direct and proximate result of Milliman's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

405. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

THIRTEENTH CAUSE OF ACTION

(Civil Conspiracy Against Milliman Defendants)

406. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

407. Defendants Milliman and Shreve acted in concert with each other and with the management of NHC, including, but not limited to, Dibsie, to obtain funds for NHC under false pretenses and to license NHC through the use of the Feasibility Study, which they knew to be false and not in accordance with required statutory and professional actuarial standards.

408. Defendants Milliman and Heijde acted in concert with each other and with management of NHC, including, but not limited to, Egan and Dibsie, to falsify reserves and financial reporting and avoid statutory supervision by their use of the 2014 Opinion, participated in the preparation of false and misleading financial information that was provided to Nevada DOI insurance regulators, and had subsequent communications with NHC and/or Nevada DOI insurance regulators, which they knew to be false and not in accordance with required statutory and professional standards.

409. As a direct and proximate result of the Milliman Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

410. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FOURTEENTH CAUSE OF ACTION

(Concert of Action Against Milliman Defendants)

411. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

412. Defendants Milliman and Shreve acted in concert with each other and the management of NHC, including, but not limited to, Dibsie, to obtain money under false pretenses and license NHC through use of the Feasibility Study, which they knew to be false and not in accordance with required statutory and professional actuarial standards.

413. Defendants Milliman and Heijde acted in concert with each other and the management of NHC, including Egan and Dibsie, to falsify reserves and avoid statutory supervision by their use of the 2014 Opinion, participated in the preparation of financial information provided to Nevada DOI insurance regulators, and had subsequent communications with NHC and/or Nevada

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

DOI insurance regulators, which they knew to be false and not in accordance with required statutory and professional standards.

414. The Milliman Defendants knew that their actions were inherently dangerous or posed a substantial risk of harm to others in that their actions could affect and disrupt the medical care of NHC's members and insured enrollees.

415. The Milliman Defendants' actions did affect and disrupt the medical care of NHC's members and enrolled insured.

416. As a direct and proximate result of the Milliman Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

417. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

CAUSES OF ACTION RELATED TO MILLENNIUM DEFENDANTS

FIFTEENTH CAUSE OF ACTION

(Professional Malpractice Against Millennium)

418. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

419. Millennium was engaged by NHC and was responsible for providing professional accounting services to NHC.

420. Such services included, but were not limited to, preparing and filing the NHC Annual Reports, quarterly reports, and other reports as listed herein.

421. Services to be performed by Millennium included the preparation of financial statements, participating in the drafting of the year 2014 Management & Discussion and Analysis that was filed with the Nevada DOI insurance regulators, evaluating general ledger entries to ensure that statutory accounting and reporting principles and rules were followed, and recommending any adjustments to adhere to statutory accounting and reporting rules prescribed by the State of Nevada.

422. Millennium had a duty to use such skill, prudence, and diligence as other members of the profession commonly possess and exercise.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

423. As detailed above, Millennium breached that duty by failing to comply with applicable statutory and professional standards.

424. As a direct and proximate result of Millennium's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

425. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

SIXTEENTH CAUSE OF ACTION

(Intentional Misrepresentation (Fraud) Against Millennium)

426. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

427. Throughout the time that Millennium performed services for NHC, Millennium represented that it was performing such services in accordance with applicable statutory, professional, and contractual standards.

428. Millennium knew or believed that its representations as stated above, were false, or Millennium had an insufficient basis of information for making such representations.

429. Plaintiff justifiably relied upon Millennium's representations.

430. As a direct and proximate result of Millennium's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

431. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

SEVENTEENTH CAUSE OF ACTION

(Negligent Misrepresentation Against Millennium)

432. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

433. Millennium, in the course of action in which it had a pecuniary interest, failed to exercise reasonable care or competence in obtaining or communicating information to Plaintiff, as set forth above.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

434. Such information included, without limitation, that the accounting services of Millennium were performed in accordance with applicable standards and that the information contained in the reports prepared by Millennium on NHC was accurate.

435. Plaintiff justifiably relied on the information it received.

436. As a direct and proximate result of Millennium's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

437. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

EIGHTEENTH CAUSE OF ACTION

(Negligence Against Millennium)

438. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

439. Millennium owed a duty of care to Plaintiff, including the duty to perform its work in accordance with applicable statutory and professional and contractual standards.

440. As detailed above, by failing to perform to applicable statutory, professional, and contractual standards, Millennium breached that duty.

441. The breach was the legal cause of Plaintiff's injuries.

442. As a direct and proximate result of Millennium's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

443. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

NINETEENTH CAUSE OF ACTION

(Breach of Contract Against Millennium)

444. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

445. Millennium and NHC entered into a valid and enforceable contract - the January 7, 2015 Service Agreement - that required Millennium to perform professional accounting and consulting services.

446. Provisions of the Service Agreement provided for Millennium to perform all services in accordance with applicable professional, statutory, and contractual standards.

447. Millennium failed to perform accounting and consulting services as required under applicable professional, statutory and contractual standards.

448. Plaintiff performed or was excused from performance under the Services Agreement.

449. As a direct and proximate result of Millennium's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

450. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

TWENTIETH CAUSE OF ACTION

(Tortious Breach of the Implied Covenant Against Millennium)

451. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

452. Millennium and NHC entered into a valid and enforceable contract - the January 7, 2015 Service Agreement - that required Millennium to perform professional accounting and consulting services.

453. Under applicable law, the Service Agreement contains an implied covenant of good faith and fair dealing among all parties.

454. A special element of reliance or fiduciary duty existed between Plaintiff and Millennium where Millennium was in a superior or trusted position.

455. In failing to perform in accordance with statutory and professional standards as set forth herein, Millennium breached the duty of good faith and engaged in misconduct in a manner that was unfaithful to the purpose of the Service Agreement.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

456. As a direct and proximate result of Millennium's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

457. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

TWENTY-FIRST CAUSE OF ACTION

(Breach of the Implied Covenant of Good Faith and Fair Dealing Against Millennium)

458. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

459. Millennium and NHC entered into a valid and enforceable contract - the January 7, 2015 Service Agreement - that required Millennium to perform professional accounting and consulting services.

460. Under applicable law, the Service Agreement contains an implied covenant of good faith and fair dealing among all parties.

461. Millennium, by failing to follow applicable professional and statutory standards as set forth herein, breached that duty by performing in a manner that was unfaithful to the purpose of the Service Agreement.

462. As a direct and proximate result of Millennium's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

463. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

TWENTY-SECOND CAUSE OF ACTION

(Negligent Performance of an Undertaking Against Millennium)

464. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

465. Millennium undertook to provide accounting and consulting services, including, but not limited to, preparing and filing financial statements on behalf of NHC.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

466. Such services included, but were not limited to, preparing and filing the NHC Annual Reports, quarterly reports, and other reports as listed herein, and it assisted with the preparation of the 2014 Management Discussion & Analysis that was reported to the Nevada DOI insurance regulators.

467. Services to be performed by Millennium also included evaluating general ledger entries to ensure that statutory accounting and reporting principles had been followed, and recommending any adjustments so as to adhere to statutory accounting and reporting rules prescribed by the State of Nevada.

468. Millennium knew or should have recognized these undertakings as being necessary for the protection of NHC's members, NHC's enrolled insured, NHC's creditors, and the State of Nevada.

469. By agreeing to perform the accounting and consulting services detailed above, Millennium undertook to perform a duty owed by NHC to its members, enrolled insureds, creditors, and regulators and to act in accordance with statutory and professional standards.

470. Millennium's failure to exercise reasonable care in performing its services, including Millennium's failure to perform accounting services in accordance with applicable standards as detailed herein and misreporting of financial information and reports, increased the risk of harm to NHC, NHC's customers and vendors, and the State of Nevada, and it unnecessarily prolonged, and it led to, the continued and unjustified existence of NHC.

471. As a direct and proximate result of Millennium's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

472. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

TWENTY-THIRD CAUSE OF ACTION

(Unjust Enrichment Against Millennium)

473. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

474. Millennium was paid for accounting and consulting services that were to be performed in accordance with professional, statutory, and contractual standards.

475. Despite not providing such services in accordance with professional, statutory, and contractual standards, and against fundamental principles of justice, equity, and good conscience, Millennium unjustly retained the fees paid to it for such services.

476. As a direct and proximate result of Millennium's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

477. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

CAUSES OF ACTION RELATED TO LARSON DEFENDANTS

TWENTY-FOURTH CAUSE OF ACTION

(Negligence Per Se - Violation of NRS 628.435 Against Larson Defendants)

478. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

479. NRS 628.435 requires, in part, that a CPA comply with all professional standards for accounting and documentation related to an audit applicable to a particular engagement.

480. Plaintiff, and those represented by Plaintiff, including the members of NHC, NHC's insured enrollees, NHC's vendors, NHC, and the State of Nevada, belong to a class of persons that NRS 628.435 was designed to protect.

481. The Larson Defendants undertook to perform audits of NHC.

482. As a result, the Larson Defendants were subject to the minimum standards as set forth in NRS 628.435.

483. As set forth above, the Larson Defendants violated NRS 628.435 by failing to perform their duties as CPAs in accordance with the minimum statutory and applicable professional standards required.

484. Plaintiff's injury was the type against which NRS 628.435 was intended to protect.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

485. As a direct and proximate result of the Larson Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

486. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

TWENTY-FIFTH CAUSE OF ACTION

(Professional Malpractice Against Larson Defendants)

487. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

488. The Larson Defendants were engaged by NHC or were responsible for providing professional accounting and auditing services to NHC.

489. Such services included but were not limited to auditing the books and records of NHC for the years ended December 31, 2013 and 2014 and its Management Discussion & Analysis for those years, and providing the audit opinions set forth in related reports, including the Audit Report Concerning NHC's December 31, 2014 and 2015 Financial Statements, The Reports of Independent Certified Public Accountants required by OMB Circular A-133, Independent Auditor's Report on Compliance for each Major Program, and Report on Internal Control Over Compliance Independent Auditor's Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards.

490. The Larson Defendants had a duty to use such skill, prudence, and diligence as other members of the profession commonly possess and exercise.

491. As detailed above, the Larson Defendants breached that duty by failing to comply with applicable statutory and professional standards.

492. As a direct and proximate result of the Larson Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

493. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

TWENTY-SIXTH CAUSE OF ACTION

(Intentional Misrepresentation (Fraud) Against Larson Defendants)

494. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

495. On or about May 29, 2014, Larson issued its audit report concerning NHC's December 31, 2013 financial statements.

496. On or about June 1, 2015, Larson issued its audit report concerning NHC's December 31, 2014 and 2015 Financial Statements.

497. The audit reports contained the following statements:

a) We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States.

b) We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified audit opinion.

c) In our opinion, the statutory financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus of Nevada Health Co-Op as of December 31, 2014, and 2013, and the results of its operations and its cash flow for the years then ended, in accordance with the financial reporting provisions of the Nevada DOI described in Note 1.

d) In our opinion, the [Supplementary] information is fairly stated in all material respects in relation to the financial statements taken as a whole.

498. On or about June 1, 2015, Larson issued its report entitled The Reports of Independent Certified Public Accountants required by OMB Circular A-133.

499. These reports included an "Independent Auditor's Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards," and an "Independent Auditor's Report on Compliance for each Major Program; Report on Internal Control Over Compliance; and Report on Schedule of Expenditures of Federal Awards Required by OMB Circular A-133."

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

500. The "Independent Auditor's Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards" contained the following statements:

a) We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States, the statutory financial statements of Nevada Health Co-Op (the Co-Op) (a nonprofit organization), which comprise the statement of financial position as of December 31, 2014, and the related statutory financial statements of activities, and cash flows for the year then ended, and the related notes to the statutory financial statements, and have issued our report thereon dated June 1, 2015.

b) ... during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses.

c) As part of obtaining reasonable assurance about whether the Co-Op's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts.

d) The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under Government Auditing Standards.

501. The "Independent Auditor's Report on Compliance for each Major Program; Report on Internal Control Over Compliance; and Report on Schedule of Expenditures of Federal Awards Required by OMB Circular A-133" contained the following statements:

a) We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program.

b) In our opinion, the Co-Op complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended December 31, 2014.

c) In planning and performing our audit of compliance, we considered the Co-Op's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with OMB Circular A-133.

d) We did not identify any deficiencies in internal control over compliance that we considered to be material weaknesses. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses.

e) We have audited the statutory financial statements of the Co-Op, as of and for the year ended December 3, 2014, and the related notes to the statutory financial statements. We issued our report thereon dated June 1, 2015, which contained an unmodified opinion on those statutory financial statements.

f) The [Schedule of Expenditures for Financial Awards] has been subjected to the auditing procedures applied in the audit of the statutory financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditures of federal awards is fairly stated in all material respects in relation to the statutory financial statements as a whole.

502. The Larson Defendants knew or believed that their representations as stated above, were false, or that the Larson Defendants had an insufficient basis of information for making the representations.

503. Plaintiff justifiably relied upon the Larson Defendants' representations.

504. As a direct and proximate result of the Larson Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

505. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

TWENTY-SEVENTH CAUSE OF ACTION

(Negligent Misrepresentation Against Larson Defendants)

506. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

507. The Larson Defendants, in the course of action in which they had a pecuniary interest, failed to exercise reasonable care or competence in obtaining or communicating information to Plaintiff as set forth above.

508. Such information included, without limitation, that the accounting and auditing services of the Larson Defendants were performed in accordance with applicable standards and other information contained in the reports of the Larson Defendants on NHC, as set forth herein.

509. Plaintiff justifiably relied on this information it received.

510. As a direct and proximate result of the Larson Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

511. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

TWENTY-EIGHTH CAUSE OF ACTION

(Negligence Against Larson Defendants)

512. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

513. The Larson Defendants owed a duty of care to Plaintiff, including the duty to perform their work in accordance with applicable statutory and professional standards.

514. As detailed above, by failing to perform to applicable statutory and professional standards, the Larson Defendants breached that duty.

515. The breach was the legal cause of Plaintiff's injuries.

516. As a direct and proximate result of the Larson Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

517. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

TWENTY-NINTH CAUSE OF ACTION

(Breach of Contract Against Larson)

518. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

519. Larson and NHC entered into two valid and enforceable contracts - the 2013 and the 2014 Engagement Letters - that required Larson to perform professional accounting and auditing services.

520. Provisions of the Engagement Letters provided for Larson to perform all services in accordance with applicable professional standards.

521. Larson failed to perform under the Engagement Letters by failing to perform accounting and auditing services as required under applicable professional and statutory standards, as detailed above.

522. Plaintiff performed or was excused from performance under the Engagement Letters.

523. As a direct and proximate result of Larson's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

524. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

THIRTIETH CAUSE OF ACTION

(Tortious Breach of the Implied Covenant Against Larson)

525. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

526. Larson and NHC entered into two valid and enforceable contracts - the 2013 and the 2014 Engagement Letters - that required Defendant to perform professional accounting and auditing services.

527. Under applicable law, the Engagement Letters contain an implied covenant of good faith and fair dealing among all parties.

528. A special element of reliance or fiduciary duty existed between Plaintiff and Larson where Larson was in a superior or trusted position.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

529. Larson breached the duty of good faith by engaging in misconduct in a manner that was unfaithful to the purpose of the Engagement Letters, by failing to perform in accordance with statutory and professional standards as set forth herein.

530. As a direct and proximate result of Larson's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

531. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

THIRTY-FIRST CAUSE OF ACTION

(Breach of the Implied Covenant of Good Faith and Fair Dealing Against Larson)

532. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

533. Larson and NHC entered into two valid and enforceable contracts - the 2013 and the 2014 Engagement Letters - that required Defendant to perform professional accounting and auditing services.

534. Under applicable law, the Engagement Letters contain an implied covenant of good faith and fair dealing among all parties.

535. Larson, by failing to follow applicable professional and statutory standards as set forth herein, breached that duty by performing in a manner that was unfaithful to the purpose of the Engagement Letters.

536. As a direct and proximate result of Larson's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

537. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

THIRTY-SECOND CAUSE OF ACTION

(Negligent Performance of an Undertaking Against Larson Defendants)

538. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

539. The Larson Defendants undertook to provide accounting and auditing services, including but not limited to examining the books and records of NHC.

540. Such services included but were not limited to auditing the books and records of NHC for the years ended December 31, 2013 and 2014 and its Management Discussion & Analysis for those years, and providing the audit opinions set forth in related reports, including the Audit Report concerning NHC's December 31, 2014 and 2015 Financial Statements, The Reports of Independent Certified Public Accountants required by OMB Circular A-133, Independent Auditor's Report on Compliance for each Major Program, and Report on Internal Control Over Compliance Independent Auditor's Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards.

541. The Larson Defendants knew or should have recognized these undertakings as necessary for the protection of NHC's members, NHC's enrolled insured, NHC's creditors, and the State of Nevada.

542. By performing the accounting and auditing services detailed above, the Larson Defendants undertook to perform a duty owed by NHC to its members, enrolled insureds, creditors, and regulators to act in accordance with statutory and professional standards.

543. The Larson Defendants' failure to exercise reasonable care in performing its services, including the Larson Defendants' failure to perform accounting and auditing services in accordance with applicable standards as detailed herein, increased the risk of harm to NHC, NHC's customers and vendors, and the State of Nevada.

544. As a direct and proximate result of the Larson Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

545. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

THIRTY-THIRD CAUSE OF ACTION

(Unjust Enrichment Against Larson)

546. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

547. Larson was paid for accounting and auditing services that were to be performed in accordance with statutory and professional standards.

548. Despite failing to provide such services in accordance with statutory and professional standards, Larson unjustly retained the fees paid to it for such services against fundamental principles of justice, equity, and good conscience.

549. As a direct and proximate result of Larson's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

550. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

CAUSES OF ACTION RELATED TO INSUREMONKEY DEFENDANTS

THIRTY-FOURTH CAUSE OF ACTION

(Intentional Misrepresentation/Fraud in the Inducement Against InsureMonkey Defendants)

551. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

552. From April through September 2013, InsureMonkey's officers, directors, and agents - including its CEO Rivlin - represented to NHC that they had the necessary skill, experience, and expertise to handle all aspects of the customer and members' services contemplated by the parties' potential agreements in a competent and professional manner.

553. Throughout the course of dealing with NHC, the InsureMonkey Defendants also misrepresented the number of customers obtained by InsureMonkey's marketing efforts and the number of insured enrollees in order to obtain additional fees and income that InsureMonkey had not earned.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

554. The InsureMonkey Defendants knew or believed that their representations were false, or the InsureMonkey Defendants had an insufficient basis of information for making the representation.

555. The InsureMonkey Defendants made such representations to induce NHC to enter into the various agreements listed herein with InsureMonkey related to member and customer services and so that CEO Rivlin could personally obtain exorbitant salaries, bonuses, and other remuneration for entering into the lucrative agreements with NHC.

556. NHC reasonably and justifiably relied upon the InsureMonkey Defendants' representations.

557. As a direct and proximate result of the InsureMonkey Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

558. In committing the acts herein above alleged, the InsureMonkey Defendants are guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from the InsureMonkey Defendants for the purpose of deterring them and others similarly situated from engaging in like conduct in the future.

559. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

THIRTY-FIFTH CAUSE OF ACTION

(Constructive Fraud Against InsureMonkey Defendants)

560. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

561. At all relevant times, a fiduciary duty existed between Plaintiff and the InsureMonkey Defendants, where the InsureMonkey Defendants were in a superior or trusted position as set forth herein.

562. The InsureMonkey Defendants owed a legal or equitable duty to NHC arising from a fiduciary or confidential relationship.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

563. The InsureMonkey Defendants breached that duty by misrepresenting or concealing material facts, i.e. that the InsureMonkey Defendants did not have the requisite skill, experience, or expertise to perform the services contemplated by the parties' agreements listed herein and that it failed to perform in a manner consistent with minimum industry standards as set forth herein.

564. The InsureMonkey Defendants also breached that duty by misrepresenting the number of customers obtained by InsureMonkey's marketing efforts and the number of insured enrollees in order to obtain additional fees and income InsureMonkey had not earned.

565. As a direct and proximate result of the InsureMonkey Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

566. In committing the acts herein above alleged, the InsureMonkey Defendants are guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from the InsureMonkey Defendants for the purpose of deterring them and others similarly situated from engaging in like conduct in the future.

567. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

THIRTY-SIXTH CAUSE OF ACTION

(Negligent Misrepresentation Against InsureMonkey Defendants)

568. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

569. The InsureMonkey Defendants, in the course of action in which they had a pecuniary interest, failed to exercise reasonable care or competence in obtaining or communicating information to NHC as set forth above.

570. Such information included, without limitation, the number of customers obtained by InsureMonkey's marketing efforts, the number of eligible enrollees, the eligibility data provided to NHC and/or CMS, and other reporting information provided to NHC or otherwise required by the parties' agreements or the CMS Loan Agreement.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

571. NHC reasonably and justifiably relied on the information it received from the InsureMonkey Defendants.

572. As a direct and proximate result of the InsureMonkey Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

573. In committing the acts herein above alleged, the InsureMonkey Defendants are guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from the InsureMonkey Defendants for the purpose of deterring them and others similarly situated from engaging in like conduct in the future.

574. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

THIRTY-SEVENTH CAUSE OF ACTION

(Breach of Fiduciary Duty Against InsureMonkey)

575. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

576. A fiduciary duty existed between NHC and InsureMonkey wherein InsureMonkey was in a superior or trusted position as set forth herein.

577. InsureMonkey breached that duty by failing to perform minimum professional standards and by otherwise providing misleading and inaccurate information as set forth above.

578. As a direct and proximate result of InsureMonkey's conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

579. In committing the acts herein above alleged, InsureMonkey is guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from InsureMonkey for the purpose of deterring it and others similarly situated from engaging in like conduct in the future.

580. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

THIRTY-EIGHTH CAUSE OF ACTION

(Negligence Against InsureMonkey)

581. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

582. InsureMonkey owed a duty of care to NHC, including the duty to perform its work in accordance with industry standards and to not provide misleading or otherwise inaccurate information upon which it intended for and knew NHC would rely.

583. As detailed above, by failing to perform to applicable professional standards, InsureMonkey breached that duty.

584. The breach was the legal cause of NHC's injuries.

585. As a direct and proximate result of InsureMonkey's conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

586. In committing the acts herein above alleged, InsureMonkey is guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from InsureMonkey for the purpose of deterring it and others similarly situated from engaging in like conduct in the future.

587. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

THIRTY-NINTH CAUSE OF ACTION

(Breach of Contract Against InsureMonkey)

588. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

589. InsureMonkey and NHC entered into a series of valid and enforceable contracts as set forth herein.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

590. InsureMonkey failed to perform under the various agreements as set forth herein, including, but not limited to, the 2013 Master Services Agreement, the 2013 Customer Service MOU, and the Master Agreement, by failing to provide the services contemplated therein in a reasonable and satisfactory manner, as detailed above.

591. NHC performed or was excused from performance with respect to all of the agreements set forth and detailed above. Such performance included paying InsureMonkey in excess of $9.4 million for services rendered.

592. As a direct and proximate result of InsureMonkey's conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

593. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FORTIETH CAUSE OF ACTION

(Tortious Breach of the Implied Covenant of Good Faith and Fair Dealing Against InsureMonkey)

594. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

595. InsureMonkey and NHC entered into a series of valid and enforceable contracts as set forth herein.

596. InsureMonkey owed a duty of good faith to Plaintiff arising from such contracts.

597. A special element of reliance or fiduciary duty existed between Plaintiff and InsureMonkey wherein InsureMonkey was in a superior or trusted position.

598. InsureMonkey breached the duty of good faith by engaging in misconduct in a manner that was unfaithful to the purpose of the agreements described herein, by failing to perform in accordance with basic, minimum professional standards as set forth herein, including, but not limited to, providing intentionally false and/or misleading and faulty sales, enrollment, and eligibility data, upon which it intended for NHC to rely.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

599. As a direct and proximate result of InsureMonkey's conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

600. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FORTY-FIRST CAUSE OF ACTION

(Breach of the Implied Covenant of Good Faith and Fair Dealing Against InsureMonkey)

601. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

602. InsureMonkey and NHC entered into a series of valid and enforceable contracts as set forth herein.

603. InsureMonkey owed a duty of good faith to Plaintiff arising from such contracts.

604. Under applicable law, these agreements contained an implied covenant of good faith and fair dealing among all parties.

605. InsureMonkey breached the duty of good faith by engaging in misconduct in a manner that was unfaithful to the purpose of the agreements described herein, by failing to perform in accordance with basic, minimum professional standards as set forth herein, including, but not limited to, providing intentionally false and/or misleading and faulty sales, enrollment, and eligibility data, upon which it intended for NHC to rely.

606. As a direct and proximate result of InsureMonkey's conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

607. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FORTY-SECOND CAUSE OF ACTION

(Negligent Performance of an Undertaking Against InsureMonkey)

608. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

609. InsureMonkey undertook to provide certain services related to tracking and reporting enrollment and eligibility data on behalf of NHC, to provide that information to both NHC and CMS for purposes of calculating certain amounts owed by NHC, to be received by NHC, or for other purposes.

610. InsureMonkey knew or should have recognized that these undertakings were necessary for the protection of NHC's members, NHC's enrolled insured, NHC's creditors, and the State of Nevada.

611. By performing the services detailed above, InsureMonkey undertook to perform a duty owed by NHC to its members, enrolled insureds, creditors, and regulators to act in accordance with statutory and professional standards, and to properly track and report enrollment and eligibility data.

612. InsureMonkey's failure to exercise reasonable care in performing its services increased the risk of harm to NHC, NHC's customers and vendors, and the State of Nevada.

613. As a direct and proximate result of InsureMonkey's conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

614. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FORTY-THIRD CAUSE OF ACTION

(Unjust Enrichment Against InsureMonkey)

615. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

616. InsureMonkey was paid over $9.4 million for services that were to be performed in accordance with certain professional and industry standards.

617. Despite its failure to provide such services and/or not providing the quality of services required, InsureMonkey unjustly retained the fees paid to it for such services against fundamental principles of justice, equity, and good conscience.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

618. As a direct and proximate result of InsureMonkey's conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

619. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FORTY-FOURTH CAUSE OF ACTION

(Negligent Hiring, Training, Supervision, and Retention Against InsureMonkey)

620. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

621. InsureMonkey owed a duty to exercise due care towards NHC in all of its dealings in providing the services contemplated by their various agreements, including, but not limited to, the Master Agreement.

622. InsureMonkey breached that duty by failing to provide services to satisfy minimum industry standards and practices.

623. InsureMonkey's failure to properly hire, train, and supervise its employees and agents to ensure that they acted in a competent and professional manner and with the requisite skill and expertise necessary to perform and complete the work was a direct and proximate cause of NHC's injuries as set forth herein.

624. InsureMonkey's decision to provide inadequate training and to hire and retain certain employees who were unsatisfactory and unable to fulfill InsureMonkey's obligations and responsibilities to NHC was the direct and proximate cause of NHC's injuries as set forth herein.

625. As detailed above, by failing to perform to applicable professional and industry standards, InsureMonkey breached that duty.

626. The breach was the legal cause of Plaintiff's injuries.

627. InsureMonkey knew or should have known that the employees and agents it had hired were unfit for their positions and would likely cause harm to third parties when placed in the positions in which InsureMonkey placed them.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

628. As a direct and proximate result of InsureMonkey's conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

629. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

CAUSES OF ACTION RELATED TO NHS

FORTY-FIFTH CAUSE OF ACTION

(Professional Malpractice Against NHS)

630. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

631. NHS was engaged by NHC and was responsible for providing professional medical utilization management and member eligibility review services to NHC.

632. Such services included, but were not limited to performing evaluations of appropriateness and medical necessity of heath care services, procedures and facilities; performing precertification of hospital admissions and outpatient procedures; processing information related to in-hospital observations; providing concurrent reviews for inpatient acute care, rehabilitation and long term acute care; providing discharge planning; performing provider appeal reviews; and performing member eligibility review, along with other services, as listed herein.

633. NHS had a duty to use such skill, prudence, and diligence as other members of the profession commonly possess and exercise.

634. As detailed above, NHS breached that duty by failing to comply with applicable contractual, professional and industry standards.

635. As a direct and proximate result of NHS's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

636. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

FORTY-SIXTH CAUSE OF ACTION

(Intentional Misrepresentation (Fraud) Against NHS)

637. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

638. Throughout the time that NHS performed services for NHC, NHS represented that it was performing such services, and that such services were being performed in accordance with applicable statutory, professional, and contractual standards.

639. NHS knew or believed that its representations as stated above, were false, or NHS had an insufficient basis of information for making such representations.

640. Plaintiff justifiably relied upon NHS's representations.

641. As a direct and proximate result of NHS's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

642. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FORTY-SEVENTH CAUSE OF ACTION

(Negligent Misrepresentation Against NHS)

643. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

644. NHS, in the course of action in which it had a pecuniary interest, failed to exercise reasonable care or competence in obtaining or communicating information to Plaintiff, as set forth above.

645. Such information included, without limitation, that the services of NHS were performed in accordance with applicable standards and that the information contained in the reports prepared by NHS was accurate.

646. Plaintiff justifiably relied on the information it received.

647. As a direct and proximate result of NHS's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

648. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FORTY-EIGHTH CAUSE OF ACTION

(Negligence Against NHS)

649. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

650. NHS owed a duty of care to Plaintiff, including the duty to perform its work in accordance with applicable statutory and professional and contractual standards.

651. As detailed above, by failing to perform to applicable statutory, professional, and contractual standards, NHS breached that duty.

652. The breach was the legal cause of Plaintiff's injuries.

653. As a direct and proximate result of NHS's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

654. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FORTY-NINTH CAUSE OF ACTION

(Breach of Contract Against NHS)

655. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

656. NHS and NHC entered into a valid and enforceable contract - the July 19, 2013 Utilization Management Services Agreement - that required NHS to perform professional medical utilization management and member eligibility review services.

657. Provisions of the Utilization Agreement provided for NHS to perform all services in accordance with applicable professional, statutory, and contractual standards.

658. NHS failed to perform accounting and consulting services as required under applicable professional, statutory and contractual standards.

659. Plaintiff performed or was excused from performance under the Utilization Agreement.

660. As a direct and proximate result of NHS's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

661. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FIFTIETH CAUSE OF ACTION

(Tortious Breach of the Implied Covenant Against NHS)

662. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

663. NHS and NHC entered into a valid and enforceable contract - the July 19, 2013 Utilization Management Services Agreement - that required NHS to perform professional medical utilization management and member eligibility review services.

664. Under applicable law, the Utilization Agreement contains an implied covenant of good faith and fair dealing among all parties.

665. A special element of reliance or fiduciary duty existed between Plaintiff and NHS where NHS was in a superior or trusted position.

666. In failing to perform in accordance with contractual, statutory and professional standards as set forth herein, NHS breached the duty of good faith and engaged in misconduct in a manner that was unfaithful to the purpose of the Service Agreement.

667. As a direct and proximate result of NHS's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

668. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

FIFTY-FIRST CAUSE OF ACTION

(Breach of the Implied Covenant of Good Faith and Fair Dealing Against NHS)

669. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

670. NHS and NHC entered into a valid and enforceable contract - the July 19, 2013 Utilization Management Services Agreement - that required NHS to perform professional medical utilization management and member eligibility review services.

671. Under applicable law, the Utilization Agreement contains an implied covenant of good faith and fair dealing among all parties.

672. NHS, by failing to follow applicable contractual, professional and statutory standards as set forth herein, breached that duty by performing in a manner that was unfaithful to the purpose of the Utilization Agreement.

673. As a direct and proximate result of NHS's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

674. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FIFTY-SECOND CAUSE OF ACTION

(Negligent Performance of an Undertaking Against NHS)

675. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

676. NHS undertook to provide medical utilization management and member eligibility review services.

677. Such services included, but were not limited to performing evaluations of appropriateness and medical necessity of heath care services, procedures and facilities; performing precertification of hospital admissions and outpatient procedures; processing information related to in-hospital observations; providing concurrent reviews for inpatient acute care, rehabilitation and long term acute care; providing discharge planning; performing provider appeal reviews; and performing member eligibility review, along with other services, as listed herein.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

678. NHS knew or should have recognized these undertakings as being necessary for the protection of NHC's members, NHC's enrolled insureds, NHC's creditors, and the State of Nevada.

679. By agreeing to perform the accounting and consulting services detailed above, NHS undertook to perform a duty owed by NHC to its members, enrolled insureds, creditors, and regulators and to act in accordance with statutory and professional standards.

680. NHS's failure to exercise reasonable care in performing its services, including NHS's failure to perform medical utilization management and member eligibility review services in accordance with applicable standards as detailed herein, increased the risk of harm to NHC, NHC's customers and vendors, and the State of Nevada, and it unnecessarily prolonged, and it led to, the continued and unjustified existence of NHC.

681. As a direct and proximate result of NHS's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

682. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FIFTY-THIRD CAUSE OF ACTION

(Unjust Enrichment Against NHS)

683. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

684. NHS was paid for medical utilization management and member eligibility review services that were to be performed in accordance with professional, statutory, and contractual standards.

685. Despite not providing such services in accordance with professional, statutory, and contractual standards, and against fundamental principles of justice, equity, and good conscience, NHS unjustly retained the fees paid to it for such services.

686. NHS's compensation was mechanically calculated based on the total persons enrolled as NHC members each month, a fee that bore little to no relation to services being provided by NHS. Upon information and belief, little work was actually performed by NHS for NHC in relation to the substantial fees paid.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

687. Upon information and belief, UHH was the owner of NHS. UHH was being paid to process and adjudicate claims of NHC, and then it was being paid again through NHS to do a quality control review check of the very claims that UHH processed, which also resulted in NHC being unjustly compensated. NHS also had a conflict of interest, or the appearance of a conflict of interest, by being engaged to provide a quality control review of claim services provided by its parent company, UHH, resulting in unjust compensation to NHS.

688. As a direct and proximate result of NHS's conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

689. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

CAUSES OF ACTION RELATED TO MANAGEMENT DEFENDANTS

FIFTY-FOURTH CAUSE OF ACTION

(Breach of Fiduciary Duty Against Management Defendants)

690. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

691. As officers and directors of NHC, the Management Defendants, and each of them, owed duties of good faith and loyalty to act in the best interests of NHC.

692. Each of the Management Defendants breached his or her duties by failing to act in the bests interests of NHC and instead in their own self-serving interests as set forth above.

693. The breaches of fiduciary duties outlined herein involved intentional misconduct, fraud, and/or a knowing violation of the law.

694. As a direct and proximate result of the Management Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

695. In committing the acts herein above alleged, the Management Defendants are guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from the Management Defendants for the purpose of deterring them and others similarly situated from engaging in like conduct in the future.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

696. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FIFTY-FIFTH CAUSE OF ACTION

(Intentional Misrepresentation/Fraud Against Management Defendants)

697. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

698. On February 28, 2015, and approximately mid-May 2015, the Management Defendants adopted and submitted the 2014 and March 2015 quarterly financial statements for NHC to the Nevada DOI insurance regulators. On or about April 1, 2015, the Management Defendants adopted and submitted a Management Discussion & Analysis that was submitted to the Nevada DOI insurance regulators as to the financial condition and prospective information of NHC.

699. On or about June 1, 2015, the Management Defendants adopted and authorized the release of the Audit Report prepared by Larson concerning NHC's December 31, 2014 and 2015 Financial Statements.

700. The financial statements, Management Discussion & Analysis, and Audit Report contained information that was false and misleading as set forth herein.

701. The Management Defendants knew or believed that their representations as stated above were false, or the Management Defendants had an insufficient basis of information for making the representations.

702. Plaintiff and those represented by Plaintiff justifiably relied upon the Management Defendants' representations contained in NHC's financial statements, Management Discussion & Analysis, and Audit Report.

703. As a direct and proximate result of the Management Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

704. In committing the acts herein above alleged, the Management Defendants are guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from the Management Defendants for the purpose of deterring them and others similarly situated from engaging in like conduct in the future.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

705. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FIFTY-SIXTH CAUSE OF ACTION

(Negligent Misrepresentation Against Management Defendants)

706. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

707. The Management Defendants, in the course of action in which they had a pecuniary interest, failed to exercise reasonable care or competence in obtaining or communicating information to Plaintiff as set forth above.

708. Such information included, without limitation, that the financial statements and Management Discussion & Analysis prepared, approved, ratified, or otherwise adopted by the Management Defendants were truthful, accurate, prepared, and performed in accordance with applicable standards.

709. Such representations involved negligence, intentional misconduct, fraud, and/or a knowing violation of the law.

710. Plaintiff justifiably relied on this information it received.

711. As a direct and proximate result of the Management Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

712. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FIFTY-SEVENTH CAUSE OF ACTION

(Constructive Fraud Against Management Defendants)

713. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

714. At all relevant times, the Management Defendants had a fiduciary and/or confidential relationship with NHC based on the facts alleged herein.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

715. The Management Defendants owed a legal or equitable duty to NHC arising from a fiduciary or confidential relationship.

716. The Management Defendants breached that duty by misrepresenting or concealing material facts by preparing, disseminating, and authorizing unreliable and untruthful financial information and a Management Discussion & Analysis concerning NHC and its operations.

717. The Management Defendants' conduct described herein involved intentional misconduct, fraud, and/or a knowing violation of the law.

718. As a direct and proximate result of the Management Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

719. In committing the acts herein above alleged, the Management Defendants are guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from the Management Defendants for the purpose of deterring them and others similarly situated from engaging in like conduct in the future.

720. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FIFTY-EIGHTH CAUSE OF ACTION

(Negligent Performance of an Undertaking Against Management Defendants)

721. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

722. The Management Defendants undertook to provide certain management and operational services to NHC, knowing that information would be used by NHC and provided to CMS for purposes of calculating certain amounts owed by NHC, to be received by NHC, or for other known purposes.

723. The Management Defendants knew or should have recognized these undertakings as necessary for the protection of NHC's members, NHC's enrolled insured, NHC's creditors, and the State of Nevada.

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

724. By performing the services detailed above, the Management Defendants undertook to perform a duty owed by NHC to its members, enrolled insureds, creditors, and regulators to act in accordance with statutory and professional standards.

725. The Management Defendants' failure to exercise reasonable care in performing its services increased the risk of harm to NHC, NHC's customers and vendors, and the State of Nevada.

726. The Management Defendants' conduct described herein involved intentional misconduct, fraud, and/or a knowing violation of the law.

727. As a direct and proximate result of the Management Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

728. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

FIFTY-NINTH CAUSE OF ACTION

(Unjust Enrichment Against Management Defendants)

729. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

730. Each of the Management Defendants was paid considerable and exorbitant amounts in compensation, including salary and bonuses without justification, and such compensation was paid despite the fact that NHC was losing millions of dollars each financial reporting period.

731. Management Defendants also engaged NHS to perform utilization review and management for claims and eligibility status in 2014, and NHC paid substantial fees to NHS for this service that also included NHS's overhead, out-of-pocket expenses, and taxes. Former Chief Executive Officer William Donahue claimed that he was unjustly pressured to sign the NHS engagement agreement. Upon information and belief, Management Director Defendant Kathleen Silver was President of NHS and UHH was its sole member, and Defendant Kathleen Silver engaged in self-dealing and was unjustly paid substantial amounts by NHS in this role, or she allowed UHH to be paid unjust amounts under this agreement. Upon information and belief, little

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

work was provided by NHS for NHC, and NHS compensation was unfairly based on a mechanical fee of how many total members existed at NHC each month; a fee that bore little to no relation to services being provided. In 2014, in excess of $1 million in claims were paid outside of enrollment when NHS was required but failed to properly perform eligibility status for member claims, with approximately $382,968 paid to NHS for it so called utilization management and member eligibility review services.

732. Some of the Management Defendants' compensation was based upon the unreliable and untruthful financial information prepared by, approved by, and/or ratified by these Management Defendants, which amounts Management Defendants are continuing to hold in violation of equity and good conscience.

733. In light of the actions set forth herein, such amounts should be disgorged from the Management Defendants and returned to NHC in the interests of equity.

734. The Management Defendants' conduct described herein involved intentional misconduct, fraud, and/or a knowing violation of the law.

735. As a direct and proximate result of the Management Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

736. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

SIXTIETH CAUSE OF ACTION

(Negligent Hiring, Training, Supervision, and Retention Against Management Defendants)

737. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

738. The Management Defendants owed a duty to exercise due care towards NHC in all of its dealings, in providing management, operational, and supervisory services to NHC.

739. The Management Defendants breached their duty by failing to provide services to satisfy basic, minimum industry standards and practices with respect to hiring, training, supervising and retaining employees, agents, consultants, and vendors on behalf of NHC.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

740. The Management Defendants' failure to properly hire, train, and supervise its employees to ensure that its employees and agents acted in a competent and professional manner with the requisite skill and expertise necessary to perform and complete the work necessary to fulfill NHC's business was the direct and proximate cause of NHC's injuries, as set forth herein.

741. The Management Defendants' decisions to retain certain employees, agents, consultants, and vendors who were unsatisfactory and unable to fulfill the Management Defendants' obligations and responsibilities were the direct and proximate cause of NHC's injuries.

742. As detailed above, by failing to perform to applicable professional and industry standards, the Management Defendants breached that duty.

743. The Management Defendants' conduct involved intentional misconduct, fraud, and/or a knowing violation of the law.

744. These actions were the legal cause of Plaintiff's injuries.

745. The Management Defendants knew or should have known that the employees, agents, consultants, and vendors they had hired were unfit for their positions and would likely cause harm to third parties when placed in the positions in which the Management Defendants placed them.

746. As a direct and proximate result of the Management Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

747. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

SIXTY-FIRST CAUSE OF ACTION

(Breach of Contract Against Management Defendants)

748. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

749. Upon information and belief, each of the Management Defendants entered into enforceable agreements with NHC, including, but not limited to employment agreements and ethics and conflicts of interest agreements, which contractually provided for Management Defendants to operate in a fiduciary manner and to exercise the utmost good faith in all transactions involving their duties and to refrain from conflicts of interest, as set forth above.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

750. The Management Defendants failed to perform under such agreements as set forth above.

751. Plaintiff performed or was excused from performance under such agreements.

752. As a direct and proximate result of the Management Defendants' conduct, Plaintiff has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

753. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

CAUSES OF ACTION RELATED TO ALL DEFENDANTS

SIXTY-SECOND CAUSE OF ACTION

(Civil Conspiracy Against All Defendants)

754. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

755. Defendants acted in concert with each other and with certain of NHC's management and vendors, including, but not limited to, Milliman, Millennium, Larson, and InsureMonkey, to falsify operating results and reserves, to conceal internal control weaknesses and other wrongdoing, and to avoid statutory supervision by their use of untruthful and/or unreliable financial data and other information they knew to be false and not in accordance with required statutory and professional standards in order to continue the flow of money to NHC, and subsequently, to the Management Defendants and NHC's vendors for their own personal gain.

756. Defendants' conduct described herein involved intentional misconduct, fraud, and/or a knowing violation of the law.

757. Each of the Defendants are jointly and severally liable for the damages described herein.

758. As a direct and proximate result of Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

759. In committing the acts herein above alleged, Defendants are guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from Defendants for the purpose of deterring them and others similarly situated from engaging in like conduct in the future.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

760. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

SIXTY-THIRD CAUSE OF ACTION

(Concert of Action Against All Defendants)

761. Plaintiff realleges and incorporates all of the allegations contained in the preceding paragraphs as if fully set forth herein.

762. Defendants acted in concert with each other and with certain of NHC's management and vendors, including, but not limited to, Milliman, Millennium, Larson, and InsureMonkey, to falsify operating results and reserves, to conceal internal control weaknesses and other wrongdoing, and to avoid statutory supervision by their use of untruthful and/or unreliable financial data and other information they knew to be false and not in accordance with required statutory and professional standards in order to continue the flow of money to NHC, and subsequently, to the Management Defendants and NHC's vendors for their own personal gain.

763. Defendants knew that their actions were inherently dangerous or posed a substantial risk of harm to others in that their actions could affect and disrupt the medical care of NHC's members and insured enrollees.

764. Defendants' actions did affect and disrupt the medical care of NHC's members and enrolled insureds.

765. The conduct described herein involved intentional misconduct, fraud, and/or a knowing violation of the law.

766. Each of the Defendants are jointly and severally liable for the damages described herein.

767. As a direct and proximate result of Defendants' conduct, NHC has suffered damages in an amount in excess of fifteen thousand dollars ($15,000).

768. In committing the acts herein above alleged, Defendants are guilty of oppression, fraud, and malice towards NHC. Therefore, NHC is entitled to recover punitive damages from the Defendants for the purpose of deterring them and others similarly situated from engaging in like conduct in the future.

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

769. Plaintiff has been required to retain the services of Greenberg Traurig, LLP to prosecute this action and is entitled to recover an award of reasonable attorneys' fees and costs incurred herein.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for relief in favor of Plaintiff and against each of the Defendants, as follows:

1. For damages in an amount in excess of fifteen thousand dollars ($15,000);

2. For prejudgment and post-judgment interest;

3. For all attorneys' fees and costs of suit; and

4. For such other and further relief as this Court may deem just and proper.

DATED this 25th day of August, 2017.

GREENBERG TRAURIG, LLP

/s/ Mark E. Ferrario, Esq.
MARK E. FERRARIO, ESQ.
Nevada Bar No. 1625
ERIC W. SWANIS, ESQ.
Nevada Bar No. 6840
DONALD L. PRUNTY, ESQ.
Nevada Bar No. 8230
3773 Howard Hughes Parkway, Suite 400 N
Las Vegas, NV 89169

Counsel for Plaintiff

GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002

MDSM
John E. Bragonje
State Bar No. 9519
E-mail:jbragonje@lrrc.com
Jennifer K. Hostetler
State Bar No. 11994
E-mail: jhostetler@lrrc.com
LEWIS ROCA ROTHGERBER CHRISTIE LLP
3993 Howard Hughes Pkwy, Suite 600
Las Vegas, NV 89169-5996
Tel: 702.949.8200
Fax: 702.949.8398

Attorneys for Defendant Millennium Consulting Services, LLC

DISTRICT COURT
CLARK COUNTY, NEVADA

STATE OF NEVADA, EX REL. COMMISSIONER OF INSURANCE, BARBARA D. RICHARDSON, IN HER OFFICIAL CAPACITY AS RECEIVER FOR NEVADA HEALTH CO-OP,

Plaintiff,

vs.

MILLIMAN, INC., a Washington Corporation, JONATHAN L. SHREVE, an Individual; MARY VAN DER HEIJDE, an Individual; MILLENNIUM CONSULTING SERVICES, LLC, a North Carolina Corporation; LARSON & COMPANY P.C., a Utah professional corporation; DENNIS T. LARSON, an Individual; MARTHA HAYES, an Individual; INSUREMONKEY, INC., a Nevada Corporation; ALEX RIVLIN, an Individual; NEVADA HEALTH SOLUTIONS, LLC, a Nevada limited liability company; PAMELA EGAN, an Individual; BASIL C. DIBSIE, an Individual; LINDA MATTOON, an Individual; TOM ZUMTOBEL, an Individual; BOBBETTE BOND, an Individual; KATHLEEN SILVER, an Individual; DOES I through X inclusive; and ROE CORPORATIONS I-X, inclusive,

Defendants.

Case No. A-17-760558-C

Dept. No. XVIII

MILLENNIUM CONSULTING SERVICES, LLC'S MOTION TO DISMISS

I. INTRODUCTION

Defendant Millennium Consulting Services, LLC moves this Court to dismiss this lawsuit pursuant to Rule 12(b) because the contract between the parties selects North Carolina courts as the exclusive venue for litigation. This Court has two issues to consider:

Enforceability. Because the forum-selection clause designates North Carolina as the sole jurisdiction for dispute resolution, a "heavy burden" shifts to plaintiff to show that some extrinsic circumstance, like fraud or unequal bargaining power, invalidates the term. But even the plaintiff repeatedly alleges in her complaint that the contract is "valid and enforceable." Unequal bargaining power manifests itself in consumer transactions, not transactions like this between sophisticated businesses dealing at arms' length.

Special Insolvency Context. The plaintiff is the Insurance Commissioner acting as liquidator for a bankrupt insurer. This unique circumstance does not nullify the forum-selection clause. Department I of this Court has been presiding over the insurer's liquidation for two years in a separate lawsuit; its order stresses that the Commissioner may file lawsuits "in other jurisdictions" and "in this state or elsewhere." The forum-selection clause complies with this Court's prior orders and the liquidation statutes.

This Court should enforce the parties forum-selection clause and dismiss this case. Any litigation must occur in North Carolina.

NOTICE OF MOTION

Please take notice that the undersigned will bring the above and foregoing "Motion to Dismiss" on for hearing before the Court on the 07 day of December, 2017 at 11:00AM .m. in Department 27 of the above-entitled court, located at the Regional Justice Center, 200 Lewis Avenue, Las Vegas, Nevada 89155.

II. FACTUAL AND PROCEDURAL BACKGROUND

This action arises out of the ongoing liquidation of an insurance company organized under the laws of and domiciled in Nevada. The Nevada Health Co-Op (hereinafter the "Health Co-Op") was "formed to provide health insurance to individuals and small business under the federal Affordable Care Act." (Compl. ¶ 2.)

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Insurer Insolvency Is Regulated by State Law Rather than the Federal Bankruptcy Code

Insurance companies cannot petition for bankruptcy relief. 11 U.S.C. § 109(b)(2) ("A person may be a debtor under chapter 7 of this title on if such person is not . . . a domestic insurance company"). As a result, the states have primary responsibility for regulating insurance, including insurance company insolvency proceedings. *See, e.g., Integrity Ins. Co. v. Martin*, 105 Nev. 16, 18, 769 P.2d 69, 70 (1989). Nevada's statutes governing the conserving, rehabilitating, reorganizing, or liquidating of an insurer are codified in NRS Chapter 696B. *See Frontier Ins. Serv. Inc. v. State ex rel. Gates*, 109 Nev. 231, 235, 849 P.2d 328, 331 (1993) (noting that Nevada is a signatory to the Uniform Insurers Liquidation Act).

The Nevada Commissioner of Insurance Takes Control of Bankrupt Insurers Under Court Supervision

The chief insurance regulator, the Nevada Commissioner of Insurance, or her deputies in the Attorney General's office, has authority to bring a statutory liquidation proceeding, and such a proceeding is the exclusive means for rehabilitating or liquidating an insolvent insurer. *See* NRS 696B.250 ("The Commissioner shall commence a delinquency proceeding authorized under this chapter."); *see also* NRS 696B.210 *to* 696B.260 (authorizing only the Commissioner to petition the court in insurer insolvency proceedings and to serve process). Only the Insurance Commissioner and her statutory deputies can serve as the receiver for the insolvent insurer. NRS 696B.290.

Department I of this Court Has Presided Over the Health Co-Op's Liquidation Proceedings Since 2015

Like many other co-ops created under the Affordable Care Act, the Health Co-Op experienced financial hardships that resulted in insolvency proceedings before Department I of this Court in September, 2015. (*See* 9/25/15 Pet. for Appointment of Commissioner as Receiver, on file in case number A-15-725244-C.)

On October 14, 2015, the Nevada Insurance Commissioner was appointed as the Health Co-Op's permanent receiver and ordered to take possession of its assets, wherever located, and to administer them under court supervision. (*See* 10/14/15 Permanent Injunction and Order

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Appointing Commissioner as Permanent Receiver of Nevada Health Co-Op, on file in case number A-15-725244-C.) On September 21, 2016, Department I adjudged the Health Co-Op insolvent and ordered the Commissioner to liquidate and distribute its assets to creditors pursuant to Nevada's claims prioritization scheme set forth in Chapter 696B. (*See* 9/21/16 Final Order Finding and Declaring Nevada Health Co-Op to Be Insolvent and Placing Nevada Health Co-Op into Liquidation, on file in case number A-15-725244-C.)

As Receiver, the Commissioner Must Recover Assets to Distribute to Creditors

Nevada's insurer insolvency statutes require the Insurance Commissioner to take charge of the insolvent insurer's business, marshals its assets, and oversee the insolvency proceeding. *See* NRS 696B.210, 696B.270, 696B.290. The act places the Insurance Commissioner at the center of the claims process, which establishes a mechanism for filing, processing, and paying claims in accordance with a statutory prioritization scheme. *See* NRS 696B.400; *see also Integrity Ins. Co. v. Martin*, 105 Nev. 16, 18, 769 P.2d 69, 70 (1989) ("The UILA authorizes the court in which a delinquency proceeding was instituted to enjoin all claims against the insurer, including claims existing prior to an order of liquidation.").

This Lawsuit Is Part of the Insurance Commissioner's Efforts, as a Receiver, to Recover Assets

Totally apart from the liquidation action that has been pending for over two years now in Department I, the Insurance Commissioner is authorized and empowered to act as a receiver[1] to assert *affirmative claims* in *any jurisdiction* to recover assets for benefit of the estate, which ultimately will be distributed to creditors according to the statutory prioritization scheme in NRS Chapter 696B.

Department I of this Court ordered that the Insurance Commissioner and her agents: "are hereby authorized to rehabilitate or liquidate CO-OP's business affairs as and when they deem appropriate under the circumstances and for that purpose may do all acts necessary or appropriate for the conservation, rehabilitation, or liquidation of [the Heath] CO-OP." (*See* 10/14/15 Permanent Injunction and Order Appointing Commissioner as Permanent Receiver of Nevada

[1] A receiver is "a disinterested person appointed by a court, or by a corporation or other person, for the protection or collection of property that is the subject of diverse claims (for example, because it belongs to a bankrupt or is otherwise being liquidated)." *Black's Law Dictionary*, 1275 (7th ed. 1999).

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Health Co-Op, on file in case number A-15-725244-C.) This broad grant of powers includes "the power" and authority to "[c]ollect all debts and monies due and claims belonging to [the Health] CO-OP, wherever located," and for this purpose:

> (i) to institute and maintain actions in other jurisdictions, in order to forestall garnishment and attachment proceedings against such debts; (ii) to do such other acts as are necessary or expedient to marshal, collect, conserve or protect [the Health Co-Op's] assets or property, including the power to . . . initiate and maintain actions at law or equity or any other type of action or proceeding of any nature, in this and other jurisdictions . . . .

(*Id.* § 14(a); *see also id.* § 14(h) (empowering the Insurance Commissioner to "institute and to prosecute . . . any and all suits and other legal proceedings, to defend suits in which [the Health] CO-OP or the Receiver is a party in this state or elsewhere, whether or not such suits are pending as of the date of this Order").)

This Lawsuit Seeks Money Damages Against 15 Defendants the Commissioner Blames for Bankrupting the Health Co-Op

The present lawsuit was filed in August, 2017. It grows out of Department I's investing the Commissioner with power, as the permanent receiver, to marshal the Health Co-Op's assets. This lawsuit seeks to recover a money judgment against 15 defendants for the benefit of the Health Co-Op's estate and its "members, insured enrollees, and creditors." (Compl. ¶ 1; *see also* Prayer ¶ 1 (seeking damages "in an amount in excess of fifteen thousand dollars ($15,000)".) In essence, the lawsuit seeks to hold the defendants responsible for the bankruptcy of the Health Co-Op. As the complaint sprawls to nearly one hundred pages in length, two categories of alleged malefactors emerge. First, "the management" of the Nevada Co-Op "intentionally [and] fraudulently" squandered "funds to unjustly enrich themselves" through "self-dealing," concealed material information, and inappropriately enrolled clients and paid claims. (Compl. ¶ 10.) Second, the Health Co-Op alleges that certain defendant service providers breached "applicable fiduciary, contractual, and statutory standards," causing "substantial [financial] losses." (Compl. ¶ 3.)

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The Movant, Defendant Millennium Consulting, Helped the Co-Op Format Regulatory Filings

Millennium Consulting, the movant, belongs to this second group. Millennium Consulting is a North Carolina limited liability company with its headquarters in Raleigh. (Compl. ¶ 19.) According to the Health Co-Op, it hired Millennium Consulting "to prepare and file [the Health Co-Op's] financial statements and supplemental reports with the Nevada [Department of Insurance] and the National Association of Insurance Commissioners . . . and to respond to inquiries from regulators." (Compl. ¶ 7.)

Millennium Consulting Is a Minor Player in the Health Co-Op's Story

In the saga of the Health Co-Op rise and fall, Millennium Consulting is a bit player. Millennium Consultant's contract, called the Services Agreement,[2] attached as Exhibit 1, gives a sense of the limited scope of its work. The Services Agreement sets Millennium Consulting's compensation at $13,950 for preparing the Health Co-Op's annual statement for 2014 and $25,050.00 for preparing the annual and quarterly statements for 2015.[3] In contrast, the Health Co-Op was initially capitalized with no less than $66 million in loans from the federal government alone. (Compl. ¶¶ 66–67.) While discovery has not yet begun, the allegations in the Health Co-Op's own complaint underscore the limited role that Millennium Consulting played.

The Health Co-Op Exaggerates Millennium Consulting's Involvement

Despite this obvious, narrow role, the Health Co-Op exaggerates Millennium's participation, claiming that it agreed "to perform the duties of an internal financial controller" and that it provided "professional accounting services." (Compl. ¶¶ 142, 419.) We appreciate that all of the plaintiff's allegations are assumed true at this juncture, but we nevertheless protest this

[2] The Health Co-Op specifically incorporates and discusses the Services Agreement between it and Millennium Consulting. (*E.g.*, Compl. ¶¶ 140–42.) A court may take judicial notice of documents that are incorporated by reference, although not attached, into a complaint if: (1) the complaint refers to the document; (2) the document is central to the plaintiff's claims; and (3) the authenticity of the document is not disputed. *E.g. Marder v. Lopez*, 450 F.3d 445, 448 (9th Cir. 2006); *see also Janas v. McCracken (in Re Silicon Graphics Sec. Litig.)*, 183 F.3d 970, 986 (9th Cir. 1999) (citation omitted) ("That doctrine permits a district court to consider documents whose contents are alleged in a complaint and whose authenticity no party questions, but which are not physically attached to the [plaintiff's] pleading."). These conditions obtain here. "Such consideration does not convert the motion to dismiss into a motion for summary judgment." *Branch v. Tunnell*, 14 F.3d 449, 454 (9th Cir. 1994).

[3] Millennium Consulting did not earn this much money; it only earned $22,953. The Health Co-Op ceased operations relatively quickly after opening for business. *See* Compl. ¶ 315 (noting that the Health Co-Op's board voted on August 17, 2015 to "cease writing new business and to suspend voluntarily its certificate of authority, effectively 'throwing in the towel' and ending any prospect of recovery").

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Lewis Roca ROTHGERBER CHRISTIE

stretching of Millennium Consulting's role. It is nonsense. Millennium merely assisted the Health Co-Op to understand and complete annual and quarterly form reports required by state regulators in accordance with accounting principles prescribed or permitted by the State of Nevada in accordance with the National Association of Insurance Commissioners (NAIC) Accounting Practices and Procedures Manual as adopted under Nevada insurance law. Millennium did not generate any of the accounting or actuarial content in the forms submitted—it merely formatted the Company's data into the statutory format prescribed and permitted by accounting rules adopted by the State of Nevada. The Health Co-Op criticizes Millennium Consulting's work product as failing to meet various standards that obscured the "the severity of [the Health Co-Op's] position" and withheld "relevant and required information regarding extraordinary accounting practices in use, the inadequacy of reserves, [and] liquidity and borrowing concerns" (Compl. ¶ 157; *see also id.* at ¶¶ 143–57), but, again, Millennium Consulting did not generate the content of any report—it merely formatted the information prepared by others, including the other defendants in this lawsuit. Typical of the embellishment directed at Millennium Consulting's narrow role, the Health Co-Op asserts nine duplicative and legally insufficient causes of action against Millennium Consulting: professional malpractice, intentional misrepresentation/fraud, negligent misrepresentation, negligence, breach of contract, tortious breach of the implied covenant, breach of the implied covenant, negligent performance of an undertaking, unjust enrichment. (Compl. ¶¶ 418–77.) Millennium Consulting denies any liability.

The Parties' Services Agreement Selects North Carolina as the Exclusive Forum for Litigation

The Health Co-Op and Millennium Consulting agreed when striking their bargain to litigate any dispute in North Carolina—Millennium Consulting's home state: "This Agreement shall be governed in regards to its execution, interpretation or enforcement in accordance with the laws of the State of North Carolina. Venue for its enforcement or any action or proceeding based on this Agreement shall be in Wake County, North Carolina." (Exhibit 1, § 8.4.)

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III. THIS COURT SHOULD ENFORCE THE PARTIES' AGREEMENT TO LITIGATE IN NORTH CAROLINA AND DISMISS THIS CASE

Courts routinely enforce forum-selection clauses. North Carolina law develops a two-part analysis. First, the clause must mandate that the parties litigate exclusively in the selected jurisdiction, as opposed to permitting litigation there and elsewhere. Here the clause mandates North Carolina as the exclusive venue. Second, a "heavy burden" then shifts to the Health Co-Op to demonstrate that the clause resulted from fraud, unequal bargaining power, or unfairness. Here, none of these factors exists. This Court must enforce the clause and dismiss this case.

A. Courts Routinely Dismiss Cases to Enforce Forum-Selection Clauses

When the parties have agreed to a valid forum-selection clause, a district court should ordinarily transfer the case to the forum specified in that clause." *Atl. Marine Constr. Co. v. United States Dist. Ct.*, 134 S. Ct. 568, 580 (2013). "Only under extraordinary circumstances unrelated to the convenience of the parties should a [*forum non conveniens*] motion be denied." *Id.*

First, "the plaintiff's choice of forum merits no weight." *Id.* "Rather, as the party defying the forum-selection clause, the plaintiff bears the burden of establishing that transfer to the forum for which the parties bargained is unwarranted." *Id.* This wide departure from the typical rule of "plaintiff's venue privilege" reflects that the plaintiff has already effectively exercised that privilege by agreeing to the forum-selection clause before a dispute ever arose. *See id.* at 582.

Second, a court "should not consider arguments about the parties' private interests." *Id.* By agreeing to a forum-selection clause, the parties "waive the right to challenge the preselected forum as inconvenient or less convenient for themselves or their witnesses, or for their pursuit of the litigation." *Id.*

And third, courts should be hesitant to "unnecessarily disrupt the parties' settled expectations" by failing to transfer a case when a valid, unambiguous forum-selection clause so requires. *Id.* at 583. Thus, "[i]n all but the most unusual cases the interest of justice is served by holding parties to their bargain." *Id.* (citations omitted). Both Nevada and North Carolina follows these same, universal precepts.

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Las Vegas, NV 89169-5996
Lewis Roca ROTHGERBER CHRISTIE

B. North Carolina Law Governs the Validity of the Forum-Selection Clause

Under Nevada law, when a contract contains a choice-of-law provision, the provision's specified law governs the validity of the forum-selection clause. *See Engel v. Ernst*, 102 Nev. 390, 395, 724 P.2d 215, 216 (1986) (recognizing the validity of choice-of-law clauses); *see also E. & J. Gallo Winery v. Andina Licores S.A.*, 446 F.3d 984, 994 (9th Cir. 2006) ("[T]he contract clearly contains a California choice-of-law clause; thus, the validity of the forum selection clause should be decided by California law, as the law of the contract, rather than by Ecuadorian law.").

C. Under North Carolina Law, the Forum Selection Clause is Valid

The clause is mandatory because it leaves the parties no choice but to litigate in North Carolina. The "heavy burden" then shifts to the Health Co-Op to prove some external reason for refusing to enforce the clause. The Co-Op cannot carry its burden. First, Millennium Consulting did not procure the clause by fraud—the Co-Op repeatedly alleges in its complaint that the contract in which the clause sits is valid. Second, unequal bargaining power manifests itself in consumer transactions, not transactions like this between sophisticated businesses dealing at arms' length. The clause is valid and must be enforced.

1. The Clause is Mandatory

The general rule is that mandatory forum selection clauses are enforced in North Carolina.[4] *Lendingtree v. Anderson*, 747 S.E.2d 292, 297 (N.C. 2013). "[M]andatory forum selection clauses recognized by North Carolina appellate courts have contained words such as 'exclusive' or 'sole' or 'only' which indicate that the contracting parties intended to make jurisdiction exclusive." *Printing Servs. of Greensboro, Inc. v. Am. Capital Group, Inc.*, 637 S.E.2d 230, 232 (N.C. 2006) (citation omitted).

Here, the forum-selection clause is mandatory. The language in the forum-selection clause in the present case states: "This Agreement shall be governed in regards to its execution, interpretation or enforcement in accordance with the laws of the State of North Carolina. Venue for its enforcement or any action or proceeding based on this Agreement shall be in Wake County,

[4] We hasten to add, however, that the result would be the same if Nevada law governed. *E.g., Tandy Computer Leasing v. Terina's Pizza*, 105 Nev. 841, 843, 784 P.2d 7, 8 (1989) (recognizing the enforceability of forum-selection clauses).

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North Carolina." (Exhibit 1, § 8.4.)

The phrases "any action or proceeding" and "shall" in the forum-selection clause match the use of the terms "any" and "shall" in forum-selection clauses regarded as mandatory in several North Carolina cases. First, in *Bryant Elec. Co. v. City of Fredericksburg*, 762 F.2d 1192, 1196 (4th Cir. 1985), the Fourth Circuit enforced a forum-selection construed under North Carolina law clause that provided, "[a]ll claims, disputes and other matters in question between [the parties] arising out of, or relating to the Contract Documents or the breach thereof . . . shall be decided by the Circuit Court of the City of Fredericksburg." Second, in *Southern Farm Supply, Inc. v. Arctic Cat Sales, Inc.*, No 5:09-cv-90, 2011 WL 2791247, at *2 (W.D.N.C. July 14, 2011), the North Carolina federal court found a forum-selection clause mandatory that stated, "[a]ny claim, action, or other dispute between the parties as to the terms of the Agreement . . . or as to any other matter arising out [of] the parties' relationship, shall be resolved by the State or Federal Courts of the State of Minnesota." The *Southern Farm* court reasoned the clause was mandatory because the exclusive language of "any" and "shall" indicated specific intent for venue in Minnesota. *Id.*

Finally, a "crucial distinction between mandatory and permissive clauses is whether the clause only mentions jurisdiction or specifically refers to venue." *Scotland Mem'l Hosp., Inc. v. Integrated Informatics, Inc.*, No. 1:02-cv-00796, 2003 WL 151852, at *4 (M.D.N.C. Jan. 8, 2003). Here, of course, the clause explicitly designates the "venue" as Wake County, North Carolina.

2. The Health Co-Op Cannot Carry the "Heavy Burden" to Show Why the Clause Should Not Be Enforced

Once it is established that a forum-selection clause is mandatory, a party "seeking to avoid enforcement of a forum selection clause carries a heavy burden and must demonstrate that the clause was the product of fraud or unequal bargaining power or that enforcement of the clause would be unfair or unreasonable." *Perkins v. CCH Computax, Inc.*, 423 S.E.2d 780, 784 (N.C. 1992).

a. THERE IS NO FRAUD HERE

The Health Co-Op does not contend that it was fraudulently induced to enter into the Services Agreement or its forum-selection clause. In fact, it refers to the Services Agreement

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repeatedly in its complaint and affirms no fewer than three times that it is "valid and enforceable contract." (Compl. ¶¶ 445, 452, 459; *see also* ¶ 140.)

b. THERE IS EQUAL BARGAINING POWER

As to "unequal bargaining power," the Heath Co-Op had the advantage because of size—its operating capital (at least $66 million according to the complaint) dwarfed Millennium Consulting's, which is a small closely held and owner-operated business. Perhaps most importantly, the concept of "unequal bargaining" power has little application in this *commercial* context where two businesses negotiated at arms' length. The concept finds its truest expression in *consumer* transactions. *See, e.g., Tillman v. Commercial Credit Loans, Inc.*, 655 S.E.2d 362, 370 (N.C. 2008) ("[T]he bargaining power between defendants and plaintiffs was unquestionably unequal in that plaintiffs are relatively unsophisticated consumers contracting with corporate defendants who drafted the arbitration clause and included it as boilerplate language in all of their loan agreements."); *Tenn. Carolina Transp., Inc. v. Strick Corp.*, 196 S.E.2d 711, 718 (Ct. App. N.C. 1973) (describing the plaintiff as "a non-consumer with bargaining power substantially equivalent" to the defendant's where both parties were corporations party to a sale contract for 150 trailers).

c. THE HEALTH CO-OP CANNOT DEMONSTRATE UNFAIRNESS

Finally, no "unfairness" or "unreasonableness" preventing enforcement of the forum-selection clause exists here. Such conclusions arise if the party seeking to enforce the clause threatens to terminate the plaintiff; verbally promises litigation can occur in a forum other than that selected by the contract; or if the contract itself results from unequal bargaining power. *See Cox v. Dine–A–Mate, Inc.*, 501 S.E.2d 353, 354–55 (Ct. App. N.C. 1998) (holding that enforcement would have been unfair and unreasonable when the employee entered into the contract under threat of termination); *Appliance Sales & Serv., Inc. v. Command Elecs. Corp.*, 443 S.E.2d 784, 790–91 (Ct. App. N.C. 1994) (holding that enforcement would be unfair and unreasonable where the defendant made representations that the plaintiff could bring suit in the civil courts of North Carolina); *Bell Atl. Tricon Leasing Corp. v Johnnie's Garbage Serv., Inc.*, 439 S.E.2d 221, 224–25 (Ct. App. N.C. 1994) (holding that enforcement would be unreasonable

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Las Vegas, NV 89169-5996
Lewis Roca ROTHGERBER CHRISTIE

and unfair where the contract was entered into with an unequal bargaining position and the defendant did not knowingly consent to the forum selection clause); *Dove Air, Inc. v. Bennett*, 226 F. Supp. 2d 771, 775 (W.D.N.C. 2002) (holding that enforcement would be unreasonable and unfair where the contract itself showed unequal bargaining power and overreaching).

IV. THE LIQUIDATION PROCEEDINGS CHANGE NO PART OF THE ANALYSIS

We suspect the Health Co-Op will attempt to avoid the forum-selection clause by claiming that special liquidation proceedings somehow nullify the clause. Such a notion is false. First, nothing in Chapter 696B mandates that a Nevada court have exclusive jurisdiction over this case. Indeed, that statute makes clear that the Commissioner may maintain even the rehabilitation action (*i.e.*, that over which Department I has been presiding for two years) "in a federal district court in another state" if she feels that "such rehabilitation or liquidation set forth in this chapter would thereby be facilitated." NRS 696B.570. In the liquidation, Department I itself of this Court repeatedly stressed in its order appointing the Commissioner as receiver that she had power to file lawsuits "in other jurisdictions" and "in this state or elsewhere." (*See* 10/14/15 Permanent Injunction and Order Appointing Commissioner as Permanent Receiver of Nevada Health Co-Op, on file in case number A-15-725244-C, §§ 14(a), 14(h).) This Court's own prior orders pave the way for enforcement of the forum-selection clause.

Additionally, those few courts that have considered forum-selection clauses in this esoteric context have enforced them. *See Foster v. Chesapeake Ins. Co., Ltd.*, 933 F.2d 1207, 1216–19 (3rd Cir. 1991) (granting the Pennsylvania insurance commissioner's motion to remand a case to state court in which commissioner, as receiver, sought $4 million allegedly due under a reinsurance agreement that included a forum-selection that eliminated the right to remove to federal court); *Dinallo v. Dunav Ins. Co.*, 672 F. Supp. 2d 368, 370–71 (S.D.N.Y. 2009) (same). The rational of these cases is simple: Because the commissioner-liquidator brought suit on behalf of an insolvent insurer and its creditors and policyholders against a third party for its alleged failure to perform a contract, the commissioner-liquidator necessarily stands in the shoes of the insolvent insurer and cannot assert a claim that arises from and is intertwined with the contract while at the same time disavowing a provision in that contract requiring litigation in the forum

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Las Vegas, NV 89169-5996
Lewis Roca ROTHGERBER CHRISTIE

selected by the parties when the bargain was struck. *See also Bennett v. Liberty Nat'l Fire Ins. Co.*, 968 F.2d 969, 972 n.4 (9th Cir.1992) (upholding arbitration clauses in the insurance liquidation context over the objection of commissioner-receiver and observing that "if the liquidator wants to enforce [insolvent's] rights under its contract, she must also assume its perceived liabilities.").

V. CONCLUSION

For all these reasons, this Court should enforce the forum-selection clause and dismiss this action.

DATED this 26th day of October, 2017.

LEWIS ROCA ROTHGERBER CHRISTIE LLP

By: /s/ John E. Bragonje
John E. Bragonje
State Bar No. 9519
E-mail: jbragonje@lrrc.com
Jennifer K. Hostetler
State Bar No. 11994
E-mail: jhostetler@lrrc.com
3993 Howard Hughes Pkwy, Suite 600
Las Vegas, NV 89169-5996
Tel: 702.949.8200
Fax: 702.949.8398

Attorneys for Defendant
Millennium Consulting Services, LLC

3993 Howard Hughes Pkwy, Suite 600
Las Vegas, NV 89169-5996
Lewis Roca ROTHGERBER CHRISTIE

CERTIFICATE OF SERVICE

Pursuant to N.R.C.P., 5(b), I hereby certify that on the 26th day of October, 2017, I electronically filed the foregoing document with the Clerk of the Court and caused a true and accurate copy of the same to be served via Court's E-Filing Systems upon the following counsel of record.

Mark E. Ferrario, Esq.
Eric W. Swanis, Esq.
Donald L. Prunty, Esq.
GREENBERG TRAURIG, LLP
3773 Howard Hughes Pkwy., Suite 400 N
Las Vegas, NV 89169

DATED this 26th day of October, 2017.

/s/ Luz Horvath
An employee of Lewis Roca Rothgerber Christie LLP

3993 Howard Hughes Pkwy, Suite 600
Las Vegas, NV 89169-5996
Lewis Roca ROTHGERBER CHRISTIE

Exhibit 1

Exhibit 1

MILLENNIUM
Consulting Services, LLC
Insurance Education & Regulatory Consulting

NEVADA HEALTH CO-OP
SERVICES AGREEMENT

THIS Agreement made the 7th day of January 2015 between Nevada Health CO-OP (herein called "Client") and Millennium Consulting Services, LLC a North Carolina Limited Liability Company (herein called "Contractor").

W I T N E S S E T H

THAT WHEREAS, the Client desires to engage the Contractor to perform certain regulatory consulting services on the terms and conditions of this Agreement hereinafter described,

THEREFORE, in consideration of the above and the mutual promises set forth below, Client and Contractor do mutually agree as follows:

1. Statutory Statement Outsourcing Services (See Schedule A)

   1.1 In consultation with Client, Contractor will prepare and file Client's Health Annual Statement including all NAIC Supplemental Exhibits and Schedules for filing with the Nevada Division of Insurance (NDOI) and the NAIC;

   1.2 In consultation with Client, Contractor will prepare and file Client's Health Quarterly Statement, including all NAIC Quarterly Supplemental Exhibits and Schedules for filing with the NDOI and the NAIC;

   1.3 In consultation with Client, Contractor will assist in the review and prepare response to any regulatory letter from the NDOI and the NAIC related to the annual and/or quarterly statement filings;

   1.4 In consultation with Client, Contractor will respond to any independent auditor inquiries regarding the preparation and filing of the Client's Audited Annual Statement Supplemental filing as needed;

   1.5 Contractor will provide statutory accounting and reporting support to Client as needed; and

14460 FALLS OF NEUSE ROAD, SUITE 149-294 • RALEIGH, NC • 27614
PHONE: (919) 569-6762 • FAX: (919) 569-0336

1.6 Acquire on behalf of Client Annual, Quarterly and Risk-Based Capital (RBC) software necessary to prepare and file statutory filings with the NDOI and the NAIC.

1.7 This Agreement does not provide for:

1.7.1 Federal and State income tax preparation and filing, and statutory accounting tax calculation and disclosure services;

1.7.2 Printing or binding of the annual or quarterly statements, nor

1.7.3 Preparation of any state specific supplemental filings unless otherwise stipulated herein.

2. Payment

2.1 Contractor agrees to accept the "Contracted Rate" price as total compensation as set forth in Schedule B as full compensation for the specific services described under this Agreement.

2.2 Client agrees that expenses and charges for any additional services, exclusive of the services set forth in Paragraph 1 and Schedule B, are payable to Contractor, at Contractor's standard hourly rate of $300 per hour for said services, and that such additional charges are in addition to the charges set forth in Schedule B.

2.3 Contractor agrees to invoice Client and Client agrees to pay Contractor as set forth in Schedule C.

2.4 Client agrees to reimburse Contractor for any and all documented and reasonably necessary travel, travel related expenses, and on-site consulting time approved in advance by Client. All on-site consulting time is billed at $2,400 per day per consultant. Travel, related travel expense and on-site consulting fees will be billed to Client by Contractor under separate invoice.

2.5 Client agrees to pay late fees to Contractor as designated in Schedule D.

3. Term and Termination

3.1 This Agreement shall be effective upon mutual execution hereof. Upon the mutual execution hereof, this Agreement shall continue, unless otherwise terminated as described herein per paragraphs 3.2 or 3.3.

3.2 Client may terminate this agreement for any reason at any time by giving Contractor a thirty (30) day advance written notice. In the event of early termination, Client shall be obligated to pay Contractor for fees and expenses actually incurred up to notice of termination at the rate of $300 per hour.

3.3 Contractor may terminate this agreement by giving Client thirty-day (30) advance written notice. If Contractor terminates this agreement within 30 days of a filing deadline for a report, Contractor will complete and file the report, or will cease all work and refund all monies paid in preparation for that report. In the event Contractor completes work Client shall be obligated to pay Contractor for fees and expenses at the contracted rate for that report.

4. Independent Contractor Status

4.1 The parties understand and agree that Contractor is an independent contractor for all purposes under this Agreement maintaining complete control over its employees and all of its subcontractors. Nothing in this Agreement shall render Contractor or any of its agents or employees, an employee or agent of Client.

4.2 Contractor understands that it must comply with all tax laws applicable to Contractor and Contractor's employees, including the filing of any necessary tax returns and the payment of all applicable employment taxes. Client shall not be required to withhold from the fees paid to Contractor any state or federal income taxes or to make payments for Social Security ("FICA") tax, unemployment insurance or any other payroll taxes.

4.3 Consistent with its duties and obligations under this Agreement, Contractor shall maintain sole and exclusive control over the manner and method by which Contractor and its employees perform services under this Agreement.

5. Confidentiality and Compliance with Privacy Laws

5.1 Contractor shall protect the confidentiality of Client's confidential information to include any information, systems, data and trade secrets, considered by Client to be confidential information and the obligations of this Section 5 shall survive termination of this Agreement.

5.2 Confidential information shall not include any information that:

5.1.1 is part of the public domain either at the time of disclosure or that which subsequently becomes part of the public domain through no fault of Contractor;

5.1.2 is known to the Contractor at the time of disclosure; or

5.1.3 is subsequently disclosed to Contractor by a third party not in violation of a confidentiality obligation owed to Client.

5.3 Immediately upon termination of this Agreement, Contractor agrees to return to Client all Client property in its possession or control.

5.4 Contractor shall maintain the confidentiality of Client's policyholder records and personal information and use policyholder information only in connection with the purposes defined in this Agreement. (For purposes of this Agreement, "Policyholder" means any person who has obtained any insurance or related service through Client. Contractor shall not use or disclose policyholder records and personal information in any way that is not explicitly authorized by this Agreement.

6. Records Retention

6.1 Contractor agrees that it will maintain and give the U.S. Department of Health and Human Services ("HHS"), the Comptroller General, the HHS Office of Inspector General, or their designees, access and the right to audit, inspect, evaluate, examine, and make excerpts, transcripts and copies of any books, contracts, records, documents and other evidence relating to the Services provided to Client under this Agreement that pertain to (as may be applicable): (a) Client's compliance with the ("CO-OP") Program requirements; and (b) Client's ability to repay loan funds to HHS.

6.2 Further, Contractor agrees to maintain such materials and evidence until the last day of Client's Performance Period or from the date of completion of any audits, evaluations or inspections whichever is later unless:

6.2.1 HHS determines there is a special need to retain a particular record or group of records for a longer period and notifies Client (who in turn notifies Contractor) at least 30 days before the normal disposition date or;

6.2.2 There has been a termination, dispute or allegation of fraud or similar fault committed by Client, or anyone contracted to act on its behalf or provide services to it or on its behalf, in which case Contractor agrees to retain records for an additional 6 years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault. In the alternative, Contractor may provide Client all records upon termination.

7. Indemnification and Insurance

7.1 Contractor shall indemnify and hold Client harmless from any and all liability for losses, costs, and expenses, including reasonable attorneys' fees, arising in connection with the following:

7.1.1 the negligence or misconduct by Contractor;

7.1.2 claims by the Contractor or its employees or agents for personal injury or property damage on premises owned or occupied by Client, unless such injury or damage is caused by the negligence or misconduct of Client, its agents or employees;

7.1.3 any violation or alleged violation by Contractor or its employees of applicable federal, state and local laws or regulations, including, but not limited to, the provisions of the National Labor Relations Act, the Equal Employment Opportunity Act, the Occupational Safety and P&C Act, the Fair Labor Standards Act and any applicable tax laws. The requirement of indemnification in this Section 7.1.3 shall apply notwithstanding any adjudication that Client is an employer or joint employer of a Contractor employee for purposes of the relevant law or regulation.

7.1.4 Client shall hold harmless and indemnify Contractor from and against any and all claims or causes of action for damages arising out of Client providing inaccurate written information to Contractor which Contractor uses in connection with the services provided by Contractor under this agreement.

7.2 Contractor will obtain and keep in force during the Agreement, a Comprehensive General Liability policy in an amount no less than $1,000,000.00, which will insure Client and its employees as insured with respect to the Services performed by the Contractor.

8. Miscellaneous

8.1 This Agreement is a personal contract for services, and Client may not assign this Agreement, whether by operation of law or otherwise, or its rights or obligations under this Agreement without Contractor's express prior written consent. Contractor may not assign this Agreement whether by operation of law or otherwise, or its rights or obligations under this Agreement without Client's prior written consent, except that Contractor may freely assign this Agreement to any company which is owned wholly or in part by Contractor or any of the individual shareholders of Contractor.

8.2 This Agreement, together with the schedules and/or forms attached hereto, constitutes the entire Agreement between the parties and supersedes all prior understandings, agreements, and arrangements, both oral and written, between the parties.

8.3 Those provisions of this Agreement which require performance after termination of this Agreement shall survive any termination or voiding of this Agreement.

8.4 This Agreement shall be governed in regards to its execution, interpretation or enforcement in accordance with the laws of the State of North Carolina. Venue for its enforcement or any action or proceeding based on this Agreement shall be in Wake County, North Carolina.

8.5 If litigation is instituted between or among the parties with respect to the arrangement contemplated by this Agreement, the prevailing party therein shall be entitled to recover, in addition to all other relief obtained, costs, expenses and fees, including attorney fees, incurred in such litigation, both in the trial court and on appeal.

8.6 As required by 2 CFR 376, Client is prohibited from employing or contracting with any individual or entity that is excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration. Specifically, Client may not employ or contract with an individual or entity who is presently debarred, suspended, proposed for debarment or declared ineligible to participate in state or federal health care programs by HHS or who is otherwise sanctioned by a court or governmental agency under the Medicare, Medicaid or

other state or federal health care program. Contractor hereby attests that neither Contractor nor its directors, officers, employees are debarred, suspended, proposed for debarment or declared ineligible to participate in state or federal health care programs. In the event Contractor becomes of aware of any change to this attestation, Contractor shall notify Client immediately.

The parties hereto have caused this Agreement to be executed, effective the date set forth above.

NEVADA HEALTH CO-OP	MILLENNIUM CONSULTING SERVICES, LLC
By: _____	By: _____
Name: Basil C. Dibsie	Name: Bruce A. Cromartie
Title: CFO	Title: President / CEO
Date: 1/14/15	Date: 1/8/2015

Client designates the following corporate contact person for servicing the provisions of this Service Agreement:

Name: Sue Melin

Address: 3900 Meadows Lane
Las Vegas, NV 89107

Phone: 702-802-4600

Fax: 702-802-4601

Email: smelin@nevadahealthcoop.org

Schedule A
Description of Consulting and Other Services

1. Prepare and file Client's Health Annual Statement and all applicable NAIC Annual Supplemental Exhibits and Schedules in accordance with statutory accounting and reporting rules prescribed and permitted by the state of Nevada.

   Contractor will prepare Client's Health Annual Statement utilizing Client's supporting Trial Balance and other supporting work papers. This will entail evaluating general ledger accounting entries, ensuring that statutory accounting and reporting principles have been followed, recommending any adjustments to adhere to statutory accounting and reporting rules prescribed by the state of domicile and preparing any supporting worksheets that may be needed in arriving at appropriate allocations of financial amounts within some of the schedules.

   As part of this assignment, Contractor also will prepare and file the following NAIC annual Supplemental Exhibits and Schedules:

   i. Accident and Health Policy Experience Exhibit
   ii. Health Risk-Based Capital Report
   iii. Investment Risk Interrogatories
   iv. Management's Discussion and Analysis
   v. Supplemental Compensation Exhibit
   vi. Supplemental Health Care Exhibit

   Contractor will enter the data into annual statement software, produce a hard copy of the filings, and submit to Client a minimum of five (5) days prior to the filing date if source data is provided in accordance with data submission schedule agreed upon by Contractor and Client.

2. Prepare and file Client's Health Quarterly Statements and all NAIC Quarterly Supplemental Exhibits and Schedules in accordance with statutory accounting and reporting rules prescribed and permitted by the state of Nevada.

   Contractor will prepare Client's Health Quarterly Statement utilizing Client's supporting Trial Balance and other supporting work papers. This will entail evaluating

general ledger accounting entries, ensuring that statutory accounting and reporting principles have been followed, recommending any adjustments to adhere to statutory accounting and reporting rules prescribed by the state of domicile, and preparing any supporting worksheets that may be needed in arriving at appropriate allocations of financial amounts within some of the schedules.

Contractor will enter the data into quarterly statement software, produce a hard copy of the filings and submit to Client a minimum of five (5) days prior to the filing date if source data is provided in accordance with data submission schedule agreed upon by Contractor and Client.

3. Assist in the review and prepare response to any regulatory letters from the Nevada Division of Insurance and/or the NAIC related to the annual and/or quarterly statement filings.

4. Respond to any independent auditor inquiries regarding the preparation and filing of the Audited Annual Statement Supplemental filing of each reporting entity as needed.

5. Upon written authorization Contractor will acquire and bill Client for the cost of the following software:

   - Annual, Quarterly, and Risk-Based Capital software necessary to prepare and file statutory filings with the Nevada Division of Insurance and NAIC.
   - Federal income tax preparation and filing, and statutory accounting tax calculation and disclosure services.

Schedule B – 2014 Reporting Period
Schedule of Client Services

The following table summarizes the cost of the **Statutory Statement Outsourcing Services for 2014** that Contractor will provide.

Description of Statutory Statement Outsourcing Services – 2014 Reporting Period	Hours	Hourly Rate	Extension
1. Initialization of contract (Mapping, account review, etc.)	8	$300	$2,400.00
2. Prepare and file Client's 2014 Health Annual Statement including all NAIC Supplemental Exhibits and Schedules with the NDOI and the NAIC.	38.5	$300	$11,550.00
3. Assist in the review and response to any regulatory letter from the NDOI and/or the NAIC related to the 2014 annual statement filing.	INCLUDED		
4. Serve as the 2014 NAIC "annual statement contact person" for inquires by the NDOI and the NAIC related to the annual statement filing.	INCLUDED		
5. Provide statutory accounting and reporting support to Client as needed.	INCLUDED		
6. Provide assistance to Client's independent audit firm in preparing the 2014 Statutory Audit Report for the NDOI.	INCLUDED		
Total Contract Price – 2014 Statutory Statement Outsourcing Services	**$13,950.00**		

Schedule B – 2015 Reporting Period
Schedule of Client Services

The following table summarizes the cost of the **Statutory Statement Outsourcing Services for 2015** that Contractor will provide.

Description of Statutory Statement Outsourcing Services – 2015 Reporting Period	Hours	Hourly Rate	Extension
1. Prepare and file Client's 2015 Health Quarterly Statements including all NAIC Supplemental Exhibits and Schedules with the NDOI and the NAIC.	45.0	$300	$13,500.00
2. Prepare and file Client's 2015 Health Annual Statement including all NAIC Supplemental Exhibits and Schedules with the NDOI and the NAIC.	38.5	$300	$11,550.00
3. Assist in the review and response to any regulatory letter from the NDOI and/or the NAIC related to the 2015 annual and/or quarterly statement filings.	INCLUDED		
4. Serve as the 2015 NAIC "annual statement contact person" for inquires by the NDOI and the NAIC related to the annual and/or quarterly statement filings.	INCLUDED		
5. Provide statutory accounting and reporting support to Client as needed.	INCLUDED		
6. Provide assistance to Client's independent audit firm in preparing the 2015 Statutory Audit Report for the NDOI.	INCLUDED		
Total Contract Price – 2015 Statutory Statement Outsourcing Services	**$25,050.00**		

Schedule C
Schedule of Payment for Services

The following summarizes the schedule for payment for services that Contractor will provide to Client.

2014 Reporting Period - Annual Statement Filing		
Item	***Due Date***	***Amount***
Annual Statement & RBC Filing Software	Upon Receipt	At Cost
Contract Initialization	Contract Signing	$2,400.00
Annual Statement Filing	February 15, 2015	$5,775.00
Annual Statement Filing	March 15, 2015	$5,775.00
Total 2014 Statement Outsourcing Contract Price		**$13,950.00**

2015 Reporting Period - Annual and Quarterly Statement Filings		
Item	***Due Date***	***Amount***
Annual Statement & RBC Filing Software	Upon Receipt	At Cost
1st Quarter Filing	May 15, 2015	$4,500.00
2nd Quarter Filing	August 15, 2015	$4,500.00
3rd Quarter Filing	November 15, 2015	$4,500.00
Annual Statement Filing	January 15, 2016	$5,775.00
Annual Statement Filing	March 15, 2016	$5,775.00
Total 2015 Statement Outsourcing Contract Price		**$25,050.00**

Schedule D
Schedule of Late Fees

Client shall provide data necessary to prepare and file statutory filings as follows:

Statement Data Due Date	Price per Reporting Entity
On or before 16 business days prior to the filing due date	As Stated
On or after 15 business days prior to the filing due date	Add $500 to contract price
On or after 10 business days prior to the filing due date	Add $1,000 to contract price
On or after 5 business days prior to the filing due date	Add $2,000 to contract price
After Due Date	Add $750 to contract price

Patrick G. Byrne, Esq. (NV Bar No. 7636)
Alex L. Fugazzi, Esq. (NV Bar No. 9022)
Aleem A. Dhalla, Esq. (NV Bar No. 14188)
SNELL & WILMER L.L.P.
3883 Howard Hughes Parkway, Suite 1100
Las Vegas, Nevada 89169
Telephone: (702) 784-5200
Facsimile: (702) 784-5252
Email: pbyrne@swlaw.com
afugazzi@swlaw.com
adhalla@swlaw.com

Attorneys for Defendants Milliman, Inc., Jonathan L. Shreve, and Mary van der Heijde

EIGHTH JUDICIAL DISTRICT COURT
CLARK COUNTY, NEVADA

STATE OF NEVADA, EX REL. COMMISSIONER OF INSURANCE, BARBARA D. RICHARDSON, IN HER OFFICIAL CAPACITY AS RECEIVER FOR NEVADA HEALTH CO-OP,

Plaintiff,

vs.

MILLIMAN, INC., a Washington Corporation; JONATHAN L. SHREVE, an Individual; MARY VAN DER HEIJDE, an Individual; MILLENNIUM CONSULTING SERVICES, LLC, a North Carolina Corporation; LARSON & COMPANY P.C., a Utah Professional Corporation; DENNIS T. LARSON, an Individual; MARTHA HAYES, an Individual; INSUREMONKEY, INC., a Nevada Corporation; ALEX RIVLIN, an Individual; NEVADA HEALTH SOLUTIONS, LLC, a Nevada Limited Liability Company; PAMELA EGAN, an Individual; BASIL C. DIBSIE, an Individual; LINDA MATTOON, an Individual; TOM ZUMTOBEL, an Individual; BOBBETTE BOND, an Individual; KATHLEEN SILVER, an Individual; DOES I through X, inclusive; and ROE CORPORATIONS I-X, inclusive,

Defendants.

Case No. A-17-760558-C

Dept. No. 27

MOTION TO COMPEL ARBITRATION

Defendants Milliman, Inc., Jonathan L. Shreve, and Mary van der Heijde (collectively "Milliman" for purposes of this motion only), by and through their attorneys, Snell & Wilmer L.L.P., move the Court to compel the Commissioner of Insurance, Barbara D. Richardson, in her official capacity as Receiver for Nevada Health CO-OP ("Plaintiff" or "Commissioner") to arbitration, consistent with the mandatory dispute resolution clause in the parties' October 20, 2011 Consulting Services Agreement. This motion is based on the pleadings and papers on file, the attached memorandum of points and authorities, with its exhibits, and any oral argument this court may entertain.

DATED this 6th day of November, 2017.

SNELL & WILMER L.L.P.

By: _____

Patrick G. Byrne, Esq. (NV Bar No. 7636)
Alex L. Fugazzi, Esq. (NV Bar No. 9022)
Aleem A. Dhalla, Esq. (NV Bar No. 14188)
3883 Howard Hughes Pkwy., Suite 1100
Las Vegas, NV 89169

Attorneys for Defendants Milliman, Inc., Jonathan L. Shreve, and Mary van der Heijde

Snell & Wilmer L.L.P.
LAW OFFICES
3883 Howard Hughes Parkway, Suite 1100
Las Vegas, Nevada 89169
702.784.5200

NOTICE OF HEARING

TO: ALL PARTIES AND THEIR RESPECTIVE COUNSEL:

PLEASE TAKE NOTICE that the undersigned will bring this **MOTION TO COMPEL ARBITRATION** on for hearing in Department 27 of the above-entitled Court on the 7 day of DECEMBER, 2017 at 10:00 a.m.

DATED this 6th day of November, 2017.

SNELL & WILMER L.L.P.

By: _____

Patrick G. Byrne, Esq. (NV Bar No. 7636)
Alex L. Fugazzi, Esq. (NV Bar No. 9022)
Aleem A. Dhalla, Esq. (NV Bar No. 14188)
3883 Howard Hughes Pkwy., Suite 1100
Las Vegas, NV 89169

Attorneys for Defendants Milliman, Inc., Jonathan L. Shreve, and Mary van der Heijde

Snell & Wilmer L.L.P. LAW OFFICES 3883 Howard Hughes Parkway, Suite 1100 Las Vegas, Nevada 89169 702.784.5200

Snell & Wilmer L.L.P.
LAW OFFICES
3883 Howard Hughes Parkway, Suite 1100
Las Vegas, Nevada 89169
702.784.5200

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Plaintiff's claims against Milliman arise out of, and relate to, the actuarial work Milliman performed pursuant to Milliman's October 20, 2011 Consulting Services Agreement (the "Agreement") with Nevada Health CO-OP ("NHC").[1] That Agreement contains a broad, mandatory arbitration clause by which the parties agreed to arbitrate "any dispute arising out of or relating to the engagement of Milliman by" NHC. The Commissioner, in her Complaint, expressly relies on the Agreement to set out her allegations and claims against Milliman, and affirmatively asserts that it is "a valid and enforceable contract." (*See, e.g.,* Compl. ¶¶ 372, 380, 388). Therefore, under controlling, on-point precedent from the Nevada and U.S. Supreme Courts, Plaintiff must abide by ***all*** terms of the Agreement, including the arbitration clause. Plaintiff cannot seek to enforce provisions of the Agreement while simultaneously disavowing the arbitration clause. *Ahlers v. Ryland Homes Nevada, LLC*, 126 Nev. 688, 367 P.3d 743 (2010) (unpublished); *Allied-Bruce Terminix Cos., Inc. v. Dobson*, 513 U.S. 265, 281 (1995). Simply put, the Court should compel Plaintiff to arbitration as contractually bound and stay this action pending resolution.

II. FACTUAL BACKGROUND

A. The NHC

The Patient Protection and Affordable Care Act ("ACA") overhauled the American medical system by attempting to increase competition in the health insurance markets and increase access to healthcare to individuals previously excluded from the healthcare system. One element of that new system was the creation of Consumer Operated and Oriented Plans, or "Co-Ops," which were intended to provide an alternative to both publicly-funded and single-payer healthcare systems.

NHC is the Nevada Co-Op established under the ACA. Formed to "provide health insurance to individuals and small business," (Compl. ¶ 2), NHC experienced such financial hardship that insolvency proceedings before Department I of this Court were instituted in

[1] A copy of the Agreement is attached as **Exhibit A**.

September 2015. (*See* 9/25/15 Pet. for Appointment of Commissioner as Receiver, on file in case number A-15-7252444-C.)

B. The NHC Insolvency Proceedings

The Nevada Insurance Commissioner was appointed as NHC's Permanent Receiver and ordered to take possession of its assets, wherever located, and to administer them under court supervision. (*See* 10/14/15 Permanent Injunction and Order Appointment Commissioner as Permanent Receiver of Nevada Health Co-Op, on file in case number A-15-725244-C (the "Receivership Order" or "Order")).

The Receivership Order anticipated that the Commissioner may need to pursue claims in forums other than this Court, such as arbitration. Specifically, the Commissioner was granted the power and authority to "[c]ollect all debts and monies due and claims belonging to [NHC], ***wherever located***," and to "initiate and maintain actions at law or equity or ***any other type of action or proceeding of any nature, in this and other jurisdictions***." *Id.* § 14(a) (emphasis added). Similarly, the Receiver is authorized to "[i]nstitute and prosecute… any and all suits ***and other legal proceedings***." *Id.* §14(h) (emphasis added).

C. The Complaint Against Milliman

On August 25, 2017 the Commissioner filed the current lawsuit as part of her efforts to obtain assets for the benefit of the estate. (*See* 10/14/15 Permanent Injunction Order Appointing Commissioner as Permanent Receiver of Nevada Health Co-Op, Case No. A-15-725244-C). While maintaining this suit, the Commissioner is also litigating in federal court against the U.S. Department of Health and Human Services, asking the court there for declaratory relief against the federal government. Unsurprisingly, the Commissioner's strategy is to avoid financial obligations it owes others, while simultaneously seeking money from defendants like Milliman to pay obligations it owes and cannot avoid.

Milliman is one of five professional service providers named in the instant case. In asserting the Milliman claims, the Commissioner liberally references the Agreement between NHC and Milliman and even identifies it as the basis for NHC's relationship with the company. (*See* Compl. ¶¶ 42, 45–56). Each of the 14 causes of actions brought against the company arise

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out of NHC's engagement of Milliman to provide actuarial services to NHC. (*See, e.g.*, Compl. ¶ 333 ("[t]he Milliman Defendants were engaged by NHC…to provide professional actuarial services to NHC")). Based in varied tort and contract theories, several of Plaintiff's claims rely upon specific provisions and obligations purportedly owed to NHC by virtue of the relationship and Agreement. For instance, Plaintiff's ninth cause of action for "Tortious Breach of the Implied Covenant" alleges that the parties "entered into a valid and enforceable contract - the Consulting Services Agreement - that required Milliman to perform professional actuarial services…[and] Milliman owed a duty of good faith to Plaintiff arising from the contract." (Compl. ¶¶ 380–82.) Similarly, in the second cause of action for "Professional Malpractice" Plaintiff states that "[t]he Milliman Defendants were engaged by NHC…to provide professional actuarial services" including certifications, feasibility studies, financial reporting, but that Milliman allegedly breached its professional actuarial duties to NHC. (Compl. ¶¶ 333–36; *see also*, Compl. ¶ 48 (stating the Agreement "provides that 'Milliman will perform all services in accordance with applicable professional standards.'"). In yet another example, Plaintiff's eighth cause of action, titled "Breach of Contract," alleges that Milliman "failed to perform under the Consulting Services Agreement." (Compl. ¶ 375).

While the Commissioner's complaint is over 95 pages in length and references various contractual obligations between NHC and Milliman, it is silent on the binding arbitration clause contained in the Agreement governing that same relationship.

D. NHC's Agreement With Milliman and its Mandatory Arbitration Provision

The initial actuarial consulting agreement dated October 20, 2011 was originally entered into by Milliman and Culinary Health Fund. *See* Agreement, Ex. A.[2] The Culinary Health Fund later created Hospitality Health, Ltd. and "assigned and transferred all rights, title, and interest" in the Agreement to Hospitality Health, Ltd. (Compl. ¶ 45). Then, NHC was formed in October

[2] A letter from Milliman to the Culinary Health Fund dated the same day and referenced in the Agreement explains the scope of Milliman's contractual relationship with the Culinary Health Fund, which included participating in creating portions of the feasibility study and business plan for Plaintiff's application to the federal government for start-up and solvency loans. *See* October 20, 2011 Letter, attached as **Exhibit B**.

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2012, and all assets and agreements of Hospitality Health, including the Agreement, were subsequently assigned to NHC. (Compl. ¶ 49).

As alleged in the complaint, the Commissioner, as Receiver for NHC, "was assigned all rights benefits and interests in the Consulting Services Agreement" (Compl. ¶ 374) and "brought this action on behalf of NHC." (Compl. ¶ 1). The Agreement contains a mandatory arbitration clause that provides:

> **5. Disputes.** In the event of ***any dispute*** arising out of or relating to the engagement of Milliman by Company, the parties agree that the dispute will be resolved ***by final and binding arbitration*** under the Commercial Arbitration Rules of the American Arbitration Association. The arbitration shall take place before a panel of three arbitrators. Within 30 days of the commencement of the arbitration, each party shall designate in writing a single neutral and independent arbitrator. The two arbitrators designated by the parties shall then select a third arbitrator. The arbitrators shall have a background in either insurance, actuarial science or law. The arbitrators shall have the authority to permit limited discovery, including depositions, prior to the arbitration hearing, and such discovery shall be conducted consistent with the Federal Rules of Civil Procedure. The arbitrators shall have no power or authority to award punitive or exemplary damages. The arbitrators may, in their discretion, award the cost of the arbitration, including reasonable attorney fees, to the prevailing party. Any award made may be confirmed in any court having jurisdiction. Any arbitration shall be confidential, and except as required by law, neither party may disclose the content or results of any arbitration hereunder without the prior written consent of the other parties, except that disclosure is permitted to a party's auditors and legal advisors.

Agreement ¶ 5, Ex. A (emphasis added). This binding provision is prominently featured as part of the main body of the contract. The clause is located in the middle of the contract, and is not buried or otherwise difficult to locate. The entire contract is short, taking up only two pages, uses the same size font throughout, and is written in similarly plain language. *Id.* -The Agreement was fully executed by Mary van der Heijde of Milliman and Bobbette Bond of Culinary Health Fund. *Id.* Both are sophisticated parties, with experience in their respective fields, and with access to counsel.

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III. ANALYSIS

A. The Nevada Uniform Arbitration Act and the Federal Arbitration Act Require Arbitration of Plaintiff's Claims against Milliman, and the Limited Exception in Those Statutes Does Not Apply

Both the Nevada Arbitration Act ("NAA"), NRS 38.206, *et seq.*, and the Federal Arbitration Act ("FAA"), 9 U.S.C. § 1, *et seq.*, contain virtually identical language mandating that contractual arbitration clauses are fully "valid, irrevocable, and enforceable, save upon which grounds as exist at law or in equity for the revocation of any contract."

The NAA states:

> An agreement contained in a record to submit to arbitration any existing or subsequent controversy arising between the parties to the agreement is valid, enforceable and irrevocable except as otherwise provided in NRS 597.995 or ***upon a ground that exists at law or in equity for the revocation of a contract.***

NRS 38.219(1) (emphasis added).[3]

Section 2 of the FAA similarly states:

> A written provision in… a contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction… shall be valid, irrevocable, and enforceable, save ***upon such grounds as exist in law or equity for the revocation of any contract.***

As the Nevada Supreme Court has stated, both the NAA and FAA express a "fundamental policy favoring the enforceability of arbitration agreements." *Tallman v. Eighth Jud. Dist. Ct.*, 131 Nev. Adv. Op. 71, 359 P.3d 113, 118 (2015); *see also State ex rel. Masto v. Second Judicial Dist. Court ex rel. Cty. of Washoe*, 125 Nev. 37, 44, 199 P.3d 828, 832 (2009) ("As a matter of public policy, Nevada courts encourage arbitration and liberally construe arbitration clauses in favor of granting arbitration.").[4]

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[3] The reference to NRS 597.995 was added to the statute in 2013, and applies "only to agreements entered into or renewed on or after October 1, 2013." *See* Assembly Bill 326 (2013). That clause therefore does not apply to the 2011 Agreement at issue here.

[4] The Agreement contains a choice of law provision, where the parties agreed that interpretation and enforcement of the Agreement would be governed by the substantive contract law of the State of New York. Agreement § 5, Ex. A. The enforcement of the arbitration provision is a procedural matter and should be governed by Nevada law. *Erie R. Co. v. Tompkins*, 304 U.S. 64, 77–78 (1938); *Tipton v. Heeren*, 109 Nev. 920, 922 & n.3 (1993) (noting that Nevada law governs procedural questions regardless of choice of law provisions). To the extent the Court chooses to apply New York law, New York similarly supports liberal enforcement of arbitration agreements. N.Y. ARBITRATION § 7503

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Where, as here, a contractual arbitration clause is broadly worded, absent an express clause excluding a particular grievance from arbitration, Nevada courts must resolve any questions regarding the arbitrability of a dispute in favor of arbitration. *Int'l Ass'n of Firefighters, Local No. 1285 v. City of Las Vegas*, 112 Nev. 1319, 1324 (1996). "Any doubts concerning the scope of arbitrable issues should be resolved in favor of arbitration." *Id.*; *see also Simula, Inc. v. Autoliv, Inc.*, 175 F.3d 716, 721 (9th Cir. 1999). In evaluating the enforceability of an arbitration clause, the court's role is "limited to determining (1) whether a valid agreement to arbitrate exists and, if it does, (2) whether the agreement encompasses the dispute at issue." *Chiron Corp. v. Ortho Diagnostic Sys., Inc.*, 207 F.3d 1126, 1130 (9th Cir. 2000). Here, (1) a binding arbitration clause is contained in the Agreement, which contract Plaintiff concedes is valid and binding, and (2) the dispute between the parties unquestionably arises from and relates to NHC's engagement of Milliman, and therefore the arbitration clause encompasses Plaintiff's causes of action against Milliman. As a result, the arbitration clause is enforceable, and Plaintiff must arbitrate its claims.[5]

Critically, the exception in the NAA and FAA for "grounds as exist at law or in equity for the revocation of any contract" does not apply here. The U.S. Supreme Court has defined that phrase to mean that only "generally applicable contract defenses, such as fraud, duress, or unconscionability, may be applied to invalidate arbitration agreements without contravening § 2" of the FAA. *Doctor's Assocs. v. Casarotto*, 517 U.S. 681, 687 (1996); *Bradley v. Harris Research, Inc.*, 275 F.3d 884, 892 (9th Cir. 2001). Here, the Commissioner is suing to ***enforce*** the Agreement, not to revoke it. At no point anywhere in the extensive complaint, does the

(McKinney); *Smith Barney Shearson Inc. v. Sacharow*, 91 N.Y.2d 39, 48 (1997) (holding New York courts have long recognized strong public policy, similar to the Federal Arbitration Act, for liberal enforcement of arbitration agreements).

[5] Nevada's public policy in favor of arbitration is consistent with the U.S. Supreme Court precedent that has expressly prohibited states from enacting any statute or "policy" that is "directly contrary to the [FAA's] language and Congress' intent" to favor arbitration. *Allied-Bruce Terminix Cos., Inc. v. Dobson*, 513 U.S. 265, 281 (1995) ("The Act makes any such state policy unlawful, for that kind of policy would place arbitration clauses on an unequal "footing," directly contrary to the Act's language and Congress' intent." (citation omitted)); *see also Southland Corp. v. Keating*, 465 U.S. 1, 10 (1984) ("In enacting §2 of the federal Act, Congress declared a national policy favoring arbitration ***and withdrew the power of the states to require a judicial forum for the resolution of claims which the contracting parties agreed to resolve by arbitration***.") (emphasis added).

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Las Vegas, Nevada 89169
702.784.5200

Receiver lay out any grounds to revoke either the Agreement as a whole, or any specific provisions. Nor does she plead for the revocation of the Agreement.

B. The Fact That the Commissioner Is the Plaintiff Does Not Preclude Enforcement of the Mandatory Arbitration Clause.

Since Milliman has established the existence of a valid arbitration agreement, it is the Commissioner's burden to establish a defense to enforcement. *Gonski v. Second Judicial Dist. Court of State ex rel. Washoe*, 126 Nev. 551, 245 P.3d 1164, 1168-69 (2010). Milliman anticipates that the Commissioner may argue that her status as Receiver allows her to avoid the binding arbitration requirement of the contract she seeks to enforce. That argument is wrong for the following reasons.

First, the Commissioner, as Receiver for NHC, is bound by the Agreement, including the arbitration clause. A receiver steps into the shoes of its predecessor. *See O'Melveny & Myers v. F.D.I.C.*, 512 U.S. 79, 82 (1994); *Anes v. Crown P'ship, Inc.*, 113 Nev. 195, 199 (1997) (citing 66 Am. Jur. 2d *Receivers* § 223 (1973)); *see also First Fin. Bank v. Lane*, 130 Nev. Adv. Op. 96, 339 P.3d 1289, 1290, 1293 (2014) (noting the Federal Deposit Insurance Corporation gained the rights of an assignee when it was appointed receiver and that the assignee steps into the shoes of the assignor). Because a receiver steps into the shoes of the represented entity, the receiver has no rights separate from the represented entity. 65 Am. Jur. 2d *Receivers* § 116; *see also Wuliger v. Manufacturers Life Ins. Co.*, 567 F.3d 787 (6th Cir. 2009). The insurance commissioner is a public official acting on behalf of the state when dealing with insolvent insurers in general, but once appointed conservator of a particular insolvent insurer, the commissioner steps into the shoes of that insurer. *Texas Commerce Bank v. Garamendi*, 28 Cal. App. 4th 1234, 1245 (1994).

That the Receiver is herself a non-signatory to the Agreement is irrelevant. Plaintiff, as Receiver for NHC, "was assigned all rights benefits and interests in the Consulting Services Agreement by Hospitality Health." (Compl. ¶¶ 1, 374). She concedes that the Agreement is "valid and enforceable." (Compl. ¶¶ 372, 380, 388). Thus, just as NHC would have been obligated to arbitrate its claims relating to the work Milliman performed pursuant to the Agreement, the Commissioner is similarly bound.

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Moreover, non-signatories of arbitration agreements can be bound by the agreement under ordinary contract and agency principles, including assumption and estoppel. *Ahlers v. Ryland Homes Nevada, LLC*, 126 Nev. 688, 367 P.3d 743 (2010) (reversing and remanding to district court to enter an order granting motion to compel arbitration); *Bridge v. Credit One Fin.*, 2016 WL 1298712, *2 (D. Nev. Mar. 31, 2016); *Hernandez v. Allied Interstate, Inc.*, 2013 WL 12123682, *4 (C.D. Cal. Aug. 27, 2013).

Courts around the country routinely hold that Insurance Commissioners acting as liquidators, receivers, or rehabilitators are bound by arbitration provisions in the contracts they assume and seek to enforce. For example, in *Bennett v. Liberty Nat. Fire Ins. Co.*, 968 F.2d 969, 972–73 (9th Cir. 1992), the Ninth Circuit enforced an arbitration clause where the dispute "is in essence a contractual one," even though "Montana has conferred on the liquidator broad jurisdiction over insurance insolvency proceedings and complete control and authority over the insolvent's assets." *See also Rich v. Cantilo & Bennett*, 492 S.W.3d 755, 762 (Tex. Ct. App. 2016) ("However, for the actions accruing independently of the Receiver's appointment and arising under the legal services agreement—in this case, the common-law claims asserting breach of fiduciary duty, conspiracy, and negligence—the Receiver, standing in the shoes of Santa Fe, is bound by the arbitration agreement to the same extent that Santa Fe is bound."), *reh'g denied* (Apr. 5, 2016), *review denied* (July 22, 2016); *Koken v. Cologne Reinsurance (Barbados), Ltd.*, 34 F. Supp. 2d 240, 256 (M.D. Pa. 1999); *Foster v. Philadelphia Mfrs.*, 592 A.2d 131(Pa. Cmwlth. 1991).

Second, the Receiver cannot pick and choose certain provisions of the Agreement to abide, and certain other ones to ignore. It is indisputable that the Receiver's claims arise from and relate to the work Milliman performed pursuant to the Agreement, and that the Receiver is suing to enforce the Agreement. The Nevada Supreme Court has expressly held that where a party "is seeking to enforce rights under [an] agreement, it cannot simultaneously avoid other portions of the agreement, such as the arbitration provision." *Ahlers v. Ryland Homes*, 126 Nev. 688 at *2. Otherwise, "to allow [a plaintiff] to claim the benefit of the contract and simultaneously avoid its burdens would both disregard equity and contravene the purposes

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underlying enactment of the Arbitration Act." *Id.*; *see also FDIC v. Ernst & Young, LLP*, 374 F.3d 579, 584 (7th Cir. 2004), (FDIC, as Receiver, could not "cherry pick" contract to avoid arbitration clause).

Third, there is no statutory provision that requires the Receiver to litigate contract and tort claims against a third-party in any particular forum or jurisdiction. Moreover, section 14(a) of the Receivership Order expressly provides that the Receiver has power to "initiate and maintain actions at law or equity ***or any other type of action or proceeding of any nature***, ***in this and other jurisdictions***." Likewise section 14(h) states that the Receiver can "[i]nstitute and prosecute… any and all suits ***and other legal proceedings***." (emphasis added). This Court's Order ***supports*** Milliman's right to arbitrate here.

While the Receiver may argue that the Receivership Order grants this Court exclusive jurisdiction "over any claims or rights respecting the Property… exclusive jurisdiction being hereby found to be essential to the safety of the public and of the claimants against the CO-OP," (*id.* § 3), that portion of the Order does not apply here, where the Receiver's claims do not affect the administration, allocation, or ownership of NHC's property or assets, and Milliman is bringing no claims "***against***" NHC. On the contrary, Plaintiff seeks to recover monetary damages from Milliman—not the recovery of NHC's property or assets—as contract and consequential damages. In all events, extending this Court's "exclusive jurisdiction" to cover the contract and tort claims against Milliman would contravene the several other express provisions of the Receivership Order that plainly allow the Receiver to litigate in this forum or "any other type of action or proceeding."

It is instructive that federal courts in the bankruptcy context routinely distinguish preference claims and other "core" insolvency matters which must proceed in the bankruptcy court, as distinct from basic contract and tort actions, in deciding to enforce arbitration agreements. It is well settled that if the proceeding involves claims like those the Commissioner

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brings against Milliman, which arise from a debtor's pre-petition common law and contract rights, and in which there is no substantive right created by bankruptcy law at issue, bankruptcy courts have ***no discretion to deny arbitration***. *See, e.g.*, *Gandy v. Gandy* (*In re Gandy)*, 299 F.3d 489, 495 (5th Cir. 2002) (stating that courts have "no discretion to refuse to compel arbitration of matters not involving 'core' bankruptcy proceedings"); *Microbilt Corp. v. Chex Sys. (In re Microbilt Corp.)*, 588 Fed. Appx. 179 (3d Cir. 2014); *Crysen/Montenay Energy Co. v. Shell Oil Co. (In re Crysen/Montenay Energy Co.*), 226 F3.d 160 (2d Cir. 2000); *Hays & Co. v. Merrill Lynch Pierce Fenner & Smith, Inc.,* 885 F.2d 1149 (3d Cir. 1989).

C. <u>The AAA Is an Adequate Forum To Adjudicate all of Plaintiff's Claims against Milliman</u>

Plaintiff's claims are arbitrable under the Agreement. Pre-dispute agreements to arbitrate must be enforced if the party may effectively vindicate those rights in the arbitral forum. *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614, 637 (1985). Here, the Agreement's arbitration clause specifies the details of the arbitration proceeding and provides for a fair and adequate forum to resolve this dispute. The arbitration clause specifies that arbitration will take place under the Commercial Arbitration Rules of the American Arbitration Association before three neutral arbitrators. Agreement ¶ 5, Ex. A. Each party will choose one neutral and independent arbitrator, each of whom will select a third. *Id.* Discovery is guided by the Federal Rules of Civil Procedure and the arbitrators have the power to award attorneys' fees and costs to the prevailing party. *Id.* The arbitration award may be confirmed in any court with jurisdiction. *Id.* Because the Agreement properly allows Plaintiff to pursue, and Milliman to defend, all claims in AAA arbitration, the forum is adequate.

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IV. CONCLUSION

Plaintiff must pursue her alleged claims against Milliman in arbitration. Nevada and federal law favor arbitration as an expedient and cost-effective method of resolving disputes, so much so that questions of arbitrability are resolved in favor of arbitration. Plaintiff and Milliman here agreed to a simple and concise Agreement that requires AAA arbitration of any dispute arising out of related to the Agreement. Plaintiff's claims against Milliman are based on the Agreement, as evidenced by the numerous times Plaintiff references it in her complaint, as well as her breach of contract claim regarding the Agreement. In sum, this Court should compel Plaintiff to arbitration and to stay this action pending resolution.

DATED this 6th day of November, 2017.

SNELL & WILMER L.L.P.

By: _____

Patrick G. Byrne, Esq. (NV Bar No. 7636)
Alex L. Fugazzi, Esq. (NV Bar No. 9022)
Aleem A. Dhalla, Esq. (NV Bar No. 14188)
3883 Howard Hughes Pkwy., Suite 1100
Las Vegas, NV 89169

Attorneys for Defendants Milliman, Inc., Jonathan L. Shreve, and Mary van der Heijde

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Las Vegas, Nevada 89169
702.784.5200

CERTIFICATE OF SERVICE

I am a resident of the State of Nevada, over the age of eighteen years, and not a party to the within action. My business address is 3883 Howard Hughes Parkway, Suite 1100, Las Vegas, Nevada 89169. On the below date, I served the above **MOTION TO COMPEL ARBITRATION** as follows:

☐	**BY FAX:** by transmitting via facsimile the document(s) listed above to the fax number(s) set forth below on this date before 5:00 p.m. pursuant to EDCR Rule 7.26(a). A printed transmission record is attached to the file copy of this document(s).
☐	**BY HAND:** by personally delivering the document(s) listed above to the person(s) at the address(es) set forth below.
☐	**BY MAIL:** by placing the document(s) listed above in a sealed envelope with postage thereon fully prepaid, in the United States mail at Las Vegas, Nevada addressed as set forth below.
☐	**BY E-MAIL:** by transmitting via e-mail the document(s) listed above to the e-mail address(es) set forth below.
☐	**BY OVERNIGHT MAIL:** by causing document(s) to be picked up by an overnight delivery service company for delivery to the addressee(s) on the next business day.
☐	**BY PERSONAL DELIVERY:** by causing personal delivery by _____, a messenger service with which this firm maintains an account, of the document(s) listed above to the person(s) at the address(es) set forth below.
X	**BY ELECTRONIC SUBMISSION:** submitted to the above-entitled Court for electronic filing and service upon the Court's Service List for the above-referenced case.

Mark E. Ferrario, Esq. Eric W. Swanis, Esq. Donald L. Prunty, Esq. GREENBERG TRAURIG, LLP 3773 Howard Hughes Parkway, Suite 400 N Las Vegas, NV 89169 *Attorneys for Plaintiff*	Samuel A. Schwartz, Esq. Frank M. Flansburg, III, Esq. SCHWARTZ FLANSBURG PLLC 6623 S. Las Vegas Blvd., Suite 300 Las Vegas, NV 89119 *Attorneys for Defendants InsureMonkey, Inc. and Alex Rivlin*
Joseph P. Garin, Esq. Angela T. Nakamura Ochoa, Esq. LIPSON, NEILSON, COLE, SELTZER & GARIN, P.C. 9900 Covington Cross Drive, Suite 120 Las Vegas, NV 89144 *Attorneys for Defendants Kathleen Silver, Bobbette Bond, Tom Zumtobel, Pam Egan, Basil Dibsie, and Linda Mattoon*	Lori E. Siderman, Esq. Russell B. Brown, Esq. MEYERS McCONNELL REISZ SIDERMAN 1745 Village Center Circle Las Vegas, Nevada 89134 *Attorneys for Defendants Martha Hayes, Dennis T. Larson, and Larson & Company P.C.*

Snell & Wilmer L.L.P. LAW OFFICES 3883 Howard Hughes Parkway, Suite 1100 Las Vegas, Nevada 89169 702.784.5200

John E. Bragonje Jennifer K. Hostetler LEWIS ROCA ROTHGERBER CHRISTIE LLP *Attorneys for Defendant Millennium Consulting Services, LLC*	Evan L. James, Esq. CHRISTENSEN JAMES & MARTIN 7440 W. Sahara Avenue Las Vegas, Nevada 89117 *Attorneys for Nevada Health Solutions, LLC*

DATED: November 6, 2017.

/s/ Gaylene Kim
An Employee of Snell & Wilmer L.L.P.

4838-1972-9492.1

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Las Vegas, Nevada 89169
702.784.5200

EXHIBIT A

EXHIBIT A

Milliman

Consulting Services Agreement

This Agreement is entered into between Milliman, Inc. (Milliman) and the **Culinary Health Fund** (Company) as of **October 20, 2011**. Company has engaged Milliman to perform consulting services as described in the letter dated **October 20, 2011** and attached hereto. Such services may be modified from time to time and may also include other general actuarial consulting services. These terms and conditions will apply to all subsequent engagements of Milliman by Company unless specifically disclaimed in writing by both parties prior to the beginning of the engagement. In consideration for Milliman agreeing to perform these services, Company agrees as follows.

1. Billing Terms Initial 6 Months. Company acknowledges the obligation to pay Milliman for services rendered, whether arising from Company's request or otherwise necessary as a result of this engagement, at Milliman's fixed fee arrangement for the personnel utilized plus all out-of-pocket expenses incurred. Milliman understands that the initial funding may not be immediately available but expects prompt payment once they become available. In the event that the health cooperative is dissolved and does not receive funds to become a going concern, Milliman will not pursue payment from individuals associated with the dissolved health cooperative for the work done for feasibility studies and business plans.

2. Billing Terms After 6 Months. Company acknowledges the obligation to pay Milliman for services rendered, whether arising from Company's request or otherwise necessary as a result of this engagement, at Milliman's normal billing rate for the personnel utilized plus all out-of-pocket expenses incurred. Milliman will bill Company periodically for services rendered and expenses incurred. All invoices are payable upon receipt. Milliman reserves the right to stop all work if any bill goes unpaid for 60 days. In the event of such termination, Milliman shall be entitled to collect the outstanding balance, as well as charges for all services and expenses incurred up to the date of termination.

3. Tool Development. Milliman shall retain all rights, title and interest (including, without limitation, all copyrights, patents, service marks, trademarks, trade secret and other intellectual property rights) in and to all technical or internal designs, methods, ideas, concepts, know-how, techniques, generic documents and templates that have been previously developed by Milliman or developed during the course of the provision of the Services provided such generic documents or templates do not contain any Company Confidential Information or proprietary data. Rights and ownership by Milliman of original technical designs, methods, ideas, concepts, know-how, and techniques shall not extend to or include all or any part of Company's proprietary data or Company Confidential Information. To the extent that Milliman may include in the materials any pre-existing Milliman proprietary information or other protected Milliman materials, Milliman agrees that Company shall be deemed to have a fully paid up license to make copies of the Milliman owned materials as part of this engagement for its internal business purposes and provided that such materials cannot be modified or distributed outside the Company without the written permission of Milliman or except as otherwise permitted hereunder.

4. Limitation of Liability. Milliman will perform all services in accordance with applicable professional standards. The parties agree that Milliman, its officers, directors, agents and employees, shall not be liable to Company, under any theory of law including negligence, tort, breach of contract or otherwise, for any damages in excess of three (3) times the professional fees paid to Milliman with respect to the work in question. In no event shall Milliman be liable for lost profits of Company or any other type of incidental or consequential damages. The foregoing limitations shall not apply in the event of the intentional fraud or willful misconduct of Milliman.

5. Disputes. In the event of any dispute arising out of or relating to the engagement of Milliman by Company, the parties agree that the dispute will be resolved by final and binding arbitration under the

Milliman

Commercial Arbitration Rules of the American Arbitration Association. The arbitration shall take place before a panel of three arbitrators. Within 30 days of the commencement of the arbitration, each party shall designate in writing a single neutral and independent arbitrator. The two arbitrators designated by the parties shall then select a third arbitrator. The arbitrators shall have a background in either insurance, actuarial science or law. The arbitrators shall have the authority to permit limited discovery, including depositions, prior to the arbitration hearing, and such discovery shall be conducted consistent with the Federal Rules of Civil Procedure. The arbitrators shall have no power or authority to award punitive or exemplary damages. The arbitrators may, in their discretion, award the cost of the arbitration, including reasonable attorney fees, to the prevailing party. Any award made may be confirmed in any court having jurisdiction. Any arbitration shall be confidential, and except as required by law, neither party may disclose the content or results of any arbitration hereunder without the prior written consent of the other parties, except that disclosure is permitted to a party's auditors and legal advisors.

6. Choice of Law. The construction, interpretation, and enforcement of this Agreement shall be governed by the substantive contract law of the State of New York without regard to its conflict of laws provisions. In the event any provision of this agreement is unenforceable as a matter of law, the remaining provisions will stay in full force and effect.

7. No Third Party Distribution. Milliman's work is prepared solely for the internal business use of Company. Milliman's work may not be provided to third parties without Milliman's prior written consent. Milliman does not intend to benefit any third party recipient of its work product, even if Milliman consents to the release of its work product to such third party.

8. Confidentiality. Any information received from Company will be considered "Confidential Information." However, information received from Company will not be considered Confidential Information if (a) the information is or comes to be generally available to the public through no fault of Milliman, (b) the information was independently developed by Milliman without resort to information from the Company, or (c) Milliman appropriately receives the information from another source who is not under an obligation of confidentiality to Company. Milliman agrees that Confidential Information shall not be disclosed to any third party.

9. Use of Milliman's Name. Company agrees that it shall not use Milliman's name, trademarks or service marks, or refer to Milliman directly or indirectly in any media release, public announcement or public disclosure, including in any promotional or marketing materials, customer lists, referral lists, websites or business presentations without Milliman's prior written consent for each such use or release, which consent shall be given in Milliman's sole discretion.

Milliman, Inc.

By: Mary van der Heyde 11/7/11
Signature and Date

Mary van der Heyde, Principal & Consulting Actuary
Print Name and Title

Culinary Health Fund

By: Bobbette Bond
Signature and Date

Bobbette Bond
Print Name and Title

EXHIBIT B

EXHIBIT B

Milliman

1400 Wewatta Street
Suite 300
Denver, CO 80202
USA

Tel +1 303 299 9400
Fax +1 303 299 9018

milliman.com

October 20, 2011

Bobbette Bond
Director of Public Policy
Culinary Health Fund
1901 Las Vegas Boulevard South
Las Vegas, NV 89104

Re: Proposal to Provide Actuarial Services in Support of CO-OP Funding Application

Dear Bobbette:

Thank you for the opportunity to present this proposal in response to your need for actuarial services in support of the CO-OP application. This letter provides some background information about Milliman in general as well as Denver practice and outlines potential proposed services given the Funding Opportunity Announcement (FOA), Funding Opportunity Number: OOCOO-11-001, CFDA: 93.545, from U.S. Department of Health and Human Services released on July 28, 2011.

Milliman is uniquely positioned to provide these studies and work with the Culinary Health Fund for a number of important reasons:

- Milliman is one of the nation's largest consulting firms with an extensive professional staff. With over 2,500 employees working from over 50 offices (30 in the United States), we have enough geographic dispersion to provide local consultants who are equipped with sophisticated resources that only a large firm can provide.

- Milliman has significant experience and expertise with developing feasibility studies that are submitted to regulators including:
    - State Department of Insurance (DOI) pro formas financial statement for organizations attempting to become licensed insurance companies.
    - Medicare Part D prescription drug plan (PDP) sponsors seeking to become risk bearing entities including assistance with all necessary exhibits for CMS.
    - Medicare Advantage feasibility studies for start-up organizations including pro forma financial statements and assistance with the DOI application.
    - Expansion of business filings for existing insurance companies that want to offer new product lines or expand geographically into new areas.

  The common elements in these projects are clients who are starting a new organization or who plan on offering new products, the need for both technical projections and innovative business solutions, and strong collaboration with senior leaders of the organizations with whom we are working.

- Milliman has extensive knowledge and experience in health care reform and the development of state health exchanges. We are working with several states to help them determine the structure

of their exchange. Our risk adjuster (Milliman Advanced Risk Adjusters – MARA) is used by the Massachusetts Health Connector and is a likely candidate for state health exchanges.

- Milliman's technical resources are highly regarded and used by the actuaries at most health insurers in the United States. Our *Health Cost Guidelines* are a comprehensive data set of medical, pharmacy and dental claim costs for commercial and senior segment insurance. In addition, the guidelines have rating models and other resources that are essential for projecting claims costs. For a new entity with no claims experience with which to create premiums, this tool provides the needed basis for rate development.

- Milliman developed the Healthcare Reform Financing Model (HCRFM) to assess, quantify, and understand the potential impact of specific health care reform proposals. The HCRFM projects the potential costs and movements of individuals and the interaction between competing medical cost payers and providers within and between the various insurance markets that comprise the health care system. This model can be used to study and project the potential covered population for a new CO-OP. The Milliman Denver practice conducted the research and development of the population take up rates associated with an introduction of new health plan option in the market as a result of healthcare reform.

- Milliman is an independent firm and is wholly owned by the firm's principals.

- Milliman has a diverse staff of professionals with extensive experience as actuaries, clinicians (physicians, pharmacists, nurses, etc.), underwriters, benefit consultants, information technology specialists, contracting experts, and many other areas.

Milliman Denver health practice has been actively involved in the CO-OP and healthcare reform implementation support for other clients. We have included the biographies of the key members of our staff here in Denver in Appendix C to provide you with a better sense of the breadth of our expertise and experience in the healthcare market. Other Milliman consultants from those offices who are participating in CO-OP work will be involved in our feasibility work as well.

We are currently performing several actuarial feasibility studies for CO-OP applicants from other states applying for the October 17th application submission, and hence already have an established process in place to complete this type of work.

Statement of Situation

The Culinary Health Fund is a multi-employer Taft-Hartley fund, established in 1981 governed by a board of trustees. It is funded by collective bargaining agreements that are negotiated by unions and funded by employers. The mission of the Culinary Health Fund is to create and maintain a delivery system of health benefits that are affordable to participants and cost-effective for employers. To achieve this, the Culinary Health Fund works actively with its network of healthcare providers and facilities.

The Culinary Health Fund made a decision to form a CO-OP as defined under Patient Protection and Affordable Care Act (PPACA). The vision of the CO-OP is to enhance access to coverage for its current membership, but also to make the plan attractive for new members. The geographic focus of this CO-OP

consists of the whole state of Nevada, with consideration of the best strategy for developing the CO-OP needs regionally in New Jersey, New York, California, and the Chicago areas.

The Culinary Health Fund has existing provider relationships in Nevada, Chicago and Atlantic City. They have attempted to have conversations with the Nevada Department of Insurance, but has received little support or interest from the department. Conversations with HHS have been encouraging, however. The fund currently employs two actuaries, one of which is a former developer of an HMO in Nevada and has been through the Nevada DOI licensing process in the past.

Scope

The attached Appendices A and B provide an outline of the feasibility study and analytic elements of the business plan that we would conduct in support of an application for joint Start-up and Solvency Loans for the Consumer Operated and Oriented Plan [CO-OP] Program.

The feasibility study and the business plan must fit together and elements from one are required in the other. For example, the business plan will provide details on proposed provider arrangements and the expected cost associated with the proposed provider arrangements is a component of the total administrative cost which will be needed in the financial projections contained in the feasibility study.

We understand that the scope of work needed to support a new CO-OP may vary from the one presented in the Appendices A and B and we will be happy to finalize it in further discussions with the CO-OP. To the extent the scope is reduced, so will be our fees, subject to the maximum not-to-exceed amount specified in the "Timing and Budget" section of the proposal.

Our planned approach to highlighting the questions and issues for weekly discussion and ongoing analysis is to develop an early version of the proforma, and continually update/revise this proforma into which all of the analytical elements of the application will feed. We believe this will be an effective way to keep track of the elements required to complete the application, many of which inform each other and therefore need to be developed in an environment of iterative review and collaboration. Our proposed project plan includes the following:

1) We will begin with a kick-off meeting/call between Milliman and the Culinary Health Fund to gain a more in depth understanding of how the health CO-OP plans on operating. This will include the health CO-OP's vision for how they will serve the insurance needs of their target population as well as any details regarding its structure and operations that it has established. Specifically, Milliman and the Culinary Health Fund will discuss and finalize how the CO-OP may operate in several states and specifics of the roll-out.

2) Our lead consultants will help the Culinary Health Fund leadership think through issues that may be currently unresolved that need to be included in the feasibility study or the business plan. In some cases this may result in additional work that is beyond the initial scope of services (e.g., assistance with selecting a claims processor) and Milliman may provide a separate engagement letter if requested. Sometimes resolution of the issue can be put aside for the time being and a reasonable assumption made in order to be able to move forward with completing the feasibility study or the business plan.

3) We will conduct the analyses necessary to assess the feasibility of the health CO-OP competing in the state exchange for membership and the potential for long term viability. Our deliverables will include a proforma and tables of results accompanied by a write up of our methods, assumptions, and observations regarding areas that are critical for success. This material may be incorporated into the health CO-OP's submission to CMS for federal loans (if the outlook is favorable). We will discuss our findings with the Culinary Health Fund leadership throughout the process.

4) Milliman will review the fully assembled application once the Culinary Health Fund has it drafted, providing editing and feedback.

We envision this engagement as a strategic partnership between Milliman and Culinary Health Fund in order to assess the viability of the CO-OP and prepare materials needed as part of the application submission process. We will answer questions related to the development of a business plan and will coordinate the exchange of necessary elements between the business plan and the feasibility study.

Timing and Budget

We recognize that we are working in a very fluid environment and are agile enough to quickly deploy appropriate resources to meet aggressive timeframes. We are prepared to begin as soon as possible in order to meet the December 31st application submission deadline.

We are coordinating the efforts of the various Milliman consulting teams that will be working on these projects and are able to reflect that efficiency in our proposed rate structure. The estimated discounted professional fees associated with analytics in support of the CO-OP applications as described in this proposal will not exceed $65,000, with $20,000 paid upon delivery of our report. We understand that our ability to collect payment for a portion of our work might be contingent upon the successful application for CO-OP start up funding. Any follow-up analyses would be estimated and billed separately.

Milliman is potentially willing to discount our fees for our work in this phase of a CO-OP's development. We do this understanding that many have little or no initial funding prior to a successful application to HHS for funds and that an ongoing consulting relationship with the successful applicant is our ultimate reward.

We understand that this work must be completed in order to meet the December 31st application submission deadline, and anticipate delivering our results by December 15th.

Milliman bills on a time and expense basis for consulting services. We bill according to the resources required for a given project. Each consultant and each member of the staff has an hourly billing rate. Time spent on a particular client project is recorded to the nearest quarter of an hour, and the client billed accordingly. We bill ongoing clients monthly for the work completed in the preceding month. Charges are due upon receipt.

Staffing

Milliman has put together a comprehensive team of subject matter experts to provide services to the State for this effort including a project manager, principal-in-charge, and project leaders.

Each of the major deliverables will have a Project Leader who will head up the team of consultants responsible for leading the work effort for that particular work stream. Those project leaders are critical to the success of this project, as they have many years of experience across the spectrum of the entire health insurance market (i.e., commercial, Medicare, Medicaid, uninsured, group, and individual).

LEAD CONSULTANT

Jill Van Den Bos, MA, is a consultant in the Denver office of Milliman with over 18 years of experience as a healthcare consultant and will serve as the project manager and a lead consultant for this project. She had a central role in developing population change factors for the Milliman Healthcare Reform Financing Model, using detailed analysis to construct underlying factors used to model changes in health insurance status during the implementation of reform.

KEY STAFF

Jonathan Shreve, FSA, MAAA, is an Equity Principal in the Denver office of Milliman as well as the CEO of Care Guidelines, a Milliman company that produces evidence-based clinical decision-making tools. He also participated heavily in the development of the Milliman Healthcare Reform Financing Model. With several decades of actuarial experience, Jonathan will provide expert review and insight in the course of this project.

Mary van der Heijde, FSA, MAAA, is a Principal in the Denver office of Milliman. She has a detailed knowledge of Health Insurance Exchanges and their potential impacts on all areas of the market. Her experience includes detailed analysis of healthcare pricing and underwriting. She will provide expert review in the course of this project.

Ksenia Draaghtel, ASA, MAAA, is a consultant in the Denver office of Milliman and an expert in predictive modeling. She has over six years of experience as a healthcare actuary and was actively involved in the creation of the Milliman Healthcare Reform Financing Model. Ksenia will assist in this project.

Michael Halford, ASA, MAAA, is a project manager in the Denver office. His key responsibility involves managing the lead consultant's projects internally to ensure that the projects smoothly from all perspectives. Michael will also assist in this project.

Appendix C presents biographies of the senior Denver consultants who will be involved in this project. Milliman's Denver, Colorado office will be the primary provider of services to the State. Milliman will utilize all appropriate staff using in-house technology services (e.g., web-based meeting tools) to reduce the need for travel.

Terms

Milliman reserves the right to evaluate the Culinary Health Fund and its leadership team to determine whether or not Milliman is willing to contract with them for this engagement due to the contingent nature of the payment for our work. We will also run our standard checks (including conflict checks) before beginning work. Contract terms will be negotiated with the Culinary Health Fund and a copy of Milliman's Consulting Services Agreement (CSA) is attached for your review and signature. We recognize that payment may be delayed beyond the normal terms written in the CSA but expect payment to be made promptly once funds are available.

We welcome the opportunity to become acquainted directly in order to gain a better understanding of the unique goals and needs of your organization. After that, we will provide you with a tailored proposal.

We look forward to the opportunity to work collaboratively with you to support the Culinary Health Fund in this effort. This proposal is based upon our best understanding of your situation, and we welcome opportunity to discuss and refine the scope if needed.

Sincerely,

Jill Van Den Bos

Jill Van Den Bos, MA
Consultant

APPENDIX A - HEALTH COOPERATIVE FEASIBILITY STUDY

The feasibility study in CFDA: 93.545 is described as follows:

> *"The applicant must submit a feasibility study, supported by actuarial analysis, which examines the likelihood of success for the CO-OP envisioned and the applicant's ability to repay the loan. The feasibility study should address the target market, products to be offered, regulatory scheme, market impact, financial solvency, economic viability, State solvency requirements and other regulations, and any other key factors. The feasibility study should identify and justify any key assumptions. It should also include pro forma financial statements with sensitivity testing for alternative enrollment scenarios and other changes in business assumptions. The professional responsible for preparing the feasibility study must certify its accuracy and objectivity."*

1) Target market assessment / Competitive analysis

a. Insurance Coverage – State Level Including Projection of Exchange Enrollment
- Individual
- Small Group
- Uninsured
- Large Group
- Medicare
- Medicaid

b. Carriers – State Level Including Projection of Exchange Participants
- Individual
- Small Group

c. Geography (Rating Areas) for the State
- Hospital Networks
- Physician Groups

d. Network Strength of Competitors
- Range of Network Discounts
- Options available to Cooperative for Contracting (Direct Contracting, Network Lease,
- Provider Partnership)

e. Prevailing Premiums for Individual Coverage

2) Products to be offered

a. Benefit designs required to comply with State Health Insurance Exchange requirements
- Basic Silver Plan
- Silver Plan Benefit designs consistent with cost sharing subsidy level requirements
- Basic Gold Plan
- Any Others

b. Premium/claim estimates for all benefit designs

3) Regulatory scheme

4) Market impact

a. Baseline population projections (from Step 1)
b. Penetration in uninsured population (uptake rates)
c. Switching from previously insured populations (switching rates)
   - Individual
   - Small group
   - Large group, as applicable

5) Financial solvency

a. Revenue projections based on covered population and premium levels
b. Claim projections based on covered population and contracting levels
c. Expense projection based on covered population

6) Economic viability

7) State solvency requirements and other regulations

a. Projected capital given state RBC requirements

APPENDIX B - HEALTH COOPERATIVE ACTUARIAL ELEMENTS OF THE BUSINESS PLAN

These include the following elements from the Business Plan description in the FOA:

- *"The applicant should explain its process for determining accurate and appropriate pricing of premiums."*
- *"Enrollment Forecast: Quantitative forecast of the enrollment totals and composition for the first 20 years of the CO-OP. Forecast numbers should be detailed, and tie to the key activities of the business plan. Assumptions used to forecast enrollment in the out-years should be documented and justified. In addition to the base case forecast, this section should include alternative scenarios upon which sensitivity analysis can be built. "*
- *"Regulatory Capital Requirements Forecast: The applicant should provide an estimation of the annual total regulatory capital requirements associated with each of the base case and alternative enrollment forecasts."*
- *"The applicant must submit pro forma financials covering the period from award through the life of the loan(s). Forecast numbers should be detailed and tie to the key activities of the business plan, including clearly articulated assumptions underlying forecasts of revenues and costs over time.*
- *The financials will include:*
  - *Cash Flow Statement that summarizes all sources and uses of cash including but not limited to the loan awards, any third party financial awards or support, start-up development costs, as well as the on-going business operations of the CO-OP;*
  - *Balance Sheet that reflects the year end assets and liabilities of the CO-OP including core regulatory capital; and*
  - *Income Statement that reflects the annual income or losses of the CO-OP consistent with their business operations and governance."*
- *"The applicant's strategy for bearing risk, including the percent of risk it plans to bear and its plan to purchase reinsurance and/or share risk with providers (if applicable)"*

1. ***Description of premium development***
2. ***Enrollment forecast***
3. ***Regulatory Capital Requirements Forecast***
4. ***Pro Forma***

APPENDIX C - RESUMES

Following you will find resumes for key staff proposed for this project.

Jill Van Den Bos, MA
Healthcare Consultant

Professional Experience

Milliman, Inc.; Denver, CO; 1992-Present; Consultant

University of Colorado at Boulder; Boulder, CO; 1988-1992

Education and Certifications

B.A. (Cum Laude), Psychology (with Honors), Davidson College, 1985

M.A., Experimental Social Psychology, University of California, Los Angeles, 1987

Professional Affiliations

Member, International Society for Pharmacoeconomics and Outcomes Research (ISPOR)

Member, Phi Beta Kappa

Awards

2nd Place Award SOA essay contest, 2010, "Providers: Reorganize and Refinance"

CDC Charles C. Shepard Award, 2009, for paper titled "Cost effectiveness of community-based physical activity interventions."

Jill works as a consultant performing traditional health actuarial functions such as claim cost evaluation, rate filings, pricing, and budget impact modeling. Clients she has served in this capacity include health plans, long term care insurance companies, employers, and providers.

She has also focused on bringing an actuarial perspective to the field of pharmacoeconomics. Experience in this area includes collaborative research with other disciplines where her roles have been the co-investigator managing the analysis and a manuscript editor. She has also done practice pattern and reimbursement research and aided in developing responses for FDA interactions. Her clients for this work have included pharmaceutical companies, the Centers for Disease Control, and academic institutions.

Her work in long-term care insurance has included typical actuarial analysis in support of pricing, product development, valuations of blocks of business, filings, and self-funded employer coverage. She co-authored the book "True Group Long-Term Care" with Jon Shreve. In this book they presented methods by which employers could offer long-term care coverage in a cost-effective fashion by using principles similar to those used for other true group employee benefits such as pension.

Selected Publications

Van Den Bos, J., Rustagi, K., Gray, T., Halford, M., Ziemkiewicz, E., Shreve, J.L. (2011). The $17.1 billion problem: The annual cost of measurable medical errors. Health Affairs; 30(4): 593-603.

Van Den Bos, J. (2010). Providers: Reorganize and refinance. SOA Health Watch; 64:44.

Perlman D., Van Den Bos, J. (2010). Medical claims database analysis of off-label prescribing: Examining off-label use by highly prescribed drugs reveals factors that differ from the usual criticism of such usage. Pharmaceutical Commerce; http://www.pharmaceuticalcommerce.com/frontEnd/1500-off_label_Milliman_PMPM_medical_claims_Van_Den_Bos_Perlman.html

Malone D.C., Waters H.C., Van Den Bos J., Popp J., Draaghtel K., Rahman M.I. (2010). A claims based Markov model for Crohn's disease. Alimentary Pharmacology & Therapeutics; 32:448 458.

Kane-Gill, S.L., Van Den Bos, J., Handler, S.M. (2010) Adverse drug reactions in hospital and ambulatory care settings identified using a large administrative database. The Annals of Pharmacotherapy; 44: 983-993.

Van Den Bos, J. (2009). Globalization of the pharmaceutical supply chain: What are the risks? SOA Health Watch; 61:1.

Nair, K.V., Tang, B., Van Den Bos, J., Zhang, V., Saseen, J.J., Naim, A., Rahman, M. (2009). Categorization of infliximab dose changes and healthcare utilization and expenditures for patients with rheumatoid arthritis in commercially insured and Medicare-eligible populations. Current Medical Research and Opinion; 25(2): 303-314.

Roux, L., Pratt, M., Tengs, T.O., Yore, M.M., Yanagawa, T.L., Van Den Bos, J., Rutt, C., Brownson, R.C., Powell, K.E., Heath, G., Kohl, H.W., Teutsch, S., Cawley, J., Lee, I., West, L., Buchner, D.M. (2008). Cost effectiveness of community-based physical activity interventions. American Journal of Preventive Medicine; 35(6):578-88.

Van Den Bos, J. (2008). Want to be in a health plan? Think like one. Pharmaceutical Executive; 28(5):36.

Van Den Bos, J., Shreve, J.L. (2008). The case for "cash" LTC insurance products. National Underwriter Life and Health; February 11, 2008.

Shreve, J.L., Van Den Bos, J. (2007). Long-term care coverage: employers' perspective. Milliman Health Perspectives; 6-8.

Selected Presentations

"Pharmacy Benefit Pricing Issues", Society of Actuaries Health Spring Meeting, Toronto, Ontario Canada, June, 2009.

"Genetic technology: Practical issues for health plans," Applied Pharmacoeconomics and Outcomes Research Forum, San Diego, California, June, 2009.

Jonathan Shreve, FSA, MAAA

Principal and Consulting Actuary

Professional Experience

Milliman, Inc.; Denver, CO; 1992-Present; Consulting Actuary

Milliman & Robertson; Radnor, PA; 1987-1991; Consulting Actuary

UNUM Life Insurance Company; Portland, ME; 1982-1987; Actuarial Analyst

Education and Certifications

Completed Society of Actuaries Fellowship Exams, 1985

B.A., Mathematics; Carleton College; Magna Cum Laude with distinction in mathematics; 1982

Professional Affiliations

Fellow, Society of Actuaries, 1985

Member, American Academy of Actuaries, 1986

Jon was elected Equity Principal in 1995 and started and leads Denver Health Practice for Milliman. He advises HMOs, insurance companies, hospitals, physician groups, and employers, especially in areas of government contracting.

At Milliman, Jon has made significant contributions to Milliman's research, including primary authorship of the Small Group Medical Underwriting Guidelines, developer of Retiree Medical Guidelines, contributor to Long-Term Care Guidelines, and developer of interactive provider capitation models.

Jon manages several groups within Milliman, including its Care Guidelines Division, and its Mexico and Brazil practices. Jon served on Milliman's Board of Directors between 2004 and 2007.

Selected Publications

True Group Long-Term Care. International Foundation of Employee Benefit Plans, Spring 2004. ISBN 0-89154-586-7

Change The Expectations In Health Care. Society of Actuaries: Visions for the Future of the U.S. Health Care System, June, 2009.

Shreve, J.L., Whittal, K. Analyze This. Best's Review, October, 2008.

Key Question: Health Insurance Optimal Rating and Underwriting Strategy for Mid-Sized Groups. Milliman Health Perspectives, Spring, 2009.

The Case for 'Cash' LTC Insurance Products. National Underwriter, February, 2008.

Selected Presentations

"Underwriting: What's Next? Opportunities and Pitfalls in a post-reform environment." HUSG, San Antonio Texas, April, 2010.

"The State of International Health Care Data-Calculating Health Insurance Liabilities." IAAHS, Capetown South Africa, March, 2010.

Selected Presentations (Continued)

"Lifestyle Based Analytics – A Practical Guide for Underwriting." Society of Actuaries Annual Meeting, Boston, Massachusetts, October, 2009.

"Best Practices in Private Healthcare Insurance Around the Globe," Joint Colloquium of the IACA, PBSS, and the IAAHS Sections, Boston, Massachusetts, May, 2008.

Mary van der Heijde, FSA, MAAA

Principal and Consulting Actuary

Professional Experience

Milliman, Inc.; Denver, CO; 2001-Present; Principal and Consulting Actuary

Education and Certifications

B.S. (with Distinction), Applied Mathematics; University of Colorado; Boulder, CO

Certificate in Actuarial Sciences; University of Colorado; Boulder, CO

Professional Affiliations

Fellow, Society of Actuaries

Member, American Academy of Actuaries

Mary's primary area of expertise includes individual and small group pricing and underwriting. She has recently done significant work assisting insurers in the individual market, including pricing, design, medical underwriting implementation, and other market and competitive considerations. Her recent projects include rate development for large insurers, researching and pricing changes in benefit coverage, and plan analysis. She leads the development of the Milliman *Medical Underwriting Guidelines* product, which is a commercially available medical underwriting guideline used by over 120 insurers in the United States.

Mary advises HMOs and insurance companies, especially in areas of individual and small group underwriting implementation and pricing. She has considerable experience in pricing, having worked intensively on pricing healthcare costs for the federal government's multi-billion dollar TRICARE program and assisting health plans with pricing for their commercial products. She has also worked with health plans in the area of predictive modeling, including the use of risk adjusters.

Mary has been heavily involved in healthcare reform with focus on both current required changes and pricing and strategy for entry to the Health Insurance Exchanges. She has two upcoming whitepapers on (1) the impact of health plan benefit changes on cost and utilization and (2) the impact of the unisex and 3:1 age ratio rate requirement on insurers.

As a Fellow in the Society of Actuaries and a Member of the American Academy of Actuaries, she actively participates in national professional organizations and meetings, including serving as the editor-in-chief of the Society of Actuaries *Health Watch* publication.

Examples of Mary's relevant experience include the following:

Commercial Products and Rate Setting: provided services to health plans for the development of annual pricing for commercial plan products and actuarial opinions on sufficiency of reserves; provided services to managed behavioral health organizations in the development of annual targets and experience monitoring; and supported the development of strategic and detailed plans for compliance with current and future changes stemming from healthcare reform. These projects are focused both on compliance and strategic planning and have included working with plans to develop strategies for planning entry to the Health Insurance Exchange market.

Medicaid and Other Capitation Rate Setting: provided services to health plans to review the adequacy of Medicaid capitation rates developed by the state and to evaluate partnership arrangements with collaborating plans; provided services to hospitals in the development of global capitation rates under an Affordable Care Act (ACA) pilot program to cover care for Medicaid and uninsured populations; provided services to state behavioral health organizations in the verification of the suitability of annual state-proposed capitation rates; and provided services to TRICARE regional providers in the development of future cost projections and negotiations with the government regarding capitation rates for future periods.

In addition, Mary has participated in projects that provided services to health plans in the strategic development of individual and small group product designs. These projects have included a full review of the underwriting workflow and rating processes, as well as development and implementation of these processes for new markets. She has also provided services to health plans and TRICARE regional providers in the use of management reporting and benchmarking to reduce waste and improve the quality of care provided and has supported the Center of Medicare and Medicaid Services (CMS) as part of Milliman's ACRP Audit team.