Case No. _____

IN THE SUPREME COURT OF NEVADA

UNITE HERE HEALTH, a multi-employer health and welfare trust, as defined in ERISA Section 3(37); and NEVADA HEALTH SOLUTIONS, LLC, a Nevada limited liability company,

Petitioners,

vs.

EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF CLARK, THE HONORABLE TARA CLARK NEWBERRY, DISTRICT COURT JUDGE,

Respondent,

- and -

STATE OF NEVADA EX REL. COMMISSIONER OF INSURANCE, BARBARA D. RICHARDSON, IN HER OFFICIAL CAPACITY AS STATUTORY RECEIVER FOR DELINQUENT DOMESTIC INSURER, NEVADA HEALTH CO-OP; and GREENBERG TRAURIG, LLP,

Real Parties in Interest.

District Court Case No. A-15-725244-C, Department XXI

APPENDIX TO PETITION FOR EXTRAORDINARY WRIT RELIEF VOLUME 17 OF 19

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February 25, 2021

APPENDIX TO PETITION FOR EXTRAORDINARY WRIT RELIEF
VOLUME 17 OF 19

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TAB 42

TAB 42

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DISTRICT COURT

CLARK COUNTY, NEVADA

STATE OF NEVADA, EX REL. COMMISSIONER OF INSURANCE, BARBARA D. RICHARDSON, IN HER OFFICIAL CAPACITY AS STATUTORY RECEIVER FOR DELINQUENT DOMESTIC INSURER,

Plaintiff,

v.

NEVADA HEALTH CO-OP,

Defendant.

Case No. A-15-725244-C
Dept. No. I

REPLY IN SUPPORT OF UNITE HERE HEALTH AND NEVADA HEALTH SOLUTIONS, LLC'S MOTION TO:

(1) DISQUALIFY GREENBERG TRAURIG, LLP AS COUNSEL FOR THE STATUTORY RECEIVER OF NEVADA HEALTH CO-OP; AND

(2) DISGORGE ATTORNEY'S FEES PAID BY NEVADA HEALTH CO-OP TO GREENBERG TRAURIG, LLP

DATE OF HEARING: DECEMBER 15, 2020

TIME OF HEARING: 9:00 A.M.

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

It Is Worse Than Expected! UHH originally gave Greenberg the benefit of the doubt when it inquired about its conflicts of interest. Perhaps Greenberg's disabling conflicts were the result of simple negligence or the failure to conduct an appropriate conflict check. Perhaps Greenberg had disclosed these conflicts to the Court at some point and UHH was unaware. ***Apparently not***. Greenberg's Opposition and the SDR's declaration instead confirm something much more sinister. Greenberg and the SDR were well aware of Greenberg's dual conflicts of interest with its other clients—Xerox and Valley, ***yet they purposefully concealed them from this Court and every single creditor of the receivership estate.***

All of the relevant legal authority, ***including cases cited by Greenberg***, unanimously confirm that Greenberg and the SDR were mandated to make these conflict of interest disclosures to this Court. As just one example:

> In situations where counsel is aware of apparent conflicts which counsel believes are outweighed by other factors, ***the conflicts must be disclosed. The court then can exercise its independent judgment***. The decision concerning the propriety of employment should not be left exclusively with counsel, whose judgment may be clouded by the benefits of the potential employment.[1]

Scoffing at this legal authority, Greenberg and the SDR do not even attempt to explain why they concealed these conflicts from this Court. Yet the answer is obvious. Had the Court been informed in December 2016 that Greenberg ***currently represented Xerox***, a potential target of the receivership estate, ***along with Valley***, a significant creditor of the receivership estate, this Court would have wisely advised the Receiver to choose an unconflicted law firm. Likewise, Greenberg and the SDR's concealment did not give the creditors—***including UHH***—the necessary information to allow them to file an objection. Greenberg and the SDR instead chose to commandeer this Court's authority and secretly plow ahead with conflicted counsel, filing four separate lawsuits and ultimately allowing Greenberg to bilk the receivership estate out of over $5 million dollars in

[1] *See, e.g., In re BH & P, Inc.,* 119 B.R. 35, 44 (D.N.J. 1990) (emphasis added).

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attorney's fees. Greenberg's willful failure to disclose—***which is now undisputed***—is grounds for disqualification in and of itself.[2]

Although Greenberg and the SDR can neither explain nor justify their blatant failure to disclose Greenberg's conflicts, they do painstakingly try to convince this Court that Greenberg's representation of a potential target and significant creditor of the receivership estate was inconsequential. Their explanation? Greenberg was merely "limited-scope" counsel, it had nothing to do with either Xerox or Valley, and a separate law firm had been retained to handle these conflicts. In essence, no harm, no foul. Yet there are numerous legal and factual problems with this so-called explanation.

First, as discussed above, ***this purported arrangement was never disclosed to this Court***, ***and this Court had no opportunity to determine whether it could cure Greenberg's undisclosed conflicts***. As addressed below, it could not.

Second, the record undeniably reflects that Greenberg was anything but "limited-scope" counsel. Greenberg is currently representing the receivership estate in ***four separate lawsuits***, and consistently appears before this Court on behalf of the receivership estate, having filed ***15 separate status reports*** and numerous motions in the receivership action. ***Greenberg has received from the receivership estate over five million dollars in fees***. On the other hand, Santoro Whitmire, the alleged "conflicts counsel" which supposedly cured Greenberg's ethical quandaries, ***has received less than two thousand dollars in fees over a four year period***. Based on these undisputed facts, it is entirely disingenuous, if not outright misleading, to label Greenberg as "limited-scope" counsel.

Finally, although Xerox is (conveniently) not a party to any of the four lawsuits in which Greenberg is lead counsel, ***Xerox's fingerprints are all over the Milliman Lawsuit and the Silver State Lawsuit***. In the Milliman Lawsuit, UHH, the Management Defendants,[3] and the InsureMonkey Defendants[4] timely sought leave to implead Xerox as a Third-Party Defendant.

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[2] *See, e.g, Buckley v. TransAmerica Inv. Corp. (In re Southern Kitchens)*, 216 B.R. 819, 829-30 (Bankr. D. Minn. 1998).

[3] The Management Defendants include Kathleen Silver, Bobbette Bond, Tom Zumtobel, Pam Egan, Basil Dibsie, and Linda Mattoon.

[4] The InsureMonkey Defendants include InsureMonkey, Inc. and Alex Rivlin.

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These Motions were filed shortly after these Defendants disclosed multiple expert reports which concluded that it was Xerox that was responsible for most, if not all, of the CO-OP's failures. Likewise, in the Silver State Lawsuit, Silver State has explicitly alleged that Xerox—not Silver State—is in possession of the funds at issue. Greenberg's conflicts of interest and its inability to sue its client—Xerox—has resulted in Greenberg blaming and suing other entities for Xerox's wrongdoing. Thus, even if this Court believes that Greenberg was truly "limited-scope" counsel (it was not), Greenberg's representation of and loyalty to Xerox has infiltrated and tainted most of the pending lawsuits in which Greenberg is lead counsel, also mandating Greenberg's disqualification.[5]

Greenberg's remaining technicalities are just as unavailing. Greenberg's standing argument conveniently ignores the undisputed fact that UHH is a creditor of the receivership estate. Greenberg's conflicts of interest and inability to blame (and sue) Xerox has harmed UHH as both a creditor of the receivership estate and as a defendant which has been sued by conflicted counsel in the Milliman Lawsuit. Likewise, Greenberg's waiver argument conveniently ignores the undisputed concealment of its conflicts of interest from this Court and from the creditors of the receivership estate. Finally, Greenberg's cries of prejudice to the receivership estate should fall on deaf ears, especially in light of the absence of any declaration from the Receiver herself. Greenberg and the SDR have only themselves to blame for hiding these conflicts from this Court for four years. Although the receivership estate may be forced to pay another attorney to get up to speed in these various matters, again, that is solely the fault of Greenberg and the SDR, and not something for which Greenberg should be rewarded with continued employment. In fact, this claim of prejudice is something that can be and should be easily resolved by granting the second aspect of the Motion—*i.e.*, forcing Greenberg to disgorge all of the attorney's fees it received from the receivership estate.

For the foregoing reasons, the Motion to Disqualify should be granted in its entirety.

[5] *See, e.g, Buckley (In re Southern Kitchens)*, 216 B.R. at 829.

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II. ADDITIONAL RELEVANT FACTS[6]

A. The Milliman Defendants' Experts Opine That Xerox is to Blame for the CO-OP's Failures.

As set forth in the Motion, there is significant documentary evidence (*e.g.*, CO-OP Board Minutes, the Deloitte Report, the February 24, 2014 letter from the CO-OP's CEO to Governor Sandoval) showing that Xerox significantly harmed the CO-OP's operations due to its inability to competently develop and administer the Xerox Exchange, not to mention the undisputed facts that the State of Nevada was forced to fire Xerox for its incompetence and that Xerox agreed to pay up to ***five million dollars*** to settle two class action lawsuits regarding its administration of the Xerox Exchange.[7] ***Unsurprisingly, Greenberg does not even attempt to rebut or explain this evidence in its Opposition***.

Yet that is not all of the evidence confirming Xerox's culpability. On October 2, 2020, the Milliman Defendants (UHH, the Management Defendants, the InsureMonkey Defendants) disclosed their expert reports. The Milliman Defendants' experts consistently opined that Xerox was primarily to blame for the CO-OP's failures, ***and that Plaintiff (the Receiver) is blaming the Milliman Defendants for damages that were caused by Xerox***. Below is a summary of the Milliman Defendants' experts' various opinions regarding the failures of Xerox and the Xerox Exchange.

1. *UHH's Experts*

a. Henry Miller Ph.D.

> The ongoing issues and challenges NHC experienced with the Exchange and Xerox were significant factors impacting claims processing. NHC's Board minutes frequently identified these difficulties:
>
> - NHC was speaking regularly with the Governor as well as other carriers regarding the challenges with data submissions from Xerox to NHC.
> - NHC did not receive any information on 3,000 members from Xerox due to the Exchange's ongoing data transfer failures.
> - The letter prepared by NHC attorneys to Xerox and the Governor outlining problems NHC was having with the Exchange and Xerox.

---

[6] These additional facts and evidence are necessary to respond to Greenberg's various arguments in its Opposition; particularly, the newfound assertion that Greenberg's role as "limited-scope" counsel somehow cured its conflicts of interest.

[7] Exhibits 3-6 of the Mot. to Disqualify.

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- How Xerox has and continues to hurt NHC's credibility in the market place and injured NHC members.
- An example of a New Year's Eve heart attack patient being left with a $410,000 bill and unmanaged care due to Xerox failing to inform NHC that the patient was an NHC member.

Below are additional key issues regarding difficulties NHC was having with Xerox and the State Exchange:

- Xerox admitted its payment collection process was working at only 45 percent capacity.
- The possible extension of payment deadlines for consumers past May 30th since 4,000 consumers wanted to pay their premiums but were unable to due to Xerox system errors.
- Xerox presented NHC with a report of 900 delinquent members dated back to January 2014 that was never timely reported and of which NHC was unaware.
- Xerox had an overall, and undeniable, negative impact on NHC's finances. NHC committed 50 percent of its resources to Xerox and Xerox-related issues starting in October 2013.

The Silver State Health Insurance Exchange concluded that Xerox data was unreliable.

- "The Exchange, as a dedicated partner to the carriers, recognize that we collectively can no longer rely on Xerox data."
- "Xerox's efforts at reconciliation over many months have not led to a timely closure of the issues and do not appear to offer the potential for resolution in the future."[8]

b. Xavier Oustalniol, CPA, CFF, CIRA

I understand that NHC started experiencing issues with Xerox as early as October 2013. A February 19, 2014, NHC Board Meeting mentions "three meetings a week with the Governor's office, the other carriers and Xerox to communicate the challenges the CO-OP is experiencing with data submission from Xerox to the CO-OP […] with […] more than 3,000 members that are on Xerox pending list that the CO-OP has not received any data on to date." Xerox's mismanagement and issues were considered as "negatively impacting the CO-OP's membership" and having failed to communicate eligibility to the CO-OP for some consumers. These issues were discussed on several occasions during NHC's subsequent Board meetings. Some of the concerns ranged from Xerox being "untimely in their reporting", to the need to"[r]esolve Xerox issues", the CO-OP "working through reconciling items with Xerox", Xerox's "payment collection process…only working at 45% capacity to accept payments […] and Xerox […] has drained the CO-OP's resources as no less than 50% of the CO-OP's resources have been committed to Xerox and Xerox related issues since October 2013."[9]

c. Christina Melnykovych, BS, RHIA, CFE, AHFI

Despite public information and private discussions regarding the detrimental impact of Xerox's failure in its administration of the Silver State Exchange, Plaintiff,

[8] Ex. 7 to Mot., pp. 38.

[9] Relevant Pages of Expert Report of Xavier Oustalniol, CPA, CFF, CIRA, pp. 22-23, attached as Exhibit 18.

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including her expert, (Henry Osowski), fails to acknowledge Xerox's catastrophic impact on CO-OP operations and carriers, in general. Moreover, Sections 2.2(c) and 2.2(e) of the ASA are clear in addressing the responsibility of the CO-OP to assure timely, valid, accurate, and complete information to its TPA (UHH), including regular scheduled eligibility data transfers. From all the evidence examined by CCI, that simply did not happen.

There is no acknowledgement by Plaintiff or Mr. Osowski that Xerox played a significant role in consuming 50% of the CO-OP's resources from open enrollment on October 1, 2013 through May 2014, when it was reported to the Formation Board. CCI's Exhibit 3, titled "Xerox/Eligibility", chronicles how Xerox-related issues plagued the CO-OP during the entire 2014 calendar year, and thereafter. On July 28, 2015, Dr. Nicole Flora addresses the work of Indegene, a company retained by the CO-OP to assist with submission of the CO-OP's risk data to HHS-CMS. "While, clearly, I would have liked a better financial outcome, I was pleased with them as our vendor. ***Our (mainly Xerox) data was hugely problematic and consumed all of the resources we had planned, limiting our ability to be proactive.***"

Emails reviewed by CCI (and referenced herein, unless otherwise specified, on Exhibit 3), between CO-OP personnel and those that include UHH, reveal communications with Xerox that include inaccurate information conveyed to CO-OP personnel, changes to the testing schedule, clarification of previously-provided information, all of them occurring perilously close, or after, the open enrollment period. On October 3, 2013, the CO-OP's CEO sends an email to Tanchica Terry (CMS) to address "Opening day report". He tells her, "Our biggest challenge remains the functionality of the state exchange. Since the vast majority of our individual market will be eligible for subsidies (advance premium tax credit), ***much of our fate is tied to the performance of the Exchange. The technical issues at the Exchange prevented people across the state, including our enrollment specialists, from completing applications for subsidies in order to formally enroll in subsidy-eligible plans.***"…[10]

Any assertion by Plaintiff, or Plaintiff's expert Henry Osowski, that UHH acted improperly or in violation of the terms of the ASA, as it pertains to eligibility, is patently false. The failures of Xerox sapped CO-OP and UHH resources. It impeded timely claims adjudication by UHH, while claims sat in the eligibility queue awaiting confirmation of eligibility status by CO-OP personnel….Xerox's failure impacted the CO-OP's ability to provide timely, reliable information to UHH, as required by Sections 2.2 (c) and 2.2 (e) of the ASA.[11]

2. *The Management Defendants' Experts.*

a. Sabrina Corlette, J.D.

The IT woes did not just dampen enrollment – they required participating insurers to devote a significant and unanticipated amount of staff time and resources to resolving the problems that arose from the dysfunctional system. In the early months of enrollment, the Silver State Exchange's IT vendor, Xerox, failed to transmit data on close to 10 percent of enrollees to insurers. This meant the companies did not have a complete picture of who had enrolled or paid their premiums. As a result of these and

[10] Relevant Pages of Expert Report of Christina Melnykovych, BS, RHIA, CFE, AHFI, pp. 34-35, attached as Exhibit 19 (emphasis in original).

[11] *Id.* at p. 39.

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other errors, the Silver State Exchange reported that calls to its call center doubled between November and December 2013, with average wait times increasing to one hour. The marketplace had to add more than 60 staff to its call center. Participating insurers, including the CO-OP, had similar increases in customer call volume, requiring a significant diversion of resources that could have been spent managing care and improving the business systems necessary for the CO-OP's long term success.[12]

Nevada's failure to have a working information technology (IT) platform for its state-run health insurance marketplace (the "Silver State Exchange") in 2013 and 2014 had disastrous consequences for a start-up like NHC that was, under law, required to generate "substantially all" of its business from that market. The non-working website was likely the primary reason NHC was not able to reach its enrollment targets.

The failures of Nevada's Silver State Exchange IT vendor, Xerox, to adequately support the state-run marketplace and transit critical enrollment and premium payment data resulted in widespread customer service challenges among all participating insurers, including NHC.[13]

b. Jeffrey L. Smith, FCA, MAAA; Matthew C. Elston, FSA, MAAA

The state exchange failed to perform its obligation to provide accurate eligibility information. Insurance companies must collect premiums from eligible enrollees and meet their contractual obligations paying claims for eligible employees. Paying claims for ineligible employees leads to excess losses. NHC relied upon the state exchange in 2014 and then the federal exchange in 2015 for enrollment eligibility. The state exchange had many challenges in 2014 and eventually was cast aside and the NV ACA on-exchange business had to migrate to the federal exchange for 2015. Enrollment on exchange with all NV carriers for the Individual market can be seen as an indicator of these issues at the state exchange. Enrollment in 2014 was 45,390 for all carriers, and in 2015 statewide enrollment grew to over 60% to 73,596. Even to the extent that enrollment records improved in 2015, when the exchange was moved to the federal platform, additional losses were already realized by NHC further contributing to its reduced capital leading toward insolvency.[14]

c. Richard L. Trembowicz

The SSE's failure in 2014 to provide accurate data in a timely basis or issue business rules governing configuration of the UHH claims system with sufficient advance notice severely compromised the performance of NHC and its vendor in their enrollment management, premium billing, and claims processing functions….[15]

In addition to SSE data integrity issues, the Exchange also suffered from an inability to engage in EDI with health plans like NHC…. Accurate eligibility, enrollment, and premium payment data forms [are] the essential foundation of accurate claims processing, and if data is inaccurate or inconsistent or not delivered in a timely

[12] Relevant Pages of Expert Report of Sabrina Corlette, J.D., pp. 29-30, attached as Exhibit 20.

[13] *Id.*, at pp. 38.

[14] Relevant Pages of Expert Report of Jeffrey L. Smith, FCA, MAAA; Matthew C. Elston, FSA, MAAA, p. 9, attached as Exhibit 21.

[15] Relevant Pages of Expert Report of Richard L. Trembowicz, pp. 12-13, attached as Exhibit 22.

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manner, it would not be possible to accurately administer enrollment or payment claims….

In summary, the Osowski Report fails to discuss at all how the failures of the SSE to maintain accurate data and provide such accurate data on a timely basis via EDI to NHC (and its vendors) affected NHC's ability to conduct eligibility and enrollment management, premium billing and reconciliation, and claims processing without error.[16]

3. *The InsureMonkey Defendants' Experts.*

a. Martin S. Hand

In my professional experience and based on the record in this case, the failure of NHC can be distilled down to three factors – any one of which would raise significant challenges in an implementation of any complexity and the combination of which all but insured that NHC would join the ranks of eighteen (18) other CO-OPs that didn't survive implementing the ACA:…

- The decisions made by the State of Nevada to initially implement their own enrollment technology platform through Xerox then, as a result of that failed launch, switch to HealthCare.gov occurred at a critical time in the project implementation and lead to unrecoverable delays in implementation.[17]

4. *Plaintiff's Experts.*

Although Plaintiff's experts largely ignore the significant impact of Xerox on the CO-OP's operations, Henry Osowski does admit that there were "problems with the reliability of reports from Xerox/Silver State Exchange…."[18] Accordingly, although Greenberg does not want to admit that Xerox's misconduct is deeply intertwined with and inseparable from Plaintiff's various allegations against many of the Milliman Defendants (including UHH), ***Mr. Osowksi confirms as much in his expert report***.

B. The Milliman Defendants Seek Leave to Add Xerox as a Third-Party Defendant.

On October 15, 2020, ***before the deadline to amend pleadings and shortly after UHH's and other Defendants' experts confirmed Xerox's culpability***, UHH filed a Motion for Leave to File a Third-Party Complaint in the Milliman Lawsuit.[19] UHH's proposed Third-Party Complaint impleads Xerox and Silver State as Third-Party Defendants pursuant to a contribution claim for

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[16] *Id.*

[17] Relevant Pages of Expert Report of Martin S. Hand, p. 34, attached as Exhibit 23.

[18] Relevant Pages of February 7, 2020 Expert Report of Henry Osowksi, p. 54, attached as Exhibit 24.

[19] Defs.' Unite Here Health and Nevada Health Solutions, LLC's Motion for Leave to File Third Party Complaint, Case No. A-17-760558-B, filed Oct. 15, 2020.

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relief.[20] UHH's contribution claim is based on Xerox's (and Silver State's) significant and repeated failures to competently develop, administer, and manage the Xerox Exchange, as described in detail above.[21] Consistent with their experts' opinions, the Management Defendants and the InsureMonkey Defendants filed Joinders to UHH's Motion, also seeking to assert contribution claims against Xerox and Silver State.[22] These Motions have been stayed pending this Court's ruling on the Motion to Disqualify.

C. Greenberg's Baseless Assertion That its Representation of Xerox Was Unrelated to Its Representation of the Receiver.

Throughout its Opposition, Greenberg proclaims (without any supporting analysis) that its prior representation of Xerox was "unrelated" to Greenberg's current representation of the Receiver.[23] Greenberg is simply wrong. A cursory review of the class action complaints filed against Xerox confirm that the allegations therein are extremely similar to the relevant expert opinions and the proposed third-party claims against Xerox in the Milliman Lawsuit.[24] Likewise, Greenberg's representation of Xerox in the regulatory action before the Nevada Department of Insurance ("NDOI") also significantly overlaps with many of the issues set forth above.[25]

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[20] *See generally id.*

[21] *See generally* Exhibit 1 to Volume 1 of the Appendix to Defs.' Unite Here Health and Nevada Health Solutions, LLC's Motion for Leave to File Third Party Complaint, Case No. A-17-760558-B, filed Oct. 15, 2020.

[22] *See generally* Management Defendants' Joinder to Motion for Leave to File Third Party Complaint, Case No. A-17-760558-B, filed Oct. 16, 2020; InsureMonkey Defendants' Joinder to Motion for Leave to File Third Party Complaint, Case No. A-17-760558-B, filed Oct. 22, 2020

[23] *See, e.g.,* Opposition to Mot. to Disqualify (the "Opp'n"), 7:2-3; *see also id.*, 16:1.

[24] *See generally* Exhibit 4 to the Opp'n, Class Action Complaint in *Basich v. State of Nevada ex rel. Silver State Health Insurance Exchange et al.*, Case No. A-14-698567-C (the "Insured Class Action"); Exhibit 5 to the Opp'n, Class Action Complaint in *Casale v. State of Nevada ex rel. Silver State Health Insurance Exchange et al.*, Case No. A-14-706171-C (the "Broker Class Action").

[25] Greenberg boldly proclaims in its Opposition that "neither NHC nor the Receiver had any involvement or interest in this investigation." (Opp'n, 7:22-23.) Greenberg completely ignores the undisputed fact that Xerox's Consent Decree with the NDOI ***was signed by Barbara Richardson, the Receiver in this action and Greenberg's client***! (Ex. 10 to Mot., p. 7.)

The following table provides a helpful summary of the relevant allegations in those three related matters.

Insured Class Action	**Broker Class Action**	**NDOI Action**
"Xerox's technology and services (i.e. Nevada Health Link) was said to support premium billing, processing, collection, aggregation and remittance, data analytics and actuarial support, health plan quality and compliance reporting, and incorporation of tax credits and subsidies in cost calculations." "As alleged herein, the Exchange and Xerox have utterly failed to create a system that works as advertised, and as a result, thousands of Nevadans remain uninsured despite payment of insurance premiums."[26]	"From the outset, the Nevada Health Link website was inundated with technical problems and glitches." "[T]he Exchange and Xerox were aware or should have been aware of multiple problems with Nevada Health Link well before the October 1, 2013 'go live' date." "[T]he Exchange and Xerox utterly failed to properly develop, administer, or oversee Nevada Health Link to ensure that the website performed as intended." "Xerox and the Exchange retained premiums paid by enrollees for months, while collecting interest on those premiums, without transmitting the premiums to the insurance carriers selected by the enrollees." "[T]he Exchange and Xerox knew as early as November 8, 2013 that Nevada Health Link was repeatedly crashing or 'freezing' during enrollment, experiencing repeated glitches, and miscalculating enrollees' health insurance premiums such that many enrollees were provided with incorrect health insurance premium." "Nevada Health Link was also improperly designed to delay the process of transferring the necessary enrollee information to the health insurance providers so that the providers would be unable to issue insurance cards or provide insurance coverage for the first 3 to 4 months…."[27]	"The examination report noted that all premium processing services appeared to be provided directly by Xerox." "The examination report identified a number of instances where premium processing resulted in certain refunds being owed, insurance coverage issues, and overpayments of premium." "The examination report also noted that, although Choice and ACS were properly licensed in Nevada as third party administrators, Xerox was not licensed as such. The examination report found that premium processing functions conducted for the Nevada Silver State Health Insurance Exchange required licensure as a third party administrator pursuant to NRS 683A.085."[28]

[26] Ex. 4 to Opp'n, at ¶¶ 4-5.

[27] Ex. 5 to Opp'n, ¶¶ 33-49.

[28] (Consent Decree, Ex. 10 to Mot. ¶¶ 4-6.) Coincidentally, Greenberg, after defending Xerox for not having the appropriate third-party administrator license, has asserted those same allegations against UHH in the Milliman Lawsuit.

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III. GREENBERG'S LACK OF MATERIAL EVIDENCE

Greenberg's Opposition is much more notable for what it does not include as opposed to what it does. These glaring evidentiary omissions are addressed below.

A. Greenberg's Purported Role as "Limited-Scope" Counsel.

Setting aside Greenberg's and the SDR's undisputed failure to disclose these conflicts, Greenberg's Opposition is based on the premise that Greenberg was "limited-scope" counsel. Greenberg's purported role as "limited-scope" counsel is based solely on the self-serving declarations of Mark Ferrario and Mark Bennett. Of course, without an evidentiary hearing or discovery (which Greenberg has conveniently opposed), UHH will have no opportunity to cross-examine Mr. Ferrario and Mr. Bennett regarding their assertions.

Nevertheless, ***it is notable that Greenberg and the SDR failed to present a single piece of documentary evidence supporting their assertions***. To the extent that Greenberg's role was truly limited in scope, it would be memorialized in Greenberg's engagement agreement with the Receiver. Yet Greenberg chose not to produce its engagement agreement, nor to produce any written evidence of this purported "limited-scope" agreement.[29] Greenberg instead relies on biased parties' recollection of discussions that supposedly occurred ***over four years ago***.[30]

There is even more missing evidence. Greenberg failed to procure a declaration or any evidence from Barbara Richardson—***the Court-Appointed Receiver and Greenberg's client***—regarding this purported arrangement. One would certainly expect that the Court-Appointed

[29] If Greenberg's engagement was "limited," the limitation was required (i) to be set forth in the engagement letter and (ii) to have received the informed consent of the client. Nevada RPC 1.2(c). There is no evidence that either of these requirements were met. In fact, Greenberg's failure to produce the engagement letter should operate against it. NRS 47.250(3) (creating a presumption that "evidence willfully suppressed would be adverse if produced."). This is because ***"when a party has relevant evidence within his control which he fails to produce, that failure gives rise to an inference that the evidence is unfavorable to him."*** *Int'l Union, United Auto., Aerospace & Agr. Implement Workers of Am. (UAW) v. N.L.R.B.*, 459 F.2d 1329, 1336 (D.C. Cir. 1972) (emphasis added); *see also Bishop v. Lucent Techs., Inc.*, 520 F.3d 516, 522 n.1 (6th Cir. 2008) (same). The rationale supporting this rule is patent: "[A] party fails to produce evidence in its control in order to conceal adverse facts." *BNSF Ry. Co. v. Bhd. Of Maint. Of Way Employees*, 550 F.3d 418, 424 (5th Cir. 2008). Thus, "[a]n adverse inference may be given significant weight because silence when one would be expected to speak is a powerful persuader." *LiButti v. United State*, 178 F.3d 114, 120 (2d Cir. 1999).

[30] The foregoing presumption (fn. 29) is enhanced and extended by NRS 47.250(4), which presumes that "higher evidence [the engagement letter] would be adverse from inferior being produced" [four year old hearsay recollections].

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Receiver and an Officer of this Court would be willing to provide a declaration under penalty of perjury with respect to this alleged agreement. Her silence is deafening!

Likewise, at the time that Greenberg and the SDR should have disclosed this purported "limited-scope" agreement to this Court (in December 2016), the Receiver was represented by the Nevada Attorney General's office and a Senior Deputy Attorney General named Joanna Grigoriev.[31] Ms. Grigoriev requested approval from this Court for her then-client (the Receiver) to retain Greenberg. Ms. Grigoriev did not inform this Court of Greenberg's representation of Xerox (and Valley) and the resulting conflicts of interest.[32] Ms. Grigoriev did not inform this Court of Greenberg's and the SDR's purported conflict remedy of screening Greenberg from any issues involving Xerox (and Valley) and hiring Santoro Whitmire as alleged "conflicts counsel."[33] Considering that Greenberg did not submit a declaration from Ms. Grigoriev, the only logical conclusion is that Greenberg and the SDR also concealed these issues with Xerox from the Nevada Attorney General's Office. One would assume that if Ms. Grigoriev knew about Greenberg's ***current representation*** of Xerox at that time, she would have certainly brought it to the Court's attention (or told the SDR to go find counsel—other than Greenberg—that was not conflicted).

In fact, Greenberg's and the SDR's concealment of the Xerox conflict from the Nevada Attorney General is even more apparent through recent filings in this Court. The Attorney General now represents Silver State in the Silver State Lawsuit. In that matter, Silver State filed a Motion to Intervene, which has now been fully briefed and denied by the Court.[34] According to Silver State, ***it only discovered Greenberg's prior representation of Xerox after reviewing UHH's Motion to Disqualify***.[35] Silver State, through the Nevada Attorney General, ***has now claimed that Greenberg***

[31] Mot. for Order to Approve Professional Rates on Order Shortening Time, filed Dec. 19 2016.

[32] *Id.*; *see also* Ex. 8 to the Mot.

[33] *Id.*

[34] Mot. to Intervene, field Sep. 29, 2020.

[35] State of Nevada, ex. rel., Silver State Health Insurance Exchange's Reply to Opposition to Motion to Intervene, 2: 9-25; 5:9-14, filed Oct. 28, 2020.

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only sued Silver State because Greenberg was ethically barred from suing Xerox.[36] Greenberg does not address any of this in its Opposition.

Finally, Greenberg's and the SDR's assertions that Greenberg was retained as "limited-scope" counsel ignores the Court's docket, and quite frankly, reality. As of May 2020, Greenberg had collected from the receivership estate ***almost five million dollars in attorney's fees***, and based on the most recent status report, ***that amount has now surpassed five million dollars***.[37] In doing so, Greenberg represented and continues to represent the Receiver ***in four separate lawsuits***, including the Milliman Lawsuit, the Silver State Lawsuit, the WellHealth Lawsuit, and a lawsuit involving the federal government. Additionally, ***Greenberg has filed 15 status reports, as well as numerous Motions, all in this Court on behalf of the receivership estate***.[38] Greenberg's actions are entirely inconsistent with any notion of a "limited-scope" role.

B. Santoro Whitmire's Purported Role as "Conflicts Counsel."

In conjunction with their assertion of "limited-scope" counsel, Greenberg and the SDR contend that Santoro Whitmire was retained as "conflicts counsel" to address any potential issues whereby Greenberg had a conflict of interest. In support of this assertion, Greenberg provides a short, vague declaration from James Whitmire, Esq. However, Mr. Whitmire's declaration does not mention Xerox or Valley, thereby raising the question as to whether his firm was actually retained as a result of Greenberg's actual conflicts of interest, or merely as "conflicts counsel" in general. Additionally, Greenberg failed to provide a copy of Santoro Whitmire's engagement agreement, which would show that it was actually retained as "conflicts counsel." Finally, Greenberg and the SDR fail to mention to this Court that Santoro Whitmire ***has billed less than $2,000 to the receivership estate since January of 2017***.[39] Needless to say, Santoro Whitmire could not have

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[36] *Id.*

[37] Twentieth Status Report, Ex. 1, filed Oct. 16, 2020.

[38] *See, e.g.,* Mot. to Coordinate Cases, filed Sep. 14, 2017; Mot. for Order to Show Cause, filed July 9, 2018; Mot. for Determination of Good Faith Sale, filed Sep. 16, 2019; Mot. for Order Authorizing Satisfaction of Hardship Claims, filed Dec. 6, 2019.

[39] Sixth Status Report, Ex. 2, filed April 5, 2017; Seventh Status Report, Ex. 2, filed July 6, 2017.

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provided the receivership estate with any meaningful legal analysis and/or services relating to Xerox and/or Valley at that price.[40]

C. The SDR's Assertion That It Was Solely Responsible for Determining Whether to Sue Xerox and/or Dispute Valley's $5 Million Claim.

The SDR also asserts that it was solely responsible for determining whether to sue Xerox or to dispute Valley's five million dollar claim, and that Greenberg supposedly had nothing to do with that determination. Again, the SDR failed to provide the Court with any documentary evidence to support this assertion. For example, assuming this is true, the SDR would have prepared some sort of written analysis analyzing the CO-OP's potential claims against Xerox. Someone certainly should have. While the SDR asserts—***without any supporting legal authority***—that the rationale for its decision not to sue Xerox is protected by the attorney-work product doctrine, any such confidentiality would not preclude this Court from examining this purported analysis *in camera*.

Additionally, the SDR (while comprised of various Texas attorneys) are not licensed attorneys in Nevada. According to legal authority cited by Greenberg in its Opposition, "[w]hile a receiver may also be an attorney, ***the receiver does not act as an attorney in the course of fulfilling the duties of the receiver***…." *S.E.C. v. Nadel*, 2012 WL 12910270 (M.D. Fla. Apr. 25, 2012) (emphasis added). This begs the question as to who was legally able to analyze whether the CO-OP had viable claims against Xerox ***under Nevada law***? Or whether there was a legal basis to challenge Valley's claim, or a portion of it? Greenberg supposedly did not. Santoro Whitmire did not bill enough to the receivership estate to perform any such analysis. And the SDR is not a licensed Nevada attorney ***and was not appointed to provide legal services***.[41] Again, this lack of material evidence indicates that Greenberg was not retained to nor acting as "limited-scope" counsel.

[40] Furthermore, if Santoro Whitmire was acting as conflicts counsel, and if it did conclude that a conflict waiver could be given in order to permit Greenberg to represent the SDR, that conflict waiver/consent would have to be memorialized in writing and consented to—in writing—by the SDR—and Xerox—after consulting with separate counsel. Nevada RPC 1.7(b). Needless to say, there exists ***no evidence whatsoever*** that any of the foregoing conditions were met.

[41] As this Court is well aware, it is a criminal offense to practice law in Nevada without a license. NRS 7.285.

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D. Additional Factual Assertions That Greenberg Failed to Rebut In Its Opposition.

Greenberg also failed to rebut numerous factual assertions that were evidenced in the Motion, thereby rendering them undisputed. They are as follows:

- Greenberg never disclosed its various conflicts of interest to this Court;
- Numerous exhibits, including CO-OP Board Minutes, a detailed letter from the CO-OP's CEO to Governor Sandoval, and the Deloitte Report, all of which showed that Xerox's actions significantly harmed the CO-OP;
- Greenberg received approximately five million dollars in attorney's fees from the receivership estate;
- Greenberg sold the CO-OP's $43,000,000 receivable from the federal government for only $10,000,000 so that it could continue to fund its attorney's fees;
- UHH is a creditor of the receivership estate;
- Greenberg sued Silver State for approximately $500,000 that is currently held by Xerox; and
- Even if the Receiver decided to pursue Xerox at this time, those claims are likely barred by the relevant statutes of limitations.

IV. ARGUMENT

A. Greenberg's Knowing Failure to Disclose its Conflicts of Interest to This Court is In and of Itself Grounds for Disqualification.

> In situations where counsel is aware of apparent conflicts which counsel believes are outweighed by other factors, ***the conflicts must be disclosed. The court then can exercise its independent judgment***. The decision concerning the propriety of employment should not be left exclusively with counsel, whose judgment may be clouded by the benefits of the potential employment.

See, e.g., In re BH & P, Inc., 119 B.R. at 44 (emphasis added). Any such disclosure must be made due to appointed counsel's fiduciary obligations to the Court. *In re Futuronics Corp*., 655 F.2d 463, 470 (2d Cir. 1981).

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It is now fully undisputed that Greenberg failed to disclose its ***then-current*** representation of Xerox and Valley at the time that it was appointed, or at any other time for that matter.[42] Greenberg did not come clean until faced with this Motion to Disqualify, or else Greenberg's conflicts likely would have never come to light. *See In re Envirodyne Indus.*, 150 B.R. 1008, 1021 (Bankr. N.D. Ill. 1993) ("Without this challenge, the court cannot say with certainty that Cleary, Gottlieb ever would have revealed these connections."). Even worse, ***Greenberg and the SDR have now admitted that they were fully aware of these disabling conflicts of interest at the time of Greenberg's retention***, but that instead of telling this Court about it, they covertly tried to resolve these conflicts on their own and to Greenberg's economic advantage. The relevant legal authority, ***including cases cited by Greenberg in its Opposition***, unanimously confirm the impropriety of such an approach.

For example, in *Buckley (In re Southern Kitchens)*, the Bankruptcy Court for the District of Minnesota addressed a conflict of interest which is a mirror image of Greenberg's representation of Xerox. The bankruptcy trustee had proposed the retention of counsel (F&W) to file an adversary proceeding against various targets of the bankruptcy estate.[43] *Id.*, 216 B.R. at 823-24. At the time of its proposed appointment, F&W represented to the court that it did not have any interests adverse to the estate, failing to mention its prior representation of Gunberg, a member of the debtor's board of directors. *Id.* at 824.

F&W's prior representation of Gunberg, ***along with F&W's failure to disclose that representation***, later became the subject of a motion to disqualify. In confirming there was a conflict of interest, the court explained:

> ***Regardless of whom a trustee has identified as an opponent***, if a past or present client of proposed counsel was involved in any way with the events that gave rise to the dispute, or could otherwise be the subject

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[42] As discussed in the Motion, the fact that Greenberg made an appearance on behalf of Valley approximately four months before it was retained by the Receiver did not absolve Greenberg from again disclosing this adverse representation at the time of its potential appointment and fully informing this Court as to how it would endeavor to represent the adverse interests of the receivership estate and one of its most significant creditors. *In re Tinley Plaza,* 142 Bankr. 272, 278-9 (Bankr. N.D. Ill. 1992) ("[T]he court has no duty to rummage through files or conduct independent factfinding investigations in order to determine whether prospective attorneys are involved in actual or potential conflicts of interest."). Greenberg did no such thing, and of course, also never disclosed its representation of Xerox to this Court.

[43] Notably, F&W was only proposed to be retained as "special counsel," similar to the "limited-scope" role that Greenberg is suddenly proclaiming here. *Id.*, 216 B.R. at 823-24.

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> of a claim based on those events, ***the client has an interest adverse to the estate and disqualification results***.

Id. at 827 (emphasis added). The court ultimately determined that because the defendants in the adversary proceeding were pointing the finger at Gunberg as the true wrongdoer, F&W's prior representation of Gunberg amounted to a disabling conflict of interest warranting disqualification. *Id*. at 827-829.

The court then addressed F&W's failure to disclose its representation of Gunberg: "***The omission of disclosure as to this connection is stunning. No more need be said.***" *Id.* at 830 (emphasis added). The court then noted that even if F&W's representation of Gunberg was not grounds for disqualification in and of itself (it was), the failure to disclose such representation would be. *Id.* at 830.

Numerous other opinions are in accord with these two simple premises. First, that conflicts of interest must be disclosed to the court in conjunction with an attorney's proposed retention (whether in a bankruptcy or receivership context) because only the court is capable of unbiasedly assessing the conflict. Second, ***nondisclosure alone is grounds for disqualification***. *See, e.g.*:

- *In re Envirodyne Indus.*, 150 B.R. at 1021 ("Failure to abide by the disclosure requirements is enough to disqualify a professional and deny compensation, regardless of whether the undisclosed connections were material or *de minimis*. … It is the court's role, not Cleary, Gottlieb's, to determine whether a disqualifying conflict of interest exists.");
- *In re Leslie Fay Cos.*, 175 B.R. 525, 537-38 (Bankr. S.D.N.Y. 1994) ("Weil Gotshal was mandated to reveal any connections which might cast any doubt on the wisdom of its retention and leave for the court the determination of whether a conflict existed. It did not comply with that obligation.");
- *In re Townson,* Case No. 12-03027-TOM-7, 2013 Bankr. LEXIS 853, at *20 (Bankr. N.D. Ala. March 7, 2013) ("If HGD believed it would have no conflicts representing both clients, it is difficult to see how HGD would not disclose these connections so that the Court and other interested parties could examine the relationships and conclude for themselves that the representation of both is no cause for concern.").

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Even Greenberg's own cited authority, *In re REA Holding Corp.*, confirms these mandatory disclosure obligations. As stated by the Southern District of New York, "it is the duty of counsel to reveal all of his connections with the bankrupt, the creditor or any other parties in interest. Had he made the disclosures then it would have devolved upon the court to determine whether conflicts existed." *In re REA Holding Corp.*, 2 B.R. at 736.[44]

Greenberg and the SDR made no such disclosures with respect to Xerox or Valley, despite their undisputed knowledge of these conflicts. As characterized by the court in *Buckley*, this omission is "stunning!" Greenberg and the SDR gave this Court no opportunity to analyze these conflicts. Likewise, Greenberg and the SDR did not give the creditors—***including UHH***—the necessary information to allow them to file an objection to Greenberg's appointment. Greenberg and the SDR instead chose to secretly plow ahead, filing four separate lawsuits and ultimately allowing Greenberg to bilk the receivership estate of over $5 million in attorney's fees. Disqualification (and disgorgement) is warranted.

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B. Greenberg's and the SDR's Unilateral, Covert Attempt to Cure Greenberg's Disabling Conflicts Did Not Suffice.

1. Greenberg and the SDR Did Not Disclose Their Supposed Conflict Remedy to this Court.

Greenberg's disclosure obligations to this Court were unavoidable and indispensable. As proposed counsel to a supposedly neutral and independent officer of this Court, Greenberg (and the SDR) had fiduciary obligations to disclose to this Court not only their potential conflicts of interest, ***but also any measures designed to cure such conflicts***. In other words, Greenberg and the SDR had an affirmative obligation to tell this Court that Greenberg would only be retained as "limited-scope" counsel due to its ***then-current*** representation of Xerox and Valley, and that Santoro Whitmire was being retained as "conflicts counsel" to handle any issues involving those parties.[45] In these types of

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[44] In citing *In re REA Holding Corp.*, ***Greenberg inaccurately described its holding***. Greenberg asserts that the court affirmed the bankruptcy court's finding of no conflict. (Opp'n, 13:21-22.) False. The Southern District of New York reversed and remanded the bankruptcy court's finding of no conflict so that the bankruptcy court could determine whether counsel's failure to disclose the potential conflict was grounds for disqualification. *Id.* at 736-37.

[45] Greenberg continuously refers to Xerox as a past client. Greenberg ignores the undisputed fact that Xerox was a current client at the time of Greenberg's appointment ***and at the time it filed the Milliman Lawsuit***, and thus, its conflict of interest should have been analyzed under Nevada RPC 1.7 (current client conflicts). The only reason it is now being analyzed with Xerox as a past client is because Greenberg and the SDR concealed this conflict for years. It does

proceedings (bankruptcy and receivership), only the Court is capable of assessing and ruling on these conflicts. *In re Coastal Equities, Inc.*, 39 B.R. 304, 306 n. 2 (Bankr. S.D. Cal. 1984). Then, and only then, could this Court make an informed decision whether to approve Greenberg's appointment and ensure that those conflict remedies are followed.

By their own design for economic gain, Greenberg and the SDR gave this Court no opportunity to do so. Greenberg and the SDR cannot point to any instance in which they informed this Court that Greenberg was "limited-scope" counsel and Santoro Whitmire was "conflicts counsel." Greenberg and the SDR cannot point to any instance in which they informed this Court that the SDR—***who is not a Nevada licensed attorney and was not appointed to provide legal services***—was solely making the decision as to whether or not to sue Xerox—a potentially significant source of recovery for the receivership estate. In other words, this purported conflict remedy was a closely guarded secret between Greenberg and the SDR, and would have remained so if not for the filing of this Motion. Regardless, because this Court was never given the opportunity to approve or disapprove of this so-called conflict remedy, and because this Court was the only one capable of approving a proposed conflicts remedy, Greenberg's and the SDR's alleged remedy is insufficient and must now be rejected (to the extent it actually exist).

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2. Greenberg's Newfound Contention That It Was "Limited-Scope" Counsel Does Not Pass the Smell Test.

Greenberg is the ***sole counsel of record*** for the Receiver and the receivership estate in four separate lawsuits: the Milliman Lawsuit, the Exchange Lawsuit, the WellHealth Lawsuit, and a lawsuit with the federal government. Greenberg is currently the ***sole counsel of record*** for the Receiver and the receivership estate in this action, and has filed 15 status reports and numerous Motions in this Court.[46] Greenberg's comprehensive role in these proceedings has allowed it to receive ***over five million dollars in attorney's fees***. This begs the obvious question: if Greenberg is

not matter in any event. As set forth in *Buckley*, "[t]he fact that the connection is past and completed, however, does not matter; sensitivity to the sway of even a diffuse surviving sense of loyalty…makes it relevant" to the analysis. *Id.*, 216 B.R. at 827.

[46] *See, e.g.,* Mot. to Coordinate Cases, filed Sep. 14, 2017; Mot. for Order to Show Cause, filed July 9, 2018; Mot. for Determination of Good Faith Sale, filed Sep. 16, 2019; Mot. for Order Authorizing Satisfaction of Hardship Claims, filed Dec. 6, 2019.

truly "limited-scope" counsel, which Nevada lawyer actually represents the Receiver with respect to other matters? And what are those other matters? It is certainly not Santoro Whitmire, which has billed less than $2,000 to the receivership estate.

In fact, until this Motion was filed, Greenberg and the SDR never used the term "limited-scope" counsel in this Court. They never used the term "conflicts counsel" in this Court. And they have failed to provide any documentary evidence (engagement agreements, correspondence, etc.) which corroborates their biased recollections that Greenberg's retention was limited due to its conflicts with Xerox and Valley. Greenberg has failed to present any evidence from its clients—Barbara Richardson (the Receiver and an Officer of this Court), Valley, or Xerox—confirming their approval of this so-called arrangement.

Greenberg's and the SDR's newfound assertion that Greenberg's role was limited does not pass the smell test, and quite frankly, stinks. Regardless, as addressed in the following section, even if Greenberg's role is truly limited in any respect, Greenberg's conflicts of interest have still tainted many of the pending lawsuits, most specifically the Milliman Lawsuit and the Silver State Lawsuit. However, to the extent this Court wishes to address the scope of Greenberg's retention further, that is a matter well-suited for discovery and an evidentiary hearing, as discussed in the Motion.

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3. Even as "Limited-Scope" Counsel, Greenberg's Conflict of Interest Taints Any Matter Involving Xerox.

Even if this Court were to believe that Greenberg was truly retained as "limited-scope" counsel, and that the SDR—which has no licensed attorneys in Nevada and was not appointed to provide legal services—was ***unilaterally deciding*** whether the CO-OP had viable claims against Xerox ***under Nevada law***, Greenberg's conflicts of interest nonetheless taint many of the pending lawsuits in which Greenberg is the sole counsel of record. That is because Xerox's actions and wrongdoings are significantly intertwined with several material aspects of those proceedings, most specifically in the Milliman Lawsuit and the Silver State Lawsuit.

As discussed above, *Buckley* presents a mirror image of Greenberg's conflict. The conflicted counsel (F&W) in *Buckley* argued that it did not have a conflict because its former client (Gunberg) was not a party to the litigation at issue, and the bankruptcy trustee did not believe that

Gunberg should be a party to the litigation at issue. *Id.*, 216 B.R. at 828. Sound familiar? The *Buckley* court vehemently disagreed. "Litigation like this cannot go ahead under the pall that its architects may not have analyzed, structured, and pled it with full detachment, ***and may be influenced by continuing loyalty to an unsued agent of the Debtor's downfall***." *Id.* at 829 (emphasis added). The *Buckley* court disqualified F&W "[b]ecause of the possibility that its former client is liable for the damage that it attributes to the Defendants…." *Id.* As recognized by another court addressing a very similar conflict, "[t]he conflict found by the Bankruptcy Court affects not merely a determination of the proper defendants in the action ***but whether it should have been commenced in the first place***." *In re Bohack Corp.,* 607 F.2d 258, 261 (2d Cir. 1979) (emphasis added).[47]

The SDR has readily admitted that "Greenberg Traurig attorneys are the ones handling the [Milliman] litigation, and they are the ones who are preparing the case for trial, which is expected to last for several weeks."[48] The SDR has further admitted that "[t]he Receiver and SDR have relied significantly on Greenberg Traurig's advice and institutional knowledge regarding the *Milliman* case."[49] In other words, the SDR has confirmed that Greenberg is the architect of the Milliman Lawsuit. ***This is a huge and insurmountable problem***. Greenberg, ***as the sole counsel of record***, and pursuant to its Rule 11 and other professional and fiduciary obligations, needed to determine the appropriate defendants to sue in the Milliman Lawsuit. Greenberg's and Mr. Ferrario's "advice and institutional knowledge" are tainted by their past representation of Xerox in multiple similar matters. Greenberg and Mr. Ferrario are ethically prohibited from assigning any blame to Xerox with respect to the failures of the CO-OP, and therefore, would be (and have been) much more inclined to blame other parties, such as UHH, the Management Defendants, and the InsureMonkey Defendants. Greenberg cannot act as an impartial arbiter of whether the CO-OP has valid claims against the

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[47] Other cases are in accord with these principles, even with the retention of "limited-scope" counsel or "special counsel." *In re F & C Int'l*, 159 B.R. 220, 222, 223 (Bankr. S.D. Ohio 1993); *In re Ginco, Inc.,* 105 Bankr. 620, 621 (D. Colo. 1988); *In re Townson,* Case No. 12-03027-TOM-7, 2013 Bankr. LEXIS 853, at *14-17 (Bankr. N.D. Ala. March 7, 2013).

[48] Decl. of Mark Bennett, Exhibit 1 to Opp'n, ¶ 25.

[49] *Id.*

Milliman Defendants because it cannot appropriately analyze those claims within the context of Xerox's substantial involvement.[50] Thus, even if Greenberg is truly "limited-scope" counsel, its representation of Xerox still falls directly within that scope***, especially considering the substantial similarities between the class action complaints, the NDOI action, and the allegations against Xerox in the Milliman Lawsuit.***

The Silver State Lawsuit suffers from the same concerns. Silver State has explicitly alleged that Xerox—and not Silver State—is in possession of the funds at issue.[51] Again, Greenberg's conflicts of interest and its inability to sue Xerox has resulted in Greenberg blaming and suing other entities for Xerox's wrongdoing. It is also likely that the WellHealth Lawsuit is similarly tainted, and based on Greenberg's actions, it certainly should not be given the benefit of the doubt. Greenberg simply cannot be permitted to continue litigating against UHH, the Management Defendants, Silver State, etc. "[b]ecause of the possibility that its former client [Xerox] is liable for the damage that it attributes to the Defendants…" *Buckley (In re Southern Kitchens)*, 216 B.R. at 829.[52]

4. Xerox's Involvement in the Milliman Lawsuit Is Genuine.

In another attempt to sidestep its conflicts and associated failures to disclose, Greenberg attempts to shift the blame and point the finger at UHH by insinuating that Xerox's involvement in the Milliman Lawsuit has been contrived solely for the purpose of raising this conflict. Greenberg's unsupported accusations are not surprising coming from counsel with loyalties to Xerox. Of course Greenberg is going to assert that Xerox should not be a Third-Party Defendant. Of course Greenberg is eventually going to oppose the pending Motions for Leave to Add Xerox as a Third-

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[50] A lawyer may not act adversely to a former client in a related matter, or use information learned there to the detriment of the former client. Nevada RPC 1.9.

[51] Answer, Case No. A-20-816161-C, ¶ 22, filed August 24, 2020.

[52] Much of Greenberg's Opposition relies on *In re AroChem Corp.*, in which counsel was permitted, ***following disclosure of the potential conflict and a three-day evidentiary hearing***, to act as "special counsel" despite its prior representation of a creditor of the estate (Wells). Notably, the *AroChem* court considered *Buckley* in its opinion. *In re Arochem Corp.*, 176 F.3d 610, 625 (2d Cir. 1999). In distinguishing *Buckley*, the court determined—***again, following a three-day evidentiary hearing***—that there was "no evidence that Wells might be responsible for the injuries asserted in the Trustee's Texas Action." *Id.* Here, however, there is overwhelming evidence that has been submitted, (expert opinions and other documentary evidence), and none of it rebutted, that Xerox is responsible for the injuries asserted in the Milliman Lawsuit.

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Party Defendant. ***That is precisely the problem with Greenberg's involvement in this case***.

Greenberg cannot explain why practically all of the Milliman Defendants—not just UHH—have sought to implead Xerox as a Third-Party Defendant. Greenberg cannot explain why practically all of the Milliman Defendants' experts—not just UHH's experts—have offered extensive opinions confirming that Xerox is to blame for the CO-OP's failures. The simplest answer is often the correct one. It is because Xerox's involvement is genuine, and eventually, a jury will determine whether the Milliman Defendants are to blame or whether Xerox is to blame. The idea that Greenberg could be involved with any such determination, regardless of whether Xerox becomes a Third-Party Defendant, was thoroughly discussed and denounced in *CFTC v. Eustace*, Nos. 05-2973, 06-1944, 2007 U.S. Dist. LEXIS 33137, at *34-35 (E.D. Pa. May 3, 2007).[53]

Greenberg's argument that Xerox's involvement is contrived was considered and rejected in *Buckley*. As was the case in *Buckley* and as is the case here, "[t]he record manifests a meritorious dispute over the reason for the reorganized Debtor's failure…." *Id.*, 216 B.R. at 828. Even if Xerox were ultimately found to be free from wrongdoing (which is inconceivable),

> [t]his finding, however, would come only after long litigation and trial. In the meantime, the estate's fortunes in this lawsuit would have been in the hands of counsel whose judgment might have been affected by the intangible but persisting influence of past loyalty. Even were the estate to establish its theory of causation, the result could be tarnished by a persisting suspicion that [Xerox's] role was covered up.

Id. at 829. Xerox's involvement cannot be untangled from the Milliman Lawsuit, especially considering it has already been framed and litigated for over three years. The only way to rectify it

[53] In an attempt to distinguish *Eustace*, Greenberg argues it should not be disqualified because only the receiver was disqualified in *Eustace* and counsel was permitted to remain in the case with the assistance of separate counsel. Greenberg glosses over the fact that counsel was only permitted to remain in that case because the court determined that counsel (as opposed to the receiver) did not have a conflict of interest because the firm had not represented the entity at issue in the receivership. *Eustace*, Nos. 05-2973, 06-1944, 2007 U.S. Dist. LEXIS 33137, at *40 (finding there is no conflict after "careful review of Rule 1.7 and Comment 34", which addresses affiliated and subsidiary organization representation.) This important distinction was also one of the reasons—***along with the key fact that the alleged conflict was never concealed from the court***—that the there was no disqualification in *S.E.C. v. Nadel*, relied upon by Greenberg in its Opposition. *Id.*, 2012 WL 12910270, at *8 (M.D. Fla. Apr. 25, 2012). Here, Greenberg represented the exact same Xerox entity in the class actions and the regulatory matter before the NDOI as the Xerox entity at issue in the Milliman Lawsuit and the Silver State Lawsuit (and perhaps even the WellHealth Lawsuit). Thus, not only does Greenberg have a disclosure issue like that discussed in *Eustace*, Greenberg also has a clear conflict of interest with no refuge into Comment 34 of Rule 1.7.

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is to require the Receiver to hire new, unbiased counsel. The Motion to Disqualify should be granted.

5. Greenberg's Conflict of Interest With Valley Remains.

As discussed above, Greenberg has appeared in this Court on numerous occasions, filing 15 separate status reports and numerous motions over a four year period. The SDR is not a Nevada licensed attorney, and thus, can only appear in this Court through Greenberg. Despite this reality, Greenberg and the SDR assert that Greenberg's representation of Valley—***one of the most significant creditors of the receivership estate***—is no longer a conflict because Greenberg has not addressed and will not address any aspect of Valley's claim.[54] But that is not the issue. As recognized by abundant legal authority, Greenberg's representation of Valley and its continued involvement in the receivership action gives the appearance that Valley will be favored over other creditors. *See, e.g., Hilti, Inc. v. HML Dev. Corp.*, Mass. Super. LEXIS 66, at *88-89 (Mass. Super. Ct. Feb. 15, 2007). In a multi-million dollar receivership action that must be conducted beyond reproach, these types of conflicts are unacceptable.

Greenberg alluded to obtaining a conflict waiver from Valley (yet failed to disclose it), which is even further evidence that Greenberg was aware of this issue yet intentionally concealed it from this Court.[55] Nevertheless, this Court needed to be involved with any such waiver to determine whether it could actually resolve the conflict. Unlikely, considering numerous courts have rejected the effectiveness of any such waiver, finding that representing a receivership or bankruptcy estate as well as a creditor of the estate in the same matter is incurable. *See, e.g., In re Project Orange Assocs., LLC,* 431 B.R. 363, 375 (Bankr. S.D.N.Y. 2010); *In re Git-N-Go, Inc.,* 321 B.R. 54, 60 (N.D. Okla. 2004); *In re Am. Energy Trading, Inc.,* 291 B.R. 154, 158 (W.D. Mo. 2003).

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[54] Greenberg asserts that it has not done any work for Valley "in this matter" since December 13, 2016. (Decl. of Mark Ferrario, Ex. 2 to Opp'n, ¶ 20.) This carefully-worded qualification indicates Greenberg likely continued to represent Valley in other matters following that date, especially when compared to Mr. Ferrario's unequivocal statement that "Greenberg Traurig does not currently represent Xerox in any matters." (*Compare with id.*, ¶ 17.) Further, Greenberg has never withdrawn from representing Valley in this matter, meaning its representation of Valley in this matter is still current. Thus, it appears that Greenberg likely represents Valley to this day in this matter and potentially in other matters, something that can be further analyzed if this Court determines that discovery and an evidentiary hearing are necessary.

[55] See fn. 29 and 40 and accompanying text, setting forth the prerequisites to conflict waivers.

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Considering that Greenberg has not been screened from the entire receivership action,[56] and has constantly appeared and continues to appear in this receivership action, Valley's (undisclosed) conflict waiver should not hold any weight. The Motion should be granted, and Greenberg should be disqualified from the receivership action.

C. UHH Has Standing to Object to Greenberg's Conflicts of Interest.

Greenberg's standing argument is erroneously based on the framework of a typical lawsuit, as opposed to a receivership or bankruptcy matter such as this. Greenberg is representing a receiver with fiduciary obligations to every single creditor of the receivership estate. *See Hilti, Inc.,* 2007 Mass. Super. LEXIS 66, at *55-56 ("[A] Receiver owes fiduciary duty to all the parties in interest, including the creditors.…"). In fact, on multiple occasions, ***Greenberg has claimed that the Receiver—and thus Greenberg by extension—also represents all of the creditors***.[57] It logically follows that any creditor would have standing to object to a court-appointed counsel's conflicts of interest that are directly affecting the receivership estate, whether through the failure to maximize the estate's assets (*i.e.*, failing to sue Xerox) or through depletion of the estate's assets due to exorbitant attorney's fees (*i.e.*, billing and receiving over five million dollars in attorney's fees).

Accordingly, in many of the cases cited throughout the Motion and above, the appointed counsel's conflict was raised by creditors of the estate. *See, e.g., In re Bohack Corp.,* 607 F.2d at 262; *In re Envirodyne Indus.*, 150 B.R. at 1011; *In re F & C Int'l*, 159 B.R. 220, 222 (Bankr. S.D. Ohio 1993). As explained by the *Bohack* court:

> In any event, several appellants do have standing. As the bankruptcy judge noted, Gulf & Western Industries, Charles G. Bluhdorn, and Don F. Gaston are listed as creditors in Schedule A-3 filed by the debtor-in possession. They allege that their pecuniary interests will suffer through the depletion of estate assets in the form of fees paid for the continued retention of Shaw & Levine as special counsel. ***Loss of assets is certainly an adverse effect upon the interests of creditors, and is unquestionably related to the bankruptcy proceeding.***

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[56] This assumes that screening is possible, which it likely is not. See Nevada RPC 1.10, which differs materially from the Model Rule.

[57] Am. Compl., ¶ 1, Case No. A-17-760558-C, filed Sep. 24, 2018 ("Plaintiff, is the Commissioner of the Nevada Division of Insurance…and sues in her capacity as NHC's court-appointed Receiver, having brought this action on behalf of NHC, NHC's members, insured enrollees, ***and creditors***.") (emphasis added); *see also id.*, ¶¶ 13, 46, 373.

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In re Bohack Corp., 607 F.2d at 262. In other instances, the conflict was raised by a defendant which had been sued by conflicted counsel. *See, e.g.*, *Eustace*, Nos. 05-2973, 06-1944, 2007 U.S. Dist. LEXIS 33137, at *13; *Buckley (In re Southern Kitchens)*, 216 B.R. at 821; *In re Townson*, Case No. 12-03027-TOM-7, 2013 Bankr. LEXIS 853, at *2. These types of parties have standing as well, as the conflict very well may have resulted in conflicted counsel blaming other parties for its client's wrongdoing. For example, UHH has been harmed by Greenberg's inability and unwillingness to blame Xerox, meaning that Greenberg has instead blamed parties such as UHH. UHH is a creditor of the receivership estate ***and*** has been sued by conflicted counsel, and therefore has standing pursuant to the above authority.[58]

Additionally, although the Nevada Supreme Court has not addressed standing within the context of a receivership, the exception set forth in *Liapis v. District Court* would certainly encompass this particular situation. *Id.*, 128 Nev. 414, 420, 282 P.3d 733, 737 (2012) ("[I]f the breach of ethics 'so infects the litigation in which disqualification is sought that it impacts the nonclient moving party's interest in a just and lawful determination of her claims, she may have the standing needed to bring a motion to disqualify based on a third-party conflict of interest or other ethical violation.'") (citation omitted). Greenberg's Xerox and Valley conflicts of interest have certainly infected and continue to infect these various proceedings. This is a multi-million dollar receivership which must be conducted beyond reproach, and any impropriety subjects the entire proceeding to scrutiny. As set forth in a similar bankruptcy context, "'the conduct of bankruptcy proceedings not only should be right but must seem right.'" *In re Bohack Corp.*, 607 F.2d at 263 (citation omitted). And as set forth above, Greenberg's conflicts have resulted in substantial harm to UHH's interests as a creditor as well as a defendant being sued by conflicted counsel. Accordingly, UHH has standing to object to Greenberg's various conflicts.

D. <u>UHH Did Not and Could Not Waive its Right to Object to Greenberg's Conflict.</u>

In another attempt to sidestep its concealment and its disabling conflicts of interest, Greenberg raises another technicality—waiver. Yet again, Greenberg fails to recognize that the

[58] UHH Proof of Claim, attached as Exhibit 25.

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typical waiver argument that may apply to a former client does not apply to the unique conflicts that arise within the context of bankruptcy and receivership matters. *In re Coastal Equities, Inc.,* 39 B.R. at 306 n. 2 ("There exists an independent duty to comply with the Code and Rules, and fully inform the Court. This was the Applicant's responsibility and it was not discharged by informing those who were not in a position to judge the fitness of an attorney for employment. Only the Court can make such a determination, and it has not granted a waiver."). *In re Envirodyne Indus.,* 150 B.R. at 1016 (confirming that bankruptcy courts do not permit noncompliance with conflict rules to be excused by waiver); *In re Am. Energy Trading, Inc.,* 291 B.R. 154, 158 (W.D. Mo. 2003) (same).

Assuming, *arguendo*, UHH was legally capable of waiving a conflict that has infiltrated this receivership action and most of its related lawsuits, Greenberg's assertion that UHH should have immediately known all the details of Greenberg's ***confidential*** attorney-client representation of Xerox and Valley is ridiculous. It should not be lost on this Court that Greenberg is trying to capitalize on the fact that UHH was ***not*** Greenberg's client for the purposes of its standing argument. In doing so, Greenberg is talking out of both sides of its mouth. ***The fact that UHH was not Greenberg's client means that UHH was not privy to the type of information that would permit UHH to immediately raise this conflict***. ***And as discussed in detail above, Greenberg successfully concealed these conflicts from this Court and all of the estate's creditors—including UHH—by failing to disclose them at the time of its appointment, or any other time for that matter***. Under these circumstances, it would be particularly inequitable to find a waiver of these serious conflicts.

Greenberg argues that its representation of Xerox in the class actions was public record, ***but fails to cite any authority indicating that UHH was required to exhaustively search the court docket for any and all of Greenberg's conflicting representations***. Greenberg also argues that UHH has "offered *no explanation whatsoever* for their delay in raising this supposed conflict that they have known about for years."[59] Greenberg fails to mention that UHH included an entire section in its Motion explaining how and when it became suspicious that Greenberg's representations of Xerox were affecting the Receiver's litigation decisions (*i.e.*, Greenberg's failure to sue Xerox along with Silver State

[59] Opp'n, 20:8-10 (emphasis in original).

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in June 2020), and thus began to inquire further into these issues.[60] UHH sent correspondence to Greenberg (to which Greenberg refused to substantively respond), served public records requests on numerous government agencies including the NDOI (through which UHH learned of Greenberg's representation of Xerox before the NDOI), and served discovery requests on the CO-OP in the Milliman Lawsuit (in which UHH conclusively learned that the CO-OP had not settled any potential claims against Xerox).[61] UHH needed to discover all of this information before it could appropriately bring this Motion before the Court. Likewise, UHH needed a full understanding of Xerox's wrongdoing and how it affected the CO-OP's claims against UHH—information that was finally confirmed upon completion of the Milliman Defendants' expert reports in October 2020. As ill-conceived as it is, Greenberg's waiver argument should be rejected.

E. The SDR's Assertions of Prejudice Can (and Should) Be Remedied by Requiring Greenberg to Disgorge Its Ill-Gotten Attorney's Fees.

Greenberg and the SDR argue that if Greenberg is disqualified, even from just the Milliman Lawsuit, the Receiver—***who has not said a thing about any of this***—will suffer extreme prejudice because Greenberg is the only law firm familiar enough with all of these proceedings to continue litigating them. Of course, Greenberg's and the SDR's cries of prejudice should fall on deaf ears considering they are solely to blame for this. ***They are the ones who decided to conceal these disabling conflicts of interest from this Court for years***.

Regardless, UHH's Motion includes the perfect and legally-supported remedy to cure this prejudice to the Receiver—disgorgement of Greenberg's attorney's fees. After Greenberg returns its ill-gotten attorney's fees to the receivership estate (approximately five million dollars), the estate will have more than enough assets to hire substitute counsel to get up to speed. While this may result in a delay, mere delay does not constitute undue prejudice, ***especially considering these matters will likely be delayed in any event due to COVID issues and trial setting backlogs***.

With respect to the disgorgement remedy, Greenberg's fleeting arguments are quite tepid. UHH cited numerous opinions in its Motion which confirm that the Court has the authority to deny

[60] Mot. to Disqualify, 14:9-15:14.

[61] *Id*.

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compensation from conflicted counsel to the extent those conflicts were undisclosed.[62] *See also In re Futuronics Corp.*, 655 F.2d at 471 (requiring disgorgement for a failure to disclose). It is now undisputed that Greenberg did not disclose these conflicts despite being aware of them at the time, thereby making that authority directly applicable. Further, Greenberg's argument that denying it compensation is inappropriate because Greenberg has already been paid is simply ludicrous. ***That approach would permit any conflicted counsel to retain its fees as long as it was able to conceal its conflicts long enough to get paid***, certainly not a sound policy in any respect. Courts do not allow bank robbers to keep stolen money if they are able to avoid getting caught for a prolonged period.

Finally, Greenberg's standing argument with respect to disgorgement fails for the same reason as its standing argument with respect to disqualification.[63] UHH is a creditor of the receivership estate and has been sued by conflicted counsel. Regardless, in this instance, the Court certainly has discretion to order disgorgement for the benefit of the receivership estate and to avoid the prejudice which Greenberg and the SDR have attempted to articulate. Accordingly, this Court should order that Greenberg's ill-gotten attorney's fees be returned to the receivership estate.

F. <u>If This Court Believes Additional Information Is Necessary, Discovery and an Evidentiary Hearing Are Appropriate.</u>

Greenberg and the SDR want this Court to take them at their word ***after admittedly concealing these conflicts of interest for almost four years***. They want this Court to simply accept that Greenberg was "limited-scope" counsel without actually providing any documentary proof of such an agreement. For the reasons set forth above, Greenberg must be disqualified regardless of the scope of its retention. However, if the Court does believe additional information is necessary, it should order discovery and an evidentiary hearing. To be sure, the vast majority of Greenberg's cited authority in support of its "limited-scope" argument all conducted some sort of evidentiary hearing to determine whether certain conflict remedies were sufficient. *See, e.g., In re Arochem*

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[62] Mot. to Disqualify, 27:11-22.

[63] Greenberg relies solely on one inapposite unpublished decision from 2014 in support of this argument. It should also be noted that the Nevada Supreme Court would never accept such a decision as precedent considering it predates January 1, 2016. Nev. R. App. P. 36(c)(3).

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Corp., 176 F.3d at 617 ("the court noted that throughout three days of hearings"). Greenberg does not provide any legitimate reason to deny such a process here.

V. CONCLUSION

Greenberg and the SDR have duped this Court and all of the creditors of the receivership estate. Despite their admitted knowledge of Greenberg's disabling conflicts, they have been hiding them for years. Only after they were caught did they come forward with some sort of pretextual and illogical justification why Greenberg's representation of Xerox and Valley is appropriate. That was for this Court to decide four years ago. Greenberg and the SDR chose not to involve this Court, ***likely because they knew it would wisely tell the Receiver to choose different and unconflicted counsel (depriving Greenberg of a substantial economic gain)***. Even worse, Greenberg's so-called conflict remedies did not actually resolve these conflicts because Xerox and Valley remain entrenched in all aspects of these proceedings. The only possible way to remedy this infection is to remove its source—Greenberg. And in order to avoid any prejudice to the receivership estate, Greenberg should be disqualified and forced to disgorge to the receivership estate the entirety of its fees.

DATED this 8th day of December, 2020.

BAILEY❖KENNEDY

By: /s/ Dennis L. Kennedy
DENNIS L. KENNEDY
JOHN R. BAILEY
JOSEPH A. LIEBMAN
Attorneys for Unite Here Health and Nevada Health Solutions, LLC

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CERTIFICATE OF SERVICE

I certify that I am an employee of BAILEY❖KENNEDY and that on the 8th day of December, 2020, service of the foregoing **REPLY IN SUPPORT OF UNITE HERE HEALTH AND NEVADA HEALTH SOLUTIONS, LLC'S MOTION TO: (1) DISQUALIFY GREENBERG TRAURIG, LLP AS COUNSEL FOR THE STATUTORY RECEIVER OF NEVADA HEALTH CO-OP; AND (2) DISGORGE ATTORNEY'S FEES PAID BY NEVADA HEALTH CO-OP TO GREENBERG TRAURIG, LLP**, was made by mandatory electronic service through the Eighth Judicial District Court's electronic filing system on all parties with an email address on record in this case.

/s/ Sharon L. Murnane
Employee of BAILEY❖KENNEDY

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EXHIBIT 18

EXHIBIT 18

DISTRICT COURT

CLARK COUNTRY, 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; UNITE HERE HEALTH, is A multi-employer health and welfare trust as defined in ERISA Section 3(37); DOES I TRHOUGH X inclusive; and ROE CORPORATIONS I-X, inclusive, Defendants.	CASE NO. A-17-760558-C DEPT. NO. XVI

EXPERT REPORT OF XAVIER OUSTALNIOL, CPA, CFF, CIRA

October 02, 2020

I. Qualifications

1. I am the partner in charge of the San Francisco office of StoneTurn, LLC, ("StoneTurn"), in California. StoneTurn is a consulting firm, which provides to companies and their counsel forensic accounting and investigative services, compliance and monitoring, data analytics, forensic technology and litigation consulting services. I have 30 years of combined professional experience providing litigation consulting, forensic accounting, and audit related services in a variety of contexts. I started my career as an auditor with Deloitte & Touche, where I audited a number of companies in a variety of industries.

2. I graduated in 1990 with a B.A./Masters Degree from the University of Paris IX, "Dauphine", in Financial and Accounting Techniques. I am a Certified Public Accountant ("CPA") in New York and California, I hold a certification in Financial Forensics, and I am a Certified Insolvency and Restructuring Advisor.

3. I have worked on litigation and bankruptcy matters in various capacities including performing damages analyses, lost profit analyses, conducting investigations into fraud, improper financial reporting, audit malpractice, other breach of contract related disputes, and other consulting assignments. I have been involved with the identification, analysis and aspects of the resolution of bankruptcy claims and avoidable transfers as part of the restructuring team of large debtors, as consultant to trustees, and for the benefit of creditors in some of the largest bankruptcies (Enron, Lehman Brothers and others). Recently, I was involved with the estimation process of damages suffered by torts claimants in the PG&E bankruptcy on behalf of the Torts Claimants Committee.

4. I have provided consulting services and expert testimony relating to damages calculations, the proper application of generally accepted accounting principles, including in connection with bankruptcy proceedings and in other contexts. I have been involved with insurance related disputes as well. I testified as an expert in federal court, provided affidavits and testimony before the ITC and at arbitration proceedings.

5. My curriculum vitae, which summarizes my qualifications and professional experience, including testimony experience and articles is attached as **Exhibit 1**.

II. Scope of Services

6. I have been retained as an expert in this matter by Unite Here Health ("UHH") and its subsidiary Nevada Health Solutions ("NHS") (collectively, "UHH/NHS") to assist counsel at Seyfarth Shaw,

LLP and Bailey Kennedy, LLP (collectively, "Counsel") in connection with the complaint filed on August 25, 2017 (the "Original Complaint")[1] by the Receiver (the "Receiver")[2,3] for Nevada Health CO-OP[4] ("NHC"), subsequently amended on September 24, 2018 ("2018.09.24 Plaintiff Amended Complaint"). NHC is a Consumer Operated and Oriented Plan Program ("CO-OP").

7. I have been asked by Counsel to review, evaluate and rebut certain alleged damages analyses and opinions offered by the Receiver and several experts retained on behalf of the Receiver in this matter. In particular, I reviewed the following expert reports:[5]

    1) Mr. Mark Fish reports dated July 30, 2019 ("2019 Fish Report") and February 07, 2020 ("2020 Fish Report"),

    2) Mr. Henry William Osowski reports dated July 30, 2019 ("2019 Osowski Report") and February 07, 2020 ("2020 Osowski Report"), and

    3) Joseph DeVito Report dated July 30, 2019 ("DeVito Report").

8. Messrs. Fish and Osowski each provided two expert reports dated July 2019 and February 2020. Neither has explained whether their latest expert report supersedes the former, or why a second report was prepared. Without such explanation, their conclusions and analyses, can be contradictory, supplemental or overlapping.

9. I will refer to Messrs. Mark Fish, Henry Osowski and Joseph DeVito collectively as the "Plaintiff's Experts" and their reports collectively as the "Plaintiff's Experts' Reports." My work on this matter is ongoing. This report summarizes my current opinions given the information available to date. If additional information is produced after the issuance of my report, I may modify or supplement my

[1] State of Nevada Commissioner of Insurance, Barbara D. Richardson, in her official capacity as Receiver for Nevada Health CO-OP v. Milliman, Inc. et. al, District Court, Clark County, Nevada, Case No. A-17-760558-C Original Complaint filed on 08-25-17.
[2] The Commissioner of the Nevada Division of Insurance, Barbara D. Richardson, in her official capacity as NHC's court-appointed Receiver.
[3] State of Nevada Commissioner of Insurance, Barbara D. Richardson, in her official capacity as Receiver for Nevada Health CO-OP v. Milliman, Inc. et. al, District Court, Clark County, Nevada, Case No. A-17-760558-C Amended Complaint filed on September 24, 2018.
[4] CO-OP is short for Consumer Operated and Oriented Plans, which were created as a program by the Patient Protection and Affordable Care Act ("ACA"). *See*, https://content.naic.org/cipr_topics/topic_health_co_op.htm, accessed 09-13-20.
[5] Also, I read the undated draft report of the Special Deputy Receiver ("SDR") for Nevada Health CO-OP ("SDR Draft Report"). No updated version of such report was provided at the time of the submission of my report. It refers to various calculations and theories of causation relating to UHH and NHS and other defendants, *inter alia*, but was not finalized, to my knowledge. The SDR does not claim to present itself as a damage expert and did not issue a final report.

analyses and opinions. None of my conclusions should be deemed or are intended to be a legal analysis or opinion.

III. Compensation

10. StoneTurn is compensated at an hourly rate of $750 for my services in connection with this matter. I was assisted by StoneTurn professionals and other consulting professionals working under my direction. Neither StoneTurn's nor my compensation is dependent upon my conclusions reached in this matter or its outcome.

IV. Summary of Opinions

11. My opinions set forth below are based upon my analysis provided hereafter of the documents and information relied upon, listed in **Exhibit 2** to my report, my research, and my professional experience, training and education.

12. I have formulated the following summary opinions:

    1) Mr. Fish does not provide an analysis of or establish the causal link/effect between the actions of UHH and the alleged damages suffered by NHC. NHC would have been insolvent in any event because of other contributing factors independent of UHH and NHS that are not considered by his analysis, including but not limited to the unforeseeable failure by the federal government to pay monies owed under the federal loans program valued by the SDR to be approximately $55 million, other changes to the regulatory environment and market-based issues, and the fact that NHC was in start-up mode and thereby relied heavily on the monies promised to it by the federal government and faced various operational challenges.

    2) Mr. Fish does not explain how UHH could have been in a position to influence or decide the timing of the disclosure of NHC's insolvency, at any point in time. Although the "deepening insolvency" theory of damages used by Mr. Fish has been previously applied to actions attributable to management, auditors, and lenders, UHH is not one of these actors. Acting solely as a third-party administrator in 2014 and 2015, UHH did not prepare NHC's financial statements and was not part of NHC; thus, UHH was not in a position, at any point in time, to disclose the insolvency of NHC.

3) Even assuming that the calculations presented, endorsed and adopted by Mr. Fish (from other experts or the SDR) could be assigned entirely to actions or inactions of UHH/NHS, they do not measure damages supposedly suffered by NHC because (1) liabilities allegedly owed to various creditors by NHC are not losses to NHC but rather to the creditors, (2) the losses incurred by NHC between two dates during which NHC was overseen by either management or the SDR – not UHH which never managed NHC – do not measure the incremental effect of the actions or inactions of UHH on the profitability of NHC, and (3) the SDR had not established whether some or all of these claims are valid liabilities.

4) Further, the calculations performed by Mr. DeVito based on the SDR status reports, adopted, endorsed and repackaged as damages by Mr. Fish under the term of "*Damages Due to Premature and Ill Prepared Commencement of Operations,"* are overstated by at least approximately $13,309,000 simply because Mr. Fish failed to perform due diligence and update Mr. DeVito's calculations with information that was available at the time of issuance of the 2020 Fish Report.

5) Mr. Fish's calculations are overstated as they consistently fail to exclude recoveries sought or actually already received by the Receiver through actions against other defendants or other parties that should decrease the alleged damages asserted against UHH/NHS as they relate to the same damage claims.[6] Mr. Fish presents the same amounts as damages multiple times from multiple defendants for different and/or similar causes of action. These alleged damages would not put NHC in the position it would have been "but for" the alleged actions or inactions of UHH/NHS and other defendants but would instead put NHC in a better financial position, which is not a correct measure of damages.

6) Mr. Fish fails to explain whether alleged damages are claimed concurrently or separately based on each cause of action. Claiming such damages concurrently

[6] For example, the SDR has a pending action against the Silver State Health Insurance Exchange (the "Exchange") for the uncollected premium payments of $510,651 and a pending action against the United States in the Court of Federal Claims for the amounts owed to NHC under the CO-OP program. The SDR has already settled claims against Millennium and is receiving settlement progress payments. Further, Mr. Fish does not offset the cost of services provided for free by the Culinary Health Fund or explain how such expenses would have been avoided if a different third-party administrator ("TPA") had been retained. Lastly, the Receiver collected $10 million from a third party in connection with the sale of receivables from the government, which I discuss later in my report (*See,* **Exhibit 3**).

would result in duplicative claims and a windfall for NHC and would be inappropriate as it results in claiming multiple times the same amounts from different or the same defendant. In fact, even assuming for the sake of argument that UHH and NHS were to be held responsible for the collapse of the NHC, my opinion is that such double counting by Mr. Fish, the SDR and Mr. DeVito, would result in a windfall of as much as approximately $818 million. (See, section C and **Exhibit 3**).

7) The remaining analyses performed by the SDR and endorsed and presented as damages by Mr. Fish, due NHC by UHH/NHS, are flawed for the following reasons:

   - Based on my analysis, UHH did not make a profit and did not unjustly enrich itself by approximately $7.7 million. Mr. Fish failed to provide a basis for adopting the SDR's calculations.
   - The reason why NHC did not collect approximately $6.2 million as claimed by the SDR is independent from UHH's actions or inactions, and because Mr. Fish failed to analyze whether it was attributable to other parties and he ignored NHC's and the United States government's role, he failed to establish any causation between the alleged damages and UHH and thus these amounts could not constitute damages.
   - Uncollected premiums of approximately $510,000 are not damages caused by UHH. Mr. Fish failed to analyze or evaluate the actions of other parties such as Xerox and the Exchange in his analysis and therefore cannot conclude that these are damages are attributable to UHH/NHS.

8) Plaintiff's Experts rely on each other's conclusions in a circular manner, and ultimately rely extensively on the SDR Draft Report or status reports, which were not prepared by anyone identified as an expert. They are mostly endorsing or adopting each other's calculations, and ultimately the SDR's calculations, without explaining the methodologies or the extent of their work to ascertain the

calculations performed by the SDR, their consultants, or the employees of NHC who remained with the SDR, as would be expected of damage experts.[7]

V. Background

A. Case Background

13. NHC, a successor to Hospitality Health, Ltd. ("Hospitality Health") was formed in October 2012 to provide Nevada citizens health insurance under the ACA. NHC started writing policies effective as of January 1, 2014. After NHC started experiencing financial and operating difficulties, a Temporary Receiver was appointed on October 1, 2015 followed by a Permanent Receiver on October 14, 2015 as well as the SDR.[8] NHC was declared insolvent and placed in liquidation on September 20, 2016.[9]

14. On August 25, 2017, the Permanent Receiver in her official capacity as court-appointed receiver for NHC filed a complaint against NHC's management, and some of its service providers, including NHS, its auditors, actuaries, consultants providing technology services, generally claiming their conduct led to NHC's losses and subsequent liquidation.[10]

15. The Amended Complaint, filed on September 24, 2018, added UHH as a defendant and lists seventy-two (72) causes of action against six providers of service, in addition to NHC's management defendants. I understand that the claims include negligence, professional malpractice, fraud, breach of fiduciary duties, breach of contract and unjust enrichment.[11]

16. In addition, on March 16, 2017, the Receiver for NHC sued the United States government to recover amounts due under various provisions of the ACA.[12] I also understand that certain parties are engaged in arbitration proceedings, such as NHC's actuarial firm and NHC has settled with others.

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[7] In the SDR Draft Report, the SDR refers to NHC employees who remained with the SDR and shared information, but we do not know who they are. The SDR Draft Report includes place holders and approximately seventy footnotes with document titles that are not referenced to any underlying Bates number, even though the SDR claims that footnotes to documents relied upon are provided where necessary.
[8] *See*, 2016.01.13 SDR First Status Report, at p. 3.
[9] *See*, 2016.10.06 SDR Fourth Status Report, at p. 8.
[10] *See*, 2017.10.06 SDR Eighth Status Report, at pp. 8-9; 2018.09.24; 2018.09.24 Plaintiff Amended Complaint, at p. 2.
[11] *See*, 2018.09.24 Plaintiff Amended Complaint, at pp. 60-119.
[12] Barbara D. Richardson, in her capacity as Receiver of Nevada Health CO-OP v. U.S. Department of Health and Human Services, United States District Court of Nevada, Case No. 2:17-cv-00775-JCM-PAL, Complaint filed on 03-16-17 ("CMS Complaint").

timely pay providers, among various other allegations.[86]

10. Nevada State Exchange and Xerox

53. The Exchange is a "state agency that operates the online [health insurance] Marketplace."[87] In 2014, the Exchange was managing enrollment and determining eligibility status without assistance from the federal government. Starting in 2015, the Exchange was still a state-based exchange but relied on the federal government to "determine eligibility and enrollment functions."[88] Collections of premiums was also handled by the state and Xerox.[89] As explained by Mr. Dibsie, "[w]e didn't have to generate a bill, mail it to the members and collect the money. That was all done [by the state and Xerox]."[90]

54. Xerox was the contractor originally hired by the Silver State Health Insurance Exchange Board ("Exchange Board") to manage the Exchange enrollment data. The relationship was abruptly ended in May 2014 by the Exchange Board citing to "performance as the reason for dropping the contractor."[91]

55. I understand that NHC started experiencing issues with Xerox as early as October 2013. A February 19, 2014, NHC Board Meeting mentions "three meetings a week with the Governor's office, the other carriers and Xerox to communicate the challenges the CO-OP is experiencing with data submission from Xerox to the CO-OP [...] with [...] more than 3,000 members that are on Xerox pending list that the CO-OP has not received any data on to date."[92] Xerox's mismanagement and issues were considered as "negatively impacting the CO-OP's membership"[93] and having failed to communicate eligibility to the CO-OP for some consumers. These issues were discussed on several occasions during NHC's subsequent Board meetings.[94] Some of the concerns ranged from Xerox being "untimely in their reporting", to the need to"[r]esolve Xerox issues", the CO-OP "working through reconciling items with Xerox", Xerox's "payment collection process...only working at 45%

[86] State of Nevada, Ex Rel. Commissioner of Insurance, Barbara D. Richardson, in her official capacity as Receiver for Nevada Health CO-OP v. WellHealth Medical Associates. et. al, District Court, Clark County, Nevada, Case No. A-20-818118-C Original Complaint filed on 07-16-20, at p. 8.
[87] *See*, https://www.nevadahealthlink.com/sshix/, accessed 08-30-20.
[88] *See*, https://www.rgj.com/story/money/business/2014/05/20/nevada-health-board-dumps-xerox-insurance-exchange/2285756/, accessed 08-30-20.
[89] *See*, 2019.03.27 Deposition of Basil Dibsie ("Dibsie Deposition 1"), at p. 35.
[90] *See*, Dibsie Deposition 1, at p. 43.
[91] *See*, https://www.rgj.com/story/news/2014/05/20/nevada-drops-xerox-health-insurance-exchange-contractor/9354649/, accessed 08-30-20.
[92] *See*, 2014.02.19 NHC Board Minutes (LARSON014367-68).
[93] Id.
[94] *See*, NHC Board Minutes (LARSON014352-55).

capacity to accept payments [...] and Xerox [...] has drained the CO-OP's resources as no less than 50% of the CO-OP's resources have been committed to Xerox and Xerox related issues since October 2013."[95]

56. I understand that ultimately, NHC assumed some of the responsibilities of the Exchange and Xerox, as a federal exchange was substituted. At the end of 2014, the state "[...] fired Xerox and the functions that Xerox was performing got transitioned to health plans [...] that's the point where [NHC] had to start doing the billings to the members."[96] After that transition, IM was responsible for putting together the program for doing the billing to members.[97]

57. I understand that the Receiver has also filed a separate lawsuit against the Exchange seeking to recover damages for unpaid insurance premiums in the amount of approximately $510,000, the same type and amount of damages it also seeks to recover against UHH in this lawsuit, which I address later in my report.

C. Overview of the Affordable Care Act and Consumer Operated and Oriented Plan Programs

58. Congress enacted the ACA in March 2010.[98] The ACA included a series of reforms designed to make affordable health insurance available to more people, expand the Medicaid program, and support "innovative medical care delivery methods" to lower the cost of health care.[99]

59. Additionally, under the ACA, insurers could not take "pre-existing conditions"[100] into account when deciding whether to provide health insurance,[101] and generally requires each person to maintain insurance coverage or make a payment to the Internal Revenue Service ("IRS") and gives tax credits to certain people to make insurance more affordable.

1. Overview Consumer Operated and Oriented Plan Programs

60. I understand that 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

[95] See 2014.05.23 NHC Board Minutes (LARSON014354, 355 and 388).
[96] See, Dibsie Deposition 1, at p. 58.
[97] Id., at p. 147.
[98] See, https://www.healthcare.gov/glossary/affordable-care-act/, accessed 09-28-20.
[99] Id.
[100] A pre-existing condition is any personal illness or health condition that was known and existed prior to the writing and signing of an insurance contract. See, https://www.cigna.com/individuals-families/understanding-insurance/what-is-a-pre-existing-condition, accessed 10-01-20.
[101] See, https://www.hhs.gov/answers/affordable-care-act/can-i-get-coverage-if-i-have-a-pre-existing-condition/index.html, accessed 09-28-20.

Exchange in the amount of the alleged unpaid/uncollected premiums.[211] In my opinion, Mr. Fish is wrong to present these amounts as alleged damages because of UHH actions or inactions.

G. Mr. Fish Calculations of Pre-Judgment Interest Are Wrong and Overstated

146. Counsel has informed me that the appropriate statutory interest to consider as pre-judgement interest is as follows: "...the judgment draws interest from the time of service of the summons and complaint [...] at a rate equal to the prime rate at the largest bank in Nevada as ascertained by the Commissioner of Financial Institutions on January 1, or July 1 [...] plus 2 percent."[212]

147. I reviewed Mr. Fish's calculation of interest as used in his alleged "*Damages Due to Premature and Ill Prepared Commencement of Operations*" and alleged "*Damages Due to Avoidable Costs of Additional Losses in Continued Operations*". He starts his calculation on July 1, 2015 for the alleged "*Damages Due to Premature and Ill Prepared Commencement of Operations*" and September 1, 2015 for his alleged "*Damages Due to Avoidable Costs of Additional Losses in Continued Operations*" instead of the date of the original complaint on August 25, 2017, which is inconsistent with the above. Despite the fact that overall Fish's numbers are unreliable, I recalculated Mr. Fish interest calculation applied to his alleged damages by properly adjusting the start date of the interest calculation, showing that Mr. Fish interest on alleged "*Damages Due to Premature and Ill Prepared Commencement of Operations*", are overstated by approximately $15.7 million (see, **Exhibit 12**) and interest on alleged "*Damages Due to Avoidable Costs of Additional Losses in Continued Operations*" by approximately $7.5 million (see, **Exhibits 13 and 13.1**) by using the proper date.

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148. My analysis is ongoing. If additional information becomes available subsequent to the date of my report, I reserve the right to supplement or amend my opinions.

Xavier Oustalniol

10/02/2020
Date

[211] See, 2020.06.05 State of Nevada, Ex, Rel. Commission of Insurance, Barbara D. Richardson, in Her Official Capacity as Receiver for Nevada Health CO-OP v. Silver State Health Insurance Exchange Complaint.
[212] See, Nevada Revised Statutes 17.130 Computation of amount of judgment; interest. https://www.leg.state.nv.us/NRS/NRS-017.html#NRS017Sec130 accessed 09-18-20.

EXHIBIT 19

EXHIBIT 19

CODING CONTINUUM, INC.

Expert Report
Prepared by
Christina Melnykovych, BS, RHIA, CFE, AHFI
Tina Pelton, RN, MS, CCS, CPC, CEMC, CCDS, COC, CRC

October 2, 2020

Re: ***State of Nevada, ex rel. Commissioner of Insurance, Barbara D. Richardson, In Her Official Capacity as Receiver for Nevada Health CO-OP v. Milliman, Inc., et al, Case No. A-17-760558-C***

I. Introduction and Professional Background

On July 25, 2019, Unite Here Health ("UHH") and Nevada Health Solutions, LLC ("NHS"), or collectively, either "the Client" or "UHH/NHS", retained the services of Coding Continuum, Inc. ("CCI"), to conduct an independent investigation in the aforementioned matter. The purpose of CCI's engagement was to review documents and formulate opinions in response to Plaintiff's Amended Complaint submitted on September 24, 2018, the draft "Special Deputy Receiver's Report for Nevada Health CO-OP, Causation and Damages for Key Vendors Unite Here Health, Nevada Health Solutions, and Insure Monkey" disclosed on August 5, 2019, and Plaintiff's experts Suzanne Schlernitzauer's and Henry Osowski's opinions prepared on July 30, 2019 and disclosed by the Plaintiff on July 31, 2019. On February 7, 2020, Plaintiff disclosed a second report prepared by Mr. Osowski. The second report is substantially different than his July 30, 2019 report.

CCI was asked to formulate opinions as more fully set forth below on the following seven issues:

- Whether UHH materially contributed to the failure of the CO-OP[1] by participating in the launch of the CO-OP.
- Whether, under the circumstances, UHH properly performed TPA services for the CO-OP.
- Whether UHH caused or contributed to the CO-OP's backlog of claims.
- Whether UHH was responsible for claims paid outside of eligibility for both medical and pharmacy services.
- Whether UHH was responsible for overpayment of claims for both medical and pharmacy services.
- Whether NHS properly performed utilization management services for CO-OP under the circumstances.
- Whether NHS failed to protect the financial interests of the CO-OP by failing to conduct utilization management activities.

[1] The use of the acronyms "CO-OP" and "NHC" in this Expert Report refer to the Nevada Health CO-OP.

This case is comprised of millions of documents that serve as the basis for allegations made by Plaintiff. Unlike Plaintiff, which has had nearly five (5) years to review this matter and, which, according to Plaintiff's Response to Unite Here Health's First Set of Requests for Admissions "[H]as not completed its investigation and/or discovery of all facts which support claims and defenses of this action"[2], CCI has had a mere fourteen (14) months, including time constraints resulting from the COVID-19 pandemic, to review documents and formulate its opinions. As of this writing, it is our understanding that approximately three million documents have been disclosed in the matter. According to Donald L. Prunty, Counsel for Plaintiff, "There's tens of millions of documents." (Deposition of Kathleen Silver, Page 247, Line 13). It is CCI's understanding that discovery is ongoing. Based on Plaintiff's 26th Supplemental Disclosure dated September 18, 2020, Plaintiff has identified no fewer than 210 witnesses, the great majority of whom have not yet been deposed.

On October 14, 2015, in Clark County, Nevada District Court, a Permanent Receiver was appointed, making the CO-OP's receivership permanent. On August 5, 2019, Plaintiff disclosed the Special Deputy Receiver's ("SDR") Draft Report. According to the draft report, work by the SDR, specifically re-adjudication of health provider claims, commenced "upon assuming control of the daily operations of NHC."[3] The report states that, "Throughout 2017, these re-adjudications were performed, following a careful review of NHC's network health agreements and other policies which affect the proper payment amount on health claims."[4]

In his expert report dated July 30, 2019, when discussing UHH, Mr. Osowski states, "Damage amounts were computed by the Special Deputy Receiver and ***appear reasonable based on the work I have performed."***[5] (Emphasis added) In an effort to determine the breadth and scope of Mr. Osowski's work, CCI requested information regarding his retention date. Despite requests by Defendants to determine the nature and timing of Mr. Osowski's retention as a consultant and/or expert for Plaintiff, no information regarding the amount of time he and his staff have been accorded to conduct an independent evaluation has been forthcoming.

The aforementioned factors, including an absence of time, such as that accorded to the SDR and Plaintiff, the dearth of critical deposition testimony from the majority of fact witnesses, the lack of disclosure of critical documents (*e.g.* Salesforce system notes), and the voluminous amount of documents and data in this case, have precluded a fulsome investigation of this matter by CCI. Nonetheless, its work includes a detailed assessment of claims associated with categories of damages asserted by Plaintiff in this case, notably claims allegedly paid outside of eligibility and those associated with alleged overpayments. CCI's analysis of each claim is memorialized in a series of exhibits attached hereto as **Exhibits 8-12**. CCI also reviewed a voluminous number of documents and interviewed UHH and NHS personnel. A list of sources consulted, and personnel interviewed is attached hereto as **Appendices A1 and A2.**

CCI will opine on the acts of third parties and the CO-OP that interrupted, disrupted, or materially impacted UHH's and NHS' services under their respective agreements. It did not

[2] Plaintiff's Response to Unite Here Health's First Set of Requests for Admission, 8/7/2020, p. 2, Lines 18-19
[3] SDR Draft Report, PLAINTIFF02479819
[4] *Ibid.*
[5] Expert Report of Henry Osowski, July 30, 2019, p. 44

perform an exhaustive review of the basis and reasoning for the CO-OP's actions and decisions under the circumstances that existed at the time those actions took place and decisions were made. CCI's findings are memorialized in the body of this report and in spreadsheet exhibits that address myriad subjects including 1) Plans/Evidence of Coverage/Schedule of Benefits ("Plans/EOCs/SOBs"), 2) Xerox/Eligibility, 3) Networks/Out Of Network/Providers Not on List/Vendors ("Networks/OON/PROVNOL/Vendors") and, 4) Claims/Crossover Issues. **Appendix F** is a key of employee/vendor initials and associated names referenced on CCI's **Exhibits 2-5**.

In addition, CCI examined and will respond to Ms. Schlernitzauer's expert opinions pertaining to the performance of NHS, and those of Mr. Osowski pertaining to UHH. Separate exhibits attached hereto respond to each of Ms. Schlernitzauer's case review findings.

Coding Continuum, Inc.

CCI is a nationally recognized consulting firm based in Tucson, Arizona. Founded in 2000, CCI provides a variety of services, all of which are directly related to the management of health information and revenue cycle functions. Services include vulnerability assessments, detailed medical coding and billing compliance reviews/audits, operational assessments, internal investigations, documentation reviews, and other client-requested services pertaining to the management of health information and revenue cycle operations. CCI also conducts self-disclosure audits for providers/practitioners who identify problems resulting in potential overbilling to federal health benefit programs. Providers/practitioners voluntarily disclose information to the Health and Human Services ("HHS") Office of Inspector General ("OIG"), including the estimated amounts of overpayments that must be returned.

In addition to its work for the provider community, CCI provides litigation support services to both plaintiffs and defendants. It provides expert testimony and consulting services to parties in matters pertaining to allegations of improper medical coding and/or billing. Its experts have been qualified in both civil and criminal cases. CCI clients include the U.S. Department of Justice ("DOJ"), including offices of the United States Attorney and Federal Bureau of Investigation ("FBI"), state Attorneys General ("AG"), some of the largest insurance carriers/health plans in the United States, welfare plans, self-funded plans, and nationally-recognized law firms. In addition to its expansive work for the DOJ, CCI also functions as an Independent Review Organization ("IRO"), conducting independent reviews for a number of clients who are operating under Corporate Integrity Agreements ("CIAs") pursuant to settlements with HHS-OIG.

CCI's coding/auditing and billing consultants have extensive experience evaluating the accuracy of ICD-9-CM/ICD-10-CM/PCS, CPT® (including Evaluation and Management ["E/M"] codes), HCPCS, and modifier use. They are well acquainted with coding rules and conventions as well as guidelines regarding proper use of specific nomenclatures, reimbursement methodologies such as MS-DRGs, APCs, CMGs, RUGs, and federal/state claims submission requirements. Most are dually credentialed by the American Health Information Management Association ("AHIMA") and the American Academy of Professional Coders ("AAPC"). CCI consultants have diverse backgrounds that include healthcare fraud examination and investigation, compliance, clinical practice, education, healthcare administration, health information management, clinical documentation improvement, revenue cycle operations, contracting,

reimbursement analysis, and cost report preparation. Two of CCI's experts have prior experience working for the Centers for Medicare and Medicaid Services ("CMS").

CCI's work for the provider community (including forensic audits and investigations, as well as operational assessments) includes engagements with large academic medical centers, community hospitals, large and small practice groups, and individual providers. Engagements frequently include baseline and compliance audits, education, vulnerability assessments, ongoing monitoring, and comprehensive pre- and post-payment reviews. CCI's services are customarily associated with compliance program initiatives, defense audits and litigation support for both plaintiffs and defendants. CCI has also conducted educational programs for its clients whose express purpose has been to provide general and individualized education on coding principles and applications, guidelines, regulatory requirements, medical necessity, and appropriate use of electronic health records ("EHRs").

II. Project Manager

Christina Melnykovych, BS, RHIA, CFE, AHFI

I am the President and CEO of CCI. I am a health information management professional, a fraud examiner and fraud investigator. I received my Bachelor of Science degree in Health Information Management from the University of Kansas in 1982 and am credentialed as a Registered Health Information Administrator ("RHIA") by AHIMA. I have maintained my AHIMA membership and credentialed status since 1982. I am also a Certified Fraud Examiner ("CFE") and an Accredited Health Care Fraud Investigator ("AHFI"). In addition to AHIMA, I am a member of the Association of Certified Fraud Examiners ("ACFE"), the National Health Care Anti-Fraud Association ("NHCAA"), the AAPC, the Health Care Compliance Association ("HCCA"), the Arizona Health Information Management Association ("AzHIMA"), the American Association of Healthcare Administrative Management ("AAHAM"), and the Women Business Leaders of the U.S. Health Care Industry Foundation ("WBL"). I also serve as a Strategic Consultant for Epstein Becker Green Advisors ("EBGA").

I have managed health information management, patient financial services, quality improvement, case and utilization management, social work, and disease management departments in quaternary, tertiary and community hospital settings. Since 1983, my responsibilities have included revenue cycle department operations at large teaching facilities and community hospitals, including hospital-owned practice locations. I served as the primary point of contact for contracted review organizations both prior to and after the inception of Medicare's Payment Error Prevention Program (Hospital Payment Monitoring Program). While employed in the provider community, I served on Corporate Compliance Committees and was the primary point of contact for outside counsel on matters pertaining to organizational compliance.

In my capacity working for the Veteran's Administration ("V.A.") and Valley Medical Center in Washington State, as the Medicare Part B contract administrator for the State of Washington, the Director of Health Information and Outcomes Management in Arizona, and the President and CEO of Coding Continuum, Inc., I have had extensive experience with regulatory compliance issues, both at the federal and state level, and have had administrative and operational responsibility for large programs and large staffs. At the inception of my career as an RHIA, it

was imperative that I understand Medicare's new Diagnosis Related Group ("DRG") prospective payment system model and its associated regulatory language. I provided physician education on the topic and was the primary point of contact for ongoing reviews performed by the local Peer Review Organization ("PRO") that conducted routine audits of clinical records at St. Luke's Hospital in Kansas City, Missouri, where I worked as the DRG Control Manager. I was directly involved in installation of a sophisticated encoding and grouping product and was responsible for reporting hospital statistics both internally and to external organizations.

My role as the Section Chief of Medical Information Services in Seattle required that I fully understand and apply policy language unique to the V.A., as well as Joint Commission accreditation standards. As the Acting Chief of Ward Administration and Chief of Medical Information Services, I was directly involved in administering and assuring adherence to policies addressing responsibilities of ancillary staff on patient care units and those that pertained to operations of both sections. I conducted reviews of Soldiers' Homes operated by the V.A. that were located outside of the Seattle metropolitan area. The V.A. operated a Mental Hygiene Clinic as well as inpatient psychiatric units. It was incumbent on me to ensure that policies related to documentation and management of health information for mental health and substance abuse were strictly adhered to. I was also directly involved in selection of an encoding and grouping product, evaluation of a proposed Ambulatory Payment Group model, submission of critical, time-sensitive data directly influencing the hospital's annual budget, conversion to a lab ordering system, and audits of the facility's skilled nursing unit.

As the Director of Medical Records and Patient Accounts at Valley Medical Center (a public hospital district facility), I was directly responsible for on-site surveys, particularly those associated with health record and billing reviews by the Washington State Department of Social and Health Services ("DSHS") and the PRO. Any on-site visits in association with complaints necessitating access to clinical records were coordinated and managed by me. I was required to understand billing and payment policies for federal, state, and commercial payers and to respond to issues arising from the submission of claims to those entities. I was directly responsible for management and administration of plans and contracts between the facility and third-party payers to assure proper billing, payment posting, collection activity, and reimbursement management. I was directly responsible for two system installations, the design, development and testing of release of information software, the negotiation of a third party contract designed to provide dictation and transcription services to a private practice group that provided emergency care at the facility, and the establishment of the facility's transitional care unit ("TCU"). I represented management during negotiations with the local labor union.

As Vice President, Medicare Part B, for the State of Washington, I was responsible for administration of the statewide Medicare Part B contract. My responsibilities included claims processing, appeals, fair hearings, program integrity (*i.e.* fraud and abuse), medical and utilization review, coverage, Medicare secondary payer, Medicare IT, and provider relations. The Medicare Part B Medical Director reported to me. I was the principal point of contact for communications with the Seattle Regional Office of the HHS OIG for purposes of case referrals for further investigative follow-up. During my tenure with Medicare, I was responsible for implementation of Physician Payment Reform and the education of 20,000 providers in Washington State regarding changes to Medicare Part B payment policy. As a Part B contractor, I was accorded

millions of dollars in program investment dollars to assure that all necessary changes were made to the IT system, that all providers, statewide, received education and that an appropriate administrative structural framework was instituted to assure a smooth transition to Physician Payment Reform, in accordance with CMS (at that time the Health Care Financing Administration or "HCFA") requirements.

I was also required by CMS to address its requirements for shared claims systems use by its contractors. This resulted in the company providing a formal response to an RFP issued by the State of Montana. As the selected shared system contractor, it was my responsibility to convert State of Montana Part B operations to our IT system, including training of personnel in Helena, MT in the use of our system. This included all claims processing functions as well as those delineated above. During my tenure, I was directed by CMS to consolidate Washington's statewide bureau system to Seattle's central operational location within a 90-day period.

At University Medical Center ("UMC") in Tucson, AZ, I was responsible for directing administrative, financial, and clinical activities. Arizona's Health Care Cost Containment System ("AHCCCS") is one of the most innovative and progressive Medicaid systems in the United States. In addition to fee-for-service payment, AHCCCS contracts with numerous Managed Care Organizations ("MCO") for services to its Members. I was directly responsible for ensuring that health records were maintained in accordance with State requirements and that University Medical Center billed compliantly to Medicare, AHCCCS and commercial payers. I routinely reviewed newly negotiated and amended payer contracts and was responsible for coordination of plans and contracts to assure compliance with preauthorization, quality and utilization, and billing requirements. I was a permanent member of the Compliance Steering Committee and, prior to the appointment of a Compliance Officer, I was the principal point of contact for outside Counsel for compliance-related matters. During my tenure, I was responsible for a major system upgrade to UMC's Patient Financial Services ("PFS") patient registration, billing, and collection system.

As a teaching facility, UMC enjoyed a close relationship with a large practice group, University Physicians, Inc. ("UPI") and the University of Arizona's College of Medicine. I worked closely with UPI's CEO, department and section chiefs, and directors when the organization prepared for National Committee for Quality Assurance ("NCQA") accreditation, including addressing implementation of the Healthcare Effectiveness Data and Information Set ("HEDIS"). Critical issues involving faculty and the practice plan necessitated that I work with the Dean of the College of Medicine.

Because of my background and experience with regulatory requirements, compliance, and physician issues, I was asked by the facility's CEO and the Chief of Surgery to assume responsibility for UMC's Quality Management Department in advance of the Joint Commission on Accreditation of Healthcare Organization ("JCAHO") survey, including its addition of performance improvement ("IOP" or "PI") standards to its survey process. I was also asked to assume responsibility for Case and Utilization Management, Social Work, and development of disease management programs, including programs for the management of diabetes and wound care. When CMS announced implementation of its Outpatient Prospective Payment System ("OPPS") model, I provided education to more than three thousand employees at UMC, largely because of my regulatory background and intimate acquaintance with regulatory policy articulated

in the OPPS Final Rule in the Federal Register. In my capacity as the Director of Patient Financial Services, I monitored clinical department performance to assure proper application of policies and procedures associated with the facility's transition to an outpatient prospective payment model.

During eight years with UMC, I was a point of contact for AHCCCS audits, Condition of Participation ("COP") surveys and JCAHO (now "Joint Commission") surveys. When UMC acquired several UPI clinics and converted them to provider-based clinics, I was part of the integration team to ensure that compliant coding and billing of facility and professional component fees occurred. Because UMC was a "teaching facility" with residency programs, I was relied upon for consultation pertaining to Medicare's supervision standards for attending physicians. I was also consulted regarding use of nonphysician practitioners ("NPPs") in freestanding and provider-based clinic settings and correct application of "incident to" regulatory requirements.

Since founding CCI, I have worked directly with numerous jurisdictional offices of the DOJ, as well as the DOJ in Washington, DC. Much of the work I perform is related to civil false claim matters and, in connection with those matters, I have worked both with federal and state governments and with law firms representing relators. In addition, I have been retained to work on criminal matters with both DOJ and AG offices in several jurisdictions as well as by defense counsel. In 2019, I provided testimony in the landmark "Escobar" case on issues of materiality and public policy.

CCI routinely works on cases that concern claims that have been presented to fee-for-service Medicare, Medicaid and Tricare programs, and Medicare's Part C program based on risk adjustment data. CCI has conducted large risk adjustment audits of Medicare Part C documentation to address proper coding and classification of diagnoses submitted by health plans administering Part C benefit programs.

Our client case load is very diverse and includes work pertaining to outpatient hospital, freestanding clinic, inpatient, Partial Hospitalization Program ("PHP"), home health, hospice, long term acute care ("LTAC"), Durable Medical Equipment ("DME"), Independent Rehabilitation Facility ("IRF"), emergency room, urgent care, freestanding diagnostic, skilled nursing home ("SNF"), and other health care services. We have evaluated issues related to dual-eligibility and state-funded Medicaid services. The subject matter varies and is frequently based on alleged violations of specific language contained in federal and/or state statutes, the Code of Federal Regulations ("CFR"), and other regulatory policies.

In addition to being a retained consultant and expert by DOJ and AG, I work with counsel for defendants who have come under scrutiny by federal, state, or commercial payers. I have been engaged as an expert by firms that provide services to welfare plans, including preauthorization, claims processing and payment, and special investigations. We have evaluated the work of TPAs and compliance with contracted obligations. Our company has a reputation for independence and providing unvarnished opinions regarding allegations. I conduct my work impartially and without prejudice. As an RHIA, CFE, AHFI, and testifying expert, it is critical that I maintain the ethical standards of each professional organization that has accorded me credentials and that I subscribe to tenets associated with expert work.

During my career, I have been asked on numerous occasions to present information regarding coding and billing compliance at national, regional, and local seminars. I have spoken at conferences sponsored by DecisionHealth, HCPro, American Healthcare Radiology Administrators, AHIMA, and AAPC. I have been interviewed by *Modern Healthcare, Briefings on APCs,* and *Radiology News.* I have provided technical expertise to the American Healthcare Radiology Administrators' *Link Coding Q & A* and have served on the advisory boards of HCPro's *APC Answer Letter* and CCH's *Compliance Edge.* I have taught the Compliance and Documentation chapters of the AAPC Professional Coders ("PMCC") curriculum. A copy of my resume is attached hereto as **Appendix B**.

As I indicated above, I have been asked to provide expert witness services on numerous occasions during the last twenty years. I have been retained by counsel for both providers and payers (including government payers) and have testified regarding coding, billing, accuracy rates, indicia of fraud, payer policies, regulatory language, materiality, and the propriety of clinical documentation. A list of my deposition and trial testimony within the past four years is attached hereto as **Appendix C**.

Tina Pelton, RN, MS, CCS, CPC, CEMC, CCDS, COC, CRC
Project Lead

I am a Registered Nurse ("RN"). I have a Master of Science ("MS") from the University of California, San Francisco with a major in Adult Critical Care Nursing and a minor in Emergency/Trauma Nursing. In addition to my nursing credentials, I have multiple certifications and licenses, including current status as a Certified Coding Specialist ("CCS"), Certified Professional Coder ("CPC"), Certified Evaluation and Management Coder ("CEMC"), Certified Clinical Documentation Specialist ("CCDS"), Certified Outpatient Coder ("COC"), and Certified Risk Adjustment Coder ("CRC"). I am a member of the American Association of Critical-Care Nurses ("AACN"), the American Academy of Professional Coders ("AAPC"), American Health Information Management Association ("AHIMA"), and the Association of Clinical Documentation Improvement Specialists ("ACDIS").

During my extensive career, I have held several positions in community, academic and long-term care settings. My primary clinical orientation has been in areas providing Critical Care (Neonatal, Pediatric & Adult), Cardiovascular, Cardiothoracic, Emergency and Trauma Care (Pediatric & Adult), and Medical/Surgical services. I have experience working as a Case Management and Utilization Review ("CM/UR") nurse, a position which requires strong clinical background. I am experienced in reviewing clinical documentation to determine the appropriateness of admission, care levels, and severity of illness. I am skilled in the application of InterQual® and MCG (formerly known as Milliman Care Guidelines®) admission, concurrent, and discharge criteria. I have extensive experience interacting with payers regarding concurrent and retrospective utilization review and facilitation of patient discharge planning needs.

In 2003, I assumed a role as a Clinical Documentation Specialist ("CDS") in a highly complex quaternary care academic medical center in Tucson, Arizona. In my capacity as a CDS, I routinely reviewed clinical documentation and interacted with healthcare providers regarding Medicare Severity Diagnosis Related Group ("MS-DRG") patient populations. My role required an

understanding of Medicare and other federal payer requirements for admission, medical necessity, International Classification of Diseases, 9th & 10th Clinical Modification ("ICD-9-CM/ICD-10-CM") coding nomenclature, MS-DRGs (including Risk of Mortality and Severity of Illness), CPT® coding nomenclature, Recovery Audit Contractor ("RAC") initiatives, rehabilitative services, and multiple other concepts associated with compliance and regulatory standards.

In my capacity as both a CM/UR and CDS nurse, I was required to access and review claims and associated billing information for individual patient accounts. I was responsible to review and obtain, if missing, authorization for admission and continued stays. I was required to document all my interactions with health plans and payers, including reviews and outcomes, in the claims and billing system. As a senior level staff member, I was frequently involved in management of concurrent and retrospective payer authorization denials, aka "Denial Rebuttals". I was responsible for review of clinical records, application of UR criteria, coordination with medical team members as needed, and preparation of either verbal or written rebuttals.

In 2010, I joined CCI as a Senior Consultant. My responsibilities include reviews of clinical records for the appropriateness of care levels and severity of illness, including the application of nationally accepted criteria set such as InterQual® and Milliman®. In addition, my role includes, but is not limited to, conducting detailed charge audits; reviews of coding, claims and billing information, and MS-DRG assignments; and assessments related to Health Information Management and revenue cycle operations. I have extensive experience accessing and reviewing claims and billing information in paper and electronic formats, including claims histories and other pertinent claims information for purposes of conducting forensic analyses. In my capacity as a Senior Consultant/Operations Manager, I routinely review cases for plaintiffs and defendants. I have worked on cases addressing the propriety of TPA services and those of Special Investigation Units ("SIUs").

I have provided consulting and expert witness services on multiple occasions during the past ten (10) years. I have been retained by counsel for both plaintiffs and defendants. A copy of my resume is attached hereto as **Appendix D.**

CCI's rate for services in this matter is $350-$400 per hour. Expert testimony is billed at a flat rate of $3,200 per day for the first eight hours and $400 per hour for every hour thereafter. Preparation of expert reports is billed at a rate of $500 per hour. CCI's fees are not contingent on the outcome of this lawsuit.

III. Background Information

Relevant background information is attached hereto as **Appendix E.**

IV. Project Scope and Approach

Project Scope

The scope of CCI's work, as discussed in Section I, focused on four (4) aspects of operations, including UHH's participation, as the CO-OP's TPA, in the launch and ongoing claims operations, payment of claims outside of eligibility, overpayment of claims, and utilization management

activities[6]. It also includes opinions regarding the work of the SDR and Plaintiff's experts, Suzanne Schlernitzauer and Henry Osowski.

Approach

As part of its investigation, CCI initiated a three-pronged approach: 1) document review, 2) teleconference and in-person interviews of UHH and NHS personnel, and, 3) analysis of statistically valid random samples ("SVRS" or the "samples") of Medical and Pharmacy claims drawn from the universe(s) of claims alleged by Plaintiff and the SDR to have been paid outside of eligibility and overpaid by UHH. As referenced earlier in this report, the SDR represented in its draft report (disclosed on August 5, 2019), that throughout 2017, it re-adjudicated claims after carefully reviewing NHC's network health agreements and other policies affecting the proper payment amount on health claims.

CCI requested that a SVRS from each universe identified by Plaintiff be drawn by a qualified expert. CCI requested that samples be drawn for each of the two calendar years of the CO-OP's operations (2014 and 2015), and that the samples represent Medical and Pharmacy claims. Pursuant to its request, Counsel delivered stratified samples to CCI, with instructions to review one hundred percent (100%) of each Certainty Stratum and a minimum of thirty (30) non-Certainty Stratum claims. Each group of selected claims was bifurcated by Medical and Pharmacy claims. CCI was instructed that, time permitting, it should evaluate additional non-Certainty Stratum claims in groups of thirty (30) claims with each increment of claims it reviewed, i.e. Medical and Pharmacy claims. A depiction of samples reviewed by CCI is attached hereto as **Exhibit 1.**

At CCI's request, it was granted "live system" access to Eldorado's Javelina system on January 23, 2020, with training in use of the system conducted on January 28, 2020. The purpose for according "live system" access to CCI was to assure that the system available to CCI replicated the contemporaneous system available to UHH during its tenure as the CO-OP's TPA[7]. The "live" version CCI worked with included contemporaneous eligibility and claims processing modules and associated data, images, and system notes entered by UHH, the CO-OP, and InsureMonkey Customer Care Center personnel during the timeframe encompassing calendar years 2014 and 2015. As referenced earlier in this report, CCI did not have access to the Salesforce system.

Exhibits detailing CCI's findings of its review of documents and claims samples are attached hereto and are specifically enumerated in later sections of this report.

V. Expert Opinions: Summary

Based on our expertise, experience, and review of materials relative to this matter, it is our opinion that:

[6] In addition to UHH, the CO-OP processed claims, including adjusting, pricing, and paying claims. Under a Per Member Per Month (PMPM) arrangement, WellHealth paid providers directly until a change was made to FFS (Fee-for-Service) processing by UHH, at the CO-OP's direction. Eldorado assisted the CO-OP with claims processing, including adjustments and "clearing" queues. It also was retained by the CO-OP to load plan and network information in 2015. In addition, the CO-OP engaged First Health to perform prior authorization, pre-certification, transitional care, and pricing.

[7] *Ibid.*

1. The CO-OP was solely responsible for the decision to "launch" on January 1, 2014, and for all operational decisions, prior to and after the launch (until receivership). External and internal factors, none of which are attributable to UHH, contributed to the demise of the CO-OP.
    a. UHH properly performed TPA services for the CO-OP under the circumstances.
    b. The CO-OP, not UHH, caused its own backlog of claims.
2. UHH did not improperly pay Medical or Pharmacy claims outside of eligibility.
3. UHH did not improperly overpay Medical or Pharmacy claims.
4. NHS properly provided utilization management services to CO-OP members, complied with industry standards and, in doing so, protected the financial interests of the CO-OP.
5. Mr. Osowski fails to address consequential factors associated with the CO-OP's operations and, in doing so, errantly assigns responsibility to UHH for the CO-OP's failure.
6. Mr. Osowski's representation that he conducted an analysis resulting in damages to the CO-OP is not substantiated by an articulated methodology and associated work product.
7. Mr. Osowski's opinion that damage amounts computed by the SDR appear reasonable is unsupported by a documented, independent methodology supporting his opinion.
8. Mr. Osowski's characterization of acts by UHH is baseless, inappropriate and does not comply with ethical standards of conduct for experts.

VI. Basis and Reasoning for Opinions

1. The CO-OP was solely responsible for the decision to "launch" on January 1, 2014, and for all operational decisions, prior to and after the launch (until receivership). External and internal factors, none of which are attributable to UHH, contributed to the demise of the CO-OP.

a. UHH properly performed TPA services for the CO-OP under the circumstances.

b. The CO-OP, not UHH, caused its own backlog of claims.

Based on its review of documents in this matter, CCI has concluded that, as the entity contracted with HHS-CMS, the CO-OP had sole purview regarding the decision to "launch" or "go live" on January 1, 2014, and for all decisions, prior to and after the launch. In addition, CCI isolated three principal factors that contributed to the CO-OP's operational challenges, and which contributed to its demise. These three factors materially impacted UHH operations, including claims processing. Because of the complexity of each, CCI has provided some basic background regarding the development of all the CO-OPs, in general, in **Appendix E**. The report narrative addresses the basis, reasoning, and context for CCI's opinions. Exhibits that substantiate each factor's influence on the CO-OP's operations and its deleterious impact on UHH operations and claims processing are attached hereto and referenced, as applicable.

Xerox Data Reconciliation: "Board of Directors heard CO-OP attorneys prospective (sic) on this topic. Action: Ms. Egan will provide CO-OP legal counsel a narrative of the issues the CO-OP encountered as a result of the bad data the CO-OP received from Xerox' termination file."[92]

Minutes of the Regular Meeting of the Formation Board of Directors of Nevada Health CO-OP: November 25, 2014

CEO Report [Xerox Reconciliation]: "***COOP sent letters to 1,900 members on the termination list as directed by the Board.*** To date, 53 members were found to be on the termination list in error, 9 members made payment arrangements and other have asked to be terminated. At the end of the month, all members that have not responded will be terminated. Action: A re-analysis of all members suspended/pended as of November 1, 2014 will be conducted including an assessment of liability. The findings will be brought to the Board for discussion at the next meeting."[93] (Bolded and italicized for emphasis)

Minutes of the Regular Meeting of the Formation Board of Directors of Nevada Health CO-OP: February 4, 2015

Enrollment: "The COOP had daily combined calls with Eldorado, InsureMonkey, NHC enrollment and operations teams' regarding data reconciliation for eligibility and payments. Enrollment data is received by the COOP through the federal exchange, NHC portal and paper applications. Payments are being received through: 1) Healthcare.gov 2) Authorize.net 3) NHC web portal 4) US mail 5) Bank drafts. The COOP experiences challenges receiving payments when the Healthcare.gov portal crashes and gives an error message to members that the carries (sic) will contact them for payment but the carrier is unaware of the member trying to make payment."[94]

Minutes of the Regular Meeting of the Formation Board of Directors of Nevada Health CO-OP: April 1, 2015

Legal/Compliance [Xerox Reconciliation] "The Silver State Exchange has proposed to carriers that the reconciliation process with Xerox be discontinued"[95]. [This is also addressed in Exhibit 3, CCI#47]

Despite public information and private discussions regarding the detrimental impact of Xerox's failure in its administration of the Silver State Exchange, Plaintiff, including her expert, (Henry Osowski), fails to acknowledge Xerox's catastrophic impact on CO-OP operations and carriers, in general. Moreover, Sections 2.2 (c) and 2.2 (e) of the ASA are clear in addressing the responsibility of the CO-OP to assure timely, valid, accurate, and complete information to its TPA (UHH), including regular scheduled eligibility data transfers. From all the evidence examined by CCI, that simply did not happen.

[92] LARSON014415
[93] LARSON014419
[94] LARSON015837
[95] PLAINTIFF00237320

There is no acknowledgement by Plaintiff or Mr. Osowski that Xerox played a significant role in consuming 50% of the CO-OP's resources from open enrollment on October 1, 2013 through May 2014, when it was reported to the Formation Board. CCI's Exhibit 3, titled "Xerox/Eligibility", chronicles how Xerox-related issues plagued the CO-OP during the entire 2014 calendar year, and thereafter. On July 28, 2015, Dr. Nicole Flora addresses the work of Indegene, a company retained by the CO-OP to assist with submission of the CO-OP's risk data to HHS-CMS. "While, clearly, I would have liked a better financial outcome, I was pleased with them as our vendor. ***Our (mainly Xerox) data was hugely problematic and consumed all of the resources we had planned, limiting our ability to be proactive."***[96] (Bolded and italicized for emphasis)

Emails reviewed by CCI (and referenced herein, unless otherwise specified, on Exhibit 3), between CO-OP personnel and those that include UHH, reveal communications with Xerox that include inaccurate information conveyed to CO-OP personnel, changes to the testing schedule, clarification of previously-provided information, all of them occurring perilously close, or after, the open enrollment period. On October 3, 2013 (Exhibit 3, CCI #8C), the CO-OP's CEO sends an email to Tanchica Terry (CMS) to address "Opening day report". He tells her, "Our biggest challenge remains the functionality of the state exchange. Since the vast majority of our individual market will be eligible for subsidies (advance premium tax credit), ***much of our fate is tied to the performance of the Exchange. The technical issues at the Exchange prevented people across the state, including our enrollment specialists, from completing applications for subsidies in order to formally enroll in subsidy-eligible plans."***[97] (Bolded and italicized for emphasis)

On October 15, 2013 (Exhibit 3, CCI #9), Shane Gruchow (Xerox) informs Pamela Egan (CO-OP) and Gwen Harris (CO-OP), "Based on recent issues, it was not feasible for us to produce the EDI transactions this week, so we have had to delay EDI testing until the ***end of the month. This was not something we wanted to do, but the result of a challenging schedule and unforeseen issues.***" (Bolded and italicized for emphasis)

By November 4-5, 2013, testing continues and it becomes obvious that Xerox is failing to provide sufficient testing data, "We did learn on a recent call with the Exchange that they sent the full spreadsheet ***including cases for which they did not send 834s***. ***They did this in order to meet their stated deadline of last Friday."*** (Exhibit 3, CCI #12). By the end of November, 2013, Pamela Egan sends an email to CO-OP personnel and Gary Odenweller and Brooke Gearhart, "All – Gwen [Harris] has agreed to take on the challenge of keeping track of our issues re: EDI testing and making sure we get the information we need back and forth from our team to the Exchange and Vice Versa, so I'm copying her on this note. If you could all copy Gwen on your correspondence with the Exchange, that will help her help us!" (Exhibit 3, CCI #16) (Bolded and italicized for emphasis)

On December 30, 2013, the CO-OP realizes it has a problem related to unique ID numbers when Randy Plum (CO-OP Director of Operations) sends an email to Lisa Simons (CO-OP Enrollment Manager) and Pamela Egan (Exhibit 3, CCI #20A), "Lisa, There is going to be a problem using one cert number for all family members, and that is when a person goes to a

[96] PLAINTIFF01131000
[97] PLAINTIFF00962798

Assertions by Mr. Osowski in his report that UHH "failed to track eligibility"[102] demonstrates not only his lack of understanding of industry standards, as discussed above, but his failure to fully investigate the CO-OP's organizational structure, its eligibility processes, and directives such as the one issued on August 12, 2014, by CO-OP personnel.

Communications regarding the aforementioned issue continued into early-August 2014 (Exhibit 5, July 2014 [7/17-8/2] CCI#15) and culminated with an email from Randy Plum to Lisa Simons, "I don't think you have the ability to delete lines (correct?). I suggest then that the pending line get added, *deleted by UHH* after the claim is processed, and lots of documentation put into notes both in the enrollment and claims notes." (PLAINTIFF00014968). In its review of allegations pertaining to claims paid outside of eligibility, CCI found no instance of improper "tampering" with the eligibility file by personnel at UHH. The function described and authorized by Mr. Plum was restricted to UHH supervisory personnel. (Italicized for emphasis)

Any assertion by Plaintiff, or Plaintiff's expert Henry Osowski, that UHH acted improperly or in violation of the terms of the ASA, as it pertains to eligibility, is patently false. The failures of Xerox sapped CO-OP and UHH resources. It impeded timely claims adjudication by UHH, while claims sat in the eligibility queue awaiting confirmation of eligibility status by CO-OP personnel. Off-exchange issues, including the decision to omit the SSN from off-exchange member enrollment requirements was a CO-OP decision that exhausted resources. The CO-OP was directly responsible for the costly impact of merging member IDs, calculating accumulators for members with multiple numbers, and other sequelae resulting from "dubious decisions", to quote Mr. Odenweller. (Underlined for emphasis)

Xerox's failure impacted the CO-OP's ability to provide timely, reliable information to UHH, as required by Sections 2.2 (c) and 2.2 (e) of the ASA.

C. Timely, Complete, and Accurate Network and Associated Provider Information

Grant Application Package: Submitted January 1, 2012

In the Grant Application Package submitted to HHS by Hospitality Health, Ltd., dated January 1, 2012, the following representations were made regarding provider networks and plans for network expansion in the Proposal Narrative:

"In 2014, HHC will begin ***providing coverage to Southern Nevadans*** (home to 70% of the state's population) ***using a large PPO network***."[103] (Bolded and italicized for emphasis)

"CHF ("Culinary Health Fund") ***will provide the stability of an existing large provider network.***"[104] (Bolded and italicized for emphasis)

[102] Osowski Expert Report, February 7, 2020, p. 7
[103] MGT002715
[104] *Ibid.*

To attribute the failure of Nevada Health CO-OP to UHH and NHS, without regard for the CO-OP's and Xerox's evident failures, is an oversimplification of the facts, and the context in which they occurred. In CCI's opinion, it is nothing more than a naked attempt to assign blame where it does not belong.

Any new information with respect to this case will be considered and may impact our opinions and analyses. As such, we reserve the right to amend or supplement our opinions if additional information becomes available.

Christina Melnykovych, BS, RHIA, CFE, AHFI

Tina Pelton, RN, MS, CPC, CEMC, CCDS, COC, CRC

EXHIBIT 20

EXHIBIT 20

EXPERT REPORT

Richardson v. Milliman, Inc., et al.

Case No: A-17-760558-C

Sabrina Corlette, J.D.
Research Professor
Georgetown University McCourt School of Public Policy
600 New Jersey Avenue, NW
Washington, DC 20001
202-687-3003
September 29, 2020

Statement of Qualifications

I, Sabrina Corlette, J.D., am a Research Professor on the faculty of Georgetown University's McCourt School of Public Policy, located in Washington, D.C. I have worked on health policy issues for 25 years, and studied the regulation of private health insurance for 22 years.

In 2010, I founded and now co-direct the Center on Health Insurance Reforms, a non-profit research arm of Georgetown's McCourt School, composed of a team of nationally recognized experts on private health insurance policy and health reform. I study health insurance underwriting, marketing, and products, as well as the complex and developing relationship between state and federal rules governing the health insurance marketplace. I am an expert on the ACA and its implementation. I support federal and state policymakers and regulators with policy expertise, and have published numerous research papers and policy briefs on private health insurance, the ACA, and the financing and delivery of health care. I have testified several times before U.S. Congressional committees on health insurance policy and the ACA, and am frequently asked by congressional staff to provide technical assistance on the development of private insurance-related legislation. I also frequently assist officials with CMS and state departments of insurance with the development of regulations and sub-regulatory guidance governing health plans and health insurance markets. I am sought out as an expert by major media outlets to explain health insurance policy developments and market trends. In the last several months, my media appearances have included: CNN, Washington Post, New York Times, PBS NewsHour, CBS News, Associated Press, National Public Radio, American Public Media's Marketplace, USA Today, The Hill, Politico, Chicago Tribune, Minneapolis Star-Tribune, NBC

News, Los Angeles Times, Philadelphia Inquirer, Washington Examiner, Fortune, The Atlantic, Houston Chronicle, Axios, Miami Herald, CQ/Roll Call, MSNBC, and many more.

I have been invited to provide testimony on health insurance policy to the following committees of the U.S. Congress:

- U.S. House Education and Labor Committee hearing, "Examining Threats to Workers with Pre-existing Conditions," February 6, 2019.
- U.S. Senate Homeland Security and Government Affairs Committee Hearing, "The History and Current Reality of the U.S. Health Care System," September 2017.
- U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health Hearing, "Health Care Solutions: Increasing Patient Choice and Plan Innovation," May 2016.
- U.S. House of Representatives Committee on Education and the Workforce Subcommittee on Health, Employment, Labor and Pensions Hearing, "Innovations in Health Care: Exploring Free-Market Solutions for a Healthy Workforce," April 2016.
- U.S. Senate Health, Education, Labor and Pensions Committee Subcommittee on Primary Health and Retirement Security Hearing, "Small Business Health Care Challenges and Opportunities," July 2015.
- U.S. House of Representatives Ways and Means Subcommittee on Health Hearing, "The Individual and Employer Mandates in the President's Health Care Law," April 2015.
- U.S. House of Representatives Energy and Commerce Subcommittee on Health Hearing: "Obamacare Implementation Problems," November 2013.

- U.S. Senate Health, Education, Labor and Pensions Committee Hearing, "A New, Open Marketplace: The Effect of Guaranteed Issue and New Rating Rules," April 2013.

I am often asked to speak as a health insurance expert before a wide range of audiences. Although too numerous to list all of them here, a sample list of my speaking engagements, exclusive of congressional testimony, includes:

- A series of three webinars for 500+ state officials on federal implementation of the health care provisions in the Families First Coronavirus Recovery Act and the Coronavirus Aid, Relief, and Economic Security Act. March 18, 26, and April 16, 2020.
- A briefing for congressional staff on pending legislation to protect patients from surprise out-of-network medical bills (approximately 30 House and Senate staff). February 27, 2020.
- Presentation to America's Health Insurance Plans (the national trade association of health insurance companies) on ACA implementation (approximately 300 health plan executives). March 15, 2019.
- Presentation to the U.S. Department of Health & Human Services' (HHS) Agency for Health Care Research and Quality on the individual market under the ACA (approximately 50 state and federal officials). September 6, 2019.
- A briefing for the HHS' Center on Consumer Information and Insurance Oversight (CCIIO) on ACA implementation issues (approximately 70 CCIIO staff). December 3, 2018.
- Testimony before California General Assembly Select Committee on Health Delivery Systems and Universal Coverage. January 17, 2018.

- Briefing for Democratic Senate Health Legislative Staff on ACA implementing rules (approximately 40 staff). November 7, 2017.
- Presentation for University of Minnesota's Humphrey School of Public Affairs on the Individual Insurance Market (approximately 75 state officials, health care stakeholders, and faculty). July 26, 2017.
- Presentation to Grantmakers in Health, an umbrella group for health care philanthropies, on ACA implementation (approximately 40 foundation executives). June 21, 2017.
- Presentation to National Association of Attorneys General on the Future of Health Reform (approximately 100 state attorneys general and their staff). April 27, 2017.
- Presentation for U.S. Senate Republican Policy Committee on individual market health insurance issues (approximately 40 GOP legislative staff). April 6, 2017.
- Webinar for health care foundation CEOs on Affordable Care Act issues (approximately 30 CEOs of U.S. health care foundations). October 21, 2016.
- Presentation to National Council of State Insurance Legislators on the ACA's CO-OP program (approximately 100 state legislators and health care stakeholders). July 15, 2016.
- Presentation to Association of Health Care Journalists on small-group health insurance market issues (approximately 50 health care journalists). September 30, 2015.
- Presentation to Federal Reserve Bank of Richmond's Board of Directors on ACA implementation (approximately 50 bank directors and staff). February 4, 2014.

Prior to founding the Center on Health Insurance Reforms, I was the Director of Health Policy at the National Partnership for Women & Families, a non-profit nonpartisan organization advocating for quality health care. In that role, I provided strategic oversight and day-to-day direction for the organization's efforts to improve insurance markets, health information technology, and the financing and delivery of health care services. I led a broad coalition of consumer, patient, and labor union stakeholders during the legislative debate over the ACA, during which time I had extensive discussions with congressional staff over the legislative language creating the CO-OP program.

Prior to joining the National Partnership, I worked as an attorney at the law firm of Hogan Lovells LLC, where I provided legal and strategic advice to clients on health care issues, with a particular emphasis on Medicare, Medicaid, HIPAA, biomedical research, and food and drug law and policy. Prior to that role, from 1997 to 2001, I served as a Professional Staff Member to the U.S. Senate Health, Education, Labor and Pensions Committee where I served as a senior advisor to U.S. Senator Tom Harkin on national health care policy, including insurance reform, medical research, the Health Insurance Portability and Accountability Act (HIPAA), food and drug law, Medicare, and health service provider issues. In that role I drafted, analyzed, negotiated, and successfully passed health care legislation, planned and carried out legislative strategy, and briefed the Senator for committee hearings, mark-ups, and Senate Floor debates. From 1995 to 1997 I worked in the White House as a researcher and junior speechwriter for First Lady Hillary Rodham Clinton. In that role I researched and wrote speeches on health care policy for the First Lady.

were not as well resourced, and several, including Nevada, ultimately abandoned their failed technology platforms and switched to HealthCare.gov for eligibility and plan enrollment functions for the second year's open enrollment period.

For the start-up CO-OPs – required under the law to generate most of their enrollment from the ACA' marketplaces – these technology failures were disastrous. According to a 2015 U.S. Department of Health & Human Services Inspector General report, states' non-working websites were a primary reason several CO-OPs, including Nevada's, were unable to meet their 2014 enrollment targets.[47]

Nevada's marketplace director reported to the board in February 2014 that the "probability that we reach our original goal to enroll 118,000 is exceedingly small."[48] Ultimately, the Silver State Exchange enrolled just 45,390 individuals after the first enrollment period.[49] Of this total, the Nevada CO-OP enrolled approximately 16,000. Although this was well below the CO-OP's target for enrollment, it reflects a healthy market share given that it had three better-known competitors on the marketplace (Anthem, Saint Mary's, and United, operating as Health Plan of Nevada).

The IT woes did not just dampen enrollment – they required participating insurers to devote a significant and unanticipated amount of staff time and resources to resolving the problems that arose from the dysfunctional system. In the early months of enrollment, the Silver State Exchange's IT vendor, Xerox, failed to transmit data on close to 10 percent of enrollees to insurers. This meant the companies did not have a complete picture of who had enrolled or paid their premiums. As a result of these and other errors, the Silver State Exchange reported

that calls to its call center doubled between November and December 2013, with average wait times increasing to one hour. The marketplace had to add more than 60 staff to its call center.[50] Participating insurers, including the CO-OP, has similar increases in customer call volume, requiring a significant diversion of resources that could have been spent managing care and improving the business systems necessary for the CO-OP's long-term success.

Challenges Pricing the New ACA Health Plans

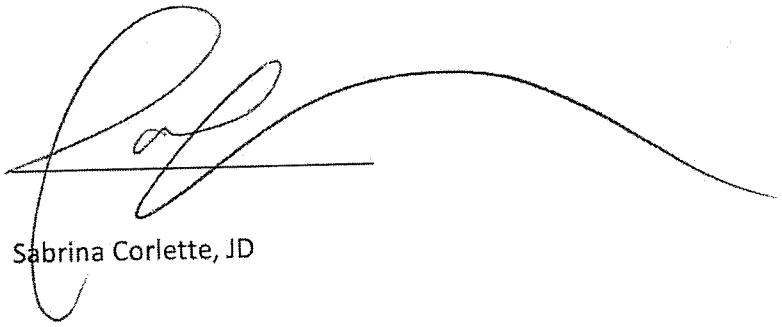
Among the most important decisions for all the insurers participating in the ACA marketplaces in 2014 was how to price their plans. For the CO-OPs, those prices could mean life or death. Set a price too high, and a new company with little name recognition could fail to attract customers. Set a price too low, the company could face massive losses if the health care costs of enrollees exceeded premium revenue. Unlike their better-financed rivals, CO-OPs in this situation had extremely thin financial cushions to weather such a scenario, particularly after Congress raided the loan funds available to support and sustain the CO-OP program.

All insurers had limited information upon which to set prices in 2013. In the wake of new reforms requiring insurers to take all applicants, regardless of health status, no one knew how many people would sign up or what their health risk would be. Insurers did predict – correctly, as it turned out – that consumers in this market would be extremely price sensitive.[51] As a result, many set prices as low as possible in order to gain market share.[52]

Existing insurers had advantages over start-up companies like the CO-OPs. First, many had already been operating in the small-group insurance market, where coverage had been "guaranteed issue" prior to the ACA reforms. Their actuaries could thus extrapolate about

required to do so. They thus had no choice but try to meet the regulatory deadlines and be operational by October 2013.

8. The unrealistic timeframes between loan award and launch required many CO-OPs to contract with third parties for key administrative functions, including claims processing, IT, and customer support. Furthermore, the CO-OPs had to negotiate and execute these third-party contracts extremely quickly. As a result, CO-OP executives around the country reported challenges with these third-party vendors due in part to their lack of familiarity with the regulatory and compliance requirements of the fully insured market.
9. Nevada's failure to have a working information technology (IT) platform for its state-run health insurance marketplace (the "Silver State Exchange") in 2013 and 2014 had disastrous consequences for a start-up like NHC that was, under law, required to generate "substantially all" of its business from that market. The non-working website was likely the primary reason NHC was not able to reach its enrollment targets.
10. The failures of Nevada's Silver State Exchange IT vendor, Xerox, to adequately support the state-run marketplace and transmit critical enrollment and premium payment data resulted in widespread customer service challenges among all participating insurers, including NHC. Furthermore, the unexpected demand for customer support generated by the marketplace's IT failures required the CO-OP to divert resources that could have been spent managing care and improving the business systems necessary for the CO-OP's long-term success.
11. NHC and the CO-OPs were not alone in suffering significant losses in the early years of the ACA's marketplaces. In total, health insurers lost $2.5 billion in the individual market



Sabrina Corlette, JD

EXHIBIT 21

EXHIBIT 21

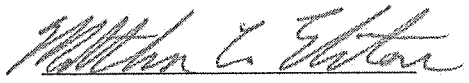
Plaintiff: RICHARDSON

v.

Defendant: Milliman, Inc. et al.

Case Number: A-17-760558-C

Expert Report of Jeffrey L. Smith, FCA, MAAA; Matthew C. Elston, FSA, MAAA

Signed:  

Date: September 28, 2020 September 28, 2020

Introduction

We, Jeffrey L. Smith and Matthew C. Elston, consulted each other and consulted the American Academy of Actuaries Discussion Paper regarding Premium Deficiency Reserves, and other relevant Actuarial Standards of Practice in forming our opinions stated in this report. We both hold these opinions as stated in this report. The opinions as stated in this report are not based on speculation or conjecture, but are based upon our training, experience as active, practicing actuarial professionals, and upon the standards set forth by the American Academy of Actuaries, and the application of actuarial principles to the facts and assumptions as stated in this report. We hold these opinions as being of the same professional validity as we would hold for any other opinion which we would offer to a client in our professional activities as actuaries. We are both associated with the firm of Diamond Consulting Group, Inc. (DCG). We are members of the American Academy of Actuaries and have been retained by the firm of Lipson | Neilson to review the reports (dated July 30, 2019 and February 7, 2020) and supplemental information provided by FTI Consulting, Inc. (FTI) related to the matter involving the Nevada Health Cooperative (NHC). We were retained to provide our analysis of the reports and provide information not otherwise included in the reports that played a major role in the financial results reported by NHC and our feedback related to the "damages" calculated by FTI. We both meet the American Academy of Actuaries qualification standards for rendering the actuarial opinions in this report.

DCG was compensated at $325 per hour for Jeffrey L. Smith's work. DCG was compensated at $290 per hour for Matthew C. Elston's work. DCG was compensated at $200 per hour and $95 per hour for support staff work.

This report states our opinions of the environment brought about by the creation of the Affordable Care Act (ACA), the lack of financial support promised by the United States Department of Health and Human Services (HHS) and the United States Centers for Medicare and Medicaid Services (CMS) that were crucial to the early financial success of the Consumer Operated and Oriented Plans (CO-OPs), the operational shortcomings of the State of Nevada, the errors of the experts retained by the Plaintiff in the referenced litigation in the approach of calculating the "damages" and the assumptions included in the proforma projections, the losses incurred, the Unpaid Claim Liability (UCL) including the Incurred But Not Reported (IBNR) reserve, the subject of Premium Deficiency Reserves (PDR) and the calculation of Risk Based Capital under various scenarios.

DCG Staff Qualifications Related to this Matter

Jeffrey L. Smith is a member of the American Academy of Actuaries and a Fellow of the Conference of Consulting Actuaries and meets the Qualification Standards of the American Academy of Actuaries for rendering Statements of Actuarial Opinion under which this actuarial communication applies.

Mr. Smith has over 45 years of actuarial experience in health care actuarial work and risk management. He has held roles as Chief Actuary and Chief Financial Officer of a statewide Blue Cross and Blue Shield Plan, senior actuarial officer of one the nation's largest managed care organizations, is currently the Appointed Actuary for two risk-bearing organizations in health insurance and has extensive experience in product development, pricing, reserving, regulatory filings, funding of start-up insurers and health care

organizations, including preparation of the Uniform Certificate of Authority Applications and financial projections, including projections made as part of the calculation of Premium Deficiency Reserves.

Mr. Elston has over 25 years of actuarial experience in both annuities and health care supporting insurance companies, state government regulators and hospital systems. He served as both Chief Health Actuary and Assistant Director over Product Regulation and Actuarial Services for the Ohio Department of Insurance (ODI) during the implementation of the ACA and developed significant components of the ODI regulatory infrastructure for health insurers that enabled the ODI to be an effective rate review organization. He provided assistance in the oversight of the licensing of Ohio's CO-OP and oversaw the review of the forms and rates used by Ohio's CO-OP. He also served as Chief Actuary for a provider-owned managed care plan that dealt with the risk management issues and risk mitigation provisions under the ACA. He has experience in product development, pricing, reserving, and regulatory filings.

Our complete resumes are included in the Appendix following this report.

Documents Serving as the Basis for this Analysis

The Appendix following this report outlines the information reviewed during the course of our analysis and used as the basis for this report.

Observations, Analysis and Considerations

Before we outline the technical issues of our report, we feel it is necessary to summarize the environment created by the Patient Protection and Affordable Care Act (PPACA, commonly referred to as the Affordable Care Act, or ACA) into which the health insurance industry was placed and under which significant decisions were required to be made with less than perfect information, with risk management constraints never before encountered, and under timelines that had previously never been as aggressive. We feel that this bears directly on the issue at hand and must be a part of any consideration related to the litigation.

Our firm was retained by organizations who were transforming products, pricing, risk analysis and business planning during the time between the enactment and implementation of the ACA. These organizations, and many professionals whom the organizations retained for professional advice and counsel, were extremely skilled in the required insurance functions. The one thing virtually all of these organizations had in common was that the results produced after implementation of the ACA were financially devastating. Across the industry, it took more than three years to arrive at a more financially viable market amid a constantly changing set of regulations. Some organizations exited the (individual exchange) market voluntarily; others reacted in the limited ways possible by increasing rates significantly and/or severely restricting provider networks. Much of the analysis during the early operational years of the ACA was focused on stabilizing the market.

Therefore, in order to assess the reasons for the demise of NHC (and the other failed ACA CO-OPs) one must consider the contributions made to this result by all of the factors involved in creating the environment in which a plan operated and by reviewing and evaluating the reasonableness of the

the risk adjustment program had to be budget neutral."[16] CMS eventually changed the formula for RA but not until the 2018 benefit year. At that point CMS allowed a reduction in the average state premium by 14% to reflect a reduction for an average level of administrative costs.

vi. Another sign that the early programs of the ACA were seen to be causing issues with startups is that states can now request adjustments of up to 50 percent of the premium used in the applicable plan year. This would be up to a 50% reduction in the statewide average premium used to calculate RA transfers and would help low premium plans. These adjustments can be applied beginning with the 2020 plan year.[17]

vii. Partial year enrollment was problematic for the RA process in 2014-2016. In those years, carriers reported experiencing higher than expected claims from partial year enrollees. Additionally, the methodology may not have captured diagnoses of chronic enrollees who enroll for only a partial year. In NV, enrollment was allowed off exchange mid-year and NHC was only requiring a 30-day waiting period. This would contribute to more partial year enrollment and associated RA challenges. Beginning in 2017, CMS modified the risk adjustment formula to account for partial-year enrollments. Again, this is a change that occurred too late and could have helped new health plans that experienced enrollment changes during the year, like many CO-OPs and startups.[18]

2. The state exchange failed to perform its obligation to provide accurate eligibility information. Insurance companies must collect premiums from eligible enrollees and meet their contractual obligations paying claims for eligible enrollees. Paying claims for ineligible enrollees leads to excess losses. NHC relied upon the state exchange in 2014 and then the federal exchange in 2015 for enrollment eligibility. The state exchange had many challenges in 2014 and eventually was cast aside and the NV ACA on-exchange business had to migrate to the federal exchange for 2015. Enrollment on exchange with all NV carriers for the Individual market can be seen as an indicator of these issues at the state exchange. Enrollment in 2014 was 45,390 for all carriers, and in 2015 statewide enrollment grew over 60% to 73,596.[19] Even to the extent that the enrollment records improved in 2015, when the exchange was moved to the federal platform, additional losses were already realized by NHC further contributing to its reduced capital leading toward insolvency. A further compounding factor in this eligible enrollment challenge was the ACA rule that new premium payment Grace Periods must be allowed for enrollees. Grace Periods allow enrollees to wait to pay premiums before carriers can terminate the policy due to nonpayment of premium. If enrollees received subsidies then the Grace Period is extended under the ACA to 90 days if the

[16] "CMS Issues Final Rule On 2018 Risk Adjustment Methodology; Litigation Likely To Continue, " Health Affairs Blog, December 10, 2018.
[17] "Unpacking The Final 2019 Payment Notice (Part 3), " Health Affairs Blog, April 12, 2018.
[18] "CMS Finalizes New Marketplace Payment Rule, Effective January 17, 2017, " Health Affairs Blog, December 18, 2016.
[19] https://www.healthinsurance.org/nevada-state-health-insurance-exchange/.

EXHIBIT 22

EXHIBIT 22

Expert Report

Richardson v. Milliman, Inc., et al

Case No: A-17-760558-C

Prepared by Richard L. Trembowicz

September 30, 2020

I. Introduction and Scope of Assignment

This expert report has been prepared at the request of J. William Ebert and Angela T. Ochoa of Lipson Neilson, legal counsel for Pamela Egan, Kathleen Silver, Basil C. Dibsie, Tom Zumtobel, Linda Mattoon, and Bobbette Bond, Defendants, in *Richardson v. Milliman, Inc., et al.* I have been asked to review the expert report of Henry Osowski (Expert Osowski) and to provide a rebuttal opinion on the same. Additionally, I was asked to opine on whether it was reasonable for the Nevada Health CO-OP (NHC) and the NHC management team to execute certain agreements and whether they were fair as entered. Specifically, I was asked to opine as to the fairness and reasonableness of the following agreements given the facts and circumstances surrounding the formation of consumer-oriented and operated plans (CO-OPs) as provided in the Affordable Care Act (ACA) and the offering of Qualified Health Plans (QHPs) by such CO-OPs:

- The Administrative Services Agreement with United Health Here (UHH) dated June 27, 2013, and by which UHH would provide so called "administrative services" to NHC effective January 1, 2014 (the UHH Agreement), the First Amendment dated March 3, 2015,[1] and effective in part January 1, 2014, and in part January 1, 2015 (the UHH First Amendment), and the Second Amendment dated August 17, 2015, by UHH, but unexecuted by NHC[2] (the UHH Second Amendment); and
- The Utilization Services Management Agreement with Nevada Health Solutions, LLC date July 19, 2013, and effective January 1, 2014 (the NHS Agreement), the First Amendment dated November 20, 2013, and effective January 1, 2014 (the NHS First Amendment), and the Second Amendment dated September 3, 2014, and effective as of September 1, 2014 (the NHS Second Amendment).

I was also asked to opine as to the reasonableness of the following agreement:

- The "Star Doctors" Network Participating Provider Agreement with WellHealth Quality Care (WellHealth) (the WellHealth Agreement) with the Nevada Cooperative Coalition executed January 23, 2014, and effective January 1, 2014, when the Agreement did not include certain provisions required to be included should WellHealth be determined to be a Delivery System Intermediary (DSI) as that term is defined in 42 U.S.C. § 1395w-25(d) as referenced in Nevada Revised Statutes (NRS) Chapter 695C.275 and Nevada Administrative Code (NAC) 695C, and should the WellHealth Agreement be determined to be a Health Service Contract.

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1 For purposes of the execution date of an agreement subject to review, the latest of dates set forth in the signature section of the Agreement or Amendment is listed as the date of execution unless there is an execution date listed in the introduction to the Agreement.

2 The Second Amendment to the UHH Agreement presented to the Expert for review was not executed by a representative of UHH, and any opinion assumes that the UHH Agreement and the Amendments were the validly existing and binding agreements of the relevant parties notwithstanding the absence of a signature.

I have also been asked to opine on whether:

» Compensation of Tom Zumtobel as Chief Executive Officer (CEO) of NHC was fair and reasonable during the period he served as NHC CEO.

In completing the assignment and preparation of this report, I reviewed the documents listed in Exhibit A.

I have also reviewed various federal and Nevada statutes, regulations, guidance, and policy manuals related to ACA or relevant to the operation of CO-OPs, and press reports and other information that is publicly available and referenced herein via footnote.

I am being compensated at the rate of $600 per hour.

II. Expert's Qualifications

My name is Richard Lawrence Trembowicz, and I am an Associate Principal who leads the Payer Services Group at Executive Consulting Group, LLC d/b/a ECG Management Consultants (ECG). ECG is based in Seattle, Washington, and is a national healthcare consulting firm with 10 US offices and approximately 230 consultants and nearly 50 years of experience in the healthcare industry. I work out of the ECG office located at 100 Cambridge Street, Boston, Massachusetts. I am a graduate of Harvard College, cum laude biology, and Boston University School of Law, cum laude, and am currently licensed as an attorney in the Commonwealth of Massachusetts, BBO# 502135.

I have more than 35 years of experience in the healthcare industry, of which the last 14 years have been predominantly devoted to the health insurance industry and providing payer strategy services to health systems and other healthcare providers.

Within the insurance industry, I focus on serving provider-owned and mid-market insurers by offering strategy, finance, operations, and technology support across all lines of business (LOBs), including Medicare, Medicare Advantage, Medicaid, and commercial fully insured individual, small group, and large group and employer self-funded plans.

I have worked with a number of health plans supporting early-stage health plan development, including market analysis and outsourced services procurement covering a substantial share of health plan operations such as licensing, plan design, accreditation, actuarial services and finance, premium billing and recovery, enrollment and eligibility, claims processing and integrity, cost containment and quality measures including utilization, care and referral management and population health, provider network and contracting, member and provider services, compliance, and data management and performance measurement.

For start-up and early-stage plans, I have been engaged to support start-up operations, including the development of operational requirements specific to a LOB, to conduct business planning and develop outsource to insource operational strategies, and to design and manage re-

quests for proposals (RFPs) to procure administrative services and pharmacy benefit management service.

For more mature plans, services have generally related to strategic planning, organizational development, performance improvement, and mergers and acquisitions, including valuation of health plans or postmerger integration. I have served as Interim Executive Director for Healthspan, an Ohio multiline insurer based in Cleveland, Ohio, and sponsored by Mercy Health (Cincinnati, Ohio), and the University of Southern California health plan covering 36,000 members.

Representative health plan clients include Kaiser Permanente, Health Alliance Plan of Michigan, CareSource, Health Alliance Medical Plan (IL), Aspirus Arise Health Plan, PacificSource, Boston Medical Center HealthNet Plan, Common Ground Health Cooperative, Best Care Partners, Inc. d/b/a Clarion Health and Best Care Assurance, LLC d/b/a Vivida Health Plan, and selected Blue Cross–branded plans.

For health system clients, I am involved in the development of payer strategy, revenue enhancement, and value-based arrangement design within health system strategic planning engagements.

Client engagements customarily involve 5 to 12 consultants, and I usually collaborate with clients to define engagement scope, develop budgets and work plans, and oversee production of deliverables and am responsible for overall project performance.

With respect to additional expertise most relevant to my engagement as an expert in this matter, I have extensive knowledge and experience working with the Massachusetts healthcare coverage mandate law passed in 2006 and known as RomneyCare, on which the ACA is modeled. RomneyCare was a groundbreaking universal coverage law that required that all individuals in Massachusetts have health insurance coverage, and that employers with more than 10 full-time employees offer coverage through an employer-funded health plan, with penalties imposed for failure to secure and maintain coverage. Massachusetts also provided subsidies to assist low-income individuals in purchasing coverage.

Starting in 2008, I provided consulting services under Paragon Health Consulting to Boston Medical Center HealthNet Plan to develop new products to offer on the Massachusetts Health Connector, the healthcare exchange where consumers could purchase health plans under RomneyCare. I became intimately familiar with the operation of RomneyCare, the coverage mandates and subsidies, methods of operation of the exchange, and the risks associated with such plans, including frequent changes in eligibility due to changes in income. I also provided services to healthcare providers such as Children's Hospital (Boston) and Steward Healthcare on the effects of RomneyCare, and later ACA, on finance and operations.

On March 23, 2010, ACA was passed into law. I immediately began assisting insurance clients and health system clients in strategic planning to operate under ACA. This work included comparing RomneyCare and ACA to identify the differences between those laws and how they would affect insurance company operations. I also served as a subcontractor lead consultant

with the Concept Group, which assisted dental insurers in multiple states in offering products on the Marketplace.[3]

In 2011, I joined Centene Corporation (NYSE-CNC) as Vice President of Business Development of its commercial insurance unit, Celtic Insurance, with the responsibility to develop the go-to-market strategy for new commercial individual Marketplace qualified health plans (QHPs) issued under ACA. Centene simultaneously launched QHPs in nine states with enrollment effective January 1, 2014, and which today is a more than $7.0 billion revenue unit of Centene. The Centene Marketplace program was the only national insurer program profitable from inception.

My duties as Vice President were wide ranging. I served as the national Marketplace-Medicaid policy liaison to the U.S. Department of Health & Human Services (HHS) and its units the Centers for Medicare & Medicaid Services (CMS) and the Center for Consumer Information and Insurance Oversight (CCIIO) and state Marketplaces. In this capacity, I participated in weekly CCIIO enrollment planning and technology implementation calls, provided policy comment on a wide range of subjects, including Marketplace and Medicaid eligibility maintenance and coverage due to anticipated frequent changes in member income, special enrollment criteria, health plan termination upon premium default, and the direct enrollment program.

I also met with a number of state Marketplaces to discuss the experiences in Massachusetts and the potential challenges of maintaining coverage eligibility for state residents as income changed. Because we expected the provider network for Centene's Marketplace plans to rely heavily on federally qualified health centers (FQHCs) and community health centers (CHCs), I also served as liaison to the National Association of Community Health Centers (NACHC) and conducted national programming concerning the impact of ACA eligibility requirements on FQHCs and CHCs, including emerging revenue opportunities and services, and revenue cycle challenges.

Centene is a national Medicaid managed care organization (MCO) that contracts with states to manage care delivery to Medicaid enrollees. I worked with the Centene Medicaid business development team and met with state health officials to discuss the challenges with maintaining coverage as enrollee income changes and that a company like Centene was best equipped to serve state residents. By offering both Medicaid and Marketplace plans, and through programs to monitor changes in enrollee eligibility, Centene could minimize disruption in coverage that could result from eligibility changes. These responsibilities required that I be intimately familiar with the ACA and its provisions related to the offering of QHPs through the federal and state Marketplaces, including the criteria and processes for determination of eligibility to purchase QHPs and for subsidies, enrollment, premium billing and recovery, claims processing, and the electronic data interchange (EDI) functional and technical specifications for sharing of information among federal and state agencies and exchanges, health plans and their vendors, and enrollees and consumers.

At Centene, I also participated in the business planning regarding ACA implementation and the offering of QHPs. The decision was made to utilize the knowledge and resources of Centene's

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[3] The Marketplace refers to the governmental agency, whether the federally facilitated exchange (FFE) or state exchanges, collectively. If there is a need for accuracy to refer to the FFE or a state exchange separately, it will be described separately.

existing Medicaid-oriented business units to support the Marketplace plans, rather than developing a separate commercial insurance infrastructure. I was responsible for development of high-level business requirements and the initial knowledge management program that managed the flow of information about ACA requirements to business unit leaders, defined their initial areas of responsibility, and provided sources of information for ongoing monitoring to support operations development and implementation. In connection with the knowledge management process, the business development team monitored CMS, CCIIO, IRS, Department of Labor (DOL), and other federal agency issuance of ACA-related regulations, guidance, and various operational manuals; monitored state Marketplace development in potential states of interest; and provided guidance to business units on issuance of business requirements and risks.

I authored a number of strategic business risk memoranda which addressed specific subjects regarding ACA and Marketplace operations and shaped the Centene QHP business strategy, including the Risk Corridor, Reinsurance, and Risk Adjustment programs, state certificate of authority (CoA) and licensing requirements for all Centene state plans that would offer QHPs, eligibility and enrollment requirements, premium billing and recovery, default termination rights and operational processes to minimize financial risk, and the legal authorization for Cost-Sharing Reduction (CSR) subsidies. Finally, the business development team prepared an analysis of the anticipated risks associated with changes in Medicaid and Marketplace member eligibility during the benefit year and quantified the potential effects of changes in eligibility on Centene income. These memoranda helped sharpen Centene's focus on the highly subsidized population and the operational policies to be implemented by Centene.

I participated in working groups that addressed QHP design and developed an innovative national provider contracting model that provided substantial financial advantage. I also participated in the selection of various outsourced vendors for marketing and sales execution, risk adjustment, and technology solutions for CMS/CCIIO and state exchange EDI, among others. Because of time constraints, Centene did not issue RFPs but instead identified companies, through our personal networks, operating in the segments where we expected to purchase outsourced services, developed business requirements, and conducted product demonstrations and interviews, fielded proposals, and selected various vendors.

Finally, the business development group estimated market size and enrollment in the states where Centene would offer QHPs, monitored various state and federal Marketplace estimates of enrollment, and monitored potential competition for Marketplace members. As part of the Marketplace member competition monitoring, we analyzed the CO-OP program, HHS start-up and solvency loan authorizations for CO-OPs, and public information for the CO-OPs in states of interest to Centene to better understand the competitive threat presented by CO-OPs. We concluded that the limitations placed on CO-OPs by federal laws, regulations, and guidance, and limited access to capital markets, created significant barriers to success and substantially increased the risk of CO-OP business failure.

Prior to 2001, my career focused on the practice of health law. Initially, I was an associate at the Boston law firm Choate, Hall & Stewart (CH&S), where I represented health systems in reimbursement planning and participated in Medicaid and Medicare litigation regarding health system reimbursement.

In 1984, I moved with other healthcare attorneys to Widett, Slater & Goldman, PC (WS&G), a Boston-based law firm. In addition to providing services similar to those offered at CH&S, I also

expanded representation of clients involved in capitated contracting and represented a number of health systems, independent practice associations (IPAs) and physician hospital organizations, and health system and physician affiliations.

During the period 1988–1991, I changed to part-time Of Counsel status at WS&G and also served as general counsel of Arbro Group, a regional skilled nursing facility and rehabilitation hospital group. At Arbro Group, I focused on the development and operation of skilled nursing facilities and rehabilitation hospitals, including real estate acquisition and local zoning, certificate of need and licensing, construction contracting and management, and reimbursement planning for new skilled nursing facilities, as well as supporting the financial planning and reimbursement of existing facilities.

In 1992 I moved with a group of 29 attorneys, including the entire WS&G health law group, from WS&G to Hutchins, Wheeler & Dittmar (HW&D). I became a shareholder of the firm in 1995.

In 2001 I elected to leave law firm practice and joined AMD Telemedicine as VP Business Development and General Counsel, where I was responsible for product development, technology licensing, and reimbursement advocacy, and developed the web infrastructure to support sales, training, and technical support.

Throughout my career, I have made over 70 presentations at conferences, with recent examples including the following:

» Piper Jaffray Investor Conference, *"FY 2019 Medicare Advantage Rates"* (March 26, 2018)

» New Jersey Hospital Association, "*Medicare Advantage: A Provider Sponsored Insurance Opportunity"* (May 18, 2018)

» 2019 Star Ratings and Quality Improvement Summit, *"Structure Your Star Ratings Program for Success: Enhancing Operational Efficiencies and Integrating Quality Improvement Programs to Boost Star Ratings"* (January 14, 2019)

» 2019 Medicare Star Ratings and Quality Management Forum, *"How to Effectively Earn and Keep High Star Ratings: A Practical Guide to Implementing Key Initiatives That Drive Superior Performance"* (July 26, 2019)

In the past four years, I have testified as an expert in a binding arbitration case: Gramercy Cardiac Diagnostic Services, PC, Claimant v. Affinity Health Plan, Inc., Respondent, AAA, Case Number: 01-14-0001-5052, New York, 2016.

In the past ten years, I have also published, or have scheduled for publication, the following articles through the ECG Thought Leadership Program:

» Richard Trembowicz, "Medicare Advantage: Physician Trusted Advisers Can Expand Patient Awareness of MA Plan Options," June 2020

» Ilana Price and Richard Trembowicz, "Integrating Physical and Behavioral Health: Key Considerations for Payers," August 2020

» Karen Kole and Richard Trembowicz, "Part One: Health Plan Valuation—Overview and Market History," September 2020

» Karen Kole and Richard Trembowicz, "Part Two: Health Plan Valuation—Methodologies and Special Considerations," publication date October 2020

» Karen Kole and Richard Trembowicz, "Part Three: Health Plan Valuation—Due Diligence Process," publication date October 2020

» Karen Kole and Richard Trembowicz, "Part Four: Health Plan Valuation—Valuation and Integration," publication date October 2020

III. Environment Related to ACA and CO-OPs

Any opinions expressed in this report are best understood with background on the unique events and circumstances surrounding the launch of the exchanges and the offering of QHPs. During the period 2010–2013, federal and state agencies were focused on the monumental task of implementing ACA, and the scale of the endeavor combined with the novel technology and operational requirements, as well as the limited amount of time, significantly affected the decision-making process for health plan executives, especially those in the CO-OPs.

A. General Business Risks in the Marketplace

1. **Members New to Insurance/Actuarial Estimation and Premiums.** The ACA objective was to secure coverage for large numbers of US citizens and legal aliens with no or limited insurance coverage and no risk history. This made it extremely difficult to predict the demand for medical services, as many new members in QHPs may have been without coverage for an extended period of time, and had previously unattended medical conditions and pent-up demand for services. This situation affected the ability to accurately estimate QHP claims and premium pricing. Contributing to the premium estimation challenge was the desire to have low premiums to build membership quickly. Many plans elected to risk inadequate premiums with the expectation that the Risk Corridor program would cover resulting losses. Ultimately, the legality of the Risk Corridor program was challenged and funding was suspended, leaving many health plans and CO-OPs with 2014 and 2015 catastrophic unfunded losses that resulted in business failure.[4]

2. **Complexity of Eligibility Criteria, Enrollment Execution, and Risk of Frequent Changes in Eligibility.** ACA attempted to piece together universal coverage for uninsured populations using three different programs, essentially creating a Rubik's Cube of eligibility and enrollment:

   a. Traditional Medicaid. This program predominantly covers parents and caretakers with children; pregnant mothers; and aged, blind, and disabled

[4] Ultimately, the Supreme Court ruled on April 27, 2020, that the federal government was liable for Risk Corridor payments, but by the time of the decision, many CO-OPs were out of business. See *Maine Community Health Options v. United States*, 140 S. Ct. 1308, 590 US ____ (2020).

The SSE assumed responsibility for determination of eligibility to purchase QHPs and for APTC and CSR subsidies, enrollment through selection of a QHP, and premium billing and payment required to effectuate a QHP under the ACA Workflow.[9] NHC's timely access to accurate data, coupled with late SSE- and HHS-issued specifications and business rules governing operation of QHPs with sufficient advance notice to permit claims processing system configuration, was critical to NHC's conduct of accurate claims processing. The SSE's failure in 2014 to provide accurate data on a timely basis or issue business rules governing configuration of the UHH claims system with sufficient advance notice severely compromised the performance of NHC and its vendor in their enrollment management, premium billing, and claims processing functions. Further, these failures outside of NHC's control, combined with more restrictive narrow network product designs when many new health plans like NHC were at their infancy in terms of network development,[10] resulted in the inability to meet standards typically applicable in mature LOBs in the health insurance industry (e.g., 90% auto-adjudication of claims, 97% claims financial accuracy, 98.5% claims payment accuracy).[11] Few if any Marketplace health plans achieved industry standard performance in 2014 for Admin Services for many of the reasons noted above. In addition, most vendors that contracted to provide services to health plans offering Marketplace QHPs exempted application of performance standards where non-performance was due in whole or in part to acts or omissions of government or quasi-government agencies.

In addition to SSE data integrity issues, the Exchange also suffered from an inability to engage in EDI with health plans like NHC. Per the ACA Workflow, eligibility and enrollment data was intended to be exchanged on a Form 834 (Benefit Enrollment and Maintenance Transaction), specified by the Health Insurance Portability and Accountability Act (HIPAA) 5010 standards for the electronic exchange of member enrollment information in a number of near-real-time EDI transactions.[12] The SSE routinely forwarded erroneous or inconsistent 834s and 820s to health plans, forcing health plans to engage in extensive manual work-arounds to piece together the eligibility, enrollment, and payment puzzle and could not even execute the most basic of transactions, the receipt of a Form 999 response transaction confirming health plan receipt of data. Accurate eligibility, enrollment, and premium payment data forms the essential foundation of accurate claims processing, and if data is inaccurate or inconsistent or not delivered in a timely manner, it would not be possible to accurately administer enrollment or payment claims,

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9 The federal Marketplace and most state Exchanges did not engage in premium billing and recovery, instead leaving that function to the health plans.

10 As an example, many of the failures cited in the Osowski Report, paragraph 13, pp. 7–8 or p. 23, fall within the categories of Admin Services that were adversely affected by inaccurate or untimely Marketplace data related to eligibility, enrollment or premium contribution, or provider network immaturity across a large number of QHPs.

11 See Osowski Report, p. 23.

12 The EDI standards applicable to insurance transactions are established by the Accredited Standards Committee (ASC) X12 of the Data Interchange Standards Association, Inc., Falls Church, Virginia.

let alone meet an industry standard common in mature LOBs such as 85%–90% auto-adjudication of claims.

In summary, the Osowski Report fails to discuss at all how the failures of the SSE to maintain accurate data and provide such accurate data on a timely basis via EDI to NHC (and its vendors) affected NHC's ability to conduct eligibility and enrollment management, premium billing and reconciliation, and claims processing without error. As such, the Osowski Report lacks foundation.

C. NHC Management Reasonably Relied on Government Agency Determinations

NHC management acted reasonably when it relied on the determinations of government agencies undertaken as official functions in the ordinary course of business.

1. SSE Enrollment Estimates. In 2013, the SSE developed a business plan with an estimated 118,000 Marketplace enrollees for 2014.[13] In establishing its own enrollment estimates, it is reasonable for the NHC management team to rely on the SSE estimates created in the conduct of the ordinary course of SSE business, and structuring vendor contracts with a 10,000-member minimum was reasonable given the SSE estimate of enrollment and the number of health plans offering QHPs in Nevada. Similarly, structuring NHC business operations with an expectation that SSE would provide accurate eligibility and enrollment and premium payment data via timely EDI transactions, including terminations, without the need for manual work-arounds for a substantial percentage of claims was reasonable.

2. HHS Loan Requirements Compliance. NHC, through its predecessor organization, filed applications with HHS to receive both start-up and solvency loans. HHS controls the development of regulations, policies, guidelines, and manuals in accordance with the requirements of ACA, governing the contents and filing of CO-OP loan applications and the criteria that must be satisfied for approval of a loan. HHS approved the NHC loan on May 17, 2012. At all times, HHS possessed the authority to rescind any loan grant and recover the balance of any unspent start-up loans.[14]

   It was reasonable for the NHC management team to rely on the government agency action issued as part of their official functions to support NHC decisions, plan and conduct operations, and enter into agreements on behalf of NHC,[15] The

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13 See Nevada Policy Research Institute (NPRI) "*Nevada Piglet Book 2014*", p. 8, and other press reports.

14 HHS initially approved 24 CO-OPs for loans, but only 23 ultimately issued QHPs. One CO-OP was approved by HHS for a loan but was denied a CoA to issue QHPs by the state insurance regulator due to solvency concerns. HHS, upon notice of denial of the CoA, rescinded the loan and recovered unspent funds.

15 Expert Osowski noted the extensive email exchanges with HHS officials reflecting full disclosure of the contracts and a robust discussion of the UHH and NHS contract terms. See Osowski Report.

CO-OP'S - CEO COMPENSATION ANALYSIS, 2013–2014
CO-OP CEO COMPENSATION SUMMARY

	Average CEO Compensation	CEO Compensation Range Low	CEO Compensation Range High	Zumtobel Compensation	Rank (from highest)	Rank: Excluding Nontax Benefits
2013	$ 306,235	$ 165,832	$ 587,245	$ 414,359	3/21	3/21
2014	$ 350,541	$ 220,065	$ 540,488	$ 428,001	5/22	10/22

However, with exclusion of nontaxable benefits from compensation, Mr. Zumtobel's compensation rank falls from 5 of 22 to 10 of 22 in 2014. The complete table of CO-OP CEO compensation is attached as Exhibit B.

NHC engaged an independent compensation consultant and conducted a compensation survey to determine Mr. Zumtobel's salary. His compensation was also approved by the board or a compensation committee of the board.[54]

It is my opinion that Mr. Zumtobel's compensation as CEO was fair and reasonable and NHC employed industry best practices to establish Mr. Zumtobel's compensation and to avoid a conflict of interest or any appearance of impropriety.

This report is dated as of this 30th day of September 2020.

Richard L. Trembowicz,
Associate Principal

ACRONYM TABLE

(ACA) Affordable Care Act
(ASC) Accredited Standards Committee
(APTC) Advance Premium Tax Credit
(BOS) Business Operations Solution
(CCIIO) Center for Consumer Information and Insurance Oversight
(CEO) Chief Executive Officer
(CH&S) Choate, Hall & Stewart
(CHC) community health center
(CHI) Colorado Health Insurance Cooperative, Inc.
(CMS) Centers for Medicare & Medicaid Services
(CoA) certificate of authority
(CO-OP) consumer-oriented and operated plan
(CSR) Cost-Sharing Reduction
(DOL) Department of Labor

[54] See Form 990, Nevada Health CO-OP, Schedule J.

EXHIBIT 23

EXHIBIT 23

EXPERT REPORT

Eighth Judicial District Court
Clark County, Nevada
Richardson v, Milliman, Inc, et al.
Case No: A-17-760558-C

Prepared by:

Mr. Martin S Hand

Founder & Principal
Manibus Consulting, LLC
October 1, 2020

Part I: Introduction and Qualifications

Background

My name is Martin Hand and I am the Founder and Principal Advisory Consultant for Manibus Consulting, LLC, a consulting firm based in Denver, CO. Manibus Consulting provides services to health plans and software vendors that service the healthcare payer market. I have over thirty (30) years of experience working exclusively for software vendors and consulting organizations that provide software and professional services to health plans. I hold a Bachelor's Degree in Computer & Information Sciences from the University of Alabama in Birmingham. My Curriculum Vitae is provided as Exhibit A.

As Founder and Principal at Manibus Consulting, I provide consulting services in an independent contractor capacity to organizations across the United States and Puerto Rico. For healthcare payer organizations, these services include system procurement (vendor solicitations for information & proposals, system selection, vendor contracting), program & project management (system implementation, operational improvement, change management, system testing, training, system configuration, software development), account management and interim leadership services. For software vendors these services include project program /project management, product management, systems development management, contracting process management, sales, sales support, client account management and interim leadership services.

Prior to founding Manibus Consulting, I worked for 13 software vendors (includes acquisitions) in multiple leadership capacities - VP, AVP, Director, Manager - in varying roles, including program management, project management, system configuration, system development, contracting process management, sales, sales support, and customer service. The size and complexities of these vendors range from start-ups (13th employee for one, 23rd employee for second) to Fortune 500 companies. The larger organizations include HP, EDS, Computer Sciences Corporation, Perot Systems, SunGard, TriZetto, and Cognizant.

My experience with software vendors has resulted in an extensive exposure to software solutions supporting most health plan operational ecosystems, including claims, provider credentialing, member services, provider services/relations, care management, case management, utilization management, disease management, broker servicing, enrollment, billing and EDI. Solutions I've sold, implemented or consulted on include TriZetto's FACETS, CareAdvance, NetworX, SEAKO's (now DST's) powerMHS, Utilization Management System, MACESS' Entrendex, I-MAX, Doc-Flo, and OCR, among others.

I founded Manibus Consulting, LLC to serve the software and healthcare payer markets, providing health plans and software companies with implementation and optimization services. These efforts include standard solution implementations for claims, imaging, workflow, CRM, OCR projects. Non-standard projects include crisis management and multi-system consolidation engagements.

Over my career I have performed project management, software implementation, software sales, contracting, support and services for over forty (40) health plans organizations, including 14 Blue Cross & Blue Shield plans, the Blue Cross Blue Shield Association, multiple Third Party Administrator servicing entities, national health plans, such as Aetna, Cigna, and UnitedHealth Group, as well as many regional and local health plans.

I am being compensated for my testimony on this case at a rate of $450 per hour, plus expenses.

Part III: Conclusion

In my professional experience and based on the record in this case, the failure of NHC can be distilled down to three factors – any one of which would raise significant challenges in an implementation of any complexity and the combination of which all but insured that NHC would join the ranks of eighteen (18) other CO-OPs that didn't survive implementing the ACA:

- The Federal Government's failed launch of the ACA created complexities that nearly all other organizations attempting to implement the ACA found insurmountable;
- The decisions made by the State of Nevada to initially implement their own enrollment technology platform through Xerox then, as a result of that failed launch, switch to HealthCare.gov occurred at a critical time in the project implementation and lead to unrecoverable delays in implementation; and
- An inexperienced leadership team at NHC was incapable of managing through the complex issues created and exacerbated by both the Federal Government (ACA) and the State of Nevada (SSE).

The Federal Government's Failed ACA Program Management, Technical Development and Launch Created Insurmountable Complexities for CO-OPs

By all accounts, the ACA was a massive program whose complexity was matched only by its size. The complexity of the ACA coupled with the inexperience of the Federal Government and CMS in development and deployment of massive technology solutions in the healthcare sector led to unsurmountable delays.[108] CMS had not implemented a program of this magnitude in almost 50 years. As documented by the GAO CMS Accountability Report, HealthCare.gov failed to launch as planned[109]. The HeathCare.Gov technology platform was not operational on NHC's enrollment go-live date of 10/1/2013 and was in actively addressing its post-enrollment go-live issues only months before the State of Nevada directed NHC to connect to it. CMS was underprepared for rolling out a program of this magnitude, evidenced by missing critical delivery dates and a highly public failed enrollment go-live.

HealthCare.Gov was a causal factor in the failure of NHC. While failures existed within the State of Nevada Exchange and NHC's Board, the record makes clear that the Federal Government's launch of the ACA directly caused the failure of 82.6% of the ACA CO-OPs.[110]

State of Nevada Technology Deployment Decisions Caused Unrecoverable Impact on NHC

Enrollment Go-Live for all CO-OPs across the country was initially set for October 1, 2013. As discussed above, the State of Nevada opted against using HealthCare.gov for enrollment and chose to develop its own enrollment technology platform to avoid the cost of outsourcing enrollment processing to the Federal Government. The State of Nevada, through the Silver State Exchange and its technology platform, NevadaHealthLink.com, owned the seminal responsibility for member enrollment. The State of Nevada abruptly pulled the plug on NevadaHealthLink.com several months after it went live because of the failure of Xerox's technology supporting NevadaHealthLink.com to accurately process enrollment for the citizens of the State of Nevada. The State of Nevada made the critical decision of switching this core enrollment functionality to the Federal Government's HealthCare.gov technology platform for enrollment data after NHC had already gone live on

[108] The Federal Government didn't provide enough launch time to the CO-OPs for implementation. Of the ten (10) CO-OPs receiving CMS Loan Awards prior to February 28, 2012, six (6) failed. All remaining thirteen (13) CO-OPs that received CMS Loan awards after February 27, 2012 failed. The Federal Government took nearly two years in preparation prior to its first CMS Loan Award.

[109] "As a result, CMS launched Healthcare.gov without verification that it met performance requirements", United States Governmental Accountability Office (2014). HEALTHCARE.GOV Ineffective Planning and Oversight Practices Underscore the Need for Improved Contract Management (GAO-14-694). Retrieved from https://www.gao.gov/assets/670/665179.pdf.

[110] The Federal CO-OP Program, implemented nationally, was so poorly defined and launched that only four (4) of 23 CO-OPs remain in business as of this writing.

EXHIBIT 24

EXHIBIT 24

EXPERT REPORT

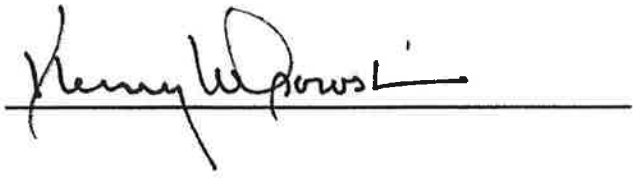
Richardson v. Milliman, Inc., et al.
Case No: A-17-760558-C

Prepared by:

Mr. Henry Osowski

Managing Partner
Strategic Health Group LLC

February 7, 2020



Part I: Introduction and Qualifications

Background and Assignment

My name is Henry William Osowski and I am co-founder and Managing Partner with Strategic Health Group LLC ("SHG") a consulting firm based in Burbank, California that provides strategic and financial services to health plans and health systems throughout the United States. My Curriculum Vitae is attached as Exhibit 1. I have more than forty years of experience in the insurance industry, of which more than thirty years has been in the health insurance industry. In my current role with SHG, I provide a broad range of services to SHG's health clients, including strategic planning support, new health plan start-up and operational implementation, new product and market growth activities, and merger/acquisition services. In my career, I have provided leadership in more than a dozen health plan start-ups, including evaluation, selection and contracting of administrative support and information technology options. These start-up health plans have included commercial, Medicaid and Medicare Advantage[1] organizations. Clients have included Providence St. Joseph Health, Adventist Health, Blue Shield of California, Care Wisconsin, Humana, Stanford University Hospital and Clinics, United Health and Devoted Health among others.

Prior to the founding of SHG, I was the Senior Vice President of Corporate Development for SCAN Health Plan, based in Long Beach, California. SCAN is a large non-profit regional health plan with more than 204,000 enrollees. In this role, I was the architect of the plan's growth from four counties to fourteen counties. Through my leadership, SCAN added more than

[1] Medicare Advantage ("MA") is a private health plan option available to Medicare Beneficiaries in-lieu-of Original Medicare; MA is administered by the Centers for Medicare and Medicaid Services ("CMS") with plan performance requirements similar to Affordable Care Act ("ACA") Qualified Health Plan requirements.

40,000 members in its expansion areas. I also served as the founding President of SCAN's Arizona Medicare Advantage and Arizona Long Term Care Medicaid plans.

Before my work at SCAN, I established a consulting firm, Osowski & Associates, that provided strategic services to health plans and related organizations throughout the United States. These services included health plan start-ups in Michigan (for CareAmerica Health Plan) and in California (for CareMore Health Plan). I moved to California in 1987 as part of the senior management team responsible for the financial turnaround of Blue Cross of California. In this capacity, I served as Vice President of Finance for the Individual/Small Group Division and later as Vice President of Strategic Planning.

Prior to moving to California, I served as Vice President of International Operations for American Family Life Assurance Company and had responsibility for the company's Canadian and European operations. I also previously served as Director of Insurance Consulting for Coopers & Lybrand. I began my insurance career with the Kemper Insurance group of companies.

I am a frequent featured speaker on relevant topics of interest in the area of health insurance, especially market development and growth strategies, care integration for Dual Eligible beneficiaries and the implications of changing Administration and Congressional policies. Some specific speaking engagements include:

- Medicare Market Innovations Forum – 2012 to 2019
- Medicaid Innovations Forum – 2013 to 2020
- Medicare Marketing and Sales Conference – 2015 to 2020

In addition, over the past ten years, I have authored or co-authored several articles on health plan development and health plan business strategies, including:

- *"Provider-Sponsored Health Plans, 5 necessities for launching a successful plan are revealed"* Executive Insight, March 2014, pages 34-35

- *"MA market downside could be a deal-breaker"* Managed Healthcare Executive, February 11, 2015
- *"New Horizons for Behavioral Health"* Healthcare Business Today, April 27, 2016
- *"FTC and DOJ May Spoil Mega-Mergers among Payers"* Health Leaders Media, July 2, 2015
- *"Disruption: The Health Care Sectors Constant Companion"* Payers & Providers, March 7, 2019
- *"Thought Leaders' Corner"* commentary on value of population health, Population Health News, May 2019
- *Value-based Care interview*, Care Analytics News, Volume 12, Number 10, September 2019
- *"An Exciting New Frontier for Medicare Advantage Plans"*, Population Health News, Volume 6, Issue 12, December 2019
- *"Thought Leaders Corner"* commentary on trends/issues that could have a potentially significant impact for healthcare stakeholders, Managed Care Online Thought Leaders, December 2019

I have previously testified as an expert on behalf of the Respondent in the American Arbitration Association, Case No. 011500034226, in the matter of Sutter Health and Sutter Health Plan, California nonprofit public benefit corporations, Claimants v. OptumInsight, Inc. f/k/a Ingenix, Inc., a Delaware corporation, Respondent. The subject of the case was a dispute relative to the health plan start-up and information technology services for a commercial health plan.

In this matter, I was asked to opine on the start-up and initial operation of NHC, the administrative and technical support provided by United Here Health ("UHH"), Eldorado, InsureMonkey and others as well as how any deficiencies or lack of competencies of these vendors contributed to the ultimate failure of NHC. I was also asked to opine on NHC management responsibilities for failures and deficiencies of UHH, Eldorado, InsureMonkey,

and others. During the completion of this assignment, I reviewed extensive documentation, including all the documents referenced in Exhibit 2: Documents Relied Upon.

I am being compensated in the above-captioned matter (or "this case") at a rate of $450 per hour, plus expenses.

my opinion that NHC should have required that the system limitations and processing issues identified by NHC and UHH staff would have been tested and fixed by UHH and Eldorado long before the system was introduced into production.

The basic core of any health insurance system is its ability to receive, validate, and accurately record who has met eligibility criteria, who has actually enrolled and who has paid any required premium. However, from the first day of operations, Javelina could not properly maintain an accurate picture of paid enrollment for NHC. One key example of Javelina's inability to support the enrollment process include issues with pre-processing on inbound 834 enrollment files from the Exchange to Javelina.[126] UHH and Javelina could not accept and accurately record NHC's membership files. The capability to capture federal payment subsidies would not be functional in Javelina until 2015.[127] Other failures, such as "[u]ncertainty if enrollment date is received and retained in Javelina,"[128] would continue to plague NHC well into 2015. The failures of the entire enrollment loading and maintenance process had a cascading effect on other business support functions, most notably claims. Failure to accurately capture and maintain eligibility, enrollment, and payment information in UHH's core system creates and environment where claims were paid for individuals who were not eligible, who had not paid the proper premium amounts, and who were not effectively enrolled on the date medical services were received.

A series of email exchanges[129] between Eldorado, UHH, and NHC, documents that testing of enrollment in Javelina was still occurring in March and April of 2014. It is not clear if the enrollment issues were ever fully resolved, even into 2015, suggesting it is very possible that NHC never had an accurate picture of its enrollment nor its premium receivables. In light of the problems with the reliability of reports from Xerox/Silver State Exchange, UHH

[126] Email chain between Tim Kneuss, Lisa Simons, *et. al.*, regarding CO-OP EDI Testing – File Reconciliation, PLAINTIFF 00053364-376, at PLAINTIFF 00053364.
[127] Email from Gary Odenweller to Basil Dibsie., dated December 3, 2014, PLAINTIFF 00522354.
[128] *Id.*
[129] Email exchanges between Tim Kneuss of Eldorado and various UHH and NHC recipients, PLAINTIFF 00053364-PLAINTIFF0053376.

EXHIBIT 25

EXHIBIT 25

POC FORM AND ACCOMPANYING INSTRUCTIONS

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

Claimant Name & Address	**Policy Information (if applicable)**
Name	Insured Name
Date of Birth SSN	Insured DOB
Company Name and Tax ID (if applicable) UNITE HERE HEALTH #23-7385560	Member ID
Street Address 711 North Commons Drive	Coverage Date(s)
City/State/Zip Aurora, IL 60504	**Alternate Contact Name & Telephone No.**
Phone (630) 236-5100 E-Mail dpatel@uniteherehealth.org	Andrea Flaherty (630) 236-5163
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)**

Services were provided to the Nevada Health CO-OP (NHC) by UNITE HERE HEALTH (UHH) under an Administrative Services Agreement and Executive Services Agreements. A final reconciliation of the services provided to NHC is ongoing and the parties continue to exchange correspondence and documents. The exact amount of the UHH claim is not yet known. The supporting documentation for the UHH claim is voluminous and will be provided to NHC upon request.

State of Illinois §
§
County of DuPage §

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.

Dharma Patel

Signature of Claimant or Authorized Agent

Dharma Patel, General Counsel

Printed Name

Sworn to and subscribed before me this 27th day of April 2017.

Ecaterina Ilioviciu

Notary Public Signature

ECATERINA ILIOVICIU
Official Seal
Notary Public - State of Illinois
My Commission Expires Nov 30, 2020

NOTE: ATTACH DOCUMENTATION TO SUPPORT YOUR CLAIM.

PROOF OF CLAIM INSTRUCTIONS

READ CAREFULLY BEFORE COMPLETING THE PROOF OF CLAIM FORM

Use this Proof of Claim **("POC")** form to make your claim against the receivership estate of Nevada Health CO-OP **("NHC")**. By accurately completing this form, you make your claim for payment and help the Special Deputy Receiver **("SDR")** properly consider your claim. *It is very important that you complete all the sections applicable to you, and sign and return the form to the SDR as provided below. Forms that are incomplete or inaccurate may result in a delay or denial of your claim.* The SDR will review your claim and determine whether you are entitled to any claim payment.

A POC FORM MUST BE COMPLETED, SIGNED, AND RECEIVED BY NHC ON OR BEFORE APRIL 28, 2017 (THE "CLAIMS DEADLINE"). ANY POC SENT BY U.S. MAIL WILL BE DEEMED TIMELY FILED SO LONG AS IT IS RECEIVED WITHIN THREE BUSINESS DAYS AFTER THE CLAIMS DEADLINE. FAILURE TO TIMELY FILE YOUR POC BEFORE THE CLAIMS DEADLINE WILL CAUSE YOUR CLAIM TO BE CLASSIFIED AS LATE AND MADE INELIGIBLE FOR A DISTRIBUTION OF ASSETS, IF ANY, FROM NHC. CLAIMS MUST BE NON-CONTINGENT AND LIQUIDATED IN AMOUNT BY THE DEADLINE TO SHARE IN NHC'S ASSETS.

To complete this form, please follow these instructions:

Provide your full name, permanent address, telephone number, and (if you have e-mail access) your e-mail address. You must notify the SDR in writing of any change in mailing address or telephone number that occurs during the receivership.

1. The "Claimant" is the person/entity believed to be owed money by NHC. You must provide the Claimant's name and Social Security number and/or Tax ID number on the POC form. The POC form must also be signed and dated. Claims filed by business organizations must be signed by an authorized representative, and the capacity of the signatory must be stated on the claim form. A power of attorney must be attached if an attorney is signing this form on behalf of a client.

   Health Care Providers ("Providers"), such as physicians or hospitals, are exempt from being required to use the POC form for existing claims that they already have filed with NHC or new claims that they may file. Providers are not required to re-file existing claims with NHC, and these existing claims will be considered timely filed so long as they comply with the pre-established procedures for processing claims in the normal course of business of NHC (*e.g.*, in most cases, claims filed for the first time more than 12 months after the date of service are considered late-filed claims by NHC and may be denied by the SDR for this reason). New claims of Providers must be filed with NHC by the Claims Deadline, but the claims for healthcare services must be submitted as they have previously been to NHC, and will still be subject to all pre-established NHC claim processing requirements and deadlines. Providers should not use this POC form for the submission of new claims. New Provider claims filed after the Claims Deadline will be considered late-filed claims and are ineligible for payment. PROVIDERS SHOULD NOT SUBMIT DUPLICATE CLAIMS (*i.e.*, claims that have been previously submitted to NHC), as this will delay the processing time for all of their claims. However, you may re-submit claims that require correction. Providers who have received any partial claim payment are not required to submit a POC form for the remaining amount owed—and they are not required to take any further action unless notified by NHC in receivership.

   Providers should contact 1-855-606-2667 or e-mail **POC@NevadaHealthCoop.org** to verify that all their claims have been submitted and are being processed.

PROOF OF CLAIM INSTRUCTIONS
READ CAREFULLY BEFORE COMPLETING THE PROOF OF CLAIM FORM

For all claims other than Providers, new claims must be submitted by the Claims Deadline by using this POC form and following these instructions. Claims received after the Claims Deadline will be considered late-filed claims and ineligible for payment.

2. If you are a **Member** filing your own claims, please note all bills must be itemized showing dates of service and type(s) of service rendered. If you previously assigned your claim to a medical provider, another person or entity, please provide the SDR a copy of the assignment.

3. Claims for healthcare services rendered in 2016 or later should not be submitted to NHC. As announced on August 25, 2015, NHC ceased providing health coverage effective January 1, 2016. All NHC policies were terminated by December 31, 2015.

4. **YOU MUST INCLUDE DOCUMENTATION SUPPORTING YOUR CLAIM.** A claim may be disallowed partially or entirely if it fails to adequately describe or document the claim. All supporting documentation must be submitted to the Receiver of NHC before the Claims Deadline.

5. To reduce expenses to the receivership estate, the SDR will not be sending acknowledgement of receipt of the POC forms. You will, however, receive notice of any decision on your claim at the address you have provided to the SDR on the POC form. If you have a change of address after submitting your POC form, you must update the SDR so that you will continue to receive correspondence regarding your claim. Claimants may contact 1-855-606-2667 or e-mail **POC@NevadaHealthCoop.org** to verify that all their POCs have been received by the SDR.

6. The receivership estate may only pay part of approved claims based on NHC's available assets.

7. If applicable, you must disclose all deposits, cash, premiums, securities, trust funds, letters of credit, or other assets of NHC you hold, control, or expect to receive from anyone other than NHC. Agents or brokers must submit an accounting of all premiums and commissions held at the time plans were terminated.

8. After you complete the POC form, review the completed form, sign in front of a Notary Public, and date. Failure to properly complete the POC form according to these instructions may cause your claim to be delayed or disallowed. It is recommended that you return the POC form using Certified Mail, Return Receipt Requested, or another method providing proof of delivery. Please retain a copy for your records, and submit the form to:

Nevada Health CO-OP
ATTN: Special Deputy Receiver/POC
840 S. Rancho Drive #4-321
Las Vegas, Nevada 89106

You may also submit your POC form by e-mail, to POC@nevadahealthcoop.org, so long as the e-mail includes an executed and sworn (*i.e.* signed and notarized) proof of claim. Claimants submitting by e-mail may wish to contact NHC to confirm that their POC form was received, particularly if they have attached large files. Claimants are responsible for assuring that their claims are received by the above deadline!