Case Nos. 82467 and 82552

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,

Appellants,

vs.

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,

Respondents.

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

APPELLANTS/PETITIONERS' REPLY APPENDIX – VOLUME 2 OF 2

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Attorneys for Appellants/Petitioners UNITE HERE HEALTH and NEVADA HEALTH SOLUTIONS, LLC

September 10, 2021

REPLY APPENDIX - VOLUME 2 OF 2

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Rule 54(b) Final Judgment and Bar Order, filed in *Janvey et al. v. Greenberg Traurig, LLP et al.*, No. 3:12-cv-04641-L, United States District Court, Northern District of Texas, Dallas Division (February 25, 2020))	1	3	187-197

TAB 4

TAB 4

APEN (CIV)

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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 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;

Case No. A-17-760558-B
Dept. No. XVI

APPENDIX OF EXHIBITS TO DEFENDANTS UNITE HERE HEALTH AND NEVADA HEALTH SOLUTIONS, LLC'S MOTION TO CONSOLIDATE CASE NO. A-20-816161-C

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 through X inclusive; and ROE CORPORATIONS I-X, inclusive,

Defendants.

Pursuant to EDCR 2.27(b), Unite Here Health and Nevada Health Solutions, LLC (collectively "UHH") file this Appendix of Exhibits to their Motion to Consolidate Case No. A-20-816161-C.

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DATED this 19th day of October, 2020.

BAILEY❖KENNEDY

By: */s/ John R. Bailey*
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CERTIFICATE OF SERVICE

I certify that I am an employee of BAILEY❖KENNEDY and that on the 19th day of October, 2020, service of the foregoing was made by mandatory electronic service through the Eighth Judicial District Court's electronic filing system and/or by depositing a true and correct copy in the U.S. Mail, first class postage prepaid, and addressed to the following at their last known address:

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EXHIBIT 1

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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 RECEIVER FOR NEVADA HEALTH CO-OP,

Plaintiff,

v.

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

Defendants.

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

PLAINTIFF'S DISCLOSURES OF EXPERT WITNESSES MARK A. FISH AND HANK OSOWSKI PURSUANT TO N.R.C.P. 16.1

GREENBERG TRAURIG,
10845 Griffith Peak Drive
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COMES NOW Plaintiff, Commissioner of Insurance BARBARA D. RICHARDSON ("Commissioner" or "Plaintiff"), in her capacity as Receiver of Nevada Health CO-OP ("NHC" or "CO-OP"), by and through her undersigned counsel, and hereby provides Plaintiff's Disclosures of Expert Witnesses Mark A. Fish and Hank Osowski Pursuant to N.R.C.P. 16.1. Plaintiff reserves her right to retain additional expert witnesses, to supplement this disclosure if additional witnesses are revealed as discovery proceeds, or if additional experts are retained, and to identify rebuttal and impeachment witnesses as may become necessary or may be revealed during the trial of this case.

1. Mark A. Fish
   FTI Consulting, Inc.
   750 Third Ave., 27th Floor
   New York, NY 10017

Mr. Mark Fish is expected to offer expert witness testimony in this matter. His anticipated testimony addresses the calculation of actuarial values, damages suffered by NHC, the role of the Larson and management defendants in failing to disclose financial information and related matters; his full report can be found at Exhibit A. Mr. Fish's current CV is attached as to his report (Exhibit B to the report), which includes a list of all cases in which she has testified within the previous four years, and any publications made within than previous 10 years. Mr. Fish's hourly rate for expert reports for this matter is $450.

2. Hank Osowski
   Strategic Health Group, LLC
   3500 West Olive Ave., Ste. 300
   Burbank, CA 91505

Mr. Henry Osowski is expected to offer expert witness testimony in this matter. His anticipated testimony addresses agreements between NHC and UHH, the performance of NHC management, the performance of UHH; UHH licensing; operational deficiencies in UHH systems; industry standard and practices, NHC's readiness to launch insurance services, and related topics; his full report can be found at Exhibit B. Mr. Osowski's current CV is attached to his report (Exhibit 1). A list of all cases in which he has testified within the previous four years is addressed in his report. Mr. Osowski's hourly rate for expert reports for this matter is $450.

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The non-retained expert disclosures are contained in Plaintiff's Eighteenth Supplemental Disclosures Pursuant to NRCP 16.1.

DATED this 7th day of February, 2020.

GREENBERG TRAURIG, LLP

/s/Donald L. Prunty
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CERTIFICATE OF SERVICE

Pursuant to Nev. R. Civ. P. 5(b)(2)(D) and E.D.C.R. 8.05, I hereby certify that on this 7th day of February, 2020, a true and correct copy of the foregoing **PLAINTIFF'S DISCLOSURES OF EXPERT WITNESSES MARK A. FISH AND HANK OSOWSKI PURSUANT TO N.R.C.P. 16.1(a)(2)** was submitted for service using the Odyssey eFileNV Electronic Service system and served on all parties with an email address on record, pursuant to Administrative Order 14-2 and Rule 9 of the N.E.F.C.R. The date and time of the electronic proof of service is in place of the date and place of deposit in the mail.

/s/ Kimberly Frederick
An employee of Greenberg Traurig, LLP

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EXHIBIT A

EIGHTH JUDICIAL DISTRICT COURT
CLARK COUNTY, NEVADA

Plaintiff: RICHARDSON

v.

Defendant: Milliman, Inc. et al.

Case Number: A-17-760558-C

Expert Report of Mark A. Fish, F.S.A., M.A.A.A.

Signed: Mark A. Fish

Date: February 7, 2020

I. Introduction

a. Nature of Engagement

FTI Consulting, Inc. (FTI, we, us) has been retained by the Receiver to provide an opinion relative to losses that the Nevada Health CO-OP (NHC) incurred, despite that it was not a financially viable entity. I, Mark Fish, will serve as expert.

In this report, I cite key shortcomings, financial and operational, that NHC suffered, including misstated financial statements and implausible forward-looking projections that were not disclosed by company management nor by its auditors, Larson & Company, PC (Larson). I also detail harmful financial misstatements caused by delayed claims processing and reporting, select losses arising from NHC's operations, and the loss of federal receivables caused by delayed claims processing and reporting. I also detail damages incurred from NHC's contractual relationships with Unite Here Health (UHH) and InsureMonkey (IM), based on a review of information provided by the Special Deputy Receiver ("SDR"), Cantilo & Bennett, L.L.P., which I view as reasonable. I have also detailed and developed a dollar range of expected claim denials from utilization review, which I view as reasonable. The utilization review information detailed and developed is based on a review of Inpatient and Outpatient 2014 claims data, subject to the utilization management review criteria outlined in the Utilization Management Services Agreement.

Details of the calculations and methodology used to arrive at damages are contained within this report.

b. Qualifications

I, Mark Fish, am a Fellow of the Society of Actuaries, a member of the American Academy of Actuaries, and meet the Qualification Standards of the American Academy of Actuaries to render the opinions in this report.

I am a Managing Director in the Health Solutions Practice of FTI Consulting, Inc. ("FTI"). I have over 25 years of experience working in various managed care and health plan actuarial, finance, network and operations positions, including senior leadership roles as Chief Actuary, Vice President of Finance, Executive Vice President of Network Management, and Chief Financial Officer for a regional health plan of 750,000 members, operating in 3 states. I have hands-on experience with the actuarial and financial aspects of health plans, including reserve setting, and submitting various applications, filings and reports to regulatory agencies.

FTI is compensated at an hourly rate of $450 for my time incurred for performing the work necessary to prepare this Report and to testify as needed. I have been assisted by others who have worked under my direction and supervision.

My compensation does not depend in any way on the conclusions I have reached or on the outcome of this case.
I have a Bachelor of Business Administration in Actuarial Science and a Bachelor of Science in Mathematics from the University of Wisconsin.

My curriculum vitae is listed in Exhibit B.

c. Documents Relied Upon

In arriving at my opinions, I have relied upon the materials and information listed in Exhibit A and performed such analysis of the materials and data received as I considered necessary.

My opinions are based upon the information available to me as of the date of this report. To the extent that additional information becomes available my analysis and opinions may need to be modified or supplemented. Such information includes any reports or opinions offered by any expert retained by NHC, Larson or other parties.

II. Background & Information Considered

NHC was placed into permanent receivership on October 14, 2015. The Commissioner of the Nevada Division of Insurance, Barbara D. Richardson, is the Receiver for NHC, and Cantilo & Bennett, L.L.P. is the appointed Special Deputy Receiver.

The Affordable Care Act (ACA) created the Consumer Operated and Oriented Plan (CO-OP) Program to give consumers the option to choose a nonprofit insurer with a strong consumer focus. NHC was a CO-OP launched under the ACA[1] and was incorporated in the State of Nevada on October 20, 2012. NHC was subsequently awarded its insurance license by the State of Nevada Division of Insurance on January 2, 2013 as a health maintenance organization (HMO) insurer. NHC began operations in 2013 with initial membership effective as of January 1, 2014.

From its outset, NHC operated at a loss and reported a net loss of $16,499,161 according to its Statutory Statement of Income for the Year Ending December 31, 2014, as reflected in the *Statutory Financial Statements and Independent Auditor's Report and Other Legal and Regulatory Information* prepared by Larson ("Larson Report").[2] In addition, NHC's Statutory Surplus as of December 31, 2104 was reported as $14,920,827.[3]

Using information from NHC's audited results, NHC's 2014 Benefit Cost Ratio (BCR), defined as the ratio of Net Hospital and Medical Benefits to Net Premium Income, was 87.1% and its Administrative Cost Ratio (ACR), defined as the ratio of Claims Cost Expenses and General Administrative Expenses to Net Premium Income, was 42.7%, resulting in an Underwriting Ratio,

[1] The Commonwealth Fund Report, p. 7.
[2] Larson Report, p. 6.
[3] Larson report, p. 5.

defined as Benefit Cost Ratio plus Administrative Cost Ratio, of 129.8%. Break-even results, before Net Investment Gains, requires an Underwriting Ratio of 100%, meaning NHC's 2014 underwriting costs were 29.8% in excess of its premium income, as shown in Table 1 below:

Table 1 NHC Year-End 2014 Financial Ratios Based on Independent Auditors Report		
Total Revenue	$55,538,950	(1)
Net Hospital and Medical Benefits	$48,393,131	(2)
Claims Adjustment Expenses	$4,579,249	(3)
General Administrative Expenses	$19,111,500	(4)
Benefit Cost Ratio	87.1%	(5) = (2) / (1)
Administrative Cost Ratio	42.7%	(6) = [(3)+(4)] / (1)
Underwriting Ratio	129.8%	(7) = (5) + (6)

FTI was engaged by the Receiver as an outside expert to evaluate NHC's historical reserves, claims information, and other related information, and to assess potential damages. Prior to receivership, NHC had their historical reserves and premium rates prepared and certified by Milliman, Inc. (Milliman), and Larson audited the statutory financial statements of NHC. On February 27, 2015, NHC management filed the company's December 31, 2014 annual financial statement with the Nevada Division of Insurance (NDOI), reflecting the company's admitted assets, liabilities, and capital and surplus of NHC as of December 31, 2014. Larson issued an unqualified opinion on June 1, 2015 as to NHC's Financial Statements, including its admitted assets, liabilities, and capital and surplus as of December 31, 2014.

Health insurance companies (HICs), such as NHC, are required to recognize certain liabilities and reserves such as those related to claims payments and premium deficiencies, if applicable. The roll-out of the ACA also introduced other requirements for HICs to recognize certain liabilities and receivables related to the ACA's risk sharing mechanisms, often referred to as the 3Rs. In particular, I address three liabilities (or receivables) in this report which have a material impact on NHC's financial results:

1. IBNR
2. PDR
3. 3Rs

a. IBNR

One of the largest liabilities on the balance sheets of HICs is the reserve for incurred but not reported (IBNR) claims. An IBNR reserve is used to reflect claims that have occurred but have not yet been reported to the HIC. Typically, an actuary will perform an estimate of INBR claims based on the HIC's historical claims experience and other related factors. Adjustments to the IBNR reserve are made based on the subsequent actual paid claims experience, often referred to as the claims run-out. If the IBNR reserve is understated (i.e., actual claims run-out is more than the IBNR reserve), the HIC reflects a negative income adjustment in the current reporting period. Conversely, if the IBNR reserve is overstated (i.e., actual claims run-out is less than the IBNR reserve), the HIC reflects a positive income adjustment in the current reporting period.

b. PDR

A premium deficiency reserve (PDR) is a reserve that is established when future premiums and current reserves are not sufficient to cover future claim payments and expenses for the remainder of a contract period. A number of factors may contribute to the need for a PDR, such as increases in underlying provider contracts, increased medical expense trends, significant changes in membership, unreasonable premium rate assumptions or aggressive pricing decisions made by management. Once the HIC determines a PDR may be necessary, an actuary performs a calculation using projected premiums, medical expenses and other expenses to determine the estimated premium deficiency. The PDR is recorded in the current reporting period, reducing net income and the statutory surplus reflected on the HIC's balance sheet.

c. 3Rs

The ACA included some protections for insurers, known as risk-sharing provisions (or 3Rs), especially in the early years of the new program. These risk-sharing provisions were included in the law with the intent of ensuring plans will be available to consumers, reduce incentives for insurers to avoid high-cost enrollees and insure those individuals who would otherwise be uninsurable. The ACA included three risk-sharing programs to mitigate the risks that a plan may enroll a disproportionate number of high cost members a permanent risk-adjustment program, a transitional reinsurance program and a temporary risk-corridor program, (the risk-adjustment program, transitional reinsurance program, and risk corridor program will be collectively referred to in this report as the "3Rs", the latter two programs running from 2014-2016). The risk-adjustment program shifts money among insurers based on the risks of the people they enroll, reducing the incentives for HICs to not enroll people with higher-than-average costs. The transitional reinsurance program looks to provide protection to plans who enroll members with very high claims by reimbursing plans for claim amounts above a certain dollar threshold. The temporary risk-corridor program limits insurer gains and losses in the early years of the program, effectively reimbursing insurers if their losses exceed a certain threshold and requiring insurers to pay into the program if their gains exceed a certain threshold. The risk corridor program was intended to be for a limited time, because insurers should be able to effectively set premium rates once data for their underlying ACA-covered experience has emerged.

An accurate estimate and posting of IBNR, PDR and the 3Rs are important. If these estimates are incorrect, the HIC's financial statements will be inaccurate. Similarly, prompt claims processing and estimation of claims liabilities is critical so that the company can file claims timely for reimbursement of 3Rs with CMS, avoiding the forfeiture or reduction of those 3R reimbursements caused from unprocessed, late-processed, or undetermined claims. Regulators, employers, consumers and others rely on HICs to record accurate estimates of these liabilities and reserves such that the company's financial statements are fairly and accurately reported. In particular, regulators rely on accurate financial statements to perform their duties in evaluating and protecting the overall financial health and solvency of the HICs. The National Association of Insurance Commissioners (NAIC) Accounting Practices and Procedures Manual discusses "Objectives of Statutory Financial Reporting". Paragraph 27 states, in part:

> "The primary responsibility of each state insurance department is to regulate insurance companies in accordance with state laws with an emphasis on solvency for the protection of policyholders. … The cornerstone of solvency measurement is financial reporting. Therefore, the regulator's ability to effectively determine relative financial condition using financial statements is of paramount importance to the protection of policyholders."[4]

A PDR supports this objective to aid in the measurement of a reporting entity's financial condition in that:

- The PDR is a tool for solvency regulation, helping to ensure that a reporting entity's contractual obligations are understood, reported, and will be adequately funded.
- The PDR accomplishes that purpose by establishing a reserve that reduces the reporting entity's statutory capital and surplus by the amount equal to the excess of future contracted benefits and associated expenses over future revenues and current contract reserves.
- The PDR helps identify situations where the reduction in statutory surplus could result in potential impairment regarding the reporting entity's ability to meet its obligations.[5]

d. RBC

The NDOI uses the industry standard Risk-Based Capital (RBC) formula to determine the overall financial health of the companies it regulates. RBC is a method of measuring the minimum amount of capital (or surplus) appropriate for a reporting entity to support its overall business operations in consideration of its size and risk profile. RBC limits the amount of risk a company can take. It requires a company with a higher amount of risk to hold a higher amount of surplus. Surplus provides a cushion to a company against the risk of insolvency and inability to make claims payments as they are owed.

[4] American Academy of Actuaries, PDR Discussion Paper, March 2007, p. 4.
[5] American Academy of Actuaries, PDR Discussion Paper, March 2007, p. 4.

The purpose of the RBC formula is to establish a minimum capital requirement based on the types of risks to which a company is exposed. Under the RBC system, regulators have the authority and statutory mandate to take preventive and corrective measures that vary depending on the capital deficiency indicated by the HIC's RBC results. These preventive and corrective measures are designed to provide for early regulatory intervention to correct problems before insolvencies become inevitable, thereby minimizing the number and adverse impact of insolvencies. The RBC formula establishes the regulatory minimum amount of capital that a company is required to maintain to avoid regulatory action and specifies certain control levels dictating action either by the HIC, regulators or both.

The control levels are defined as follows:

Company Action Level (CAL)	= 200% of Authorized Control Level
Regulatory Action Level (RAL)	= 150% of Authorized Control Level
Authorized Control Level (ACL)	= 100% of Authorized Control Level
Mandatory Control Level (MCL)	= 70% of Authorized Control Level

Falling below the CAL (i.e., <200% ACL) is the first trigger within RBC and the company is to submit a plan to improve its RBC ratio into compliance. Further actions are required if a company's RBC triggers the other levels, including the company coming under regulatory control if RBC falls below the MCL.

III. NHC's 2014 Annual Statement Filing

In its December 31, 2014 annual NAIC regulatory filing, submitted February 27, 2015, NHC reported a net loss of $15,295,456 and statutory surplus of $16,124,532.[6] However, based upon my review of the information available at the time NHC was developing its year-end 2014 financial statements, NHC's financial statements as of December 31, 2014 did not accurately reflect the company's true financial position. Specifically, NHC understated IBNR and chose not to recognize a PDR despite the negative 2014 financial results. Furthermore, Larson and Company, its auditors failed to disclose these inadequacies in their various reports relied on by the NDOI. Had NHC accurately recorded the IBNR reserve and recognized a PDR in their annual filing to the NDOI, the resulting impact to statutory surplus and RBC would have triggered regulatory action. The impact of appropriate IBNR and PDR reserve levels on year-end 2014 statutory surplus is addressed further below in my report. NHC could have improved its recoveries of 3Rs for calendar year 2014 but was unable to do so due to delays in processing and reporting of claims before 3R reports had to be filed in early 2015 for calendar year 2014. Thus, NHC forfeited or reduced its 3R recoveries for year 2014.

[6] NAIC Filing 2014 Annual.pdf

To further illustrate NHC's financial challenge, Table 1 above indicated that NHC's 2014 Underwriting Ratio was 129.8%, meaning NHC's financial performance in 2015 would need to improve by approximately 30% to simply break even. Based on my experience, a 30% financial improvement over a one-year period would be extraordinary, absent a material impact such as an excessively large premium rate increase or a vast reduction in operating expenses—neither of which could have been realistically forecasted for or occurred at NHC. To this point, NHC's 2015 rate increases were not excessive, with a 6.19% average requested increase for Individuals[7] and a 7.55% average requested *decrease* for Small Groups,[8] indicating NHC's financial improvement would need to be achieved through significant reductions in medical expenses, administrative expenses, or both, which also did not happen at NHC in year 2015.

Regulators Expressed Concern Over NHC's Overall Financial Performance and Lack of PDR for Year-End 2014

Annette James, FSA, MAAA, Lead Actuary, NDOI raised the establishment of a PDR in her February 2, 2015 email, prior to NHC finalizing its 2014 results, where she suggested that "the premium deficiency reserve as of 12/31 may also be significant"[9] and challenged the reasonability of turning 2015 around such that no PDR was required given NHC's 2014 losses, stating, "it appears to be optimistic for the Co-op to go from a $21 million deficit as of 12/31/14 to surplus position within a year."[10] In a follow-up email, dated February 26, 2015, Ms. James once again expressed concern that a PDR of $0 "appears to be understated",[11] when NHC submitted its annual regulatory filing.

In addition, CMS sent a letter via electronic mail on May 11, 2015 to NHC expressing concern that NHC could have certain financial issues that may impede the organization's short-term viability.[12] CMS had provided NHC with start-up and solvency loans of $16,980,047 and $42,965,683, respectively, totaling $59,945,730 as of December 31, 2014.[13] Consequently, CMS, as lender, had serious concerns that NHC's financial losses could exceed its working capital.[14]

CMS' continued concern over the financial health of NHC led to an on-site visit of NHC on June 24-25, 2015, to gain a deeper understanding of NHC's true financial position. CMS' review identified financial distress that constrained all core functional areas of NHC's business and significant operational shortcomings that threatened NHC's viability. Those issues included:

- Understated IBNR and other liabilities by $5.2 million for the year ending December 31, 2014 (net loss impact of $1.2M after recalculating risk corridor premium receivable);

[7] Rate Change Justification – Individual.pdf
[8] Rate Change Justification – Small Group.pdf
[9] PLAINTIFF00313521
[10] PLAINTIFF00286502
[11] PLAINTIFF00286501
[12] PLAINTIFF003628
[13] Larson Report, p. 19.
[14] PLAINTIFF003628

- Net losses through April in excess of $10 million, with further losses expected;
- RBC ratios projected to be lower than 450%;
- Projected Administrative Cost Ratio of 32% for 2015;
- Insufficient cash on hand to pay anticipated claims in the next eight months;
- 28% of unprocessed claims remaining beyond 60 days of receipt.[15]

NHC Management Actively Discussed a PDR Requirement and Its Impact

Based on my review of the related documents, NHC management was very aware of the need to evaluate a PDR and to assess the corresponding impact to NHC's financial statements. In a February 2, 2015 email from Annette James to Mr. Basil Dibsie (NHC's Chief Financial Officer), Ms. James comments "[b]ased on your projections, I imagine that the premium deficiency reserve as of 12/31 may also be significant",[16] suggesting projections by NHC were not favorable.

In the same email string, Mr. Dibsie asks Colleen Norris (Milliman) and Jill Van Den Bos (Milliman), "How would you like to handle? Do we have to book anticipated 2015 losses as PDR in year-end 2014?"[17]

Ms. Norris replied to Mr. Dibsie, "To answer your question, it is common to book anticipated 2015 losses as PDR at year-end 2014. This way anticipated losses are recognized earlier, improving future financial performance."

Based on these communications in early February 2015, it is my understanding that NHC was projecting a loss in 2015 and had received guidance from both the NDOI and Milliman that a PDR should be booked in such a situation. This guidance was before NHC was required to submit its annual NAIC regulatory filing by March 1, 2015.

Indeed, in a February 27, 2015 email[18] from Mr. Dibsie to Kathleen Lace of the NDOI, Mr. Dibsie provided an updated NHC business plan pro-forma as of February 27, 2015, which provided that NHC would incur an operating loss of $9,862,342 in 2015.[19]

Further, in an email dated March 6, 2015, from Mr. Dibsie to Ms. James of the NDOI, he provided another NHC business plan pro-forma update as of March 6, 2015 (or a week later from the February 27, 2015 update), which provided that NHC would incur an operating loss of $9,568,381 in 2015.[20]

[15] PLAINTIFF003632
[16] 030 20150202 PLAINTIFF00313520.pdf
[17] 031 20150203 PLAINTIFF00312847.pdf
[18] February 27, 2015 is also the same date when NHC filed its 2014 annual financial statement with the Nevada Division of Insurance.
[19] Nevada Health Plan CO-OP Business Plan Update Pro Forma 2-27-15.xlsx.
[20] Nevada Health CO-OP Business Plan Update DOI 3-6-15.xlsm.

Ms. James provided guidance as to the calculation and communication of a PDR to Ms. Norris, Ms. Van Den Bos and Mr. Dibsie in a February 14, 2015 email.[21] Along with the guidance information, Ms. James provided specific comments relevant to NHC's PDR calculation, including:

- "In particular, based on the high level of expenses, and the level of underwriting losses projected for 2015, along with the premium increase limitations built into the ACA …. NHC should be projecting all groups through the end of the projection period (to 12/31/2015) using reasonable and supportable projection assumptions."[22]
- "Based on our conversation with NHC, projected expenses are expected to be much lower than the level experienced in 2014. A significant change in the expense level needs to be justified based on concrete data which explicitly supports the reduction in expenses compared to historical results. The basis for the new expense level should be clearly articulated in the actuarial memorandum."[23]
- "It is not acceptable to calculate a PDR as of 12/31/2014 based on the fact that the 2014 contracts for non-group business will be terminated at year-end and, since 'new' contracts will be issued for 2015, there will be little or no 'in-force' business to project as of 12/31/2014 … Given the timing of the annual enrollment period it is simply no longer reasonable to project only in-force polices."[24]

Mr. Dibsie forwarded Ms. James' email to Ms. Norris and Pamela Egan (NHC's CEO), commenting, "That is A LOT of info for us. Good news is the risk corridor. The PDR will be heavily reliant on our forecast. So, that can't be too aggressive for this purpose, nor too conservative. Collen N., do you want to schedule a call Tuesday to discuss the forecast for the PDR?"[25]

Regarding Ms. James' third point above, it is my understanding that NHC decided to terminate certain non-group (i.e., Individual) policies effective 12/31/2014 which were converted or replaced by new policies effective 1/1/2015. It is also my understanding that NHC assumed there would be a material and substantial increase in overall membership, as reflected in their February 27, 2015, and March 6, 2015, updated business plan pro-formas and rate filings provided to NDOI, and it was assumed existing NHC members whose policies were terminated would convert to one of the new NHC policies.[26]

[21] 033 20150215 PLAINTIFF00301184.pdf
[22] 033 20150215 PLAINTIFF00301184.pdf
[23] 033 20150215 PLAINTIFF00301184.pdf
[24] 033 20150215 PLAINTIFF00301184.pdf
[25] 034 20150215 PLAINTIFF00301101.pdf
[26] The February 27, 2015 and March 6, 2015 NHC business plan pro-forma updates provided to the NDOI both projected beginning membership of 15,574 in January 2015, with year-end membership of 32,450 in the February 27 pro-forma and slightly higher year-end membership of 33,450 in the March 6 pro-forma.

Ms. James' guidance indicated projections for both the current in-force policies and new policies should be considered in the overall PDR calculation. This guidance is consistent with my experience calculating PDRs.

This guidance was relevant to NHC as Mr. Dibsie, in response to Ms. James' February 2, 2015 email, writes "I am not sure how significant they (Milliman) consider the PDR since it would normally cover contracts that carry over into the following year, that may have insufficient premium rates. The majority of our business in year one, as you know, technically got terminated 12/31/14 and the plans re-rated for effective 2015."[27]

Mr. Dibsie forwarded his reply to Ms. Norris, who responded "Broadly speaking, we agree that a PDR for 2014 doesn't make sense since those contracts have already largely terminated."[28]

However, in a February 2, 2015 email to Mr. Dibsie, Ms. James indicated "the plan terminations were considered a technicality since the 2014 plans were all mapped to 2015 plans under the uniform modification rules. Therefore, I would expect the PDR to be in the neighborhood of the expected operating loss for 2015."[29]

Based on my experience and understanding of PDR calculation requirements[30], the new policies effective 1/1/2015 needed to be included in the PDR calculation since existing NHC membership was seamlessly transitioned from terminated policies in year 2014 to new in-force policies in 2015.

NHC leadership was seemingly aware of the impact a large PDR would have on the NHC's financial results and RBC levels. In his March 28, 2019 deposition, Mr. Dibsie, in response to a question asking, "Given that the Co-Op was at or below required risk-based capital levels, a significant PDR would have made it difficult or impossible to avoid regulatory action?",[31] states "If there was an agreement to book it."[32]

Further, in response to a question asking "In determining how to get around showing a big loss for the PDRs, did you discover by using favorable forecasts you could influence the calculation of the PDR?",[33] Mr. Dibsie states "Based on the definition, that would be correct."[34] In his deposition, Mr. Dibsie also acknowledged that NHC's PDR calculations "did not show a zero"[35] and "if we did a PDR calculation it would not be zero".[36]

[27] 030 20150202 PLAINTIFF00313520.pdf
[28] 030 20150202 PLAINTIFF00313520.pdf
[29] 031 20150203 PLAINTIFF00312847.pdf
[30] SSAP No. 54, p. 54-5.
[31] Basil Dibsie Vol 2 ROUGH_full.pdf, p. 39
[32] Basil Dibsie Vol 2 ROUGH_full.pdf, p. 39
[33] Basil Dibsie Vol 2 ROUGH_full.pdf, p. 40
[34] Basil Dibsie Vol 2 ROUGH_full.pdf, p. 40
[35] Basil Dibsie Vol 2 ROUGH_full.pdf, p. 45
[36] Basil Dibsie Vol 2 ROUGH_full.pdf, p. 46

In my experience, a PDR calculation that does not show zero would be recorded in the company's financial statements. The PDR amount would be booked as a liability on the company's balance sheet with a corresponding negative impact to the company's income statement.

As stated previously, NHC submitted its annual NAIC regulatory filing with a PDR of $0, from which Ms. James expressed concern that PDR was understated. Specifically, in a February 26, 2015 email to Mr. Dibsie, Ms. James writes:

> "We are concerned that the preliminary December 31, 2014 premium deficiency reserve, PDR of zero, which was discussed during that call, appears to be understated. While the projected premiums and claims appear to be in line with our expectations, the level of projected expenses combined with the expected risk corridor receipts appear to be optimistic resulting in a PDR that appears to be understated from a big picture perspective, it appears to be optimistic for the Co-Op to go from a 21 million-dollar deficit as of 12/31/14 to a surplus position within a year. We, therefore, urge you and your actuaries to review the estimates and ensure that an appropriate level of conservatism is incorporated into the year-end estimates."[37] Mr. Dibsie, responds "I don't believe Milliman or the CO-OP has ever projected an overall surplus for 2015 in our recent draft proformas. That would be overly optimistic as you state."[38]

Nevertheless, Milliman's 2014 Actuarial Memorandum to Ms. Egan, signed by Mary van der Heijde and dated March 13, 2015, stated "It is my conclusion that NHC does not need to hold a Premium Deficiency Reserve (PDR)".[39]

As noted above, Ms. James commented that the "based on our conversations with NHC, projected expenses are expected to be much lower than the level experienced in 2014. A significant change in the expense level needs to be justified based on concrete data which explicitly supports the reduction in expenses compared to historical results."[40] Based on my experience, an expense improvement of this magnitude would be highly unlikely.

In NHC's June 30, 2015, quarterly financial statement filing with the NDOI, NHC had already incurred an operating year-to-date loss of $30,422,201, which included recording a PDR of $15,900,000.[41] Further, according to financial information from the Receiver's records, NHC's actual loss for year 2015 was $75,304,617.[42] The Company's reported results as of June 30, 2015, and final results as of December 31, 2015, provide support that the company's operating loss forecasts were grossly understated for year 2015. Even so, NHC management was aware that

[37] 038 20150227 PLAINTIFF00286501.pdf
[38] 038 20150227 PLAINTIFF00286501.pdf
[39] 042b 20150313 08_PLAINTIFF00004655_2018-12-11PLAINTIFFProd.pdf
[40] 033 20150215 PLAINTIFF00301184.pdf
[41] NAIC Filing Q2 2015.pdf.
[42] FS 12.15 AO 07.18.17 2015.xlsx.

NHC would incur a loss for year 2015, even by their own business plan forecasts, and failed to record any PDR for such eventuality of loss. Larson also failed to act on this information when performing its audit functions for year 2014.

IV. IBNR Impact

FTI calculated IBNR as of December 31, 2014 using data available as of February 2015 at the time NHC was preparing its annual NAIC regulatory filing. FTI used paid claims information through December 31, 2014 and developed an IBNR reserve of $10.5 million, after recognizing reinsurance recoveries consistent with the estimates developed by Milliman.

Milliman calculated two IBNR reserves as of December 31, 2014, one in support of NHC's annual NAIC regulatory filing in February 2015 and then again in support of NHC's annual audit in May 2015. Milliman's IBNR estimates were $5.6 million and $10.6 million, respectively, representing a $5 million increase in the December 31, 2014 IBNR reserve as reported in the NHC's annual NAIC regulatory filing versus NHC's annual audit.

The difference between FTI's IBNR reserve versus what was reported in NHC's annual NAIC statement would have further reduced NHC's surplus by $4.9 million, as summarized in Table 3 below.

As noted, there was a substantial claims backlog of unprocessed claims for calendar year 2014, and FTI calculates that this claim backlog problem at NHC understated IBNR by approximately $5 million as of year-end 2014, as shown in Table 2 below.

Table 2
Year-End 2014 IBNR Reserves & Impact on Surplus
(in $Millions)

		Milliman IBNR Calculation[1]	
		Annual Statement	Audit
	FTI IBNR[1,2]	as of March-2015	as of June-2015
IBNR	$10.5	$5.6	$10.6
Impact on Surplus[3]		($4.9)	$0.1

[1]FTI and Milliman IBNR calculations are net of $2M of estimated transitional reinsurance

[2]FTI calculated IBNR using paid claims data available as of February-2015

[3]Impact on NHC's reported surplus based on the FTI vs. Milliman IBNR calculation

V. Premium Deficiency Reserve Impact

As previously noted, Milliman recommended that a PDR need not be established for year-end 2014. Not recommending NHC to book a PDR for 2014 was not reasonable given NHC's 2014 financial results and was inconsistent with the Actuarial Standards Board, ASOP No. 42 - *Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims*. Section 3.4 of ASOP No. 42 outlines the considerations for determining a PDR, including:

> "The actuary should establish a premium deficiency reserve when such a reserve is required. Premium deficiency reserves are typically established for financial reporting purposes. They may also be established for other purposes such as management reporting. The actuary commonly performs a gross premium valuation in order to determine whether or not a deficiency exists."[43]

There is considerable evidence that NHC Management recognized that the PDR calculation is heavily dependent on the choice of selected assumptions and projections. Milliman provided NHC with copies of their model so that NHC Management could explore the effects of changes to NHC's projections. Larson failed to adequately test the NHC assumptions and projections used.[44]

As previously noted, Ms. James, the lead actuary for the NDOI, strongly questioned the lack of a PDR. NHC posted a $16.5 million loss for 2014, with an Underwriting Ratio of 129.8%, meaning NHC would need to improve their 2015 financial results by at least 30% over their 2014 results to simply break even.

To assess the appropriateness of a $0 PDR for year-end 2014, I analyzed NHC data that was available at February 2015, data which could have been used at the time to determine if a PDR was required as part of NHC's annual statement filing.

Table 3 below shows PDR amounts for year-end 2014 based on data that was available as of February 2015. Reserve amounts are calculated based on a range of BCR scenarios.

[43] ASOP No. 42, p. 7.
[44] Expert Report of Joseph DeVito "DeVito Report", July 30, 2019, p. 24.

Table 3 NHC Year-End 2014 Premium Deficiency Reserves Based on Varying Benefit Cost Ratios				
LOB	(A) 2014 Results	(B) Milliman Rate Filing	(C) Mid-Point of (A) and (B)	(D) Break Even
Individual	87.1%	83.0%	85.1%	67.5%
Small Group	87.1%	85.0%	86.1%	74.2%
Large Group	87.1%	88.0%	87.6%	84.2%
Aggregate	87.1%	83.8%	85.4%	70.1%
PDR	($15,808,318)	($12,816,590)	($14,419,108)	$0

The Scenario (A) reserve amount of $15.8 million represents the year-end 2014 PDR liability assuming 2015 BCRs were at 2014 experience levels as reported in NHC's annual audit report, reflective of the backlog of unprocessed claims (Table 1 – Line 5).

The Scenario (B) reserve amount of $12.8 million represents the year-end 2014 PDR liability assuming the BCR percentages in Milliman's 2015 rate filing projections.

The Scenario (C) reserve amount of $14.4 million represents the year-end 2014 PDR liability assuming 2015 BCR improvement over 2014 experience, but only half as much as the Milliman projections assumed.

The Scenario (D) reserve amount of $0.0 million and corresponding BCR of 70.1% represent what the 2015 BCR would have to be to generate a PDR of $0.0m.

In other words, NHC's 2015 experience and aggregate BCR would have to improve from its 2014 experience of 87.1% to 70.1% to justify not establishing a PDR at year-end 2014. This represents a 20% overall improvement.

It should also be noted that the large backlog of unprocessed claims for year 2014 also had a material impact on calculating the PDR for year 2014, as inaccurate claim loss data for year 2014 adversely impacted the PDR loss calculations for year-end 2014.

Milliman as NHC's Appointed Actuary

Milliman, as the appointed actuary for NHC, issued an initial and then a subsequent revised Statement of Actuarial Opinion regarding NHC's reserves on March 1, 2015, and May 14, 2015, respectively. In addition, Milliman issued an Actuarial Memorandum to NHC on March 13, 2015, in support of its opinion. In forming its opinion, Milliman relied upon data prepared by NHC which Milliman evaluated for reasonableness and consistency. NHC's CEO, Pamela Egan, certified to the accuracy and completeness of the data provided to Milliman.

Based on my experience as a former Chief Actuary, Milliman, in its role as NHC's appointed actuary, would have worked closely with NHC management to develop assumptions and review the underlying information used in forming its opinions, particularly given that this was NHC's first year of doing business, as Milliman would have wanted to fully understand how their original 2014 pricing assumptions compared to actual 2014 results in order to establish the year-end 2014 reserves. Consequently, NHC's 2014 results, related assumptions, and NHC's overall operational performance indicators, such as NHC's ability to pay claims timely and accurately, should have been critical factors in forming Milliman's opinion.

In my opinion, however, Milliman, in conjunction with NHC management, chose overly aggressive assumptions that did not reflect NHC's actual experience. For example, in reviewing Milliman's 2014 PDR assumptions,[45] Milliman chose very aggressive Benefit Cost Ratios (BCRs), as shown in Table 4 below, particularly given NHC's 2014 BCR as reported in its NAIC annual statement filing before reinsurance recoveries was 102%.[46]

Table 4
Milliman 2014 PDR Projection Assumptions
(as a % of Premium)

Relativities	Individual	Small Group	Large Group
1. Claims	89.6%	69.7%	85.0%
2. Capitated Claims	1.2%	1.6%	0.0%
3. Cost-Sharing Reductions	9.8%	0.0%	0.0%
4. Transitional Reinsurance	11.4%	0.0%	0.0%
5. Risk Adjustment	0.0%	0.0%	0.0%
6. Risk Corridors	0.0%	0.0%	0.0%
7. Commercial Reinsurance Recovery	1.8%	2.8%	3.8%
8. Benefit Cost Ratio = 1 + 2 - 3 - 4 - 7	67.7%	68.5%	81.2%

[45] PDR Calculation.xlsm
[46] NAIC Filing 2014 Annual.pdf, p. 4, Line 16, Column 2 / Line 8, Column 2

As a result, using the assumptions shown in Table 4, Milliman opined in both its March 1, 2015, and May 14, 2015, Statements of Actuarial Opinion that a PDR was not necessary.[47,48] However, on July 31, 2015, approximately two months after its May 14, 2015, opinion, Milliman determined a PDR of $15.9 million was necessary as of June 30, 2015.[49] It's important to note that since the PDR was recorded as of June 30, 2015, the reserve only recognized the estimated losses for the last six months of 2015 and did not include approximately $15 million in losses already incurred by that date.

Further, as previously mentioned, Milliman and NHC management should have accounted for the substantial backlog of unprocessed claims when Milliman developed the initial 2014 year-end IBNR reserve on March 1, 2015, which Milliman then increased by $5 million in the revised May 14, 2015, opinion, approximately only two months later. Milliman and NHC management also made the unrealistic assumption that the IBNR increase reflected in Milliman's May 14, 2015, opinion would mostly be offset by an increase in the federal Risk Corridors receivable, with both adjustments reflected in Larson's year-end audit. However, it should have been apparent that NHC would not fully recover the federal receivables, including Risk Corridors, since given the substantial claims backlog, NHC would not be able to process the 2014 claims timely before the submission deadline used to determine the 2014 federal receivables. Understating actual paid claims in the federal receivables submission would severely understate the actual monies owed to NHC.

Impact to NHC's NAIC Annual Statement Filing

NHC's statutory surplus as of December 31, 2014, as reported in its NAIC annual statement filing, was $16,124,532.[50] Had an appropriate IBNR and PDR been established in a timely manner, NHC's resulting statutory surplus would have been negative (i.e., insolvent) under all 3 PDR scenarios (Scenarios A, B and C) from Table 3.

It's also my understanding that NHC did not accrue at the end of December 2014 a large claim adjusting expense of $826,445.74 for an invoice from their Pharmacy Benefits Manager, Catamaran, covering the second half of December 2014.[51] Had NHC appropriately accrued the payable due to Catamaran, NHC's surplus would have been reduced by an equivalent amount.

Table 5 below summarizes the impact to statutory surplus and RBC, had appropriate levels of IBNR and PDR plus the Catamaran liability been recorded by NHC in its annual statement filing, using Scenario A as the best estimate PDR scenario which assumes NHC's 2015 BCR results are consistent with 2014:

[47] Nevada Health CO-OP 2014 Statement of Actuarial Opinion.pdf
[48] NVH updated Actuarial Opinion and Affirmation (May 2015).pdf
[49] Premium Deficiency Reserve as of June 30 2015-07-31.pdf
[50] NHC NAIC Filing 2014 Annual.pdf, p. 4, Col. 3
[51] DeVito Report, p. 34.

Table 5
Impact on Year End 2014 Solvency
Reported RBC vs. Revised RBC with PDR, Change in IBNR & PBM Payable
Annual Statement Filing
(in $Millions)

	ACL	PDR	TAC	RBC %	Implication
Reported RBC YE 2014[1]	$2.4	$0.0	$16.1	685%	No Action Required
Revised RBC YE 2014					
• PDR (Scenario A)[2]	2.4	15.8	0.3	**13%**	MCL
• PDR (Scenario A)[2] + IBNR[3] + PBM[4]	2.4	21.5	-5.4	**-230%**	Insolvent

[1]NAIC Filing 2014 Annual RBC.pdf
[2]Scenario A PDR = $15.8M from Table 4
[3]Change in IBNR = $4.9M from Table 3
[4]Payable to Catamaran PBM = $0.83M

Table 5 Notes

ACL: Authorized Control Level
PDR: Premium Deficiency Reserve
MCL: Mandatory Control Level = 70% of ACL
RBC % = TAC / ACL
TAC: Company's Total Adjusted Capital (Surplus)

In my opinion, had NHC accurately recorded the IBNR reserve, recognized a PDR, and booked the Catamaran payable in their NAIC annual statement filing to the Nevada DOI, the resulting impact to statutory surplus and RBC would have triggered regulatory action. Consequently, NHC would have recognized its insolvency sooner, forcing the wind-down and closure of insurance operations sooner, and avoiding additional losses incurred throughout 2015.

Impact to NHC's Audit Report Prepared by Larson

Larson, as Auditor, was in a unique position to identify key financial issues of NHC, and had a responsibility to ensure the accuracy of the reported financial statements for year-end 2014 in its year-end audit of NHC, including the reasonableness of the underlying assumptions and reported liabilities as stated in the Milliman report.

Based on my industry experience as both a former Chief Actuary and Chief Financial Officer of a health plan, auditors conducting the year-end audit used their own independent actuaries to validate the actuarial liabilities of the plan, such as IBNR and PDR, and did not rely upon the estimates calculated by the plan's internal actuaries. Milliman, in its relationship with NHC, was serving as NHC's internal actuary. In my opinion, Larson should have used an independent actuary to review the actuarial liabilities established by Milliman. Based on my experience, the review conducted by the independent actuary for a plan like NHC would likely take one-to-two weeks once the historical claims data was received.

Had Larson recognized that the liabilities as stated were inconsistent and understated based on NHC's experience, they should have issued a qualified opinion regarding NHC as a going-

concern,[52] signaling to regulators and NHC's directors and leadership the need to ascertain whether NHC should cease operations, thereby reducing continued losses in 2015. Larson failed to appropriately question and challenge the overly aggressive, unsupportable, and unrealistic assumptions and information of NHC and Milliman when evaluating the actuarial opinions for year 2014.

According to Larson workpapers, Larson mistakenly believed that the NDOI had authorized the reporting of no PDR. However, the apparent alleged correspondence concerning this belief did not support this contention, nor was the departure from applicable reporting standards disclosed in Larson's audit report.[53]

In addition, it is my understanding that NHC's April 2015 financial results, which reflected a year-to-date net loss of $10.3M, were available at the time when Larson issued its year end audit report on June 1, 2015. A quick reasonability calculation of whether a PDR was necessary as of December 31, 2014, would have been to simply annualize the April year-to-date net loss, resulting in a projected net loss of approximately $31M. Even allowing for improvement over the last eight months of 2015, such as reducing the monthly burn rate by 50% (i.e., $2.5M loss per month, January through April versus $1.25M loss per month, May through December), would have yielded an estimated PDR of $20M. In my opinion, at a minimum, projected losses of this significance should have prompted Larson to conduct an independent review as to whether a PDR was necessary.

Based on my review, Larson did not perform appropriate checks on Milliman's work or follow through on the concerns of regulators of which Larson was aware. These failures allowed continued operations and continued losses through 2015. In fact, NHC recorded a $15.9 million PDR as part of the June 30, 2015 statements, less than two months after Larson issued their 2014 audit report on June 1, 2015, which did not include a PDR. Furthermore, NHC's inability to timely process and report its accurate claims liability for 2014 was a key factor to its later inaccurate reporting of financials for that year, which also enabled the company to stay in business in 2015 longer than it should have.

The subsequent increase in reserves and continued poor financial performance effectively rendered the company financially unviable, leading to NHC eventually being placed in receivership by the NDOI on October 14, 2015. It's important to note that since the PDR was recorded as of June 30, 2015, the reserve only recognized the estimated losses for the last six months of 2015 and did not include approximately $15 million in losses already incurred by that date.

[52] DeVito Report, p. 36.
[53] DeVito Report, p. 24.

Impact to NHC's Loan Agreement with CMS

Hospitality Health, LLC (HHC), predecessor to NHC, provided CMS with a business plan ("Business Plan") for start-up operations of a health care CO-OP in Nevada. The Business Plan was relied upon by CMS and resulted in CMS (as "Lender") granting HHC (then organized as Hospitality Health, Ltd., as "Borrower") a start-up loan totaling $17,105,047 maximum and a solvency loan totaling $48,820,349 maximum (collectively, "Loan Agreement") for its health care operations.

The Business Plan provided the following as part of HHC's risk-bearing strategy:

> "HHC will request a solvency loan amount that will allow it to withstand adverse experience and maintain capital levels above the minimum requirement. HHC has set a 500% RBC target that it feels is adequate, yet not excessive. It is HHC's intent to manage their surplus to this target by reducing member premiums or improving quality for its members if surplus is in excess of this target. The solvency loan amount requested has been tested under five alternate scenarios and under each scenario, by requesting solvency funds which will initially meet HHC's targeted capital needs based on a moderately adverse scenario, the loan will be able to be repaid on time and at no point in the 20 year projection is HHC expected to fall below the 200% RBC level."[54]

NHC's Loan Agreement with CMS had certain program requirements regarding the minimum reserve levels that must be held by NHC. Specifically, *Section 7.2.(b)* of the loan agreement was as follows:

> "The surplus reserves held by Borrower cannot be more than 10% below the RBC level stated in the Business Plan for the applicable year at any time (e.g. If the reserve level established in the Business Plan and funded by the Solvency Load for a particular year is 300% of risk based capital ("RBC"), the surplus reserves held by Borrower shall not fall below 270% of RBC at any time during such applicable year)."[55]

Accordingly, NHC was required to maintain 500% RBC under the Loan Agreement for 2014 but no less than 450%.[56] Based on NHC's Authorized Control Level (= 100% RBC) of $2.4M as reported in its 2014 annual statement filing, 450% of RBC results in a minimum reserve level per the Loan Agreement of $10.6M.

Table 6 below summarizes various RBC reserve levels for NHC at the end of 2014:

[54] HHC Business Plan, p. 45.
[55] CMS Loan Agreement, p. 24
[56] 450% = 500% x (1 – 10%)

Table 6 RBC Levels Based on NHC's 2014 Annual Statement Filing (in $Millions)		
		RBC%
NHC's Total Adjusted Capital[1]	$16.1	685%
Mandatory Control Level[1]	1.6	70%
Authorized Control Level[1]	2.4	100%
Company Action Level	4.7	200%
RBC per NHC Business Plan	11.8	500%
Minimum RBC per CMS Loan Agreement	10.6	450%

[1]NAIC Filing 2014 Annual RBC.pdf

Had appropriate levels of IBNR and PDR, as well as the Catamaran payable, been recorded by NHC in its annual statement filing at the end of 2014, as summarized in Table 5 above, NHC would have fallen well below the minimum RBC level of 450% provision as per the Loan Agreement and, in fact, would have been insolvent. Consequently, NHC would have failed to maintain the requisite RBC as of year-end 2014 to be compliant with the provisions of the Loan Agreement.

NHC's insolvency and violation of the required RBC under the Loan Agreement likely would have been considered material adverse effects and breaches of the Loan Agreement, requiring NHC to provide notices to CMS under *Section 13. COVENANTS, 13.1.12 Notice of Material Adverse Effect*, [57] *(a)* and *(e)* of the Loan Agreement: [58]

> *13.1.2 Notice of Material Adverse Effect*
>
> *Borrower will promptly furnish written notice to Lender of:*
>
> *(a) The occurrence of any default or event of default under any contractual agreement of Borrower or a Affiliated Party; or ….*
> (e) *Material Adverse Effect. Any development or event of which Borrower has knowledge that has had or could reasonably be expected to have a Material Adverse Effect; …*
>
> *Each notice pursuant to this Section 13.1.2 shall be accompanied by a certificate of a responsible officer of Borrower setting forth details of the occurrence referred to therein and stating what action, if any, Borrower proposes to take with respect thereto.*

[57] CMS Loan Agreement, Section 2. Definitions, 2.1 Defined Terms, "Material Adverse Effect" means any occurrence, condition, event, change, consequence or effect that is or could reasonably be expected to be materially adverse to or otherwise detrimentally effect the business, operations, results of operations, assets, liabilities, or financial condition of Borrower or the CO-OP, p. 11.
[58] CMS Loan Agreement, p. 31.

To my knowledge, neither NHC, nor its auditor Larson, notified CMS, the NDOI, nor NHC's Board of Directors of any issues with NHC's Loan Agreement.

In addition, NHC's surplus level below 450% of RBC and insolvency would have led to default under the Loan Agreement, as defined in *Section 15. DEFAULT; EVENTS OF DEFAULT*.[59] Specifically, per *Section 15.1. Events of Default*, NHC would have committed at least two events of default to CMS under the Loan Agreement:

> *Section 15.1 (c)* – default of covenant for minimum surplus level less than 450% RBC
> *Section 15.1 (d)* – default for ceasing to be solvent

Section 15.2 of the Loan Agreement[60] provided that NHC would have a thirty (30) day cure period after promptly notifying CMS of the event(s) of default, but not later than 10 business days after the occurrence of default (no notice was given). But even if NHC had provided such a notice, it could not have cured the default of not having the requisite surplus for its required RBC under the Loan Agreement.

As shown in Table 6 above, NHC was required to have no less than 450% RBC at year-end 2014, which was $10.6 million. NHC's insolvency at year-end 2014, as shown in Table 5 above, would have been -$5.4 million. As of year-end 2014, the unused amount of its solvency loan with CMS was $5,854,666 after a $3,152,275 draw on February 26, 2015, right before NHC issued its annual statement on February 27, 2015. Thus, even if NHC had used the remaining available solvency loan amount of $5,854,666 up to the maximum level, NHC's surplus would been only $0.5 million, well below the required CMS 450% RBC required threshold of $10.6 million.

Consequently, NHC could not have cured its loan default with CMS via the additional solvency loan funds. As a result, CMS would have had default rights under *Section 15.3 Rights and Remedies of Lender* of the Loan Agreement,[61] which included the following:

> (a) all obligations of CMS terminating;
> (b) calling all principal and interest due under the loans; and,
> (c) repayment of any unused loan funds.

CMS was further entitled to pursue any and all legal rights and remedies against NHC for an event of default.

Also, even if NHC had borrowed the full amount of its unused solvency loan, it was also subject to regulatory action by the NDOI for failing to have a surplus level above the Mandatory Control Level of 70% RBC, or $1.6 million, as shown in Table 6 above.

[59] CMS Loan Agreement, p. 36.
[60] CMS Loan Agreement, p. 37.
[61] CMS Loan Agreement, p. 37.

In my opinion, insolvency, a loan default, loss of CMS funding, or a calling of the CMS loans due, which was inevitable due to a loan default, would have been the end of NHC as a viable organization, certainly when NHC filed its annual statement on February 27, 2015, or the latest by March 31, 2015, when Larson should have recognized NHC's financial issues.[62]

VI. Impact of NHC's Operational Deficiencies' Impact on 3R Calculations

a. Impact on 3R Calculations

NHC had operational deficiencies that inhibited the correct calculation of CMS' 3Rs. These deficiencies included the slow processing of claims[63] and the timely and accurate data submission to CMS needed to calculate NHC's Federal 3R payables and receivables.

CMS requires that data be submitted annually by May 1st. NHC's inadequate claims processing functions meant that data submitted to CMS was incomplete, negatively impacting NHC's net Federal receivables.

The Receiver had a retrospective analysis performed of what the 3R receivable (payables) would have been had complete 2014 claims data been processed, collected and submitted to CMS.

Table 7 below shows each of the 3R categories as filed for 2014, based on incomplete claims data, and corresponding figures recalculated using complete claims data as subsequently compiled by Indegene[64], a data management vendor for the risk adjustment calculation, and under the SDR's direction for the transitional reinsurance and risk corridor calculations for year 2014.[65]

[62] DeVito Report, p. 39.
[63] PLAINTIFF003632
[64] FTI has reviewed and found to be reasonable the Indegene revised calculations of risk adjustment for year 2014.
[65] FTI has reviewed and found to be reasonable the revised calculations of transitional reinsurance and risk corridor for year 2014.

Table 7 NHC Year-End 2014 Federal (Payables) Receivables As Filed vs With Complete Submission Data			
Federal Category	**(A)** **Filed for 2014[1]**	**(B)** **Revised with Complete Data[2]**	**(C) = (B) - (A)** **Impact to NHC**
Risk Adjustment Income (Liability)	($3,629,890)	($2,790,221)	$839,669
Federal Transitional Reinsurance	$10,078,725	$10,651,482	$572,757
Risk Corridor	10,700,240	15,463,297	$4,763,057
Total	$17,149,075	$23,324,558	$6,175,483

[1] Risk Adjustment and Transitional Reinsurance as provided by CMS in 2014 MLR Template (Excel); Risk Corridor calculated by NHC using CMS provided 2014 Risk Corridor Template (Excel)

[2] Recalculated amounts assuming complete submission data

Column C shows that complete and processed claims data would have resulted in NHC having a lower risk-adjustment liability and higher reinsurance and risk corridor receivables, such that each of the categories of the ACA's federal program were negatively impacted by the incomplete processing, collection and submission of claims data to CMS.

b. Impact on Claims Processing

NHC's operational deficiencies also included the slow processing of claims. Nevada's insurance code requires claims be paid within 30 days after the claim is approved; otherwise, interest shall also be paid.[66] Based on my industry experience, 30 days to process approved claims is common in many other states and is often referred to as the "prompt pay" requirement.

The following four charts illustrate NHC's slow processing of claims:[67]

- Charts 1 and 2 show the distribution of claims paid by incurred month, for 2014 and 2015, respectively, reflecting the number of days required to pay the claim once received
- Charts 3 and 4 show the claims inventory at the end of each month, for 2014 and 2015, respectively, including the number of claims on hand over 30 days old, often referred to as the claims "backlog"

[66] 2010 Nevada Code, TITLE 57 INSURANCE, Chapter 683A.0879, https://www.leg.state.nv.us/NRS/NRS-683A.html#NRS683ASec0879

[67] Source: 2019-12-23 – Data Breakout Project (NHC Claims Lag).xlsx

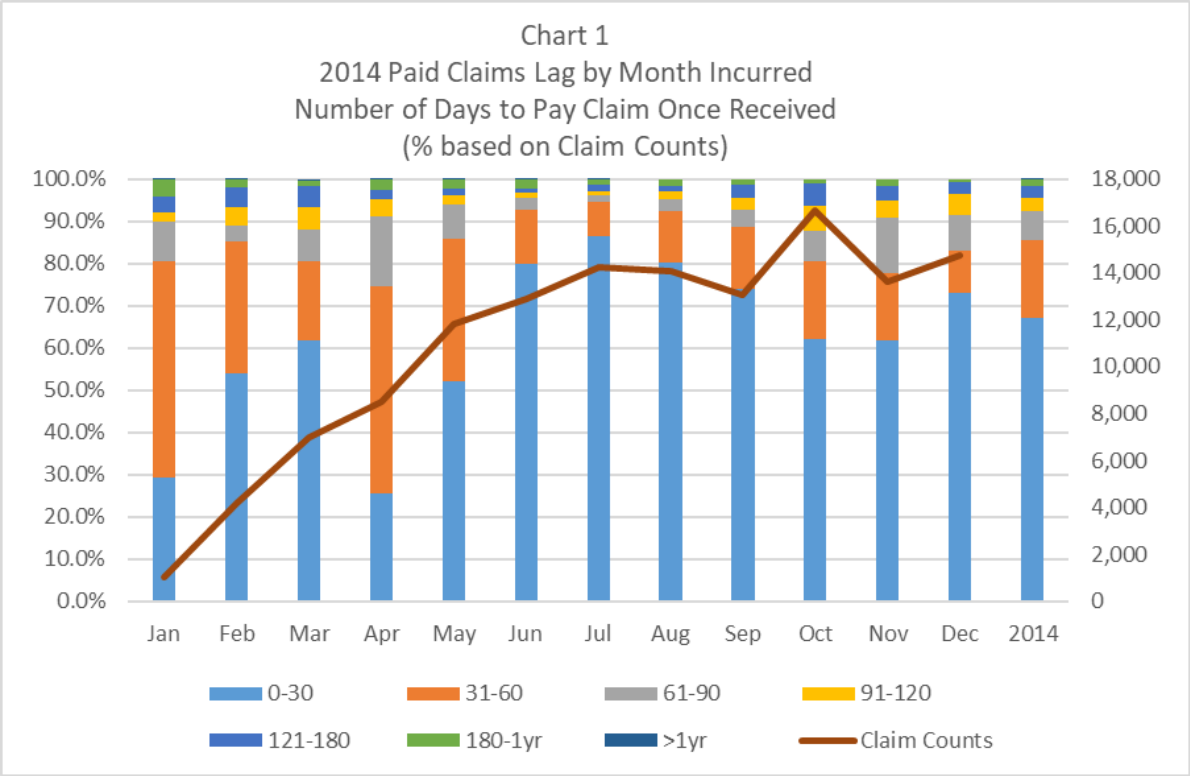


Chart 1
2014 Paid Claims Lag by Month Incurred
Number of Days to Pay Claim Once Received
(% based on Claim Counts)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
2014
0-30
31-60
61-90
91-120
121-180
180-1yr
>1yr
Claim Counts

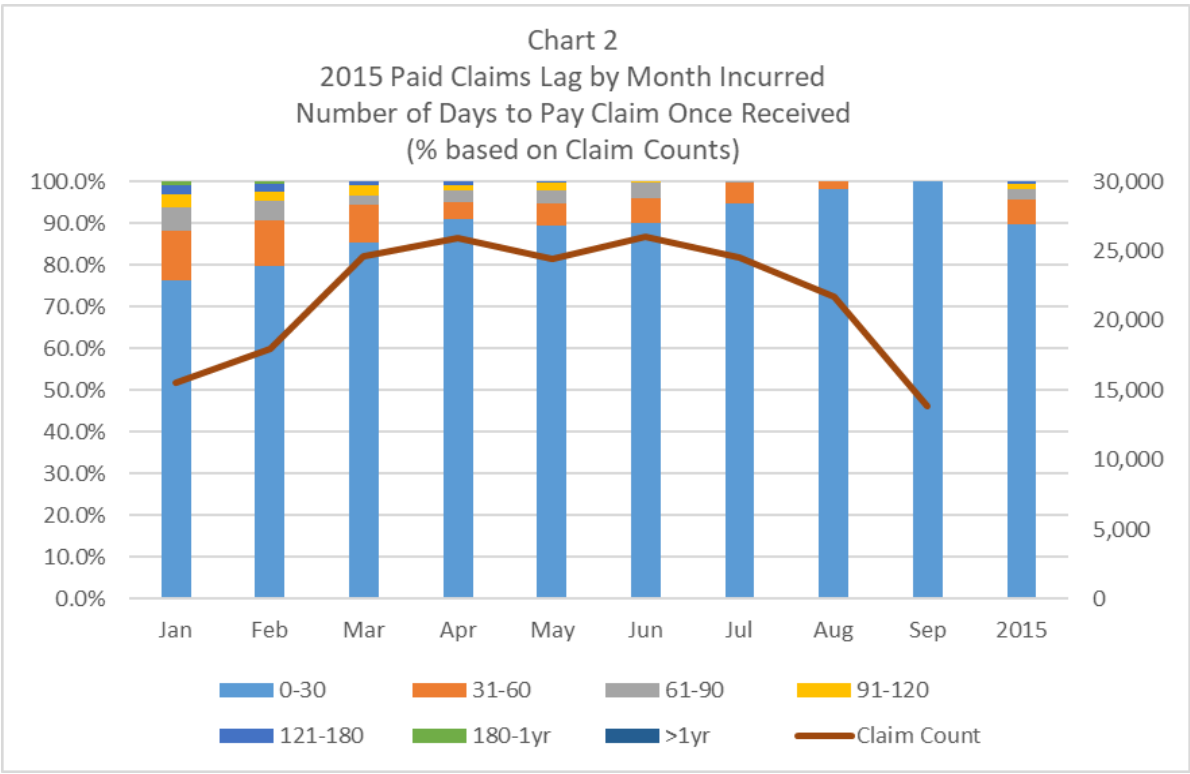


Chart 2
2015 Paid Claims Lag by Month Incurred
Number of Days to Pay Claim Once Received
(% based on Claim Counts)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
30,000
25,000
20,000
15,000
10,000
5,000
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
2015
0-30
31-60
61-90
91-120
121-180
180-1yr
>1yr
Claim Count

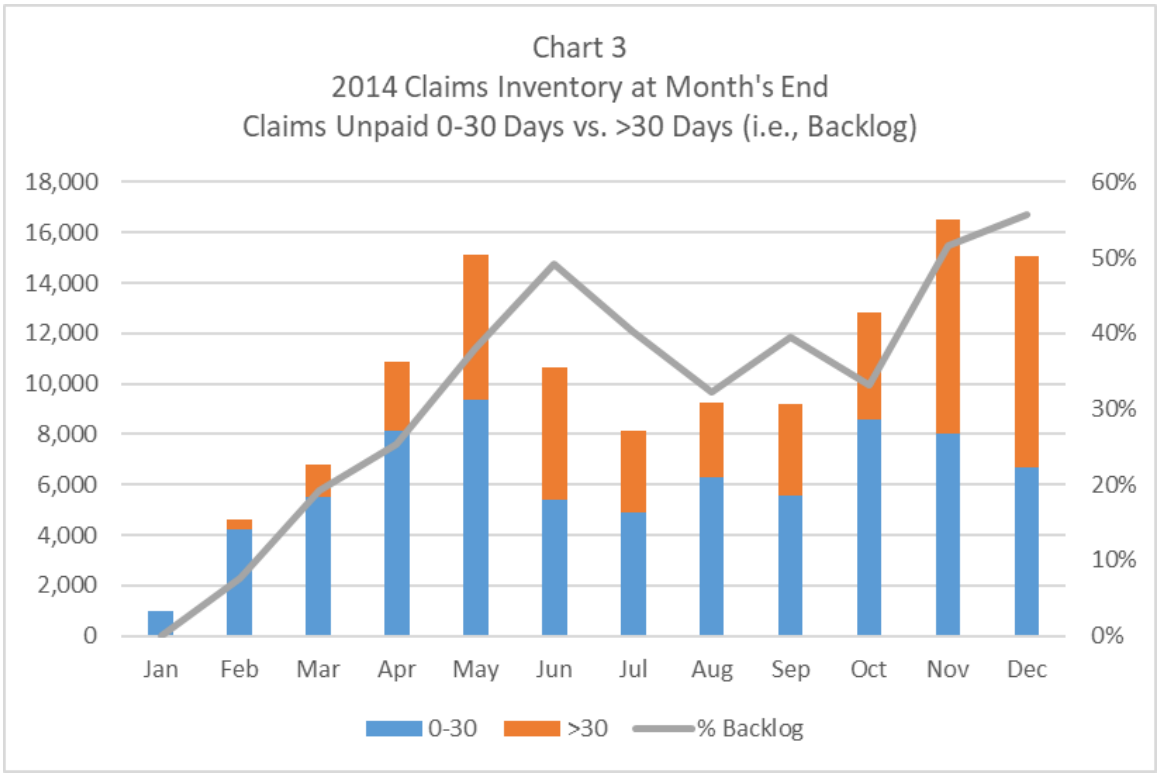


Chart 3
2014 Claims Inventory at Month's End
Claims Unpaid 0-30 Days vs. >30 Days (i.e., Backlog)
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
60%
50%
40%
30%
20%
10%
0%
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
0-30
>30
% Backlog

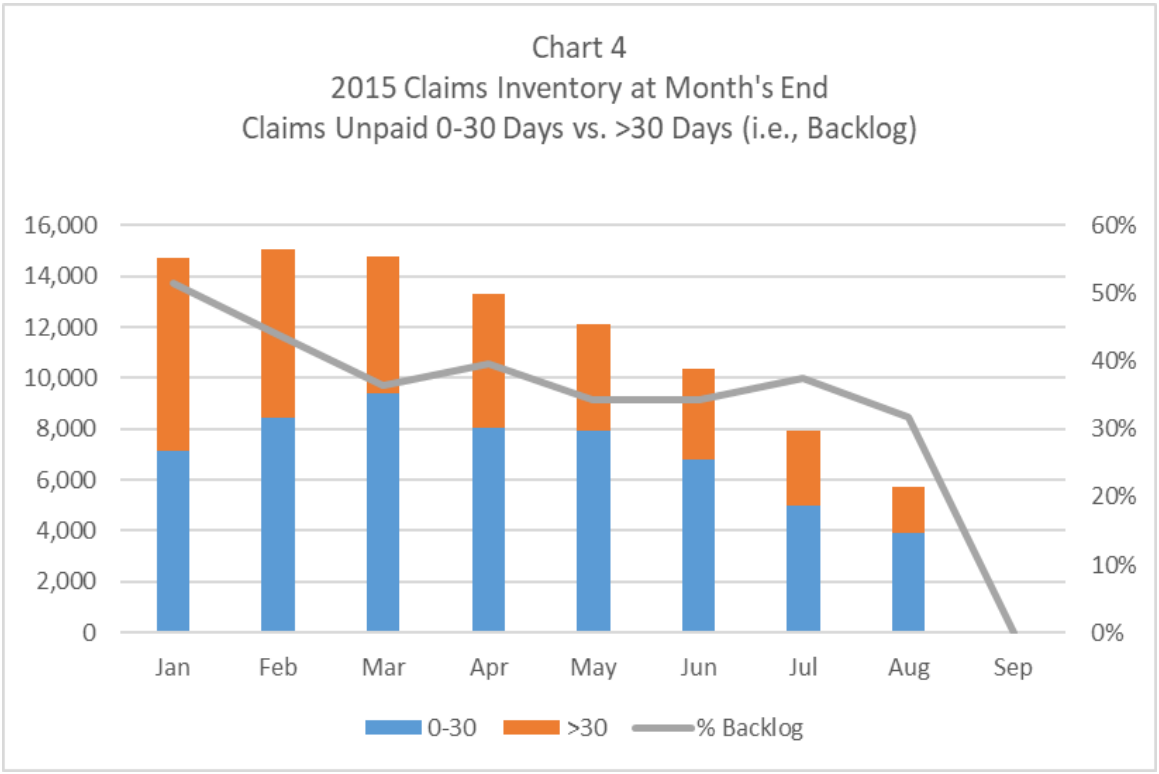


Chart 4
2015 Claims Inventory at Month's End
Claims Unpaid 0-30 Days vs. >30 Days (i.e., Backlog)
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
60%
50%
40%
30%
20%
10%
0%
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
0-30
>30
% Backlog

Based on my industry experience, insurance companies without major operational deficiencies pay claims at a very high rate (e.g., 98%) within 30 days, particularly given prompt pay requirements and associated interest penalties. As can be seen in Charts 1 and 2, NHC experienced major prompt pay issues, particularly at its outset and throughout 2014. In addition, Charts 3 and 4 illustrate that NHC experienced severe backlog issues (i.e., unpaid claims over 30 days) beginning in May 2014, reaching a high of nearly 60% at the end of 2014. As discussed above, the delays in claims processing and associated claims backlog had severe operational and financial impacts on NHC.

VII. Summary of Damages

a. Damages due to Avoidable Costs of Additional Losses in Continued Operation

On September 25, 2015, the state of Nevada sought the appointment of the Commissioner of Insurance as Receiver of NHC, and on October 1, 2015, the Commissioner was appointed as the Receiver of NHC. NHC's insurance contracts terminated on December 31, 2015, if not terminated sooner by nonpayment of member premiums. Had appropriate action been taken sooner, concerning proper claims processing and financial reporting for year 2014, NHC's insurance contracts would have been terminated in early 2015. By terminating insurance contracts early in 2015, NHC would have avoided substantial losses in 2015 from the date when such contracts should have been terminated.

I have determined damages as the avoidable cost of additional losses incurred by NHC resulting from continued operations though financially unsustainable. The losses represent additional losses in net income from claims and expenses, additional loan debt to CMS, and amounts owed to vendors and creditors.

Table 8 below shows Damages for continued operations beyond a range of plausible dates at which NHC could have been recognized as financially unsustainable, ceased operations and foregone the additional losses related to continued operations. Table 8 illustrates that the additional losses would have been avoided with early recognition of financial unsustainability and early action. Based on and my analysis, there were $72.7 million in damages calculated as follows:

Table 8 Damages Avoidable Costs of Additional Losses in Continued Operation Had Operations Ceased as of 4/30/2015 Related to Nevada Health CO-OP (in $Millions)	
Net Damages	
Loss in Net Income[1]	$61.1
Claims Incurred Not Recognized In 2015 Reported Net Income	(1.4)
Loan from CMS	5.9
Amounts Owed to Other Creditors	4.1
Less: 2015 3Rs Receivables (Full Credit)[2]	($16.9)
Damages Due to Avoidable Costs (Before Interest)	**$52.7**
Interest	
Interest to October 31, 2020[3,4]	**$20.0**
Damages Due to Avoidable Costs (After Interest)	**$72.7**

[1]Net Income per financial statements: ($10.3m) at 4/30/15

[2]Assumes 100% of Risk Corridor Receivable is collectable for analysis

[3]Interest calculated at 2% over the prime rate as set by the Nevada Commissioner of Financial Institutions, with interest due from 9/1/2015 and assuming a 10/31/2020 judgement date

[4]Interest will continue to accrue if judgement date is beyond 10/31/2020

Damages are calculated as incremental losses incurred beyond April 30, 2015 at which time NHC could and should have been recognized as financially unsustainable, whereby NHC would have ceased operations and foregone additional losses incurred.

Incremental losses are based on Net Income over the period per financial statements, adjusted for actual claims runout, plus incremental amounts owed to CMS and other creditors or vendors.

Full credit (i.e., CMS funding at 100%) was given for the temporary Risk Corridor program. Total damages include interest to October31, 2020, calculated at 2% over the prime rate as set by the Nevada Commissioner of Financial Institutions.[68]

[68]http://fid.nv.gov/uploadedFiles/fidnvgov/content/Resources/Prime%20Interest%20Rate%20Jan.%201,%202019.pdf

b. Damages Due to Premature and Ill Prepared Commencement of Operations

It's my understanding NHC entered into a consulting agreement and Third-Party Administrator (TPA) agreement with UHH.[69] I further understand that NHC entered into a number of contractual agreements with InsureMonkey (IM)[70] to provide information technology, enrollment, customer service and other support of NHC's participation on Nevada's State Health Insurance Exchange (HIE).

Due to the actions and failures of the Management Defendants, UHH and IM, NHC was not prepared to sell policies or commence operations on the initial open enrollment date of October 1, 2013 (*see Expert Report of Henry Osowski dated February 7, 2020*). As a result, NHC suffered damages that could have been avoided were it not for the actions and failures of the Management Defendants, UHH and IM.

I have reviewed Mr. Osowski's expert report and computed damages that could have been avoided but for the actions and failures of the Management Defendant, UHH and IM. Based on the calculation of insolvency in the Expert Report of Joseph J. DeVito dated July 30, 2019 and my interest calculations, there were $142.4 million in damages, as show in Table 9 below. Total damages include interest to October31, 2020, calculated at 2% over the prime rate as set by the Nevada Commissioner of Financial Institutions.[71]

[69] Osowski Report, p. 4.
[70] Osowski Report, pp. 41 – 42.
[71] http://fid.nv.gov/uploadedFiles/fidnvgov/content/Resources/Prime%20Interest%20Rate%20Jan.%201,%202019.pdf

Table 9
Damages
Damages Due to Premature and Ill Prepared Commencement of Operations
(in $Thousands)

Assets	$521.8
Solvency Loan	(48,820.3)
Start-Up Loan	(17,080.1)
Notices of Claim Determination	(33,700.0)
Policy Claims	(20.8)
Subtotal	($99,099.4)
Proofs of Claims - Class C	(3,360.0)
Damages (Before Interest)[1]	**($102,459.4)**
Interest	
Interest to October 31, 2020[2,3]	**($39,981.6)**
Damages (After Interest)	**($142,441.0)**

[1]Per Expert Report of Joseph J. DeVito dated July 30, 2019, Exhibit 4, p. 66.

[2]Interest calculated at 2% over the prime rate as set by the Nevada Commissioner of Financial Institutions, with interest due from 7/1/2015 and assuming a 10/31/2020 judgement date

[3]Interest will continue to accrue if judgement date is beyond 10/31/2020

c. Damages Due to Failure of Duties Performed by Unite Here Health and InsureMonkey, including Failure of Duties by NHC Management

I have reviewed Mr. Osowski's expert report dated February 7, 2020, in which Mr. Osowski outlines multiple failure of duties performed by UHH and IM in accordance with the applicable contracts with NHC, resulting in economic damages sustained by NHC, and Mr. Osowski further outlines that these failures of duties were also the failure of duties by NHC management.[72]

In addition to NHC management having caused damages for all of the items mentioned for UHH and IM, NHC management is also responsible for damages for the improper WellHealth Capitation Agreement. The failure of NHC management duties, which resulted in damages from the WellHealth agreement, is further detailed in Mr. Osowski's report dated February 7, 2020. In this connection, NHC entered into an unfavorable capitation agreement with WellHealth whereby NHC paid $3,597,764.47 in capitation payments to WellHealth during 2014, but WellHealth only paid $2,442,903.45 in claims under the capitation agreement, resulting in a difference of $1,154,861.02 (or 32%).

I have also reviewed the corresponding damage amounts and calculations computed by the SDR related to these failures, all of which also apply to NHC management per Mr. Osowski's report, and which appear reasonable based upon the review and due diligence that I have performed.

Summary of Related Damages

1. Damages for Claims Paid Outside of Eligibility: $9,343,351.85[73,74,75]

   UHH paid claims for members who were not eligible on the HIE due to the inability to correctly reconcile enrollment information, totaling $5,593,327.73 in 2014. Further, UHH or NHC erroneously paid medical and prescription drug claims payments to ineligible members totaling $3,750,024.12 in 2015, which was again caused by the failure to properly maintain and track NHC enrollment files or properly reconcile membership enrollment with the HIE. As further detailed in Mr. Osowski's report dated February 7, 2020, UHH failed to properly set up an adequate data processing and information technology system for NHC before and after its operations commenced in 2014, which led to claims being paid outside of enrollment and enrollment information not being properly tracked. UHH is responsible for the aforementioned claims paid outside of enrollment for years 2014 and 2015.

   Additionally, IM contracted to provide external systems interfaces for NHC, including those necessary to support NHC's enrollment requirements and integration of the HIE.[76] As further detailed in Mr. Osowski's report dated February 7, 2020, IM failed to provide a working

[72] Osowski Report
[73] PLAINTIFF02479810 – 03 Total 2014 Claims POE.XLSX
[74] 02 2015 Medical Claims POE No PHI.xlsx
[75] 02 RxClaim_2015_2018-02-04 No PHI.xlsx
[76] See Master Services Agreement, Statement of Work # 1 at PLAINTIFF00002930 – PLAINTIFF00002972

interface with the HIE enrollment system during 2014 which caused failures and corruption of enrollment information. IM also contracted to provide the billing services for NHC during 2015 and failed to create an adequate system for billing collection and eligibility determination in 2015. These failures and corrupt information in turn led to payment of claims outside of eligibility for 2014 and 2015. As a result, IM was also responsible for the claims paid outside of eligibility during 2014 and 2015.

2. Damages for Provider Claims Overpayments: $1,163,851.67[77,78]

   $1,163,851.67 remains uncollected by NHC in medical expenses overpaid by UHH in 2014 and 2015, such overpayments having been made for several reasons: the incorrect calculation of claim allowable, processing under the wrong network, payment outside the terms of medical authorization, payment under incorrect procedure coding, payment under incorrect policy terms, redundant claims processing, and miscellaneous claims processing errors involving manual mis-keying of claims data.

3. Damages for Duplicate Claims Payments: $133,888.94[79]

   UHH made duplicate claims payments to providers who were covered under the capitation arrangement with WellHealth, totaling $133,888.94 in 2014.

4. Damages for Loss of Federal Receivables: $6,175,483.44

   Table 7 above summarizes the loss of federal receivables (i.e., Risk Adjustment, Federal Transitional Reinsurance and Risk Corridor) as a result of UHH's failure to adjudicate NHC's claims on an accurate and timely basis.

5. Damages for Payments Made to UHH: $7,686,381.50[80]

   UHH was unjustly enriched as UHH failed in its duties as NHC' third-party administrator and NHC made payments to UHH totaling $7,686,381.50 during the time UHH served as its administrator.

6. Damages for Uncollected Premiums from the Nevada State HIE: $510,651.27[81]

   UHH under collected premium payments from the HIE totaling $510,651.27 in 2014.

[77] PLAINTIFF02479807 – 15 OVERPAYMENT BREAKDOWN BY TAX ID tab only MK.xlsx
[78] PLAINTIFF02478846 – 09 Claims Overpayment Refund Deposits 2014 to 2018.pdf
[79] 19b 16 13 09 transaction list 01MK and DS.xlsx
[80] Table of Contents rev 02.xlsx
[81] 02 SAMPLE SSHIX 2018.10.12.xlsx

7. Damages for Payments Made to IM: $11,970,661[82]

   IM was unjustly enriched as IM failed in its duties under the contracts with NHC and NHC made payments to IM totaling $11,970,661.

8. Damages for Claims Paid Outside of Eligibility: $3,750,024.12[83,84]

   As further detailed in Mr. Osowski's report dated February 7, 2020, IM was used by NHC for calendar year 2015 to properly administer, reconcile, and correct enrollment eligibility data for this calendar year, which would have fixed ongoing enrollment eligibility issues at NHC for proper enrollment administration. IM failed to fix and to properly administer the enrollment information process for calendar year 2015. These IM failures resulted in erroneously paid medical and prescription drug claims payments to ineligible members that totaled $3,750,024.12 for calendar year 2015, and these failures were again caused by the failure to properly maintain and track NHC enrollment files or properly reconcile membership enrollment with the HIE.

   Based on the failures listed above, there were $51.4 million in damages, including $14.4 million in interest, due from July 1, 2015 to October31, 2020, calculated at 2% over the prime rate as set by the Nevada Commissioner of Financial Institutions.[85]

[82] PLAINTIFF02479634 – 15 Summary Insure Monkey payments.pdf
[83] 02 2015 Medical Claims POE No PHI.xlsx
[84] 02 RxClaim_2015_2018-02-04 No PHI.xlsx
[85] http://fid.nv.gov/uploadedFiles/fidnvgov/content/Resources/Prime%20Interest%20Rate%20Jan.%201,%202019.pdf

d. Damages Due to Failure of Duties Performed by Nevada Health Solutions

Further evidence of the management conflict of interest between NHC and UHH, and its related entities, may be found in the utilization management services arrangement between NHC and Nevada Health Solutions ("NHS"), a wholly owned subsidiary of UHH. The NHC – NHS agreement,[86] submitted to and approved by CMS as required in the program requirements,[87] outlined the scope of services NHS was to provide on behalf of NHC.[88] Exhibit A of this agreement summarized the services to be provided by NHS and establishes the fee to be paid by NHC. [89] Exhibit B contains a detailed delegated services grid that lists the specific activities to be performed by NHS, including: [90]

- Diagnostic/Radiology Precertification
- Inpatient Utilization Review
- Concurrent Utilization Review
- Retrospective Review
- Outpatient Utilization Review
- Home Health Review
- DME/Prosthetics
- Physician Review

As expected in such a delegated arrangement, NHS had responsibility for all but a few of the services. Exhibit C detailed NHS' UM Program.[91] Based on my industry experience, the information collectively contained in Exhibits B and C are consistent with what I would expect to see in a delegated UM arrangement.

Following CMS' review and approval, NHC and NHS materially modified the agreement via an amendment[92] that substantially limited NHS' scope and eliminated key functional responsibilities, such as precertification of hospital admissions and precertification of outpatient procedures. This amendment also modified Exhibit A and deleted Exhibit B. The base agreement was further modified by a second amendment[93] that eliminated NHS responsibility to provide "Transitional Care Services". It's my understanding that these changes to the base agreement, that were significantly detrimental to NHC, were never submitted to CMS for review and approval, contrary to the requirements of CMS policy requirements.

[86] Utilization Management Services Agreement, p. 1.
[87] Utilization Management Services Agreement, Exhibit D, p. 95.
[88] Utilization Management Services Agreement, p. 4.
[89] Utilization Management Services Agreement, Exhibit A, p. 22.
[90] Utilization Management Services Agreement, Exhibit B, p. 23.
[91] Utilization Management Services Agreement, Exhibit C, p. 36.
[92] First Amendment to Utilization Management Services Agreement, p. 96.
[93] Second Amendment to Utilization Management Services Agreement, p. 99.

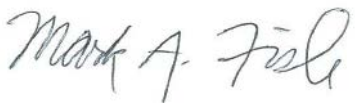
It's also my understanding that a very small number of claims were denied by NHS. Based on my industry experience, UM programs consistent with the program as outlined in the agreement between NHC and NHS typically result in claim denial rates between 5% to 10%.[94] Using these percentages, I developed a dollar range of expected claim denials based on a review of Inpatient and Outpatient 2014 claims data, totaling $13.0 million and $2.4 million, respectively, subject to the UM review criteria outlined in the agreement.

Table 10 below summarizes the range, including a point estimate of 7.5%:

Table 10
Claims Subject to NHS Utilization Management Program
Estimated Dollar Range of Denials
2014
(in $Millions)

		5% Denial Rate	7.5% Denial Rate	10% Denial Rate
Inpatient	$13.0	$0.65	$0.98	$1.30
Outpatient	$2.4	$0.12	$0.18	$0.24
Total	$15.4	$0.77	$1.16	$1.54

Respectfully Submitted,



Mark A. Fish

February 7, 2020

[94] A Rand Corporation Research Brief indicated a 9% denial rate resulting from the utilization review process

Exhibit A – Documents Considered and Relied Upon

Matter Related Documents

- 021a 20141230 27_PLAINTIFF00337508_2018-12-11PLAINTIFFProd.pdf
- 030 20150202 PLAINTIFF00313520.pdf
- 031 20150203 PLAINTIFF00312847.pdf
- 033 20150215 PLAINTIFF00301184.pdf
- 034 20150215 PLAINTIFF00301101.pdf
- 036 20150226 PLAINTIFF01244794.pdf
- 038 20150227 PLAINTIFF00286501.pdf
- 039.pdf
- 042a 20150313 07_PLAINTIFF00004654_2018-12-11PLAINTIFFProd.pdf
- 042b 20150313 08_PLAINTIFF00004655_2018-12-11PLAINTIFFProd.pdf
- 049a 20150514 15_PLAINTIFF00244645_2018-12-11PLAINTIFFProd.pdf
- 050a 20150514 05_PLAINTIFF00005031_2018-12-11PLAINTIFFProd.pdf
- 056.pdf
- Exhibit 103 (Hatch).PDF
- Exhibit 105 (Hatch).PDF
- PLAINTIFF00171787_2018-12-11PLAINTIFF . CMS Loan Agreement.pdf
- Basil Dibsie Vol 1 FINAL_full_ex.pdf
- Basil Dibsie Vol 2 ROUGH_full.pdf
- PLAINTIFF00188016 – 00188021.pdf
- PLAINTIFF01456770.pdf
- PLAINTIFF01456776.pdf
- PLAINTIFF01456780.pdf
- PLAINTIFF01456783.pdf
- PLAINTIFF01456789.pdf
- PLAINTIFF01456796.pdf
- PLAINTIFF01456803.pdf
- PLAINTIFF01456810.pdf
- PLAINTIFF01456816.pdf
- PLAINTIFF01456821.pdf
- PLAINTIFF01456826.pdf
- PLAINTIFF01456863.pdf
- PLAINTIFF01456868.pdf
- PLAINTIFF01456875.pdf
- PLAINTIFF01456879.pdf
- PLAINTIFF01456884.pdf
- PLAINTIFF01456889.pdf
- PLAINTIFF01456905.pdf
- PLAINTIFF01456907.pdf
- PLAINTIFF01457023.pdf
- PLAINTIFF01459241.pdf
- PLAINTIFF01459242.pdf

- PLAINTIFF01459257.pdf
- PLAINTIFF01461232.pdf
- Exhibit 24 5.11.2015 CMS letter to Egan (Hayes).pdf
- Exhibit 26 7.30.2015 CMS letter to Egan (Hayes).pdf
- Exhibit 99 5.18.2015 email chain re NHC Response to CMS Request (Hatch)….pdf
- Nevada Health Plan CO-OP Business Plan Update Pro Forma 2-27-15.xlsx
- Nevada Health CO-OP Business Plan Update DOI 3-6-15.xlsm
- 06 02 2014 Membership with Group Totals.xlsx
- 03 2015 Membership SUB DEP Mike_AO 1 08 2017.xlsx
- FS 12.15 AO 07.18.17 2015.xlsx
- 01 01 MLR_RC_Template_NV.xlsx
- 01 03 MLR_Template_Nevada.xlsx
- 04 01 MLR_RC_Template_NV Re Calc.xlsx
- 04 03 MLR_Template_Nevada Re Calc.xlsm
- Indegene Healthcare, Risk Adjustment Insights for Nevada Health CO-OP, NHC_Risk_Adjustment_Insights_09252018_ver3.02.docx
- 2014 NHC Statutory Audited Financial Statements.pdf, Nevada Health Co-Op, Statutory Financial Statements and Independent Auditor's Report, For the Years Ended December 31, 2014 and 2013, "Larson Report"
- Annual Statement of the Nevada Health CO-OP, For the Year Ended December 31, 2014, NAIC Filing 2014 Annual.pdf
- NAIC Filing 2014 Annual RBC.PDF
- Quarterly Statement of the Nevada Health CO-OP, For the Quarter Ended June 30, 2015, NAIC Filing Q2 2015.pdf
- Rate Change Justification, Nevada Health CO-OP, Small Group, Rate Change Justification – Small Group.pdf
- Rate Change Justification, Nevada Health CO-OP, Individual, Rate Change Justification – Individual.pdf
- Expert Report of Joseph DeVito "DeVito Report", dated July 30, 2019
- Expert Report of Henry Osowski, dated February 7, 2020
- Nevada Hospitality Health CO-OP Business Plan, 18485-0000002798-0019 – NHH.BusinessPlan.PDF
- AppendixF.AppExhibits.NHH.xlsx
- PDR Calculation.xlsm
- Milliman – NHC 2015 PDR Results 7-31-2015.xlsm
- Milliman – IBNR Model 2015-04-28.xlsm
- Milliman Transitional Reins Calc 8760502.xlsm
- NHC 6-year Proforma (8-13-15).xlsm
- NHC Proforma Update 5-07-15.xlsm
- Premium Deficiency Reserve as of June 30 2015-07-31.pdf
- NVH updated Actuarial Opinion and Affirmation (May 2015).pdf
- Nevada Health CO-OP 2014 Statement of Actuarial Opinion.pdf
- Nevada Rate Filing Template v5 – Individual.pdf
- Nevada Rate Filing Template v5 – Small Group.pdf
- PLAINTIFF02479810 – 03 Total 2014 Claims POE.XLSX
- PLAINTIFF02479807 – 15 OVERPAYMENT BREAKDOWN BY TAX ID tab only MK.xlsx
- PLAINTIFF02478846 – 09 Claims Overpayment Refund Deposits 2014 to 2018.pdf

- 12 01 NHC payments Vendors and Executives.xlsx
- 19b 16 13 09 transaction list 01MK and DS.xlsx
- 01 01 Rx_Payments_2014year fr Brooke.xlsx
- Table of Contents rev 02.xlsx
- 02 SAMPLE SSHIX 2018.10.12.xlsx
- PLAINTIFF02479634 – 15 Summary Insure Monkey payments.pdf
- 02 2015 Medical Claims POE No PHI.xlsx
- 02 RxClaim_2015_2018-02-04 No PHI.xlsx
- 1568_35_119733 NHC Annette Comments IBNR File 051415.pdf
- Claim_L – NHS.2014.agregate 2.COOP IP Auth Report_01-01-14 thru 01-01-15_3.xlsx
- Claim_M – NHS.2014.aggregate.COOP OP Auth Report_01-01-14 thru 01-01-15_3.xlsx
- Utilization Management Service Agr NSH000001 – 000100.pdf
- 2019-12-23 – Data Breakout Project (NHC Claims Lag).xlsx
- Master Services Agreement, Statement of Work # 1 at PLAINTIFF00002930 – PLAINTIFF00002972

Publicly Available Documents and Information

- Corlette, S, Miskell, S, Lerche, J, Giovannelli, J, The Commonwealth Fund, *Why Are Many CO-OPs Failing?* (December 2015)
- Statement of Statutory Accounting Principles No. 54 (SSAP No. 54), Individual and Group Accident and Health Contracts
- Actuarial Standards Board, Actuarial Standard of Practice No. 42 (ASOP No. 42), Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims
- Center for Consumer Information & Insurance Oversight (CCIIO), Centers for Medicare & Medicaid Services (CMS) Risk Corridors Payments for the 2014 Benefit Year, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RC_Obligation_Guidance_11-19-15.pdf
- Nevada Commissioner of Financial Institutions, Prime Interest Rate, http://fid.nv.gov/uploadedFiles/fidnvgov/content/Resources/Prime%20Interest%20Rate%20Jan.%201,%202019.pdf
- Weilant, M, Milliman Research Report, *Premium deficiency reserve requirements for accident and health insurance* (December 2012)
- American Academy of Actuaries, *Fact Sheet: ACA Risk-Sharing Mechanisms*
- RAND Corporation, Research Brief, *Inside the Black Box of Managed Care Decisions*
- 2010 Nevada Code, TITLE 57 INSURANCE, Chapter 683A.0879, https://www.leg.state.nv.us/NRS/NRS-683A.html#NRS683ASec0879

Exhibit B – Curriculum Vitae of Mark Fish, F.S.A., M.A.A.A.

FTI Consulting, Inc.
3 Times Square
9th Floor
New York, NY 10036
Tel: +1 518 256 7830
mark.fish@fticonsulting.com

EDUCATION

B.S. Business Administration, Actuarial Science
B.S. Mathematics
University of Wisconsin

CERTIFICATIONS

Fellow, Society of Actuaries
Member, American Academy of Actuaries
Certified Managed Care Executive, Association of Health Insurance Plans

PROFESSIONAL EXPERIENCE

FTI Consulting, Inc.

Managing Director	December 2013 to Present

MVP Health Care

Executive Vice President, Chief Financial Officer	May 2010 to September 2013
Executive Vice President, Medical Affairs (Interim)	November 2009 to December 2010
Executive Vice President, Network Management	January 2006 to May 2010
Vice President of Finance	September 2003 to January 2006
Vice President of Actuarial & Chief Actuary	March 1999 to September 2003

Milliman, Inc.

Consulting Actuary	October 1996 to March 1999

Aetna, Inc.

Actuary	January 1989 to October 1996

Mark Fish is a Managing Director with FTI Consulting and is based in New York. He is part of the Health Solutions practice focusing on Health Plans, Managed Care and Value Based Transformation. While at FTI, he has assisted numerous clients with actuarial modeling, value-based care initiatives, payment models, ACO development, risk management strategies and managed care contracting. Mr. Fish has more than 25 years of healthcare industry experience. He has served in various leadership positions in his career in finance, operations, contracting, strategy, analytics, actuarial and risk management.

Prior to joining FTI, Mr. Fish served as the Chief Financial Officer at MVP Health Care, where he was responsible for the oversight of operations with revenue exceeding $2.5B, an investment portfolio of $500MM, and an administrative expense budget of $270MM. He was a member of the Executive Leadership Team and held executive positions as Chief Actuary, Chief Financial Officer, EVP Network Management and EVP Medical Affairs.

During Mr. Fish's tenure as Chief Financial Officer, MVP reported Net Income of $100 million over a 3-year period. In addition, he led a $100 million financial turnaround of MVP's Commercial business and directed a $57 million (20%) reduction in administrative expenses. He was the executive sponsor for the company's ACA Health Exchange strategy and was responsible for the financial results of MVP's Medicare Advantage and Managed Medicaid government programs and TPA businesses covering 150,000 and 130,000 members, respectively.

As Executive Vice President of Network Management, Mr. Fish had responsibility for MVP's provider network of health systems, hospitals, physicians, IPAs, PHOs and ancillary providers for all lines of business. Under his direction, MVP partnered with CIGNA to offer a national network to its members.

Mr. Fish served as MVP's first in-house Chief Actuary. In his role as Chief Actuary, Mr. Fish had overall responsibility for MVP's $2 Billion premium rate setting process and benefit analysis for Commercial, Self-Insured TPA, Medicare and Medicaid business units, and underwriting support for MVP's experience rated business.

Additionally, Mr. Fish has experience as a Consulting Actuary at Milliman and began his career at Aetna in their actuarial leadership development program.

PUBLICATIONS

FTI Journal

- *"A Roadmap for Healthcare Convergence"* May 2014
- *"The Great Divide – How Payers and Physicians View Value Based Arrangements"* September 2014

REPRESENTATIVE MATTERS

- Sutter Health and Sutter Health Plan v. OptumInsight, Inc. f/k/a Ingenix, Inc. Cas No. 011500034226. Expert reports January 2017 and March 2017. Rebuttal report February 2017. Served as health plan executive and operations expert witness. Provided deposition and testimony.
- East Texas Medical Center vs. BLUE CROSS & BLUE SHIELD OF TEXAS, a Division of HEALTH CARE SERVICE CORPORATION, AETNA HEALTH, INC., AETNA LIFE INSURANCE COMPANY, CIGNA HEAL THCARE OF TEXAS, INC., and CIGNA HEALTH AND LIFE INSURANCE COMPANY, CAUSE NO. 15-1165-C, District Court, Tyler, TX. Provided deposition. No testimony.
- D.T. v. NECA/IBEW FAMILY MEDICAL CARE PLAN & THE BOARD OF TRUSTEES OF THE NECA/IBEW FAMILY MEDICAL CARE PLAN, Case Number: 17-cv-00004-RAJ. Expert report June 2019. Rebuttal report July 2019. Served as actuarial expert witness. Provided deposition. No testimony.

EXHIBIT B

EXPERT REPORT

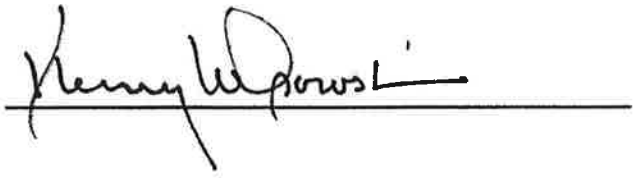
Richardson v. Milliman, Inc., et al.
Case No: A-17-760558-C

Prepared by:

Mr. Henry Osowski

Managing Partner
Strategic Health Group LLC

February 7, 2020



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.

Part II: Summary of Opinions

The following is a summary of my opinions

UHH and the NHC Management Defendants

1. It is an industry standard procedure to conduct proper due diligence and analyze the knowledge, experience and past performance of potential Third-Party Administrator ("TPA"), including those with adequate experience and information technology capabilities prior to the selection of a TPA.
2. Prior to the selection of UHH as NHC's TPA there was no detailed documentation of NHC's functional business requirements or any known detailed information technology system design for NHC's needs. UHH lacked the knowledge and experience relative to multi-line commercial health insurance products to appropriately produce such documentation.
3. It is an industry standard procedure and information technology best practice to create detailed documentation of the functional needs of an insurer and a detailed information technology system design prior to selecting an insurance administration platform.
4. At the time of the selection of UHH to provide TPA services to NHC and thereafter, there were several qualified TPA's with multi-product commercial experience and adequate information technology systems to capably service NHC.
5. At the time of selection of UHH, UHH was inexperienced in servicing multi-product commercial insurance plans and incapable of meeting the functional business needs of a multi-product commercial health insurer like NHC.
6. UHH was unprepared to properly support the functional business requirements of NHC and unwilling to meet the reasonable performance requirements of the CO-OP Program[2].

[2] Email from Gary Odenweller to Randy Plum of 9-27-2013 "… UHH does not wish to commit to a higher performance standard for the CO-OP than it does for its own members.", UHH0406764

7. NHC was disadvantaged in negotiations between NHC and UHH as certain NHC management was employed by UHH and was concurrently serving leadership positions with both NHC and UHH thereby creating a significant conflict of interest.
8. Management Defendants ignored the warnings of NHC's attorneys that the contracts with UHH were not industry standard and refused to change provisions that UHH wanted.
9. Management Defendants ignored the comments of CMS that the contracts with UHH were not industry standard and refused to change provisions that UHH wanted.
10. Were it not for the conflict of interest between NHC Management and UHH, it is unlikely that NHC, as an independent organization, would have contracted for TPA services with UHH, an organization that it knew, or should have known, did not have the experience, information technology support or qualifications to perform the required TPA services.
11. Were it not for the conflict of interest between NHC Management and UHH, it is unlikely that NHC would have agreed to the provisions contained in the agreements with UHH.
12. The Administrative Services Agreement[3]("ASA"), and the earlier Consulting Agreement[4] entered into between Nevada Health CO-OP ("NHC") and Unite Here Health ("UHH") were not industry standard, were materially unfavorably weighted against NHC, and failed to include appropriate performance standards and measures, as well as penalties for non-performance.
13. UHH failed to meet industry and contractual standards under the contracts with UHH by among other issues:
    - Failing to properly load provider information into its systems
    - Failing to properly track eligibility
    - Failing to properly track member deductibles and maximum out of pocket costs
    - Failing to properly adjudicate claims
    - Failing to timely adjudicate claims

[3] Administrative Services Agreement, dated June 27, 2013, UHH 0000006-033
[4] Consulting Agreement dated January 30, 2013, effective May 17, 2012, UHH0000041-65

- Failing to timely provide accurate information to NHC
- Failing to true up costs under the relevant contracts.
- Failing to provide adequate data processing systems
- Failing to meet industry accepted rates for self-adjudication
- Overpayment of claims
- Failure to provide adequate and timely information concerning backlogs, and claims outstanding
- Failing to be properly licensed as a Third-Party Administrator in Nevada.

14. Given UHH's failure to be registered with the Nevada Division of Insurance ("DOI") as a third-party administrator, and UHH's lack of any TPA experience for a multi-plan commercial enterprise, it was a violation of industry standards of care to select and retain UHH as NHC's TPA.
15. Further, NHC management's and UHH's failure to comply with the Centers for Medicare and Medicaid Services ("CMS") contract review and approval requirements, CMS' CO-OP Performance Requirements and Service Level Standards[5] and Nevada DOI TPA registration requirements were further examples of what would become a pattern of non-compliant behavior with industry standards, statutory requirements and regulatory requirements by both NHC's management and UHH.
16. The lack of functional business requirements documentation and a detail system design for NHC's business created a configuration of the Javelina system that was incapable of meeting the business requirements of NHC and contributed significantly to NHC's demise. UHH was responsible for the selection of the Javelina system and in Exhibit A Schedule of Services of the Administrative Services Agreement UHH contractually promised to "7. Operate computer systems necessary for its performance of its duties and obligations …."[6]

[5] CMS Service Level, Contract Provision and/or Management Reporting, Performance Requirements and Service Level Standards, 18579-0000503638, PLANTIFF02499119 - PLANTIFF02499120

[6] Schedule of Administrative Services, attached as Exhibit A to the Administrative Services Agreement, dated June 27, 2013, UHH 0000006-033 at UHH 0000023.

17. UHH did not perform "…consistent with industry-recognized standards."[7] In my judgment, UHH's failure to meet its industry-recognized and contractual obligations under the terms of the TPA agreement and other agreements with NHC, was a primary factor in NHC's demise.
18. The failure of the NHC's Management Defendants including certain members of the Board of Directors, irrespective of their status as employees of UHH on loan to NHC, to properly select a TPA, supervise the activities of UHH, operate independently from UHH, manage the business of NHC reasonably, and act within the bounds of standard industry practices as required by Section 2.1 of the Administrative Services Agreement[8] were a material breaches of each individual's fiduciary responsibility[9] to NHC.

INSUREMONKEY

19. InsureMonkey misrepresented their experience, products, subject matter expertise and the scalability and ease of interrelation of their products with other vendor products[10].
20. InsureMonkey's contracts were not industry standard contracts and disadvantaged NHC.
21. InsureMonkey failed to meet industry standard and contractual requirements in its role as NHC's defacto information technology systems integrator and service provider for supporting applications by, among other failures:
    - Failure to record and identify delinquent premiums resulting in uncollected earned premiums and an inability to properly bill CMS for premium subsidies

[7] Administrative Services Agreement, dated June 27, 2013, section 2.1at UHH 0000007.
[8] Administrative Services Agreement, dated June 27, 2013, section 2.1at UHH 0000007
[9] Sample NHC Ethics and Conflicts of Interest Policy as signed by Ms. Kathy Silver on February 19, 2014, PLAINTIFF00562503 – PLAINTIFF00562512
[10] IM cover letter and proposal, September 21, 2012, Plaintiff 00003490-3627

- Failure to accurately process and reconcile enrollment and eligibility information resulting in claims being paid for ineligible members
- Failure to "develop a comprehensive model of member services[11]"
- Failure to develop a broker portal and data interchange module
- Failure to appropriately integrate NHC systems including electronic enrollment and member services systems

22. InsureMonkey failed to exercise reasonable care by industry standards in obtaining and communicating the number of eligible enrollees and eligibility data to NHC and or CMS.
23. InsureMonkey was overpaid based on enrollment data that InsureMonkey knew or should have known was incorrect, and retained such payments.
24. NHC's management, and certain members of the Board of Directors, failed to properly select IM, supervise the activities of IM, and managed the business of NHC unreasonably and outside of the bounds of standard industry practices.

[11] Memorandum of Understanding between NHC and IM dated September 3, 2013, PLAINTIFF 00000790-794.

MANAGEMENT DEFENDANTS

25. The Management Defendants failed to act in the best interests of NHC by awarding and then continuing related party contracts and arrangements to benefit UHH and Nevada Health Solutions ("NHS" – a start-up entity owned and controlled by UHH and providing utilization review management services to NHC) at the expense of NHC.
26. The Management Defendants failed to act in the best interests of NHC by amending the NHS contract where it stripped many key utilization review management services from the original NHS contract, and failing to first submit this amended NHS core contract to both CMS and the NDOI for regulatory review and response. The Management Defendants failed to use proper due diligence in awarding a utilization review management contract to NHS. NHS was itself a start-up entity without a proven track record to perform robust utilization review management services for an insurer offering commercial health plans.
27. Management Defendants failed to exercise reasonable care in the performance of services including but not limited to:
    a. the awarding of contracts to unqualified related parties;
    b. amending the NHS contract to remove key utilization review services and failing to submit this amended contract in advance to both CMS and the NDOI;
    c. Awarding UHH the ASA contract knowing UHH was unlicensed in the State of Nevada as a TPA;
    d. The awarding a capitation agreement to WellHealth without WellHealth being approved as a Delivery System Intermediary ("DSI") by the NDOI.
    e. Launching NHC when it was unable to fulfill the basic requirements of an insurer to properly determine eligibility, track provider payment schedules, and adjudicate claims;
    f. Failing to take appropriate action to address system and vendor failures;

g. Failing to disclose adequate and accurate financial information (see reports of Mark Fish and Joseph DeVito.)

h. Failing to timely notify NDOI and CMS of internal control and financial issues impacting NHC's ability to timely and accurately process claims and NHC's impaired viability.

28. Management Defendants mislead the NDOI concerning the processing of claims by UHH to avoid UHH licensure and to reflect that NHC was operationally compliant.

Part III: NHC Plan Development and Organization Failures and Issues

1. TPA contract

Based on my experience as a health plan executive and consultant/advisor to multiple commercial health plans, typical TPA agreements generally available in the marketplace, balance the interests of both the customer (health plan) and the TPA (vendor) and include specific provisions for performance standards and expected service level performance requirements, such as those provided by CMS' CO-OP Program Performance Requirements and Service Level Standards[12] or the claim timeliness performance standard required of non-profit health insurance companies by Nevada statute[13]. Based on my experience, standard industry agreements will generally include financial penalties for non-performance and failure to meet agreed upon service level standards. In my opinion, the TPA agreement thrust upon NHC was not industry standard, was unfavorably weighted against NHC, and failed to include appropriate and required performance standards and measures, reasonably fair customer termination rights, as well as financial penalties for non-performance.

Importantly, UHH specifically rejected service level standards and penalties as recommended by CMS. In a September 27, 2013 email from Gary Odenweller of UHH to Randy Plum of NHC[14], Mr. Odenweller states "However, the suggested service level standards for Processing and Financial Accuracy exceed those utilized by UHH for its own business." Later in the same document he further states "While we have no doubt those metrics will be met and likely exceeded in the administration of the CO-OP claims by UHH, UHH does not wish to commit to a higher performance standard for the CO-OP than it does for its own members."

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[12] CMS Service Level, Contract Provision and/or Management Reporting, Performance Requirements and Service Level Standards, 18579-0000503638, PLANTIFF02499119 - PLANTIFF02499120

[13] Nevada Revised Statutes, Section 695B.2505

[14] Email from Gary Odenweller to Randy Plum dated 9/29/2013, UHH0406764

In that same email[15] Mr. Odenweller rejects any financial penalties for non-performance and proposes instead a "CO-OP option to terminate contract if [performance standards] not met for 3 consecutive quarters". This is a nonsensical proposal as three consecutive quarters of non-performance by UHH would have significantly imperiled NHC and failed to give NHC adequate time or opportunity to seek an alternate administrator. Importantly, since key NHC management were employed by UHH, this termination option was not likely to ever be exercised. The CMS recommended performance standards, including stated national benchmarks[16] and financial penalties[17], were reasonable and should have been incorporated in the ASA.

Failure to include service level performance standards and associated penalties prevented NHC from having the necessary contractual tools in which to mandate service level improvements by UHH or terminate the agreement with UHH for non-performance. UHH's failure to be registered with the Nevada DOI as a TPA in violation of its obligation to comply with all applicable rules and regulations[18] (*see* below) should have combined with these contract deficiencies to signal an alert to NHC management that the TPA Agreement should not have been signed.

A. The TPA Agreement Was Improperly Negotiated by Related Parties.

In negotiating the TPA agreement between NHC and UHH, there was a real conflict of interest between these "related parties." This conflict was evidenced by the dual roles played by employees of UHH who served as key members of the NHC management team

[15] *Id.*
[16] CMS provided Performance Requirements and Service Level Standards, Page 3, 18579-0000503638_0001.003, PLANTIFF02499121 - PLANTIFF02499131
[17] CMS provided Performance Requirements and Service Level Standards, Page 10, 18579-0000503638_0001.010, PLANTIFF02499121 - PLANTIFF02499131
[18] Administrative Services Agreement, Section 2.1(g), dated June 27, 2013, UHH 0000006-033

and/or members of the NHC Board of Directors. For example, Ms. Kathleen Silver was an NHC Board member and also President of the Culinary Health Fund, an affiliate of UHH; Mr. Tom Zumtobel, while serving as Vice President of Strategy for UHH, took on the role of CEO and Board member for NHC; and Ms. Bobbette Bond was Director of Health Policy for UHH while serving as Chief Project Officer for NHC. This conflict was noted by CMS when it conducted its Performance Audit in December 20, 2013.[19]

NHC's own Ethics and Conflict of Interest Policy clearly recognizes the prospect of potential conflicts. The second paragraph of Article 1 states "Consequently, there exists between the CO-OP and its Board of Directors (each a "Director"), officers ("Officers") and members ("Members"), a fiduciary duty that carries with it a duty of loyalty and fidelity. Directors and Officers have the responsibility to honestly and prudently administer the affairs of the CO-OP, and to exercise their best care, skill and judgment in the sole interest and for the sole benefit of the CO-OP and its Members. Those persons shall exercise the utmost good faith in all transactions involved in their duties, and shall not use their positions with the CO-OP or knowledge gained therefrom for their personal benefit or for the benefit of a person or entity other than the CO-OP and its Members. The interests of the CO-OP must be the first priority in all decisions and actions."[20]

The related party issue was also known to both NHC and UHH, based on a series of communications with NHC's certified public accountant and NHC's counsel, both of whom confirmed that UHH qualified as a related organization.[21] Importantly, were it not for this conflict, it is unlikely that NHC, as an independent organization, would have contracted for TPA services with UHH, an organization that it knew, or should have known, did not have

[19] Nevada Health CO-OP Performance Audit, dated December 20, 2013, and NHC's Redlined Responses, 18579-0000236329 and 18579-0000236329_0001, PLAINITFF02476762, PLAINTIFF2476945 – PLAINTIFF02476950

[20] NHC, Ethics and Conflicts of Interest Policy, Revised 8/6/2013

[21] Communications between Tom Zumtobel, Glenn L. Goodnough, Partner of Stewart, Archibald & Barney, LLP, and Darryl Landahl, Esq., 18579-0000872749, PLAINTIFF02476740 - PLAINTIFF02476741.

the experience, information technology support or qualifications to perform the required TPA services as shown below.

B. The TPA Agreement Failed to Meet Industry Standards or CMS Requirements and Recommendations.

My review of the NHC - UHH TPA contract[22] showed it did not meet industry standards or CMS' requirements. Additionally, as noted by Ms. Tanchica Terry, representing CMS, in an email to Mr. Zumtobel on July 26, 2013[23] the terms were heavily weighted to favor the interests of UHH over NHC. Evidence supporting this conclusion include:

1. Significant potential for conflict of interest existed as NHC "negotiators" were UHH employees on loan to NHC;
2. NHC management failed to maintain an "arms-length" independent relationship with UHH as NHC's TPA vendor;
3. The agreement contained inadequate performance standards and non-performance penalties;
4. There was only cursory recognition of NHC's oversight responsibility and the tools to hold UHH accountable for its performance;
5. UHH, though an experienced administrator of Taft-Hartley health benefit plans, had no experience as a TPA managing multiple ACA commercial market benefit plans, nor processing claims with as much complexity as was planned with NHC; and
6. There was no apparent recognition by UHH of the differing complexities and regulatory requirements of an ACA "Qualified Health Plan" to participate in the commercial markets.

[22] Administrative Services Agreement, dated June 27, 2013, UHH 0000006-033.
[23] Email from Ms. Tanchica Terry to Mr. Tom Zumtobel, July 26, 2013, 18579-0000862749.0001, PLAINTIFF02476747

7. The agreement failed to incorporate any of the performance requirements and service level standards recommended by CMS[24]

Furthermore, it is not entirely clear which of the twenty-three listed services in Exhibit A of the January 30, 2013 Consulting Agreement[25] or the twenty-two listed services in Exhibit A of the June 27, 2013 Administrative Services Agreement[26] were business functions actually required and desired by NHC. Importantly, there was no evidence or other documentation to support the qualifications and experience of UHH to perform the listed services for a multi-product commercial health plan.

It was evident, even before launch, that UHH's selection of the Javelina system, was primarily intended to support UHH's own business[27] and never adequately met the functional business needs of NHC. In spite of attempts to significantly modify the Javelina system by Eldorado to try to meet the business requirements of NHC, UHH was never in a position to rely on the Javelina system to support NHC. This is clear evidence that UHH was unprepared and incapable of supporting the business needs of NHC. Without a solid technology platform, UHH did not have the appropriate tools necessary to support NHC's functional business needs, and this was a major factor in UHH's significant performance deficiencies. UHH's poor performance required NHC to seek other administrative solutions at significant additional costs and without reduction of payment by NHC to UHH. These alternative solutions, which required additional interface programming and significant customization by the Javelina software vendor, included seeking multiple outside vendors of service and technology, such as InsureMonkey, as well as adding additional internal staff

[24] Email, and attachment, from Ms. Tanchica Terry of CMS to Mr. Tom Zumtobel et al on July 30, 2013, 18579-0000503638, PLANTIFF02499119 - PLANTIFF02499120
[25] Consulting Agreement between Unite Here Health and Hospitality Health, Ltd., dated January 30, 2013, PLAINTIFF 01182250-PLAINTIFF01182274.
[26] Administrative Services Agreement, dated June 27, 2013, UHH 0000006-033.
[27] Claims System Discussion, UHH 0367471. In fact, in a May 15, 2012 memo from Gary Odenweller to himself,[27] he appears to summarize the process used by UHH to select a new claims system for itself. *See* Gary Odenweller memo regarding Claim System Review and Selection Process, dated May 15, 2012, UHH 0367499.

to assume the administrative burden caused by UHH's failures to perform its duties as an administrator under the TPA agreement.

It is also my opinion that UHH specifically failed to meet the requirements of Sections 2.1 and 2.1(g) of the June 27, 2013 Administrative Services Agreement[28] whereby UHH "agree to provide the Administrative Services with such skill and care … consistent with industry recognized standards." Furthermore, in violation of Section 1.6 of the NHC-UHH Consulting Agreement[29] and specifically Section 2.1(g) of the ASA[30],UHH failed to "comply in all material aspects with all applicable laws, rules and regulations in the performance of the Administrative Services," including its agreement to be "subject to certain Nevada state laws in connection with certain of the Administrative Services."[31]

In an email exchange from NHC counsel Darryl T. Landahl of Brownstein Hyatt Farber Schreck, LLP, to Bobbette Bond and Bill Donahue,[32] Mr. Landahl provides a summary of his recommendations of modifications to UHH's proposed TPA contract terms. His recommendations and suggested modifications were consistent with industry standards and enumerated to better protect NHC's rights. These recommendations and modifications include resolution of the TPA licensing requirement, TPA obligations being conditioned on meeting its obligations as an ERISA plan (NHC was not subject to ERISA requirements, and this language "would not be included in a typical TPA agreement"), and indemnity provisions, which were overwhelming in favor of UHH.

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[28] *Id*.
[29] Consulting Agreement between Unite Here Health and Hospitality Health, Ltd., dated January 30, 2013, Page 3, PLAINTIFF 01182250-274.
[30] Administrative Services Agreement, dated June 27, 2013, UHH 0000006-033.
[31] *Id.*
[32] Email from Darryl T. Landahl, Esq. to Bobbette Bond and Bill Donahue regarding TPA Agreement revisions, dated May 8, 2013, 18579-0000277029, PLAINTIFF02476716 - PLAINTIFF02476717

In an email exchange between Cara S. Elias of Brownstein Hyatt Farber Schreck, LLP, and Bill Donahue and Bobbette Bond of NHC,[33] Ms. Elias summarized the Fund's response to NHC requested changes in the draft TPA agreement. Highlighted below are some key Fund responses to NHC's suggested industry standard changes and Ms. Elias' recommendations (in italics) for NHC include:

- "2.1: They changed the standard back to the level of services they have historically provided …. [T]he standard we have requested is industry standard and necessary to show this is an arms-length agreement. *Revised rejected.*"
- "7.1(a): They changed the exception…to cases where the Provider acted in gross negligence (not just negligence) …. [T]hey should not be indemnified even if they are only negligent. This is industry standard. ***Bill, please advise. This is a business decision***"
- "7.2: They added back the certain limitations section." (note: section 7.2(a) revision was accepted, 7.2(b) was rejected as inconsistent with agreed indemnification in 7.1, 7.3(c) revision was accepted, and 7.4(d) was directed to Bill Donahue for a business decision)
- "7.5: They removed the provision holding TPA liability for penalties for any non-compliance with applicable law… *Revision rejected*."
- "8.1: They limit audits to no more than biannually. This is not market. *Revision rejected.*"
- "Schedule A: They removed the right to review and approve the Disaster Recovery Plan. *Revised to allow us [NHC] to request revisions.*"
- "9.5: They limit COOPs ability to review the UM program to annually. *Rejected revision.*"
- "9.6: They remove COOPs ability to request corrections/changes to the UM program (administered by IHH's wholly owned UM provider) and also remove COOPs right to revoke delegation of UM services. *Rejected revision.*"

[33] Email chain from Cara S. Elias to Bill Donahue and Bobbette Bond, dated June 12, 2013, 18579-0000295733.0010, PLAINTIFF02476718 - PLAINTIFF02476736

In a separate email response to Bobbette Bond *et al*.,[34] Ms. Elias wrote, "I think we need to use an industry-wide accepted standard of care to demonstrate the relationship between COOP and the Fund is 'arms-length.'" Ms. Bond responded on June 17, 2013,[35] stating, "I am just concerned that things might be getting confused because Bill, Darryl and you don't have any experience with the Fund – The Fund is not in the business of contracting out its services. So, this is going to stay complicated." Ms. Bond's comments confirm the conflict of interest issues and manifest that the interests of the Fund superseded those of NHC, the TPA's customer.

On June 24, 2013 Bill Donahue, then NHC's CEO, wrote to Darryl T. Landahl,[36] "… we've agreed to accept the 'gross negligence' standard for the time being …. I will memorialize the salient business reasons for accepting this position, in light of the totality of circumstances and the significant business advantage that working with this particular partner brings to the COOP. Over time, and even perhaps before we actually begin processing any claims, we may be able to put other assurance mechanisms in place that will allow for language more closely approximating 'industry standard' for these types of agreements." It is not clear if Mr. Donahue ever memorialized the rationale for these non-standard provisions, but did related in this email what he called "totality of circumstances and significant business advantage" as to the rationale for agreeing to sign such a one-sided contract with language unfavorable to NHC.

In May of 2013, NHC brought on an individual from outside the organization, Mr. Bill Donahue, to operate as NHC's CEO. In a letter to NHC's Board,[37] Mr. Donahue alleges that he was inappropriately terminated on July 19, 2013 to prevent him investigating "several

[34] *Id*.
[35] Email from Bobbette Bond to Cara Elias, dated June 17, 2013, 18579-0000276295, PLAINITFF02424600 – PLAINTIFF02424603
[36] Email from Bill Donahue to Darryl T. Landahl, dated June 24, 2013, 18579-0000276194, PLAINTIFF02476737 – PLAINITFF02476739
[37] Donahue letter to NHC Board of Directors, dated September 5, 2013, PLAINTIFF 003634-644.

instances of questionable contracts and other transactions …" Mr. Donahue also alleges that he "was pressured" by Mr. Zumbotel and Ms. Bond to sign the TPA and UM service contracts as a non-related party to UHH. He also alleges, "They [presumably Mr. Zumbotel and Ms. Bond] needed someone to sign those contracts that didn't know that the two companies the COOP was contracting with [*i.e.* UHH and Nevada Health Solutions, LLC] were not legally capable of performing the contracted services in Nevada." Though Mr. Donahue indicated that he "noted several deficiencies in the language of the TPA contract that cut against the interests of the COOP and were not industry standard … Ultimately, I agreed, under the pressure of time and circumstances, to the sub-standard contract terms …." It appears that if the contracts had not been signed by July 1, 2013, NHC would have forfeited an opportunity to draw down more than $1 million in additional federal funds[38]. In my opinion, the behavior of NHC/UHH management, raises the question of whether by entering into this administration arrangement the objective was to create a strong foundation for the CO-OP to succeed or simply drawing down federal funds at any cost, was irresponsible and not in the best interest of the CO-OP.

On July 19, 2013, Mr. Donahue informed NHC counsel, Mr. Landahl, and Mr. Zumbotel and Ms. Bond that on the following business day, he intended to discuss the problems with both the TPA and UR contracts with program managers from CMS[39]. Mr. Donahue was terminated within hours of his disclosure that he was about to become a "whistle-blower" regarding the conflicting actions of UHH leadership.

On July 26, 2013 Ms. Tanchica L. Terry of CMS emailed Tom Zumtobel *et al.*[40] with a reminder of CMS' contract review and prior approval requirement. Ms. Tanchica Terry of CMS wrote to Darryl T. Landahl *et al*[41] and included CMS policy on Core Contract and

[38] *Id*

[39] *Id*

[40] Email from Tanchica L. Terry to Tom Zumtobel *et al*., dated July 26, 2013, regarding Core Contract Review: TPA Agreement,18579-0000860496, PLAINTIFF02476747 - PLAINTIFF02476749

[41] Tanchica L. Terry to Darryl T. Landahl *et al.*, dated July 17, 2013,18579-0000854407_0003, PLAINTIFF02477047 - PLAINTIFF02477049

Business Plan Modification Guidelines.[42] These guidelines identified as core to NHC's business certain contracts, including Employment Agreements for Top Executives, Facilities, Third Party Administrator, Information Technology Services and Quality Assurance. Also specified are "Contracts with Sponsors." This guidance was published on November 14, 2012 and required:

1. "Core contracts and modifications to all contracts must be submitted to CMS for approval prior to execution.
2. CO-OPs may not use any CMS funds for a core contract prior to its review and approval by CMS."

This same email identified thirty specific comments and questions from CMS and Navigant relative to the NHC/UHH agreement. These questions/comments ranged from simple language changes to more substantive concerns relative to clarity on the range of services offered through the TPA, and the lack of TPA performance standards and penalties for non-performance. Ms. Terry noted, "Generally speaking this contract tends to be a little one-sided for the TPA – there are some 'best practice' provisions that are strongly recommended…" and "CMS believes that this agreement can be enhanced to support more balance between the CO-OP and TPA including effective vendor performance management ongoing and long term." Four days later, Ms. Terry sent to Mr. Zumtobel a series of documents that included performance requirements[43].

This review[44] of the ASA contract by CMS and Navigant Healthcare, a CMS contractor and nationally recognized healthcare consulting organization, raised multiple concerns and

[42] CMS letter to Consumer Operated and Oriented Plan (CO-OP) Program Loan Recipients regarding CMS guidance regarding core contract and business plan modifications, 18579-0000854407_0003_0001, PLAINTIFF02477050 - PLAINTIFF02477052.
[43] Performance Requirements and Service Level Standards, attached to email correspondence from Tanchica Terry of CMS to Tom Zumtobel, *et al.*,18579-0000854407_0008, and 18579-0000854407_0008_0001, PLAINTIFF02476932 - PLAINTIFF02476933; PLAINTIFF02476934 - PLAINTIFF02476944.
[44] *See* Email correspondence from Tanchica Terry of CMS to Tom Zumtobel, dated July 26, 2013,18579-0000860496, PLAINTIFF02476747 - PLAINTIFF02476749

issues with the ASA agreement. CMS subsequently provided multiple examples of performance requirements and service level standards[45] that, based on my experience, are typically included in a standard ASA contract. Included among the standards I would expect to see in this ASA agreement are the following examples:

1. Speed to answer member service calls – 80% in less than 30 seconds
2. Call abandonment rate – less than 3-4%
3. First call resolution – 85-90%
4. Claims auto-adjudication rate – >90%
5. Claims paid accurately per benefit plan – >97%
6. Claims dollars paid accurately - >98.5%
7. Claims received electronically – >88%

NHC/UHH's response[46] to CMS appears to me to be dismissive of the CMS/Navigant concerns, and it does not appear that any of CMS' recommendations were ever adopted or incorporated into the NHC-UHH ASA contract. In an email to Mr. Zumtobel[47] NHC's counsel Mr. Landahl wrote "After execution, Tanchica sent the attached email about needing approval of the agreement and provided CMS' comments on the agreement, and which triggered discussions about necessary revisions. You and Bobbette were going to take those away to discuss with UNITE. I was not involved after this, so I'm not sure where this ended up with CMS". The contract terms remained unbalanced in favor of UHH for the length of the contract.

[45] Performance Requirements and Service Level Standards, attached to email correspondence from Tanchica Terry of CMS to Tom Zumtobel, *et al.*,18579-0000854407_0008 and 18579-0000854407_0008_0001, PLAINTIFF02476932 - PLAINTIFF02476933; PLAINTIFF02476934 - PLAINTIFF02476944

[46] Email response from Tom Zumtobel to Tanchica Terry, dated July 26, 2013. 18579-0000860496, PLAINTIFF02476747 - PLAINTIFF02476749

[47] Email from Darryl T. Landahl to Tom Zumtobel dated December 18, 2013, 18579-0000854407, PLAINTIFF02476757 - PLAINTIFF02476758

It is not clear from any subsequent documentation if NHC and UHH ever seriously considered these CMS requirements relative to the Administrative Services Agreement[48], if any subsequent negotiations were ever held between NHC and UHH or if the suggestions were simply ignored, indicating a culture of non-compliance with state and federal guidance, regulations and rules.

In a subsequent status call held on July 26, 2013, Ms. Terry's notes[49] indicates that CMS/Navigant would provide NHC with suggested contract language and sample performance level standards. This documentation was provided by Ms. Terry on July 30, 2013.[50] There is no evidence that NHC and UHH ever considered the terms provided by Ms. Terry, nor was the final contract between NHC and UHH ever submitted to CMS for review as required prior to execution, nor were the contractual performance requirements ever modified.

UHH Was Unprepared to Provide Specific Administrative Functional Support Required under the Contract, and Adopted an IT System That Was Incapable of Effectuating the Same.

Of importance to the contract discussion is the fact that UHH was unprepared, in my view, to take on the specific administrative functional support required of a multi-product commercial health plan, as evidenced by its lack of experience with the complexities of such multi-product commercial insurers and its lack of information technology to support these complex administrative functions. This readiness deficiency was known, or should have been known, to management of both NHC and UHH.

[48] Administrative Services Agreement, dated June 27, 2013, UHH 0000006-033.
[49] Tanchica L. Terry to Tom Zumtobel
[50] Email and attachment from Tanchica L. Terry to Tom Zumtobel, *et al*., dated July 30, 2013,18579-0000854407_0008, PLAINTIFF02476932 - PLAINTIFF02476933

In my experience, there were several seasoned health care IT systems and experienced commercial market TPAs available in the marketplace at the time to support NHC's business requirements. These included IT solutions from Amisys and UHH's existing system vendor Trizetto (both Facets and QNXT systems supported commercial clients), as well as TPA solutions from Optum/United, Cognizant and Evolent. NHC should have been conducting a comprehensive assessment of available administrative support options. I have seen no evidence that NHC, or its related party UHH, conducted a serious and comprehensive assessment of other commercial health plan administrative or information technology support options. The process instead appears designed to capture and enhance the revenue flow to UHH and to use NHC as the means to upgrade and improve UHH's own technology platform. Even referring to the use of the Javelina system for "the CO-OP experiment"[51] At the time of the selection process, UHH, via its Trizetto system did not have an information technology platform to support the business requirements of a multi-product commercial health plan. As such, it appears the primary goal of the information technology search was to find a solution to UHH's future needs as a Taft-Hartley administrator, using NHC as a "pilot."[52]

A claims system discussion produced by UHH[53] (not dated or attributed) appears to outline a summary of the claims selection process to replace UHH's Trizetto claims system. It reveals that an evaluation team (members not documented) explored various "considerations" that included, "We can select a system for CO-OP only and thoroughly test before we commit to [Culinary Health] fund." The same process summary document[54] concluded with a "possible action" to "engage Eldorado for CO-OP only (Pilot) thoroughly experiencing the system before the [Culinary Health] fund commits."

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[51] Email from Michael Gulling of UHH to Tim Kneuss of Eldorado of October 30, 2014, 18485-0000689498,PLAINTIFF01460944 – PLAINTIFF01460945

[52] Claims System Discussion, UHH 0367471. In fact, in a May 15, 2012 memo from Gary Odenweller to himself,[52] he appears to summarize the process used by UHH to select a new claims system for itself. *See* Gary Odenweller memo regarding Claim System Review and Selection Process, dated May 15, 2012, UHH 0367499.

[53] Claims System Discussion, UHH 0367471.

[54] *Id*.

It is not clear from these system evaluation process summary documents exactly which functional business requirements were used to evaluate the appropriateness of any of these UHH-evaluated options, so as to meet the functional business requirements of NHC as a multi-product commercial health plan. Based on the documentation I reviewed, it appears a detailed system design overview document was never attempted until December of 2014, and finalized in April of 2015[55], and only then in response to an inquiry from CMS, which was nearly two years after the decision had been made to use the Javelina system. Had such a business requirements document and system design plan been conducted relative to NHC's business requirements before system selection, UHH would have at least been able to objectively and comprehensively assess if Javelina was capable of supporting NHC's business.

Indeed, it is clear from multiple correspondence threads that Javelina as initially developed was not capable of supporting NHC's business needs. Importantly, unlike the Culinary Health Fund, NHC was a multi-product commercial health plan, and as such, it required a system that could support such a business plan. However, although several common commercial health plan IT applications were available to support a multi-product commercial health plan in the marketplace, other than Trizetto (which had tested commercial health plan IT system solutions in the market) neither of the other two vendors evaluated (*i.e.* Eldorado and Healthation) were apparently designed to support such needs absent extensive system modification[56].

It is expected in standard TPA agreements that the administrator provide tested information technology systems and platforms, as well as support personnel to meet the specific responsibilities and performance standards agreed to in the TPA agreement. Though some limited client customization may be required to meet specific plan

[55] Trizetto Architecture Diagram – NHC Conceptual Architecture, Plaintiff 01321048
[56] Claims System Discussion, UHH 0367471

requirements, it is highly unusual for extensive system modification, as was required to make the Javelina system work for NHC's business, to be included in a traditional TPA arrangement. That such extensive system modification of an untested system was required with the UHH selected Javelina system suggests that UHH was never prepared, nor had the capability, to deliver the contracted services to NHC without these material modifications. Furthermore, it shows that UHH contracted with Eldorado for its own benefit[57] [58], and without NHC's best interest at the forefront. Indeed, in my view, UHH's failure relative to the selection and use of the Javelina system directly and significantly contributed to NHC's demise.

In my nearly forty years of experience with insurance information technology and systems, I have never witnessed a successful system implementation that did not begin with a detail documentation of functional business requirements and a detail system design. The lack of functional business requirements documentation and a detail system design created a situation in which UHH accepted the configuration of the Javelina system that it should have known was incapable of meeting the business requirements of NHC which it failed to document. Responsibility for this failure rests solely with UHH which was responsible for the selection of the Javelina system and its contractually obligated requirement to "operate computer systems necessary for its performance of its duties and obligations."[59] [60]

The operational deficiencies and limited capabilities of the Eldorado Javelina system, coupled with UHH's lack of experience with multi-product commercial health insurance, created an environment where NHC and UHH had to cobble together a disparate network

[57] Claims System Discussion, UHH 0367471. In fact, in a May 15, 2012 memo from Gary Odenweller to himself,[57] he appears to summarize the process used by UHH to select a new claims system for itself. *See* Gary Odenweller memo regarding Claim System Review and Selection Process, dated May 15, 2012, UHH 0367499.
[58] Claims System Discussion, UHH 0367471.
[59] Schedule of Administrative Services #7, attached as Exhibit A to the Administrative Services Agreement, dated June 27, 2013, UHH 0000006-033 at UHH 0000023.
[60] Consulting Agreement between Unite Here Health and Hospitality Health, Ltd., dated January 30, 2013, PLAINTIFF 01182250-PLAINTIFF01182274

of disconnected vendors, such as InsureMonkey, in an attempt to create a workable information technology solution. This approach featured multiple critical points of complex system integration and created multiple points of functional failure.

C. Summary

In my opinion, the TPA agreement thrust upon NHC was not industry standard, failed to meet CMS recommended performance standards[61], was unfavorably weighted against NHC, failed to include appropriate penalties for failure to meet performance standards and measures, and should not have been signed because of UHH's lack of administrative qualifications and capability for a multi-product commercial plan. Further, its failure to be registered with the Nevada DOI as an administrator as required by Nevada statutes should have been a red flag to NHC's management relative to UHH's commitment to NHC.

Additionally, UHH was unprepared or unwilling to provide administrative functional support, as required by the ASA[62] and Consulting contract[63], and placed its own needs above NHC's needs in choosing an IT system that was incapable of meeting NHC's business needs[64]. Further, it is my opinion that NHC's and UHH's failure to comply with CMS contract review and approval requirements and Nevada TPA registration requirements was an early example of what would become a pattern of non-compliance by both NHC and UHH with industry standards, regulatory direction and requirements.

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[61] Performance Requirements and Service Level Standards, attached to email correspondence from Tanchica Terry of CMS to Tom Zumtobel, *et al.*,18579-0000854407_0008 and 18579-0000854407_0008_0001, PLAINTIFF02476932 - PLAINTIFF02476933; PLAINTIFF02476934 - PLAINTIFF02476944

[62] Administrative Services Agreement, dated June 27, 2013, UHH 0000006-033

[63] Consulting Agreement between Unite Here Health and Hospitality Health, Ltd., dated January 30, 2013, PLAINTIFF 01182250-274

[64] Claims System Discussion, UHH 0367471. In fact, in a May 15, 2012 memo from Gary Odenweller to himself,[64] he appears to summarize the process used by UHH to select a new claims system for itself. *See* Gary Odenweller memo regarding Claim System Review and Selection Process, dated May 15, 2012, UHH 0367499.

2. TPA Licensure by UHH

Adding to the TPA contract issues and concerns was the fact that UHH was not licensed as a TPA by the Nevada DOI, in violation of Nevada statutes/regulations[65] and Section 2.1(g) of the Administrative Services Agreement of June 27, 2013[66]. In my experience working with start-up health plans in multiple states as both a senior executive and consultant/advisor, compliance with state regulatory requirements is mandatory. With regard to TPA registration requirements, most state regulators require organizations, seeking to provide administrative support services to licensed commercial health plans, be registered/licensed by the state in order to perform these administrative services. Registration or licensing is an assurance to the insurance regulator of the TPA's fiscal responsibility and financial integrity and general ability to run a solvent business. Nevada had such a requirement that an organization obtain a Certificate of Registration with the Nevada DOI. It is my opinion that UHH, and by reference NHC, despite the clarity of the September 18, 2013 letter from the Nevada DOI[67], intentionally refused to comply with this requirement and subsequently misled both CMS[68] and the Nevada DOI[69] regarding its intentions and regulatory compliance for administrative services. NHC management was complicit in this scheme to mislead CMS and Nevada DOI, when it should instead have refused to contract with UHH for TPA services.

From my experience in obtaining similar TPA registrations or licensing in several states, including Arizona, California, Florida and Texas, registration is a straightforward and timely process, with reasonable documentation requirements. Documentation included items such as an application, a plan of operation, biographical affidavits of the TPA's principal officers

[65] Nevada Revised Statutes 689B.255 and 695B.2505
[66] Administrative Services Agreement, dated June 27, 2013, UHH 0000006-033
[67] Letter from Todd Rich to Tom Zumtobel, dated September 18, 2013, PLAINTIFF 01461928-931.
[68] Letter from Tom Zumtobel to Tanchica Terry, October 25, 2013, Plaintiff 01459476
[69] Letter from Tom Zumtobel to Todd Rich, Nevada DOI, November 12, 2013, Plaintiff 00899492

and managers, the TPA's financial statements and a fidelity bond. In my opinion there should have been no reason for UHH's failure to obtain the needed registration on a timely basis nor should NHC have ever signed the agreement with UHH until such time as the Nevada TPA registration or licensing process had been completed.

On August 20, 2013, Ms. Gwendolyn Harris, NHC's compliance manager, advised Tom Zumtobel, NHC's CEO, of the requirements that UHH register as a TPA with the Nevada DOI.[70]UHH (Gary Odenweller) was subsequently advised of this requirement, and forwarded the application packet to UHH counsel.[71]

1. NHC management and UHH counsel were informed by NHC's counsel, Darryl Landahl of Brownstein Hyatt Farber Schreck, LLP, [72] of the Nevada DOI TPA registration requirement. Ms. Bond replied to Mr. Landahl[73] that "this will completely freak out the Fund." NHC's counsel also advises NHC that "Nevada has a utilization review agent registration requirement as well, which the Fund may have to comply with if they are performing UR/medical management for the COOP."
2. Not content with the advice of Mr. Landahl, Ms. Bond sought a second opinion from Ms. Connie Akridge, a Partner with Holland & Hart LLP on the issue. Ms. Akridge provided the same counsel:[74]: "If… Nevada Health CO-OP will contract with the Fund, which will perform the TPA services, then the Fund must register as a TPA."

Rather than complying with Nevada law, NHC, via its related party entity UHH, and in direct contradiction with the uniform opinions of its two different legal counsels, NHC instead

[70] Email from Ms. Harris to Mr. Zumtobel, UHH 0292549-551.
[71] *Id.*
[72] Email correspondence between Darryl T. Landahl, Brownstein Hyatt Farber Schreck, LLP, and Bobbette Bond *et al*., dated May 6, 2013,18777-0000028969, PLAINTIFF02476712 PLAINTIFF02476714
[73] Ibid
[74] Email from Connie Akridge to Bobbette Bond, dated May 6, 2013, 18579-0000288728, PLAINTIFF02476715 - PLAINTIFF02476715

adopted the position of UHH's third counsel's advocacy opinion[75], arguing that UHH was not subject to these requirements because of a Taft-Hartley exemption even though NHC was not a Taft-Hartley plan. NHC instead was a Qualified Health Plan under the requirements of the Affordable Care Act (ACA) in the Nevada commercial market).[76] In fact, the memo from Mr. Whitehead to Mr. Zumtobel that was forwarded to the Nevada DOI was specifically prepared by Mr. Whitehead to the specific request of Mr. Zumtobel who sought this specific determination[77]. Mr. Whitehead, at Mr. Zumtobel's request, opined,[78] "… it does not appear that the Fund is required to be licensed as an administrator in order to provide services to NHC." This legal opinion was presented to Nevada DOI by NHC management as fact, when even Mr. Whitehead advises "In any event, this is an "advocacy" document, so treat it accordingly"[79].

There was clearly an internal debate between NHC, UHH, and counsel for both parties relative to the Nevada DOI requirement that UHH register as a third-party administrator. While NHC's counsel[80] [81] maintained that UHH was required to register, it appears that UHH strongly resisted such TPA registration.

Management also provided the UHH legal opinion on TPA licensure to CMS,[82] stating NHC/UHH's position and informing CMS that Nevada DOI was reviewing the opinion. Mr. Zumtobel indicated that in the case of an adverse decision by the DOI, "[W]e are willing to pursue licensure."

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[75] Memorandum from Mitchel D. Whitehead and Yvette Kotchounian of Seyfarth Shaw LLP, dated September 9, 2013, to Tom Zumtobel and Bobbette Bond, PLAINTIFF 01461943-946.

[76] Zumtobel letter to Tanchica Terry of CMS, dated October 25, 2013, PLAINTIFF 01459476.
[77] Email from Mitch Whiteheadl to TomZumtobel on September 9, 2013, PLAINTIFF 01461922
[78] Memorandum from Mitchel D. Whitehead and Yvette Kotchounian of Seyfarth Shaw LLP, dated September 9, 2013, to Tom Zumtobel and Bobbette Bond, PLAINTIFF 01461943-946.
[79] Email from Whitehead to Zumtobel et al, 9/9/2013, Plaintiff 01461922
[80] Email from Connie Akridge to Bobbette Bond on May 6, 2013, 18579-0000288720, PLAINTIFF00620410 - PLAINTIFF00620411
[81] Email exchange between Darryl T. Landahl and Bobbette Bond on May 6, 2013, 18777-0000028969, PLAINTIFF02476712 - PLAINTIFF02476714
[82] Email from Tom Zumtobel to Tanchica L. Terry, PLAINTIFF 01461927.

On September 18, 2013, NHC received the formal response[83] from the Nevada DOI. Therein, the DOI's legal counsel, Ms. Alexia Emmermann, clearly stated, "As the Division understands the facts presented, without having a certificate of registration as an administrator, Unite Here Health is not authorized to provide administrator services to the CO-OP plans." Mr. Rich then outlined the options available to NHC:

1. "The CO-OP may service its own claims as it is licensed as an HMO;
2. The organization that will service its claims of the CO-OP may obtain a certificate of registration as an administrator for an organization; or
3. The CO-OP may hire a third-party administrator that currently has a certificate of registration with the Division."

Despite the clarity of the Nevada DOI legal opinion, in a subsequent letter to CMS,[84] Mr. Zumtobel continued to maintain that UHH was not subject to these regulations. Mr. Zumtobel stated that of the available options presented by the DOI, "The most acceptable of which is for Nevada Health CO-OP to employ a claims staff to oversee the processing at Unite Here Health." Oversight of the claims processing, which was a responsibility of NHC, did not alleviate UHH of its contractual obligations and UHH remained the sole provider of claims services until August 2014. Not only did the DOI clearly never offer this as an option, but Mr. Zumtobel's position seems to ignore the fact that UHH would still be acting in the role of an administrator and would be processing NHC's claims. It appears that this was an effort to distract CMS from the real intent of NHC and UHH, which was to move forward with UHH acting as NHC's TPA, while remaining unlicensed, in violation of Nevada law. Subsequent to this communication with CMS, it appears that NHC counsel from Brownstein Hyatt Farber Schreck LLP were no longer engaged to support NHC with TPA contracting or TPA licensing advice.

[83] Letter from Todd Rich to Tom Zumtobel, dated September 18, 2013, PLAINTIFF 01461928-31
[84] Letter from Tom Zumtobel to Tanchica L. Terry, dated October 25, 2013PLAINTIFF 01459476.

In response to the Nevada DOI's position on TPA registration, Mr. Zumtobel sent a letter[85] to Todd Rich on November 12, 2013 outlining NHC's actions, stating "We will employ our primary claims team on-site at our NHC's offices in Las Vegas….The local adjusters will handle all local hospital and complex claims….Unite Here Health will provide scale if we experience a high volume of claims as we refine the auto adjudication process. Importantly, the auto adjudication process was never refined, leaving considerable manual work and compounding the backlog. Unite Here Health staff is being trained to adjudicate traditional physician claims and provide back-up…." It wasn't until nearly a year later, August 2014, that NHC did bring on claims staff to handle some anesthesia claims adjustments and claims from non-coalition surgery centers. As no modifications were made to the TPA agreement or to the TPA reimbursement schedule, the claims team in Aurora, Illinois was integral to the plan development process and was gearing up to handle NHC claims, it appears that Mr. Zumtobel intentionally misled Mr. Rich and the Nevada DOI. It does not appear from any other documentation, that NHC initially intended to adjudicate its own claims, and where it did begin to adjudicate some of its own claims, this was done to avoid large penalties on hospital claims due to UHH's inability to timely process claims. [86] The TPA arrangement between NHC and UHH remained in functional operation until the transition of UHH from the contract with Receivership.

In the same document, Mr. Zumtobel misled Nevada DOI[87] relative to the intentions of NHC regarding NHC oversight of UHH, stating NHC would hire an employee who would be "based in the UHH claims operation." The identified "employee" was reported to be Mr. Gary Odenweller, a long-time UHH employee who signed an Independent Contractor Agreement[88] with NHC. It does not appear that Mr. Odenweller was ever an employee of

[85] Letter from Tom Zumtobel to Todd Rich, dated November 12, 2013, PLAINTIFF 00899492
[86] See e-mails between Brooke Gearhart and Randy Plum (June 4-5, 2014), regarding Hospital Coalition Claims being funneled in a separate "queue" to an NHC employee for processing, 18579-0000450983, PLAINTIFF01461817 - PLAINTIFF01461819
[87] *Id.*
[88] NHC – Odenweller Independent Contractor Agreement, effective January 1, 2014, PLAINTIFF01460377

NHC, ever actually resided in Las Vegas, nor ever intended to reside in Las Vegas. None-the-less, UHH was still responsible for claims processing and payment and was still required to register with the Nevada DOI.

UHH had an obligation to register as an administrator with the Nevada DOI and with NHC's management, who were related to UHH and intentionally misled CMS and the Nevada DOI so as to avoid TPA licensure. UHH also failed to comply with the terms of Section 2.1(g) of the Administrative Services Agreement[89] that it would "comply in all material respects with all applicable laws, rules and regulations…" In my opinion, the failure of UHH to obtain a Nevada Certificate of Registration as a TPA was a violation of industry standards and Nevada statues, a violation of the above section 2.1(g) of the ASA. It was inappropriate and a violation of industry standards for UHH and the NHC management defendants to have signed a TPA agreement with UHH before such time as UHH completed its registration or licensing process with the Nevada DOI.

Part IV: NHC Not Ready to Launch as Structured

It is my opinion that the design and development process relating to the launch of NHC as a health plan offering commercial health insurance products on the Silver State Exchange was flawed from the beginning. UHH was unqualified to provide TPA services to NHC and failed to properly register with the Nevada DOI. UHH did not have any experience with a multi-product commercial health plan that would have provided a suitable foundation of knowledge and understanding of the functional business requirements of such a multi-product commercial health plan.

[89] Administrative Services Agreement, dated June 27, 2013, UHH 0000006-033

Importantly, UHH was conflicted in the development of NHC, especially in the decision to select the Javelina system to form the core technology platform for NHC, which UHH had previously evaluated and desired to use for their own purposes. Evidence[90] indicates that the primary purpose of the system evaluation process was to secure a new claim system for UHH. There is further evidence[91] that UHH viewed the NHC obligations as "the COOP experiment." In my opinion, this lack of experience, competency and understanding of the functional business requirements created a cascade of mistakes and deficiencies which impaired the development and operation of NHC.

A. UHH Failed to Properly Evaluate, Test, and Select a Capable Claims Processing System.

If the goal had been to independently find a business solution to NHC's functional business needs, UHH, as NHC's sponsor, should have sought one of the available tested marketplace solutions to support NHC. As an executive responsible for the start-up and development of health plans, and as a consultant/advisor to more than a dozen organizations starting new health plans, a responsible health plan executive would, early in the process, always undertake an assessment of the functional business requirements of the organization relative to the organizational capabilities of the start-up or parent organization. A responsible executive would assess the qualifications and capabilities of the organizations against the required functional business requirements of the identified line of business. For a commercial health insurer offering multiple health benefit plans, the key functional business requirements include:

1. The ability to support a sales process, including internal and external sales channels;

[90] Email communications between Odenweller and Zumtobel, May 17 – June 8, 2012, UHH 0367500

[91] Email from Michael Gulling of UHH to Tim Kneuss of Eldorado, dated October 30,2014, PLAINTIFF 01460944-945.

2. The ability to accurately collect and validate enrollment and eligibility information on each individual beneficiary, including the primary beneficiary, a spouse and any dependents;
3. The ability to facilitate selection of a particular benefit plan option;
4. The ability of the prospective enrollee to select, if required, a primary care physician from the available provider network;
5. The ability to bill, collect and apply the appropriate premium to the member's account;
6. The ability to load and manage a contracted network of health care providers, including primary care and specialty physicians, hospitals and health facilities, and other ancillary services. This requirement includes contract details and payment reimbursement details;
7. The ability of the plan to accurately receive, process and pay claims for covered services based on the selected benefit plan in compliance with timeliness standards;
8. The ability of the plan to effectively manage a series of medical management protocols including any service preauthorization requirements or other reviews;
9. The ability of the plan to accurately report critical information to financial systems; and
10. The ability of the plan to meet internal and external information reporting requirements

Though not exhaustive, this is a foundational list of business requirements necessary to support the core business of a multi-product commercial health plan.

UHH's own contractual obligations, as defined in the ASA[92], included:

1. Process all the claims for medical benefits under the Benefit Plan(s) in accordance with general industry standards. TPA shall establish necessary procedures for

[92] Administrative Services Agreement, dated June 27, 2013, Exhibit A Schedule of Administrative Services, Items 1-22, UHH 0000006-033

receiving all claims for medical benefits, timely processing medical claims for benefits and for distribution of payment of claims after appropriate adjudication.

2. Meet all government rules related to claims processing and due dates and responses to Beneficiaries. Forward all unresolved appeals to the CO-OP for final adjudication.

3. Generate an Explanation of Benefits ("EOB") notifying any Beneficiary whose request for plan benefits is denied of the reasons for denial and of his/her right to have the denial reviewed. The EOB shall be in a format agreed upon with CO-OP.

4. Provide a monthly extract and standardized management report of claims data based on specifications mutually agreed upon by the TPA and CO-OP. Work with CO-OP to develop, at CO-OP's expense, processes for the collection of additional data that may, in the future, be required by CO-OP. Such additional data may include eligibility data (such as domestic partner, college student, QMCSO status) and/or claims data.

5. Refer to CO-OP 1) any claims or class of claims CO-OP shall specify; 2) any disputed claims which question the language of Benefit Plans or other appeals of denied claims; 3) any claims involving questions of eligibility or entitlement of the Beneficiary for coverage under the Benefit Plan which cannot be resolved by TPA; 4) any pattern of possible fraud, abuse or high dollar trends; and (5) any questions with respect to the specific language of provider contracts. When any claim is referred to CO-OP, the CO-OP shall be responsible for meeting the requirements of paragraph 2 above.

6. Prepare files of appeal and claim denials for consideration by the CO-O's appeals committee and attend meetings of the appeals committee as requested by CO-OP.

7. Operate computer systems necessary for its performance of its duties and obligations under the terms of this Agreement. In addition, TPA agrees to make changes to and maintain its systems as necessary to comply with all governmental laws and regulations, including HIPAA. If any required systems change is specific to only the Administrative Services provided to CO-OP, the Actual Cost of implementing such change shall be paid by the CO-OP.

8. TPA also acknowledges that CO-OP has certain reporting requirements and agrees to fully cooperate and work with CO-OP toward the development of effective reports. TPA shall provide CO-OP with data and reports in a format acceptable to CO-OP. The Actual Cost of the additional reporting shall be paid by the CO-OP.

9. TPA will notify CO-OP of the changes in the Javelina benefits administration computer system. A change will include implementation of new releases of claims processing or eligibility software, removal of an existing claims processing or eligibility function or addition of a new claims processing or eligibility function in the current release of the software that is used to administer benefits under a Benefit Plan.

10. TPA will develop and implement a mutually agreed upon random internal claims audit process to be utilized for CO-OP.

11. TPA shall provide the staff necessary to provide the administrative and claims services described in this Schedule. The staff shall be employees or agents of TPA and subject to its direction and control.

12. TPA will maintain a Disaster Recovery Plan, which will be provided to CO-OP upon request and will submit revisions to the Disaster Recovery Plan to CO-OP as soon as reasonably practicable. CO-OP may request revisions to the Disaster Recovery Plan which TPA will consider in good faith for adoption.

13. TPA shall maintain secured, controlled, audited and reliable sources to their systems in accordance with industry standards and CO-OP's reasonable specifications.

14. TPA shall provide CO-OP with timely, complete and verified data feeds to CO-OP's internal data warehouse pursuant to CO-OP specifications. Data feed specifications for medical claims shall include concise and complete collection of all captured information as submitted by providers on Industry Standard claim forms or electronic claim formats. Such data will be collected regardless if processed electronically or manually. Data feeds will also include eligibility data stored within the claims systems. Additional collection to include complete field information as submitted on ADA Standard Claim Forms. The Actual Costs related to any additional programming will be borne by CO-OP.

15. The TPA will use an appropriate claim editing software for code editing and payment rationale in accordance with industry standards.

16. TPA shall use acceptable industry standard claims payment processes, including Coordination of Benefits (COB) where applicable.

17. TPA shall work with CO-OP in implementing new benefit designs and/or contracted professional medical provider rates.

18. Assist with the preparation and filing of any Federal and State reports, which are required by law.

19. Arrange for the distribution of forms required in the processing of CO-OP claims, as agreed upon by both parties.

20. Maintain all claim files relating to CO-OP consistent with the time requirements in Exhibit D, paragraph 6.

21. At CO-OP's cost, provide other members of CO-OP's staff or contracted entities, such as auditors, legal counsel and TPA's, with all available information pertaining to CO-OP as reasonably requested by CO-OP and within mutually agreed upon timeframes.

22. TPA will supply CO-OP vendors with eligibility data as directed by CO-OP, with the Actual Cost of any programming expenses to be paid by CO-OP.

It does not appear that anyone at UHH had the experience and understanding of commercial health plan functional requirements, or of ACA markets in particular, to properly define the TPA functional and system processing requirements to Eldorado, the designers and programmers of the Javelina software, so as to properly support NHC; nor did UHH obtain adequate external expertise to support the design requirements process. It is also unclear if anyone at Eldorado had experience with commercial health care plan business and processing requirements. It appears that there was never a detailed system design document prepared by UHH and Trizetto until nearly two years after system selection, when in December, 2014, finalized April, 2015, a system architecture design[93] was prepared in response to a request was received from CMS for system documentation. Based on the facts I reviewed, it appears that system development was an exercise carried out by individuals who had neither the experience, nor the expertise, to provide appropriate guidance.

[93] Trizetto Architecture Diagram – NHC Conceptual Architecture, Plaintiff 01321048-49

UHH was solely responsible for selecting the Javelina software[94], and it was UHH's responsibility under the ASA[95] to "Operate computer systems necessary for its performance of its duties and obligations under the terms of this Agreement." which did not perform:

1. The Javelina system was not "state of the art" [96] to support an ACA Qualified Health Plan serving a commercial market. The system as configured and operated by UHH was generally unable to perform even routine administrative tasks such as receipt and verification of enrollment and eligibility information, receipt and verification of premium payment information, provider contracted fee schedules, and, importantly, pay claims in alignment with basic industry standards. If Javelina was in use by any other multi-product commercial health plan, it was not obvious from the system's performance.
2. The Javelina system as configured and operated by UHH did not have "the flexibility to accommodate innovative benefits design and reimbursement relationships in a highly automated, accurate and efficient operation."[97]
3. The Javelina system as configured and operated by UHH could not accommodate multiple benefit designs (149 different benefit plans in 2014 and 259 plans for 2015)[98], nor could it accommodate and correctly pay multiple provider fee schedules[99].
4. The Javelina system as configured and operated by UHH could not support the calculation and accumulation of beneficiary out-of-pocket co-pays and deductibles to meet NHC's obligation to limit beneficiary contributions, and this major deficiency would become a significant source of incorrectly paid claims and excessive member out-of-pocket payments.

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[94] Claims System Discussion, UHH0367471
[95] Administrative Services Agreement, dated June 27, 2013, Exhibit A Schedule of Administrative Services, Item 7, UHH 0000006-033
[96] Zumtobel letter to Todd Rich, Deputy Insurance Commissioner, dated November 12, 2013, PLAINTIFF 01461889.
[97] *Id.*
[98] Excel spreadsheet with benefit plan summaries for all 2014 and 2015 NHC benefit offerings, 18579-0001835241, PLANTIFF02499132 - PLANTIFF02499133
[99] Deposition of Kathleen Silver, pages 84-86,

5. The Javelina system as configured and operated by UHH could not to any substantive degree "auto-adjudicate" provider claims submissions via a series of critical edits and data checks, thereby causing significantly greater manual claims processing (Gearhart email of August 25, 2014 identifies "auto-adjudication rate at about 40%")[100], increased error rates, and unacceptable claims backlogs.

From the documentation I have reviewed, it does not appear that UHH, nor NHC management, performed any material due diligence of Javelina system capabilities to support multiple complex commercial benefit plans prior to adoption, or does it appear that any comprehensive search of alternative experienced marketplace commercial health plan IT systems was ever conducted to provide the appropriate foundation for UHH's TPA work on behalf of NHC. From UHH documentation,[101] it appears that, other than Eldorado, the only information technology solutions, explored by the UHH team were Trizetto (UHH's existing technology vendor) and Healthation. This documentation appears to show the system evaluation centered on four categories including claims, data, health care delivery, and customer service. Based on the team's summary evaluation, Eldorado ranked highest in each category. The UHH evaluation team's identified concerns relative to the Eldorado software solution were identified as:

1. Claims – **none**
2. Data – **mass adjudication**
3. Health care delivery – **value based reimbursement**
4. Customer service – **customer service capabilities**

Although Trizetto was one of the leading technology vendors to several commercial health plans, the documentation does not indicate any of the other Trizetto solutions was ever explored.

[100] Emails Odenweller-Gearhart, August 25, 2014, Plaintiff 01461896
[101] Claims System Discussion, UHH 0367471.

UHH's selection of Eldorado's Javelina system required significant modification to overcome its lack of functionality and major deficiencies in existing functionality to meet the business requirements of NHC's TPA support needs. The lack of functionality also required NHC to contract with other third party vendors, such as InsureMonkey, to provide required functionality increasing the complexities of system integration and data integrity. Of interest is the fact that NHC had to obtain contracts for these additional services that were the responsibility of UHH[102] and UHH's failure to perform agreed services. UHH's abdication, of its responsibility to provide TPA services to NHC in compliance with the agreed services in the ASA[103] and the Consulting agreement[104], as well as Sections 8.2 and13.1.5 of the CMS loan agreement[105], placed an undue burden on NHC management, staff and financial resources.

Evidence[106] indicates that UHH selected Javelina for NHC because UHH had, in 2011 or 2012, already determined that Javelina would be the replacement for its old RIMS system. Javelina was better suited for a single benefit plan, such as a Taft-Hartley plan, than a multi-product commercial plan such as NHC. There is no evidence that UHH ever conducted a detail assessment of the requirements to support NHC's functional business needs. As such, the Javelina selection would provide UHH with extensive knowledge of the Javelina system structure and logic for its own purposes[107], to NHC's detriment.

[102] NHC – UHH Administrative Services Agreement, dated June 27, 2013, PLAINTIFF 00451639-667.
[103] Administrative Services Agreement, dated June 27, 2013, Exhibit A Schedule of Administrative Services, Items 1-22, UHH 0000006-033
[104] Consulting Agreement between Unite Here Health and Hospitality Health, Ltd., dated January 30, 2013, PLAINTIFF 01182250-274
[105] CMS – NHC Loan Agreement, May 17, 2012, Plaintiff 00171787 - 00171868
[106] Deposition of Kathleen Silver, December 18, 2018, page 67, lines 2-6
[107] Claims System Discussion, UHH 0367471

While UHH staff appear to have performed some system testing of the Javelina system prior to launch, this testing failed to confirm the ability of UHH to perform the full range of duties required in the ASA[108]. These duties included the following:

1. Process all the claims for medical benefits under the Benefit Plan(s) in accordance with general industry standards. TPA shall establish necessary procedures for receiving all claims for medical benefits, timely processing medical claims for benefits and for distribution of payment of claims after appropriate adjudication.

2. Meet all government rules related to claims processing and due dates and responses to Beneficiaries. Forward all unresolved appeals to the CO-OP for final adjudication.

3. Generate an Explanation of Benefits ("EOB") notifying any Beneficiary whose request for plan benefits is denied of the reasons for denial and of his/her right to have the denial reviewed. The EOB shall be in a format agreed upon with CO-OP.

4. Provide a monthly extract and standardized management report of claims data based on specifications mutually agreed upon by the TPA and CO-OP. Work with CO-OP to develop, at CO-OP's expense, processes for the collection of additional data that may, in the future, be required by CO-OP. Such additional data may include eligibility data (such as domestic partner, college student, QMCSO status) and/or claims data.

5. Refer to CO-OP 1) any claims or class of claims CO-OP shall specify; 2) any disputed claims which question the language of Benefit Plans or other appeals of denied claims; 3) any claims involving questions of eligibility or entitlement of the Beneficiary for coverage under the Benefit Plan which cannot be resolved by TPA; 4)

[108] Administrative Services Agreement, dated June 27, 2013, Exhibit A Schedule of Administrative Services, Items 1-22, UHH 0000006-033

any pattern of possible fraud, abuse or high dollar trends; and (5) any questions with respect to the specific language of provider contracts. When any claim is referred to CO-OP, the CO-OP shall be responsible for meeting the requirements of paragraph 2 above.

6. Prepare files of appeal and claim denials for consideration by the CO-O's appeals committee and attend meetings of the appeals committee as requested by CO-OP.

7. Operate computer systems necessary for its performance of its duties and obligations under the terms of this Agreement. In addition, TPA agrees to make changes to and maintain its systems as necessary to comply with all governmental laws and regulations, including HIPAA. If any required systems change is specific to only the Administrative Services provided to CO-OP, the Actual Cost of implementing such change shall be paid by the CO-OP.

8. TPA also acknowledges that CO-OP has certain reporting requirements and agrees to full cooperate and work with CO-OP toward the development of effective reports. TPA shall provide CO-OP with data and reports in a format acceptable to CO-OP. The Actual Cost of the additional reporting shall be paid by the CO-OP.

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10. TPA will develop and implement a mutually agreed upon random internal claims audit process to be utilized for CO-OP.

11. TPA shall provide the staff necessary to provide the administrative and claims services described in this Schedule. The staff shall be employees or agents of TPA and subject to its direction and control.

12. TPA will maintain a Disaster Recovery Plan, which will be provided to CO-OP upon request and will submit revisions to the Disaster Recovery Plan to CO-OP as soon as reasonably practicable. CO-OP may request revisions to the Disaster Recovery Plan which TPA will consider in good faith for adoption.

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17. TPA shall work with CO-OP in implementing new benefit designs and/or contracted professional medical provider rates.

18. Assist with the preparation and filing of any Federal and State reports, which are required by law.

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20. Maintain all claim files relating to CO-OP consistent with the time requirements in Exhibit D, paragraph 6.

21. At CO-OP's cost, provide other members of CO-OP's staff or contracted entities, such as auditors, legal counsel and TPA's, with all available information pertaining to CO-OP as reasonably requested by CO-OP and within mutually agreed upon timeframes.

22. TPA will supply CO-OP vendors with eligibility data as directed by CO-OP, with the Actual Cost of any programming expenses to be paid by CO-OP.

The limited system testing even failed to identify simple processing errors and confirm required functional requirements, much less identify the major system deficiencies that would haunt NHC during its first and second years of operation.

The apparent deficiencies in UHH's ability to perform the services required by the TPA agreement and the severe limitations of the Javelina system should have been known to NHC management and would have been obvious, had appropriate system testing occurred. It is my opinion that UHH management knew, or should have known, the functionality of the Javelina system was not properly designed, nor operationally ready, to support the business of NHC due to severe functional deficiencies and integration problems with the

Javelina system prior to January 1, 2014; yet UHH still proceeded with an aggressive launch. Basic system implementation, functional design, and integration issues was forced to continue throughout 2014 and into 2015 because it was not complete at the time of launch. In fact, the Javelina system was never able to adequately perform the critical administrative functions necessary to support NHC's business as system deficiencies and problems, such as eligibility, premium and CMS billing, claims accumulators, and broker payments, continued to surface as late as June, 2015[109] [110] [111]. These deficiencies and system performance problems had significant negative financial implications[112] for NHC.

Even as NHC was quickly approaching the Silver State Exchange open enrollment period, UHH was unprepared to properly establish the foundation for supporting NHC's launch and to devote full and appropriate resources to take on its TPA responsibilities. Brooke Gearhart, UHH Claims Manager, noted,[113] "UHH is going to be raised as an impediment to leadership" and the linked sub-bullet states "Advised that we appreciate the importance and urgency of the matter but can't do anything w/o a resource."

B. NHC Offered an Excessive Number of Complex Benefit Plans, Which Confused the Claims System.

In my opinion, NHC offered an excessive number of complex benefit plans, 149 in 2014 and 259 in 2015[114], on the Nevada Exchange which significantly complicated the plan's launch.

[109] Email exchanges between Mark Jolley, Amanda Weitzel, Michael Grim, Pam Egan and others from May 28, 2015 through June 5, 2015, 18579-0000192237, PLAINTIFF00004044 – PLAINTIFF00004051
[110] Plum emails, 6/11/2015, Plaintiff 02476903
[111] Dibsie – Weitzel email exchange, 6/18-23/2015, Plaintiff 00004042
[112] Please refer to the Damages section of this report
[113] Handwritten notes of Brooke Gearhart, dated October 31, 2013, UHH0367170.
[114] Excel spreadsheet with benefit plan summaries for all 2014 and 2015 NHC benefit offerings, 18579-0001835241, PLANTIFF02499132 - PLANTIFF02499133

The unconventional number of complex benefit options NHC proposed to offer on the Nevada Exchange would seem to indicate a "membership growth first" business strategy designed to attract enrollment from diverse market segments. This is confirmed by Board meeting minutes.[115] While insurance products are often built on a foundation of "the law of large numbers," growth for growth sake, without the proper financial discipline to appropriately design and price benefit plans and without sufficient confidence that the TPA's administrative capabilities are stable and tested enough to support the plan's business requirements, is an extremely risky approach to starting a new insurance business. Making mistakes in any of these areas with a large enrollment base can create a material strain on a new plan's fragile capital reserves. A more conservative growth approach has the advantage of enabling the new plan to make corrections and adjustments to its system and operations and importantly, preserve capital.

Given the deficiencies of the UHH selected Javelina system, the inexperience of NHC and UHH management and personnel with multi-product commercial health benefit plans, NHC management would have been less negligent to approach the market in a more conservative, slower growth fashion, offering a limited number of benefit plans to the ACA commercial market, pricing the benefits much less aggressively, and allowing UHH additional time to complete its TPA information technology support systems. This more conservative approach would likely have reduced some of the extensive losses experienced by NHC.

Though it is unlikely that fewer benefit plans would have completely mitigated the Javelina system's poor performance or the poor performance and deficiencies of UHH, which led to UHH's inability to meet its contractual obligations in the ASA[116], the benefit complexity

[115] NHC Board of Directors Meeting Minutes of January 22, 2014 and March 25, 2014, Plaintiff 01456863 and Plaintiff 01456783

[116] Administrative Services Agreement, dated June 27, 2013, Exhibit A Schedule of Administrative Services, Items 1-22, UHH 0000006-033

added significantly to the failure of UHH and the Javelina software to appropriately pay claims.

The Culinary Fund/UHH signed participating provider agreements that reportedly offered different fee schedules for different benefit plans[117]. In my opinion, this approach to provider contracting was highly unusual, not industry standard, and added significantly to the difficulties of paying claims correctly. Through my own experience and conversations with network development executives from major health plans offering multiple ACA and other commercial products, I have confirmed that the industry standard is to have a single fee schedule/reimbursement formula as the foundation for provider reimbursement; in some line of business (e.g. commercial, Medicare, and Medicaid), variation in the percent of reimbursement of the fee schedule is routine, and deductibles and member co-pays may influence the amount ultimately paid to the provider by the plan.

In my opinion, the convergence of UHH's poor performance, UHH's inability to meet the terms of the TPA agreement, UHH's failure to meet its fiduciary responsibilities, the major deficiencies in the Javelina system, the inexperience and incompetence of UHH relative to the business and regulatory requirements of an ACA Qualified Health Plan or commercial health plan, generally, and many potential conflicts of interest, all contributed to a "perfect storm" of poor performance that impaired and jeopardized the chances of success for NHC.

Though obligated to participate in the ACA program beginning January 1, 2014 (October 1, 2013 for the ACA's Open Enrollment Period), recognizing the myriad of problems and deficiencies with UHH and the Javelina system, in my opinion NHC was not ready to be launched, as structured, as a health care plan effective January 1, 2014. In this connection, NHC management should not have launched NHC as a healthcare plan effective January 1, 2014, and UHH should have disclosed the deficiencies and shortcomings of the Javelina system well before the anticipated launch of NHC in business, as well as UHH's own inability

[117] Deposition of Kathleen Silver, December 18, 2018, pages 84-86

to effectively manage the claims system and claims adjudication processes for NHC. In my opinion the failure of NHC management, irrespective of their status as employees of UHH on loan to NHC[118] and in violation of NHC's Ethics and Conflict of Interest Policy[119], to properly supervise the activities of UHH, operate independently from UHH, and manage the business of NHC within the bounds of standard industry practices, reflect that NHC management breached their fiduciary responsibility to NHC.

Part V: Plan Operation Issues and Deficiencies

1. Unite Here Health

It is my opinion that UHH failed to perform its services consistent with industry standards for a TPA and was materially deficient in meeting the obligations it assumed under the Consulting Agreement[120] and in the Schedule of Administrative Services to the Administrative Services Agreement.[121] In my opinion, UHH was deficient and failed to meet industry standards as to Consulting Agreement identified services,[122] including: (a) claims processing systems development and implementation, (b) physician profiling systems access and standard reporting and the further development of the same, (c) enrollment system development and implementation, and (d) customer service systems development and implementation. Relative to the Administrative Services Agreement, my opinion is that

[118] Executive Service Agreements of Thomas Zumtobel and Bobbette Bond, UHH0000090 and UHH0000076

[119] Sample NHC Ethics and Conflicts of Interest Policy as signed by Ms. Kathy Silver on February 19, 2014, PLAINTIFF00562503 – PLAINTIFF00562512

[120] Consulting Agreement between Unite Here Health and Hospitality Health, Ltd. Dated as of January 30, 2013 to be effective as of May 17, 2012, UHH 0000041-065.

[121] Administrative Services Agreement, dated June 27, 2013, Exhibit A Schedule of Administrative Services, Items 1-22, UHH 0000006-033

[122] Consulting Agreement between Unite Here Health and Hospitality Health, Ltd. Dated as of January 30, 2013 to be effective as of May 17, 2012, UHH 0000041-065.

UHH was deficient in many of the agreed services that UHH was to provide[123], including specifically, but not limited to, the following items:

- 1. "Process all claims for medical benefits under the Benefit Plan(s) in accordance with general industry standards. TPA shall establish necessary procedures for receiving all claims for medical benefits, timely processing medical claims for benefits and for distribution of payment of claims after appropriate adjudication."
- 2. "Meet all governmental rules related to claims processing and due dates…"
- 7. "Operate computer systems necessary for its performance of its duties and obligations …"
- 8. "TPA also acknowledges that CO-OP has certain reporting requirements and agrees to fully cooperate and work with CO-OP toward the development of effective reports."
- 10. "TPA will develop and implement a mutually agreed upon random internal claims audit process to be utilized for the CO-OP."
- 11. "TPA shall provide the staff necessary to provide the administrative and claims services described in this schedule."
- 15. "The TPA will use an appropriate claims editing software for code editing and payment rationale in accordance with industry standards."
- 16. "TPA shall use acceptable industry standard claims payment processes…"
- 18. "Assist with the preparation and filing of any Federal and State reports, which are required by law."
- 22. "TPA will supply CO-OP vendors with eligibility data as directed by CO-OP…"

These UHH failures and deficiencies, particularly its responsibilities under the Consulting Agreement[124], specifically:

(a) Claims processing systems development and implementation;

[123] Administrative Services Agreement, dated June 27, 2013, Exhibit A Schedule of Administrative Services, Items 1-22, UHH 0000006-033

[124] Consulting Agreement between Unite Here Health and Hospitality Health, Ltd. Dated as of January 30, 2013 to be effective as of May 17, 2012, UHH 0000041-065.

(e) Enrollment system development and implementation;

(f) Customer service systems development and implementation;

(j) Information technology systems and support services (and selection, negotiation and contracting services for its own systems))

and the ASA[125], specifically:

1. Process all the claims for medical benefits under the Benefit Plan(s) in accordance with general industry standards. TPA shall establish necessary procedures for receiving all claims for medical benefits, timely processing medical claims for benefits and for distribution of payment of claims after appropriate adjudication.

7. Operate computer systems necessary for its performance of its duties and obligations under the terms of this Agreement. In addition, TPA agrees to make changes to and maintain its systems as necessary to comply with all governmental laws and regulations, including HIPAA. If any required systems change is specific to only the Administrative Services provided to CO-OP, the Actual Cost of implementing such change shall be paid by the CO-OP.

15. The TPA will use an appropriate claim editing software for code editing and payment rationale in accordance with industry standards.

These failures and deficiencies of UHH's performance in meeting the obligations above were, in my opinion, major material contributors to the ultimate demise of NHC.

The foundational failure in my opinion was UHH's selection of the Javelina system, and the failure of its design system to support the functional business requirements of NHC. Though it is not unusual for processing issues to occur during the life cycle of a system, it is

[125] Administrative Services Agreement, dated June 27, 2013, Exhibit A Schedule of Administrative Services, Items 1-22, UHH 0000006-033

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.

should have immediately undertaken a reconciliation effort to validate enrollment, eligibility, and payment information to ensure that accurate information was put into the Javelina system. I see no evidence of an enrollment reconciliation process until late 2014 when InsureMonkey was engaged in a reconciliation project.

In my opinion, there are several far-reaching implications to this lack of accurate enrollment, eligibility, and payment data, including failure to collect properly owed premium and federal subsidy payments, paying claims for ineligible and non-enrolled members, and denying claims for legitimately enrolled members.

If the pre-launch warning signs were not sufficient to demonstrate that the Javelina system, which UHH selected and was designed for UHH, was incomplete and incapable of supporting the functional business needs of NHC, then early operation of the system gave added proof that the system configuration and functionality deficiencies remained a significant operational problem. Documentation confirms the nature of these serious system deficiencies and issues, beginning in 2013, and continuing throughout 2014 and into 2015. Some of the critical issues included unreconciled eligibility, enrollment and payment data, missing data fields,[130] and 835 updates not working.[131] Eldorado dismissed these issues and responded that "the system is working as designed."

Early in the program implementation process (January 29, 2014), Ms. Brooke Gearhart, claims manager for UHH, reported[132] on several Eldorado/Javelina Issues. These included:

1. Prior Auth not working correctly
2. WF rules can't be edited
3. Pends require a work-around
4. Remark code limitations/iCES

[130] October 24, 2013 IT UM/UR Meeting, UHH 0367172.
[131] November 7, 2013 Javelina Users Group Agenda, UHH 0368126-127.
[132] Gearhart hand-written notes, UHH 0368245-377 at UHH 0368336.

5. Responsiveness (80%)
6. Inadequate training

In this same note,[133] Ms. Gearhart identified more than fourteen (14) specific "COOP/UHH Issues," including benefit plan info, enrollment set-up and staffing, and Exchange/IM readiness for enrollment and payment.

On January 30, 2014, Ms. Gearhart noted[134] that on the issue of prior authorizations "… AND if there are more than one code on the claim. Only one is authed [sic] but they both pay… "Per Kirsten/Eldorado, this is just how the system works[135]."

The failures of the Javelina system, to meet even the basic business requirements of NHC, including, the inability to correctly integrate enrollment, eligibility, and premium payment data, the failure to perform routine edits on claims submissions to facilitate automatic adjudication, and other failures, as detailed below, led UHH to manually adjudicate a high percentage of routine claims resulting in significant overpayments and incorrect payments requiring "extensive manual adjustments."[136] The claims processing issues continued well into 2014, when UHH asked[137] for additional staff "due to a number of issues that were not anticipated previously or that have proved significantly more complicated or long running that we had planned." This request was in addition to an earlier approved request for temporary staff. Per the ASA, it was UHH's responsibility to "provide the staff necessary to provide the administrative and claims services described in this Schedule." [138] Citing an attached email from Ms. Brooke Gearhart[139], Mr. Odenweller supported the request for

[133] *Id.*
[134] Hand-written notes regarding January 30, 2014 Call with Eldorado, UHH 0368122-123.
[135] Id.
[136] Handwritten notes of Brooke Gearhart, UHH0368245-377.
[137] Emails from Michael Gulling - Tom Zumtobel on March 25, 2014, PLAINTIFF 01337560-564.
[138] Administrative Services Agreement, dated June 27, 2013, Exhibit A Schedule of Administrative Services, Item 11, UHH 0000006-033
[139] Emails from Michael Gulling - Tom Zumtobel on March 25, 2014, PLAINTIFF 01337560-PLAINTIFF01337564.

additional staff, stating "[T]wo persons who will be unable to process claims due to the need for them to take on other roles," as one "will have to be providing provider and network maintenance indefinitely" and "we will have to pull a staff member to be able to provide QA of the other claims analysts." Ms. Gearhart also identified "difficulties with validating eligibility and multiple changes associated with network setups we are expecting and experiencing the need for many adjustments that are coming through from previously processed claims."

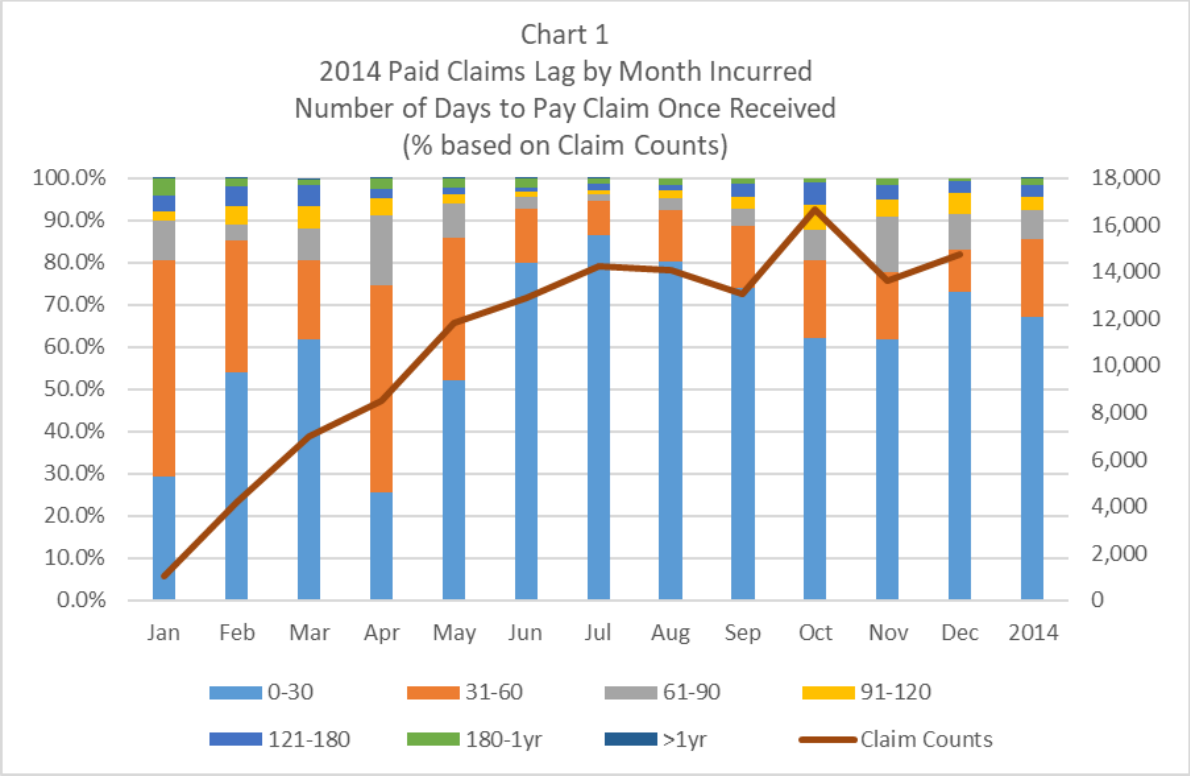
There are so many claims issues caused by the failure of the Javelina system to support the business requirements of NHC that it is difficult to catalogue them all. Identified below are several examples of claims issues that had severe and important financial implications for NHC:

1. Claims edits and processing codes not working[140]
2. Incorrect application of member co-pays[141]
3. Claims processed without benefit of out-of-pocket accumulator[142]
4. Manual entry of payment codes when values not in the system[143]
5. System benefit code incorrectly set up requiring manual application[144]
6. Authorization process failure in Javelina required UHH to waive pre-certification requirements and pay all claims[145]

All of these, and many more system deficiencies and failures, created an environment where UHH experienced severe claims backlogs (see NHC Claims lag charts below from

[140] Summary of meeting notes by Randy Plum, PLAINTIFF 00003911-912.
[141] Email chain regarding Emergency Room Benefits Question/Claim Processing Policy, PLAINTIFF 01461820-824.
[142] Email from Michael Gulling to Randy Plum regarding OOP adjustments, PLAINTIFF 0247680..
[143] Email chain among Nicole Flora, Pam Egan, and Brooke Gearhart, PLAINTIFF 01451494-495.
[144] Email exchange between Randy Plum and Brooke Gearhart, dated July 29, 2014, PLAINTIFF 01461831-834.
[145] Email exchange between Brooke Gearhart and Randy Plum, dated June 1, 2014, PLAINTIFF 02476805-806.

expert report of Mark Fish dated February 7, 2020) and were forced to manually process claims and use other manual workarounds to provide services to NHC. The backlogs were in part reduced by UHH's efforts to just pay the backlogged claims without fully verifying NHC's responsibility to pay. This UHH action was to the significant financial detriment of NHC.



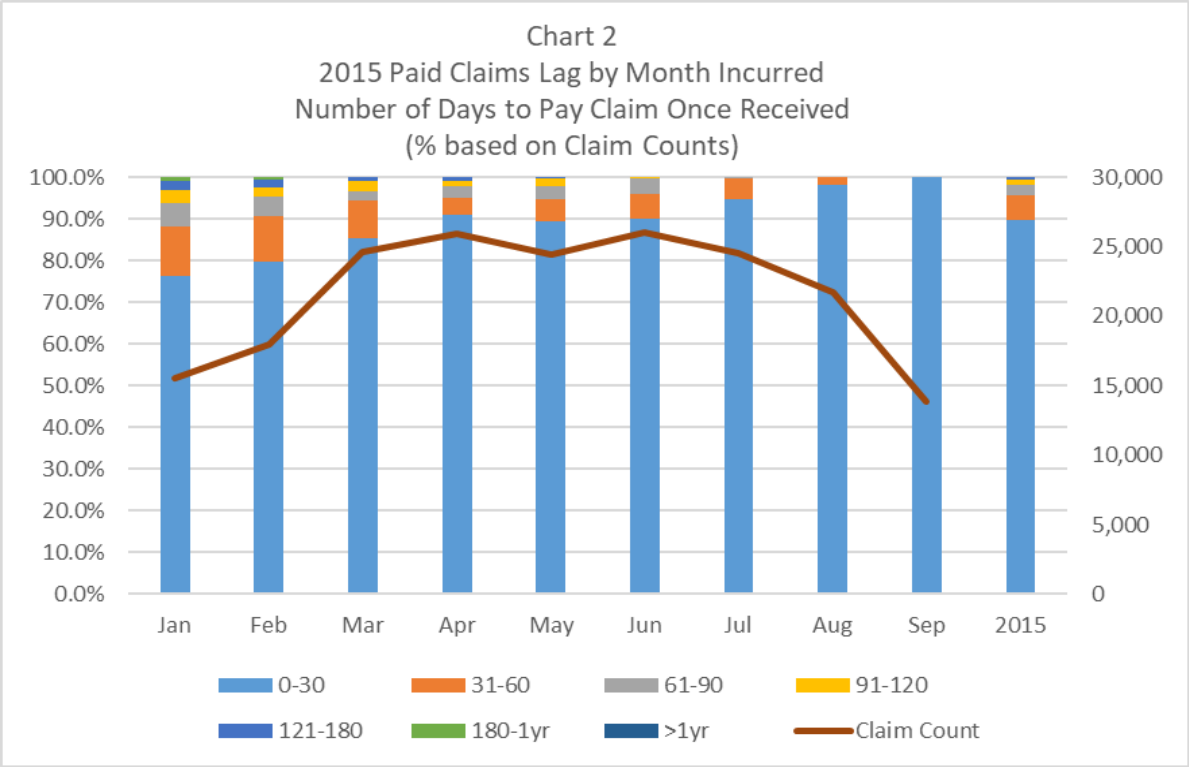


Chart 2
2015 Paid Claims Lag by Month Incurred
Number of Days to Pay Claim Once Received
(% based on Claim Counts)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
30,000
25,000
20,000
15,000
10,000
5,000
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
2015
0-30
31-60
61-90
91-120
121-180
180-1yr
>1yr
Claim Count

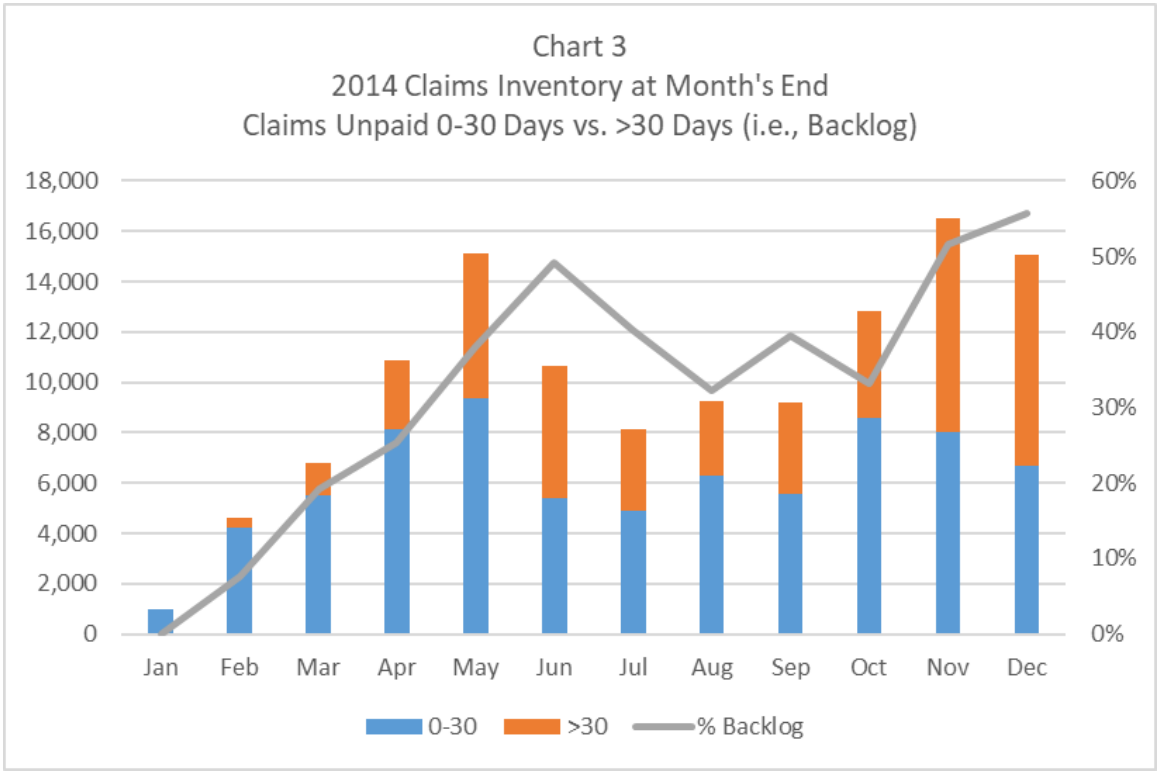


Chart 3
2014 Claims Inventory at Month's End
Claims Unpaid 0-30 Days vs. >30 Days (i.e., Backlog)
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
60%
50%
40%
30%
20%
10%
0%
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
0-30
>30
% Backlog

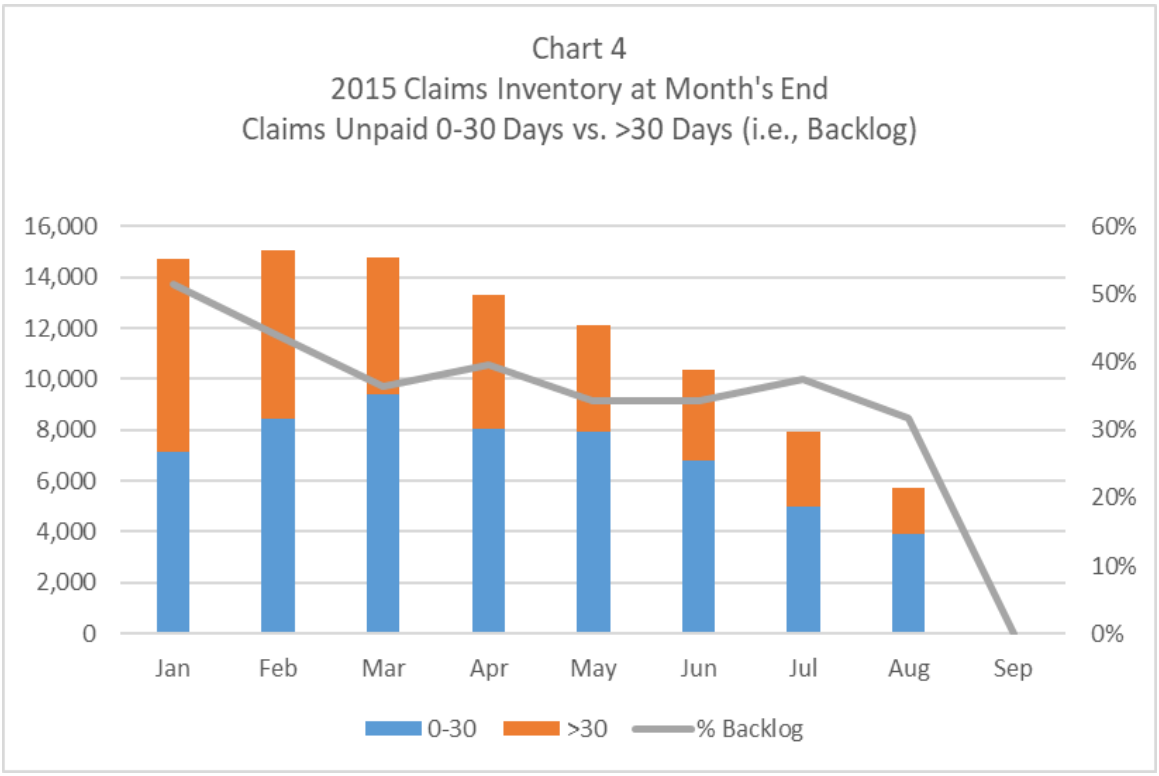


Chart 4
2015 Claims Inventory at Month's End
Claims Unpaid 0-30 Days vs. >30 Days (i.e., Backlog)
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
60%
50%
40%
30%
20%
10%
0%
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
0-30
>30
% Backlog

Frustration with the Javelina system was evident in a July 2014 email exchange between Brooke Gearhart of UHH and Mark Jolley at Insure Monkey,[146] wherein Ms. Gearhart parenthetically stated, "[C]urrently the functionality in our claim system is defective." The backlogs were reported to the NHC Board[147] by Pam Egan, who indicated they were currently "working through glitches in the functionality of the Javelina system that has held back auto adjudication of claims."

In my experience, I would expect see about eighty-five percent (85%) or higher auto-adjudication of claims in a TPA or health plan system. The CMS provided Performance Requirements and Service Level Standards identified a National Benchmark for auto-adjudication of 91%.[148] I would also typically see between ninety and ninety-five percent (90-95%) of inbound claims received electronically through Electronic Data Interchange ("EDI"). Eight months after the launch of NHC, UHH was reporting[149] that UHH's performance on auto-adjudication was about forty percent (40%) and EDI receipts were at sixty-five percent (65%). This performance level was nowhere near industry standard.

One of the most continuing problematic aspects of UHH's claim process was in dealing with a contracted network called WellHealth. WellHealth created a point-of-service narrow network of physicians called the Star Doctors and negotiated a capitated contract with NHC.[150] This contract called for WellHealth to receive a monthly capitated payment $92.40 for all NHC members who selected a Star Doctors physician. Additionally, NHC was required

[146] Email exchanges from Brooke Gearhart to Mark Jolley, dated July 30, 2014, at PLAINTIFF 01074042 (Plaintiff 01074037-48)
[147] NHC Board of Director meeting minutes for June 24, 2014, PLAINTIFF01457025 and PLAINTIFF01457026.
[148] Performance Requirements and Service Level Standards, attached to email correspondence from Tanchica Terry of CMS to Tom Zumtobel, *et al.*,18579-0000854407_0008 and 18579-0000854407_0008_0001, PLAINTIFF02476932 - PLAINTIFF02476933; PLAINTIFF02476934 - PLAINTIFF02476944
[149] Email from Brooke Gearhart to Gary Odenweller and Michael Gulling, dated August 25, 2014, PLAINTIFF 01461896-897.
[150] WellHealth – Star Doctors Network Participating Provider Agreement –Fully Executed, PLAINITFF 00170371-PLAINITFF00170391, 18485-000000319.

to initially pay WellHealth a "Network Access and Management Fee" of $100,000, plus a monthly access fee of $5,000 on execution of the agreement and additional monthly payments for a period of ten months.

There were other issues with the initial WellHealth agreement that should have raised alarms with NHC management, but were intentionally or inappropriately ignored by NHC management. These include:

- Section 2.05 – Out-of-Network Leakage – NHC agreed to fund 50% of costs incurred and paid out to out-of-network providers despite paying WellHealth a monthly capitation amount
- Section 3.13 –Compliance with State and Federal Law – NHC executed the agreement with WellHealth despite knowing that WellHealth had failed to register with the Nevada DOI as a Delivery System Intermediary ("DSI"). WellHealth was in violation of this Section 3.13 which required WellHealth to "comply with all applicable provisions of State and Federal law."
- Section 4.02 – Provider Organization Statement and Claims Submission – This section of the agreement required WellHealth to submit any fee-for-service claims 'within ninety (90) days of the date of service for payment to be made" by NHC. This was an unusual provision of a participating provider agreement as often provider submissions of claims can extend beyond such ninety-day requirement.
- Section 4.06 – Claims Cost Target – This section of the agreement committed NHC to renegotiate the compensation to WellHealth if the target amount for Covered Services was five percent (5%) greater or lesser than the $238 PMPM target.

Further, in Amendment Number 2 of the Network Participating Provider Agreement[151] NHC agrees to reduce capitation to WellHealth from $92.40 to $78.81 for June 2014 and $73.30 for July 2014. NHC also agreed that "Provider Organization shall remain responsible for the

[151] Amendment Number 2, effective July 1, 2014, PLAINITFF 00000943-PLAINTIFF00000947

payment of claims incurred between January 1st, 2014 and July 31st, 2014 … provided, however, should any claim on a PMPM basis for June and July exceed $55.00 (the "Excess") NV CO-OP shall be responsible for the payment of the Excess." The Amendment further states "The parties agree that any claim to be submitted by a Provider must be no later than ninety ("90") days after service. Accordingly, in no event shall Provider Organization be responsible for any claims originally submitted after 90 days for Member services from January 1, 2014 through July 31, 2014." These requirements are far from industry standard and should have been rejected by NHC management.

In my experience, in a typical capitated arrangement the capitated network providers would be instructed to submit all claims to the network manager, in this case WellHealth. The network manager would pay the provider claims and in turn submit an encounter report to the health plan in order to catalogue the services provided. An encounter is not a claim and should not be paid by the health plan.

The earliest problems began to surface in November and December 2013 as UHH was beginning to understand the complexity of the WellHealth agreement.[152] On March 5, 2014 UHH reported it "had difficulties loading the WellHealth provider file as file was not completely loaded by UHH and some providers were already in Javelina without a network affiliation."[153] UHH also reported that "the "% of Medicare did not load for the WellHealth provider file… claims adjustments necessary for claims submitted to be repriced."[154] During the course of the contract term, UHH paid a significant number of claims for WellHealth providers, which legitimately should have been the responsibility of WellHealth, since capitation payment for those member's services had already been paid to WellHealth by

[152] Brook Gearhart handwritten notes of November 6, 2013 and December 9, 2013, UHH0368317 and UHH0367963
[153] Email from Brooke Gearhart to Cynthia Hall, dated March 5, 2014, PLAINTIFF01474447.
[154] *Id.*

UHH. UHH was unable to resolve problems related to the WellHealth panel of physicians, and such problems continued into 2015. [155]

Under the terms of the "Star Doctors" Network Participating Provider Agreement between WellHealth Quality Care and Nevada Cooperative Coalition[sic], and specifically paragraph 4.02, "[c]laims must be submitted within ninety (90) days of the date of service for payment to be made. Provider Organization [i.e., WellHealth], may not bill Member for any Covered Service by reason of denial of payment by NV CO-OP for submission of statement later than ninety (90) days from the date of service. Provider Organization understands that NV CO-OP will process claims according to standard Medicare rules and regulations, where applicable.

As established just above, NHC paid WellHealth on capitation in advance for all health plan members expected to fall under the WellHealth participating provider agreement. Further, as also established above, NHC had a claims backlog totaling in the tens of thousands. In the event that NHC was not able to timely process applicable health claims, WellHealth was not obliged to make payment on such claims. As noted above, this was not industry standard and as a practical business matter an unreasonable requirement to limit WellHealth's fiduciary responsibilities for Providers who have provided a Covered Service to NHC's Members, especially in light of the UHH start-up difficulties in appropriately paying claims. As a result, NHC thus overpaid in capitation payments to WellHealth that, by reason of the claims backlog, WellHealth was not obliged to later make good to providers and health plan members.

In my experience, there are two ways to handle such a capitated arrangement. The first is for all of the capitated network's claims to be sent directly to that network, in this case WellHealth, for payment. In some instances, a health plan, for a variety of reasons, may elect to pay some claims for these network providers and then deduct the amount of claims

[155] Email exchange among UHH, Eldorado, and NHC, PLAINTIFF 01462404-405.

paid from the network's capitated payment. UHH paid the claims it received, but failed to instruct NHC to deduct these amounts from WellHealth's capitation payment, resulting in significant duplicate payments[156]. By paying claims for which WellHealth was financially responsible, UHH was duplicating the administrative costs included in the WellHealth capitated agreement. I have seen no evidence that UHH or NHC attempted to reconcile UHH's erroneous payments made to WellHealth physicians. Such payments were the financial responsibility of WellHealth.

During this first critical year of operation, Javelina was generally unresponsive to UHH, and claims issues continued to surface with the authorization processes. In an email exchange between UHH and Eldorado,[157] UHH advised, "[W]e believe the problem around authorizations is one of a system defect or at least of reasonable functionality to support auto adjudication and Fund's and COOP's business needs. UHH was lead [sic] to believe when we engaged with Eldorado that the processes associated with authorizations and referrals was robust and would enhance auto adjudication to meet our business needs. As you know this has proven not to be the case with the COOP experiment…" On the topic of accumulators failing, in June, 2014 UHH advised Eldorado[158] that "accumulator rebuilds still not functioning correctly. Can find no reason for accounts being out of balance, so not moving forward with accumulator rebuilds. Re overpayment, UHH has not pursued collection due to legal counsel concerns." As late as September 1, 2015, UHH was reporting[159] that accumulators still an issue, which is critical…Claims are being processed incorrectly and this is going to result in another year that we have to calculate manually and issue checks to members for reimbursement. As a result of UHH's and Eldorado/Javelina's failures, it is my opinion that NHC members, NHC providers and NHC itself all suffered from increased member payments for services, delays in paying providers for services rendered

[156] See Part VI: Summary of Damages, #3 Damages for Duplicate Claims Payments
[157] Email from Michael Gulling to Tim Kneuss on October 30, 2014, PLAINTIFF 01460944-945.
[158] CO-OP Touchpoint Call Agenda, July 28, 2014, PLAINTIFF 00010229.
[159] Email chain regarding NHC/ECI Bi-Weekly Ticket Review, PLAINTIFF 01449869-882.

to NHC members, incorrect payments made to providers, overpayments made to providers, and duplicate payments made to providers.

UHH's failure to properly meet the requirements of the January 30,2013 Consulting Agreement[160] and the June 27, 2013 Administrative Services Agreement[161] and, importantly, the failure of UHH to maintain the integrity of the data residing in the Javelina system and to pay claims in a timely and correct manner caused NHC to miss multiple critical deadlines for submission of claims and financial data to the CMS, Nevada DOI, and others. These failures caused NHC significant harm[162], as failing to provide accurate, timely claims data to CMS negatively affected NHC's ability to collect large federal risk reimbursement payments and distorted the financial information reported to the Board of Directors and regulators.

As stated above, UHH had the obligation to deliver a fully functional system to support NHC business.[163] Because the functionality of the Javelina system was missing so many required functions and was unable to perform as needed to support NHC's business, NHC was required to contract with multiple third parties to extensively interface with Javelina in order provide required functionality, including InsureMonkey, Authorize.net and others. This integration was an inefficient, complex process and failed to cure the deficiencies.

Beginning in August of 2014 there were documented discussions[164] of UHH Aurora bailing on its claims processing responsibilities and transferring processing to NHC in Las Vegas. It appears that UHH's plan was to transition most claims to Las Vegas by June 2015 and to complete the full transition by January 2016. Concurrent with these conversations, NHC

[160] Consulting Agreement between Unite Here Health and Hospitality Health, Ltd. Dated as of January 30, 2013 to be effective as of May 17, 2012, UHH 0000041-065.
[161] NHC – UHH Administrative Services Agreement as of June 27, 2013, PLAINTIFF 00451638-667.
[162] See Part VI: Summary of Damages, #7 Damages for Loss of Federal Receivables
[163] Administrative Services Agreement, dated June 27, 2013, Exhibit A Schedule of Administrative Services, Item 7, UHH 0000006-033
[164] Gearhart notes from an October 29, 2014 meeting in Las Vegas, UHH 0367535-536; Gearhart handwritten notes of November 11, 2014, UHH 0368245-377 at UHH 0368349.

management, a related party, agreed to take over all interest in the Eldorado agreement which UHH dumped on NHC.[165]

Insure Monkey

Insure Monkey ("IM") described itself as a diversified provider of brokerage, agency, customer service, software development, and enrollment data processing services. IM was contracted by NHC on April 17, 2013[166] to assist NHC "develop online technology applications for individual and small group enrollment into Consumer Oriented and Operated Plan (COOP) sponsored health benefit plans and help meet NVHC goals for membership both on and off the Silver State Insurance Exchange." The specific "Scope of Work" required IM to "deliver an online shopping and enrollment solution … Software will include all code for the consumer facing user interface, individual enrollment, small group enrollment (employer and employee), broker/navigator management, and external systems integrations through web services." NHC further engaged with InsureMonkey in August of 2013[167] to "provide to NHC a private labeled contact center for consumer and small group enrollment" during the initial open enrollment period from October 1, 2013 – March 31, 2014. The scope included "three primary components, People, Process and Technology."

NHC and IM subsequently incorporated these memorandums of understanding into a Master Services Agreement ("MSA"), dated August 1, 2014 and added two separate Statements of Work. The first of these Statements[168] pledged IM to "provide technical and software engineering services" for the purpose of "supporting certain software systems and technology development and infrastructure … supporting NHC enrollment, customer service

[165] Assignment and Assumption Agreement effective March 1, 2015, PLAINTIFF 00051045-048.
[166] Memorandum of Understanding between NHC and IM, dated April 17, 2013, PLAINTIFF00274020 – PLAINITIFF00274026.
[167] Memorandum of Understanding between NHC and IM dated August 1, 2013, PLAINTIFF 00000776.
[168] Statement of Work #1 between NHC and IM dated August 1, 2014, PLAINTIFF00000813 – PLAINTIFF00000816.

and member services software." In effect, IM had become NHC's in house IT expert to manage required system integration processes.

The second Statement of Work[169] obligated IM to support NHC's customer service function by "provid[ing] staff, operate and manage the Call Center," including enrollment services, member and provider services, any offsite services, and marketing.

In a third memorandum of understanding,[170] IM agreed to "develop a comprehensive model of member services that addresses all aspects of stakeholder management." IM promised to "leverage its systems and its ability to drive workflows while capturing valuable member data and then transforming that data into progress personalized member specific outreaches."

NHC, which had insufficient technology expertise on its own staff, would increasingly come to rely on IM as its technology arm. IM lacked the capabilities to appropriately perform its duties, being unable to properly address the specific technology issues and problems that surfaced during NHC's operational launch and which continued well into 2015, Some examples of the issues with IM that surfaced are:

1. Modifications to customer enrollment data are not currently possible in IM's system and changes generate a new 834 (enrollment record) which must be caught by hand or it will overwrite member's enrollment[171]
2. System posting more money than batched. Multiple 820 (payment record) files combined. Huge reconciliation effort necessary.[172]
3. 834s and 820s from IM not being imported into Javelina[173]

[169] Statement of Work #2 between NHC and IM dated August 1, 2014, PLAINTIFF00000817 – PLAINTIFF00000819..
[170] Memorandum of Understanding between NHC and IM dated September 3, 2013, PLAINTIFF 00000790-794.
[171] Email exchanges between IM and NHC of February 11, 2014, IM_Rivlin_000391981-982.
[172] Email exchanges between NHC, IM and Eldorado on February 21, 2014, PLAINTIFF 02424641-647.
[173] Email exchange between IM and Eldorado dated May 14, 2014, IM_Rivlin_000624586-588.

4. Insured and dependent information not properly maintained and integrated; IM staff inappropriately made changes to member records[174]
5. Significant customer service problems continued well into 2015[175]
6. Significant problems with premium billing and reconciliation – member claims inappropriately denied as "not eligible" even though payment has been made[176]
7. Enrollment issues including inappropriate terminations continued at least through mid-2015[177]
8. Payment and billing reconciliation issues identified approximately 2,300 – 4,000 federal subsidy members that were active in Javelina but had not been billed to CMS for subsidy payments; "problem may have existed for many months[178]
9. Failing to implement an interface between the State Exchange and Javelina to support eligibility determinations.

As a result of IM's failures and its inability to perform its services, NHC paid claims to individuals who were not eligible at the time of service[179], IM failed to fulfill its responsibilities to provide required technical and operational services, and failed to properly capture and track NHC's actual enrollment and payment receipts. In my opinion NHC was dependent and relied extensively on IM to provide a broad range of technical services, but IM was negligent in carrying out its contractual obligations to NHC and failed to disclose to NHC that it did not have the capabilities to perform its contracted services. NHC still did not have an integrated technology solution on which it could rely to support its business needs.

[174]Email exchanges between Laura Miglietti and Mark Jolley and others from January 8, 2015 – January 15, 2015, PLAINTIFF 00003833-835..
[175] Email exchange between Shellye Wimber of IM and Lisa Simmons *et al*., dated January 22, 2015, PLAINTIFF 00003852-855.
[176] Email exchange between Pam Egan and Mark Jolley *et al*., dated November 5, 2014, PLAINTIFF 00002908-910., .
[177] Email chain regarding Termed Members, PLAINTIFF 00004028-031.
[178] Email exchanges between Basil Dibsie, Amanda Weitzel and others from May 28,2015- June 6, 2015, PLAINTIFF 00004044-051.
[179] See Part 6 of Summary of Damages

Nevada Health Solutions, LLC

Further evidence of the management conflict of interest between NHC and UHH, and its related entities, may be found in the utilization management services arrangement between NHC and Nevada Health Solutions ("NHS"), a wholly owned subsidiary of UHH. The NHC – NHS agreement[180], submitted to and approved by CMS as required in the program requirements[181], outlined the scope of services NHS was to provide on behalf of NHC[182]. Exhibit A of this agreement summarized the services to be provided by NHS and establishes the fee to be paid by NHC. Exhibit B contains a detailed delegated services grid that lists the specific activities to be performed by NHS.

Following CMS' review and approval, NHC and NHS materially modified the agreement via an amendment[183] that substantially limited NHS' scope and eliminated key functional responsibilities, such as precertification of hospital admissions and precertification of outpatient procedures. This amendment also modified Exhibit A and deleted Exhibit B. The base agreement was further modified by a second amendment[184] that eliminated NHS responsibility to provide "Transitional Care Services". These changes to the base agreement, that were significantly detrimental to NHC, were never submitted to CMS for review and approval contrary to the requirements of CMS policy requirements, were not industry standard, and deprived NHC of important utilization review savings for health care claims.

[180] Utilization Management Services Agreement of July 19, 2013, (NHS0000001 – NHS0000100)
[181] CMS Core Contract and Business Plan Modification Guidelines, 11/14/2012, 18579-0000854407, PLAINTIFF02476757 - PLAINTIFF02476758
[182] Utilization Management Services Agreement of July 19, 2013, Section I, Scope of Services, Subsections 1.1 through 1.13, (NHS0000001 – NHS0000100)
[183] First Amendment to Utilization Management Services Agreement, 11/20/2013, PLAINTIFF02499134 – PLAINTIFF02499136
[184] Second Amendment to Utilization Management Services Agreement, 9/3/14, PLAINTIFF00562503 – PLAINTIFF00562512

Part VI: SUMMARY OF DAMAGES

In my opinion, NHC suffered significant economic damages due to the Management Defendants', UHH's and IM's failure to perform its duties in accordance with applicable professional and industry standards in serving as NHC's Third Party Administrator. In the Summary of Opinions in Part II of this Expert Report and throughout this report I recite why I hold these beliefs. Based on my analysis of the expert report of Mr. Mark Fish dated February 7, 2020 the following damages were suffered by NHC as a result of the actions of the Management Defendants, UHH and InsureMonkey. Damage amounts were obtained from the expert report of Mark Fish.

a. Damages Due to Premature and Ill Prepared Commencement of Operations

NHC entered into a consulting agreement and Third-Party Administrator (TPA) agreement with UHH. NHC further entered into a number of contractual agreements with InsureMonkey (IM) to provide information technology, enrollment, customer service and other support of NHC's participation on Nevada's State Health Insurance Exchange (HIE).

Due to the actions and failures of the Management Defendants, UHH and IM, NHC was not prepared to sell policies or commence operations on the initial open enrollment date of October 1, 2013. As a result, NHC suffered damages that could have been avoided were it not for the actions and failures of the Management Defendants, UHH and IM.

Based on Mr. Fish's calculations there were $142.4 million in damages as a result of NHC's premature and ill prepared commencement of operations.

b. Damages Due to Failure of Duties Performed by Unite Here Health and InsureMonkey, including Failure of Duties by NHC Management

Unite Here Heath, InsureMonkey and the Management Defendants failed in their contractual, professional and other duties as detailed herein resulting in substantial damages to NHC as outlined below:

1. Damages for Claims Paid Outside of Eligibility: $9,343,351.85

   UHH paid claims for members who were not eligible on the Health Insurance Exchange (HIE) due to the inability to correctly reconcile enrollment information, totaling $5,593,327.73 in 2014. Further, UHH erroneously paid medical and prescription drug claims payments to ineligible members totaling $3,750,024.12 in 2015, which was again caused by the failure to properly maintain and track NHC enrollment files or properly reconcile membership enrollment with the HIE. UHH failed to properly set up an adequate data processing and information technology system for NHC before and after its operations commenced in 2014, which led to claims being paid outside of enrollment and enrollment information not being properly tracked. UHH is responsible for the aforementioned claims paid outside of enrollment for years 2014 and 2015.

   Additionally, InsureMonkey contracted to provide external systems interfaces for NHC, including those necessary to support NHC's enrollment requirements and integration of the State Exchange[185]. InsureMonkey failed to provide a working interface with the State Exchange enrollment system during 2014 which caused failures and corruption of enrollment information. InsureMonkey also contracted to provide the billing and related services for NHC during 2015 and failed to create an adequate system for billing collection and eligibility determination in 2015. These failures and corrupt information in turn led to payment of claims outside of eligibility for 2014 and 2015. As a result, InsureMonkey was also responsible for the claims paid outside of eligibility during 2014 and 2015.

2. Damages for Provider Claims Overpayments: $1,163,851.67

   $1,163,851.67 remains uncollected by NHC in medical expenses overpaid by UHH in 2014 and 2015, such overpayments having been made for several reasons: the incorrect calculation of claim allowable, processing under the wrong network, payment outside the terms of medical authorization, payment under incorrect procedure coding, payment under

[185] See Master Services Agreement and Statement of Work #1 at Plaintiff 00002930-2972

incorrect policy terms, redundant claims processing, and miscellaneous claims processing errors involving manual miss-keying of claims data.

3. Damages for Duplicate Claims Payments: $133,888.94

   UHH made duplicate claims payments to providers who were covered under the capitation arrangement with WellHealth, totaling $133,888.94 in 2014.

4. Damages for Loss of Federal Receivables: $6,175,483.44

   NHC lost Federal Receivables in the amount of $6,175,483 as a result of UHH's failure to adjudicate NHC's claims on an accurate and timely basis.

5. Damages for Payments Made to UHH: $7,686,381.50

   UHH was unjustly enriched as UHH failed in its duties as NHC' third-party administrator and NHC made payments to UHH totaling $7,686,381.50 during the time UHH served as its administrator.

6. Damages for Uncollected Premiums from the Nevada State HIE: $510,651.27

   UHH is responsible for under collected premium payments from the HIE totaling $510,651.27 in 2014 by not setting up proper data systems to maintain and track NHC enrollment files, including no setup of a proper data system for the reconciliation of membership enrollment with the HIE.

7. Damages for Payments Made to IM: $11,970,661

   IM was unjustly enriched as IM failed in its duties under the contracts with NHC and NHC made payments to IM totaling $11,970,661.

Based on the failures listed immediately above, there were $51.4 million in the above damages, including $14.4 million in interest, due from July 1, 2015 to October 31, 2020.[186]

[186] See Expert Report of Mark Fish dated February 7, 2020.

1. Exhibit 1 – Curriculum Vita

HENRY W. OSOWSKI
MANAGING PARTNER
STRATEGIC HEALTH GROUP, LLC

3500 West Olive Avenue
Suite 300
Burbank, CA 91505
Telephone: 818-279-2196

Experience

April 2011 – Present
Strategic Health Group LLC
I am a Co-Founding Member and Managing Partner of Strategic Health Group a boutique consulting organization created to provide strategic, financial and operational services to commercial, Medicare and Medicaid health plans and health systems. During this period, I have led several engagements for the firm's clients on strategic and operational challenges of Medicare Advantage traditional and special needs plans, Dual Integrated Care programs, Medicaid (Medi-Cal in California) plans and commercial plans. The Firm's clients include health plans and health systems in California, Wisconsin, Florida, Texas, Michigan, Illinois, New Mexico and Hawaii. Included among my successful client engagements have been more than nine client plan licensing and development undertakings for commercial, Medicare Advantage and Medicaid business startups in multiple states.

June 2004 – April 2011
SCAN Health Plan/SCAN Group
During this period, I served as the Senior Vice President of Corporate Development for SCAN Health Plan. I was a key member of the senior leadership team that turned the company around from a "near death experience" into an exceptionally strong financial position and one of the largest nonprofit Medicare Advantage plans in the country. Through my leadership, I led SCAN's expansion into seven additional California counties, adding more than 40,000 new enrollees to SCAN. I also led SCAN's first out-of-state expansion into Arizona where I then served as President of SCAN Health Plan Arizona and SCAN Long Term Care, a Medicaid contractor for the Arizona Long Term Care System (ALTCS). I also co-led the organization's strategic planning efforts and initiated an innovation development regimen to seek improvements in care coordination practices and future care outcome protocols.

February 1990 – June 2004
Osowski & Associates
I created a specialized health care consulting organization to provide a range of strategic, financial and development services for health plans, physician groups and health systems. My clients included Medicare Advantage, Medicaid and commercial health plans in California, Michigan, Illinois, Texas and Florida and a major U.S technology company.

September 1987 – February 1990
Blue Cross of California
I began my California career as a member of the senior management team responsible for the turnaround and financial survival of Blue Cross of California. In my tenure with Blue Cross, I served as Vice President Finance for the Individual and Small Group Division, as well as Vice President of Strategic Planning.

July 1985 – September 1987
I served as Vice President International Operations for American Family Life Assurance Corporation where I directed the development of start-up operations in the United Kingdom, Germany and Italy. I also had responsibility for directing the financial turnaround of the company's Canadian operations.

March 1980 – July 1985
I served in a variety of consulting positions, first with Coopers & Lybrand as Director of Insurance Consulting Services and later as an individual and sub-contractor to established firms including Towers Perrin.

September 1968 – March 1980
I served in a variety of positions with progressive responsibility with the Kemper Insurance Companies, beginning my career as a Claims Examiner with a full line of property and casualty insurance products, a Claims trainer, an Operations Improvement analyst and Director of Consumer Affairs.

Speaking and Author Activities
I am a frequent featured speaker on Medicare Advantage strategy topics, including market entry development and growth strategies, care integration for Dual Eligible Beneficiaries, acute care and behavioral health care integration, and the strategic implications of changing Administration and Congressional priorities.
Specific speaking engagements have included:

- Medicare Market Innovations conference (2012, 2013, 2014, 2015, 2016, 2017 and 2018)
- Medicaid Innovations Forum (2013, 2014, 2015, 2016, 2017, 2018 and 2019)
- Health Plan Alliance Annual Government Program Conference (2014) and webinar (2015)

- Health Education Associates Behavioral Health Integration Conference (2014, 2015 and 2016)
- Health Education Associates Medicare Marketing and Sales Conference (2015, 2017 and 2019)
- CalNet annual behavioral health provider planning session (2014 and 2015)
- Managed Care On-Line (MCOL) Medicare Advantage landscape and opportunities, webinar (2016)

I have authored or co-authored several articles on health plan development for health systems and Medicare Advantage strategies. I have also been a quoted source of expertise for publications. These include:

- *"Disruption: The Healthcare Sectors Constant Companion,"* Payers & Providers, March 7, 2019
- *"Insurers on a Shopping Spree for All Sorts of Providers,"* Managed Care Magazine, November 20, 2018
- *"As the Baby Boom Generation Ages What Do You Do,"* Healthcare Marketing Report, August 21, 2018
- *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

Prior Expert Witness Activity

I have been an expert witness on two prior occasions. First, in a matter related to a dispute regarding the contract terms of a strategic agreement involving the participation of the parties in competing managed care networks, especially for Medicare Advantage plan partners in a highly competitive Southern California market. I prepared and submitted my declaration, but was not required to testify.

The second expert witness case was a breach of contract dispute before an arbitration panel relative to a health plan start-up and operation between the leading U.S. provider of administrative, clinical and information technology services to health plans and provider organizations and a major California health system. I testified on behalf of the service provider relative to the licensing and operational launch of a start-up health plan. The service provider prevailed in this matter.

Education

I received an Associate of Arts degree from Mount Wachusett Community College in Gardner, Massachusetts in 1967, and I attended Massachusetts State College at Salem, studying History and Political Science

Exhibit 2 – Documents Relied Upon

1. Administrative Services Agreement 18579-0000235528, PLAINTIFF00451633
2. Consulting Agreement UHH 0000041-065
3. CMS Performance Requirements and Service Level Standards 18579-0000503638, PLANTIFF02499119 thru PLANTIFF02499120
4. Odenweller email to Plum re: Performance Standards UHH0406764
5. Sample NHC Ethics and Conflict of Interest Policy (Kathy Silver signed), PLAINTIFF00562503 – PLAINTIFF00562512
6. Nevada Revised Statutes 689B.255 and 695B.2505
7. PWC Performance Audit of NHC Plaintiff 00350824-830, Plaintiff,00608185-213 and Plaintiff00452861-869
8. Zumtobel communications re "Related Party"18579-0000872749, PLAINTIFF02476740 - PLAINTIFF02476741
9. Zumtobel response to Ms. Terry Tanchica's evaluation of ASA 18579-0000860496, PLAINTIFF02476747 - PLAINTIFF02476749
10. Claims System discussion: Odenweller 5/15/12 email UHH 0367499 and unattributed evaluation summary UHH 0367471-72
11. Landahl email to Bond re ASA provisions 18579-0000277029, PLAINTIFF02476716 - PLAINTIFF02476717
12. Email chain among Cara Elias, Tom Tom Zumtobel & Bobbette Bond re: ASA negotiation 18579-0000295733.0001-0019, PLAINTIFF02476718 - PLAINTIFF02476736
13. Bond email to Elias 6/17/13 re ASA negotiation Plaintiff 02424600-03
14. Email chain bond, Donahue & Landahl 6/24/13 18579-0000276194, PLAINTIFF02476737 – PLAINITFF02476739
15. Donahue letter to independent directors 9/5/13 Plaintiff 003634
16. Terry email & performance standards 18579-0000854407_0008, PLAINTIFF02476932 - PLAINTIFF02476933
17. Terry email re CMS/Navigant ASA review 18579-0000860496, PLAINTIFF02476747 - PLAINTIFF02476749
18. Terry email re CMS cont5act review 1875-0000854407, PLAINTIFF02476757 - PLAINTIFF02476758
19. Email chain re TPA licensure UHH 0292549-551
20. Odenweller/Zumtobel emails, UHH0367500
21. Gulling email to Kneuss (Eldorado) Plaintiff 01460944
22. Trizetto Architecture Diagram Plaintiff 01321048
23. NVDOI Rich to Zumtobel 9/18/13 18579-0000292025, PLAINTIFF02476754 - PLAINTIFF02476754
24. Zumtobel to Terry 10/25/13 Plaintiff01459476
25. Zumtobel Rich NV DOI 11/12/13 Plaintiff 00899492
26. Landahl to Bond re TPA Licensure 18777-0000028969, PLAINTIFF02476712 - PLAINTIFF02476714
27. Ackridge to Bond re TPA Licensure 18579-0000288728, PLAINTIFF02476715 - PLAINTIFF02476715

28. Emails from Whitehead to Zumtobel et al Plaintiff 10461922
29. Memo from Whitehead to Zumtobel & Bond Plaintiff 10461943
30. Email from Ackridge to Bond 5/6/13 X0000288720, PLAINTIFF00620410 - PLAINTIFF00620411
31. Emails Landahl and Bond 5/6/13 18777-0000028969, PLAINTIFF02476712 - PLAINTIFF02476714
32. Email Zumtobel to Terry 9/13/13 Plaintiff 01461927
33. Emails between Gearhart & Plum 18579-0000450983, PLAINTIFF01461817 - PLAINTIFF01461819
34. NHC-Odenweller Independent Contractor Agreement Plaintiff 01460377
35. Odenweller – Gearhart emails 8/25/16 Plaintiff 01461896
36. CMS-NHC Loan Agreement Plaintiff 00171787-868
37. Excerpts – Deposition Kathleen Silver, 12/18/18
38. Email exchanges Jolley-Weitzel-Dibsie et al 18579-0000192237, PLAINTIFF00004044 – PLAINTIFF00004051
39. Plum emails 6/11/15 Plaintiff 02476903
40. Dibsie-Weitzel email exchange, 6/18-23/15, Plaintiff 00004042
41. NHC Board meeting minutes January 22,2014, Plaintiff 01456863
42. NHC Board meeting minutes February 19,2014 Plaintiff 01456868
43. NCH Board meeting minutes March 25,2014 Plaintiff 01456783
44. Excerpts from deposition of Kathleen Silver, December 18,2018
45. Executive Service Agreement Thomas Zumtobel, UHH 0000090
46. Executive Service Agreement Bobbette Bond, UHH 0000076
47. Email Chain Kneuss, Simons, et al EDI listing, Plaintiff 00053364-75
48. Email exchange Dibsie-Odenweller, Plaintiff 00522353-57
49. Gearhart notes 10/24/2013 IT UM/UR meeting, UHH 0367172
50. Javelina User Group Agenda, 11/7/2013, UHH 0368126
51. Gearhart notes 1/29/2014 Eldorado/Javelina issues, UHH 0368336
52. Gearhart Notes 1/30/2014 Call w/Eldorado, UHH 40368122
53. Gearhart Notes 2/4/2014 Eldorado Status Meeting, UHH 0368340
54. Email Gulling to Zumtobel, 3/25/2014 – 4/9/2014, UHH01337560-64
55. R. Plum meeting notes 3/4/14, Plaintiff 00003911-12
56. Email Chain re Emergency Room Benefits, Plaintiff 01461820-24
57. Email Gulling to Plum re OOP adjustments, Plaintiff 02476804
58. Email Chain Flora, Egan & Gearhart, Plaintiff 01451494
59. Emails Plum to Gearhart 7/29/2014, Plaintiff 01461831-34
60. Email Gearhart to Plumb 6/1/2014, Plaintiff 02476805-06
61. Monthly Roll-up NHC Claims Inventory 4/14 – 8/15
62. Emails Gearhart, & Jolley et al. Plaintiff 01074037-48
63. NHC Board meeting minutes 6/24/2014, Plaintiff 01457023-28
64. Emails Gearhart to Odenweller & Gulling, 8/25/14, Plaintiff 01461896
65. Gearhart notes 11/6/13 and 12/9/13, UHH 0368245-377 at UHH0368316 and also UHH0367963
66. Email 3/6/14 Gearhart to Hall, Plaintiff 01474446

67. Emails Plum, to Grimm et al, 2/3/15 – 2/4/15, Plaintiff 01462404
68. Excerpts from Utilization Management Services Agreement,7/19/2013
69. First Amendment to Utilization Management Services Agreement 11/20/13, PLAINTIFF02499134 – PLAINTIFF02499136.
70. Second Amendment to Utilization Management Service Agreement 9/3/14, PLAINTIFF00000924 – PLANTIFF00000925
71. CMS Core Contract & Business Plan Modification Guidelines, 18579-000085440 PLAINTIFF02476757 - PLAINTIFF024767587
72. Excel spreadsheet with NHC benefit plan summaries for 2014 benefit offerings 18579-0001835241, PLANTIFF02499132 - PLANTIFF02499133
73. Expert Report of Mark A. Fish, F.S.A., M.A.A.A., dated February 7, 2020
74. All documents disclosed in the Expert Report of Mr. Henry Osowski, dated July 30, 2019

Reception

From: efilingmail@tylerhost.net
Sent: Monday, October 19, 2020 4:29 PM
To: BKfederaldownloads
Subject: Notification of Service for Case: A-17-760558-B, Nevada Commissioner of Insurance, Plaintiff(s)vs.Milliman Inc, Defendant(s) for filing Appendix - APEN (CIV), Envelope Number: 6799623

Notification of Service

Case Number: A-17-760558-B
Case Style: Nevada Commissioner of Insurance, Plaintiff(s)vs.Milliman Inc, Defendant(s)
Envelope Number: 6799623

This is a notification of service for the filing listed. Please click the link below to retrieve the submitted document.

Filing Details	
Case Number	A-17-760558-B
Case Style	Nevada Commissioner of Insurance, Plaintiff(s)vs.Milliman Inc, Defendant(s)
Date/Time Submitted	10/19/2020 4:25 PM PST
Filing Type	Appendix - APEN (CIV)
Filing Description	Appendix of Exhibits to Defendants Unite Here Health and Nevada Health Solutions, LLC's Motion to Consolidate Case No. A-20-816161-C
Filed By	Sharon Murnane
Service Contacts	Nevada Commissioner of Insurance: Eric Swanis (swanise@gtlaw.com) Andrea Rosehill (rosehilla@gtlaw.com) Mark Ferrario (ferrariom@gtlaw.com) Megan Sheffield (sheffieldm@gtlaw.com) Cynthia Ney (neyc@gtlaw.com) Donald Prunty (pruntyd@gtlaw.com) LVGT docketing (lvlitdock@gtlaw.com)

	Jason Hicks (hicksja@gtlaw.com) Kimberly Frederick (frederickk@gtlaw.com) Evelyn Gaddi (escobargaddie@gtlaw.com) Christian Spaulding (spauldingc@gtlaw.com) Shermielynn Irasga (irasgas@gtlaw.com) Milliman Inc: Patrick Byrne (pbyrne@swlaw.com) Jeanne Forrest (jforrest@swlaw.com) Alex Fugazzi (afugazzi@swlaw.com) Docket Docket (docket_las@swlaw.com) Aleem Dhalla (adhalla@swlaw.com) Justin Kattan (justin.kattan@dentons.com) D'Andrea Dunn (ddunn@swlaw.com) Taylor Higgins (thiggins@swlaw.com) Larson & Company PC: Mursal Nyazi (nyazi@mmrs-law.com) Martha Hayes: Lori Siderman (siderman@mmrs-law.com) Russell Brown (brown@mmrs-law.com) InsureMonkey Inc: Matthew Pruitt (mpruitt@alversontaylor.com)

	Copy Room (efile@alversontaylor.com) Kurt Bonds (kbonds@alversontaylor.com) Brian Blankenship (brian@nvfirm.com) Anthony MacKenzie (mackenzie@nvfirm.com) Alex Rivlin: Brian Blankenship (brian@nvfirm.com) Anthony MacKenzie (mackenzie@nvfirm.com) Nevada Health Solutions LLC: John Bailey (jbailey@baileykennedy.com) Bailey Kennedy, LLP (bkfederaldownloads@baileykennedy.com) Suzanna Bonham (SBonham@seyfarth.com) Emma Mata (EMata@seyfarth.com) Joseph Liebman (jliebman@baileykennedy.com) Other Service Contacts not associated with a party on the case: Susana Nutt (snutt@lipsonneilson.com) Angela Nakamura Ochoa (aochoa@lipsonneilson.com) Ann Fukushima (fukushima@mmrs-law.com) Jonathan Wong (jwong@lipsonneilson.com) Monice Campbell (monice@envision.legal) Juan Cerezo (jcerezo@lipsonneilson.com) Darnell Lynch (dlynch@lipsonneilson.com) Denise Doyle (service@cb-firm.com)

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TAB 5

TAB 5

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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 RECEIVER FOR NEVADA HEALTH CO-OP,

Plaintiff,

-vs-

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

Defendants.

CASE NO.: A-17-760558-B
DEPT. NO.: XVI

HEARING DATE(S) ENTERED IN ODYSSEY

5TH AMENDED ORDER SETTING CIVIL JURY TRIAL, PRE-TRIAL, CALENDAR CALL, AND DEADLINES FOR MOTIONS; AMENDED DISCOVERY SCHEDULING ORDER

TIMOTHY C. WILLIAMS
DISTRICT JUDGE

DEPARTMENT SIXTEEN
LAS VEGAS NV 89155

Case Number: A-17-760558-B

Pursuant to the Status Check held on January 14, 2021, the Discovery Deadlines and Trial dates are hereby amended as follows:

IT IS HEREBY ORDERED that the parties will comply with the following deadlines:

Plaintiff's designation of rebuttal experts	**April 16, 2021**
Defendants' designation of rebuttal experts against Co-Defendants	**April 16, 2021**
Motions to amend pleadings or add parties	C**LOSED**
Discovery Cut Off	**December 31, 2021**
Dispositive Motions	**February 18, 2022**
Motions in Limine	**March 4, 2022**

IT IS HEREBY ORDERED THAT:

A. The above entitled case is set to be tried to a jury on a **five week stack** to begin **May 16, 2022 at 9:30 a.m.**

B. Pre-Trial Conference/Calendar Call will be held on **April 28, 2022 at 10:30 a.m.**

C. A Status Check re Trial Readiness is set for **February 2, 2022** at **9:00 a.m.**

D. The Pre-Trial Memorandum must be filed no later than **May 12, 2022,** with a courtesy copy delivered to Department XVI. All parties, (Attorneys and parties in proper person) **MUST** comply with **All REQUIREMENTS** of EDCR 2.67, 2.68 and 2.69. Counsel should include in the Memorandum an identification of orders on all motions in limine or motions for partial summary judgment previously made, a summary of any anticipated legal issues remaining, a brief summary of the opinions to be offered by any witness to be called to offer opinion testimony as well as any objections to the opinion testimony.

E. All motions in limine must be in writing and filed no later than **March 4, 2022. Orders shortening time will not be signed except in <u>extreme emergencies</u>**.

F. All original depositions anticipated to be used in any manner during the trial must be delivered to the clerk prior to the firm trial date given at Calendar Call. If deposition testimony is anticipated to be used in lieu of live testimony, a designation (by page/line citation) of the portions of the testimony to be offered must be filed and served by facsimile or hand, two (2) judicial days prior to the firm trial date given at Calendar Call. Any objections or counter-designations (by page/line citation) of testimony must be filed and served by facsimile or hand, one (1) judicial day prior to the firm trial date given at Calendar Call. Counsel shall advise the clerk prior to publication.

G. In accordance with EDCR 2.67, counsel shall meet, review, and discuss exhibits. All exhibits must comply with EDCR 2.27. Two (2) sets must be three-hole punched and placed in three ring binders along with the exhibit list. The sets must be delivered to the clerk two days prior to the firm trial setting (given at Pre-Trial/Calendar Call). Any demonstrative exhibits including exemplars anticipated to be used must be disclosed prior to the calendar call. Pursuant to EDCR 2.68, counsel shall be prepared to stipulate or make specific objections to individual proposed exhibits. Unless otherwise agreed to by the parties, demonstrative exhibits are marked for identification but not admitted into evidence.

H. In accordance with EDCR 2.67, counsel shall meet, review, and discuss items to be included in the Jury Notebook. Pursuant to EDCR 2.68, counsel shall be prepared to stipulate or make specific objections to items to be included in the Jury Notebook.

I. In accordance with EDCR 2.67, counsel shall meet and discuss pre-instructions to the jury, jury instructions, special interrogatories, if requested, and verdict forms. Each side shall provide the Court, prior to the firm trial date given at Calendar Call., an agreed set of jury

TIMOTHY C. WILLIAMS
DISTRICT JUDGE

DEPARTMENT SIXTEEN
LAS VEGAS NV 89155

instructions and proposed form of verdict along with any additional proposed jury instructions with an electronic copy in Word format.

Failure of the designated trial attorney or any party appearing in proper person to appear for any court appearances or to comply with this Order shall result in any of the following: (1) dismissal of the action (2) default judgment; (3) monetary sanctions; (4) vacation of trial date; and/or any other appropriate remedy or sanction.

Counsel is asked to notify the Court Reporter at least two (2) weeks in advance if they are going to require daily copies of the transcripts of this trial or real time court reporting. Failure to do so may result in a delay in the production of the transcripts or the availability of real time court reporting.

Counsel must advise the Court immediately when the case settles or is otherwise resolved prior to trial. A Stipulation which terminates a case by dismissal shall also indicate whether a Scheduling Order has been filed and if a trial date has been set, and the date of that trial. A copy should be given to Chambers.

DATED this 14th day of January, 2021.

TIMOTHY C. WILLIAMS
DISTRICT JUDGE

CERTIFICATE

I hereby certify that on or about the date filed, this document was e-served to all registered service contacts on Odyssey File & Serve for Case No. A760558.

/s/ Lynn Berkheimer
LYNN BERKHEIMER
Judicial Executive Assistant
Dept. No. XVI

Reception

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Subject: Notification of Service for Case: A-17-760558-B, Nevada Commissioner of Insurance, Plaintiff(s)vs.Milliman Inc, Defendant(s) for filing Amended Order Setting Jury Trial - ARJT (CIV), Envelope Number: 7235614

Notification of Service

Case Number: A-17-760558-B
Case Style: Nevada Commissioner of Insurance, Plaintiff(s)vs.Milliman Inc, Defendant(s)
Envelope Number: 7235614

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Filing Details	
Case Number	A-17-760558-B
Case Style	Nevada Commissioner of Insurance, Plaintiff(s)vs.Milliman Inc, Defendant(s)
Date/Time Submitted	1/14/2021 4:54 PM PST
Filing Type	Amended Order Setting Jury Trial - ARJT (CIV)
Filing Description	5 TH AMENDED ORDER SETTING CIVIL JURY TRIAL, PRE-TRIAL, CALENDAR CALL, AND DEADLINES FOR MOTIONS; AMENDED DISCOVERY SCHEDULING ORDER
Filed By	Lynn Berkheimer
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