Case No. _____

IN THE SUPREME COURT OF NEVADA

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Elizabeth A. Brown
Clerk of Supreme Court

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 TIMOTHY C. WILLIAMS, DISTRICT COURT JUDGE,

Respondent

- and –

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

Real Party in Interest.

District Court Case No. A-17-760558-B, Department XVI

APPENDIX TO PETITION FOR EXTRAORDINARY WRIT RELIEF
VOLUME 6 OF 11

JOHN R. BAILEY, Nevada Bar No. 0137
DENNIS L. KENNEDY, Nevada Bar No. 1462
SARAH E. HARMON, Nevada Bar No. 8106
JOSEPH A. LIEBMAN, Nevada Bar No. 10125

Docket 83135 Document 2021-18913

BAILEY❖KENNEDY
8984 Spanish Ridge Avenue
Las Vegas, Nevada 89148-1302
Telephone: 702.562.8820
Facsimile: 702.562.8821
JBailey@BaileyKennedy.com
DKennedy@BaileyKennedy.com
SHarmon@BaileyKennedy.com
JLiebman@BaileyKennedy.com

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

June 30, 2021

APPENDIX TO PETITION FOR EXTRAORDINARY WRIT RELIEF
VOLUME 6 OF 11

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TAB 26

EXHIBIT I

EXHIBIT I

A-15-725244-C

DISTRICT COURT CIVIL COVER SHEET

County, Nevada

I

Case No. .....
(Assigned by Clerk's Office)

I. Party Information *(provide both home and mailing addresses if different)*

Plaintiff(s) (name/address/phone):	Defendant(s) (name/address/phone):
State of Nevada, ex rel Commissioner of Insurance,i	Nevada Health CO-OP
in her Official Capacity as Statutory Receiver for	
Delinquent Domestic Insurer	
Attorney (name/address/phone):	**Attorney (name/address/phone):**
Joanna N. Grigoriev, SDAG	
Office of the Attorney General	
555 E. Washington Ave., #3900	
Las Vegas, NV 89101 702-486-3101	

II. Nature of Controversy *(please select the one most applicable filing type below)*

Civil Case Filing Types

Real Property	Torts	
Landlord/Tenant	**Negligence**	**Other Torts**
☐ Unlawful Detainer	☐ Auto	☐ Product Liability
☐ Other Landlord/Tenant	☐ Premises Liability	☐ Intentional Misconduct
Title to Property	☐ Other Negligence	☐ Employment Tort
☐ Judicial Foreclosure	**Malpractice**	☐ Insurance Tort
☐ Other Title to Property	☐ Medical/Dental	☐ Other Tort
Other Real Property	☐ Legal	
☐ Condemnation/Eminent Domain	☐ Accounting	
☐ Other Real Property	☐ Other Malpractice	

Probate	Construction Defect & Contract	Judicial Review/Appeal
Probate *(select case type and estate value)*	**Construction Defect**	**Judicial Review**
☐ Summary Administration	☐ Chapter 40	☐ Foreclosure Mediation Case
☐ General Administration	☐ Other Construction Defect	☐ Petition to Seal Records
☐ Special Administration	**Contract Case**	☐ Mental Competency
☐ Set Aside	☐ Uniform Commercial Code	**Nevada State Agency Appeal**
☐ Trust/Conservatorship	☐ Building and Construction	☐ Department of Motor Vehicle
☐ Other Probate	☐ Insurance Carrier	☐ Worker's Compensation
Estate Value	☐ Commercial Instrument	☐ Other Nevada State Agency
☐ Over $200,000	☐ Collection of Accounts	**Appeal Other**
☐ Between $100,000 and $200,000	☐ Employment Contract	☐ Appeal from Lower Court
☐ Under $100,000 or Unknown	☐ Other Contract	☐ Other Judicial Review/Appeal
☐ Under $2,500		

Civil Writ		Other Civil Filing
Civil Writ		**Other Civil Filing**
☐ Writ of Habeas Corpus	☐ Writ of Prohibition	☐ Compromise of Minor's Claim
☐ Writ of Mandamus	☐ Other Civil Writ	☐ Foreign Judgment
☐ Writ of Quo Warrant		☒ Other Civil Matters

Business Court filings should be filed using the Business Court civil coversheet.

09/25/2015
Date

Signature of initiating party or representative

See other side for family-related case filings.

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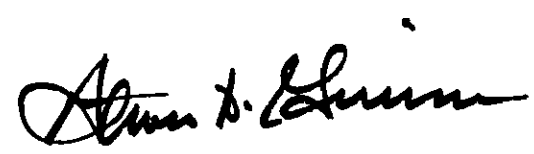

CLERK OF THE COURT

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

IN THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA

CLARK COUNTY, NEVADA

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

PETITION FOR APPOINTMENT OF COMMISSIONER AS RECEIVER AND OTHER PERMANENT RELIEF; REQUEST FOR TEMPORARY INJUNCTION PURSUANT TO NRS 696B.270(1)

COMES NOW Plaintiff State of Nevada, ex rel. Acting Commissioner of Insurance, Amy L. Parks ("Commissioner"), pursuant to Nevada Revised Statute ("NRS") 696B.250, and petitions this Honorable Court, which has original jurisdiction of delinquency proceedings pursuant to NRS 696B.190(1), to appoint the Commissioner as Receiver of the NEVADA HEALTH CO-OP ("CO-OP"), Company ID No. 119733 and NAIC ID No. 15132, for the purpose of conservation/rehabilitation and to grant permanent injunctive and other relief authorized by Chapter 696B of the NRS and other applicable law, in order to finally ascertain

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the CO-OP's true and current state of affairs, to conserve its assets, and protect the policyholders and public from the dangers inherent to the delinquency of this entity. To that end, it is respectfully requested that the Court issue an order directing the CO-OP to appear in Court on the day fixed in the order and show cause why the Petition should not be granted.

The Commissioner further respectfully requests that the Court issue the following interim orders for injunctive relief pending the show cause hearing and further orders by the Court, on the grounds set forth in this Petition and as permitted in NRS 696B.270(1):

1. Pursuant to NRS 696B.210(2), on the grounds that the insurer is in unsound condition, and pursuant to NRS 696B.210(14), on the grounds that the majority of its directors consented to conservation/rehabilitation, to appoint the Commissioner as Temporary Receiver pending further orders by the Court, to enter the business and immediately oversee the operation and conservation/ rehabilitation of the business.

2. Pursuant to NRS 696B.270, pending further orders by the Court, to immediately enjoin the CO-OP, the officers, directors, stockholders, members, subscribers, agents, employees, and all other persons from transacting any further business on behalf of the CO-OP unless otherwise directed by the Receiver, or from wasting or disposing of any assets or property of the CO-OP.

3. Pursuant to NRS 696B.340, pending further orders by the Court, to immediately enjoin any and all persons from the commencement or prosecution of any actions by or on behalf of the CO-OP, or against the CO-OP. Further, all persons should be restrained from obtaining any preferences, judgments, attachments, or other liens as to any property of the CO-OP, or making any levy against the CO-OP or against their assets or any part thereof.

4. Pursuant to NRS 696B.270, pending further orders by the Court, to enjoin all persons other than the Receiver, or as directed by the Receiver, from withdrawal of any funds from the CO-OP's accounts, or removal of other property from the CO-OP.

5. Authorizing the Commissioner as Temporary Receiver to impose such partial or full lien or moratoria on any disbursements for such time and under such terms as she deems necessary and appropriate for the protection of members and creditors, provided that such

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lien or moratoria shall apply in the same manner to all similarly situated persons and providing that under no circumstances shall the Receiver or her representatives be liable to any person for a good faith decision to impose, or refrain from imposing, such lien or moratorium.

6. Authorizing the Commissioner as Temporary Receiver to make such arrangements for the replacement or continuation of health care coverage provided by the CO-OP as she deems appropriate and in the interest of the CO-OP's members and to enter into such as agreements as she deems necessary for that purpose.

7. Authorizing the Commissioner as Temporary Receiver to appoint, without prior notice to or prior approval by the Court, such Special Deputy Receiver and consultants as she deems necessary for the conduct of the CO-OP's receivership; such Special Deputy Receiver thereby being vested with all the rights, duties, and authority of the Temporary Receiver subject to the supervision of the Commissioner as Temporary Receiver and of the Court.

8. Authorizing the Commissioner as Temporary Receiver to issue such Directives as she deems appropriate to memorialize and provide notice of the exercise of her authority under the Court's Orders and applicable law.

The Commissioner requests that, following the hearing to show cause, the Court issue orders to:

1. Pursuant to NRS 696B.210, appoint the Commissioner as Permanent Receiver to enter the business and immediately oversee the operation and conservation/rehabilitation of the business;

2. Pursuant to NRS 696B.255(1) and NRS 696B.290(6), authorize the Commissioner as Receiver to employ special deputies, counsel, assistants, employees, accountants, actuaries, investment counselors, asset managers, consultants, assistants, and other personnel as she considers necessary, without prior notice to or prior approval by the Court.

3. Pursuant to NRS 696B.255(1), authorize the Receiver to fix the compensation of special deputies, counsels, clerks and assistants with the approval of the Court and thereafter, without prior notice or prior approval of the Court, to pay compensation at such approved rate,

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in addition to any other administrative expenses of taking possession of, conserving, collecting, or otherwise dealing with, the business and property of CO-OP: all actions to be subsequently included in Receiver's quarterly reports and subject to the Court's review, as provided in NRS 696B.290(7).

4. Pursuant to NRS 696B.270, permanently enjoin the CO-OP, the officers, directors, stockholders, members, subscribers, agents, employees, and all other persons from transacting any further business on behalf of the CO-OP unless otherwise directed by the Receiver, or from wasting or disposing of any assets or property of the CO-OP;

5. Pursuant to NRS 696B.340, permanently enjoin any and all persons from the commencement or prosecution of any actions by or on behalf of the CO-OP, or against the CO-OP. Further, all persons should be restrained from obtaining any preferences, judgments, attachments, or other liens as to any property of the CO-OP, or making any levy against the CO-OP or against their assets or any part thereof;

6. Pursuant to NRS 696B.270, permanently enjoin all persons other than the Receiver, or as directed by the Receiver, from withdrawal of any funds from the CO-OP's accounts, or removal of other property from the CO-OP;

7. Pursuant to NRS 696B.290 and 696B.270, vest the Commissioner as Receiver with the title to all of the CO-OP's real and personal property of every kind whatsoever and take possession of the assets wherever located, whether in the possession of the CO-OP or its officers, directors, employees, consultants, attorneys, agents, managers, parents, subsidiaries, affiliated corporations, or those acting in concert with any of these persons, and any other persons, including, but not limited to, all property, offices maintained or utilized by the CO-OP, books, papers, contracts, deposits, stocks, securities, rights of action, accounts, documents, data records, papers, evidences of debt, bonds, debentures, mortgages, furniture, fixtures, office supplies, safe deposit boxes, legal/litigation files, and all books and records of insurers, and administer them under the general supervision of the Court;

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8. Make all relief granted in the interim order permanent, and

9. Authorize the Commissioner as Receiver to take any and all actions that she deems advisable in connection with conservation/rehabilitation of the CO-OP, and as provided in Chapter 696B of the NRS and any other applicable law.

DATED this 25th day of September, 2015.

ADAM PAUL LAXALT
Attorney General

By: /s/ Joanna N. Grigoriev
JOANNA N. GRIGORIEV
Senior Deputy Attorney General
Attorney for the Division of Insurance

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

POINTS AND AUTHORITIES

I. Introduction

Pursuant to the provisions of Chapter 696B of the Nevada Revised Statutes ("NRS"), the Commissioner seeks to commence a delinquency proceeding against the CO-OP on the grounds that, without intervention of a Receiver for conservation/rehabilitation purposes, it is in such an unsound condition as to render its further transaction of insurance presently or prospectively hazardous to its policyholders, or creditors, or the public, as set forth in NRS 696B.210(2). *See* Ex. A and B (with supporting documents), *Affidavit of Insurance Examiner, Kathleen Lace; Affidavit of Lead Actuary, Annette James, respectively.* On August 17, 2015, the CO-OP's Board of Directors authorized and approved a voluntary suspension of the company's certificate of authority and, therefore, the cessation of the selling or marketing of any new business for 2016 as well as during the remainder of 2015. *Id.* On August 21, 2015, the Commissioner issued an Order of Voluntary Suspension. *See* Ex C. The CO-OP subsequently provided a proposed wind-down plan to the Division for review.

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II. Facts

NEVADA HEALTH CO-OP ("CO-OP"), Company ID No. 119733 and NAIC ID No. 15132, is incorporated as a nonprofit, non-stock cooperative corporation pursuant to NRS 81.410 - .540, inclusive, and operates as a health maintenance organization ("HMO") chartered in Nevada, with a certificate of authority issued on January 2, 2013. It operates as an HMO under the authority of NRS Chapter 695C.

The Patient Protection and Affordable Care Act ("ACA") established health insurance exchanges in order to provide individuals and small businesses another option through which to shop for health insurance and possibly receive certain tax credits. To expand the number of health insurance plans that could be made available on the exchanges, the ACA also provided for the creation of the Consumer Operated and Oriented Plan program ("Program"). This Program is overseen by the Centers for Medicare and Medicaid Services' ("CMS").

In order to assist in the creation of co-ops through the Program, CMS made two types of loans to qualified applicants including the CO-OP: Startup Loans which were intended to assist co-op applicants with approved costs for beginning operations; and Solvency Loans that were intended to assist applicants with meeting the capital reserve requirement of the State in which they intended to be domiciled. Subsequent to receipt of the Startup and Solvency Loans from CMS, no additional Federal funds are forthcoming for the capitalization of the CO-OP.

The CO-OP, which was created through the Program, is a private, nonprofit, member-owned insurance company subject to State insurance laws and certain Federal statutes, rules, regulations, and terms. For example, the CO-OP cannot offer equity interests to private investors. Additionally, because the CO-OP is organized as an HMO, there is no guaranty fund association protection available to its policyholders. NRS 686C.100.

The CO-OP's most recent financial statement filed as of June 30, 2015, pursuant to NRS 680A.270, reported total admitted assets of $ 47,923,084, total liabilities of $ 40,788,422 and capital & surplus in the amount of $7,134,662. As of June 30, 2015, the CO-OP reported a net loss of ($30,422,301).

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Las Vegas, Nevada 89101

On August 21, 2015, the CO-OP was allowed a limited one-time permitted practice to report the CMS Startup funds as surplus rather than as a liability in accordance with SSAP No. 15 – Debt and Holding Company Obligations. This permitted practice was limited to the CO-OP's second quarter reporting period which ended on June 30, 2015.

According to the analysis by Division of Insurance Examiner, Kathleen Lace, (Ex. A), there has been significant, materially-adverse loss development, such that the CO-OP is now unsound pursuant to NRS 696B.210(2):

- The CO-OP's operating loss in the most previous 6-month period, is greater than 50 percent of the insurer's surplus which is in excess of the statutory minimum surplus required for HMOs pursuant to Nevada Administrative Code ("NAC") 695C.130.
- Upon expiration of the permitted practice, the CO-OP's capital & surplus will likely show that it is below the statutory minimum requirement pursuant to NAC 695C.130.
- The CO-OP does not have access to additional sources of capital to improve its financial outlook.

Additional evidence supporting the conclusion that the CO-OP is in unsound condition is provided and further explained in the Affidavit of Division of Insurance Lead Actuary, Annette James (Ex. B), and is summarized as follows:

- The CO-OP's claims unpaid reserve has increased significantly over the first six months of 2015.
- Continued losses over the first six months of 2015 resulted in the immediate recognition of a large premium deficiency reserve as of June 30, 2015.
- The collectability of the CO-OP's accounts receivable from the Federal Risk Corridor program in the amount of $16,200,240 as of June 30, 2015, is uncertain.

An unsound/hazardous condition serves as grounds for receivership pursuant to NRS 696B.210(2). Additionally, the consent of the board of directors also serves as grounds for said receivership pursuant to NRS 696B.210(14) (Ex. D). The foregoing facts constitute grounds to place the CO-OP in a receivership pursuant to NRS 696B.210 and 696B.290. These facts also support an order of injunction as provided in NRS 696B.270(1).

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III. Analysis

A. Receivership

Chapter 696B of the NRS governs delinquency proceedings, including by conservation, rehabilitation, or liquidation, against all persons and entities defined in NRS 696B.020. Nevada has adopted the Uniform Insurers Liquidation Act ("UILA"). *See* NRS 696B.280, 696B.030 - .180 and NRS 696B.290 - .340. The UILA serves the purpose to "make uniform the laws of those states which enact it," NRS 696B.280(3), and to provide for a uniform and orderly method of making claims against an insolvent insurer and distributing an insolvent insurer's assets. It prevents local creditors from seizing the assets of an insurer while liquidation proceedings are administered, thus ensuring that all creditors of the insolvent company, regardless of their geographical location, are treated equally. *See Ace Grain Co. v. Rhode Island Ins. Co.*, 107 F. Supp. 80 (S.D.N.Y. 1952), *aff'd*, 199 F. 2d. 758 (2d Cir. 1953).

In the State of Nevada, where this delinquent insurer is domiciled, the Commissioner is the proper authority to be appointed as the Receiver for proceedings to administer the CO-OP's assets. *See* NRS 696B.290. Under the statutory scheme patterned after UILA, the Receiver takes possession and control of the insurer's property and "steps into the shoes" of the insurer and proceeds to administer the receivership. *Am Jur. Receivers* § 116. Her powers are derived from the governing statutes, and not from the court. *See State ex. Rel. Sizemore v. United Physicians Ins. Risk Retention*, 56 S.W. 3d 557, 563 (Tenn. Ct. App. 2001) (citations omitted). The receiver is afforded great deference, as evidenced by the language of NRS 696B.290(7): "the court shall not withhold approval or disapprove any such action unless found by the court after a hearing thereon in open court to be unlawful, arbitrary or capricious." *Id.*

Unsound condition is grounds for receivership. NRS 696B.210(2). Additionally, the consent of the board of directors provides grounds under NRS 696B.210(14). The Commissioner, as Receiver in the state of domicile, is vested with title to all of the company's property and has the sole right to receive the books, records, and assets of the delinquent

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Las Vegas, Nevada 89101

company, wherever located, to satisfy the claims of policyholders and creditors in this state and elsewhere, pursuant to NRS 696B.290. Claims against the insurer, including any claims of Nevada residents, are reviewed pursuant to the provisions of NRS Chapter 696B. These provisions apply broadly to all corporations, firms, associations, societies, entities or individuals doing insurance business in Nevada. The Commissioner as Receiver is responsible for the proper administration of assets.

The Petition filed in this case seeks an order appointing the Commissioner as the Receiver as to the assets and special deposits of the CO-OP located within this state and elsewhere. NRS 696B.250 sets forth the proper procedure as follows:

> 1. The Commissioner shall commence a delinquency proceeding authorized under this chapter, the Attorney General representing the Commissioner, by filing a petition in a court of proper jurisdiction praying for appointment of the Commissioner as receiver of the insurer.
> 2. Upon the filing of the petition the court shall issue an order directing the insurer to appear in court on the day fixed in the order and show cause why the petition should not be granted. Unless good cause is shown for a shorter period, the order shall require the insurer so to show cause not less than 15 days nor more than 30 days from the date of the order.
> 3. The order to show cause and service thereof on the insurer shall constitute due and legal process and shall be in lieu of any other process otherwise provided by law or court rule.

The District Court has original jurisdiction of delinquency proceedings under NRS 696B.010 - .565 and "may make all necessary or proper orders to carry out the purposes of those sections." *See* NRS 696B.190(1). In this case, as indicated in Ex. A and B and the supporting documents, the CO-OP is unsound as provided in NRS 696B.210(2). As such, proceeding with this receivership is appropriate.

B. <u>Injunctions</u>

The Commissioner is under a duty to act for the protection of subscribers, members, and policyholders and conserve the available assets. To this end, the Commissioner may seek an injunction to stay the commencement or prosecution of actions and the procuring of judgment against the insurer, restrain the consummation of business transactions, prohibit interference with the delinquency proceedings, or prevent waste of the assets. *See* NRS

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696B.270 and NRS 696B.340. "The UILA authorizes the court in which a delinquency proceeding was instituted to enjoin all claims against the insurer...." *Integrity Ins. Co. v. Martin*, 105 Nev. 16, 18, 769 P.2d 69, 70 (1989). This Court may issue such injunctions in this matter without notice upon the commencement of these delinquency proceedings as provided in NRS 696B.270:

> 1. Upon application by the Commissioner for such an order to show cause, or at any time thereafter, **the court may without notice issue an injunction** restraining the insurer, its officers, directors, stockholders, members, subscribers, agents and all other persons from the transaction of its business or the waste or disposition of its property until the further order of the court. . . .
> 2. **The court may at any time during a proceeding** under NRS 696B.010 to 696B.565, inclusive, **issue such other injunctions** or orders as may be deemed necessary to prevent interference with the Commissioner or the proceeding, or waste of the assets of the insurer, or the commencement or prosecution of any actions, or the obtaining of preferences, judgments, attachments or other liens, or the making of any levy against the insurer or against its assets or any part thereof.
> 3. No bond may be required of the Commissioner as a prerequisite for the issuance of any injunction or restraining order pursuant to this section. (Emphasis added).

The Commissioner seeks to preserve the status quo and to enforce the purposes of NRS 696B.270, and to protect policyholders of the CO-OP from the wasting of assets, as well as potential collection actions pending payment of claims. The CO-OP is in unsound condition and has been subject to such methods and practices in the conduct of its business as to render its further transaction of insurance, without formal conservation/rehabilitation receivership efforts by the Commissioner, presently or prospectively hazardous to the policyholders, creditors and the public. As evident from Exhibits A and B attached hereto, an order of an immediate injunction pending further orders of the Court is essential to preserve the assets, the status quo, to enforce the purposes of NRS 696B.270, and to protect insureds and creditors of the CO-OP from collection actions pending payment of claims.

IV. Conclusion

Based on the foregoing, the Commissioner respectfully requests that the Court issue an Order to Show Cause directing the CO-OP to appear and show cause why the Petition to Appoint Commissioner as Receiver and Associated Relief should not be granted. The

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Las Vegas, Nevada 89101

Commissioner further requests that the Court issue interim orders of injunction as set forth herein, pending the show cause hearing and further orders of the Court as set forth herein. The statutory immunity of NRS 696B.565 extends to deputy receivers as officers or agents of the Receiver.

The Commissioner respectfully requests further that the Court grant the Petition for Appointment of Commissioner as Receiver, along with the associated permanent relief and injunctions.

DATED this 25th day of September, 2015.

ADAM PAUL LAXALT
Attorney General

By: /s/ Joanna N. Grigoriev
JOANNA N. GRIGORIEV
Senior Deputy Attorney General
Attorney for the Division of Insurance

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

EXHIBIT A

TO

PETITION FOR APPOINTMENT OF COMMISSIONER AS RECEIVER AND OTHER PERMANENT RELIEF; REQUEST FOR TEMPORARY INJUNCTION PURSUANT TO NRS 696B.270(1)

STATE OF NEVADA
DEPARTEMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE

AFFIDAVIT OF KATHLEEN LACE IN SUPPORT OF PETITION FOR APPOINTMENT OF COMMISSIONER AS RECEIVER AND OTHER PERMANENT RELIEF; REQUEST FOR TEMPORARY INJUNCTION PURSUANT TO NRS 696B.270(1)

STATE OF NEVADA)
) ss:
COUNTY OF CARSON CITY)

I, Kathleen Lace, being duly sworn, on oath, depose and say that:

1. I am an Insurance Examiner I in the Corporate and Financial Affairs Section for the State of Nevada, Department of Business and Industry, Division of Insurance ("Division").

2. I have a Bachelor of Science in Health Ecology, a four-year undergraduate degree from the University of Nevada, Reno, secured in 1999. I have a Masters Degree in Business Administration ("MBA") with a concentration in Accounting and Finance obtained from the University of Nevada, Reno in 2005. I received the Associate Professional in Insurance Regulation ("APIR") designation awarded by the National Association of Insurance Commissioners in 2014.

3. From December 2014 to August 2015, I was the financial analyst assigned at the Division to review the financial information and related documents filed with the Division by the Nevada Health CO-OP ("CO-OP" or "Company"). I am providing this Affidavit in my capacity and responsibility as the assigned analyst during that period.

4. Attachment 1 is the Certificate of Authority granted to the CO-OP as a Health Maintenance Organization ("HMO") on January 2, 2013, and as amended on July 3, 2013. As an HMO, the CO-OP is subject to Nevada law in Chapter 695C and, pursuant to Nevada Revised Statute ("NRS") 686C.100, the CO-OP is not eligible to participate in the Nevada Life and Health Insurance Guaranty Association. The CO-OP is incorporated as a Nevada nonprofit cooperative corporation without stock, pursuant

to NRS 81.410 - .540, inclusive.

5. Pursuant to NRS 695C.210(1), the CO-OP was required to file a full and true statement of its financial condition, transactions and affairs; and an accurate statement of its financial condition, in accordance with the NAIC Annual Statement Instructions and NAIC Accounting Practices and Procedures Manual. NRS 695C.210(1). Attachment 2 includes pages 1-5 of the CO-OP's 2014 Health Annual Statement (financial) submitted on March 3, 2015.

6. Nevada Administrative Code ("NAC") 695C.130 requires that health companies, such as the CO-OP, maintain a minimum capital and surplus balance of $1,500,000.

7. Pages 1-5 of the CO-OP's most recent Quarterly Statement (financial), as of June 30, 2015, are attached as Attachment 3.

8. The CO-OP's June 30, 2015 financial statement reflects total admitted assets of $47,923,084 and total liabilities of $40,788,422, resulting in capital and surplus of $7,134,662.

9. The CO-OP reported a net loss as of June, 30, 2015, of ($30,422,301). For the 2014 calendar year, the CO-OP reported a net loss of ($15,295,456).

10. On June 30, 2015, the policyholders' surplus of $7,134,662 was comprised of $48,820,349 of surplus notes, $151,601 of aggregate write-ins for special surplus funds, and $17,080,047 of aggregate write-ins for other than special surplus funds, less ($58,917,335) in unassigned funds from operating losses since the CO-OP's inception.

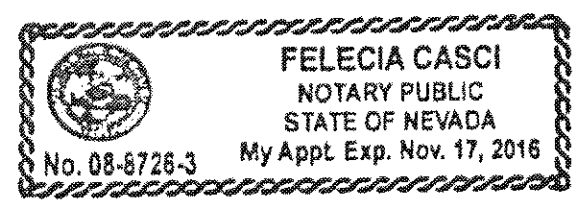
11. On August 21, 2015, the Division approved a temporary, limited one-time permitted practice to allow the CMS Startup loan, in the amount of $17,080,047, to be reported as surplus rather than a liability in accordance with SSAP No. 15 – Debt and Holding Company Obligations. The time period during which the permitted practice was allowed was limited to the June 30, 2015 Quarterly Statement. A copy of the permitted practice is attached as Attachment 4.

12. Due to the significant losses experienced since its inception, along with the lack of new sources of capital, the CO-OP is unsound pursuant to NRS 696B.210(2).

13. I declare under penalty of perjury that the foregoing is true and correct based on my personal knowledge.

Kathleen Lace
Insurance Examiner I

SUBSCRIBED and SWORN to
before me this 25 day of September, 2015.



NOTARY PUBLIC

ATTACHMENT 1

TO

AFFIDAVIT OF KATHLEEN LACE IN SUPPORT OF PETITION FOR APPOINTMENT OF COMMISSIONER AS RECEIVER AND OTHER PERMANENT RELIEF; REQUEST FOR TEMPORARY INJUNCTION PURSUANT TO NRS 696B.270(1)

Certificate of Authority

STATE OF NEVADA
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INSURANCE
Carson City, Nevada

Nevada ID #: **119733**

THE **NEVADA HEALTH CO-OP**

Incorporated in the State of **NEVADA**

Home office at **LAS VEGAS, NEVADA**

having duly qualified, is hereby licensed to transact:

**** HEALTH MAINTENANCE ORGANIZATION (NRS 695C) ****

(Service Area by Counties and zip codes): Clark – All zip codes

insurance business within the State of Nevada until terminated at the request of the insurer or suspended or revoked by the Commissioner of Insurance.

Original Certificate Dated at Carson City,

Nevada this 2nd day of January, 2013

Commissioner of Insurance

Amended
Certificate of Authority

STATE OF NEVADA
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INSURANCE
Carson City, Nevada

Nevada ID: **119733**

THE **NEVADA HEALTH CO-OP**

Incorporated in the State of **NEVADA**

Home office at **LAS VEGAS, NEVADA**

having duly qualified is hereby licensed to transact:

**** HEALTH MAINTENANCE ORGANIZATION (NRS 695C) ****

(Service Area: All zip codes in Nevada)

insurance business within the State of Nevada until terminated at the request of the insurer or suspended or revoked by the Commissioner of Insurance.

Original Certificate Dated at Carson City, Nevada

this 2nd day of January, 2013

Amended this 3rd day of July, 2013

Commissioner of Insurance

ATTACHMENT 2

TO

AFFIDAVIT OF KATHLEEN LACE IN SUPPORT OF PETITION FOR APPOINTMENT OF COMMISSIONER AS RECEIVER AND OTHER PERMANENT RELIEF; REQUEST FOR TEMPORARY INJUNCTION PURSUANT TO NRS 696B.270(1)

HEALTH ANNUAL STATEMENT

FOR THE YEAR ENDED DECEMBER 31, 2014
OF THE CONDITION AND AFFAIRS OF THE

Nevada Health CO-OP

NAIC Group Code 0000 (Current) 0000 (Prior) NAIC Company Code 15132 Employer's ID Number 90-0917873

Organized under the Laws of Nevada, State of Domicile or Port of Entry NV

Country of Domicile United States of America

Licensed as business type Health Maintenance Organization

Is HMO Federally Qualified? Yes [ ] No [X]

Incorporated/Organized 10/30/2012 Commenced Business 01/01/2014

Statutory Home Office 3960 Meadows Lane Suite 214 (Street and Number) Las Vegas , NV, US 89107 (City or Town, State, Country and Zip Code)

Main Administrative Office 3960 Meadows Lane Suite 214 (Street and Number)
Las Vegas , NV, US 89107 (City or Town, State, Country and Zip Code) 702-802-4600 (Area Code) (Telephone Number)

Mail Address 3960 Meadows Lane Suite 214 (Street and Number or P.O. Box) Las Vegas , NV, US 89107 (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 3960 Meadows Lane Suite 214 (Street and Number)
Las Vegas , NV, US 89107 (City or Town, State, Country and Zip Code) 702 802 4600 (Area Code) (Telephone Number)

Internet Website Address nevadahealthcoop.org

Statutory Statement Contact Basil Charles Dibsie (Name) 702 802 4600 (Area Code) (Telephone Number)
bdibsie@nevadahealthcoop.org (E-mail Address) 702 805 4601 (FAX Number)

OFFICERS

Chief Executive Officer Pamela Lynn Egan #
Secretary Bobbette Adele Bond

OTHER

DIRECTORS OR TRUSTEES

Danny Lynn Thompson
Christine Joy Cardale
Donald Ray Taylor Jr.

State of Nevada
County of Clark SS:

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Pamela Lynn Egan
CEO

Basil Charles Dibsie
CFO

Subscribed and sworn to before me this 28th day of February 2015

Michele Schultz
CEO Executive Assistant
October 17, 2016

a. Is this an original filing? Yes [X] No [ ]
b. If no,
1. State the amendment number
2. Date filed
3. Number of pages attached

MICHELE SCHULTZ
NOTARY PUBLIC, STATE OF NEVADA
My Commission Expires: 10-17-16
Certificate No: 12-8295-1

RECEIVED
RB
MAR - 3
PM - 3/2/15

ASSETS

		Current Year 1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	Prior Year 4 Net Admitted Assets
1.	Bonds (Schedule D)	23,855,511		23,855,511	0
2.	Stocks (Schedule D):				
	2.1 Preferred stocks			0	0
	2.2 Common stocks			0	0
3.	Mortgage loans on real estate (Schedule B):				
	3.1 First liens			0	0
	3.2 Other than first liens			0	0
4.	Real estate (Schedule A):				
	4.1 Properties occupied by the company (less $ encumbrances)			0	0
	4.2 Properties held for the production of income (less $ encumbrances)			0	0
	4.3 Properties held for sale (less $ encumbrances)			0	0
5.	Cash ($ 3,806,157 , Schedule E - Part 1), cash equivalents ($, Schedule E - Part 2) and short-term investments ($ 39,343 , Schedule DA)	3,845,501		3,845,501	35,933,436
6.	Contract loans, (including $ premium notes)			0	0
7.	Derivatives (Schedule DB)			0	0
8.	Other invested assets (Schedule BA)			0	0
9.	Receivables for securities			0	0
10.	Securities lending reinvested collateral assets (Schedule DL)			0	0
11.	Aggregate write-ins for invested assets	0	0	0	0
12.	Subtotals, cash and invested assets (Lines 1 to 11)	27,701,012	0	27,701,012	35,933,436
13.	Title plants less $ charged off (for Title insurers only)			0	0
14.	Investment income due and accrued	67,052		67,052	0
15.	Premiums and considerations:				
	15.1 Uncollected premiums and agents' balances in the course of collection	1,479,646	1,256,702	222,944	0
	15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ earned but unbilled premiums)			0	0
	15.3 Accrued retrospective premiums	4,391,073		4,391,073	0
16.	Reinsurance:				
	16.1 Amounts recoverable from reinsurers	7,092,348		7,092,348	0
	16.2 Funds held by or deposited with reinsured companies			0	0
	16.3 Other amounts receivable under reinsurance contracts	323,405		323,405	0
17.	Amounts receivable relating to uninsured plans			0	0
18.1	Current federal and foreign income tax recoverable and interest thereon			0	0
18.2	Net deferred tax asset			0	0
19.	Guaranty funds receivable or on deposit			0	0
20.	Electronic data processing equipment and software	737,002		737,002	311,715
21.	Furniture and equipment, including health care delivery assets ($)	362,958	362,958	0	0
22.	Net adjustment in assets and liabilities due to foreign exchange rates			0	0
23.	Receivables from parent, subsidiaries and affiliates			0	0
24.	Health care ($ 151,597) and other amounts receivable	298,906	147,299	151,607	0
25.	Aggregate write-ins for other than invested assets	3,468,223	316,948	3,152,275	0
26.	Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	45,822,626	2,083,907	43,738,719	36,145,151
27.	From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0	0
28.	Total (Lines 26 and 27)	45,822,626	2,083,907	43,738,719	36,145,151
	DETAILS OF WRITE-INS				
1101.					
1102.					
1103.					
1198.	Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199.	Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above)	0	0	0	0
2501.	Solvency Loan Receivable	3,152,275		3,152,275	0
2502.	Accrued Receivable	70,560	70,560	0	0
2503.	Prepaid Assets	103,765	103,765	0	
2598.	Summary of remaining write-ins for Line 25 from overflow page	142,623	142,623	0	0
2599.	Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	3,468,223	316,948	3,152,275	0

LIABILITIES, CAPITAL AND SURPLUS

	Current Year 1 Covered	2 Uncovered	3 Total	Prior Year 4 Total
1. Claims unpaid (less $ 2,092,202 reinsurance ceded)	5,608,001		5,608,001	0
2. Accrued medical incentive pool and bonus amounts			0	0
3. Unpaid claims adjustment expenses	233,000		233,000	0
4. Aggregate health policy reserves, including the liability of $ 0 for medical loss ratio rebate per the Public Health Service Act			0	0
5. Aggregate life policy reserves			0	0
6. Property/casualty unearned premium reserves			0	0
7. Aggregate health claim reserves			0	0
8. Premiums received in advance	1,964,034		1,964,034	381,715
9. General expenses due or accrued	2,259,374		2,259,374	842,090
10.1 Current federal and foreign income tax payable and interest thereon (including $ on realized capital gains (losses))			0	0
10.2 Net deferred tax liability			0	0
11. Ceded reinsurance premiums payable	569,730		569,730	0
12. Amounts withheld or retained for the account of others			0	0
13. Remittances and items not allocated			0	0
14. Borrowed money (including $ current) and interest thereon $ (including $ current)	16,980,047		16,980,047	16,962,245
15. Amounts due to parent, subsidiaries and affiliates			0	0
16. Derivatives			0	0
17. Payable for securities			0	0
18. Payable for securities lending			0	0
19. Funds held under reinsurance treaties (with $ authorized reinsurers, $ 0 unauthorized reinsurers and $ 0 certified reinsurers)			0	0
20. Reinsurance in unauthorized and certified ($) companies			0	0
21. Net adjustments in assets and liabilities due to foreign exchange rates			0	0
22. Liability for amounts held under uninsured plans			0	0
23. Aggregate write-ins for other liabilities (including $ current)	0	0	0	0
24. Total liabilities (Lines 1 to 23)	27,614,186	0	27,614,186	18,186,051
25. Aggregate write-ins for special surplus funds	XXX	XXX	83,199	0
26. Common capital stock	XXX	XXX		
27. Preferred capital stock	XXX	XXX		
28. Gross paid in and contributed surplus	XXX	XXX		
29. Surplus notes	XXX	XXX	42,865,583	18,680,047
30. Aggregate write-ins for other than special surplus funds	XXX	XXX	0	0
31. Unassigned funds (surplus)	XXX	XXX	(26,924,350)	(10,720,947)
32. Less treasury stock, at cost				
32.1 shares common (value included in Line 26 $)	XXX	XXX		
32.2 shares preferred (value included in Line 27 $)	XXX	XXX		
33. Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	16,124,532	7,959,100
34. Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	43,738,718	26,145,151
DETAILS OF WRITE-INS				
2301.				
2302.				
2303.				
2398. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399. Totals (Lines 2301 thru 2303 plus 2398)(Line 23 above)	0	0	0	0
2501. 9010 ACA Assessment	XXX	XXX	83,199	
2502.	XXX	XXX		
2503.	XXX	XXX		
2598. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	XXX	XXX	83,199	0
3001.	XXX	XXX		
3002.	XXX	XXX		
3003.	XXX	XXX		
3098. Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099. Totals (Lines 3001 thru 3003 plus 3098)(Line 30 above)	XXX	XXX	0	0

STATEMENT OF REVENUE AND EXPENSES

		Current Year 1 Uncovered	Current Year 2 Total	Prior Year 3 Total
1.	Member Months	XXX	162,632	0
2.	Net premium income (including $ non-health premium income)	XXX	51,526,023	
3.	Change in unearned premium reserves and reserve for rate credits	XXX	0	
4.	Fee-for-service (net of $ medical expenses)	XXX	0	
5.	Risk revenue	XXX	0	
6.	Aggregate write-ins for other health care related revenues	XXX	0	0
7.	Aggregate write-ins for other non-health revenues	XXX	0	15,000
8.	Total revenues (Lines 2 to 7)	XXX	51,526,023	15,000
	Hospital and Medical:			
9.	Hospital/medical benefits		40,240,031	
10.	Other professional services		8,937	
11.	Outside referrals		0	
12.	Emergency room and out-of-area		0	
13.	Prescription drugs		12,331,645	
14.	Aggregate write-ins for other hospital and medical	0	0	0
15.	Incentive pool, withhold adjustments and bonus amounts		0	
16.	Subtotal (Lines 9 to 15)	0	52,580,613	0
	Less:			
17.	Net reinsurance recoveries		9,184,580	
18.	Total hospital and medical (Lines 16 minus 17)	0	43,396,033	0
19.	Non-health claims (net)			
20.	Claims adjustment expenses, including $ 1,174,826 cost containment expenses		4,429,831	0
21.	General administrative expenses		19,041,284	7,928,516
22.	Increase in reserves for life and accident and health contracts (including $ increase in reserves for life only)		0	0
23.	Total underwriting deductions (Lines 18 through 22)	0	66,867,248	7,928,516
24.	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	(15,341,225)	(7,913,516)
25.	Net investment income earned (Exhibit of Net Investment Income, Line 17)		44,607	5,113
26.	Net realized capital gains (losses) less capital gains tax of $		$62	
27.	Net investment gains (losses) (Lines 25 plus 26)	0	45,769	5,113
28.	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $) (amount charged off $)]			
29.	Aggregate write-ins for other income or expenses	0	0	0
30.	Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	(15,295,456)	(7,908,403)
31.	Federal and foreign income taxes incurred	XXX		
32.	Net income (loss) (Lines 30 minus 31)	XXX	(15,295,456)	(7,908,403)
	DETAILS OF WRITE-INS			
0601.		XXX		
0602.		XXX		
0603.		XXX		
0698.	Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0
0699.	Totals (Lines 0601 thru 0603 plus 0698)(Line 6 above)	XXX	0	0
0701.	Unrestricted Marketing Funds	XXX		15,000
0702.		XXX		
0703.		XXX		
0798.	Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0
0799.	Totals (Lines 0701 thru 0703 plus 0798)(Line 7 above)	XXX	0	15,000
1401.				
1402.				
1403.				
1498.	Summary of remaining write-ins for Line 14 from overflow page	0	0	0
1499.	Totals (Lines 1401 thru 1403 plus 1498)(Line 14 above)	0	0	0
2901.				
2902.				
2903.				
2998.	Summary of remaining write-ins for Line 29 from overflow page	0	0	0
2999.	Totals (Lines 2901 thru 2903 plus 2998)(Line 29 above)	0	0	0

STATEMENT OF REVENUE AND EXPENSES (Continued)

	1 Current Year	2 Prior Year
CAPITAL AND SURPLUS ACCOUNT		
33. Capital and surplus prior reporting year	7,959,100	(1,125,614)
34. Net income or (loss) from Line 32	(15,285,456)	(7,908,403)
35. Change in valuation basis of aggregate policy and claim reserves		
36. Change in net unrealized capital gains (losses) less capital gains tax of $		
37. Change in net unrealized foreign exchange capital gain or (loss)		
38. Change in net deferred income tax		
39. Change in nonadmitted assets	(396,377)	(1,686,930)
40. Change in unauthorized and certified reinsurance	0	0
41. Change in treasury stock	0	0
42. Change in surplus notes	24,285,636	18,680,047
43. Cumulative effect of changes in accounting principles		
44. Capital Changes		
44.1 Paid in	0	0
44.2 Transferred from surplus (Stock Dividend)	0	0
44.3 Transferred to surplus		
45. Surplus adjustments:		
45.1 Paid in	0	0
45.2 Transferred to capital (Stock Dividend)		
45.3 Transferred from capital		
46. Dividends to stockholders		
47. Aggregate write-ins for gains or (losses) in surplus	(427,770)	0
48. Net change in capital and surplus (Lines 34 to 47)	8,165,433	9,084,714
49. Capital and surplus end of reporting period (Line 33 plus 48)	16,124,533	7,959,100
DETAILS OF WRITE-INS		
4701. Prior Period Adjustment	(427,770)	
4702.		
4703.		
4798. Summary of remaining write-ins for Line 47 from overflow page	0	0
4799. Totals (Lines 4701 thru 4703 plus 4798)(Line 47 above)	(427,770)	0

ATTACHMENT 3

TO

AFFIDAVIT OF KATHLEEN LACE IN SUPPORT OF PETITION FOR APPOINTMENT OF COMMISSIONER AS RECEIVER AND OTHER PERMANENT RELIEF; REQUEST FOR TEMPORARY INJUNCTION PURSUANT TO NRS 696B.270(1)

QUARTERLY STATEMENT

AS OF JUNE 30, 2015

OF THE CONDITION AND AFFAIRS OF THE

NEVADA HEALTH CO-OP

NAIC Group Code 0000 (Current Period) 0000 (Prior Period) NAIC Company Code 15132 Employer's ID Number 90-0917873

Organized under the Laws of Nevada State of Domicile or Port of Entry Nevada

Country of Domicile United States of America

Licensed as business type: Life, Accident & Health[ ] Property/Casualty[ ] Hospital, Medical & Dental Service or Indemnity[ ]
Dental Service Corporation[ ] Vision Service Corporation[ ] Health Maintenance Organization[X]
Other[ ] Is HMO Federally Qualified? Yes[ ] No[X] N/A[ ]

Incorporated/Organized 10/30/2012 Commenced Business 01/01/2014

Statutory Home Office 3900 MEADOWS LANE SUITE 214 (Street and Number) LAS VEGAS, NV, US 89107 (City or Town, State, Country and Zip Code)

Main Administrative Office 3900 MEADOWS LANE SUITE 214 (Street and Number)
LAS VEGAS, NV, US 89107 (City or Town, State, Country and Zip Code) (702)802-4600 (Area Code) (Telephone Number)

Mail Address 3900 MEADOWS LANE SUITE 214 (Street and Number or P.O. Box) LAS VEGAS, NV, US 89107 (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 3900 MEADOWS LANE SUITE 214 (Street and Number)
LAS VEGAS, NV, US 89107 (City or Town, State, Country and Zip Code) (702)802-4600 (Area Code) (Telephone Number)

Internet Web Site Address NEVADAHEALTHCOOP.ORG

Statutory Statement Contact BASIL CHARLES DIBSIE (Name) (702)802-4600 (Area Code)(Telephone Number)(Extension)
BDIBSIE@NEVADAHEALTHCOOP.ORG (E-Mail Address) (702)802-4601 (Fax Number)

OFFICERS

Name	Title	
PAMELA LYNN EGAN	CHIEF EXECUTIVE OFFICER	
LINDA IRENE MATTON	CHIEF OPERATING OFFICER	#
BASIL CHARLES DIBSIE	CHIEF FINANCIAL OFFICER	#
NICOLE RENEE FLORA MD	CHIEF MEDICAL OFFICER	#

OTHERS

DIRECTORS OR TRUSTEES

DANNY LYNN THOMPSON
RONALD RAY TAYLOR JR.
CHRISTINE JOY CARAFELLI

RECEIVED AUG 24 DIVISION OF INSURANCE STATE OF NEVADA

State of Nevada
County of Clark ss

The officers of this reporting entity, being duly sworn, each depose and say that they are the described officers of the said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

(Signature)	(Signature)	(Signature)
PAMELA LYNN EGAN	BASIL CHARLES DIBSIE	
(Printed Name)	(Printed Name)	(Printed Name)
1	2	3
CHIEF EXECUTIVE OFFICER	CHIEF FINANCIAL OFFICER	
(Title)	(Title)	(Title)

Subscribed and sworn to before me this 21 day of August 2015

a. Is this an original filing? Yes[X] No[ ]
b. If no, 1. State the amendment number
2. Date filed
3. Number of pages attached

(Notary Public Signature)

MICHELE SCHULTZ
NOTARY PUBLIC, STATE OF NEVADA
My Commission Expires: 10-17-16
Certificate No: 12-8206-1

ASSETS

		Current Statement Date 1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 December 31 Prior Year Net Admitted Assets
1	Bonds	857,410		857,410	23,855,511
2	Stocks				
	2.1 Preferred stocks				
	2.2 Common stocks				
3	Mortgage loans on real estate				
	3.1 First liens				
	3.2 Other than first liens				
4	Real estate				
	4.1 Properties occupied by the company (less $ 0 encumbrances)				
	4.2 Properties held for the production of income (less $ 0 encumbrances)				
	4.3 Properties held for sale (less $ 0 encumbrances)				
5	Cash ($ 7,818,076), cash equivalents ($ 0) and short-term investments ($ 4,196,316)	12,014,392		12,014,392	3,845,501
6	Contract loans (including $ 0 premium notes)				
7.	Derivatives				
8	Other invested assets				
9	Receivables for securities				
10.	Securities lending reinvested collateral assets				
11.	Aggregate write-ins for invested assets				
12.	Subtotals, cash and invested assets (Lines 1 to 11)	12,871,802		12,871,802	27,701,012
13.	Title plants less $ 0 charged off (for Title insurers only)				
14.	Investment income due and accrued	1,884		1,884	67,052
15.	Premiums and considerations:				
	15.1 Uncollected premiums and agents' balances in the course of collection	6,254,851	1,222,263	5,032,588	222,944
	15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ 0 earned but unbilled premiums)				
	15.3 Accrued retrospective premiums	16,200,240		16,200,240	4,291,073
16	Reinsurance:				
	16.1 Amounts recoverable from reinsurers	12,670,001		12,670,001	7,092,348
	16.2 Funds held by or deposited with reinsured companies				
	16.3 Other amounts receivable under reinsurance contracts	323,405		323,405	323,405
17	Amounts receivable relating to uninsured plans				
18.1	Current federal and foreign income tax recoverable and interest thereon				
18.2	Net deferred tax asset				
19	Guaranty funds receivable or on deposit				
20	Electronic data processing equipment and software	571,686		571,686	737,002
21	Furniture and equipment, including health care delivery assets ($ 0)	422,953	422,953		
22	Net adjustments in assets and liabilities due to foreign exchange rates				
23	Receivables from parent, subsidiaries and affiliates				
24	Health care ($ 251,477) and other amounts receivable	582,628	331,151	251,477	151,607
25	Aggregate write-ins for other than invested assets	406,117	406,117		3,152,275
26	TOTAL assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	50,305,567	2,382,483	47,923,084	43,739,718
27	From Separate Accounts, Segregated Accounts and Protected Cell Accounts				
28	TOTAL (Lines 26 and 27)	50,305,567	2,382,483	47,923,084	43,739,718
DETAILS OF WRITE-INS					
1101.					
1102.					
1103.					
1198.	Summary of remaining write-ins for Line 11 from overflow page				
1199.	TOTALS (Lines 1101 through 1103 plus 1198) (Line 11 above)				
2501.	SOLVENCY LOAN RECEIVABLE				3,152,275
2502.	ACCRUED RECEIVABLE	174,493	174,493		
2503.	PREPAID ASSETS	89,001	89,001		
2598.	Summary of remaining write-ins for Line 25 from overflow page	142,623	142,623		
2599.	TOTALS (Lines 2501 through 2503 plus 2598) (Line 25 above)	406,117	406,117		3,152,275

LIABILITIES, CAPITAL AND SURPLUS

		Current Period			Prior Year
		1 Covered	2 Uncovered	3 Total	4 Total
1	Claims unpaid (less $..... .....0 reinsurance ceded)	15,027,286		15,027,286	5,608,001
2	Accrued medical incentive pool and bonus amounts				
3	Unpaid claims adjustment expenses	869,612		869,612	233,000
4	Aggregate health policy reserves, including the liability of $ .. 0 for medical loss ratio rebate per the Public Health Service Act	19,529,890		19,529,890	
5	Aggregate life policy reserves				
6	Property/casualty unearned premium reserve				
7	Aggregate health claim reserves				
8	Premiums received in advance	2,115,524		2,115,524	1,964,034
9	General expenses due or accrued	2,611,506		2,611,506	2,259,374
10.1	Current federal and foreign income tax payable and interest thereon (including $ 0 on realized gains (losses))				
10.2	Net deferred tax liability				
11	Ceded reinsurance premiums payable	634,421		634,421	569,730
12	Amounts withheld or retained for the account of others				
13	Remittances and items not allocated				
14	Borrowed money (including $ 0 current) and interest thereon $ 0 (including $ 0 current)				16,980,047
15	Amounts due to parent, subsidiaries and affiliates				
16	Derivatives				
17	Payable for securities	182		182	
18	Payable for securities lending				
19	Funds held under reinsurance treaties with ($ 0 authorized reinsurers, $ 0 unauthorized reinsurers and $ 0 certified reinsurers)				
20	Reinsurance in unauthorized and certified ($ 0) companies				
21	Net adjustments in assets and liabilities due to foreign exchange rates				
22	Liability for amounts held under uninsured plans				
23	Aggregate write-ins for other liabilities (including $ 0 current)				
24	Total liabilities (Lines 1 to 23)	40,788,422		40,788,422	27,614,186
25	Aggregate write-ins for special surplus funds	XXX	XXX	151,601	83,199
26	Common capital stock	XXX	XXX		
27	Preferred capital stock	XXX	XXX		
28	Gross paid in and contributed surplus	XXX	XXX		
29	Surplus notes	XXX	XXX	46,870,349	42,965,683
30.	Aggregate write-ins for other than special surplus funds	XXX	XXX	17,080,047	
31.	Unassigned funds (surplus)	XXX	XXX	(58,917,335)	(26,924,350)
32.	Less treasury stock, at cost:				
	32.1 .....0 shares common (value included in Line 26 $..... 0)	XXX	XXX		
	32.2 .....0 shares preferred (value included in Line 27 $..... 0)	XXX	XXX		
33.	Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	7,134,662	16,124,532
34.	Total Liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	47,923,084	43,738,718
DETAILS OF WRITE-INS					
2301.	.....				
2302.	.....				
2303.	.....				
2398.	Summary of remaining write-ins for Line 23 from overflow page				
2399.	TOTALS (Lines 2301 through 2303 plus 2398) (Line 23 above)				
2501.	9010 ACA ASSESSMENT	XXX	XXX	151,601	83,199
2502.	.....	XXX	XXX		
2503.	.....	XXX	XXX		
2598.	Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX		
2599.	TOTALS (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX	151,601	83,199
3001.	CMS Start-up Loans	XXX	XXX	17,080,047	
3002.	.....	XXX	XXX		
3003.	.....	XXX	XXX		
3098.	Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX		
3099.	TOTALS (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX	17,080,047	

STATEMENT AS OF June 30, 2015 OF THE NEVADA HEALTH CO-OP

STATEMENT OF REVENUE AND EXPENSES

		Current Year To Date		Prior Year To Date	Prior Year Ended December 31
		1 Uncovered	2 Total	3 Total	4 Total
1	Member Months	XXX	124,064		162,632
2	Net premium income (including $ 0 non-health premium income)	XXX	47,877,767	7,027,249	51,526,023
3	Change in unearned premium reserves and reserves for rate credits	XXX			
4	Fee-for-service (net of $ 0 medical expenses)	XXX			
5	Risk revenue	XXX			
6	Aggregate write-ins for other health care related revenues	XXX			
7	Aggregate write-ins for other non-health revenues	XXX			
8	Total revenues (Lines 2 to 7)	XXX	47,877,767	7,027,249	51,526,023
Hospital and Medical:					
9	Hospital/medical benefits		35,303,149	3,581,631	40,240,031
10	Other professional services		9,294	1,118,007	8,537
11	Outside referrals				
12	Emergency room and out-of-area				
13	Prescription drugs		14,523,726	1,063,453	12,331,845
14	Aggregate write-ins for other hospital and medical				
15	Incentive pool, withhold adjustments and bonus amounts				
16	Subtotal (Lines 9 to 15)		49,836,170	5,763,091	52,580,413
Less:					
17	Net reinsurance recoveries		4,066,071		9,184,580
18	Total hospital and medical (Lines 16 minus 17)		45,770,100	5,763,091	43,395,833
19	Non-health claims (net)				
20	Claims adjustment expenses, including $ 677,311 cost containment expenses		3,161,436		4,429,931
21	General administrative expenses		13,348,083	5,010,309	19,041,284
22	Increase in reserves for life and accident and health contracts (including $ 0 increase in reserves for life only)		16,900,000		
23	Total underwriting deductions (Lines 18 through 22)		78,179,819	10,773,400	66,867,248
24	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	(30,301,850)	(3,746,151)	(15,341,225)
25	Net investment income earned		(124,449)	4,826	44,807
26	Net realized capital gains (losses) less capital gains tax of $ 0		3,998		962
27	Net investment gains or (losses) (Lines 25 plus 26)		(120,451)	4,826	45,769
28	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $ 0) (amount charged off $ 0)]				
29	Aggregate write-ins for other income or expenses				
30	Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	(30,422,301)	(3,681,525)	(15,295,456)
31	Federal and foreign income taxes incurred	XXX			
32	Net income (loss) (Lines 30 minus 31)	XXX	(30,422,301)	(3,681,525)	(15,295,456)
DETAILS OF WRITE-INS					
0601		XXX			
0602		XXX			
0603		XXX			
0698	Summary of remaining write-ins for Line 6 from overflow page	XXX			
0699	TOTALS (Lines 0601 through 0603 plus 0698) (Line 6 above)	XXX			
0701		XXX			
0702		XXX			
0703		XXX			
0798	Summary of remaining write-ins for Line 7 from overflow page	XXX			
0799	TOTALS (Lines 0701 through 0703 plus 0798) (Line 7 above)	XXX			
1401					
1402					
1403					
1498	Summary of remaining write-ins for Line 14 from overflow page				
1499	TOTALS (Lines 1401 through 1403 plus 1498) (Line 14 above)				
2901					
2902					
2903					
2998	Summary of remaining write-ins for Line 29 from overflow page				
2999	TOTALS (Lines 2901 through 2903 plus 2998) (Line 29 above)				

STATEMENT OF REVENUE AND EXPENSES (Continued)

		1 Current Year To Date	2 Prior Year To Date	3 Prior Year Ended December 31
	CAPITAL & SURPLUS ACCOUNT			
33.	Capital and surplus prior reporting year	16,124,533	7,959,100	7,959,100
34.	Net income or (loss) from Line 32	(30,422,301)	(3,681,525)	(15,295,456)
35.	Change in valuation basis of aggregate policy and claim reserves			
36.	Change in net unrealized capital gains (losses) less capital gains tax of $.....0			
37.	Change in net unrealized foreign exchange capital gain or (loss)			
38.	Change in net deferred income tax			
39.	Change in nonadmitted assets	(298,577)	893,901	(396,977)
40.	Change in unauthorized and certified reinsurance			
41.	Change in treasury stock			
42.	Change in surplus notes	5,854,666	21,133,361	24,285,636
43.	Cumulative effect of changes in accounting principles	17,080,047		
44.	Capital Changes			
	44.1 Paid in			
	44.2 Transferred from surplus (Stock Dividend)			
	44.3 Transferred to surplus			
45.	Surplus adjustments			
	45.1 Paid in			
	45.2 Transferred to capital (Stock Dividend)			
	45.3 Transferred from capital			
46.	Dividends to stockholders			
47.	Aggregate write-ins for gains or (losses) in surplus	(1,203,705)	(427,770)	(427,770)
48.	Net change in capital and surplus (Lines 34 to 47)	(8,989,870)	17,917,967	8,165,433
49.	Capital and surplus end of reporting period (Line 33 plus 48)	7,134,663	25,877,067	16,124,533
	DETAILS OF WRITE-INS			
4701.	PRIOR YEAR ADJUSTMENT SUBSEQUENT TO THE ANNUAL FILING	(1,203,705)	(427,770)	(427,770)
4702.				
4703.				
4798.	Summary of remaining write-ins for Line 47 from overflow page			
4799.	TOTALS (Lines 4701 through 4703 plus 4798) (Line 47 above)	(1,203,705)	(427,770)	(427,770)

ATTACHMENT 4

TO

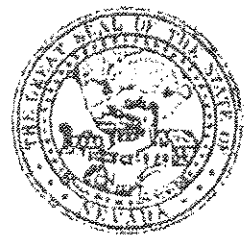
AFFIDAVIT OF KATHLEEN LACE IN SUPPORT OF PETITION FOR APPOINTMENT OF COMMISSIONER AS RECEIVER AND OTHER PERMANENT RELIEF; REQUEST FOR TEMPORARY INJUNCTION PURSUANT TO NRS 696B.270(1)

BRIAN SANDOVAL
Governor

STATE OF NEVADA

BRUCE H. BRESLOW
Director

AMY L. PARKS
Acting Commissioner



DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE
1818 East College Pkwy., Suite 103
Carson City, Nevada 89706
(775) 687-0700 • Fax (775) 687-0787
Website: doi.nv.gov
E-mail: insinfo@doi.nv.gov

August 21, 2015

Pamela Egan
Chief Executive Officer
Nevada Health CO-OP
3900 Meadows Lane
Las Vegas, NV 89107

SENT VIA E-MAIL:
pegan@nevadahealthcoop.org
CERTIFIED MAIL NO.
7012 2920 0001 8639 3661

Re: Request for Reconsideration of Permitted Practice

Dear Ms. Egan:

Please accept this letter in response to your request for reconsideration of permitted practice dated August 20, 2015. On August 10, 2015, on behalf of the Nevada Health CO-OP ("NHC"), you requested that NHC be granted a permitted practice by the State of Nevada, Department of Business and Industry, Division of Insurance ("Division"), to remove from your 2015 second quarter financial statement, the liability of a $17,080,047 debt ("Debt") for the start-up loan from the Centers for Medicare & Medicaid Services ("CMS"). The Debt is currently being treated as a long term liability in accordance with SSAP No. 15 – Debt and Holding Company Obligations. On August 14, 2015, this request was denied.

On Monday, August 17, 2015, you provided information to the Division that NHC, through a Board resolution on August 15, 2015, resolved to cease certain operations in Nevada for the 2015 plan year, withdraw its proposed 2016 health benefit plans and not seek certification, voluntarily suspend NHC's Certificate of Authority, and immediately cease and desist from selling health benefit plans in 2015. Moreover, you requested assistance from the Division in effecting a voluntary and orderly run-off for NHC's 2015 operations, recognizing that the paramount concern is for policyholders, providers, and consumers. Also on August, 17, 2015, you requested, and the Division granted, an extension until the end of business on August 21, 2015, for NHC to submit its 2015 second quarter financial statement.

In order to accomplish a voluntary and orderly run-off of NHC's 2015 operations, you have now requested that the Acting Commissioner reconsider granting a permitted practice deviating from SSAP No. 15, and allow NHC to not report the Debt as a liability in its 2015 second quarter financial statement. This is now requested based on the Board's resolution to submit to a voluntary surrender of its Certificate of Authority, cease certain operations in Nevada, commence a voluntary and orderly run-off for its 2015 operations, and a commitment to its policyholders, providers and consumers.

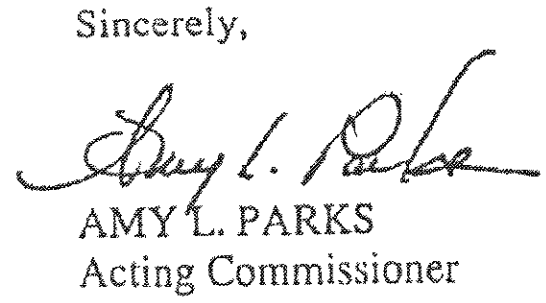
The request for a permitted practice to allow NHC to not report the Debt as a liability on its 2015 second quarter financial statement is granted *contingent on the following terms and conditions*:

- NHC not write or solicit any new business in the state of Nevada for the 2015 plan year, withdraw its proposed 2016 health benefit plans and not seek certification of those health benefit plans, voluntarily suspend NHC's Certificate of Authority, and immediately cease and desist from selling health benefit plans in 2015; and
- NHC submit to the Division for review an approvable run-off plan by Friday, August 28, 2015; and
- NHC understands and agrees that the run-off will include supervision by the Division and cooperation with the Division and CMS in achieving an orderly run-off in the best interests of consumers.

Failure to meet any or all of the conditions as outlined above for this conditional permitted practice may result in the immediate reversion of the permitted practice such that the Debt will be treated as a long term liability post hoc for the NHC's 2015 quarterly financial statement in accordance with long term liability in accordance with SSAP No. 15 – Debt and Holding Company Obligations.

Thank you for your cooperation and commitment to the policyholders, providers, and consumers in Nevada. If any further request or extension is needed beyond the second quarter filing, a separate request to renew the permitted practice must be made in writing. Please do not hesitate to contact me if you have any questions or need additional information.

Sincerely,



AMY L. PARKS
Acting Commissioner

c: Omar Akel, Chief Insurance Examiner

EXHIBIT B

TO

PETITION FOR APPOINTMENT OF COMMISSIONER AS RECEIVER AND OTHER PERMANENT RELIEF; REQUEST FOR TEMPORARY INJUNCTION PURSUANT TO NRS 696B.270(1)

STATE OF NEVADA
DEPARTEMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE

AFFIDAVIT OF ANNETTE JAMES IN SUPPORT OF PETITION FOR APPOINTMENT OF COMMISSIONER AS RECEIVER AND OTHER PERMANENT RELIEF; REQUEST FOR TEMPORARY INJUNCTION PURSUANT TO NRS 696B.270(1)

STATE OF NEVADA)
) ss:
COUNTY OF CARSON CITY)

I, Annette James, being duly sworn, on oath, depose and say that:

1. I am a Lead Actuary for the State of Nevada, Department of Business and Industry, Division of Insurance ("Division").

2. I have a Bachelor of Science in Actuarial Science, a four-year undergraduate degree from Drake University, Des Moines, Iowa. I am a Fellow of the Society of Actuaries, a member of the American Academy of Actuaries, and a Fellow of the Conference of Consulting Actuaries.

I am an active volunteer in the actuarial and regulatory community. I am a member of the Health Committee of the Actuarial Standards Board[1] ("ASB"), a member of the Health Practice International Committee and the Financial Reporting and Solvency Committee of the American Academy of Actuaries. I also serve on the AV/MV Work Group and the Risk Sharing Subcommittee of the Individual and Small Group Committee of the Health Practice Council of the American Academy of Actuaries. Additionally, I am a member of the Committee for Collaboration between the Financial Reporting and Health Sections of the Society of Actuaries.

3. As the Lead Actuary for Life and Health insurance matters at the Division, I am responsible for reviewing the actuarial reserves and actuarial assets included in the financial statements and related documents filed with the Division by the Nevada Health CO-OP ("CO-OP" or "Company"). I am providing this Affidavit in my capacity as

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[1] The ASB sets professional standards for the actuarial profession in the United States.

the Lead Actuary for Life and Health insurance matters.

4. During my review of the CO-OP's financial statements as of December 31, 2014, and as of March 31, 2015, I noted the significant and continuing underwriting losses experienced by the CO-OP which indicates that the premiums charged were insufficient. As a result, I requested that the CO-OP establish a premium deficiency reserve ("PDR")[2] as of June 30, 2015, in accordance with Statement of Statutory Accounting Principles ("SSAP") No. 54 and the applicable actuarial standards of practice ("ASOP"). The CO-OP's actuaries calculated the PDR to be $15,900,000 as of June 30, 2015, and this amount was recorded on the June 30, 2015 quarterly financial statements. I reviewed the calculation of the PDR and found it to be reasonable and in accordance with the appropriate ASOPs. The PDR accounted for $15,900,000 of the $30,422,301 loss reported as of June 30, 2015.

5. I also reviewed the claims unpaid liability of $15,027,286 and found it to be a reasonable estimate of the claims that were incurred and not yet paid as of June 30, 2015.

6. As of June 30, 2015, the CO-OP reported a receivable of $16,200,240 as the amount expected to be received from the Centers for Medicare and Medicaid Services ("CMS") under the Federal Risk Corridor program. The calculations of the amounts due to be paid to the CO-OP appear to be reasonable. However, since only the amounts collected under this three-year program may be distributed, and CMS has not yet released its initial report of the program's collections and distributions, there is significant uncertainty about the timing and magnitude of the actual payments. Pursuant to SSAP 107, the entire amount is currently being recognized as a receivable since the Risk Corridor amounts will be considered as admitted assets regardless of when it is collected and information relating to the ultimate collectability of amounts due

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[2] A premium deficiency reserve is required to be held if it is expected that claims and expenses will exceed premiums charged during the contract period.

under this program is not yet available. The collectability of the amounts receivable under the Risk Corridor program is not an actuarial assumption and is, therefore, beyond the scope of my review.

7. On September 23, 2015, the CO-OP provided the Division with draft financials as of August 31, 2015. However, the actuarial items are currently under review for accuracy and reasonableness.

8. Due to the size of the liabilities in relation to assets, the inadequacy of premiums to support incurred claims and expenses, and the uncertainty surrounding the collectability of large receivables, the CO-OP is unsound pursuant to NRS 696B.210(2).

9. I declare under penalty of perjury that the foregoing is true and correct based on my personal knowledge.

Annette James

Annette James, FSA, MAAA, FCA,
Lead Actuary

SUBSCRIBED and SWORN to
before me this 25 day of September, 2015.

Felecia Casci

NOTARY PUBLIC

FELECIA CASCI
NOTARY PUBLIC
STATE OF NEVADA
No. 08-8726-3 My Appt. Exp. Nov. 17, 2016

EXHIBIT C

TO

PETITION FOR APPOINTMENT OF COMMISSIONER AS RECEIVER AND OTHER PERMANENT RELIEF; REQUEST FOR TEMPORARY INJUNCTION PURSUANT TO NRS 696B.270(1)

FILED
AUG 21
Div. of Insurance
State of Nevada

STATE OF NEVADA
DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE

IN THE MATTER OF

NEVADA HEALTH CO-OP.

_____/

CAUSE NO. 15.0268
COMPANY ID NO. 119733
NAIC ID NO. 15132

ORDER OF VOLUNTARY SUSPENSION OF CERTIFICATE OF AUTHORITY

WHEREAS, the NEVADA HEALTH CO-OP ("NHC") is a health maintenance organization domiciled in the state of Nevada, Company ID No. 119733, and NAIC ID NO. 15132; and

WHEREAS, pursuant to Chapter 695C of the Nevada Revised Statutes ("NRS"), on January 2, 2013, NHC received a Certificate of Authority from the State of Nevada, Department of Business and Industry, Division of Insurance ("Division"), to establish or operate a health maintenance organization in the state of Nevada (Exhibit A); and

WHEREAS, on July 3, 2013, NHC received an Amended Certificate of Authority reflecting the service area as all zip codes in Nevada (Exhibit B); and

WHEREAS, NHC, pursuant to a Board resolution on August 15, 2015, and subsequent request on August 17, 2015, has resolved and agreed to voluntarily suspend its Certificate of Authority and establish an orderly run-off plan for its operations; and

WHEREAS, the Commissioner finds that it would be in the best interests of the people of this state that NHC's Certificate of Authority be suspended effective on the date of this Order; and

WHEREAS, effective immediately, NHC shall:

(1) Not write any new business or solicit any new enrollees in the state of Nevada;

(2) Continue to administer its 2015 health care plans in accordance with a run-off plan approved by the Commissioner;

(3) File its annual statements and pay required fees; and

(4) Complete any further items outlined by the Commissioner.

WHEREAS, it is the policy of the Commissioner that the Certificate of Authority is not transferrable and, pursuant to NRS 680A.160, remains at all times the property of the state of Nevada; and

WHEREAS, NRS 680A.160 requires that the insurer shall promptly deliver the Certificate of Authority to the Commissioner upon its suspension, termination or expiration.

IT IS THEREFORE ORDERED that:

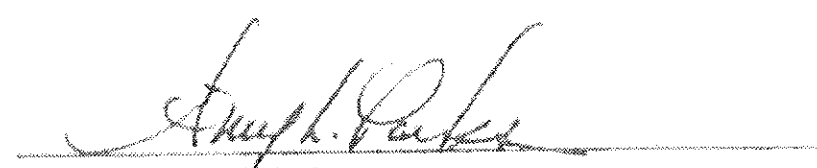
1. The Certificate of Authority of NHC, Company ID No. 119733 and NAIC ID No. 15132, is hereby voluntarily suspended pursuant to NRS 695C.330, effective August 21, 2015, according to the above.

2. NHC requested a voluntary suspension and, as a result, waived its right to a hearing pursuant to NRS 695C.330.

3. Nothing in this Order shall prevent the Commissioner from pursuing any other subsequent regulatory action as may be necessary.

4. NHC shall forthwith deliver to the Commissioner the Nevada Certificate of Authority, Company ID No. 119733.

SO ORDERED this 21st day of August, 2015.



AMY L. PARKS
Acting Commissioner of Insurance

Certificate of Authority

STATE OF NEVADA
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INSURANCE
Carson City, Nevada

Nevada ID #: 119733

THE NEVADA HEALTH CO-OP

Incorporated in the State of NEVADA

Home office at LAS VEGAS, NEVADA

having duly qualified, is hereby licensed to transact:

** HEALTH MAINTENANCE ORGANIZATION (NRS 695C) **

(Service Area by Counties and zip codes): Clark – All zip codes

insurance business within the State of Nevada until terminated at the request of the insurer or suspended or revoked by the Commissioner of Insurance.

Original Certificate Dated at Carson City, Nevada this 2nd day of January, 2013

Commissioner of Insurance

EXHIBIT A
PAGE 1 OF 1

Amended Certificate of Authority

STATE OF NEVADA
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INSURANCE
Carson City, Nevada

Nevada ID: 119733

THE NEVADA HEALTH CO-OP

Incorporated in the State of NEVADA

Home office at LAS VEGAS, NEVADA

having duly qualified, is hereby licensed to transact:

** HEALTH MAINTENANCE ORGANIZATION (NRS 695C) **
(Service Area: All zip codes in Nevada)

insurance business within the State of Nevada until terminated at the request of the insurer or suspended or revoked by the Commissioner of Insurance.

Original Certificate Dated at Carson City, Nevada

this 2nd day of January, 2013

Amended this 3rd day of July, 2013

Commissioner of Insurance

EXHIBIT B
PAGE 1 OF 1

CERTIFICATE OF MAILING

I hereby certify that I have this day served the **ORDER OF VOLUNTARY SUSPENSION OF CERTIFICATE OF AUTHORITY, CAUSE NO. 15.0268**, via e-mail, and by mailing a true and correct copy thereof, properly addressed with postage prepaid, certified mail, return receipt requested, to the following:

Pamela Egan
Chief Executive Officer
Nevada Health CO-OP
3900 Meadows Lane
Las Vegas, NV 89107
CERTIFIED MAIL NO. 7012 2920 0001 8639 3661
E-MAIL: pegan@nevadahealthcoop.org

DATED this 21st day of August, 2015.

Terri Verbruggen

Employee of the State of Nevada
Department of Business and Industry
Division of Insurance

EXHIBIT D

TO

PETITION FOR APPOINTMENT OF COMMISSIONER AS RECEIVER AND OTHER PERMANENT RELIEF; REQUEST FOR TEMPORARY INJUNCTION PURSUANT TO NRS 696B.270(1)

RESOLUTION OF THE BOARD OF DIRECTORS OF NEVADA HEALTH CO-OP

The Board of Directors (the "Board") of Nevada Health CO-OP, a Nevada non-profit cooperative corporation ("CO-OP"), pursuant to Article IV.I of the CO-OP Bylaws, do hereby adopt the following resolution:

WHEREAS, pursuant to Nevada Revised Statutes Section 78.315 and Section 82.206, as well as Article IV.H. of the CO-OP's Bylaws, the Board may by resolution, passed by a majority of the Board, take action to approve and cooperate with the Nevada Department of Insurance (the "Division") in its filing for a Conservation/Rehabilitation Receivership (the "Receivership") to preserve assets during the wind-down of the CO-OP;

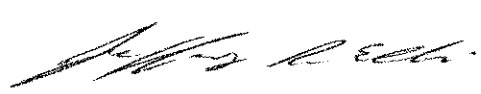
WHEREAS, the Board believes it is in the best interest of the CO-OP's members to cooperate with the Division in the filing for Receivership and preservation of assets during the wind-down of the CO-OP;

NOW, THEREFORE, BE IT RESOLVED, that the Board hereby authorizes and approves cooperation with the Division in the filing for Receivership and other actions as may be necessary and appropriate to preserve assets during the wind-down of the CO-OP;

BE IT FURTHER RESOLVED, that all acts and things done by any officer of the CO-OP as any of them deemed necessary or appropriate in connection with the foregoing resolutions hereby are, in all respects ratified, confirmed, approved and adopted as acts by and on behalf of the CO-OP.

Unanimously adopted by the Board of Directors as of this 25th day of September, 2015:

BOARD OF DIRECTORS



JEFF ELLIS

ITS: CHAIRMAN

EXHIBIT J

EXHIBIT J

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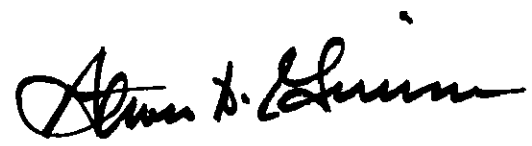

CLERK OF THE COURT

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

IN THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA

CLARK COUNTY, NEVADA

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

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

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

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

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

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Las Vegas, Nevada 89101

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

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

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

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

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

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

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

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

IT IS SO ORDERED

DATED this 14 day of October, 2015.

DISTRICT COURT JUDGE

Respectfully submitted by:

ADAM PAUL LAXALT
Attorney General

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

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

NOTICE TO BE PROVIDED TO:

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

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

TAB 27

TAB 27

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Steven D. Grierson
CLERK OF THE COURT

APEN (CIV)
JOHN R. BAILEY
Nevada Bar No. 0137
SARAH E. HARMON
Nevada Bar No. 8106
JOSEPH A. LIEBMAN
Nevada Bar No. 10125
REBECCA L. CROOKER
Nevada Bar No. 15202
BAILEY❖KENNEDY
8984 Spanish Ridge Avenue
Las Vegas, Nevada 89148-1302
Telephone: 702.562.8820
Facsimile: 702.562.8821
JBailey@BaileyKennedy.com
SHarmon@BaileyKennedy.com
JLiebman@BaileyKennedy.com
RCrooker@BaileyKennedy.com

SUZANNA C. BONHAM
Texas Bar No. 24012307
EMMA C. MATA
Texas Bar No. 24029470
SEYFARTH SHAW LLP
700 Milam, Suite 1400
Houston, Texas 77002
Telephone: 713.225.2300
SBonham@seyfarth.com
EMata@seyfarth.com

Attorneys for Defendants
Unite Here Health and Nevada Health Solutions, LLC

BAILEY❖KENNEDY
8984 SPANISH RIDGE AVENUE
LAS VEGAS, NEVADA 89148-1302
702.562.8820

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 FOR LEAVE TO FILE THIRD-PARTY COMPLAINT** **VOLUME 2 OF 2**

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, Volume 2 of 2, to their Motion for Leave to File Third Party Complaint.

BAILEY ❖ KENNEDY
8984 SPANISH RIDGE AVENUE
LAS VEGAS, NEVADA 89148-1302
702.562.8820

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I	Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1), Case No. 15-725244-C	181-226
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DATED this 15th day of October, 2020.

BAILEY❖KENNEDY

By: /s/ John R. Bailey
JOHN R. BAILEY
SARAH E. HARMON
JOSEPH A. LIEBMAN
REBECCA L. CROOKER

SEYFARTH SHAW LLP
SUZANNA C. BONHAM
EMMA C. MATA
Attorneys for Defendants Unite Here Health and Nevada Health Solutions, LLC

BAILEY❖KENNEDY
8984 SPANISH RIDGE AVENUE
LAS VEGAS, NEVADA 89148-1302
702.562.8820

CERTIFICATE OF SERVICE

I certify that I am an employee of BAILEY❖KENNEDY and that on the 15th 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 addresses:

MARK E. FERRARIO ERIC W. SWANIS DONALD L. PRUNTY **GREENBERG TRAURIG LLP** 10845 Griffith Peak Drive, Suite 600 Las Vegas, Nevada 89135	Email: ferrariom@gtlaw.com swanise@gtlaw.com pruntyd@gtlaw.com *Attorneys for Plaintiff*
JOSEPH P. GARIN ANGELA T. NAKAMURA OCHOA **LIPSON NEILSON, P.C.** 9900 Covington Cross Drive, Suite 120 Las Vegas, Nevada 89135	Email: jgarin@lipsonneilson.com aochoa@lipsonneilson.com *Attorneys for Defendants Kathleen Silver, Bobbette Bond, Tom Zumtobel, Pamela Egan, Basil Dibsie, and Linda Mattoon*
KURT R. BONDS MATTHEW PRUITT **ALVERSON TAYLOR & SANDERS** 6605 Grand Montecito Parkway, Suite 200 Las Vegas, Nevada 89149	Email: kbonds@alversontaylor.com mpruitt@alversontaylor.com *Attorneys for Defendants InsureMonkey, Inc. and Alex Rivlin*
LORI E. SIDERMAN RUSSELL B. BROWN **MEYERS MCCONNELL REISZ SIDERMAN** 1745 Village Center Circle Las Vegas, Nevada 89134	Email: siderman@mmrs-law.com brown@mmrs-law.com *Attorneys for Defendants Martha Hayes, Dennis T. Larson, and Larson & Co, P.C.*

/s/ Sharon Murnane
Employee of BAILEY❖KENNEDY

BAILEY❖KENNEDY
8984 SPANISH RIDGE AVENUE
LAS VEGAS, NEVADA 89148-1302
702.562.8820

EXHIBIT K

EXHIBIT K

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

Plaintiff,

v.

MILLIMAN, INC., a Washington Corporation; JONATHAN L. SHREVE, an Individual; MARY VAN DER HEIJDE, an Individual; MILLENNIUM CONSULTING SERVICES, LLC, a North Carolina Corporation; LARSON & COMPANY P.C., a Utah Professional Corporation; DENNIS T. LARSON, an Individual; MARTHA HAYES, an Individual; INSUREMONKEY, INC., a Nevada Corporation; ALEX RIVLIN, an Individual; NEVADA HEALTH SOLUTIONS, LLC, a Nevada Limited Liability Company; PAMELA EGAN, an Individual; BASIL C. DIBSIE, an Individual; LINDA MATTOON, an Individual; TOM ZUMTOBEL, an Individual; BOBBETTE BOND, an Individual; KATHLEEN SILVER, an Individual; UNITE HERE HEALTH, is a multi-employer health and welfare trust as defined in ERISA Section 3(37); DOES I through X inclusive; and ROE CORPORATIONS I-X, inclusive,

Defendants.

Case No. A-17-760558-C
Dept. No. XVI
In the District Court
Clark County, Nevada

Expert Report of:

Henry Miller, Ph.D.
October 2, 2020

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1. Introduction

My name is Henry Miller, Ph.D. I am a Managing Director in the Health Analytics practice of Berkeley Research Group, LLC. I have worked on health care issues for almost 50 years. I have conducted studies on these issues for the federal Medicare program, State Medicaid programs and more than 40 health insurers. I have testified on these issues in the U.S. Congress, several State legislatures and in federal, state and local courts and in arbitrations.

2. Summary of Qualifications

I have worked on Federal health policy issues for most of my career, including issues related to the Federal government's role in funding and supporting private health insurance plans. This work began almost 50 years ago when the Department of Health and Human Services provided grants and technical assistance to Health Maintenance Organizations (HMOs). I led a technical assistance effort to establish and improve HMO financial management. I also worked with the Centers for Medicare and Medicaid Services (CMS) on several issues related to Medicare + Choice and Medicare Advantage (MA) plans, including assignments relating to the submission of claims and encounter data by plans and the development of CMS' risk adjustment formula for setting MA premiums. I subsequently worked with several insurers on MA plan issues.

My Federal health policy experience includes assignments for health agencies throughout the government, including the Health Resources and Services Administration, the National Center for Health Statistics, the National Institutes of Health, and the Agency for Healthcare Research and Quality. I also conducted several additional assignments for CMS.

My experience in working with health insurers and third-party administrators is also extensive. I have worked with more than 40 health plans, including most of the Nation's largest health insurers as well as most Blue Cross and Blue Shield plans. This work included evaluation of claims processing systems, design of benefit programs, development of provider networks and establishment of provider fee schedules and payment systems. I also worked with the Boards of Blue Cross and Blue Shield plans to evaluate management structures.

I have worked with third-party administrators (TPAs) on a variety of issues ranging from evaluations of marketing materials to reviews of claims processing issues and the development of provider payment approaches. This work was completed for TPAs in different regions of the U.S.

My experience in utilization management includes comprehensive reviews of utilization management approaches for Blue Cross and Blue Shield plans. In this work, I addressed the cost-benefit of specific approaches, including different aspects of pre-admission certification and determinations of medical necessity. I also assisted health insurers in structuring their utilization management functions and communicating their utilization management procedures and findings to providers.

My curriculum vitae is attached to this report as Appendix A.

3. Scope of Assignment

I was asked by the law firms of Seyfarth Shaw LLP and Bailey Kennedy to review materials and offer my expert opinions on issues related to the case of *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.* (Milliman)*; Jonathan L. Shreve; Mary Van Der Heijde; Millennium Consulting Services, LLC* (Millennium)*; Larson & Company, P.C.* (Larson)*; Dennis T. Larson; Martha Hayes; InsureMonkey, Inc.* (InsureMonkey or IM)*; Alex Rivlin; Nevada Health Solutions, LLC; Pamela Egan; Basil C. Dibsie; Linda Mattoon; Tom Zumtobel; Bobbette Bond; Kathleen Silver* (collectively NHC Management Defendants)*; and Unite Here Health* (collectively Defendants) (the Case).[1] My opinions are limited to two defendants: Unite Here Health (UHH) and Nevada Health Solutions (NHS). I was specifically asked to offer opinions on the cause of the failure of the Nevada Health CO-OP (NHC), whether UHH and/or NHS caused or was a substantial factor in bringing about the failure of NHC, as well as the reports prepared by Plaintiff's experts.[2,3]

BRG is receiving compensation for all work on this matter at hourly billing rates. BRG is compensated $750 per hour for Dr. Miller's services, and at rates between $160 per hour to $600 per hour for other BRG personnel, depending upon level and experience. BRG's compensation for work on this matter is not contingent upon the outcome of this matter or the opinions reached.

4. Background of Case

When the Patient Protection and Affordable Care Act (ACA) was enacted in 2010, it included a section on the establishment of Consumer Operated and Oriented Plans (commonly referred to as "cooperatives" or "CO-OPs" that would compete with health insurers to provide health coverage.[4] CO-OPs are private, nonprofit, state-licensed health insurance carriers.[5] Their plans are sold on either a state health insurance exchange or on the Federal health insurance exchange, commonly referred to as "exchanges" or "marketplaces." Most CO-OPs focus on providing coverage to individuals rather than groups.

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[1] Amended Complaint. State of Nevada, Ex Rel. v Milliman, Inc., et al. (September 24, 2018).

[2] Special Deputy Receiver's Report for Nevada Health CO-OP, Causation and Damages for Key Vendors Unite Here Health, Nevada Health Solutions, and InsureMonkey. PLAINTIFF02479813-02479851. (DRAFT SDR Report); Expert Report of Mark A. Fish, F.S.A., M.A.A.A., dated February 7, 2020. (Fish Report II); Expert Report of Henry William Osowski, dated February 7, 2020. (Osowski Report II); Expert Report of Joseph J. DeVito, dated July 30, 2019 (DeVito Report). It is unclear if the Fish Report II and Osowski Report II amend, supersede or supplement their initial reports from July 2019 (Osowski Report I and Fish Report I), therefore, my opinions are primarily responsive to the Fish Report II and Osowski Report II except when I discuss inconsistencies and/or overlap between the versions.

[3] I was also asked to assist in drawing random and representative samples of the following SDR claim number related damage categories: (1) DRAFT SDR Report's 2014 & 2015 Claims Overpayments, (2) DRAFT SDR Report's 2014 Claims Paid Outside of Eligibility (POE) and (3) DRAFT SDR Report's 2015 Claims POE. See Appendix B.

[4] 111th Congress. "Patient Protection and Affordable Care Act". Public Law 111–148, dated March 23, 2010. Section 1322(a)(1).

[5] 111th Congress. "Patient Protection and Affordable Care Act". Public Law 111–148, dated March 23, 2010. Section 1322(a)(2).

Originally, Congress expected to fund the CO-OP Program with $10 billion in grants, but this amount was reduced to $6 billion and rather than grants, the government made the money available as loans.[6] This change occurred as the Democratic majority House of Representatives became a Republican majority in the elections of 2010. In 2011 and 2012, funding was cut even further.[7] Eventually, a total of $2.4 billion in loans was awarded to the 23 CO-OPs that were part of the Federal CO-OP Program.[8] Most of these CO-OPs were newly established and used Federal funds to support their organizational activities.[9]

NHC was one of the newly established organizations. NHC was the successor to Hospitality Health, Ltd. (HH), which was established by the Culinary Health Fund (CHF) in 2011.[10] NHC began providing health coverage to Nevada residents on January 1, 2014 and ceased providing coverage on August 17, 2015, due to its deteriorating financial condition.[11] NHC was placed into receivership on September 25, 2015.[12] It did not have sufficient funds to meet the requirements of providers and insureds.[13]

NHC contracted with several vendors to perform many of its activities, including UHH for consulting[14] and third party administrative services,[15] and NHS for medical utilization review services.[16] UHH is a multi-employer Taft-Hartley Trust Fund that serves union employees in the hospitality, food service and

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[6] Bash, D. and Barrett, T. "Negotiations over health insurance co-ops at impasse." CNNpolitics, dated June 23, 2009. Available at http://edition.cnn.com/2009/POLITICS/06/23/health.care/index.html?iref=newssearch. See also Redhead, S. C. "Appropriations and Fund Transfers in the Affordable Care Act (ACA)". Congressional Research Service, dated February 7, 2017, p. 6. Available at https://fas.org/sgp/crs/misc/R41301.pdf.
[7] Levinson, D. R. "Actual Enrollment and Profitability was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might affect Their Ability to Repay Loan Provided Under the Affordable Care Act". Department of Health and Human Services: Office of Inspector General, dated July 2015. A-005-14-00055, p. 12.
[8] Levinson, D. R. "Actual Enrollment and Profitability was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loan Provided Under the Affordable Care Act". Department of Health and Human Services: Office of Inspector General, dated July 2015. A-005-14-00055, p. ii.
[9] Levinson, D. R. "Actual Enrollment and Profitability was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loan Provided Under the Affordable Care Act". Department of Health and Human Services: Office of Inspector General, dated July 2015. A-005-14-00055, p. i.
[10] Amended Complaint, State of Nevada, Ex Rel. v. Milliman, Inc., et al. (September 24, 2018). ¶ 3.
[11] Amended Complaint, State of Nevada, Ex Rel. v. Milliman, Inc., et al. (September 24, 2018). ¶ 4.
[12] Amended Complaint, State of Nevada, Ex Rel. v. Milliman, Inc., et al. (September 24, 2018). ¶ 5.
[13] Amended Complaint, State of Nevada, Ex Rel. v. Milliman, Inc., et al. (September 24, 2018). ¶ 8.
[14] Consulting Agreement between Unite Here Health and Hospitality Health, Ltd., dated January 30, 2013. UHH0000041-UHH0000065; Letter from Jeff Ellis, Director and Co-Chair of Nevada Health CO-OP and Hospitality Health Ltd. to Matthew Walker, CEO of Unite Here Health regarding Assignment of Consulting Agreement from Hospitality Health, Ltd. to Nevada Health CO-OP, dated May 8, 2013. UHH0000066; Letter of Clarification regarding the Consulting Agreement, dated May 16, 2013. UHH0000067. (Consulting Agreement)
[15] Administrative Services Agreement between Unite Here Health and Nevada Health CO-OP, dated on June 27, 2013 and Amendments and Agreement Letters. UHH0000001-UHH0000039. (ASA)
[16] Utilization Management Services Agreement between Nevada Health CO-OP and Nevada Health Solutions, LLC, dated July 19, 2013. NHS0000001-NHS0000100. Business Associate Agreement between Nevada Health Solutions and Nevada Health CO-OP, effective October 1, 2013. NHS0000101-NHS0000117. Termination Letter from Kathy Silver, President of NHS, to Tom Zumtobel, Chief Executive Officer of NHC, Regarding Utilization Management Services Agreement dated as of July 19, 2013 between Nevada Health CO-OP ("CO-OP") and NHS, as amended (the "Agreement"), dated October 23, 2014. NHS0000118.

gaming industries.[17] NHS is a URAC accredited provider of medical management services including pre-admission certification, concurrent review, and case management.[18]

Plaintiff alleges that UHH and NHS caused or substantially contributed to the failure of NHC. Specifically, Plaintiff alleges that UHH failed to properly assure the eligibility of insureds, paid claims for which insureds were not eligible, did not properly report insurance data and mishandled recordkeeping and computer systems.[19] In addition, Plaintiff alleges that NHS did little work for NHC and was paid unfairly due to its capitation agreement.[20]

Defendants UHH and NHS deny all of Plaintiff's allegations.[21] As discussed in subsequent sections of this report, it is clear that UHH and NHS did not cause or substantially contribute to the failure of NHC. Instead, NHC failed because the Federal CO-OP program failed and because NHC's claims costs substantially exceeded its premium revenue, and due to various operational issues unrelated to the actions of UHH and NHS.[22]

5. Summary of Opinions

A summary of my primary opinions, which I discuss in detail in this report, are as follows:

- The Federal ACA program systematically failed, causing the collapse/failure of NHC as well as 18 other CO-OPs[23];
- UHH and/or NHS did not cause the failure of NHC nor were they (either individually or collectively) a substantial factor in bringing about NHC's failure, damages or losses. Instead, like other CO-OPs across the U.S., NHC failed because its claims cost exceeded its premium revenue and because the Federal Government failed to provide expected financial support;
- Plaintiff's experts fail to demonstrate that UHH and/or NHS caused the failure of NHC; and
- Plaintiff's experts' opinions regarding damages are seriously flawed.

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[17] Unite Here Health. "Mission & Overview". Available at https://www.uhh.org/about.

[18] Nevada Health Solutions. "About Nevada Health Solutions". Available at https://www.nevadahealthsolutions.org/about/. See also URAC Certificate of Full Accreditation awarded to NHS effective First Friday of November 2013 to First Tuesday of November 2016. Certificate Number: U130019-3546. NHS0000658. "URAC was originally incorporated under the name Utilization Review Accreditation Commission." See https://www.urac.org/accreditation-faqs.

[19] Amended Complaint. State of Nevada, Ex Rel. v Milliman, Inc., et al. (September 24, 2018). ¶31.

[20] Amended Complaint. State of Nevada, Ex Rel. v Milliman, Inc., et al. (September 24, 2018). ¶38.

[21] Nevada Health Solutions, LLC's Answer to Amended Complaint. State of Nevada, Ex Rel. v. Milliman, Inc., et al. (July 30, 2019). ¶ 4. Unite Here Health's Answer to Amended Complaint. State of Nevada, Ex Rel. v. Milliman, Inc., et al. (October 22, 2018). ¶ 4.

[22] The operational issues are specifically addressed in the Expert Report of Christina Melnykovych and Tina Pelton, Coding Continuum, Inc. dated October 2, 2020 (CCI Report) as well as in this report.

[23] A 19th CO-OP, New Mexico Health Connections, has announced that it has also failed and will cease operations on December 31, 2020.

In forming my opinions, I was assisted by BRG professionals and other consulting professionals working under my direction. A list of data and documents relied upon in forming my opinions is presented in Appendix C.

6. The Federal Affordable Care Act (ACA) CO-OP Program Failed

In my opinion, NHC failed for reasons that are unrelated to the activities of UHH and NHS. Specifically, it is critically important to understand that the Federal CO-OP Program failed. NHC was one of 23 CO-OPs that were funded with loans from the Federal CO-OP Program. All 23 CO-OPs experienced serious financial problems. Eighteen of the 23 CO-OPs failed within the same time frame as NHC and none of those 18 CO-OPs used UHH and/or NHS. An additional CO-OP (New Mexico Health Connections) announced that it is closing at the end of 2020. This CO-OP also did not use UHH and/or NHS. As of the date of this report, the remaining CO-OPs have struggled to maintain their financial viability. While the failure of the Federal CO-OP Program was undeniably the primary cause of NHC's failure, additional factors that contributed to NHC's failure are discussed in subsequent sections and in the CCI Report.

6.1 Overview of the Affordable Care Act

The ACA was enacted in 2010.[24] A key goal of the ACA was to "make affordable health insurance available to more people."[25] "Between 2013 and 2016, the number of uninsured individuals in Nevada declined from 570,000 to 330,000, a 42.1 percent decrease."[26] The ACA made many reforms to the individual insurance market such as[27]:

- Requiring guaranteed coverage of pre-existing health conditions;
- Adding coverage of preventive health services and essential health benefits;
- Ending lifetime limits on coverage;
- Limiting community rating based on age;
- Providing subsidies; and
- Establishing an individual penalty for not having health insurance.

Aspects of the ACA are especially relevant to this case. For example, a key intent of the ACA was to make coverage available and affordable for people with preexisting conditions.[28] People with

[24] 111th Congress. "Patient Protection and Affordable Care Act". Public Law 111–148, dated March 23, 2010.
[25] HealthCare.gov. "Affordable Care Act (ACA)". Available at https://www.healthcare.gov/glossary/affordable-care-act/.
[26] Ballotpedia. "Effect of the Affordable Care Act in Nevada". Available at https://ballotpedia.org/Effect_of_the_Affordable_Care_Act_in_Nevada.
[27] 111th Congress. "Patient Protection and Affordable Care Act". Public Law 111–148, dated March 23, 2010. Section 1501.
[28] HealthCare.gov. "Coverage for pre-existing conditions". Available at https://www.healthcare.gov/coverage/pre-existing-conditions/. Department of Human & Health Services. "Pre-Existing Conditions". Available at https://www.hhs.gov/healthcare/about-the-aca/pre-existing-conditions/index.html. See also CCIIO. "At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform". CMS. Available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-

preexisting conditions could get coverage if they were members of a large employer group, but coverage was not available for their preexisting conditions if they needed to pursue individual or small group coverage.[29] As a result, a substantial portion of the population that the ACA was aimed at was assumed to be sicker than the general population. To counteract the risk associated with providing coverage to a sicker population, the ACA included an "individual mandate" that required everyone to have health coverage or pay a penalty.[30] There was little data available, however, on the extent of use of medical services by the sicker population or the number of people who would choose to pay a penalty rather than purchase health coverage. Entities that elected to offer coverage, such as NHC and the other CO-OPs that were funded under the ACA, did not have a database they could use to make accurate actuarial projections of medical use in order to set premiums.

The ACA also created a new environment in which coverage was to be sold. Each state was given an opportunity to create its own health insurance exchange or elect to use the Federal exchange.[31] Coverage providers made their policies available on the exchanges and individuals seeking to purchase coverage could choose among them. Health insurance exchanges were a new idea that needed to be established quickly to meet the ACA's requirements for offering coverage by the beginning of 2014.[32] Exchanges needed to establish systems for determining eligibility for coverage, for determining the availability of financial support on an individual level, and for reporting enrollment to insurance carriers who offered policies on the exchange. Although funding was available for establishing exchanges, many exchanges struggled with implementation requirements in the short time frame that was available to them.

As noted, the ACA included a section on the establishment of private, non-profit cooperatives (CO-OPs) that would compete with health insurers to provide health coverage.[33] These CO-OP plans were sold on state health insurance exchanges or on the Federal health insurance exchange.

Resources/preexisting. ("The Center for Consumer Information and Insurance Oversight (CCIIO) is charged with helping implement many reforms of the Affordable Care Act, the historic health reform bill that was signed into law March 23, 2010. CCIIO oversees the implementation of the provisions related to private health insurance. In particular, CCIIO is working with states to establish new Health Insurance Marketplaces." Available at https://www.cms.gov/CCIIO)

[29] Rovner, J. "Did the ACA Create Preexisting Condition Protections for People In Employer Plans?". Kaiser Health News, dated May 21, 2019. Available at https://khn.org/news/did-the-aca-create-preexisting-condition-protections-for-people-in-employer-plans/.

[30] Rosso, R. J. "The Individual Mandate for Health Insurance Coverage: In Brief". Congressional Research Service, updated on August 25, 2020, p. 1. Available at https://fas.org/sgp/crs/misc/R44438.pdf.

[31] Forsberg, V. C., "Overview of Health Insurance Exchanges". Congressional Research Service. June 20, 2018. Available at https://fas.org/sgp/crs/misc/R44065.pdf.

[32] 111th Congress. "Patient Protection and Affordable Care Act". Public Law 111–148, dated March 23, 2010. Section 1321(b).

[33] 111th Congress. "Patient Protection and Affordable Care Act". Public Law 111–148, dated March 23, 2010. Section 1322(a)(1).

6.2 The CO-OP Program Failed Due to Market-Based Issues and the Failure of the Federal Government to Provide Expected Support

The Federal CO-OP program is widely seen as a failure that is generally attributed to market-based and legislative issues.[34] Nineteen of 23 federally funded CO-OPs, including NHC, failed prior to 2020 and one CO-OP failed in 2020, which equates to an overall 87 percent failure rate.[35] All 23 federally funded CO-OPs started selling insurance contracts at the beginning of 2014.[36] By the end of 2015, over half of all CO-OPs (12 total) had failed (including NHC) and five more CO-OPs failed in 2016.[37] Two failed in 2017.[38] One failed in 2020.[39] As of the date of this report, the remaining three that are operating have experienced financial difficulties. As discussed in the sections below, several reasons are cited as being responsible for the failure of the Federal CO-OP Program,[40] including:

- Claims Costs Exceeded Premium Revenue;
- Congressional and Regulatory Changes Destabilized the CO-OP Program;
- The CO-OPs Were Disadvantaged Compared to Their Commercial Competitors; and
- The ACA's 3 R's Failed to Protect CO-OPs from Substantial Losses.

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[34] U.S. Government Publishing Office. "Review of the Affordable Care Act health insurance Co-Op Program: Hearing Before the Permanent Subcommittee on Investigations of the Committee on Homeland Security and Governmental Affairs". United States Senate, One Hundred Fourteenth Congress, Second Session, dated March 10, 2016, pp. 1-2. See also Corlette, S.; Miskell, S.; Lerche, J.; and Giovannelli, J. "Why Are Many CO-Ops Failing? How New Nonprofit Health Plans Have Responded to Market Competition", The Commonwealth Fund, dated December 2015, p. 7. Available at https://www.commonwealthfund.org/publications/fund-reports/2015/dec/why-are-many-co-ops-failing-how-new-nonprofit-health-plans-have.

[35] See Table 2. See also: New Mexico Health Connections. "New Mexico Health Connections, Non-Profit Health Insurer, to Cease Operations in 2021". PRNewswire, dated August 11, 2020. https://www.prnewswire.com/news-releases/new-mexico-health-connections-non-profit-health-insurer-to-cease-operations-in-2021-301110358.html.

[36] Levinson, D. R. "Actual Enrollment and Profitability was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loan Provided Under the Affordable Care Act". Department of Health and Human Services: Office of Inspector General, dated July 2015. A-005-14-00055, p. ii.

[37] Jarmon, G. L. "CMS Oversight Must Continue Because All Remaining Consumer Operated and Oriented Plans Were Not Profitable and May Not Be Viable and Sustainable". Department of Health and Human Services: Office of Inspector General, dated August 2017. A-05-16-00027, p. 1.

[38] Evergreen Health Cooperative (MD) was "unable to offer or bind any new individual policies during Open Enrollment for the 2017 plan year (for policies effective January 1, 2017)" and was "prohibited from selling or renewing any insurance policies" in July 2017. See https://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=2016122 and https://insurance.maryland.gov/Consumer/Documents/Evergreen/Evergreen-Order-Release-7272017.pdf. Minuteman Health, Inc. (MA) stopped writing business as of January 1, 2018. See https://www.nh.gov/insurance/media/pr/2017/documents/06-23-17-nhid-minuteman-to-stop-offering-insurance-in-2018.pdf.

[39] New Mexico Health Connections. "New Mexico Health Connections, Non-Profit Health Insurer, to Cease Operations in 2021". PRNewswire, dated August 11, 2020. Available at https://www.prnewswire.com/news-releases/new-mexico-health-connections-non-profit-health-insurer-to-cease-operations-in-2021-301110358.html.

[40] Corlette, S.; Miskell, M.; Lerche, J.; and Giovannelli, J. "Why Are Many CO-Ops Failing? How New Nonprofit Health Plans Have Responded to Market Competition". The Commonwealth Fund, dated December 2015, pp. 7-8. Available at https://www.commonwealthfund.org/publications/fund-reports/2015/dec/why-are-many-co-ops-failing-how-new-nonprofit-health-plans-have.

6.3 CO-OPs' Claims Costs Exceeded Premium Revenue

As discussed, a primary goal of the ACA was to "make affordable health insurance available to more people."[41] But, "the law's elimination of medical underwriting and health-rating restrictions, and its limits on age rating, have made the market more attractive to older, sicker people."[42] In a report prepared by the Society of Actuaries, the authors described the significance of this and related issues. They noted that in the national individual market, per member per month claims costs rose by approximately 38.0 percent from 2013 to 2014 and then by an additional 30.0 percent from 2014 to 2015.[43] The reasons cited for the increase were:

> "Individual market PMPM claims costs essentially doubled from 2009–2015. The bulk of this increase took place in 2014 and 2015 with the inclusion of ACA Health Insurance Exchange experience…This was driven by the elimination of medical underwriting and the advent of covering preexisting conditions, which had generally not been covered in previous Individual plans. In addition to this, there were large benefit plan design changes where benefits previously not required and often not covered under the old individual policies were now required to be covered as part of the ACA EHBs. Finally, the shifting of membership toward higher age brackets with greater costs also contributed to PMPM increases."[44]

In late 2013, after insurers had already started marketing 2014 plans, CMS announced a transitional relief measure where states could allow individuals and small groups to keep their 2013 ACA-non-compliant plans.[45] The non-compliant ACA plans, or grandfathered plans, were <u>not</u> required to offer free preventive care, end yearly limits on coverage, or cover people with pre-existing health conditions.[46] The CO-OPs' 2014 membership projections and premiums were set well before CMS implemented these transitional relief measures which effectively limited the likelihood that healthy individuals and small groups would enter the ACA risk pool. The negative impact on CO-OPs was substantial because many plans attracted fewer healthy members, and a large number of sicker members. For example,

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[41] HealthCare.gov. "Affordable Care Act (ACA)". Available at https://www.healthcare.gov/glossary/affordable-care-act/.

[42] Glied, S. A. and Jackson, A. "Who Entered and Exited the Individual Health Insurance Market Before and After the Affordable Care Act? Evidence from the Medical Expenditure Panel Survey". The Commonwealth Fund, dated November 29, 2018. Available at https://www.commonwealthfund.org/publications/issue-briefs/2018/nov/who-entered-exited-insurance-market-before-after-aca.

[43] Natsis, A.; Owen, R.; Hargraves, J.; and Hui, A. "Commercial Health Care Cost and Utilization Trends, 2009-2015". Society of Actuaries®, p. 16. Available at https://www.healthcostinstitute.org/images/pdfs/2019-commerical-health-care-cost-utilization-trends-report.pdf.

[44] Natsis, A.; Owen, R.; Hargraves, J.; and Hui, A. "Commercial Health Care Cost and Utilization Trends, 2009-2015". Society of Actuaries®, p. 16. Available at https://www.healthcostinstitute.org/images/pdfs/2019-commerical-health-care-cost-utilization-trends-report.pdf

[45] CCIIO. " Letter from Gary Cohen, Director of CCIIO, to Insurance Commissioners". CMS, dated on November 14, 2013. Available at https://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF.

[46] HealthCare.gov. "Health insurance rights & protection: Grandfathered health insurance plans". Available at https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/.

> "In Iowa, most of the Wellmark (BCBS) market share continues to be in non-compliant plans (the grandmothered/grandfathered pre-ACA plans), so Wellmark cherry picks its own market share. Over three years, news reports show Wellmark lost $90 million on ACA compliant plans, with one enrollee accounting for $18 million in claims for one year alone. So, for 2018, Wellmark will not only leave the marketplace, it will stop offering all ACA compliant plans, keeping in force just their pre-ACA policies."[47]

This is exactly what happened during the 2014 enrollment year. Enrollment in CO-OP plans was generally lower than initial projections and claims expense exceeded premium revenue.[48] Most of the CO-OPs had lower than projected actual enrollment.[49] "For 19 of the 23 CO-OPs with net losses, claims expense exceeded premium revenue for this period. The remaining CO-OPs with net losses reported higher premium revenues than claims expense, but revenue was insufficient to meet general administrative expenses."[50] According to the McKinsey Center for U.S. Health System Reform, CO-OPs were the least profitable carrier type in 2014.[51]

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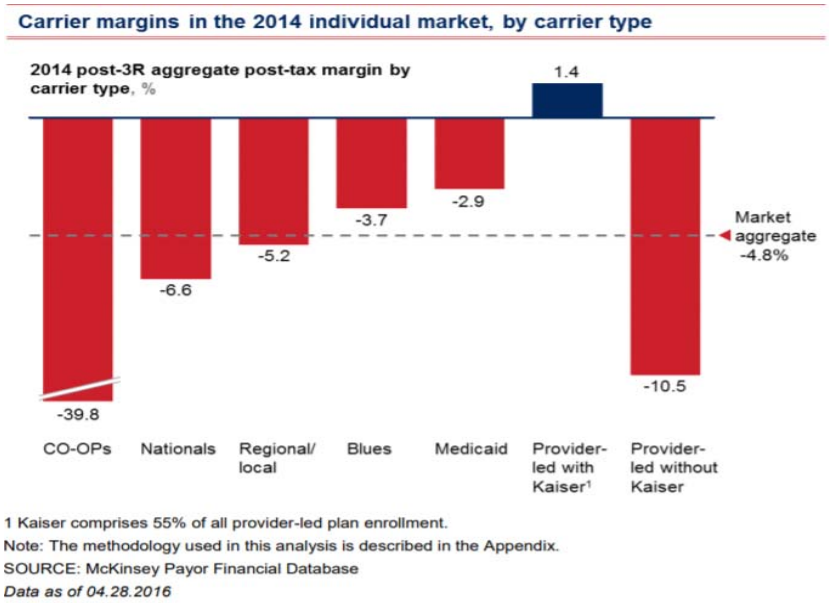
[47] Khazan, O. "Why So Many Insurers Are Leaving Obamacare". The Atlantic, dated on May 11, 2017. Available at https://www.theatlantic.com/health/archive/2017/05/why-so-many-insurers-are-leaving-obamacare/526137/.

[48] Levinson, D. R. "Actual Enrollment and Profitability was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loan Provided Under the Affordable Care Act". Department of Health and Human Services: Office of Inspector General, dated July 2015. A-005-14-00055, p. 8.

[49] Levinson, D. R. "Actual Enrollment and Profitability was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loan Provided Under the Affordable Care Act". Department of Health and Human Services: Office of Inspector General, dated July 2015. A-005-14-00055. Table 1.

[50] Levinson, D. R. "Actual Enrollment and Profitability was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loan Provided Under the Affordable Care Act". Department of Health and Human Services: Office of Inspector General, dated July 2015. A-005-14-00055, p. 8.

[51] McKinsey & Company. "Exchanges three years in: Market variations and factors affecting performance". McKinsey Center for U.S. Health System Reform, updated as of May 13, 2016. Exhibit 2, p. 3. Available at https://healthcare.mckinsey.com/sites/default/files/Intel%20Brief%20-%20Individual%20Market%20Performance%20and%20Outlook%20(public)_vF.pdf.



In my opinion, unexpected high claims costs occurred because of the difficulty that all insurers had with projecting claims costs for a population that was different than populations that had been insured in the past. This problem was discussed frequently in the industry literature.[52] The majority of the people seeking coverage on the exchanges were previously uninsured. Although people who had coverage through an employer of at least one member of a family may have had group coverage, there was no data source to identify the claims costs of the uninsured population. This was especially true for the CO-OPs that had no claims data available to them when they began offering health coverage in 2014.

6.4 Congressional and Regulatory Changes Destabilized the CO-OP Program

Both Congress and the Executive Branch instituted substantial changes to the CO-OP program after the ACA was passed. These changes limited funding for the CO-OPs and established policies that limited and/or eliminated their opportunities for success.

As mentioned, the ACA initially set aside $10 billion in grants for CO-OP activities.[53] When the program was passed, however, the $10 billion was reduced to $6 billion and the funds were to be distributed as loans rather than grants.[54] Two types of loans were established – loans for starting up operations and loans to meet financial solvency requirements of State Insurance Departments.[55]

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[52] See, for example, https://www.healthinsurance.org/maine-state-health-insurance-exchange/, and https://www.healthinsurance.org/montana-state-health-insurance-exchange/.
[53] Bash, D. and Barrett, T. "Negotiations over health insurance co-ops at impasse." CNNpolitics, dated June 23, 2009. Available at http://edition.cnn.com/2009/POLITICS/06/23/health.care/index.html?iref=newssearch.
[54] Redhead, S. C. "Appropriations and Fund Transfers in the Affordable Care Act (ACA)". Congressional Research Service dated February 7, 2017, p. 6. Available at https://fas.org/sgp/crs/misc/R41301.pdf.
[55] CCIIO. "New Federal Loan Program Helps Nonprofits Create Customer-Driven Health Insurers". CMS. Available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/coop_final_rule.

The $6 billion in funding was further reduced before the ACA was implemented. In 2011 and 2012, appropriations bills that were passed reduced the funding level to $3.4 billion.[56] At the end of 2012, CO-OP funding was reduced again under the American Taxpayer Relief Act.[57] In 2013, some funds were sequestered, and CMS ended up awarding only $2.5 billion in loans to CO-OPs, a 76% reduction from the initial level.[58]

As discussed, CO-OPs faced a substantial challenge in 2013 when the Administration announced that insurers could wait to cancel plans not in compliance with the ACA.[59] As a result, at least some healthier people who liked their current plans continued to purchase them outside of exchanges, which meant that enrollees purchasing coverage on the exchanges were sicker and, therefore, more costly than expected.

The ACA also built in methods to limit risk assumed by the CO-OPs.[60] One of these provisions was the risk-corridor program which redistributed funds from insurers who exceeded their target to insurers who had made less than their target.[61] In 2014, after CO-OPs were up and running, the new Congress required the program to be budget-neutral and as a result, the Administration indicated that only 12.6 percent of the funds originally expected to be available for risk corridor payments would actually be available to CO-OPs to continue their operations.[62] (In other words, CO-OPs received only 12.6 percent of the Federal funds they were originally promised, expected, and relied upon to subsidize their losses.) Many CO-OPs were already in critical financial condition and this reduction by Congress assured their failure.

Some CO-OPs challenged the Administration's actions on reducing risk corridor payments in court and on April 27, 2020, the United States Supreme Court issued its decision in *Maine Community Health*

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[56] Redhead, S. C. "Appropriations and Fund Transfers in the Affordable Care Act (ACA)". Congressional Research Service dated February 7, 2017, p. 9. Available at https://fas.org/sgp/crs/misc/R41301.pdf.
[57] Redhead, S. C. "Appropriations and Fund Transfers in the Affordable Care Act (ACA)". Congressional Research Service dated February 7, 2017, p. 9. Available at https://fas.org/sgp/crs/misc/R41301.pdf.
[58] CCIIO. "Loan Program Helps Support Customer-Driven Non-Profit Health Insurers". CMS, updated on December 16, 2014. Available at https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program. See also Redhead, S. C. "Appropriations and Fund Transfers in the Affordable Care Act (ACA)". Congressional Research Service dated February 7, 2017, p. 9. Available at https://fas.org/sgp/crs/misc/R41301.pdf.
[59] CCIIO. "Letter from Gary Cohen, Director of CCIIO, to Insurance Commissioners". CMS, dated on November 14, 2013. Available at https://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF.
[60] CCIIO. "Reinsurance, Risk Corridors, and Risk Adjustment Final Rule". CMS, dated March 2012. Available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/3rs-final-rule.pdf.
[61] Cox, C.; Semanskee, A.; Claxton, G.; and Levitt, L. "Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors". Kaiser Family Foundation, dated August 17, 2016. Available at https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/.
[62] CCIO. "Risk Corridors Payment Proration Rate for 2014". CMS, dated October 1, 2015. Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf.

Options v. United States.[63] The decision concluded that the government was, and now is, obligated to pay an additional $12 billion in risk corridor payments.[64] The Supreme Court was clear in its opinion that the Federal government was obligated to pay the disputed funds to the CO-OPs, but its decision comes years after the vast majority of CO-OPs had already failed.

In my opinion, the substantial difference in funding by the Government between the CO-OPs' original expectations and the amounts actually made available to them led to the destabilization of the Federal CO-OP Program and was a substantial factor in bringing about the CO-OPs' failures, including the failure of NHC.

6.5 The CO-OPs Were Disadvantaged Compared to Their Commercial Competitors

The CO-OPs were disadvantaged compared to their commercial competitors in many key aspects. Starting a health insurance company is complex. First, CO-OPs had very short start-up periods. Loans were awarded in 2012 for a January 1, 2014 start date.[65] Short start-up periods meant decisions on benefit design and premium rate settings had to be made quickly with little available data to project enrollment and costs likely to be incurred by members. Further, coverage was primarily offered to individuals, many of whom had not had coverage previously. In addition, most CO-OPs were facing substantial competition from established insurers and had to set premiums at the same or lower levels than their competitors in order to gain enrollment.[66]

CO-OPs were told that their success depended, in part, on their ability to participate in the first open enrollment period offered by the Health Insurance Exchanges which was occurring at the end of 2013.[67] In its final report, the Federal Advisory Board on the Consumer Operated and Oriented Plan Program recommended that:

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[63] Supreme Court of the United States. Maine Community Health Options v. United States, 590 U. S. ___ (2020). Nos. 18-1023, 18-1028, 18-1038.

[64] Keith, K. "Supreme Court Rules That Insurers are Entitled to Risk Corridors Payments: What the Court Said and What Happens Next". Health Affairs Blog, dated April 28, 2020. DOI: 10.1377/hblog20200427.34146/full/. Available at https://www.healthaffairs.org/do/10.1377/hblog20200427.34146/full/.

[65] Levinson, D. R. "The Centers for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Program Loans in Accordance With Federal Requirements, and Continued Oversight is Needed". Department of Health and Human Services: Office of Inspector General, dated July 2013. A-005-12-00043. Available at https://oig.hhs.gov/oas/reports/region5/51200043.pdf. See also CCIIO. "Loan Program Helps Support Customer-Driven Non-Profit Health Insurers". CMS, updated on December 16, 2014. Available at https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.

[66] Corlette, S.; Miskell, M.; Lerche, J.; and Giovannelli, J. "Why Are Many CO-Ops Failing? How New Nonprofit Health Plans Have Responded to Market Competition". The Commonwealth Fund, dated December 2015, p. 7. Available at https://www.commonwealthfund.org/publications/fund-reports/2015/dec/why-are-many-co-ops-failing-how-new-nonprofit-health-plans-have.

[67] CCIIO. "Report of the Federal Advisory Board on the Consumer Operated and Oriented Plan (CO-OP) Program". CMS, dated April 15, 2011, pp. 15 & 37. Available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/coop_faca_finalreport_04152011.pdf.

> "The Advisory Board recognizes that the need to compete for plan membership means that it will be highly desirable for new CO-OP plans to be ready to enroll members during the first open enrollment period offered by Health Benefit Exchanges. The Advisory Board also recognizes the amount of work and length of time required for CO-OPs to be able to be open for business on this timetable. In order to provide funding for CO-OPs to be ready to accept enrollment in late 2013, the Department should issue draft regulations in Spring 2011. It should issue final regulations and the loan/grant solicitation in Summer 2011, with the capability to receive and review applications in Fall 2011. Because participation in the Health Benefit Exchange is essential to CO-OP viability and the ability to repay loans and grants, a CO-OP should be able to participate in its state's Exchange regardless of the Exchange model adopted in the state."[68]

The Federal government's CO-OP Advisory Board recognized that CO-OPs' financial viability required start-up activities to be completed in less than two years, especially if start-up loans were to be repaid in five years. At the time that the Advisory Board's report was issued, the Board expected $6 billion in loans to be available. As previously discussed, only $2.4 billion was actually made available to CO-OPs.

Other issues also constrained the CO-OPs' operations; namely:

- CO-OPs had limited access to external capital sources. By mid-2016, HHS recognized that CO-OPs had "encountered challenging market conditions in their early years" and that "in the absence of additional Federal loans to CO–OPs, many of these entities would benefit from the infusion of private capital to assist them in achieving long-term stability and competitive success in the market."[69] Initially, "entities offering loans, investments, and services to participate on the board of directors, as is common practice in the private sector" and equity interests could not be offered to equity investors, making it nearly impossible for CO-OPs to access private capital. Effective in May 2016, HHS amended CO-OP requirements to "provide CO–OPs with flexibility common among private market health insurance issuers,"[70] but the changes came too late for many of the CO-OPs. Additionally, "substantially all" of the CO-OPs' business must be in the individual and small-group insurance markets,[71] which meant they could not access the profitable large employer market dominated by their commercial competitors.

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[68] CCIIO. "Report of the Federal Advisory Board on the Consumer Operated and Oriented Plan (CO-OP) Program". CMS, dated April 15, 2011, p. 20. Available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/coop_faca_finalreport_04152011.pdf.

[69] Department of Health and Human Services. "45 CFR Parts 155 and 156: Patient Protection and Affordable Care Act; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program". Federal Register, Vol. 81, No. 91, effective on May 11, 2016, p. 29148. Available at https://www.govinfo.gov/content/pkg/FR-2016-05-11/pdf/2016-11017.pdf.

[70] Department of Health and Human Services. "45 CFR Parts 155 and 156: Patient Protection and Affordable Care Act; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program". Federal Register, Vol. 81, No. 91, effective on May 11, 2016, p. 29148. Available at https://www.govinfo.gov/content/pkg/FR-2016-05-11/pdf/2016-11017.pdf.

[71] Department of Health and Human Services. "45 CFR Part 156: Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan (CO-OP) Program". Federal Register, Vol. 76, No. 239,

- CO-OPs were prohibited from using federal funds to market their policies. As noted, for most of the CO-OPs, including NHC, there were few other sources of capital and their marketing activities were severely constrained at a time when competing insurers were actively offering individual policies on state health insurance exchanges without limitations on their marketing efforts.[72]

- The ACA introduced medical loss ratio limits for all insurers, but these limits especially (adversely) affected CO-OPs. The ACA required health insurers to retain no more than 20 percent of their premium revenues for administrative expenses and surplus.[73] More mature insurers had significant reserves that allowed them to address this constraint, but start-up organizations like CO-OPs had no such resources. This constraint further limited CO-OPs' ability to meet their capital needs.

- ACA legislation prohibited CO-OPs from including any person with current health insurance experience on their boards.[74] Although the intent of the prohibition appeared to be encouragement of consumer participation in the CO-OPs, it created a limitation by excluding important expertise that could help support the CO-OPs' operations.

- A mature insurer has data that can be used to both project enrollment and set premium rates. CO-OPs did not have access to such data. If they set premium rates too high, they would obtain less enrollment which would mean that their capability to retain capital to pay back their start-up loan was limited. If they set premium rates too low, they would experience greater enrollment but face much higher risk that they would attract sicker members who would require higher claim payments. Mature insurers have both reserves to offset these potential problems and data that allow them to accurately predict premium rates. CO-OPs, however, were at a significant disadvantage without the data that their competitors had.[75] Mature insurers had data

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effective December 13, 2011. 45 CFR § 156.515(c)(1), p. 77413. Available at https://www.govinfo.gov/content/pkg/FR-2011-12-13/pdf/FR-2011-12-13.pdf.

[72] Corlette, S.; Miskell, M.; Lerche, J.; and Giovannelli, J. "Why Are Many CO-Ops Failing? How New Nonprofit Health Plans Have Responded to Market Competition". The Commonwealth Fund, dated December 2015, p. 7. Available at https://www.commonwealthfund.org/publications/fund-reports/2015/dec/why-are-many-co-ops-failing-how-new-nonprofit-health-plans-have.

[73] Department of Health and Human Services. "Title 45: Public Welfare". Federal Register, revised as of October 1, 2011. 45 CFR § 158.210, p. 790. Available at https://www.govinfo.gov/content/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-sec158-210.pdf. See also CCIIO. "CCIIO Examinations, Audits and Reviews of Issuers: Issuer Resources". CMS. Available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Exams_Audits_Reviews_Issuer_Resources-.

[74] Department of Health and Human Services. "45 CFR Parts 153, 155, 156, et al." Federal Register, Vol. 76, No. 239. effective December 13, 2011. 45 CFR § 156.515(b)(2)(v); 45 CFR § 156.510(b)(1)(i); 45 CFR § 156.505, pp. 77412 & 77413. Available at https://www.govinfo.gov/content/pkg/FR-2011-12-13/pdf/2011.-.

[75] Corlette, S.; Miskell, M.; Lerche, J.; and Giovannelli, J. "Why Are Many CO-Ops Failing? How New Nonprofit Health Plans Have Responded to Market Competition". The Commonwealth Fund, dated December 2015, p. 7.

on the number of high-risk members in their group lines of business as well as the cost of their claims. They were better prepared to establish appropriate premium rates, although as discussed elsewhere in this report, they also underestimated claims costs. It is obvious that mature insurers had substantial reserves that allowed them to absorb losses in the first year of offering products on the Exchanges. Insurers such as United Healthcare, Aetna and Humana had hundreds of millions of dollars in reserves while their exchange products represented only a small portion of their total insured members.[76] In contrast, most CO-OPs' only source of reserves were Federal loans.

- All states have risk-based capital (RBC) requirements for insurance companies doing business in their state. "RBC limits the amount of risk a company can take"[77] and helps to ensure that a health insurance company has enough money to pay its medical claims. CMS recognized that "in most states, sufficient RBC levels are between 200 percent and 300 percent" but that the "CO-OP Loan Agreement requires a CO-OP to maintain a surplus level of 500 percent Risk-Based Capital (RBC)" and failure to do could result in a default under the loan.[78,79] As discussed, the CO-OPs already had limited access to external capital sources unlike their commercial competitors and increased RBC requirements put the CO-OPs at a further financial disadvantage.

- The short time frame available for CO-OPs to initiate operations also required them to outsource key aspects of their operations.[80] It is for this reason that most CO-OPs (like NHC) turned to contracts with third-party administrators (TPAs) and utilization management companies rather than attempting to initially build their own claims processing and review systems.

- Several CO-OPs (including NHC) incurred increased information technology costs due to technical issues. For example, CMS expected CO-OPs to process the substantial majority of claims electronically, but limitations caused, in part, by the technical issues faced by the

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Available at https://www.commonwealthfund.org/publications/fund-reports/2015/dec/why-are-many-co-ops-failing-how-new-nonprofit-health-plans-have.

[76] 2015 Forms 10-K for United Health Group Inc., Aetna Inc. /PA/ and Humana Inc. United States Securities and Exchange Commission. Available at https://www.sec.gov/.

[77] The Center for Insurance Policy and Research. "Risk-Based Capital". National Association of Insurance Commission, updated June 24, 2020. Available at https://content.naic.org/cipr_topics/topic_risk_based_capital.htm.

[78] CCIIO. "Frequently Asked Questions on the Consumer Operated and Oriented Plan (COOP) Program" CMS, dated on January 27, 2016, p. 2. Available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CO-OP-Questions-Final-1-27-16.pdf.

[79] CCIIO. "CO-OP Program Guidance Manual". CMS, dated July 29, 2015. Version 1, p. 45. Available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CO-OP-Guidance-Manual-7-29-15-final.pdf.

[80] Levinson, D. "Early Implementation of the Consumer Operated and Oriented Plan Loan Program". Department of Health and Human Services: Office of Inspector General, dated July 2013. OEI-01-12-00290. Available at https://oig.hhs.gov/oei/reports/oei-01-12-00290.pdf.

exchanges, led to the need to process paper rather than electronic claims. Paper claims are considerably costlier to process.

In general, CO-OPs were substantially disadvantaged when compared to commercial competitors, and these disadvantages, created by the ACA, were substantial factors in bringing about the failure of the Federal CO-OP Program, including the failure of NHC.

6.6 The ACA's 3 Rs Failed to Protect CO-OPs from Huge Losses

The ACA established a risk management/premium stabilization program often referred to as the "3 Rs." The 3Rs consist of "a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program to provide payments to health insurance issuers that cover higher-risk populations and to more evenly spread the financial risk borne by issuers."[81] The premium stabilization program led CO-OPs to price their policies more aggressively.[82] Aggressive pricing was needed because CO-OPs had to compete on Health Insurance Exchanges with more established commercial insurers.[83] In its article on NHC's closure, Modern Healthcare reported:

> "The closure in Nevada also reinforces how difficult it is for new insurers to enter a marketplace that is dominated by large carriers with noticeable brands and footprints, such as local Blue Cross and Blue Shield plans and national giants like Aetna and Anthem."[84]

Most CO-OPs (including NHC) counted on the premium stabilization program to provide a financial cushion if their pricing turned out to be too aggressive.[85] Specifically, the purpose of the risk corridor program was to "protect against uncertainty in rate setting for qualified health plans by limiting the extent of issuers' financial losses and gains."[86] After CO-OP premium pricing decisions had already been

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[81] Department of Health and Human Services. "45 CFR Parts 153, 155, 156, 157, and 158: Patient Protection and Affordable Act; HHS Notice of Benefit and Payment Parameter for 2014". Federal Register, Vol. 78, No. 47, dated March 11, 2013, p. 15411. Available at https://www.govinfo.gov/content/pkg/FR-2013-03-11/pdf/2013-04902.pdf.

[82] Department of Health and Human Services. "45 CFR Part 153: Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment". Federal Register, Vol. 77, No. 57, effective on March 23, 2012. Available at https://www.govinfo.gov/content/pkg/FR-2012-03-23/pdf/2012-6594.pdf.

[83] James, J., "The CO-OP Health Insurance Program". Health Affairs Health Policy Brief, dated February 28, 2013. DOI: 10.1377/hpb20130228.47227, p. 1. Available at https://www.healthaffairs.org/do/10.1377/hpb20130228.47227/full/. See also GAO. "Private Health Insurance: Premiums and Enrollment for New Nonprofit Health Insurance Issuers Varied Significantly in 2014". Report to Congressional Requesters, dated April 2015. GAO-15-304, p. 21. Available at http://www.gao.gov/assets/670/669945.pdf.

[84] Herman, B. "With Nevada co-op closing, are more to come?" Modern Healthcare, dated August 27, 2015. Available at https://www.modernhealthcare.com/article/20150827/NEWS/150829888/with-nevada-co-op-closing-are-more-to-come.

[85] Goodell, S."Risk Corridors (Updated)." Health Affairs Health Policy Brief, updated on February 19, 2015. DOI: 10.1377/hpb201502019.938066, p. 2. Available at https://www.healthaffairs.org/do/10.1377/hpb20150219.938066/full/healthpolicybrief_134.pdf.

[86] Department of Health and Human Services. "45 CFR Parts 153, 155, 156, 157 and 158: Patient Protection and Affordable Act; HHS Notice of Benefit and Payment Parameter for 2014". Federal Register, Vol. 78, No. 47, dated

made, stabilization payments were reduced to the CO-OPs by subsequent budget changes by Congress and payments were significantly lower than expected. As previously noted, in 2014, CO-OPs received only 12.6 percent of the risk corridor payments they expected to receive (and should have been received, based on the United States Supreme Court's decision in *Maine Community Health Options v. United States*).[87] In addition, payments were substantially delayed.[88] As a result, the vast majority of CO-OPs experienced financial shortfalls that they could not overcome. In its amicus brief to the United States Supreme Court in the *Moda* case, the National Association of Insurance Commissioners (NAIC) argued that, "as to the risk corridor program, the government has not been a fair or reliable partner. Through the ACA, the government induced insurers into the health insurance market only to directly compromise these companies' financial condition once they committed."[89] The Supreme Court agreed with NAIC and concluded that:

> "In establishing the temporary Risk Corridors program, Congress created a rare money-mandating obligation requiring the Federal Government to make payments under §1342's formula...These holdings reflect a principle as old as the Nation itself: The Government should honor its obligations. Soon after ratification, Alexander Hamilton stressed this insight as a cornerstone of fiscal policy."[90]

Further, under the permanent risk adjustment program, many CO-OPs owed money, while large established health plans received payments.[91] The risk adjustment program transfers funds from plans with healthier enrollees to plans with less healthy enrollees to avoid adverse selection. As discussed, for the 2014 benefit year, the CO-OPs did not meet enrollment projections and had claims and/or administrative expenses that exceeded premiums. A report by The American Academy of Actuaries concluded that, "If an insurer has low premiums due to incorrectly anticipating the total market and then attracted a healthier-than-average membership resulting in a risk adjustment transfer payment, there may not be sufficient premiums to cover the transfer payment. If an insurer does not have

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on March 11, 2013 Page 15411. Available at https://www.govinfo.gov/content/pkg/FR-2013-03-11/pdf/2013-04902.pdf.

[87] CCIIO. "Risk Corridors Payment Proration Rate for 2014". CMS, dated October 1, 2015. Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf.

[88] Corlette, S.; Miskell, S.; Lerche, J.; and Giovannelli, J. "Why Are Many CO-Ops Failing? How New Nonprofit Health Plans Have Responded to Market Competition". The Commonwealth Fund, dated December 2015, p. 8. Available at https://www.commonwealthfund.org/publications/fund-reports/2015/dec/why-are-many-co-ops-failing-how-new-nonprofit-health-plans-have.

[89] Supreme Court of the United States. "Brief for the National Association of Insurance Commissioners as Amicus Curiae in Support of Petitioners" for the matter of Moda Health Plan, Inc. et al., v. United States, dated September 6, 2019. Available at https://www.supremecourt.gov/DocketPDF/18/18-1023/114975/20190906134843972_18-1023_18-1028_18-1038tsacNationalAssociationOfInsuranceCommissioners.pdf.

[90] Supreme Court of the United States. Maine Community Health Options v. United States, 590 U. S._____(2020), Nos. 18-1023, 18-1028, 18-1038, p. 30.

[91] CCIIO. "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year". CMS, revised on September 17, 2015. Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf.

sufficient premiums to cover its claims and administrative expenses, the shortfall could result in solvency problems unless the insurer has adequate surplus or access to additional funds from external sources."[92] In my opinion, it is highly unlikely that any health insurers would have entered into the ACA market absent the establishment of the 3Rs program.

6.7 The Health Exchanges Were Plagued by Technical Issues

Technical issues with the health exchanges during the initial enrollment period contributed to lower enrollment, inaccurate application data, and increased administrative costs for many CO-OPs. The ACA "requires the establishment of a health insurance marketplace in each state and the District of Columbia to assist individuals and small businesses in comparing, selecting, and enrolling in health plans offered by participating private issuers of qualified health plans."[93] States could establish their own marketplace or use the federally facilitated marketplace, (Healthcare.gov), which was created by CMS for states not establishing their own.[94] The online marketplaces, also called exchanges, are where consumers shop for ACA plans and submit enrollment information. The exchange system is responsible for making eligibility determinations, applying subsidies, facilitating data exchange with the individual health plans, and in some instances collecting and transmitting premiums. In 2014, 36 states used the federally facilitated marketplace and the other 14 states and Washington, D.C. launched their own marketplaces.[95, 96] The ACA required marketplaces to be operational by January 1, 2014.[97] The launch of Healthcare.gov and the state marketplaces for the first open enrollment period suffered from several technical issues, including both front-end and back-end issues.[98] Front-end problems consisted of website outages, delays and error messages.[99] Back-end issues impacted the transfer of information from the exchanges to the insurance carriers resulting in insurance companies either missing or receiving "incorrect, incomplete or

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[92] American Academy of Actuaries. "Insights on the ACA Risk Adjustment Program". A Public Policy Issue Paper, dated April 2016, p. 11. Available at https://www.actuary.org/sites/default/files/files/imce/Insights_on_the_ACA_Risk_Adjustment_Program.pdf.

[93] GAO. "CMS Has Taken Steps to Address Problems, but Needs to Further Implement System Development Best Practices". Report to Congressional Requesters, dated March 2015. GAO-15-238, p. 1. Available at https://www.gao.gov/assets/670/668834.pdf.

[94] GAO. "CMS Has Taken Steps to Address Problems, but Needs to Further Implement System Development Best Practices". Report to Congressional Requesters, dated March 2015. GAO-15-238, pp. 3-4. Available at https://www.gao.gov/assets/670/668834.pdf.

[95] OIG. "Challenge 1: Implementing, Operating, and Overseeing the Health Insurance Marketplaces. Available at https://oig.hhs.gov/reports-and-publications/top-challenges/2014/challenge01.asp.

[96] Vestal, C. and Ollove, M. "Why Some State Health Exchanges Worked". Kaiser Health News, dated December 11, 2013. Available at https://khn.org/news/why-some-state-run-health-exchanges-worked/.

[97] 111th Congress. "Patient Protection and Affordable Care Act". Public Law 111–148, dated March 23, 2010. Section 1321(c).

[98] Levinson, D. R. "HealthCare.gov: CMS Management of the Federal Marketplace, A Case Study". Department of Health and Human Services: Office of Inspector General, dated February 2016. OEI-06-14-00350, pp. i & ii. Available at https://oig.hhs.gov/oei/reports/oei-06-14-00350.pdf. See also Ornstein, C. "Epic Fail: Where Four See State Health Exchanges Went Wrong." ProPublica, dated February 6, 2014. Available at https://www.propublica.org/article/epic-fail-where-four-state-health-exchanges-went-wrong.

[99] GAO. "CMS Has Taken Steps to Address Problems, But Needs to Further Implement System Development Best Practices". Report to Congressional Requesters, dated March 2015. GAO-15-238, p. 13. Available at https://www.gao.gov/assets/670/668834.pdf. See also Exhibit 1.

duplicate" application files.[100] The HHS OIG cited marketplace technical difficulties as one reason why CO-OPs experienced lower-than-projected enrollment for 2014. These technical problems that affected the exchanges caused the CBO to reduce their 2014 estimate of enrollment by 1 million people.[101]

6.8 Commercial Insurers' Exchange Products Struggled Financially

Not only did CO-OPs experience difficulties when ACA policies were first made available in 2014, commercial insurers experienced similar problems. National commercial insurers are now less commonly found on the exchanges. In 2013, 70 percent of the issuers in the individual markets were limited coverage specialists and large national commercial carriers; by 2017 they comprised about only 30 percent of issuers.[102] Large losses due to lower-than-anticipated enrollments and sicker enrollees were cited as the main reason for withdrawal from the state exchanges.[103] Between 2014 and 2016, Aetna lost nearly $700 million in its individual exchange business line and completely exited the exchanges in 2018.[104] Humana lost money on its individual exchange business as well. "In late 2015 the company [Humana] set aside $176 million in reserves to cover losses on the individual business;"[105]Humana pulled out of the ACA exchanges for 2018.[106] UnitedHealth lost $475 million in 2015 and anticipated losing $650 million in 2016 on its marketplace business, resulting in mostly exiting the health insurance exchanges in 2017.[107] An article by The Washington Post, quoting Katherine Hempstead, who directs the Robert Wood Johnson Foundation's work on health insurance, said of UnitedHealth,

> "They're the largest carrier. They're very good at looking at their own data, 'If they can't make this work, that means this is a really tough environment.'"[108]

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[100] Cheney, K. and Millman, J., "State exchanges hit data snags." Politico, dated December 6, 2013. Available at https://www.politico.com/story/2013/12/obamacare-state-exchanges-technical-glitches-100757.
[101] CBO. "Appendix B: Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act". The Budget and Economic Outlook: 2014 to 2024, dated February 2014. Page 112. Available at https://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixB.pdf.
[102] Hempstead, K. "A Big Picture Look at the Individual Market, 2013-2017". Robert Wood Johnson Foundation, dated June 6, 2017. Available at https://www.rwjf.org/content/rwjf/en/library/research/2017/05/a-big-picture-look-at-the-individual-market.html.
[103] Reuters. "Cigna joins health insurance industry pullback from Obamacare". St. Louis Post-Dispatch, dated November 4, 2016. Available at https://www.stltoday.com/business/local/cigna-joins-health-insurance-industry-pullback-from-obamacare/article_5903d9ad-7131-5da4-a7e3-c62a3184ef4e.html.
[104] Luhby, T. "Aetna to Obamacare: We're outta here". CNN Business, dated May 10, 2017. Available at https://money.cnn.com/2017/05/10/news/economy/aetna-obamacare/.
[105] Reuters Staff. "Humana may exit Obamacare individual plans in some states". Reuters, dated May 4, 2016. Available at https://www.reuters.com/article/us-humana-results-idUSKCN0XV1BH.
[106] Luhby, T. "Humana pulls out of Obamacare for 2018". CNN Business, dated February 14, 2017. Available at https://money.cnn.com/2017/02/14/news/economy/humana-obamacare-insurer/.
[107] Galewitz, P. "United Healthcare to Exit All but 'Handful' Of Obamacare Markets in 2017". Kaiser Health News, dated April 19, 2016. Available at https://khn.org/news/unitedhealthcare-to-exit-all-but-handful-of-obamacare-markets-in-2017/.
[108] Goldstein, A. and Johnson, C. Y. "UnitedHealth Group says it is scaling back efforts in ACA exchanges". The Washington Post, dated on November 19, 2015. Available at https://www.washingtonpost.com/national/health-

The large national insurance carriers' exchange business was small in comparison to their employer sponsored and Medicare Advantage business, allowing them to absorb large losses unlike the CO-OPs. The distribution of individual and group coverage for all commercial insurers for relevant years is shown in Table 1.[109]

Table 1
Distribution of Commercial Group and Individual Health Coverage

Type of Coverage	2012	2013	2014	2015
United States:				
Individual Coverage	9.26%	9.43%	10.91%	12.50%
Group Coverage	90.74%	90.57%	89.09%	87.50%
Nevada:				
Individual Coverage	9.62%	7.55%	9.26%	12.73%
Group Coverage	90.38%	92.45%	90.74%	87.27%

Prior to the implementation of the ACA, approximately 90 percent of commercial health insurers' business was in group coverage. Individual coverage represented only approximately 10 percent. Even after the implementation of the ACA, individual coverage only accounted for 15 percent of all commercial health coverage. Although commercial insurers suffered losses in the early years of the implementation of the ACA, these losses had a limited impact on their overall profitability. The vast majority of CO-OP coverage was for individuals and they had no other business to offset their losses.

In my opinion, the problems experienced by commercial insurers, as well as CO-OPs, makes it undeniably clear that it was very difficult for any entity (including NHC) to accurately predict enrollment and claims volume for the new products offered on the exchanges.

6.9 Nineteen of the 23 CO-OPs Failed

The reasons cited above for the failure of the Federal CO-OP Program caused 19 of 23 CO-OPs (including NHC) to cease operations as of the date of this report. In addition, on August 11, 2020, the New Mexico CO-OP announced that it would cease operations as of December 31, 2020.[110] Table 2 identifies the CO-OPs that failed (in the order of the date that they ceased operations) as well as the reasons cited for their individual failures:

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science/unitedhealthcare-says-it-is-scaling-back-efforts-in-aca-exchanges/2015/11/19/5c45d9e0-8ee2-11e5-baf4-bdf37355da0c_story.html.

[109] Kaiser Family Foundation. "Health Insurance Coverage of the Total Population". State Health Facts Data. Available at https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[110] New Mexico Health Connections. "New Mexico Health Connections, Non-Profit Health Insurer, to Cease Operations in 2021". PRNewswire, dated August 11, 2020. https://www.prnewswire.com/news-releases/new-mexico-health-connections-non-profit-health-insurer-to-cease-operations-in-2021-301110358.html.

Table 2[111]
Health Insurance CO-OPs That Failed

State	CO-OP	Date Ceased Operations	Higher Than Expected Claims Costs	Lower than Expected Premium Revenue	Limited Capital/ Insolvency	Federal Risk Adjustment Higher/Lower than Expected	Exchange Technical Issues
Iowa/Nebraska	Midwest Members Health	2/28/2015	√	√	√	√	√
New York	Freelancers Health Service Corporation	9/25/2015		√	√	√	
Tennessee	Community Health Alliance Mutual Insurance Company	10/14/2015		√	√		√
Colorado	Colorado Health Insurance Cooperative	10/16/2015			√	√	
South Carolina	Consumers Choice Health Insurance Company	10/22/2015			√	√	√
Utah	Arches Community Health Care	10/27/2015			√	√	√

[111] Primary source for information in Table 2 is U.S. Health Policy Gateway. Available at http://ushealthpolicygateway.com/vii-key-policy-issues-regulation-and-reform/patient-protection-and-affordable-care-act-ppaca/ppaca-repeal/components-of-aca-not-working-well/components-of-aca-not-working-well-health-exchanges/nonprofit-consumer-operated-and-orinted-plan-organizations-co-os/impact-by-state/. See also Exhibit 2.

State	CO-OP	Date Ceased Operations	Higher Than Expected Claims Costs	Lower than Expected Premium Revenue	Limited Capital/ Insolvency	Federal Risk Adjustment Higher/Lower than Expected	Exchange Technical Issues
Arizona	Compass Cooperative Health Network d/b/a Meritus Health Partners Service	10/30/2015		√	√		√
Michigan	Michigan Consumers Healthcare CO-OP	11/3/2015	√	√	√	√	√
Kentucky	Kentucky Health Care Cooperative	12/31/2015	√		√	√	
Louisiana	Louisiana Health Cooperative	12/31/2015			√		√
Nevada	Nevada Health Cooperative	12/31/2015	√	√	√	√	√
Oregon	Freelancers CO-OP of Oregon d/b/a Health Republic Insurance of Oregon	12/31/2015	√		√	√	√
Ohio	Coordinated Health Plans of Ohio	5/26/2016			√		√

State	CO-OP	Date Ceased Operations	Higher Than Expected Claims Costs	Lower than Expected Premium Revenue	Limited Capital/ Insolvency	Federal Risk Adjustment Higher/Lower than Expected	Exchange Technical Issues
Oregon	Oregon's Health CO-OP (formerly Community Care of Oregon)	7/11/2016	√		√	√	√
Illinois	Land of Lincoln Health	7/14/2016			√	√	√
New Jersey	Freelancers CO-OP of New Jersey	9/12/2016			√	√	√
Connecticut	Healthy - CT	11/1/2016			√	√	
Massachusetts	Minuteman Health	6/23/2017		√	√	√	√
Maryland	Evergreen Health Cooperative	7/31/2017			√	√	√
	Count		6	7	19	15	15
	Percent of Total (Count/19)		32%	37%	100%	79%	79%

As of the date of this report, four CO-OPs are still operating; namely:

New Mexico Health Connections. Although it is currently operating, New Mexico Health Connections announced that it will cease operations on December 31, 2020, citing continuing high claims costs and the absence of opportunities for investment.[112] Previously, it experienced serious financial problems through 2017[113] as it incurred $40 million in losses from 2014 through 2016 and an additional $10 million loss in 2017.[114,115] The CO-OP also faced difficulties because of its inability to meet the requirements of the Federal government's risk adjustment program; the Federal government indicated that the CO-OP owed $8.9 million for 2017.[116] In 2017, the CO-OP's entire Board of Directors resigned in an effort to get the State's Superintendent of Insurance to take control of what the Directors described as an insolvent organization.[117] Rather than taking control of the CO-OP, the Superintendent approved the sale of the CO-OP's commercial business to Evolent Health, a for-profit health insurer, for more than $10 million.[118]

Maine Community Health Options. It was the only CO-OP that recorded a profit in 2014, but it experienced substantial losses in 2015 and 2016.[119] Losses for 2015 totaled $74 million including operating losses of $31 million and a premium deficiency reserve of $43 million for 2016. Early in 2016, the Maine Bureau of Insurance asked the CO-OP to stop selling underpriced plans. By the end of the year, the CO-OP ceased selling individual coverage and enrollment was frozen. In 2016, the CO-OP closed its operations in New Hampshire.[120] In addition, the Bureau of Insurance initiated a

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[112] New Mexico Health Connections. "New Mexico Health Connections, Non-Profit Health Insurer, to Cease Operations in 2021". PRNewswire, dated August 11, 2020. https://www.prnewswire.com/news-releases/new-mexico-health-connections-non-profit-health-insurer-to-cease-operations-in-2021-301110358.html.
[113] Baca, M. C., "Health Connections board sought state control". Albuquerque Journal, dated January 9, 2018. Available at https://www.abqjournal.com/1117076/health-connections-board-resigned.html.
[114] Baca, M. C., "Health Connections board sought state control". Albuquerque Journal, dated January 9, 2018. Available at https://www.abqjournal.com/1117076/health-connections-board-resigned.html.
[115] Jarmon, G. L. "CMS Oversight Must Continue Because All Remaining Consumer Operated and Oriented Plans Were Not Profitable and May Not be Viable and Sustainable". Department of Health and Human Services: Office of Inspector General, dated August 2017. A-005-16-00027. Table 3.
[116] New Mexico Health Connections. "NM lawsuit central to 'Obamacare' change". In the News, dated July 9, 2018. Available at https://mynmhc.org/In_the_News.aspx?c74293735b5a4721b9c160aa3438c41bblogPostId=17a637592ae04c2f8996f9c26835ec33.
[117] Baca, M. C. "Health Connections board sought state control". Albuquerque Journal, dated on January 9, 2018. Available at https://www.abqjournal.com/1117076/health-connections-board-resigned.html.
[118] New Mexico Health Connections. "Evolent Health Completes Acquisition of Assets from New Mexico Health Connections". In the News, dated January 2, 2018. Available at https://www.mynmhc.org/In_the_News.aspx?c74293735b5a4721b9c160aa3438c41bblogPostId=0e567dc28d934196a890ec11a49731b0#BlogContent.
[119] Jarmon, G. L. "CMS Oversight Must Continue Because All Remaining Consumer Operated and Oriented Plans Were Not Profitable and may not be Viable and Sustainable". Department of Health and Human Services: Office of Inspector General, dated August 2017. A-005-16-00027. Table 3.
[120] New Hampshire Insurance Department. "Maine-Based Health Insurance Co-op to Withdraw from NH in 2017". Press Release, dated on September 1, 2016. Available at https://www.nh.gov/insurance/media/pr/2016/documents/090116.pdf

plan to put the CO-OP in receivership. The plan, which included termination of up to 20 percent of the CO-OP's policies, was rejected by CMS.[121]

Montana Health Cooperative. It continues to provide coverage[122] although it experienced substantial losses in its first two years (it also provides coverage in Idaho). It lost $6 million in 2014 and more than $40 million in 2015.[123] Worries that the CO-OP was overextending its resources and heading towards insolvency led it to discontinue offering coverage during the first six months of 2017.[124] In 2019, Matt Rosendale, the Montana State Auditor who oversaw the state's health insurance market, remarked that he believed that the CO-OP would remain in operation but doubted that it would be able to repay the loans it received from the Federal government.[125]

Common Ground Healthcare Cooperative (Wisconsin). It incurred more than $84 million in losses by the end of 2015 and continued to incur losses in 2016 and 2017.[126,127] In 2016, the CO-OP made a substantial change in its provider network, moving from a broad network to contracting with just two health systems. This change allowed the CO-OP to cut costs. At the same time, it increased premiums which led to its generation of operating profits in 2018.

In my opinion, it is obvious that the failure of nearly all of the Federally funded CO-OPs was due in part to claims costs greatly exceeding expectations and capital limitations that were inherent in the ACA. Most start-up businesses experience losses in their initial years of operation. Start-ups that succeed typically have financial resources that allow them to survive their early years. Not only did the CO-OPs have limited financial resources as they started operations, they did not even receive the resources that they were told they would receive from the Federal government. When the Federal government's risk corridor program was funded with only 12.6 percent of the funds promised to them and which they expected to have, most CO-OPs' insolvency and failure was virtually guaranteed.

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[121] Norris, L. "Maine health insurance marketplace: history and news of the state's exchange". healthinsurance.org, dated September 1, 2020. Available at https://www.healthinsurance.org/maine-state-health-insurance-exchange/.
[122] Mountain Health CO-OP. Available at https://www.mountainhealth.coop/.
[123] Jarmon, G. L. CMS Oversight Must Continue Because All Remaining Consumer Operated and Oriented Plans Were Not Profitable and may not be Viable and Sustainable". Department of Health and Human Services: Office of Inspector General, dated on August 2017. A-005-16-00027. Table 3.
[124] Calvan, B. C. "Montana's Health Co-op Remains Standing As Others Falter". Montana Publica Radio, dated on August 14, 2017. Available at https://www.mtpr.org/post/montanas-health-co-op-remains-standing-others-falter.
[125] Calvan, B. C. "Montana's Health Co-op Remains Standing As Others Falter". Montana Publica Radio, dated on August 14, 2017. Available at https://www.mtpr.org/post/montanas-health-co-op-remains-standing-others-falter.
[126] Jarmon, G. L. "CMS Oversight Must Continue Because All Remaining Consumer Operated and Oriented Plans Were Not Profitable and may not be Viable and Sustainable". Department of Health and Human Services: Office of Inspector General, dated on August 2017. A-005-16-00027. Table 3.
[127] Boulton, G. "Common Ground Healthcare Cooperative faces a few fateful months". Journal Sentinel, dated July 18, 2016. Available at http://archive.jsonline.com/business/common-ground-healthcare-cooperative-faces-a-few-fateful-months-b99761764z1-387365621.html.

7. NHC Failed for Similar Reasons as the Other CO-OPs

Plaintiff's experts completely ignore the failure of the Federal CO-OP Program and instead attribute NHC's failure to UHH and NHS (and the other defendants in the Case). None of the other CO-OPs used UHH and NHS, and yet 18 of them (out of 23) failed during the same general time period, and the remaining CO-OPs struggled financially (one of which is closing at the end of 2020). In my opinion, NHC failed due to the failure of the Federal CO-OP Program, and not because of UHH's and/or NHS's performance. Further, and most importantly, nothing UHH or NHS did or failed to do caused or was a substantial factor in bringing about NHC's failure; in other words, NHC would have failed irrespective of how well its vendors (like UHH and NHS) performed.

When NHC announced it was winding down, NHC's Chief Executive Officer (Pam Egan) stated, "With a second year of high claims costs and limited opportunities for new investment, it has become clear that the amount of growth required to provide quality care at reasonable rates will be unlikely in the next plan year."[128] NHC's Receiver – the Commissioner of the Nevada Department of Insurance – publicly cited the following three main reasons as causing NHC to be financially unsound:

- "The CO-OP's operating loss in the most previous 6-month period, is greater than 50 percent of the insurer's surplus which is in excess of the statutory minimum surplus required for HMOs pursuant to Nevada Administrative Code ("NAC") 695C.130.
- Upon expiration of the permitted practice, the CO-OP's capital & surplus will likely show that it is below the statutory minimum requirement pursuant to NAC 695C.130.
- The CO-OP does not have access to additional sources of capital to improve its financial outlook."[129]

The Receiver provided additional evidence that supported the conclusion that NHC was in an unsound condition, summarized as follows:

- "The CO-OP's claims unpaid reserve has increased significantly over the first six months of 2015.
- Continued losses over the first six months of 2015 resulted in the immediate recognition of a large premium deficiency reserve as of June 30, 2015.
- The collectability of the CO-OP's accounts receivable from the Federal Risk Corridor program in the amount of $16,200,240 as of June 30, 2015, is uncertain."[130]

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[128] Insurance Business. "Breaking News: Thousands left without coverage as ACA co-op goes out of business". Insurance Business America, dated on August 26, 2015. Available at https://www.insurancebusinessmag.com/us/news/breaking-news/breaking-news-thousands-left-without-coverage-as-aca-coop-goes-out-of-business-24183.aspx.

[129] Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1). State of Nevada, Ex Rel. v. Nevada Health CO-OP (September 25, 2015). Case No: A-15-725244-C. PLAINTIFF01039973-01040018 at 01039979.

[130] Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1). State of Nevada, Ex Rel. v. Nevada Health CO-OP (September 25, 2015). Case No: A-15-725244-C. PLAINTIFF01039973-01040018 at 01039979.

The Receiver's Insurance Examiner stated, "Due to the significant losses experienced since its inception, along with the lack of new sources of capital, the CO-OP is unsound pursuant to NRS 696B.210(2)."[131] And the Receiver's Lead Actuary stated, "Due to the size of the liabilities in relation to assets, the inadequacy of premiums to support incurred claims and expenses, and the uncertainty surrounding the collectability of large receivables, the CO-OP is unsound pursuant to NRS 696B.210(2)."[132]

Importantly, public announcements by NHC and the Receiver make no mention of UHH and/or NHS as the cause or substantial factor in bringing about NHC's failure.

7.1 NHC Claims Costs Exceeded Premium Revenue

NHC experienced significantly higher than expected claims costs in plan years 2014 and 2015. In 2014, a forecast prepared by Basil Dibsie (NHC's Chief Financial Officer) and presented to the NHC Board of Directors in February 2014, budgeted $38 million in member claims costs for the plan year 2014.[133] However, NHC's member claims costs were $57 million for the plan year 2014[134], which is 48 percent more than forecasted. For the plan year 2015, $88 million was budgeted for claims costs for NHC's members, according to a forecast prepared by Milliman.[135] Similar to 2014, NHC experienced significantly higher than expected medical costs for its members in 2015 (i.e., $111 million[136]), $24 million more than budgeted (or 27 percent higher). Not only were claims costs significantly higher than budgeted, but premium revenue also failed to meet expectations. These data are presented in Table 3 below.

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[131] Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1). State of Nevada, Ex Rel. v. Nevada Health CO-OP (September 25, 2015). Case No: A-15-725244-C. PLAINTIFF01039973-01040018 at 01039985-01939988.

[132] Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1). State of Nevada, Ex Rel. v. Nevada Health CO-OP (September 25, 2015). Case No: A-15-725244-C. PLAINTIFF01039973-01040018 at 01040007-1040010.

[133] 2014 NHC Budget/Forecast Presented to NHC BOD, dated February 14, 2014. PLAINTIFF00564202.xlsx.

[134] Javelina SDR Backup. PLAINTIFF02484563. Actual total medical costs in 2014 and 2015 calculated by *Dateincurred* in *AdjudicationResult* table. NHC's capitation rates were also more than forecasted, Milliman calculated PMPM at $73 while WellHealth was at $92.50 PMPM. See NHC Board of Directors Minutes for May 23, 2014. LARSON014384-LARSON014390.

[135] 2015 NHC Budget/Forecast in NHC Internal Pro Forma Prepared by Milliman. PLAINTIFF00501321.xlsm.

[136] Javelina SDR Backup. PLAINTIFF02484563. Actual Total Medical Costs in 2014 and 2015 Calculated by *Dateincurred* in *AdjudicationResult* table. Actual medical costs are exclusive of capitation payments, rebates, and reinsurance payments/recoveries. See also, "…particularly given NHC's 2014 BCR as reported in its NAIC annual statement filing before reinsurance recoveries was 102%." Fish II Report, p. 16. See also, "For the year ended December 31, 2014, NHC reported net premium income of $55.5 million which was not even sufficient to cover hospital and medical benefits incurred of $57.5 million, excluding reinsurance." DeVito Report, p. 20.

Table 3
CO-OP Budgeted vs. Actual Claims Costs in 2014 and 2015

	2014			2015		
	Forecast	Actual	Pct. Diff.	Forecast	Actual	Pct. Diff.
Membership	175,152	162,632	-7.1%	307,982	170,252	-44.7%
Premium Revenue ($)	49,774,325	51,526,023	3.5%	97,545,851	83,166,546	-14.7%
Total Claims Costs ($)	38,281,138	56,715,824	48.2%	87,541,855	111,376,195	27.2%

Increased claims costs incurred by NHC in plan years 2014 and 2015 were not due to an unexpectedly high number of members. In fact, NHC failed to meet its budgeted enrollment figures in both years. In 2014, NHC forecasted a total of 175,172 member-months,[137] but only enrolled members for a total of 162,632 member-months,[138] missing expectations by 7 percent. For the plan year 2015, NHC missed its enrollment expectations by 45 percent, with 307,982 member- months budgeted,[139] but only 170,252 experienced.[140] The Receiver noted that "continued losses over the first six months of 2015 resulted in the immediate recognition of a large premium deficiency reserve as of June 30, 2015."[141]

Higher than expected claims costs experienced by NHC were due to several factors unique to members enrolled in ACA policies, especially the enrollment of sicker than expected members. There is no evidence that higher claims costs were due to the actions of UHH and/or NHS. NHC's claims cost experience was similar to the claims cost experience of all insurers that entered the ACA individual market.

I already noted that it was difficult for CO-OPs, including NHC, to estimate claims cost based on past experience (since there was no past experience), especially for the costs of members with preexisting conditions. Little information was available to project how claims costs would change once the ACA was implemented.

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[137] Member months: total number of individuals enrolled times the total number of months enrolled. See 2014 NHC Budget/Forecast Presented to NHC BOD, dated February 14, 2014. PLAINTIFF00564202.
[138] 2014 Annual Statement of the Nevada Health CO-OP to the Insurance Department of the State of Nevada. PLAINTIFF01461315-01461404.
[139] 2015 NHC Budget/Forecast in NHC Internal Pro Forma Prepared by Milliman. PLAINTIFF00501321.xlsm.
[140] Nevada Health Co-Op Income Statement for the Period from January 1, 2015 to December 31, 2015 As of July 18, 2017. PLANTIFF02499092.
[141] Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1). State of Nevada, Ex Rel. v. Nevada Health CO-OP. Filed September 25, 2015. Case No: A-15-725244-C. PLAINTIFF01039973-01040018 at 01039979.

The following two analyses describe the difference between NHC's expectations of claims costs and its actual experience. First, the expected distribution of claims costs among types of care for 2014 were identified in rate submissions to the Nevada Department of Insurance.[142] The actual distribution of claims costs was calculated using Javelina data.[143] Table 4 presents this data.

Table 4
Expected and Actual Distribution of Claims Costs - 2014[144]

Type of Claims Cost	Expected Distribution	Percent	Actual Distribution	Percent
Inpatient Hospital	$9,188,416	23.00%	$16,110,222	28.41%
Outpatient Hospital	$10,826,351	27.10%	$9,112,009	16.07%
Professional	$11,066,049	27.70%	$19,015,003	33.53%
Medications (Rx)	$8,069,827	20.20%	$12,478,588	22.00%
Other	$798,993	2.00%	$0	0.00%
Total	**$39,949,636**	**100%**	**$56,715,824**	**100%**

It is most notable that in 2014, inpatient hospital claims costs on a dollar basis were 75.3 percent higher than expected and professional claims costs on a dollar basis were 71.8 percent higher than expected. In comparison, overall claims costs on a dollar basis for 2014 were 41.9 percent higher than expected. In my opinion, the higher levels of inpatient hospital costs and professional costs were primarily due to the enrollment of sicker people than expected.

NHC's enrollment of sicker people is borne out in the second analysis, which is presented in Table 5, below. As previously noted, the enrollment of people with preexisting conditions was significantly changed with the implementation of the ACA. Previously, people with preexisting conditions did not have access to health coverage and, as a result, there was a pent-up demand for coverage. To determine the impact of this increased demand, I used Javelina data to identify claims for NHC members with preexisting conditions who enrolled in 2014, when coverage became available to them. I used

[142] Data Collection Template. PLAINTIFF00914461.xlsm.
[143] UHH Javelina SDR Backup File. PLAINTIFF02484563.
[144] Expected distribution: Expected Distribution was calculated from PLAINTIFF00914461. Claims for Inpatient Hospital, Outpatient Hospital, Professional, Medications (Rx) were calculated using Section II: Components of Premium Increase. For each product included in the analysis, cost of claims per member month for each type of claim were multiplied by the projected member months for that product. Percentage distribution of claims by type were calculated and applied to the total expected claims. Actual Distribution: The actual distribution was calculated using the *AdjudicationResult* table from the SDR's Javelina SQL backup (PLAINTIFF02484563) for claims incurred in 2014. The *FormType* and *InpatOutpat* fields were used to categorize claims. Claims costs were calculated using the *TotProvPaid* field for medical claims and using *TotCharge* minus *TotPatResp* for Rx claims. In addition to claims with *ClaimStatus* "PAID", claims with *ClaimStatus* "PAY" (not yet paid) are also included in these totals. Totals are not equal to the sum of the values due to rounding.

primary diagnosis codes to identify enrollees with preexisting conditions and included all of their claims (inpatient hospital, outpatient hospital, professional, medications and other).[145]

There is no universally accepted definition of a preexisting condition other than it is a condition that was present when a person sought to purchase health insurance, and which would have disqualified them for coverage prior to the ACA. For this reason, I selected only a sample of preexisting conditions, based on industry literature.[146] Several additional conditions could qualify as preexisting, which means that the list of conditions and the total claims costs attributed to them in Table 5 is likely higher than I calculated.

Table 5
Claims Cost Distribution for Preexisting Conditions – 2014[147]

Pre-Existing Condition	Claims Cost*	Percent of Total Claims Cost	Percent of Total Claims
Hypertension	$13,902,380	24.51%	12.58%
Cancer	$11,573,781	20.41%	7.12%
Diabetes	$9,502,422	16.75%	8.16%
Renal Disease	$5,901,314	10.41%	4.09%
Congestive Heart Failure	$5,200,711	9.17%	1.97%
Coronary Artery Disease	$4,791,827	8.45%	3.06%
HIV	$3,202,906	5.65%	0.92%
COPD	$3,107,306	5.48%	2.83%
Asthma	$2,127,048	3.75%	2.07%
Hepatitis	$1,850,444	3.26%	0.99%
Multiple Sclerosis	$1,251,985	2.21%	0.30%
Crohn's Disease/Ulcerative Colitis	$1,138,018	2.01%	0.80%
Maternity**	$1,014,676	1.79%	0.69%
Epilepsy	$805,651	1.42%	0.51%
Lupus	$398,380	0.70%	0.37%
Stroke	$197,920	0.35%	0.22%
Parkinson's Disease	$52,438	0.09%	0.07%
Cerebral Palsy	$29,260	0.05%	0.04%
Sum Total*	**$66,048,464**	**116.46%**	**46.79%**
Distinct Total*	**$37,473,872**	**66.07%**	**27.59%**

[145] See Exhibit 3.
[146] See https://www.kff.org/health-reform/issue-brief/pre-existing-condition-prevalence-for-individuals-and-families/, https://www.insubuy.com/visitor-medical-insurance-pre-existing-conditions/, and https://www.healthcare.gov/glossary/pre-existing-condition/.
[147] Calculated using the *AdjudicationResult* table from the SDR's Javelina SQL backup (PLAINTIFF02484563) for claims incurred in 2014. Claims costs were calculated using the *TotProvPaid* field. Claims costs were calculated using the *TotProvPaid* field for medical claims and using *TotCharge* minus *TotPatResp* for Rx claims. In addition to claims with *ClaimStatus* "PAID", claims with *ClaimStatus* "PAY" (not yet paid) are also included in these totals.

*Claims cost includes the total costs for enrollees who have the condition listed. Because some enrollees have multiple conditions, there is double counting of claims costs as listed for each condition. For this reason, the sum of the percent of total cost (Sum Total) exceeds 100 percent. The distinct total eliminates all double counting and counts only individual members and their claims cost regardless of their number or pre-existing conditions.
**Maternity costs include costs for members who were pregnant prior to January 1, 2014.

Enrollees with preexisting conditions accounted for 66.1 percent of NHC's total claims costs in 2014.[148] Some preexisting conditions are especially costly. Only 474 enrollees (3.7 percent of all enrollees with claims) had claims that identified a primary diagnosis of cancer, but these enrollees accounted for 20.4 percent of NHC claims costs. Only 92 enrollees (0.7 percent of all enrollees with claims) had a primary diagnosis of congestive heart failure, but these enrollees accounted for 9.2 percent of NHC claims cost. In my opinion, it is clear that higher than expected claims costs was one of the most significant contributing factors to the failure of NHC. This factor is not attributable to UHH and/or NHS.

7.2 NHC was Disadvantaged Compared to Its Commercial Competitors

NHC had a very short start-up period. NHC's solvency and startup loans closed on May 17, 2012[149] for a January 1, 2014 start date. Premium rate setting had to be completed quickly with little available data to project enrollment and costs likely to be incurred by members who would enroll. Prior to the 2014 enrollment, NHC had no actual claims experience to use for premium rate setting. A mature insurer is more likely to have data that can be used to both project enrollment and set premium rates. CO-OPs (including NHC) did not have access to such data. If they set premium rates too high, they would receive less enrollment which would mean that their capability to retain capital to pay back their start-up loan was limited. If they set premium rates too low, they would experience greater enrollment but face much higher risk that they would attract sicker members who would require higher claims payments. Mature insurers have both reserves to offset these potential problems and data that allow them to more accurately predict premium rates. NHC (as well as the other CO-OPs), however, were at a distinct disadvantage without the data that their commercial competitors had.[150]

NHC was facing substantial competition from established insurers and had to set premiums at the same or lower levels than their competitors in order to gain enrollment.[151] As a result, for 2014 enrollment,

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[148] If an enrollee, identified by the *PatientID* field in the *AdjudicationResult* table of the SDR's Javelina SQL backup (PLAINTIFF02484563), was found to have at least one claim with a primary diagnosis code (*PrimaryICD*) associated with a preexisting condition then they are assumed to have the preexisting condition. I found that there was a total of 12,654 enrollees with claims in 2014.
[149] Loan Agreement between CMS and Hospitality Health, Ltd., closing date May 17, 2012. LARSON000782-000863. First Amendment to the Loan Agreement. PLAINTIFF00428776-00428779. Second Amendment to the Loan Agreement. PLAINTIFF00637180-00637187.
[150] Corlette, S.; Miskell, S.; Lerche, J.; and Giovannelli, J. "Why Are Many CO-OPs Failing? How New Nonprofit Health Plans Have Responded to Market Competition". The Commonwealth Fund, dated December 2015, p. 14. Available at https://www.commonwealthfund.org/publications/fund-reports/2015/dec/why-are-many-co-ops-failing-how-new-nonprofit-health-plans-have.
[151] Feasibility Study of Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MG002725-MGT002762.

NHC signed up the highest percentage of individuals on the exchange who did not have health coverage previously.[152]

Other issues also constrained NHC's operations as compared to commercial competitors. Like the other CO-OPs, NHC had limited access to external capital sources. NHC's primary funding sources were CMS start-up and solvency loans.[153] Importantly, NHC's Receiver publicly cited NHC's lack of "access to additional sources of capital to improve its financial outlook" as a reason for NHC's being "unsound."[154] Additionally, all of NHC's business was in the individual and small-group insurance markets,[155] excluding them from the profitable large employer market dominated by their commercial competitors.

As mentioned previously, ACA legislation prohibited CO-OPs from including any person with current health insurance experience on their boards.[156] Although the intent of the prohibition appeared to be encouragement of consumer participation in the CO-OPs, it created a limitation by excluding important expertise that could help support the CO-OPs' operations.

At its demise, NHC was unable to maintain Nevada's statutory minimum financial requirements let alone a surplus level of 500 percent RBC as required under its CMS loans.[157]

7.3 ACA's 3 R's Failed to Protect NHC From Huge Losses

NHC expected a significantly higher Federal risk corridor payment than it received. For 2014, NHC calculated a risk corridor receivable of $10.7 million.[158] As of June 30, 2015, NHC had a risk corridor

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[152] The Nelson A. Rockefeller Institute of Government. "Nevada: Round 1 State-Level Field Network Study of the Implementation of the Affordable Care Act", dated March 2014. Page 7.

[153] NHC's sponsoring entity provided de minimums support. CHF invested in-kind supporting valued at $121,398; pledged private financial support in the amount to $575,000; and agreed to waive its network access fee of $1 PMPM at an estimated value of $488,688 per year for the first three years. See Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MTG003343 at 002711.

[154] Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1). State of Nevada, Ex Rel. v. Nevada Health CO-OP (September 25, 2015). Case No: A-15-725244-C. PLAINTIFF01039973-01040018 at 01039979.

[155] Department of Health and Human Services. "45 CFR Part 156: Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan (CO-OP) Program". Federal Register, Vol. 76, No. 239, effective December 13, 2011. 45 CFR § 156.515(c)(1), p. 77413. Available at https://www.govinfo.gov/content/pkg/FR-2011-12-13/pdf/FR-2011-12-13.pdf. See also Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343.

[156] Department of Health and Human Services. "45 CFR Parts 153, 155, 156, et al." Federal Register, Vol. 76, No. 239. effective December 13, 2011. 45 CFR § 156.515(b)(2)(v); 45 CFR § 156.510(b)(1)(i); 45 CFR § 156.505, pp. 77412 & 77413. Available at https://www.govinfo.gov/content/pkg/FR-2011-12-13/pdf/2011.-

[157] Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1). State of Nevada, Ex Rel. v. Nevada Health CO-OP (September 25, 2015). Case No: A-15-725244-C. PLAINTIFF01039973-01040018 at 01039979.

[158] CCIIO." Risk Corridors Payment and Charge Amounts for Benefit Year 2014". CMS, dated on November 19, 2015. Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf.

receivable of $16.2 million.[159] In total, NHC had a risk corridor receivable of $43.0 million.[160]NHC's Receiver stated that "the collectability of the CO-OP's accounts receivable from the Federal Risk Corridor program [ ] is uncertain."[161] The continued uncertainty of the federal receivables led NHC to conclude that winding down was "a reasonable next step."[162] The Receiver and NHC were correct; not only was the federal receivable uncertain, it was untimely.[163] As discussed, days after the Receiver's petition was filed, "HHS announced that payment proration rate for 2014 will be approximately 12.6 percent."[164] The proration resulted in a payment to NHC in the amount of $1.4 million,[165] $9.3 million less than expected; in other words, based on the Federal government's promises, NHC expected to receive $10.7 million, but received only $1.4 million. Although the United States Supreme Court decided on April 27, 2020, that the Federal government must make additional risk corridor payments, it is unclear how that decision will affect NHC and other CO-OPs that are now out of business. In any case, the failure of the Federal government to have made timely risk corridor payments to NHC substantially contributed to its insolvency and its ultimate failure.

7.4 The Nevada State Health Insurance Exchange Was Plagued by Technical Issues

Like health insurance exchanges in many other states, Nevada's exchange, the Silver State Health Insurance Exchange (Exchange), was plagued by technical issues. The State of Nevada contracted with Xerox (specifically, Xerox State Healthcare, LLC) in 2012 to build its online marketplace, including software that was to accept online applications and payments from consumers.[166] Significant problems with the Silver State Health Insurance Exchange, and specifically with Xerox, led to Xerox's contract

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[159] Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1). State of Nevada, Ex Rel. v. Nevada Health CO-OP (September 25, 2015). Case No: A-15-725244-C. PLAINTIFF01039973-01040018 at 01039979.

[160] Declaration of Mark F. Bennett for the matter of Barbara D. Richardson v. The United States, dated September 9, 2020. Case 1:18-cv-01731-MHS. A1-142 at A14. See also Opposition to Motion to Dismiss, and Cross-Motion for Summary Judgement for the matter of Barbara D. Richardson v. The United States, dated September 9, 2020. Case 1:18-cv-01731-MHS, p. 6.

[161] Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1). State of Nevada, Ex Rel. v. Nevada Health CO-OP (September 25, 2015). Case No: A-15-725244-C. PLAINTIFF01039973-01040018 at 01039979.

[162] Email and Attachments from Pamela Egan to Board Members Regarding Releases, dated September 25, 2015. UHH0540765-0540767.

[163] "HHS will begin collection of risk corridors charges in November 2015, and will begin remitting risk corridors payments to issuers starting December 2015." See CCIIO. "Risk Corridors Payment and Charge Amounts for Benefit Year 2014". CMS, dated November 19, 2015. Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf.

[164] CCIIO. "Risk Corridors Payment and Charge Amounts for Benefit Year 2014". CMS, dated November 19, 2015. Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf.

[165] CCIIO. "Risk Corridors Payment and Charge Amounts for Benefit Year 2014". CMS, dated November 19, 2015. Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf.

[166] "Nevada, Xerox in private talks to settle $75 million health care contract out of court". Las Vegas Sun, dated October 1, 2014. Available at https://lasvegassun.com/news/2014/oct/01/nevada-xerox-private-talks-settle-75-million-healt/.

being terminated in May 2014, all of which is well documented both publicly[167] and in the record.[168] The state identified more than 1,500 defects in the system.[169] But, the State and Xerox apparently agreed to settle their differences out of court.[170] However, two class-action lawsuits were filed against Xerox and Nevada's health exchange on behalf of: (i) hundreds of consumers harmed by the system failures, and (ii) insurance brokers who were never compensated due to system failures.[171] Consumers reported that they paid for insurance through the Silver State Exchange but were not reported as covered,[172] and brokers reported that they never received compensation on commissions due to "glitch-ridden payment and billing software for the exchange."[173] These lawsuits were jointly settled for 5 million dollars.[174] Additionally, on June 5, 2020, NHC sued the Silver State Health Insurance Exchange in an effort to collect premium payments that allegedly were paid to the Exchange, but were never paid to NHC.[175] The Exchange's Answer to the lawsuit points to the technical issues with Xerox as its defense.[176]

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[167] The Associated Press. "Nevada dumps Xerox for health exchange". Reno Gazette Journal, dated May 20, 2014. Available at https://www.rgj.com/story/money/business/2014/05/20/nevada-health-board-dumps-xerox-insurance-exchange/2285756/. See also Roerink, K., "Nevada fires Xerox, will join federal health care exchange". Las Vegas Sun, dated May 20, 2014. Available at https://lasvegassun.com/news/2014/may/20/nevada-fires-xerox-will-join-federal-health-care-e/. See also Chereb, S., "Report: No quick fix for Nevada health exchange". Las Vegas Sun, dated April 29, 2014. Available at https://lasvegassun.com/news/2014/apr/29/report-no-quick-fix-nevada-health-exchange/.

[168] NHC Board of Directors Minutes for October 16, 2013. LARSON000689-LARSON000692 at LARSON000690; NHC Board of Directors Minutes for November 20, 2013. LARSON000693-LARSON000696 at LARSON000695.; NHC Board of Directors Minutes for January 22, 2014. LARSON014362-LARSON014366 at LARSON014364.; NHC Board of Directors Minutes for February 19, 2014. LARSON014367-LARSON014370 at LARSON014368. See also, PLAINTIFF001131000-001131003: Xerox data was hugely problematic related to 2014 3Rs submission; and PLAINTIFF01116369-01116373: "We have not been able to reconcile to the premium information CMS used for the Risk Corridors and need Edge server data (with identifiers) to do so."

[169] Chereb, S. "Report: No quick fix for Nevada health exchange". Las Vegas Sun, dated April 29, 2014. Available at https://lasvegassun.com/news/2014/apr/29/report-no-quick-fix-nevada-health-exchange/.

[170] "Nevada, Xerox in private talks to settle $75 million health care contract out of court". Las Vegas Sun, dated October 1, 2014. Available at https://lasvegassun.com/news/2014/oct/01/nevada-xerox-private-talks-settle-75-million-healt/.

[171] The Associated Press. "Suit filed against Xerox, Nevada health exchange". Reno Gazette Journal. April 2, 2014. Available at https://www.rgj.com/story/news/2014/04/02/suit-filed-xerox-nevada-health-exchange/7214399/. Roerink, K. "Another disgruntled group files suit against Xerox and state". Las Vegas Sun, dated August 27, 2014. Available at https://lasvegassun.com/news/2014/aug/27/class-action-lawsuit-targets-xerox-and-state/.

[172] Ornick, K. "Mass of people slipping though big cracks in state health exchange". Las Vegas Sun, dated June 22, 2014. Available at https://lasvegassun.com/news/2014/jun/22/mass-people-slipping-through-big-cracks-state-heal/.

[173] Roerink, K. "Another disgruntled group files suit against Xerox and state," Las Vegas Sun, dated August 27, 2014. Available at https://lasvegassun.com/news/2014/aug/27/class-action-lawsuit-targets-xerox-and-state/.

[174] Joint Stipulation of Settlement and Release. Lawrence Basich et. al. v. Xerox State Healthcare, LLC; and Patrick Casale, et. al. v. Xerox State Healthcare, LLC. (September 9, 2016). Case No. A-14-706171-C.

[175] Complaint. State of Nevada, Ex. Rel. Commissioner of Insurance, Barbara D. Richardson v. Silver State Health Insurance (June 5, 2020). Case No: A-20-816161- C.

[176] Silver State Health Insurance Exchange's Answer. State of Nevada, Ex. Rel. Commissioner of Insurance, Barbara D. Richardson, In Her official Capacity as a Receiver for Nevada Health CO-OP v. Silver State Health Insurance Exchange. A-20-816161- C.

The ongoing issues and challenges NHC experienced with the Exchange and Xerox were significant factors impacting claims processing.[177] NHC's Board minutes frequently identified these difficulties:[178]

- NHC was speaking regularly with the Governor as well as other carriers regarding the challenges with data submissions from Xerox to NHC.
- NHC did not receive any information on 3,000 members from Xerox due to the Exchange's on-going data transfer failures.
- The letter prepared by NHC attorneys to Xerox and the Governor outlining problems NHC was having with the Exchange and Xerox.[179]
- How Xerox has and continues to hurt NHC's credibility in the market place and injured NHC members.
- An example of a New Year's Eve heart attack patient being left with a $410,000 bill and unmanaged care due to Xerox failing to inform NHC that the patient was an NHC member.

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

- Xerox admitted its payment collection process was working at only 45 percent capacity.
- The possible extension of payment deadlines for consumers past May 30th since 4,000 consumers wanted to pay their premiums but were unable to due to Xerox system errors.
- Xerox presented NHC with a report of 900 delinquent members dated back to January 2014 that was never timely reported and of which NHC was unaware.[180]
- Xerox had an overall, and undeniable, negative impact on NHC's finances. NHC committed 50 percent of its resources to Xerox and Xerox-related issues starting in October 2013.[181]

The Silver State Health Insurance Exchange concluded that Xerox data was unreliable.[182]

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

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[177] NHC Board of Directors Minutes for February 19, 2014. LARSON014367-014370 at 14367-68.
[178] NHC Board of Directors Minutes for February 19, 2014. LARSON014367-014370 at 14367-68.
[179] Letter from Tom Zumtobel, Chief Executive Officer of NHC, to Governor Brian Sandoval and Will Saunders, President of Xerox State Healthcare, LLC, dated February 24, 2014. UHH0353824-0353827.
[180] NHC Board of Directors Minutes for May 23, 2014. LARSON014384-014390 at 014388.
[181] NHC Board of Directors Minutes for May 23, 2014. LARSON014384-014390 at 014388.
[182] Email between Steve Fitzsimmons, Managing Associate General Counsel of Anthem Blue Cross Blue Shield, and Damon Haycock, Silver State Health Insurance Exchange, Regarding Redline edits to Proposed Reconciliation Plan; NOPHI, dated March 6-26, 2015. PLAINTIFF01096199-01096204 at 01096200 & 01096203.

Further, NHC budget overruns were due in part to the transition from the State Exchange to the Federal exchange. As reflected in NHC's September 2014 Board minutes, one reason administrative costs were higher than the budgeted amount was IT (information technology) expenses were higher than expected due to the shift from the State to the Federal exchange for direct enrollment.[183]

The preceding discussions make it clear that NHC did not fail because of any activities of UHH and/or NHS.[184] Instead, it failed because the entire Federal CO-OP program failed and because NHC's claims costs substantially exceeded its premium revenues. In other words, if UHH and NHS had performed perfectly, NHC would still have failed.

8. Osowski's Opinions Fail to Establish UHH and/or NHS as the Cause for NHC's Failure

Henry Osowski's (Osowski) report includes a set of opinions, some of which relate to UHH, and a list of damages he attributes to UHH. Osowski does not calculate these damages. Instead, he simply accepts the damages listed by Plaintiff's expert Mark Fish (Fish) in his report without any independent validation. In addition, Fish has accepted many of the damage amounts calculated by the Special Deputy Receiver (SDR) in its draft report. For this reason, I do not address Osowski's damages presentation in this section. The damages discussion is presented in my subsequent analyses of the Fish and DRAFT SDR reports.

In his report, Osowski identifies 28 opinions that relate to his belief that UHH and the NHC Management Defendants, IM, and NHS performed at levels below industry standards and failed to act in the best interests of NHC.[185] Eighteen of his opinions relate to UHH and the NHC Management Defendants.[186] Based on these opinions, Osowski concludes that NHC suffered damages due to UHH's failure to perform its duties and for contributing to NHC's ill prepared commencement of operations.[187] He makes no effort to (i) identify how each of his opinions caused NHC to be ill prepared to commence operations: (ii) account for the issues discussed in Sections 6 and 7 of this report regarding the failure of the Federal CO-OP program and NHC's unexpectedly high medical costs which were the primary causes of NHC's failure; or (iii) identify and explain the substantial vetting and guidance that NHC received from both CMS and industry experts prior to selling policies or commencing operations on the initial open enrollment date of October 1, 2013.

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[183] NHC Board of Directors Minutes for November 25, 2014. LARSON014417-014421 at 014419-20.
[184] See also NHC Board of Director Minutes for October 18, 2014, "A discussion of the financials indicated that the September financials will show significant changes as additional information has become available, including a revised IBNR from Milliman. The CO-OP expects a high MLR and a significant, but not unexpected loss at the end of the first year of operations. As expected, this is due to pent up demand for medical care, new relationships with providers and with members. In addition, the CO-OP had significant unplanned expenditures resulting from the failure of the State Exchange system, the move from the State System to the FFM, and the addition of direct enrollment, payment and billing responsibilities to CO-OP operation." LARSON014414-014416 at 014414.
[185] Osowski Report II, pp. 6-12.
[186] Osowski Report II, pp. 6-9.
[187] Osowski Report II, pp. 71-73.

Osowski lists 18 opinions related to UHH and the NHC Management Defendants that I have grouped into three categories:

- Opinions related to the process of selecting UHH as NHC's TPA and UHH's capabilities to serve as NHC's TPA;
- Opinions related to the alleged conflict of interest between UHH and NHC that Osowski perceives; and
- Opinions based on UHH's alleged failures to meet industry and contractual standards.

In this section, these three categories are used to guide the discussion of Osowski's 18 opinions. I first provide an overview of CMS' oversight and NHC's reliance on industry experts during commencement operations and then discuss each of the three categories.

8.1 Oversight of NHC's Commencement of Operations

As previously discussed, the CO-OP program was established under the ACA which gave CMS the authority to provide loans to capitalize the CO-OPs. As stated by the Commissioner/Receiver, "NHC and its predecessors in interest were formed to provide health insurance to individuals and small businesses under the federal [ACA]."[188] In order to receive a loan, CO-OPs, including NHC, went through a rigorous application process. The Catalog of Federal Domestic Assistance (CFDA) Number: 93.545 described the funding opportunity for the CO-OP program start-up and solvency loans.[189] The grant application required voluminous documentation categorized into thirteen sections[190]:

1. Standard Forms,
2. Application Cover Letter,
3. Application Abstract,
4. Project Narrative,
5. Feasibility Study,
6. Business Plan,
7. Governance and Licensure,
8. Evidence of Nonprofit Status,
9. List of Relevant Statutory and Regulatory Citations Regarding State Licensure,
10. Eligibility Affidavit and Application Certification,
11. Affidavits(s) of Criminal and/or Civil Proceedings,

[188] Amended Complaint. State of Nevada, Ex Rel. v Milliman, Inc., et al. (September 24, 2018). ¶ 2.
[189] CCIIO. "Initial Announcement Invitation to Apply". CMS, dated July 28, 2011. CFDA: 93.545.
[190] CCIIO. "Initial Announcement Invitation to Apply". CMS, dated July 28, 2011. CFDA: 93.545, pp. 30-37.

12. Affidavit of Eligibility to Participate in Federal Programs, and

13. Evidence of Private Support.

On January 1, 2012, HH, the predecessor to NHC, submitted its grant application package for Catalog of Federal Domestic Assistance (CFDA) Number: 93.545.[191] HH's grant application package was 653 pages.[192] Per the Invitation to Apply to CFDA: 93.545, "The business plan is the most important component of the application, and is weighted at 62 percent of the application review score."[193] NHC relied on Milliman to render actuarial opinions in preparing a significant portion of the business plan and the entire feasibility study. Milliman expected that sections of their report would be integrated "directly into the application"[194] and that their full report included as an attachment to the application.[195] Milliman provided assistance for the following items in the grant application:[196]

- Feasibility Study
- Process for determining accurate and appropriate pricing of premiums
- Enrollment Forecast
- Regulatory Capital Requirements Forecast
- Pro Forma Financials including cash flow statement, balance sheet, and income statement
- Risk bearing strategy

Per Milliman, "The Feasibility Study and the Business Plan must fit together and elements from one are required for completion of the other."[197] Based on their analysis, Milliman's found that[198]:

The results of our analyses suggest that HHC will be able to achieve the following goals:

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

It should be noted that Milliman completed the analyses that are included in the business plan and feasibility study without assuming any risk sharing gain or loss due to lack of data needed to make a reasonable estimate.[199] Therefore, even without the risk sharing protections established by the ACA, Milliman concluded that NHC would be financially viable and able to meet its financial obligations.

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[191] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343.
[192] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343.
[193] CCIIO. "Initial Announcement Invitation to Apply". CMS, dated July 28, 2011. CFDA: 93.545, p. 32.
[194] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MGT002725.
[195] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MGT002729.
[196] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MGT002730-MGT002731.
[197] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MGT002731.
[198] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MGT002732.
[199] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MGT002758.

The business plan evidences NHC's commitment to building a well-qualified team by enlisting organizations, leaders, contractors, and consultants with industry experience[200]:

- Sponsors: UHH and the Nevada Health Services Coalition
- Management Team (resumes included in application): Tom Zumtobel, Vice President of Strategy for UHH (CEO): Kevin Gittens, Chief Financial Officer for UHH (CFO); Bobbette Bond, Executive Director of the Nevada Healthcare Policy Group and Director of Public Policy of the CHF (CPO): Pei Tang, Vice President, Healthcare Informatics and Outcomes of ALERE (CIO)
- Formation Board of Directors: Kathy Silver, President of the CHF; Jeff Ellis, Vice-President and CFO of Corporate Benefits of MGM Resorts International; Tom Zumtobel, Vice President of Strategy for UHH; Bobbette Bond, Executive Director of the Nevada Healthcare Policy Group; Andy Brignone, Shareholder in the law firm Brownstein Hyatt Farber Schreck; Betsy Gibertson, Chief of Strategy for UHH; D. Taylor, Secretary-Treasurer of Culinary Workers Union Local 226 in Las Vegas, and Vice President and Gaming Division Director of UHH
- Contractors:
    - CHF: "During the first year of the plan's implementation in the Las Vegas area, HHC will contract with CHF 's Las Vegas office for a variety of health care management services, the data warehouse, and access to the CHF provider network for CO-OP members."[201]
    - UHH: "HHC will subcontract the initial plan enrollment, administration and management to UNITE HERE HEALTH through its Las Vegas office, the Culinary Health Fund."
    - Health Services Coalition: Hospital network
    - Milliman: "HHC will subcontract with Milliman for actuarial services in support of premium pricing, targeting, policy development, and budgets."
    - InsureMonkey and Ceridian Exchange Services, LLC: "InsureMonkey (or an entity with similar capacity) will develop the online enrollment system, including a link from the HHC website to the Nevada Silver State Exchange so that members may select HHC on the Exchange, enroll electronically, and pay premiums online."
    - American Health Holding: Cost management products
    - Catalyst Rx: Pharmacy benefits management
- Consultants:
    - Insurance Licensing Services: to be determined
    - Clinical Service Improvements: Arnold Milstein, MD, MPH and Brain Trust
    - Marketing Consultant: Richard Ross

Applications were reviewed by an "objective review panel of qualified external experts with applicable knowledge and experience" with CMS making the award decision.[202] The loan agreement between CMS

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[200] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MGT002763-MGT002769.

[201] "Hospitality Health CO-OP (HHC)". Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MGT002714.

[202] CMS. CFDA: 93.545. Dated July 28, 2011. See also, "To assist CMS in awarding CO-OP loans, we have obtained services from Deloitte Consulting, LLP to establish, and manage qualified expert, objective technical panels

and HH was closed on May 17, 2012.[203] In 2013, the Nevada Department of Insurance reviewed and approved the CMS/NHC loan agreement.[204]

Under the loan agreement, start-up funding disbursements were contingent upon NHC meeting specific conditions and milestones.[205] NHC had nearly 100 milestones to complete to obtain funding.[206] Furthermore, each milestone required completion of predecessor milestones and submission of documentation to CMS.[207] The disbursement schedule required that most of the milestones needed to commence operations were to be completed prior to the first enrollment period.[208] Osowski opines that commencement activities were failures due to UHH, but such activities were the responsibilities of NHC and were primarily performed by NHC,[209] and overseen by CMS under the disbursement schedule.[210] Additionally, NHC and its CMS account manager (AM) had regularly scheduled status calls starting in June of 2012 to discuss NHC's milestone activities, review and request required documentation, and answer questions.[211]

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responsible for reviewing applications and providing recommendations to CMS staff." See https://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.

[203] Loan Agreement. LARSON000782-000863.

[204] Declaration of Mark F. Bennett. Barbara D. Richardson v. The United States, dated September 9, 2020. Case 1:18-cv-01731-MHS.

[205] 3.8. Conditions Precedent for Loan Disbursement of Loan Agreement. LARSON000782 at LARSON000797-98. See also, "Mr. Zumtobel expressed that CMS is providing significant oversight using the disbursement schedule and milestone project plan." HH Board of Directors Minutes for June 15, 2012. PLAINTIFF01145759-01145763 at 01145760.

[206] Loan Agreement. LARSON000782-000863. CO-OP Program Start-Up Loan Detailed Disbursement Schedule. UHH0358131.

[207] Loan Agreement. LARSON000782-000863; and CO-OP Program Start-Up Loan Detailed Disbursement Schedule. UHH0358131.xlsx. See also: UHH0515427; UHH0515424; UHH0578455; UHH0578426; UHH0578538; UHH0578537; PLAINTIFF00927838; PLAINTIFF00927837; PLAINTIFF00620046; PLAINTIFF00620043; PLAINTIFF00616404; PLAINTIFF00616402; PLAINTIFF00638092; PLAINTIFF00638090; UHH0532726; UHH0532724; PLAINTIFF00410478; PLAINTIFF00410475; PLAINTIFF00387709; PLAINTIFF00387707; PLAINTIFF00355369; PLAINTIFF00355366; PLAINTIFF00352965; PLAINTIFF00352965; PLAINTIFF00784962; PLAINTIFF00784960; PLAINTIFF00784961; PLAINTIFF00572020; PLAINTIFF00436143; PLAINTIFF00436141; PLAINTIFF00460374; PLAINTIFF00460376; PLAINTIFF00460373.

[208] Loan Agreement. LARSON000782-000863. CO-OP Program Start-Up Loan Detailed Disbursement Schedule. UHH0358131.xlsx

[209] Executive Services Agreement between Unite Here Health, Hospitality Health, Ltd., and Thomas Zumtobel dated September 13, 2012. PLAINTIFF00912140-00912150. Executive Services Agreement between Unite Here Health, Hospitality Health, Ltd., and Bobbette Bond, dated September 13, 2012. UHH0000076-0000089. (Executive Services Agreements). HH Board of Directors Minutes dated December 10, 2011. PLAINTIFF00457385-PLAINTIFF00457389. (UHH provided assistance under the Consulting Agreement between UHH and NHC dated as of January 30, 2013, to be effective as of May 17, 2012. PLAINTIFF00523772. The Executive Services Agreements and Consulting Agreement were negotiated at arm's length through separate legal counsel for each side). See Exhibit 4.

[210] Loan Agreement. LARSON000782-000863. CO-OP Program Start-Up Loan Detailed Disbursement Schedule. UHH0358131.xlsx

[211] HH Board of Directors Minutes dated June 15, 2012. PLAINTIFF01145759-01145763 at 01145760. See also, UHH0606924; UHH0607054; UHH0607052; UHH0554101; UHH0577231; UHH0553828; UHH0553668; UHH0553652; UHH0553499; UHH0577255; UHH0599149; UHH0577186; UHH0577188; UHH0553213; UHH0552955; UHH0552873; UHH0551149; UHH0551153; UHH0577126; UHH0577134; UHH0551684;

CMS had broad oversight power under the loan agreement.[212],[213] On August 15, 2013, CMS conducted a site visit at NHC,[214] and it was reported to the board that "CMS was satisfied with the CO-OP's operational progress."[215] However, the Onsite Visit Summary Report indicated the overall status of the CO-OP was delayed and noted areas of strengths as well as concerns.[216]Additionally, in 2013, PricewaterhouseCoopers LLP (PwC) audited NHC for the purpose of assisting "CMS in its assessment of Nevada Health CO-OP's compliance with certain provisions of its loan agreement."[217] The audit report with NHC's responses was submitted to CMS by NHC on February 10, 2014.[218]

Most importantly, CMS could elect to terminate NHC's loan agreement and cease distributions for program viability reasons:

> "Lender may elect to terminate this Agreement if it determines in its sole and absolute discretion that Borrower will not be likely to be able to establish a viable and sustainable CO-OP that serves the interests of its community and the goals of the CO-OP Program…."[219]

Yet, CMS made all disbursements for milestones through Q2 2014 totaling $16,930,047.00 by December 31, 2013 evidencing CMS considered all predecessor milestones complete and required documentation sufficient.[220]

It is clear that CMS concluded that NHC was, in fact, prepared to commence operations as of the first open enrollment period.

UHH0551131; UHH0551659; UHH0555008; UHH0551289; UHH0577156; PLAINTIFF00784783; PLAINTIFF00930537; PLAINTIFF00624267; PLAINTIFF00623909; PLAINTIFF00690235; PLAINTIFF00622602; PLAINTIFF00970237; PLAINTIFF00590675; PLAINTIFF00686876; PLAINTIFF00912439; PLAINTIFF00453089; PLAINTIFF00437223; PLAINTIFF00080351; PLAINTIFF00453197; PLAINTIFF00784478.

[212] Loan Agreement. Section 11. LARSON000782-000863 at 000810.

[213] Levinson, D. "Early Implementation of the Consumer Operated and Oriented Plan Loan Program". Department of Health and Human Services: Office of Inspector General, dated July 2013. OEI-01-12-00290. Available at https://oig.hhs.gov/oei/reports/oei-01-12-00290.pdf.

[214] Email from Michele Schultz, CEO Executive Assistant of NHC, to KSilver; Christine Carafelli; and Jeffrey Ellis, Regarding CMS Site Visit Agenda, dated August 14, 2013. PLAINTIFF00911104. See also Agenda of Nevada Health CO-OP Site Visit – August 15, 2013. PLAINTIFF00911105.

[215] NHC Board of Directors Minutes for August 16, 2013. LARSON000680-LARSON000683 at 000680.

[216] Email from COOP-CMS-TA-Support to Tom Zumtobel, Chief Executive Officer of NHC, Regarding Attached: Nevada Onsite Visit Summary Report, dated October 18, 2013. PLAINTIFF00958700-00958701. CCIIO. "CO-OP Onsite Visit Summary Report". CMS, dated October 2013. PLAINTIFF00958702-00958710.

[217] PwC. "Nevada Health CO-OP Performance Audit Report", dated January 28, 2014. PLAINTIFF00452852-00452883.

[218] Email from Basil Dibsie, Chief Financial Officer of NHC, to Tanchica Terry, CMS/CCIIO, Regarding PWC Audit, dated February 10, 2014. PLAINTIFF00452851. See also PwC. "Nevada Health CO-OP Performance Audit Report", dated January 28, 2014. PLAINTIFF00452852-00452883.PLAINTIFF00452852.

[219] Loan Agreement. Section 16.2. LARSON000782-000863 at 000820-21.

[220] Loan Agreement. LARSON000782-000863. CO-OP Program Start-Up Loan Detailed Disbursement Schedule. UHH0358131.xlsx See also Nevada Health CO-OP Trial Balance as of December 31, 2012. LARSON000154-000157. See also Nevada Health CO-OP General Ledger as of December 31, 2013. LARSON000171-306.

8.2 UHH was Prepared and Capable of Providing TPA Services to NHC

Osowski's opinions regarding the process of selecting UHH as NHC's TPA and UHH's capability to serve as NHC's TPA are addressed in this section. The relevant Osowski opinions are[221]:

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 TPAs 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.

UHH's TPA contract met CMS' requirements. Osowski's opinion that the Administrative Services Agreement (ASA) between NHC and UHH was not industry standard and weighted against NHC has no foundation. UHH has been successfully providing administrative services for decades.[222] Between 2012-2015, for non NHC plans, UHH paid over 1.7 million claims, consisting of 4.6 million claim lines, for plans with an average of 57,000+ members per year.[223] Under the ASA, UHH agreed to "provide the administrative services with such skill and care as [UHH] has exercised historically in providing similar services to itself and consistent with industry-recognized standards."[224] As discussed, the loan agreement required disbursement of start-up funding to be contingent upon the CO-OP meeting specific conditions and milestones.[225] A portion of the CO-OPs disbursement for business structuring activities was to approve a Contract with Fund/vendor for Third Party Administrator(TPA) services.[226] Although

[221] Osowski Report II, p. 6.
[222] Unite Here Health. "Mission & Overview". Available at https://www.uhh.org/about.
[223] UHH0632395.
[224] ASA. ¶2.1.
[225] 3.8. Conditions Precedent for Loan Disbursement of Loan Agreement. LARSON000782-000863 at LARSON000797-98.
[226] Appendix 1 – Schedule A: Start-Up Disbursements and Milestones of Loan Agreement. LARSON000782 at LARSON000834.

CMS suggested that the CO-OP Program Performance Requirements and Service Level Standards be incorporated into the ASA,[227] CMS distributed funds for this milestone without their recommended performance standards or financial penalties.[228] CMS' concerns with the ASA were reported to the NHC Board of Directors and performance standards were not an issue[229]:

> **IV. Administrative Services Agreement Status**
>
> Mr. Zumtobel stated that there are four (4) outstanding issues with CMS for approval: connect the ASA to the Business Plan, estimate it against the budget, adjust how they will use the Fund, and build Claims into the budget number. Mr. Landahl added that the cost incurred was factored into the original Business Plan.

Osowski's opinion that, "the CMS recommended performance standards, including stated national benchmarks and financial penalties, were reasonable and should have been incorporated in the ASA"[230] is not supported by CMS' actions.

Further, Osowski ignores the important point that UHH's historical performance standards were similar to CMS's CO-OP Program Performance Requirements and Service Level Standards. For example, based on historical performance, UHH expected 90 percent of the claim volume to come from electronically submitted claims[231] while the CMS' standards cited an 88 percent standard for claims received electronically.[232]

Osowski's comments regarding system design requirements are wrong. As discussed, under the loan agreement, start-up funding disbursement was contingent upon the CO-OP meeting specific conditions and milestones.[233] In order to obtain QTR 3 2012 funding related to the establishment of the claims system, the CO-OP had to "Identify vendor options for claims system," "Identify three potential vendors for claims system as well as review criteria for vendor selection," and provide a "Description of three

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[227] Email from Tanchica Terry, CMS/CCIIO, to Tom Zumtobel, NHC, Regarding Core Contract Review: TPA Agreement, dated July 26, 2013. PLAINTIFF00685281-00685283. See also Email from Tanchica Terry, CMS/CCIIO to Tom Zumtobel, NHC, Regarding Nevada Sample Contract Language and Performance Standards, dated July 30, 2013. UHH0290495-0290496.; and Performance Requirements and Service Level Standards UHH02904970-0290507.

[228] Account Manager Approval for Start-up Loan Disbursement, dated December 10, 2013. PLAINTIFF00436143-00436145. Account manager comments, "The core contract have been reviewed and approved by CMS." See Email from Michele Schultz, CEO Executive Assistant of NHC, to Tanchica Terry, CMS/CCIIO and Nicole Gordon, CMS/CCIIO, Regarding Nevada Health CO-OPO Disbursement Request, dated October 31, 2013. PLAINTIFF00638090 and Attachment 2: Start-up Loan Disbursement Request Form, dated October 31, 2013. PLAINTIFF00638092.xlsx.

[229] HH Board of Directors Minutes for December 12, 2012. UHH0533093-UHH0533095.

[230] Osowski Report II, p. 14.

[231] Email between Michael Gulling, Director, Claims Department of UHH, and Randy Plum, Director of Operations of NHC, Regarding Print to EDI, dated February 28, 2014. PLAINTIFF00049070-0049071 at 00049070.

[232] Performance Requirements and Service Level Standards. PLAINTIFF02476934-02476944 at 02476936.

[233] 3.8. Conditions Precedent for Loan Disbursement of Loan Agreement. LARSON000782-000863 at LARSON000797-98.

vendors and products under consideration for enrollment system."[234] In order to obtain QTR 4 2012 funding related to the establishment of claims system, the CO-OP had to select a claims system vendor and provide a "Description of vendor desired for claims system with description of needs," and a "Signed contract for claims system and implementation schedule."[235] As reflected in Exhibit 5, a robust claims system evaluation of three vendors was performed by a claims system steering committee. The vendors were Healthation, Eldorado, and TriZetto. Each vendor responded to informational requests, provided details on functionality, assessed system needs, presented system demos, and participated in on-site meetings.[236] The CO-OP was fully funded for the establishment of the claims system on December 20, 2013.[237] The CMS account manager approved the start-up loan disbursement when all predecessor milestones were complete and the core contract was reviewed.[238] However, claims processing issues were not due to the lack of a system design or the functional capabilities of Javelina, but as discussed, were due to the compressed timeline to launch a health plan, the inability to get accurate membership information from the State Exchange and Xerox, the high percentage of paper claims, NHC's inability to provide benefit plan and fee schedule information to UHH on a timely basis, and other daily operational issues (as discussed in detail in the CCI Report).

8.3 NHC Was Not Disadvantaged by the Relationship between UHH and the NHC Management Defendants

Osowski's opinions Nos.7 through 11 are discussed in this section. These opinions are:

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.

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[234] Appendix 1 – Schedule A: Start-Up Disbursements and Milestones of Loan Agreement. LARSON000782-000863 at LARSON000835.
[235] Appendix 1 – Schedule A: Start-Up Disbursements and Milestones of Loan Agreement. LARSON000782-000863 at LARSON000836.
[236] See Exhibit 5.
[237] Email from Terry Tanchica (CMS/CCIIO) to Basil Dibsie, Director of Finance for NHC Regarding Disbursement Request for Core Contract Funding, dated December 31, 2013. PLAINTIFF00436141 – 00436142 at 00436141.
[238] Account Manager Approval for Start-up Loan Disbursement for NHC, dated October 31, 2013. PLANTIFF00436143-00436145 at PLANTIFF00436145.

CMS' issues with NHC management personnel working for UHH were resolved. Osowski claims that UHH's activities were affected because NHC managers were employed by UHH, but this arrangement was acceptable to CMS. The NHC management team and Board of Directors were approved by CMS (with full knowledge of the nature of the professional relationships of NHC managers and Board members being affiliated with UHH) during the CO-OP eligibility review and loan application process.[239] In fact, CMS expected the CO-OP to hire an experienced management team; one of the permitted uses of the CMS loan funds was for costs associated with "Hiring a management team with **adequate insurance expertise**…."[240] (Emphasis added.) The executive services agreement was reviewed and accepted by CMS.[241] Further, it is clear from the documentation that CHF, UHH, and NHC exercised care to disclose any potential conflicts of interest and NHC had non-UHH management personnel making key operational decisions, Ms. Egan (the CO-OP CEO, eff. Nov. 15, 2014), Ms. Mattoon, Ms. Harris, Dr. Flora, Mr. Dibsie, Mr. Plum, Ms. Sandoval, Ms. Simons, Ms. Rodriquez, Ms. Manchester, Mr. Knapp, and others, were directly responsible for daily CO-OP operations.[242]

In its Grant Application Package, NHC, as successor to Hospitality Health, Ltd., disclosed that, "Hospitality Health, Ltd. was founded in 2011 by the Culinary Health Fund of Las Vegas, a Taft-Hartley health plan; its parent organization UNITE HERE HEALTH; and the Nevada Health Services Coalition."[243] Leaders from these organizations created the NHC formation board and NHC planned to use this "highly qualified management team" to "replicate [CHF's] successful administrative and service delivery structure."[244] CHF was NHC's sponsoring entity and it was specifically disclosed to CMS that "CHF pledged ongoing private financial support in the amount of $575,000" and would "waive CHF's network access fee of $1 per member per month" an estimated savings on average of $488,688 per year for the first three years.[245] CMS was clearly aware of the relationships between NHC, CHF, and UHH. While CHF and UHH would have supportive roles, NHC would be the entity held responsible by CMS.[246]
NHC's formation Board of Directors were aware that CMS had questions about NHC's relationship with UHH[247] and addressed them. Board of Directors minutes describe CMS' questions and the answers that were provided[248]:

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[239] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343.
[240] 3.5. Permitted Use of Loan Funds of Loan Agreement. LARSON000782-000863 at LARSON000795.
[241] Email between Darryl Landahl, Brownstein Hyatt Farber Schreck, LLP, and Johanna Fabian-Marks, CMS/OL, Regarding HH Executive Services Agreements – CO-OP Program Questions, dated July 5-18, 2012. UHH0553556-0553558.; Email between Johanna Fabian-Marks, CMS/OL, and Lindsey Levenberg, CHF, Regarding HH Executive services contracts, dated July 27, 2012. UHH0543438-0543440.
[242] CCI Report.
[243] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at 002709.
[244] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at 002709.
[245] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at 002711.
[246] HH Board of Directors Minutes for December 10, 2011. PLAINTIFF00457385-PLAINTIFF00457389.
[247] HH Board of Directors Minutes for May 4, 2012. UHH360458-0360468 at 0360459.
[248] HH Board of Directors Minutes for May 7, 2012. PLAINTIFF01461068-PLAINTIFF01461075 at PLAINTIFF01461071.

Mr. Zumtobel explained they had a CMS call on Friday and that there had been some new issues raised. He said it was interesting because CMS didn't even raise the issues on today's call. He adds that he believes the board should be aware of it and that the issue is on how they are reaping services from the fund and how when he and Ms. Bond are both employed by the fund but contracted employees with the COOP would they make sure to keep the right check and balances in place. He explained that the Fund is not for profit and that the COOP and Fund have common mission serving their members first and are completely aligned and are in a fully transparent relationship.

Mr. Ellis asks, was there any concern expressed that the COOP would be used for the benefit of the Union or anything of that sort?

Ms. Bond replies no and that her impression was that they are only funding COOPs that seem to have a strong support system in place and that can work with CMS short timeframes. She continues and says that it seemed that those who have been funded either have history of a COOP or have a strong support system in place like theirs. Believes CMS views as all benefiting and COOP will be able to thrive. The only issue CMS had was to be sure that whatever is touched there is no conflict.

The management of NHC was ultimately the responsibility of the Board of Directors.[249] The formation Board of Directors made certain that key functions would be separated. For example, "The Accounting department will be an external entity. This came from a recommendation from one of the Fund Trustees to avoid NHC funding being in any way the responsibility of the Fund Staff."[250]

CMS was fully aware of NHC's management structure and its relationships to UHH, approved NHC's loan application, and fully funded NHC's executive services contracts.

The ASA was not weighted against NHC as Osowski claims. UHH was fully aware that it could not earn a profit from its relationship with NHC, and provided administrative services at cost.[251] In addition, the NHC Board had Mercer undertake a market analysis to assure the reasonableness of UHH's pricing.[252] Mercer found that UHH's pricing was competitive,[253] and that "given the not-for-profit structure of both parties, a financial penalty for non-performance would not be a viable approach in this situation."[254]

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[249] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MGT003047-003060.
[250] HH Board of Directors Minutes for May 4, 2012. UHH360458-0360468 at 0360462.
[251] HH Board of Directors Minutes for May 4, 2012. UHH360458-0360468 at 0360460.
[252] NHC Board of Directors Minutes for October 16, 2013. LARSON000689-LARSON000692 at 000692. See also Email from Denise P. Jewell, CPA, CLU, Principal of Mercer, to Tom Zumtobel, NHC, Regarding Final Documents – Mercer Study for NV Co-op, dated December 13, 2013. PLAINTIFF00896007.
[253] Jewell, D. "Nevada Health Co-op Benchmarking Project". Mercer, dated December 2013. PLAINTIFF00896008-00896021 at 00896009. Self-Funded, Network Access, Administrative, and Other Fees Tables. PLAINTIFF00896022-00896026.
[254] Jewell, D. "Nevada Health Co-op Benchmarking Project". Mercer, dated December 2013. PLAINTIFF00896008-00896021 at 00896018.

Additionally, Osowski claims that the ASA was "thrust upon NHC" and negotiated by related parties.[255] Pursuant to a conversation with UHH, I have been able to confirm that the ASA was negotiated at arm's length through separate legal counsel for each side. I have had an opportunity to review some,[256] but not all documents related to these negotiations, and I may modify my report after I have had an opportunity to complete my review.

Transactions between related parties commonly occur in the normal course of business. When an entity has an affiliate that has the capability to perform needed functions for the entity, it often finds advantages in working with the affiliate rather than a previously unknown vendor. This is especially true in the health insurance industry. For example, a small group of Blue Cross and Blue Shield plans created a mental health utilization management company and then turned that function over to the new entity. South Carolina Blue Cross and Blue Shield created an independent company (TriZetto) to provide its claims processing system and United Healthcare created Optum and contracted with it to perform several of United's activities. In fact, "the Receiver has availed herself of the services of the SDR's affiliate, Palomar Financial, LC ("Palomar") "…. in her receivership of the CO-OP.[257]

8.4 UHH Properly Performed TPA Services

This section discusses the following opinions cited by Osowski[258]:

12. The Administrative Services Agreement ("ASA"), and the earlier Consulting Agreement 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.
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 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.

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[255] Osowski Report II. Page 13.
[256] Email between Cara S. Elias of Brownstein Hyatt Farber Schreck, LLP, and Bobbette Bond, MPH, Project Officer of NHC, Regarding TPA and UM Agreements, dated June 12-18, 2013. PLAINTIFF02476718-02476736. Email between Cara S. Elias, Brownstein Hyatt Farber Schreck, LLP, and Bobbette Bond, MPH, Project Officer of NHC, Regarding TPA and UM Agreements, dated June 17, 2013. PLAINTIFF02424600-02424603. UHH0632186.
[257] First Status Report. State of Nevada, Ex Rel. v. Nevada Health CO-OP (January 13, 2016). Case No. A-15-725244-C.
[258] Osowski Report II, pp. 7-9.

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 …."
17. UHH did not perform "…consistent with industry-recognized standards." 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 were a material breaches of each individual's fiduciary responsibility to NHC.

Osowski's reliance on his understanding of industry standards to support his opinions is misguided. The industry standards Osowski refers to are based on his experience in working in the typical commercial, Medicare Advantage and Medicaid managed care environments. Osowski ignores key aspects of NHC's activities that make it unique. For example, the CO-OP program was a new concept that was initially dependent on Federal funding. Although there were a handful of CO-OPs that previously existed, their start-ups were not based on Federal funding and were not governed by the requirements of the ACA and its associated regulations. NHC was one of a group of 23 organizations that were entering an environment for which there was little, if any, precedent. Furthermore, NHC and the other 22 CO-OPs did not have the benefit of affiliation with an established insurer as do most Medicare Advantage and Medicaid managed care plans. Not only were the CO-OPs required to start up on their own, they had to complete their start-up activities in a very limited time frame. When Osowski cites industry standards, he makes no accommodations for the uniqueness of NHC and the Federal CO-OP program. When Osowski indicates that UHH failed to meet industry standards, he ignores a critically important point. CMS, the Federal agency that funded and regulated NHC, reviewed and approved all of NHC's and UHH's actions and activities that Osowski now opines failed to meet industry standards. As discussed, NHC had to report to CMS on each of its activities and did so, in detail and in accordance with milestones agreed to by CMS. CMS's funding was based on the completion of milestones. NHC and UHH met CMS' requirements. The "industry standards" to which Osowski refers are not subject to Federal oversight, i.e., CMS' requirements. Osowski is comparing the proverbial apples to oranges.

Osowski concentrates on UHH as the cause of NHC's failure and ignores the myriad of vendors used by NHC. Osowski completely fails to consider the significant problems caused by Xerox and the State Exchange as well as other vendors that affected NHC operations. Instead, he opines that "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."[259] As discussed, problems with the State Exchange and Xerox that led to Xerox's contract being terminated are well documented both publicly and in the record, yet Osowski fails to consider them. Osowski attributes no damages to either Xerox's or the State Exchange's failures and deficiencies.

In his discussion of claims processing, Osowski does not adequately consider that UHH was not the only entity that provided claims processing services to NHC. In fact, UHH did not even perform the majority of claims processing services. Other entities, including NHC, itself, Eldorado, Catamaran, First Health and WellHealth all processed NHC claims.

Osowski completely ignores many of NHC's vendors who also faced implementation challenges and caused NHC to incur budget overruns. Minutes of NHC's Board of Directors clearly illustrate this finding:

- For March 2014, there were two administrative expenses that were "out of budget categories." "Actuarial is over budget" and for UHH there was a carryover charge from the prior month. But, NHC finished under the budgeted deficit amount which was favorable for March 2014.[260]
- For April 2014, the broker commissions were higher than expected and the actuarial expenses were over budget, the customer service/enrollment fees were over budget and found that a $23,000 on-going depreciation amount that wasn't budgeted will re-occur each month.[261]
- As of May 2014, the "broker commission category is out of budget and will remain out of budget for the year." Actuarial expenses were over budget and the temporary help category was over budget due to the need for "assistance in the areas of enrollment data entry and healthcare delivery." UHH was out of budget and consultant and contractor expenses were over budget. "IT expenses for the month are out of budget due to annual computer and internet license renewals" and network access fees from First Health were over budget."[262]
- In June 2014, broker commissions remained over budget, actuarial expenses were over budget, UHH was over budget, enrollment/customer service was over budget for InsureMonkey, and legal fees were over budget.[263]
- For July 2014, broker commissions remained over budget, enrollment/customer service was higher than projected and would remain over budget through the end of the year, UHH was over budget, ongoing depreciation was over budget, and media expense was out of budget.[264]

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[259] Osowski Report II, p. 9.
[260] NHC Board of Directors Minutes for May 23, 2014. LARSON014384-LARSON014390 at 014385-86.
[261] NHC Board of Directors Minutes for June 24, 2014. LARSON014391-LARSON014396 at 014392.
[262] NHC Board of Directors Minutes for August 7, 2014. LARSON014397-LARSON014402 at 014398-014399.
[263] NHC Board of Directors Minutes for August 26, 2014. LARSON014403-LARSON014409 at 014404.
[264] NHC Board of Directors Minutes for on September 30, 2014. LARSON014410-LARSON014413 at 014411.

- In September 2014 administrative costs were higher than budget due to "1) higher than expected broker participation with commissions at 10 percent, 2) increased compensation and 3) benefits expenses due to the need for additional staffing, 4) higher than expected IT expenses due to the shift to the Federal Exchange.[265]

It should be noted that 2014 general administrative expenses, which are exclusive of claims adjudication and cost containment expenses, totaled $19 million which exceeded the total start-up loan amount.[266] The largest administrative expenses other than salary and wages were for Enrollment/Premium/CS Ongoing ($3.9 million) and Broker Commissions ($1.7 million).[267]

TPA licensure issues are a red herring. Osowski repeats the SDR's claim that UHH's lack of a TPA license affected its performance as it sought to meet NHC's needs. The lack of a license is not related to performance. It is noteworthy that the penalty for failure to obtain a TPA license in Nevada is an administrative fine of not more than $1,000.[268] As in most of the allegations brought by the Receiver, no effort is made to identify how UHH's lack of a TPA license caused damages to NHC. In fact, whether or not UHH had a TPA license has no impact on NHC or any alleged damages.

Instead, the important issue is whether UHH's performance of TPA services were proper under the circumstances (and CMS' requirements). UHH was successful in performing TPA functions for many years prior to the formation of NHC. In addition, as discussed, CMS approved NHC's use of UHH as a TPA. When relevant data are examined, Osowski's opinion that UHH was incompetent is not based on the facts and has not been proven. Osowski apparently bases his opinion, at least in part, on UHH's supposed processing of claims outside of eligibility and making overpayments to providers. As shown in Section 9 of this report and addressed in detail in the CCI Report, the basis of his opinion is incorrect. Like the SDR, Osowski holds UHH responsible for paying claims outside of eligibility when the eligibility data that was needed by UHH was solely the responsibility of NHC and/or was unreliable. Osowski also, as noted, ignores other vendors that failed to meet their obligations (e.g., Xerox and the State Exchange) and who were actually responsible for the problems that Osowski attributes to UHH.

Osowski opines that the failure of NHC was due to UHH's faulty claims processing, but the claims that he and the SDR assert were processed incorrectly is a small fraction of all of the claims that were processed. The SDR's allegations that most of the claims in question were incorrectly processed are unproven (See Section 9 of this report). In this context, Osowski's theory of causation and liability that UHH was negligent as a vendor and that any and all alleged damages should be associated with UHH has no foundation.

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[265] NHC Board of Directors Minutes for November 25, 2015. LARSON014417-LARSON014421 at 014419-20.
[266] 2014 Annual Statement of the Nevada Health CO-OP to the Insurance Department of the State of Nevada. PLAINTIFF01461315-01461404.
[267] Trial Balance for NHC as of December 31, 2014. PLAINTIFF00007705.xlsx. 2014 Annual Statement of the Nevada Health CO-OP to the Insurance Department of the State of Nevada. PLAINTIFF01461315-01461404.
[268] "Chapter 683A – Persons Involved in Sale or Administration of Insurance". NRS 683A.090. Available at https://www.leg.state.nv.us/nrs/NRS-683A.html#NRS683ASec090.

For service dates in 2014 and 2015, the Javelina claims data[269] shows that 244,342 non-zero paid medical claims (totaling $93.0 million) were processed and paid. I have analyzed the claims for which the SDR asserts damages and find that only 5,686 (2 percent of 244,273) claims and $2.1 million (2 percent of $93.0 million) are even potentially subject to dispute.[270] Table 6 summarizes the paid medical claims incurred in 2014 and 2015 by NHC.

Table 6
SDR Damage Claim Numbers vs. All Other Claims (Paid Medical Claims Incurred in 2014 and 2015)[271]

		# of Claims	% of All Claims	Total Paid Amount	% of Total Paid
2014	All Other Claims	103,582	42.40%	$43,473,776	46.72%
	SDR Damage Claim Numbers*	677	0.28%	$422,873	0.45%
	Total	104,259	42.68%	$43,896,650	47.18%
2015	All Other Claims	135,005	55.27%	$47,521,486	51.07%
	SDR Damage Claim Numbers*	5,009	2.05%	$1,630,178	1.75%
	Total	140,014	57.32%	$49,151,665	52.82%
Overall	All Other Claims	238,587	97.67%	$90,995,263	97.79%
	SDR Damage Claim Numbers*	5,686	2.33%	$2,053,052	2.21%
	Total	**244,273**	**100.00%**	**$93,048,314**	**100.00%**

The small fraction of claims that Osowski asserts were incorrectly processed nullifies his opinion that these claims were an "essential part of the explanation for NHC's hazardous financial condition.[272]" To illustrate how small a fraction these allegedly incorrectly processed claims were to the overall claims volume of NHC, I have summarized these claims by the month in which they were incurred for health plan years 2014 and 2015[273] below.

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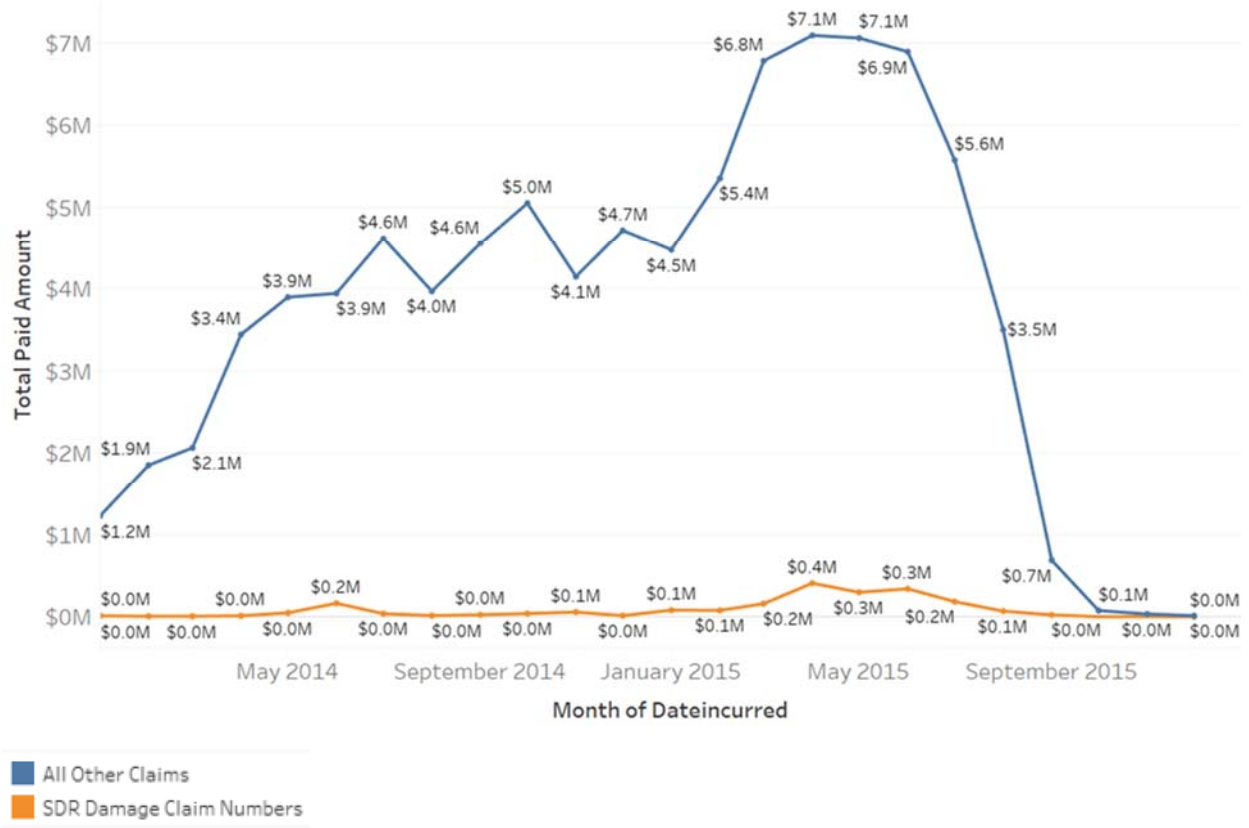
[269] Table: *AdjudicationResult of* SDR Javelina SQL Backup File. PLAINTIFF02484563.
[270] The SDR asserts that claims were paid outside of eligibility for members that are shown as eligible in the SDR's Javelina SQL backup (PLAINTIFF02484563). I have excluded these claims in this analysis. I understand that NHC was operating under "presumed eligibility" and therefore any potential damages may be overstated. See NHC Board of Directors Minutes for January 22, 2014. LARSON014362-LARSON014366; and NHC Board of Directors Minutes for April 29, 2014. LARSON014377-LARSON014383.
[271] Calculated using the *AdjudicationResult* table from the SDR's Javelina SQL backup (PLAINTIFF02484563) for claims incurred in 2014 and 2015, having a *BenefitPlanName* other than "Rx Plan" (exclude Rx claims) and *Claimstatus* "PAID" and a non-zero value for *TotProvPaid*. Claims costs were calculated using the *TotProvPaid* field. I removed the alleged paid outside of eligibility damage claims that I found to be eligible in the SDR's Javelina SQL backup (PLAINTIFF02484563). The $2.05 million of claims include alleged damages from payments for claims paid outside eligibility in 2015, which the SDR attributes to InsureMonkey. Without explanation, Mr. Fish has now attributed these damages to UHH. Therefore, the alleged SDR damage claims in the table above are likely overstated.
[272] DRAFT SDR Report, p. 4. PLAINTIFF02479813-02479851 at 0247916.
[273] Calculated using the *AdjudicationResult* table from the SDR's Javelina SQL backup (PLAINTIFF02484563) for claims incurred in 2014 and 2015, having a *BenefitPlanName* other than "RX Plan" (exclude Rx claims) and *Claimstatus* "PAID" and a non-zero value for *TotProvPaid*. Claims costs were calculated using the *TotProvPaid* field.

Figure 1
SDR Damage Claim Numbers vs. All Other Claims (Paid Medical Claims Incurred in 2014 and 2015)



The above figure illustrates how the allegedly incorrectly processed claims make up only a small fraction of all claims processed, even when viewed on a monthly basis.

Osowski fails to demonstrate that UHH was responsible for creating a backlog of unprocessed and unpaid claims. Osowski (as well as Fish and the SDR) opine that UHH was responsible for "meaningful delays in the timely processing of claims"[274] and that UHH was in breach of the NHC-UHH Administrative Services Agreement due to the claim backlog and related claim aging reports.[275] Osowski asserts his opinion without actually performing any analysis regarding the causes of the backlog, who or what was responsible for the backlog, and what relative contributions these causes might have played on the overall backlog. Instead, he declares that UHH is solely responsible for the backlog. In fact, many other

I corrected for the claims that I found to be eligible when I examined the claims alleged to be paid outside eligibility. The $2.05 million of potentially damaged claims include alleged damages from payments for claims paid outside eligibility in 2015, which the SDR attributes to InsureMonkey. Without explanation, Mr. Fish has now attributed these damages to UHH. Therefore, the potentially damaged claims in the table above are likely overstated.

[274] DRAFT SDR Report, p. 12. PLAINTIFF02479813-02479851 at 0247924.

[275] DRAFT SDR Report, p. 14. PLAINTIFF02479813-02479851 at 0247926.

contributing factors outside of UHH's responsibility contributed to the backlog as discussed in this section and in the CCI Report.

Osowski relies on the SDR's analysis of claims backlog which fails to address all of the causes of the backlog, (which are well documented in the work papers that the DRAFT SDR Report cites for its backlog statistics). For example, the SDR cites to the NHC Board Minutes from February 19, 2014:

> "Even by February 19, 2014, the CO-OP had received 2,800 claims, but had only processed and paid 42, a total of just $8,000."[276]

The SDR fails to mention any of the critical factors that contributed to the claims backlog, factors which are addressed in the same NHC Board minutes document. One significant factor driving difficulties with claims processing, which was outside of UHH's responsibilities as TPA, was the on-going issues and challenges NHC was experiencing with the State Exchange and Xerox.[277] Highlights from the NHC Board minutes the DRAFT SDR Report fails to mention include:

- NHC was speaking regularly with the Nevada State Governor and other carriers regarding the challenges with data submissions from Xerox to NHC.
- The 3,000 new members that NHC has not received any information on from Xerox due to the State Exchange's on-going data transfer failures.
- The letter prepared by NHC attorneys to Xerox and the Nevada State Governor outlining problems NHC was having with the State Exchange and Xerox.
- How Xerox has and continues to hurt NHC's credibility in the market place and injured NHC members.
- An example of a New Year's Eve heart attack patient being left with a $410,000 bill and unmanaged care due to Xerox failing to inform NHC that the patient was an NHC member.
- The fact that, over 82 percent of the 2,800 claims (2,300 claims) were paper claims.[278]

The DRAFT SDR Report's next set of citations continues to ignore multiple pages that describe Board discussions regarding difficulties NHC was having with Xerox and the State Exchange, along with other key factors driving the claims backlog. The DRAFT SDR Report cites the May 23, 2014, NHC Board minutes[279] stating that by this date claims pending adjudication had reached 5,500.[280] However, the SDR fails to mention the continued difficulties with Xerox and the State Exchange and how they were adversely affecting NHC and its ability to process claims. Below are key issues ignored by the SDR and Osowski:

- Xerox, finally admitting their payment collection process is only working at 45 percent capacity.

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[276] DRAFT SDR Report, p. 12. PLAINTIFF02479813-02479851 at 0247924.
[277] NHC Board of Directors Minutes for February 19, 2014. LARSON014367-LARSON014370 at 014368.
[278] See PLAINTIFF00388225-229 at 00388225 ("Plum admits expectations were that 80 percent would be electronic and 'opposite is true'").
[279] NHC Board of Directors Minutes for May 23, 2014. LARSON014384-LARSON014390 at 014386.
[280] DRAFT SDR Report, p. 12. PLAINTIFF02479813-02479851 at 0247924.

- The possible extension of payment deadlines for consumers past May 30th since 4,000 consumers wanted to pay their premiums but were unable to, because of Xerox system errors.
- Xerox presenting NHC with a report of 900 delinquent members dated back to January 2014 that was never reported and of which NHC and UHH were unaware.
- The overall, and undeniable, negative impact Xerox and the State Exchange had on NHC's finances. Fifty percent of resources had been committed to Xerox and Xerox related issues since October 2013.

Osowski not only fails to establish that the claim backlog was caused by UHH, but he fails to establish what a normal or expected level of claim backlog would be for a newly created health insurance company, with newly implemented systems, such as NHC. In fact, the U.S. Senate Report, titled *Failure of the Affordable Care Act Health Insurance CO-OPs*, dated March 10, 2016, identifies the challenges all ACA CO-OPs were experiencing. In particular, the report describes the CO-OPs' struggle to hire staff and to build their technological systems.[281]

Although Osowski makes references to claim backlog numbers from the NHC Board minutes referencing issues with the Javelina system such as "glitches with the functionality of the Javelina system that has held back auto adjudication of claims"[282], he fails to establish that these backlogs or technological challenges were unique to NHC. In fact, it is well-documented that similar challenges were experienced by other CO-OPs, as described in the U.S. Senate report.

Furthermore, the email correspondence between NHC's CEO and UHH's COO highlights the need for more staff and the significant frustration surrounding the claim backlog due to actions and business decisions made by NHC (not UHH).[283] This email from UHH's COO describes NHC's decisions and actions and how these decisions directly impacted the claim backlog. Issues identified by UHH's COO regarding NHC actions that were driving the claim backlog include:

- Retroactive contracts;
- Inconsistent direction;
- 40-letter agreements requiring manual processing;
- Hundreds of CRM requests from NHC to UHH staff; and
- Information is unclear and not timely.

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[281] U.S. Government Publishing Office. "Review of the Affordable Care Act Health Insurance Co-Op Program: Hearing Before the Permanent Subcommittee on Investigations of the Committee on Homeland Security and Governmental Affairs", United States Senate, One Hundred Fourteenth Congress, Second Session, dated March 10, 2016, p. 16.
[282] DRAFT SDR Report, p. 12. PLAINTIFF02479813-02479851 at 0247924.
[283] Email from Dolores Michael, Chief Operating Officer of UHH, and Tom Zumtobel, Chief Executive Officer of NHC, Regarding September Inventory Report, dated September 23, 2014. PLAINTIFF00869027-00869029.

The full email from UHH's COO is below[284]:

From: Michael, Dolores [DMICHAEL@UNITEHEREHEALTH.ORG]
Sent: 9/23/2014 8:56:01 AM
To: Tom Zumtobel [tzumtobel@nevadahealthcoop.org]
Subject: September Inventory report
Attachments: image007.jpg; image008.png; image009.png; image010.png; image011.png; image012.png; image013.png; image014.jpg; image015.gif; image016.png; image017.png; image018.png; image019.png
Importance: High

Tom,

I know you and Mike will be talking about what is driving up the inventory, however, I feel the need to make sure that you are aware of our significant frustration with the inventory as well. There are so many adjustments that continue to distract from normal processing. I hope your staff is keeping you in the loop about the issues that take away from processing time. Some of the things that are frustrating from our end are:

- Retroactive contracts – We just completed over 600 adjustments associated with Desert Radiology that needed to be done due to retro contract issues. There is also a new retroactive Chiro contract that will cause adjustments. Any retroactive contract generally cause adjustments to claims. We get pressured to make these adjustments from CO-OP staff.
- There seems to be inconsistency in direction we have been given regarding processing Comprehensive Cancer Center claims that will cause manual intervention
- There are over 40 Letter Agreements (LOAs) that require special manual processing
- Reinsurance requires a lot of communication and staff engagement.
- We have recently completed responses on hundreds of CRMs – requests from your staff to review claims mostly to identify status or to validate if a claim was processed correctly that turn out to be correct

We cannot keep up our normal processing and handle all of these manual interventions without more staff. Furthermore, we are already late in getting the 2015 Plan Building work done. We need information from the CO-OP to move this forward. Also, we have asked Pam and Basil for additional staffing which we should have hired by now in order to be properly trained. As we talked a couple of weeks ago, the alternative is for you to hire the staff and help move this work forward.

It becomes very frustrating to us when we can't process claims efficiently due to these continued adjustments, or when manual work takes over streamlined processing and when information is unclear or not given to us timely. This highlights the reason why it is important for your staff to get more familiar with how to process claims as quickly as possible. I will be happy to discuss this with you at your convenience.

Dolores Michael
Chief Operating Officer

As discussed by UHH's COO (Dolores Michael), there were many other contributing factors to the claims backlog, many of which were outside of UHH's responsibility or were issues expected with a start-up business that is implementing new computer systems, such as a claims processing system. Osowski incorrectly asserts the backlog was caused by UHH without performing any analysis as to the backlog's actual causes. Improperly, Osowski simply assumes UHH is responsible for the backlog without providing any evidence.

9. Analysis of Plaintiff's Experts' Damages Reports

Plaintiff's experts rely heavily on work completed by the SDR and submitted in the report entitled: Special Deputy Receiver's Report for Nevada Health CO-OP, Causation and Damages for Key Vendors

[284] Email from Dolores Michael, Chief Operating Officer of UHH, and Tom Zumtobel, Chief Executive Officer of NHC, Regarding September Inventory Report, dated September 23, 2014. PLAINTIFF00869027-00869029 at 00869022.

Unite Here Health, Nevada Health Solutions, and InsureMonkey.[285] In this section, the reports prepared by the SDR and Mark Fish (Fish) are addressed.[286]
In my summary of opinions, which was presented earlier in this report, I indicated that Receiver's experts' opinions on damages were seriously flawed. I provide a detailed analysis of these flaws in this section of my report. Because Fish's and Osowski's analyses are dependent on the DRAFT SDR Report, I discuss significant flaws in key components of the SDR's analysis prior to addressing Fish's and Osowski's reports. Three important points, however, must be addressed before describing the flaws in the SDR's report.

First, in my experience, damages are attributed to a defendant because a plaintiff was injured by the defendant's actions. In this case, the injury experienced by NHC is its failure or demise, but neither Fish nor Osowski demonstrate or otherwise offer any evidence that UHH and/or NHS were substantial factors causing this failure. Instead of trying to establish a causal link between the actions of UHH and/or NHS and the failure of NHC, Fish and Osowski identify only problems and issues that they speculate are related to UHH and NHS activities. Although they fail to provide evidence that these alleged activities caused or were a substantial factor in bringing about NHC's failure, they identify amounts related to these activities that they incorrectly refer to as damages.

Second, neither Fish nor Osowski account for the actions of either (i) other vendor defendants namely Milliman, Millennium, InsureMonkey, or Larson, or (ii) other vendors that provided services to NHC, namely the Nevada State Exchange or Xerox. None of the Receiver's Experts acknowledge or even consider that the SDR has multiple overlapping claims and pending actions against various NHC vendors with the potential to result in a double recovery of damages if not properly accounted for. I am aware of the following:

- The SDR's complaint against WellHealth, Medsource and various individual defendants;[287] the SDR claimed damages under various theories such as failure to become a state approved TPA, breach of fiduciary duty, and failure to perform to industry standards. But, most importantly the SDR asserts that, "WellHealth was unable to keep up with claims processing and certain providers were not receiving payments on time, resulting in financial losses, financial misreporting, improper setting of rates, loss of federal receivables, and further draw downs on CMS loans by NHC." These claims are substantially similar to claims against UHH and/or NHS yet Fish and Osowski fail to recognize or account for a potential double recovery of damages.

[285] DRAFT SDR Report. PLAINTIFF02479813-02479851.
[286] I do not directly address the DeVito Report.
[287] Complaint. State of Nevada, Ex Rel. Commissioner of Insurance, Barbara D. Richardson v. WellHealth Medical Associates (Volker), PLLC, et al. Case No. A-20-818118-C.

- The court granted defendant Milliman, Inc.'s motion to compel arbitration.[288] Milliman performed actuarial and consulting services for NHC. Fish opines that the performance of actuarial and consulting services is directly related to Avoidable Costs of Additional Losses:[289]

  > 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.

  Therefore, it is unclear which and to what extent the different vendors are allegedly responsible for $72,700,000 in damages for Avoidable Costs of Additional Losses. Fish has failed to recognize or account for a potential double recovery of damages.
- The SDR asserts that "Millennium failed in its responsibilities which included, without limitation, ensuring that statutory accounting and reporting principles had been followed, and its work resulted in financial misreporting to the Nevada DOI, and the prolongation of NHC's business at great loss beyond the point at which NHC's operations would have been halted but for Defendant Millennium's acts and conduct."[290] Fish fails to address the fact that the SDR settled these claims, claims that are similar to claims made against UHH, with Millennium for $162,500,[291] but Fish attributes Avoidable Costs of Additional Losses to UHH in the amount of $72,700,000 under the same theory.
- As alleged by the SDR, "Larson served as NHC's independent auditor that, among other issues, performed deficient audits, failed to adequately inspect and value reserves and receivables, failed to properly disclose related party transactions, and failed to disclose the existence of substantial doubts about NHC's inability to continue as a going concern."[292] Fish opines that the performance of auditing services is directly related to Avoidable Costs of Additional Losses:[293]:

  > 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.

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[288] Notice of Entry of Order Granting Milliman's Motion to Compel Arbitration. State of Nevada, Ex Rel. Commissioner of Insurance, Barbara D. Richardson v. Milliman, Inc. et al. (March 12, 2018). Case No: A-17-760558-B.
[289] Fish Report II, p. 18.
[290] Amended Complaint. State of Nevada, Ex Rel. v Milliman, Inc., et al. (September 24, 2018). ¶ 23.
[291] State of Nevada, Ex Rel. Commissioner of Insurance, Barbara D. Richardson, In Her Official Capacity as Receiver for Nevada Health CO-OP v. Milliman, Inc. et al. Eighth Judicial District Court. Clark County, Nevada. Case No.: A-17-760558-C. Joint Motion for Determination of Good Faith Settlement by Plaintiff and Defendant Millennium Consulting Services, LLC on Order Shortening Time.
[292] Amended Complaint. State of Nevada, Ex Rel. v Milliman, Inc., et al. (September 24, 2018). ¶ 24.
[293] Fish report II, p. 18.

> 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]

Therefore, it is unclear which and to what extent various vendors are allegedly responsible for $72,700,000 in damages for Avoidable Costs of Additional Losses. Fish has failed to recognize or account for a potential double recovery of damages.

- Most telling, however, is that the SDR is alleging the **exact** same amount of damages in a complaint against the Silver State Insurance Exchange that Fish and Osowski are attributing to UHH, "Defendant has retained five hundred ten thousand six hundred fifty-one dollars and twenty-seven cents ($510,651.27) of premiums paid by Nevada citizens for purchase of health care insurance plans from NHC (the 'Retained Premiums')".[294] The Receiver is attempting to obtain a double recovery for the same alleged injury. This clearly illustrates that Fish and Osowski have done no independent calculations or analysis of damages and are relying solely on the SDR work product to claim damages with no causal link. In reference to the SDR's claimed damages, the Silver State Health Insurance Exchange came to the same conclusion, "the SDR's own contractor, Red River Consulting was unable to corroborate the spreadsheet figures as presenting an accurate picture of liability…."[295]

The SDR's Complaint against the Silver State Insurance Exchange includes:[296]

> 24. Defendant has retained five hundred ten thousand six hundred fifty-one dollars and twenty-seven cents ($510,651.27) of premiums paid by Nevada citizens for purchase of health care insurance plans from NHC (the "Retained Premiums").

The Fish Report II includes:[297]

> 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.

The Osowski Report II includes:[298]

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[294] Complaint. State of Nevada, Ex. Rel. Commissioner of Insurance, Barbara D. Richardson v. Silver State Health Insurance (June 5, 2020). Case No: A-20-816161- C.

[295] Letter from Heather Korbulic, Executive Director of Silver State Health Insurance Exchange, to Mark Bennett, Special Deputy Receiver of Nevada Health CO-OP, Regarding Nevada Health CO-OP ("NHC"); Demand for Payment of Underpaid Premium Amounts to NHC: Your File No. 70750-000, dated April 17, 2019. PLAINTIFF02499352-02499353 at PLAINTIFF02499352.

[296] Complaint. State of Nevada, Ex. Rel. Commissioner of Insurance, Barbara D. Richardson v. Silver State Health Insurance (June 5, 2020). Case No: A-20-816161- C

[297] Fish Report II, p. 32.

[298] Osowski Report II, p. 73.

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.

Third, to address the "damages" identified by Fish and Osowski in their February 2020 reports, they must be itemized. Table 7 presents an itemized list of these damages.

Table 7
Damages Identified by the SDR and Adopted by Fish and Osowski in Their February 2020 Reports

Description	Source	Amount
2014-2015 Claims Paid Outside of Eligibility	SDR	$9,343,352
2014-2015 Overpayment of Claims	SDR	$1,163,852
2014-2015 Duplicate Claims Payments	SDR	$133,889
Loss of Federal Receivables	SDR	$6,175,483
Uncollected Premiums from State Exchange	SDR	$510,651
Utilization Management Damages	Fish	$1,160,000
Damages for All Amounts Paid to UHH	SDR	$7,686,382
Avoidable Costs of Additional Losses	Fish	$72,700,000
Damages Due to Premature Commencement of Operations	SDR/DeVito	$142,441,000

Seven of the nine categories listed in Table 7 are addressed in this report. These categories are:

- 2014-2015 Claims Paid Outside of Eligibility,
- 2014-2015 Overpayment of Claims,
- 2014-2015 Duplicate Claims Payments,
- Loss of Federal Receivables,
- Uncollected Premiums from State Exchange, and
- Utilization Management Damages.
- Avoidable Costs of Additional Losses

Three categories are primarily addressed in a report prepared by another expert (Xavier Oustalniol[299]). These categories are:

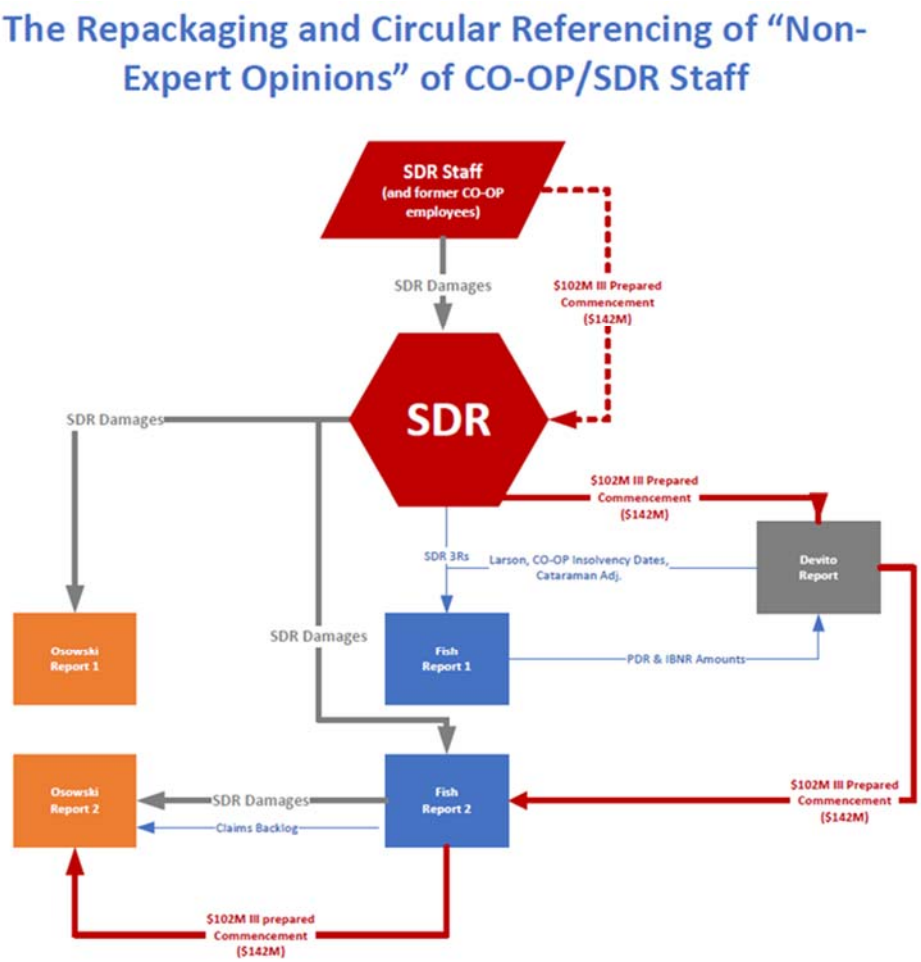
- Damages for All Amounts Paid to UHH,
- Avoidable Costs of Additional Losses, and
- Damages Due to Premature Commencement of Operations.

In addition, Mr. Oustalniol also addresses the loss of Federal receivables.

[299] Expert Report of Xavier Oustalniol, StoneTurn, LLC dated October 2, 2020 (Oustalniol Report)

9.1 The SDR's Calculation of Damages is Substantially Flawed

The SDR submitted a draft report that has yet to be updated. Although the DRAFT SDR Report is a draft, it is important to review because, in most instances, Fish and Osowski adopt the SDR's damage calculations rather than doing their own calculations. As reflected in the diagram below, substantially all of Fish and Osowski's damages, other than interest, were calculated by the SDR.[300]



It should be noted that the four reports prepared by Mr. Fish[301] and Mr. Osowski[302] flip-flop on who believes the DRAFT SDR Report's damages appear reasonable. On July 30, 2019, the original Fish Report was silent on the SDR Damages, and it was the original Osowski Report that asserted the DRAFT SDR

[300] Michael Katigbak (Controller for NHC), "has not been specially retained…as an expert in this matter" but may "testify regarding damage calculations for NHC." Plaintiff's Twentieth Supplemental Disclosures Pursuant to NRCP 16.1. State of Nevada, Ex Rel. v Milliman, Inc., et al (February 21, 2020). The revised 3 Rs calculations in Table 7 were performed by Indegene. See Fish Report II, p. 23.
[301] Fish Report I and Fish Report II.
[302] Osowski Report I and Osowski Report II.

Report's damages "appear reasonable."[303] Then, in the February 7, 2020 Fish Report which includes the DRAFT SDR Report's damages, Fish also opines that the SDR Damages "appear reasonable based upon the review and due diligence that I have performed."[304] The February 7, 2020 Osowski Report, however, is now silent on the DRAFT SDR Report's damages and merely cites the February 7, 2020 Fish Report as its source of damages.[305] Further, in apparent deference to Fish, Osowski has literally copied and pasted several of the Fish's paragraphs and damage amounts into his report. For example, below are snippets from the two reports showing the verbatim copy and paste:

Fish Report II[306]

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.

Osowski Report II[307]

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.

Both Fish's and Osowski's updated reports are silent as to why they flip-flopped on who believes the DRAFT SDR Report's damages appear reasonable. However, both of their updated reports are consistent with their original reports in that they are again completely silent with respect to describing any due diligence or testing they performed to ensure the DRAFT SDR Report's damages are "reasonable." In this report, I show that the DRAFT SDR Report's damage methodologies, calculations, and estimates are deficient and unreliable.

[303] Osowski Report I, p. 44.
[304] Fish Report II, p.31.
[305] Osowski Report II, p.71.
[306] Fish Report II, p. 31.
[307] Osowski Report II, p.72.

Another deficiency of the February 7, 2020 Fish Report is that it mixes and matches the damage categories of the DRAFT SDR Report between different defendants in the case, contradicting the DRAFT SDR Report itself. For example, the Fish Report claims $9.343 million in damages for claims paid outside of eligibility (POE)[308] for both 2014 and 2015 ($5.593 million for 2014 and $3.75 million for 2015); however, the DRAFT SDR Report attributes only the alleged $5.593 million of 2014 POE damages to UHH, while attributing the $3.75 million of 2015 POE damages to InsureMonkey.

The DRAFT SDR Report clearly states that the 2015 POE damages are associated with InsureMonkey and never even mentions UHH as part of the 2015 POE damages discussion:

> "IM had the responsibility to properly administrate raw enrollment and payment data files necessary for proper recordkeeping of eligibility, coverage status, and claims payment history for CO-OP members.[309]"
>
> "…to the extent that NHC's enrollment systems contained ambiguous information, and incorrect information were not updated to the most recent eligibility status, that is the result of InsureMonkey's negligence."[310]
>
> "The payment of claims outside of eligibility, made in reliance on inaccurate, poorly maintained, or ambiguous claims and enrollment data, is IM's responsibility as systems administrator."[311]

Both Fish and Osowski fail to mention the mixing and matching of damages between the different defendants and provide no justification or discussion as to why they contradict the DRAFT SDR Report's findings and conclusions regarding the 2015 POE damages attributable to UHH.

This irreconcilable contradiction between Fish and the DRAFT SDR Report regarding the 2015 POE damages is not surprising given that the Receiver's experts have failed to establish causality on a claim by claim basis. Without a coherent theory of liability for UHH and a detailed, claim-based damage analysis, it is not difficult to see why Fish and (Osowski via the "copy and paste" damages of Fish into his report) contradict the DRAFT SDR Report. This contradiction alone causes the alleged 2015 POE damages associated with UHH to be deficient and therefore unreliable.

Based on my review of the Javelina claims database, the various damage figures in the DRAFT SDR Report appear to have been generated by multiple NHC staff members and contractors, such as accountants, controllers, and claims analysts and were not created by any of the Receiver's damages experts. It appears that these various NHC staff created several ad-hoc schedules for the different SDR damage categories, without apparently considering that the damage categories may overlap between

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[308] Fish Report II, p. 31.
[309] DRAFT SDR Report, p. 28. PLAINTIFF02479813-02479851 at 02479840.
[310] DRAFT SDR Report, p. 29. PLAINTIFF02479813-02479851 at 02479841.
[311] DRAFT SDR Report, p. 30. PLAINTIFF02479813-02479851 at 02479842.

the different defendants and/or damage categories. While Fish claims to have performed "due diligence[312]" on the damages set forth in the DRAFT SDR Report and that the damages "appear reasonable[313]"; it does not appear that he performed the most basic due diligence of checking whether the SDR's staff double counted damages. Again, the failure of the SDR, Fish, and Osowski to prevent double, or even triple counting of damages renders the SDR's damage amounts to be deficient and therefore unreliable. Further, the copying and pasting of the same damage figures that are in the DRAFT SDR Report into the Fish and Osowski reports[314] clearly renders these two reports' damage amounts to be deficient and therefore unreliable.

For example, the DRAFT SDR Report alleges $3.8 million in damages for claims paid outside of eligibility in 2015[315] of which $1.5 million is for medical claims.[316] The DRAFT SDR Report also alleges $1.1 million in damages for overpayments to providers.[317] The underlying schedules referenced in the DRAFT SDR Report[318] to support these alleged damages appear to have been created or partially created by NHC employees during the SDR's control of the CO-OP.[319] However, they did not investigate or control for the possibility that damage amounts might be overlapping or double-counted with other damage categories or with other defendants. A simple analysis of the claim numbers produced in the SDR working schedules show that over 90 percent[320] of the alleged overpayment to providers[321] are double-counted or overlapping with 2015 medical claims allegedly paid outside of eligibility[322]damage category. A Venn diagram of the double counting is below:

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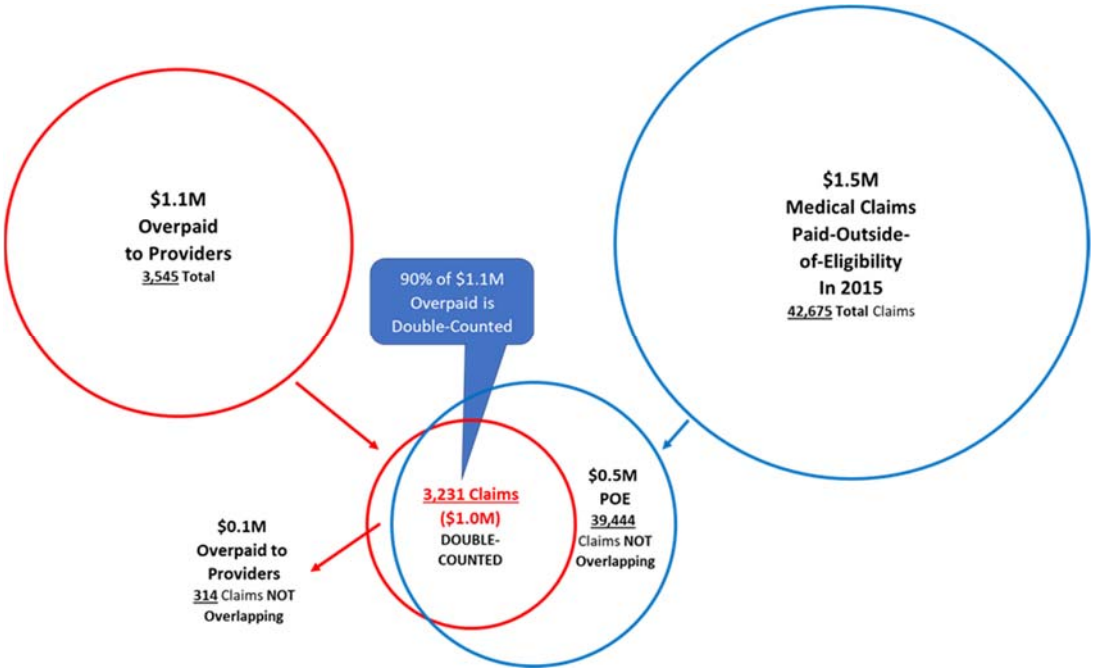
[312] Fish Report II, p.31.
[313] Fish Report II, p. 31.
[314] Osowski Report I and II, Fish Report II.
[315] As discussed in prior paragraphs, these damages are attributable to InsureMonkey by the DRAFT SDR Report, however, they are also irrationally and simultaneously attributable to UHH by Fish.
[316] DRAFT SDR Report, p. 29. PLAINTIFF02479813-02479851 at 02479841.
[317] DRAFT SDR Report, p. 8. PLAINTIFF02479813-02479851 at 02479820.
[318] DRAFT SDR Report, p. 7, FN#7 PLAINTIFF02479813-02479851 at PLAINTIFF02479819.
[319] The column headings in the Excel workbook (PLAINTIFF02479807) make reference to "Mike K" and "Jeff K".
[320] The overlapping dollar amounts for the alleged overpayments to providers not clawed back will not exactly tie out with the dollar amounts for the alleged 2015 medical claims paid outside eligibility because overpayments can be partially damaged, however, a claim paid outside eligibility is considered to be fully damaged.
[321] There appears to be a typo in the Plaintiff work paper PLAINTIFF02479807, worksheet "$1.1 Mil overpayment". The information associated with claim number 215-0000338540-20 actually matches the information for claim number 215-0000338540-02 in the *AdjudicationResult* table of the SDR's Javelina backup. If this error is corrected there will be 313 Not Overlapping Overpaid Claims, 49,443 Not Overlapping POE 2015 Claims and 3,232 Overlapping claims between the two damage categories.
[322] Plaintiffs included Rx claims in their workpaper, even though these are supposed to only be medical claims paid outside eligibility. PLAINTIFF02479920. The number of 2015 medical claims paid outside eligibility is 17,615, of which 14,383 are not overlapping.

Figure 2
SDR Damage Categories Overlap Ninety Percent [323]

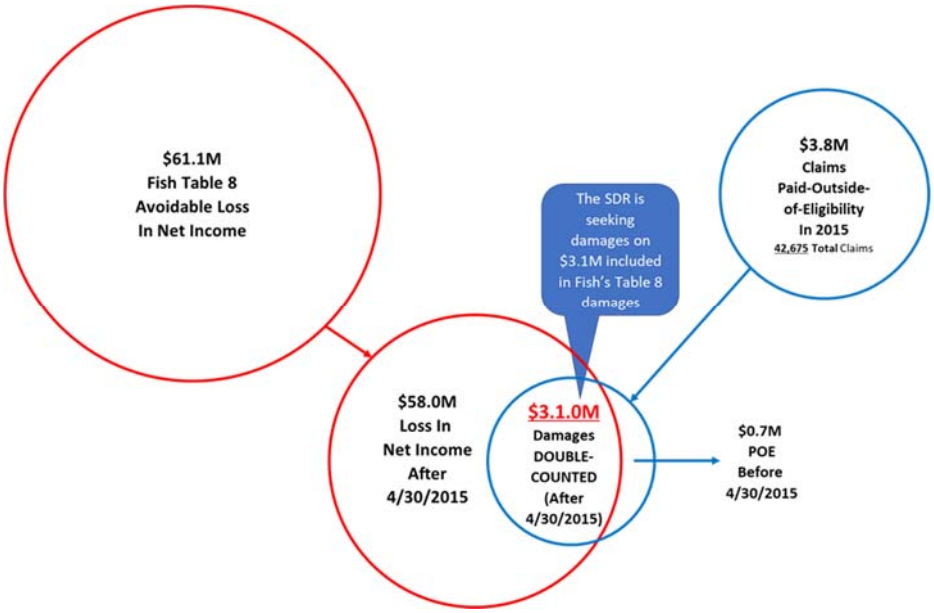


This overlapping or double counting problem is not limited to one or two damage categories but is endemic to the DRAFT SDR Report's fatally flawed damage methodology. There was no attempt by the SDR, the SDR's staff, Fish or Osowski to acknowledge, control or account for overlapping damages. Instead, Fish and Osowski appear to have simply taken the SDR's damage categories at face value and copied and pasted the values into their reports and added the categories together. They appear to be unaware that many of these categories overlap and are being double counted across defendants and damage categories.

For example, Fish also alleges $61.1 million in avoidable loss in net income in his Table 8, but most of the medical claims flowing through Fish's Table 8 damages are included in the 2015 paid outside of eligibility damages and are therefore double (or possibly even triple) counted. In fact, 82 percent of the $3.8 million of 2015 paid outside of eligibility damages are double counted in Fish's Table 8 damages as illustrated by the Venn diagram below:

[323] The Venn diagram was created by comparing the list of damaged claim numbers from the SDR's working papers on 2015 medical claims paid outside eligibility (PLAINTIFF02479920) and on claims with overpayments to providers (PLAINTIFF02479807).

Figure 3
Eighty Percent of SDR Damage 2015 Paid Outside of Eligibility Overlap[324]



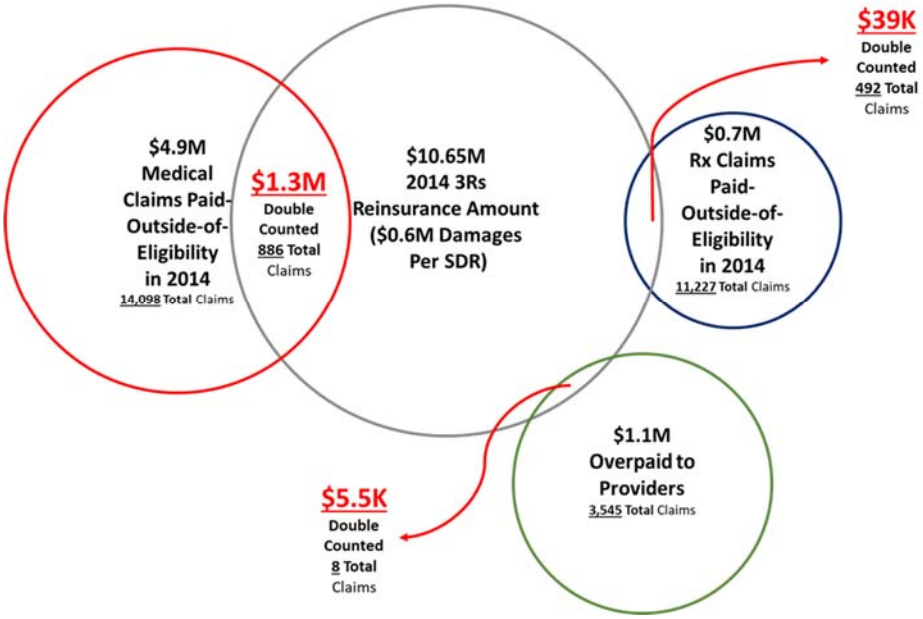
As mentioned, double counting is endemic in the DRAFT SDR Report's damage categories, something that was apparently missed by Fish in performing his "due diligence". Another example of double counting is related to the SDR's alleged damages regarding the supposed lost Federal 3Rs receivable and the other SDR damage categories, such as the 2014 overpayments and 2014 paid outside of eligibility damages.[325] Again, just as I discussed earlier, the SDR, Fish and Osowski double and triple count damages across these SDR damage categories and defendants.

For example, the SDR and Fish allege $572,757 of damages concerning the Federal Transitional Reinsurance submission.[326] This reinsurance submission includes claim numbers and paid amounts in the other damage categories that are double, and triple counted. That is, there are claim numbers in the Federal reinsurance submission that the SDR, Fish, and Osowski are considering "eligible" and are requesting this money from the Federal government, while simultaneously these same claim numbers are being considered as "ineligible" by the SDR, Fish and Osowski when requesting (alleged) damages from UHH for claims that allegedly should not have been paid (outside eligibility) or were overpaid. The diagram below shows that 26 percent of the alleged 2014 medical claims paid outside of eligibility are associated with claims that are being double counted in the Federal Reinsurance submissions and are

[324] The Venn diagram was created by comparing the values from Table 8 in the Fish Report II with the damages associated with claims paid after 4/30/2015 from the SDR's working paper on 2015 medical and Rx claims paid outside eligibility (PLAINTIFF02479920 and PLAINTIFF02479921). The date field used was *PaymentDate* from the *AdjudicationResult* table of the SDR's Javelina backup (PLAINTIFF02484563).
[325] DRAFT SDR Report, pp. 14-18. PLAINTIFF02479813-02479851 at 02479826-02479830.
[326] Fish Report II, Table 7 and DRAFT SDR Report, p. 17. PLAINTIFF02479813-02479851 at 02479829.

therefore, according to the SDR, Fish and Osowski, simultaneously "eligible" and "ineligible" depending on the entity from which the SDR is requesting damages.

Figure 4
Lost Federal 3Rs Receivable are Double-/Triple-Counted[327]



Characterizing claims as eligible in some instances and ineligible in other instances in order to put them in different damages categories and attribute them to UHH, on the one hand, and the Federal government, on the other, could allow the Receiver (on behalf of NHC) to recover a windfall from the alleged double and triple counting of damage dollars, by receiving twice the amount of money that the Receiver alleges NHC has been damaged. This double counting is easily seen by examining the SDR's damage calculations on an individual patient basis. For example, the DRAFT SDR Report's reinsurance calculation includes $126,152 of "eligible" payments for patient certification number 120000000667334, of which $81,720 is alleged damages. Simultaneously the DRAFT SDR Report's "2014 Medical Claims Paid Outside of Eligibility" include the same $126,152 as "ineligible" for patient certification number 120000000667334, thus double counting the $126,152 of claims in both calculations, resulting in a double count of $81,720 of alleged damages.

[327] The diagram was created by comparing the 2014 claims paid outside eligibility taken from SDR's working paper (PLAINTIFF02479810), claims with overpayments to providers taken from the SDR's working paper (PLAINTIFF02479807) and the claims alleged to be damaged with the claims associated with patients with Patient Cert Numbers found in the SDR's working paper on Federal Transitional Reinsurance (PLAINTIFF02479805). The claims were looked up in the *AdjudicationResult* table in the SDR's Javelina backup (PLAINTIFF02484563) using the Patient Cert Num.

The example below illustrates this double counting of damages for patient certification number 120000000667334.[328] The top snippet is from the DRAFT SDR Report's reinsurance working papers, while the bottom snippet is from the DRAFT SDR Report's working papers for the 2014 medical claims paid outside of eligibility. The total paid amount between the two is identical ($126,152), documenting the double-counting, of which $81,720 are double-counted damages. Put more simply, this means that if NHC were to collect on both damage categories, it would receive $207,872 = ($126,152 for the "ineligible" 2014 medical POE) + ($81,720 for "eligible" reinsurance) for claims that on which NHC only paid $126,152, a profit or windfall of either $81,720 or $126,152, depending on which one of the "eligible/ineligible" scenarios were true or of $207,872 if the claims were properly paid.

3R Reinsurance Double Counting Example

Reinsurance -*Patient Cert Number - 120000000667334*

	2014 Medical and RX Claims By Enrollee				In Network	Tot Med RX	FTR for		FTR
	(Active, Individual, Paid)	Medical	RX	Tot Med RX	MOOP	Claims Paid	GT45K	FTR for	Before
	Patient_Cert_Num Patient_Lastname Patient_Firstname	Claims Paid	Claims Paid	Claims Paid	Share Family	Less CSR MOOP	LT 250K	GT 250K	CSR MOOP
120000000667334	120000000667334 Schneider Charlene	126,151.59	568.21	126,719.80	-	126,719.80	81,719.80	-	81,719.80

Source: SDR Report, FN#41 - PLAINTIFF02479805

"Eligible" Reinsurance Dollars

Double Counted Damages

2014 Medical Claims POE - *Patient Cert Number - 120000000667334*

Nevada Health Co-Op Claims (Medical) Paid Outside Eligibility 2014

	Rows	Plan_ID_number	On_Off_ Individual_ Group	Metal_Level	Benefit_ Plan_Name	Product	Claimnumber	Fromdate	Through date	NetProvider PaymentAmt	Facility_Name
1	7364	34996NV003000101	OnExchange	P	Southern Star/Estrella Platinum Standard	MM	214-000[illegible]5084-02	5/19/2014	5/19/2014	24.58	Comprehensive Cancer Centers of Nevada
2	7554	34996NV003000101	OnExchange	P	Southern Star/Estrella Platinum Standard	MM	214-000003[illegible]0-02	5/20/2014	5/20/2014	23.41	Comprehensive Cancer Centers of Nevada
3	7555	34996NV003000101	OnExchange	P	Southern Star/Estrella Platinum Standard	MM	214-000003617[illegible]02	5/20/2014	5/20/2014	39.86	Comprehensive Cancer Centers of Nevada
4	7556	34996NV003000101	OnExchange	P	Southern Star/Estrella Platinum Standard	MM	214-000003617[illegible]-02	5/20/2014	5/20/2014	68.44	Comprehensive Cancer Centers of Nevada
5	7557	34996NV003000101	OnExchange	P	Southern Star/Estrella Platinum Standard	MM	214-000003623[illegible]5-00	5/20/2014	5/20/2014	24.68	Comprehensive Cancer Centers of Nevada
.	.	.	.	.	.	.	.	.	.	.	.
.	.	.	.	.	.	.	.	.	.	.	.
.	.	.	.	.	.	.	.	.	.	.	.
.	.	.	.	.	.	.	.	.	.	.	.
441	33929	34996NV003000101	OnExchange	P	Southern Star/Estrella Platinum Standard	MM	215-0000156235-00	12/24/2014	[illegible]/24/2014	327.53	Fremont Emergency Services
442	34078	34996NV003000101	OnExchange	P	Southern Star/Estrella Platinum Standard	MM	215-0000196185-00	12/2/2014	12/[illegible]/2014	44.86	INFUSYSTEM, INC
443	34079	34996NV003000101	OnExchange	P	Southern Star/Estrella Platinum Standard	MM	215-0000196186-00	12/17/2014	12/17/[illegible]014	44.86	INFUSYSTEM, INC
444	34080	34996NV003000101	OnExchange	P	Southern Star/Estrella Platinum Standard	MM	215-0000196186-00	12/13/2014	12/13/20[illegible]	246.65	INFUSYSTEM, INC
Total							444 Claims			$126,151.59	

Source: PLAINTIFF02479810

"Ineligible" 2014 Medical POE Dollars

The double counting of alleged damages across damage categories and between defendants is endemic throughout the major damage categories of the SDR, Fish and Osowski reports including but not limited to:

- 2014 and 2015 POE damages
- 2014-2015 overpayment
- The loss of the Federal receivable
- Out of pocket accumulators
- Damage amounts paid to UHH
- Uncollected Premiums from the State exchange -
- Table 8 of the Fish Report II – avoidable costs of additional losses in continued operation

[328] I identified the claims alleged to be paid outside eligibility for Patient Cert Num 120000000667334 using the *AdjudicationResult* table SDR's Javelina backup (PLAINTIFF02484563) and the SDR's working paper on 2014 claims paid outside eligibility (PLAINTIFF02479810). The "ineligible" amount ties out exactly with the total "eligible" amount for the same Patient Cert Num found in the SDR's reinsurance working paper (PLAINTIFF02479805).

- Table 9 of the Fish Report II – Premature and ill-prepared commencement of operations

All of this double-counting of alleged damages also flows through to Fish's calculation of interest on damages, which only further exacerbates the Receiver's double-counting of damages when interest is compounded.

The analyses and examples that I present above are only illustrative and do not identify the full extent of the SDR's, Fish's, and Osowski's double counting. The analyses demonstrate gross errors and inadequacies in the damage methodologies, calculations, and conclusions in the three reports, rendering the damage amounts deficient and therefore unreliable.

9.2 UHH and NHS Were Not Responsible for Claims Paid Outside of Eligibility

The SDR asserts that UHH was responsible for making determinations of a member's eligibility, and any resulting damages from claims paid outside of a member's eligibility are attributed to UHH.[329] The SDR also asserts that "An essential aspect of health claims adjudication is the determination of a member's eligibility before payment."[330] Contrary to the SDR's assertions that UHH was responsible for eligibility determinations, eligibility determinations were the responsibility of NHC, not UHH, as outlined in the NHC-UHH Administrative Services Agreement:

> "The CO-OP shall provide and/or direct the appropriate entity to provide regular scheduled eligibility, claims and other data transfers to TPA, as mutually agreed are necessary to perform the Administrative Services."[331]

Further, the ASA goes on to instruct UHH to refer to NHC for "any claims involving questions of eligibility."[332]

As outlined in the ASA, determination of a member's eligibility is a standard separation of responsibilities between a TPA and an insurance provider. The industry-standard in both health care claims processing and in general financial control situations is to have the duties of eligibility and claims payments separate, restricting the TPA's ability to both create plan members' eligibility and to pay their claims.

The SDR makes a highly questionable (and inaccurate) argument that UHH, in its role as TPA, was to override NCH's determinations of member eligibility, something that UHH had no authority to do. Without any support, the SDR assumes that UHH failed to exercise the authority it did not have and is now liable for the alleged damages associated with NHC's member eligibility determinations.

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[329] DRAFT SDR Report, Section IV.A. PLAINTIFF02479813-2479851 at 02479816-2479819.
[330] DRAFT SDR Report, p. 5. PLAINTIFF02479813-2479851 at 02479817.
[331] ASA, p. 4. UHH0000006-0000033 at 0000009.
[332] ASA, p. 18. UHH0000006-0000033 at 0000023.

NHC's role as the entity responsible for determining a member's eligibility is made clear in an NHC document called "Eligibility Determination Process, Effective 8/12/2014."[333] This document contains a list of four steps that "should be used to determine a member's eligibility and the accuracy of any enrollment data."[334] While both NHC and Xerox are mentioned in these four steps, UHH is not mentioned at all.

Furthermore, the State Exchange enrollment data maintained by Xerox and used by NHC to determine eligibility was known to be unreliable**.** For health plan year 2014, NHC relied on enrollment data from the Silver State Health Insurance Exchange (the "State Exchange Data") for members who used the state-sponsored online health portal to enroll for insurance coverage.[335]

The SDR claims that this enrollment data, which was maintained by Xerox, was subject to monthly reconciliations with NHC's enrollment system.[336] However, he SDR provides no foundation as to the reliability of the monthly State Exchange Data to determine a member's eligibility. There were, in fact, many emails and communications at the time, indicating that the State Exchange Data were completely unreliable and could not be used to make accurate eligibility determinations. Additionally, "the SDR has been repeatedly told, the database was the work of Xerox, and the Exchange does not accept the data therein as accurate."[337] Nevertheless, the SDR still uses the State Exchange Data to attribute alleged damages for claims paid outside of eligibility to UHH.[338]

For example, the following is an email from Anthem Blue Cross and Blue Shield Managing Associate General Counsel that includes reference to NHC declaring that the State Exchange Data for 2014 cannot be relied upon for eligibility and premium payment and that each carrier will come to its own conclusion as to whether it is willing to extend coverage with no assurances that a premium was collected or will be remitted.[339] I note that this email, regarding 2014 member eligibility, is dated March 25, 2015.

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[333] Eligibility Determination Process effective August 12, 2014. PLAINTIFF00080366.
[334] Eligibility Determination Process effective August 12, 2014. PLAINTIFF00080366.
[335] DRAFT SDR Report, p. 5. PLAINTIFF02479813-2479851 at 02479817.
[336] DRAFT SDR Report, p. 5. PLAINTIFF02479813-2479851 at 02479817.
[337] Letter from Heather Korbulic, Executive Director of Silver State Health Insurance Exchange, to Mark Bennett, Special Deputy Receiver of Nevada Health CO-OP, Regarding Nevada Health CO-OP ("NHC"); Demand for Payment of Underpaid Premium Amounts to NHC: Your File No. 70750-000, dated April 17, 2019. PLAINTIFF02499352-02499353 at PLAINTIFF02499352.
[338] DRAFT SDR Report, p. 6. PLAINTIFF02479813-2479851 at 02479818.
[339] Email between Steve Fitzsimmons, Managing Associate General Counsel of Anthem Blue Cross Blue Shield, and Damon Haycock, Silver State Health Insurance Exchange, Regarding Redline edits to Proposed Reconciliation Plan; NOPHI, dated March 6-26, 2015. PLAINTIFF01096199-01096204 at 01096201-0196202.

Figure 5
Email Chain from Anthem Blue Cross Blue Shield Associate General Counsel that Included the CO-OP[340]

From: Fitzsimmons, Stephen
Sent: Wednesday, March 25, 2015 12:42 PM
To: 'Damon Haycock'
Cc: Mathews, Collins T; Laura Rich; Bruce Gilbert; Murphy, Mike Nevada
Subject: RE: Redline edits to Proposed Reconciliation Plan; NOPHI

Damon -

Thank you for your feedback.

We agree with the Exchange's conclusion, that the Exchange and carriers collectively cannot rely on the Xerox data. But because any substitute, or reconciled version, of that data will be used by consumers and carriers in representing to the government the coverage, subsidies and CSRs which were in effect in 2014, we believe it is important that CMS agree that the reconciled version is the "official record" of 2014 eligibility and premium payment.

If the Exchange/Xerox is not willing or able to obtain that assurance, then consumers and carriers are left with the risk that the information they submit to the government may not be consistent with what the Exchange/Xerox has previously reported or later submits. As a result, it is possible that carriers may point out to CMS that its respective submissions are based on the unreliable Exchange/Xerox data and/or their efforts to try to reconcile that data and thus may not be identical to what the Exchange/Xerox submits.

Likewise, as the proposed reconciliation would be used as the basis for carriers in extending coverage and incurring claims liability, if the Exchange cannot or will not ensure that its subcontractor Xerox will abide by the financial consequences of the reconciliation (e.g. forwarding to carriers the premium due) then the Exchange should anticipate that each carrier may come to its own conclusion as to whether it is willing to extend coverage with no assurance that premium was collected or will be remitted as was required of Xerox. This may lead to greater confusion and abrasion among consumers, brokers and providers.

I provide this as context for why carriers asked for more formal and binding assurances be included in the proposal; but also to avoid any surprise or misunderstanding if carriers raise these issues as part of their efforts to finalize their 2014 eligibility, premium, commission and subsidy figures.

Should you have any questions, please call me at your convenience. Otherwise, we will proceed with the expectation that each carrier will evaluate and respond to these concerns as they deem appropriate.

Thanks

Steve Fitzsimmons
Anthem Blue Cross and Blue Shield
Managing Associate General Counsel
700 Broadway, Mail Stop CO0105-0560
Denver, CO 80273
(303) 831-3041 Phone
(303) 831-2278 Fax
stephen.fitzsimmons@anthem.com

As the Anthem Blue Cross and Blue Shield Associate General Counsel's email outlines, the State Exchange was having great difficulty in providing Nevada insurance carriers with reliable enrollment information and the insurance carrier (i.e., NHC not UHH) was responsible for making the eligibility determinations given the contemporaneous information available.[341] These member enrollment decisions were made ad-hoc by NHC and required an individualized review of the member's claim and enrollment history.

[340] Email between Steve Fitzsimmons, Managing Associate General Counsel of Anthem Blue Cross Blue Shield, and Damon Haycock, Silver State Health Insurance Exchange, Regarding Redline edits to Proposed Reconciliation Plan; NOPHI, dated March 6-26, 2015. PLAINTIFF01096199-01096204 at 01096201-0196202.
[341] DeVito Report, p. 13-14.

Using their blanket determinations of member eligibility, the SDR alleges that $4.86 million in medical claims were processed and approved for payment by UHH in 2014 for members who were not eligible at the time.[342] These ineligibility findings by the Receiver's Experts, however, were made months, and even years, after the actual claim submissions. The SDR's current findings which are based on updated and corrected State Exchange premium payment data was simply not available at the time these claims were adjudicated and approved for payment.[343]

In addition to not using the contemporaneously available enrollment data to quantify alleged eligibility damages, the SDR chose to ignore that it was NHC, (not UHH) that was responsible for eligibility determinations. The contemporaneous Javelina data supports this finding by showing that nearly all of the claims allegedly paid outside of eligibility in 2014 were based upon eligibility determinations that were made by NHC staff not UHH staff.

I analyzed all of the medical claims allegedly paid outside of eligibility using Javelina eligibility data. My analysis shows that 94.2 percent of the SDR's $5.59 million in alleged damages for claims paid outside of eligibility were, in fact, paid for eligible members. The remaining 5.8 percent of the SDR alleged damages would need to have an individualized investigation to confirm whether each claim was in fact paid outside of eligibility, and if so, what the cause(s) of the outside of eligibility payment were.[344] As shown in Table 8, the SDR attributes $5.59 million in alleged damages due to claims paid outside of eligibility, when, in fact, only $325,981 ($5,593,352 alleged by the SDR less $5,267,371 that was paid within the eligibility period) was potentially paid outside of eligibility.

[342] DRAFT SDR Report, p. 5. PLAINTIFF02479813-2479851 at 02479817.
[343] DRAFT SDR Report, p. 5. PLAINTIFF02479813-2479851 at 02479817.
[344] For example, two claims (214-0000044905-00, 214-0000114800-00) that initially appeared to be ineligible via a computer query were in fact processed correctly and paid within the eligibility period when a simple review of the claims history and notes was performed.

Table 8
Claims Paid Outside of Eligibility[345]

Type	Alleged SDR Paid Outside of Eligibility Damages	Paid *Within* Eligibility Period	Percent of SDR Damages
Medical	$4,861,542	$4,620,460	95.0%
Rx	$731,810	$646,911	88.4%
Total	**$5,593,352**	**$5,267,371**	**94.2%**

9.3 The Number and Value of Overpaid Claims is Substantially Overstated

The SDR identifies categories of allegedly overpaid claims that overlap with other SDR damage categories (2015 claims paid outside of eligibility in particular) by as much as 90 percent (as is illustrated and discussed earlier in this report). The overlap demonstrates that these claims have a multiplicity of issues that should be disentangled, and a causal analysis should be performed to determine damages, which neither the SDR nor Plaintiff's experts undertook.

The existence of a 90 percent overlap renders the overpaid damages to be deficient and unreliable. In addition, the method used in the SDR's overpayment analysis uses an apparently ineffective keyword search, and not a thorough detailed claim review. The SDR alleges that UHH overpaid medical claims in health plan years 2014 and 2015.[346] Under the false premise that UHH is solely responsible for any overpayments, the SDR attempts to use, albeit in vain, an unreliable text-search methodology to classify 3,549 alleged instances of overpayments.[347] Simply stated, the SDR employs a simple keyword search on the notes section of claim records within the Javelina system in an attempt to identify categories of claims with alleged overpayments without actually assessing the validity of the claim or its paid amount and whether the alleged damage amount was caused by UHH. The SDR concludes, without any substantive analysis or evidence, that a claim amount should be categorized as alleged damages and associated with UHH when a claim number shows up in their arbitrary keyword search methodology.

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[345] Eligibility periods were determined using information from the *EmpEligibilityCoverage* table from the SDR's Javelina SQL backup (PLAINTIFF02484563) for claims incurred in 2014. The *EmployeeID* and *Claimnumber* fields from the *AdjudicationResult* table, also from the SDR's Javelina SQL backup (PLAINTIFF02484563), were used to link the information from the Plaintiff's 2014 Paid Outside of Eligibility damages workbook (PLAINTIFF02479810) to the *EmpEligibilityCoverage* table. Paid amounts for Medical claims were identified using the *NetProviderPaymentAmt* field from the 2014 Paid Outside of Eligibility damages workbook (PLAINTIFF02479810). Paid amounts for Rx claims were identified using the *Net_Payment* field in the 2014 Paid Outside of Eligibility damages workbook (PLAINTIFF02479810). If the *EmpEligibilityCoverage* table showed the employee was active at the time the claim was incurred, then it was deemed to have been paid within eligibility. I understand that NHC was operating under "presumed eligibility" and therefore any potential damages may be overstated. See NHC Board of Directors Minutes for January 22, 2014. LARSON014362-LARSON014366; and NHC Board of Directors Minutes for April 29, 2014. LARSON014377-LARSON014383.
[346] DRAFT SDR Report, Section IV.B. PLAINTIFF02479813-2479851 at 02479819-2479821.
[347] Claims Overpayment Refund Amounts By Key Word Found in Claims Notes. PLAINTIFF02479807.xlsx.

The alleged damages associated with these 3,549 claims are the result of an undocumented workflow performed by the SDR staff. There is no supporting documentation to assess the validity of the SDR staff's determination of an overpayment or even what the cause of the overpayment was, or which entity was responsible. For example, an alleged overpayment could have been the result of NHC's, UHH's, InsureMonkey's, or another unknown entity's actions. The DRAFT SDR Report is silent on such issues and apparently assigns fault to UHH as long as the SDR staff member entered comments such as "provider" or "termed" or "policy" or "requested a refund from a provider". The SDR fails to provide any evidence that these overpayments were in fact overpayments and are a result of UHH's actions. The keyword searches on the Claims Note data performed by the SDR are as follows:

Figure 6
SDR workpapers - Claims Overpayment Refund Amounts By Key Word Found in Claims Notes

	A	B	C	D	E	F
1		Total of $1,163,852 in Uncollected				
2		Claims Overpayment Refund Amounts				
3		By Key Word Found In Claims Notes				
4						
5		Overpayment	$947,806	81.4%		Comment: In the over 3500+ Claim IDs with over $1.1 Mil in Uncollected Claims Overpayment Refund Amounts, it was not surprising to observe that the most frequent words found were "overpayment" and "provider". Because the Claims Notes section involved Claims personnel typing in their own words as opposed to selecting applicable reason code(s) for each Claims Overpayment amount, then the reasonable option was to manually scan for at least the top 20 key words present in each of the 3500+ Claim IDs with an uncollected claims overpayment refund amount. After the key words were identified, the data was filtered to sum the uncollected claims overpayment refund amounts. There are overlaps where more than 1 key word is found in the Claim Notes of a Claim ID such as the word "overpayment" and the word "provider" is found in a Claim Note for a particular Claim ID. As a result, the aggregate of the uncollected claims overpayment refund amounts is $2.6 Mil even though the total of uncollected claims overpayment refund amounts is only $1.1 Mil.
6		Provider	$834,288	71.7%		
7		Termed	$129,975	11.2%		
8		Policy	$120,143	10.3%		
9		Miscellaneous	$115,633	9.9%		
10		Authorization	$96,419	8.3%		
11		Service	$83,476	7.2%		
12		Reduction	$50,499	4.3%		
13		Svc Line	$50,306	4.3%		
14		#N/A	$41,978	3.6%		
15		Allowable	$38,733	3.3%		
16		Network	$26,632	2.3%		
17		Eligibility	$25,937	2.2%		
18		Coverage	$18,169	1.6%		
19		Duplicate	$17,747	1.5%		
20		Incorrect	$13,700	1.2%		
21		Procedure	$10,973	0.9%		
22		Hospital	$4,090	0.4%		
23		Co-Pay	$3,187	0.3%		
24		Wrong	$3,032	0.3%		
25		WellHealth	$1,390	0.1%		
26		Aggregate (not total)	$2,634,113	100.0%		
27						

The above snapshot from the SDR workpapers[348] describes how the SDR also double counted unpaid amounts, recounting the $1,163,852 being counted and summed up multiple times as they attempt to categorize their unsubstantiated overpayment amounts.

The SDR is also attributing damages to UHH for claim numbers that never even existed while UHH was performing TPA services for NHC, only further documenting and highlighting the unreliable nature of the SDR analysis. As reflected below, the SDR's spreadsheet[349] includes damages and claim numbers for

[348] Claims Overpayment Refund Amounts By Key Word Found in Claims Notes. PLAINTIFF02479807.xlsx.
[349] Claims Overpayment Refund Amounts By Key Word Found in Claims Notes. PLAINTIFF02479807.xlsx.

dates incurred after UHH was no longer the TPA, with some costs incurred as late as in 2018. The SDR analysis of overpaid claims using a key-word search is unreliable.

Figure 7
SDR workpapers - Claims Overpayment Refund Amounts By Key Word Found in Claims Notes

C	D	E	F	G	H	I	J
CLAIM NUMBER	Full 15 digit Claim ID No per Mike K	DATE INCURRED	PROVIDER TAX ID	FACILITY	OVERPAYMENT AMOU	SDR LETTER SENT	NOTES
215-0000654285-00	215-0000654285-00	9/22/2015	481267451	WEE CARE PEDIATRICS	1.91	06/26/17	REQUEST REFUND FROM PATIENT. 08/09/2017
215-0000654544-00	215-0000654544-00	9/22/2015	880182329	CARDIOLOGY & CARDIOVASCULAR CONS	71.73	06/26/17	
215-0000654107-00	215-0000654107-00	9/23/2015	203516398	ADVANCED PAIN MANAGEMENT CENTER	122.64	06/26/17	
215-0000758338-00	215-0000758338-00	10/21/2015	043290453	HARMONY HEALTHCARE	78.75	06/26/17	
215-814480-00	215-0000814480-00	11/17/2015	043290453	PHC OF NEVADA HARMONY HEALTH	78.75	05/26/17	
215-849916-00	215-0000849916-00	11/24/2015	880384150	GREEN VALLEY OB/GYN ASSOCIATES	699.66	02/15/18	50% hardship payment, per SDR send letter to request refunds. 2/14/2018 EP
215-829936-00	215-0000829936-00	12/4/2015	043290453	PHC OF NEVADA HARMONY HEALTH	78.75	05/26/17	
216-29551-00	216-0000029551-00	12/10/2015	880384150	GREEN VALLEY OB/GYN ASSOCIATES	74.73	05/22/17	50% hardship payment, per SDR send letter to request refunds. 2/14/2018 EP
215-273116-00	215-0000273116-00	4/17/2018	043290453	PHC OF NEVADA HARMONY HEALTH	43.25	05/10/17	
215-428428-00	215-0000428428-00	6/17/2018	200562668	NEVADA HEART AND VASCULAR CENTER	476.31	05/11/17	
215-276663-00	215-0000276663-00	4/21/2115	880367250	PEDIATRIX MEDICAL GROUP OF NEVADA	293.22	04/28/17	PROVIDER RESPONDED NO REFUND WILL BE MADE DUE TO LACHES. 06/08/2017

9.4 2014-2015 Duplicate Claims Payments

In its draft report, the SDR indicates it commissioned an effort to identify duplicate payments for the plan year 2014. The SDR then indicates that a minimum of $133,888.94 of duplicate payments were made and that these duplicate payments were caused by UHH.[350] This damages calculation, like the others in the DRAFT SDR Report which were adopted by Fish and Osowski, fail to demonstrate or otherwise offer any evidence that UHH and/or NHS were substantial factors causing an alleged duplicate payment. Instead, in its draft report, the SDR presents unrelated working papers to support their alleged damages claim.[351] It is unclear which supporting materials Fish and Osowski reviewed to allow them to adopt the DRAFT SDR Report's unsubstantiated alleged damages.

The Plaintiff's subsequent working paper production related to duplicate payments[352] fails to demonstrate duplicate payments were in fact made, and that UHH was the cause of these alleged duplicate payments. The SDR, Fish, and Osowski's failure to consider the many actions and decisions taken by NHC, NHC's other vendors, including Xerox, WellHealth[353],and InsureMonkey, that influenced claims processing, means that the $133,888.94 alleged damage finding is unreliable and deficient.

9.5 Loss of Federal Receivables

Fish fails to disclose that NHC, and Non-UHH personnel, performed the inaccurate 3R estimations and calculations, not UHH. Fish's Table 7 identifies each of the 3R category calculations as the NHC filed them in 2014 versus what was subsequently recalculated by the SDR or Indegene.[354] The overall difference between these three different 3R calculations is $6.175 million, the amount that Fish asserts

[350] DRAFT SDR Report, Section IV.C. PLAINTIFF02479813-2479851 at 02479821-2479822.
[351] PLAINTIFF02479805.
[352] PLANTIFF02498744, PLANTIFF02499016.
[353] Many of these unconsidered operational issues and NHC decisions surrounding WellHealth are documented in the CCI Report.
[354] Indegene was the CO-OP's retained financial and actuarial consultant. See Fish Report II, p. 24. Table 7.

as alleged damages attributable to UHH.[355] Fish asserts, without any evidence, that the driver of the difference between the two calculations is "UHH's failure to adjudicate NHC's claims on an accurate and timely basis."[356] However, Fish fails to discuss or disclose what caused NHC's incorrect 3R's submission or what the source of the error was. After looking through the Receiver's working papers, it is my opinion that the primary cause of the $6.175 million difference is NHC's failure to accurately estimate and input accounting entries in the CMS Excel templates for the 3R's calculations. It was not anything that UHH did or failed to do.

The 3Rs calculations are an actuarial and accounting-driven process, not a TPA-driven process. In fact, the primary contemporaneous emails and discussions regarding the preparation of NHC's submission of 3R calculations to CMS do not materially involve UHH employees. Specifically, there were many email exchanges between NHC finance personnel and Milliman regarding how to complete the CMS 3R template and what adjustments and corrections were needed. For example, on July 29, 2015, two days before NHC's risk corridor submission was due to CMS, NHC's Chief Financial Officer(Basil Dibsie) requested assistance from Milliman to review his preparation of this receivable.[357] In this email, Dibsie states that the results of the risk corridor calculation are higher than the original estimate and that he would like Milliman to review the submission for "reasonableness." More specifically, only two days before this submission was due to CMS, Dibsie's risk corridor calculations were roughly $15 million, $5 million higher than NHC's original estimate of $10 million[358].

From: Basil Dibsie
Sent: Wednesday, July 29, 2015 4:51 PM
To: Jill Van Den Bos <jill.van.den.bos@milliman.com>
Subject: MLR & Risk Corridor
Importance: High

Hi Jill,
I am almost complete with my MLR & RC models. If I send them to you, is there someone at Milliman that can do a review for reasonableness? I am coming up quite a bit higher at $14,641,967 for Individual and $310,050 for Small Group totaling $14,952,017. As compared to the $10M original estimate. I will also send some of my back-up worksheets used. Please let me know. Thanks,

nhc nevada health co-op
simply better

Basil Dibsie
Chief Financial Officer

3900 Meadows Lane | Suite 214 | Las Vegas, NV 89107
tel (702) 789-7432 | fax (702) 802-4601 | cel (702) 901-1395

www.nevadahealthcoop.org

[355] Fish Report II, p. 24. Table 7.
[356] Fish Report II, p. 32. No. 4.
[357] Email between Basil Dibsie, Chief Financial Officer of NHC, and Jill Van Den Bos, ASA, MAAA, MA, Senior Consultant of Milliman, regarding MRL & Risk Corridor, dated July 30, 2015. PLAINTIFF01045249-01045250 at 01045250.
[358] Email between Basil Dibsie, Chief Financial Officer of NHC, and Jill Van Den Bos, ASA, MAAA, MA, Senior Consultant of Milliman, regarding MRL & Risk Corridor, dated July 30, 2015. PLAINTIFF01045249-01045250 at 01045250.

Five hours after Dibsie's request to Milliman for assistance reviewing this unexpected result, he emailed Milliman (presented below) again to say, "actually I had a revision and now it's ~11.6M."[359]

From: Basil Dibsie [mailto:bdibsie@nevadahealthcoop.org]
Sent: Wednesday, July 29, 2015 9:42 PM
To: Jill Van Den Bos <jill.van.den.bos@milliman.com>
Cc: Katie Matthews <Katie.Matthews@milliman.com>; Travis Gray <travis.gray@milliman.com>
Subject: RE: MLR & Risk Corridor

Actually I had a revision and now it's ~$11.6M.

Dibsie's risk corridor calculation went from a $10 million estimated receivable to a $15 million receivable, back down to $11.6 million, all over the course of one day, just 48 hours before the submission was due to CMS. The confusion regarding the risk corridor receivable continued through July 31, 2015, the day that this receivable was due. In an email from Milliman to Dibsie, two pages of comments and questions are presented based upon their review of his risk corridor model.[360]

Importantly, no UHH employee was party to this email exchange, nor was anyone from UHH asked to review or perform due diligence on the claims-related entries that NHC employees entered into the spreadsheet. Yet Fish attributes damages to UHH for actuarial and accounting calculations, and submission errors for which UHH, as the TPA, was not involved.

The CMS risk corridor submission template allows for a claims backlog to not adversely affect the submitting entity -- NHC simply fails to make an accurate submission. The CMS risk corridor submission template allows for the existence of a claims backlog and for the CO-OP to enter accounting estimates into the template to appropriately control for a 2014 claims backlog.[361] In other words, the CMS risk corridor template allowed NHC to get the same risk corridor payment irrespective of the size of the claims backlog, as long as NHC correctly entered the actuarial and accounting entries into the template. The template has an input for the estimated total claims incurred in 2014 but not paid as of March 31, 2015.[362] This was one of the key accounting inputs that NHC did not accurately estimate and is the primary driver of Table 7's $6.175 million difference in 3R calculations. The 2014 claims that were incurred, but not yet paid before March 31, 2015, is a number inputted into NHC's risk corridor submissions by NHC. These actuarial calculations and accounting entries did not involve UHH.

In fact, NHC could have performed a similar claims backlog analysis at the time of its first submission as that recently performed by the SDR, which is now presented in Fish's Table 7. For example, Fish

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[359] Email between Basil Dibsie, Chief Financial Officer of NHC, and Jill Van Den Bos, ASA, MAAA, MA, Senior Consultant of Milliman, regarding MRL & Risk Corridor, dated July 30, 2015. PLAINTIFF01045249-01045250 at 01045249.
[360] Email from Katie Matthews, Actuarial Assistant of Milliman, to Basil Dibsie Regarding MLR & Risk Corridor Review Notes, dated July 31, 2015. PLAINTIFF001243342-1243343.
[361] Center for Medicare & Medicaid Services (CMS) Medical Loss Ratio (MLR) Annual Reporting Form Filing Instructions for the 2014 MLR Reporting Year. PLAINTIFF00188885-000188938. See also PLAINTIFF00179755.
[362] PLAINTIFF02479890, Pt 2, Line 2.2b.

presents a claims run-off analysis[363] and documents the type of analysis that was available to NHC at the time of its first risk corridor submission. Fish's actuarial analysis highlights the fact that NHC's risk corridor submission deficiency was due to an NHC failure that had nothing to do with UHH or the scale of NHC's claims backlog, but ultimately with NHC's actuarial and accounting failures.

Lastly, NHC went through a data validation and resubmission process in September 2015 for its 2014 risk corridor filing[364], making a submission to CMS on September 14, 2015[365]. Even after going through this data validation and resubmission process, NHC failed to make an accurate submission of its risk corridor irrespective of the claims backlog red herring.

Fish presents misleading claims backlog charts without any analysis of the causes and context of the backlog. Further, Fish presents a series of misleading backlog charts[366] without any context or analysis as to the cause of the claims backlog. In fact, Fish fails to show that UHH caused any of his calculated claims backlog and if so, what proportion of the backlog was caused by (i) UHH's actions versus NHC decisions, (ii) failures of the State Exchange and Xerox, (iii) InsureMonkey, (iv) Eldorado, or (v) any of the other litany of factors that can cause a claim processing delay. This failure of establishing causation between UHH's actions and a claims backlog is consistent with the fact that NHC was responsible for its failure to submit its 3R calculations properly, and now the SDR and Plaintiff's experts attempt to attribute damages to UHH to for what are actually NHC's mistakes.

For example, without providing context or explanation, Fish opines that insurance companies "…pay claims at a very high rate (e.g., 98 percent) within 30 days…"[367] and that NHC experienced "…major prompt pay issues, particularly at its outset and throughout 2014."[368] Fish fails to disclose that NHC, at the beginning of 2014, was receiving the majority of its claims in *paper* form rather than *electronic* form as originally envisioned in its business plans.[369] The figure below shows that during the initial days of the CO-OP, the majority of claims were submitted as paper claims.

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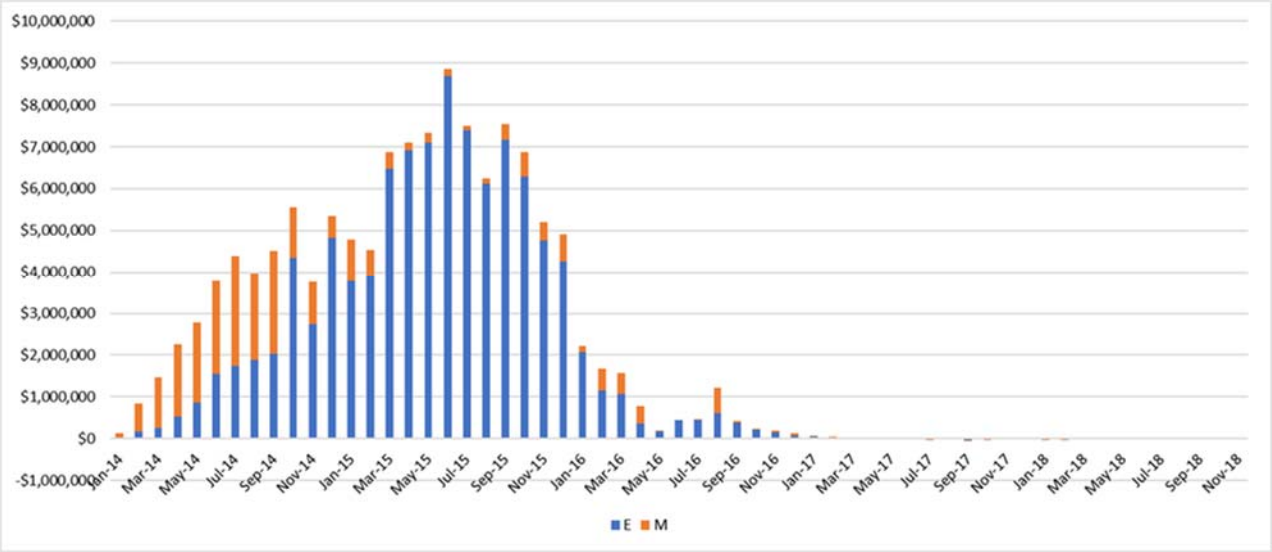
[363] 2015 Actual Premium and Membership Revenue. PLAINTIFF02499092.xlsx.
[364] PLAINTIFF00179755.
[365] PLAINTIFF00177493.
[366] Fish Report II, pp. 25-26, Charts 1-4.
[367] Fish Report II, p. 27
[368] Fish Report II, p. 27.
[369] Email between Michael Gulling, Director, Claims Department of UHH, and Randy Plum, Director of Operations of NHC, Regarding Print to EDI, dated February 28, 2014. PLAINTIFF00049070-00049071.

Figure 8
Medical Claims Received by Type of Claim (Electronic vs. Paper)[370]



This high level of paper and manual claims processing renders Fish's 98 percent of claims being processed and paid within 30 days standard as irrelevant since most insurance companies would be receiving the vast majority of their claims in electronic form, which allows for more efficient and faster processing.

Fish's charts present the claims inventory over time but ignore claims processing improvements. By focusing on the claims inventory alone, Fish ignores UHH's improvements in claims processing over time and allows for the initial paper claims and State Exchange eligibility issues to grossly distort the performance metrics presented in Fish's charts 1-4. For example, concurrent UHH and NHC discussions regarding the claims backlog indicates that claims processing metrics dramatically improve as NHC's business operations matured, the volume of paper claims were reduced, and the difficulties of the State Exchange eligibility issues subsided. On February 2, 2015, the COO of NHC sent the claims manager of UHH an email congratulating UHH on the claims processing improvements and provided the following table describing the claims processing improvements.[371]

[370] Calculated for all medical claims in the *AdjudicationResult* table from the SDR's Javelina SQL backup (PLAINTIFF02484563). For claims with *BenefitPlanName* other than "RX Plan" and the type of claim is identified by the *ClaimSource* field which can have the value "E" for electronic claims and "M" for manual or paper claims.
[371] Email from Linda I. Mattoon, Chief Operating Officer of NHC, to Brooke D. Gearhart, Claims Manager of UHH, Regarding Claims Received and Processed 2014, dated February 2, 2014. PLAINTIFF00032486-00032487.

From: Gearhart, Brooke [/O=HEREIU-IL/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=BGEARHART]
Sent: 2/3/2015 2:18:12 PM
To: Mattoon, Linda [LMattoon@nevadahealthcoop.org]
Subject: RE: Claims Received and Processed 2014

That is nice to see, thank you for that little gift Linda!

Brooke D. Gearhart
Claims Manager
UNITE HERE HEALTH
711 N. Commons Drive, Aurora, IL 60504
Mobile: 630.450.0826
Desk: 630.236.5192
Fax: 630.786.1664
bgearhart@uniteherehealth.org

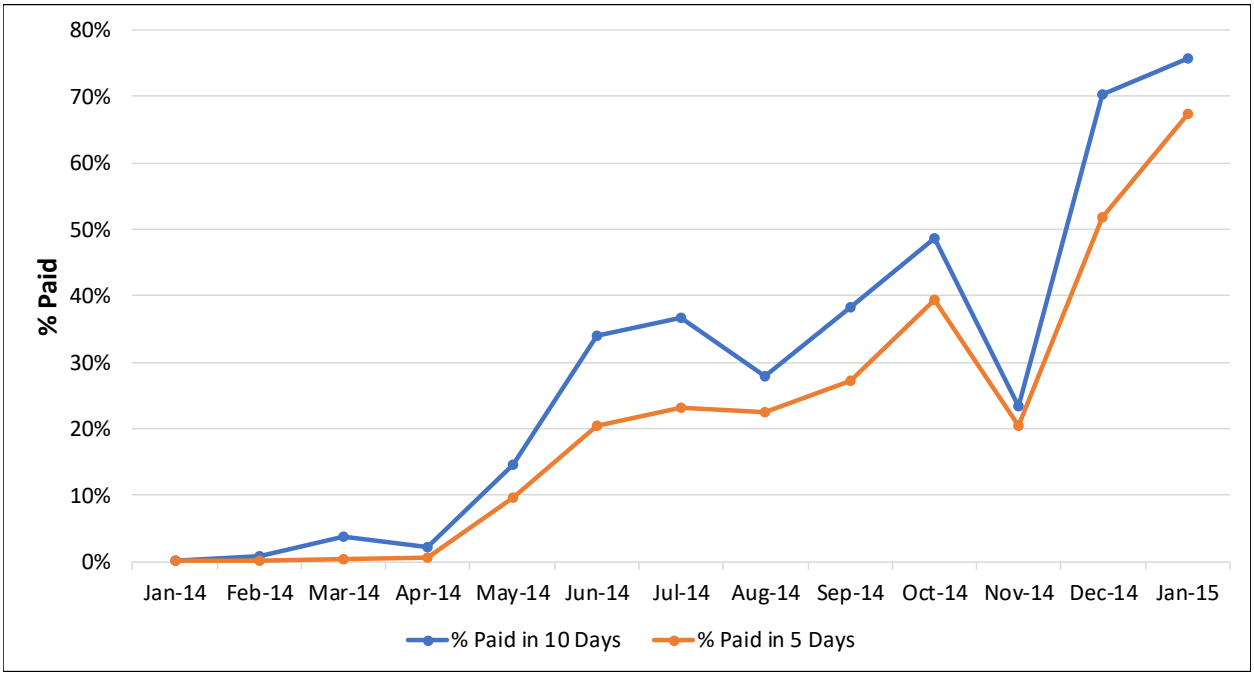
From: Linda I. Mattoon [mailto:lmattoon@nevadahealthcoop.org]
Sent: Monday, February 02, 2015 4:37 PM
To: Gearhart, Brooke
Subject: Claims Received and Processed 2014

Brooke – I'm pulling info together for the board meeting and thought I would share the following table with you since it demonstrates so well the progress that has been made and the increase in the volume of claims. We are usually focused on system problems, issues and the claims backlog and sometimes we forget what was accomplished – together UHH and NHC processed 259,444 claims…despite all the challenges! Nice!!

Number of Claims Received	Month Received	Number Paid in 10 Days	Percent Paid in 10 Days	Number Paid In 5 Days	Percent Paid In 5 Days
3,251	Jan-14	2	0.1%	2	0.1%
7,714	Feb-14	67	0.9%	9	0.1%
11,818	Mar-14	432	3.7%	32	0.3%
15,043	Apr-14	320	2.1%	103	0.7%
20,219	May-14	2,947	14.6%	1,968	9.7%
21,851	Jun-14	7,404	33.9%	4,447	20.4%
24,339	Jul-14	8,922	36.7%	5,657	23.2%
31,558	Aug-14	8,830	28.0%	7,117	22.6%
32,105	Sep-14	12,286	38.3%	8,742	27.2%
36,102	Oct-14	17,545	48.6%	14,276	39.5%
33,187	Nov-14	7,739	23.3%	6,771	20.4%
36,376	Dec-14	25,605	70.4%	18,805	51.7%
31,648	Jan-15	23,980	75.8%	21,340	67.4%
273,563	Total Claims Received 2014				
14,119	Number of Unpaid Claims on 12.31.2014				
5.16%	Percent of Claims Unpaid				

Data in the COO's table are presented graphically below:

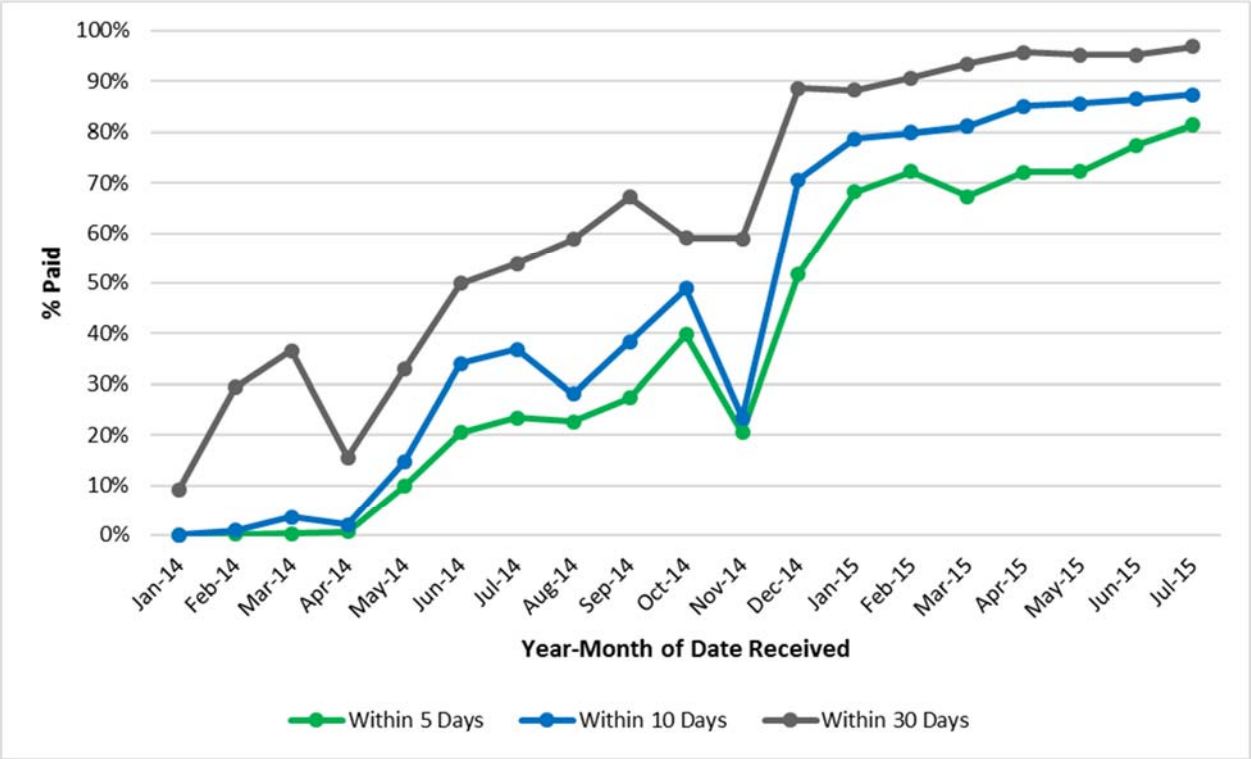
Figure 9
Percent of Claims Paid in 5 and 10 Days by Date Claim Received[372]



NHC's COO's claims processing metrics show that by January 2015, 76 percent of the claims received were processed within 10 days, up from 2.1 percent in April 2014. I performed a similar analysis as NHC's COO performed for claims received from 2014 to 2015 and find that by February 2015, over 90 percent of the claims were being processed within 30 days, and by April 2015, 95 percent of claims were processed within 30 days. The dramatic processing improvement for which NHC's COO was congratulating UHH is presented below:

[372] This chart is just a visual representation of the table in the email sent by the COO of NHC to the claims manager of UHH on February 2, 2015. The chart is aggregated by the month and year of when the claim was received.

Figure 10
Percent of Claims Paid in 5, 10 and 30 Days by Date Claim Received[373]



Additionally, not only does Fish's inventory analysis ignore the claims processing improvements described, it also fails to account for the instructions from NHC's CEO (Pam Egan) to focus on 2015 claims, making 2015 the priority rather than the 2014 claims backlog. This instruction of prioritizing 2015 claims is illustrated in an email dated January 6, 2015, from Linda I. Mattoon, NHC's COO, describing NHC's CEO's (Pam Egan) prioritization of the 2015 claims versus the 2014 claims backlog.[374]

[373] Calculated using the *AdjudicationResult* table from the SDR's Javelina SQL backup (PLAINTIFF02484563) for claims received from January 2014 to July 2015. The days taken to pay a claim is calculated as the difference between the *Datereceived* and *PaymentDate* fields.
[374] Email between Brooke D. Gearhart, Claim Manager of UHH, and Linda I. Mattoon, Chief Operating Officer of NHC, Regarding 2015 Claims, dated January 6-7, 2015. PLAINTIFF00033421-00033422 at PLAINTIFF00033421.

From: Linda I. Mattoon [mailto:lmattoon@nevadahealthcoop.org]
Sent: Tuesday, January 06, 2015 2:08 PM
To: Barbara Rodriguez; Sandoval, Christina; Gearhart, Brooke
Subject: 2015 Claims
Importance: High

Good Afternoon Ladies,

Pam would very much like us to keep 2015 claims current as we work on the 2014 backlog. We have identified three groups whose 2015 eligibility is not in Javelina yet:

1) Approximately 500 members that were in the JQS
2) Small groups
3) Pre-Audit File exceptions

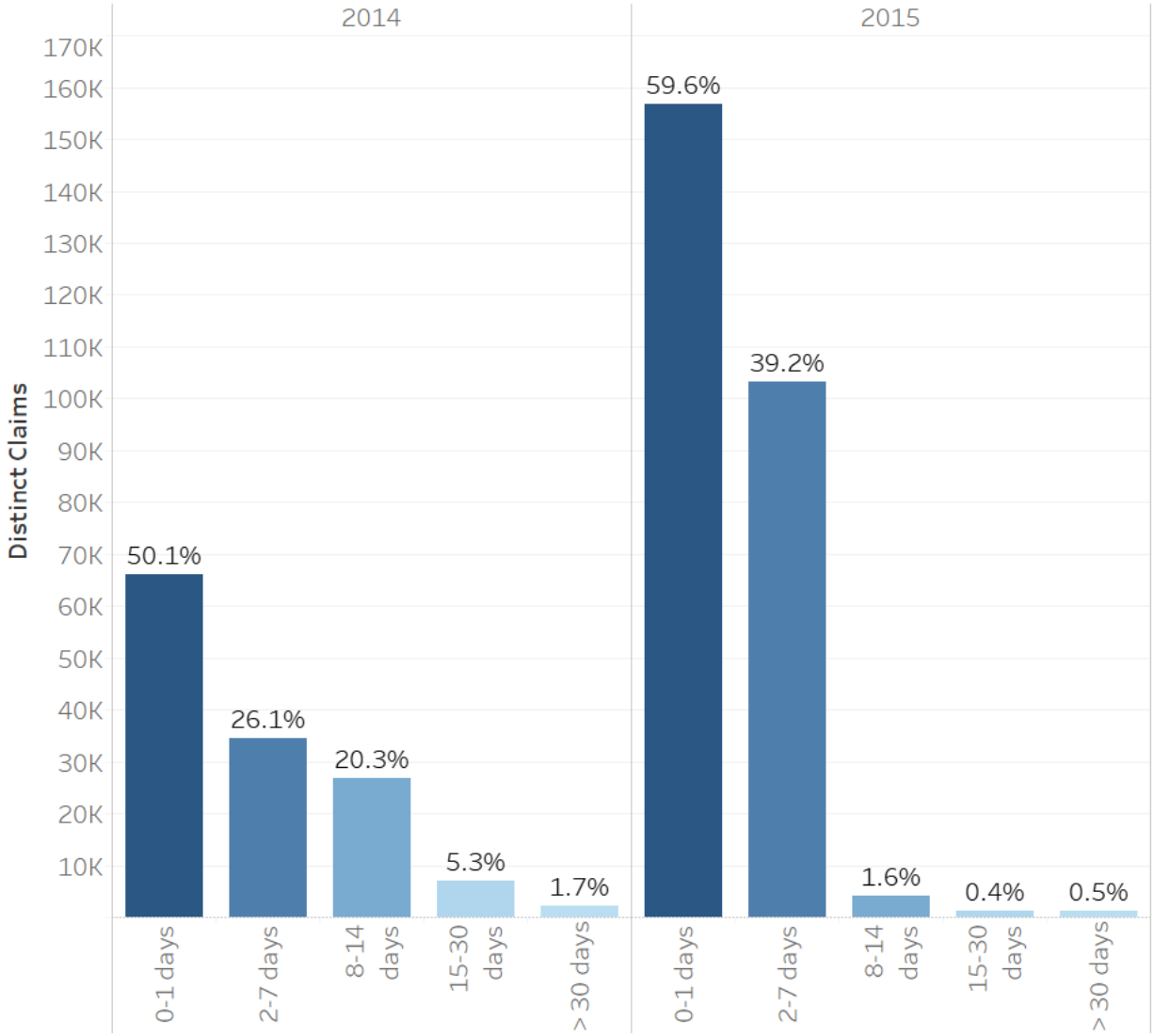
It may be the end of this week, possibly early next week, before all of the eligibility issues are straightened out and uploaded into Javelina. I am hopeful the eligibility will be straightened out before too many claims are received; however, since 2015 claims are a priority and we have known eligibility issues, would it be helpful to create a queue for 2015 eligibility issues?

Let me know your thoughts – thanks!

Fish's claims backlog inventories and processing metrics are misleading because he fails to account for NHC's CEO instructing UHH and CO-OP claims processing staff to prioritize the 2015 claims over the 2014 claims backlog. It is then misleading and inappropriate to use the 2014 claims backlog metrics against UHH when it was told to focus on 2015 claims. In fact, UHH did precisely as NHC instructed, focus and prioritize the 2015 claims over the 2014 backlog; the prior charts and tables on the monthly percent of claims paid in less than 30 days demonstrate continual improvement and execution of NHC's business prioritization.

Most importantly, Fish fails to recognize that regardless of the volume of unpaid claims, claims were entered into Javelina on a timely basis, meaning the data were available and could have been used to control for a claims back log. As reflected in the figure below, 96.5 percent of claims in 2014 and 98.8 percent of claims in 2015 were entered into Javelina between 0-14 days from the date received evidencing no significant lag in data availability (over 50 percent in both years were entered into Javelina within 0-1 days).

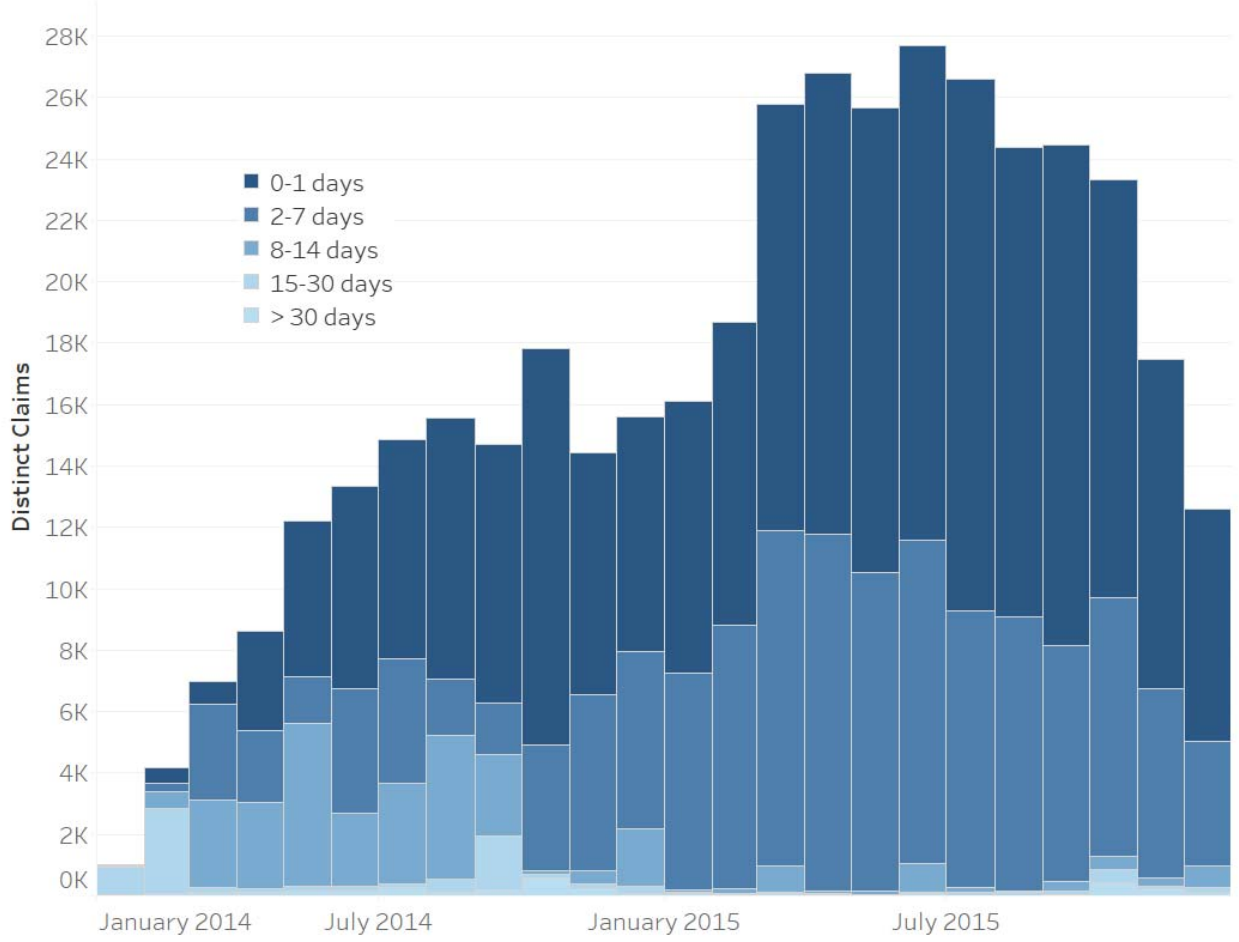
Figure 11
Days Taken to Enter Claims in Javelina[375]



[375] Calculated using the *AdjudicationResult* table from the SDR's Javelina SQL backup (PLAINTIFF02484563) for all claims received in 2014 and 2015 having *BenefitPlanName* values other than "RX Plan". The days taken to enter a claim in Javelina was calculated as *CreatedDate - Datereceived*. The chart shows the volume of claims (# of distinct 14-digit *Claimnumber*) in (i) 0-1 day, (ii) 2-7 days, (iii) 8-14 days, (iv) 15-30 days and (v) more than 30 days. Claims with a *CreatedDate* value that comes before the *Datereceived* are excluded. I also aggregated the charts by Month-Year of *Datereceived* and looked at the claims volume each month from January 2014 - December 2015.

As reflected in the figure below, by the end of 2014 and into 2015, a majority of the claims were entered into Javelina between 0-7 days.

Figure 12
Days Taken to Enter Claims in Javelina[376]



Fish claims he "reviewed" the 3R calculations and that they are "reasonable" even though his own working papers appear to contradict the 3R calculations he presents in Table 7. In addition to failing to establish or demonstrate that the claims backlog was caused by UHH and that the claims backlog caused NHC to make its allegedly inaccurate submissions, Fish appears to have performed work that contradicts the recalculated amounts he presents as "reasonable"[377] damages in Table 7 of his report.

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[376] Calculated using the *AdjudicationResult* table from the SDR's Javelina SQL backup (PLAINTIFF02484563) for all claims received in 2014 and 2015 having *BenefitPlanName* values other than "RX Plan". The days taken to enter a claim in Javelina was calculated as *CreatedDate - Datereceived*. The chart shows the volume of claims (# of distinct 14-digit *Claimnumber*) in (i) 0-1 day, (ii) 2-7 days, (iii) 8-14 days, (iv) 15-30 days and (v) more than 30 days. Claims with a *CreatedDate* value that comes before the *Datereceived* are excluded. I also aggregated the charts by Month-Year of *Datereceived* and looked at the claims volume each month from January 2014 - December 2015.
[377] Fish Report II, p. 23, FN #64-65.

Fish's working papers includes a "Claims Lag 2014" analysis which identifies when 2014 incurred claims were received and paid by NHC.[378] Fish uses these calculations for his revised IBNR Reserves - Table 2 and Table 8 but does not appear to cross-check his results with the amounts the SDR used for the revised Risk Corridor calculations. Nonetheless, Fish states the SDR's numbers are "reasonable."

For example, Fish's working papers show a total of $56.539 million paid for claims incurred in 2014 and received in 2014-2016.[379] His working papers also show a total of $5.696 million of 2014-incurred claims received after December 31, 2014.

Figure 13
Fish Workpaper – Claims Lag 2014

2014 Incurreds Received after 12/31/14	5,696,595
2014 Incurreds Received after 4/30/15	654,984
2014 Incurreds Received after 6/30/15	479,113
2014 Incurreds Received after 5/31/15	394,665

2014 Medical and RX Claims Received

Year Received	Month Received	Date Incurred JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2014	JAN	322,647												322,647
2014	FEB	544,188	683,542											1,227,730
2014	MAR	119,043	731,368	1,165,124										2,015,535
2014	APR	58,177	300,531	875,621	1,768,123									3,002,453
2014	MAY	35,119	73,700	120,476	1,342,858	2,067,368			0	0				3,639,521
2014	JUN	119,766	42,859	130,623	301,197	1,769,219	2,522,068							4,885,732
2014	JUL	36,615	105,239	91,950	372,348	278,019	2,095,755	2,557,719	0					5,537,644
2014	AUG	95,233	67,894	136,297	118,077	151,303	266,402	1,642,597	2,946,007					5,423,810
2014	SEP	15,547	90,625	43,205	87,542	382,932	127,613	621,506	1,529,764	2,927,079				5,825,814
2014	OCT	21,478	57,119	28,179	26,888	101,538	92,663	716,828	443,349	2,124,735	3,512,590			7,125,369
2014	NOV	4,476	28,144	19,885	68,200	50,489	36,623	64,884	99,879	298,956	1,693,349	2,719,985		5,084,870
2014	DEC	7,751	16,292	17,043	21,234	16,551	63,970	75,924	120,673	326,453	512,954	2,127,243	3,446,191	6,752,278
2015	JAN	51,638	10,887	10,333	(10,658)	19,614	18,581	41,368	103,875	70,253	537,181	341,388	2,112,525	3,306,985
2015	FEB	8,348	7,625	4,628	22,096	11,523	13,647	40,412	64,808	43,987	86,527	111,849	269,946	685,393
2015	MAR	973	261	17,757	24,574	42,165	49,432	74,620	38,595	41,787	121,524	88,621	157,515	657,825
2015	APR	1,130	17,161	2,912	18,045	6,766	11,449	22,386	15,493	56,548	67,064	52,330	120,122	391,407
2015	MAY	993	3,966	3,714	5,477	7,879	5,635	13,371	19,712	24,645	12,200	55,497	107,232	260,319
2015	JUN	(57)	1,226	(3,063)	7,080	(4,431)	(62,980)	(3,091)	17,481	(31,503)	10,734	(34,621)	18,779	(84,448)
2015	JUL	1,599	(3,236)	(11,405)	(62,410)	(16,515)	(42,455)	16,085	28,823	(2,570)	38,163	10,987	23,330	(19,605)
2015	AUG	528	6,834	(220)	(494)	(63,861)	677	5,862	8,317	34,740	57,861	71,543	31,874	153,660
2015	SEP	0	8	(700)	31,130	6,703	8,189	10,591	53,864	26,989	35,472	55,089	35,374	262,709
2015	OCT	1,723		(194)	(188)	167	787	2,766	370	2,440	2,482	(10,013)	3,447	3,788
2015	NOV	104	(7,340)	(2,909)		464	700	(2,813)	(2,093)	(584)	(15,190)	(1,209)	9,568	(21,300)
2015	DEC	(154)	826			13,041	132	(1,999)	217	(19,460)	97	287	66	(6,947)
2016	JAN		0	0	0	0		306	1,627	348	(436)	9,791	(83)	11,553
2016	FEB	6		(793)	(2,579)	(94)	(100)	(520)		0	(166)		(1,258)	(5,505)
2016	MAR	(722)		(5,153)	(17,690)	0	39	295	(300)	(4,127)	(272)	301	(3,555)	(31,184)
2016	APR		0		0	275	546	361	14,055	9,787	11,287	1,147	1,405	38,862
2016	MAY		11			0	0	(312)	1,206	481	0	460	594	2,440
2016	JUN	1,224						1,880		857	(42)	1,921	0	5,841
2016	JUL	0		(104)		0	(192)		3	0	912	705	844	2,169
2016	AUG		0	185	540	855	0	1,986	716	45	(23,059)	6,717	6,544	(5,471)
2016	SEP	282		12	348	550	27	164	288	57,900	283	1,001	250	61,105
2016	OCT	514	666	1,954	580	226	2,267	90	461	675	4,011	4,576	2,612	18,631
2016	NOV				640		100	0	359	426	5,718	109	115	7,468
2016	DEC				(21)		60			4,546	(3,900)		213	897
		1,448,170	2,236,209	2,645,358	4,122,936	4,842,746	5,211,634	5,903,265	5,507,548	5,995,431	6,667,345	5,615,704	6,343,652	56,539,997

This analysis and the two referenced amounts are not consistent with the SDR's revised risk corridor calculations that Fish says are "reasonable." [380] A portion of the SDR's re-estimated risk corridor workbook[381] is below:

[378] 2015 Actual Premium and Membership Revenue. PLAINTIFF02499092.xlsx.
[379] PLANTIFF02499092.
[380] Fish Report II, p. 23. FN #64-65.
[381] The MLR Calculator with the 2014 MLR Annual Reporting Form. PLAINTIFF02479890.xlsm.

Figure 14
SDR's Re-Estimated Risk Corridor Workbook

Part 2 Premium and Claims

Line Description	SHCE	1 Health Insurance INDIVIDUAL Total as of 12/31/14	2 Health Insurance INDIVIDUAL Total as of 3/31/15
2. Claims			
2.1 Claims Paid			
2.1a Claims paid during the MLR reporting year regardless of incurred date		$50,084,268	
2.1b Claims incurred only during the MLR reporting year, paid through 3/31 of the following year			$57,646,916
2.2 Direct claim liability			
2.2a Liability as of 12/31 of MLR reporting year for all claims regardless of incurred date	Pt 2, Ln 2.2	$12,722,691	
2.2b Liability for claims incurred only during the MLR reporting year, calculated as of 3/31 of the following year			$12,526,290
2.3 Direct claim liability prior year	Pt 2, Ln 2.3		
2.4 Direct claim reserves			
2.4a Reserves as of 12/31 of MLR reporting year for all claims regardless of incurred date	Pt 2, Ln 2.4		
2.4b Reserves for claims incurred only during the MLR reporting year, calculated as of 3/31 of the following year			
2.5 Direct claim reserves prior year	Pt 2, Ln 2.5		
2.6 Direct contract reserves			
2.6a Direct contract reserves 12/31 column	Pt 2, Ln 2.6		
2.6b Direct contract reserves 3/31, dual contract, deferred columns			
2.7 Direct contract reserves prior year	Pt 2, Ln 2.7		
2.8 Experience rating refunds (rate credits) paid			
2.8a Experience rating refunds, with all incurred dates, paid in the MLR reporting year	Pt 2, Ln 2.8		
2.8b Experience rating refunds associated with premium earned only in the reporting year and paid through 3/31 of the following year			
2.9 Reserve for experience rating refunds (rate credits)			
2.9a Reserved in MLR reporting year regardless of incurred date	Pt 2, Ln 2.9		
2.9b Reserves specific to the MLR reporting year through 3/31 of the following year			
2.10 Reserve for experience rating refunds (rate credits) prior year	Pt 2, Ln 2.10		
2.11 Incurred medical incentive pool and bonuses			
2.11a Paid medical incentive pools and bonuses MLR Reporting year	Pt 2, Ln 2.11a		
2.11b Accrued medical incentive pools and bonuses MLR Reporting year	Pt 2, Ln 2.11b		
2.11c Accrued medical incentive pools and bonuses prior year	Pt 2, Ln 2.11c		
2.12 Net healthcare receivables			
2.12a Healthcare receivables MLR Reporting year	Pt 2, Ln 2.12a		
2.12b Healthcare receivables prior year	Pt 2, Ln 2.12b		
2.13 Contingent benefit and lawsuit reserves			

... Company Information | Pt 1 Summary of Data | Pt 2 Premium and Claims | Pt 3 MLR and Rebate Calculation | Pt 4

The SDR's revised risk corridor workbook indicates that a total of $57.646 million was paid for 2014 incurred claims by March 31, 2015, while Fish's total incurred claims in 2014 and received from 2014-2016 is $56.539 million, a $1.1 million discrepancy. One would expect Fish's total to be larger than the SDR's given that the SDR's calculation contains only claims received from January 2014 to March 2015, whereas Fish's number contains claims received from January 2014 to December 2016.

In addition, the SDR's revised risk corridor workbook indicates $12.526 million for claims incurred in 2014 but not yet paid as of March 31, 2015, while Fish's working papers indicate a total of $5.697 million of claims incurred in 2014 and received after December 31, 2014, a discrepancy of over $6.83 million.

Both the SDR and Fish make no effort to reconcile these large discrepancies, nor do they discuss how their calculations can be "reasonable." I note that these discrepancies are approximately the amount of alleged damages identified in the DRAFT SDR Report and Fish's Report as shown in Fish's Table 7.

9.6 Uncollected Premiums from the Nevada State Exchange

The SDR states that UHH "under collected" premium payments from the Nevada State Exchange[382] although it was never UHH's responsibility to collect premium payments from members or from the State Exchange. In fact, "Barbara D. Richardson, Commissioner of Insurance in the State of Nevada, in her official capacity as Permanent Receiver of Nevada Health Co-Op" is suing the Silver State Health Insurance Exchange, the party responsible for collection of premium payments.[383] In the Complaint against the Silver State Health Insurance Exchange, the Commissioner asserts that "Nevada citizens who purchased a health care insurance plan from [NHC] through the Exchange submitted their premium payments directly to [the Silver State Health Exchange] through the Exchange; and that "after collecting the premium payments" the Silver State Health Insurance Exchange "would transfer those premium payments to [NHC]".[384] The Commissioner further asserts that there was a contract between NHC and the Silver State Insurance Exchange that was breached when the Silver State Insurance Exchange failed to remit premium payments it collected to NHC for NHC plans purchased on the Exchange.[385]Contrary to the allegations in the Commissioner's Complaint, the experts hired by the SDR in this matter are asserting that collection of premiums was UHH's responsibility, with which the Commissioner (the Receiver herein) clearly disagrees. In the Second Demand for Payment of Underpaid Premium Amounts to NHC, the Commissioner/Receiver's position is clear that "NHC relied solely on the Exchange for 2014 premium data."[386]

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[382] DRAFT SDR Report, p. 21 & 22. PLAINTIFF02479813-02479851 at 02479833-34. Fish Report II, p.32, ¶6.
[383] Complaint. State of Nevada, Ex. Rel. Commissioner of Insurance, Barbara D. Richardson v. Silver State Health Insurance (June 5, 2020). Case No: A-20-816161- C.
[384] Complaint. State of Nevada, Ex. Rel. Commissioner of Insurance, Barbara D. Richardson v. Silver State Health Insurance (June 5, 2020). Case No: A-20-816161- C.
[385] Complaint. State of Nevada, Ex. Rel. Commissioner of Insurance, Barbara D. Richardson v. Silver State Health Insurance (June 5, 2020). Case No: A-20-816161- C.
[386] Letter from Mark Bennett, Special Deputy Receiver of Nevada Health CO-OP, to Heather Korbulic, Executive Director of Silver State Health Insurance Exchange, Regarding Nevada Health CO-OP ("NHC"); Second Demand for Payment of Underpaid Premium Amounts to NHC: Your File No. 70750-000, dated September 6, 2019. PLAINTIFF02499214-02499215.

nhc nevada health co-op

In Receivership for Liquidation

BARBARA D. RICHARDSON, *Receiver*
CANTILO & BENNETT, L.L.P., *Special Deputy Receiver*

September 6, 2019

VIA E-MAIL (hkorbulic@exchange.nv.gov)

Ms. Heather Korbulic
Executive Director
Silver State Health Insurance Exchange

Re: Nevada Health CO-OP ("NHC"); Second Demand for Payment of Underpaid Premium Amounts to NHC; Our File No. 70750-000

Dear Ms. Korbulic:

This letter is in response to your letter dated April 17, 2019, regarding NHC's request for payment relating to an underpayment of 2014 premiums, and there has been a delay in responding while we addressed some other receivership matters. We had previously requested all premium payment information pertaining to NHC, and the data that the Exchange provided included columns that showed a "coverage total" that exceeds the "check amount" total by $510,651.27.[1] Before our initial demand letter, we requested further information for these columns, or any reasonable explanation aside from the appearance of an underpayment—and the Exchange did not provide further information concerning its own data. As such, $510,651.27 is owed to NHC by the Exchange.

To recap, our request for payment is based upon data that we received directly from the Exchange—the spreadsheet that we provided with our prior letter comes directly from a table that was transferred to us from the Exchange. NHC relied solely on the Exchange for 2014 premium data, as the Exchange was the intermediary that collected premium monies (and NHC did not collect these premium monies directly). NHC does not have a source for premium data outside of the data received from the Exchange, and in response to your reply letter, there is therefore no reason that NHC should provide data to the Exchange—as the Exchange itself (and not NHC) is the source for the data that reflects a balance now due NHC.

From your letter, we understand that the Exchange is concerned about the quality of Xerox data.[2] However, the Exchange (not NHC) is responsible for shortcomings, if any, in the quality of the work of its vendor, Xerox. The Exchange has provided no legal basis for its apparent position that NHC should bear the damages of failures by the Exchange or its vendor, Xerox (with whom NHC has no direct contractual relation).

It should be noted that Osowski simply accepts the SDR's allegation in this case and inappropriately assigns causation for uncollected premiums to UHH: "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."[387]

The determination of member eligibility was clearly a responsibility of NHC, as is established in the ASA.[388] The SDR acknowledges that it was NHC and the State Exchange's responsibility to handle enrollment, payment processing, and reconciliation, *not* UHH. Specifically, the SDR correctly asserts that

[387] Osowski Report II, p. 73.
[388] ASA, Exhibit A, ¶5.

the State Exchange "handled enrollment and payment processing functions for NHC, providing the resulting information and premium payments on a monthly basis to the CO-OP as part of a records reconciliation process."[389] However, the SDR then goes on to suggest, without any foundation or evidence, that UHH, in its role as TPA, was to override NHC's determination of member eligibility (i.e., due to lack of premium payment), something that UHH had no authority to do.

NHC performed member eligibility determinations and reconciliations with the State Exchange premium payment data. This is clearly demonstrated in the email exchange on July 23, 2014, regarding "Member Premiums added to detail file for Xerox Rec" among Gary Odenweller, Ryan Myers (Sr. Financial Analyst), Basil Dibsie (CFO), Gwendolyn Harris (Compliance Officer) and Lisa Simons (Enrollment Manager), *all* NHC staff, which discussed the reconciliation of premium payments from the State Exchange with eligibility information in Javelina.[390] The email states:

From: Odenweller, Gary [mailto:GODENWELLER@uniteherehealth.org]
Sent: Wednesday, July 23, 2014 4:08 PM
To: Ryan Myers
Cc: Basil Dibsie; Gwendolyn Harris; Lisa Simons
Subject: RE: Member Premiums added to detail file for Xerox Rec

Ryan,
Per our phone conversation, and following an extensive conversation I had with Lisa Simons, I'm sorry to say that the premium information that you are seeking is just not available.

In my discussion with Lisa, I advised her that I was unable to reconcile either the Billing History files or the Payment files to the membership population information. There were thousands of members for whom I could not locate any premium billing or payment information. Lisa told me that was because there were many erroneous records provided by the Exchange, and those records had not been entered into Javelina for several months for fear the many errors would contaminate the valid records already existing in Javelina. She indicated that she and her staff work on identifying and correcting the problems as time permits, but other priorities have caused delays in fixing the incorrect information supplied by the Exchange.

In the absence of complete and accurate premium/payment data, I'm unable to provide you with a meaningful report for your reconciliation. Let me know if you have any questions or need any further information.

-Gary

Gary M. Odenweller
10078 Hidden Pines Lane, Bonita Springs, FL 34135
Cell: (630) 452-5505 Ph: (239) 301-0979
godenweller@nevadahealthcoop.org

This NHC email shows that UHH staff were not even part of the discussions regarding the reconciliation between State Exchange premium payments, enrollment, eligibility, and Javelina, as this was a NHC responsibility and is reflected in the contemporaneous email correspondence. This reality is in stark

[389] DRAFT SDR Report, p. 21. PLAINTIFF02479813-02479851 at 02479833.
[390] Email between Ryan Myers, Sr. Financial Analyst/Underwriter of NHC, and Gary M. Odenweller, NHC, Regarding Member Premiums added to detail file for Xerox Rec, dated July 23, 2014. PLAINTIFF00043890-00043891 at PLAINTIFF00043890.

contrast to the ex-post rewriting of history attempted by the SDR where UHH was (incorrectly) alleged to have been responsible for determinations of member eligibility and premium payments.

This email further highlights the failure of the State Exchange (and Xerox) to provide actionable data and information to NHC on enrollment and premium payments, so much so, that NHC's enrollment team had not been entering the information into Javelina for *months* for fear the many errors would *contaminate* the valid eligibility records already in Javelina. Lastly, this correspondence demonstrates that it was Lisa Simons' (NHC's Enrollment Manager) team that was in charge of identifying and correcting the problems associated with the enrollment and premium data from the State Exchange (and Xerox), not UHH. Yet the SDR attributes alleged damages to UHH for the failures of NHC and the State Exchange, and for roles and responsibilities that UHH was not authorized to perform.

Not only does the SDR fail to demonstrate how there are premium payment damages attributable to UHH, the SDR's demand letter for payment of underpaid premiums to the State Exchange, dated March 29, 2019, raises questions as to whether underpayments actually occurred. Specifically, the SDR demand letter characterizes the $510,651.27 alleged underpayment as an "apparent" underpayment and requests that the State Exchange help investigate the premiums with "insights" and "explanations",[391] even though in the last sentence of the letter the SDR ultimately demands the funds directly from the State Exchange. Like so many of the SDR's demands, this letter and analysis raise the question as to why UHH is even involved in these damage allegations, which are for alleged mistakes and errors surrounding NHC's activities and involving the reconciliations of data sets for which UHH, as TPA, was not responsible.

9.7 Fish's Estimates an Expected Dollar Range of Denials Based Upon a Single Source and Fails to use the Single Source's Finding Correctly, Rendering his Expected Denial Amounts Deficient and therefore Unreliable.

Fish (inappropriately) uses the findings from a single source[392] to justify his alternative claims denial rate of 5 percent to 10 percent and Table 10's damage range of $770,000 to $1,540,000 with respect to NHS.[393] Specifically, Fish cites a 15-year-old research brief from the RAND Corporation as the sole basis for his denial rate estimates. This 15-year-old RAND Corporation brief, however, does not support Mr. Fish's use of its denial rates. The RAND Corporation researchers expressly made it clear that their results cannot be generalized:

[391] PLAINTIFF02479935.
[392] RAND Institute for Civil Justice RAND Health. "Inside the black box of managed care decisions: Understanding patient disputes over coverage denials". Research Brief, dated 2004. Available at https://www.rand.org/pubs/research_briefs/RB9039.html.
[393] Fish report II, p.35.

> "These studies are based on data from two HMOs and two medical groups in California. Therefore, they cannot be generalized to the country as a whole."[394]

Fish also neglects to identify other significant limitations of the research brief, mainly that the denial rate of 9 percent is calculated before any patients appeal their denials. In other words, the estimated dollar range of denials presented in Fish's Table 9 do not include the results of patient appeals. Therefore, these estimated dollar amounts do not represent damages because they exclude the amounts patients would ultimately be paid after their appeal processes have been completed. The research Fish, himself, cites identifies the success rates of appeals, indicating that:

> "Enrollees won more than three-fourths of all post-services appeals…"[395]
> "Patients won nearly all appeals over emergency care." [396]
> "The most striking finding: Patients prevailed in over 90 percent of appeals involving emergency department care."[397]

If Fish applied the 90 percent successful prevailing appeals rate to his cited 9 percent denial rate, the post-appeal denial rate would be less than 1 percent, much closer to the "very small number of claims" that were denied by NHC.

The RAND Corporation research brief also describes how the denial rate varies significantly across the different types of procedures and claims. For example, the most commonly denied claims involved durable medical equipment. Denial rates for durable medical equipment were 23 percent versus relatively low denial rates for speech therapy and chiropractic services. Fish does nothing to differentiate denial rates by the types of claims and inappropriately applies a single aggregate denial rate across a spectrum of claims, counter to the very research brief he cites.

9.8 Avoidable Costs of Additional Losses

Fish fails to establish any link between the alleged claims backlog[398] and NHC's failure to (i) accurately record IBNR, (ii) calculate the PDR for year 2014, and (iii) file accurate financial statements. Fish and

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[394] RAND Institute for Civil Justice RAND Health. "Inside the black box of managed care decisions: Understanding patient disputes over coverage denials". Research Brief, dated 2004, p4. Available at https://www.rand.org/pubs/research_briefs/RB9039.html.
[395] RAND Institute for Civil Justice RAND Health. "Inside the black box of managed care decisions: Understanding patient disputes over coverage denials". Research Brief, dated 2004, p. 2. Available at https://www.rand.org/pubs/research_briefs/RB9039.html.
[396] RAND Institute for Civil Justice RAND Health. "Inside the black box of managed care decisions: Understanding patient disputes over coverage denials". Research Brief, dated 2004, p. 2. Available at https://www.rand.org/pubs/research_briefs/RB9039.html.
[397] RAND Institute for Civil Justice RAND Health. "Inside the black box of managed care decisions: Understanding patient disputes over coverage denials". Research Brief, dated 2004, p. 3. Available at https://www.rand.org/pubs/research_briefs/RB9039.html.
[398] Fish Report II, pp. 25-26, Charts 1-4.

DeVito opine multiple times that Milliman, Larson, and NHC management were responsible for these failures, including but not limited to:

- "..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."[399]
- 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."[400]
- Noting the unprocessed claims for calendar year 2014, Fish was able to calculate "IBNR using paid claims data available as of February-2015."[401]
- Fish states, "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."[402]
- "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."[403]
- "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."[404]
- "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."[405]

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[399] Fish Report II, p.7.
[400] Fish Report II, p.7.
[401] Fish Report II, p. 13. See also "Ms. Silver asked about the claims lag data and how it impacted Milliman estimates. Mr. Dibsie explained current data was used including all pended and paid claims data from the system." NHC Meeting Minutes August 26, 2014. LARSON014403-014409 at 014403.
[402] Fish Report II, p. 14.
[403] Fish Report II, p. 16.
[404] Fish Report II, p.17.
[405] Fish Report II, p. 17.

- "Larson issued audit opinions that failed to comply with SAP, as prescribed or permitted by the Nevada DOI in the conduct of its audits of NHC, for the years ended December 31, 2013 and December 31, 2014. For the year ended December 31, 2014, Larson failed to adequately audit and evaluate Premium Deficiency Reserves ("PDR"), Claim Reserves and Incurred But Not Reported ("IBNR") claims, significant receivables and failed to adequately audit and disclose the existence of substantial doubt about NHC's ability to continue as a going concern and, as a result, increased the losses ultimately suffered by NHC."[406]
- "Larson should have recognized by March 31, 2015 that NHC had materially misstated its year-end 2014 financial condition and its ability to meet minimum capital and surplus requirements at year-end 2014."[407]
- "NHC's financial condition would make the company subject to being placed into receivership as of March 31, 2015, if NHC or Larson had reported to the Nevada Commissioner NHC's misstated 2014 financial condition and its inability to meet minimum capital and surplus requirements at year-end 2014 only; or, if Larson had reported to the Nevada Commissioner that NHC's internal controls were inadequate to prevent a material misstatement of NHC's financial statements."[408]
- "Larson's 2014 audit workpapers contain no audit evidence indicating that an evaluation of NHC's ability to continue as a going concern was conducted."[409]
- "Per FTI's Expert Report, Mr. Mark Fish used data that was available in February 2015 and could also have been used by Larson during the conduct of its 2014 audit to determine whether a PDR was required as of December 31, 2014."[410]
- "Per FTI's Expert Report, Mr. Mark Fish used the data of subsequent operational results that was available to Larson prior to the issuance of its audit report to determine whether a PDR was required as of December 31, 2014."[411]
- "In particular, had Larson properly audited NHC's internal controls over the completeness and accuracy of its claims processing and payments systems, Larson should have found the existence of a significant claims backlog, should have reported this material internal control weakness to NHC's Board of Directors and/or Audit Committee, should have developed audit procedures to adequately audit Milliman's initial calculation of IBNR giving consideration to obtaining an independent actuary, and ultimately would have known, on or about March 31, 2015, that IBNR was understated by approximately $5.0 million."[412]
- "By not requiring NHC to at least record these three adjustments as of December 31, 2014, Larson enabled NHC to continue its operations while insolvent, causing additional losses and NHC's total deficit to grow."[413] (adjustments: "PDR of approximately $15.8 million… as the best

[406] DeVito Report, pp. 2-3.
[407] DeVito Report, p. 3.
[408] DeVito Report, p. 3.
[409] DeVito Report, p. 20.
[410] DeVito Report, p. 25.
[411] DeVito Report, p. 26.
[412] DeVito Report, p. 28.
[413] DeVito Report, p. 39.

- estimate made by Mr. Mark Fish," "improper recognition of the $3.1 million Solvency Loan," and "the understatement of claim adjusting costs of approximately $826,000."[414])
- "As detailed above, Larson should have recognized no later than March 31, 2015 that NHC's 2014 Annual Statement filed with the Nevada DOI and the NAIC was materially misstated and that NHC did not meet minimum capital and surplus requirements."[415]

Importantly Fish opines that:

> "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."[416]

and

> "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."[417]

Although Fish states, "the delays in claims processing and associated claims backlog had severe operational and financial impacts on NHC"[418] and "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,"[419] these statements contradict his earlier opinions that (i) NHC, Milliman, and Larson had the requisite information available at the time NHC was developing its year-end 2014 financial statements, (ii) the claims backlog should have been accounted for, and (iii) his calculations use data available as of February-2015. Although clearly unreliable, neither of Fish's contradictory opinions support his overall conclusory opinion that UHH caused Plaintiff's alleged damages for avoidable costs.

10. Conclusion

In my opinion, neither UHH nor NHS (either individually or collectively) caused, nor were they a substantial factor in bringing about NHC's failure/insolvency. The entire Federal CO-OP program failed. NHC failed for the same reasons that nearly all of the federally funded CO-OPs failed, i.e., they experienced unexpectedly high claims costs and they did not receive the financial assistance they were promised by the Federal government. Contrary to Osowski's opinion, it is my opinion that UHH and NHS

[414] DeVito Report, p. 38.
[415] DeVito Report, p. 41.
[416] Fish Report II, p.18.
[417] Fish Report II, p.19.
[418] Fish Report II, p. 27.
[419] Fish Report II, p.19.

performed effectively and that NHC would have failed or otherwise become insolvent regardless of the actions or inactions of UHH and/or NHS. Further, the alleged damages cited by the SDR, Fish, and Osowski are methodologically flawed; their damage calculations are deficient and therefore unreliable. Most importantly, in my opinion, NHC would have failed even if UHH and NHS had performed their functions perfectly.

This report is based on information known to me as of this date. If additional information is made available, I may modify my report. I may also be asked to present opinions on additional issues in this case.

Henry Miller

_____

Henry Miller, Ph.D. October 2, 2020

EXHIBIT L

EXHIBIT L

One Hundred One North Carson Street
Carson City, Nevada 89701
Office: (775) 684-5670
Fax No.: (775) 684-5683

555 East Washington Avenue, Suite 5100
Las Vegas, Nevada 89101
Office: (702) 486-2500
Fax No.: (702) 486-2505

Office of the Governor

June 26, 2020

John R. Bailey
Bailey Kennedy Attorney at Law
8984 Spanish Ridge Avenue
Las Vegas, NV 89148
jbailey@baileykennedy.com

Re: Public Records Request

Dear Mr. Kennedy,

Thank you for your request for public records dated May 28, 2020. Due to a large volume of incoming physical mail, as well as turnover on our administrative staff, your request did not reach the Governor's Interim General Counsel until Friday, June 19, 2020, when your June 16, 2020 letter arrived. Please accept this letter as a formal acknowledgement of your request as required by the Nevada Public Records Act. You have requested:

1. Any and all records—including, but not limited to documents, communications, correspondence, transcripts, notes, and recordings—relating to the contractual relationship between Silver State Health Insurance Exchange and Xerox State Healthcare, LLC ("Xerox").
2. Any and all records relating to any and all communications—including, but not limited to telephonic, facsimile, electronic email, standard mail, or otherwise—between the Governor's Office and Xerox.
3. Any and all records relating to meetings between the Governor's Office and Xerox—including, but not limited to notes, calendars, and day-planners.
4. All materials—including, but not limited to documents, communications, correspondence, transcripts, notes, and recordings—relating to Deloitte Consulting, LLP's ("Deloitte") Assessment of Xerox.
5. Any and all records relating to any and all communications—including, but not limited to telephonic, facsimile, electronic email, standard mail, or otherwise—between the Governor's Office and Deloitte—regarding Deloitte's Assessment of Xerox.
6. Any and all records relating to meetings between the Governor's Office and Deloitte—including, but not limited to notes, calendars, and day-planners—regarding Deloitte's Assessment of Xerox.
7. Any and all complaints received, between January 1, 2012, and December 31, 2014, from any individuals or entities, regarding Xerox.

8. Any and all complaints received, between January 1, 2012, and December 31, 2014, from any individuals or entities, regarding the Silver State Health Insurance Exchange.

Please allow ten to twelve weeks for our office to compile and transmit any documents responsive to your requests.

Should you have any further questions, please feel free to contact our office.

Sincerely,

Governor's Staff
Office of Governor Sisolak

EXHIBIT M

EXHIBIT M

AARON D. FORD
Attorney General

KYLE E. N. GEORGE
First Assistant Attorney General

CHRISTINE JONES BRADY
Second Assistant Attorney General

JESSICA L. ADAIR
Chief of Staff

RACHEL J. ANDERSON
General Counsel

HEIDI PARRY STERN
Solicitor General

STATE OF NEVADA

OFFICE OF THE ATTORNEY GENERAL

555 E. Washington Ave. Suite 3900
Las Vegas, Nevada 89101

August 31, 2020

Via Electronic Mail

John R. Bailey
Bailey Kennedy
8984 Spanish Ridge Avenue
Las Vegas, NV 89148
702-851-0051
JBailey@baileykennedy.com

Re: Public Records Request, received May 28, 2020

Dear John R. Bailey:

Thank you for contacting the Office of the Attorney General ("OAG") to submit a public records request. This request received May 28, 2020 seeks certain records, specifically:

> "1. Any and all records- including, but not limited to documents, communications, correspondence, transcripts, notes, and recordings- relating to the contractual relationship between Silver State Health Insurance Exchange and Xerox State Healthcare, LLC ("Xerox").
>
> 2. Any and all records relating to any and all communications- including, but not limited to telephonic, facsimile, electronic email, standard mail, or otherwise between the Office of the Attorney General and Xerox.
>
> 3. Any and all records relating to meetings between the Office of the Attorney General and Xerox-including, but not limited to notes, calendars, and day planners.
>
> 4. All materials-including, but not limited to documents, communications, correspondence, transcripts, notes, and recordings- relating to Deloitte Consulting, LLP's ("Deloitte") Assessment of Xerox.

5. Any and all records relating to any and all communications-including, but not limited to telephonic, facsimile, electronic email, standard mail, or otherwise between the Office of the Attorney General and Deloitte- regarding Deloitte's Assessment of Xerox.

6. Any and all records relating to meetings between the Office of the Attorney General and Deloitte-including, but not limited to notes, calendars, and day planners-regarding Deloitte' s Assessment of Xerox.

7. Any and all complaints received, between January 1, 2012, and December 31, 2014, from any individuals or entities, regarding Xerox.

8. Any and all complaints received, between January 1, 2012, and December 31, 2014, from any individuals or entities, regarding the Silver State Health Insurance Exchange."

The OAG had previously provided an anticipated response date of September 4, 2020 However, our office will require additional time to complete our gathering and review of potentially responsive records. We anticipate responding to this request by October 23, 2020.

We appreciate your patience with this review. Once again, thank you for contacting the Office of the Attorney General.

Sincerely,

AARON D. FORD
Attorney General

By: Rachel J. Anderson
Public Records Official

TAB 28

TAB 28

Electronically Filed
10/15/2020 7:06 PM
Steven D. Grierson
CLERK OF THE COURT

MLEV (CIV)
JOHN R. BAILEY
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JOSEPH A. LIEBMAN
Nevada Bar No. 10125
REBECCA L. CROOKER
Nevada Bar No. 15202
BAILEY❖KENNEDY
8984 Spanish Ridge Avenue
Las Vegas, Nevada 89148-1302
Telephone: 702.562.8820
Facsimile: 702.562.8821
JBailey@BaileyKennedy.com
SHarmon@BaileyKennedy.com
JLiebman@BaileyKennedy.com
RCrooker@BaileyKennedy.com

SUZANNA C. BONHAM
Texas Bar No. 24012307
EMMA C. MATA
Texas Bar No. 24029470
SEYFARTH SHAW LLP
700 Milam, Suite 1400
Houston, Texas 77002
Telephone: 713.225.2300
SBonham@seyfarth.com
EMata@seyfarth.com

Attorneys for Defendants
Unite Here Health and Nevada Health Solutions, LLC

BAILEY❖KENNEDY
8984 SPANISH RIDGE AVENUE
LAS VEGAS, NEVADA 89148-1302
702.562.8820

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 **DEFENDANTS UNITE HERE HEALTH AND NEVADA HEALTH SOLUTIONS, LLC'S MOTION FOR LEAVE TO FILE THIRD-PARTY COMPLAINT** **(Hearing Requested)**

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 NRCP 14(a)(1), Defendants Unite Here Health and Nevada Health Solutions, LLC (jointly, "UHH") hereby seek leave (the "Motion for Leave") to file a Third-Party Complaint against Conduent State Healthcare, LLC, f/k/a Xerox State Healthcare, LLC ("Xerox") and State of Nevada ex rel. Silver State Health Insurance Exchange ("Silver State") (jointly, the "Proposed Third-Party Defendants"). As detailed below, UHH is entitled to contribution from the Proposed Third-Party Defendants in the event that Plaintiff Nevada Health CO-OP (the "CO-OP" or "NHC") obtains a judgment against UHH. Pursuant to EDCR 2.30(a), a copy of the Proposed Third-Party Complaint is attached hereto as Exhibit A.

This Motion for Leave is made and based on the papers and pleadings on file, the following Memorandum of Points and Authorities, the exhibits attached hereto, and any oral argument as may be heard by this Court.

DATED this 15th day of October, 2020.

BAILEY❖KENNEDY

By: /s/ John R. Bailey
JOHN R. BAILEY
SARAH E. HARMON
JOSEPH A. LIEBMAN
REBECCA L. CROOKER

SEYFARTH SHAW LLP
SUZANNA C. BONHAM
EMMA C. MATA
Attorneys for Defendants/Third-Party Plaintiffs Unite Here Health and Nevada Health Solutions, LLC

BAILEY❖KENNEDY
8984 SPANISH RIDGE AVENUE
LAS VEGAS, NEVADA 89148-1302
702.562.8820

I. INTRODUCTION

Discovery has revealed that two non-parties—Xerox and Silver State—are responsible for a significant amount of the harm the CO-OP alleges it suffered from UHH's alleged conduct. As a result, under NRCP 14(a) and well-established Nevada law, UHH may assert an inchoate claim for contribution against Xerox and Silver State via third-party practice in this litigation. Third-party practice promotes NRCP 14(a)'s goal of judicial economy and avoiding inconsistent judgments. If leave is not granted and UHH is found liable to the CO-OP, UHH will be forced to file a separate lawsuit against Xerox and Silver State. Requiring a separate lawsuit would be grossly inefficient and would risk inconsistent findings by different courts. Accordingly, this Court should grant leave to UHH to file its Proposed Third-Party Complaint.

Courts look at various factors—while keeping Rule 14(a)'s goal of promoting judicial economy at the forefront—in deciding whether to grant leave to a defendant to assert a third-party claim, including: "(1) possible prejudice to the plaintiff, (2) the possible prejudice to the third-party defendants, (3) the reasons for the delay in joinder, and (4) whether the joinder will delay or unnecessarily complicate the trial."[1] Here, these factors clearly support giving UHH leave to file their Proposed Third-Party Complaint. First, there is no prejudice to the CO-OP. If anything, the CO-OP will benefit from having additional sources of recovery if liability is established. Second, there is no prejudice to Xerox or Silver State in participating in this litigation versus participating in a separate action for contribution; in fact, the availability of evidence and the knowledge possessed by witnesses will likely be greater in this action than in a subsequent action several years from now. Third, UHH justifiably waited to bring these third-party claims until they obtained and reviewed sufficient evidence—including, but not limited to, documents produced in discovery, documents received from public records requests, and opinions from their experts—before deciding to seek leave. Fourth, joinder of Xerox and Silver State (which are currently involved in related litigation with the CO-OP) in this litigation is not likely to delay or complicate trial, and is being requested prior to the Court's deadline for amending pleadings and adding parties.

[1] *United States v. New Castle Cty.*, 111 F.R.D. 628, 632 (D. Del. 1986).

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8984 SPANISH RIDGE AVENUE
LAS VEGAS, NEVADA 89148-1302
702.562.8820

In sum, this Court should grant the Motion in its entirety and permit UHH to file its Proposed Third-Party Complaint.

II. RELEVANT FACTS AND PROCEDURAL HISTORY

A. Xerox and Silver State's Involvement and Their Relationship to the CO-OP.

In 2010, the United States enacted the Patient Protection and Affordable Care Act ("ACA"). Relevant here, the ACA provided for the creation of American Health Benefit Exchanges, commonly referred to as "health exchanges," where consumers could evaluate and purchase insurance plans.[2] The ACA required that each state could either create its own health exchange or use the federal health exchange (often referred to as a "federally-facilitated exchange").[3]

Nevada elected to create its own health exchange and created an agency, Silver State, to develop and oversee Nevada's health exchange.[4] In 2012, Silver State awarded Xerox a $72 million contract to develop, administer, and manage Nevada's health exchange—the Xerox Exchange.[5] In developing, administering, and managing the Xerox Exchange, Xerox's primary duties included ensuring that the Xerox Exchange promptly transferred consumer data and consumer premium payments to insurers and/or their vendors.[6]

Beginning with its initial rollout on October 1, 2013, the Xerox Exchange was a disaster—it suffered from an egregious number of technical defects.[7] For example, many consumers would select and pay for insurance through the Xerox Exchange but, due to Xerox's failures, their information and payments were never transmitted to insurers, including the CO-OP.[8]

Indeed, the CO-OP's own board minutes indicate the difficulties it faced as a result of the poorly designed and poorly managed Xerox Exchange. For example, the CO-OP's board minutes

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[2] 42 U.S.C. § 18301(b).

[3] *Compare id. with* 42 U.S.C. § 18041(c).

[4] NRS 695I.200.

[5] *See* Exhibit B, Xerox Contract, at 2 ¶ 6.

[6] *See* Exhibit C, Silver State Exchange Requirements Matrix.

[7] Exhibit D, Deloitte Report.

[8] *Id.* at 42-43.

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8984 SPANISH RIDGE AVENUE
LAS VEGAS, NEVADA 89148-1302
702.562.8820

reflect that they had numerous meetings with government officials, other insurers, and Xerox to discuss "the challenges the CO-OP [wa]s experiencing with data submission from Xerox to the CO-OP," such as "more than 3,000 members that are on Xerox pending list that the CO-OP has not received any data on to date."[9] The CO-OP complained that Xerox's negligence was "negatively impacting the CO-OP's membership,"[10] that Xerox's "payment collection process…[was] only working at 45% capacity to accept payments, … [and that Xerox] … has drained the CO-OP's resources[,] as no less than 50% of the CO-OP's resources have been committed to Xerox and Xerox related issues since October 2013."[11] In fact, Xerox's failures caused significant damage to the CO-OP for an extended period of time, as aptly summarized in the CO-OP CEO's February 24, 2014 letter to Governor Brian Sandoval and to Xerox.[12]

Xerox's catastrophes led Silver State to engage Deloitte Consulting LLP ("Deloitte") to evaluate the failings of the Xerox Exchange and Silver State's options going forward.[13] Deloitte's report found over ***1,500 defects*** with the Xerox Exchange, over 500 of which were of a "higher severity."[14] Ultimately, Silver State elected to terminate its contract with Xerox and switch to a federally-facilitated exchange.[15]

Indeed, Xerox and Silver State faced two class-action lawsuits based on their failure to develop, administer, and manage the Xerox Exchange:

- *Basich v. Xerox State Healthcare, LLC, et al.*, Case No. A-14-698567-C, a class action complaint filed on behalf of all Nevada consumers who purchased an insurance policy on the Xerox Exchange and did not receive the benefits of such policy; and

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[9] Exhibit E, 2014.02.19 NHC Board Minutes (LARSON014368).

[10] *Id.*

[11] Exhibit F, 2014.05.23 NHC Board Minutes (LARSON014354, 355 and 388).

[12] Exhibit G, Feb. 24, 2014 Letter from Tom Zumtobel.

[13] Exhibit D, Deloitte Report.

[14] *Id.* at 9.

[15] Kyle Roerink, *Nevada, Xerox in private talks to settle $75 million health care contract out of court*, LAS VEGAS SUN (Oct. 1, 2014), *available at* https://lasvegassun.com/news/2014/oct/01/nevada-xerox-private-talks-settle-75-million-healt/.

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8984 SPANISH RIDGE AVENUE
LAS VEGAS, NEVADA 89148-1302
702.562.8820

- *Casale v. State of Nevada Ex. Rel. Silver State Health Insurance Exchange, et al.*, Case No. A-14-706171-C, a class action complaint filed on behalf of all Nevada brokers owed unpaid commissions for the sale of insurance policies on the Xerox Exchange.[16]

Ultimately, Xerox agreed to pay up to $5 million to satisfy class member claims and $1.75 million in attorneys' fees and costs.[17]

B. The Receivership.

On September 25, 2015, the Nevada Attorney General, on behalf of the Nevada Division of Insurance (the "NDOI"), filed a Petition for Appointment of Commissioner as Receiver for the CO-OP "for the purpose of conservation/rehabilitation."[18] On October 14, 2015, the Eighth Judicial District Court (Judge Cory) granted the Petition.[19] The Receiver and the Special Deputy Receiver were "authorized to rehabilitate or liquidate the CO-OP's business and affairs as and when they deem appropriate under the circumstances…."[20] The Receiver was further authorized to "[i]nstitute and to prosecute, in the name of CO-OP or in her own name, any and all suits and other legal proceedings…on such terms and conditions as she deems appropriate."[21]

C. The Receiver, on Behalf of the CO-OP, Initiates This Lawsuit.

On August 25, 2017, the Receiver, on behalf of the CO-OP, initiated this lawsuit by filing its initial Complaint against numerous entities and individuals, including Nevada Health Solutions, LLC.[22] In essence, the CO-OP alleged defendants—mainly vendors of the CO-OP and the vendors'

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[16] Exhibit H, Joint Mot. for Final Approval of Class Settlement, Certification of Settlement Class, Approval of Attorney's Fees and Costs, and Entry of Final Order.

[17] *Id.*

[18] Exhibit I, Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1), at 1:26-2:2, filed on Sept. 25, 2015, *State of Nevada, ex rel. Commissioner of Insurance v. Nevada Health CO-OP*, Case No. 15-725244-C.

[19] Exhibit J, Permanent Injunction and Order Appointing Commissioner as Permanent Receiver of Nevada Health CO-OP, filed Oct. 14, 2015, *State of Nevada, ex rel. Commissioner of Insurance v. Nevada Health CO-OP*, Case No. 15-725244-C.

[20] *Id.* at 2:16-18.

[21] *Id.* at 8:16-22.

[22] *See generally* Compl., filed on Aug. 25, 2017.

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8984 SPANISH RIDGE AVENUE
LAS VEGAS, NEVADA 89148-1302
702.562.8820

officers—caused the CO-OP to fail.[23] Nevada Health Solutions, LLC, filed its answer on November 7, 2017.

D. The Parties Attend a Judicial Settlement Conference.

On January 23, 2018, the Court ordered the parties to participate in a judicial settlement conference.[24] The Judicial Settlement Conference was held on June 8, 2018, before the Honorable Nancy Allf.[25] The parties were not able to resolve this matter.[26]

E. Certain Defendants Compel Arbitration.

On November 6, 2017, Defendants Milliman, Inc.; Jonathan L. Shreve; and Mary van der Heijde filed a Motion to Compel Arbitration. On March 12, 2018, the Court granted the Motion.[27] The CO-OP filed a Motion for Reconsideration, which was denied on August 8, 2018.[28]

F. The CO-OP Amends Its Complaint.

On July 17, 2018, the CO-OP moved for leave to file an Amended Complaint to add additional factual allegations, remove certain claims, and add Unite Here Health as a defendant.[29] The Court granted the CO-OP leave to file its Amended Complaint,[30] and it did so on September 24, 2018.[31] Unite Here Health filed its Answer to the Amended Complaint on October 22, 2018.[32]

G. UHH Conducts Discovery Concerning Xerox and Silver State.

During the course of discovery, it became apparent to UHH that Xerox and Silver State could potentially be liable to the CO-OP for their negligence in developing, operating, and managing the Xerox Exchange (as detailed in Section II.A, *supra*). Accordingly, UHH served written discovery

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[23] *See generally id.*

[24] *See* Minute Order, filed on Jan. 23, 2018.

[25] *See* Minute Order, filed on June 8, 2018.

[26] *Id.*

[27] Order Granting Milliman's Motion to Compel Arbitration, filed on March 12, 2018.

[28] Order Denying Plaintiff's Motion for Reconsideration, filed on August 18, 2018.

[29] *See generally* Plaintiff's Motion to Amend Complaint, filed on July 17, 2018.

[30] Order Granting Motion to Amend Complaint, filed on September 18, 2018.

[31] Amended Complaint, filed on September 24, 2018.

[32] Unite Here Health's Answer to Amended Complaint, filed on October 22, 2018.

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8984 SPANISH RIDGE AVENUE
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702.562.8820

on the CO-OP concerning its relationship with Xerox and Silver State and made public records requests to the State of Nevada (including to the Nevada Department of Insurance).

H. UHH's Expert Finds That Xerox and Silver State Are Responsible for Much of the CO-OP's Alleged Damages.

With the information obtained in discovery and from the public records requests, UHH obtained opinions from its experts indicating that much of the harm the CO-OP is attempting to blame on UHH was actually the result of Xerox and Silver State's negligence in developing, administering, and managing the Xerox Exchange.[33]

III. THE PROPOSED THIRD-PARTY COMPLAINT

A copy of the Proposed Third-Party Complaint is attached to this Motion as Exhibit A. In essence, UHH alleges that Xerox and Silver State breached their duties to the CO-OP and its vendors (including UHH) by negligently and carelessly developing, administering, and managing the Xerox Exchange. Accordingly, UHH seeks contribution from Xerox and Silver State in the event that UHH is found liable to the CO-OP.

IV. ARGUMENT

A. Standard of Decision.

NRCP 14(a) provides that a "defending party may, as third-party plaintiff, file a third-party complaint against a nonparty, the third-party defendant, who is or may be liable to it for all or part of the claim against it." "The primary purpose of impleading third parties is to promote judicial efficiency by eliminating circuity of actions," that is, "to avoid a situation that arises when a defendant has been held liable to a plaintiff and then finds it necessary to bring a separate action against a third individual who may be liable to defendant for all or part of plaintiff's original claim." *Tourangeau v. Uniroyal, Inc.*, 189 F.R.D. 42, 48 (D. Conn. 1999) (internal quotation marks omitted).[34]

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[33] *See e.g.*, Exhibit K, Dr. Henry Miller Report, at 36-39, 56-57, 93 (addressing issues with Xerox Exchange).

[34] "Federal cases interpreting the Federal Rules of Civil Procedure 'are strong persuasive authority,'" for interpreting the Nevada Rules of Civil Procedure. *Exec. Mgmt. Ltd. v. Ticor Title Ins. Co.*, 118 Nev. 46, 53, 38 P.3d 872, 876 (2002) (citing *Las Vegas Novelty v. Fernandez*, 106 Nev. 113, 119, 787 P.2d 772, 776 (1990)).

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8984 SPANISH RIDGE AVENUE
LAS VEGAS, NEVADA 89148-1302
702.562.8820

The Nevada Supreme Court has "repeatedly recognized that a third-party plaintiff has the right" to assert an inchoate claim for contribution against a third-party defendant, meaning they may "seek contribution in an original action prior to entry of judgment." *Pack v. LaTourette*, 128 Nev. 264, 269, 277 P.3d 1246, 1249 (2012). "Specifically, NRCP 14(a) allows a third-party plaintiff to implead a third-party defendant who is or may be liable to the third-party plaintiff for all or part of the plaintiff's claim at any time after [the] commencement of the action." *Id.* (internal quotation marks omitted) (alteration in original).

If more than fourteen days have elapsed from the defending party's service of its original answer, the defending party must obtain the court's leave to file the third-party complaint. NRCP 14(a). "Timely motions for leave to implead non-parties should be ***freely granted to promote this efficiency*** unless to do so would prejudice the plaintiff, unduly complicate the trial, or would foster an obviously unmeritorious claim." *Shafarman v. Ryder Truck Rental Inc.*, 100 F.R.D. 454, 459 (S.D.N.Y. 1984) (emphasis added). In deciding whether to give leave, courts often look to various factors such as: "(1) possible prejudice to the plaintiff, (2) the possible prejudice to the third-party defendants, (3) the reasons for the delay in joinder, and (4) whether the joinder will delay or unnecessarily complicate the trial." *See United States v. New Castle Cty.*, 111 F.R.D. 628, 632 (D. Del. 1986). Courts weigh such "factors against Rule 14's goal of avoiding circuity of actions and a multiplicity of suits." *Id.*

As detailed below, an analysis of these factors and Rule 14(a)'s goal of promoting judicial efficiency demonstrates that the Court should give UHH leave to file its Proposed Third-Party Complaint against Xerox and Silver State.

B. UHH Should Be Granted Leave to File Their Proposed Third-Party Complaint.

1. There is No Prejudice to the Plaintiff—if Anything, Plaintiff Will Benefit From the Addition of Two New Potential Sources for Recovery.

The addition of Xerox and Silver State will not cause any potential prejudice to the CO-OP. In fact, the CO-OP is currently suing Silver State to recover unpaid premiums—a related lawsuit

BAILEY ❖ KENNEDY
8984 SPANISH RIDGE AVENUE
LAS VEGAS, NEVADA 89148-1302
702.562.8820

which will likely be consolidated into this matter.[35] Regardless, the joinder of Xerox and Silver State provides two additional sources of recovery for the CO-OP. *See id.* (finding addition of third-party defendant was likely to "expedite the settlement of claims," and supported giving leave to defendant to file third-party complaint).

2. There Is No Prejudice to the Proposed Third Party Defendants—They Have Already Engaged in Substantial Litigation Over Their Failures Concerning the Xerox Exchange.

The "prejudice to a third-party defendant must be measured by whether the third-party defendant will incur greater expense or be at a greater disadvantage in defending a third-party suit than in defending a separate action brought against it." *Id.* at 633 (internal quotation marks omitted). The third-party defendant has the "burden to show substantial litigation handicap[s]." *Id.* (internal quotation marks omitted) (alteration in original).

Here, neither Xerox nor Silver State can demonstrate a substantial litigation handicap. Indeed, as detailed above, Xerox and Silver State have already heavily litigated their failures concerning the development, administration, and management of the Xerox Exchange (i.e. the class action lawsuits). And, again, Silver State is currently being sued by the CO-OP.

3. UHH Needed to Conduct Discovery Before Seeking Leave to File Its Proposed Third-Party Complaint.

The party seeking leave has the burden of explaining the timing of the motion. *Id.* at 634. "To determine the merits of a Third-Party Plaintiff's excuse for a delay in joinder, the Court should give greater weight to the nature of the cause of action and the circumstances of the particular case than to the mere quantity of elapsed time." *Id.* In complex matters that require significant investigation, discovery, or expert analysis to evaluate potential claims against third-party defendants, significant delays—including delays of up to three (3) years—are justified. *Id.* at 634-36 (holding delay of three years was justified where discovery and consultation with experts was necessary to evaluate potential claims against third-party defendants); *accord Zielinski v. Zappala*,

[35] *See State of Nevada, ex rel. Commissioner of Insurance v. Silver State Health Insurance Exchange*, Case No. A-20-816161-C.

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8984 SPANISH RIDGE AVENUE
LAS VEGAS, NEVADA 89148-1302
702.562.8820

470 F. Supp. 351, 353 (E.D. Pa. 1979) (finding sixteen-month delay was justified where defendant sought two expert opinions before seeking leave).

Here, the deadline to amend pleadings and add parties has not yet passed and UHH needed to conduct substantial discovery and consult with experts before it sought leave to file its Proposed Third Party Complaint—a decision UHH did not take lightly. As detailed above, based on certain information it learned in discovery, UHH then sought specific discovery concerning Xerox and Silver State. Further, UHH served public records requests to various Nevada agencies concerning Silver State's relationship with Xerox. Based on that information,[36] UHH obtained expert opinions indicating that Xerox's and Silver State's negligence in developing, administering, and managing the Xerox Exchange was responsible for a substantial amount of the harm that the CO-OP alleges it suffered and for which it seeks to hold UHH liable. Based on the information received in discovery and the expert opinions UHH obtained, UHH determined to seek leave to add Xerox and Silver State as third-party defendants. Thus, although some time has elapsed from when UHH initially filed their answers in this matter, UHH did not have the information it needed to assert a claim for contribution against Xerox and Silver State until recently. *See New Castle Cty.*, 111 F.R.D. at 634 (finding defendant acted "with reasonable dispatch," where it had to "analyz[e] and verify[] the discovery responses made by Third-Party Defendants," and "consult[] with scientific and medical experts.").

4. Joinder of Xerox and Silver State Will Not Delay or Complicate Trial.

The close of discovery in this matter is not until February 19, 2021, and this matter is on a May 3, 2021, jury trial stack.[37] Considering the significant backlog of trials due to COVID-related issues, and the Constitutional requirement of conducting criminal trials first, it is unclear whether the existing trial date is even feasible. Nevertheless, considering that the CO-OP is currently suing Silver State in a related matter and given that both Silver State and Xerox have had to engage in prior litigation concerning the same subject matter (i.e. the class actions), it is unlikely that their addition as third-party defendants will cause delay of the trial or unduly complicate trial.

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[36] Notably, the Nevada agencies have not yet made a complete production in response to UHH's request. *See* Exhibit L, Letter from the Office of the Governor to John R. Bailey, dated June 26, 2020; Exhibit M, Letter from the Office of the Attorney General to John R. Bailey, dated August 31, 2020.

[37] UHH intends to move to strike the CO-OP's demand for a jury trial.

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8984 SPANISH RIDGE AVENUE
LAS VEGAS, NEVADA 89148-1302
702.562.8820

5. Giving Leave to UHH to File the Proposed Third-Party Complaint Will Promote Rule 14(a)'s Goal of Judicial Economy by Avoiding a Separate Lawsuit for Contribution (if Necessary).

There are strong policy reasons for giving UHH leave to file its Proposed Third-Party Complaint. "Third-party practice fosters efficient litigation by packaging the underlying claim for liability and any indemnity or contribution claims in a single case," which "spares the judicial system and at least some of the parties the waste and expense of multiple suits." 3 Moore's Federal Practice - Civil § 14.03 (2020).[38] Further, third-party practice "avoids the possibility of inconsistent judgments" as the joinder "of all persons interested in the ultimate resolution of the dispute binds them to a single judgment." *Id.* If the third-party defendant is not added, the defendant must bring a separate action for contribution, and, "[b]ecause the alleged . . . contributor is not bound by the judgment in the first case (because it was not a party) the defendant might be unsuccessful," and the defendant may "incur a liability it should have been able to pass on to another." *Id.* "Effecting joinder of the . . . contributor in a single case thus promotes judicial economy and fosters a consistent outcome that allows the defendant to avoid these potential harms." *Id.*

Indeed, the promotion of Rule 14(a)'s policy goals often—by itself—outweighs findings of potential prejudice or delay. *See e.g.*, *Green Valley Corp. v. Caldo Oil Co.*, No. 09-CV-04028-LHK, 2011 U.S. Dist. LEXIS 44540, at *21-22 (N.D. Cal. Apr. 18, 2011) (granting defendant's motion for leave to file a third-party complaint despite finding (i) defendant's delay was not justified and (ii) the addition of third-party defendants would likely slow discovery and possibly require a new trial date, because requiring defendant to bring a separate action "would frustrate judicial efficiency.").

Here, granting UHH leave to file its Proposed Third-Party Complaint promotes Rule 14(a)'s goal of increasing judicial economy. Granting UHH leave will avoid the necessity of a separate lawsuit for contribution (if necessary). Further, granting UHH leave will avoid the possibility of inconsistent judgments—*i.e.*, a finding of liability in this action and a finding of no liability in a subsequent contribution action. Accordingly, to promote Rule 14(a)'s sound policy goals, this Court should give UHH leave to assert contribution claims against Xerox and Silver State.

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[38] The Nevada Supreme Court often relies on Moore's Federal Practice. *See, e.g.*, *NC-DSH, Inc. v. Garner*, 125 Nev. 647, 654-55, 218 P.3d 853, 858-59 (2009).

BAILEY ❖ KENNEDY
8984 SPANISH RIDGE AVENUE
LAS VEGAS, NEVADA 89148-1302
702.562.8820

In sum, there is good cause for this Court to grant UHH leave to file its Proposed Third-Party Complaint because (i) the CO-OP will not suffer any prejudice, (ii) Xerox and Silver State will not suffer any prejudice, (iii) UHH justifiably waited to ensure they had all necessary information and opinions prior to seeking leave, and (iv) it is unlikely to delay or complicate the trial. Moreover, granting UHH leave will promote Rule 14(a)'s goals of judicial economy and avoiding inconsistent judgments.

V. CONCLUSION

For the reasons set forth above, this Court should grant UHH leave to file their Proposed Third-Party Complaint against Xerox and Silver State. Neither the CO-OP, Xerox, nor Silver State will suffer any prejudice and doing so will promote Rule 14(a)'s goal of judicial economy.

DATED this 15th day of October, 2020.

BAILEY❖KENNEDY

By: /s/ John R. Bailey
JOHN R. BAILEY
SARAH E. HARMON
JOSEPH A. LIEBMAN
REBECCA L. CROOKER

SEYFARTH SHAW LLP
SUZANNA C. BONHAM
EMMA C. MATA
Attorneys for Defendants/Third-Party Plaintiffs
Unite Here Health and Nevada Health Solutions, LLC

BAILEY❖KENNEDY
8984 SPANISH RIDGE AVENUE
LAS VEGAS, NEVADA 89148-1302
702.562.8820

CERTIFICATE OF SERVICE

I certify that I am an employee of BAILEY❖KENNEDY and that on the 15th 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 addresses:

MARK E. FERRARIO ERIC W. SWANIS DONALD L. PRUNTY **GREENBERG TRAURIG LLP** 10845 Griffith Peak Drive, Suite 600 Las Vegas, Nevada 89135	Email: ferrariom@gtlaw.com swanise@gtlaw.com pruntyd@gtlaw.com *Attorneys for Plaintiff*
JOSEPH P. GARIN ANGELA T. NAKAMURA OCHOA **LIPSON NEILSON, P.C.** 9900 Covington Cross Drive, Suite 120 Las Vegas, Nevada 89135	Email: jgarin@lipsonneilson.com aochoa@lipsonneilson.com *Attorneys for Defendants Kathleen Silver, Bobbette Bond, Tom Zumtobel, Pamela Egan, Basil Dibsie, and Linda Mattoon*
KURT R. BONDS MATTHEW PRUITT **ALVERSON TAYLOR & SANDERS** 6605 Grand Montecito Parkway, Suite 200 Las Vegas, Nevada 89149	Email: kbonds@alversontaylor.com mpruitt@alversontaylor.com *Attorneys for Defendants InsureMonkey, Inc. and Alex Rivlin*
LORI E. SIDERMAN RUSSELL B. BROWN **MEYERS MCCONNELL REISZ SIDERMAN** 1745 Village Center Circle Las Vegas, Nevada 89134	Email: siderman@mmrs-law.com brown@mmrs-law.com *Attorneys for Defendants Martha Hayes, Dennis T. Larson, and Larson & Co, P.C.*

/s/ Sharon Murnane
Employee of BAILEY❖KENNEDY

BAILEY❖KENNEDY
8984 SPANISH RIDGE AVENUE
LAS VEGAS, NEVADA 89148-1302
702.562.8820

TAB 29

TAB 29

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Steven D. Grierson
CLERK OF THE COURT

LIPSON NEILSON P.C.
JOSEPH P. GARIN, ESQ.
Nevada Bar No. 6653
ANGELA T. NAKAMURA OCHOA, ESQ.
Nevada Bar No. 10164
9900 Covington Cross Drive, Suite 120
Las Vegas, Nevada 89144
(702) 382-1500
Fax (702) 382-1512
jgarin@lipsonneilson.com
aochoa@lipsonneilson.com
Attorneys for Defendants
Kathleen Silver, Bobbette Bond,
Tom Zumtobel, Pam Egan,
Basil Dibsie and Linda Mattoon

DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiff,

vs.

MILLIMAN, INC., a Washington Corporation; JONATHAN L. SHREVE, an Individual; MARY VAN DER HEIJDE, an Individual; MILLENNIUM CONSULTING SERVICES, LLC, a North Carolina Corporation; LARSON & COMPANY P.C., a Utah Professional Corporation; DENNIS T. LARSON, an Individual; MARTHA HAYES, an Individual; INSUREMONKEY, INC., a Nevada Corporation; ALEX RIVLIN, an Individual; NEVADA HEALTH SOLUTIONS, LLC, a Nevada Limited Liability Company; PAMELA EGAN, an Individual; BASIL C. DIBSIE, an Individual; LINDA MATTOON, an Individual; TOM ZUMTOBEL, an Individual; BOBBETTE BOND, an Individual; KATHLEEN SILVER, an Individual; UNITE HERE HEALTH, 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.: 16

DEFENDANTS PAMELA EGAN, BASIL DIBSIE, LINDA MATTOON, BOBBETTE BOND, TOM ZUMTOBEL, AND KATHLEEN SILVER'S JOINDER TO UNITE HERE HEALTH AND NEVADA HEALTH SOLUTIONS, LLC'S MOTION FOR LEAVE TO FILE THIRD-PARTY COMPLAINT

Hearing Date: November 18, 2020
Hearing Time: 9:00 a.m.

LIPSON NEILSON P.C.
9900 Covington Cross Drive, Suite 120
Las Vegas, Nevada 89144
(702) 382-1500 FAX: (702) 382-1512

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,

Third-Party Plaintiffs,

vs.

CONDUENT STATE HEALTHCARE, LLC f/k/a Xerox State Healthcare, LLC, a Delaware limited liability company; AND STATE OF NEVADA EX REL. SILVER STATE HEALTH INSURANCE EXCHANGE,

Third-Party Defendants.

Defendants Kathleen Silver, Bobbette Bond, Tom Zumtobel, Pam Egan, Basil Dibsie and Linda Mattoon (collectively "Defendants") by and through their counsel of record at Lipson Neilson P.C. hereby file their Joinder to Defendants Unite Here Health and Nevada Health Solutions, LLC's Motion for Leave to File Third-Party Complaint ("Motion").

Defendants join in the arguments and positions set forth in Unite Here Health and Nevada Health Solution, LLC's Motion as though fully set forth herein.

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LIPSON NEILSON P.C.
9900 Covington Cross Drive, Suite 120
Las Vegas, Nevada 89144
(702) 382-1500 FAX: (702) 382-1512

Defendants further add that a proposed Third-Party Complaint against Conduent State Healthcare, LLC fka Xerox State Healthcare, LLC and State of Nevada ex rel. Silver State Health Insurance Exchange is attached hereto as Exhibit A.

Dated this 16th day of October, 2020.

LIPSON NEILSON P.C.

/s/ Angela Ochoa

By: _____

Joseph P. Garin, Esq. NV Bar No. 6653
Angela T. Nakamura Ochoa, Esq. NV Bar No. 10164
Jonathan K. Wong, Esq. NV Bar No. 13621
9900 Covington Cross Dr., Suite 120
Las Vegas, NV 89144
Attorneys for Defendants
Kathleen Silver, Bobbette Bond,
Tom Zumtobel, Pam Egan,
Basil Dibsie and Linda Mattoon

LIPSON NEILSON P.C.
9900 Covington Cross Drive, Suite 120
Las Vegas, Nevada 89144
(702) 382-1500 FAX: (702) 382-1512

LIPSON NEILSON P.C.
9900 Covington Cross Drive, Suite 120
Las Vegas, Nevada 89144
(702) 382-1500 FAX: (702) 382-1512

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b) and Administrative Order 14-2, I certify that on the 16th day of October, 2020, I electronically transmitted the foregoing **DEFENDANTS PAMELA EGAN, BASIL DIBSIE, LINDA MATTOON, BOBBETTE BOND, TOM ZUMTOBEL, AND KATHLEEN SILVER'S JOINDER TO UNITE HERE HEALTH AND NEVADA HEALTH SOLUTIONS, LLC'S MOTION FOR LEAVE TO FILE THIRD PARTY COMPLAINT** the Clerk's Office using the Odyssey E-File & Serve System for filing and transmittal to the following Odyssey E-File & Serve registrants and where indicated by an asterisk via US Mail:

Mark E. Ferrario, Esq. Eric W. Swanis, Esq. Donald L. Prunty, Esq. GREENBERG TRAURIG, LLP 3773 Howard Hughes Pkwy., Suite 400 N Las Vegas, NV 89169 Phone: (702) 792-3773 Fax: (702) 792-9002 ferrariom@gtlaw.com swanise@gtlaw.com pruntyd@gtlaw.com *Attorneys for Plaintiff*	Suzanna C. Bonham, Esq. Emma C. Mata, Esq. SEYFARTH SHAW LLP 700 Milam, Suite 1400 Houston, Texas 77002 Phone: (713) 225-2300 sbonham@seyfarth.com emata@seyfarth.com *Attorneys for Defendants Unite Here Health and Nevada Health Solutions, LLC*
Kurt R. Bonds, Esq. Mark Pruitt, Esq. ALVERSON TAYLOR & SANDERS 6605 Grand Montecito Parkway, Suite 200 Las Vegas, NV 89149 Phone: (702) 384-7000 Fax: (702) 385-7000 *efile@alversontaylor.com* *Attorneys for Defendants InsureMonkey, Inc. and Alex Rivlin*	Lori E. Siderman, Esq. Russell B. Brown, Esq. MEYERS McCONNELL REISZ SIDERMAN 1745 Village Center Circle Las Vegas, NV 89134 Phone: (702) 253-1377 Fax: (702) 248-6192 *Attorneys for Defendants Martha Hayes and Dennis T. Larson*

John R. Bailey, Esq. Joseph A. Liebman, Esq. BAILEY KENNEDY 8984 Spanish Ridge Avenue Las Vegas, NV 89148 Phone: (702) 562-8820 Fax: (702) 562-8821 jbailey@baileykennedy.com jliebman@baileykenndy.com *Attorneys for Defendants Nevada Health Solutions, LLC and Unite Here Health*	

/s/ Angela Nakamura Ochoa

_____

An Employee of LIPSON NEILSON P.C.

LIPSON NEILSON P.C.
9900 Covington Cross Drive, Suite 120
Las Vegas, Nevada 89144
(702) 382-1500 FAX: (702) 382-1512

EXHIBIT “A”

EXHIBIT “A”

LIPSON NEILSON P.C.
JOSEPH P. GARIN, ESQ.
Nevada Bar No. 6653
ANGELA T. NAKAMURA OCHOA, ESQ.
Nevada Bar No. 10164
9900 Covington Cross Drive, Suite 120
Las Vegas, Nevada 89144
(702) 382-1500
Fax (702) 382-1512
jgarin@lipsonneilson.com
aochoa@lipsonneilson.com
Attorneys for Defendants
Kathleen Silver, Bobbette Bond,
Tom Zumtobel, Pam Egan,
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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, an Individual; TOM ZUMTOBEL, an Individual; BOBBETTE BOND, an Individual; KATHLEEN SILVER, an Individual; UNITE HERE HEALTH, 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.: 16 **DEFENDANTS/THIRD PARTY PLAINTIFF PAMELA EGAN, BASIL DIBSIE, LINDA MATTOON, BOBBETTE BOND, TOM ZUMTOBEL, AND KATHLEEN SILVER'S THIRD-PARTY COMPLAINT**

LIPSON NEILSON P.C.
9900 Covington Cross Drive, Suite 120
Las Vegas, Nevada 89144
(702) 382-1500 FAX: (702) 382-1512

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,

Third-Party Plaintiffs,

vs.

CONDUENT STATE HEALTHCARE, LLC f/k/a Xerox State Healthcare, LLC, a Delaware limited liability company; AND STATE OF NEVADA EX REL. SILVER STATE HEALTH INSURANCE EXCHANGE,

Third-Party Defendants.

Pursuant to NRCP 14(a), Defendants/Third Party Plaintiffs Kathleen Silver, Bobbette Bond, Tom Zumtobel, Pam Egan, Basil Dibsie and Linda Mattoon (collectively "Management") by and through their counsel of record at Lipson Neilson P.C. hereby file this Third-Party Complaint against Third-Party Defendants Conduent State Healthcare, LLC f/k/a Xerox State Healthcare, LLC ("Xerox") and State of Nevada ex rel. Silver State Health Insurance Exchange ("Silver State") (jointly, the "Third-Party Defendants") and allege as follows:

PARTIES

1. Defendant/Third-Party Plaintiff Kathleen Silver is an individual who at all times relevant was a resident of Clark County, Nevada.

2. Defendant/Third-Party Plaintiff Bobbette Bond is an individual who at all times relevant was a resident of Clark County, Nevada.

3. Defendant/Third-Party Plaintiff Tom Zumtobel is an individual who at all times relevant was a resident of Nevada.

4. Defendant/Third-Party Plaintiff Pam Egan is an individual who at all times relevant was a resident of Clark County, Nevada.

5. Defendant/Third-Party Plaintiff Basil Dibsie is an individual who at all times

LIPSON NEILSON P.C.
9900 Covington Cross Drive, Suite 120
Las Vegas, Nevada 89144
(702) 382-1500 FAX: (702) 382-1512

relevant was a resident of Clark County, Nevada.

6. Defendant/Third-Party Plaintiff Linda Mattoon is an individual who at all times relevant was a resident of Nevada.

7. Third-Party Defendant Xerox is a Delaware limited liability company with its principal place of business in Morris County, New Jersey.

8. Third-Party Defendant Silver State is an agency of the State of Nevada.

JURISDICTION AND VENUE

9. This Court has personal jurisdiction over Third-Party Defendants because the acts complained of herein were committed by Third-Party Defendants within the State of Nevada.

10. This Court has subject matter jurisdiction over this matter because Third-Party Defendants' potential liability is in excess of $15,000.

11. Venue is proper pursuant to the ancillary venue doctrine; further, venue is proper in the Eighth Judicial District Court for the State of Nevada because Nevada Healthcare Solutions, LLC is domiciled in Clark County, Nevada and because the cause of action, or some part thereof, arose in Clark County, Nevada.

FACTUAL ALLEGATIONS

The ACA, CO-Ops, and Health Exchanges

12. In 2010, the United States Congress enacted the Patient Protection and Affordable Care Act ("ACA"), which was signed into law by then President Barack Obama.

13. The ACA provided for the establishment of private, non-profit Consumer Operated and Oriented Plans-like Plaintiff Nevada Health CO-OP (the "CO-OP" or "NHC")-to compete with for-profit insurance plans.

14. Additionally, the ACA provided for the creation of Health Insurance Marketplaces, commonly referred to as "health exchanges."

15. The ACA provided that each State could either create its own health exchange or use the federal health exchange (often referred to as a "federally-facilitated exchange").

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9900 Covington Cross Drive, Suite 120
Las Vegas, Nevada 89144
(702) 382-1500 FAX: (702) 382-1512

16. Insurance companies and Consumer Operated and Oriented Plans made their insurance policies available on the health exchanges for individuals seeking to purchase coverage.

17. Although some support was available, State that elected to create their own health exchanges had to invest substantial resources to develop them.

18. Health exchange systems had to be capable of doing many things in order to succeed.

19. For example, a health exchange system needed to be able to determine eligibility for coverage, report enrollment to insurance carrier or CO-Ops when a consumer enrolled in its plan, and collect/distribute premium payments to insurers, among other things.

Silver State Contracts with Xerox to Develop the Exchange

20. Nevada elected to create its own health exchange and created an agency, Silver State, to develop and oversee Nevada's health exchange.

21. In 2012, Silver State awarded Xerox a $72 million contract to develop, administer, and manage Nevada's health exchange, which it named the "Nevada Health Link" (hereinafter, the "Xerox Exchange").

22. In developing, administering, and managing the Xerox Exchange, two of Xerox's primary duties (among others) were to ensure that the Xerox Exchange promptly: (1) transferred consumer data to insurers and/or their vendors; and (2) transferred consumer's premium payments to insurers and/or their vendors.

23. Beginning with its initial rollout on October 1, 2013, the Exchange was a disaster—it suffered from an egregious number of technical defects.

24. For example, many consumers would select and pay for insurance through Xerox Exchange but, due to Third-Party Defendants' failures, their information and payments were never transmitted to insurers.

25. Indeed, the CO-OP's own board minutes indicate the difficulties it faces as a result of the poorly-designed and poorly-managed Xerox Exchange.

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9900 Covington Cross Drive, Suite 120
Las Vegas, Nevada 89144
(702) 382-1500 FAX: (702) 382-1512

26. For example, the CO-OP's board minutes reflect that its representatives had numerous meetings with government officials, other insurers, and Xerox to discuss "the challenges the CO-OP is experiencing with data submission from Xerox to the CO-OP," such as "more than 3,000 members that are on Xerox pending list that the CO-OP has not received any data on to date."

27. The CO-OP's board members complained that Xerox's negligence was "negatively impacting the CO-OP's membership," that Xerox's "payment collection process. . .[was] only working at 45% capacity to accept payments,. . .[and Xerox] . . .ha[d] drained the CO-OP's resources[,] as no less than 50% of the CO-OP's resources have been committed to Xerox and Xerox related issues since October 2013."

28. Silver State engaged Deloitte Consulting LLP ("Deloitte") to evaluate the failings of Xerox Exchange and Silver State's options going forward.

29. Deloitte found over ***1,500 defects*** with Xerox Exchange, over 500 of which were of a "higher severity."

30. Ultimately, Silver State elected to terminate its contract with Serox and switch to a federally-facilitated health exchange while maintaining the "Nevada Health Link" moniker.

Lawsuit Against Third-Party Defendants

31. Third-Party Defendants' negligence in developing, administering, and managing the Xerox Exchange caused substantial harm to consumers, insurers, and insurance brokers.

32. Two class-action lawsuits (the "Class Actions") were filed against Third-Party Defendants based on their negligence:

(a) *Basich v. State of Nevada ex rel. Silver State Health Insurance Exchange*, Case No. A-14-698567-C (Dist. Ct. Nev.): a class of consumers that had attempted to obtain insurance on the Xerox Exchange but failed to do so as a result of Third-Party Defendants' negligence; and

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9900 Covington Cross Drive, Suite 120
Las Vegas, Nevada 89144
(702) 382-1500 FAX: (702) 382-1512

(b) *Casale v. State of Nevada ex rel. Silver State Health Insurance Exchange*, Case No. A-14-706171-C (Dist. Ct. Nev.): a class insurance brokers that had sought to sell insurance plans to consumers through the Xerox Exchange but were unable to do so as a result of Third-Party Defendants' negligence.

33. The Class Actions were consolidated and both were certified by the court as class actions.

34. The Class Actions ultimately settled based on Xerox's agreement to pay up to $5 million to satisfy class member claims and to pay $1.75 million in attorneys' fees and costs.

35. Additionally, Xerox faced a regulatory action before the State of Nevada, Department of Business and Industry, Division of Insurance, involving Xerox's deficient performance and negligence in developing, administering, and managing the Xerox Exchange (*In the Matter of Xerox State Healthcare, LLC,* Cause No. 17.0299).

Third-Party Defendants' Negligence Substantially Harms the CO-OP and its Vendors

36. Third-Party Defendants' negligence in developing, administering, and managing the Xerox Exchange caused substantial harm to the CO-OP and its vendors (including UHH), including, but not limited to, failures to transfer data from the Xerox Exchange to the CO-OP's vendors and failures with the Xerox Exchange's payment collection process (which Xerox admitted only worked at 45 percent capacity).

37. For example, the CO-OP discovered that Third-Party Defendants had failed to transmit data concerning ***3,000 new members*** to the CO-OP or its vendors due to the Xerox Exchange's failings.

38. The CO-OP's own board minutes stated that it had committed 50 percent of its resources to Xerox-related issues beginning in October 2013.

39. Third-Party Defendants' negligence caused substantial harm to the CO-OP and its vendors, and materially contributed to the CO-OP's ultimate failure as a viable health plan.

LIPSON NEILSON P.C.
9900 Covington Cross Drive, Suite 120
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(702) 382-1500 FAX: (702) 382-1512

The CO-OP Sues UHH and Other Vendors, but Fails to Sue Xerox or Silver State

40. On August 25, 2017, Barbara D. Richardson, Commissioner of Insurance of the State of Nevada, sued Defendant/Third-Party Plaintiffs Kathleen Silver, Bobbette Bond, Tom Zumtobel, Pam Egan, Basil Dibsie and Linda Mattoon (and numerous others) on behalf of the CO-OP in her capacity as its statutory receiver.

41. On September 24, 2018, Barbara D. Richardson, Commissioner of Insurance of the State of Nevada filed a First Amended Complaint.

42. The First Amended Complaint alleged in pertinent part that Management acted negligently and fraudulently in managing the operations of the CO-OP and caused the CO-OP's demise.

43. In reality, the issues the CO-OP complains of were caused by actions outside of Management's control—including, but not limited to Third-Party Defendants' negligence in developing, administering and managing the Xerox Exchange.

44. Notably, the CO-OP elected not to sue Xerox or Silver State despite overwhelming evidence of Xerox's and Silver State's negligence in developing, administering, and managing the Xerox Exchange.

45. Further, while the CO-OP has sued Silver State, its claims against Silver State concern $510,651.27 for premiums Silver State has retained; the CO-OP has failed to sue Silver State for its negligence in managing and overseeing Xerox's development, administration, and management of the Xerox Exchange.

FIRST CAUSE OF ACTION

(Contribution)

46. Management realleges and incorporates by reference the above allegations as though fully set forth herein.

47. Third-Party Defendants owed duties to the CO-OP, its vendors and Management to use reasonable care to develop, administer, and manage the Exchange.

48. Third-Party Defendants breached their duties to the CO-OP, its vendors and Management by negligently and carelessly developing, administering and managing the

LIPSON NEILSON P.C.
9900 Covington Cross Drive, Suite 120
Las Vegas, Nevada 89144
(702) 382-1500 FAX: (702) 382-1512

Exchange.

49. Third-Party Defendants failed to exercise even the slightest degree of care, which amounts to gross negligence.

50. Third-Party Defendants' negligence proximately caused harm to the CO-OP, its vendors and Management, materially contributing to the CO-OP's failure as a viable health plan.

51. Third-Party Defendants' negligence proximately caused harm to Management by materially interfering with Management's ability to perform its duties and obligations.

52. Accordingly, if the CO-OP obtains any recovery from Management, then Management is entitled to contribution from Third-Party Defendants, including reasonable attorneys' fees and costs incurred in defending this action.

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LIPSON NEILSON P.C.
9900 Covington Cross Drive, Suite 120
Las Vegas, Nevada 89144
(702) 382-1500 FAX: (702) 382-1512

PRAYER FOR RELIEF

WHEREFORE, Management demands judgment against Third-Party Defendants as follows:

1. For a judicial determination of the rights and duties between Management and Third-Party Defendants in the event that Management is held liable to the CO-OP;
2. For contribution from Third-Party Defendants, in the event Management is held liable to the CO-OP, in an amount to be determined at trial;
3. For judgment in excess of $15,000.00, in an amount to be determined at trial;
4. For costs incurred in this action;
5. For reasonable attorneys' fees;
6. For such other and further relief as the Court considers just and proper.

Dated this ___ day of October, 2020.

LIPSON NEILSON P.C.

By: _____

Joseph P. Garin, Esq. NV Bar No. 6653
Angela T. Nakamura Ochoa, Esq. NV Bar No. 10164
Jonathan K. Wong, Esq. NV Bar No. 13621
9900 Covington Cross Dr., Suite 120
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LIPSON NEILSON P.C.
9900 Covington Cross Drive, Suite 120
Las Vegas, Nevada 89144
(702) 382-1500 FAX: (702) 382-1512