**Case No. _____**

IN THE SUPREME COURT OF NEVADA



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

Petitioners,

vs.

EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF CLARK, THE HONORABLE 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 10 OF 11

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**June 30, 2021**

**APPENDIX TO PETITION FOR EXTRAORDINARY WRIT RELIEF**
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DISTRICT COURT
CLARK COUNTY, NEVADA

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**COMBINED RESPONSE TO MOTIONS (I) FOR LEAVE TO FILE THIRD-PARTY COMPLAINT AND (II) TO CONSOLIDATE**

Although defendants Nevada Health Solutions and Unite Here Health ("Unite") have filed joint motions seeking leave to file a third-party complaint that, if granted, they would then have consolidated for all purposes, including trial, with the pending amended complaint filed on behalf of the Receiver for Nevada Health Co-Op, the proposed third-party complaint does not assert a

claim on behalf of Nevada Health Solutions.[1] And, as for Unite, the third-party complaint is merely an attempt to state a claim that is barred as a matter of law, which leaves nothing to consolidate. See NRCP 42.[2]

## SUMMARY OF ARGUMENT

The proposed third-party complaint asserts a claim for contribution on behalf of Unite against two third-party defendants.[3] Contribution, however, is available only against a joint tortfeasor who shares some responsibility for the failure to carry out a "common obligation." [See authorities cited in section 1, below] None of the Receiver's claims against Unite are tied to any joint obligation that Unite shared with either of the proposed third party-defendants. Instead, the Receiver's claims against Unite arise out of obligations for which Unite was solely responsible. The Receiver's amended complaint asserts three claims against Unite under a variety of legal theories of recovery.[4] Two of those

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[1] The proposed third-party complaint (at 7) asserts a single cause of action only on behalf of Unite, and the complaint's prayer for relief (at 7-8) seeks a judgment only in favor of Unite.

[2] Under NRCP 42, two actions may be consolidated only if they "involve a common question of law or fact." As explained throughout this memorandum, the proposed third party-complaint does not raise a common question of law. Nor does that complaint raise a common question of fact. [See especially section 1, below]

[3] The proposed third-party defendants are Conduent State Healthcare, LLC, which was previously known as Xerox State Healthcare, and the State of Nevada ex rel. Silver State Health Insurance Exchange.

[4] Separate legal theories are not separate claims, even when "the several legal theories depend on different shadings of the fact, or would emphasize different elements of the facts, or would call for different measures of liability or different kinds of relief." Restatement (Second) of Judgments §24 cmt c (1992); *see also Bethesda Luth. Homes & Servs., Inc. v. Born* 238 F.3d 853, 857 (7th Cir. 2001) (stating that "a claim is not an argument or a ground but the events claimed to give rise to a right to a legal remedy"); *Andrews v. Medical Excess, LLC*, 863 F.Supp.2d 1137, 1140 (M.D. Ala. 2012) ("A right of recovery is distinct from a

claims are based on Unite's failures to perform what it promised and seek either contract-based or quasi-contract (unjust enrichment) damages, and the third claim seeks tort-based damages attributable to Unite's intentional misconduct. By asserting an entitlement to contribution should the Receiver recover on any of those claims, the proposed third-party complaint ignores that contribution is unavailable for a contract-based claim [see authorities cited in section 2, below], a quasi-contract, or unjust enrichment, claim [see authorities cited in section 3, below], and an intentional tort claim [see authorities cited in section 4 below].

A district court acts appropriately by denying a motion to amend a complaint when the proposed complaint will not survive a motion to dismiss. *E.g.*, *Halcrow, Inc. v. Eighth Jud. Dist. Ct.*, 129 Nev. 394, 398, 302 P.2d 1148, 1152 (2013) (ordering district court to vacate order granting leave to file amended complaint and stating that a proposed amended complaint should be disallowed "if the plaintiff seeks to amend the complaint in order to plead an impermissible claim"); *Nutton v. Sunset Station, Inc.*, 131 Nev. 279, 289, 357 P.3d 966, 973 (Ct. App. 2015) (stating that "leave to amend, even if timely sought, need not be granted if the proposed amendment would be 'futile'"). The same outcome is warranted here because the proposed third-party complaint seeks to assert a claim for contribution on behalf of Unite to which, as a matter of law, it is not entitled. And, without that complaint, the motion to consolidate becomes irrelevant.

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theory of liability; a plaintiff may have only one right of recovery though she advances a variety of legal theories to support that recover[y]" (citation, internal quotation marks, and italics omitted)); *Orthodontic Centers v. Michaels*, 407 F.Supp.2d 934, 936 (N.D. Ill. 2005) (stating that "different legal theories . . . do not multiply the number of claims for relief").

## REASONS TO REJECT THE THIRD-PARTY COMPLAINT

### A. The Proposed Complaint Is Meritless.

The motion to bring a third-party complaint against Xerox should be rejected for the simple reason that it does not state a cognizable contribution claim. The request for amendment is futile. *See Halcrow, Inc. v. Eighth Judicial Dist. Court*, 129 Nev. 394, 398, 302 P.3d 1148, 1152 (2013) ("Leave to amend should not be granted if the proposed amendment would be futile.").

**1. Contribution Is Unavailable in the Absence of a Common Obligation.**

The proposed third-party complaint overlooks that a claim for contribution exists only among *joint* tortfeasors. NRS 17.225(1); *see also* Restatement (Second) of Torts § 886A cmt. b (1979). And, "joint" means two or more persons who are liable for the same harm that arises out of a "common obligation." *E.g.*, *Berg Chilling Sys., Inc. v. Hull Corp.*, 435 F.3d 455, 472 (3d. Cir. 2006) (stating that contribution is "an attempt by equity to distribute equally among those who have *a common obligation*, the burden of performing *that obligation*" (citation and internal quotation marks omitted, emphasis added)); *Huggins v. Graves*, 337 F.2d 486, 489 (6th Cir. 1964) (recognizing that a "basic element[]" of a contribution claim is "that both parties be under a common obligation"); *Ford Motor Co. v. Edgewood Props., Inc.*, Civil Action Nos. 06-1278, 06-4266, 2008 WL 4559770, at *18 (D.N.J. Oct. 8, 2008) (stating that the "majority view" recognizes a common obligation as an element of a contribution claim).[5] In the absence of a common obligation, a contribution

[5] *Accord Amphibious Partners, LLC v. Redman*, 534 F.3d 1357, 1362 (10th Cir. 2008) (stating that contribution arises out of a "common obligation"); *Asdar Group v. Pillsbury, Madison & Sutro*, 99 F.3d 289, 295 (9th Cir. 1996) (stating that the right to contribution exists to relieve the claimant of bearing "more than his just and equitable share of the common obligation"); *Fink v. Spirit Servs. of WV, LLC*, Civil Action No. 2:16-cv-08669, 2017 WL 4248872, at *3 (S.D. W.Va. Sept. 25, 2017) ("The right of contribution arises when [parties owe]

claim fails. *See Berg Chilling Sys.*, 435 F.3d at 472.

The proposed third-party complaint all but concedes that its asserted contribution claim is not predicated on a common obligation for which joint liability exists. That proposed complaint acknowledges (at 6, para. 38) that the Receiver's pending claims against Unite are based on Unite's contractual obligations to provide medical utilization services and third-party administration of insurance claims. At the same time, the proposed complaint alleges (at 7, para. 43) that Unite's contribution claim is based on a different obligation, *viz.*, the third-party defendants' obligation to "develop[], administer[], and manag[e]" a health insurance marketplace, or exchange, that Nevada elected to create.

*Nova Info. Sys., Inc. v. Greenwich Ins. Co.*, is instructive here, where on facts far more compelling than the facts of this case, the court rejected a contribution claim because it did not arise from a common obligation. 365 F.3d 996, 1006 (11th Cir. 2004). Nova maintained that it was entitled to contribution from Greenwich for reimbursing passengers of a failed ocean cruise line who had used their credit cards to prepay for cruises that never occurred.

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a common obligation to the party who suffered tortious harm" (citation and internal quotation marks omitted, alteration in original)); *CBR Funding, LLC v. Jones*, No. 1:13-cv-01280-JDB-egb, 2015 WL 1529090, at *4 (W.D. Tenn. Apr. 2, 2015) ("The right of contribution only exists between parties who share a common obligation or liability" (citation and internal quotation marks omitted)); *Peters v. Maxim Healthcare Servs., Inc.*, Civil No. 9-204-B-W, 2009 WL 2986665, at *3 n.2 (D. Me. Sept. 15, 2009 (recognizing that a contribution claim "involves a common obligation" (citation and internal quotation marks omitted)); *Abney-Revard, Inc. v. Associated Materials, Inc.*, No. CV 05-528-PK, 2007 WL 1467302, at *1 (D. Or. May 17, 2007) (stating that "statutory and common-law claims" for contribution "require . . . a common obligation"); *Virginia Int'l Terminals, Inc. v. Ceres Marine Terminals, Inc.*, 879 F.Supp. 31, 32 (E.D. Va. 1995) (recognizing a "common obligation" as an element of a contribution claim); *see also* NRS 101.010 *et seq.* (discussing rights of "coobligors" under the Uniform Joint Obligations Act).

Nova, however, was contractually obligated to reimburse only the cruise line's merchant bank, which processed the credit card charges, while Greenwich, unlike Nova, was obligated to reimburse the passengers. "Accordingly, no 'common obligation' existed between [Nova and Greenwich] sufficient to maintain a claim for contribution," even though the money paid by Nova to the merchant bank was "ultimately paid to [the] passengers." 365 F.3d at 1006.[6]

**2. Contribution Is Unavailable for a Contract-Based Claim.**

Leaving concerns about the absence of a common obligation aside, the contribution claim asserted in the third-party complete is based on a misapprehension regarding the nature of the claims that the Receiver's amended complaint asserts against Unite. With two exceptions discussed below, the various causes of action stated in the Receiver's complaint are not independent claims but, instead, legal theories in aid of a claim based on Unite's breaches of its two contracts to provide consulting services and third-party administrative services. [Amend. Complaint (9/24/18) at 115-16; see also n. 3, above]

Contribution, however, is available only for liability in tort and not for a breach of contract. NRS 17.225(1).[7] And, in the circumstances here, there is no

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[6] See also *Erickson v. Erickson*, where, as here, the defendant/third-party plaintiff and the third-party defendants all owed duties to the same plaintiff, but those duties were not common obligations, thus compelling the dismissal of the third-party complaint for failure to state a claim: "[T]he right to contribution only arises when parties having a common obligation are sued on that obligation." 849 F.Supp. 453, 457-59 (S.D. W.Va. 1994).

[7] NRS 17.225(1) states that, except for reasons not applicable here, "where two or more persons become jointly or severally *liable in tort* for the same injury to person or property or for the same wrongful death, there is a right of contribution among them even though judgment has not been recovered against all or any of them." (Emphasis added). *See also Hospital Auth. of Rockdale Cnty. v. GS Capital Partners V Fund, L.P.*, No. 09 Civ. 8716(PAC), 2011 WL 182066, at

recognized exception to the plain meaning rule of statutory construction that would permit disregarding the unambiguous restriction in section 17.225 that limits contribution claims to tort liability. *E.g.*, *Bigpond v. State*, 128 Nev. 108, 114, 270 P.3d 1244, 1248 (2012) ("We must attribute the plain meaning to a statute that is not ambiguous" (citation and internal quotation marks omitted)); *Pope v. Motel 6,* 121 Nev. 307, 314, 114 P.3d 277, 282 (2005) "[W]e are bound to follow a statute's plain meaning when the language is unambiguous").[8]

To be sure, the Receiver's amended complaint does state causes of action to which labels are attached that often describe tort claims. But that has no bearing on the outcome here because "[m]erely designating a cause of action as a tort" does not make it a tort. *Bank of Am. NT v. SA Hubert*, 153 Wash.2d 102, 124, 101 P.3d 409, 420 (2004) (concluding that negligence claim "sound[ed] in contract"); *see also Alaska Pac. Assur. Co. v. Collins*, 794 P.2d 936, 946 (Alaska

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*4 (S.D.N.Y. Jan. 20, 2011) (plaintiff could not benefit from liquidated damages paid under contract to which it was not a party: two separate contracts meant there were two separate injuries); *see also Knight v. Docu-Fax, Inc.*, 838 F.Supp. 1579, 1580 (N.D. Ga. 1993) (recognizing that two separate contracts meant there were "two separate alleged sources of injury"); *see generally Techreations, Inc. v. National Safety Council*, 650 F. Supp. 337, 340 (N.D. Ill. 1986) ("[I]f a plaintiff is the victim of the breach of two separate contracts on the same day, this may constitute two injuries").

[8] Courts elsewhere have recognized repeatedly that, as here, there is no right to contribution for a claim that seeks compensatory damages attributable to a contract breach. *E.g.*, *National Fire Ins. Co. v. Johnson Controls Fire Protection LP*, No. 2:19-14050-Rosenberg/Maynard, 2019 WL 3766880, at *1 (S.D. Fla. Aug. 9, 2019); *Wells Fargo Fin. Leasing, Inc. v. Tulley Auto. Group, Inc.*, Civil No. 16-cv-218-LM, 2017 WL 3841840, at *4 (D. N.H. Sept. 1, 2017); *United States ex rel. Ryan v. Staten Island Univ. Hosp.*, No. 04-CV-2483 (JG)(CLP), 2011 WL 1841795, at *7 (E.D.N.Y. May 13, 2011); *AutoZone, Inc. v. Glidden Co.*, 737 F.Supp.2d 936, 946 (W.D. Tenn. 2010); *Pine Grove Mfr. Homes v. Indiana Lumbermens Mut. Ins. Co.*, Civil Action No. 3:08-CV-1233, 2009 WL 4810560, at *3 (M.D. Pa. Dec. 8, 2009); *Maxwell v. Phillips*, No. 1:06CV00510, 2007 WL 2156337, at *8 (M.D.N.C. July 25, 2007); *In re Crazy Eddie Sec. Lit.*, 802 F.Supp. 804, 815 (E.D.N.Y. 1992).

1990) (stating that "an action for negligence in breaching a specific contractual duty sounds in contract"). Instead, with the exception of the two claims discussed later in this memorandum, the various causes of action asserted in the amended complaint arise from the same set of relevant facts, seek the same contract-based damages award, and thus, they are not independent claims but merely alternative theories of recovery based on Unite's breaches of its two contracts because those causes of action would not exist but-for Unite's contracts. *See Sherwin v. Infinity Auto Ins. Co.*, No. 2:11-CV-43 JCM (VCF), 2011 WL 5598344, at *2 (D. Nev. Nov. 16, 2011) (concluding that, because "a bad faith cause of action" was based on the same set of facts supporting plaintiff's contract and statutory claims, "the bad faith causes of action are not separate and distinct claims, but simply alternative legal theories of recovery"); *see also* Restatement (Second) of Judgments §24(1) (1982) (recognizing that a claim is a right to a remedy with respect to all or part of a transaction); *see generally CBI NA-CON, Inc. v. UOP Inc.*, 961 S.W.2d 336, 341 (Tex. App. Houston 1st Dist. 1997) ("Every breach of contract should not become a tort action, particularly where no consumers are involved and there is no fraud or personal injury, but only economic injury arising out of the very duties imposed by the contract").

In addition to two separate counts for breaches of contract (*viz.*, count 67 (at 115), the Consulting Agreement, and count 68 (at 115-16), the Administrative Services Agreement), the Receiver's amended complaint includes the following:

- Counts 65 (at 113-14), 66 (at 114-15), and 71 (at 118): Negligence, Gross Negligence, and Negligent Performance – A tort claim will be recognized only for the breach of a duty imposed by law, or in other words, a claim that, as here, is predicated on the failure to honor a duty imposed by a contract is a contract claim.

*E.g., FDIC v. Citizens Bank & Trust Co.*, 592 F.2d 364, 369 (7th Cir. 1979) (recognizing that tort liability exists only "for breach of a duty imposed by statute or case law and not by contract"); *Bank of Am.*, 153 Wash.2d at 124, 101 P.3d at 420 ("An action sounds in contract when the act complained of is a breach of a specific term of the contract, without reference to the legal duties imposed by law on that relationship"); *Alaska Pac.*, 794 P.2d at 946 ("Only where the duty breached is one imposed by law, such as traditional tort law duty furthering social policy, may an action between contracting parties sound in tort" and otherwise, "[p]romises set forth in a contract must be enforced by an action on that contract").[9] Here, the asserted negligence in each of the three negligence counts consists only of failures to perform duties that did not exist but for Unite's contracts and not the failure to comply with any extra-contractual duty imposed by law. As such, those three counts, albeit in different ways, state a single claim for contract damages attributable to Unite's contract breaches. *E.g.*, *Alaska Pac.,* 794 P.2d at 946 ("We decline to hold that where a party breaches a contractual promise 'negligently,' such conduct may form the basis for a tort action").

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[9] *Accord e.g.*, *Quinn v. Workforce 2000, Inc.*, 887 F.Supp. 1311, 136 (E.D. Tex. 1995) ("[T]o state a tort claim independent from a contract claim, Plaintiff must show breach of a duty imposed by law rather than just a duty imposed under the contract," and "[w]hen the injury is only the economic loss to the subject of the contract itself, the action sounds in contract alone" (citation omitted)); *Lancaster v. Susa P'ship, L.P.*, 300 Ga.App. 567, 570, 685 S.E.2d 474, 477 (2009) ("Mere failure to perform a contract does not constitute a tort. A plaintiff in a breach of contract case has a tort claim only where, in addition to breaching the contract, the defendant also breaches an independent duty imposed by law" (citation, internal quotation marks, and alteration omitted)); *see also Calex Exp., Inc. v. Bank of Am.*, 410 F.Supp. 407, 413 (M.D.Pa. 2005) (granting summary judgment denying negligence claim because "[plaintiff] has identified no duty imposed by tort law").

- Count 64 (at 113): Malpractice – As stated in the amended complaint, the asserted malpractice is tied exclusively to Unite's failure to perform contractual duties. Because the asserted malpractice implicates no extra-contractual legal duty, the malpractice asserted in the amended complaint does not constitute a tort claim. [See especially Amend. Complaint (9/24/18) at 113, para. 837][10]

- Counts 69 (at 116-17) and 70 (at 117): Breaches of the Implied Covenant of Good Faith and Fair Dealing (two contracts) – "Generally, a breach of the implied covenants is a contract-based claim." *Shaw v. CitiMortgage, Inc.*, 201 F.Supp.3d 1222, 1254 (D. Nev. 2016). A claim for breach of the implied covenants of good faith and fair dealing will be recognized as a tort claim only "in rare and exceptional cases." *Id.* at 1254 (quoting *Max Baer Prods., Ltd. v. Riverwood Partners, LLC*, No. 3:09-cv-00512-RCJ-RAM, 2010 WL 3743926, at *5 (D. Nev. Sept. 20, 2010)). A bad faith claim "does not arise simply from a particularly egregious or willful breach of a contract." *Max Baer*, 2010 WL 3743926, at *5. Instead, a tort claim for breach of the implied covenant of good faith and fair dealing requires a "special relationship" between the contracting parties. *Shaw*, 201 F.Supp.3d at 1254. "A special relationship is characterized by elements of public interest, adhesion, and fiduciary responsibility." *Baer*, 2010 WL 3743926, at *5; *see also Shaw*, 201 F.Supp.3d at 1254. The Receiver's complaint does not, nor could it sensibly, allege that something resembling a fiduciary or other special relationship was implicit in either of Unite's two contracts that are the subjects of the Receiver's amended

[10] Claims for malpractice that sound in tort typically arise when the law imposes special duties on relationships that are, unlike here, between professionals and their clients. *See e.g.*, *SCF Arizona v. Wachovia Bank, N.A.*, No. 09 Civ. 9513(WHP), 2010 WL 5422505, at *8 (S.D.N.Y. 2010).

complaint. Accordingly, the bad faith causes of action appearing in the amended complaint are merely alternative legal theories in aid of a claim for contract, and not tort, damages. *See also Barmat v. John & Jane Doe Partners A-D*, 155 Ariz. 519, 523, 747 P.2d 1218, 1222 (1987) (holding that when "the duty breached is not imposed by law, but is a duty created by the contractual relationship, and would not exist 'but for' the contract," then breach of implied contractual covenants "sounds in contract").

**3. Contribution Is Unavailable for an Unjust Enrichment Claim.**

The Receiver's amended complaint asserts a noncontract-based cause of action (count 72 (at 118-19) for unjust enrichment.[11] But, as explained above, even if unjust enrichment were viewed here as a claim independent of all other causes of action, should the Receiver recover on that claim, contribution would be unavailable because a common obligation does not exist. *See Nova Info. Sys.*, 365 F.3d at 1006-07; Restatement (Third) of Restitution and Unjust Enrichment § 23 cmt. d (stating that a contribution claim "arises when the claimant has discharged all or part of a *joint obligation* (emphasis added)); *see also id.*, Rptr. note d (stating that "[c]ontribution is therefore quintessentially a claim between jointly and severally liable parties" (citation and internal quotation marks omitted)); *see generally* nn. 4-5 above and accompanying text.

Apart from that, the third-party complaint effectively ignores that, in the circumstances here, the Receiver's unjust enrichment theory of recovery is rooted in the fact that Unite has been paid money to which it is not entitled. *E.g.*, *Leasepartners Corp. v. Robert L. Brooks Trust*, 113 Nev. 747, 756, 942 P.2d 182, 187 (1997) ("The doctrine of unjust enrichment or recovery in quasi

[11] A claim for unjust enrichment assumes the absence of a contract. *E.g., Leasepartners Corp. v. Robert L. Brooks Trust*, 113 Nev. 747, 756, 942 P.2d 182, 187 (1997); *see also Schmall v. Government Employees Ins. Co.*, 240 F.Supp.3d 1093, 1097 (D. Nev. 2016).

contract applies to situations where there is no legal contract but where the person sought to be charged is in possession of money or property which in good conscience and justice he should not retain"). The third-party complaint would allow Unite to retain at least some of the money to which it is not entitled, namely by having the third-party defendants pick up the tab. No authority, and certainly no authority identified in the motion seeking leave to file the third-party complaint, supports that outcome.

**4. Contribution Is Unavailable for an Intentional Tort Claim.**

The one remaining cause of action appearing in the Receiver's amended complaint that implicates Unite is count 63 (at 111-12), which identifies a series of events, all of them amounting to "intentional misconduct, fraud, and/or a knowing violation of the law," for which Unite and others are liable. In other words, count 63 asserts that Unite engaged in tortious conduct, *and* that conduct was intentional. If Unite were found liable on that count, however, Unite would not be entitled to contribution from anyone else because "[t]here is no right of contribution in favor of any tortfeasor who has intentionally caused or contributed to the injury." NRS 17.255; *see also Evans v. Dean Witter Reynolds, Inc.*, 116 Nev. 598, 611, 5 P.3d 1043, 1051 (2000) (referring to refusal of "Nevada 'contribution' statutes" to allow "one intentional tortfeasor [to take] advantage of restitution made by another" as "long-standing public policy").

The contention that, unless the two motions are granted, the Receiver may be able to recover the same damages twice is a fear that is imagined and not real. Apart from the absence of any authority suggesting that contention is sufficient to overcome the flaws in the third-party complaint discussed to this point, to the extent that the Receiver is awarded damages on its complaint against Unite in this case, it is beyond fair dispute that the Receiver would be barred from seeking damages for the same injury from anyone else in other litigation. *See e.g.*, *Elyousef v. O'Reilly & Ferrario, LLC*, 126 Nev. 441, 444, 245

P.3d 547, 549 (2010) (stating that "a plaintiff can recover only once for a single injury"); *see also U-Haul Co. of Nevada, Inc. v. Gregory J. Kramer, Ltd.*, No. 2:12-CV-231-KJD-CWH, 2013 WL 4601078, at *2 (D. Nev. Aug. 28, 2013) (same). *Cf. Western Tech., Inc. v. All-American Golf Center*, 122 Nev. 869, 872-73, 139 P.3d 858, 860 (2006) (recognizing that, to prevent "excess recovery by the plaintiff," a jury award of damages will be offset by settlement amounts paid by other parties).

**B. Even if the Contribution Claim Had Merit, It Should Not Be Allowed in this Action.**

Although the third-party complaint does not state a claim for relief, it would not matter if it did. That is because while a contribution claim *may* be brought "in the same action in which [the] judgment is entered against two or more tortfeasors," such a claim may equally be enforced in a "*separate* action following entry of judgment." *Pack v. LaTourette*, 128 Nev. 264, 269–70, 277 P.3d 1246, 1249–50 (2012) (emphasis added) (quoting *Bell & Gossett Co. v. Oak Grove Investors*, 108 Nev. 958, 963, 843 P.2d 351, 354 (1992)) and citing NRS 17.285(1), (2)). In fact, regardless of the statute of limitations on the underlying tort claim, the statute of limitations on a contribution claim does not even begin to run until "after the judgment has become final by lapse of time for appeal or after appellate review." *Saylor v. Arcotta*, 126 Nev. 92, 96, 225 P.3d 1276, 1279 (2010) (NRS 17.285(3)).

Thus, denying Defendants' motion to add a contribution claim against Xerox at this late stage would not forfeit Defendants' claim altogether, if such a claim exists. It would merely ensure that the claim is brought at a time and in a forum when it will not disrupt the claims already set for trial.

**C. Amendment Would Prejudice Nevada Health Co-op.**

The Nevada Supreme Court recently clarified that delay, alone, is "[s]ufficient reasons to deny a motion to amend a pleading." *MEI-GSR*

*Holdings, LLC v. Peppermill Casinos, Inc.*, 134 Nev. 235, 239–40, 416 P.3d 249, 254–55 (2018) (quoting *Kantor v. Kantor*, 116 Nev. 886, 891–93, 8 P.3d 825, 828–29 (2000)) (rejecting casino's argument that "delay alone is insufficient grounds to deny a motion to amend"). Similar to Unite's and NHS's motion here, the plaintiff in *MEI-GSR* waited a year and half before seeking leave to amend the complaint. *Id.*

The *MEI-GSR* Court cited to *Kantor*, and noted there that "the information supporting [the plaintiff's] amended complaint was available to [her] when she filed her original complaint." *Id.*

Here, Unite's representatives have known since at least 2014 about potential issues involving Xerox and the Exchange. (Bennett Decl., at ¶¶ 10–13.) Nothing prevented Unite from moving to bring Xerox into this case as soon as Unite was named as a defendant.

And although the dilatoriness alone would justify denying the motion, the prejudice to Nevada Health Co-op and the other defendants is significant. Adding a new defendant at this stage—while discovery has been ongoing for years—would significantly impair the parties' ability to prepare for trial on the existing claims and defenses. (Bennett Decl., at ¶¶ 7–8, 17.)

That delay is particularly pernicious in the context of this receivership, as the delay does not merely harm the interests of the litigant itself, but all those claimants of the receivership who must await a recovery in litigation to obtain a distribution. (Bennett Decl., at ¶¶ 20–21.)

Finally, as discussed below, the "mere" delay is imposing significant costs on the receivership. Its litigation expenses depend, in part, on how quickly the case proceeds to trial. Every month of delay is a month that the receivership has to pay for costs, such as the $25,000 for an electronic discovery database, that takes away from the ultimate recovery for the receiver's claimants. (Bennett Decl., at ¶¶ 8, 20–21.)

The fact that this Court had previously extended discovery deadlines and the trial date is further reason to reject Unite's and NHS's belated request now. *See MEI-GSR Holdings, LLC*, 134 Nev. at 239–40, 416 P.3d at 255 (citing *Stephens v. S. Nev. Music Co.*, 89 Nev. 104, 106, 507 P.2d 138, 139 (1973) and noting that a prior extension of discovery deadlines and trial continuance "severely undermined" the plaintiff's allegation that it would be prejudiced if not permitted to amend).

## REASONS TO REJECT CONSOLIDATION

### A. The Motion Is Moot.

As discussed, this Court should deny the motion to add Xerox as a third-party defendant. If it does so, it may simply dismiss the request to consolidate as moot.

### B. Consolidation Is Inappropriate.

Regardless of mootness, consolidation would be costly and improper here. The 2020 case against the Exchange does not involve Unite or NHS, at all. The case against the Exchange is on a discrete, simple issue—the Exchange's failure to remit insurance premiums that it collected on the Co-op's behalf. (Bennett Decl. ¶ 19.) Because of the simplicity of the issues in that case, the district court there ordered an efficient case management schedule, with trial beginning in November 2021, if the case does not resolve even sooner. (*Id.*)

Consolidating those claims with this asset-recovery litigation—which, due to its complexity and the difference in the claims involved, began in 2017 but is not headed to trial until 2022—would vastly hamper the receiver's ability to timely recover on the claims against the Exchange. (Bennett Decl., at ¶ 21.) Not only would the addition of the Exchange lawsuit to this case increase the complexity of this case, but it would require this Court to become familiar with

an entirely new set of claims, involving different parties and a different contract, and would thwart the track that the Exchange lawsuit is already on.

"Courts have routinely denied consolidation motions where there is a stark difference in the procedural posture of the actions, finding that judicial economy would not be served by consolidating two actions at disparate stages of litigation." *KGK Jewelry LLC v. ESDNetwork*, 11CV9236-LTS-RLE, 2014 WL 7333291, at *2 (S.D.N.Y. Dec. 24, 2014). Even if there were an overlap in the issues to be tried, the relatively expedited schedule of the premium-collection case against the Exchange should not be derailed.

Again, the delay from consolidation would impose unacceptable costs on claimants of the receivership, including for increased discovery and administrative costs. (*See* Bennett Decl., at ¶¶ 8, 21.)

Under these circumstances, the Court should deny consolidation.

## CONCLUSION

The Motion for Leave to File Third-Party Complaint filed by defendants Unite Here Health and Nevada Healthcare Solutions should be denied, and their Motion to Consolidate should be dismissed as moot or else denied on its merits.

Dated this 29th day of March, 2021.

LEWIS ROCA ROTHGERBER CHRISTIE LLP

By: */s/ Daniel F. Polsenberg*
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## CERTIFICATE OF SERVICE

I certify that on March 29, 2021, I electronically filed and served the foregoing "*COMBINED RESPONSE TO MOTIONS (I) FOR LEAVE TO FILE THIRD-PARTY COMPLAINT AND (II) TO CONSOLIDATE*" through the Court's electronic filing system, electronic service of the foregoing documents shall be submitted upon all recipients listed on the master service list.

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# *EXHIBIT 1*

***DECLARATION OF MARK BENNETT TO PLAINTIFF'S COMBINED RESPONSE TO MOTIONS: (I) FOR LEAVE TO FILE THIRD -PARTY AMENDED COMPLAINT; AND (II) TO CONSOLIDATE***

# *EXHIBIT 1*

***DECLARATION OF MARK BENNETT TO PLAINTIFF'S COMBINED RESPONSE TO MOTIONS: (I) FOR LEAVE TO FILE THIRD -PARTY AMENDED COMPLAINT; AND (II) TO CONSOLIDATE***

**DECL**

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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,<br>Plaintiff,<br>v.<br>MILLIMAN, INC., *et al.*,<br>Defendants. | Case No. A-17-760558-B<br>Dept. No. 16 |
| STATE OF NEVADA, ex rel. Commissioner of Insurance, BARBARA D. RICHARDSON, in her Official Capacity as Receiver for NEVADA HEALTH CO-OP,<br>Plaintiff,<br>v.<br>SILVER STATE HEALTH INSURANCE EXCHANGE,<br>Defendants. | Case No. A-20-816161-C<br>Dept. No. 8<br><br>Hearing Date: April 14, 2021<br>Hearing Time: 9:00 a.m. |

## DECLARATION OF MARK F. BENNETT

I, Mark F. Bennett, declare under penalty of perjury:

1. I am an attorney with, and an authorized representative of, Cantilo & Bennett, L.L.P., the special deputy receiver for Nevada Health Co-op ("NHC" or the "CO-OP").

2. On August 25, 2017, Counsel for the Receiver filed in Clark County District Court a complaint (Case No. A-17-760558-C in Department No. 18) against individuals, third-party vendors, and professional service firms which

are alleged to have contributed to NHC's losses by failing to adhere to applicable standards of professional care and requirements imposed by law, misrepresentation concerning quality and standard of care for services performed, and breaches of contract, duty, and implied covenants of good faith and fair dealing. The complaint named NHC's former actuaries, accountants, auditors, and providers of certain business operations and utilization review services, including several of NHC former directors and executive management.

3. On July 17, 2018, the Receiver sought an order granting leave to amend the August 25, 2017, complaint against certain of NHC's various directors, officers, and third-party contractors, citing the discovery of additional facts in support of assertions made in the first complaint, and to add a new defendant, Unite Here Health ("UHH"), to the existing proceedings. The Motion to Amend Complaint was approved via an order entered on September 18, 2018. The above-referenced claims in this Amended Complaint are referred to herein as the Receiver's "Asset Recovery Litigation"--and the defendants therein will be referred to herein as the "Defendants."

4. There have been six trial settings in the Asset Recovery Litigation, with each scheduling order also changing the dates for expert reports and discovery. Three of those trial dates—May 20, 2019, October 14, 2019, and January 9, 2020 would have all occurred before COVID protocols were implemented in March 2020.[1] The case is now set for trial on May 16, 2022, under the fifth amended scheduling order, with final rebuttal expert reports due on April 16, 2021, and final discovery due before December 31, 2021. The Asset Recovery Litigation case would have been tried at least three times earlier but for the delays and distractions caused by UHH and Nevada Health Solutions, LLC ("NHS") as mentioned in this declaration.

[1] The other trial dates were October 5, 2020 under the third scheduling order, and May 3, 2021 under the fourth scheduling order.

5. As background, when the Receiver's expert reports came due on July 30, 2019, they were timely filed in this Asset Recovery Litigation. However, when the Defendants had to file their expert reports by August 24, 2019, they could not complete them on time and pleaded with the Court for more time—and received substantial extra time until June 9, 2020. Despite that significant June 9, 2020, deadline extension, the Defendants sought and received an additional extension from the Court by which to file their expert reports—*i.e.*, October 2, 2020. The filing of Defendants' expert reports was more than 14 months after the Receiver filed initial expert reports on July 30, 2019.

6. Before COVID protocols were put in place, the Receiver had taken depositions and was in the process of taking further depositions. On the other hand, the Defendants did not notice or take a single deposition in the Asset Recovery Litigation to learn or understand the case against them.

7. During the course of litigation, though, the Defendants have requested and received numerous rounds of written litigation discovery. The discovery process became open to the Defendants after the Court's first scheduling order on January 24, 2018--and became open to the UHH Defendant after it was added as a party in July 2018. Indeed, the UHH, NHS, InsureMonkey, and director and officer defendants have requested the following discovery since the case began:

> UHH—eight requests for production beginning on February 22, 2019 and ending on February 8, 2021. Three sets of interrogatories beginning on March 5, 2019 and ending on July 8, 2020.
>
> NHS (a subsidiary of UHH)-- one request for production on August 12, 2019. One set of interrogatories August 12, 2019.

InsureMonkey-- two requests for production beginning on July 23, 2018 and ending on September 24, 2019. Two sets of interrogatories beginning on July 23, 2018 and ending on September 24, 2019.

Director & Officers—eight requests for production beginning on October 23, 2018 and ending on October 10, 2020. Ten sets of interrogatories beginning on October 25, 2018 and ending on December 2, 2019.

8. To sustain the Asset Recovery Litigation, the Receiver has had to pay or incur the costs for the Greenberg firm, conflicts legal counsel, consultants, and experts. In addition, the Receiver has had to absorb the costs of maintaining a litigation database in Relativity, an electronic discovery platform, so that many millions of pages of documents could be made available to the Defendants during discovery under the Court's ESI protocol. The monthly cost of the CO-OP to maintain Relativity is approximately $25,000 per month, but these costs can increase markedly in any month when requests for discovery are made. As noted, the Defendants have made numerous discovery requests to the Receiver, much of which was legally objectionable. The expense of this litigation database is significant, and these costs are being prolonged and increased each time discovery is extended.

9. As acknowledged in the business plan for Hospitality Health, which was the corporate precursor to NHC, nearly all of NHC's day-to-day executives had direct personal and professional ties to UHH or its affiliates, such as the Culinary Health Fund.[2] That business plan is included herewith as Exhibit 1. These individuals included Kathy Silver (NHC Co-Chair and President of the Culinary Health Fund), Jeff Ellis (NHC Co-Chair and CFO of Corporate Benefits of MGM Resorts International, a UHH trustee), Tom Zumtobel (NHC CEO

[2] Exhibit 1, 18485-0000002798_0019, Nevada Hospitality Health CO-OP Business Plan.

and Vice President of Strategy for UHH), Bobbette Bond (NHC Chief Project Officer and Director of Public Policy of the Culinary Health Fund), and "D" Taylor (Donald Taylor, NHC board member and Secretary-Treasurer of Culinary Workers Union Local 226 in Las Vegas, and Vice-President and Gaming Division Director of UNITE-HERE). The Culinary Health Fund is tied to UHH, being the health fund for the Culinary Workers Union which UHH administers.

10. In several of NHC's 2014 board meetings, and in which UHH representatives were present and participated, the board discussed the Exchange and Xerox's handling of CO-OP enrollments, and they blamed the Exchange and Xerox for member enrollment processing issues and costs of NHC.

11. Included herewith as Exhibit 2 are the February 19, 2014, NHC Formation Board minutes, cited and relied upon by UHH themselves in their Motions, which detail the discussion about the CO-OP's challenges in processing enrollment through the State Exchange.[3] The Exchange and Xerox were also discussed at the April 29, 2014 meeting, the minutes of which are attached as Exhibit 3.[4] Issues with Xerox and the Exchange were further discussed at the May 24, 2014, NHC board meeting, the minutes of which are included herewith as Exhibit 4.[5]

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[3] Exhibit 2, 18485-0001266117_0007, February 19, 2014, Minutes of the Regular Meeting of the Formation Board of Directors of Nevada Health CO-OP. Attendees included Jeff Ellis, Bobbette Bond, Christine Carafelli (likely related to Ms. Bond, see https://healthienevada.org/christine-bond-carafelli/), Kathy Silver, Tom Zumtobel, and James Clough Esq. (Seyfarth Shaw, UHH's own legal counsel).

[4] Exhibit 3, 18485-0001266117_0003, April 29, 2014, Minutes of the Regular Meeting of the Formation Board of Directors of Nevada Health CO-OP. Attendees included Jeff Ellis, Bobbette Bond, Christine Carafelli, Kathy Silver, Tom Zumtobel, D. Taylor, and James Clough, Esq.

[5] Exhibit 4, 18485-0001266117_0015, May 23, 2014, Minutes of the Regular Meeting of the Formation Board of Directors of Nevada Health CO-OP. Attendees included Jeff Ellis, Christine Carafelli, and Tom Zumtobel.

12. Taken altogether, these minutes establish that UHH, through its various representatives who controlled NHC, knew all of the relevant details concerning the issues faced by Xerox and the Exchange. Within weeks of health plan launch in 2014, NHC and UHH were aware of the data transmission and consistency issues, the Exchange's internal discussions concerning replacements to Xerox, the responsibilities NHC would have to take on in the case that such a transition was made, the expenses likely to be incurred, the potential for filing or joining litigation against Xerox and the Exchange, and the effects on the CO-OP's own insureds. These same minutes also plainly state that NHC had internal discussions with legal counsel concerning the propriety of filing litigation or participating in pending litigation against Xerox and the Exchange for injuries sustained.

13. It is simply not believable that UHH only discovered Xerox and the Exchange's potential liability through discovery and expert reports in October 2020. A careful review of the CO-OP's internal records does not indicate that NHC elected to file or participate in litigation when the supposed injuries were sustained in 2014, but now when it may serve to delay or obstruct the instant litigation, the inclusion of Xerox and the Exchange is considered absolutely necessary. UHH had access to these board minutes, and all other NHC files, both through their numerous representatives contracted to the CO-OP, as well as from their direct participation in the board meetings themselves in 2014.

14. In 2020, while the CO-OP case had pended since August 25, 2017 (as to all defendants other than UHH) and July 2018 (as to UHH), UHH and NHS now state (in their October 15, 2020 Motion For Leave To File Third Party Complaint in the Asset Recovery Litigation) that, "discovery has revealed that two non-parties—Xerox and the Exchange—are responsible for a significant amount of the harm the CO-OP alleges it suffered from UHH's alleged conduct." UHH and NHS now seek contribution from Xerox and the Exchange under the

premise of some newfound information learned in discovery and from expert reports.

15. As noted, UHH and NHS (a subsidiary under the control of UHH before the CO-OP's receivership) were already well aware of NHC board members stated position in year 2014 that Xerox and the Exchange had caused enrollment issues and costs for the CO-OP, and UHH and NHS failed to take a single deposition in this case before COVID protocols occurred in March 2020—despite over a year and a half to do so.

16. On October 8, 2020, UHH and NHS filed their motion to disqualify the Greenberg firm from representing the Receiver and to disgorge the firm's prior paid fees. The claimed disqualification was on the basis of the Greenberg firm's representation of Xerox in another matter and in representing Valley Health System. The Asset Recovery Litigation had to thereafter be temporarily stayed pending the outcome of this motion in the receivership court. The motion to disqualify and disgorgement were heard before then receivership court Judge Kenneth Cory who by minute order on December 31, 2020, denied the relief requested by UHH and NHS. On February 8, 2021, Defendants UHH and NHS filed their Notice of Appeal, seeking review of the Order Denying the Motion to Disqualify Greenberg Traurig, LLP and to Disgorge Attorneys' Fees. They also filed a Petition for Extraordinary Writ Relief with the Nevada Supreme Court on February 25, 2021. On March 12, 2021, the Receiver filed an opposition to the writ petition proceedings and Countermotion to Dismiss Appeal.

17. Adding Xerox and the Exchange to this Asset Recovery Litigation will delay, distract from, and substantially increase costs of this Asset Recovery Litigation. These are not the first motions or actions taken by these parties to delay and distract this case. As noted, UHH and NHS unsuccessfully tried to disqualify the Greenberg firm with no basis pursuant to Judge Cory's order.

Similarly, in the past, UHH and NHS have requested and requested again and again that expert reports be delayed. They filed objections to the sale of the risk corridor receivable in the NHC receivership court action. Recently, they filed objections to the rates and retention of the Lewis Roca law firm as conflicts counsel to the Receiver, despite no standing for bringing such objection.

18. As well, in this Asset Recovery Litigation, they have filed a motion to seek attorney client discoverable information, a motion to consolidate the Receiver's action against the Exchange into this Asset Recovery Litigation case, and have filed an appeal and writ of Judge Cory's order on their rejected (and unsupported) effort to disqualify the Greenberg Traurig law firm from prosecuting this Asset Recovery Litigation.

19. The Receiver's case against the Exchange (the "Receiver's Exchange Litigation") is for mere breach of contract that insurance premiums were not remitted to the CO-OP by the Exchange, which is much different than the far more encompassing claims for contribution sought by UHH and NHS.[6] The Scheduling Order for the Receiver's Exchange Litigation is as follows: initial expert reports due May 10, 2021, rebuttal expert reports by June 11, 2021, discovery deadline of July 16, 2021, and trial date of November 15, 2021. The Receiver filed the Receiver's Exchange Litigation on June 5, 2020, and the Receiver fully expects this litigation to be tried on November 15, 2021, if not resolved sooner. The Receiver seeks $510,651.27 of uncollected premiums from the Exchange, which is a recovery of funds needed for the receivership estate.

[6] The contribution claims against Xerox and the Exchange are for amounts that UHH and NHS may ultimately pay the Receiver for the demise of NHC and dissipation of its assets.

20. The NHC receivership began on October 1, 2015. Unpaid member and healthcare provider claims of the CO-OP, which are the current claim priorities to be paid, total in the tens of millions. These CO-OP claims have been unpaid since the receivership began in October 2015, with many millions of the CO-OP's funds dissipated because of the Defendants' pre-receivership actions. The funds recovered from the Asset Recovery Litigation will enable further distributions to these deserving claimants who have waited more than five years for distributions of their outstanding claims.

21. The CO-OP is not a private corporation where shareholders just bear the losses of the organization. It is a non-profit member owned company, which is deeply insolvent because of the Defendants' actions. Hospitals and doctors agreed to provide medical services to members of the CO-OP, believing that the CO-OP would honor its obligations. Money spent in the Asset Recovery Litigation is the use of member and medical provider funds, not the use of a stockholder's money. As mentioned, member and medical provider claimants have waited years for financial distributions from the CO-OP receivership estate, and these distributions are very dependent on litigation recoveries and avoiding the dissipation of receivership estate assets. For these reasons, it is imperative that no new parties be added to the Asset Recovery Litigation to further complicate or delay existing litigation schedules, which would also drain the few precious remaining resources of the CO-OP to properly maintain its litigation. It is also imperative that the limited case against the Exchange proceed quickly to trial to allow recovery of payments that can be distributed to claimants.

22. I declare under penalty of perjury perjury under the law of the State of Nevada that the foregoing is true and correct (NRS 53.045).

Dated this 29th day of March, 2021.

MARK F. BENNETT

# EXHIBIT 1

# EXHIBIT 1

HospitalityHealth LLC

# BUSINESS PLAN

The Business Plan for the Hospitality Health Co-op (HHC) is based on the sponsors' experience in running an effective, efficient Taft-Hartley healthcare plan since 1979.

The HHC will build on the experience of UNITE-HERE HEALTH in providing access to high quality care for low-income people in Nevada through the Culinary Health Fund (CHF). Rather than create barriers to appropriate care, CHF promotes care through:

- Providing staffing to facilitate the adoption of integrated care models;
- Encouraging preventive care;
- Encouraging early diagnosis and treatment;
- Encouraging good management of chronic diseases; and
- Removing barriers to use of health plan benefits through such innovations as a "free" pharmacy, guaranteed appointments within 24 hours, and through plan-employed case managers and health navigators who help participants effectively utilize care.

The CO-OP will benefit from strategic partnerships with other organizations that set the standards for high quality, affordable health care at a higher level of service and a better price than elsewhere in the industry. Dr. Arnold Milstein, currently directing the Clinical Excellence Research Center at Stanford University, has been a consultant to UNITE HERE HEALTH for over five years. He and the team he selects will provide assistance in the development of new clinical service designs that improve health and patients' experience of their care, while lowering annual per capita health-care spending.

# SECTION A: MANAGEMENT TEAM

The development team has selected a highly qualified management team to lead the Hospitality Health CO-OP through the further planning and implementation of the organization, including contracting with providers, enrolling members, managing service delivery, paying claims, reviewing experience to improve quality and efficiency, and assisting members in obtaining all needed services. The organizational structure was designed in consultation with Culinary Health Fund staff members who helped identify essential elements to assign as high priorities for leadership within the organization, and those elements that might be efficiently and effectively contracted out to vendors. Well-qualified management team members, all of whom have significant experience with the Culinary Health Fund and have trained their successors so that they may migrate to the new CO-OP, have been enlisted to operate the new entity.

**Please see attached Organizational Charts, position descriptions and resumes.**

## *CHIEF EXECUTIVE OFFICER: TOM ZUMTOBEL*

The Chief Executive Officer will have overall responsibility for leading the HHC. This will include coordination of all departments, policy development internally and with outside entities (government, sub-contractors, trade organizations, consumer groups) and ensuring the quality and cost-effectiveness of services. The Chief Executive Officer will also be responsible for working with the Formation Board to effect a smooth and timely transition to the Operational Board, including conduct of elections among CO-OP members to seat a member-elected Board of Directors to govern the CO-OP after the first year.

Tom Zumtobel is a nationally recognized leader in healthcare financing. Mr. Zumtobel is Vice President of Strategy for UNITE HERE HEALTH after five years of leadership as President of the Culinary Health Fund. Tom designed and implemented the in-sourcing of the Fund's PPO network of more than 2,500 providers, the development of a Fund-employed network of Nurse Case Managers and Patient Advocates, and the expansion of a robust data analysis system. These innovations created a direct service and communication channel with providers, resulting in improved quality of care at a lower cost to the Fund.

## *CHIEF OPERATING OFFICER: TO BE HIRED*

The Chief Operating Officer will oversee the service delivery components of the CO-OP's business. The key components of this work include relations with CO-OP members and with care providers. The Chief Operating Officer will be responsible for negotiating agreements with clinical and non-clinical service providers, both outpatient and inpatient, and for provider credentialing. The claims processing function will also be under the jurisdiction of the Chief Operating Officer. This position has extensive responsibility for all clinical and non-clinical relationships with CO-OP members, including outreach, enrollment, client advocacy and case management functions, all of which are central to the mission of the CO-OP. The Chief Operating Officer is tasked with the efficient and effective operation of the CO-OP so that members are able to use their health plan to obtain high quality services, and that providers are dedicated to the care of CO-OP members through clear understandings of CO-OP expectations,

simple procedures for approval of deviations from standard protocols, and timely payment of claims.

## *CHIEF FINANCIAL OFFICER: KEVIN GITTENS*

The Chief Financial Officer is focused on managing the income necessary to fund the administration, services and claims of the HHC. An early responsibility of the Chief Financial Officer will be establishing a system for obtaining federal subsidies for the cost of premiums for HHC members, and managing the collection of premiums from those members who wholly or partially pay their own premiums. The Chief Financial Officer will also work with the management team to design and market a small business-targeted health plan during the first five years of CO-OP operation. Actuarial projections and ongoing cost analysis will be provided by the Chief Financial Officer to guide the CO-OP's business planning and benefits designs. The Board of Directors will receive and approve an annual budget for the CO-OP, and will work with the Chief Financial Officer to track spending during each fiscal year and make any necessary adjustments to ensure the plan's effectiveness in meeting the needs of its members.

Kevin Gittens has served as the Chief Financial Officer for UNITE HERE HEALTH since 1992, where he is responsible for all financial analysis and underwriting pertaining to the funding requirements of the Fund, maintaining a balance between the negotiated contract contribution rates and the cost of providing health care for the collective bargaining parties and the member participants, and all financial reporting and tracking with respect to compliance with funding requirement s and the Fund's reserve policy. Prior to joining the Fund, Mr. Gittens spent eight years as an underwriter at Metropolitan Life Insurance Company, with unlimited underwriting authority across all lines of health coverage, and six years as a consultant with The Segal Company in Chicago, where he developed and staffed the group benefits analyst and underwriting position in the Chicago Office, and was responsible for all underwriting and financial analysis for Segal's Chicago clients.

## *CHIEF PROJECT OFFICER: BOBBETTE BOND*

The Chief Project Officer has primary responsibility for compliance with all legal and regulatory requirements of a CO-OP participating on the Silver State Exchange. The Chief Project Officer will work with the Nevada Department of Insurance to ensure the CO-OP is fully adhering to Nevada and federal law, and will be responsible for all regulatory reports and legal requirements. The Chief Project Officer will also oversee participation in community partnerships, interaction with the Silver State Exchange, and policy collaboratives. Development of the CO-OP innovations will also include the Chief Project Officer. The Chief Project Officer will serve as the CO-OP's Authorized Organizational Representative (AOR) to the Centers for Medicare and Medicaid Services and the Center for Consumer Information and Insurance Oversight.

Bobbette Bond, MPH is Executive Director of the Nevada Healthcare Policy Group and Director of Public Policy of the Culinary Health Fund. A specialist in health care quality improvement, cost containment, and access to care, Ms. Bond is also the Healthcare Policy Liaison for the Health Services Coalition, a group of 24 self-funded health plans in Southern Nevada that contracts as a group with hospitals in the service area.

## *CHIEF HEALTH INFORMATION OFFICER: PEI TANG*

The Culinary Health Fund has achieved high levels of quality and efficiency through a dedication to analysis of all the information available to it as a health insurer. The development team believes that the ability to maintain high quality health care in an environment of limited resources is dependent upon sophisticated analysis of available information both within the plan and outside the plan, such as health behavior surveys and adoption of evidence-based practices. The Chief Health Information Officer will provide this leadership. The CHIO will also have primary responsibility for the adoption of electronic health records and other health information technology by the CO-OP, in an environment new to these now-standard practices. In recognition of the essential nature of health information and the effort required to implement among Nevada providers as the Silver State Exchange begins to make health care coverage available to all state residents, this position will be a key member of HHC's management team.

Pei Tang is the Vice President, Healthcare Informatics and Outcomes of ALERE, a leading innovator in patient-centered health management. Ms. Tang was the architect of the company's nationally recognized Healthcare Informatics function, which informs the development of diagnostic and disease management products.

## *MEDICAL DIRECTOR: TO BE HIRED*

The Medical Director is the clinical leader of the CO-OP. The Medical Director is actively involved in continuously re-shaping care to improve patient satisfaction, improve health outcomes, and decrease combined health spending within the CO-OP's membership. The Medical Director makes specific and detailed policy recommendations to the Board of Directors, and gives procedural direction to the implementing staff. The Medical Director is a principal contact with providers in the CO-OP network.

The Medical Director will have an unrestricted medical license in the State of Nevada, and certification in at least one specialty recognized by the American Board of Medical Specialties. He or she will have at least ten years of clinical practice coupled with participation in a leadership role in a medical, insurance, or other related organization responsible for managing healthcare delivery systems, and will be an expert in current benefits laws and regulations.

Please see resumes of management team members in Appendix C.

## *FORMATION BOARD OF DIRECTORS*

The Formation Board of Directors is comprised of individuals with diverse expertise in health care benefits administration, all of whom have considerable experience as part of the Board, management staff, and legal team of the Culinary Health Fund. Members of the Board, which met on December 10, 2011, include:

- **Kathy Silver, Co-chair**
  President of the Culinary Health Fund, and most recently the Chief Executive Officer of University Medical Center, the only public hospital in Southern Nevada.

- **Jeff Ellis, Co-chair**
  Vice-President and CFO of Corporate Benefits of MGM Resorts International.

- **Tom Zumtobel**
  Appointed CEO of the Hospitality Health Coop, and the Vice President of Strategy for UNITE HERE HEALTH.

- **Bobbette Bond, Secretary**
  Appointed Chief Project Officer of the Hospitality Health Coop and the Executive Director of the Nevada Healthcare Policy Group.

- **Andy Brignone**
  Shareholder in the law firm Brownstein Hyatt Farber Schreck specializing in employee benefits law, and a member of the Health Services Coalition Executive Committee for ten years.

- **Betsy Gilbertson**
  Chief of Strategy for UNITE HERE HEALTH, former President of the Culinary Health Fund, and former Co-Chair of the Health Services Coalition.

- **D. Taylor**
  Secretary-Treasurer of Culinary Workers Union Local 226 in Las Vegas, and Vice-President and Gaming Division Director of UNITE-HERE.

## *KEY SPONSORS*

The Hospitality Health CO-OP is sponsored by UNITE HERE HEALTH, the Culinary Health Fund in Las Vegas, and the Nevada Health Services Coalition.

## *CONTRACTORS*

**Culinary Health Fund**

- Health care management
- Data warehouse
- Staff development
- Finance

- Contracting
- Hosting of board meetings (in-kind)
- Provider profiles (in-kind)
- Network access (in-kind)
- Marketing (in-kind)

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.

**UNITE-HERE HEALTH**

- Claims
- Call center
- Enrollment
- New data warehouse

HHC will subcontract the initial plan enrollment, administration and management to UNITE HERE HEALTH through its Las Vegas office, the Culinary Health Fund. The Las Vegas fund serves the highest concentration of UNITE HERE members in the nation, and has substantial locally-sourced service enhancements through its office on the Strip in the heart of Las Vegas.

UNITE HERE HEALTH is a multi-employer Taft-Hartley fund founded in 1979. The non-profit fund administers self-funded benefits to which plan members are entitled under collective bargaining agreements negotiated by unions. The organization is governed by a Board of Trustees that includes equal membership by employee representatives and employer representatives from companies including Hyatt Hotels, Harrah's, Starwood, MGM, Boyd Gaming, and Tishman.

**Health Services Coalition**

- Hospital network

HHC will also join the Health Services Coalition (HSC), a 23-member purchasing council of self-funded plans led by CHF. The Coalition negotiates hospital and pharmacy contracts with providers in the Las Vegas area. HSC contracts include reporting requirements, quality metrics, and patient satisfaction indices.

**Milliman**

- Actuarial services

HHC will subcontract with Milliman for actuarial services in support of premium pricing, targeting, policy development, and budgets.

**InsureMonkey and Ceridian Exchange Services, LLC**

- Online enrollment linked to Silver State Exchange

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

HHC will use the existing CHF contract, or independently contract with American Health Holding (AHH) for utilization management services, medical review, independent external review, and out-of-network repricing and negotiations.

**Catalyst Rx**

- Pharmacy benefits management

The CO-OP will use the existing CHF contract, or independently contract with Catalyst Rx, as its Pharmacy Benefits Management (PBM) partner.

## *CONSULTANTS*

**Insurance Licensing Services: to be determined**

Hospitality Health CO-OP will obtain the services of a consultant during the first two years to assist in compliance with all necessary requirements for health plan licensure in Nevada.

**Clinical Service Improvements: Arnold Milstein, MD, MPH and Brain Trust**

Dr. Milstein will consult with the CO-OP on lowering costs through improvements in quality of care. Dr. Milstein is the Medical Director of the Pacific Business Group on Health (PBGH), the largest regional health care improvement coalition in the U.S. He is a Professor of Medicine at Stanford University, and has established the Clinical Excellence Research Center at Stanford, a transdisciplinary research center composed of faculty from Stanford's business, engineering and medical schools working in collaboration to develop new clinical service designs that improve health and patients' experience of their care, while lowering annual per capita health-care spending. These service designs are intended to form the basis of new "best practices" and standards of care in medical care delivery, quality assurance management, and reimbursement practices. Dr. Milstein will bring a "brain trust" of health care financing and quality improvement experts who include Dr. Alan Glaseroff, an expert in rural health; Dr. Molly Coye, Chief Innovations Officer of the UCLA Health Center; and Dr. David Lawrence, former Chairman and CEO of Kaiser Foundation Health Plan. Biographical sketches of these individuals are attached in Appendix D.

**Marketing Consultant: Richard Ross**

The Culinary Health Fund will contribute the services of Richard Ross, a top marketing consultant who creates effective campaigns to engage and educate the diverse, low- and moderate-income people who comprise the target market for the CO-OP. Ross will work with HHC during the planning phase (2012-2013) to develop the educational messages that will introduce HHC to Nevada residents who will be selecting health insurance plans from the Silver State Exchange.

# SECTION B: PROVIDER ARRANGEMENTS, TARGET MARKETS AND PRODUCTS

Plan management competence is essential in our competitive health care market, which has a highly consolidated health insurance market, a predominantly for-profit health care industry, and a large percentage of both uninsured families and low income households.

In the population center of northern Nevada (Washoe County), there are primarily non-profit hospitals and two hospital-owned health plans. In rural frontier Nevada, population density is sparse - all health care resources are limited and many are nonprofit. By stark contrast in the south (Clark County), both the health insurance market and the hospital systems are heavily dominated by a small number of national investor-owned companies that extract profit from the state and build little community capacity. There is no nonprofit health care coverage other than the public health programs (Medicare, Medicaid, NV Check Up, and the Clark County Indigent Fund). There is one public hospital.

**The Hospitality Health CO-OP proposes to initiate services in Southern Nevada (the Las Vegas area, comprising Clark County and Nye County) in 2014. Northwest Nevada (Washoe County) will be added in 2015, and the balance of the state will be added in 2016.**

## *NEVADA GEOGRAPHY AND POPULATION: A SNAPSHOT*

Geography and population density divides Nevada into three distinct geographic areas – Southern Nevada, Northern Nevada, and rural land in between - still known as the Frontier.

The target market for the Hospitality Health Coop is the state of Nevada, the 7th-largest state in nation (110,560 square miles). Nevada is largely comprised of arid and semi-arid lands, with much of the state's southern area located within the Mojave Desert. The northwest portion of Nevada is in the Sierra Nevada mountains, and the northern and central parts of the state are in the Great Basin.

Nevada's population of 2.7 million ranks 35th among the 50 states. **Over 70% of Nevada residents** live in Clark and Nye counties, which comprise Las Vegas metropolitan area. About 20% of residents live in Washoe County (Reno) and Carson City, which is the state capital. The remaining 10% are widely dispersed in small and moderate-sized communities.

The Las Vegas area is the fastest-growing area in the U.S. The combined population of Clark and Nye counties in 2000 was 1,408,250; by 2010 it had increased 41.6% to 1,995,215. This growth means that many Las Vegas-area residents lack the community and family ties that support effective use of health services, such as a personal physician, family members who can help care for people who are ill, and logistical support (babysitting, rides to the doctor) that helps ensure that individuals get the care they need.

Clark County's population is 29.1% Latino, with 31% of individuals speaking a language other than English in their homes, indicating a need to provide health services in Spanish and other languages. In addressing complex and detailed medical issues, nationally-recognized best practices require medical discussions to be conducted in the language in which the patient is most comfortable.[1]

In October, 2011, the Las Vegas SMSA had an unemployment rate of 13.4%. The state of Nevada consistently has the highest unemployment rate in the U.S. as the economic crisis has greatly impacted the convention business, vacation travel, and the gaming industry.

Southern Nevada's economy is overwhelmingly dependent on the hospitality industry. Seasonal differences in tourism affect employment for individuals whose hours may fluctuate based on hotel occupancy, conventions, and the weather. During the current recession, Nevada's unemployment rate is the worst in the nation at 13.4%[2] as convention business, vacation travel, and the gaming industry struggle with the current economic crisis.

The cities of Reno, Lake Tahoe and Carson City, also dependent on hospitality and gaming, have some jobs based in mining and oil extraction. The hospitality industry employs 300,000 workers, or 27% of Nevada's 1.1 million member labor force.[3]

## *HEALTH STATUS IN NEVADA: A SNAPSHOT*

Nevada has documented health disparities by both race and income; minorities and persons of lower incomes have worse-than-average health statuses. Issues of health for minority and low-income individuals are of key importance in Nevada, where nearly 45% of the state's population is non-white and a higher percentage of minority individuals experience poverty.[4] Furthermore, the Kaiser Family Foundation "State Health Facts" website rates health disparity in Nevada by race/ethnicity/gender at 2.15, as compared to a score of 1.99 nationwide.[5] The Department of Health reports that the greatest health disparities exist by income and race.[6] African Americans have the worst rates for diabetes deaths, nephritis, septicemia, and homicide, as well as a higher-than expected (as compared to national averages) rate of deaths from heart disease.

Nevada is ranked 47th among the 50 states by the Commonwealth Fund State Scorecard for Health, 2009, [7] ranking low in three of the four measures.

- Nevada ranks #51 in **Prevention and Treatment** (measured by the individual having a medical home, children receiving immunizations, medical and dental screenings, and patients receiving written instructions upon discharge from the hospital). Lack of health care coverage and the cost of medical visits (including co-pays) present barriers to obtaining needed prevention and treatment.

[1] Chen, Alice Hm, M.D., Language Barriers in Health Care Settings: *An Annotated Bibliography of the Research Literature,* The California Endowment, 2003.
[2] www.bls.gov/LAU, October, 2011
[3] Nevada Resort Association, "The Facts About Gaming in Nevada", February, 2011.
[4] http://health.nv.gov/MinorityHealth/minority_rpt.pdf
[5] http://www.statehealthfacts.org/profileind.jsp?cat=15&rgn=30
[6] http://health.nv.gov/MinorityHealth/minority_rpt.pdf
[7] www.commonwealthfund.org

- Nevada ranks 47th in **Access,** largely due to the high rate of uninsured people, including children. Nevada ranks #37 in the percentage of adults who needed to see a doctor by could not afford to.
- Nevada ranks better in **Avoidable Hospital Use and Costs** at 27th, despite poor performance on Medicare indices. This is partially due to the current high proportion of self-funded health care plans that provide affordable cost share to employees at employment with collective bargaining agrrements.
- Nevada ranks 39th for **Healthy Living**, 49th in suicides, 38th in colorectal cancer deaths, and 37th in adults who smoke.
- For several other key indicators of health access and the quality of care, Nevada is well below the national norm. The following chart illustrates some of these disparities:

**Nevada Health Disparities**[8]

| Indicator | Nevada | U.S. |
|---|---|---|
| Prenatal care: percentage who obtained care in first trimester of pregnancy | 71.5% | 83.2% |
| Influenza and pneumonia: death rate per 100,000 | 18.4 | 16.2 |
| Heart disease death rate per 100,000 | 200 | 190 |

Nevada residents have lower rates of education and higher rates of illiteracy than other states with similar ethnicities in the population.[9] People who do not speak English have a difficult time finding health care providers who can communicate with them in their native language, and in this population, the use of children to translate often results in under-reporting of symptoms and difficulty in communicating severity on both sides (doctor and patient).

## *THE NEVADA HEALTH CARE AND COVERAGE MARKET: A SNAPSHOT*

**Health Care:** Nevada's health care system differs from other states in several significant ways. The system is heavily based in the **investor-owned** health care sector, with few non-profit options among hospitals, health plans, or physician groups. While most states have non-profit health plans and hospitals that were founded by faith communities or universities, Nevada's hospitals are predominantly investor-owned, for-profit entities. There is a large population that is **uninsured.** Quality of medical services is low, and **access to** affordable, quality health care in Southern Nevada is among the worst in the United States. A 2006 study by the United Way of Southern Nevada,[10] had the following findings:

- Health care in southern and rural Nevada is characterized by critical resource shortages. Fifty five census tracts in Clark County are designated as Medically Underserved, and have serious shortages of primary care, dental care, and mental health professionals. One out of every six children has no health insurance coverage.
- Respondents to the United Way survey identified access to healthcare, the ability to afford prescription medication, and lack of health insurance coverage as their top concerns.
- Feelings of anxiety, stress, and depression were major personal issues identified by respondents to the United Way survey. The HHC plan design addresses these issues in

[8] Kaiser Family Foundation, statehealthfacts.org.
[9] U.S. Census, 2010, quickfacts.census.gov
[10] United Way of Southern Nevada, Southern Nevada Community Assessment, 2007.

several ways, including the use of health navigators to build personal relationships with HHC members to improve utilization and to help members overcome barriers to treatment compliance.

- Concern about financial issues and the fear of unanticipated needs such as medical problems is a constant for many Southern Nevada families, who have little or no discretionary spending capacity.

**Health Care Coverage:** A more complete summary of the number of uninsured residents in Nevada is included in Section D with the Enrollment strategy. For those with insurance, the Nevada health insurance market is predominantly self-insured. Employer-paid self-insurance plans cover 62% of covered lives. Seven carriers dominate the current market for individual and small group policies in Nevada. **UnitedHealth Group** is a stockholder-owned company that represents the largest number of people covered in Nevada. **Wellpoint, Inc.** was founded in 1982 with the consolidation of Blue Cross of Northern California (established in 1936) and Blue Cross of Southern California (established in 1937). WellPoint was formed in 1992 to operate Blue Cross of California's managed care business. In 1993, Blue Cross of California spun off its managed care business into a separate publicly traded entity, WellPoint Health Networks Inc. In 1996, Blue Cross of California completed the conversion of all its business to for-profit status, resulting in a restructuring that designated WellPoint Health Networks Inc. as the parent organization. Aetna Group, founded in 1850, is a large, national, for-profit carrier with a variety of health management subsidiaries. Assurant Group, based in New York, sells property insurance in addition to health, life, disability, and dental insurance. **Humana** is a large, for-profit company specializing in health insurance and health solutions. **St. Mary's Health Care Corp group**, affiliated with the Catholic Healthcare West hospital group, is a health insurance company affiliated until recently with St. Mary's Medical Center in Reno. The Medical Center is currently being sold to Community Health Systems, a for-profit corporation, but the insurance group has said it will remain unchanged. **Principal Financial Group** is a publicly traded corporation, formerly Bankers Life Association, based in Des Moines, Iowa.

Currently there are 37 carriers who offer individual, small group, and fully insured large group coverage in Nevada. HHC plans to offer individual and small group coverage both on and off the Exchanges. HHC also intends to offer large group coverage. The majority of HHC's membership is expected to come from the individual Exchange market and from low-income employees in the hospitality industry, who will be encouraged to join HHC. The Nevada insurance market currently has two carriers, UnitedHealth Group and Wellpoint, with a large percentage of the market (74% individual, 67% small group, and 80% large group). The rest of the market is composed of carriers with market penetration rates of 9% or less.

Exhibit 8 in Appendix F shows covered lives at the end of 2010 by carrier in individual, small group, and large group fully insured health insurance markets for Nevada. These data were obtained through Insurance Analyst Pro®, a product of Highline Data, LLC.

## *TARGET MARKET*

Exhibit 9 in Appendix F presents the combined projected market size by market segment and income-to-federal poverty level ratio for Nevada for the period immediately prior to Exchange implementation as well as for 2014-2016. This exhibit is an output of Milliman's enrollment

forecasting described in the enrollment forecast section of Section D of the Business Plan. These counts can be interpreted as the potential pool of members for which HHC will be competing. Note that several of the line items in this exhibit pertain to CHF members, current and former. These include a split out of self-insured members with CHF versus the rest of the self-insured market, and persons seeking coverage on the individual Exchange who were previously CHF members versus the rest of the persons on the individual Exchange. Because of the sponsoring relationship between CHF and HHC, population projections show the CHF membership specifically in order to track potential movement of members from CHF to HHC.

We have shown three sets of market figures that are needed for the scenario testing of enrollment projections. The low scenario includes the presence of a Basic Health Plan offering, which will reduce the pool of potential members by removing people in the individual and uninsured populations with income under 200% FPL. The presence of a Basic Health Plan would also deter CHF from encouraging its lower income members from seeking coverage with HHC since these members would be funneled to the Basic Health Plan, so former CHF members are not shown moving to the individual Exchange in this scenario. The low scenario also excludes the possibility of employers terminating their employer-sponsored insurance plans, which further reduces the projected number of potential CO-OP members.

Nevada faces unique challenges due to the fact that the state has been especially hard-hit by the economic downturn of the past several years. This has a significant impact on employer-sponsored insurance. For those who do have employer-sponsored insurance, the department of health reports that a disproportionate number are white. Likewise, a higher proportion of minorities are uninsured.

It is clear that the target market for the CO-OP will be a challenging one – the market is mixed, with large numbers of individuals who have struggled to find health insurance. Their needs are unknown since they do not appear in most claim databases. They range from educated and familiar with insurance to those who find the system difficult, overwhelming, and confusing. In order to be successful with this mixed and varied group, the CO-OP will need to be flexible, responsive, and able to provide information in a manner that the individual finds respectful and comfortable.

## *PRODUCT OFFERINGS*

HHC plans to offer a qualified health plan at the bronze, silver, gold, and platinum levels on the individual market Exchange. Further, HHC intends to offer at least one plan in the small group market outside the Exchange. Thus, to meet the requirements outlined in the FOA, HHC will offer at least one silver and gold benefit plan in each Small Business Health Options Program (SHOP) in its market. The product offerings will be designed to meet the benefit requirements in each Exchange and be attractive in the marketplace alongside competitor plans. Exhibit 11 presents a summary of potential plan designs that would meet the actuarial present value requirements of the Affordable Care Act. The actual benefit designs of the plans offered both on and off the Exchanges will likely vary from these presented here as regulations make requirements and options clearer.

For large groups, HHC intends to work with the sponsoring employers to design benefit plans that meet the needs of their employees and results in the least amount of coverage disruption.

Because of HHC's existing relationship with the CHF and providers in the Nevada market, large group coverage is likely.

## *PROCESS FOR DETERMINING APPROPRIATE PREMIUMS*

HHC's rate-setting strategy will be to generate adequate revenue to cover its costs and to repay its loans. Once target capital levels have been established and progress has been made on reducing the solvency loan balance, it is HHC's intent to reduce premiums to a level commensurate with expenses such that the members see an immediate benefit in the form of premium reductions.

HHC plans to use a standard actuarial process for setting premiums that considers the care delivery approaches in place at the time of rate setting. This includes developing a manual rate, which reflects a base period of claims projected forward to the future rating period. HHC will apply typical adjustments to project the base period claims to the future rating period, including, but not necessarily limited to health care trend, benefit plan changes, changes in the mix of age and gender, and geographic changes. HHC plans to estimate group-specific claims using the manual rate formula and the group's experience.

## *TIMELINE FOR ASSEMBLING A PROVIDER NETWORK*

HHC will utilize the current 2,213 physicians, 586 pharmacies, and 1,275 ancillary professionals who form the provider network in Southern Nevada developed by CHF. Physicians, hospitals, skilled nursing facilities, physical therapists, pharmacies, mental health professionals and other ancillary providers have been credentialed and are already submitting claims and utilization data to CHF. Current contracts allow assignment of contract provisions to additional covered groups administered by CHF, and these contracts will be amended to include claims for services provided to CO-OP members. CHF will provide access to its network for CO-OP members without the payment of the customary access fee of $1 per month per member.

The CHF provider network is comprehensive and robust. The current Provider Directory can be accessed at http://www.culinaryhealthfund.org/Participants/ProviderSearch/PPO_Directory.aspx, and attached in the Appendices. Current staffing levels are detailed on the following table:

**COMPARATIVE STAFFING RATIOS - 2011**

| Specialty | # Culinary Physicians (6/11) | Age-appropriate Population (6/11) | Culinary FTE's per 100,000 | Physician Workforce in Nevada - 2011* | | |
|---|---|---|---|---|---|---|
| | | | | Staff Model FTE's per 100,000 | Las Vegas FTE's per 100,000 | United States FTE's per 100,000 |
| ALLERGY/IMMUNOLOGY | 5 | 118,731 | 4.2 | 1.4 | 0.6 | 1.3 |
| ANESTHESIOLOGY | 226 | 118,731 | 190.3 | 9.1 | 14.2 | 13.6 |
| ANESTHESIOLOGY - C.R.N.A. | 15 | 118,731 | 12.6 | --- | --- | --- |
| AUDIOLOGY | 8 | 118,731 | 6.7 | --- | --- | --- |
| CARDIOLOGY | 100 | 72,102 | 138.7 | 5.0 | 5.2 | 7.0 |
| CARDIOLOGY - PEDIATRIC | 13 | 46,629 | 27.9 | --- | 0.4 | 0.6 |
| CARDIOVASCULAR/THORACIC SURGERY | 26 | 118,731 | 21.9 | --- | 1.3 | 1.4 |
| COLON/RECTAL SURGERY | 5 | 118,731 | 4.2 | --- | 0.2 | 0.5 |
| DERMATOLOGY | 43 | 118,731 | 36.2 | 2.6 | 2.0 | 3.6 |
| EAR, NOSE AND THROAT | 30 | 118,731 | 25.3 | 3.0 | 1.7 | 3.3 |
| EMERGENCY MEDICINE | 141 | 118,731 | 118.8 | 5.2 | 9.6 | 10.2 |
| ENDOCRINOLOGY | 12 | 72,102 | 16.6 | 1.0 | --- | --- |
| ENDOCRINOLOGY - PEDIATRIC | 3 | 46,629 | 6.4 | --- | --- | --- |
| ENDOCRINOLOGY - REPRODUCTIVE | 4 | 37,542 | 10.7 | --- | --- | --- |
| GASTROENTEROLOGY | 43 | 72,102 | 59.6 | 2.9 | 2.7 | 4.0 |
| GASTROENTEROLOGY - PEDIATRIC | 6 | 46,629 | 12.9 | --- | --- | --- |
| GENERAL SURGERY | 71 | 72,102 | 98.5 | 8.8 | 8.2 | 11.9 |
| GENERAL SURGERY - PEDIATRIC | 7 | 46,629 | 15.0 | --- | --- | --- |
| GENERAL VASCULAR SURGERY | 4 | 118,731 | 3.4 | --- | 0.0 | 0.0 |
| GENERAL/FAMILY PRACTICE | 193 | 118,731 | 162.6 | 42.6 | 21.3 | 30.1 |
| GYNECOLOGIC ONCOLOGY | 8 | 37,542 | 21.3 | --- | --- | --- |
| GYNECOLOGY | 7 | 37,542 | 18.6 | --- | --- | --- |
| HEMATOLOGY/ONCOLOGY | 51 | 72,102 | 70.7 | 2.4 | --- | --- |
| HEMATOLOGY/ONCOLOGY - PEDIATRIC | 4 | 46,629 | 8.6 | --- | --- | --- |
| INFECTIOUS DISEASE | 22 | 72,102 | 30.5 | 0.6 | --- | --- |
| INFECTIOUS DISEASE - PEDIATRIC | 2 | 46,629 | 4.3 | --- | --- | --- |
| INTERNAL MEDICINE | 208 | 72,102 | 288.5 | 20.0 | 37.0 | 49.4 |
| NEONATOLOGY | 24 | 37,542 | 63.9 | --- | --- | --- |
| NEPHROLOGY | 53 | 72,102 | 73.5 | 1.3 | --- | --- |
| NEPHROLOGY - PEDIATRIC | 2 | 46,629 | 4.3 | --- | --- | --- |
| NEUROLOGY | 33 | 72,102 | 45.8 | 2.3 | 2.7 | 4.6 |
| NEUROLOGY - PEDIATRIC | 4 | 46,629 | 8.6 | --- | --- | --- |
| NEUROSURGERY | 21 | 118,731 | 17.7 | 1.0 | 1.1 | 1.8 |
| OB/GYN | 132 | 37,542 | 351.6 | 11.3 | 10.7 | 13.5 |
| OPHTHALMOLOGY | 66 | 72,102 | 91.5 | 5.5 | 3.7 | 5.8 |
| OPHTHALMOLOGY - PEDIATRIC | 4 | 46,629 | 8.6 | --- | --- | --- |
| ORAL SURGERY | 5 | 118,731 | 4.2 | --- | --- | --- |
| ORTHOPEDIC SURGERY | 109 | 72,102 | 151.2 | 6.4 | 5.2 | 8.0 |
| ORTHOPEDIC SURGERY - PEDIATRIC | 5 | 46,629 | 10.7 | --- | --- | --- |
| PAIN MANAGEMENT | 33 | 118,731 | 27.8 | --- | --- | --- |
| PATHOLOGY | 12 | 118,731 | 10.1 | 1.8 | 2.9 | 5.4 |
| PEDIATRICS | 140 | 46,629 | 300.2 | 15.5 | 13.8 | 23.4 |
| PERINATOLOGY | 15 | 37,542 | 40.0 | --- | --- | --- |
| PHYSICAL MEDICINE/REHAB | 18 | 118,731 | 15.2 | --- | 2.2 | 2.8 |
| PLASTIC SURGERY | 8 | 118,731 | 6.7 | --- | 2.0 | 2.3 |
| PODIATRY | 38 | 72,102 | 52.7 | --- | --- | --- |
| PULMONOLOGY | 31 | 72,102 | 43.0 | 1.9 | 2.3 | 3.3 |
| PULMONOLOGY - PEDIATRIC | 4 | 46,629 | 8.6 | --- | --- | --- |
| RADIATION THERAPY | 13 | 118,731 | 10.9 | --- | 1.0 | 1.5 |
| RADIOLOGY | 144 | 118,731 | 121.3 | 13.7 | 7.9 | 10.9 |
| RHEUMATOLOGY | 6 | 118,731 | 5.1 | 1.0 | --- | --- |
| UROLOGY | 31 | 72,102 | 43.0 | 3.3 | 2.4 | 3.3 |
| UROLOGY - PEDIATRIC | 5 | 46,629 | 10.7 | --- | --- | --- |
| **TOTAL** | **2,213** | | **2,941.9** | **169.6** | **162.3** | **223.5** |

* In patient care with self-designated specialty

In Northern Nevada we will build a delivery system using the successful CHF model. HHC will identify those physicians who provide high quality care in relation to their peers in the region based on CHF metrics, and will partner with them to build a provider network. The implementation work for this stage of the roll-out will be initiated during the second planning year (2013) and the first implementation year (2014) when HHC is active on the Exchange and

providers in Northern Nevada will be attracted to participating in a robust and well-regarded provider network.

In Rural Nevada, HHC will build on existing relationships with the Great Basin Primary Care Association and the Indian tribes, which are the principal sources of safety-net care for rural residents.

## *CONTRACTING STRATEGY*

CHF has committed to provide access to their provider network as an "in-kind" contribution to HHC. The advantage of this approach is that CHF has 2,213 physicians, 586 pharmacies, and 1,275 ancillary professionals contracted in the Southern Nevada service area, and they are contractually bound to accept the CO-OP members at the same price that they are paid by CHF.

CHF provider contracting procedures ensure that services are high quality, cost-effective, medically necessary, and accessible to plan members. CHF's contracting procedure begins with analysis of the need for additional providers in a particular specialty or service. In addition to review of utilization data and member feedback, the current physician pool provides input on the need, and research is conducted to ensure consistency with best practices in the field. CHF may issue a Request for Information to solicit rates and services available in the community, and potential vendors are selected based on this information and a financial analysis. CHF then makes an offer of a contract detailing rates and other terms of service. When a provider accepts the offer, they must submit all licensing, liability insurance and tax information to CHF, which conducts an investigation and a legal review of the provider. When there is a question about the provider's credentials, a peer review is conducted by a committee of CHF providers. If the provider is approved, a contract is offered. Any contract for services not previously offered, or at rates that are higher than those already in place with similar providers, must be approved by the Trustees of UNITE HERE HEALTH.

The Hospitality Health CO-OP will build on the success of CHF in using **physician profiling** to identify those physicians whose outcomes and cost-effectiveness of care are above average, and to use incentives and client interface (health navigators and RN case managers) to steer consumers to use these physicians. While the current literature[11] identifies the driving forces behind over-utilization in health care as, generally, defensive medicine, patient demand, and fee-for-service reimbursement, CHF has demonstrated that by comparing physician performance using a metric that takes into account treatment strategy, patient outcome, and cost, a standard of care can be established that allows for comparison among physicians within a given geographic area and patient population. Through its robust data warehouse and sophisticated data analysis department, CHF has defined how care is delivered within specific specialties and episodes of care (medical conditions) in the Las Vegas area and the CHF membership population. These metrics allow for comparison among physicians, creating a database of results that may be used by each physician to assess and modify his or her own performance. By assuming that a "standard of care" can be defined by the norm of the dataset, physicians are motivated to avoid

[11] Most recently, http://www.hhnmag.com/hhnmag/HHNDaily/HHNDailyDisplay.dhtml?id=2220002864

practices that deviate significantly from the norm. CHF makes these data available to physicians in the network, and designs incentives that encourage physicians to submit data, use electronic medical records, and maintain a standard of practice that is at or above the average.

## *METHODS FOR PROVIDER PAYMENT*

The CO-OP will employ various provider payment methodologies, including fee for services, global/bundled rates, primary care rate incentives, primary care capitation, per diems, diagnostic related groups, and Medicare APCs.

The variety of methods is required due to the lack of provider sophistication in the market. The physician market in Nevada, with very limited exceptions, has not had experience managing financial risk. The operational approach of many local insurance carriers has been to delegate risk to physicians without consideration of the provider's ability to manage risk. This approach has negatively impacted the quality and cost of care, and has deterred the development of sophisticated risk-bearing providers. The CO-OP will build on the strategy of Culinary Health Fund, which has worked with providers to strengthen their capabilities to manage risk, and then to pass the risk on to the providers. As providers gain skills and sophistication in managing risk through collaboration with HHC, the payment methods will adapt and evolve to reflect the CO-OP's mission of high quality, affordable health care to our participants at better value with better service than is otherwise available in the market.

This strategy is illustrated by three examples from the CHF experience. (1) As CHF has promoted the use of electronic medical records, those physicians who are committed to the meaningful use of new patient management tools have been recognized by financial incentives, enhanced training, and other encouragements. (2) CHF's implementation of the medical home initiative augments the CMS incentives for primary care providers that have certified systems in place. (3) CHF created a knee and hip reimbursement bundle to accommodate low acuity knee and hip replacements that could be safely provided in an outpatient setting, with recovery outside of an acute care hospital. With a successful evaluation of the first phase of this program, CHF is now in the process of expanding the bundling program to include low acuity back surgery.

It will take several years to transition away from fee for service and more properly align incentives for both patients and physicians. However, experience and the CO-OP's mission drive HHC to prepare physicians for involvement in the risk-bearing process, and to continue to build a network of providers with the skills and willingness to participate in new approaches to provider payment.

## *INTEGRATION OF HEALTH CARE*

The CO-OP's quality improvement philosophy will be grounded in the key aims identified in the National Research Council's (NRC) 2001 report "Crossing the Quality Chasm".[12] Quality improvement, especially in Nevada, is a long march that rewards tenacity and consistency of message. Based on the experience of the CO-OP's leadership in testing approaches and

[12] National Research Council. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: The National Academies Press, 2001.

interventions on behalf of the Culinary Health Fund, the CO-OP will actively engage in the six key areas for improvement in health care described by the NRC:

- **Safety.** The NRC observed that while all health care services are intended to be helpful to patients, injury and harm are sometimes the result of services.

The CO-OP will replicate the Culinary Health Fund's model of the Physician Quality Review Committee, which was established as a way for nurses to bring the Fund's attention to unsafe care without risk to themselves or their patients. This model has proven highly successful in identifying providers or procedures that violate the maxim, "first, do no harm."

- **Effectiveness.** The NRC report helped to integrate the concept of "evidence-based care" into health systems as a standard for deciding whether an intervention would benefit the patient, and refraining from offering services that are not likely to benefit patients based on a scientifically valid, peer-reviewed examination.

The CO-OP will replicate the CHF's Physician Peer Measurement and Management Program, which uses physician-specific data to analyze patterns of care, outcomes and costs, and applies average-based metrics to determine which treatments and which physicians are "above average". By discontinuing contracting with providers who are below average, the standard of care improves continuously.

- **Patient-centered care.** The NRC stressed the importance of care that is respectful of and responsive to individual patient preferences, needs and values, thereby ensuring that patient values guide all clinical decisions.

The CO-OP will develop a health navigator initiative, in which trained lay navigators are empowered with relationships to the health care system, including access to clinical, operational, and leadership levels.[13] The navigators, who are culturally and linguistically grounded with the patient population, serve as a comfortable and trusting point of contact with each member. The navigators are able to communicate with members and systematically resolve the issues affecting utilization of health care services. Navigators will also provide important feedback to the CO-OP about the needs and values of the members.

- **Timely care.** The NRC identified delays in attention to health care needs as a key problem in the health care delivery system. Patients tend to judge the quality of the health care they receive by the timeliness by which their health needs are recognized and treated.

The CO-OP will utilize the CHF's popular Dr. Tomorrow program to avoid unnecessary delays in treatment while preventing unnecessary emergency room visits. The CO-OP will also replicate CHF's transitional care program, which provides intensive case management in discharge planning and managing of care as a member moves from in-patient care to an ambulatory setting.

[13] Health navigators are similar to *promotoras de salud*, HIV/AIDS treatment advocates, and peer advocates working in chronic disease settings such as arthritis, breast cancer, and mental health. www.minorityhealth.hhs.gov

These practices are the foundational to the concept of responsive, patient-centered care, and have demonstrated effectiveness in saving health plan dollars.

- **Effective care.** The NRC study pointed to waste of equipment, supplies, ideas, energy and time as key factors in unnecessary health care costs.

The CO-OP will implement a robust data warehouse with proven analysis capabilities to identify and eliminate waste, thereby reducing the cost of health care for the CO-OP and its members.

- **Equitable care.** The NRC study emphasized the importance of eliminating disparities in the quality of care that may occur due to differences in personal characteristics and circumstances, such as gender, ethnicity, geographic location and social/economic status.

The CO-OP has incorporated this goal into its mission and into all aspects of its business plan. Equitable access is made available through the availability of a large group of providers, offering robust choices to plan members throughout the geographic area served by the CO-OP. Diversity of choice is strengthened through providers who are part of the culture of our members. The CHF physician network, which will serve as the initial network for CO-OP members, has more than 1,200 physicians who speak a second language,[14] allowing services to be delivered in the language in which the patient is most comfortable. In addition to recruiting providers from diverse cultures into the network, the CO-OP's efforts to expand access go beyond contracting, communications, and data-sharing to provide incentives for the incorporation of electronic medical records and the adoption of telemedicine. The CO-OP's leadership believes that these innovations ultimately serve to break down the isolation of medical practice styles, and replace them with collaborative models for the growth and development of physician practices. Wider engagement and collaboration, and the creation of incentives that do not relate to the wealth or culture of the patient, are central to both the Affordable Care Act and the CO-OP model, and will ultimately ensure equitable and consistent care for all Americans.

14

| Language | # | Language | # | Language | # | Language | # | Language | # | Language | # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Arabic | 34 | Farsi | 21 | Hebrew | 6 | Mandarin | 37 | Russian | 32 | Vietnamese | 36 |
| Armenian | 6 | French | 65 | Hindi | 83 | Persian | 7 | Sign language | 2 | | |
| Bengali | 5 | German | 39 | Italian | 21 | Polish | 9 | Spanish | 564 | | |
| Cantonese | 21 | Greek | 9 | Japanese | 10 | Portuguese | 18 | Tagalog | 112 | | |
| Chinese | 50 | Gujarati | 10 | Korean | 12 | Punjabi | 21 | Urdu | 46 | | |

# SECTION C: BUDGET AND BUDGET NARRATIVE

The start-up loan will fund the costs of staffing the CO-OP during the licensure process, initial enrollment, and development of the CO-OP infrastructure. In addition to staff, subcontracts, and consultants, proceeds of the federal loan will be used for travel, training, furniture, equipment, mandatory printing, and overhead costs.

In designing the financial plan for the Hospitality Health CO-OP (HHC), the development team created three budget scenarios based on high, medium, and low enrollment. The scenarios reflect the significant number of staff positions that are scalable in relation to the CO-OP membership. All three scenarios are submitted as 6.a.Operating Budget Detail.xls. The medium enrollment was determined to be the "best estimate" for preparation of the Feasibility Study by Milliman (see Appendix F, Exhibit 1a), and is therefore the budget reflected on the 424a and in this narrative.

A timeline listing major activities and milestones is found on the next page.

## *PRIVATE SUPPORT*

Culinary Health Fund will continue to make significant financial contributions to the CO-OP. To date, CHF has contributed the following to the development of HHC, totaling **$124,398**:

| | |
|---|---|
| Proposal and Business Plan writing (cash) | $25,000 |
| Program development and Business Plan writing: 33 staff members of CHF and UHH contributed to the development of the proposal.[15] | $96,398 |
| Travel, meeting arrangements, calls, supplies | $3,000 |

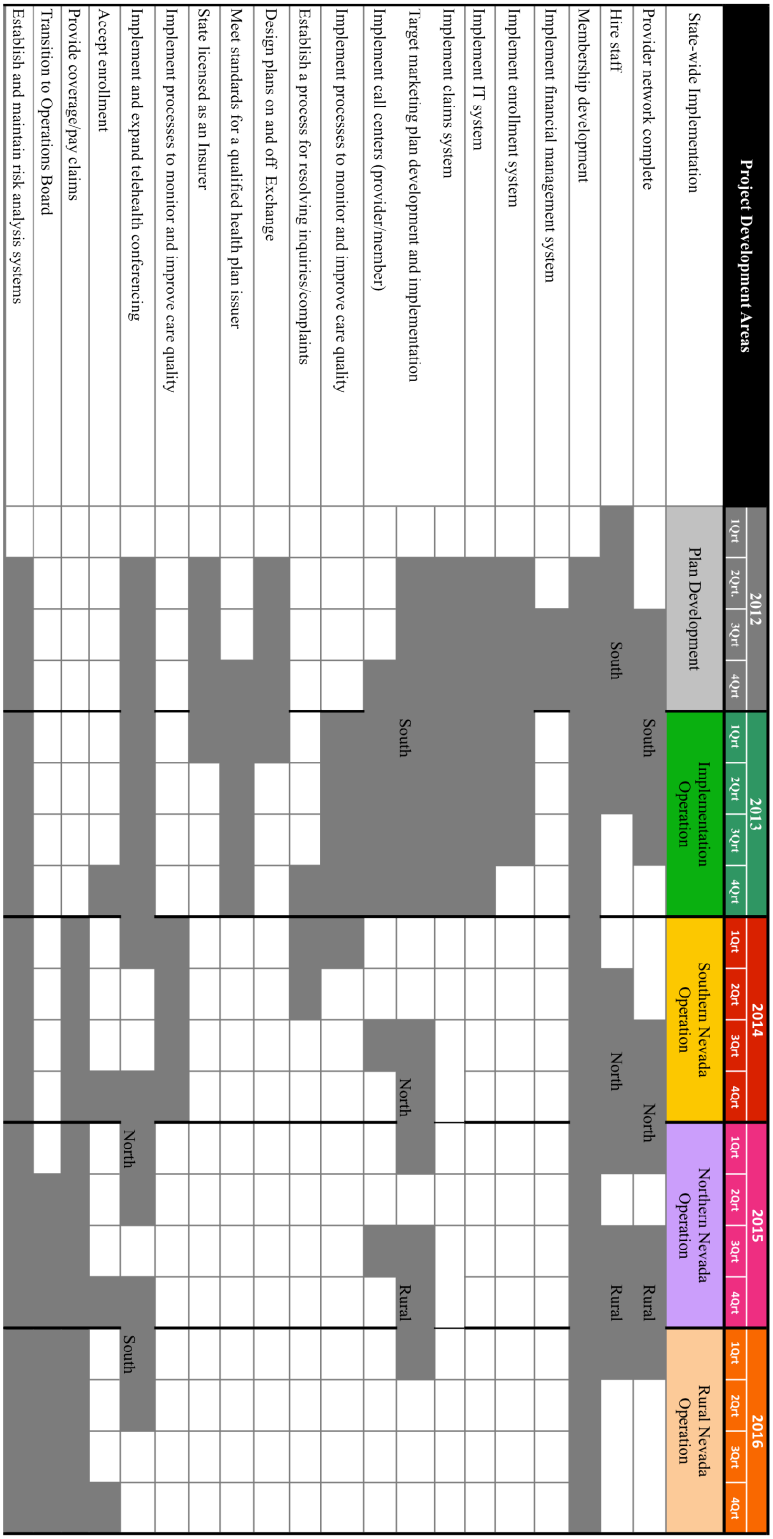
After approval of the loan, CHF will continue its contributions to support of HHC as follows:

| | |
|---|---|
| Outreach to potential members of HHC and explanation of benefits, etc. | $50,000/year for two years |
| Waiver of Network Access Fee for PPO | $1/member/month for 20 years; average for first three years of medium enrollment is $488,688/year |
| Set-up of data warehouse | $200,000 |
| Marketing: branding, marketing plan, materials | $75,000 |
| Access to provider profiles | $200,000 |
| Total | $575,000 in first two years; $488,688/year thereafter |

[15] The following staff, consultants and leadership of CHF and UHH contributed to this proposal:

| | | | | | |
|---|---|---|---|---|---|
| Andrea Schwartzman | Bryan Schmidt | Deb Noens | Jeff Ellis | Mina Pinney | Sharon Jacobs |
| Andy Brignone | Cara Elias | Elizabeth Gilbertson | Kathy Silver | Mitch Whitehead | Sheila Ramirez |
| Becky Timmons | Cyndi Pearson | Francisca Suarez | Kevin Gittens | Morty Miller | Steve Nauman |
| Ben Conley | D Taylor | Gary Odenweller | Kim Pein | Nancy Nikolski | Tom Mayer |
| Bobbette Bond | Deb Manchester | Germaine Devine-Berling | Leslie Johnstone | Patti Spears | Tom Caplice |
| | Iris Salinas | Maria Martinez-Riach | | Richard McCracken | Tom Zumtobel |

**Hospitality Health, Ltd.:** CO-OP Project Milestones Timeline



A detailed budget spreadsheet is attached as 6.a. Operating budget detail.xlsx and is uploaded to Grants.gov as the Budget Narrative.

## *Year 1: 2012*

Staffing of the HHC will begin in April 2012 with the hiring of the Chief Executive Officer (CEO), the Chief Project Officer (CPO), an Administrative Assistant, and the part-time In-House Counsel. These individuals will primarily focus on state licensure, preliminary contracting, and planning. The Chief Financial Officer (CFO) and the Chief Health Information Officer will be added to the staff in July 2012, along with administrative assistants. As possible and appropriate, executives will be hired on a part-time basis in order to utilize funds most effectively.

Consultants and subcontractors will assist in the design of the enrollment interface, the preparation of applications for licensure, and the establishment of systems for financial management, forecasting, quality assurance, and claims payment. A Medical Director will also be designated as a consultant. Outside counsel will be obtained.

Other costs for Year 1 include training, professional printing, staff recruitment, an audit, fiduciary insurance, in-state travel to achieve licensure and conduct board meetings, and out-of-state travel to meet with CCIIO and other federal regulators. Some hardware, proprietary software, other equipment, and furniture will be purchased during Year 1. A line item for overhead will pay for office space, telephone and internet access, office supplies, and other general expenses.

Total budget for 2012: **$4,716,866**

## *Year 2: 2013*

Staffing will continue to be added in 2013 as activities require additional staffing. An Advocacy Director will be hired to oversee the development of the Navigator program, which will begin operation as enrollment commences. The first navigators, case managers and nurses will be hired, and all direct patient care employees will be trained before enrollment begins. The analytics and informatics staff will also be hired and trained during 2013, along with subsidies staff. In-house actuary and compliance staff will also be hired during 2013.

Development of the CO-OP in Northern Nevada will begin during 2013, and individuals will be hired to staff this effort.

Other costs for Year 2 include training, printing, outside counsel, staff recruitment, an audit, fiduciary insurance, in-state travel, and out-of-state travel to meet with CCIIO and other federal regulators. Some hardware, proprietary software, other equipment, and furniture will be purchased during Year 2. Videoconferencing equipment will be purchased. A line item for overhead will pay for office space, telephone and internet access, office supplies, and other general expenses. Some leased services are budgeted for 2013.

Total budget for 2013: **$7,828,939**

## *Year 3: 2014*

Staffing will increase slightly during 2014 as additional staff members are added in scale to membership growth, but the significant difference in budget between 2013 and 2014 is the positions that were added in late 2013 that are now funded for 12 months. Since licensure will be in place, the consultant for that activity is no longer in the budget.

Development of the CO-OP in Rural Nevada (the Frontier) will begin during 2014, and individuals will be hired to staff this effort.

Other costs for Year 3 include training, professional printing, outside counsel, staff recruitment, an audit, fiduciary insurance, in-state travel to achieve licensure and conduct board meetings, and out-of-state travel to meet with CCIIO and other federal regulators. Additional videoconferencing equipment will be purchased. A line item for overhead will pay for office space, telephone and internet access, office supplies, and other general expenses. Some leased services, including claims management and enrollment, are budgeted for 2014.

Total budget for 2014: **$16,548,148**

## *Year 4: 2015*

Staffing will scale up per membership growth in 2015. The CO-OP will go statewide, including Rural Nevada on January 1, 2015. Patient care staffing and telemedicine reflect the additional services to be provided to this new membership.

Other costs for Year 4 include training, professional printing, outside counsel, staff recruitment, an audit, fiduciary insurance, in-state travel to achieve licensure and conduct board meetings, and out-of-state travel to meet with CCIIO and other federal regulators. Additional videoconferencing equipment will be purchased. A line item for overhead will pay for office space, telephone and internet access, office supplies, and other general expenses. Some leased services, including claims management and enrollment, are budgeted for 2015.

Total budget for 2015: **$20,602,186**

## *Year 5: 2016*

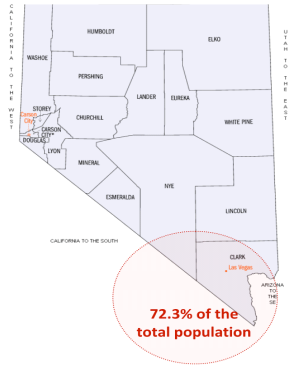
Increases in personnel costs in 2016 are additional member care employees scaled to the number of members in the CO-OP.

Other costs for Year 5 include training, professional printing, outside counsel, staff recruitment, an audit, fiduciary insurance, in-state travel to achieve licensure and conduct board meetings, and out-of-state travel to meet with CCIIO and other federal regulators. Additional videoconferencing equipment will be purchased. A line item for overhead will pay for office space, telephone and internet access, office supplies, and other general expenses. Some leased services, including claims management and enrollment, are budgeted for 2015.

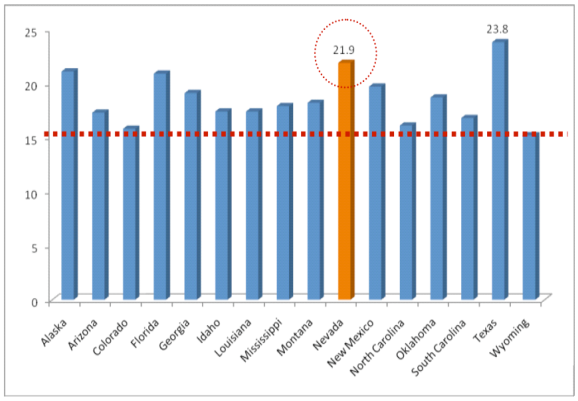
Total budget for 2016: **$23,352,644**

# SECTION D: ENROLLMENT STRATEGY, ENROLLMENT FORECAST, AND REGULATORY CAPITAL

**Nevada Uninsured Population**




**Percentage of Uninsured Residents in States at/or above the United States Average, 2009**



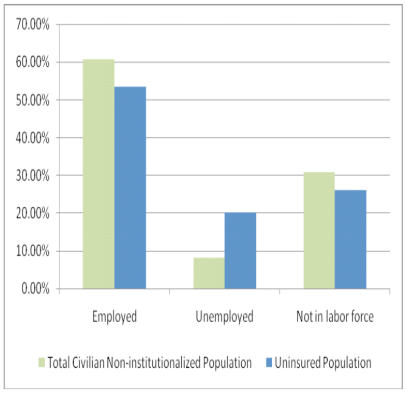

## *ENROLLMENT STRATEGY*

Nevada has one of the highest uninsured rates in the country (see chart above). This uninsured population is concentrated mostly in Clark County, the population center for the state, where the Hospitality Health CO-OP will begin (see map above). It also has a high proportion of young, immigrant, low income residents, particularly Latino minorities. These working uninsured minorities in the hospitality-related industries represent a large target market in Nevada (see charts below). The focus of the Hospitality Health CO-OP will initially be those members who are uninsured through their hospitality-related employment, and those who were previously members of a self-funded plan in the Health Services Coalition, particularly those who have high bilingual and health literacy needs. Secondary focus will be on others who are uninsured in Clark County.

**Nevada's Working Uninsured Population by Industry Type, 2009**

| | Nevada's Working Uninsured by Industry Type | % of Nevada's Working Uninsured by Industry Type |
|---|---|---|
| Arts, entertainment, and recreation, and accommodation and food services | 66,273 | 26.5% |
| Professional, scientific, and management, and administrative and waste management services | 37,013 | 14.8% |
| Retail trade | 34,762 | 13.9% |
| Construction | 30,011 | 12.0% |
| Educational services, and health care and social assistance | 22,258 | 8.9% |
| All other industries | 59,771 | 23.9% |
| Total | 250,088 | 100% |

**Nevada Uninsured by Employment Status, 2009**



**Working Uninsured:** Of the 250,088 identified as employed without insurance in Nevada in 2009[16], entertainment/hospitality represents 26.5%, virtually all of whom might be interested in a hospitality-related Health CO-OP. The Hospitality industry represents the largest employment sector in the state directly employing those working in travel, dining, hotels, outdoor recreation, gaming, and hundreds of small restaurants, coffee shops, and fast food franchises. In addition, a portion of the 25.9% of retail and construction industries are closely related and dependent on the hospitality industry through trucking, laundry and linens, security staffing, and construction of hospitality facilities. Many of these entities operate around the clock, but primarily employ part-time workers, and insurance, when offered, is only available to those working full-time This significant part-time workforce, excluded from employer coverage requirements under the Affordable Care Act, will benefit from affordable coverage through Hospitality Health CO-OP.

**Internal outreach to current and past member-related entities:** Many of these workers previously were insured or had relatives with insurance under the Culinary Health Fund or another fund in the Health Services Coalition. The Health Services Coalition therefore offers an important outreach opportunity to its member organizations, comprised of employers with both union and non-union workers, as well as several union health plans. These employers and unions are all related to the hospitality industry, either directly or indirectly. Many have formal and informal relationships with the working uninsured. In collaboration with the Health Services Coalition, HHC will focus outreach efforts on these potential partners.

**Outreach to the broader community**: HHC will use the resources of the CHF marketing consultant to develop a community outreach campaign targeting the thousands of additional families in our communities working without health care coverage as we develop the CO-OP membership in Clark and Washoe Counties. During expansion to rural Nevada in 2016, the CO-OP plans will already be well established in Clark County, and will be new but stable in Washoe County. Outreach will require substantial additional planning in the many difficult Frontier segments of Nevada who may be drawn to an outdoor recreation and ranching message regarding coverage.

**Latino Community:** The largest uninsured ethnic group in Nevada is the Latino population, comprising 37% of the uninsured in the state (see table on following page). This population has additional barriers to obtaining quality health care services, including lower income, lower levels of literacy (particularly health care literacy), language barriers, and cultural characteristics that discourage prevention and early intervention. Nearly forty percent of CHF's self-funded membership is comprised of Spanish-speaking individuals. Out of necessity and respect for the importance of cultural connection for effective communication about health care, the Fund has a significant working knowledge of the communication style and resource needs of the Latino members we serve.

[16] Public Consulting Group, "An Overview of the Uninsured in the State of Nevada", memorandum to Nevada Division of Health Care Financing and Policy, 8/3/2011.

The CHF communication and advocacy department is primarily Spanish-speaking, and all materials are created bilingually and adapted for cultural competency. CHF was the first plan to create an Explanation of Benefits mailed to our Las Vegas members for each health care visit in both Spanish and English. Because CHF is known to be bilingually accessible and aware of Latino cultural norms affecting health care, we plan to use the CHF legacy to attract Latino Nevadans to HHC.

**Nevada's Uninsured Population by Race and Ethnicity, 2009**

| | Total Nevada Population | Percentage of Total Nevada Population | Nevada Uninsured Population | % Nevada Uninsured Population | Uninsured by Race and Ethnicity |
|---|---|---|---|---|---|
| White alone, not Hispanic or Latino | 1,452,405 | 55.65% | 222,852 | 38.99% | 15.34% |
| Hispanic or Latino (of any race) | 693,984 | 26.59% | 258,298 | 45.19% | 37.22% |
| Black or African-American alone | 197,203 | 7.56% | 39,179 | 6.85% | 19.87% |
| American-Indian and Alaska Native alone | 30,682 | 1.18% | 9,243 | 1.62% | 30.13% |
| Asian alone | 173,786 | 6.66% | 29,839 | 5.22% | 17.17% |
| Native Hawaiian and Other Pacific Islander alone | 13,464 | 0.52% | 2,752 | 0.48% | 20.44% |
| Other (two or more races / other race non-Hispanic) | 48,517 | 1.86% | 9,452 | 1.65% | 19.48% |
| **Total** | **2,610,041** | **100%** | **571,615** | **100%** | **21.9%** |

The Culinary Health Fund also has a significant population of Filipino and Asian members, and HHC will develop a special recruitment and enrollment strategy targeting this population, including written materials, community visibility, and contact with previous CHF members.

**COMMUNICATION CHANNELS**

The Formation Board understands that most consumers are unfamiliar with shopping for a health care plan – most have no coverage, have coverage that has been selected by their employer, or have publicly funded coverage. Selection of a health care plan, and in particular understanding the unique value of a non-profit CO-OP, will require education and outreach.. HHC will enlist the assistance of the CHF marketing team to develop an education campaign focused on the hospitality-related industries in Nevada. Prior experience with this population suggests that word-of-mouth channels are particularly effective at work, at church, and with family, friends and co-workers, rather than what arrives in the mailbox. Radio is more effective in mass communication than television.

**Website with 'human touch' support:** Little health care experience has involved the internet or websites to date, including the CHF website. A website is needed, however, to participate on the exchange. This virtual service will be supported by an onsite customer services office and call center in Las Vegas, as well as an office in Washoe County during Year Four.

**Direct mail to past members:** Part of the comprehensive outreach plan to be developed in 2012 will be to target those who have participated in Culinary Health Fund in the past, but no longer

have Culinary benefits. Although direct mail has limited success in general, a targeted mailing campaign may have a higher success rate because the Culinary Health Fund has high satisfaction ratings among members, measured both by member satisfaction surveys and through focus groups. We would like to invite those who have previous experience as participants in the Culinary Health Plan to choose its new "sister" health plan, HHC, where they can expect to feel similarly positive about their health care coverage.

**Employee locations:** Employee cafeterias and Union Halls, the Health Service Coalition partners, and employment training centers will be used as locations for first time and annual enrollments, as well as the ongoing recruitment of new members.

**Provider offices:** The CO-OP outreach team will also focus on provider offices with which we already have a relationship to distribute marketing and enrollment materials.

**Mass Media:** While television and newspaper advertising is not a cost-effective medium, radio advertising will be used as an advertising/marketing tool as well, particularly for the Latino community. In addition, significant effort will be placed on personal outreach and coordination, described below.

**ENROLLMENT AND HEALTH NAVIGATORS**

Development of a successful CO-OP community will depend on the engagement of members in their own health care, and the creation of a strong CO-OP network. Achieving both these outcomes will require substantial resources. The health navigators will be the key point of contact for members beginning at enrollment. Each CO-OP health navigator will be assigned to and follow a caseload of members throughout their CO-OP membership. A health navigator training program will be developed that will educate these non-clinical employees prior to the first major enrollment drive in the fall of 2013.

Each navigator will have a caseload of approximately 500 members, and will engage members during enrollment, assist with enrollment or post-enrollment orientation, assess member and dependent health care needs, determine if they are appropriate candidates for referral to special programs for members with chronic conditions, connect members with other community resources, and serve as the 'link' for the member in the CO-OP. The relationship will continue throughout their CO-OP membership. This program will focus on improving health care and health coverage literacy, patient engagement to develop skill in the use of health care, and development of a community network for the CO-OP, which will reduce the clinical resources needed by the CO-OP.

**ENROLLMENT MECHANICS**

HHC will contract with a provider of enrollment contractor to develop a web portal interface; self-service or "concierge" (chat or telephone) service; decision-making tools to help consumers select the plan and providers who most closely fit their needs; 24/7 interface; online customer

service; a call center; mail communication; application and eligibility screening; account management; on-line, retail or mail payment of bills; and administrative reporting.

## *ENROLLMENT FORECASTS*

Milliman constructed a detailed population model to project the market enrollment in 2014-2016 (Appendix F, Exhibit 9). To project HHC's enrollment during the first three years of operation (2014-2016), we applied HHC's estimated market penetration to our market projections. Appendix F, Exhibit 10a summarizes HHC's expected enrollment in each of the first three years for each enrollment forecast scenario, reported separately by line of business.

We then assumed annual growth rates of 5% for 2017 through 2019 and 2% from 2020 through 2033 for members who were not previously members of the CHF. For the members coming from the CHF, we assumed 0% growth after 2017. We expect significant shifts in the insurance marketplace during the first two years Exchanges are in operation. By 2016, most of these shifts are expected to have occurred, and the year-to-year population movement in subsequent years is expected to be much smaller. Appendix F, Exhibit 10b includes projections of HHC's expected enrollment in 2014-2033 by enrollment scenario.

The following subsections describe the data sources, assumptions, and methodology underlying these projections.

### DATA SOURCES

The projections are based on the distribution of the CO-OP target service area population starting at the end of 2013, stratified by current insurance status, poverty status (income relative to FPL), health status, and family size. The Current Population Survey (CPS) provides state-level data on each of these strata. We adjusted the raw CPS data after considering data available from two other sources:

- Insurance Analyst Pro® (IAP), available through Highline Data LLC, aggregates data provided to the NAIC. It contains data on sizes of the individual and fully insured group markets.
- The Medicaid Statistical Information System (MSIS) is a database available through the Department of Health and Human Services. It provides data on Medicaid enrollment in each state.

We ensured the total baseline population matches the total CPS population but adjusted the size of individual market segments to better align with data reported by IAP and MSIS.

Because HHC is initially targeting the Las Vegas metropolitan area of Nevada and we assumed different penetration rates for these versus the phase I and phase II coverage areas, it was necessary to break down the statewide population counts into the different service areas.

To arrive at a final baseline population distribution for 2014 (immediately prior to Exchange operation), we trended the entire population from 2011 to 2014 based on recent population trends in the CO-OP service area. Further detail on how these adjustments were made can be found in the next subsection.

## METHODOLOGY FOR ENROLLMENT FORECASTING

*1. Determine baseline (pre-Exchange) population distribution in the target service area.*

The statewide population data described above was first broken down into the areas being targeted so that we represented the reduced 2014 initial service area for Nevada. We made the following three adjustments when moving from a statewide population to a portion of the state's population.

- A population adjustment factor, equal to the service area's population divided by the entire state's population.
- An income adjustment factor. This factor was estimated by comparing the state's median income to the estimated median income of the service area counties.
- A health status adjustment factor. Based on estimates from County Health Rankings,[17] the initial service area in Nevada is slightly less healthy than the state as a whole. This factor was estimated by comparing the state's health ranking to the estimated health ranking of the initial service area counties.

Income and health status factors were developed such that the aggregate population of the CO-OP service area is approximately equal to the statewide population times the CO-OP service area's fraction of the state's population. For Nevada, the size of the remaining portions of the state was calculated as the complement to the adjusted size of the 2014 initially targeted portion such that the overall population estimates remained unchanged.

The CPS data were also adjusted to split the population in the 125%-to-150% of FPL stratum in two groups: 125%-to-138% of FPL and 138%-to-150% of FPL. The individuals with income not exceeding 138% of FPL will be eligible for Medicaid. We assumed a uniform distribution of income-to-poverty within this band.

Although the baseline population projections include individuals with Medicare, Medicaid, or other government (e.g., military) health insurance coverage, these members are not likely candidates for enrollment in HHC. They are included in the baseline population to ensure that no one is left out of the population but are not thereafter an important piece of the population modeling.

*2. Calculate individual Exchange subsidy and the Exchange take-up rate (i.e., the proportion of individuals purchasing insurance through the Exchange)*

To enroll in HHC, a prospective member must make two decisions. First, the prospective member (or small group) must decide to enroll in a plan on the Exchange. Then, the prospective member (or small group) must select HHC rather than any of the other available plans. The first decision is assumed to be primarily affected by current insurance status (insured or uninsured)

[17] www.countyhealthrankings.org/

and by the federal subsidy provided if the member enrolls in an Exchange-based plan. This individual subsidy is a function of several factors:

- The maximum member contribution to premium allowed by the Affordable Care Act, which is a function of member's income
- The tax penalty for being uninsured, which is a function of income (net of exemptions), family size, and the penalty parameters provided in the Affordable Care Act.
- The assumed second-lowest available Silver plan premium amount, which forms the basis of the subsidy calculation.

In these calculations, income and dependent exemptions are assumed to grow at 2.3%, annually based on recent trends in the Consumer Price Index for All Urban Consumers (CPI-U). Health insurance premiums are assumed to grow at 7.7% annually based on recent trends in the Milliman Medical Index.[18]

For each population stratum, we calculated the subsidy percentage members would receive if they chose to enroll in an Exchange plan. For each subsidy level, we assume a probability of selecting an Exchange plan. This assumed probability for the currently uninsured persons was estimated based on a study of Massachusetts reform experience. The assumed probability for the currently insured individuals was based on a study of "switching" rates observed in similar situations where a new low cost plan offering was made available. The take up probability, is dependent on insurance status (all else equal, uninsureds are more likely to take up coverage on the Exchange than people with existing insurance), health status (all else equal, less healthy people are more likely to take up coverage on the Exchange than healthier people), and income-to-poverty ratio (all else equal, wealthier people are more likely to take up coverage on the Exchange than less wealthy people). The take-up probabilities described in this subsection for persons whose employer sponsored insurance was terminated are expected to behave similarly to the uninsured persons and take-up coverage on the Exchange at a higher rate due to the fact that after the loss of group coverage they must seek new coverage or be subject to the penalty.

Individual and uninsured Exchange take-up probabilities also vary across the three years (2014-2016). For example, an uninsured person would have a lower take-up probability (all else equal) in 2015 than in 2014 if that same person had been uninsured and elected to forgo Exchange coverage in 2014.

*3. Model population movements in each year*

Starting with a baseline (start of 2014) population, we model each year's transitions from one insurance status to another. Along the way, members may exit the market (i.e., become unavailable to enroll in HHC) if they have income below 138% of FPL and start or eventually become uninsured (due to termination of employer-sponsored coverage). Members below 200% FPL are also assumed to exit the market if the state decides to offer a Basic Health Plan.

[18] See http://insight.milliman.com/article.php?cntid=7628 for the latest Milliman Medical Index report and a more detailed description of methodology.

The model was not designed to measure labor market changes; in other words, we assume there are no changes from 2014–2016 in the portion of the population employed by small, medium, and large employers. We do, however, model changes in how these different employer sizes elect to provide health insurance to their employees. In each year, we assume a certain percentage of small and large employers will elect to terminate coverage entirely (giving employees the choice to be uninsured or to select individual coverage on the Exchange) or to self insure their benefits.

It should be noted that before modeling the population movements described above, we removed the approximately 120,000 members currently covered by the CHF from the self-insured market because the CHF will remain self-insured and therefore our modeling reflects this intention for future years.

Within the small group market, we assume that one-half percent of small groups (2-50 covered lives) will elect to purchase coverage from the Exchange rather than through brokers. For small groups of 51-100 covered lives, we assume one-eighth percent will purchase coverage through the Exchange. These assumptions are based on studies of the insurance marketplace in Massachusetts, Utah, and California, all of which have experienced low SHOP Exchange take up rates due to the lack of the incentives for small group participation on the Exchange.

In each year, we apply the employer-sponsored insurance transition probabilities and individual/uninsured Exchange take-up rates to estimate the population in each of the insurance statuses listed below (stratified by income-to-poverty ratio, health status, and family size). HHC is expecting to enroll members from the Individual Exchange, fully insured small groups both on and off the SHOP Exchange, and fully insured large groups.

a. Individual off Exchange
b. Individual on Exchange
c. Uninsured
d. Employer self-insured
e. Small group (2-50) fully insured, on Exchange
f. Small group (2-50) fully insured, off Exchange
g. Small group (51-100) fully insured, on Exchange
h. Small group (51-100) fully insured, off Exchange
i. Large group (>100), fully insured

*4. Estimate HHC's enrollment by market segment*

The subsection above describes the methodology to estimate the total population stratified by insurance status. For each of the "on Exchange" statuses (both individual and small group), we apply penetration assumptions to estimate HHC's total enrollment. In addition to the estimated HHC enrollment resulting from applying the penetration assumptions, we also included in the Individual on Exchange group a subset of members currently covered by the CHF who are expected to seek coverage through the Exchange due to the presence of cost sharing subsidies. These are those members whose income-to-poverty ratio is between 138% and 200% FPL.

A full description of the market penetration assumptions can be found in the Feasibility Study.

**SENSITIVITY TESTS**

Four important sensitivity tests were performed on these results. The first sensitivity test involves altering the assumption of whether the state offers or does not offer a BHP. In the event the state does offer a BHP, individuals not eligible for Medicaid but with income under 200% of FPL would enroll in the BHP rather than in a plan on the Exchange. Thus, existence of a BHP could significantly reduce the population enrolling in the individual exchange, and therefore could significantly reduce HHC's enrollment.

A second sensitivity test models HHC's enrollment if there were no terminations of employer-sponsored insurance. In this scenario, fewer people would enter the individual Exchange, lowering HHC's enrollment. While we do not believe this is a realistic scenario, it does provide a more conservative estimate of enrollment.

HHC could attract slightly more members if Nevada elects to allow small groups of 51-100 lives to enter the exchange in 2014 rather than 2016. Given the vast majority of HHC's enrollment is expected to come from individual members and the Exchange take-up rate among groups of this size is expected to be very low, this assumption does not have a material impact on total population size and therefore this was not included in our sensitivity scenarios.

Lastly, we tested HHC's market penetration. Exhibit 10b includes HHC's projected 2014-2033 enrollment for each enrollment forecast scenario.

For all scenarios, detailed modeling was performed for the years 2014 through 2016. Projected members in future years were estimated using 5% trend for the years 2017 through 2019, and 2% thereafter for members who were not previously members of the CHF. For the members coming from the CHF, we assumed 0% growth after 2017 to reflect the stability of the group.

## *REGULATORY CAPITAL PROJECTIONS*

Please refer to Appendix F, Exhibit 7 for projected surplus and minimum capital requirement for years 2014 through 2033 for each of the six scenarios tested. A detailed description of the scenarios can be found in the Feasibility Study section of the application.

# SECTION E: LOAN FUNDING AND REPAYMENT SCHEDULE

Funding will be made available to CO-OPs to fund initial start-up costs as well as to capitalize these newly formed risk-bearing entities. Tables 2 and 3 show the projected amount of funds needed for start-up costs and targeted capital amount along with the projected repayment schedule of these loans respectively. The interest rate for the start-up loans and solvency loans were assumed to be 0.4% and 0.875% respectively.

The start-up loan amounts and the timing of them correspond to the budget set forth by HHC during the pre-operational years. We included a 10% cushion in excess of budgeted expenditures in 2012 and 2013 to allow HHC flexibility to meet operational expenses once the CO-OP begins selling policies in 2014. This is intended to prevent HHC from having initial cash flow shortages while membership and revenues grow.

**Table 2 - Start-up loan amount and repayment schedule ($000)**

| Year | Draw | Principal repayment | Interest Paid | Year-end balance |
|---|---|---|---|---|
| 2012 | $6,634 | $0 | $0 | $6,660 |
| 2013 | 7,821 | 0 | 0 | 14,539 |
| 2014 | 0 | 0 | 0 | 14,597 |
| 2015 | 0 | 0 | 0 | 14,655 |
| 2016 | 0 | 0 | 0 | 14,714 |
| 2017 | 0 | 6,634 | 318 | 7,821 |
| 2018 | 0 | 7,821 | 31 | 0 |

The strategy used to determine the solvency loan amounts, the timing of the draws, and the payback schedule is described in detail in the Feasibility Study. We chose to request solvency funds which would allow the CO-OP to withstand moderately adverse experience once the transitional Exchange reinsurance mechanism for years 2014-2016 ceases to exist. This is the reason for the additional draw in 2017. The drawdown and payback schedule shown below is the one proposed to HHS. All of the scenarios tested use this loan draw and repayment schedule.

Our reasoning for having a single draw schedule with a set repayment schedule was to demonstrate that under all of the scenarios tested, the loans could be repaid within the specified time period without having to make contingent arrangements for loan draws and repayment under various scenarios. In reality, if experience emerges and surplus levels are such that HHC can repay the loan sooner or reduce the drawdown amounts without exposing itself unnecessarily to increased risk, HHC will consider this.

**Table 3 - Solvency loan amount and repayment schedule ($000)**

| Year | Draw | Principal repayment | Interest Paid | Year-end balance |
|---|---|---|---|---|
| 2012 | $1,500 | $0 | $0 | $1,513 |
| 2013 | 0 | 0 | 0 | $1,526 |
| 2014 | 37,673 | 0 | 0 | $39,543 |
| 2015 | 0 | 0 | 0 | $39,889 |
| 2016 | 0 | 0 | 0 | $40,238 |
| 2017 | 16,858 | 0 | 0 | $57,595 |
| 2018 | 0 | 0 | 0 | $58,099 |
| 2019 | 0 | 4,267 | 0 | $51,764 |
| 2020 | 0 | 6,392 | 2,576 | $45,372 |
| 2021 | 0 | 17,107 | 453 | $28,264 |
| 2022 | 0 | 6,589 | 397 | $21,675 |
| 2023 | 0 | 0 | 247 | $21,865 |
| 2024 | 0 | 0 | 0 | $22,056 |
| 2025 | 0 | 0 | 0 | $22,249 |
| 2026 | 0 | 0 | 0 | $22,444 |
| 2027 | 0 | 0 | 0 | $22,640 |
| 2028 | 0 | 2,524 | 1,163 | $19,151 |
| 2029 | 0 | 12,135 | 168 | $7,016 |
| 2030 | 0 | 6,553 | 61 | $463 |
| 2031 | 0 | 463 | 4 | $0 |

We project that given the loan requests and the repayment schedules above, HHC will be able to repay all borrowed funds within the specified timeframe under each of the six scenarios included in our feasibility study.

# SECTION F: PRO FORMA FINANCIALS

Please refer to and Appendix F, Exhibits 1a through 6c for the income statement, balance sheet, and cash flow statement for each of the six scenarios included in the Feasibility Study.

# SECTION G: OPERATIONS

## *1. MEMBERSHIP DEVELOPMENT*

Hospitality Health CO-OP will leverage the existing community relationships with the Health Services Coalition, the unions, and community providers for membership outreach concurrently with a targeted strategy for hospitality-related employers. In addition, a marketing plan will be developed for the community with targeted mail and radio using a marketing consultant familiar with this community and our target groups.

Plan development will target all membership income levels, with special consideration of the needs of multilingual and lower income members, and use the health navigators program to help attract these populations. Plan price will attract additional members.

Sustainability in membership development will be provided by both attention to Board development and membership leadership recruitment, and an ongoing quality review process of measuring, reviewing, and improving the products and process.

Please see Table G.1 on the following page.

**Table G.1: Timeline of key activities related to membership development**

| | 2012 | | | | 2013 | | | | 2014 | | | | 2015 | | | | 2016 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quarter | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 |
| **BOARD DEVELOPMENT** | | | | | | | | | | | | | | | | | | | | |
| Establish Consumer Advisory Board | | ■ | ■ | | | | | | | | | | | | | | | | | |
| Complete membership development team | | ■ | ■ | | | | | | | | | | | | | | | | | |
| **NAVIGATION PROGRAM** | | | | | | | | | | | | | | | | | | | | |
| Train Health Navigators | | | | ■ | | | | | | | | | | | | | | | | |
| **PLAN DESIGN** | | | | | | | | | | | | | | | | | | | | |
| Design Plans on exchange | | | | ■ | ■ | | | | | | | | | | | | | | | |
| Design Plans off exchange | | | | ■ | ■ | | | | | | | | | | | | | | | |
| **ENROLLMENT STRATEGY** | | | | | | | | | | | | | | | | | | | | |
| Implement Coalition strategy | | ■ | ■ | ■ | ■ | | | | | | | | | | | | | | | |
| Identify external outreach partners | | ■ | ■ | | | | | | | | | | | | | | | | | |
| Develop broker strategy | | ■ | ■ | | | | | | | | | | | | | | | | | |
| Select retail targets for enrollments | | ■ | ■ | | | | | | | | | | | | | | | | | |
| Recruit new partner | | | | | ■ | ■ | | | | | | | | | | | | | | |
| Complete community leaders meetings | | | | | ■ | ■ | | | | | | | | | | | | | | |
| Complete CO-OP membership website | | | | | | | ■ | | | | | | | | | | | | | |
| Complete Enrollment set up | | | | | | | ■ | | | | | | | | | | | | | |
| Implement community radio and print | | | | | | | ■ | | | | | | | | | | | | | |
| Complete mail campaign | | | | | | | ■ | | | | | | | | | | | | | |
| Visits to large employers in Coalition | | | | | | | ■ | | | | | | | | | | | | | |
| Marketing visits to all unions in Coalition | | | | | | | ■ | | | | | | | | | | | | | |
| Implement provider outreach strategy | | | | | | | ■ | | | | | | | | | | | | | |
| Complete broker | | | | | | | ■ | | | | | | | | | | | | | |
| Conduct enrollments | | | | | | | | ■ | | | | | | | | | | | | |
| Enroll first members | | | | | | | | ■ | | | | | | | | | | | | |
| Identify Northern/ rural enrollment sites | | | | | | | | | | ■ | ■ | ■ | | | | | | | | |
| Hire and train Northern enrollment staff | | | | | | | | | | | ■ | | | | | | | | | |
| Enroll members in Northern Nevada | | | | | | | | | | | | ■ | | | | | | | | |
| Hire and train rural enrollment staff | | | | | | | | | | | | | | | ■ | | | | | |
| Enroll members in rural Nevada | | | | | | | | | | | | | | | | ■ | | | | |
| **SUSTAINABILITY** | | | | | | | | | | | | | | | | | | | | |
| Poll membership re: enrollment process | | | | | | | | | | ■ | | | | | | | | | | |
| Follow-up training for enrollment staff | | | | | | | | | | | ■ | | | | | | | | | |
| Identify member leaders | | | | | | | | | ■ | | | | ■ | | | | ■ | | | |
| Quarterly benchmark, review, improve | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |

## *2 . PLAN FOR IMPLEMENTING FINANCIAL MANAGEMENT SYSTEM*

The CO-OP will have an independent financial management system established under the direction of the CFO. The Board of Directors will oversee the process, and will approve the financial management policies and procedures. The establishment of the financial management system will begin in August, 2012 and will be completed in December of 2012.

**Table G.2: Timeline for implementation of financial management system**

| | 2012 | | | | 2013 | | | | 2014 | | | | 2015 | | | | 2016 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quarter | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 |
| **DEVELOP ACCOUNTING SYSTEM** | | | | | | | | | | | | | | | | | | | | |
| Select accounting software | | | | | | | | | | | | | | | | | | | | |
| Contract accounting software | | | | | | | | | | | | | | | | | | | | |
| Installation of accounting software | | | | | | | | | | | | | | | | | | | | |
| Define accounting staffing/responsibilities | | | | | | | | | | | | | | | | | | | | |
| **CASH MANAGEMENT SYSTEM** | | | | | | | | | | | | | | | | | | | | |
| Establish accounts | | | | | | | | | | | | | | | | | | | | |
| Develop premium billing, receivable and cash receipts processes | | | | | | | | | | | | | | | | | | | | |
| Develop accounts payable and cash disbursement procedures | | | | | | | | | | | | | | | | | | | | |
| **PAYROLL MANAGEMENT SYSTEM** | | | | | | | | | | | | | | | | | | | | |
| Select payroll service provider | | | | | | | | | | | | | | | | | | | | |
| Implement payroll software | | | | | | | | | | | | | | | | | | | | |
| Develop payroll processes | | | | | | | | | | | | | | | | | | | | |
| **SUSTAINABILITY** | | | | | | | | | | | | | | | | | | | | |
| Develop Annual Budgeting Process | | | | | | | | | | | | | | | | | | | | |
| Develop Long-term Financial Planning for Forecasting and Projections | | | | | | | | | | | | | | | | | | | | |
| Quarterly benchmark, review and improve | | | | | | | | | | | | | | | | | | | | |

## *3. PLAN AND TIMELINE FOR BUILDING OR RENTING A SECURE AND SCALABLE IT SYSTEM FOR ADMINISTRATIVE FUNCTIONS AND CLINICAL FUNCTIONS*

With the assistance of the IT Department of UNITE HERE HEALTH, HHC will build a secure and scalable IT system for eligibility and enrollment, data warehouse, and claims payments. The system will be complete by the time enrollment begins in October 2013.

**TableG.3: Timeline for implementation of IT system**

| | 2012 | | | | 2013 | | | | 2014 | | | | 2015 | | | | 2016 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quarter | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 |
| **DEVELOP ENROLLMENT SYSTEM** | | | | | | | | | | | | | | | | | | | | |
| Contract with eligibility vendor | | | | | | | | | | | | | | | | | | | | |
| Project planning | | | | | | | | | | | | | | | | | | | | |
| Project initiation and kickoff | | | | | | | | | | | | | | | | | | | | |
| Development and testing of system | | | | | | | | | | | | | | | | | | | | |
| Organizational readiness, interface with other systems, training | | | | | | | | | | | | | | | | | | | | |
| Implementation of online enrollment | | | | | | | | | | | | | | | | | | | | |
| **DEVELOP DATA WAREHOUSE** | | | | | | | | | | | | | | | | | | | | |
| Hardware and licensing | | | | | | | | | | | | | | | | | | | | |
| Identify data exchange requirements | | | | | | | | | | | | | | | | | | | | |
| Develop data exchange system | | | | | | | | | | | | | | | | | | | | |
| Design data warehouse | | | | | | | | | | | | | | | | | | | | |
| Analysis, development and testing | | | | | | | | | | | | | | | | | | | | |
| Deployment | | | | | | | | | | | | | | | | | | | | |
| **DEVELOP CLAIMS PAYMENT SYSTEM** | | | | | | | | | | | | | | | | | | | | |
| Provider contract review and repricing | | | | | | | | | | | | | | | | | | | | |
| Benefit plan and vendor analysis | | | | | | | | | | | | | | | | | | | | |
| Build benefit plans in claims system | | | | | | | | | | | | | | | | | | | | |
| Auto-adjudication completion | | | | | | | | | | | | | | | | | | | | |
| Hire key claims staff | | | | | | | | | | | | | | | | | | | | |
| Test system, repricing, auto-adjudication | | | | | | | | | | | | | | | | | | | | |
| Finish staffing and equip workspace | | | | | | | | | | | | | | | | | | | | |
| **Sustainability** | | | | | | | | | | | | | | | | | | | | |
| Test claims/precertification/provider loads and fulfillment/correspondence | | | | | | | | | | | | | | | | | | | | |
| Quarterly benchmark, review and improve | | | | | | | | | | | | | | | | | | | | |

## *4. PLAN AND TIMELINE FOR INNOVATIVE TECHNOLOGY AND/OR COMPLIANCE WITH HIT*

**PLANS FOR INNOVATION AND HEALTH INFORMATION TECHNOLOGY**

Hospitality Health proposes to use the in-kind support provided by the Culinary Health Fund (CHF) to develop two major innovation initiatives that can improve patient and provider satisfaction, reduce health care costs, and focus on patient outcomes. These innovation initiatives will be possible early in the development of the CO-OP because it will have the foundation of the CHF provider tools to build upon. This foundation allows the CO-OP to begin

with an established broad network, a provider payment incentive to implement an electronic health record in physician offices, and a well established local provider profiling tool to measure physician efficiency and quality.

Because of this strong foundation, the CO-OP has the opportunity to develop and blend together two new quality and cost innovations focused on improving the health and health care of chronically ill patients by coupling human outreach with new health information technology. Both a well-resourced ***health care navigator program*** and a ***telehealth collaborative*** will allow the CO-OP to create one plan design focused on new methods for addressing the significant health care needs of the high-cost chronically ill.

**Health navigators:** Hospitality Health CO-OP will develop a **health navigator program** to serve as the critical human touch for both "boots on the ground" in identifying community resources to support member and provider development; and in connecting with members and patients to become active partners in their health care. Upon enrollment in Hospitality Health, each CO-OP member will be connected to a Hospitality Health navigator. This navigator will support three interrelated CO-OP functions: the development of the CO-OP; the education and patient activation process of our member/patient population, and the support of the CO-OP innovation and integration projects. The navigators will be a vital link in the health services provided to CO-OP members. Navigators will support members in completing their care through phone calls and reminder postcards, assistance with making follow-up appointments, and follow up after planned care to obtain member feedback on quality and accessibility of services.

**Telemedicine collaborative**: Hospitality Health proposes to have the CO-OP health navigators participate in the development of a public-private partnership with the University of Nevada, Division of Health Sciences, a large telemedicine partner, a readmission reduction partner, and the Culinary Health Fund. This collaborative will develop one plan option that will focus on the development of a core delivery system that uses a complete and integrated online telehealth program solution that allows payors and their healthcare providers to have immediate, live, and clinically meaningful consultations online through video, secure text, chat or phone. The CO-OP health navigators will help enroll patients in the plan using the core delivery system and linked primary care collaborative, and support the patient and provider as they develop care focused on better health and lower costs by bringing convenient access to needed care while removing barriers of geography, mobility, and timeliness of healthcare services. The Linked PC Coordinated Online Care Suite will support targeted complex care interventions and continuity of care through bi-directional data exchange and integration within core delivery systems – while reducing medical costs by shifting care away from higher-cost settings such as ERs, urgent care centers and crowded provider offices. The Coordinated Online Care Suite allows treatment across the care continuum, from acute care needs to the creation of specific online best practices to treat high-cost chronic conditions. This technology can quickly bring together coordinated multi-disciplinary care teams to collaborate on behalf of patients with specific and comorbid conditions. Linked PC's public-private partnership and methodology will be supported by the CO-OP health navigators who will help identify possible high-value patients, compile patient survey data, track patient outcomes and help patients in the PC-linked Core delivery begin to use online and video patient visit technology.

Two additional innovative technologies are still gaining acceptance in the Nevada provider community. CHF is a leader in the effort to promote adoption of meaningful electronic health records and physician profiling. Hospitality Health CO-OP will promote their use from its inception.

**Electronic health records in physician offices:** CHF currently collaborates with the Nevada REO to convert physician offices to the meaningful use of electronic health records. This collaboration includes increased reimbursement to our primary care physicians who use an electronic health record of their choice for the functions required by CMS for meaningful use. Approximately 30% of physician groups contracted with CHF now use an EHR. As this rate increases, the CO-OP will benefit from the increased EHR saturation among its network that will allow the use of more integrated HIT, such as the linked primary care program outlined above.

**Physician profiling program:** CHF will make it profiling program available to the Hospitality Health CO-OP as an in-kind contribution. CHF has, over the last decade, developed its own physician profiling program tracking care delivered by all network doctors in the Las Vegas community. This has allowed the profile program to define for the patient population and the provider network within a specific geographic area how care is delivered by episodes of care (i.e. medical condition) within each specialty. While the system is not perfect, it has created a comparative database of results that each physician can use to assess and modify his or her own performance. Thus, CHF has codified the local 'standard of care' that our participants receive, and we can assume that on average it is more optimal than care that deviates dramatically from the norm. In this way, we motivate and shape provider behavior to become more uniform and less variable, which translates into better quality and often, although not always, less costly care as well.

Please see Table G.4 beginning on the next page.

## Table G.4: Timeline for Implementation of Innovations

| | 2012 | | | | 2013 | | | | 2014 | | | | 2015 | | | | 2016 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quarter | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 |
| **HEALTH NAVIGATOR** | | | | | | | | | | | | | | | | | | | | |
| Plan Navigator and telehealth 'linked' PC | | | ■ | ■ | | | | | | | | | | | | | | | | |
| Train Health Navigators /CDS providers | | | | | | ■ | ■ | ■ | | | | | | | | | | | | |
| Health Navigators market to membership | | | | | | ■ | ■ | ■ | | | | | | | | | | | | |
| Members enroll | | | | | | ■ | ■ | ■ | | | | | | | | | | | | |
| Patients begin access of CDS plan | | | | | | | | | ■ | | | | | | | | | | | |
| **TELE-HEALTH COLLABORATIVE** | | | | | | | | | | | | | | | | | | | | |
| Form public/private collaborative | | ■ | ■ | | | | | | | | | | | | | | | | | |
| Establish Telemedicine capabilities | | | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | | | | | |
| Link core delivery system to EMR | | | | | | | | | ■ | ■ | | | | | | | | | | |
| Design Benefit Plan to support telehealth-based core delivery system | | | | | ■ | ■ | ■ | | | | | | | | | | | | | |
| Market plan to high value patients | | | | | | ■ | ■ | ■ | | | | | | | | | | | | |
| CDS doctors start use of linked PC | | | | | | | | | ■ | | | | | | | | | | | |
| Northern expansion of linked PC/CDS | | | | | | | | | | | ■ | | | | | | | | | |
| Recruit Northern CDS candidates | | | | | | | | | | | ■ | ■ | | | | | | | | |
| North plan marketing and enrollment | | | | | | | | | | | | ■ | | | | | | | | |
| Introduce direct video visit to patients | | | | | | | | | | | | | ■ | ■ | ■ | | | | | |
| Access leverage for all plans and regions | | | | | | | | | | | | | ■ | ■ | ■ | | | | | |
| Rural expansion of linked PC/CDS , model direct tele-health visit for rural members | | | | | | | | | | | | | | | ■ | ■ | | | | |
| Enroll rural members in CDS | | | | | | | | | | | | | | | | ■ | | | | |
| Establish direct visits between patient/provider | | | | | | | | | | | | | | | | | | ■ | ■ | |
| **ELECTRONIC MEDICAL RECORD** | | | | | | | | | | | | | | | | | | | | |
| Continue EMR for meaningful use | | ■ | ■ | | | | | | | | | | | | | | | | | |
| Share data between providers | | | | | | | | ■ | ■ | | | | | | | | | | | |
| EMR - integrate into provider EMRs | | | | | | | | | ■ | ■ | | | | | | | | | | |
| Select vendor, complete leasing for EMR | | ■ | ■ | | | | | | | | | | | | | | | | | |
| Develop provider outreach strategies. | | ■ | ■ | | | | | | | | | | | | | | | | | |
| Target offices not on EMR with leased EMR | | | ■ | ■ | | | | | | | | | | | | | | | | |
| Train staff in installation/oversight of EMR | | | | ■ | ■ | | | | | | | | | | | | | | | |
| Pilot EMR in Medical Home | | | | ■ | ■ | | | | | | | | | | | | | | | |
| Patient records feed into EMR | | | | | ■ | ■ | | | | | | | | | | | | | | |
| Share data between providers – north/rurals | | | | | | | | | | | | | ■ | ■ | ■ | ■ | ■ | ■ | | |
| Integrate CDS into EMRs – north/rurals | | | | | | | | | | | | | | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| **PHYSICIAN PROFILING PROGRAM** | | | | | | | | | | | | | | | | | | | | |
| Select CDS participating providers | | | ■ | ■ | | | | | | | | | | | | | | | | |
| **SUSTAINABILITY** | | | | | | | | | | | | | | | | | | | | |
| Conduct Quarterly meetings with CDS | | | | | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Begin North quarterly meetings | | | | | | | | | | | | | ■ | ■ | ■ | | | | | |
| Begin Rural quarterly meetings | | | | | | | | | | | | | | | | | | ■ | ■ | ■ |
| Quarterly benchmark, review and improve | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |

## *5. TIMELINE OF KEY ACTIVITIES AND CONTRACTS REQUIRED TO ACCEPT APPLICATIONS FOR ENROLLMENT AND PROVIDE COVERAGE*

Hospitality Health CO-OP plans to contract with an enrollment vendor such as Insure Monkey to develop the enrollment system with interface to the Silver State Exchange and conduct enrollment for the CO-OP. A draft proposal from Insure Monkey, which is headquartered in Nevada and is currently used by the largest commercial insurance carrier in Nevada, is attached in Appendix D. While the opportunity to work with a vendor headquartered in Nevada is desirable, if possible, the CO-OP leadership will assess other vendors and any additional viable vendors for this service will submit bids. CO-OP leadership will then negotiate a contract and rate that will meet the needs of the CO-OP structure and future members while providing services as efficiently as possible.

As described in the following timeline, system design and interface with the Exchange will be completed by the end of 2012, in preparation for beginning enrollment in October, 2013. All systems will be tested, and information collection and feedback loops will be established to populate the data warehouse and inform any necessary program modifications.

The expansion of the network to Northern Nevada (Reno) in January 2015, and to the balance of the state (Rural Nevada) in January 2016, will be preceded by enrollment campaigns in those areas.

Please see Table G.5 beginning on the next page.

**Table G.5: Timeline for accepting enrollment and providing coverage**

| | 2012 | | | | 2013 | | | | 2014 | | | | 2015 | | | | 2016 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quarter | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 |
| **DEVELOP ENROLLMENT MODULE** | | | | | | | | | | | | | | | | | | | | |
| Contract with enrollment Vendor | | | | | | | | | | | | | | | | | | | | |
| Create implementation team, project plan | | | | | | | | | | | | | | | | | | | | |
| Complete customer service options for website, walk in, telephone, mail in, retail. | | | | | | | | | | | | | | | | | | | | |
| Complete web portal interface, customer service, enrollment applications, billing, and financial reporting | | | | | | | | | | | | | | | | | | | | |
| Hire and Train Enrollment Staff | | | | | | | | | | | | | | | | | | | | |
| Integrate enrollment functions with Claims | | | | | | | | | | | | | | | | | | | | |
| Complete premium calculator installment, | | | | | | | | | | | | | | | | | | | | |
| Complete eligibility verification application | | | | | | | | | | | | | | | | | | | | |
| Complete account management application | | | | | | | | | | | | | | | | | | | | |
| Pilot test on Silver State Exchange | | | | | | | | | | | | | | | | | | | | |
| Translate enrollment Applications | | | | | | | | | | | | | | | | | | | | |
| Complete enrollment instructions | | | | | | | | | | | | | | | | | | | | |
| **COLLECTING PREMIUMS** | | | | | | | | | | | | | | | | | | | | |
| Install bilingual statements, collections | | | | | | | | | | | | | | | | | | | | |
| Design transaction reports | | | | | | | | | | | | | | | | | | | | |
| Complete online bill payment set up | | | | | | | | | | | | | | | | | | | | |
| Install retail bill payment options | | | | | | | | | | | | | | | | | | | | |
| Begin collecting premiums | | | | | | | | | | | | | | | | | | | | |
| Begin collecting subsidies | | | | | | | | | | | | | | | | | | | | |
| Complete financial report integration | | | | | | | | | | | | | | | | | | | | |
| Expand enrollment capacity to North | | | | | | | | | | | | | | | | | | | | |
| Expand enrollment capacity to Rurals | | | | | | | | | | | | | | | | | | | | |
| **SUSTAINABILITY** | | | | | | | | | | | | | | | | | | | | |
| Quarterly benchmark, review and improve | | | | | | | | | | | | | | | | | | | | |

## *6. DESCRIPTION OF STAFFING NEEDS AND TIMELINE DEMONSTRATING HOW STAFFING WILL BE ADDED OVER TIME*

The Hospitality Health CO-OP will rely on a highly experienced executive leadership, as outlined in Section A of the Business plan. This leadership will be supported by a robust staff model based on experience demonstrating the importance of a team in identifying plan and community trends that can erode plan effectiveness and financial stability. Both the clinical support team and the health navigator program will provide good return on their investment in the form of reduced plan trend if the CO-OP team is working effectively. A complete description of the proposed CO-OP staffing is located in Appendices A and B, including all job descriptions. The five-year operating budget (6.a. Operating budget detail.xlsx) shows when each position will be added. The proposed organizational structure is charted for each of the first five plan years in Appendix A.

## *7. STRATEGY FOR BEARING RISK AND PLAN TO PURCHASE REINSURANCE OR SHARE WITH PROVIDERS*

During 2012, UNITE HERE HEALTH will establish a robust local data warehouse in Las Vegas for Hospitality Health CO-OP. The data warehouse will be used extensively by the CO-OP to inform the design of benefits and the structure of the delivery system for each plan offered by the CO-OP. The establishment of the data warehouse will be an in-kind contribution of UNITE HERE HEALTH, valued at $200,000.

The data warehouse will collect all data and generate extensive reports on a daily, monthly, and quarterly basis. An example of the reports that will be generated is attached in AppendixH.MARS.pdf. Daily reports will include:

- Baseline total medical spend
- Study of demographics
- Top five professional diagnoses
- ER report
- Hospital census
- Out of area care
- Paid claims (CY2014
- Study of spend by category:
  - Inpatient medical/surgical days
  - Facility emergency room
  - Physician office visit
  - Pharmacy
  - Facility outpatient surgery
  - Radiology
  - Summary of facilities
  - Top dollars paid by facility
  - Top 5 hospital – inpatient services
  - Top 5 facilities – outpatient services
  - Professional Services Summary
  - Top 5 Professional Service Providers

Based on the data analysis, HHC will develop a model of a medical home and primary care physician supported by a rich environment of electronic medical records, telemedicine, and electronic consults. This model will be piloted in Southern Nevada so that it will be an important component of the care available when the CO-OP begins to market its policies in the Rural Nevada area, which has severe shortages of primary care physicians as well as specialists.

In 2013 and 2014, HHC will develop a model of risk-sharing with providers. This model will be developed in collaboration with contracted providers through a series of quarterly meetings during which HHC will share provider experience data, and providers will make recommendations to HHC on how costs can be managed and shared. By the beginning of 2015, the model will be fully developed and ready for implementation.

**Table G.7: Timetable for establishing system to predict risk**

| | 2012 | | | | 2013 | | | | 2014 | | | | 2015 | | | | 2016 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quarter | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 |
| **BENCHMARK** | | | | | | | | | | | | | | | | | | | | |
| Establish robust data warehouse | | | | | | | | | | | | | | | | | | | | |
| **REINSURANCE** | | | | | | | | | | | | | | | | | | | | |
| Identify re-insurance options. | | | | | | | | | | | | | | | | | | | | |
| Identify care-specific coverage options | | | | | | | | | | | | | | | | | | | | |
| Contract for reinsurance | | | | | | | | | | | | | | | | | | | | |
| Develop capacity for future provider risk sharing (see innovation plan, g. 4) | | | | | | | | | | | | | | | | | | | | |
| **DEVELOP ANALYSIS CAPACITY** | | | | | | | | | | | | | | | | | | | | |
| Develop dashboard reports (MARS report) | | | | | | | | | | | | | | | | | | | | |
| Selection core delivery | | | | | | | | | | | | | | | | | | | | |
| Contract global rates for knees, hips, backs | | | | | | | | | | | | | | | | | | | | |
| Establish primary care incentive based on medical home | | | | | | | | | | | | | | | | | | | | |
| Continue EMR | | | | | | | | | | | | | | | | | | | | |
| Begin Linked video teleconferencing | | | | | | | | | | | | | | | | | | | | |
| Use modeling to contract selected providers | | | | | | | | | | | | | | | | | | | | |
| Train CDS providers on model | | | | | | | | | | | | | | | | | | | | |
| Complete provider risk management capacity building | | | | | | | | | | | | | | | | | | | | |
| **DELEGATE RISK** | | | | | | | | | | | | | | | | | | | | |
| Begin data collection from plans | | | | | | | | | | | | | | | | | | | | |
| Segment data by specialties, target for risk-sharing | | | | | | | | | | | | | | | | | | | | |
| *Physicians start cases | | | | | | | | | | | | | | | | | | | | |
| Develop tools to transition segmented providers to accountable providers in 2015 | | | | | | | | | | | | | | | | | | | | |
| Delegate risk to accountable providers; use tools to measure outcomes | | | | | | | | | | | | | | | | | | | | |
| **SUSTAINABILITY** | | | | | | | | | | | | | | | | | | | | |
| Quarterly benchmark, review and improve | | | | | | | | | | | | | | | | | | | | |

## *RISK BEARING STRATEGY*

HHC will be a risk-bearing entity and will takes steps to reduce the risk exposure associated with operating a health plan. These are outlined below.

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

2. HHC intends to purchase reinsurance with low deductible ($200,000) coverage to provide protection against large claims. HHC will endeavor to obtain coverage at a competitive price.

3. HHC will, in accordance with the expectations of CO-OPs, plans to enter into contracts with providers that not only reduce the overall cost of healthcare but will also pass some of the financial risk to participating providers. Risk-sharing with providers serves to help align incentives between the plan and its providers, and has the effect of reducing unnecessary utilization. The following contracting strategies will be used:

    a. Bundled payments for orthopedic procedures, cardiac, and other bundles
    b. Case rate payments for hospital services, and
    c. Primary care provider risk-bearing in the context of medical homes.

## *REINSURANCE*

HHC realizes it will have to purchase reinsurance to avoid significant annual fluctuations in claims that could threaten solvency. HHC also realizes the need for reinsurance is greater in the early years when it has fewer members. The intent is to review reinsurance options and purchase reinsurance that provides the most value to HHC. It is HHC's intent to take a conservative approach and purchase individual stop-loss coverage with a deductible of $200,000.

Once HHC selects a reinsurer, detailed analysis will be performed to gain a better understanding of the variability in large claims, HHC's ability to bear such risk (especially in the early years of the CO-OP), and the cost of the reinsurance including any capital contribution. HHC expects to re-evaluate the need for reinsurance annually as claim history is established.

# EXHIBIT 2

# EXHIBIT 2

**MINUTES OF THE REGULAR MEETING OF**
**THE FORMATION BOARD OF DIRECTORS OF NEVADA HEALTH CO-OP**

**February 19, 2014**

A regular meeting of the Board of Directors of Nevada Health CO-OP, a Nevada non-profit, non-stock cooperative corporation (the "CO-OP"), was held on February 19, 2014, at 3900 Meadows Lane, Suite 100, Las Vegas, NV 89107 pursuant to notice duly given. The following Directors were present: Jeff Ellis, Bobbette Bond, Christine Carafelli, Kathy Silver, Tom Zumtobel and Danny Thompson. D Taylor was not present.
The following guests were present: Lynn Fulstone Esq. (Lionel Sawyer Collins) Basil Dibsie, Chief Financial Officer (NHC), Dr. Nicole Flora, Chief Medical Officer, (NHC) and Pam Egan, Chief Development Officer (NHC). Cara Elias Esq. (Brownstein Hyatt Farber Schreck) and James Clough Esq. (Seyfarth Shaw, LLP) attended telephonically. Michele Schultz was present as minute's taker.

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Mr. Ellis called the meeting to order at 1:10pm.

**I** **Executive Session:** *Language for this section will be drafted and circulated under separate cover.*

**II** **Approval of Minutes:** Mr. Ellis asked members if there were any objections or corrections to the January 22, 2014 Board meeting minutes. No objections were heard. Ms. Silver motioned to approve the minutes. Mr. Thompson seconded Ms. Silver's motion. All in favor. Motion carried.

Mr. Zumtobel asked Mr. Ellis to adjust the order of the Board Agenda so that he could present an update on The Silver State Health Insurance Exchange while Mr. Brignone was still present. Mr. Ellis asked Board Members if there was any objection to the request. No objection heard.

**V** **Operational Report:**

**1. Nevada Health Link Update:** Mr. Zumtobel explained the on-going issues and challenges the CO-OP has been experiencing with the enrollment process through the State Exchange. Mr. Zumtobel explained that he has been participating in three meetings a week with the Governor's

office, the other carriers and Xerox to communicate the challenges the CO-OP is experiencing with data submission from Xerox to the CO-OP. Currently, there are more than 3,000 members that are on Xerox's pending list that the CO-OP has not received any data on to date. The 834's and 820's remain being delayed getting to the CO-OP and when received, the data is incomplete. Mr. Zumtobel informed the Board that he is speaking regularly with Governor Sandoval's office regarding the CO-OP's challenges with Xerox. He went on the say the contract the State of Nevada has with Xerox has some concerning gaps. One such gap being no performance guarantee written in the contract between the State and Xerox. Mr. Zumtobel reported to the Board that at the last Exchange Board meeting during public comments, a consumer came forward and reported that he had suffered a heart attack December 31, 2013 resulting in his need for immediate heart surgery that left him with a 410k hospital bill. The consumer was reported by Xerox to be a Nevada Health CO-OP member although the CO-OP had no record of this. Xerox had not communicated eligibility to the CO-OP on this consumer's behalf. Mr. Zumtobel went on to say from what has been communicated thus far, this consumer originally looked at the CO-OP but ultimately selected another carrier (Health Plan of Nevada). Mr. Zumtobel stated to the Board that Xerox is negatively impacting the CO-OP's membership. If the CO-OP was aware of this consumer being our member the CO-OP could manage his care. Mr. Ellis voiced his concern as to where the State's responsibility to the consumer and to the CO-OP lied. Mr. Ellis went on to say that the CO-OP had no opportunity to manage the patient. Mr. Zumtobel introduced to the Board the idea of sending a letter to Governor Brian Sandoval outlining the CO-OP's complaint that the CO-OP had no opportunity to manage this patient, the negative impact Xerox is having on the CO-OP's membership and the difficulty of advocating through this broken exchange. The Board Members and CO-OP attorneys spent time strategizing. Mr. Brignone discussed his thoughts to the Board. Board members all agreed to have the CO-OPs' attorneys prepare a letter to Xerox and to Governor Brian Sandoval outlining: 1) the problems the CO-OP is experiencing with Xerox 2) How Xerox has injured the CO-OP's members by not addressing the over 3, 000 members on the pending list 3) How Xerox has and continues to hurt the CO-OP's credibility in the market place.

**III** **Financial Report: December Financial Statements:** Mr. Dibsie presented to the Board the December 2013 Balance Sheet, Statement of Operations and Cash Flow Statement. The Board members discussed various aspects of these financials reports. Mr. Dibsie informed the Board that the CO-OP had a total of forty-five (45) employees at the end of 2013. In January 2014, there was one (1) additional employee hired. Mr. Dibsie informed the Board he had extended two

(2) employment offers for his department to fill the positions of Accounts Payable Clerk and Underwriter for Large Groups. These two (2) additions to staff will bring the staff total to forty-eight (48) CO-OP employees by the end of March 2014.

**CMS Additional Funding Request Update:** Mr. Dibsie updated the Board on the status of the CO-OP's request for additional funding from CMS. He explained that two weeks prior he participated in a status call with CMS whereby CMS was seeking CO-OP responses to additional questions around its request for funding. Mr. Dibsie stated the questions CMS were seeking answers to were: 1) CMS wanted the CO-OP's Administrative Budget for 2014. 2) CMS requested the CO-OP's membership forecast for 2015-2033. Mr. Dibsie informed the Board that it appears the process by which CMS has used in the past to determine the outcome of CO-OP's seeking additional funding as changed. Mr. Dibsie added that the CO-OP and CMS are still engaging in conversations around the CO-OP's request and looks forward to the final disposition. Mr. Ellis asked how the remaining solvency funding would be transferred to the CO-OP. Both Mr. Zumtobel and Mr. Dibsie were unsure how the remaining solvency funding would be delivered to the CO-OP, or the exact request process. Mr. Zumtobel stated he felt CMS was trying to work through delivery method particularly with the current political climate in Washington DC. Mr. Ellis asked if the CO-OP had started to pay claims. Ms. Egan reported to Mr. Ellis and the board that there has been a total of 2, 800 claims received, approximately 2,300 of which were submitted in paper form and of that, 42 claims have been paid. Total amount of claims paid out to date is $8k.

**2014 Forecast/Draft Budget:** Mr. Dibsie presented to the Board spreadsheets related to Nevada Health CO-OP's 2014 Forecast which illustrated the overall assumptions for Membership, Premium Revenue, Benefit Cost, Investment Income, and Operational Administrative Expenses. Additionally, Mr. Dibsie reviewed Nevada Health CO-OP's 2014 Budget-Forecast which outlined the monthly forecast summary with membership at the top and the financials at the bottom. Lastly, the Preliminary Operational Budget was presented to the Board. Mr. Dibsie explained the detailed listing of the CO-OP's Operational Administrative Budget. He explained that the first three columns in the spreadsheet illustrate the operational figures for 2013 while the fourth column represents the Preliminary Budget for 2014. Ms. Carafelli expressed her satisfaction with Mr. Dibsie's presentation.

**IV Outreach Plan**

This section was not discussed.

Due to the meeting going over the allotted time, Mr. Ellis motioned to adjourn the meeting. Mr. Zumtobel asked that the Board take up the issue of him transitioning from Unite Here Health to Nevada Health CO-OP at the March meeting. Mr. Zumtobel stated he always planned to come over to the CO-OP and would like direction on next steps. Ms. Bond suggested that the Board consider forming a separate committee to focus on the negotiations of Mr. Zumtobel's transition. Secondly, Ms. Bond asked the Board to take up the issue of the CO-OP adopting a policy of not hiring relatives at the March 2014 Board meeting. Mr. Ellis accepted Ms. Bond's request to have these points heard at the next Board meeting.

Mr. Ellis adjourned the meeting at 2:40pm (PST).

# EXHIBIT 3

# EXHIBIT 3

**MINUTES OF THE REGULAR MEETING OF**
**THE FORMATION BOARD OF DIRECTORS OF NEVADA HEALTH CO-OP**

**April 29, 2014**

A regular meeting of the Board of Directors of Nevada Health CO-OP, a Nevada non-profit, non-stock cooperative corporation (the "CO-OP"), was held on April 29, 2014, at 3900 Meadows Lane, Suite 100, Las Vegas, NV 89107 pursuant to notice duly given. The following Directors were present: Jeff Ellis, Bobbette Bond, Christine Carafelli, Kathy Silver and Tom Zumtobel. D Taylor and Danny Thompson attended telephonically.
The following guests were present: Basil Dibsie, Chief Financial Officer (NHC), Dr. Nicole Flora, Chief Medical Officer, (NHC), Pam Egan, Chief Development Officer (NHC) and Gwendolyn Harris, Compliance Officer (NHC). James Clough Esq. (Seyfarth Shaw, LLP) and Cara Elias Esq. (Brownstein Hyatt Farber Schreck) attended telephonically. Michele Schultz was present as minute's taker.

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Mr. Ellis called the meeting to order at 1:05pm.

**I** **Approval of Minutes:** Mr. Zumtobel identified Board members present to those participating telephonically. Mr. Ellis asked Board members if they had an opportunity to review the minutes from the March 2014 meeting. Mr. Ellis asked if there were any objections to the March 2014 Board meeting minutes. No objections were expressed. Ms. Silver motioned to approve the minutes. Ms. Carafelli seconded Ms. Silver's motion. All in favor. Motion carried.

**II** **Financial Report:**

**Enrollment:** Mr. Dibsie presented the enrollment figures as of April 28, 2014. There are 14,493 members enrolled with the CO-OP. Mr. Dibsie reported that in the past month 5,000 consumers became members and in the past week the CO-OP added an additional 900 members. Mr. Dibsie stated the CO-OP continues to work on the pending list and expects to convert some of those to members during the special enrollment period. He stated the CO-OP is on target with the initial enrollment projections of 14,000 members by April 2014.

**February Financial Statements:** Mr. Ellis asked what percentage of total membership selected was Dr. Warren Volkers' group. Mr. Zumtobel responded that almost half of the CO-OP's membership at approximately 7,200 members are enrolled in a WellHealth plan. Ms. Silver

asked about the Union Star plan. Mr. Zumtobel stated the plan is Dr. Volker's group at WellHealth Network and the plan was designed to attract small unions and members that did not have enough hours. Mr. Ellis asked if the Star plan on Exchange was the cheapest plan. Mr. Zumtobel responded that the Star plan ended up being the most affordable. Milliman gave CO-OP good managed care credit to both the WellHealth and Neighborhood plans, although Neighborhood did not get enough value to offset their capitation. Milliman provided an average premium of $259.62 and CO-OP is receiving $355.54 which is about 37% higher. Good news is the CO-OP has room on Administrative loss ratio, however the CO-OP has older members that need to be managed. Mr. Zumtobel stated that Dr. Flora is familiar with risk adjustment which is helpful if the older members are too sick. Ms. Silver asked how subsidy applied to the CO-OP plans. Dr. Flora responded that all the plans can receive a subsidy however, only on the Silver plan is there cost share.

Mr. Dibsie reviewed the Statement of Operations report for February 2014. Mr. Dibsie pointed out the CO-OP's PMPM is higher since members are still enrolling. Benefit cost on the cost ratio side is 84.9% for the month because of the age of members and lack of claims data available for the month. Additionally, the higher PMPM gave the CO-OP additional Administrative dollars. Mr. Ellis asked how much of the actual outsourced costs are fixed or will it go up with enrollment. Mr. Dibsie responded that there is an Administrative fee with Unite Here Health that is PMPM. Further, enrollment and customer service expenses will decrease. Mr. Zumtobel stated the customer service agreements with InsureMonkey are cost plus and are expected to go down. Mr. Zumtobel asked Mr. Dibsie to look at the enrollment expense with InsureMonkey after the special enrollment period. Mr. Dibsie indicated that the only item that stood out for the monthly Administrative cost was the legal fee for the month which he explained were due to the Congressional Inquiry expense resulting in a variance for legal fees of $17,556.

Mr. Taylor asked the status of the ongoing investigation by the Congressional Oversight Committee. Ms. Harris responded that the CO-OP had submitted its final documentation to the most recent Congressional Committee Inquiry. Ms. Harris went on to say that there were some CO-OP's that had received additional request from the Congressional Committee. Ms. Bond asked why other CO-OP's had received additional requests. Ms. Harris speculated that perhaps it was due to low enrollment since the scope of the additional questions centered on enrollment projections. Ms. Elias added it could be in part due to limited information provided in response to the inquiry.

Mr. Dibsie reviewed the Supplemental Schedule – Premium & Membership report for January/February 2014. The spreadsheet was prepared at the request of the Board which broke down premium revenue into subsidy and unsubsidized revenue. There is an approximate total of 67% of premium revenue that is generated from subsidy with 33% being the members' responsibility. Mr. Ellis asked if the CO-OP was receiving the subsidy revenue from the government. Mr. Dibsie responded the CO-OP is receiving the funds the 21st of each month. Ms. Bond asked if the IT expense for ICloud was fixed. Mr. Zumtobel stated he was looking for ways to drive down that expense, but felt somewhat stuck as the CO-OP is in a multi-year contract. Potentially, Unite Here Health may take over a portion of the cost as they convert to Javelina.

Mr. Dibsie reviewed the Balance sheet for February 2014. There is a decrease in startup funding by 1.6M for the month of February. Mr. Dibsie went on to report the CO-OPs' balance is under 2M in startup funding as of April. Mr. Dibsie reviewed the balance of the CO-OP's solvency funding stating Bank of America is holding 2.9M. The investment managers are holding 15M. Long term bonds are being purchased on the CO-OP's behalf with these funds. The interest income has doubled since the middle of February. The CO-OP received an additional 21M in solvency funding at the end of March which was placed with the investment managers. Mr. Dibsie asked the Board what type of Bonds they thought best not to purchase. Mr. Zumtobel proposed this question may be best considered by the Audit Committee or by the Board drafting a policy that speaks to the CO-OP's corporate culture. Mr. Thompson stated he would bring back the guidelines the AFL-CIO uses to determine their bond investments. Mr. Dibsie presented a spreadsheet that showed the month over month for January/February compared to year-to-date budget. He explained that overall, the CO-OP's administrative expenses are favorable at $152, 000 year-to-date. He asked if any Board members had questions.

**Claims Reports:** Mr. Dibsie presented the claims report as of April 24, 2014. He presented a spreadsheet sheet whereby the claims were segregated by month of service. The CO-OP has paid out 7,200 claims totaling 1.6 M. Currently, there are 3,600 pending claims. Ms. Silver asked if the claims report was segregated geographically. Mr. Dibsie indicated the spreadsheet was not broken down by Northern and Southern regions. Ms. Silver asked if the CO-OP's rates in Northern Nevada were competitive. Mr. Zumtobel responded that the CO-OP's rates were 40% higher than its competitors. Ms. Bond and Mr. Zumtobel expressed their surprise that the CO-OP had any members in the North. Mr. Zumtobel added that according to northern Brokers, the

CO-OP's network gave consumers an option other than St. Mary's and Hometown to choose from which may be in part due to the high unexpected membership in the North. In the future, the CO-OP plans to put a narrower network together.

Mr. Dibsie asked if there were any additional reports the Board would like to review monthly.

Mr. Ellis asked how many unpaid claims the CO-OP has in its system. Mr. Dibsie advised there were approximately 3,600 pended claims. Mr. Zumtobel stated some claims are pended because the CO-OP is not clear on the fee schedules. Dr. Flora added that there is a learning curve for the CO-OP and that organizational, the CO-OP doesn't want to deny claims due to its lack of understanding. Mr. Ellis asked what the criteria is for pending claims. Mr. Zumtobel stated the claims based off of presumed eligibility are pending. Ms. Egan added there are two triggers that automatically pend a claim. 1) non-eligible 2) out-of-network. Additionally, if there are identified issues, the CO-OP has elected to clear the issue prior to payment so that the payments are correct and thus limit the need to have to adjust after. Ms. Silver asked how the CO-OP was handling Dignity Health claims. Dr. Flora stated the CO-OP is not seeing a lot of Dignity claims and are reviewing the ones that are coming in. Ms. Bond suggested auditing the Dignity claims so as to not negatively impact the CO-OP's reputation in the community.

## III Outreach Plan

**Xerox**: Ms. Bond reported that the Exchange has been having weekly Board meetings. Mr. Zumtobel, Ms. Bond and Ms. Harris have been participating in these reoccurring meetings. Ms. Egan and Ms. Harris participate in the weekly SWAT call meetings while Mr. Zumtobel is participating in the weekly carrier calls with the Exchange.

Mr. Ellis asked how the Exchange is doing financially since the State fell short on their projected membership goals. Mr. Zumtobel stated that the carriers will end up supporting the Exchange. Going forward, Ms. Bond is concerned that once the State is over 13 in something there is no need having a State Exchange and the State may be better off going on to the Federal Exchange. Ms. Bond hopes the State will not allow this to happen. Ms. Bond stated she believes the Exchange Board is not particularly concerned with this issue as much as the carriers are.
Mr. Taylor asked if the Exchange Board has discussed going on the Federal Exchange or the McCallister lawsuit. Mr. Zumtobel responded the Exchange had not discussed the McCallister lawsuit. Further, Exchange staff provide several options to the Board which included: 1) Move

Away from Xerox 2) Move partially away from Xerox 3) Get on the Federal Exchange (the State Board thought there was not enough time to get operations up and running by the next open enrollment) 4) or Bring in Deloitte, which is what the State decided to do. Mr. Zumtobel believes Deloitte may eventually take over for Xerox as they did in Connecticut which is thought of as a great success. Mr. Zumtobel asked Gwen what she thought. Ms. Harris agreed with Mr. Zumtobel that Deloitte would eventually take over the Nevada State Exchange from Xerox. Ms. Bond and Mr. Zumtobel expressed their concern that the State will spin off premium management to the carriers. They believe the CO-OP can handle premium management however, there concern is the accuracy of the data the CO-OP would receive from the State. Ms. Bond added that the other carriers are on board with the State giving the individual carriers the premium management of their members but they too are concerned about the data they would receive from the State.

**Special Enrollment Update:**

Ms. Bond state there are three categories related to the States pending list. There are some with HIX ID's and InsureMonkey staff is reaching out to all 500 +. There were others that reached out to CO-OP but did not have HIX ID's but can sign an attestation declaring their effort to enroll via the States website. The last category is the group of consumers that walked in and were unable to get through the State system and unable to get HIX ID's. This group will sign an attestation declaring their effort to enroll via the States website. Mr. Ellis asked can we get these people enrolled for this year. Ms. Bond and Mr. Zumtobel believe we may be able to convert 10% of the consumers from the pending list. Mr. Zumtobel added there is one Xerox staff person on-site working through the issues that have the CO-OP's pended members stuck on the State Exchange.

## IV Operational Report:

In the interest of time, Mr. Zumtobel circulated his April 2014 Operational Report to the Board. (Attached)

**Board Development:** Mr. Zumtobel reported this is a CMS requirement and that all CO-OP's have the same obligation. Ms. Harris is involved in a bi-weekly NASHCO workgroup. Ms. Harris reported that there are several workgroups: 1) Elections vendor workgroup (workgroup that is seeking out a vendor that all the CO-OP's may use) 2) Communications to Members workgroup 3) Legal Compliance & Election Procedures workgroup 4) New Board Member training workgroup that Ms. Harris participates in regularly. Ms. Elias reported on the CO-OP's

need to form a Consumer Advisory Board in 2014. Ms. Elias indicated she would circulate the Bylaws to the Board and briefly explained the functioning of the Consumer Advisory Board as: it should be comprised of providers in community or well-educated consumers in the industry that reside in Nevada that can advise the CO-OP Board on key issues in the community. Nominating Committee must consist of three or more with one member appointed by the Consumer Advisory Committee. Ms. Elias stated there were three items that need to be addressed in the next couple of months. 1) Consumer Advisory Board established 2) Nominating Committee established 3) By June 30, 2014 - Date and location of 4th quarter annual meeting. Mr. Ellis asked when the operational board majority had to be CO-OP members. Ms. Elias responded by the end of 2015. She went on to say the fully Operational Board must be transitioned over at the beginning of 2016. Mr. Zumtobel and the Board discussed the work and complexity of establishing the Operational Board.

**Compliance Report:** Ms. Harris reported the CO-OP's Compliance Plan. Ms. Harris discussed the Direction to develop a culture of compliance. She stated the Board is obligated to oversee the Compliance Plan but delegates the oversight to the Compliance Officer who is also the Privacy Officer. Ms. Harris reviewed the CO-OP's plan and identified several areas: 1. Policies & Procedures 2. Oversight – coming from the Compliance Officer and Compliance Committee. Ms. Harris recommends the Compliance Committee be comprised of CO-OP employees versus just leadership as written in to the original Compliance Plan. 3. Training & Education (HIPPA and Healthcare fraud training and specific departmental trainings) 4. Communication (i.e. intranet to publish policies and a hotline phone number to report abuse) 5. Enforcement – publishing the disciplinary guidelines and following through with auditing and monitoring with the support of the CEO and Senior Leadership) 6. Monitoring and Auditing with corrective action plan. Under the Fraud Waste and Abuse section, Ms. Harris requested the language found on page 7 be revised to reflect that the CO-OP will check people against the Federal programs excluded list at time of hire and periodically throughout their employment 7) Corrective Action Plan for Offenses. Ms. Carafelli asked if there was a Federal regulatory body that monitors compliance. Ms. Harris responded there is no single regulatory agency that has oversight over all aspects of compliance, but the Office of Inspector General of US Department of Health & Human Services has enforcement responsibility for HIPAA Privacy Rule. Discussion regarding criminal background checks for employees were discussed. Ms. Harris asked the Board to approve the CO-OP's revised Compliance Plan. Mr. Ellis motioned to approve the revised Compliance Plan.

Mr. Taylor seconded the motion. All board members voted "yes". Revised Compliance Plan adopted.

**2015 Pricing Discussion:** This topic was not discussed

**Large Group Strategy:** Ms. Bond reported Mr. Dibsie is beginning to work with the actuaries to develop a strategy for large employers.

**Claims:** Discussed in Financial Report

**Customer Service:** Addressed in written Operation Report

**Staffing**: Ms. Bond presented to the Board a draft policy on hiring relatives of current staff and vendors that supply staffing to the CO-OP. She outline that the CO-OP currently had one employee at the CO-OP that is related to a Director and other, an InsureMonkey employee that is related to a CO-OP employee. Board members discussed the impact on the growth of the CO-OP and current staff. Mr. Ellis stated his company (MGM) would not accept a policy that is restrictive as the proposed policy. He stated that as long as relatives worked in different departments and did not directly report to another relative, there is no need to exclude family members from working at the CO-OP. Ms. Bond stated the CO-OP is not as large as MGM and felt that particularly due to the CO-OP's size, the employee is reporting up to relatives in the end. Mr. Taylor added in his experience with union banquet staff, he had dealt with issues of employing family members. He thought it best to adapt the policy brought forth by Ms. Bond that excludes relatives from working at the CO-OP. He felt it eliminates the appearance of favoritism. Ms. Carafelli motioned to adopt the policy moving forward and to grandfather the two existing cases from harm. Ms. Silver seconded the motion. Mr. Ellis: asked the Board to vote. All Board members voted "yes" Policy was adopted.

**CEO Contract:** This topic was not discussed

Mr. Ellis adjourned the meeting at 2:30pm (PST).

# EXHIBIT 4

# EXHIBIT 4

# MINUTES OF THE REGULAR MEETING OF
# THE FORMATION BOARD OF DIRECTORS OF NEVADA HEALTH CO-OP

**May 23, 2014**

A regular meeting of the Board of Directors of Nevada Health CO-OP, a Nevada non-profit, non-stock cooperative corporation (the "CO-OP"), was held on May 23, 2014, at 3900 Meadows Lane, Suite 100, Las Vegas, NV 89107 pursuant to notice duly given. The following Directors were present: Jeff Ellis, Christine Carafelli and Tom Zumtobel. Bobbette Bond, D Taylor and Danny Thompson were not in attendance.

The following guests were present: Basil Dibsie, Chief Financial Officer (NHC), Dr. Nicole Flora, Chief Medical Officer, (NHC) and Gwendolyn Harris, Compliance Officer (NHC). Cara Elias Esq. (Brownstein Hyatt Farber Schreck) attended telephonically. Michele Schultz was present as minute's taker.

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Mr. Ellis called the meeting to order at 11:10am.

**I** **Approval of Minutes:** Chairman Ellis discussed Roll Call with Ms. Elias and Tom Zumtobel. Meeting continued with the understanding no decisions would be made since 4 members were unable to attend the Board meeting

**II** **Financial Report:**

**Enrollment:** Mr. Dibsie presented the enrollment figures as of May 19, 2014. There are 15,088 members enrolled with the CO-OP. In the past month, the CO-OP gained 600 new members. The Exchange enrolled an additional 1,200 members since the last Board report. Mr. Dibsie stated the CO-OP has 36% of the market share. Mr. Ellis asked if the CO-OP continues to carry the market share. Mr. Zumtobel stated in the last Exchange report, Sierra gained the lead over the CO-OP by 1% which translates to a couple hundred more members. The CO-OP is working to regain the market share by doing outreach to the consumers on the pended list to receive payments. The CO-OP has until May 30th, the end of the special enrollment period to do this outreach. Mr. Ellis asked how many of the CO-OP's members have selected Dr. Volker's network. Mr. Dibsie responded 8,500 members are in Dr. Volker's Star network.

**March Financial Statements:** Mr. Dibsie reviewed the Statement of Operations report for March 2014. Mr. Dibsie stated the CO-OP's membership is currently 1,200 short of the projected target but expects enrollment to be higher than the targeted 13,000 on Exchange by the end of May. The CO-OP is still receiving premium from enrollment through the end of May. The premiums have a 22% higher than projected PMPM due to the CO-OP's demographics. Mr. Dibsie pointed out the benefit cost for the month has a 16% higher than projected PMPM, also due to demographics. Benefit cost ratio for the month is 76.6% with year to date on target at 80%.

Mr. Ellis asked if the premium tax, broker commissions, and exchange fee expenses will remain the same. Mr. Dibsie thought the broker commissions could possibly increase. He went on to explain that the Brokers unexpectedly provided 20% of the CO-OP's Exchange business at 2,300 members. Mr. Zumtobel stated he was not sure if the higher than expected Broker contribution was due to the problems consumers were experiencing with the Exchange and therefore providing an alternative entry point for signing up.

Mr. Dibsie reviewed the Administrative Expenses. He announced there were two out of budget categories. Actuarial is over budget on timing due to Nevada State Exchange moving to a "Supported State Based Marketplace" causing Rate Filings to be done earlier. The change will impact timeline and expenses. Mr. Zumtobel stated under the "State Supported Based Marketplace", there will be an earlier deadline for plan submissions. The CO-OP's filing deadline is June 27th. Mr. Ellis asked how the actuaries are doing with plan pricing for next year. Mr. Dibsie stated Milliman's rates have been coming back steady with only a 6 or 7% increase, but there is much work to be done. Mr. Zumtobel added that WellHealth will more than likely have to transition to a fee for service option for their products as there capitation rate is higher than expected claims cost as projected by Milliman. If WellHealth doesn't adjust, the pricing of their rates could be still approximately 20% higher for next year. Mr. Zumtobel stated a higher premium could reduce membership for WellHealth and CO-OP. Ms. Carafelli asked if it's expected that WellHealth will reduce its capitation rate to remain competitive and maintain enrollment. Mr. Zumtobel believes WellHealth eventually will reduce its capitation rate. Ms. Carafelli asked about the fee for service rate compared to the Medicaid rate. Mr. Zumtobel replied that Milliman used the Fund's experience to establish the fee for service equivalent. The Funds' fee for service experience is $73 PMPM while WellHealth is at $92.50 pmpm.

Mr. Dibsie pointed out the monthly expenditure from Unite Here Health administrative costs was over budget due to a 53K carry over charge from the prior month. Claims agreement for ICES software was a onetime payment of 21K. Mr. Dibsie pointed out the CO-OP operated at $985,000 deficit for the month and finished under the budgeted deficit amount of 1.1M. Favorable for March 2014.

Mr. Dibsie reviewed the Supplemental Schedule – Premium & Membership report for March 2014. The spreadsheet breaks the premium revenue into subsidy and unsubsidized revenue on and off Exchange. Approximately 70% of premium revenue is generated from subsidy with 30% being the members' responsibility. 78% of the Exchange membership is receiving a subsidy. Mr. Ellis thought the percentage would be higher with almost everyone that went on the Exchange receiving a subsidy. Dr. Flora added that most consumers were unaware they could go directly to a carrier.

Mr. Dibsie reviewed the Balance sheet for March 2014. He pointed out the CO-OP received $21M in solvency funding in March. Solvency funds continue to be held with the investment managers with $15M being invested at the end of March. Interest income for the month after all is invested is estimated at $25K. The IBNR is $3M. There are $48M in assets at the end of March. Mr. Ellis asked if the CO-OP was above its Capital Surplus requirement. Mr. Dibsie respond, the CO-OP is above Capital Surplus. Mr. Dibsie informed the Board the NAIC filing for the current quarter was completed by the due date of May 15th. RBC is filed in the annual NAIC filing report.

Mr. Dibsie presented a 3 month Statement of Operations. He explained that overall the CO-OP deficit is favorable by $208,000 year-to-date. The Administrative expenses are favorable by $158,000 versus year to date budget.

**Claims Reports:** Mr. Dibsie presented the claims report as of May 16, 2014. Total of 2.3M paid out for 9,900 claims segregated by month of service. Mr. Ellis asked what the Culinary Health Funds pays on average per claim. Mr. Zumtobel responded he was unsure but thought it was around $2.00 range. There are currently 5,500 pended claims with the majority coming in in April. Mr. Ellis asked if the CO-OP had an ageing tracking report for claims. Dr. Flora responded that she did and would send to Mr. Dibsie.

### 2013 Draft Audit Report

Mr. Dibsie reported the A-133 Compliance Report related to the Audit of Federal Awards recipients to ensure compliance with CMS program. The CO-OP has hired Larson & Company, a Utah company to perform the audit. Mr. Dibsie pointed out on page eight current checklist of findings. There was only one significant deficiency regarding the CO-OP's prior practice for payment approval. The findings were old findings found within the CMS audit of 2013 whereby expenditures were not reviewed by anyone else other than prepare/requestor. CO-OP's response was there is in-house CFO and Sr. Accountant and all internal controls are in place.

## III Outreach Plan

**Xerox**: Mr. Zumtobel reported on the Exchange Board decision to replace Xerox and form a Supported State Based Marketplace. The new system will actually be hosted by the Federal Exchange with the State of Nevada operating it. The Silver Sate Exchange staff visited with CMS and collectively, decided to form the Supported State Based Exchange which was one of many options considered. There is a zero cost for the Supported State Exchange per the Exchange Board. This plan will stay in affect for one year, then go out to bid for a replacement to Xerox. Mr. Ellis asked what the States responsibility with the new structure is. Ms. Harris reported the States responsibility under the new system is: (1) the shopping experience on the front end for consumers to navigate through (2) all advertising for State Exchange (3) on the back end, is where the eligibility and enrollment will take place and be passed to the carriers. Mr. Zumtobel explains that under the new structure, the Division of Insurance keeps primary position for plan review and if the Federal system took over, the Nevada Division of Insurance would be secondary to CMS. Mr. Ellis asked who is doing open enrollment for 2015. Ms. Harris responded the new structure will take affect for 2015 however, Xerox will continue to handle qualifying life events. Mr. Zumtobel has two concerns: (1) The CO-OP has to collect and manage premium payments starting no later than open enrollment 2014. In the meantime, the State will continue to collect premium payments on behalf of the CO-OP. (2) The renewal process for existing members. Ms. Harris explained the challenges in getting the Federal Exchange the current data considering the accuracy issues with Xerox data. The board discussed the ability to utilize Navigators to initiate pre-enrollment prior to open enrollment. Ms. Carafelli asked if the State is open to allowing consumers to remain on their existing plan if they take no action during the open enrollment period. Ms. Harris replied she expects the Exchange to do something similar.

**Special Enrollment Update:** Mr**.** Zumtobel reported the special open enrollment ends May 30, 2014. With the challenges Xerox is having with their payment channels, the CO-OP has been trying to set up a payment process. Xerox finally admitted their payment collection process is only working at 45% capacity to accept payments. Ms. Carafelli asked if the CO-OP had the ability to accept payments. Mr. Dibsie responded the CO-OP can only accept off exchange payments. The Governor's office and the Exchange Board Chair are aware of the payment collection issues with Xerox and may consider extending the deadline for consumers to make payments past May 30th. There are over 4,000 consumers wanting to pay there premium but are unable due to the system errors with Xerox. Mr. Zumtobel explained to the Board that Xerox claims there are no appeals on record. Mr. Zumtobel disagreed with that assertion as the CO-OP assists with appeals on consumers' behalf regularly. Further, Xerox presented the CO-OP with the Exchange's most recent delinquency report that listed over 900 members dated back to January 2014 that were never reported and the CO-OP was unaware of. Mr. Zumtobel expressed the overall negative impact Xerox has had on the CO-OP business. 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. Mr. Dibsie stated CO-OP staff along with the on-sight Xerox representative, will be reaching out to the 900 pended consumers and provide them an opportunity to pay.

Mr. Zumtobel explained that claims report consist of 6,000 pending claims as well as 6,000 pre-pending claims that are backlogged. The total number of pending claims is mostly the result of glitches with the CO-OP's new processing system, Javelina. Some of the glitches with Javelina were explained as: (1) cannot connect the prior authorization with a claim. Prior authorizations were paying everything or nothing. Javelina claims system is not allocating co-pays. Due to these system glitches, no claims are able to be auto adjudicated. Even after the pended claim has been corrected, the claim has to be manually processed. (2) There is a learning curve for Unite Here Health with the new system as this is a new system for them. (3) The volume of claims. El Dorado/Javelina sent a claims specialist to Unite Here Health to better understand the challenges the claims department had been experiencing. The feedback from both Unite Here Health and Eldorado was positive in that both sides heard each other and understand the problems Unite Here Health has been experiencing. Moving forward, out-patient claims that require authorization will be released and once the claims come in, the authorization will be acquired. Dr. Flora is working with doctors to show the CO-OP's commitment to paying them. Additionally, there are several new processors onboarding in the next week to assist the CO-OP with claims processing. Mr.

Zumtobel will meet with the Division of Insurance and explain the challenges the CO-OP has faced with the timely processing of claims. The hope is with the CO-OP being upfront with the Division of Insurance about the delayed processing of claims, the Division of Insurance will allow the CO-OP additional time to work through the learning curve. Concern was expressed as the Division of Insurance allowed the CO-OP to process claims out of Aurora. Mr. Ellis asked about the timeframe to get the claims processing moving. Dr. Flora estimates in the next run she anticipates 30-40% of claims to auto-adjudicate and within the next 4-5 weeks the backlog will be caught up.

## IV Operational Report:

**Board Development:** Mr. Zumtobel stated he hoped to have a list of potential members for the Consumer Advisory Group. According to the By-laws, one member from the CO-OP's Consumer Advisory Group will select one member to work with the Nominating Committee. Ms. Harris and Ms. Bond will be working to establish the annual fourth quarter meeting date in accordance with the program requirements. The deadline is June 30th 2014 to establish a date and location of the annual meeting. The board discussed ways to find interested members who would like to serve on the Board and are good communicators. Mr. Zumtobel thought of polling the customer care crew to get their feedback on consumers who may be potential candidates for the Board.

Mr. Zumtobel asked Ms. Harris to provide the Board a brief report on her meeting with Bill Oemichen. Ms. Harris reported she met with Bill Oemichen, CEO/President of Health Cooperative Network in Madison, WI. He leads a network of cooperatives from varying sectors in WI. Additionally, he is considered to be an expert in the education/training of new Operational Boards that have members who have never served on a Board prior. Mr. Oemichen advised it can take 5 years to engage members to get involved in a cooperative. He recommended using a newsletter, social media and your own Webpage to engage members. He spoke about how to train members and provided training materials to Ms. Harris for her to review. Oemichen assisted in drafting the language contained within the regulations of the CMS program regarding the Consumer Advisory Board. Mr. Oemichen is grant supported and assists organizations with training and education of new Board members. Ms. Carafelli recommended, if it was affordable for the CO-OP, that the CO-OP engage Mr. Oemichen to assist in the training of new Board members. She pointed out challenges she has experienced on other Boards that had consumer members that had no Board training.

**2015 Pricing Discussion:** This topic was not discussed

**Large Group Strategy:** Mr. Ellis asked about the CO-OP's Large Group sales. Mr. Dibsie reported that the CO-OP is participating in a Broker event in June. Mr. Zumtobel is working to grow the CO-OP's sales sophistication to write large group. .Additionally, Mr. Dibsie and Mr. Zumtobel have been working to get the value for large group tiered network. They are working on a skinny model with Brady Linens to provide primary care. There is concern that if the CO-OP landed a 1,000 member group or larger, there may be challenges with the CO-OP's ability to manage a group that size.

**Staffing**: This topic was not discussed

**CEO Contract:** This topic was not discussed

Mr. Ellis adjourned the meeting at 12:15pm (PST).

# TAB 43

# TAB 43

**RIS (CIV)**
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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiff,

v.

MILLIMAN, INC., a Washington Corporation; JONATHAN L. SHREVE, an Individual; MARY VAN DER HEIJDE, an Individual; MILLENNIUM CONSULTING SERVICES, LLC, a North Carolina Corporation; LARSON & COMPANY P.C., a Utah Professional Corporation; DENNIS T. LARSON, an Individual; MARTHA HAYES, an Individual;

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

**DEFENDANTS UNITE HERE HEALTH AND NEVADA HEALTH SOLUTIONS, LLC'S CONSOLIDATED REPLY IN SUPPORT OF THEIR: (1) MOTION FOR LEAVE TO FILE THIRD-PARTY COMPLAINT; AND (2) MOTION TO CONSOLIDATE**

Date of Hearing: April 14, 2021

Time of Hearing: 9:00 a.m.

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.

## I. INTRODUCTION

***The Elephant in the Room***

The CO-OP's consolidated opposition to the Motion for Leave and the Motion to Consolidate is a fervent defense of Xerox—a culpable party and source of recovery the CO-OP ***should be*** directly pursuing. The CO-OP's devotion to Xerox cannot be questioned. The CO-OP dedicates an incredible 12 of 16 pages in its opposition ***attacking its own claims*** as part of its campaign to shield Xerox from any specter of liability. If its motive was not painfully obvious, the CO-OP's self-flagellation would appear quite unusual. But the CO-OP's motive is obvious. The CO-OP believes (erroneously) that it can avoid a conflict of interest which its counsel and the architect of this lawsuit (Greenberg Traurig) has with respect to Xerox by keeping Xerox out of this lawsuit. Greenberg Traurig previously represented Xerox in substantially related litigation, prohibiting Greenberg Traurig from suing Xerox on behalf of the CO-OP in this matter. If Xerox becomes a party to this litigation (which it should be), Greenberg Traurig's existing conflict will exacerbate, causing it to face even more conflicting duties between the CO-OP and Xerox, which is undoubtedly the reason why the CO-OP did not sue Xerox in the first place. But Greenberg Traurig's self-inflicted conflict is not a reason to deny UHH leave to assert contribution claims against Xerox. Indeed, the CO-OP's opposition fails to provide any legally tenable basis to deny leave.

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***The Applicable Analysis***

Initially, courts have held that parties unaffected by a proposed pleading lack standing to assert futility arguments on behalf of a proposed defendant. Instead, an unaffected party (like the CO-OP here) may only oppose a motion for leave on grounds that impact that party (*e.g.*, delay and prejudice). Accordingly, the CO-OP lacks standing to assert futility arguments on behalf of Xerox (or Silver State).[1]

Second, even if the CO-OP somehow had standing to assert futility arguments on behalf of its counsel's former client Xerox, the futility claims utterly lack merit. The CO-OP contends that its claims against UHH sound in contract, not tort. However, the vast majority of claims asserted by the CO-OP against UHH are torts. In its proposed Second Amended Complaint, the CO-OP asserts ***fifteen (15) tort claims*** against both Unite Here Health and Nevada Health Solutions, LLC.[2] The CO-OP's assertion that its tort claims are not really tort claims is, at best, disingenuous. The tort claims are premised on non-contractual duties the CO-OP alleges UHH owed to the CO-OP. Moreover, the CO-OP seeks ***punitive damages*** against UHH, which is plainly not available as a contractual remedy. The CO-OP's effort to create Schrödinger's tort—a tort that is simultaneously both a tort and not a tort—is unavailing.[3] Accordingly, UHH is entitled to seek contribution from Xerox and Silver State as to certain of the CO-OP's tort claims.

Third, the CO-OP's contention that UHH could file a separate action against Xerox is neither here nor there. The CO-OP's argument would render NRCP 14(a) a nullity if leave were denied based on a defendant's ability to file a separate action—defendants always have the option

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[1] Notably, the Proposed Third-Party Complaint also seeks to add Silver State as a third-party defendant. (*See* Appx. Mot. for Leave, Ex. A, Proposed Third-Party Complaint.) Yet, it appears the CO-OP is unconcerned with UHH adding Silver State as a third-party defendant—the CO-OP mentions Silver State (i.e., the Exchange) only a handful of times in its opposition. (*See, e.g.*, Opp. at 2:21-23 n.3.) ***Perhaps that is because the CO-OP's counsel did not previously represent Silver State in substantially related litigation.***

[2] The CO-OP states that the Proposed Third-Party Complaint does not assert any claims on behalf of Nevada Health Solutions, LLC. (Opp. at 1:23 – 2:1, *see also id.* at 2:16-17 n.1.) Wrong. Both the Proposed Third-Party Complaint and the Motion for Leave specifically define "UHH" to include both Unite Here Health and its affiliated entity Nevada Health Solutions, LLC. (Ex. A, Proposed Third-Party Complaint, at 2:19-20 ("Defendants/Third-Party Plaintiffs Unite Here Health and Nevada Healthcare Solutions, LLC (***jointly, 'UHH'***) . . . .") (emphasis added).)

[3] *See Westside Estate Agency, Inc. v. Randall*, 211 Cal. Rptr. 3d 119, 128 (Cal. Ct. App. 2016) ("Westside makes an argument that only Schrödinger's cat could appreciate when it simultaneously and paradoxically insists that it *is* and that it *is not* invoking the doctrine of equitable estoppel.").



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to file a separate action. The goal of NRCP 14(a) is to promote judicial economy and avoid inconsistent judgments by enabling defendants to assert contribution claims against third-party defendants in an original action. Here, giving UHH leave to file its Proposed Third-Party Complaint will promote that goal by enabling the CO-OP's claims and UHH's contribution claims to be resolved in the same action—a much more efficient use of judicial resources that will avoid the possibility of inconsistent judgments.[4]

Fourth, the CO-OP's contention that UHH delayed seeking leave is completely misplaced. At the outset of this matter, UHH did not understand (and could not have understood) the interaction between the CO-OP's claims against UHH and UHH's potential contribution claim against Xerox and Silver State. Instead, UHH needed to conduct discovery and consult with its experts—and UHH did not have the information and analysis it needed to assert a claim for contribution against Xerox and Silver State until recently. UHH should not be blamed for ensuring that it had both a factual and legal basis for a contribution claim prior to seeking leave***, especially considering the Motion for Leave was filed within the deadline agreed to by the CO-OP and set by the Court***.

Fifth, the CO-OP cannot demonstrate any cognizable prejudice in granting UHH leave. The joinder of Xerox and Silver State provides two additional potential sources of recovery for the CO-OP and there is no reason to believe that discovery or trial will be unnecessarily delayed or prolonged. The Parties are still in the midst of discovery—which does not close until December 31, 2021. In fact, the CO-OP recently produced ***43,264 documents*** approximately six weeks ago. Simply put, discovery is far from over. Moreover, the CO-OP sought and obtained a stay concerning the Motion for Leave, delaying its resolution for months. The CO-OP should not be allowed to weaponize its self-created delay as a basis for denial.

Finally, the CO-OP's cursory opposition to the Motion to Consolidate lacks merit. In this matter, the CO-OP is seeking uncollected insurance premiums from UHH totaling $510,651.27. In

[4] The Court should note that many of the other Defendants (i.e., Insuremonkey, Inc., Alex Rivlin, Pamela Egan, Basil Dibsie, Linda Mattoon, Bobbette Bond, and Kathleen Silver) have also joined in the Motion for Leave and seek to add Xerox and the Silver State Exchange as Third Party Defendants. Accordingly, denial of the Motion to Leave may not lead to just one additional lawsuit—it may very well lead to multiple new lawsuits.



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the Silver State Exchange Action, the CO-OP is seeking the same $510,651.27 in uncollected insurance premiums from Silver State. They both concern the same uncollected insurance premiums. Likely recognizing the similarity between the matters, Silver State has not opposed consolidation. Regardless, to prevent a double-recovery and to ensure consistent judgments, this Court should consolidate the Silver State Exchange Action into this matter.

In sum, this Court should grant the Motion for Leave and the Motion to Consolidate. Doing so will promote judicial economy and avoid the possibility of inconsistent judgments.

## II. ARGUMENT

### A. UHH Should Be Given Leave to File the Proposed Third-Party Complaint.

#### *1. The CO-OP's Futility Argument Fails.*

The CO-OP's primary basis for opposing the Motion for Leave is a nonsensical argument that UHH's contribution claims against Xerox are futile. (Opp. at 2:4 – 15:7.)

a. The CO-OP Lacks Standing to Assert Futility Arguments on Behalf of the Proposed Third-Party Defendants.

"Current parties unaffected by a proposed amendment do not have standing to assert claims of futility on behalf of proposed defendants." *Coleman v. Apple Eight Hosp. Mgmt.*, No. 6:16-cv-01343-JTM, 2017 U.S. Dist. LEXIS 70151, at *8 (D. Kan. May 8, 2017); *Chesler v. City of Jersey City*, Civil Action No. 2:15-cv-1825-SDW-ESK, 2019 U.S. Dist. LEXIS 204989, at *8-9 (D.N.J. Nov. 26, 2019) (same); *Bailey v. B. Braun Med. Inc.*, No. 1:16-cv-1544-WSD, 2017 U.S. Dist. LEXIS 66133, at *6 (N.D. Ga. May 1, 2017) (finding party not affected by proposed amended pleading "lack[ed] standing to challenge the proposed amendment on the grounds of futility."). Instead, "current parties only possess standing to challenge an amended pleading directed to proposed new parties on the basis of undue delay and/or prejudice." *Custom Pak Brokerage, LLC v. Dandrea Produce, Inc.*, No. 13-5592 (NLH/AMD), 2014 U.S. Dist. LEXIS 31681, at *7 (D.N.J. Feb. 27, 2014).

Put simply, despite devoting twelve pages of their opposition to the issue, the CO-OP lacks standing to challenge the Proposed Third-Party Complaint on futility grounds. Instead, any "Rule 12 defenses to [UHH's] third-party claim are properly raised by [Xerox and Silver State] in [their]



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answer to the third-party complaint, not by . . . the [CO-OP] in opposition to a motion for leave to file." *Clark Cnty. v. Jacobs Facilities, Inc.*, No. 2:10-CV-00194-LRH-PAL, 2011 U.S. Dist. LEXIS 108888, at *4-5 (D. Nev. Sep. 21, 2011); *see also Goodrich v. Grg Enters.*, No. 2:20-cv-00671-JCM-NJK, 2020 U.S. Dist. LEXIS 187589, at *7 (D. Nev. Oct. 8, 2020) ("[W]hether Defendants' third-party complaint states a claim upon which relief can be granted is inconsequential for purposes of the instant motion [for leave]. At the appropriate time, [the proposed third-party defendant] may raise any objections to the merits of Defendants' third-party complaint.").

In sum, because the CO-OP lacks standing to challenge the Proposed Third-Party Complaint on futility grounds, this Court should disregard its efforts to do so.

b. UHH's Contribution Claim Is Not Futile.

Even assuming this Court finds that the CO-OP has standing to assert a futility argument on behalf of Xerox (which it should not), the futility argument fails. Specifically, the CO-OP contends that its ***15 tort claims*** are really disguised contract claims and that a claim for contribution must arise from a "common obligation." (*See* Opp. at 4:8 – 6:6.) This argument misses the mark.

A proposed pleading is futile where it "would not withstand a motion to dismiss." *Pedigo v. County of Los Angeles*, 24 F. App'x 779, 785 (9th Cir. 2001). A motion to dismiss will be granted "only if it appears ***beyond a doubt*** that [the plaintiff] could prove no set of facts, which, if true, would entitle [the plaintiff] to relief." *Buzz Stew, LLC v. City of N. Las Vegas*, 124 Nev. 224, 228, 181 P.3d 670, 672 (2008) (emphasis added). The Court must "regard all factual allegations in the complaint as true and draw all inferences in favor of the nonmoving party." *Rocker v. KPMG LLP*, 122 Nev. 1185, 1192, 148 P.3d 703, 707 (2006), *abrogated on other grounds by Buzz Stew, LLC*, 124 Nev. at 228, 181 P.3d at 672. "The standard of review for a dismissal under NRCP 12(b)(5) is rigorous," and "the test for determining whether the allegations of a complaint are sufficient to assert a claim for relief is whether the allegations give fair notice of the nature and basis of a legally sufficient claim and the relief requested." *Breliant v. Preferred Equities Corp.*, 109 Nev. 842, 846, 858 P.2d 1258, 1260 (1993).

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Here, UHH's claims in the Proposed Third-Amended Complaint are far from futile—they are meritorious. UHH has a right to seek contribution from Xerox and Silver State for their potential liability for the CO-OP's alleged damages.

Nevada's contribution statute provides that "where two or more persons become jointly or severally liable in tort ***for the same injury to person or property*** . . . , there is a right of contribution among them even though judgment has not been recovered against all or any of them." *See* NRS 17.225(1) (emphasis added). Stated more simply, a "right of contribution is present where there is an injury for which two persons are jointly or severally liable." *Republic Silver State Disposal, Inc. v. Cash*, 136 Nev. __, __, 478 P.3d 362, 364 (2020). The right of contribution exists "regardless of whether the tortious conduct may be characterized as successive." *Id.* For example, a tortfeasor causing a personal injury may assert a contribution claim against a doctor that "subsequently negligently treat[s] the original injury." *Id.* The right of contribution is only unavailable if the third-party defendant "produced a *completely* independent injury . . . ." *Id.* (emphasis in original).

Moreover, under Nevada law, "[c]ontribution is a creature of statute," not a creation of common law. *Doctors Co. v. Vincent*, 120 Nev. 644, 650, 98 P.3d 681, 686 (2004). All of the cases cited by the CO-OP discussing a "common obligation" are based on equitable contribution[5] and have no persuasive value in evaluating the specific language of NRS 17.225(1). Accordingly, in evaluating a contribution claim, the only question is whether Xerox and Silver State may be

[5] *See Nova Info. Sys. v. Greenwich Ins. Co.*, 365 F.3d 996, 1006 (11th Cir. 2004) ("The doctrine of ***equitable*** contribution attempts to distribute equally among those who have a common obligation, the burden of performing that obligation.") (emphasis added) (internal quotation marks omitted); *Berg Chilling Sys. v. Hull Corp.*, 435 F.3d 455, 472 (3d Cir. 2006) (analyzing equitable contribution); *Huggins v. Graves*, 337 F.2d 486, 489 (6th Cir. 1964) (same); *Amphibious Partners, LLC v. Redman*, 534 F.3d 1357, 1362 (10th Cir. 2008) (same); *Fink v. Spirit Servs. of WV, LLC*, Civil Action No. 2:16-cv-08669, 2017 U.S. Dist. LEXIS 156846, at *11-12 (S.D. W. Va. Sep. 25, 2017) (same); *Terminals v. Ceres Marine Terminals*, 879 F. Supp. 31, 32 (E.D. Va. 1995) (same); *Peters v. Maxim Healthcare Servs.*, No. 9-204-B-W, 2009 U.S. Dist. LEXIS 86469, at *8 n.2 (D. Me. Sep. 15, 2009) ("***Equitable*** contribution involves a 'common obligation.'") (emphasis added); *Va. Int'l Abney-Revard, Inc. v. Associated Materials, Inc.*, No. CV 05-528-PK, 2007 U.S. Dist. LEXIS 37012, at *2-3 (D. Or. May 17, 2007) (discussing Oregon common law contribution and Oregon's specific statute) *CBR Funding, LLC v. Jones*, No. 1:13-cv-01280-JDB-egb, 2015 U.S. Dist. LEXIS 43569, at *10 (W.D. Tenn. Apr. 2, 2015) (discussing equitable contribution among co-guarantors); *Asdar Grp. v. Pillsbury, Madison & Sutro*, 99 F.3d 289, 295 (9th Cir. 1996) (authorities on equitable contribution in evaluating when a claim for contribution under federal securities laws discussing accrues). Further, the "majority view" language quoted by the CO-OP from *Ford Motor Co. v. Edgewood Props.*, Civil Action No. 06-1278, 2008 U.S. Dist. LEXIS 80191, at *55 (D.N.J. Oct. 8, 2008), is actually a quote from *Zotta v. Otis Elevator Co.,* 165 A.2d 840, 842 (N.J. App. Div. 1961), which discusses equitable contribution.



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"jointly or severally liable in tort ***for the same injury***" the CO-OP alleges that UHH is liable for—not whether they share a common obligation. *See* NRS 17.225(1) (emphasis added). As the Nevada Supreme Court recently explained, "***whether the parties are joint or successive tortfeasors is not material***, so long as both parties are liable for the injury for which contribution is sought." *Republic Silver State Disposal, Inc.*, 136 Nev. at __, 478 P.3d at 363 (emphasis added). Indeed, if the CO-OP's analysis were correct, Nevada law would not allow a tortfeasor causing a personal injury to assert a contribution claim against a doctor who negligently treats the injury because the tortfeasor and the doctor do not share a "common duty." However, Nevada law plainly provides for such contribution claims. *See Republic Silver State Disposal, Inc.*, 136 Nev. at __, 478 P.3d at 364. This is because the focus is on joint or several liability for the ***injury***, not a common obligation. *See id.* at __, 478 at 363; *see also* NRS 17.225(1).

With these principles in mind, UHH plainly has stated a viable claim for contribution against Xerox and Silver State. In its proposed Second Amended Complaint (the filing of which UHH has not opposed), the CO-OP asserts the following tort claims against UHH for which UHH may, minimally,[6] seek contribution:

Nevada Health Solutions, LLC

- Professional Malpractice (47th Cause of Action)
- Negligence (48th Cause of Action)
- Gross Negligence (49th Cause of Action)
- Negligent Performance of an Undertaking (53rd Cause of Action)

Unite Here Health

- Professional Malpractice (64th Cause of Action)
- Negligence (65th Cause of Action)
- Gross Negligence (66th Cause of Action)
- Negligent Performance of an Undertaking (71st Cause of Action)

(Motion for Leave to File Second Am. Compl., filed on Oct. 16, 2020, at Ex. 1.)

[6] UHH does not concede that contribution is unavailable as to other claims pled by the CO-OP.



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Despite the CO-OP's best efforts to dismiss its own tort claims for the benefit of Xerox, the eight causes of action all sound in tort. The claims are not based solely on alleged breaches of duties arising from contract, but primarily arise from alleged breaches imposed by law—i.e., "professional and industry standards":

- Professional Malpractice: "[UHH] had a duty to use such skill, prudence, and diligence as other members of the profession commonly possess and exercise. . . . [UHH] breached that duty by failing to comply with applicable contractual, ***professional and industry standards***." (*Id.* ¶¶ 712-13, 841-42 (emphasis added).)
- Negligence: "[UHH] owed a duty of care to Plaintiff, including the duty to perform its work in accordance with applicable ***statutory, professional,*** and contractual standards. . . . [B]y failing to perform to applicable ***statutory, professional***, and contractual standards, [UHH] breached that duty." (*Id.* ¶¶ 717-18, 846-47 (emphasis added).)
- Gross Negligence: "[UHH] owed a duty of care to NHC, including the duty to perform its work in accordance with ***industry standards*** . . . . [UHH] failed to perform to applicable professional standards, by failing to exercise even the slightest degree of care." (*Id.* ¶¶ 723-24, 856-57 (emphasis added).)
- Negligent Performance of an Undertaking: "By agreeing to perform the medical utilization and member eligibility review services detailed above, [UHH] undertook to perform a duty owed by NHC to its members, enrolled insureds, creditors, and regulators and to act in accordance with ***statutory and professional standards***." (*Id.* ¶¶ 754, 895 (emphasis added).)

Plainly, these claims allege that UHH breached a duty imposed by law—statutory, professional, and industry standards—existing independent from any duties UHH owed arising from contract. In fact, the CO-OP has designated two experts to specifically address industry standards and practices to show that UHH did breach the standard of care (*i.e.*, its negligence-based claims). The CO-OP also seeks ***punitive damages*** for its gross negligence claim, which is not

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available as a contractual remedy. (*Id.* ¶¶ 728, 861.) The CO-OP's claims state they are torts, they read like torts, and they seek tort damages—the only reasonable conclusion is they are torts.[7]

Most importantly, the alleged injury suffered by the CO-OP is the same injury for which UHH seeks contribution from Xerox and Silver State. Specifically, the CO-OP alleges that UHH's and the other codefendants' mismanagement and negligence "caused significant losses to NHC, its members, insured enrollees, and creditors, among others, until [the CO-OP] ultimately failed . . . ." (*Id.* ¶ 45.) Similarly, in its Proposed Third-Party Complaint, UHH seeks contribution for Xerox and Silver State's mismanagement and negligence which "proximately caused harm to the CO-OP and its vendors (including UHH), materially contributing to the CO-OP's failure as a viable health plan. (Appx. Mot. for Leave, Ex. A., Proposed Third-Party Compl. ¶ 46.) Further, as explained in the Motion for Leave, UHH's expert recently concluded that Xerox is to blame for much of the alleged negligence for which the CO-OP believes (incorrectly) that UHH should be held liable. (Appx. Mot. for Leave, Ex. K, Dr. Henry Miller Report, at 36-39, 56-57, 93 (addressing issues with Xerox Exchange).)

In the end, the CO-OP cannot meet Xerox's and Silver State's burden to demonstrate, ***beyond a doubt***, that UHH "could prove no set of facts, which, if true, would entitle [UHH] to relief." *Buzz Stew, LLC*, 124 Nev. at 228, 181 P.3d at 672. Accordingly, UHH's Proposed Third-Party Complaint is not futile.

***2. That UHH Could Institute a Separate Action Against the Third-Party Defendants Is Irrelevant—Enabling UHH to Assert a Contribution Claim in This Action Will Promote Efficiencies and Save Court Resources.***

The CO-OP argues that UHH can assert an independent contribution claim against Xerox (again neglecting Silver State) outside of this matter. (Opp. at 13:8-25.) This argument misses the mark.

Initially, a defendant always has the option of asserting contribution in a separate action. However, NRCP 14(a) provides a mechanism for a defendant/third-party plaintiff to assert an

[7] In fact, the CO-OP's proposed Second Amended Complaint seeks to rescind any and all agreements between the CO-OP and UHH, which would leave nothing but tort claims. (Pl.'s Mot. for Leave to File Sec. Am. Compl., 4:24-27, filed Oct. 16, 2020.)



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inchoate claim for contribution against a third-party defendant "in an original action prior to entry of judgment." *Pack v. LaTourette*, 128 Nev. 264, 269, 277 P.3d 1246, 1249 (2012). Accordingly, the fact that UHH could file a separate action against Xerox is wholly irrelevant.

Moreover, enabling a defendant/third-party plaintiff to add a third-party defendant to an original action promotes two primary goals: (i) judicial economy by avoiding a second trial between the defendant/third-party plaintiff and third-party defendant on the same underlying facts and issues; and (ii) it avoids the possibility of inconsistent judgments (e.g., a finding of liability in the original action and then a finding of non-liability in the contribution action). 3 Moore's Federal Practice - Civil § 14.03 (2020); *accord Tourangeau v. Uniroyal, Inc.*, 189 F.R.D. 42, 48 (D. Conn. 1999). Here, enabling UHH (and the other moving Defendants) to file its Proposed Third-Party Complaint will increase efficiencies—by not requiring UHH and the other moving Defendants to separately sue Xerox and Silver State—and will substantially reduce the risk of inconsistent judgments.

In sum, the fact that UHH could assert an independent action against Xerox and Silver State is immaterial. Instead, allowing UHH leave to file its Proposed Third-Party Complaint will enable greater efficiency by avoiding an unnecessary, separate trial.

***3. UHH Did Not Unduly Delay in Seeking Leave.***

The CO-OP, making a cursory analysis of the facts and issues, contends that UHH unduly delayed in seeking leave to file its Proposed Third-Party Complaint. (Opp. at 13:26 – 14:13.) Another misplaced argument.

As explained in the Motion for Leave, "[t]o 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." *See United States v. New Castle Cty.*, 111 F.R.D. 628, 633 (D. Del. 1986). Indeed, 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.

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Here, UHH had to conduct substantial discovery and consult with its experts before it sought leave to file its Proposed Third-Party Complaint—***notably prior to the expiration of the deadline to seek amendment***. While UHH was aware of Xerox's and Silver State's involvement,[8] it was unable to evaluate its potential contribution claims against them until it (i) fully understood the nature of the CO-OP's claims against UHH[9] and (ii) had the ability to consult with its experts who determined that Xerox and Silver State were to blame for much of what the CO-OP now (wrongfully) blames UHH. Specifically, based on certain information it learned in discovery, UHH sought specific discovery concerning Xerox and Silver State (e.g., serving public records requests to various Nevada agencies concerning Silver State's relationship with Xerox). Based on receiving that information, 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 the CO-OP now seeks to hold UHH liable. *See Zielinski v. Zappala*, 470 F. Supp. 351, 353 (E.D. Pa. 1979) (finding sixteen-month delay was justified where defendant sought two expert opinions before seeking leave).

Further, the CO-OP has delayed resolution of the Motion for Leave. Specifically, the CO-OP sought and obtained a stay (through agreement of the defendants) that prolonged the resolution of the Motion for Leave by over four months. (*See* Order Staying the Litigation, filed on Nov. 10, 2020.) The CO-OP also requested additional time (over two months) in order to hire new counsel to respond to this Motion for Leave, because its current counsel supposedly could not ethically respond due to its existing conflicts of interest relating to Xerox. (*Id.*) If this Motion for Leave had been heard in the ordinary course, it would have been resolved on November 18, 2020,

[8] The CO-OP's reliance on the Declaration of Mark Bennett is misplaced. Mr. Bennett's testimony is primarily his interpretation of the procedural history of this matter and his analysis of the underlying facts—neither of which are admissible evidence. *See McKenna v. State*, 114 Nev. 1044, 1053, 968 P.2d 739, 745 (1998) (holding argument of counsel is not evidence).

[9] In fact, the CO-OP's claims have been a moving target throughout this litigation—even before its current effort to jettison its tort claims while maintaining them at the same time. It was not until the CO-OP disclosed their final expert reports in February 2020 that UHH began to understand the allegations against them. In fact, even the CO-OP's counsel admitted in open court that the CO-OP's initial expert disclosures in July 2019 were anything but clear. Even now, UHH continues to conduct discovery to gain a better understanding of the claims and allegations against them.



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when it was originally set for hearing. (*See* Notice of Hearing, filed on Oct. 16, 2020.) The CO-OP cannot use its own requested delay and its counsel's conflicts of interest as a basis to deny the Motion for Leave.

In sum, UHH should not be blamed for conducting discovery and carefully evaluating the evidence before seeking leave to assert claims against Xerox and Silver State. UHH's obligations under NRCP 11 required it.

#### *4. The CO-OP Cannot Demonstrate Cognizable Prejudice From Allowing UHH to Add the Proposed Third-Party Defendants—if Anything, It Will Provide Another Potential Source of Recovery for Plaintiff.*

The CO-OP argues, without much explanation, that it will suffer prejudice in the form of delay and additional litigation expenses. (Opp. at 14:14 – 15:7.) This argument fails.

Initially, discovery in this matter does not close until December 31, 2021—which gives the parties over seven (7) months to conduct discovery on Xerox and Silver State. Subject to the unpredictable COVID pandemic, this is likely more than sufficient time to conduct discovery without further extensions or moving trial. Indeed, the CO-OP produced 42,264 documents approximately six weeks ago—a strong indication that the parties are in the midst of discovery, not towards the end of it.

Further, both Xerox and Silver State have already engaged in litigation over similar issues—they are not coming into the litigation as parties completely unfamiliar with the issues being addressed in this litigation. The CO-OP has already sued Silver State (*i.e.*, the Silver State Exchange Action). Xerox has similarly faced litigation over its failures with respect to the Xerox Exchange previously (*i.e.*, the class actions). In fact, the CO-OP's counsel (Greenberg Traurig) is very familiar with these class actions, having represented Xerox in both of them. Given that both Silver State and Xerox have engaged in litigation concerning the same subject matter, they will enter this matter with a head start in understanding the facts and issues being addressed in this matter.

Even if delay were likely, 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)

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(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.").

Further, far from causing any prejudice to the CO-OP, the joinder of Xerox and Silver State provides two additional sources of recovery. *See New Castle Cty.*, 111 F.R.D. at 632 (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).

In sum, the CO-OP cannot demonstrate any cognizable prejudice it will suffer if UHH is given leave to file its Proposed Third-Party Complaint. Instead, it will promote NRCP 14(a)'s goals of efficiency and avoiding inconsistent judgments. *See e.g.*, *Green Valley Corp.*, No. 09-CV-04028-LHK, 2011 U.S. Dist. LEXIS 44540, at *21-22.

**B. This Court Should Consolidate the Silver State Exchange Action Into This Action to Promote Judicial Economy.**

The CO-OP makes a half-hearted effort to oppose the Motion to Consolidate, arguing (i) the Motion to Consolidate is somehow moot if the Court denies the Motion for Leave, and (ii) that consolidation is inappropriate based on differences in their procedural posture. (Opp. at 15:8 – 16:13.) These arguments miss the mark.

First, the Motion to Consolidate is not contingent on the Court granting the Motion for Leave. They are independent Motions. Irrespective of whether this Court gives UHH leave to file its Proposed Third-Party Complaint (which it should), consolidation of the Silver State Exchange Action into this action is appropriate because the CO-OP is seeking uncollected insurance premiums totaling $510,651.27 from UHH in this action and from Silver State in the Silver State Exchange Action—***the same uncollected insurance premiums***. Accordingly, it makes much more sense to try the CO-OP's claims on the same subject matter in one case instead of two. Indeed, without consolidation, there is a substantial risk of inconsistent judgments—or even a double recovery for the CO-OP if it were to prevail in both actions.

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Second, the procedural posture of the Silver State Exchange Action and this action are not far off from one another. While the Silver State Exchange Action is scheduled to be tried prior to this action, the efficiencies of consolidation outweigh any additional costs the parties may incur.

In sum, this Court should consolidate the Silver State Exchange Action into this action because they both concern the same subject—uncollected insurance premiums.

## III. CONCLUSION

For the reasons set forth above and in the Motion for Leave, this Court should grant UHH leave to file their Proposed Third-Party Complaint against Xerox and Silver State. The CO-OP lacks standing to assert futility arguments; the claims are not futile because contribution is appropriate; 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.

Further, this Court should consolidate the Silver State Exchange Action into this action. They both concern the same subject matter and trying the cases together will promote efficiency and avoid any potential for a double recovery.

DATED this 7th day of April, 2021.

BAILEY❖KENNEDY

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**CERTIFICATE OF SERVICE**

I certify that I am an employee of BAILEY❖KENNEDY and that on the 7th day of April, 2021, service of the foregoing was made by mandatory electronic service through the Eighth Judicial District Court's electronic filing system and/or by depositing a true and correct copy in the U.S. Mail, first class postage prepaid, and addressed to the following at their last known address:

| | |
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# TAB 44

# TAB 44

CASE NO. A-17-760558-B

DOCKET U

DEPT. XVI

DISTRICT COURT

CLARK COUNTY, NEVADA

* * * * *

NEVADA COMMISSIONER OF INSURANCE,

Plaintiff,

vs.

MILLIMAN INC,

Defendant.

REPORTER'S TRANSCRIPT
OF
HEARING

(VIA TELEPHONIC CONFERENCE CALL)

BEFORE THE HONORABLE JUDGE TIMOTHY C. WILLIAMS

DISTRICT COURT JUDGE

DATED WEDNESDAY, APRIL 14, 2021

REPORTED BY: PEGGY ISOM, RMR, NV CCR #541

APPEARANCES:

FOR NEVADA COMMISSIONER OF INSURANCE:

(PURSUANT TO ADMINISTRATIVE ORDER 20-10, ALL MATTERS IN DEPARTMENT 16 ARE BEING HEARD VIA TELEPHONIC APPEARANCE)

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LAS VEGAS, NEVADA; WEDNESDAY, APRIL 14, 2021

9:39 A.M.

P R O C E E D I N G S

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THE COURT: Next up, page 14 of the calendar. Nevada Commissioner of Insurance vs. Milliman Inc. And let's go ahead and set forth our appearances for the record.

09:39:50 MR. SMITH: Good morning, your Honor. Abe Smith, Dan Polsenberg, Don Prunty, and Mark Ferrario for plaintiff, the receiver.

MS. OCHOA: Good morning, your Honor. Angela Ochoa on behalf of the management defendants.

09:40:07 MR. BAILEY: Good morning, your Honor. This is John Bailey, Joseph Liebman, and Suzanna Bonham on behalf of defendants Unite Here Health and Nevada Health Solutions.

MR. PRUITT: Good morning, your Honor.

09:40:19 Matthew Pruitt on behalf of InsureMonkey and Alex Rivlin.

MS. SIDERMAN: Good morning, your Honor. Lori Siderman on behalf of Larson & Company.

THE COURT: All right. Does that cover all

09:40:34 appearances?

09:40:38 MR. POLSENBERG: Your Honor, Dan Polsenberg. I want to make sure this is reported.

THE COURT: Thank you, Mr. Polsenberg, on that.

09:40:45 Anyway, once again, good morning to everyone. Just a couple of -- I'm looking here, and I was thinking about this case. And it's currently set for trial on May 16th of 2022, which is over a year from now; and I think hypothetically a couple of things can

09:41:02 happen during that time period.

Number one, we'll be trying cases, jury trials, by then. Secondly, there's two things going on from an infrastructure perspective. I just had a tour of the fifth floor, and the entire fifth floor it's

09:41:16 anticipated will become business court and much bigger courtrooms, facilities. I was looking at my prospective courtroom. For example, I actually have two anterooms, which would be really nice, you know. And it's probably about the same size of the courtroom

09:41:30 I had on the 12th floor, which I think is wonderful.

And so all the four business court judges will be on the same floor together, from what I gather, potentially. And then last, but not least, we can't overlook the changes, potential changes, to the 17th

09:41:46 floor which will be like, I guess, the old

09:41:49 Seventh Street or Eighth Street location where Judge Earl was at. And that will become our complex civil litigation center right here at the RJC, which I think is great news when you really look at it from
09:42:03 that perspective. Because I was thinking about this case, and to be candid with everyone, I think I can probably try this in my new courtroom. You know, it's big enough. And if not, we have the 17th floor. And I think that's wonderful from an infrastructure
09:42:15 perspective.

But, anyway, let's move on to, I guess, the matters at hand. And we do have some motions currently pending. And we have a motion for consolidation. Plaintiff's motion to file a second amended complaint.
09:42:30 And defendant Unite Here Health, their motion for leave to file a third amended complaint.

And so where should we start as far as those matters are concerned? The first on the calendar would be the motion for leave to file the third-party
09:42:48 complaint.

Counsel.

MR. BAILEY: Your Honor, that is John Bailey. If you'd like to start there, I'd welcome that, and I'll get started.

09:42:59 THE COURT: Okay. Well, I think that's the

09:43:03 first matter on calendar, Mr. Bailey. And unless there is some sort of agreement, I just go in order.

MR. BAILEY: That sounds fine.

THE COURT: Okay.

09:43:11 MR. BAILEY: Through our motion, this is a motion for me to file a third party complaint; and through our motion my clients, Unite Here Health and Nevada Health Solutions, seek to add the Silver State Health Insurance Exchange and Xerox as third-party

09:43:30 defendants in the case of contribution claims. And here's why.

As you may recall, Unite Here Health was the co-op's third-party administrator. And as such, it was responsible for processing the health claims of the

09:43:49 co-op's insured, claims that were submitted by providers like doctors and hospitals.

The information that Unite Here Health needed to process those claims came from the Silver State Health Insurance Exchange and particularly the company

09:44:08 that the Exchange hired to develop, operate, and manage the Exchange, Xerox.

Xerox received information and premiums directly from individuals who signed up through the state's exchange. Those are consumers.

09:44:25 Xerox made ultimate determinations and Xerox

09:44:29 was supposed to timely and accurately provide that information to all of the insurers who were part of the Exchange, including the co-op.

The problem was Xerox failed and its system 09:44:45 was a complete disaster. The information Xerox provided to the insurers on the Exchange, including the information it provided to Unite Here Health on behalf of the co-op was untimely, inaccurate, and incomplete. So much so that Nevada terminated its almost 09:45:07 $100 million contract with Xerox.

And you will see that we cited on pages 4 and 5 of our motion the overwhelming and uncontradicted evidence of Xerox's failures, including an independent report from Deloitte commissioned by the state which 09:45:27 found over 1500 defects in the Xerox system.

Xerox's failures resulted in two class action lawsuits against it, one by insureds and the other by insurance brokers.

Notwithstanding Xerox's failures, after the 09:45:45 receiver took over the co-op, it filed this litigation and specifically filed both tort and contract claims against Unite Here Health asserting that my client, Unite Here Health, failed to properly perform its duties as the co-op's third-party administrator. In 09:46:07 other words, instead of suing the culpable party,

09:46:11 Xerox, the receiver sued my client.

Now, you are probably asking the obvious question, which is why didn't the receiver sue Xerox? The answer is because the receiver's legal counsel, 09:46:22 Greenberg Taurig and Mr. Ferrario, also represented Xerox in substantially-related litigation, namely the two class action lawsuits that I mentioned. As we all know, you can't sue your own client on behalf of another client. That issue, Greenberg's conflicts of 09:46:43 interest and their concealment of the conflicts from the receivership court, is presently before the Nevada Supreme Court.

But the point is we are seeking to bring Xerox and the Exchange into this case as third-party 09:46:58 defendants on contribution claims because any liability for failing to properly and timely process insurance claims lies with Xerox, not my client, which leads me to the analysis under Rule 14(a), which is designed to promote judicial efficiency and economy and avoid 09:47:22 inconsistent rulings.

I have four quick points that I'd like to make in a response to the receiver's opposition, which all lead to the granting of our motion.

Point number one, our motion was timely filed 09:47:37 prior to the Court's deadline for adding parties and

09:47:41 adding claims.

Point number two, there has been no showing by the receiver that she or the co-op would be prejudiced by adding Xerox and the Exchange to this case.

09:47:56 In fact, the discovery deadline is not until December 31st of this year, eight months from now. And as you just mentioned, the trial date is set for May 2022, over a year from now.

Point number three, most if not all of the

09:48:13 other defendants in this case have joined in our motion.

And finally point number four, as you indicated on the Court's calendar this morning is the receiver's motion seeking leave to file a second

09:48:28 amended complaint. In other words, the receiver is seeking to add new claims in this case.

And, by the way, we didn't file an opposition to the receiver's motion because we recognized that a timely filed motion seeking to add parties or new

09:48:46 claims are to be freely granted.

Let me quickly address really the only argument made by the receiver in her opposition. The receiver contends that the only claims asserted by the co-op against my client are contract claims; and,

09:49:02 therefore, it would be futile to add Xerox and the

09:49:06 Exchange because you can't get contribution on contract claims. That's simply not true.

First, courts hold that unaffected parties, like the co-op here, do not have standing to assert 09:49:22 futility arguments on behalf of the proposed third-party defendant like Xerox. In other words, why would or should the co-op care about claims that are not being asserted against it?

Number two, even if the receiver did have 09:49:37 standing, it is undisputed that the co-op has asserted numerous tort-based claims against Unite Here Health and Nevada Health Solutions in this case, not merely contract claims. And we don't have to look any further than the co-op's 65th cause of action against Unite 09:49:57 Here Health for negligence. And it also requests punitive damages, which you certainly can't get if all you're asserting is contract claims.

Moreover, in their second amended complaint the co-op seeks to assert 15 tort claims against both 09:50:15 Unite Here Health and Nevada Health Solutions. And to give an example, they assert negligence claims, negligent performance of an undertaking, and professional malpractice. Those are not contract-based claims.

09:50:31 And we have analyzed each of these claims on

09:50:33 pages 8 through 10 of our reply. There can simply be no reasonable dispute that these tort claims are claims from which contribution is available.

So unless you have any questions, your Honor, 09:50:46 we ask that you grant our motion because such motions are freely granted. And more importantly, because allowing us to bring in the state Exchange and especially Xerox will promote judicial economy and avoid inconsistent results.

09:51:09 THE COURT: All right. Thank you, sir.

MR. PRUITT: Your Honor, this is Matthew Pruitt on behalf of InsureMonkey and Alex Rivlin. I just wanted to note that we joined in that motion and that our joinder has been unopposed, and which, just to 09:51:26 repeat the -- join in the same arguments that were just made.

THE COURT: Okay, sir. Thank you.

MR. PRUITT: Thank you.

THE COURT: And we'll hear from the 09:51:36 opposition.

MR. SMITH: Good morning, your Honor. Abe Smith. I just wanted to make sure before I start whether, whether Mr. Bailey also wanted to address his motion for consolidation first or whether we'll take 09:51:48 those separately.

09:51:54 MR. BAILEY: Your Honor, John Bailey. It was my understanding from your official comments that you wanted to take each motion in order. So --

THE COURT: Yes.

09:52:02 MS. BAILEY: -- at this point I think we're only addressing the motion seeking leave to add a third-party defendant.

THE COURT: And that's all we're considering right now.

09:52:11 MR. SMITH: All right. Thank you, your Honor. Again, Abe Smith for the plaintiff, the receiver.

Mr. Bailey's reply brief talks about the elephant in the room. And it's an apt phrase, but I think he misconstrues what the elephant is. The 09:52:28 elephant in the room is that he's gone in front of Judge Cory in the receivership court to try to disqualify the counsel of the receiver's choice, Greenberg Taurig, well into this litigation.

He failed in front of Judge Cory. He's taken 09:52:45 that issue up to the Supreme Court. The Supreme Court will issue its decision. But for right now the order stands that Greenberg Taurig is not disqualified as a result of any kind of conflict.

Having lost in front of the receivership 09:53:00 court, having failed to qualify -- disqualify

09:53:02 Greenberg Traurig, Unite Health is now trying to achieve the same tactic by other means. They're belatedly bringing the claim that could have been brought years earlier and that they admit can expressly
09:53:18 be brought after the judgment in this action. There's no need for it to be brought in this action.

The only reason they're trying to tie it within this action is for the reason that they went in front of Judge Cory to get the counsel of the
09:53:30 receiver's choice, Greenberg Traurig, disqualified even though they're the ones that have been intimately involved in preparing for trial for nearly four years now, trying to get them kicked off the case and force others to proceed or start anew with counsel, like me,
09:53:46 who is much less familiar with the issues in this case.

So, let me address -- there are nondiscretionary reasons that require the Court to deny the motion and then I'll also address some of the more discretionary reasons.

09:54:01 The first -- the first reason that the Court has to deny the motion is that the claim is meritless. Mr. Bailey in his reply brief, again for the first time, says, oh, well, the receiver doesn't have standing to oppose a motion to bring a third-party
09:54:18 defendant in. Of course we do.

09:54:23 I was looking for -- I thought that was a surprising doctrine, something as serious as standing. So I looked at the cases that he cited. All of them, of course, unpublished cases. And if you go down -- 09:54:32 they really follow a rabbit hole down to -- to one case from the 11th Circuit, which you might expect that case to actually hold that, yes, you know, defendant -- or the plaintiff cannot oppose a motion to add a third-party defendant on grounds of futility; but 09:54:51 that's not what the case is about.

The case that they're -- that has been cited to called National Independent Theater Exhibitors, Inc. versus Charter Financial Group, it's at 747 F.2d, page 1396. Again, this is the 11th Circuit, and they 09:55:14 actually talk about one of the standards in deciding a motion under Rule 14(a) as the futility of amendment.

And, in fact, one of the -- the analysis of the Court goes on to say: Plaintiffs in moving for leave to amend made no showing in their factual 09:55:32 allegations as to how the additional parties could be held liable on any of the claims they were asserting against -- in that case Charter -- the party defendant -- the proposed third-party defendants.

The cases that the plaintiff cites -- and 09:55:46 that's a published case -- the cases the plaintiff

09:55:48 cites are all unpublished. I went back to Wright and Miller and, of course, I found that there was no such doctrine on a plaintiff lacking standing to oppose a Rule 14(a) motion on grounds of futility.

09:56:04 In fact, the Wright Miller section relevant to this, which is Section 1443, says as a result that a timely application for interpleader, which is the procedure that plaintiff -- that the defendant is invoking here, should be granted except when it would

09:56:19 delay or disadvantage the existing action, which I think Mr. Bailey agrees with is the background to oppose, or the third-party claim obviously lacks merit. I believe that that is getting to the same issue as the futility analysis under a Rule 15 motion.

09:56:37 And, in fact, we have cases, again, because I didn't realize that this was going to be a -- a contested topic, I didn't realize that we need to establish our standing to be able to oppose a motion on the ground that the purported complaint would not --

09:56:51 would not state a claim.

But let me just give you one citation, Kopan -- that's K-O-P-A-N -- vs. George Washington University.

THE COURT: I don't mind saying this --

09:57:07 MR. SMITH: The citation is 67 --

03:07:54 (Multiple speaker cross-talk)

THE COURT: I'm not as -- sir, I don't want to cut you off -- sir, I don't want to cut you off --

MR. SMITH: Yes.

09:57:12 THE COURT: -- but I'm not as concerned about the standing issue.

MR. SMITH: Very good, your Honor. I will -- I will move on to the merits then.

So the only action that's been -- that the

09:57:22 third party complaint purports to add is one for contribution. And I was waiting to see whether they were relying on anything other than the Uniform Contribution Against Tortfeasor's Act, which is NRS 17.225.

09:57:39 They don't. Their reply brief confirms that they're only relying on that statutory section. But what they miss is that there's a difference between what we might call personal injury or injury to property torts and business torts for economic injury

09:57:57 for economic losses.

They invoke the image of Schwemminger's quark, which is really a kind of a misapplication of a quantum physics principle where you can have a particle that exists in quantum superposition, but if you happen to

09:58:15 tie the behavior of a quantum particle to something

09:58:19 like whether a cat lives or dies, then they say, well, the cat was simultaneously alive or dead. But that's not actually true in the sense that when anybody observes the experiment, they can see, okay, is the cat 09:58:31 was alive or dead.

So not to get too much on a tangent, but that's what they call shorting the swerve is this idea that we've asserted tort claims, but we're construing them as based on a contract so somehow that invalidates 09:58:47 our argument that the Uniform Contribution Against Tortfeasors Act wouldn't apply in this situation.

Well, let me tell you that the Uniform Contribution Against Tortfeasors Act does not apply by the express language of that -- of that statute. It -- 09:59:00 it not only limits it to a tort, which is what we've been talking about, but it's a tort for an injury to person or property or for the same wrongful death. We don't have here an injury to person or property or wrongful death. We have economic harm. We have an 09:59:22 injury that is -- is purely economic. And it's that kind of claim to which the Uniform Contribution Against Tortfeasors Act does not apply.

They raise the Republic Services case, which is different, right? Because there you had joint 09:59:38 liability for a personal injury. The victim of the car

09:59:40 crash there could have equally sued the doctor or the negligent driver for the pinnacle breach that caused the nerve damage.

But here UHH is not in the position of a car 09:59:52 accident victim. And -- I'm sorry, the receiver is not in the position of a car accident victim. UHH is not in the position of the negligent driver. We don't have personal injuries or injuries to property. And -- and as I've discussed now, the receiver could not go after 10:00:11 Xerox for the same claims, for the same injuries that it's pursuing against UHH, the Unite Health.

So, first on the contract claims, I think it's clear there is no -- there is no contribution. But all of the tort claims are, of course, linked to the duty 10:00:29 that arises under our contract. We hired Unite Health to protect us from companies like Xerox. I don't think we're going to pretend here that Xerox was -- was stellar and flawless in its performance for the Exchange, but that's not the relationship that we have. 10:00:52 We have a relationship with UHH to provide the very services that would have protected the receiver against -- against problems that arise in the dissemination of information from the Exchange.

The -- Xerox itself developed workarounds for 10:01:10 its -- for its admitted software problems within a few

10:01:13 months of the launch of the Exchange. So by February, March 2014 the Exchange is providing all of the information that the insurance -- that the insurance companies, the co-ops like -- like the receiver here, 10:01:27 need in order to process claims to be able to decide who's actually insured, who's paid their premiums. That information was flowing to the -- to NHC.

The problem was that -- that UHH which had been contracted to provide the system so that it could 10:01:47 link up the Exchanges information was never in place. That's why we're suing UHH. The problem was not the Exchange's failure to provide information.

At most, that caused delay of a couple of months. But then -- and, of course, it might have 10:02:05 caused issues with people signing up for insurance premiums, but that's not what we're suing for. We're suing UHH for the failure of the company because it was processing claims just by paying them whenever somebody -- whenever a doctor claimed that somebody 10:02:20 had -- had signed up with NHC for insurance because they didn't have the system in place to actually process the information that was coming from the Exchange.

The breach of the implied covenant, of course, 10:02:34 is also -- you know, that comes in two forms. There's

10:02:36 the implied covenant that arises from the contract and then there is a tortious breach of the implied covenant. Of course, the breach of contract, again, that's something that UHH can't pass on to Xerox or the
10:02:50 Exchange. That's a contract that UHH entered into with NHC, so it's not entitled to seek contribution as a result of that breach.

But even if it were based -- even if we're talking about the tortious base and there were some,
10:03:07 you know, special relationship on which we're basing that claim against UHH, there wouldn't be the same relationship that UHH has with the Exchange or Xerox such that UHH could then pass on its liability under that claim to Xerox for the Exchange.

10:03:25 So again, as we said in our opposition, I'm surprised they didn't take our opposition at face value. There is no contribution action for this kind of -- for these kind of actions, whether we're calling them contract actions or even if you, you know, accept
10:03:44 the characterization as torts. Regardless, they're not torts for what -- for what NRS 17.225 requires, which is injury to person or property, not economic harm. So that's a nondiscretionary reason why the Court has to deny the motion.

10:04:00 But let's -- let's talk about their argument

10:04:03 that there's no prejudice to Unite Health. Well, I'm sorry. Let me back up. So the -- they say that there's no prejudice to us in -- in allowing them to amend the complaint. Well, actually, there is no
10:04:19 prejudice to them in denying the motion to amend. They've agreed and the cases that they cite Pack vs. LaTourette, Salem vs. Alcada, all those cases make clear that, yes, you can bring a contribution action a year after the judgment in this action. There's no
10:04:36 need for it to be in this action.

As I'll discuss in a moment, the real purpose of that, of bringing it in this action is really just to disqualify the counsel of choice for the receiver. And Mr. Bailey raised the issue of inconsistent
10:04:51 judgment; I've never seen what -- what it is that he thinks would be the inconsistent judgment. The issue in this case would be the Unite Health liability for the demise of the Exchange.

We're not talking about a claim that -- we're
10:05:11 not talking in this context about the liability that the -- that the UHH would be able to pass on to the -- to the Exchange or to Xerox. In a separate action for contribution they would be able to make all those claims.

10:05:29 So even if it were true that the -- in the

10:05:31 second action the judge or the jury deciding it decided that, no, UHH is not entitled to share this liability with the -- with Xerox or the Exchange, that wouldn't be inconsistent judgment. That would be a proper
10:05:47 application of contribution principles to a judgment that had previously been decided against UHH.

And, again, in light of the fact that we're not talking about personal injuries here, I don't know that this is even relevant. But to the extent that we
10:06:04 are, they would still have the opportunity under cases like Banks versus Sunrise Hospital to point the finger at -- that are nonparties as long as they can say, look, either we are not negligent and so we have no liability or the entire responsibility for the
10:06:21 negligence rests with a nonparty like Xerox.

Now let's talk about the prejudice to Unite Health. They say there is no prejudice. In fact, the claim that it would somehow benefit us to bring Xerox into the case. Well, no, it would prejudice us. The
10:06:38 elephant in the room, as they call it, is that -- is that the receiver would be deprived of the counsel to which they're entitled.

Judge Cory already found that there's no conflict in allowing Greenberg Traurig to represent the
10:06:52 receiver in this case. The effect of granting their

motion would be to raise a conflict to try to kick Greenberg off the case.

I know your Honor has dealt with these sort of issues before you were involved in the endoscopy cases years ago, where our firm, you know, came in. We originally represented the Teva defendants. Then we came in to represent United Healthcare, which is different parties from Unite Health here.

Your Honor asked reasonable about -- questions about whether our firm was allowed to proceed, and you found yes, that these claims are different, the -- that it would not prejudice plaintiffs to allow Lewis Roca to represent two different defendants as long as those claims were separate. So your Honor is familiar with how to address this, and your Honor understands the importance of allowing parties to -- to select the counsel of their choice. It's not a light decision.

In this case they frame it as, well, this is just another 15(a) motion. No, this is not a normal 15(a) motion. This is a 15(a) motion that would have -- I'm sorry, 14(a) I apologize. This is a 14(a) motion that would have the effect of trying --

MR. POLSENBERG: Judge, Judge, Judge, if I can just clarify for Mr. Smith, we are not conceding that this was -- absolutely results in the conflicting of

10:08:17 Greenberg Traurig. But we are arguing that that's the reason they are doing this.

THE COURT: I do understand that, and it's subtle, Mr. Polsenberg, but I do get that. In fact --

10:08:33 MR. POLSENBERG: I've never been accused by you of being subtle, Judge.

MS. SMITH: Thank you, Dan, for correcting what might have been a too subtle argument on my part.

I think this is important. I think we should

10:08:46 stop the accusations, especially in this proceeding and especially given the ruling from Judge Cory, this kind of smear of Greenberg Traurig, the accusation that they've -- that they've engaged in unethical conduct, we've already presented the affidavits to Judge Cory,

10:09:05 and there's simply no basis -- Greenberg Traurig was not involved in the decision whether or not to sue Xerox.

And -- and that decision was taken well before the engagement of Greenberg Traurig. The receiver

10:09:20 would not have engaged Greenberg Traurig as the new trial counsel in this matter had it not already decided that the claims against Xerox lacked merit.

And that's -- and that's the truth. We've said in our discovery responses that, look, if we -- if

10:09:36 the receiver sees information that would justify

10:09:40 bringing a claim against Xerox, we'll bring it. The receiver has conflicts counsel expressly for that purpose. But the evidence simply does not support it. The evidence supports the claims against Unite Health, 10:09:53 but not the claims against Xerox.

Independent of the fact that this would be a vehicle for attempting to exclude the counsel of the receiver's choice, we have a serious problem with the delay that this motion would cause -- that this 10:10:09 impleader would cause.

Plaintiff -- the UHH cites to this case, Green Valley Corp. vs. Caldo Oil Company that says, well, you know, actually the goal -- the policy goals of 14(a) are enough even if there's no other -- nothing else 10:10:26 justifying the relief.

Well, actually, that case also says that -- that mere delay would not be a reason to deny the 14(a) motion. But, in fact, the Nevada Supreme Court has taken a different tact. We cited the MEI-GSR vs. 10:10:45 Peppermill case, and they disagree with those federal authorities, and they say, yes, delay alone can be a sufficient reason to deny a motion to amend. And here it isn't just delay, but it's prejudicial delay.

So UHH, they concede that it's a complicated 10:11:07 case. We've set forth in our declaration from the

10:11:11 special deputy receiver some of the discovery process in this case. UHH has gotten multiple trial extensions, and NHS, Nevada Health Solutions, they were in this case from the beginning, from 2017. The UHH, 10:11:29 they've been in it for I think more than two years now.

But in any event, in that time UHH has gotten multiple trial extensions, including more than a year to -- for their preparation of expert reports. But now they're claiming despite the admitted need for long, 10:11:50 extensive discovery for themselves, that they're going to force Xerox and the Exchange to complete all of their discovery before the end of this year and be ready for trial in May 22 of 2022. I'm sorry, but that's not realistic.

10:12:07 Given the complexities of the claims in this case, I don't see how we -- we go to trial in 2022, certainly not May 2022, given the -- given the sort of extensions that UHH has required for its own discovery. You -- you can just compare the two complaints in this 10:12:25 case. This -- we'll bring this up a little bit more when we come to the motion to consolidate, but for our claim right now against the Exchange it's just six pages. But the complaint in this case is 120 pages. This is a complicated case.

10:12:40 And, plus, the -- the delays that granting

10:12:43 this motion would inevitably produce would also create problems with the five-year rule. I understand with COVID we've got the special -- the new amendment to Rule 41(a). We've got some new way. But this case has
10:12:56 been pending since -- since 2017. And -- and once those pandemic restrictions are lifted, we are going to run into the five-year rule as a result of bringing Xerox into this case.

As far as the argument that this is actually a
10:13:10 benefit to us, it's simply not true. They're not -- Xerox is not another source of recovery. It's not like our damages would be greater by bringing -- by bringing Xerox into this case. Rather, it's -- it's an -- it's a potential way for -- for the -- for UHH to try to say
10:13:37 that while we shouldn't be liable. And for diminished recovery against UHH -- and, again, this (indiscernible) is not relevant to the issue on consolidation, but these are not the same claims, the claims involving the Exchange. They said both in their
10:13:53 motion and in their reply brief that, well, we're asserting the same claim against the Exchange as against UHH for this 510,000. No, no, it's not the same. We're -- the 510,000 against the Exchange, that is a -- a failure of the Exchange to remit payments
10:14:11 that they collected from insureds. We're not saying

10:14:13 UHH has those payments. We're saying the Exchange has those payments and they just need to remit them to -- to NHC.

What we're saying in this case is that UHH 10:14:25 failed to perform its obligations under the agreement so egregiously that it caused the failure of the co-op. It's quite different. We're not talking about hundreds and thousands in this case. We're talking about tens of millions of dollars.

10:14:38 And I do believe that there was undue delay. We've had undisputed evidence. Mr. Bennett was the only one that provided a declaration on the subject about the -- about what -- what -- about what UHH knew and when they knew it. We have just -- the 10:14:56 representation of counsel that, well, it needed to consult with its experts. We don't have any evidence, we don't have any affidavit from the expert confirming this.

And we know that -- that not only was UHH 10:15:09 aware because its principals were involved with the NHC board meetings, but even it's counsel in this case, Greenberg Traurig, was at the meetings back in February of 2014 discussing the problems that they have with Xerox. UHH needs to be on high alert that if any claim 10:15:29 were brought against it, yeah. If it thought that

there was a valid way to bringing Xerox, it could have done so years ago.

And I think it's a serious enough delay that it would justify denying their motion even if there were no recourse for UHH to bring the motion -- to bring a contribution claim later. But in this case the solution of denying their motion actually doesn't cause that harsh result because, again, they have the right to bring a contribution action, one exists, after the conclusion of this case, after a judgment in this case.

And -- and let me address -- just address one final point.

We've been accused of delay in responding to this motion in that somehow that justifies the delay in bringing the motion. But I'd just like to point out to your Honor that -- that no. The delay was caused by the fact that they brought a motion to bring in Xerox which Greenberg Traurig, in an effort to avoid even the appearance of impropriety, I know it's not the standard for the lawyer's disqualification. They brought in conflicts counsel, us, to address this motion; but it takes time to get approval from the receivership court, it took time for us to be able to clear -- you know, to clear our representation to be able to come in. So that's -- that's not a fault of the receiver for

10:16:53 requesting an extension to respondents' motion.

Does your Honor have any questions before I turn back to Mr. Bailey?

THE COURT: Not at this point, but I'm going 10:17:02 to have questions for both of you once you're done.

MR. SMITH: Very good.

THE COURT: Okay. Mr. Bailey.

MR. BAILEY: Thank you, your Honor. Let me try to very succinctly address what I view as kind of a 10:17:18 tortured argument.

Number one, what you heard was them saying that the reason we brought this motion was not to attempt to hold Xerox and the Exchange liable for contribution. But what we're really trying to do is 10:17:39 disqualification of Greenberg Taurig.

Well, two points to that. Number one, we filed this motion long before Judge Cory ruled on our motion for disqualification. So that in and of itself tells you that that's not why we brought the motion.

10:17:59 Number two, the purpose for bringing this motion is to seek contribution from Xerox and the Exchange should there be a finding of liability against my client.

Next, the argument about -- that these -- that 10:18:21 our contribution claim is futile. You know, your

10:18:24 Honor, if you grant our motion, and you should, that will not preclude Xerox or the Exchange from asserting all of their 12(b) defenses, including a motion to dismiss our third-party claims for contribution.

10:18:40 What you hear is the receiver -- and, again, we're not asserting claims against the receiver. You hear the receiver trying to step into the shoes of Xerox and make arguments about futility and the viability of the contribution claim.

10:18:57 Well, granting our motion will not preclude Xerox and the Exchange from making those motions if they believe them to be viable -- if they believe the motion to be viable.

Finally, the only two real bases that you see

10:19:14 courts deny these kinds of motions are if you can demonstrate undue delay or prejudice. And you hear the receiver say, well, wait a minute. They could have brought this motion sooner.

And the answer to that is, no, we really could

10:19:35 not have brought this motion sooner. First of all, we brought it timely. We certainly brought it before your deadline. But we -- we were receiving information, third-party information on public record requests to understand Xerox's role in all of this in the middle

10:19:52 part of last year.

10:19:54 And those public records requests went to governmental agencies, and that's how we, as I recall, obtained a copy of the Deloitte assessment of Xerox. So we received that information the middle of last
10:20:10 year, and we timely filed our motion in October of last year.

In terms of delays, you know, I know you don't want us to get into a very detailed argument about delay. But there has been requests to continue things
10:20:27 from both sides. In fact, I distinctly remember standing in front of you last year or maybe the latter part of 2019 when the receiver produced their expert report and Mr. Ferrario looked at it and said, yes, your Honor, this is very confusing; we're going to have
10:20:47 to redo all of this. And they had to redo it. And so we had to continue the expert report deadline.

In the latter part of last year, the receiver came to you and requested a stay of this case for several months, which you granted and ultimately the
10:21:06 first part of this year you lifted that stay. My point is only this: Delay in terms of parties asking for what are normal processes in the context of litigation has happened in this case. But that's what happens when things don't come together precisely as you would
10:21:26 want them to, particularly when you're dealing with

10:21:29 COVID.

My point is we timely filed our motion. It would make no sense for us to not include all of the potential culpable parties in this case. And, again, 10:21:44 we're not asserting claims against the receiver. We want to assert them against third parties.

And I would suggest to you that the only way you can promote judicial efficiency and economy is to grant the motion.

10:22:08 THE COURT: Mr. Bailey, I have a question for you. What about this one issue, and the issue would focus on potentially if I granted the motion, that could create a conflict of interest in this case; therefore, plaintiff could be precluded their counsel 10:22:25 of choice.

And the reason why I bring that up is this -- because this is somewhat -- I mean, for me it's not really unique because coming from construction defects, we dealt with third-party practice daily, all the time 10:22:37 regarding contribution claims, regarding claims involving equitable indemnity, implied indemnity, which to me is the same thing except you have a contract that doesn't have an express indemnity provision. And then we dealt with express indemnity and interpretation of 10:22:53 all the contracts under Brown and all that litany of

10:22:56 cases.

But here's my point. And this is -- this is why I think this is really kind of nuanced, because normally -- I don't mind saying this -- I have 10:23:07 routinely granted motions like this in the past. And I have.

But I never -- when you bring up the issue regarding, okay, if I grant the motion, then there's a genuine issue regarding whether or not potentially 10:23:23 there can be a conflict of interest in this case. In contrast -- and remember this, if I don't grant the motion, that doesn't preclude contribution claims from being brought down the road in another case.

And so I'm looking at it because -- I mean, I 10:23:38 get it. I understand what the cases say regarding undue delay, prejudice. And Nevada appears -- I always think undue delay is a big deal, and it could result in prejudice regardless. I do. But this is a little bit nuanced here.

10:23:54 And what do I -- what should I consider in that regard? Because even hypothetically, if I bifurcate it or did something from a trial protocol perspective, nonetheless once they're in the case, then there could be a potential conflict of interest, and 10:24:15 that could impact the plaintiff's retention of counsel.

10:24:20 And understand this, and this is why I think the time -- the timing is important, because, for example, if a motion like this was brought back in early -- because the complaint was filed in
10:24:33 August 25th, 2017. If a motion like this was brought in maybe 2018, early on in the case, okay, you just deal with it at that point and let the chips fall.

But here we are, three-and-a-half, close to four years in litigation. And I think that could be
10:24:54 very problematic in an extremely complex case like this to force any party to go out and get new counsel.

What do I do under those circumstances? The only reason why I bring it up, I don't mind telling you, that's what I'm thinking about.

10:25:16 MR. BAILEY: Well, your Honor, this is John Bailey. I'm glad you asked that question, and I'll tell you what I believe you should do, which is to grant the motion, and here's why.

It has been my understanding and it has been
10:25:30 the representation of the special deputy receiver and Greenberg that the reason Lewis and Roca is in this case and represents the co-op and the receiver and special deputy receiver is because of the conflict issue.

10:25:50 So you're asking me what happens if Xerox is

10:25:56 brought into this case? Well, the answer is from the receiver, the special deputy receiver and Greenberg Taurig, we have conflicts counsel, Lewis and Roca, who will handle that matter. So your concern about what
10:26:14 could potentially happen has been answered by the receiver, special deputy receiver and Greenberg because everyone, if they have special conflicts counsel and if a conflict arises, their conflicts counsel will handle the representation of the co-op going forwards.

10:26:38 So in answer to your question and your other point dealing with what -- what would happen in a case where Xerox and the Exchange came in, well, the only claim against them is for contribution. They're not directly involved in -- they're not directly involved
10:27:11 with claims brought against them by other -- by the co-op in this case to be able to get things done in the next eight months of discovery? Seems fairly reasonable to me to be able to go to trial over a year from now? Seems very reasonable to me.

10:27:28 I -- I don't share any concern that if we immediately serve Xerox they're going to come in and do whatever they do. They're going to protect their interests. But your primary point about the receiver having the counsel of her choice, well, she has told
10:27:48 everyone including Judge Cory that they have special

10:27:51 conflicts counsel, formerly Whitmire, and now apparently it's Lewis and Roca.

So this whole problem that they created had nothing to do with Unite Here Health or Nevada Health 10:28:07 Solutions. This problem they created, they're taking the position that they have a solution for it. And that solution -- they wanted to, but it shouldn't tack on the decision to grant this motion. It's well-founded and should be granted and any decision 10:28:28 that has -- (telephonic audio glitch) -- can do so.

THE COURT REPORTER: I'm sorry, counsel; it cut out again. I didn't hear the very ending. And we have background noise from somebody. I'm not sure where it's coming from.

10:28:48 MR. POLSENBERG: I'm unmuted because I'm expecting to address the Judge's question next.

THE COURT: I think Mr. Bailey at the very end, your last statement for the record, I don't think the court reporter got the entire statement; is that 10:29:07 correct?

THE COURT REPORTER: That is correct.

MR. BAILEY: I'm sorry, where did I leave off? What was the last thing you heard me say?

MR. POLSENBERG: The last three words he said 10:29:39 according to my notes were "to do so."

10:29:48 MR. BAILEY: Your Honor, I -- I -- I was wrapping up my comments. My point is -- is simply that there is no undue delay. This is a complicated case, but is no undue delay.

10:30:01 And the receiver, the special deputy receiver and all of her counsel have essentially assured all of us that they have a plan if a conflict arise because they have special counsel. Initially they had the Santoro Driggs firm as special conflicts counsel, and

10:30:24 now they apparently have Lewis and Roca as special conflicts counsel. So the receiver -- there can be no dispute that the receiver had the counsel that she wants for the particular purposes that she needs counsel for.

10:30:40 The -- the problem, the conflicts issue, is not an issue that was created by my clients or any of the defendants. The motion -- your thoughts about the motion should not be driven by issues created by the receiver and her counsel, particularly in light of the

10:31:02 fact that she has now taken the position, she being the receiver, that she has the solution for all of this by having conflicts counsel Lewis and Roca. So --

MR. POLSENBERG: Judge, I'm sorry, but that's just ridiculous.

10:31:14 THE COURT: Wait, wait, wait, wait, wait,

wait.

MR. BAILEY: Well --

THE COURT: Wait, wait, wait, wait, wait.

Mr. Polsenberg, you know I'm going to give you an opportunity to say what you have to say, sir. You know that.

MR. POLSENBERG: All right.

THE COURT: Were you done, Mr. Bailey?

MR. BAILEY: Your Honor, if -- I don't think this is a big point, but I don't want to underestimate the level of concern that you might have about it. If you'd like us to provide supplemental briefing, and I will pull out the declaration of the special deputy receiver that says we have contemplated a potential conflict and we have conflicts counsel that we would use.

I have seen that declaration because it was presented in Judge Cory's court. So if you -- if it's important for your purpose, your Honor, to see that declaration and to see that briefing, I will certainly provide it to you because it's really a nonissue.

To now say that the receiver can't go forward without the counsel of her choice is just simply inconsistent with statements that the receiver has made in the past and it's inconsistent with the fact that

today in front of you is Lewis and Roca, Mr. Abraham and Mr. Polsenberg.

So --

MR. POLSENBERG: Polsenberg.

MR. BAILEY: I'm sorry, Dan. Did I mispronounce your name?

MR. POLSENBERG: No, I thought you forgot it.

MR. BAILEY: I wouldn't do that.

But my point is that the receiver has the counsel that she wants and that should not be an impediment to you doing what you would always do, which would be to grant timely filed motions to bring in additional parties and additional claims, as the receiver is trying to do in their motion to file a second amended complaint. They're bringing in additional claims.

THE COURT: I understand, sir. And thank you.

And, I guess, we'll pass the floor to Mr. Polsenberg.

MR. POLSENBERG: Thank you, your Honor. Dan Polsenberg.

So let's talk about what conflicts counsel is. The reason we came in as conflicts counsel is because we wanted to make sure there was no appearance of impropriety on the decision whether to bring Xerox in

10:33:28 as a third-party defendant because of the potential that GT has for somebody raising a conflict.

So they -- the thinking is in ethics areas -- and I know Bailey Kennedy is one of the leading firms 10:33:44 in that area -- the thinking is that you don't have the lawyer who could possibly have a conflict decide whether or not to oppose. So they brought us in.

I mean, you know, we're appellate lawyers. We're law and motion lawyers. We reviewed this. We 10:34:00 thought under the circumstances it was appropriate to oppose. And, your Honor, I would submit it's appropriate for you to deny this motion bringing the third party claim.

But that doesn't mean I can take over and try 10:34:14 this case. This case is so overwhelming -- although I had planned to argue this today myself, it's just so big that it was more economical for the client for me to have Abe argue it because he could read all the cases, he could look at some of the file. But this 10:34:34 file is overwhelming. There's no way I could be ready to try this case, assuming I'm even competent. You know? I'm Dan Polsenberg; I'm not Mark Ferrario.

He's been in the -- he's a great lawyer, he's been in this case for years. They waited three years 10:34:51 to raise this issue. And, yes, I submit they raised

10:34:55 this issue to get him off the case.

THE COURT: And Mr. Polsenberg --

MR. POLSENBERG: And I think that's an important consideration --

10:35:01 THE COURT: Mr. Polsenberg, I don't want to cut you off remember when I started this discussion I think my view on whether to grant or deny the motion would have been much different hypothetically if the -- if the motion was filed back in 2018, for an example.

10:35:20 MR. POLSENBERG: Exactly, exactly.

THE COURT: And the way I view that is this: The case is -- we're now three-and-a-half-plus years or so into the case, and it's -- I will admit it's a complex case. There's no question about it.

10:35:32 MR. POLSENBERG: Right.

THE COURT: And -- and, actually, I was -- that's probably why I started out at the very beginning because I know right now currently I couldn't hear this case in my courtroom. By the time it goes to trial, I

10:35:43 will have alternatives available probably to hear it either in 5D and/or on the 17th floor. I get that.

MR. POLSENBERG: That would be so much fun.

THE COURT: Yeah. But my spin is this --

MR. POLSENBERG: I spent a lot of good times

10:35:54 on the 17th floor.

10:35:55 THE COURT: Yeah. And my point is this, though. When I look at it, are those factors I have to consider? And the reason why I bring that up is this: I'm always going to tell you what I'm thinking about at
10:36:05 the time, and I think we get better records that way anyway.

MR. POLSENBERG: Right. And, you know, Abe brought up the fact of your very intricate ruling on the motion to disqualify counsel in the endoscopy case.
10:36:23 I believe the same kind of practical considerations -- they knew about Xerox from the beginning. If they really wanted to bring Xerox in, they would have done it years ago, if they weren't just trying to disqualify counsel and put my client at a
10:36:41 disadvantage.

And, you know what, it's going to be even worse, Judge, if we're looking practicalities, you know, I mentioned before what I do for a living. If GT were disqualified, you know, we would run a writ
10:36:58 petition to the Supreme Court. There's no way that we're going to trial -- if you grant this motion, there is no way we're going to trial in May, May of next year. So all of those issues about delay I think are critical to your discretionary ruling.
10:37:23 Now, Mr. Smith pointed out there's some

10:37:25 nondiscretionary issues, but I think the discretionary issues -- the practicalities -- I mean, we all live in the real world. I mean, even appellate lawyers live in the real world occasionally.

10:37:38 This would be a bad move. And, yes, I apologize that earlier I said that Mr. Bailey's positions were ridiculous. But, you know, they were.

THE COURT: What about an alleged business tort exception to the contribution amongst tortfeasors

10:38:02 act, is that really legitimate?

MR. POLSENBERG: No.

THE COURT: Yeah. I was wondering about that. I feel --

MR. POLSENBERG: No.

10:38:09 THE COURT: But go ahead.

MR. POLSENBERG: You know, I've -- I've been doing contribution since I argued Buck vs. Greyhound in 1987. So -- I don't think everybody understands contribution. It's different for -- although you say

10:38:27 it's similar to indemnity --

THE COURT: Well, not really --

MR. POLSENBERG: -- in Nevada --

THE COURT: No, no, no.

MR. POLSENBERG: -- it is --

10:38:32 THE COURT: No, no. I'm not saying that.

10:38:34 What I was talking about was -- I mean, I clearly get the distinction --

MR. POLSENBERG: Right.

THE COURT: -- between implied indemnity or
10:38:42 equitable indemnity based on a nexus and/or preexisting relationship, of course. And just as important, too, the whole line of cases when it comes to interpretation of expressing indemnity agreements starting with Brown and its litany of cases and how I have to look at the
10:38:55 specific language.

MR. POLSENBERG: Yes.

THE COURT: I mean, I get that, Mr. Polsenberg.

MR. POLSENBERG: And, Judge, we could go all
10:39:00 the way back to Reed vs. Royal --

THE COURT: Yes.

MR. POLSENBERG: -- which Rex Jimmerson argued, where -- where I think the Nevada Supreme Court split from California and where they're going.

10:39:14 So, and honestly they have no prejudice. If they want a contribution action, they can still bring a separate contribution action without throwing a stink bomb into this courtroom.

THE COURT: All right. I understand your
10:39:29 position, sir.

10:39:30 MR. POLSENBERG: Thank you, your Honor.

THE COURT: Okay. Mr. Bailey, you get the last word to address any issues I raised with Mr. Polsenberg.

10:39:39 MR. BAILEY: Your Honor, my -- my last words are that in -- we did not file this motion to try to disqualify Greenberg. We filed a motion before Judge Cory for that purpose, and that's before the Nevada Supreme Court.

10:40:02 In this case we filed a motion because there's a culpable party for the claims that the co-op is asserting against us, and we're not that culpable party. It is the Exchange and Xerox. And that's why we're filing the claims, and that's why we're filing

10:40:23 for contribution.

The point about delay, because I think that's something that you're concerned about, when you say we could have filed this years ago --

THE COURT: And understand this, and I think

10:40:37 it's really even more nuanced than that.

I mean -- what I was saying was my decision would be much easier hypothetically if the motion had been filed back in, say, 2018 or 2019. It becomes much more difficult from an analysis perspective in this

10:41:00 respect based upon just the timing of the motion. And

10:41:02 I'm not saying that's due to the fault of anyone as far as discovery is concerned in this case. Because I do understand that we've had COVID, I understand we've had counsel involved in this case for a long time. And
10:41:18 based upon my experience, complex litigation is just a different animal and things happen.

And I'm not saying anyone was dilatory necessarily as far as the motion is concerned. I'm looking at it from a practical impact of the motion in
10:41:34 that now we're currently set for trial coming up next year, and this is a complex case in which counsel of choice on behalf of the plaintiff has been in position for three-and-a-half years prosecuting this case. And that's more of where I'm at right now.

10:41:58 So it's not -- I'm not looking at it from, well -- in a very simplistic manner, well, this should have been filed earlier. I do realize there is an issue regarding getting the appropriate documentation to support this claim. Maybe that happened in October
10:42:13 or whatever. I get it. I do.

And all I'm saying is this. I'm not saying this isn't a simple decision, well, you should have done this a long time ago, Mr. Bailey. That's not my thought process at all. I'm looking at it from the
10:42:30 perspective as to what impact will it have, ultimately,

10:42:32 on the prosecution and defense of this case. That's where I'm at, Mr. Bailey. I just want to tell you that.

MR. BAILEY: No. And I appreciate that, your
10:42:39 Honor, and I don't disagree with you. But it's important to note in your consideration that it was not until the co-op filed its expert opinions in late 2019 that it spelled out its allegation and its claims against you -- my client, Unite Here Health, that we
10:43:05 were able to then determine that a contribution claim would be appropriate. And then when we put that information to our own experts in 2020, our own experts concluded the culpability of Xerox.

So I appreciate your point, but we were not in
10:43:26 a position in 2017 to file this motion, particularly given our ethical duties under Rule 11. So it wasn't until late 2019 when we received the co-op's expert opinion that this issue got teed up, we put it in front of our experts, we immediately sent out public records
10:43:47 requests to governmental agencies.

And that information flowed in to us sometime in the middle of last year, and we immediately filed this motion, which again was timely based on your existing scheduling order.

10:44:05 So, you know, to suggest -- I understand your

10:44:10 point. It's a lot easier decision to make if we had filed in 2017. The issue had not been teed up until late 2019. And then we filed this motion timely in October of 2020.

10:44:27 So I would ask you to do exactly what the rule requires, which is to promote judicial efficiency and economy. To suggest that we can, after this case is over, go and file a contribution claim, yes, we can. Can you imagine putting that -- all of this information 10:44:51 would have to be retried in front of another judge. That's what courts try to avoid. We try to get everything done with all claims and all parties in one case.

And that's what we're asking you to do, allow 10:45:04 us to file a contribution claim against the real culpable party because in the event there's liability found against my client, that lability belongs at the feet of Xerox and, indirectly, the state Exchange.

So based on that, I would ask you to grant the 10:45:25 motion.

THE COURT: And I just have one more comment in that regard because we were talking about a potential post -- say in this case a post judgment action if necessary as it pertains to the rights to 10:45:40 enforce contribution under Chapter 17.285. What

10:45:45 prejudice would there be pertaining to your client?

MR. BAILEY: If we filed an action after this case is over?

THE COURT: Yes, sir.

10:45:55 MR. BAILEY: Well, you certainly have the prejudice of witnesses being asked to testify even a greater period of time than they would have had they testified in this case.

It just -- it really -- when you have the

10:46:13 ability to consolidate or to bring that -- that small contribution claim into this case, it really makes no logical or reasonable sense to require a party to wait until after this case is over to then go file a contribution claim. It just practically makes no

10:46:34 sense.

It's not efficient in terms of evidence. It's not efficient in terms of witnesses. And it certainly isn't efficient in terms of amount of resources that you're almost doubling for no -- for no good reason.

10:46:50 THE COURT: Any comments on that, Mr. Polsenberg, because I didn't ask you that question?

MR. POLSENBERG: No, Judge. I think you know where I am. And I think I know where you are.

THE COURT: Okay. This is what I -- this

10:47:05 is -- let me see.

10:47:09 MR. BAILEY: And, by the way, Judge, just -- I hate to interrupt you, but remember my client Unite Here Health was not even added to this case until September of 2018.

10:47:21 THE COURT: I understand that. I do.

Let's talk briefly about the motion to consolidate. I want to keep this ball in the air for a time period.

MR. BAILEY: Would you like me to get started?

10:47:55 THE COURT: Yes.

MR. BAILEY: Okay. This is a relatively simple exercise. In our case before you, one of the claims the receiver is asserting against my client, Unite Here Health, is for alleged uncollected insurance

10:48:13 premiums in the amount of 5,000 -- $510,651.27.

In a separate action -- I believe it's in front of Judge Peterson -- the receiver filed a suit against the Silver State Health Insurance Exchange for the same $510,651.27 for, as they allege, uncollected

10:48:39 insurance premiums.

So you have the same claim by the same plaintiff about the exact same subject matter pending in two different pieces of litigation. Precisely what Rule 42(a)(2) is designed to address. And that is

10:48:58 consolidation of different litigation into one case to

promote judicial efficiency and economy.

From my view there's just simply no basis upon which the Court should deny consolidation when you have two pieces of litigation involving the exact same subject matter, the same plaintiff is asserting the exact same claim against two different sets of defendants. And that's exactly what consolidation is for.

THE COURT: All right. Okay.

MR. SMITH: Your Honor, Abe Smith.

THE COURT: Yes; yes, sir.

MR. SMITH: Abe Smith for the receiver.

Quick point initially, and I do apologize, but I didn't notice this before I started preparing for this hearing. But I think we have a jurisdictional issue, at least due process issue here.

I sort of assumed that, you know, the motion to consolidate, as your Honor knows, needs to be filed in both cases. But then it's the judge in the lower case number that decides the motion to consolidate. But here the motion was not filed in the -- in the Exchange case. In fact, as far as I can tell, the Exchange was never even served a copy of the motion.

They certainly have a right to respond, of course. As you know, one of the factors in determining

10:50:32 a motion to consolidate is prejudice to the parties. Well, the Exchange would be a party to this action if you grant consolidation. And they haven't been given an opportunity to respond, which of course they have a 10:50:47 due process right to. And I don't know what they would say.

Obviously, we oppose it; and so you can deny the motion just based on -- on the prejudice to us. But you certainly can't grant the motion because a 10:50:59 party who would be affected by this hasn't been given due process, hasn't even been given notice of the motion.

I'm not as concerned -- you know, it would have been polite to let Judge Barisich know about this 10:51:13 motion, but I think the -- the main issue is really that it was not served on all the parties that would be affected by consolidation. So I think that's that -- that that's, again, a nondiscretionary issue. You need to deny the motion on that basis.

10:51:28 But even if we were to somehow excuse that jurisdictional or due process defect, again, you should deny the motion.

They talk about this issue of a potentially double recovery. That's simply not true. The -- if we 10:51:45 prevail in the action for the Exchange, which again as

10:51:49 I mentioned earlier, that's a six-page complaint compared to the 120-page complaint here that was filed three years after the complaint in this action. It's going to trial this year.

10:51:59 So when that easy, straightforward claim is resolved, the claim that we are asserting against the claim -- against the Exchange will no longer exist in this case. So if you want to think about it in terms of double recovery, either we simply won't be asserting

10:52:14 those damages against the Unite Health or they would get an offset for any recovery against -- against the Exchange. So there is no issue of double recovery.

And they talk about this -- this 510,000 as if it's, quote, the exact same damages. No. First of

10:52:33 all, in their motion they fudge a little bit. They call it the Xerox -- Xerox Exchange. There is no such entity, of course. But it makes it seem like the claim that we're bringing against the Exchange would be the same as a claim against Xerox.

10:52:51 The claim against UHH, Unite Health, is that the failure to perform their duties lead to the demise of the co-op, and that's why this claim is for the tens of millions of dollars that it would take to repay insureds. That's why we're in a receivership action.

10:53:08 This is an asset recovery case.

10:53:10 And there are -- there are claimants waiting to -- to -- to get recovery from the -- from the receivership estate, and they've been negatively affected by -- by the co-op's failure, mainly because 10:53:21 of the Exchange. Again, this is just, this 150 -- this is our, sorry, 510,000. This is for payments that the Exchange collected and simply didn't remit to -- to the -- to the co-op.

We're not -- we're not claiming that the co-op 10:53:39 failed because of the lack of this $510,000. That would make the other case a much bigger case, a much more complicated case.

I think that case should go forward in the department that it's already been assigned to and on 10:53:55 the trial date that it's already been given to it.

Of course, we don't -- we don't have the claim in this case that UHH received the unremitted funds from the Exchange. That's our claim against the Exchange. Again, you need -- we need to separate those 10:54:09 two.

The issue of the -- of the Unite Health failing to process information from the Exchange so that we could have known and been able to reconcile the issues with the Exchange not remitting premiums, that's 10:54:26 one issue. But in the case against the Exchange, it's

far more straightforward.

So, again, this is -- these are not the same claims, and it would be prejudicial. This is a receivership, your Honor. This is not the case of an ordinary litigant who, you know, they can -- they can spend their time and their money the way they want and it only affects the litigants. Here we have parties with claimants, we have insureds that are waiting for a recovery in this case.

Delaying the action against the Exchange would mean a delay in potential payers that we could -- that we could -- be used to fund the receivership and pay off claims. So I don't think it's appropriate to add that layer to this case when that case is already set for trial in November of this year.

Thank you, your Honor.

THE COURT: Thank you, sir.

And, Mr.Bailey?

MR. BAILEY: Yes, your Honor.

For the record, we provided the Deputy Attorney General Michelle, who I believe is counsel of record in the other case, with a copy of our motion to consolidate. And I believe that was on February the 24th of this year.

So if there -- you heard him say they're not

10:55:56 sure that the AG's office received a copy of this, the answer is yes, they did.

MR. LIEBMAN: Your Honor, this is Joseph. Actually, we sent an email. We sent it back on 10:56:09 October 19th of 2020, we sent courtesy copies.

MR. BAILEY: Okay. So the AG's office is clearly aware as of October of last year of the motion to consolidate.

Let me address the merits which -- of course, 10:56:27 your Honor, you practiced law for many years, and you've been sitting on the bench for many years. Does the argument that the co-op's counsel just made make any sense to you? Because it doesn't make any sense to me when you say that you can't -- you can't get 10:56:45 inconsistent results in two different cases where you're asking for the same amount.

It is undisputed that one of the claims for damages in our case is a claim against Unite Here Health for the $510,000 and some change. That is the 10:57:08 exact same amount that the co-op is seeking from the Exchange in a different case.

What happens in that situation 100 percent of the time is you consolidate those cases so that you avoid inconsistent results, which is clearly a 10:57:29 possibility, and you promote judicial efficiency, which

10:57:34 is what should happen.

So I -- I mean, I can't tell you more than that. This is a routine same subject matter by the same plaintiff in two different pieces of litigation 10:57:48 that should be consolidated.

THE COURT: And I just have one final question and -- for you, Mr. Bailey, in this regard. If I grant consolidation, what does that do to trial protocol in this case?

10:58:04 MR. BAILEY: In terms of when the case would go to trial?

THE COURT: No, no, no. As far as how the -- how the case would proceed during the trial.

MR. BAILEY: Well, I think that because this 10:58:22 is in a discrete amount of money -- I can't speak for the Exchange because I don't know what their defenses may or may not be, but I think this is the kind of issue that the Court can take up.

I don't know if they selected a jury in that 10:58:40 case or not. But this is the kind of issue that you can take up at the initiation of trial since it is a discrete amount of money and either it's owed, it's not owed, it's somewhere, or it's nowhere. But this seems to me something that you can take up right at the 10:59:00 beginning of trial and resolve, particularly if there's

10:59:04 been no demand for a jury in the other case.
THE COURT: Okay. I guess the answer, we don't know yet what impact it would have on trial protocol, right? Because --
10:59:26 MR. BAILEY: Well, we don't because --
THE COURT: Yeah.
MR. BAILEY: Because the AG's office is not here. And, by the way, they have not filed an opposition to the consolidation motion despite having
10:59:37 notice of it.
THE COURT: All right.
My last question would be this. The consolidation wouldn't present any -- any sort of conflict; is that correct?
10:59:52 MR. BAILEY: Not to my knowledge.
THE COURT: Anyone want to join in from the --
MR. SMITH: Your Honor, yeah. Let me just address -- I can't speak as to the conflict issue. Perhaps one of the attorneys from Greenberg can answer
11:00:09 that question.
But, yeah, I think there's no question this would disrupt the conduct of trial. And I guess I'm confused as to why Mr. Bailey thinks that this would -- that trying the Exchange case first, because it is on
11:00:29 track to be tried first, why that would cause prejudice

11:00:31 to him. Because either -- either we won't recover against the Exchange, in which case we're just where we are now, or we will recover against the Exchange.

And, actually, if we don't recover against the
11:00:46 Exchange there may be issue preclusion problems. If we recover against the Exchange, they get a full (indiscernible) that's no longer part of our case here. So that just goes away. So I'm not sure why they would be concerned about trying that case which is already on
11:01:00 a short trial. Again, this is -- this is something that we want expedited, why that would be rolled in front of these people into this case.

MR. POLSENBERG: Right. If they set -- Dan Polsenberg. If they set the amount -- if the jury sets
11:01:14 the amount, then that's the amount.

MR. BAILEY: Your Honor, this a John Bailey --

MR. FERRARIO: This is Mark Ferrario on the question of conflict. Mr. Prunty advised me in that other case, which is a very discrete, short case that
11:01:34 will probably, if we keep the November trial date, probably won't last all of a week, the state is moving to bring Xerox into that case, so you end up creating the same issues if you consolidate that very discrete simple case into this case.

11:01:52 And the thing that's getting lost here is if

11:01:56 we prevail against the state, then there is no claim for that same amount of money vis-à-vis UHH. So judicial economy dictates we get that issue off the table in November or have it crystallized in November. 11:02:13 There should be no delay in resolving that issue. And we shouldn't then import another potential conflict issue into this case, which is much greater than the half a million dollars that we're fighting there.

So all of the evils that were addressed 11:02:35 previously by Mr. Polsenberg and Mr. Smith can resurface again with consolidating this other case that's already set to be tried in November. So --

MR. BAILEY: Your Honor -- your Honor, this is John Bailey. May I respond?

11:02:48 THE COURT: Of course, Mr. Bailey.

MR. BAILEY: Number one, Ferrario just said that there's a potential for Xerox to be brought into the other case.

Well, if that is true, then that would be a 11:03:02 conflict for Greenberg which would require some solution that could be their disqualification. So the same issue that they're talking about out of one side of their mouth, they're trying to get you to do just the opposite, by telling you -- by not telling you that 11:03:22 if Xerox is brought into the other case, that they have

11:03:25 a problem.

Number two is you just heard Mr. Abraham say that the issue against the Exchange is for uncollected premiums. And the issue in our case against us is not 11:03:42 necessarily for the uncollected premiums, it's for the service we provided and that somehow that service didn't allow them to collect the uncollected premiums.

So you could potentially have, if you don't consolidate, them getting an award in the other case 11:04:03 and still coming after my client in this case for the exact same amount of money. Again, that's why you consolidate cases, so you don't have inconsistent results.

MR. FERRARIO: That won't happen, your Honor. 11:04:17 And I have to address something. I really take offense -- I've had to sit here and listen to a lot of comments from Mr. Bailey and his partner over the past few months, but you asked me a question, your Honor, and I answered it. And now Mr. Bailey is accusing me 11:04:36 of talking out of both sides of my mouth because I simply answered your question.

And, you know, we'll deal with whatever happens in that other case. There's a motion pending. I believe Mr. Prunty can speak to that.

11:04:52 To add Xerox, that will be addressed in that

other case.

And, quite frankly, if I were in Mr. Bailey's shoes, I would be wanting that case to go forward because I would be hoping, I guess, that the Exchange recovered the money from the state so his damages would be reduced. But here I have him wanting to delay that to further confuse or complicate this case, and I think it's pretty obvious as to why.

So, again, I -- I answered your question, Judge. That's what I attempted to do --

THE COURT: And I just have one more question for you.

MR. FERRARIO: I wasn't speaking out of both sides of my mouth.

THE COURT: Yeah. I just have one more question for you, Mr. Ferrario. If I grant a consolidation, what would that do to the trial protocol in this case?

MR. FERRARIO: I think it -- I think it complicates it because of all these other issues. You end up probably having, if you consolidate with -- I think there is a motion pending; and, again, Mr. Prunty can speak to that, your Honor -- we end up having all the same issues that were addressed by Mr. Polsenberg and Mr. Smith. You also delay the resolution of an

11:05:58 issue that should be resolved in November.

So you unduly complicate this case. And then you have to figure out how do you sequence it? You're right. Do you put it at the end? Do you put it at the 11:06:10 beginning? I suspect you're not going to want to put it at the beginning, and I don't know off the top of my head -- and I apologize, your Honor, you asked a good question about whether there's -- or somebody raised the issue, whether there's a jury or bench, I don't 11:06:22 know if that case is a jury or bench trial off the top of my head.

Don, do you know?

MR. PRUNTY: I don't know off the top of my head. I don't -- I believe it's a jury trial. And 11:06:32 there's -- there's one other jurisdictional issue which I believe one of the contracts has and maybe Lewis and Roca can address this.

MR. SMITH: Don.

MR. PRUNTY: There is a contractual issue 11:06:48 where there is exclusive jurisdiction in Carson City on some of those, on -- I believe it's in that other case because the contract -- I believe it's between Xerox and the Exchange -- and maybe Abe can address this -- requires that the case be heard in Carson City.

11:07:14 MR. SMITH: But, Don, that would -- this is

11:07:14 Abe. That would be if Xerox were brought into that case, it would have to be transferred to -- to the First Judicial District.

MR. PRUNTY: Right. And so my point is there's a pending motion to bring Xerox into that case, I believe. And so as these things play out, you know, it gets back to the same -- the same issue that, you know, this is strategy to try to disqualify the state from having their -- their representatives of choice.

That motion is pending in the other case. If it's granted, then you're back to Carson City. It just -- it just turns this into -- this case and the complications greatly can, you know, make this case far more complicated and delays things by going through these -- these in and outs.

And I believe that a copy and -- of that agreement may be in, Abe, what you submitted to the Court. But I know that argument, I believe, is there.

MR. FERRARIO: Yes, your Honor; so I think you can see that -- just by the dialogue we're having here, it would greatly complicate this trial, which is already complicated. And, as you said, I am comforted to hear that we're going to have a courtroom to accommodate us.

As you know, I've been in front of you a

11:08:42 number of times in this case asking for a trial date, and I think it -- it is very important that we maintain that May trial date for some of the reasons articulated by Mr. Smith when he talked about the other
11:08:55 constituencies here that have an interest in this case.

And so what we should do is not complicate or add issues to this case, but get this case to trial. With that, I'll conclude with -- turn it over to Mr. Polsenberg and Mr. Smith.

11:09:12 MR. POLSENBERG: Judge, Dan Polsenberg. Actually, I think you will be facing Contingent B issues if you consolidate because these may have to be tried separately. So I don't think it makes sense to consolidate and then order a separate trial.

11:09:32 THE COURT: Well -- and that was one of the issues I was contemplating, Mr. Polsenberg. And I don't mind saying it because I'm trying to figure out -- and maybe it's because we dealt with a lot of trial protocol issues in construction defects. I don't
11:09:44 know if they deal with that as much in other areas of litigation. But that's something we had to consider every time a case went to trial for many different reasons.

But I'm looking at this. And I'm very much
11:09:58 pleased with the dialogue and argument we've had

11:10:02 because, from my perspective, it's been extremely helpful and insightful as far as where this case is. And before I rule on it, I'm going to do two things. Number one, Mr. Bailey is the moving party. Of course, 11:10:16 I'm going to give him the last word; and then I'm going to go back and sit down and think about this for a day or two.

MR. POLSENBERG: Yeah.

THE COURT: And calculate where we're at and 11:10:24 where we need to be.

I do understand all the arguments, and it is nuanced, and -- and that's probably one of the reasons why I don't place artificial time limitations on lawyers like some other judges do, because I want to 11:10:38 know everything that's going on and to get a -- a general picture of the current state of the litigation in order for me to make a -- I would hope a well-reasoned and thoughtful decision. But, anyway, that's subject to review too; right?

11:10:55 But --

MR. POLSENBERG: Yes, yes.

THE COURT: Anyway. Mr. Bailey, you're the moving party, sir. You get the last word.

MR. POLSENBERG: Judge, can I say two 11:11:05 things --

11:11:06 THE COURT: Yes.

MR. POLSENBERG: -- really quickly?

I think before I said 52(b) when I meant 42(b).

11:11:13 THE COURT: Yes.

MR. POLSENBERG: And you're right, I -- you know, I've done a lot of construction defect work and I've represented contractors. And, you know, we would bring a third-party claim against everybody who picked

11:11:29 up a hammer. But we did it early on, so that's a big difference.

THE COURT: All right. Thank you, sir.

Mr. Bailey, you have the last word, sir.

MR. BAILEY: Thank you, your Honor. Just a

11:11:45 couple points.

Number one, I was not being critical of Mr. Ferrario, the person. I was being critical of his statements. I've known Mark for 30 years, and I have the highest regard for him. So to the extent he took

11:12:04 that in a way that I did not mean, I apologize for that.

Number two, these arguments that you hear Mr. Polsenberg, Mr. Ferrario, Mr. Prunty, Mr. Abraham making about consolidation --

11:12:17 THE COURT: Yes.

11:12:17 MR. BAILEY: -- if you go back and look at their opposition, which is on consolidation, which is all of maybe a page and a half long, none of those arguments are in there.

11:12:29 None of those arguments about Xerox, none of these arguments about jurisdiction, none of these arguments about Carson City are in there. And I would just ask you to look at the merits of consolidation on what the parties have submitted to you.

11:12:45 My belief is what you have heard this morning is an attempt by four different lawyers to try to make this as confusing as possible in hopes you would not do what you should be doing, which is consolidating this matter.

11:13:03 So that's my point on consolidation. And -- and I'll leave it at that.

Thank you, your Honor.

THE COURT: All right. And I think we've covered all topics; is that correct? There's nothing

11:13:17 else pending for today, is there? Wait, wait. Let me look.

MR. PRUNTY: Your Honor --

THE COURT: Oh, yes. We have one other motion. It was unopposed; right?

11:13:26 MR. PRUNTY: Correct.

11:13:26 THE COURT: Was that -- let me -- you are correct, sir. That was plaintiff's motion for leave to file a second amended complaint?

MR. PRUNTY: Correct, your Honor. That was 11:13:35 unopposed.

And I would ask for, as a clean-up matter, you had signed a stipulation and order because we were removing certain claims against certain of the officers and directors. As a clean-up matter, if we could also 11:13:53 just remove those claims when we file the second amended complaint, we'd appreciate that.

THE COURT: Any issue in that regard, Mr. Bailey?

MR. BAILEY: No, your Honor. I have no 11:14:09 objection to that. I will note just for the record, your Honor, that we did not oppose the filing of the second amended complaint, which adds a variety of new claims and tort claims, which if you're thinking about our other motion seeking leave to add the Exchange and 11:14:30 Xerox, and to the extent that you're concerned about adding more time to this case, I would ask you to focus on the fact that the receiver right now is adding multiple additional claims to this case.

So, you know, what's good for the goose has to 11:14:49 be good for the gander. Thank you, your Honor.

11:14:52 THE COURT: You're welcome, sir.

As far as the unopposed motion is concerned, sir, that are will be granted. All right --

MR. POLSENBERG: Judge, just to correct the

11:15:01 record on one thing --

THE COURT: Yes, sir.

MR. POLSENBERG: Mr. Abraham is actually Mr. Smith; and you may recall in the endoscopy case every time I introduced him I said Mr. Smith, and

11:15:15 that's his real name.

THE COURT: Yes. All right. Okay. Got it.

Anyway, that covers, I think, today's hearing. And I'll get you a minute order out on both issues. I'm going to think about it.

11:15:30 MR. FERRARIO: Thank you, your Honor.

THE COURT: All right.

MR. PRUNTY: Thank you, your Honor.

THE COURT: Enjoy your day.

IN UNISON: Thank you, your Honor.

(Proceedings were concluded.)

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REPORTER'S CERTIFICATE

STATE OF NEVADA)
:SS
COUNTY OF CLARK)

I, PEGGY ISOM, CERTIFIED SHORTHAND REPORTER DO HEREBY CERTIFY THAT I TOOK DOWN IN STENOTYPE ALL OF THE PROCEEDINGS HAD IN THE BEFORE-ENTITLED MATTER AT THE TIME AND PLACE INDICATED, AND THAT THEREAFTER SAID STENOTYPE NOTES WERE TRANSCRIBED INTO TYPEWRITING AT AND UNDER MY DIRECTION AND SUPERVISION AND THE FOREGOING TRANSCRIPT CONSTITUTES A FULL, TRUE AND ACCURATE RECORD TO THE BEST OF MY ABILITY OF THE PROCEEDINGS HAD.

IN WITNESS WHEREOF, I HAVE HEREUNTO SUBSCRIBED MY NAME IN MY OFFICE IN THE COUNTY OF CLARK, STATE OF NEVADA.

_____
PEGGY ISOM, RMR, CCR 541