MARK E. FERRARIO, ESQ.
Nevada Bar No. 1625
ERIC W. SWANIS, ESQ.
Nevada Bar No. 6840
GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
Facsimile: (702) 792-9002
Emails: ferrariom@gtlaw.com
swanise@gtlaw.com

Counsel for Plaintiff

IN THE UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

BARBARA D. RICHARDSON, in her capacity as Receiver of Nevada Health Co-Op., Plaintiff, v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; THOMAS E. PRICE, M.D., in his capacity as the U.S. Secretary of Health and Human Services; and THE UNITED STATES, Defendants.	CASE NO. **COMPLAINT AND DEMAND FOR JURY TRIAL**

COMPLAINT FOR DECLARATORY JUDGMENT

Plaintiff states the following allegations and cause of action against Defendants.

1. Plaintiff, Barbara D. Richardson, is the Commissioner of Insurance in the state of Nevada ("Plaintiff" or "Commissioner") appointed by the Eighth Judicial District Court, Clark County, Nevada, to serve as the receiver ("Receiver") of Nevada Health Co-Op ("NHC"), in the matter captioned *State Of Nevada, Ex rel. Commissioner of Insurance, In Her Official Capacity As Statutory Receiver For Delinquent Domestic Insurer v. Nevada Health Co-Op*, Case No. A-15-

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

725244, pending before the Eighth Judicial District Court, Clark County, Nevada. Ms. Richardson brings this suit in her capacity as receiver of NHC.

2. Defendant the U.S. Department of Health and Human Services ("HHS") is an agency of the federal government.

3. Defendant the Centers for Medicare & Medicaid Services ("CMS") is an operating division of HHS and is an agency of the federal government.

4. Defendant Thomas E Price, M.D., is the acting Secretary of HHS.

5. Defendant United States is a proper defendant to this action under 5 U.S.C. §§ 702 and 704.

6. Plaintiff seeks judicial review of a final agency action of Defendants pursuant to 5 U.S.C. § 702 of the federal Administrative Procedure Act ("APA"), which provides that "[a] person suffering legal wrong because of an agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof."

7. Plaintiff seeks a declaratory judgment whether the federal government is legally entitled to assert setoffs, under federal common law or otherwise, for monies claimed against NHC through funds that HHS/CMS is statutorily obligated to pay to NHC. The Court may grant such relief pursuant to the Declaratory Judgment Act, 28 U.S.C. § 2201 *et seq.*

8. By this action, Plaintiff is not seeking a monetary judgment or damages against Defendants.

9. There exists no other adequate remedy in a different court except the relief Plaintiff seeks herein under the APA. Specifically, this Court has the authority to issue the remedy sought by Plaintiff, namely, declaratory relief.

10. Pursuant to 28 U.S.C. § 1331, the Court has subject matter jurisdiction over this dispute wherein Plaintiff alleges Defendants have violated federal statutory provisions as outlined below.

11. Venue is proper in this Court because a substantial part of the events or omissions giving rise to Plaintiff's claims occurred in this district, this dispute impacts the NHC receivership

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

and liquidation estate ("NHC Estate" or "Estate") in this district, with such estate being liquidated in a proceeding pending before the Eighth Judicial District Court, Clark County, state of Nevada, and Plaintiff resides in and performs services in her capacity as receiver of NHC in this district. In addition, Section 19.2 of the loan agreement (described below) states that "The parties further agree that they consent to the jurisdiction of the Federal Courts located within such State and the courts of appeal therefrom, and waive any claim of lack of jurisdiction or *forum non conveniens*." Furthermore, this matter directly affects thousands of Americans (healthcare consumers and providers) in this district who are unable to address their chronic and acute health care needs or pay for their daily living expenses, all owing principally to their having entrusted themselves to the government's much vaunted health care program described below.

12. On March 23, 2010, President Obama signed into law what is referred to as the "Patient Protection and Affordable Care Act" or "ACA." The ACA established the Consumer Operated and Oriented Plan ("CO-OP") program, which authorized the creation of nonprofit health insurance issuers to offer qualified health plans to individuals and small groups. 42 U.S.C. § 18042(a)(1)-(2). Through the ACA, Congress authorized and directed HHS/CMS to establish and operate the CO-OP program. The CO-OP program was entirely a creature of the ACA. But for the legislation, CO-OPs such as NHC would not exist.

13. Congress authorized and appropriated billions of dollars to fund the start-up and solvency funding needed by the CO-OPs, making the federal government the largest investor in and founder of the CO-OP program. As such, it was obvious that in the event of a CO-OP insolvency, the predominate creditor claims would be policyholder and federal government claims.

14. On July 28, 2010, HHS issued a Funding Opportunity Announcement for the federal CO-OP program under the ACA. The ACA authorized two funding types "to persons applying to become qualified nonprofit health insurance issuers" under the CO-OP program:

a. Start-up loans "to provide assistance to such person in meeting its start-up costs;" and

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GREENBERG TRAURIG, LLP
3773 Howard Hughes Parkway
Suite 400 North
Las Vegas, Nevada 89169
Telephone: (702) 792-3773
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b. Grants "to provide assistance to such person in meeting any solvency requirements of States in which the person seeks to be licensed to issue qualified health plans." 42 U.S.C. § 18042(b)(1).

15. Insurer rehabilitation and insolvency have long been under the exclusive jurisdiction of the states. Congress did not alter that in the ACA. To the contrary, the ACA and its implementing regulations reflect Congress's intent to preserve state regulation of health insurer solvency requirements and proceedings relating to financially distressed or insolvent insurers. Specifically, the ACA includes an express provision, under a clause entitled "No interference with State regulatory authority," which states: "Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title." 42 U.S.C. § 18041(d). Furthermore, Congress directed the Secretary of HHS to promulgate regulations "with respect to the repayment of [loans to CO-OPs] ***in a manner that is consistent with State solvency regulations and other similar State laws*** **that may apply**." 42 U.S.C. § 18042(b)(3) (emphasis added). Likewise, the ACA provided that "[i]n promulgating such regulations, the Secretary shall provide that such loans shall be repaid within 5 years and such grants shall be repaid within 15 years, ***taking into consideration any appropriate State reserve requirements, solvency regulations, and requisite surplus note arrangements*** that must be constructed in a State to provide for such repayment prior to awarding such loans and grants." *Id*. (emphasis added).

16. In July 2011, CMS published proposed regulations implementing the ACA and noted that insurer liquidation is typically handled under state law rather than federal law, stating as follows:

> State law establishes a variety of required regulatory actions if an insurer's RBC [risk based capital] falls below established levels or percent of RBC. *These regulatory interventions can range from a corrective action plan to liquidation of the insurer if it is insolvent. Solvency and the financial health of insurers is historically a State- regulated function.*[1]

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[1] Proposed Rules, 45 C.F.R. Part 156, 76 FR 43237-01, July 20, 2011 (emphasis added).

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

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

17. There were several comments submitted in response to proposed regulations regarding plans to avert insolvency,[2] and HHS/CMS responded by noting that: "*[i]n the potential case of insurer financial distress, a CO-OP follows the same process as traditional issuers and must comply with all applicable State laws and regulations*."[3] In the final regulation, HHS/CMS addressed the comments only by including ways to "reduc[e] the risk of insolvency."[4] HHS/CMS stated that "[m]ost of those who have expressed interest in the program are…likely to be viable because of their private support, healthcare experience, and business expertise."[5] Thus, the implementing regulations attempted only to "reduce the risk of insolvency," but made no attempt to regulate the process of liquidation of an insolvent insurer, which was left to the states.

18. By recognizing and preserving the states' jurisdiction over any insolvency proceeding, the federal government consented to application of state law in relation to all aspects of the liquidation, including priority of claimants. In other words, Congress did not express any intent, express or implied, to preempt state regulation of insurer insolvency, including in relation to the CO-OPs.

19. The final regulations regarding repayment of CO-OP loans are consistent with 42 U.S.C. § 18042(b)(3)'s requirement that those repayment regulations be "consistent with state solvency regulations and other similar state laws that may apply" and take "into consideration any appropriate state reserve requirements, solvency regulations, and requisite surplus note arrangements that must be construed in a state to provide for such repayment prior to awarding such loans and grants." Specifically, 45 C.F.R. 156.520(b) provides that repayment of CO-OP loans is "[s]ubject to [the CO-OP's] ability to meet State reserve requirements, solvency regulations, or requisite surplus note arrangements."

20. In 2012, NHC was formed as a health maintenance organization (HMO) with a certificate of authority granted by the State of Nevada Division of Insurance, effective January 2, 2013. NHC was formed under a provision of the ACA providing for the formation of consumer

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[2] *See* Final Rules, Responses and Comments, 45 C.F.R. 156, E.6 and F Dec. 13, 2011.
[3] *Id.*
[4] *Id.* at Section F, "Alternatives Considered."
[5] *Id.*

operated and oriented plans. NHC was required to operate as a non-profit, consumer-driven health insurance issuer for the benefit of the public. NHC's primary business was to provide ACA-compliant health coverage to residents of Nevada, and it operated its business for the benefit of Nevadans within the state, save for certain arrangements to provide nationwide health coverage to Nevadans traveling outside the state in certain circumstances.

21. As an HMO, NHC was subject to NRS 695C.145(2)(b), which requires Nevada HMOs to comply with, among other statutes, NRS 693A.180 (regarding borrowing). NRS 693A.180 provides, in relevant part:

> [An insurer subject to NRS 693A.180] . . . may without pledge of assets borrow money to defray expenses of its organization, provide surplus funds or for any purpose of its business, upon a written agreement that such money is required to be repaid only out of the insurer's surplus . . . . *Money so borrowed, together with the interest thereon if so stipulated in the agreement, shall not* form a part of the insurer's legal liabilities except as to its surplus . . . or *be the basis of any setoff*; but until repaid, financial statements filed or published by the insurer shall show as a footnote thereto the amount thereof then unpaid together with any interest thereon accrued but unpaid.

(emphasis added).

22. In 2012, HHS approved and authorized federal funding to NHC[6] to operate as a CO-OP as defined in 42 U.S.C. § 18042(a)(1)-(2). On May 17, 2012, HHS/CMS and NHC closed on a loan agreement ("Loan Agreement") that included promissory notes for a Start-up Loan to NHC of $17,045,047 (defined as intended for costs associated with establishing NHC), and a second promissory note for a Solvency Loan to NHC in the amount of $48,820,349 (defined as intended to meet State solvency and State Reserve Requirements) (together, the "Loans"). When NHC was notified that its application for federal funding had been approved, the loan terms were offered on a take-it-or-leave it basis. HHS/CMS drafted the Loan Agreement and, with few exceptions not at issue here, requested that NHC agree to the Loan Agreement terms without any possibility of negotiating different or amended terms.

[6] NHC's predecessor in interest, Hospitality Health, Ltd., applied for and received the federal funding. On November 25, 2012, an amendment to the Loan Agreement was executed, assigning Hospitality Health, Ltd.'s rights and liabilities under the Loan Agreement to NHC. In December 2012, Hospitality Health, Ltd. and NHC executed a general assignment and assumption agreement, which was subsequently ratified by the companies' boards of directors.

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

23. Because the Start-up Loan was a loan to provide assistance to NHC in meeting its start-up costs for purposes of 42 U.S.C. § 18042(b)(1)(A), repayment of the Start-up Loan is, under 42 U.S.C § 18042(b)(3), subject to "State solvency regulations and other similar State laws that may apply," including "any appropriate State reserve requirements, solvency regulations, and requisite surplus note arrangements that must be constructed in a State to provide for such repayment prior to awarding such loans." In NHC's case, those State laws include NRS 695C.145(2)(b) and NRS 693A.180.

24. Because the Start-up Loan was intended to defray expenses of NHC's organization (*i.e.*, start-up), NRS 693A.180 restricts the Start-up Loan's balance (both principal and interest) to being repaid only out of NHC's surplus (of which there is none), and expressly prohibits the Start-up Loan's balance from being the basis of any setoff.

25. Because the Solvency Loan was a loan to provide assistance to NHC in meeting Nevada solvency requirements for purposes of 42 U.S.C. § 18042(b)(1)(B), repayment of the Solvency Loan is, under 42 U.S.C § 18042(b)(3), subject to "State solvency regulations and other similar State laws that may apply," including "any appropriate State reserve requirements, solvency regulations, and requisite surplus note arrangements that must be constructed in a State to provide for such repayment prior to awarding such loans." Those include NRS 695C.145(2)(b) and NRS 693A.180.

26. Because the Solvency Loan was intended to provide surplus and for purposes of NHC's business (including complying with State solvency and State Reserve Requirements), NRS 693A.180 restricts the Solvency Loan's balance (both principal and interest) to being repaid only out of NHC's surplus (of which there is none), and expressly prohibits the Solvency Loan's balance from being the basis of any setoff.

27. Like NRS 693A.180, the Loan Agreement expressly subordinates repayment of both the Start-up Loan and the Solvency Loan to all claims (accordingly, for purposes of the NRS 696B.420 priority scheme, HHS/CMS's claims are class (k) claims under "surplus notes . . . or similar obligations"). Section 3.1 of the Loan Agreement states "Lender is providing to Borrower

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

funds for CO-OP Program purposes through two Loans, each of which shall be on par with the other for security purposes, and each of which shall be governed and controlled for all purposes by this Agreement, including its Appendices." Additionally, Section 3.4 states "the Loans and other Obligations will be general obligations of Borrower. ***Because the intent of the Loans, and the Solvency Loan in particular, is to provide financing to Borrower that meets the definition of 'risk based capital' for State Insurance Laws purposes***, the Loans will have a claim on cash flow and reserves of Borrower that is subordinate to (a) claims payments, (b) Basic Operating Expenses, and (c) maintenance of required reserve funds while Borrower is operating as a CO-OP under State Insurance Laws." (emphasis added) NHC would never have existed but for the enactment of the ACA and congressional authorization for the start-up and solvency loans. Additionally, the timing of the Loans suggests that the transaction was nothing more than a capital contribution. The purpose of the Loans was to capitalize NHC. The Loans used to create NHC were simply a governmental effort to facilitate the creation of NHC under the ACA. Because the Loans are, in reality, a capital contribution, their re-payment is subordinate to all other claims against NHC.

28. Additionally, Section 15.3(c) provides that "Borrower must immediately repay any unused Loan Funds to Lender *following the resolution of any outstanding debts and run out of any outstanding claim obligations*, *consistent with State Insurance Laws*." (emphasis added) Likewise, Section 16.2 provides that if the [Loan Agreement] is terminated under that section, "all Principal and Interest must be repaid prior to dissolution consistent with applicable Federal requirements and State Insurance Laws, *unless and only to the extent that such payment is otherwise prevented, restricted, or delayed by a State Solvency Payment Restriction*." (emphasis added). In defining "State Solvency Payment Restriction," the Loan Agreement acknowledges that state insurance laws or regulatory action by a state insurance agency or department may create an "actual legal impediment or restriction on repayment of Loan funds pursuant to the terms of this Agreement." Sections 4.4 and 5.6 provide that unless the lender terminates the Loan Agreement for cause under Section 16.3, the Borrower's repayment of the Start-up Loan amount and the Solvency Loan

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

Principal and Interest shall be "*subject to Borrower's ability to meet State Reserve Requirements and other solvency regulations or requisite surplus note arrangements*." (emphasis added).

29. Finally, Section 3.8(c) of the Loan Agreement required, as a condition precedent of the Loan Agreement, that the Borrower submit the affirmation attached as Appendix 10, signed by the Deputy Insurance Commissioner of the State of Nevada, affirming that the Loans (*i.e.*, the Start-Up Loan *and* the Solvency Loan) would be accepted as regulatory capital, the repayment of which is expressly made subject to Statement of Statutory Accounting Principles No. 41 ("Surplus Notes") and subordinated to the claims of any NHC's policyholders, claimants, beneficiaries, and all other class of creditors other than surplus note holders (*e.g.*, CMS/HHS under the terms of the Loan Agreement).

30. Section 3.8(c) and Appendix 10 of the Loan Agreement also provide that interest payments and principal repayments of the Loans require prior approval of the Commissioner of Insurance (which, of course, has not been given in light of NHC's insolvency).

31. Section 19.12 of the Loan Agreement ("Right of Set-Off") only preserved "*available* rights, remedies and techniques to collect delinquent debts, such as . . . administrative offset," notwithstanding any other provisions of the Loan Agreement to the contrary. (emphasis added). As noted above, NRS 693A.180 is one of the State reserve requirements, solvency regulations, requisite surplus note arrangements, and other similar laws incorporated by reference in 42 U.S.C. § 18042(b)(3) and C.F.R. 156.520(b). As also noted above, NRS 693A.180 makes set-off of the Start-up Loan or the Solvency Loan unavailable as a matter of controlling law. Therefore, Section 19.12 did not preserve for CMS/HHS any "available" right to set-off against the balance of either the Start-up Loan or the Solvency Loan, because no such right was available under law.

32. In addition to the statutes, regulations, and Loan Agreement provisions referenced above, the Office of Inspector General ("OIG") for HHS has reported that the OIG had "reviewed the CO-OPs'…loan agreements" and concluded that even though CMS had the right to terminate its loan agreements with the CO-OPs, in the event of such termination, "[a] CO-OP must resolve *any outstanding debts or other accommodation of outstanding claim obligations before repaying the*

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

loan funds to CMS."[7] The Inspector General recommended that HHS/CMS "pursue available remedies for recovery of funds from terminated CO-OPs, [but] in accordance with the loan agreements." HHS/CMS had the opportunity to review and submit written comments on the Inspector General's report, and HHS/CMS "concurred with [the OIG's] recommendations." If HHS/CMS had not concurred, it would have called into question the solvency of all CO-OPs at that time.

33. HHS/CMS made the Start-up Loan and Solvency Loan to NHC subject to the repayment restrictions of 42 U.S.C. § 18042(b)(3), C.F.R. 156.520(b), above-cited terms of the Loan Agreement, and Nevada's reserve requirements, solvency regulations, requisite surplus note arrangements, and other similar laws incorporated by reference (*e.g.*, NRS 695C.145(2)(b) and NRS 693A.180).

34. On April 19, 2013, the Nevada Division of Insurance approved NHC's request to have the solvency portion of the May 17, 2012 Loan Agreement, *i.e.*, the Solvency Loan, be accepted as a surplus note. Even without such express approval, repayment of both the Solvency Loan and the Start-up Loan may only be repaid from surplus pursuant to NRS 695C.145(2)(b), NRS 693A.180, and section 3.8(c) and Appendix 10 of the Loan Agreement.

35. Although NHC received funding and was subject to the federal CO-OP program, NHC was established and operated as a Nevada company licensed by the state of Nevada to issue health insurance plans in this state.

36. NHC began selling products on and off the Silver State Health Insurance Exchange (the "Exchange") on January 1, 2014, and its products included individual, small group, and large group managed care coverage.

37. During 2014, NHC's first year operating as a health insurer, NHC experienced serious and sustained financial distress, having a significant operating loss and its liabilities exceeding assets.

[7] Levinson, Daniel R., on behalf of the Office of Inspector General for HHS, *Actual Enrollment and Profitability Was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loans Provided Under the Affordable Care Act,*" July 2015 (emphasis added).

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

38. Anticipating such hardships, the ACA had created three risk mitigation programs, referred to as the "3R" programs, standing for federal Reinsurance, Risk Adjustment, and Risk Corridors programs. These programs are integral to the ACA, and directly benefit the federal government.

39. In addition, the ACA required the government to subsidize lower-income insureds through the Advance Payment of Premium Tax Credits ("APTC") and the Cost Sharing Reduction ("CSR") programs. APTC was designed to assist lower-income individuals in paying premiums for health insurance plans purchased through the exchange. CSR was designed as a discount that lowers the amount insureds have to pay out-of-pocket.

40. One of the "3R" programs intended to level the playing field for issuers and to protect insurers from loss risks associated with the launch of the ACA, the Risk Corridors program, was established to mitigate the pricing risk that issuers faced because they had very limited data to use to estimate who would enroll in plans operating under the 2014 ACA rules and what their health costs would be.

41. Congress mandated that "[CMS/HHS] shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums." 42 U.S.C. § 18062(a).

42. The Risk Corridors program was designed to limit insurer gains and losses. Under the 42 U.S.C. § 18062, a participating plan must pay to the Secretary of HHS certain sums if the plan's costs are less than a "target amount" of premium revenues. If the plan's costs are greater than a certain percentage of the "target amount" of premium revenues, then HHS/CMS "shall pay" certain sums to qualified health plans such as NHC.

43. Under the 42 U.S.C. § 18062 and its implementing regulations, NHC is owed $9.5 million under the Risk Corridors program for the 2014 policy year and $33,654,360.99 for 2015. NHC is owed an additional $14.5 million for non-Risk Corridors payments for 2014. Under 42

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

U.S.C. § 18062(b)(1) and 45 C.F.R. § 153.510(b), the "Secretary [of HHS] *shall pay*" these outstanding amounts to NHC. (emphasis added)

44. On February 2, 2015, CMS issued a statement stating:

> HHS/CMS *anticipates that Risk Corridors collections will be sufficient to pay for all Risk Corridors payments*. If Risk Corridors collections are insufficient to make Risk Corridors payments for a year, all Risk Corridors payments for that year will be reduced pro rata to the extent of any shortfall. Risk Corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year in a proportional manner, up to the point where issuers are reimbursed in full for the previous years….[8]

45. In other words, only after 100% of 2014 Risk Corridors payments are funded will 2015 and 2016 Risk Corridors revenues be applied to 2015 or 2016 Risk Corridors payments due.

46. Despite its statutory mandate and assurance, HHS/CMS announced that participating plans would receive only up to 12.6 % owed to plans under the Risk Corridors program for 2014.

47. HHS/CMS attributed the shortfall in the Secretary's mandated payments to the plans to a shortfall in issuer payments into the program and purported limits on Defendants' ability to pay the remaining obligation despite this shortfall.

48. On December 21, 2015 NHC received $1,158,961.89 and on January 22, 2016 it received an additional $4,910.27, these sums constituting its 12.6% 2014 Risk Corridors payment announced by HHS/CMS.

49. Apart from the 12.6% of Risk Corridors payments for 2014, HHS/CMS has not made *any* payment to NHC for the balance of the 2014 and any of the 2015 Risk Corridors balances (approximately $43 million), although HHS/CMS has made Risk Corridors payments to other plans.

50. In July 2015, the OIG issued a report stating that 21 of the 23 CO-OPs in operation nationwide, *including NHC*, had incurred net losses as of December 31, 2014. The OIG expressed belief in this report that the conspicuously low rates of enrollment for the CO-OPs, in many cases

[8] *See* CMS FAX ID 8759, Pub'd 02/02/2015, available at: https://www.regtap.info/faq_viewe.php?i=8759, (emphasis added).

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

far lower than initial projections, would limit the ability of these plans to repay the applicable start-up and solvency loans given by CMS.

51. As of August 2015, NHC held policies for more than 14,000 Nevadans.

52. By letter to members and interested parties dated August 25, 2015, NHC's executive leadership indicated that it had been decided, via a vote of the board of directors (which was held on August 15, 2015), that health insurance policies would no longer be offered by NHC after December 31, 2015, and that NHC would voluntarily cease operations after that date. Two members of the board of directors resigned on September 29, 2015, and the remaining board members consented to NHC being placed in receivership via unanimous vote shortly thereafter.

53. On September 25, 2015, the acting Nevada Insurance Commissioner, Amy L. Parks, filed her Petition For Appointment Of Commissioner As Receiver And Other Permanent Relief; Request For Temporary Injunction Pursuant to NRS 696B.270(1) with the Eighth Judicial District Court, Clark County, Nevada (the "Receivership Court").

54. On October 1, 2015, the Receivership Court issued its Order Appointing The Acting Insurance Commissioner, Amy L. Parks, as Temporary Receiver of NHC Pending Further Orders Of The Court And Granting Temporary Injunctive Relief Pursuant to NRS 696B.270 (the "Temporary Receivership Order").

55. On October 14, 2015, the Receivership Court entered its Permanent Injunction And Order Appointing Commissioner As Permanent Receiver of Nevada Health CO-OP (the "Permanent Receivership Order") and appointing the law firm of Cantilo & Bennett, LLP as Special Deputy Receiver ("SDR") of NHC in accordance with Chapter 696B of the Nevada Revised Statutes. The Permanent Receivership Order provides that, *inter alia*, the Receiver and SDR are vested with all powers and authority under Chapter 696B of the Nevada Revised Statutes, the Receiver is vested pursuant to NRS 696B.290 with exclusive title to all of NHC's property including causes of action and rights to participate in legal proceedings, and the Receivership Court has sole jurisdiction over all property and claims respecting NHC's property to the exclusion of any other court. Additionally, the Permanent Receivership Order states, *inter alia*:

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

a. All secured creditors or parties, pledge holders, lien holders, collateral holders or other persons claiming secured, priority or preferred interest in any property or assets of (NHC), ***including any governmental entity***, are hereby enjoined from taking any steps whatsoever to transfer, sell, encumber, attach, dispose of or exercise purported rights in or against the Property;

b. No bank, savings and loan association or other financial institutions shall, without first obtaining permission of the Receiver, ***exercise any form of setoff, alleged setoff, lien, or other form of self-help whatsoever*** or refuse to transfer the Property to the Receiver's control; and

c. No judgment, order, attachment, garnishment sale, assignment, transfer, hypothecation, ***lien***, security interest or other legal process of any kind with respect to or affecting co-op or the property shall be effective or enforceable or form the basis for a claim against [NHC] or the Property unless entered by the court, or unless the court has issued its specific order, upon good cause shown and after due notice and hearing, permitting same. (emphasis added).

56. Having been served with a copy of the Permanent Receivership Order, HHS/CMS did not object to or challenge it before the Receivership Court.

57. On December 23, 2015, CMS provided notice to the Receiver that it was terminating, effective December 31, 2015, the Loan Agreement, declaring that the remaining unpaid loan balance, together with all interest thereon, fees, costs, and expenses, were immediately due and payable by NHC without further notice or right to cure.

58. On January 27, 2016, CMS confirmed that the Solvency Loan is "comprehensively subordinate" meaning it is "subordinate to claims of policy holders, beneficiary claims, and all other classes of creditors other than another surplus note"[9]

59. On February 22, 2016, NHC filed its First Motion for Order Authorizing Payments, asserting that repayment of the Loans is subordinate to NHC's claim obligations and

[9] *See* https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CO-OP-Questions-Final-1-27-16.pdf.

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

reserve/solvency requirements under various state and federal laws and regulations. HHS/CMS was served with a copy of that motion, but did not file an opposition. As such, HHS/CMS consented at least tacitly to the granting of NHC's motion and waived any argument that the Federal Priority Act ("FPA") preempts and/or supersedes other state and federal statutes establishing that repayment of the loans is subordinate to NHC's claim obligations.

60. On March 8, 2016, HHS/CMS stated that an "administrative hold" on payables due to NHC had been implemented at the request of the U.S. Department of Justice and applied to, *inter alia*, advance payments of premium tax credits, payments under the reinsurance, risk corridors and risk adjustment programs, refunds of reinsurance contributions, cost sharing reduction, and reconciliation amounts owed. In other words, HHS/CMS unilaterally, and without written notice or legal justification, placed a "hold" on any payments owed to the NHC estate.

61. Via a Notice of Substitution of Receiver dated April 6, 2016, interested parties of the NHC Estate were informed of the substitution of Insurance Commissioner Barbara D. Richardson in place and stead of former Acting Commissioner Amy L. Parks as a receiver of NHC subsequent to Commissioner Richardson's appointment as Commissioner of Insurance for the state of Nevada.

62. On June 30, 2016, CMS released its summary report on ACA Reinsurance and Risk Adjustment transfers for the 2015 benefit year, stating NHC is owed a Reinsurance payment of $8,842,009.69 and a net Risk Adjustment transfer of $4,532,560.29 for coverage year 2015.

63. On July 21, 2016, the Receiver filed a Motion For Final Order Finding And Declaring Nevada Health Co-Op To Be Insolvent, Placing Nevada Health Co-Op Into Liquidation, And Granting Related Relief.

64. On September 9, 2016, HHS/CMS issued a memorandum stating "all 2015 benefit year [risk corridors] collections will be used towards remaining 2014 benefit year risk corridors payments, and no funds will be available at this time for 2015 benefit year risk corridors payments." CMS further recognized that the Affordable Care Act requires HHS/CMS to make full payments to issuers and that HHS will record Risk Corridors payments due as an obligation of the United States government for which full payment is required.

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

65. On September 20, 2016, the Receivership Court issued its Final Order Finding and Declaring Nevada Health Co-Op to Be Insolvent and Placing Nevada Health Co-Op into Liquidation, determining that NHC was insolvent ("Liquidation Order"). Under that order, the deadline for the filing of all claims against the NHC Estate is April 28, 2017.

66. On September 29, 2016, consistent with its purported set-off entitlement, HHS/CMS claimed that $7,092,856.62 had been offset against funds payable to NHC from the "outstanding amount of the Start-up Loan." Prospectively, HHS/CMS also stated that it "***will continue to hold payments to Nevada Health Cooperative and exercise its right of offset to recover the remaining amounts owed to CMS***." (emphasis added)

67. On October 7, 2016, the Receivership Court issued a Final Order Granting Other Relief Related to Receiver's Motion for Final Order Finding and Declaring Nevada Health Co-Op to Be Insolvent and Placing Nevada Health Co-Op into Liquidation.

68. On November 28, 2016, HHS/CMS rejected the SDR's objections to CMS' September 2016 offset of the Start-up Loan balance against $7,092,856.62 that CMS owes NHC in Risk Corridors and Transitional Reinsurance payments.

69. At a hearing in a similar case, counsel for HHS/CMS was unable to provide any statutory or regulatory authority supporting the government's "administrative hold" on monies owed to a CO-OP. *See* Transcript of Proceedings, Dec. 15, 2016, *Gerhart v. U.S. Department of Health and Human Services, et al.,* Case No. 4:16-cv-00151 (D. Iowa), at 6:22-8:2.

70. On January 19, 2017, HHS/CMS claimed that $2,482,100.22 had been offset against funds payable to NHC, including $1,997,812.80 from "[NHC's] outstanding amount of the Start-up Loan." Prospectively, HHS/CMS again stated that it "***will continue to hold payments to Nevada Health Cooperative and exercise its right of offset to recover the remaining amounts owed to CMS***." (emphasis added)

71. On February 28, 2017, in addition to asserting an offset of $9,874.95 from "[NHC's] outstanding amount of the Start-up Loan," HHS/CMS claimed that, prospectively, "C***MS will not make payments to NHC until NHC's debts owed to the Federal government are paid in full.***

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

CMS will continue to hold payments to NHC and exercise its right of offset to recover all remaining debts." (emphasis added) In its February 28, 2017 letter, HHS/CMS claimed, for the first time, that it was entitled to these offsets under 45 C.F.R. § 156.1215 and Federal common law.

72. In addition to the prospective nature of the payments to which NHC is entitled as described above, the parties have a complex ongoing relationship. Indeed, HHS/CMS and the SDR have had and continue to have extensive communications regarding the rehabilitation and ultimate liquidation of NHC. Moreover, NHC's ongoing filing activities with HHS/CMS will affect balances due for insurance business written by NHC. Future filings -including those pertaining to the CSR, the MLR rebate, and Risk Adjustment and Risk Corridors payments - will ultimately impact debits and credits owed by and between NHC and CMS/HHS.

73. HHS/CMS, by and through its agents, has received copies of the receivership Court's orders, including the Liquidation Order. To date, HHS/CMS has not appeared before the Receivership Court nor objected any of its orders, including the Liquidation Order. However, Defendants have repeatedly, with knowledge of the Permanent Receivership Order, violated the Permanent Receivership Order which precludes self-help remedies.

74. The Receivership Court has been and still is the place where all of the pending issues should be resolved. However, because Defendants have ignored the jurisdiction and authority of the Receivership Court, there is a shadow of uncertainty over the Nevada liquidation proceeding and the Receivership Court's authority to resolve the HHS/CMS claim, which is integral to the liquidation of NHC and resolution of other outstanding creditors' claims.

75. This Court has the authority and jurisdiction over Defendants. This action is therefore the most efficient and practical option to resolve the outstanding issues between Plaintiff and Defendants.

Count I – Request for Declaratory Judgment

76. Plaintiff incorporates by reference all prior allegations of this Complaint.

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

77. There exists a ripe and justiciable controversy between Plaintiff and Defendants regarding various debits and credits as between the Estate of NHC and Defendants, and any right by Defendants to set off payments owed to the Estate based on claims obligations of the Estate.

78. By unilaterally asserting set-offs against funds to which NHC is entitled, Defendants have wrongfully disregarded and violated the provisions of the ACA, Nevada's insolvency laws, and the orders of the Receivership Court.

79. HHS/CMS has decided not to pay NHC the millions of dollars that HHS/CMS has a duty to pay under the Risk Corridors provision of the ACA, despite an express statutory directive that the Secretary of HHS "shall" pay such amount and the fact that HHS/CMS has issued partial Risk Corridors payments to other insurers.

80. The above-listed agency actions also exceed HHS/CMS's statutory jurisdiction and authority, were unlawful and violated the express statutory provisions of the Affordable Care Act.

81. All of the above-listed agency actions are final. There are no internal administrative remedies with respect to the above-listed agency actions. In the alternative, any internal administrative remedies that exist with respect to the above-listed agency actions are permissive, not mandatory, and the time to use such internal administrative remedies has expired.

82. Plaintiff, as Receiver of the NHC Estate, is adversely affected and aggrieved by the above-listed agency actions insofar as the actions have illegally interfered with the orderly liquidation of the NHC Estate, deprived the NHC Estate of assets, and violated the rights of NHC's creditors.

83. Further, declaratory (and equitable) relief–relief only available from this Court under the APA–is necessary to define the rights and actions of the parties with respect to the Nevada insolvency proceeding and the steps HHS/CMS is required to take, or not take, on a prospective basis, in light of application of Nevada law governing priority.

84. For the reasons set forth herein, Plaintiffs ask for the Court to hold that Defendants' purported set off actions are unlawful final agency actions.

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

85. For the reasons set forth herein, Plaintiff asks the Court to issue the following declarations:

a. That the federal government's offsets and prospective offsets alleged herein are unlawful under Nevada State reserve requirements, solvency regulations, requisite surplus note arrangements, and similar laws incorporated by reference by 42 U.S.C. § 18042(b)(3) and 45 C.F.R. 156.520(b), including NRS 695C.145(2)(b), NRS 693A.180, and NRS 696B.420(1)(k).

b. That pursuant to the same laws, repayment of the Start-up Loan, like the Solvency Loan, is subordinated to the claims of NHC's policyholders and subscriber members.

c. That even if set-off by HHS/CMS of the balance under the Start-up Loan or the Solvency Loan against 3R payments to NHC were not expressly prohibited by controlling federal and state law, the set-off requirement of mutuality between those debts would be lacking. In this connection, the repayment of loaned funds, when subordinated so that the funds may serve as regulatory capital, is not a mutual debt vis-à-vis non-subordinated debts.

d. That any set-off by HHS/CMS in relation to the 3R payments to NHC is improper because there is no "mutuality" of debits and credits. The federal government is a mere conduit of issuer-paid funds in relation to elements of the 3R programs, particularly the Risk Adjustment and Reinsurance programs, and that portion of the Risk Corridors program that is issuer funded.

WHEREFORE, Plaintiffs ask the Court to enter the declaratory relief requested, and all other relief deemed just and equitable, including but not limited to attorney fees and costs.

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

DEMAND FOR JURY TRIAL

To the extent there is any issue that may be determined by a jury in this matter, Plaintiff hereby demands trial by jury.

DATED: March 16, 2017.

GREENBERG TRAURIG, LLP

/s/ Mark E. Ferrario
MARK E. FERRARIO, ESQ.
Nevada Bar No. 1625
ERIC W. SWANIS, ESQ.
Nevada Bar No. 6840
3773 Howard Hughes Parkway, Suite 400 North
Las Vegas, Nevada 89169
Counsel for Plaintiff

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