19TH JUDICIAL DISTRICT COURT FOR THE PARISH OF EAST BATON ROUGE

STATE OF LOUISIANA

NO.: 651,069 SECTION 22

JAMES J. DONELON, COMMISSIONER OF INSURANCE
FOR THE STATE OF LOUISIANA, IN HIS CAPACITY AS REHABILITATOR OF
LOUISIANA HEALTH COOPERATIVE, INC.

VERSUS

TERRY S. SHILLING, GEORGE G. CROMER, WARNER L. THOMAS, IV, WILLIAM A. OLIVER, CHARLES D. CALVI, PATRICK C. POWERS, CGI TECHNOLOGIES AND SOLUTIONS, INC., GROUP RESOURCES INCORPORATED, BEAM PARTNERS, LLC, MILLIMAN, INC., BUCK CONSULTANTS, LLC, AND TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA

FILED: _____ _____
DEPUTY CLERK

MEMORANDUM OF BUCK GLOBAL, LLC IN OPPOSITION TO PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT REGARDING "REGULATOR FAULT" OR "RECEIVER FAULT" DEFENSES OR, IN THE ALTERNATIVE, MOTION TO STRIKE DEFENSES PRECLUDED AS A MATTER OF LAW

I. INTRODUCTION

Defendant, Buck Global, LLC ("Buck"), respectfully submits this Memorandum in Opposition to the Plaintiff's[1] Motion for Partial Summary Judgment Regarding "Regulator "Fault" or "Receiver Fault" Defenses Or, In the Alternative, Motion to Strike Defenses Precluded As a Matter of Law. As set forth below, Plaintiff's motion should be denied or deferred as premature, in that there has not been an "opportunity for adequate discovery" as mandated by Louisiana Code of Civil Procedure Article (La. Code Civ. P. art.) 966(A)(3). Treated alternatively as a "motion to strike," Plaintiff's motion seeks a "drastic remedy" that is "disfavored" and should not be granted in a vacuum, and before there has been a fair opportunity for discovery and pretrial development. *Carr v. Abel*, 10-835 (La. App. 5 Cir. 3/29/11); 64 So.3d 292, 296, *writ denied*, 2011-0860 (La. 6/3/11); 63 So.3d 1016.

Even if Plaintiff's motion was procedurally proper (which it is not), the motion, as applied to defendant Buck, seeks to shield Plaintiff from having to prove the elements of his case. For example, Plaintiff seeks to preclude Buck from discovering facts demonstrating that

[1] James J. Donelon, Louisiana Commissioner of Insurance, as Rehabilitator of Louisiana Health Cooperative, Inc. ("LAHC").

"Plaintiff's damages, if any, were not caused by Buck." Plaintiff goes even farther than attempting to preclude discovery on this point, arguing that the facts alleged in his own petition are irrelevant. Thus, Plaintiff's motion essentially argues that there is no relevance to the question of whether Buck was negligent or if any action by Buck harmed Plaintiff.

Similarly, having alleged that Buck is liable for misleading the regulator, Plaintiff now seeks to avoid the question of whether the regulator was actually misled. Plaintiff seeks to turn the burden of proof upside down and backwards – declaring that he does not have to prove his allegations, and asking the Court to preclude the defendant from introducing evidence disproving the allegations. Plaintiff thereby seeks to deprive Buck of its constitutional right to present a defense.

Further, having successfully argued that the Commissioner, as regulator, is not the Plaintiff for purposes of discovery, Plaintiff now seeks to shield himself, *as Plaintiff*, using protections applicable to the *regulator*.

Plaintiff's motion is contrary to Louisiana law. As respects Buck (and without regard to how the Court rules as to other defendants), Plaintiff has affirmatively *waived* any immunity from pre-receivership "regulator fault" defenses otherwise provided under La. R.S. 22:2043.1(B) by accusing Buck of having made *misrepresentations that misled* the regulator. Second Supplemental, Amending and Restated Petition for Damages and Request for Jury Trial ("SAP"), Exhibit ("Ex.") A attached hereto, at ¶ 144. Plaintiff's allegations against Buck have thereby placed the regulator's pre-receivership knowledge and conduct with respect to Buck's actuarial reports directly at issue, waiving any statutory immunity from defenses going to that knowledge and conduct.

And Plaintiff's motion for partial summary judgment/to strike *post*-receivership defenses based upon the Rehabilitator's *post*-receivership conduct has no support in Louisiana law. To the contrary, another subpart of La. R.S. 22:2043.1 – subpart (C) - while barring causes of action *against* and/or imposition of liability *upon* the Commissioner, is conspicuously *silent* as to *defenses*. The oft-applied Civilian maxim of statutory interpretation, *expressio unius est exclusio alterius* ("the explicit mention of one (thing) is the exclusion of another"), compels the conclusion that the legislature had no intention of barring assertion of defenses, including failure

to mitigate damages, arising from the Commissioner as Rehabilitator's *post*-receivership conduct, which the Commissioner has previously judicially admitted is in a separate, *non*-regulatory capacity.

As further support for its opposition and for the sake of efficiency, Buck respectfully adopts and incorporates the arguments set forth in the Memorandum of Milliman, Inc. in Opposition to Motion for Partial Summary Judgment Regarding "Regulator Fault" or "Receiver Fault" Defenses Or, In the Alternative, Motion to Strike Defenses Precluded as a Matter of Law. As the Plaintiff's motion for partial summary judgment/to strike is premature and contrary to procedural and substantive Louisiana law, it should be denied outright or deferred pending the completion of discovery.

After having sullied Buck's reputation for the past ***four years*** with serious accusations of having misled the regulators of LAHC, yesterday at 4:30 p.m. Plaintiff's counsel served defense counsel with a proposed *Fourth* amended petition purporting to withdraw that accusation. This eleventh hour maneuver, filed late in the afternoon the day before Buck's instant opposition brief was due, should be seen for what it is – a naked attempt to prevent disclosure of highly relevant LDI documents that Buck fully expects will show that both the LDI and its consulting actuaries carefully considered, understood and *agreed with* Buck's rate projections and methodology – thereby contradicting the Commissioner's claims that Buck's work product was deficient and negligent.

Buck therefore respectfully requests that the Commissioner's motion for leave to amend be set for separate hearing and Buck provides notice that it reserves all rights to oppose the amendment and to seek recovery of attorney's fees, costs and expenses resulting from the Commissioner's gamesmanship. And, whether or not the amendment is ultimately allowed and regardless of how the Court might rule on the instant motion to strike defenses, the LDI's knowledge and conduct remain directly relevant to the issue of Buck's liability. The LDI's documents will go directly to disproving the Commissioner's claims of negligence. Those documents thus are fully discoverable, with or without Plaintiff's proposed fourth amended petition. Buck is constitutionally guaranteed the right to fully and fairly present those issues to

the jury. But, for today, Buck opposes the Commissioner's motion based upon the pleadings as they exist ***today***.

II. BACKGROUND

A. Relevant Procedural History

Louisiana Health Cooperative, Inc. ("LAHC") was a qualified nonprofit health insurer co-operative organized in 2011. In September 2015, LAHC was placed into rehabilitation under the control of Plaintiff, James J. Donelon, Commissioner of Insurance for the State of Louisiana, as Rehabilitator.

In August 2016, the Commissioner, appearing herein as Rehabilitator, filed an initial petition in this suit against several Defendants, including LAHC's former directors and officers (the "D&O Defendants"),[2] the developer and initial manager of LAHC, Beam Partners, LLC ("Beam"), and LAHC's third-party administrators, CGI Technology and Solutions, Inc. ("CGI") and GRI.[3] Later in 2016, he amended his suit to name two Defendants who provided actuarial services to LAHC – Buck and Milliman, Inc.. Then, in 2017, he added several insurers of LAHC's directors and officers. SAP, Exhibit A hereto.

B. The Commissioner's claims against Buck have placed the regulator's pre-receivership knowledge and conduct directly at issue.

In unmistakable terms, the Commissioner, as Rehabilitator, has accused Buck, through its actuarial reports, of making misrepresentations that supposedly misled both LAHC and the Louisiana Department of Insurance ("LDI") in its pre-receivership capacity as the regulator of LAHC:

> "Buck's advice and/or reports to the LAHC and/or LDI and/or CMS concerning LAHC's funding needs *negligently misrepresented* the actual funding needs and premium rates of LAHC." SAP, Ex. A, ¶ 144.

The Commissioner's claims against Buck thus have placed the regulator's pre-receivership knowledge and conduct with respect to Buck's actuarial advice and reports *directly at issue*.[4] As

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[2] The D&O Defendants are now named as nominal defendants pursuant to a "Gasquet" settlement.

[3] Plaintiff has settled his claims against Beam and CGI.

[4] The Commissioner has made identical "misrepresentation" claims against Milliman, providing it with the same argument that the Commissioner has waived the La. R.S.

shown below, those claims have opened the door to defenses going to those issues, waiving the provisions of 22:2043.1(B) to the extent, if any, they might otherwise bar Buck from asserting such defenses, whether or not characterized as "regulator fault" defenses. And further, without regard to affirmative defenses or issues of "regulator fault," the LDI's materials bear directly upon the issue of Buck's liability.

C. The Commissioner's suit seeks to hold all defendants jointly liable for the total sum loss to the company in rehabilitation.

According to the Commissioner's suit, the supposed acts or omissions of the defendants caused LAHC's insolvency and its total, present net deficit. The Commissioner, as Rehabilitator, thus seeks to hold all defendants jointly responsible for the undifferentiated total current loss to the company in rehabilitation, without tying any particular loss to any particular act or omission by any particular defendant. SAP at ¶ 22 ("Because of Defendants' gross negligence, as of December 31, 2015, LAHC had lost more than $82 million"); and p. 42, Prayer for Relief. As shown below, the Rehabilitator's expansive damage theory of necessity opens the door to post-receivership defenses, including failure to mitigate, going to the extent to which the Rehabilitator's own conduct may have contributed to and/or caused losses to the company in rehabilitation.

III. ARGUMENT AND AUTHORITIES

A. The Commissioner's motion for partial summary judgment contravenes La. Code Civ. P. art. 966(A)(3).

1. The Commissioner's motion is overbroad and insufficient

At the outset, the Court should deny the Commissioner's motion for being overbroad and insufficient. The Commissioner moves the court to grant summary judgment/strike over 50 defenses asserted by various defendants, which he ambiguously lumps into four broad categories. The Commissioner does not independently discuss the viability of these categories — much less each Defendant's individual defenses—or present case authority addressing each defense. Because he has failed to demonstrate why, as a matter of law, each Defendant's particular affirmative defenses should be barred or stricken, the Commissioner's motion

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22:2043.1(B) immunity from regulatory defenses relevant to his claims against Milliman. Ex. A, SAP, ¶ 139.

should be denied. *See F.D.I.C. v. Johnson*, 35 F. Supp. 3d 1286, 1291 (D. Nev. 2014) (discussing the insufficiency of a similar motion because it failed to state with particularity the grounds for seeking summary judgment: "Instead of showing the Court why, as a matter of law, each of Defendants' fourteen affirmative defenses should be barred, the FDIC-R groups Defendants' affirmative defenses into an ambiguous mass and asserts that it is entitled to summary judgment. Furthermore, the FDIC-R's arguments are vague, unorganized, and circumambulatory.").

2. There has been no opportunity for discovery

Further, the Commissioner's motion for partial summary judgment is improper at this early stage of litigation and should be denied. The Commissioner's partial summary judgment motion contravenes La. Code Civ. P. art. 966(A)(3), which expressly precludes the granting of summary judgment until "[a]fter an opportunity for adequate discovery." The requirement that a motion for summary judgment be considered only after "adequate discovery" is intended to allow parties a "fair opportunity to carry out discovery and to present their claim." *Welch v. East Baton Rouge Parish Metro. Council*, 2010-1532 (La. App. 1 Cir. 3/25/11), 64 So. 3d 249, 254; *see also Simoneaux v. E.I. du Pont de Nemours and Co., Inc.*, 483 So. 2d 908, 913 (La. 1986).

Here, there has been no such adequate opportunity for discovery or other pre-trial factual development. The parties have yet to even agree upon a protocol to govern the Commissioner's production of electronic data responsive to the defendants' written discovery requests – meaning that to date the Commissioner has produced only a small fraction of the documents and data that are responsive to the defendants' outstanding discovery requests.

Under the Court's most recent Case Management Schedule, document production is not scheduled to be substantially completed until March 1, 2021; depositions are not scheduled to begin until April of 2021; and expert disclosures are not set to begin until November 15, 2021. By any measure, there has been *no* "opportunity for adequate discovery" as explicitly required by La. Code Civ. P. art. 966(A)(3). The Commissioner's partial summary judgment motion is thus premature and should be denied or deferred pending the substantial completion of discovery in this case. *See Roadrunner Transp. Sys. v. Brown*, 2017-

0040 (La. App. 4 Cir. 5/10/17), 219 So. 3d 1265, 1272; *see also Welch*, 64 So. 3d at 254; *Leake & Andersson, LLP v. SIA Ins. Co. (Risk Retention Group), Ltd.*, 2003–1600, p. 4 (La. App. 4 Cir. 3/3/04), 868 So.2d 967, 969 (finding summary judgment premature when the information the opposing party seeks to discover pertains directly to the unresolved factual issue in the case).

3. The Commissioner confuses and conflates issues of liability and defense

Denial and/or deferment of the Commissioner's motion for partial summary judgment is particularly appropriate when, as here, it is unclear whether and how complex factual issues may properly be cast as going to issues of liability as opposed to defenses and/or may bear upon both liability and defensive theories at the same time. *See, e.g.*, *F.D.I.C. v. Dosland*, No. C13-4046-MWB, 2014 WL 1347118, at *4 (N.D. Iowa Apr. 4, 2014) ("FDIC–R must prove that the defendants' conduct violated an applicable standard of care. It is within the realm of reasonable possibility that internal OTS documents may contain information that is relevant to the defendants' denials that any such violations occurred."); *F.D.I.C. v. Berling*, No. 14-CV-00137-CMA-MJW, 2015 WL 3777408, at *2 (D. Colo. June 16, 2015) ("The documents may ultimately prove inadmissible for a variety of reasons. But either way, they might nonetheless contain information leading to the discovery of admissible evidence."); *F.D.I.C. v. Clementz*, No. 2:13-CV-00737-MJP, 2014 WL 4384064, at *3 (W.D. Wash. Sept. 4, 2014) (rejecting FDIC-R's argument that former D&O's of failed bank should not be entitled to discovery relevant to affirmative defenses).

The Commissioner's own supporting brief illustrates the impracticality, confusion, and great potential for legal error attendant to asking the Court to rule in advance on the availability, or not, of the defenses that each defendant has pled using different words and in contexts that are particular to each defendant. As but one absurd example, the Commissioner asks the Court to eliminate Buck's Eleventh Defense, which asserts that "Plaintiff's damages, if any, were not caused by Buck." Commissioner's Mem., p. 5. Hence, the Commissioner, at the outset of the case and before any real discovery has occurred, seeks to win his case on the essential element of

causation by depriving Buck of the opportunity to prove that it did not cause the damages that the Commissioner seeks to recover.

Further, as shown below, Louisiana law provides no support for the Commissioner's attempt to eliminate defenses arising from his admittedly *non*-regulatory, post-receivership conduct as Rehabilitator. But various parties, including Buck, have pled defenses that address both pre- and post-receivership conduct in the same defense, further complicating any attempt to rule on defenses now, before the facts and their application to specific issues of liability and/or defenses have been fleshed out. *See, e.g.*, Buck's Fifth, Sixth, and Eighth Defenses.

Ruling "in a vacuum" on the availability, or not, of particular defenses, in advance of the procedurally mandated "opportunity for adequate discovery," could cause the Court to mistakenly cast a particular issue as going to a defense rather than an issue of liability, and *vice versa.* Defendants frequently assert denials of liability in the form of defenses in an abundance of caution and to avoid any risk of waiver. But asserting a liability issue in the form of a defense does not make it any less an issue of liability. It is what it is. *E.g.*, *Bienvenu v. Allstate Ins. Co.*, 2001-2248 (La. App. 4 Cir. 5/8/02), 819 So. 2d 1077, 1080 ("However, an issue does not automatically become an affirmative defense, as that term is defined by Louisiana caselaw, simply because it appears among the items listed in La. C.C.P. art. 1005, or because courts have recognized it as an affirmative defense in other cases. Whether an issue is an affirmative defense is a question of fact, determined by the circumstances of the individual case.").

As but one example, by seeking to eliminate Buck's Seventh Defense – that the Commissioner and his agents reviewed and approved of Buck's reports and projections - the Commissioner potentially seeks to deprive Buck of the ability to prove that the LDI and its own actuaries *agreed* with Buck's actuarial reports and projections. That evidence shows that Buck was *not* negligent and its work product was indeed reasonable and professional - going directly to defeating the Commissioner's *liability* claims against Buck. That showing is *not* a defense of "regulator fault." Commissioner's Mem., pp. 5, 17. Indeed, Buck's contention is the precise *opposite* of a defense of regulator "fault." Buck is confident that the regulator carefully and *correctly* approved of Buck's work product. Hence, without regard to how this Court might rule

on the instant motion, Buck is fully entitled to present that evidence to the jury on the issue of liability.

These practical difficulties illustrate why Article 966(A)(3) wisely precludes summary judgment before there has been "an opportunity for adequate discovery." *See, e.g., Simon v. Belaire*, 2011-442 (La. App. 3 Cir. 10/5/11), 74 So. 3d 1250, 1252 (finding that the "failure to allow Defendants to complete discovery, as set out in the trial court's discovery schedule, renders the motion for summary judgment premature"); *Ploue v. Intercoastal Fin. Grp.*, 2008-2314 (La. App. 1 Cir. 5/8/09), 2009 WL 1270253, at *3 (finding the granting of summary judgment premature because there were unresolved factual issues of liability that could only be fleshed out through discovery). In short, defendants should not be required to oppose the instant summary judgment motion "in the dark." They are entitled to "adequate discovery" first, after which summary judgment issues can fairly be raised by all parties and determined by the Court "in the light" of what discovery reveals.

B. <u>Listing of material, genuinely disputed facts</u>

As contemplated by Uniform Local Rule 9.10(b)(1) and La. Code Civ. P. art. 967(C), Buck attaches hereto as Exhibit B the affidavit of David Godofsky, attesting to the need for adequate discovery of material factual issues going to the Commissioner's claims against Buck before the Court rules on Plaintiff's partial summary judgment motion. *Bass P'ship v. Fortmayer*, 2004-1438 (La. App. 4 Cir. 3/9/05), 899 So. 2d 68, 73 ("[W]hen the [party] alleges sufficient reasons why additional evidence to oppose the summary judgment motion could not be produced, it is an abuse of discretion for the trial court to deny [a] request for a continuance."). Those genuinely disputed material facts include:

- Whether, and the extent to which, Louisiana Department of Insurance ("LDI") personnel analyzed and reviewed Buck's actuarial reports. If so, did they conclude Buck's methodology was reasonable and sound, contradicting Plaintiff's allegations that Buck negligently prepared those reports and that its reports were misleading?
- Whether, and the extent to which, the LDI's consulting actuaries analyzed and reviewed Buck's actuarial reports. If so, did they conclude Buck's

methodology was reasonable and sound, contradicting Plaintiff's allegations that Buck negligently prepared those reports and that its reports were misleading?

- Or whether the LAHC, the LDI and/or its consulting actuaries failed to review or rely upon Buck's actuarial reports, in which case LAHC and the LDI could not have been misled.
- What actions did the LAHC and/or LDI take based on Buck's reports that give rise to liability for Buck, and do those acts establish that the LAHC and LDI were not misled by anything Buck said or did?
- Whether the Commissioner, as Rehabilitator's, post-rehabilitation acts or omissions contributed to the total, undifferentiated loss that he seeks to recover in this case. What acts or omissions of the Commissioner, as Rehabilitator, contributed to that loss, and in what amount?

C. Plaintiff's motion, treated alternatively as a motion to strike, is greatly disfavored and should be denied.

Plaintiff's alternative motion to strike should also be denied for similar reasons. It is well-established that "motions to strike are viewed with disfavor and are infrequently granted." *See, e.g., Cole v. Cole*, 2018-0523 (La. App. 1 Cir. 9/21/18), 264 So. 3d 537, 544; *Carr v. Abel*, 10-835 (La. App. 5 Cir. 3/29/11), 64 So. 3d 292, 296, *writ denied*, 2011-0860 (La. 6/3/11), 63 So. 3d 1016; *Hazelwood Farm, Inc. v. Liberty Oil & Gas Corp.*, 2001-0345 (La. App. 3 Cir. 6/20/01), 790 So. 2d 93, 98, *writ denied*, 01-2115 (La. 7/26/01), 794 So. 2d 834; *accord Cain v. Exxon Mobil Corporation*, 400 F. Supp. 3d 514, 520 (M.D. La. 2019); *Smuggler-Durant Mining Corp.*, 823 F. Supp. 873, 875 (D. Colo. 1993) (striking allegations or dismissing pleadings pursuant to Rule 12(f) is "a generally-disfavored, drastic remedy").[5] "It is disfavored because

[5] Because the source of La. Code of Civ. P. art. 964 is found in Federal Rule of Civil Procedure 12(f), decisions of the federal courts may be used for guidance. *Cole v. Cole*, 2018-0523 (La. App. 1 Cir. 9/21/18), 264 So. 3d 537, 544. *See also see also Vaughn v. Commercial Union Ins. Co. of New York*, 263 So. 2d 50, 52 (La. Ct. App. 4 Cir.), *writ denied*, 262 La. 1107, 266 So. 2d 425 (La. 1972) ("In interpreting an article of the Louisiana Code of Civil Procedure which is essentially based upon one of the federal rules, the Louisiana courts rely upon prior interpretations by the federal courts of the source federal rules as a persuasive guide to the intended meaning of such a Louisiana code article.") (citations omitted).

striking a portion of a pleading is a drastic remedy, and because it is often sought by the movant simply as a dilatory tactic." *Carr*, 64 So. 3d at 296.

Moreover, motions to strike should not be used to resolve "unsettled questions of law that should be examined later in the proceedings." *F.D.I.C. v Stovall*, No. 2:14-CV-00029, 2014 WL 8251465 (N.D. Ga. Oct. 2, 2014). Rather, a "motion to strike is only proper if it can be shown that the allegations being challenged are so unrelated to a plaintiff's claims as to be unworthy of any consideration and that their presence in the pleading would be prejudicial to the moving party." *Hazelwood Farm*, 790 So. 2d at 98. When the sufficiency of the defense depends upon disputed issues of fact or questions of law, a motion to strike an affirmative defense should be denied. *See United States v. Marisol, Inc.*, 725 F. Supp. 833, 836 (M.D. Pa. 1984). Particularly when, as here, there is a significant risk that factual issues to be developed through discovery may bear upon issues of liability, defense, and/or both, a motion to strike filed "in a vacuum" and before factual development of the case should be denied.

D. As to his claims against Buck, the Commissioner has placed the regulator's knowledge and conduct directly at issue, waiving La. R.S. 22:2043.1(B).

La. R.S. § 22:2043.1(B) provides that "[n]o action or inaction by the insurance regulatory authorities may be asserted as a defense to a claim by the receiver." However, the Commissioner has placed regulatory conduct directly at issue, and Buck's defenses are aimed at testing the veracity of these allegations. As with other statutory immunities, protections and privileges, a litigant waives such protections by asserting claims that put particular matters and facts at issue, thereby opening the door to defenses and evidence that otherwise would be foreclosed by statute or jurisprudence. "Placing-at-issue waiver occurs when a privilege-holder pleads a claim or a defense in such a way that he will be forced inevitably to draw upon a privileged communication at trial in order to prevail." *Smith v. Kavanaugh, Pierson & Talley*, 513 So. 2d 1138, 1145 (La. 1987). By so doing, the holder places at issue and waives his or her privilege on the same subject under his or her control. *Id.*

This familiar, tried and true principle of "at issue" waiver is applied in numerous analogous contexts and should be applied here. For example:

- A litigant forfeits statutory attorney-client privileges, otherwise guaranteed under La. Code of Evidence art. 506, by asserting claims and/or defenses that place attorney-client communications "at issue." By electing to introduce his attorney-client communications at trial, a party creates a "special unfairness to his adversary" and thereby waives his privilege as to such communications. *State v. Dominguez*, 2010-1868 (La. App. 1 Cir. 12/8/10), 52 So. 3d 1117, 1120 (quoting *Smith*, 513 So. 2d at 1141).
- Litigants, civil and criminal, waive statutory protections against admission of character evidence by asserting claims or defenses that place their character "at issue." "The introduction of evidence of 'good character' places character at issue, thereby permitting the state to cross examine the defendant's character witness about his or her knowledge of the defendant's particular conduct, prior arrests, or other acts relevant to the moral qualities pertinent to defendant's crime and to introduce evidence of the defendant's bad character in rebuttal of the testimony of the defendant's character witness." *State v. Taylor*, 07-869 (La. App. 5 Cir. 4/29/08), 985 So. 2d 266, 269 (citing *State v. Rault*, 445 So. 2d 1203 (La. 1984)); *see also* La. Code Evid. arts. 608(C), 405(A).
- Criminal defendants waive their constitutional Fifth Amendment privileges and immunities by testifying in their own defense, opening themselves up to cross examination. A criminal defendant who takes the stand "cannot reasonably claim that the Fifth Amendment gives him . . . an immunity from cross-examination on the matters he has himself put in dispute." *State v. Heaton*, 2000-260 (La. App. 3 Cir. 10/11/00), 770 So. 2d 477, 480 (quoting *Mitchell v. United States*, 526 U.S. 314, 119 S. Ct. 1307, 143 L.Ed.2d 424 (1999)).
- Governmental entities waive constitutional and statutory sovereign immunities when they sue private defendants. *See Reed-Salsberry v. State Through the Dep't of Pub. Safety & Corr.*, 51,104 (La. App. 2 Cir. 2/15/17), 216 So. 3d 226, 228 ("A foundational premise of the federal system is that states, as sovereigns, are immune from suits for damages, save as they elect to waive that defense.").

And so, here, the Commissioner, by explicitly accusing Buck of *misleading* the LDI regarding LAHC's funding needs and premium rates (SAP, ¶ 144), has placed *directly at issue* the regulator's pre-receivership knowledge and conduct relating to those issues. *See F.D.I.C. v. Wise*, 139 F.R.D. 168, 172 (D. Colo. 1991) (Since the FDIC affirmatively placed the requested information at issue by alleging, among other things, that the regulators were misled, "allowing it to assert privileges to protect against disclosure of these regulatory documents would be manifestly unfair to defendants."). The Commissioner has thereby *waived* any statutory immunity from Buck's defenses going to those issues – whether characterized as a "regulator fault" defense or otherwise. The Commissioner has thus opened the door to all of the following issues that Buck is entitled to fully discover and assert defensively:

- Did LDI personnel analyze and review Buck's actuarial reports, or not? If so, to what extent? Did LDI conclude Buck's methodology was reasonable and sound, contrary to Plaintiff's allegations that Buck was negligent and that its reports were misleading?
- Did the LDI's consulting actuaries analyze and review Buck's actuarial reports, or not? If so, to what extent? Did they conclude Buck's methodology was reasonable and sound, contrary to Plaintiff's allegations that Buck was negligent and its reports were misleading?
- Or, did LDI fail to review or rely upon Buck's actuarial reports, in which case it could not have been misled?
- What actions did LAHC and LDI take based on Buck's supposed misrepresentations, that give rise to liability for Buck? Did those acts establish that they were not misled by anything Buck said or did?

As to Buck, therefore, the Court can and should disregard all of the Commissioner's citations to other cases barring the assertion of pre-receivership "regulator fault" defenses in other contexts. Plaintiff's Mem. at 12. *None* of those cases involved claims – like those asserted against Buck here – that a defendant affirmatively made misrepresentations that

misled the regulator. *None* of those cases address the "at issue" waiver principle that should drive this Court's decision that Buck is entitled to assert defenses on the very matters that the Commissioner has placed directly at issue as against Buck.

E. Depriving Buck of the ability to fully defend itself against all claims asserted against it would work a denial of its fundamental due process rights.

The government's improper attempt in this case to cut off Buck's right to assert defenses going to the regulator's knowledge and conduct with respect to Buck's actuarial reports is of serious constitutional dimension. Prohibiting Buck from fully and fairly defending itself on the very issues that the Commissioner has asserted against it would work a denial of Buck's fundamental due process rights under both the U.S. and the Louisiana constitutions. Due process ensures that litigants will have "an opportunity to present every available defense." *Philip Morris USA v. Williams,* 549 U.S. 346, 353 (2007). *See also National Union Fire Ins. Co. of Pittsburgh v. City Savings, F.S.B.*, 28 F.3d 376, 394 (3d Cir. 1994); *Placida Prof'l Ctr., LLC v. F.D.I.C.*, 512 F. App'x 938, 949-950 (11th Cir. 2013) (barring defendants' affirmative defenses against FDIC as receiver "does not comport with due process").

In *National Union*, the Court held that barring defenses to the receiver's counterclaims would "result in an unconstitutional deprivation of due process:"

> ***Property which one stands to lose as a result of a lawsuit is a property interest protected by the Due Process Clause***, and the Due Process Clause prevents denying potential litigants use of established adjudicatory procedures, where such an action would be the equivalent of denying them an opportunity to be heard upon their claimed rights. ***If parties were barred from presenting defenses and affirmative defenses to claims which have been filed against them, they would not only be unconstitutionally deprived of their opportunity to be heard, but they would invariably lose on the merits of the claims brought against them. Such a serious deprivation of property without due process of law cannot be countenanced in our constitutional system***.

28 F.3d at 394; *see also Schettler v. RalRon Capital Corp*., 128 Nev. 209, 220, 275 P.3d 933, 940 (Nev. 2012). Due process mandates that Buck be permitted to defend itself fully against the Commissioner's accusations.

F. LDI's knowledge and conduct are relevant to liability issues even if the Commissioner's proposed amendment is permitted

As set forth above, even if the Court allows the Commissioner's eleventh-hour attempt to amend his petition to withdraw his four-year old accusation that Buck misled the regulators, LDI's knowledge and conduct remain very much at issue with respect to Buck's liability. Buck believes that evidence of LDI's and its actuaries' review and approval of Buck's methodology and rate projections will *directly contradict* the Commissioner's claims that Buck's work product was unreasonable and negligent. Thus, Buck will seek to prove that the Commissioner, through the instant suit, is trying to repudiate the conclusions of the LDI's own actuaries. Those are issues of liability, not defense. Buck is legally and constitutionally entitled to discover evidence to disprove the Commissioner's liability theory and to present that evidence to the jury.

G. Louisiana law fully permits assertion of *post*-receivership defenses against the Rehabilitator in the very same *non*-regulatory capacity in which he has filed this suit.

1. La. R.S. § 22:2043.1 and the Rehabilitation Order cannot be read to preclude *post*-receivership defenses

Nothing in Louisiana statutory law or jurisprudence supports the Commissioner's motion for partial summary judgment and/or to strike defenses arising from the Rehabilitator's *post*-receivership conduct. To the contrary, another subpart of La. R.S. § 22:2043.1 – subpart (C) - while barring causes of action *against* and/or imposition of liability *upon* the Commissioner in his capacity as receiver, liquidator, rehabilitator or conservator, or otherwise, is conspicuously *silent* as to *defenses*. A defense is not a "cause of action," but rather a response to an action or claim. *See National Union Fire Ins. Co. of Pittsburgh, P.A. v. City Sav., F.S.B.*, 28 F.3d 376, 393 (3rd Circ. 1994) (FIRREA, barring "actions or "claims," does not bar defenses. ". . . it is plain enough that a defense or an affirmative defense is neither an 'action' nor a 'claim' but rather is a response to an action or a claim."); *Johnson*, 35 F. Supp. 3d at 1296 (declining to apply the FTCA's discretionary function exception to a defense or affirmative defense because the language of the statute only bars a claim); *Schettler v. RalRon Capital Corp.*, 128 Nev. 209, 220, 275 P.3d 933, 940 (Nev. 2012) (joining the majority view holding that, because FIRREA's

jurisdictional bar did not contain the term "defense," affirmative defense," or "proposed affirmative defense" in its statutory language, FIRREA's jurisdictional bar does not apply to defenses or affirmative defenses).

Further, La. Civ. Code art. 2323 explicitly mandates that immunity from causes of action or liability does *not* insulate a party from comparative fault defenses. Comparative fault defenses may be asserted "regardless of whether the person is a party to the action or a nonparty, and regardless of the person's . . . immunity by statute." La. Civ. Code art. 2323(A). Louisiana courts have long held that immunity from liability does not prohibit a defendant from asserting comparative fault defenses and introducing evidence that the immune party or non-party is at fault for part or all of plaintiff's alleged injury. *Foley v. Entergy Louisiana, Inc*., 2004-1967 (La. App. 4 Cir. 2/15/06), 925 So. 2d 638, 641, writ granted, 2006-0983 (La. 6/30/06), 933 So. 2d 130, *aff'd with respect to allocation of fault to otherwise immune party*, 2006-0983 (La. 11/29/06), 946 So. 2d 144. *See also Gatlin v. Entergy Corp*., 04–0034, pp. 5–6 (La. App. 4 Cir. 5/4/05), 904 So. 2d 31, 35, writ denied, 2005-1509 (La. 12/16/05), 917 So. 2d 1114 (holding that La. C.C. art 2323(A) requires all evidence of fault from any person to be considered even though third-party was statutorily immune under worker's compensation law); *Morella v. Bd. of Comm'rs of Port of New Orleans*, 2007-0864 (La. App. 4 Cir. 5/14/08), 988 So. 2d 266, 275, writ denied, 2008-2362 (La. 1/16/09), 998 So. 2d 100, and writ denied, 2008-2422 (La. 1/16/09), 998 So. 2d 101 (holding that "the independent comparative fault of the tort-immune employer-lessee" must be allocated).

Subpart (B) of La. R.S. § 22:2043.1, addressed above, barring defenses based upon "action or inaction by the insurance regulatory authorities" is, by the Rehabilitator's own prior judicial admissions, limited to *pre-receivership* regulatory conduct of the LDI. Post-receivership, the Commissioner, as rehabilitator/receiver, acts in a separate, exclusively *non*-regulatory capacity, as the Commissioner's own prior briefing in this case exhaustively points out.[6]

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[6] *See* the Rehabilitator's 9/17/20 Opposition Memorandum to Defendants' Motion to Compel at pp. 2-7; *e.g.*, p. 3: "The Commissioner acting as Regulator and the Commissioner acting as Receiver are legally distinct and separate entities as a matter of law and fact;" p. 7: "The Commissioner's role as regulator is independent of his role as Receiver;" p. 9: ". . . . the Receiver does not

La. R.S. § 22:2043.1(C), by its own explicit terms, does *not* bar defenses based upon the Commissioner's conduct in that post-receivership, non-regulatory capacity. "[T]he paramount consideration for statutory interpretation is the ascertainment of the legislative intent." *Fontenot v. Chevron U.S.A. Inc.*, 95-1425 (La. 7/2/96), 676 So. 2d 557, 562. "When a law is clear and unambiguous and its application does not lead to absurd consequences, the law shall be applied as written and no further interpretation may be made in search of the intent of the legislature." La. Civ. Code Art. 9; *see also* La. Rev. Stat. § 24:177(B)(1) (The plain text of the law is the best evidence of legislative intent).

The oft-applied Civilian maxim of statutory interpretation, *expressio unius est exclusio alterius* ("the explicit mention of one (thing) is the exclusion of another"), compels the conclusion that the legislature had no intention of barring assertion of defenses, including failure to mitigate damages, arising from the Commissioner as Rehabilitator's post-receivership conduct in a *non*-regulatory capacity. *See State Through Dep't of Pub. Safety & Corrs., Office of State Police, Riverboat Gaming Div. v. La. Riverboat Gaming Comm'n & Horseshoe Entm't*, 94-1872 (La. 5/22/95), 655 So. 2d 292, 302 (This doctrine "dictates that when the legislature specifically enumerates a series of things . . . the legislature's omission of other items, which could have easily been included in the statute is deemed intentional.").

The very same principle of interpretation applies to the Order of Rehabilitation entered by the receivership court. Ex. I to Plaintiff's Mem. The Order of Rehabilitation merely incorporates the statutory prohibition on claims *against or* imposition of liability *upon* the Commissioner, but is notably *silent* as to defenses. Nothing in the Order of Rehabilitation prohibits defenses, including failure to mitigate, based upon the Rehabilitator's conduct in his *non*-regulatory post-receivership capacity.

2. Louisiana law comports fully with the "separate capacities" doctrine

This plain reading of the statute's and the Rehabilitation Order's language comports fully with the "separate capacities" doctrine. While, in the pre-receivership context, the regulator acts in a "separate capacity" from that of the Rehabilitator, in the post-receivership world the

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premise his claims upon any rights asserted by the Commissioner of Insurance acting as regulator or the LDI."

Commissioner, As Rehabilitator, acts in the *very same capacity* in which he has filed the instant lawsuit against the defendants. Hence, there is no reason to prohibit the assertion of defenses, including failure to mitigate, arising from such conduct in the same capacity in which the Commissioner, as Rehabilitator, has sued the defendants.

The Louisiana federal court, in *National Credit Union Admin Bd. v. Aho, et. al,* 1991 WL 174671 (E.D. La. 1991), applying Louisiana law, expressly recognized this fundamental distinction and refused to bar the assertion of defenses arising from the governmental receiver's post-receivership conduct.[7] "The affirmative defenses brought against the NCUAB are brought against it as conservator and liquidator, not as regulator, and primarily relate a defense that any negligence of Aho was not the cause of any damage sustained by CCPCU and ultimately to the National Credit Union Share Insurance Fund." 1991 WL 174671 at *6.

Courts applying the law of other states have likewise allowed post-receivership defenses based upon the same distinction. *E.g., FDIC v. Skow*, 741 F.3d 1342 (11th Cir. 2013) (allowing assertion of defenses, including failure to mitigate, arising from post-receivership conduct because in same capacity in which suit is filed); *F.D.I.C. v. Hsing*, No. 12-CV-1530 YGR, 2012 WL 3283425, at *3 (N.D. Cal. Aug. 10, 2012) (appraisal company's comparative fault theories were appropriately raised as affirmative defenses to the FDIC's claims of fraud, negligence, and breach of contract); *Fed. Deposit Ins. Corp. v. Arrillaga-Torrens*, 212 F. Supp. 3d 312, 348 (D.P.R. 2016) ("The court is persuaded that the FDIC as receiver is subject to defenses based on state law."); *Resolution Trust Corp. v. Mass. Mut. Life Ins. Co.*, 93 F. Supp. 2d 300, 307-310 (W.D. N.Y. 2000) (allowing defendant to assert affirmative defenses based on the FDIC's alleged contributory negligence and alleged failure to mitigate damages); *F.D.I.C. v. Ornstein*, 73 F. Supp. 2d 277, 287 (E.D. N.Y. 1999) (denying motion to strike affirmative defense to the extent it relies on post-receivership conduct and defense of mitigation of damages); *Resolution Trust Corp. v. Evans*, 1993 WL 354796, at *4 (E.D. La. Sept. 3, 1993) (unpublished opinion) (refusing to strike defendants' affirmative defense of failure to mitigate damages).

[7] The *Aho* case was decided before the enactment of La. R.S. § 22:2043.1 (B) and (C). Nonetheless, because the statute, by its explicit terms, does *not* bar *post*-receivership defenses, the *Aho* court's allowance of such defenses under Louisiana law because the receiver/rehabilitator acts in a non-regulatory capacity remains good law.

None of the cases cited by the Commissioner bars the assertion of *post*-receivership defenses under Louisiana law. The Commissioner's inaccurate description of *Foster v. Monsour Med. Found.*, 667 A.2d 18, 20 (Pa. Commw. 1995)—as precluding defenses based on liquidator fault—misstates the court's holding. As recited by the Pennsylvania court in *Foster*, the "sole issue" before it was "whether the actions of the Insurance Commissioner *prior to the order of liquidation* of an insurance company can be asserted as affirmative defenses in an action commenced by the Statutory Liquidator." *Id.* at 19 (emphasis added). The court held that, under *Pennsylvania* law, "pre-liquidation regulatory conduct of the Insurance Commissioner . . . could not be raised against a Statutory Liquidator." *Id.* at 20. The court's discussion of defenses arising from the Liquidator's actions (cited by the Commissioner at p. 12) was in dicta. *See id.* at 21. Importantly, in *Foster* there were no apparent allegations that the defendants made misrepresentations that misled the regulator. Nevertheless, *Foster* is not controlling as it did not address or apply Louisiana law.

The Commissioner's lengthy discussion of *Wooley v. Lucksinger,* 2009-0571 (La. 4/1/11), 61 So.3d 507, 606, is of no use to the Court, as that case does not address or purport to bar *post*-receivership defenses and was decided under Texas, not Louisiana, law. There is ***no*** Louisiana statute, order, case applying Louisiana law, or other legal authority barring assertion of defenses, including failure to mitigate damages, against the Commissioner in his *post*-receivership, non-regulatory capacity as Receiver/Rehabilitator.

3. The Commissioner's "no receiver duty" argument has no support in Louisiana law

Despite the total absence of supporting Louisiana law authority, the Commissioner appears to conclusively assert an all-encompassing "no duty" rule to bar all "receiver fault" defenses. The Commissioner therefore moves the Court to sweep away all defendants' comparative fault defenses, failure to mitigate defenses, and equitable defenses of estoppel, waiver, unclean hands, ratification, and laches.

The Commissioner's "no receiver duty" argument fails because there is no Louisiana law whatsoever to support it. None of the cases cited by the Commissioner address the duty of regulators or receivers in the context of comparative fault defenses, nor does he provide any

meaningful analysis showing that an alleged lack of duty precludes the Defendants' various defenses he seeks to exclude. As shown above, La. R.S. 22:2043.1 contains no provision that insulates the Commissioner from state law affirmative defenses based on the Commissioner's post-receivership conduct and there is no other Louisiana authority barring such defenses. And in the *Aho* case, the Louisiana federal court, applying Louisiana law, found *no basis* for applying the "no duty" rule as a bar to defenses based on the post-receivership conduct of a governmental receiver. 1991 WL 174671 at * 5.

Courts around the nation likewise have refused to apply "no duty" concepts as a bar to post-receivership failure to mitigate/comparative fault defenses. *F.D.I.C. v. Skow*, 741 F.3d 1342 (11th Cir. 2013) (holding that "no duty rule," which "bars tort actions," cannot "bar affirmative defenses asserted against the FDIC when [the FDIC] is the one advancing claims"); *Resolution Tr. Corp. v. Massachusetts Mut. Life Ins. Co.*, 93 F. Supp. 2d 300, 308 (W.D.N.Y. 2000) (rejecting "no duty" argument asserted to strike defense of failure to mitigate because "the duty to mitigate damages is not, in fact, a duty owed to anyone else"); *Resolution Tr. Corp. v. Evans*, No. CIV. A. 92-0756, 1993 WL 354796, at *4 (E.D. La. Sept. 3, 1993) (unpublished opinion) ("While the RTC has no duty to the institution, neither are the defendants liable for damages which they did not cause. The defense of failure to mitigate damages is directed more to quantum than to liability."). *See also FDIC v. Dodson*, No. 4:13cv416-MW/CAS, 2014 WL 11511069, at *6 (N.D. Fla. 2014) (denying the motion to strike affirmative defenses and rejecting identical argument under Florida's comparative negligence system); *see also Johnson*, 35 F. Supp. 3d at 1293 (rejecting plaintiff's argument that defendants' affirmative defense are barred under "no duty" rule because plaintiff failed to show affirmative defenses were barred under state law).

4. Comparative fault rules must be applied to the Rehabilitator

Under Louisiana's comparative fault regime, "in any action for damages where a person suffers injury, death, or loss, the degree or percentage of fault of all persons causing or contributing to the injury, death, or loss shall be determined, regardless of whether the person is a party to the action or a nonparty, and regardless of the person's . . . immunity by statute." La. Civ. Code art. 2323 (A); *see also Landry v. Doe*, 2019-0880 (La. App. 1 Cir. 6/26/20), 2020 WL

3481703, at *24 (citing *Willis v. Noble Drilling (US), Inc.*, 2011-598 (La. App. 5th Cir. 11/13/12), 105 So.3d 828, 842). The trier of fact must consider both the nature of conduct of each person at fault and the extent of the causal connection between the conduct and damages. *Watson v. State Farm Fire & Casualty Ins. Co.*, 469 So. 2d 967 (La. 1985).

Additionally, "[o]ur jurisprudence has long recognized that an injured plaintiff has the duty to exercise reasonable diligence and ordinary care to minimize his damages after the injury has been inflicted." *Hager v. State, ex rel. Dep't of Transp. & Dev.*, 2006-1557 (La. App. 1 Cir. 1/16/08), 978 So. 2d 454, 474, *writ denied*, 2008-0347 (La. 4/18/08), 978 So. 2d 349, and *writ denied*, 2008-0385 (La. 4/18/08), 978 So. 2d 349; *see also Ornstein*, 73 F. Supp. 2d at 287 (under New York's comparative negligence regime duty to mitigate applied to FDIC when acting in its capacity as receiver). There is ***no*** Louisiana law or other authority that would displace or prevent the full application of Civil Code articles 2323 and 2324 comparative fault rules to the Commissioner, as Rehabilitator's, post-receivership conduct.

The relevance of post-receivership defenses is particularly obvious in the instant case, in which the Rehabilitator seeks to hold all defendants jointly responsible for the undifferentiated total loss to the company in rehabilitation, including post-rehabilitation losses, without tying any particular loss to any particular act or omission by any particular defendant. SAP, Ex. A at ¶ 22 ("Because of Defendants' gross negligence, as of **December 31, 2015**, LAHC had lost more than $82 million"); and p. 42, Prayer for Relief. The Rehabilitator's expansive damage theory of necessity opens the door to post-receivership defenses, including failure to mitigate, going to the extent to which the Rehabilitator's own conduct may have contributed to and/or caused the loss that he seeks to recover from the defendants.

This Court, indeed, has already implicitly recognized the relevance and import of post-receivership, failure to mitigate defenses by ordering the Rehabilitator to provide periodic reports to the Court and all defendants on the Rehabilitator's claims and recoveries in the "Risk-Corridor" class action litigation. *See* August 4, 2020 Order entered by this Court. Because the Commissioner, as Rehabilitator, acts in a *separate,* non-regulatory capacity, he should be treated no differently than any other plaintiff. He should have no reason to expect that he would be

insulated from defenses, including failure to mitigate damages, assertable against any other plaintiff whose acts may have contributed to the losses sought to be recovered.

Plaintiff has failed to show that the affirmative defenses at issue are wholly unrelated to this case or that, as a matter of law, such defenses cannot succeed. Consequently, the Court should find that the Commissioner has failed to meet his burden under La. Code Civ. Proc. art. 964 to support the "drastic" and "disfavored" remedy of striking Buck's Fifth, Sixth, Seventh, Eighth, and Eleventh affirmative defenses. And summary judgment should be denied for the reasons set forth above.

IV. CONCLUSION

As the Plaintiff's motion for partial summary judgment/to strike is premature and contrary to procedural and substantive Louisiana law, it should be denied outright or deferred pending the completion of discovery.

Respectfully submitted,

/s/ James A. Brown
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the above and foregoing has been served upon all counsel of record by e-mail, this 5th day of November, 2020.

/s/ James A. Brown

JAMES J. DONELON, COMMISSIONER OF INSURANCE FOR THE STATE OF LOUISIANA, IN HIS CAPACITY AS REHABILITATOR OF LOUISIANA HEALTH COOPERATIVE, INC.	:	SUIT NO.: 651,069 SECTION: 22
versus	:	19TH JUDICIAL DISTRICT COURT
TERRY S. SHILLING, GEORGE G. CROMER, WARNER L. THOMAS, IV, WILLIAM A. OLIVER, CHARLES D. CALVI, PATRICK C. POWERS, CGI TECHNOLOGIES AND SOLUTIONS, INC., GROUP RESOURCES INCORPORATED, BEAM PARTNERS, LLC, MILLIMAN, INC., BUCK CONSULTANTS, LLC. AND TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA	:	PARISH OF EAST BATON ROUGE STATE OF LOUISIANA

SECOND SUPPLEMENTAL, AMENDING AND RESTATED PETITION FOR DAMAGES AND REQUEST FOR JURY TRIAL

NOW INTO COURT, through undersigned counsel, comes James J. Donelon, Commissioner of Insurance for the State of Louisiana in his capacity as Rehabilitator of Louisiana Health Cooperative, Inc., through his duly appointed Receiver, Billy Bostick, who respectfully requests that this SECOND SUPPLEMENTAL, AMENDING AND RESTATED PETITION FOR DAMAGES AND REQUEST FOR JURY TRIAL be filed herein and served upon all named Defendants; and respectfully represents:

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EXHIBIT
A

1.

That the caption of this matter be amended to read as follows:

JAMES J. DONELON, COMMISSIONER OF INSURANCE FOR THE STATE OF LOUISIANA, IN HIS CAPACITY AS REHABILITATOR OF LOUISIANA HEALTH COOPERATIVE, INC.	:	SUIT NO.: 651,069 SECTION: 22
versus	:	
	:	PARISH OF EAST BATON ROUGE
CGI TECHNOLOGIES AND SOLUTIONS, INC., GROUP RESOURCES INCORPORATED, BEAM PARTNERS, LLC, MILLIMAN, INC., BUCK CONSULTANTS, LLC. WARNER L. THOMAS, IV, WILLIAM A. OLIVER, SCOTT POSECAI, PAT QUIINLAN, PETER NOVEMBER, MICHAEL HULEFELD, ALLIED WORLD SPECIALTY INSURANCE COMPANY a/k/a DARWIN NATIONAL ASSURANCE COMPANY, ATLANTIC SPECIALTY INSURANCE COMPANY, EVANSTON INSURANCE COMPANY, RSUI INDEMNITY COMPANY AND ZURICH AMERICAN INSURANCE COMPANY	:	19TH JUDICIAL DISTRICT COURT
	:	STATE OF LOUISIANA

JURISDICTION AND VENUE

2.

This Court has jurisdiction over this dispute involving Louisiana Health Cooperative, Inc., ("LAHC") a Louisiana Nonprofit Corporation that holds a health maintenance organization ("HMO") license from the Louisiana Department of Insurance, is domiciled, organized and doing business in the State of Louisiana, and maintains its home office in Louisiana.

3.

This Court has jurisdiction over all of the named Defendants because each of them has transacted business or provided services in Louisiana, has caused damages in Louisiana, and because each of them is obligated to or holding assets of Louisiana Health Cooperative, Inc.

4.

Venue is proper in this Court pursuant to the provision of the Louisiana Insurance Code, including La. R.S. 22:257, which dictates that the Nineteenth Judicial District Court has exclusive jurisdiction over this proceeding and La. R.S. 22:2004, which provides for venue in this Court and Parish, as well as other provisions of Louisiana law.

PARTIES

5.

Plaintiff

The Plaintiff herein is James J. Donelon, Commissioner of Insurance for the State of Louisiana in his capacity as Rehabilitator of Louisiana Health Cooperative, Inc., through his duly appointed Receiver, Billy Bostick ("Plaintiff").

6.

Louisiana Health Cooperative, Inc. ("LAHC") is a Nonprofit Corporation incorporated in Louisiana on or about September 12, 2011. LAHC was organized in 2011 as a qualified nonprofit health insurer under Section 501(c)(29) of the Internal Revenue Code, Section 1322 of the Patient Protection and Affordable Care Act of 2010, the Louisiana Nonprofit Corporation Law, and Louisiana Insurance Law.

7.

A Petition for Rehabilitation of LAHC was filed in the 19th JDC, Parish of East Baton Rouge, on September 1, 2015; on September 1, 2015, an Order of Rehabilitation was entered, and on September 21, 2015, this Order of Rehabilitation was made permanent and placed LAHC into rehabilitation and under the direction and control of the Commissioner of Insurance for the State of Louisiana as Rehabilitator, and Billy Bostick as the duly appointed Receiver of LAHC.

8.

Plaintiff has the authority and power to take action as deemed necessary to rehabilitate LAHC. Plaintiff may pursue all legal remedies available to LAHC, where tortious conduct or breach of any contractual or fiduciary obligation detrimental to LAHC by any person or entity has been discovered, that caused damages to LAHC, its members, policyholders, claimants, and/or creditors.

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9.

Defendants

Named Defendants herein are the following:

10.

D&O Defendants

Each of the D&O Defendants listed below are named only as Nominal Defendants in this matter, to the extent that insurance coverage, other than the Travelers Casualty and Surety Company of America policy, may apply to the claims asserted against them herein:

a. **WARNER L. THOMAS, IV ("Thomas"),** an individual of the full age of majority domiciled in the State of Louisiana. Thomas was a Director of LAHC from 2011 until approximately January 2014. Thomas was Ochsner Health System's Chief Operating Officer from 1998 until September 1, 2012; Ochsner's President from 1998 until present; and Ochsner's Chief Executive Officer from September 1, 2012, until present. Thomas is a Nominal Defendant only.

b. **WILLIAM A. OLIVER ("Oliver"),** an individual of the full age of majority domiciled in the State of Louisiana. Oliver was a Director of LAHC from 2011 through 2015. Upon information and belief, Oliver was a director and/or officer of Ochsner Health Systems at pertinent times hereto. Oliver is a Nominal Defendant only.

c. **SCOTT POSECAI ("Posecai"),** an individual of the full age of majority domiciled in the State of Louisiana. Posecai was a Director of LAHC from 2011 until October 28, 2013, and Treasurer of LAHC from September 25, 2012, until October 28, 2013. Posecai has been Chief Financial Officer of the Ochsner Clinic Foundation since 2001 and CFO of the Ochsner Health System since 2006. Posecai is a Nominal Defendant only.

d. **PATRICK QUIINLAN ("Quinlan"),** an individual of the full age of majority domiciled in the State of Louisiana. Quinlan was a Director of LAHC from September 25, 2012, until approximately January 2013. Quinlan was Chief Executive Officer of Ochsner Health System from 2001 until September 2, 2012. Quinlan is a Nominal Defendant only.

e. **PETER NOVEMBER ("November"),** an individual of the full age of majority domiciled in the State of Louisiana. November was a Director of LAHC from May 23, 2013, until 2015, and Secretary commencing July 9, 2013. Upon joining Ochsner in 2012, November initially served as Senior Vice President, General Counsel, and Chief Compliance Officer for Ochsner

Health System, and he currently is Executive Vice President and Chief Administrative Officer of Ochsner Health System. November is a Nominal Defendant only.

f. **MICHAEL HULEFELD ("Hulefeld"),** an individual of the full age of majority domiciled in the State of Louisiana. Hulefeld was a Director of LAHC from May 23, 2013, until 2015. Hulefeld is Executive Vice President and Chief Operating Officer of Ochsner Health System, and he previously served as the Chief Executive Officer of Ochsner Medical Center. Hulefeld is a Nominal Defendant only.

11.

TPA Defendants

a. **CGI TECHNOLOGIES AND SOLUTIONS, INC. ("CGI"),** a foreign corporation believed to be domiciled in Delaware with its principal place of business in Virginia. From approximately March 2013 to approximately November 2014, CGI served as the Third Party Administrator of LAHC and/or worked for LAHC to transition its TPA work to GRI. CGI contracted with and did work for LAHC in Louisiana.

b. **GROUP RESOURCES INCORPORATED ("GRI"),** a foreign corporation believed to be domiciled in Georgia with its principal place of business in Georgia. From approximately May 2014 to approximately May 2016, GRI served as the Third Party Administrator of LAHC. GRI contracted with and did work for LAHC in Louisiana.

12.

Beam Partners, LLC

a. **BEAM PARTNERS, LLC ("Beam Partners"),** a foreign corporation believed to be domiciled in Georgia with its principal place of business in Georgia. From prior to LAHC's incorporation in 2011 through approximately mid-2014, Beam Partners developed and managed LAHC. Beam Partners contracted with and did work for LAHC in Louisiana.

13.

Actuary Defendants

a. **MILLIMAN, INC. ("Milliman"),** a foreign corporation believed to be domiciled in Washington with its principal place of business in Washington. From approximately August 2011 to March 2014, Milliman provided professional actuarial services to LAHC.

b. **BUCK CONSULTANTS, LLC ("Buck"),** a foreign corporation believed to be domiciled in Delaware with its principal place of business in New York. From approximately March 2014 through July 2015, Buck provided professional actuarial services to LAHC.

14.

Insurer Defendants

a. **ALLIED WORLD SPECIALTY INSURANCE COMPANY a/k/a DARWIN NATIONAL ASSURANCE COMPANY ("Allied/Darwin"),** a foreign insurer, doing business in the State of Louisiana and subject to the regulatory authority of the Louisiana Department of Insurance, who issued an applicable policy or policies to Ochsner Clinic Foundation that provide coverage for claims asserted herein.

b. **ATLANTIC SPECIALTY INSURANCE COMPANY ("Atlantic"),** a foreign insurer, doing business in the State of Louisiana and subject to the regulatory authority of the Louisiana Department of Insurance, who issued an applicable policy or policies to Ochsner Clinic Foundation that provide coverage for claims asserted herein.

c. **EVANSTON INSURANCE COMPANY ("Evanston"),** a foreign insurer, doing business in the State of Louisiana and subject to the regulatory authority of the Louisiana Department of Insurance, who issued an applicable policy or policies to Ochsner Clinic Foundation that provide coverage for claims asserted herein.

d. **RSUI INDEMNITY COMPANY ("RSUI Indemnity"),** a foreign insurer, doing business in the State of Louisiana and subject to the regulatory authority of the Louisiana Department of Insurance, who issued an applicable policy or policies to Ochsner Clinic Foundation that provide coverage for claims asserted herein.

e. **ZURICH AMERICAN INSURANCE COMPANY ("Zurich"),** a foreign insurer, doing business in the State of Louisiana and subject to the regulatory authority of the Louisiana Department of Insurance, who issued an applicable policy or policies to Ochsner Clinic Foundation that provide coverage for claims asserted herein.

DEFINED TERMS

15.

As used herein, the following terms are defined as follows:

1. "**D&O Defendants**" shall refer to and mean those directors and officers of LAHC named as either original Defendants and/or Nominal Defendants herein, specifically: Terry S.

Shilling, George G. Cromer, Warner L. Thomas, IV, William A. Oliver, Charles D. Calvi, and Patrick C. Powers; Scott Posecai; Pat Quinlan; Peter November; and Michael Hulefeld.

2. "**TPA Defendants**" shall refer to and mean those third party administrators hired by LAHC to oversee, manage, and otherwise operate LAHC named as Defendants herein, specifically: CGI Technologies and Solutions, Inc. and Group Resources Incorporated.

3. "**Insurer Defendant**" shall refer to and mean those insurance companies named herein which provide insurance coverage for any of the claims asserted herein by LAHC against any of the Defendants named herein, including: Allied/Darwin, Atlantic, Evanston, RSUI Indemnity, and Zurich.

4. **"Actuary Defendants"** shall refer to and mean those actuaries hired by LAHC to perform actuarial services for LAHC and named as Defendants herein, specifically: Milliman, Inc. ("Milliman") and Buck Consulting, Inc. ("Buck").

5. "**LDI**" shall refer to and mean the Louisiana Department of Insurance.

6. "**CMS**" shall refer to the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

7. **"Nominal Defendants"** shall refer to and mean those D&O Defendants and Other Insured Persons (as defined in the underlying settlement agreements between Plaintiff and Travelers Casualty and Surety Company of America and others), including but not limited to Warner L. Thomas, IV; William A. Oliver; Scott Posecai; Pat Quinlan; Peter November; and Michael Hulefeld, who are named herein solely to effectuate Plaintiff's right to proceed against any insurance companies, other than Travelers Casualty and Surety Company of America, which provided coverage for Plaintiff's allegations herein; including but not limited to Allied World Specialty Insurance Company a/k/a Darwin National Assurance Company; Atlantic Specialty Insurance Company; Evanston Insurance Company; RSUI Indemnity Company; and Zurich American Insurance Company, all pursuant to Plaintiff's *Gasquet* release of the D&O Defendants, Other Insured Persons, and Travelers Casualty and Surety Company of America.

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FACTUAL BACKGROUND

16.

The Patient Protection and Affordable Care Act ("ACA") established health insurance exchanges (commonly called "marketplaces") to allow individuals and small businesses to shop for health insurance in all states across the nation. To expand the number of available health insurance plans available in the marketplaces, the ACA established the Consumer Operated and Oriented Plan ("CO-OP") program. The ACA further directed the Secretary of Health and Human Services to loan money to the CO-OP's created in each state. Beginning on January 1, 2014, each CO-OP was allowed to offer health insurance through the newly minted marketplaces for its respective state. A total of 23 CO-OP's were created and funded as of January 1, 2014. State regulators, like the Louisiana Department of Insurance ("LDI"), have the primary oversight of CO-OP's as health insurance issuers.

17.

In Louisiana, the CO-OP created and funded pursuant to the ACA was Louisiana Health Cooperative, Inc. ("LAHC"), a Louisiana Nonprofit Corporation that holds a health maintenance organization ("HMO") license from the LDI. Incorporated in 2011, LAHC eventually applied for and received loans from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS") totaling more than $65 million. Specifically, according to the 2012 Loan Agreement with LAHC, the Louisiana CO-OP was awarded a Start-up Loan of $12,426,560, and a Solvency Loan of $52,614,100. Pursuant to the ACA, these loans were to be awarded only to entities that demonstrated a high probability of becoming financially viable. All CO-OP loans must be repaid with interest. LAHC's Start-up Loan must be repaid no later than five (5) years from disbursement; and LAHC's Solvency Loan must be repaid no later than fifteen (15) years from disbursement.

18.

From the start, because of the gross negligence of the Defendants named herein, LAHC failed miserably. Before ever offering a policy to the public, LAHC lost approximately $8 million in 2013. While projecting a modest loss of about $1.9 million in 2014 in its loan application to CMS, LAHC actually lost about $20 million in its first year in business. And although LAHC projected turning a modest profit of about $1.7 million in 2015, it actually lost more than $54 million by the end of that year.

19.

The actuaries hired by LAHC to determine the CO-OP's feasibility, assess its funding needs, and set the premium rates to be charged by LAHC in both 2014 and 2015, breached their respective duties owed to LAHC. The actuaries hired by LAHC grossly underestimated the level of expenses that LAHC would incur, made erroneous assumptions regarding LAHC's relative position in the marketplace, and grossly misunderstood or miscalculated how the risk adjustment component of the ACA would impact LAHC. Rather than LAHC either receiving a risk adjustment payment or LAHC not being assessed any such risk adjustment payment at all, as the actuaries erroneously predicted, in actuality, LAHC incurred significant risk adjustment payments in both 2014 and 2015. These failures of the actuaries who served LAHC were a significant factor in causing LAHC's ultimate collapse.

20.

Not only did LAHC lose a tremendous amount of money, but, from its inception, LAHC was unable to process and manage the eligibility, enrollment, and claims handling aspects of the HMO competently. Almost every aspect of LAHC's eligibility, enrollment, and claims handling process was deficient, resulting in numerous unpaid claims, untimely paid claims, and erroneously paid claims.

21.

By July 2015, only eighteen months after it started issuing policies, LAHC decided to stop doing business. The LDI placed LAHC in rehabilitation in September 2015, and a Receiver, Billy Bostick, was appointed by this Court to take control of the failed Louisiana CO-OP.

22.

The various parties who created, developed, managed, and worked for LAHC (i.e., the Defendants named herein) completely failed to meet their respective obligations to the subscribers, providers, and creditors of this Louisiana HMO. From the beginning of its existence, LAHC was completely ill-equipped to service the needs of its subscribers (i.e., its members / policyholders), the healthcare providers who provided medical services to its members, and the vendors who did business with LAHC. As described in detail herein, the conduct of the Defendants named herein went way beyond simple negligence. For instance, when the LDI took over the operations of LAHC, the CO-OP had a backlog of approximately 50,000 claims that had not been processed.

Because of Defendant's gross negligence, as of December 31, 2015, LAHC had lost more than $82 million.

23.

As set forth herein, Defendants are liable to Plaintiff for all compensatory damages caused by their actionable conduct.

CAUSES OF ACTION

Count One: Breach of Fiduciary Duty (Against the D&O Defendants and Insurer Defendants)

24.

Plaintiff repeats and realleges each and every allegation set forth in the foregoing paragraphs as if fully set forth herein.

25.

The D&O Defendants owed LAHC, its members, and its creditors, fiduciary duties of loyalty, including the exercise of oversight as pleaded herein, due care, and the duty to act in good faith and in the best interest of LAHC. The D&O Defendants stand in a fiduciary relation to LAHC and its members and creditors and must discharge their fiduciary duties in good faith, and with that diligence, care, judgment and skill which the ordinarily prudent person would exercise under similar circumstances in like position.

26.

At all times when LAHC was insolvent and/or in the zone of insolvency, the D&O Defendants owed these fiduciary duties to the creditors of LAHC as well.

27.

The conduct of the D&O Defendants of LAHC, as pled herein, went beyond simple negligence. The conduct of the D&O Defendants constitutes gross negligence, and in some cases, willful misconduct. In other words, the D&O Defendants did not simply act negligently in the management and supervision of and their dealings with LAHC, but the D&O Defendants acted grossly negligently, incompetently in many instances, and deliberately, in other instances, all in a manner that damaged LAHC, its members, providers and creditors.

28.

The D&O Defendants knew or should have known that Beam Partners was unqualified and unsuited to develop and manage LAHC.

29.

The D&O Defendants knew or should have known that GRI was unqualified and unsuited to develop and manage LAHC.

30.

The failure of the D&O Defendants to select a competent TPA, negotiate an acceptable contract with GRI, and manage and oversee Beam Partners, CGI, and GRI's conduct, constitutes gross negligence on the part of the D&O Defendants that caused LAHC to hire other vendors and/or additional employees, in effect, to either do work and/or fix work that should have been competently done by Beam Partners, CGI, and/or GRI, resulting in tremendous additional and unnecessary expenses and inefficiencies to LAHC which played a significant role in LAHC's failure.

31.

The D&O Defendants breached their fiduciary obligations in the following, non-exclusive, ways:

a. Paying excessive salaries to LAHC executives in relation to the poor, inadequate, or non-existent services rendered by them to LAHC and/or on its behalf;

b. Paying excessive bonuses to LAHC executives in relation to the poor, inadequate, or non-existent services renders by them to LAHC and/or on its behalf;

c. Grossly inadequate oversight of LAHC operations;

d. Grossly inadequate oversight of contracts with outside vendors, including CGI and GRI;

e. Lack of regularly scheduled and meaningful meetings of the Board of Directors and management; the few board meetings that took place (one in 2012; four in 2013; six in 2014; and one in 2015), generally lasted about an hour;

f. Gross negligence in hiring key management and executives with limited or inadequate health insurance experience;

g. Gross failure to protect the personal health information of subscribers; unauthorized disclosure of subscribers' personal health information; for example, in February 2014, an incorrect setting within LAHC's document production system caused 154 member ID cards to be erroneously distributed;

h. Gross failure to issue ID cards to members accurately and timely;

i. Gross failure to pay claims timely (if at all);

j. Gross failure to bill premiums accurately and timely;

k. Gross failure to properly calculate member out-of-pocket responsibilities resulting in members being over-billed for their portion of services rendered by providers;

l. Gross failure to collect premium payments timely (if at all);

m. Gross failure to process and record the effective dates of policies accurately or consistently;

n. Gross failure to process and record the termination dates of policies accurately or consistently;

o. Gross failure to process invoices correctly and timely;

p. Gross failure to determine and report eligibility of members accurately;

q. Gross failure to have in place and/or to implement a financial policy or procedure to verify check register expenditures;

r. Gross failure to have in place and/or to implement a financial policy or procedure to verify credit card expenditures; for example, in or around October to November 2013, a VP of IT Operations at LAHC, Larry Butler, misused his LAHC credit card by incurring more than $35,000 in charges, the vast majority of which were personal expenses, on a corporate account with limits of $5,000;

s. Gross failure to have in place and/or to implement a financial policy or procedure to verify sponsor invoices;

t. Gross failure to have in place and/or to implement policies and procedures regarding operational, financial, and compliance areas (such as background checks, corrective action plans, procurement, contract management, and financial management) before engaging in meaningful work and offering insurance coverage to the public;

u. Gross failure to understand, implement, and enforce the applicable "grace period" pertaining to subscribers as per the ACA and Louisiana Law, La. R.S. 22:1260.31, *et. seq.*;

v. Gross failure to record and report LAHC's claims reserves (IBNR) accurately;

w. Gross failure to report and appoint agents and brokers;

x. Gross failure to record and report the level of care provided to LAHC members, enrollees, and subscribers accurately;

y. As of March 2014, LAHC described its own system to process enrollment, eligibility, and claims handling as a "broken" process;

z. Grossly negligent to choose GRI to replace CGI; went from the frying pan into the fire; GRI was unqualified, ill-equipped, and unable to service the needs of LAHC, its members, providers, and creditors;

aa. Erroneously terminating coverage for fully subsidized subscribers;

bb. Failing to provide notice to providers regarding member terminations and lapses due to non-payment of premiums;

cc. Failing to provide notice (delinquency letters) to subscribers prior to terminating coverage;

dd. Failing to maintain an Information Technology environment with adequate controls and risk mitigation to protect the data, processes, and integrity of LAHC data;

ee. Failing to collect binder payments on-time;

ff. Failing to terminate members when binder payments were not received;

gg. Failing to correct ambiguities in the GRI contract(s);

hh. Failing to select qualified vendors

ii. Failing to select qualified management;

jj. They knew or should have known, prior to the public rollout of LAHC in January 2014, that LAHC would not be a viable HMO, and yet they proceeded to offer policies and services to the public and members knowing that LAHC would fail;

kk. They caused and/or allowed LAHC to misrepresent the financial condition and viability of LAHC to the LDI, the federal government, its member, its creditors, and the public, thereby allowing LAHC to remain in operation much longer that they should and would otherwise have, adding additional members and incurring additional claims and debt;

ll. They knowingly paid excessive salaries, professional service fees, and consulting fees, as alleged herein, without receiving appropriate value to LAHC;

mm. They failed to implement internal controls that would have prevented the gross waste and damages sustained by LAHC as a result of their gross negligence;

nn. They concealed LAHC's true financial condition and insolvency and artificially prolonged LAHC's corporate life beyond insolvency all to the detriment of LAHC, its members, and its creditors;

oo. They grossly mismanaged LAHC's affairs;

pp. They grossly failed to exercise oversight or supervise LAHC's financial affairs;

qq. They failed to operate LAHC in a reasonably prudent manner;

rr. They failed in their duty to operate LAHC in compliance with the laws and regulations applicable to them; and

ss. Other acts of gross negligence as may be later discovered.

32.

The D&O Defendants also breached their fiduciary duty of loyalty, due care, and good faith by allowing, if not fostering, individuals with conflicts of interest to influence, if not control, LAHC, all to the detriment of LAHC, its members, providers, and creditors.

33.

Because of the grossly negligent conduct of the D&O Defendants, LAHC was woefully not prepared for its roll-out to the public on January 1, 2014.

34.

By approximately March 2014, just three (3) months after its ill-advised roll-out, the D&O Defendants compounded an already bad situation by deciding to replace CGI with GRI as TPA. At this point, the D&O Defendants should have either exercised appropriate oversight and management to reform CGI's grossly inadequate performance, or the D&O Defendants should have terminated the Agreement with CGI and found a suitable TPA, or the D&O Defendants

should have ceased operations altogether. Instead, the D&O Defendants made matters worse by hiring a TPA that was even less qualified and less prepared than CGI for the job: GRI.

35.

To further damage the struggling LAHC, in approximately mid-2014, the D&O Defendants decided to switch healthcare provider networks from Verity Healthnet, LLC ("Verity") to Primary Healthcare Systems ("PHCS"). Once again, the D&O Defendants' conduct constitutes gross negligence that further damaged LAHC, its members, providers, and creditors.

36.

The D&O Defendants, in breaching both their duty of loyalty and duty of care, showed a conscious disregard for the best interests of LAHC, its members, providers and creditors.

37.

As a direct and proximate result of the gross negligence and foregoing failures of the D&O Defendants to perform their fiduciary obligations, LAHC, its members, its providers and its creditors have sustained substantial, compensable damages for which the D&O Defendants and the Insurer Defendants are liable, and for which Plaintiff is entitled to recover in this action.

38.

The compensable damages caused by the D&O Defendants' grossly negligent conduct, if not willful conduct, include, but are not limited to:

a. damages in the form of all losses sustained by LAHC from its inception (i.e., they should have never started LAHC in the first place);

b. damages in the form of lost profits (i.e., the amount LAHC would have earned, if any, but for their conduct);

c. damages in the form of excessive losses (i.e., the difference between the amount LAHC would have lost, if any, and the amount LAHC did lose, because of their conduct);

d. damages in the form of deepening insolvency (i.e., the damages caused by their decision to prolong the corporate existence of LAHC beyond insolvency);

e. damages in the form of all legitimate debts owed to creditors of LAHC, including but not limited to those unpaid debts owed to health care providers who delivered services to members of LAHC, any debts owed to members of LAHC that were not paid, and the debt owed to CMS (both principal and interest) as a result of LAHC's gross negligence as pled herein;

f. disgorgement of all excessive salaries, bonuses, profits, benefits, and other compensation inappropriately obtained by them;

g. damages in the form of all excessive administrative, operational, and/or management expenses, including:

    i. Untimely payment of member and provider claims;

ii. Incorrect payment of member and provider claims;

iii. Increased interest expense due to incorrect and/or untimely claims payments:

iv. Increased expenses due to incorrect and/or untimely claims payments;

v. Incorrect and/or untimely payment of agent/broker commissions:

vi. Inaccurate and/or untimely collection of premium due for health coverage;

vii. Increased expenses for services from LAHC vendors other than the third party administrator;

viii. Increased expenses for provider networks and medical services;

ix. Loss of money due to LAHC from the Center for Medicare and Medicaid Services ("CMS") for risk adjustments;

x. Fines incurred for failure to have agents/brokers properly appointed; and

xi. Inability to repay the millions of dollars loaned to LAHC by the federal government.

h. all costs and disbursements of this action, including all compensable litigation expenses.

39.

Plaintiff recently reached a *Gasquet* settlement with the originally named D&O Defendants, specifically: Shilling, Cromer, Thomas, Oliver, Calvi, and Powers. Pursuant to the terms of the parties' settlement agreement, the D&O Defendants and Other Insured Persons (i.e., other employees or directors of LAHC) may be named as nominal defendants to the extent Plaintiff elects to pursue his rights against any excess insurer of the D&O Defendants or Other Insured Persons by naming such insurers in this suit (other than Travelers). In accordance with the settlement agreement, Plaintiff has named the Insurer Defendants as excess insurers, and he has named the following as nominal defendants herein: Thomas; Oliver; Posecai; Quinlan; November; and Hulefeld.

40.

The Insurer Defendants are liable to the Plaintiff jointly, severally and *in solido* with the D&O Defendants to the extent of the limits of its respective policies of insurance, for the following reasons:

a. Allied/Darwin issued a Directors and Officers Liability Policy to Ochsner Clinic Foundation, with policy limits, upon information and belief, of $5,000,000.00, which policy was in full force and effect at all relevant times and provided insurance coverage to the D&O Defendants for some or all of the claims asserted herein by Plaintiff;

b. Allied/Darwin issued an Excess Insurance Policy to Ochsner Clinic Foundation, with policy limits, upon information and belief, of $5,000,000.00, which policy was in full force and effect at all relevant times and provided insurance coverage to the D&O Defendants for some or all of the claims asserted herein by Plaintiff;

c. Atlantic issued a Follow Form Excess Policy to Ochsner Clinic Foundation, with policy limits, upon information and belief, of $10,000,000.00, which policy was in full force and effect at all relevant times and provided insurance coverage to the D&O Defendants for some or all of the claims asserted herein by Plaintiff;

d. Evanston issued an Excess Management Liability Policy to Ochsner Clinic Foundation, with policy limits, upon information and belief, of $5,000,000.00, which policy was in full force and effect at all relevant times and provided insurance coverage to the D&O Defendants for some or all of the claims asserted herein by Plaintiff;

e. RSUI Indemnity issued an Excess Liability Policy to Ochsner Clinic Foundation, with policy limits, upon information and belief, of 10,000,000.00, which policy was in full force and effect at all relevant times and provided insurance coverage to the D&O Defendants for some or all of the claims asserted herein by Plaintiff;

f. Zurich issued a Zurich Excess Select Insurance Policy to Ochsner Clinic Foundation, with policy limits, upon information and belief, of $10,000,000.00, which policy was in full force and effect at all relevant times and provided insurance coverage to the D&O Defendants for some or all of the claims asserted herein by Plaintiff.

41.

The Insurer Defendants provide coverage for the liability of executives or employees of Ochsner Clinic Foundation who act as director or officer of any non-for-profit entity, such as LAHC, at the request of Ochsner. The Nominal Defendants, Thomas, Oliver, Posecai, Quinlan, November, and Hulefeld, were all Ochsner executives and/or employees who also served as directors and/or officers of LAHC at the request of Ochsner.

Count Two: Breach of Contract
(Against the TPA Defendants and Beam Partners)

42.

Plaintiff repeats and realleges each and every allegation set forth in the foregoing paragraphs as if fully set forth herein.

CGI

43.

On or about February 15, 2013, LAHC and CGI entered into an Administrative Services Agreement ("Agreement") whereby CGI agreed to perform certain administrative and management services to LAHC in exchange for certain monetary compensation as set forth in the Agreement. A true and correct copy of the Agreement and all exhibits was attached and incorporated by reference in the original Petition for Damages as "Exhibit 1."

44.

Under the terms of the Agreement, CGI represented and warranted, *inter alia,* that "CGI personnel who perform the services under the Agreement shall have the appropriate training, licensure and or certification to perform each task assigned to them" and that "CGI will make a good faith effort to maintain consistent staff performing the delegated functions" for LAHC.

45.

Under the terms of the Agreement, CGI was, among other things, obligated to:

a. Function as a Third Party Administrator for LAHC;

b. Accurately process and pay claims for covered services provided to LAHC's members by participating providers according to payment terms regarding timeliness and the rates and amounts set forth in LAHC's Participating Provider Agreements.

c. Accurately process and pay claims for covered services provided to LAHC's members by providers;

d. Competently perform all of those tasks set forth in the Agreement, including Exhibit 2 thereto, such as paying claims, adjudicating claims, determining covered services, identifying and processing clean and unclean claims, collecting and processing all encounter data, transmitting denial notifications to members and providers, transmitting all required notices, tracking and reporting its performance, tracking, reporting and reconciling all records regarding deductibles and benefit accumulators, monitoring all claims, submitting all claims, tracking, reporting, and paying all interest on late paid claims, coordinating the payment and processing of all claims and EOBs, and developing and implementing a functional coding system; and

e. Competently perform all of those tasks expected and required of a Third Party Administration, whether specified in the Agreement or not.

46.

CGI breached its obligations and warranties set forth in the Agreement in a grossly negligent manner, all in the following, non-exclusive ways:

a. Failed to pay claims at the proper contract rates and amounts, thus resulting in an overpayment of claims;

b. Failed to accurately and properly process enrollment segments and failed to timely reconcile enrollment segments;

c. Failed to provide proper notice to providers regarding member terminations and lapses due to non-payment of premiums;

d. Failed to issue appropriate identification cards to subscribers;

e. Failed to provide proper notice (delinquency letters) so subscribers prior to terminating coverage;

f. Failed to process claims properly;

g. Failed to enter, record, and process paper claims properly;

h. Failed to establish, manage, and run the call center for LAHC properly;

i. Failed to implement a billing system that would accurately calculate balance due;

j. Failed to appropriately establish an EDGE server and/or failed to appropriately or timely provide the Department of Health and Human Services with access to required data on the EDGE server; and

k. Other acts of gross negligence as may be later discovered.

47.

As of March 2014, just three (3) months after its roll-out, LAHC described the system designed and implemented by CGI to process enrollment, eligibility, and claims handling, as a "broken" process. Indeed, the conduct of CGI, as described herein in detail, goes well beyond simple negligence; almost every facet of the system designed and implemented by CGI as a third party administrator of LAHC was a failure. CGI's conduct, as described herein in detail, constitutes gross negligence.

48.

Subsequently, LAHC and CGI memorialized their agreement to terminate the CGI Agreement via Letter Agreement dated June 19, 2014 ("Letter Agreement") (Exhibit 3). Assuming that this purported release is applicable to Plaintiff's claims against CGI, which Plaintiff expressly denies, the express terms of this Letter Agreement make clear that LAHC did not release CGI for "obligations assumed" by this Letter Agreement.

49.

According to this Letter Agreement, although the Original Agreement allegedly terminated on April 30, 2014, CGI assumed numerous obligations, including:

- For "the six month wind-down period [from April 2011 through October 2011], CGI shall provide such wind-down services as the parties may agree in a wind-down plan, all in accordance with Sections 2.5 and 2.5.1 of the Original Agreement." (Exhibit 3, ¶ 1).
- "The general scope and structure of the wind down period is as specified in Attachment 1 to this Letter Agreement." (Exhibit 3, ¶ 2). Attachment 1 to the Letter Agreement further specifies that, during the wind down period, CGI was responsible for transferring "membership data," "enrollment data," "paid claim data," "pending and/or in-flight claim data," "file server records," and "other data transfer as the parties agree" to GRI. (Exhibit 3, Attachment 1).

- "During the wind-down period, CGI will make commercially reasonable efforts to perform the Delegated Functions in accordance with the Service Level Specifications set forth in Section 6 in Exhibit 1 to the Original Agreement." (Exhibit 3, ¶ 3).

50.

Further, as evidenced by correspondence from LAHC to CGI dated April 17, 2014, requesting that the Original Agreement between LAHC and CGI be terminated because of numerous specific failures of CGI to perform under the agreement and asserting that "CGI is in fundamental breach of the Agreement, CGI continued to provide services to LAHC during the transitional "wind down" period. Specifically, in addition to detailing the numerous failures of CGI to perform, according to this correspondence:

- "LAHC must transition the revoked Delegated Functions to other organization(s) while relying on CGI to cooperatively effect a smooth and orderly transition of those services as required by Article 3.13.6."
- "Consistent with the provisions of Article 3.13.6 of the Agreement, LAHC expects that CGI continue to provide services, including information and exchanges as reasonably requested by LAHC or its designee, until effective transition on or about October 1, 2014."

51.

The services performed by CGI after April 30, 2014 are "obligations assumed" by the Letter Agreement. CGI breached its obligations and warranties set forth in the Letter Agreement in a grossly negligent manner.

52.

CGI was paid a total of approximately $1,176,224.42 by LAHC over the course of their working relationship from approximately April 2013 to November 2014. Of this total amount, $539,139.59—or about 46%—was paid to CGI on or after April 30, 2014, the alleged termination date of the original agreement. CGI did substantial work for LAHC after April 30, 2014 during the transitional or "wind down" period as GRI assumed the role of third party administrator of LAHC. For example, both before and after April 30, 2014, CGI:

- failed to ensure that its personnel who performed services for LAHC were adequately and appropriately trained, licensed, and certified to perform the services and functions delegated by LAHC to CGI;
- failed to accurately process and pay claims on LAHC's behalf in a timely manner at the correct rates and amounts;

- failed to cause LAHC to accurately process and pay health insurance claims in a timely manner at the correct rates and amounts; and
- in general, failed to provide for a smooth and seamless transition of LAHC's ongoing business to GRI.

53.

CGI's breaches of its warranties and obligations in both the Original Agreement and the Letter Agreement have directly caused LAHC to incur substantial, compensatory damages which are recoverable by Plaintiff herein.

GRI

54.

GRI was not qualified to render the services as a third party administrator ("TPA") that LAHC needed to be successful. Rather than decline taking on a job that was outside of its capabilities, GRI wrongly agreed to replace CGI and serve as TPA for LAHC. GRI's decision to serve as LAHC's TPA constitutes gross negligence, if not a conscious disregard for the best interests of LAHC, its members, providers, and creditors. But for GRI's gross negligence, most of LAHC's substantial, compensatory damages would have been avoided.

55.

In or about July 2014, LAHC and GRI entered into an Administrative Services Agreement whereby GRI agreed to perform certain administrative and management services to LAHC in exchange for certain monetary compensation as set forth in the Administrative Services Agreement. The Administrative Services Agreement had an effective date of July 1, 2014. The Administrative Services Agreement was amended both in September 2014 and December 2014. A true and correct copy of the Administrative Services Agreement and all amendments and exhibits are collectively referred to as the "Agreement" and were attached and incorporated by reference in the original Petition for Damages as "Exhibit 2." A true and correct copy of the Delegation Agreement between LAHC and GRI effective August 20, 2014, was attached and incorporated by reference in the First Supplemental, Amending and Restated Petition For Damages as "Exhibit 2A."

56.

Under the terms of the Agreement, CGI represented and warranted that "GRI personnel who perform or provide the Delegated Services specified services under this Agreement shall

possess the appropriate authorization, license, bond and certificates, and are full and appropriately trained, to properly perform the tasks assigned to them."

57.

Under the terms of the Agreement, GRI was, among other things, obligated to:

a. Accurately process and pay claims for covered services provided to LAHC's members by participating providers according to payment terms regarding timeliness and the rates and amounts set forth in LAHC's Participating Provider Agreements.

b. Accurately process and pay claims for covered services provided to LAHC's members by providers;

c. Competently perform all of those tasks set forth in the Agreement, including Exhibit A-1 to the agreement, such as paying claims, adjudicating claims, determining covered services, identifying and processing clean and unclean claims, collecting and processing all encounter data, transmitting denial notifications to members and providers, transmitting all required notices, tracking and reporting its performance, tracking, reporting and reconciling all records regarding deductibles and benefit accumulators, monitoring all claims, submitting all claims, tracking, reporting, and paying all interest on late paid claims, coordinating the payment and processing of all claims and EOBs, and developing and implementing a functional coding system; and

d. Competently perform all of those tasks expected and required of a Third Party Administration, whether specified in the Agreement or not.

58.

GRI breached its obligations and warranties set forth in the Agreement in a grossly negligent manner, all in the following, non-exclusive ways:

a. GRI failed to meet most, if not all, of the performance standards mandated by the Services Agreement of July 1, 2014;

b. GRI was unqualified, ill-equipped, and unable to service the needs of LAHC, its member, providers, and creditors;

c. GRI knew or should have known that it was unqualified to service the needs of LAHC;

d. Pursuant to GRI's Service Agreement, GRI was responsible for critical processes that are typically covered by such a health insurance administrative service provider contracts, including the receipt and processing of member premium payments, the calculation and payment of broker commissions, and the process of managing calls into LAHC;

e. GRI wholly failed to provide sufficient and adequately trained personnel to perform the services GRI agreed to perform under the Agreement;

f. Failed to process and pay claims on a timely basis, resulting in interest payment alone in excess of $600,000.00;

g. Failed to pay claims at the proper contract rates and amounts, thus resulting in an overpayment of claims;

h. Failed to accurately and properly process enrollment segments and failed to timely reconcile enrollment segments;

i. Erroneously terminated coverage for fully subsidized subscribers ($0 Invoices);

j. Failed to provide proper notice to providers regarding member terminations and lapses due to non-payment of premiums;

k. Failed to timely process enrollment interface (ANSI 834) from CMS;

l. Failed to accurately process enrollment interface (ANSI 834) from CMS;

m. Failed to pass CMS data edits for CMS Enrollment Reconciliation Process;

n. Submitted inaccurate data to the CMS Enrollment Reconciliation Process causing erroneous terminations;

o. Failed to pass CMS data edits for Enrollment Terminations & Cancellations Interface (ANSI 834) to CMS;

p. Failed to pass CMS data edits for Edge Server Enrollment Submissions to CMS;

q. Failed to use standard coding for illustrating non-effectuated members (using years 1915 and 1900 as termination year);

r. Failed to provide proper notice (delinquency letters) to subscribers prior to terminating coverage;

s. Failed to invoice subscribers accurately when APTC changed;

t. Failed to invoice subscribers for previously unpaid amounts (no balance forward);

u. Failed to cancel members for non-payment of binder payment;

v. Failed to cancel members after passive enrollment;

w. Failed to administer member benefits (maximum out-of-pockets exceeded);

x. Failed to pay interest on claims to providers;

y. Failed to pay claims within the contractual timeframes;

z. Failed to adjust claims after retroactive disenrollments;

aa. Failure to examine claims for potential subrogation

bb. Failed to maintain adequate customer service staffing and call center technology;

cc. Failed to process APTC changes from CMS within an appropriate timeframe;

dd. Failed to capture all claims diagnoses data from providers;

ee. Failed to pass CMS data edits for Edge Server claims submissions to CMS;

ff. Failed to load the 1,817 claims from the 4/29/16 and 5/2/16 check runs onto the EDGE Server;

gg. Incorrectly calculated claim adjustments, especially as it pertains to a subscriber's maximum out-of-pocket limit;

hh. Paid claims for members that never effectuated;

ii. Failed to protect the personal health information of subscribers;

jj. Failed to issue ID cards to members accurately and timely and without effective dates;

kk. Failed to have in place and/or to implement a financial policy or procedure to verify credit card expenditures;

ll. Failed to understand, implement, and enforce the applicable "grace period" pertaining to subscribers as per the ACA and Louisiana Law, La. R.S. 22:1260.31, *et. seq.*;

mm. Failed to record and report LAHC's claims reserves (IBNR) accurately;

nn. Failed to report and appoint agents and brokers appropriately;

oo. Failed to record and report the level of care provided to LAHC members, enrollees, and subscribers accurately; and

pp. Failed to maintain an Information Technology environment with adequate controls and risk mitigation to protect the data, processes, and integrity of LAHC data.

qq. Failed to maintain correct Taxpayer Identification Numbers for providers and submitted incorrect Taxpayer Identification Numbers on tax forms for approximately 135 providers, resulting in IRS penalties and fines of at least $37,700.

59.

According to the Agreement, GRI was obligated to pay claims within the time frame required by applicable law; and if claims were paid untimely because of GRI's conduct, GRI "shall be responsible for paying any required interest penalty to Providers." Because of GRI's gross negligence and non-performance of its contractual obligations owed to LAHC, numerous claims were paid late and significant interest penalties were incurred and paid by LAHC. GRI is obligated to pay all such interest penalties.

60.

GRI's gross negligence and breaches of its warranties and obligations in the Agreement have directly caused LAHC to incur substantial, compensatory damages which are recoverable by Plaintiff herein.

Beam Partners

61.

Beam Partners was not qualified to render the services as a manager and developer and/or third party administrator ("TPA") that the start-up, LAHC, needed to be successful. Rather than decline taking on a job that was outside of its capabilities, Beam Partners wrongly orchestrated and agreed to manage, develop, and serve as TPA for LAHC from its inception. Beam Partner's decision to manage, develop, and effectively serve as LAHC's TPA constitutes gross negligence, if not a conscious disregard for the best interests of LAHC, its members, providers, and creditors.

But for Beam's gross negligence, all of LAHC's substantial, compensatory damages would have been avoided.

62.

Given that numerous individuals who either owned, managed and/or worked for Beam Partners, including Terry Shilling, Alan Bayham, Mark Gentry, Jim McHaney, Deborah Sidener, Jim Krainz, Jim Pittman, Michael Hartnett, Eric LeMarbre, Etosha McGee, Diana Pitchford, Darla Coates, were also involved with and managed LAHC from the beginning as officers, directors, and employees of LAHC, for all intents and purposes, Beam Partners was closely related to and acted as LAHC.

63.

From approximately September 2012 through May 2014, LAHC paid more than $3.7 million in the form of consulting fees, performance fees, and expenses to Beam Partners.

64.

LAHC and Beam Partners, LLC entered into a Management and Development Agreement whereby Beam Partners agreed to perform certain management, administrative, and developmental services for LAHC in exchange for certain monetary compensation as set forth in the Management and Development Agreement. Warner Thomas, as Chair of the Board of Directors of LAHC, signed this Management and Development Agreement on October 8, 2012; Terry Shilling signed the Management and Development Agreement on behalf of Beam Partners, LLC, with an effective date of August 28, 2012. At this time, Terry Shilling was simultaneously the Interim CEO of LAHC and a member and owner of Beam Partners. This Agreement was amended at least twice. A true and correct of the Management and Development Agreement, all Exhibits thereto (with the exception of Exhibit 2, "Performance Objectives for Services"; which is unavailable, Amendment 1, and Amendment 2), was attached and incorporated by reference om the original Petition for Damages as "Exhibit 3."

65.

According to the terms of the Agreement, Beam Partners agreed to provide "services essential to the formation of the Cooperative and its application for CO-OP program loans," including training all directors, securing the requisite licensure from LDI, developing a network of providers for LAHC, recruiting and vetting candidates for positions at LAHC, creating

processes, systems, and forms for the operation of LAHC, and identifying, negotiating and executing administrative services for the operation of LAHC.

66.

In short, Beam Partners agreed to transform the start-up LAHC into a well-organized, well-funded, and well-run HMO prior to January 1, 2014, the roll-out date of LAHC to the public. Beam Partners utterly failed to meet its contractual obligations owed to LAHC, and breached its obligations and warranties set forth in the Agreement in a grossly negligent manner, all in the following, non-exclusive ways:

a. Failing to identify, select, and retain qualified third party contractors for LAHC, including but not limited to CGI and/or GRI;

b. Failing to train all directors of LAHC regarding how to manage such an HMO;

c. Failing to develop a network of providers for LAHC;

d. Failing to recruit and adequately vet appropriate candidates for positions at LAHC;

e. Failing to create adequate and/or functioning processes, systems, and forms for the operation of LAHC;

f. Failing to to identify, negotiate, and execute adequate and/or functioning administrative services for the operation of LAHC;

g. Failing to report and provide LAHC with complete, accurate, and detailed records of its performance of all services provided to LAHC;

h. Failing to adequately disclose conflict of interests regarding Beam Partners and LAHC to any regulatory authority;

i. Failing to provide sufficient and adequately trained personnel to perform the services Beam Partners agreed to perform under the Agreement; and

j. In general, by completely failing to have LAHC ready and able to meet its obligations to the public, members, providers, and creditors on or before the roll-out date of January 1, 2014.

67.

The numerous failures of Beam Partners to perform its obligations owed to LAHC constitute gross negligence, if not a conscious disregard for the best interests of LAHC, its members, providers, and creditors.

68.

To the extent that Beam Partners made the decision to keep using CGI as TPA until it was too late, Beam Partners is grossly negligent in that it knew or should have known that CGI was unqualified to serve as TPA.

69.

To the extent that Beam Partners made the decision to replace CGI with GRI as TPA, Beam Partners is grossly negligent in that it knew or should have known that GRI was unqualified to serve as TPA.

70.

To the extent that Beam Partners made the decision to terminate the Verity contract, Beam Partners is grossly negligent in that it knew or should have known that terminating the Verity contract would be a substantial factor in causing LAHC to incur additional, unnecessary expense and, ultimately, to collapse.

71.

Beam Partners' gross negligence and breaches of its warranties and obligations in the Agreement have directly caused LAHC to incur substantial, compensatory damages which are recoverable by Plaintiff herein.

Count Three: Gross Negligence and Negligence
(Against the TPA Defendants and Beam Partners)

72.

Plaintiff repeats and realleges each and every allegation set forth in the foregoing paragraphs as if fully set forth herein.

73.

CGI, GRI, and Beam Partners each had a duty to ensure that its personnel who performed services for LAHC were adequately and appropriately trained, licensed, and certified to perform the services and functions delegated by LAHC to each of them.

74.

CGI, GRI, and Beam Partners each had a duty to accurately process and pay claims on LAHC's behalf in a timely manner at the correct rates and amounts.

75.

CGI, GRI, and Beam Partners each had a duty to perform their obligations in a reasonable, competent, and professional manner.

76.

CGI, GRI, and Beam Partners each breached their duties in that it negligently failed to cause LAHC to accurately process and pay health insurance claims in a timely manner at the correct rates and amounts.

77.

CGI, GRI, and Beam Partners each breached their duties in that they negligently and wholly failed to perform their obligations in a reasonable, competent, and professional manner.

78.

CGI, GRI, and Beam Partners each were grossly negligent in that they wantonly failed to provide a sufficient number of adequately trained personnel who had sufficient knowledge of the system program utilized by LAHC to process and pay health insurance claims at the correct rates and amounts in complete and reckless disregard of the rights of LAHC, its members, providers, and creditors.

79.

CGI, GRI, and Beam Partners each were grossly negligent in that they wantonly failed to cause LAHC to accurately process and pay health insurance claims in a timely manner at the correct health insurance rates and amounts in complete and reckless disregard of the rights of LAHC, its members, providers, and creditors.

80.

As a direct and proximate result of CGI's, GRI's, and Beam Partners' negligence or gross negligence, LAHC has incurred substantial, compensatory damages, which are recoverable herein by Plaintiff.

Count Four: Professional Negligence And Breach of Contract (Against the Actuary Defendants)

81.

Plaintiff repeats and realleges each and every allegation set forth in the foregoing paragraphs as if fully set forth herein.

Milliman

82.

At all relevant times, Milliman held itself out as having expertise to provide actuarial services and advice to health insurers like LAHC.

83.

In or around August 2011, Milliman was engaged by Shilling on behalf of Beam Partners and/or LAHC to provide "actuarial support" for LAHC, including the production of a "feasibility study and loan application as directed by the Funding Opportunity Announcement (Funding

Opportunity Number: 00-COO-11-001, CFDA 93.545) released from the U.S. Department of Health Services ("HHS") on July 28, 2011." This engagement letter pre-dated LAHC's formal contract with Beam Partners by a year; the engagement letter dated August 4, 2011, was addressed to Shilling as "Owner/Partner" of "Beam Partners," and was signed by Shilling on August 15, 2011, on behalf of LAHC. Indeed, this engagement letter pre-dated the incorporation of LAHC by about a month or so (LAHC was first registered with the Louisiana Secretary of State's Office on or about September 12, 2011).

84.

In the feasibility study dated March 30, 2012, prepared by Milliman for LAHC to use in support of its loan application to CMS, Milliman concluded that, in general, LAHC "will be economically viable based upon our [Milliman's] base case and moderately adverse scenarios." According to Milliman's actuarial analysis, "the projections for the scenarios are conservative, and in each of the scenarios modeled, LAHC remains financially solvent and is able to pay back federal loans within the required time periods." Furthermore, Milliman estimated that "LAHC will be able to meet Louisiana's solvency and reserve requirements."

85.

The Milliman feasibility study was prepared using unrealistic assumption sets. None of the enrollment scenarios considered the possibility that LAHC would have trouble attracting an adequate level of enrollment (which is what actually happened in 2014 and 2015) and every economic scenario assumed that the loss ratio in nearly every modeled year would be 85% (an outlier loss ratio was never higher than 91%). These assumptions completely disregarded the very real possibility that there would be significant volatility in enrollment and/or the medical loss ratio. With all of the uncertainty within the ACA, a competent actuary would have understood that it was a very realistic possibility that LAHC would fail to be viable. Some of the modeled scenarios should have reflected this possibility. The Milliman feasibility study would imply that two "black swan" events occurred in 2014 and 2015 with low enrollment and very high medical costs. In actuality, these possibilities should have been anticipated by Milliman when they prepared the LAHC feasibility study.

86.

If CMS is considered to be a regulatory body, the actuary who prepared the feasibility study would be guided by Actuarial Standard of Practice (ASOP) No. 8 – Regulatory Filings for Health

Benefits, Accident & Health Insurance, and Entities Providing Health Benefits. The following paragraphs are applicable:

- Paragraph 3.4.2 of ASOP No. 8 states that the actuary "should consider the impact of future changes in the underlying covered population on the projected claims. These changes may include, but are not limited to, changes in demographics, risk profile, or family composition". In the context of this feasibility study, Milliman should have considered the possibility that LAHC would not be able to successfully attract the level of enrollment necessary for LAHC to remain viable as an entity.

- Paragraphs 3.4.3 and 3.4.6 of ASOP No. 8 deal with claim morbidity and health cost trends. Given the enormous level of uncertainty with respect to the claim morbidity of the population that would be covered under the ACA (including many individuals who were previously uninsurable due to known medical conditions), Milliman should have generated economic scenarios that considered the possibility that the loss ratio of LAHC would have exceed 91%. Established insurance entities with statistically credible claim experience will occasionally misprice their insurance products with resulting loss ratios exceeding 100%. Milliman should have recognized that high loss ratios were a very real possibility (given the known uncertainty of the covered population) for LAHC and illustrated such scenarios in the feasibility study.

87.

Milliman's failure to consider the possibility of these adverse enrollment and/or medical loss ratio scenarios resulted in a feasibility study where every single scenario illustrated that LAHC would be generating significant cash earnings over the mid to long term time period. The only question to the reader of the feasibility study was how much money would be earned by LAHC.

88.

Upon information and belief, Milliman conditioned payment for its preparation of LAHC's feasibility study upon LAHC being awarded a loan by CMS. That is, Milliman would only receive payment for its services if LAHC's efforts to secure a loan from CMS were successful. By conditioning payment upon a successful result, Milliman may have compromised its independence as an actuary and thereby breached its duty to LAHC.

89.

Based in large part on the work performed by Milliman and relied upon by LAHC, in September 2012, LAHC was awarded a loan to become a qualified nonprofit health insurance issuer under the Consumer-Operated and Oriented Plan (CO-OP) Program established by Section 1322 of the ACA and applicable regulations. In other words, based in large part on the work performed by Milliman and relied upon by LAHC, the federal government authorized a Start-up Loan of $12,426,560 to LAHC, and a Solvency Loan of $54,614,100 to LAHC.

90.

In or around November 2012, Milliman was engaged by Shilling on behalf of LAHC to "develop 2014 premium rates in Louisiana" for LAHC. This engagement letter dated November 13, 2012, was addressed to Shilling as "Chief Executive" of LAHC and was signed by Shilling on behalf of LAHC on November 14, 2012.

91.

In the "Three Year Pro Forma Reports" dated August 15, 2013, prepared by Milliman and relied upon by LAHC, Milliman concluded and projected that, in general, LAHC would be economically viable, able to remain financially solvent, able to pay back federal loans within the required time periods, and would be able to meet Louisiana's solvency and reserve requirements. In reliance upon Milliman's professional services and actuarial estimates and projections, LAHC set its premium rate for 2014.

92.

The actuarial work performed by Milliman for LAHC, including the feasibility study and pro forma reports, were unreliable, inaccurate, and not the result of careful, professional analysis.

93.

For instance, according to the actuarial work performed by Milliman and relied upon by LAHC and the federal government as part of the ACA process, Milliman estimated that LAHC would lose $1,892,000 in 2014 (i.e., that LAHC's net income in 2014 would be negative $1,892,000). In actuality, LAHC reported a statutory loss of more than $20 million in 2014 (i.e., LAHC's statutory net income in 2014 was actually negative $20 million+). Milliman and LAHC's projections for 2014 were off by a factor of more than 10. For 2015, Milliman's projections were even more inaccurate: although Milliman projected that LAHC would earn $1,662,000 in 2015 (i.e., LAHC's net income in 2015 would be positive $1,662,000), in actuality, LAHC reported a statutory loss of more than $54 million in 2015 (i.e., LAHC's statutory net income in 2015 was actually negative $54 million+). Milliman and LAHC's projections for 2015 were off by a factor of more than 32.

94.

Milliman owed a duty to LAHC to exercise reasonable care, and to act in accordance with the professional standards applicable to actuaries in providing its services to LAHC.

95.

Milliman's actuarial memorandums prepared as part of the 2014 rate filings for the individual and small group lines of business indicate that they assumed that LAHC would achieve provider discounts on their statewide PPO product that were equal to Blue Cross Blue Shield of Louisiana ("BCBSLA"). No support was provided for the basis of this assumption.

96.

Provider discounts are a key driver of the unit costs of medical (non-pharmacy) expenses that are incurred by LAHC members. Since providers (hospitals and physicians) typically provide the largest insurance carriers with the highest (compared to smaller carriers) discounts off billed charges, it was not reasonable for Milliman to assume that a start-up insurance entity with zero enrollment would be in a position to negotiate provider discounts as large as BCBSLA. Since LAHC was utilizing a rental network in 2014 (rather than building their own network), Milliman should have analyzed the level of discounts that would be present in the selected network (Verity Healthnet, LLC) and quantify the difference between these discounts and the BCBSLA discounts since a primary basis of the 2014 rate manual was the level of 2013 BCBSLA rates for their most popular individual and small group products.

97.

When developing estimates of the level of insured claims expense loads for 2014, Milliman would be guided by Actuarial Standard of Practice (ASOP) No. 5 – Incurred Health and Disability Claims. Paragraph 3.2.2 of ASOP No. 5 states that the actuary should consider economic influences that affect the level of incurred claims. ASOP No. 5 specifically says that should consider changes in managed care contracts and provider fee schedule changes when developing estimates of incurred claims.

98.

Based on a review of the LAHC actuarial memorandums for individual and small group, upon currently available information and belief, no support has been provided for the assumption that LAHC would achieve provider discounts equal to BCBSLA. This assumption was not reasonable; if Milliman assumed a lower level of provider discounts, the calculated premium rates would have been higher. As a result, LAHC's statutory losses in 2014 would have been lower.

99.

Milliman grossly underestimated the level of non-claim expenses in 2014. In Milliman's 2014 rate development, they assumed that the "per member per month" (PMPM) level of administrative expenses, taxes, and fees (non-claim expenses) would be $70.85 PMPM for the individual line of business. For the small group line of business, the level of non-claim expenses built into the rate development was $87.00 PMPM. Milliman projected total 2014 member months of 240,000 and 96,000 for the individual and small group lines of business respectively.

100.

The actual level of expenses in 2014 was significantly higher. On a composite basis, the PMPM level of non-claim expenses was $145.70. Total member months were 111,689 of which 98.9% were from the individual line of business. At least part of the pricing error was due to Milliman significantly over-estimating the level of 2014 enrollment. For the component of LAHC expenses that were fixed, the impact of this incorrect enrollment estimate would be that they would need to be spread over a fewer number of members. This would result in the significantly higher level of expenses on a per member basis.

101.

When developing expense loads for 2014, Milliman would be guided by Actuarial Standard of Practice (ASOP) No. 8 – Regulatory Filings for Health Benefits, Accident & Health Insurance, and Entities Providing Health Benefits. The following sections of ASOP No. 8 are relevant for LAHC:

- Paragraph 3.4.2 of ASOP No. 8 states that the actuary "should consider the impact of future changes in the underlying covered population on the projected claims. These changes may include, but are not limited to, changes in demographics, risk profile, or family composition."

- Paragraph 3.4.4 of ASOP No. 8 instructs the actuary to "use appropriate methods and assumptions for calculating the non-benefit expenses component of premium rates. Possible methods include, but are not limited to, the use of a target loss ratio or the estimation of expenses appropriately attributed to the health benefit on a percentage of premium or fixed-dollar basis. When estimating the latter amounts, the actuary should consider the health plan entity's own experience, reasonably anticipated internal or external future events, inflation, and business plans. The actuary may also consider relevant external studies. The actuary should consider the reasonableness of the non-benefit expense component of premium rates relative to projected expenses."

102.

While there clearly was uncertainty about the overall size of the overall ACA Marketplace, it was unreasonable for Milliman to assume that LAHC, as an unknown entity in the Louisiana health insurance market, would be able to enroll 28,000 members (20,000 individual and 8,000

small group) in the first year of operation. While assuming a lower level of enrollment would have resulted in higher premiums, Milliman was aware that a significant percentage of the individual enrollment would be receiving government subsidies and thus would have limited sensitivity to pricing differences between the various plans offered on the ACA exchange.

103.

Assuming 100% individual members, the impact of this expense miscalculation is 111,689 times ($145.70 - $70.85), or about $8.4 million.

104.

When developing their estimate of the level of Risk Adjustment ("RA") transfer payments to build into the 2014 premium rates, Milliman assumed that there would be no difference in coding intensity between LAHC and the other insurance carriers in the State of Louisiana. This assumption was not reasonable as Milliman should have known that a small start-up health insurance carrier would be in no position to code claims as efficiently as Blue Cross Blue Shield of Louisiana ("BCBSLA") and other established insurance carriers.

105.

Whatever difference that Milliman assumed as the true morbidity difference between the members that LAHC would enroll and the average state enrollment, it was not reasonable to assume that there would be no difference in claim coding intensity. If Milliman had assumed a lower level of coding intensity for LAHC, this would have resulted in a lower assumed average risk score for LAHC for 2014. As a result, the calculated premiums would have been higher.

106.

When developing estimates of average LAHC risk scores for 2014, Milliman would have been guided by Actuarial Standard of Practice (ASOP) No. 45 – The Use of Health Status Based Risk Adjustment Methodologies. The following sections of ASOP No. 45 are relevant for LAHC with respect to the estimation of relative coding intensity:

- Paragraph 3.2.3 states that "Because risk adjustment model results are affected by the accuracy and completeness of diagnosis codes or services coded, the actuary should consider the impact of differences in the accuracy and completeness of coding across organizations and time periods."

107.

There is no indication that any meaningful assessment of LAHC claim coding capabilities took place by Milliman which resulted in the unreasonable assumption that LAHC's coding efficacy would be the same as larger established health insurance carriers which have years of

experience paying claims optimizing the RA coding for some of those claims under other RA programs such as the long established RA program in the Medicare Advantage product.

108.

In their 2014 rating, Milliman assumed that LAHC would actually receive $3.20 PMPM for the individual line of business and $0.00 for the small group line of business. In actuality, the company was assessed a 2014 RA liability of $7,456,986 and $36,622 for the individual and small group lines of business respectively in June 2015 by the Center for Medicare and Medicaid Services (CMS). If Milliman had used a more reasonable assumption with respect to claim coding intensity, some of this liability would have been built into the 2014 premium rates.

109.

Milliman breached its duty by failing to discharge its duties to LAHC with reasonable care, and to act in accordance with the professional standards applicable to actuaries, by failing to produce a feasibility study that was accurate and reliable, by failing to set premium rates for LAHC that were accurate and reliable, and, in general, by failing to exercise the reasonable judgment expected of professional actuaries under like circumstances.

110.

Milliman's failure to exercise reasonable care, and its failure to act in accordance with the professional standards applicable to actuaries, and its breach of contract, was the legal cause of all of, or substantially all of, LAHC's damages as set forth herein.

Buck

111.

At all relevant times, Buck held itself out as having expertise to provide actuarial services and advice to health insurers like LAHC.

112.

In or around March 2014, Buck was engaged by LAHC to perform "certain actuarial and consulting services" for LAHC, including but not limited to: a review of the actuarial work previously performed by Milliman, "develop cost models to prepare 2015 rates for Public Exchange," "present target rates for review and revision," "review and price new plan designs," and "prepare and submit rate filings and assist" LAHC with "state rate filing" with LDI. Buck's engagement letter was signed by Powers on behalf of LAHC on April 4, 2014, and had an effective date of April 1, 2014. On or about December 1, 2014, this contract was amended, inter alia, to

extend the term of Buck's engagement through November 30, 2015, and provided for an additional fee of $380,000 to be paid to Buck for its actuarial services provided to LAHC.

113.

On or about April 2, 2015, Buck issued its "Statement of Actuarial Opinion" to LAHC which was relied upon by LAHC and used to support its periodic ACA reporting requirements to the federal government. In Buck's actuarial opinion, "the March 2015 pro forma financial report is a reasonable projection of LAHC's financial position, subject to the qualifications noted below." In effect, Buck vouched for LAHC's economic health and continuing viability. Buck's professional opinion was clearly inaccurate and unreliable. LAHC would close its doors about three (3) months after Buck issued its April report, and LAHC would ultimately lose more than approximately $54 million in 2015 alone.

114.

The actuarial work performed by Buck was unreliable, inaccurate, and not the result of careful, professional analysis. Furthermore, upon information and belief, Buck may have been unqualified, given its limited experience with insurers like LAHC, to provide actuarial services to LAHC.

115.

Buck owed a duty to LAHC to exercise reasonable care, and to act in accordance with the professional standards applicable to actuaries in providing its services to LAHC.

116.

When Buck developed individual and small group premium rates for 2015, they essentially disregarded the claim experience that had emerged from the start of LAHC operations on January 1, 2014 until the filing was finalized in August 2014. Buck's explanation for not utilizing the claim experience was that it was not statistically credible. Although the claim data was not fully credible, it was unreasonable for Buck to completely disregard LAHC's claim data and incurred claim estimates that were made for statutory financial reporting.

117.

When analyzing credibility of claim data, the actuary would be guided by Actuarial Standard of Practice (ASOP) No. 25 – Credibility Procedures. ASOP No. 25 discusses the concept of two types of experience:

- Subject experience - A specific set of data drawn from the experience under consideration for the purpose of predicting the parameter under study.

- Relevant Experience - Sets of data, that include data other than the subject experience, that, in the actuary's judgment, are predictive of the parameter under study (including but not limited to loss ratios, claims, mortality, payment patterns, persistency, or expenses). Relevant experience may include subject experience as a subset.

118.

For the 2015 pricing exercise, the Subject Experience would be the LAHC claims data and the Relevant Experience was the manual claim data (obtained from Optum) that Buck used to develop rates for 2015. Buck judgmentally applied, through a credibility procedure, 100% weight to the manual claim data (Relevant Experience) and 0% weight to the actual claim experience of LAHC.

119.

By the time the 2015 rate filing was submitted, LAHC would have already prepared their June 30, 2014 statutory financial statements that reported a level of incurred claims of $23.3 million gross of Cost Sharing Reductions (CSR). This level on claims, on a per capita level, implies that LAHC would need a rate increase in the range of at least 40%. The incurred claim estimate prepared for statutory reporting effectively amounts to a data set of "Subject Experience" that was ignored by Buck.

120.

ASOP No 25 provides the following guidance to actuaries:

- Paragraph 3.2 states that "The actuary should use an appropriate credibility procedure when determining if the subject experience has full credibility or when blending the subject experience with the relevant experience."

- Paragraph 3.4 states that "The actuary should use professional judgment when selecting, developing, or using a credibility procedure."

121.

Buck's professional judgement in this case was to completely disregard the LAHC data that was available because they concluded that it had no predictive value in their credibility procedure. They arrived at this conclusion even though the filed rate increase for 2015 was inconsistent with the necessary rate increase that was implied by the incurred claim estimates reported on the LAHC statutory financial statements.

122.

At the time the 2015 rate filing was submitted in August 2014, there were already claims incurred and paid in the period from 1/1/2014 to 6/30/2014 of $220 PMPM (paid through July 2014) gross of Cost Sharing Reduction subsidies ("CSR"). It was readily apparent that there were

very significant claim adjudication issues with LAHC's TPA and that the actual ultimate level of incurred claims would be significantly higher than $220 PMPM and much higher than Buck's estimate of the manual level of LAHC claims.

123.

Buck underestimated the level of non-claim expenses in 2015. In Buck's 2015 rate development, they assumed that the "per member per month" (PMPM) level of administrative expenses, taxes, and fees (non-claim expenses) would be $96.24 PMPM for the individual line of business. For the small group line of business, the level of non-claim expenses built into the rate development was $96.70 PMPM. Per Buck, the expense load was based on a May 2014 expense budget that was prepared by LAHC.

124.

When developing expense loads for 2015, Buck would be guided by Actuarial Standard of Practice (ASOP) No. 8 – Regulatory Filings for Health Benefits, Accident & Health Insurance, and Entities Providing Health Benefits. The following sections of ASOP No. 8 are relevant for LAHC:

- Paragraph 3.4.2 of ASOP No. 8 states that the actuary "should consider the impact of future changes in the underlying covered population on the projected claims. These changes may include, but are not limited to, changes in demographics, risk profile, or family composition".

- Paragraph 3.4.4 of ASOP No. 8 instructs the actuary to "use appropriate methods and assumptions for calculating the non-benefit expenses component of premium rates. Possible methods include, but are not limited to, the use of a target loss ratio or the estimation of expenses appropriately attributed to the health benefit on a percentage of premium or fixed-dollar basis. When estimating the latter amounts, the actuary should consider the health plan entity's own experience, reasonably anticipated internal or external future events, inflation, and business plans. The actuary may also consider relevant external studies. The actuary should consider the reasonableness of the non-benefit expense component of premium rates relative to projected expenses."

125.

The actual level of expenses in 2015 was moderately higher. On a composite basis, the PMPM level of non-claim expenses was $111.05. Total member months were 165,682 of which 99.4% were from the individual line of business.

126.

When developing their estimate of the level of Risk Adjustment ("RA") transfer payments to build into the 2015 premium rates, Buck assumed that there would be no difference in coding intensity between LAHC and the other insurance carriers in the State of Louisiana. This assumption was not reasonable as Buck should have known that a small start-up health insurance

carrier would be in no position to code claims as efficiently as BCBSLA and other established insurance carriers.

127.

Whatever difference that Buck assumed as the true morbidity difference between the members that LAHC would enroll and the average state enrollment, it was not reasonable to assume that there would be no difference in claim coding intensity. If Buck had assumed a lower level of coding intensity for LAHC, this would have resulted in lower assumed average risk score for LAHC for 2015. As a result, the calculated premiums would have been higher.

128.

In their rate filing, Buck also noted that the average age of the LAHC enrollees was lower than the State of Louisiana average. Since age is component of the risk score calculation, the younger than average population provided some evidence that the average risk score for the LAHC would be lower than the state average. It was not reasonable for Buck to ignore this known difference in member ages between LAHC and the state average.

129.

When developing estimates of average LAHC risk scores for 2014, Buck would be guided by Actuarial Standard of Practice (ASOP) No. 45 – The Use of Health Status Based Risk Adjustment Methodologies. The following sections of ASOP No. 45 is relevant for LAHC with respect to the estimation of relative coding intensity:

- Paragraph 3.2.3 states that "Because risk adjustment model results are affected by the accuracy and completeness of diagnosis codes or services coded, the actuary should consider the impact of differences in the accuracy and completeness of coding across organizations and time periods."

130.

There is no indication that any meaningful assessment of LAHC claim coding capabilities took place by Buck which resulted in the unreasonable assumption that LAHC's coding efficacy would be the same as larger established health insurance carriers which have years of experience paying claims optimizing the RA coding for some of those claims under other RA programs such as the long established RA program in the Medicare Advantage product.

131.

Data Quality is also relevant with respect to Buck ignoring the known demographic data when developing an estimate of the RA transfer payment that should be built into the 2015 rates. Paragraph 3.2 of ASOP No. 23 states "In undertaking an analysis, the actuary should consider

what data to use. The actuary should consider the scope of the assignment and the intended use of the analysis being performed in order to determine the nature of the data needed and the number of Alternative data sets or data sources, if any, to be considered." Because demographic data was available, Buck should have used it to build in some level of RA transfer payment just on that basis alone (without regard for the coding intensity issue).

132.

In their 2015 rating, Buck assumed that LAHC would have a $0 RA transfer payment. In actuality, the company was assessed a 2015 RA liability of $8,658,833 and $177,963 for the individual and small group lines of business respectively in June 2016 by the Center for Medicare and Medicaid Services (CMS). If Buck had incorporated the known demographic information and used a more reasonable assumption with respect to claim coding intensity, some of this liability would have been built into the 2015 premium rates.

133.

Buck breached its duty by failing to discharge its duties to LAHC with reasonable care, and to act in accordance with the professional standards applicable to actuaries, by failing to produce a feasibility study that was accurate and reliable, by failing to set premium rates for LAHC that were accurate and reliable, and, in general, by failing to exercise the reasonable judgment expected of professional actuaries under like circumstances.

134.

Buck's failure to exercise reasonable care, and its failure to act in accordance with the professional standards applicable to actuaries was the legal cause of all of, or substantially all of, LAHC's damages as set forth herein.

Count Five: Negligent Misrepresentation
(Against the Actuary Defendants)

135.

Plaintiff repeats and realleges each and every allegation set forth in the foregoing paragraphs as if fully set forth herein.

Milliman

136.

At all relevant times, Milliman held itself out as having expertise to provide actuarial services and advice to health insurers like LAHC.

137.

At all relevant times, Milliman held a special position of confidence and trust with respect to LAHC.

138.

LAHC justifiably expected Milliman to communicate with care when advising LAHC concerning its funding needs and the appropriate premium for LAHC.

139.

Milliman's advice and/or reports to LAHC and/or LDI and/or CMS concerning LAHC's funding needs negligently misrepresented the actual funding needs and premium rates of LAHC.

140.

Milliman had a duty to provide accurate and up-to-date information to LAHC that Milliman knew or should have known LAHC would rely on in making its decision concerning the amount of premium to charge policyholders.

Buck

141.

At all relevant times, Buck held itself out as having expertise to provide actuarial services and advice to insurers such as LAHC.

142.

At all relevant times, Buck held a special position of confidence and trust with respect to LAHC.

143.

LAHC justifiably expected Buck to communicate with care when advising LAHC concerning its funding needs and the appropriate premium rates for LAHC.

144.

Buck's advice and/or reports to the LAHC and/or LDI and/or CMS concerning LAHC's funding needs negligently misrepresented the actual funding needs and premium rates of LAHC.

145.

Buck had a duty to provide accurate and up-to-date information to LAHC that Buck knew or should have known LAHC would rely on in making its decision concerning the amount of premium to charge policyholders.

PRESCRIPTION AND DISCOVERY OF TORTIOUS CONDUCT

146.

Plaintiff shows that LAHC was adversely dominated by the Defendants named herein, who effectively concealed the bases for the causes of action stated herein. Plaintiff did not discover the causes of action stated herein until well after the Receiver was appointed and these matters were investigated as part of the pending Receivership proceeding. Furthermore, Plaintiff had no ability to bring these actions prior to receiving authority as a result of the Receivership orders entered regarding LAHC. Further, none of the creditors, claimants, policyholders or members of LAHC knew or had any reason to know of any cause of action for the acts and omissions described in this Petition until after LAHC was placed into Receivership.

147.

Plaintiff further shows that the activities of the Defendants named herein constituted continuing torts which began in 2011 and continued unabated until shortly before LAHC was placed into Receivership, or at least in the case of GRI, continued until its services were terminated by LAHC in May 2016.

148.

Applicable statutes of limitations and prescriptive/peremptive periods did not commence as to Plaintiff until shortly before LAHC was placed into Receivership, at the earliest.

149.

Further, according to applicable Louisiana law, once the Commissioner of Insurance filed suit seeking an order of rehabilitation regarding LAHC on September 1, 2015, the running of prescription and preemption as to all claims in favor of LAHC was immediately suspended and tolled during the pendency of the LAHC Receivership proceeding; La.R.S. 22:2008(B).

JURY DEMAND

150.

Plaintiff is entitled to and hereby demands a trial by jury on all triable issues.

[REMAINDER OF PAGE INTENTIONALLY LEFT BLANK]

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, James J. Donelon, Commissioner of Insurance for the State of Louisiana in his capacity as Rehabilitator of Louisiana Health Cooperative, Inc., through his duly appointed Receiver, Billy Bostick, prays and demands that the following Defendants named herein, CGI Technologies and Solutions, Inc., Group Resources Incorporated, Beam Partners, LLC, Milliman, Inc., Buck Consultants, LLC, Allied World Specialty Insurance Company a/k/a Darwin National Assurance Company, Atlantic Specialty Insurance Company, Evanston Insurance Company, RSUI Indemnity Company, and Zurich American Insurance Company, be cited to appear and answer, and that upon a final hearing of the cause, judgment be entered against Defendants and in favor of Plaintiff for all compensable damages in an amount reasonable in the premises, including:

a. All compensatory damages allowed by applicable law caused by Defendants' actionable conduct;

b. the recovery from Defendants of all administrative costs incurred as a result of the necessary rehabilitation and/or liquidation proceedings;

c. all fees, expenses, and compensation of any kind paid by LAHC to the D&O Defendants, Beam Partners, CGI, GRI, Milliman, and Buck;

d. all recoverable costs and litigation expenses incurred herein;

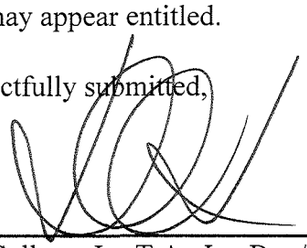
e. all judicial interest;

f. any and all attorneys' fees recoverable pursuant to statute and/or contract;

g. any and all equitable relief to which Plaintiff may appear properly entitled; and

h. all further relief to which Plaintiff may appear entitled.

Respectfully submitted,



J. E. Cullens, Jr., T.A., La. Bar #23011
Edward J. Walters, Jr., La. Bar #13214
Darrel J. Papillion, La. Bar #23243
David Abboud Thomas, La. Bar #22701
Jennifer Wise Moroux, La. Bar #31368
WALTERS, PAPILLION, THOMAS, CULLENS, LLC
12345 Perkins Road, Bldg One
Baton Rouge, LA 70810
Phone: (225) 236-3636
Facsimile: (225) 236-3650

[SERVICE INFORMATION ON FOLLOWING PAGES]

PLEASE SERVE A COPY OF:

THE PETITION FOR DAMAGES AND JURY DEMAND
AND
THE FIRST SUPPLEMENTAL, AMENDING AND RESTATED PETITION
AND
THE SECOND SUPPLEMENTAL, AMENDING AND RESTATED PETITION

UPON THE FOLLOWING DEFENDANTS:

ALLIED WORLD SPECIALTY INSURANCE COMPANY a/k/a DARWIN NATIONAL ASSURANCE COMPANY

ATLANTIC SPECIALTY INSURANCE COMPANY

EVANSTON INSURANCE COMPANY

RSUI INDEMNITY COMPANY

ZURICH AMERICAN INSURANCE COMPANY

All through their agent for service of process:

The Louisiana Secretary of State
8585 Archives Avenue
Baton Rouge, LA 70809

PLEASE SERVE A COPY OF:

THE SECOND SUPPLEMENTAL, AMENDING AND RESTATED PETITION

UPON THE FOLLOWING DEFENDANTS:

CGI TECHNOLOGIES AND SOLUTIONS, INC.
VIA LONG ARM SERVICE
Through its agent for service of process:
Corporation Service Company
2711 Centerville Road
Suite 400
Wilmington, DE 19808

GROUP RESOURCES INCORPORATED
VIA LONG ARM SERVICE
Through its agent for service of process:
Philip H. Weener
5887 Glendridge Drive
Suite 275
Atlanta, GA 30328

BEAM PARTNERS, LLC
VIA LONG ARM SERVICE
Through its agent for service of process:
Terry Shilling
2451 Cumberland Parkway, #3170
Atlanta, GA 30339

MILLIMAN, INC.
VIA LONG ARM SERVICE
Through its agent for service of process:
CT Corporation System
505 Union Avenue SE
Suite 120
Olympia, WA 98501

BUCK CONSULTANTS, LLC
VIA LONG ARM SERVICE
Through its agent for service of process:
Corporation Service Company
2711 Centerville Road
Suite 400
Wilmington, DE 19808

CERTIFICATE OF SERVICE

In addition to requesting service on the previously named defendants as directed on the prior page, undersigned counsel hereby certifies that the following counsel of record have been served this date pursuant to La.C.C.P. art. 1313 by transmitting a copy of the SECOND SUPPLEMENTAL, AMENDING AND RESTATED PETITION FOR DAMAGES AND REQUEST FOR JURY TRIAL by electronic means to the following defense counsel:

Harry (Skip) J. Philips, Jr.
Taylor Porter
Post Office Box 2471
Baton Rouge, LA 70821
Skip.philips@taylorporter.com

W. Brett Mason
Stone Pigman
301 Main Street, #1150
Baton Rouge, LA 70825
bmason@stonepigman.com

James A. Brown
Liskow & Lewis
One Shell Square
701 Poydras Street, #5000
New Orleans, LA 70139
jabrown@liskow.com

V. Thomas Clark, Jr.
Adams and Reese, LLP
450 Laurel Street
Suite 1900
Baton Rouge, LA 70801
Tom.clark@arlaw.com

Frederic Theodore 'Ted' Le Clercq
Deutsch Kerrigan, LLP
755 Magazine Street
New Orleans, LA 70130
ted@deutschkerrigan.com

Baton Rouge, Louisiana this 25th day of October, 2017.

J. E. Cullens, Jr.

June 19, 2014

Greg Cromer
CEO
Louisiana Health Cooperative, Inc.
3445 N Causeway Blvd
Metairie, LA 70002

Re: Termination of Administrative Services Agreement

Dear Greg:

I am writing to memorialize our agreement regarding termination of the Administrative Services Agreement (the "Original Agreement") between the Louisiana Health Cooperative, Inc. ("LAHC") and CGI Technologies and Solutions Inc. ("CGI") dated February 15, 2013. Once executed by you in the space provided, this letter agreement (this "Letter Agreement") shall be effective on the date of such execution and shall constitute an amendment to the Original Agreement. In the event of conflict between the terms of this Letter Agreement and the Original Agreement, the terms of this Letter Agreement shall control.

1. For the convenience of LAHC, the Original Agreement shall terminate on April 30, 2014. CGI shall continue to perform the Delegated Functions through April 30, 2014, to be followed by a six month wind-down period as specified in Section 2.5 of the Original Agreement. For the six month wind-down period, CGI shall provide such wind-down services as the parties may agree in a wind-down plan, all in accordance with Sections 2.5 and 2.5.1 of the Original Agreement.

2. LAHC shall pay all CGI invoices issued to date. CGI shall also be compensated for performance of the Delegated Functions prior to termination of the Original Agreement in accordance with Exhibit 1 to the Original Agreement. The general scope and structure of the wind down period is as specified in Attachment 1 to this Letter Agreement. CGI's compensation for services during the wind-down period shall be a fixed price of $75,000 per month for May and $60,000 per month for June and at LAHC direction on a time-and-materials basis July through October. In addition to CGI's compensation for performing Delegated Services during the wind-down period, LAHC will continue to pay Healthation (Aldera) Access Fees and direct expenses in accordance with Exhibit 1 of the Original Agreement . CGI waives all deferred implementation fees specified in Section 1 of Exhibit 1 to the Original Agreement (i.e., those implementation fees payable on December 31 of 2014, 2015 and 2016). LAHC waives all interest on late paid claims specified in Section 1.6 of Exhibit 2 to the Original Agreement.

3. No Service Level Credits shall be assessed for failures to meet one or more Service Level Specifications effective March 1, 2014. During the wind-down period, CGI will make commercially reasonable efforts to perform the Delegated Functions in accordance with the Service Level Specifications set forth in Section 6 in Exhibit 1 to the Original Agreement, but no additional CGI personnel will be assigned to the LAHC account for purposes of improving CGI's performance.

4. Neither party hereto will make any statement to any third party that disparages the other party's performance under the Original Agreement, nor will either party make statement to any third party that disparages any person or persons involved in the performance of the Original Agreement. LAHC will also

provide to CGI a reasonably complimentary letter of reference that CGI may use at its discretion in future efforts to secure new business.

5. Except for obligations assumed herein, LAHC and CGI hereby release each other, and their respective directors, officers, agents, employees, representatives, insurers, parents and subsidiaries, from any and all claims that either may have against the other arising out of or relating to the Original Agreement. Greg, , if the foregoing accurately states our agreement to amend the Original Agreement, please sign below in the space provided (two signed originals enclosed) and return one fully executed original to me.

Sincerely,

David L. Henderson
Senior Vice President
CGI Technologies and Solutions Inc.

SO AGREED:

Greg Cromer
CEO
Louisiana Health Cooperative, Inc.

6/19/2014
Date

Attachment 1 – Wind Down Period Services

1. **May and June 2014**

From May 1 to June 30, CGI will perform the Delegated Services as well as the following in-scope transition services, which will be further defined and mutually agreed in the more detailed Transition Plan;

In Scope

- Membership data transfer to GRI as follows:
  - Aldera Member Extract file, delivered initially at 6/1 and finally at 7/1
- Enrollment data transfer to GRI as follows:
  - 834 EDI files received from FFM, files received between 6/1 and 7/1
  - Effectuation EDI files sent to FFM, files sent between 6/1 and 7/1
  - Spreadsheets received from LAHC reflecting Bswift off-exchange enrollments, files received between 6/1 and 7/1
- Paid claim data transfer to GRI as follows:
  - TBD
- Pended and/or in-flight claim data transfer to GRI as follows:
  - TBD
- Compilation and hand-over of all Aldera and CGI file server records back to 10/1/13 where retention is required by law or regulation and/or essential for GRI continued operation, as listed and agreed with LAHC, as of the record date that all CGI processing terminates; destruction of all other records not listed and agreed with LAHC as soon as all CGI processing terminates
- Other data transfer as the parties agree

Not in Scope

- Completion of delivery of any intended system or interworking functionality not already operational at 5/16, except as the parties agree in advance
- Provider data updates or contract price/fee schedule updates, except as CGI determines helpful or necessary for claims processing
- Processing of any claims received after 6/8, regardless of service date
- Processing of member billings and associated payments for enrollments or enrollment modifications with an effective date of 7/1 or later
- Mailing of ID cards or welcome kits to paid-thru members with an effective date of 7/1 or later; the final mailing to be no later than GRI's initial bulk mailing of new ID cards
- Health Risk Assessment processing after 5/31
- FFM or other 3rd party system data reconciliation beyond 6/30

2. July to October 2014

Beginning July 1, CGI will perform all services on a Time and Materials basis, at the request of LAHC, using the rates in the table below. LAHC will make requests in writing and CGI will provide an estimate for approval by LAHC before any work is performed.

Role	Rate per Hour
Data Analyst Sr.	120.00
Data Analyst Jr.	100.00
Claim Supervisor	60.00
Project Manager	120.00
Claim Examiner or Customer Service Rep	35.00
Expenses	As Agreed

19TH JUDICIAL DISTRICT COURT FOR THE PARISH OF EAST BATON ROUGE

STATE OF LOUISIANA

NO.: 651,069 SECTION 22

JAMES J. DONELON, COMMISSIONER OF INSURANCE

FOR THE STATE OF LOUISIANA, IN HIS CAPACITY AS REHABILITATOR OF LOUISIANA HEALTH COOPERATIVE, INC.

VERSUS

TERRY S. SHILLING, GEORGE G. CROMER, WARNER L. THOMAS, IV, WILLIAM A. OLIVER, CHARLES D. CALVI, PATRICK C. POWERS, CGI TECHNOLOGIES AND SOLUTIONS, INC., GROUP RESOURCES INCORPORATED, BEAM PARTNERS, LLC, MILLIMAN, INC., BUCK CONSULTANTS, LLC, AND TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA

FILED: _____ _____

DEPUTY CLERK

AFFIDAVIT OF DAVID R. GODOFSKY

Commonwealth of Virginia

BEFORE ME, the undersigned Notary, duly commissioned and qualified in and for the Commonwealth of Virginia, personally came and appeared David R. Godofsky, who, upon being duly sworn, did depose and attest as follows:

1. I, David R. Godofsky, am a person of the full age of majority who is serving as co-counsel *pro hac vice* for defendant Buck Global, LLC (previously known as Buck Consultants, LLC) ("Buck") in the above-captioned case. I have reviewed the pleadings

EXHIBIT B

and briefs filed in this case and am familiar with the issues raised this case. I have personal knowledge of the following genuine, material factual issues for which discovery is necessary and should be granted before the Court addresses Plaintiff's Motion for Partial Summary Judgment Regarding "Regulator Fault" or "Receiver Fault" Defenses:

- Whether, and the extent to which, Louisiana Department of Insurance ("LDI") personnel analyzed and reviewed Buck's actuarial reports. If so, did they conclude Buck's methodology was reasonable and sound, contradicting Plaintiff's allegations that Buck negligently prepared those reports and that its reports misled the LDI?
- Whether, and the extent to which, the LDI's consulting actuaries analyzed and reviewed Buck's actuarial reports. If so, did they conclude Buck's methodology was reasonable and sound, contradicting Plaintiff's allegations that Buck negligently prepared those reports and that its reports misled the LDI?
- Or whether the LDI and/or its consulting actuaries failed to review or rely upon Buck's actuarial reports, in which case the LDI could not have been misled.
- What actions did the LDI take based on Buck's reports that give rise to liability for Buck, and do those acts establish that the LDI was not misled by anything Buck said or did?
- Whether the Commissioner, as Rehabilitator's, post-rehabilitation acts or omissions contributed to the total, undifferentiated loss that he seeks to recover in this case. What acts or omissions of the Commissioner, as Rehabilitator, contributed to that loss, and in what amount?

2. Further affiant sayeth not.

David R. Godofsky, Affiant

SWORN TO and subscribed before me, Notary,

on the 5th day of November, 2020, in

Fairfax County, Commonwealth of Virginia

PARCHELLE D MATTHEWS
NOTARY PUBLIC
COMMONWEALTH OF VIRGINIA
MY COMMISSION EXPIRES JULY 31, 2023
COMMISSION # 7589736

NOTARY PUBLIC