APPENDIX

EXHIBIT A

Supreme Court of Louisiana

FOR IMMEDIATE NEWS RELEASE NEWS RELEASE #014

FROM: CLERK OF SUPREME COURT OF LOUISIANA

The Opinion(s) handed down on the **27th day of April, 2020** are as follows:

BY Crain, J.:

2019-C-00514 JAMES J. DONELON, COMMISSIONER OF INSURANCE FOR THE STATE OF LOUISIANA, IN HIS CAPACITY AS REHABILITATOR OF LOUISIANA HEALTH COOPERATIVE, INC. VS. 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)

We granted this writ to determine whether the Louisiana Commissioner of Insurance, as rehabilitator of a health insurance cooperative, in an action arising out of an agreement between the cooperative and a third-party contractor, is bound by an arbitration clause in that agreement. We find the Commissioner not bound by the arbitration clause.

REVERSED AND REMANDED.

Retired Judge James H. Boddie, Jr., appointed Justice ad hoc, sitting for Justice Marcus R. Clark.

Weimer, J., concurs and assigns reasons.

04/27/20

SUPREME COURT OF LOUISIANA

No. 2019-C-00514

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

VS.

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

ON WRIT OF CERTIORARI TO THE COURT OF APPEAL, FIRST CIRCUIT, PARISH OF EAST BATON ROUGE

CRAIN, J.[1]

We granted this writ to determine whether the Louisiana Commissioner of Insurance, as rehabilitator of a health insurance cooperative, in an action arising out of an agreement between the cooperative and a third-party contractor, is bound by an arbitration clause in that agreement. We find the Commissioner not bound by the arbitration clause.

BACKGROUND

The facts critical to resolving this issue are not disputed. The Louisiana Health Cooperative, Inc. ("LAHC"), a health insurance cooperative created in 2011 pursuant to the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq.* (2010), entered an agreement with Milliman, Inc. for actuarial and other services. By July 2015, the LAHC was out of business and allegedly insolvent.

Louisiana Insurance Commissioner James J. Donelon ("Commissioner"), through the Deputy Commissioner of Financial Solvency, filed suit in the Nineteenth

[1] Retired Judge James Boddie, Jr., appointed Justice ad hoc, sitting for Justice Clark.

Judicial District Court seeking a permanent order of rehabilitation relative to the LAHC. The district court entered an order confirming the Commissioner as rehabilitator and vesting him with authority to enforce contract performance by any party who had contracted with the LAHC.

The Commissioner then sued multiple defendants in the Nineteenth Judicial District Court, asserting claims against Milliman for professional negligence, breach of contract, and negligent misrepresentation. According to that suit, the acts or omissions of Milliman caused or contributed to the LAHC's insolvency.

Milliman responded by filing a declinatory exception of lack of subject matter jurisdiction, arguing the Commissioner must arbitrate his claims pursuant to an arbitration clause in the agreement between the LAHC and Milliman.[2] The Commissioner contended he is not bound by the arbitration clause and, pursuant to Louisiana Revised Statutes 22:257(F), exclusive jurisdiction for the claims against Milliman rests in the Nineteenth Judicial District Court.[3]

The district court denied Milliman's exception. The court of appeal reversed, treating Milliman's exception as an exception of prematurity and sustaining it, thus requiring the Commissioner to arbitrate his claims. *Donelon v. Shilling*, 2017-1545 (La. 2/28/19), 2019 WL 993328 (unpublished).

The Commissioner now makes several arguments for reversing the court of appeal. He argues a choice-of-law provision dictates that New York law applies,

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[2] Section 4 of the agreement provides "any dispute arising out of or relating to the engagement of Milliman by [the LAHC] … will be resolved by final and binding arbitration under the Commercial Arbitration Rules of the American Arbitration Association." We note that the American Arbitration Association administers the case, but the applicable arbitration law is the Federal Arbitration Act (9 U.S.C. § 1 *et seq.*) because the FAA applies to all arbitrations "involving [interstate] commerce." *Allied-Bruce Terminix Cos. v. Dobson*, 513 U.S. 265, 115 S.Ct. 834, 130 L.Ed.2d 753 (1995). Milliman is domiciled in Washington and the LAHC in Louisiana; therefore, interstate commerce is involved.

[3] Louisiana Revised Statutes 22:257(F) provides:

> The commissioner is specifically empowered to take over and liquidate the affairs of any health maintenance organization experiencing financial difficulty at such time as he deems it necessary by applying to the Nineteenth Judicial District Court for permission to take over and fix the conditions thereof. The Nineteenth Judicial District Court shall have exclusive jurisdiction over any suit arising from such takeover and liquidation. The commissioner shall be authorized to issue appropriate regulations to implement an orderly procedure to wind up the affairs of any financially troubled health maintenance organization.

which law prohibits enforcement of arbitration agreements in contracts with insolvent insurers in either liquidation or rehabilitation. If state law applies, the Commissioner avers it reverse preempts the Federal Arbitration Act pursuant to the McCarran-Ferguson Act, 15 U.S.C. §§ 1011, *et. seq.* He also asserts the Nineteenth Judicial District Court has exclusive jurisdiction, points to policy reasons to distinguish himself, as rehabilitator, from the LAHC when enforcing the contract, and contends the court of appeal incorrectly applied the direct-benefits estoppel doctrine to enforce the arbitration clause.

ANALYSIS

We must determine whether the Commissioner can be compelled to arbitrate pursuant to an arbitration clause in an agreement to which he is not a party. Critical to this determination is the source of the Commissioner's authority to enforce the contract. To the extent the source is statutory, private parties have a limited ability to contractually interfere.

Louisiana Constitution Article IV, Section 11, provides, "There shall be a Department of Insurance, headed by the commissioner of insurance. The department shall exercise such functions and the commissioner shall have powers and perform duties authorized by this constitution or provided by law." The drafters of the constitution chose to leave the task of defining the powers and duties of the Commissioner to the legislature. *See Wooley v. State Farm Fire & Cas. Ins. Co*., 2004-882 (La. 1/19/05), 893 So. 2d 746, 767, ("Ultimately, [the 1973 Constitutional Convention delegates] voted not to designate any powers and duties in the constitution and to allow the legislature to specify the Commissioner's powers and duties.") The legislature then enacted, in Chapter 9 of the Insurance Code, the Louisiana Rehabilitation, Liquidation, Conservation Act ("RLCA"), La. R.S. 22: 2001, *et seq.*, comprehensively setting forth the Commissioner's rights and obligations relative to insolvent insurers.

Louisiana Revised Statutes 22:2008[4] and 2009[5] generally give the Commissioner the right to enforce the contracts of an insolvent insurer. Louisiana Revised Statutes 22:2004(A) governs where the Commissioner may bring an action to enforce such contracts, providing, in pertinent part: "[a]n action under this Chapter brought by the commissioner of insurance, in that capacity, or as conservator, rehabilitator, or liquidator may be brought in the Nineteenth Judicial District Court for the parish of East Baton Rouge or any court where venue is proper under any other provision of law."[6]

This suit related to the contract between the LAHC and Milliman is "an action brought under [the RLCA]" by "the commissioner of insurance . . .as rehabilitator." The plain language of Louisiana Revised Statutes 22:2004(A) grants authority for the Commissioner to bring such an action in the Nineteenth Judicial District Court or any *court* where venue is proper. The statute permits the Commissioner to choose where and how to litigate an action. By using the permissive "may," the statute does not foreclose the option of arbitration, if provided in a contract, but effectively delegates the choice to the Commissioner. We hold that Louisiana Revised Statutes

[4] Louisiana Revised Statutes 22:2008 provides in pertinent part:

> A. After a full hearing, which shall be held by the court without delay, the court shall enter an order either dismissing the petition or finding that sufficient cause exists for rehabilitation or liquidation and directing the commissioner of insurance to take possession of the property, business, and affairs of such insurer and to rehabilitate or liquidate the same as the case may be. The commissioner of insurance shall be responsible on his official bond for all assets coming into his possession. The commissioner of insurance and his successor and successors in office shall be vested by operation of law with the title to all property, contracts, and rights of action of the insurer as of the date of the order directing rehabilitation or liquidation.

[5] Louisiana Revised Statutes 22:2009 provides in pertinent part:

> A. Upon the entry of an order directing rehabilitation, the commissioner of insurance shall immediately proceed to conduct the business of the insurer and take such steps towards removal of the causes and conditions which have made such proceedings necessary as may be expedient.

[6] Louisiana Revised Statutes 22:2004 is titled "Venue." An arbitration clause has been characterized by this court as a type of venue selection clause. See *e.g. Hodges v. Reasonover*, 2012-0043 (La. 7/2/12), 103 So.3d 1069, 1076 ("An arbitration clause does not inherently limit or alter either party's substantive rights; it simply provides for an alternative venue for the resolution of disputes.")

22:2004(A) is an express grant of authority for the Commissioner to bring this suit in court, rather than arbitration.

This holding is consistent with the purpose and spirit of the RLCA. The Commissioner is a protector of public interests, and the legislature designed the statutory scheme to ensure the protection of such interests. Louisiana Revised Statutes 22:2(A)(1) provides, in pertinent part: "Insurance is an industry affected with the public interest and it is the purpose of this Code to regulate that industry in all its phases. Pursuant to the authority contained in the Constitution of Louisiana, the office of the commissioner of insurance is created. It shall be the duty of the commissioner of insurance to administer the provisions of this Code." The Commissioner's role is aptly described in *LeBlanc v. Bernard*, 554 So. 2d 1378, 1381 (La. App. 1 Cir. 1989), *writ denied*, 559 So. 2d 1357 (La. 1990):

> The Commissioner of Insurance as rehabilitator or liquidator owes an overriding duty to the people of the State of Louisiana. The *raison d'etre* of his office is because the insurance industry is "affected with the public interest." La. R.S. 22:2. Any duties imposed upon that office, therefore, must be performed with the public interest foremost in mind. The Commissioner's responsibilities as rehabilitator or liquidator include, additionally, protection of the policyholders, creditors, and the insurer itself. *Republic of Texas Savings Assoc. v. First Republic Life Ins. Co.*, 417 So. 2d 1251, 1254 (La. App. 1 Cir.) *writ denied*, 422 So.2d 161 (La. 1982).
>
> This court has previously held that defendant, as rehabilitator, "does not stand precisely in the shoes of First Republic." *Id.*

Also supportive of our interpretation is Louisiana Revised Statutes 22:2004(C), which provides: "If an action is filed in more than one venue, the court *shall consolidate* all such cases into one court where venue is proper." Both this statutory requirement for consolidation and the Commissioner's authority to enforce contracts in the venue of his choice promote the efficient and cohesive management of the affairs of insolvent insurers, which is a matter of substantial public interest.

The Commissioner urges that Louisiana Revised Statutes 22:257(F) vests "exclusive jurisdiction" for this action in the Nineteenth Judicial District Court.

However, this statute applies only to the "*takeover and liquidation* of a health maintenance organization." The subject suit arises from the rehabilitation of the LAHC, not its liquidation.[7] Nevertheless, Louisiana Revised Statutes 22:257(F) does support our view of the RLCA as a comprehensive statutory scheme facilitating the Commissioner's management of insolvent insurers. Specifically, the statute aligns with Louisiana Revised Statutes 22:2009, which allows the Commissioner to convert a rehabilitation proceeding to liquidation when he deems it necessary. Thus, the Commissioner may choose the Nineteenth Judicial District Court to bring an action as rehabilitator, then convert from rehabilitation to liquidation where the Nineteenth Judicial District Court's jurisdiction is mandatory. Louisiana Revised Statutes 22:2004(C)'s use of "one court" likewise facilitates the transition between these different types of receivership.

The ability of the Commissioner to seek to enjoin interference with rehabilitation proceedings is also part of the statutory scheme and reinforces the Commissioner's authority to choose a court as the forum to proceed. Louisiana Revised Statutes 22:2006 grants the court "jurisdiction over matters brought by . . . the commissioner of insurance . . .to issue an injunction." Louisiana Revised Statutes 22:2007(D) then provides, "The court having jurisdiction over a proceeding under this Chapter [the RLCA] shall have the authority to issue such orders, including injunctive relief, as appropriate, for the enforcement of this Section [delinquency proceeding or any investigation related to the insolvency proceeding]." An arbitrator is not typically empowered to issue injunctive relief. *Horseshoe Entm't v. Lepinski*,

[7] As part of a comprehensive statutory scheme relating to the management of insolvent insurers, the legislature has purposefully distinguished between "liquidation" and "rehabilitation." Thus, Louisiana Revised Statutes 22:257(F) does not directly apply to the commissioner as rehabilitator. This legislative distinction is evidenced in Louisiana Revised Statutes 22:2008 (providing for the suspension of prescription when the commissioner seeks a rehabilitation order, but interruption if he seeks an order of liquidation); Louisiana Revised Statutes 22:2009 (providing for the commissioner of insurance to immediately proceed to conduct the business of the insurer as rehabilitator and also providing for the conversion from rehabilitation to liquidation when necessary*)*; Louisiana Revised Statutes 22:2010 (providing for the commissioner to proceed to liquidate the property, business, and affairs of the insurer.)

40,753 (La. App. 2 Cir. 3/8/06), 923 So. 2d 929, 936, *writ denied*, 2006-0792 (La. 6/2/06), 929 So. 2d 1259.

Both parties have argued extensively that the contract controls. Particularly, they contend resolution of the arbitrability issue hinges on the parties' contractual intent relative to an apparent conflict between a New York choice of law provision and the arbitration clause. However, to the extent the agreement seeks to alter a statutory right granted to the Commissioner, the parties' intent is not determinative. Where the legislature, through positive law, empowers the Commissioner to bring an action in court, private parties cannot contract to deprive him of that right. *See* La. C.C. art. 1971 (parties are free to contract for any object that is *lawful*, possible, and determined or determinable.)[8] The court in *Brown v. Associated Ins. Consultants, Inc.*, 97-1396 (La. App. 1 Cir. 6/29/98), 714 So. 2d 939, 942 noted:

> This statutory scheme for the liquidation and/or rehabilitation of insurers is comprehensive and exclusive in scope. . . .
>
> Moreover, any attempt. . . to enjoin the Commissioner (through the appointed liquidator) from performing his role as liquidator would clearly violate the exclusivity of the rehabilitation scheme provided by law.

Because Louisiana Revised Statutes 22:2004(A) grants the Commissioner the right to choose the forum for his action, a private agreement depriving him of that right, "would clearly violate the exclusivity of the rehabilitation scheme." *Brown*, 714 So.2d 942. Consequently, the parties' intent is not relevant and we pretermit any analysis of the allegedly conflicting provisions in the agreement.

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[8] *See also Louisiana Smoked Prod., Inc. v. Savoie's Sausage & Food Prod., Inc.*, 96-1716 (La. 7/1/97), 696 So. 2d 1373, 1380–81 ("In a free enterprise system, parties are free to contract except for those instances where the government places restrictions for reasons of public policy. The state may legitimately restrict the parties' right to contract if the proposed bargain is found to . . . contravene some . . . matter of public policy.") *See Bernard v. Fireside Commercial Life Ins. Co.*, 633 So. 2d 177, 185 (La. App. 1 Cir. 1993), ("Louisiana has enacted a statutory scheme specifically designed for insurance insolvency, which takes precedence over general law to the extent that the general law is inconsistent with the provisions or purpose of the comprehensive, statutory scheme.") By statutorily addressing insurance insolvency, general contract law is overridden to the extent it is inconsistent with the RLCA, or the purposes behind it. *Crist v. Benton Casing Serv.*, 572 So. 2d 99, 102 (La. App. 1 Cir. 1990), *writ denied*, 573 So. 2d 1143 (La. 1991).

Similarly, we find it unnecessary to address the doctrine of direct benefits estoppel and its effect on the Commissioner as a non-signatory to the agreement.[9] This jurisprudentially created type of estoppel is an equitable remedy. *Courville*, 218 So.3d at 148. Equitable remedies are only available in the absence of legislation and custom. La.Civ.Code art. 4. Because an express grant of authority exists in favor of the Commissioner, resort to equity is unwarranted. *See Gulf Refining Co.*, 171 So.2d 846, 854 (1936).

Our holding that Louisiana law allows the Commissioner to decline binding arbitration does not dispose of the issue entirely. We must now determine if the FAA, the applicable federal arbitration law, preempts Louisiana law, thus compelling arbitration. By operation of the Supremacy Clause in the United States Constitution, we acknowledge the FAA preempts inconsistent state law. 9 U.S.C. § 1, *et seq.*; U.S. Const. art. VI, Clause 2. Louisiana Revised Statutes 22:2004(A) is arguably inconsistent with the FAA, which favors arbitration. However, the Commissioner argues state law reverse preempts the FAA by virtue of the McCarran-Ferguson Act. McCarran-Ferguson exempts from federal preemption state laws enacted "for the purpose of regulating the business of insurance." 15 U.S. § 1012. Congress has mandated that "[t]he business of insurance, and every person engaged therein, shall be subject to the laws of . . . States which relate to the regulation . . . of such business." *Id.* at 1012(a). No federal law "shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance." *Id.* at 1012(b).

[9] Direct benefits estoppel prevents a non-signatory from escaping the effects of an arbitration clause when he knowingly exploits and receives a benefit from the agreement containing the arbitration clause. *See Courville v. Allied Professionals Insurance Co.*, 2016-1354 (La. App. 1 Cir. 4/12/17), 218 So.3d 144, 148, n.3, *writ denied*, 2017-0783 (La. 10/27/17), 228 So.3d 1223.

Courts have adopted a three-part test to determine when a state law, through application of McCarran-Ferguson, reverse preempts federal law: (1) when the federal statute is not specifically related to the insurance business, (2) when the state statute was enacted to regulate insurance, and (3) when application of the federal statute would invalidate, impair, or supersede the state statute. *Am. Bankers Ins. Co. of Fla. v. Inman*, 436 F.3d 490, 493 (5th Cir. 2006).

The FAA does not specifically relate to "the business of insurance." *Id.* Thus, the first test for reverse preemption is satisfied.

Next is whether Louisiana Revised Statutes 22:2004(A) was enacted "for the purpose of regulating the business of insurance." *Id.* The Commissioner persuasively argues Louisiana's comprehensive statutory scheme for handling insolvent insurers, including the right to choose the forum for actions brought by him as rehabilitator, serves the purpose of regulating the business of insurance and is within the scope of McCarran-Ferguson. *See Munich Am. Reinsurance Co. v. Crawford*, 141 F.3d 585, 591 (5th Cir. 1998).

In *Munich* the court considered whether Oklahoma law governing insurance company delinquency proceedings reverse preempted the FAA. Oklahoma, like most states, enacted its insurance regulatory scheme under the "shield provided by the McCarran-Ferguson Act." *Id.*, citing *Harford Cas. Ins. Co. v. Corococan*, 807 F.2d 38, 43 (2d Cir.1986). Oklahoma courts, as the "primary expositors of Oklahoma law and public policy, have expressly declared that Oklahoma's Insurers Liquidation Act is designed to protect the public in general, and *policyholders of an insolvent insurer in particular*." *Id.* at 592. The court ultimately held the provisions of the insurance insolvency scheme were enacted for the purpose of regulating the

business of insurance and reverse preempted the FAA, thus exempting the Oklahoma insurance commissioner from arbitration. [10]

The *Munich* court relied heavily on *Stephens v. American Int'l Ins. Co.*, 66 F.3d 41 (2d Cir.1995), which found an anti-arbitration provision in Kentucky's Insurance Rehabilitation and Liquidation Law was enacted to regulate the business of insurance and was not preempted by the FAA. The *Stephens* court reasoned the Kentucky liquidation scheme protects policyholders by "assuring that an insolvent insurer will be liquidated in an orderly and predictable manner and the anti-arbitration provision is simply one piece of that mechanism." *Stephens*, 66 F.3d at 45.

Although not binding on us, we are persuaded by these federal court decisions. While *Munich* and *Stephens* involved liquidation, not rehabilitation, the distinction is immaterial when considering the overall statutory scheme, as both are legal devices used by the Commissioner to manage insolvent insurers. Similar to Oklahoma and Kentucky, Louisiana's RLCA was enacted for the purpose of regulating the business of insurance. Louisiana Revised Statutes 22:2004(A), is part of the RLCA. La. R.S. 22:2001, *et seq.* Section 2004(A) authorizes the Commissioner to select the forum for "all actions under [the RLCA] brought by the commissioner . . .as rehabilitator." Section 2008 gives the Commissioner "title to all property, contracts, and rights of action of the insurer." Section 2009 mandates that the Commissioner "proceed to conduct the business of the insurer." This statutory scheme for rehabilitation and liquidation of insurers is comprehensive and

[10] The *Munich* court utilized a three-part test set forth in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129, 102 S.Ct. 3002, 73 L.Ed.2d 647 (1982) to evaluate whether the Oklahoma law regulated the business of insurance: (1) "whether the practice in question has the effect of transferring or spreading a policyholder's risk;" (2) "whether the practice is an integral part of the policy relationship between the insurer and the insured;" and (3) "whether the practice is limited to entities within the insurance industry." The court in *Pierno* noted that no single factor is determinative, but examination of all the factors may lead to the conclusion that a state law regulates the "business of insurance." *Id.* The *Munich* court found Oklahoma's comprehensive regulatory scheme sufficient to satisfy at least two of three *Pireno* factors: "First, it is crucial to the relationship between the insurance company and its policyholders for both parties to know that, in the event of insolvency, the insurance company will be liquidated in an organized fashion." *Munich*, 141 F.3d 585 (1998). Second, the court found the liquidation scheme limited, by its nature, to entities in the insurance industry. "It does not apply to insolvent companies generally, but only to insolvent insurance companies." *Id*. The same factors are met relative to Louisiana's comprehensive regulatory scheme.

exclusive in scope. *Brown v. Associated Ins. Consultants, Inc.*, 97-1396 (La. App. 1 Cir. 6/29/98), 714 So. 2d 939, 942. It balances the interests of policyholders, creditors, and claimants. *LeBlanc v. Bernard*, 554 So. 2d at 1383–84. It was enacted to regulate insurance "in the public interest." La. R.S. 22:2(A)(1). Section 2004 is part of a coherent policy to address that interest. *Health Net, Inc. v. Wooley*, 534 F.3d 487, 496 (5th Cir. 2008).

Milliman argues *United States Treasury Dept. v. Fabe*, 508 U.S. 491, 505, 113 S.Ct. 2202, 124 L.Ed. 2d 449 (1993) prohibits consideration of the insurance statutory scheme as a whole when determining whether a specific statute was enacted for the purpose of regulating the business of insurance. We disagree. The *Fabe* court considered whether a federal priority statute was superseded by a conflicting state priority statute, where the latter was part of a larger statutory scheme enacted to regulate insolvent insurers. The *Fabe* court observed that an individual statute can reverse preempt federal law to the extent the specific statute regulates policyholder interests. However, the court found the provisions that did not directly affect policyholder interests were not enacted for the purpose of regulating the business of insurance and, thus, had no reverse preemptive effect. The *Munich* court rejected an expansive application of the *Fabe* holding, finding "the court stopped short of directing that [a parsing of statutes] approach be taken in every case." *Munich*, 141 F.3d 592. It continued:

> This uncertainty need not concern us today, however, because if we are required to parse [Oklahoma Insurance regulation law], the specific provisions of the statute at issue here —vesting exclusive original jurisdiction of delinquency proceedings in the Oklahoma state court and authorizing the court to enjoin any action interfering with the delinquency proceedings—are laws enacted clearly for the purpose of regulating the business of insurance. These provisions give the state court the power to decide all issues relating to disposition of an insolvent insurance company's assets, including whether any given property is part of the insolvent estate in the first place.

Id.

Louisiana, like Oklahoma, adopted a comprehensive scheme to regulate insolvent insurers, including granting the Commissioner, as rehabilitator, the authority to choose which forum to bring an action. The policy reasons for this grant of discretion mirror those of Oklahoma: "the orderly adjudication of claims;" the avoidance of "unnecessary and wasteful dissipation of the insolvent company's funds" that would occur if the receiver had to litigate in different forums nationwide; the elimination of "the risk of conflicting rulings, piecemeal litigation of claims, and unequal treatment of claimants." *Munich*, 141 F.3d at 593. While each of these concerns alone may not justify avoiding the arbitration clause, collectively they support our holding that the venue selection provision in Section 2004 was enacted for the purpose of regulating the business of insurance.

Last, reverse preemption does not apply unless the FAA acts to "invalidate, supersede, or impair" the RLCA, particularly the venue provision. Forcing arbitration upon the Commissioner conflicts with the Louisiana law authorizing him to choose which forum to proceed in as rehabilitator. This conflict sufficiently impairs the Commissioner's rights under Section 2004 to trigger McCarran-Ferguson's reverse preemption effect.

CONCLUSION

For the reasons stated herein, we find the Louisiana Rehabilitation, Liquidation, and Conservation Act, specifically Louisiana Revised Statutes 22:2004(A), prevents the Commissioner from being compelled to arbitration. We reverse the judgment of the court of appeal and remand for proceedings consistent with this opinion.

REVERSED AND REMANDED.

04/27/20

SUPREME COURT OF LOUISIANA

NO. 2019-C-00514

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

ON WRIT OF CERTIORARI TO THE COURT OF APPEAL, FIRST CIRCUIT, PARISH OF EAST BATON ROUGE

WEIMER, J.,concurring.

The statute central to this case, La. R.S. 22:2004(A), provides that an "action by the commissioner of insurance, in that capacity, or as conservator, rehabilitator, or liquidator may be brought **in the Nineteenth Judicial District Court** for the parish of East Baton Rouge **or any court** where venue is proper under any other provision of law." (Emphasis added.) Arbitration is not mentioned in the statute. Accordingly, I believe the commissioner is not statutorily authorized to elect arbitration, but is limited to litigation, in court, as described in La. R.S. 22:2004(A). Thus, I respectfully concur; I join the majority opinion in all other respects.

EXHIBIT B

Supreme Court
STATE OF LOUISIANA
New Orleans

May 18, 2020

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Re: JAMES J. DONELON,
COMMISSIONER OF INSURANCE
FOR THE STATE OF LOUISIANA, IN
HIS CAPACITY AS
REHABILITATOR OF LOUISIANA
HEALTH COOPERATIVE, INC. VS.
TERRY S. SHILLING, ET AL.
2019-C-00514

Dear Counsel:

This is to advise that the court took the following action on your Motion for Stay filed in the above entitled matter.

Motion to stay denied.

With kindest regards, I remain,

Very truly yours,

Ryan Chan
Deputy Clerk

RC: RC
ccs: All Counsel
Court of Appeal, First Circuit: 2017 CW 1545
19th Judicial District Court: 651,069 - JDC:19 Div:F

EXHIBIT C

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Notice of Judgment and Disposition

February 28, 2019

Docket Number: 2017 - CW - 1545

James L. 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

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In accordance with Local Rule 6 of the Court of Appeal, First Circuit, I hereby certify that this notice of judgment and disposition and the attached disposition were transmitted this date to the trial judge or equivalent, all counsel of record, and all parties not represented by counsel.

Peggy J. Landry

RODD NAQUIN
CLERK OF COURT

STATE OF LOUISIANA
COURT OF APPEAL
FIRST CIRCUIT
2017 CW 1545

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

Judgment Rendered: FEB 2 8 2019

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On review from the Nineteenth Judicial District Court
Parish of East Baton Rouge
State of Louisiana

Case No. 651,069

The Honorable Timothy E. Kelley

****

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****

BEFORE: HIGGINBOTHAM, HOLDRIDGE, and PENZATO, JJ.

HOLDRIDGE, J.

In this writ application, applicant, Milliman, Inc. ("Milliman"), challenges the ruling of the trial court, which overruled Milliman's Declinatory Exception raising the objection of Lack of Subject Matter Jurisdiction.[1] For the following reasons, we reverse the ruling of the trial court and dismiss the claims of James J. Donelon, Commissioner of Insurance for the State of Louisiana, through his duly appointed Receiver, Billy Bostick, against Milliman, without prejudice.

FACTS AND PROCEDURAL HISTORY

This matter arises from the insolvency and the rehabilitation of Louisiana Health Cooperative, Inc. ("LAHC"). LAHC executed a Consulting Services Agreement ("Agreement") with Milliman for actuarial services. The Agreement states, in pertinent part, as follows:

> This Agreement is entered into between [Milliman] and [LAHC] (Company) as of August 4, 2011. Company has engaged Milliman to perform consulting services as described in the letter dated August 4, 2011 and attached hereto. The parties agree that these terms and conditions will apply to all current and subsequent engagements of Milliman by Company unless specifically disclaimed in writing by both parties prior to the beginning of the engagement. In consideration for Milliman agreeing to perform these services, Company agrees as follows.
>
> ***
>
> 4. **DISPUTES.** In the event of any dispute arising out of or relating to the engagement of Milliman by Company, the parties agree that the dispute will be resolved by final and binding arbitration under the Commercial Arbitration Rules of the American Arbitration Association. ...
>
> 5. **CHOICE OF LAW.** The construction, interpretation, and enforcement of this Agreement shall be governed by the substantive contract law of the State of New York without regard to its conflict of laws provisions. In the event any provision of this agreement is unenforceable as a matter of law, the remaining provisions will stay in full force and effect.

[1] The companion case involving the Declinatory Exception raising the objection of Improper Venue and writ application filed by Buck Consultants, LLC, Docket No. 2017 CW 1483, is decided by this Court under a separate ruling.

Representatives of Milliman and LAHC signed the Agreement on August 4, 2011, and August 15, 2011, respectively.

A Proposal for Actuarial Services ("Engagement Letter") from Milliman to Beam Partners, dated August 4, 2011, was attached to the Agreement. The Engagement Letter outlined that Beam Partners was working with LAHC, which is sponsored by Ochsner Health System, to investigate the creation of a Consumer Operated and Oriented Plan ("CO-OP") in Louisiana. Beam Partners, on behalf of LAHC, had asked Milliman to provide a proposal for actuarial support of the proposed CO-OP, with initial support including assistance with a feasibility study and LAHC's loan application in response to Funding Opportunity Announcement No. OO-COO-11-001, CFDA 93.545 released from the U.S. Department of Health and Human Services on July 28, 2011. The Engagement Letter provided Milliman's work plan as well as timing, staffing, and professional fees.

It is alleged that LAHC became registered with the Louisiana Secretary of State on September 12, 2011, and applied for and received loans from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, in 2012. However, it is undisputed that, by July 2015, LAHC stopped doing business.

On September 21, 2015, in response to a verified petition and testimony on behalf of Caroline Brock, Deputy Commissioner of Financial Solvency for the Louisiana Department of Insurance and Billy Bostick, a Permanent Order of Rehabilitation and Injunctive Relief (the "Rehabilitation Order") was signed, confirming James J. Donelon, Commissioner of Insurance for the State of Louisiana ("the Commissioner") as Rehabilitator of LAHC and Billy Bostick as Receiver of LAHC. The Rehabilitation Order further states, in pertinent part, as follows:

> [T]he requirements for rehabilitation under the provisions of La. R.S. 22:2001, et seq., have been met ... LAHC shall be and hereby is

> placed into rehabilitation under the direction and control of the Commissioner
>
> ***
>
> IT IS FURTHER ORDERED, ADJUDGED AND DECREED that ... any and all persons and entities shall be and hereby are permanently enjoined from obtaining preferences, judgments, attachments or other like liens or the making of any levy against LAHC, its property and assets
>
> ***
>
> IT IS FURTHER ORDERED, ADJUDGED AND DECREED that the Rehabilitator shall be and hereby is entitled to the right to enforce or cancel ... contract performance by any party who had contracted with LAHC.
>
> ***
>
> IT IS FURTHER ORDERED, ADJUDGED AND DECREED that LAHC providers and contractors are required to abide by the terms of their contracts with LAHC
>
> ***
>
> IT IS FURTHER ORDERED, ADJUDGED AND DECREED that the Rehabilitator and Receiver of LAHC ... shall be and hereby are allowed and authorized to ... [c]ommence and maintain all legal actions necessary, wherever necessary, for the proper administration of this rehabilitation proceeding
>
> ***
>
> IT IS FURTHER ORDERED, ADJUDGED AND DECREED that all contracts between LAHC and any and all persons or entities providing services to LAHC ... shall remain in full force and effect unless canceled by the Receiver, until further order of this Court.

On August 31, 2016, the Commissioner, as Rehabilitator of LAHC, through his duly appointed Receiver, Billy Bostick, filed a Petition for Damages and Jury Demand, in a separate matter from the rehabilitation proceeding, asserting claims of breach of fiduciary duty, breach of contract, negligence, and gross negligence against multiple defendants and seeking damages in connection with LAHC's failure. Milliman was named as a defendant in the Commissioner's First Supplemental, Amending and Restated Petition for Damages and Request for Jury Trial filed on November 29, 2016.

The Commissioner alleged professional negligence, breach of contract, and negligent misrepresentation against Milliman. The Commissioner stated that Milliman was engaged *via* the Engagement Letter to provide "actuarial support" for LAHC including the production of a feasibility report and loan application.

The Commissioner further alleged that Milliman was engaged *via* a separate engagement letter dated November 13, 2012, to develop 2014 premium rates in Louisiana.[2]

As to the professional negligence and breach of contract claims, the Commissioner alleged the following: (1) the feasibility study was prepared using unrealistic and unreasonable assumption sets failing to consider the possibility of adverse enrollment and/or medical loss ratio scenarios; (2) Milliman conditioned its payment upon LAHC being awarded a loan, compromising its actuarial independence and breaching its duty to LAHC; (3) Milliman's feasibility study and pro forma reports were unreliable, inaccurate, and not the result of careful professional analysis; (4) Milliman owed a duty to LAHC to exercise reasonable care in accordance with the professional standards for actuaries; (5) Milliman provided actuarial memorandums for 2014 rate filings utilizing unreasonable assumptions, grossly underestimating the level of non-claim expenses in 2014, and providing no basis for assumptions made therein; (6) Milliman breached its duty to LAHC by failing to discharge its duties with reasonable care, failing to act in accordance with the professional standards applicable to actuaries, failing to produce an accurate and reliable feasibility study, failing to set premium rates that were accurate and reliable, and failing to exercise the reasonable judgment expected of professional actuaries under like circumstances; and (7) Milliman's failure to exercise reasonable care, failure to act in accordance with the professional standards applicable to actuaries and breach of contract were the legal causes of all or substantially all of LAHC's damages. The Commissioner further alleged that Milliman's advice and reports to LAHC negligently misrepresented the actual funding needs and premium rates of LAHC, and Milliman had a duty to provide accurate and up-to-date information to LAHC that

[2] A copy of the November 13, 2012 Engagement Letter has not been provided to this Court and is not in evidence.

Milliman knew or should have known LAHC would rely on in making its decision concerning premium amounts.

In response to the First Supplemental, Amending and Restated Petition for Damages, Milliman filed a Declinatory Exception raising the objection of Lack of Subject Matter Jurisdiction, asserting that the Commissioner's claims against it must be arbitrated, pursuant to the arbitration provision in the Agreement. Milliman requested that the Commissioner's claims against it be dismissed, with prejudice. Attached to Milliman's exception was a copy of the Agreement and the Engagement Letter.

The Commissioner opposed the exception arguing, in pertinent part, as follows: (1) the Rehabilitation, Liquidation, Conservation Act, La. R.S. 22:2001 *et seq.* ("the RLC Act") of the Louisiana Insurance Code is comprehensive and exclusive in scope, and La. R.S. 22:257(F) gives the Nineteenth Judicial District Court exclusive jurisdiction of this matter; (2) arbitration interferes with the rehabilitation proceeding in violation of the Rehabilitation Order; (3) the Commissioner did not sign the Agreement and is not bound by the arbitration provision; (4) Milliman does not cite or distinguish Ohio Supreme Court's decision in **Taylor v. Ernst & Young, L.L.P.**, 2011-Ohio-5262, 130 Ohio St. 3d 411, 958 N.E.2d 1203; (5) the Commissioner does not stand precisely in the shoes of the insolvent insurer because he acts as an officer of the State and owes an overriding duty to the people of the State of Louisiana; and (6) the Commissioner's claims do not arise from the Engagement Letter because the Commissioner is not seeking a declaration of Milliman's obligations under the Engagement Letter and the Commissioner's allegations against Milliman do not require the court to interpret the Engagement Letter to determine Milliman's obligations. Attached to the Commissioner's opposition was a copy of the First

Supplemental, Amending and Restated Petition for Damages and the Rehabilitation Order.

Milliman filed a reply arguing, in pertinent part, as follows: (1) the Commissioner is vested with title to all contracts of LAHC, pursuant to La. R.S. 22:2008(A), and no provision of the RLC Act vests the Commissioner with greater rights than those LAHC held; (2) La. R.S. 22:257(F), which gives the Nineteenth Judicial District Court exclusive jurisdiction over suits arising from the takeover and liquidation of a health maintenance organization, does not apply herein because LAHC is not in liquidation; (3) enforcement of the arbitration provision does not violate the Rehabilitation Order; (4) the Commissioner is bound to the arbitration provision, despite being a non-signatory, because the Commissioner has sued Milliman for breach of the Agreement; (5) the Ohio Supreme Court's decision in **Taylor** is not binding on this Court and is factually distinguishable; (6) the Commissioner stands in the shoes of LAHC for purposes of exercising the rights and being obligated by the restrictions of the Agreement; and (7) the Commissioner's claims against Milliman arise out of the Agreement because the Engagement Letter was incorporated into the Agreement and the claims against Milliman arise out of the contractual relationship between LAHC and Milliman.

A hearing on the Declinatory Exception raising the objection of Lack of Subject Matter Jurisdiction was held on August 25, 2017. Copies of the Agreement, the Engagement Letter and the Rehabilitation Order were introduced into evidence at the hearing.

The trial court denied the exception. Milliman filed a writ application, seeking supervisory review of the trial court's judgment that denied its Declinatory Exception raising the objection of Lack of Subject Matter Jurisdiction

and asking that the trial court's judgment be reversed. We granted *certiorari* and stayed the trial court proceeding.

ERROR

Milliman argues that the trial court erroneously denied its Declinatory Exception raising the objection of Lack of Subject Matter Jurisdiction, where the trial court found that the Commissioner's claims against Milliman must be heard in the Nineteenth Judicial District Court rather than in arbitration, in violation of the language of the Rehabilitation Order, the Louisiana Insurance Code, the Louisiana Binding Arbitration Law and Federal Arbitration Act, and controlling jurisprudence of this Court and the U.S. Supreme Court.

STANDARD OF REVIEW

Milliman filed a Declinatory Exception raising the objection of Lack of Subject Matter Jurisdiction, arguing that the Commissioner's claims should be dismissed with prejudice because the trial court does not have subject matter jurisdiction in light of the arbitration provision in the Agreement. Subject matter jurisdiction is the legal power and authority of a court to hear and determine a particular class of actions or proceedings, based upon the object of the demand, the amount in dispute, or the value of the right asserted. La. Code Civ. P. art. 2. A judgment rendered by a court which has no jurisdiction over the subject matter of the action or proceeding is void. *See* La. Code Civ. P. arts. 3 and 925(C). A trial court is precluded from exercising jurisdiction once arbitration has commenced. **Williams v. International Offshore Services, LLC**, 2011-1240 (La. App. 1 Cir. 12/7/12), 106 So.3d 212, 217, *writ denied*, 2013-0259 (La. 3/8/13), 109 So.3d 367. Furthermore, subject matter jurisdiction cannot be waived or conferred by the consent of the parties. **Id.** However, arbitration has not yet commenced in this matter, and the trial court has not yet been divested of subject matter jurisdiction. Moreover, the arbitration provision is powerless to

waive or confer subject matter jurisdiction. Therefore, an exception of lack of subject matter jurisdiction is not a proper procedural vehicle to raise arbitration.

However, "[e]very pleading shall be so construed as to do substantial justice." La. Code Civ. P. art. 865. In this regard, an exception is treated as what it actually is, not as what it is entitled. **Smith v. Smith**, 341 So.2d 1147, 1148 (La. App. 1 Cir. 1976) (*citing* **Jackson v. Dickens**, 236 So.2d 81, 83 (La. App. 1 Cir. 1970)). The defense that a plaintiff is not entitled to judicial relief because of a valid agreement to submit claims to arbitration may be raised by the dilatory exception of prematurity. **Green v. Regions Bank**, 2013-0771 (La. App. 1 Cir. 3/19/14), 2014 WL 3555820, *2 (unpublished) (*citing* **Cook v. AAA Worldwide Travel Agency**, 360 So.2d 839, 841 (La. 1978); **O'Neal v. Total Car Franchising Corp.**, 44,793 (La. App. 2 Cir. 12/16/09), 27 So.3d 317, 319). Therefore, this Court will consider Milliman's Declinatory Exception raising the objection of Lack of Subject Matter Jurisdiction as a Dilatory Exception raising the objection of Prematurity, which properly raises arbitration.

Louisiana Code of Civil Procedure article 926(A)(1) provides for the dilatory exception raising the objection of prematurity. Such an objection is intended to retard the progress of the action rather than defeat it. La. Code Civ. P. art. 923. A suit is premature if it is brought before the right to enforce the claim sued on has accrued. La. Code Civ. P. art. 423.

Prematurity is determined by the facts existing at the time suit is filed. **Houghton v. Our Lady of the Lake Hospital, Inc.**, 2003-0135 (La. App. 1 Cir. 7/16/03), 859 So.2d 103, 106 (*citing* **Hidalgo v. Wilson Certified Express, Inc.**, 94-1322 (La. App. 1 Cir. 5/14/96), 676 So.2d 114, 116; **Allied Signal, Inc. v. Jackson**, 96-0138 (La. App. 1 Cir. 2/14/97), 691 So.2d 150, 157 n.9, *writ denied*, 97-0660 (La. 4/25/97), 692 So.2d 1091). Evidence may be introduced to support or controvert the exception, when the grounds do not

appear from the petition. La. Code Civ. P. art. 930. The objection of prematurity raises the issue of whether the judicial cause of action has yet come into existence because some prerequisite condition has not been fulfilled. **Bridges v. Smith**, 2001-2166, (La. App. 1 Cir. 9/27/02), 832 So.2d 307, 310, *writ denied*, 2002-2951 (La. 2/14/03), 836 So.2d 121. The objection contemplates that the action was brought prior to some procedure or assigned time, and is usually utilized in cases where the applicable law or contract has provided a procedure for one aggrieved of a decision to seek relief before resorting to judicial action. **Plaisance v. Davis**, 2003-0767 (La. App. 1 Cir. 11/7/03), 868 So.2d 711, 716, *writ denied*, 2003-3362 (La. 2/13/04), 867 So.2d 699; **Harris v. Metropolitan Life Insurance Co.**, 2009-34 (La. App. 1 Cir. 2/5/10), 35 So.3d 266, 274. An exception of prematurity raising a question of law is subject to a *de novo* standard of review on appeal. **Bridges v. Citimortgage, Inc.**, 2011-1508 (La. App. 1 Cir. 5/24/12), 2012 WL 1922457, *1, *writ denied*, 2012-1739 (La. 11/2/12), 99 So.3d 673 (*citing* La. Code Civ. P. art. 926; **Bridges**, 832 So.2d at 310).

The facts are not in dispute with respect to this writ application. The issue before us is whether the trial court correctly interpreted and applied the law in denying the exception and refusing to enforce the arbitration provision. This is a question of law subject to a *de novo* standard of review.

Appellate review of questions of law is simply a review of whether the trial court was legally correct or legally incorrect. **Bridges**, 832 So.2d at 310 (*citing* **City of Baker School Board v. East Baton Rouge Parish School Board**, 99-2505 (La. App. 1 Cir. 2/18/00), 754 So.2d 291, 292). On legal issues, the appellate court gives no special weight to the findings of the trial court, but exercises its constitutional duty to review questions of law and renders judgment on the record. **Bridges**, 832 So.2d at 310 (*citing* **Northwest Louisiana**

Production Credit Association v. State, Department of Revenue and Taxation, 98-1995 (La. App. 1 Cir. 11/5/99), 746 So.2d 280, 282.

When the issue of failure to arbitrate is raised by the dilatory exception raising the objection of prematurity, the defendant pleading the exception has the burden of showing the existence of a valid contract to arbitrate, by reason of which the judicial action is premature. **Green**, 2014 WL 3555820 at *2 (*citing* **Cook**, 360 So.2d at 841; **O'Neal**, 27 So.3d at 319). If the dilatory exception of prematurity is sustained, the premature action shall be dismissed. **Green**, 2014 WL 3555820 at *2 (*citing* La. Code Civ. P. art 933).

DISCUSSION

The positive law of Louisiana favors arbitration. **Aguillard v. Auction Mgmt. Corp.**, 2004-2804 (La. 6/29/05), 908 So.2d 1, 7 *superseded by statute on other grounds*, as stated in **Arkel Constructors, Inc. v. Duplantier & Meric, Architects, L.L.C.**, 2006-1950 (La. App. 1 Cir. 7/25/07), 965 So.2d 455, 458-59. Louisiana Revised Statutes 9:4201 of the Louisiana Binding Arbitration Law ("LBAL"), specifically states as follows:

> A provision in any written contract to settle by arbitration a controversy thereafter arising out of the contract, or out of the refusal to perform the whole or any part thereof, or an agreement in writing between two or more persons to submit to arbitration any controversy existing between them at the time of the agreement to submit, shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.

Such favorable treatment echoes the Federal Arbitration Act ("FAA"), 9 U.S.C. § 1, *et seq.* **Aguillard**, 908 So.2d at 7. Section 2 of the FAA provides:

> A written provision in any maritime transaction or a contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction, or the refusal to perform the whole or any part thereof, or an agreement in writing to submit to arbitration an existing controversy arising out of such a contract, transaction, or refusal, shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.

The Louisiana Supreme Court in **Aguillard** adopted the liberal federal policy favoring arbitration agreements, and a Louisiana presumption of arbitrability now exists with regard to the enforceability of arbitration agreements. *See* **Vishal Hospitality, LLC v. Choice Hotels International, Inc.**, 2004-0568 (La. App. 1 Cir. 6/28/06), 939 So.2d 414, 416, *writ denied*, 2006-2517 (La. 1/12/07), 948 So.2d 152 (*citing* **Aguillard**, 908 So.2d at 3-4). Louisiana courts look to federal law in interpreting the LBAL, because it is virtually identical to the FAA. **Snyder v. Belmont Homes, Inc.**, 2004-0445 (La. App. 1 Cir. 2/16/05), 899 So.2d 57, 60, *writ denied*, 2005-1075 (La. 6/17/05), 904 So.2d 699. In this regard, determinations regarding the viability and scope of arbitration clauses would be the same under either law, and is consistent with the federal jurisprudence interpreting the FAA which may be considered in construing the LBAL. **Lafleur v. Law Offices of Anthony G. Buzbee, P.C.**, 2006-0466 (La. App. 1 Cir. 3/23/07), 960 So.2d 105, 111, *called into doubt on other grounds*, as stated in **Arkel Constructors, Inc.**, 965 So.2d at 459 (citations omitted).

Even when the scope of an arbitration clause is fairly debatable or reasonably in doubt, the court should decide the question of construction in favor of arbitration. **Aguillard**, 908 So.2d at 18. The weight of this presumption is heavy and arbitration should not be denied unless it can be said with positive assurance that an arbitration clause is not susceptible of an interpretation that could cover the dispute at issue. **Id.** Therefore, even if some legitimate doubt could be hypothesized, the Louisiana Supreme Court requires resolution of the doubt in favor of arbitration. **Id.**

A two-step analysis is applied to determine whether a party is required to arbitrate. **Snyder**, 899 So.2d at 61-62 (*citing* **Fleetwood Enterprises, Inc. v. Gaskamp**, 280 F.3d 1069, 1073 (5th Cir. 2002), *opinion supplemented on denial of rehearing*, 303 F.3d 570 (5th Cir. 2002)). The first inquiry is whether the party

has agreed to arbitrate the dispute, which contains two questions: (1) whether there is a valid agreement to arbitrate; and (2) whether the dispute in question falls within the scope of that arbitration agreement. Then, the court must determine whether legal constraints external to the parties' agreement foreclosed the arbitration of those claims. **Fleetwood Enterprises, Inc.**, 280 F.3d at 1073.

Validity of the Agreement to Arbitrate

As to whether there is a valid agreement to arbitrate, arbitration is a matter of contract, and a party cannot be required to arbitrate any dispute he has not agreed so to submit. **Snyder**, 899 So.2d at 63 (*citing* **Billieson v. City of New Orleans**, 2002-1993 (La. App. 4 Cir. 9/17/03), 863 So.2d 557, 561, *writ denied*, 2004-0563 (La. 4/23/04), 870 So.2d 303). The burden of proof is on Milliman to establish that a valid and enforceable arbitration agreement exists. *See* **Lafleur**, 960 So.2d at 109. If Milliman satisfies its burden of proof establishing its right to arbitration, the burden then shifts to the Commissioner to demonstrate that he did not consent to arbitration or his consent was vitiated by error, which rendered the arbitration provision unenforceable. **Id.**

The policy favoring arbitration does not apply to a determination of whether there is a valid agreement to arbitrate between the parties. **Snyder**, 899 So.2d at 62. Rather, ordinary state law contract principles determine who is bound. **Id.** In determining whether the parties agreed to arbitrate a certain matter, courts apply the contract law of the particular state that governs the agreement. **Id.** at 61.

In making that determination[3], Louisiana's codal provisions concerning choice of laws provide, in part, that the parties are free to select the law that will

[3] The trial court did not address the choice-of-law provision contained in the Agreement. The issue was first raised *via* the Commissioner's Post-Argument Brief filed after oral argument with this Court. **(Commissioner's Post Argument Brief, pp. 4-8)**

govern contracts "except to the extent that law contravenes the public policy of the state whose law would otherwise be applicable under Article 3537." La. Civ. Code art. 3540. In this regard, the Agreement contains a choice-of-law provision which states, in pertinent part, as follows: "The construction, interpretation, and enforcement of this Agreement shall be governed by the substantive contract law of the State of New York without regard to its conflict of laws provisions."

In order to determine if New York law should be applied, it must first be determined whether Louisiana law is applicable under an analysis of La. Civ. Code art. 3537 and, if so, whether New York law contravenes the public policy of Louisiana. Louisiana Civil Code article 3537 provides that the issue of which state law applies to a conventional obligation "is governed by the law of the state whose policies would be most seriously impaired if its law were not applied to that issue." *See also* La. Civ. Code art. 3515. In making this analysis, we must look to each state's connection to the parties and the transaction, as well as its interests in the conflict, to determine which state would bear the most serious legal, social, economic, and other consequences if its laws were not applied to the issues at hand. La. Civ. Code art. 3537, 1991 Revision Comments – Comment (c).

Generally, an appellate court will not consider issues raised for the first time on appeal. **Segura v. Frank**, 630 So.2d 714, 725 (La. 1994). Uniform Rules, Courts of Appeal, Rule 1-3 further articulates that "[t]he Courts of Appeal will review only issues which were submitted to the trial court and which are contained in specifications or assignments of error, unless the interest of justice clearly requires otherwise." As noted in the Official Revision Comment (a) to La. Code Civ. P. art. 2164, "[t]he purpose of this article [Article 2164] is to give the appellate court complete freedom to do justice on the record irrespective of whether a particular legal point or theory was made, argued, or passed on by the court below." This Court has considered a question of conflicts or choice of laws for the first time on appeal, when the question is necessarily invoked by the issues before it. *See e.g.* **Berard v. L–3 Communications Vertex Aerospace, LLC**, 2009-1202 (La. App. 1 Cir. 2/12/10), 35 So.3d 334, 340, n.1, *writ denied*, 2010-0715 (La. 6/4/10), 38 So.3d 302.

Because courts apply the contract law of the particular state governing the agreement containing the arbitration provision when determining the validity of the arbitration provision, we must determine what state's law applies to the Agreement.

There is no record evidence as to the place of negotiation, formation, and performance of the Agreement. It is undisputed that LAHC is a Louisiana corporation doing business in Louisiana. Moreover, the object of the Agreement was to prepare a feasibility study and assist with LAHC's loan application to enable it to offer insurance in Louisiana. It is undisputed that Milliman is domiciled in Washington with its principal place of business in Washington.

Louisiana has a strong public policy favoring the enforcement of arbitration provisions. However, the New York courts have prohibited the enforcement of arbitration provisions in contracts with insurers when the insurer is insolvent and is in either rehabilitation or liquidation. *See e.g.* **Matter of Allcity Insurance Co.**, 66 A.D.2d 531, 535-38, 413 N.Y.S.2d 929, 932 (1979); **Knickerbocker Agency, Inc. v. Holz**, 4 N.Y.2d 245, 251-54, 149 N.E.2d 885, 889 (1958); **Washburn v. Corcoran**, 643 F.Supp. 554, 556-57 (S.D.N.Y. 1986). For reasons discussed in this opinion, Louisiana contains no such limitation. Therefore, La. Civil Code art. 3540 precludes the application of New York law herein, because the application of New York law would reach a different result than that reached by the application of Louisiana law.

Applying Louisiana law, arbitration agreements and provisions are to be enforced unless they are invalid under principles of Louisiana state law that govern all contracts. **Lafleur**, 960 So.2d at 112. Applicable contract defenses such as fraud, duress, or unconscionability, may be applied to invalidate arbitration agreements. **Id.** One of the conditions of a valid contract is the consent of both parties. **Id.** (*citing* La. Civ. Code art. 1927).

The parties do not dispute that the underlying arbitration agreement, as between LAHC and Milliman is valid. Representatives of both LAHC and Milliman signed the Agreement. It is well-settled that a party who signs a written instrument is presumed to know its contents. **Aguillard**, 908 So.2d at 17.

However, the Commissioner did not sign the Agreement and argues that he is not bound to the arbitration provision contained therein. Milliman responded that the Commissioner has asserted claims against it based on Milliman's alleged breach of the Agreement, yet impermissibly seeks to avoid the arbitration provision in that same Agreement.

A non-signatory to a contract containing an arbitration provision may be bound by that provision under accepted theories of agency or contract law. **Courville v. Allied Professionals Insurance Co.**, 2016-1354 (La. App. 1 Cir. 4/12/17), 218 So.3d 144, 148, n.3, *writ denied*, 2017-0783 (La. 10/27/17), 228 So.3d 1223 (internal citations omitted). When a signatory to a contract requiring arbitration seeks to compel a non-signatory to arbitrate a dispute, as in the present case, the signatory is required to establish that the non-signatory derived a direct benefit from the contract. **Id.** Direct-benefit estoppel applies when a non-signatory plaintiff sues to enforce a contract containing an arbitration provision yet seeks to avoid an arbitration provision. **Id.** The non-signatory cannot have it both ways; he cannot rely on the contract when it works to his advantage and then repudiate the contract when it works to his disadvantage. **Id.** On the other hand, when the non-signatory's claims are not associated with the enforcement of the contract containing the arbitration provision, the non-signatory is not bound to arbitrate those claims. **Id.**

The Commissioner has brought breach of contract, professional negligence, and negligent misrepresentation claims against Milliman based on Milliman's allegedly deficient performance under the Agreement. The Commissioner's breach of contract claims against Milliman seek to enforce the Agreement containing the arbitration provision. Furthermore, claims for negligence and negligent performance arising from work performed pursuant to a contract may be contractual in nature and subject to the arbitration provision

in the contract. *See e.g.* **Green**, 2014 WL 355820, at *5-7; **Shroyer v. Foster**, 2001-0385 (La. App. 1 Cir. 3/28/02), 814 So.2d 83, 89, *superseded by statute on unrelated grounds*, as stated in **Arkel Constructors, Inc.**, 965 So.2d at 458-49. Apart from the Agreement, there would have been no performance by Milliman and no alleged breach of professional standards and negligent misrepresentation. As such, the Commissioner's claims against Milliman for professional negligence and negligent misrepresentation, like the claim for breach of contract, are associated with the enforcement of the Agreement, making direct-benefit estoppel applicable. The Commissioner, despite being a non-signatory, cannot sue to enforce the Agreement and avoid the arbitration provision. Accordingly, the arbitration provision is valid.

Scope of the Arbitration Provision

Next, it must be determined whether, the Commissioner's claims against Milliman fall within the scope of the arbitration provision. The Commissioner argues that his claims do not arise from the Engagement Letter because the Commissioner is not seeking a declaration of Milliman's obligations thereunder and his allegations against Milliman do not require the court to interpret the Engagement Letter to determine Milliman's obligations. Milliman argues that its contractual relationship and obligations with LAHC are embodied in the Engagement Letter, and the conduct complained of arises out of the contractual relationship. Milliman notes that it would not have had a duty to LAHC but for the Agreement.

In construing an arbitration agreement under the FAA, for example, a determination of whether a dispute falls within an arbitration clause requires the court to characterize the clause as "broad" or "narrow." **Snyder**, 899 So.2d at 62 (*citing* **Hornbeck Offshore (1984) Corp. v. Coastal Carriers Corp.**, 981 F.2d 752, 754-55 (5th Cir. 1993)). If the court finds that the clause is broad,

then any dispute between the parties falls within the scope of the clause if it is connected with or related to the contract. **Id.** A narrow clause, for example, restricts and requires that the dispute literally "arise out of the contract" and relate to the parties' performance of the contract. **Id.** (*citing* **Pennzoil Exploration & Production Co. v. Ramco Energy Ltd.**, 139 F.3d 1061, 1067 (5th Cir. 1998). However, a broad arbitration clause governs disputes that "relate to" or "are connected with" the contract. **Pennzoil Exploration & Production Co.**, 139 F.3d at 1067.

The arbitration provision at issue states that "[i]n the event of any dispute arising out of or relating to the engagement of Milliman by Company [LAHC], parties agree that the dispute will be resolved by final and binding arbitration ..." The term "any," when used in an arbitration provision, is broad. *See e.g.* **In Re Complaint of Hornbeck Offshore (1984) Corp.**, 981 F.2d 752, 755 (5th Cir. 1993) (arbitration clauses containing the "any dispute" language are of the broad type).

Moreover, other courts have found the phrase "relating to," in particular, to be very broad in the context of arbitration provisions. *See e.g.* **Prima Paint Corp. v. Flood & Conklin Manufacturing Co.**, 388 U.S. 395, 406, 87 S.Ct. 1801, 1807, 18 L.Ed.2d 1270 (1967) (agreement to arbitrate "[a]ny controversy or claim arising out of or relating to this Agreement, or the breach thereof" is "easily broad enough" to encompass a claim of fraud in the inducement regarding the contract); *See also* **Nauru Phosphate Royalties, Inc. v. Drago Daic Interests, Inc.**, 138 F.3d 160, 165 (5th Cir. 1998); **Hamel-Schwulst v. Country Place Mortgage, Ltd.**, 406 Fed. Appx. 906, 913 (5th Cir. 2010).

Furthermore, broad arbitration provisions mandating arbitration for claims "arising from or relating to" the contract have been found to include tort claims such as negligent misrepresentation, negligent manufacture, and negligent repair

as well as any disagreement over any rights and violations reasonably traceable to the pertinent contract. *See e.g.* **Rain CII Carbon LLC v. ConocoPhillips Co.**, 2012-0203 (La. App. 4 Cir. 10/24/12), 105 So.3d 757, 763, *writ denied*, 2012-2496 (La. 1/18/13), 107 So.3d 631 (arbitration clause providing "[a]ny controversy or claim arising out of or relating to this Agreement, or the breach thereof, shall be settled by arbitration" was broad enough to include breach of contract claims as well as claims for negligent representation, unfair trade practices, and indemnification); *See also* **Vector Electric & Controls, Inc. v. ABM Industries Inc.**, No. CV31500252JWDRLB (M.D. La. Jan. 11, 2016), 2016 WL 126752 at *5; **Snyder**, 899 So.2d at 62 (*citing* **Izzi v. Mesquite Country Club**, 186 Cal.App.3d 1309, 231 Cal. Rptr. 315 (1986). Therefore, we find the arbitration provision at issue herein is of the broad type.

The Commissioner specifically alleged that Milliman was engaged, *via* the Engagement Letter dated August 4, 2011, to provide "'actuarial support' for LAHC, including production of a feasibility study and loan application." Furthermore, the Commissioner alleged that Milliman was engaged, *via* a separate engagement letter dated November 13, 2012, to "develop 2014 premium rates in Louisiana" for LAHC. The remainder of the Commissioner's allegations attack Milliman's actuarial work, the feasibility study, pro forma reports, actuarial memorandums prepared for the 2014 rate filings, and advice on LAHC's funding needs. Each of these claims relates to LAHC's engagement of Milliman to provide a feasibility study, assist with LAHC's loan application, and develop premium rates.[4] The roots of each of the Commissioner's claims,

[4] As noted, a copy of the Engagement Letter dated November 13, 2012, is not in evidence. However, the copy of the Agreement in evidence reflects that its "terms and conditions will apply to all current and subsequent engagements of Milliman by [LAHC] unless specifically disclaimed in writing by both parties prior to the beginning of the engagement." There is no allegation or record evidence that either LAHC or Milliman disclaimed the terms of the Agreement, in writing or otherwise, prior to the beginning of the November 2012 engagement. Therefore, Milliman's work under the 2012 engagement would fall under the terms of the Agreement and the arbitration provision.

whether resounding in contract or tort, are the Agreement. But for Milliman's allegedly defective performance under the Agreement, the Commissioner would have no tort claim against Milliman.

The Commissioner further relies upon **Taylor**, a decision from the Ohio Supreme Court, arguing that the claims do not fall under the scope of the arbitration provision, because the Commissioner is not seeking a declaration of Milliman's obligations under the Agreement. In **Taylor**, Ernst & Young ("E & Y"), an independent accounting firm, provided auditing services to American Chambers Life Insurance Company ("ACLIC"). E & Y submitted an audit report to the Ohio Department of Insurance ("ODI"). The audit was undertaken pursuant to an engagement letter signed by E & Y and ACLIC that contained an arbitration clause. The **Taylor** decision does not provide the exact language of the arbitration provision but states that "[t]he agreement provides that all claims 'related to' the services covered in the engagement letter shall be arbitrated." **Id**. at 1213, n.5. The superintendent later filed an action to place ACLIC in rehabilitation, and a final liquidation order was entered based on ACLIC's insolvency. The superintendent then filed suit against E & Y alleging that E & Y had "negligently failed to perform its duties as the independent certified public accountant retained to conduct the audit of ACLIC's December 31, 1998, Annual Statement, thus breaching the duties owed (i.e. the malpractice claim), and E & Y had received preferential or fraudulent payments of more than $25,000 (i.e. the preference claim). E & Y sought to compel the matter to arbitration.

The Ohio Supreme Court found that the test for whether the claims fell under the scope of the arbitration provision was not whether the superintendent's claims "relate to" the subject matter of the engagement letter but instead whether the liquidator, a non-signatory, asserted claims that arise from the contract containing the arbitration clause. **Id**. at 1213. In reference to

the claim for malpractice, the court found that this claim arose from statutory duties and certifications filed in public record by ACLIC and E & Y and did not seek judicial interpretation of the engagement letter. The claims could be resolved without reference to the engagement letter and did not arise from the engagement letter and was not arbitrable. As to the preference claim, the court found that preference and fraudulent-transfer claims arise only by virtue of statute and arise only in favor of the liquidator, and they could not as a matter of law arise from a contract entered into by an insolvent insurer.

This Court is not bound by decisions of the Ohio Supreme Court. Nevertheless, the **Taylor** decision is distinguishable. In **Taylor**, the liquidator sued for breach of the auditor's statutory duties, specifically malpractice and preference claims, that did not require reference to the contract or engagement letter for determination. Moreover, the **Taylor** liquidator did not sue for breach of contract. In the present case, the Commissioner is suing for breach of contract, which requires reference to the Agreement and the incorporated Engagement Letter. Furthermore, the Commissioner's claims for negligence and negligent misrepresentation are not determinable by reference to any particular statutory duty of actuaries, and the Commissioner cites no statutory duty that Milliman allegedly breached. As such, **Taylor** is distinguishable.

In the present case, each of the Commissioner's claims relate to Milliman's engagement. Moreover, even if the scope of an arbitration clause is fairly debatable or reasonably in doubt, the court should decide the question of construction in favor of arbitration. **Aguillard**, 908 So.2d at 18. Accordingly, all of the Commissioner's claims against Milliman fall within the scope of the arbitration provision.

Whether the Claims Are Non-Arbitrable

Finally, it must be determined whether any statute or legal constraint renders the matter non-arbitrable. Both the FAA and the LBAL contain identical language that written agreements to arbitrate disputes "shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract." La. R.S. 9:4201; 9 U.S.C. § 2. Federal courts interpreting the FAA allow for a determination to be made as to whether any federal statute or policy renders the claims non-arbitrable. **Sherer v. Green Tree Servicing LLC**, 548 F.3d 379, 381 (5th Cir. 2008). Utilizing federal cases to interpret the LBAL, it must be determined whether any statute or legal constraints external to the parties' agreement foreclosed the arbitration of those claims. **Mitsubishi Motors Corp. v. Soler Chrysler–Plymouth, Inc.**, 473 U.S. 614, 628, 105 S.Ct. 3346, 3353-55, 87 L.Ed.2d 444 (1985); **Sherer**, 548 F.3d at 381.

In this regard, the Commissioner argues that the RLC Act and La. R.S. 22:257(F) preclude arbitration and venue is mandatory in the Nineteenth Judicial District Court. Milliman argues that the Insurance Code does not grant the Commissioner greater rights than LAHC had, under the Agreement, and La. R.S. 22:257(F) is not applicable because LAHC is not in "liquidation." The RLC Act sets forth the provisions pertaining to rehabilitation, liquidation, and conservation of insurers. La. R.S. 22:2001. La. R.S. 22:2(A)(1) states that insurance is "an industry affected with the public interest." The Commissioner is charged with the duty of administering the Insurance Code. La. Const. art. IV, § 11; La. R.S. 22:2(A)(1). As liquidator or rehabilitator of an insurance company, the Commissioner acts as an officer of the state to protect the interests of the public, the policyholders, the creditors, and the insurer. **Green v. Louisiana Underwriters Ins. Co.**, 571 So.2d 610, 615 (La. 1990). However, the Commissioner's role as such does not involve the assertion or protection of any

state interest or right. **Id.** The Commissioner, in his role as liquidator or rehabilitator, represents the insurer's interests and not the state's. **Id.** at 615, n.10.

The statutory scheme for the liquidation and/or rehabilitation of insurers is comprehensive and exclusive in scope. **Brown v. Associated Ins. Consultants, Inc.**, 97-1396 (La. App. 1 Cir. 6/29/98), 714 So.2d 939, 942. This statutory scheme takes precedence over general law to the extent that the general law is inconsistent with the provisions or purpose of the comprehensive, statutory scheme. **Bernard v. Fireside Commercial Life Ins. Co.**, 92-0237 (La. App. 1 Cir. 1993), 633 So.2d 177, 185, *writ denied*, 93-3170 (La. 1994), 634 So.2d 839.

Louisiana Revised Statutes 22:2004 (renumbered from La. R.S. 22:732.3 by 2008 La. Acts, No. 415, § 1, eff. Jan. 1, 2009) is entitled "Venue" and states as follows:

> A. An action under this Chapter brought by the commissioner of insurance, in that capacity, or as conservator, rehabilitator, or liquidator may be brought in the Nineteenth Judicial District Court for the parish of East Baton Rouge or any court where venue is proper under any other provision of law.
>
> B. Any action under this Chapter may also be brought in the parish where at least twenty-five percent of the policyholders of the insurer reside.
>
> C. If an action is filed in more than one venue, the court shall consolidate all such cases into one court where venue is proper.

When originally added by 1993 La. Acts, No. 955, § 1, La. R.S. 22:2004 stated as follows:

> An action under this Part brought by the commissioner of insurance, in that capacity, or as conservator, rehabilitator, or liquidator may be brought in the Nineteenth Judicial District Court for the Parish of East Baton Rouge or any court where venue is proper under any other provision of law, at the sole option of the commissioner of insurance. *See* 1993 La. Acts, No. 955, § 1.

However, in 1997, the legislature amended the statute to its current form, removing the language "at the sole option of the commissioner of insurance" from the statute. *See* 1997 La. Acts, No. 1298, § 1. Accordingly, venue for actions brought by the Commissioner of Insurance, pursuant to the RLC Act, is no longer at the sole option of the Commissioner or Insurance.

LAHC is in rehabilitation, pursuant to the Rehabilitation Order designating the Commissioner as Rehabilitator and authorizing him to commence and maintain all legal actions necessary, wherever necessary, for the proper administration of the rehabilitation proceeding. LAHC presently is not in liquidation, which is different than rehabilitation.[5] Prematurity is determined by the facts existing at the time suit is filed. **Houghton**, 859 So.2d at 106. As such, the exclusive venue provision of La. R.S. 22:257(F) does not apply and does not render the matter non-arbitrable. *See also* **Wooley v. AmCare Health Plans of Louisiana, Inc.**, 2005-2025 (La. App. 1 Cir. 10/25/06), 944 So.2d 668, 677 n.7 (in a suit by the Commissioner against contractor of insolvent insurer, this Court noted that there was "no mandatory Louisiana venue statute applicable herein and ... [La. R.S. 22:2004(A) formerly] La. R.S. 22:732.3 [(A)] controls in Louisiana").

Furthermore, nothing in the Rehabilitation Order expressly prohibits arbitration. The Rehabilitation Order notes that the "Rehabilitator ... shall be and

---

[5] Louisiana Revised Statutes 22:2009 (formerly La. R.S. 22:736) sets out the duties of the Commissioner as a rehabilitator. **Dardar v. Insurance Guaranty Association**, 556 So.2d 272, 274 (La. App. 1 Cir. 1990). Under this statute, the Commissioner conducts the business of the insurer in an attempt to remove the causes and conditions which were grounds for the rehabilitation and may apply to the court at any time for either an order directing liquidation, if further efforts to rehabilitate the insurer would be futile, or for an order permitting the insurer to resume control of the business, if the causes and conditions which made the proceeding necessary have been removed. **Id.**

La. R.S. 22:2010 (formerly La. R.S. 22:737), however, deals with the duties of the Commissioner as a liquidator. **Dardar**, 556 So.2d at 274. Under this statute, he may sell property of the insurer, give notice to claimants of the insurer to present claims and, to protect policyholders of the insurer whose contracts were cancelled by the liquidation order, solicit a contract whereby a solvent insurer assumes some or all liabilities of former policyholders. **Id.** These acts for the most part are subject to the prior approval of the court. **Id.**

hereby are allowed and authorized to ... [c]ommence and maintain all legal actions necessary, wherever necessary, for the proper administration of this rehabilitation proceeding ..." Moreover, contracts such as the Agreement remain in "full force and effect," and "LAHC providers and contractors [such as Milliman] are required to abide by the terms of their contracts with LAHC ..."

The Commissioner argues that the Rehabilitation Order's injunction provisions prevent arbitration. However, the injunction provisions of the Rehabilitation Order are not applicable to bar arbitration because Milliman is not suing LAHC, the Commissioner, or the Receiver and does not seek any property, encumbrance, or liability from LAHC, the Commissioner, or the Receiver. Instead, Milliman is the defendant. Moreover, the assertion of exceptions, including those asserting an arbitration provision like the present case, causes no interference in violation of the Rehabilitation Order.

Citing this Court's decisions in **LeBlanc v. Bernard**, 554 So.2d 1378, 1381 (La. App. 1 Cir. 1989), *writ denied*, 559 So.2d 1357 (La. 1990), and **Republic of Texas Savings Association v. First Republic Life Insurance Co.**, 417 So.2d 1251, 1254 (La. App. 1 Cir. 1982), *writ denied*, 422 So.2d 161 (La. 1982), the Commissioner argues that public policy prohibits arbitration because he "owes an overriding duty to the public of the State of Louisiana" and does not stand precisely in the shoes of the insolvent insurer. In **LeBlanc**, 554 So.2d at 1379-80, this Court found that the Commissioner does not stand in the shoes of an insolvent insurer; however, in **LeBlanc**, a claim was brought *against* the Commissioner as a party defendant by a plaintiff seeking to dissolve a sale and regain certain immovable property under the control of the Commissioner in his capacity as rehabilitator of an insurance company. Similarly, in **Republic of Texas Savings Association**, 417 So.2d at 1253-54, the Commissioner objected to a foreclosure proceeding being brought against the insolvent insurer's

property, and this Court found that the Commissioner did not stand in the shoes of the insolvent insurer in that he was not barred from raising certain defenses, although the insurer may have been barred from asserting said defenses.

In the present case, the Commissioner, as plaintiff, sued Milliman. No claims are being brought against the Commissioner, LAHC, or LAHC's property, as contrasted with facts of **LeBlanc** and **Republic of Texas Savings Association**. Since the **LeBlanc** and **Republic of Texas** decisions, this Court has found that the Commissioner, as rehabilitator, "takes control of the insurer, has the authority to conduct business ... steps into the shoes of the insurer" and "is bound by the same constraints as is the insurer in the normal course of business." **Dardar v. Insurance Guaranty Association**, 556 So.2d 272, 274 (La. App. 1 Cir. 1990).

Similarly, the Rehabilitation Order states that "LAHC providers and contractors are required to abide by the terms of their contracts with LAHC ..." Although La. R.S. 22:2009(E)(4) allows the Commissioner to "disavow any contracts to which the insurer is a party," it only allows disavowal of an entire contract rather than repudiating certain provisions. The Commissioner is bound to the terms of the Agreement including the arbitration provision, as LAHC would have been.

This Court is bound to uphold the arbitration provision, since we have found no exception in the law or jurisprudence that would allow for an exception to its enforcement. In light of Louisiana's strong public policy favoring arbitration and consistent with the views expressed herein, we find that the trial court erred in overruling Milliman's exception.

CONCLUSION

For the reasons stated, the judgment of the trial court is reversed. The claims of the Commissioner against Milliman are dismissed, without prejudice.

REVERSED.

EXHIBIT D

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

STATE
SEP 15 2017
DEPUTY CLERK OF COURT

JUDGMENT

A contradictory hearing regarding the following matters:

1. **DECLINATORY EXCEPTION OF LACK OF SUBJECT MATTER JURISDICTION**, filed herein by defendant, Milliman, Inc. ("Milliman");

2. **DECLINATORY EXCEPTION OF IMPROPER VENUE**, filed herein by defendant, Buck Consultants, LLC ("Buck");

3. **PEREMPTORY EXCEPTION OF PRESCRIPTION**, filed herein by defendant, Group Resources Incorporated ("GRI"); and

4. **CGI'S MOTION FOR SUMMARY JUDGMENT**, filed herein by defendant, CGI Technologies and Solutions, Inc. ("CGI").

was held pursuant to applicable law on August 25, 2017, in Baton Rouge, Louisiana, before the Honorable Timothy Kelley; present at the hearing were:

J. E. Cullens, Jr., attorney for plaintiff, James J. Donelon, Commissioner of Insurance for the State of Louisiana, in his capacity as Rehabilitator of Louisiana Health Cooperative, Inc.

James A. Brown, attorney for defendant, Buck Consultants, LLC

W. Brett Mason, attorney for defendant, Group Resources Incorporated

V. Thomas Clark, Jr., attorney for defendant, Milliman, Inc.

Frederick Theodore Le Clercq, attorney for defendant, Beam Partners, LLC

Harry J. Philips, Jr., attorney for defendant, CGI Technologies and Solutions, Inc.

Considering the evidence and exhibits admitted at this hearing, the pleadings and memoranda filed by the parties, applicable law, the argument of counsel, and for the reasons stated in open court at the hearing of this matter:

REC'D C.P.
SEP 26 2017

IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that MILLIMAN INC.'S DECLINATORY EXCEPTION OF LACK OF SUBJECT MATTER JURISDICTION is **DENIED.**

IT IS FURTHER HEREBY ORDERED, ADJUDGED, AND DECREED that BUCK CONSULTANTS, LLC'S DECLINATORY EXCEPTION OF IMPROPER VENUE is **DENIED.**

IT IS FURTHER HEREBY ORDERED, ADJUDGED, AND DECREED that GROUP RESOURCES INCORPORATED'S PEREMPTORY EXCEPTION OF PRESCRIPTION is **DENIED.**

IT IS FURTHER HEREBY ORDERED, ADJUDGED, AND DECREED that CGI TECHNOLOGIES AND SOLUTIONS, INC.'S MOTION FOR SUMMARY JUDGMENT is **DENIED, WITHOUT PREJUDICE.**

IT IS FURTHER HEREBY ORDERED, ADJUDGED, AND DECREED that this Court's previous order staying general discovery regarding the merits of this litigation dated April 26, 2017, is hereby **LIFTED**; furthermore, it is contemplated that all parties will timely confer and propose a **CASE SCHEDULING ORDER** it is contemplated that all parties will timely confer and propose and acceptable case scheduling order to be adopted by this Court.

IT IS FURTHER HEREBY ORDERED, ADJUDGED, AND DECREED that each defendant shall have 30 days from the date of the mailing of the signed judgment to file a notice of intent to seek supervisory writs.

SIGNED this 19 day of September, 2017, at Baton Rouge, Louisiana.

HON. JUDGE TIMOTHY KELLEY, 19th JDC

PLEASE PROVIDE NOTICE OF JUDGMENT
PURSUANT TO LSA–CCP ART. 1913

I HEREBY CERTIFY THAT ON THIS DAY A COPY OF THE WRITTEN REASONS FOR JUDGMENT / JUDGMENT / ORDER / WAS MAILED BY ME, WITH SUFFICIENT POSTAGE AFFIXED TO: Robert Barth Jr. V.E. Cullens, Matthew Farley, James Brown, V. Thomas Clark, Jr. Henry Olinde, Jr., DONE AND SIGNED ON 9-25-17 Robert David, Jr.
DEPUTY CLERK OF COURT
W. Britt Mann, Robert Barton, Jackie Le Clercq, Thomas McEachin, Richard Bourdon, Ryan Temple, Justin Marocco, Mirais Holden, Alexander Breckinridge

2017 SEP 15 PM 12:35
DEPUTY CLERK OF COURT

RULE 9.5 CERTIFICATION

Pursuant to Uniform Local Rule 9.5, I certify that I first circulated this proposed JUDGMENT to counsel for all parties via email on August 30, 2017, and then circulated a revised version on September 7, 2017, and that:

X No opposition was received; or

__ The following opposition was received:

I have allowed at least five (5) working days before presentation to the court.

Certified this 15th day of September, 2017.

J. E. Cullens, Jr.

Respectfully submitted,

J. E. Cullens, Jr., T.A., La. Bar #23011
Edward J. Walters, Jr., La. Bar #13214
Jennifer Wise Moroux, La. Bar #31368
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CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing has been furnished via U.S. Mail, postage prepaid, and via e-mail, to all counsel of record as follows:

I hereby certify that a true copy of the foregoing has been furnished via via e-mail to all counsel of record as follows:

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Baton Rouge, Louisiana this 15th day of SEPTEMBER, 2017.

J. E. Cullens, Jr.

EAST BATON ROUGE PARISH
2017 SEP 15 PM 12:34
DEPUTY CLERK OF COURT

EXHIBIT E

NINETEENTH JUDICIAL DISTRICT COURT

PARISH OF EAST BATON ROUGE

STATE OF LOUISIANA

CIVIL SECTION 22

. . . . . .

JAMES J. DONELON .

V. . NO. 651069

TERRY S. SHILLING, ET AL .

. . . . . .

FRIDAY, AUGUST 25, 2017

* * * * *

HEARING AND ORAL REASONS FOR JUDGMENT ON (1) DECLINATORY EXCEPTION OF LACK OF SUBJECT MATTER JURISDICTION FILED ON BEHALF OF MILLIMAN, INC., (2) DECLINATORY EXCEPTION OF IMPROPER VENUE FILED ON BEHALF OF BUCK CONSULTANTS, LLC, (3) EXCEPTION OF PREMATURITY, OR IN THE ALTERNATIVE, MOTION TO STAY PROCEEDINGS FILED ON BEHALF OF BEAM PARTNERS, LLC, AND (4) PEREMPTORY EXCEPTION OF PRESCRIPTION FILED ON BEHALF OF GROUP RESOURCES, INC.

* * * * *

THE HONORABLE TIMOTHY KELLEY, JUDGE PRESIDING

APPEARANCES	FOR
J CULLENS,JR & JENNIFER MOROUX	PLAINTIFFS
JAMES BROWN	BUCK CONSLTNS
SKIP PHILIPS & RYAN FRENCH	CGI TECHNOLOGY & SOLUTIONS
W. MASON	GROUP RESOURCES
V. CLARK, JR. & GRANT GUILLOT	MILLIMAN ,INC.
RICHARD BAUDOUIN	TRAVELER'S CAS. SURITY CO.

REPORTED AND TRANSCRIBED BY KRISTINE M. FERACHI, CCR

#87173

THIS CLAUSE, SECTION 2004 DEALS ONLY WITH THE VENUE FOR THOSE PROCEEDINGS. THEY CAN GO CHASE COMPANIES OR INDIVIDUALS WHEREVER THEY WANT. AS YOU SEE, IF YOU LOOK UNDER PARAGRAPH-B, THERE IS A PREDICATE THERE FOR 25 PERCENT OF THE POLICYHOLDERS AND WHERE THEY RESIDE.

THE COURT: YES, BUT IT TALKS ABOUT IN THE PARISH. WHAT IS THE ONLY STATE THAT HAS PARISHES? US.

MR. CLARK: WHAT I MEANT THOUGH, YOUR HONOR, WAS, IT IS DRIVEN BY NATURE OF WHERE ARE THE INTERESTS HELD TO PURSUE AN ORDER OF LIQUIDATION AND REHABILITATION, NOT TO PURSUE A BUSINESS CLAIM.

THE COURT: I UNDERSTAND WHAT YOU ARE TRYING TO ARGUE. YOU ARE SAYING THIS IS NOT -- YOUR ACTION, WHERE THEY ARE CHASING CLAIMS TO OBTAIN FUNDS FOR THE HEALTHY REHABILITATION OF THIS IN ORDER TO ENABLE THAT TO OCCUR DOES NOT FALL UNDER THAT CHAPTER. IT FALLS UNDER GENERAL CONTRACT OR TORT LAW.

MR. CLARK: EXACTLY, AND IN THAT CASE, THE ARBITRATION CLAUSE -- EXCUSE ME, THE ARBITRATION PROVISION RECOGNITION AND 9:4201 SHOULD CONTROL THIS.

THE COURT: OKAY. THANKS.

MR. CLARK: THANK YOU, YOUR HONOR.

THE COURT: I THINK YOU AND I JUST HAVE TO AGREE TO DISAGREE, AND UNFORTUNATELY, THE DISAGREEMENT AMONG US GOES AGAINST YOU.

THE DISPUTE VERY DEFINITELY PRESENTS A

NOVEL QUESTION, WHETHER THE COMMISSIONER AS THE REHABILITATOR IS EQUALLY BOUND TO THE TERMS OF THE AGREEMENT ENTERED INTO BY THE INSOLVENT INSURER THAT HAS BEEN PLACED IN ITS CHARGE. IN THIS CASE, THE PLAINTIFF'S CLAIMS AT LEAST IN PART ARISE OUT OF HIS CONTRACTURAL OBLIGATIONS SET FORTH IN A CONSULTING SERVICES AGREEMENT. THE PLAINTIFF HAS SET FORTH SEVERAL ARGUMENTS ATTEMPTING TO EXCULPATE HIM FROM ARBITRATING IN NEW YORK; HOWEVER, HIS ONLY PUBLIC POLICY ARGUMENT FRANKLY IS VERY SUCCESSFUL IN DOING SO. THE PUBLIC POLICY CONSIDERATIONS IMPLICATED HERE ARE OVERWHELMINGLY IN FAVOR OF THE PLAINTIFF. AS A REHABILITATOR, THE COMMISSIONER HAS AN OVERRIDING DUTY TO PROTECT OUR PUBLIC. AS NOTED IN THE **LEBLANC VERSUS BERNARD** -- THE COMMISSIONER'S OFFICE IS BECAUSE THE INSURANCE INDUSTRY IS, QUOTE, AFFECTED WITH THE PUBLIC INTEREST.

LOUISIANA R.S. 22:2, ANY DUTIES IMPOSED UPON THAT OFFICE THEREFORE MUST BE PERFORMED WITH THE PUBLIC INTEREST FOREMOST IN ITS MIND. FOR THIS REASON THE COMMISSIONER AS REHABILITATOR DOES NOT MERELY STAND IN THE SHOES OF L.A.H.C. DONELON'S DUTIES OWED UNDER THE R.L.C. ARE MUCH MORE EXPANSIVE AND EXTENDS NOT ONLY TO L.A.H.C., BUT ALSO TO THE CITIZENS OF LOUISIANA. IT IS IMAGINABLE THAT MANY DOMESTIC INSURANCE COMPANIES' LOCATIONS WITHIN THE STATE HAVE ENTERED INTO AGREEMENTS WITH THIRD PARTIES THAT CONTAINS ARBITRATION OR

FORUM SELECTION CLAUSES, AND IT WOULD BE ABSURD TO REQUIRE DONELON TO LITIGATE ANY DISPUTE ARISING OUT OF THESE AGREEMENTS ALL OVER THE U.S. NOT ONLY WOULD IT STRAIN THE FINANCIAL RESOURCES OF THE STATE, BUT IT WOULD ALSO COMPROMISE DONELON'S ABILITY TO EFFECTIVELY EXECUTE HIS STATUTORY RESPONSIBILITIES AS REHABILITATOR. THUS, WHILE LOUISIANA'S PUBLIC INTEREST IN ENFORCING ARBITRATION AGREEMENTS IS STRONG, DONELON'S DUTY TO THE PUBLIC IS STRONGER.

IT SHOULD BE NOTED THAT MILLIMAN ENTERED INTO AN AGREEMENT WITH THE LOUISIANA INSURANCE COMPANY. IT IS CERTAINLY FORESEEABLE THAT SHOULD L.A.H.C. GO UNDER, IT WOULD BE SUBJECT TO A TAKEOVER BY THE INSURANCE COMMISSION. MILLIMAN ARGUES THAT LOUISIANA R.S. 22:2004 IS PERMISSIVE AND THEREFORE ALLOWS FOR ARBITRATION. HOWEVER, LOUISIANA R.S. 22:2004 READ IN PARI MATERIA WITH 22:257 OF THE H.M.O. ACT SUGGESTS OTHERWISE. ALTHOUGH THE COMMISSIONER MAY CHOOSE THE VENUE IN WHICH TO BRING THIS ACTION, THE ACTION MUST NONETHELESS BE BROUGHT IN A LOUISIANA STATE COURT. IT WOULD NOT MAKE SENSE FOR THE LEGISLATURE TO RESTRICT JURISDICTION TO LOUISIANA ONLY FOR LIQUIDATION ACTIONS WHILE ALLOWING REHABILITATION ACTIONS TO BE LITIGATED ANYWHERE IN THE UNITED STATES.

NEXT, LOUISIANA R.S. 9:4201 OF THE LOUISIANA BINDING ARBITRATION LAW PROVIDES THAT ARBITRATION AGREEMENTS ARE ENFORCEABLE SAVE

UPON SUCH GROUNDS AS EXIST AT LAW OR IN EQUITY. IN THIS CASE THERE ARE GROUNDS THAT EXIST AT LAW, AND PUBLIC POLICY CONCERNS WHICH FALL WITHIN THAT STATUTE AS THE EXCEPTION TO A BINDING ARBITRATION REQUIREMENT. FURTHER, THE REHABILITATION ORDER SPECIFICALLY EXCLUDES THE ABILITY TO ADJUDICATE ANY ISSUE IN ANY OTHER VENUE OTHER THAN THIS.

SO, I HAVE TO DENY THE EXCEPTION OF LACK OF SUBJECT MATTER JURISDICTION, AND COSTS ASSESSED FOR THIS HEARING ONLY AGAINST MILLIMAN.

NEXT WOULD BE IMPROPER VENUE BY BUCK CONSULTANTS, L.L.C. I WONDER HOW THAT IS GOING TO GO. GO AHEAD.

MR. BROWN: YOUR HONOR, I WOULD BEGIN BY POINTING OUT THAT THERE IS A DISTINCTION BETWEEN ARBITRATION AND FORUM SELECTION.

THE COURT: THERE SURE IS.

MR. BROWN: JAMES BROWN REPRESENTING BUCK CONSULTANTS. THE REHABILITATION ORDER --

THE COURT: I AM SORRY, LET ME INTERRUPT YOU. MR. CULLENS, AS YOU WON THAT, WOULD YOU DO THE ORDER ON THAT EXCEPTION OF LACK OF SUBJECT MATTER JURISDICTION, PLEASE?

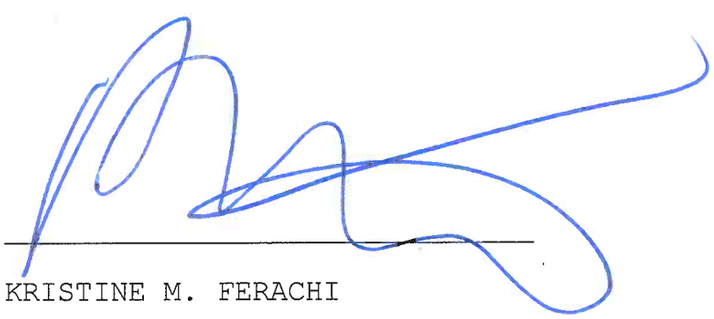
MR. CULLENS: YES, YOUR HONOR.

THE COURT: MAKE SURE UNDER 9.5 YOU PROVIDE IT TO OPPOSING COUNSEL AT LEAST FIVE DAYS PRIOR TO SUBMITTING IT TO ME. TIME FOR THE CLOCK TO START FOR YOUR POST-HEARING RELIEF; IN THIS CASE IT WOULD BE A WRIT, WOULD BE THE DAY AFTER MY SECRETARY, WHO IS A DEPUTY

C E R T I F I C A T E

I, KRISTINE M. FERACHI, CCR, OFFICIAL OR DEPUTY OFFICIAL COURT REPORTER IN AND FOR THE STATE OF LOUISIANA EMPLOYED AS AN OFFICIAL OR DEPUTY OFFICIAL COURT REPORTER BY THE 19TH JUDICIAL DISTRICT COURT FOR THE STATE OF LOUISIANA AS THE OFFICER BEFORE WHOM THIS TESTIMONY WAS TAKEN DO HEREBY CERTIFY THAT THIS TESTIMONY WAS REPORTED BY ME IN THE STENOTYPE REPORTING METHOD, WAS PREPARED AND TRANSCRIBED BY ME OR UNDER MY DIRECTION AND SUPERVISION, AND IS A TRUE AND CORRECT TRANSCRIPT TO THE BEST OF MY ABILITY AND UNDERSTANDING. THE TRANSCRIPT HAS BEEN PREPARED IN COMPLIANCE WITH TRANSCRIPT FORMAT GUIDELINES REQUIRED BY THE STATUTE OR BY RULES OF THE BOARD OR BY THE SUPREME COURT OF LOUISIANA, AND THAT I AM NOT RELATED TO COUNSEL OR TO THE PARTIES HEREIN, NOR AM I OTHERWISE INTERESTED IN THE OUTCOME OF THIS MATTER.

WITNESS MY HAND THIS 25TH DAY OF AUGUST, 2017.



KRISTINE M. FERACHI
OFFICIAL COURT REPORTER
19TH JUDICIAL DISTRICT COURT
CCR #87173

EXHIBIT F

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

STATE
NOV 29 2016
BY: DEPUTY CLERK OF COURT

FIRST 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 FIRST SUPPLEMENTAL, AMENDING AND RESTATED PETITION FOR DAMAGES AND REQUEST FOR JURY TRIAL be filed herein and served upon all named Defendants; and respectfully represents:

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	:	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

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.

9.

Defendants

Named Defendants herein are the following:

10.

D&O Defendants

a. **TERRY S. SHILLING** ("**Shilling**"), an individual of the full age of majority domiciled in the State of Georgia. Shilling was the Chief Executive Officer, President and Director of LAHC, from 2011 until approximately 2013.

b. **GEORGE G. CROMER** ("**Cromer**"), an individual of the full age of majority domiciled in the State of Louisiana. Cromer was the Chief Executive Officer of LAHC after Shilling, from 2013 until approximately August 2015.

c. **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.

d. **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.

e. **CHARLES D. CALVI** ("**Calvi**"), an individual of the full age of majority domiciled in the State of Louisiana. Calvi was the Executive Vice President and Marketing Officer of LAHC from 2014 until approximately August 2015.

f. **PATRICK C. POWERS** ("**Powers**"), an individual of the full age of majority who is currently, upon information and belief, domiciled in the State of Tennessee. Powers was the Chief Financial Officer and Treasurer of LAHC from 2014 until approximately April 2015.

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 May 2014, CGI served as the Third Party Administrator of LAHC. 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 Defendant

a. **TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA ("Travelers")**, 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 LAHC 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 Defendants herein, specifically: Terry S. Shilling, George G. Cromer, Warner L. Thomas, IV, William A. Oliver, Charles D. Calvi, and Patrick C. Powers.

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: Travelers Casualty and Surety Company of America ("Travelers").

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.

[THE REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK]

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 Defendant)

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 Defendant 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.

The Insurer Defendant is 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. Travelers Casualty and Surety Company of America issued a Private Company Directors and Officers Liability Insurance Policy to LAHC, with policy limits, upon information and belief, of $3,000,000.00, 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. Travelers Casualty and Surety Company of America issued a Managed Care Errors and Omissions Liability Insurance Policy to LAHC, with policy limits, upon information and belief, of $3,000,000.00, 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.

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

40.

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

CGI

41.

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."

42.

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.

43.

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 task expected and required of a Third Party Administration, whether specified in the Agreement or not.

44.

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.

45.

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.

46.

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

GRI

47.

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

48.

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." Attached hereto as "Exhibit 2A" is a true and correct copy of the Delegation Agreement between LAHC and GRI effective August 20, 2014.

49.

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."

50.

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 task expected and required of a Third Party Administration, whether specified in the Agreement or not.

51.

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.

52.

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.

53.

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

54.

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.

55.

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.

56.

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.

57.

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."

58.

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.

59.

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.

60.

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.

61.

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.

62.

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.

63.

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.

64.

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)

65.

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

66.

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.

67.

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.

68.

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

69.

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.

70.

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.

71.

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.

72.

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.

73.

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)

74.

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

Milliman

75.

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

76.

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).

77.

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."

78.

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.

79.

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.

80.

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.

81.

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.

82.

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.

83.

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.

84.

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.

85.

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.

86.

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.

87.

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.

88.

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.

89.

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.

90.

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.

91.

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.

92.

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.

93.

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.

94.

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."

95.

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.

96.

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

97.

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.

98.

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.

99.

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."

100.

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.

101.

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.

102.

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.

103.

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

104.

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

105.

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.

106.

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.

107.

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.

108.

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.

109.

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.

110.

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.

111.

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.

112.

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.

113.

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."

114.

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.

115.

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.

116.

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.

117.

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."

118.

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.

119.

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.

120.

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.

121.

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.

122.

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."

123.

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.

124.

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).

125.

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.

126.

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.

127.

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)

128.

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

Milliman

129.

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

130.

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

131.

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

132.

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.

133.

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

134.

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

135.

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

136.

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

137.

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.

138.

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

139.

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.

140.

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.

141.

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.

142.

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

143.

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

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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 Defendants named herein, 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, 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

FILED
NOV 29 PM 1:42
DEPUTY CLERK OF COURT

[SERVICE INFORMATION ON FOLLOWING PAGES]

PLEASE SERVE THE FOLLOWING DEFENDANTS WITH THE PETITION FOR DAMAGES AND JURY DEMAND *AND* FIRST SUPPLEMENTAL, AMENDING AND RESTATED PETITION AS FOLLOWS:

~~TERRY~~ S. SHILLING
VIA LONG ARM SERVICE
4271 Brookview Drive SE
Atlanta, GA 30339

GEORGE G. CROMER
308 Margon Court
Slidell, LA 70458

WARNER L. THOMAS, IV
1514 Jefferson Highway
New Orleans, LA 70121

~~WILLIAM~~ A. OLIVER
VIA LONG ARM SERVICE
345 Harbor Drive
Old Hickory, TN 37138

CHARLES D. CALVI
18437 E. Village Way Drive
Baton Rouge, LA 70810

PATRICK C. POWERS
9572 Wesson Street
Baton Rouge, LA 70809

~~CGI TECH~~NOLOGIES 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 RES~~OURCES INCORPORATED
VIA LONG ARM SERVICE
Through its agent for service of process:
Philip H. Weener
5887 Glendridge Drive
Suite 275
Atlanta, GA 30328

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

TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA
Through its agent for service of process:
LA Secretary of State
8585 Archives Avenue
Baton Rouge, LA 70809

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

Delegation Agreement
Louisiana Health Cooperative, Inc.
and
Group Resources, Inc.

THIS DELGATION AGREEMENT ("Agreement") effective August 20, 2014, ("Effective Date") is between Louisiana Health Cooperative (LAHC) and Group Resources, Inc. (GRI).

WHEREAS, LAHC desires to delegate to GRI certain activities pursuant to the terms of the Administrative Services Agreement By and Between Group Resources, Inc. and Louisiana Health Cooperative, Inc. Delegated activities include Practitioner & Hospital Directories and key Member Communications functions, collectively defined as "Delegated Activities", for members; and

WHEREAS, LAHC may update this Delegation Agreement from time to time; and

WHEREAS, GRI agrees that its Delegated Activities standards meet and shall continue to meet all applicable standards of the National Committee for Quality Assurance ("NCQA"), and LAHC's policies and any applicable federal laws, regulations or regulatory authority, and any applicable state laws or regulations or other state regulatory authority; and

WHEREAS, although certain activities have been delegated, LAHC shall maintain accountability and oversight responsibilities for all Delegated Activities.

NOW THEREFORE, LAHC agrees to delegate to GRI all Delegated Activities and GRI agrees to comply with the following requirements and to provide all necessary documentation associated with these requirements in support of the LAHC NCQA Accreditation Survey.

SECTION 1

Delegated Activities and Responsibilities: Member Communications Functions

1.1 Member Inquiry and Complaint Resolution and Tracking – GRI will handle member inquiries, complaints, and grievances following LAHC established policies. GRI will assist members in documenting their written grievance. GRI will document all member inquiries, complaints, and grievances, distinguishing between behavioral health and non-behavioral health complaints and categorize into the following categories:

- Quality of Care
- Access
- Quality and Service
- Billing and Financial Issues
- Quality of Practitioner Office Site
- Utilization Management
- Case Management
- Disease Management

1.2 Member Services by Telephone – GRI will handle member calls, including calls regarding authorization requirements and member benefit and financial responsibility. GRI will transfer calls regarding pharmacy benefits to the PBM.

1.3 Member Services by Web – GRI will ensure a Member Portal that includes the ability to order ID cards, determine authorization requirements, and determine member benefit and financial responsibility.

1.4 Member Information Distribution – GRI will distribute information to members upon enrollment, including key subscriber information, member rights and responsibilities statement, and privacy notifications.

1.5 GRI shall provide LAHC with the following reports:

Reporting Requirements	Frequency
Mailing Volume Reports, detailing new enrollment mailings	Monthly: due within 30 days of the last day of the report month.
Telephone Service Reports including monthly call volume, Average Speed of Answer (ASA), abandonment rate, and service level	Monthly: due within 30 days of the last day of the report month.
Telephone Inquiry Quality and Accuracy Reports	Quarterly: due 30 days of the last day of the report quarter
Complaint and Inquiry Reports (complaints and inquiry volume by type)	Monthly: due 30 days of the last day of the report month.
Web-site Quality and Accuracy Reports (quality and accuracy of the response provided by the Website for ID cards, authorization information, and member benefit and financial responsibility)	Quarterly: due 30 days from the last day of the report quarter

SECTION 2

LAHC's Responsibilities

2.1 LAHC shall assign a liaison responsible for problem identification and resolution of the delegated program who assists in ongoing problem solving, communication, and coordination between GRI and LAHC.

2.2 LAHC shall provide prior written notification of any change which may be required for GRI to comply with standards required by either regulatory, accrediting, or legislative bodies.

2.3 LAHC shall maintain accountability and oversight responsibilities for all Delegated Activities.

2.4 LAHC shall maintain responsibility for providing new and revised practitioner and hospital information to GRI.

2.5 LAHC shall maintain responsibility for member appeals.
2.6 LAHC may provide GRI with cost estimator tool to be included on member portal.
2.7 LAHC shall provide GRI with the required authorization list.
2.8 LAHC shall provide GRI with Member Experience data and clinical performance data as available and upon delegate request.

SECTION 3

Monitoring of Delegated Activities

3.1 Audits - GRI shall cooperate and fully participate in audits, site visits and other monitoring of GRI's Delegated Activities conducted by LAHC.

3.2 Annual Audit - GRI shall obtain and maintain in good standing its NCQA Health Information Products (HIP) certification. If NCQA HIP certification is not obtained and maintained in good standing, LAHC will complete an annual evaluation of GRI's program.

3.3 Deficiencies and Corrective Action Plan - Notwithstanding any other service levels and remedies in the Agreement, in the event deficiencies are noted during reporting or an audit, GRI shall develop a corrective action plan (CAP) for the specific Delegated Activity that is determined by LAHC to be deficient. The CAP shall include specifics of and timelines for correcting the deficiency, and shall be provided to LAHC within 30 calendar days of LAHC's report of its findings. LAHC shall review and comment on the CAP. The CAP shall be implemented by GRI within the specified timeframes listed therein. In the event, the CAP is not developed and/or implemented, delegation of the specific Delegated Activity, subject to the CAP, may be revoked.

SECTION 4

Corrective Action if Delegate Fails to Perform

4.1 **Termination of Delegation Agreement.** The Delegation Agreement or certain Delegation Activities may be terminated as follows:

A. By LAHC at any time, for "without cause" termination, upon 90 days written notice.
B. By LAHC immediately, due to full revocation of Delegated Activities performed under this Delegation Agreement.
C. By either party, in the event of a breach of this Delegation Agreement by the other party, upon 60 days prior written notice to the other party if the breach has not been cured within 60 days after notice of such breach.

4.2 **Revocation of Certain Delegated Activities.** LAHC retains the right to revoke the delegation of a specific Delegated Activity as follows:

A. At any time for a "without cause" revocation upon 90 days written notice.
B. Immediately in the event any material deficiencies are not corrected or in the event GRI fails to develop a CAP pursuant to Section 3 of this Delegation Agreement.

IN **WITNESS WHEREOF,** the parties have executed this agreement on the date shown below.

DELEGATION AGREEMENT

LOUSIANA HEALTH COOPERATIVE, Inc.		Group Resources, Inc.	
By:		By:	
Print Name:	Greg Cromer	Print Name:	ANDREW WILLOUGHBY
Print Title:	Chief Executive Officer	Print Title:	SVP & COO
Date:	09/02/2014	Date:	8/26/14

EXHIBIT G

CONSULTING SERVICES AGREEMENT

This Agreement is entered into between Milliman, Inc. (Milliman) and Louisiana Health Cooperative, Inc. (Company) as of August 4, 2011. Company has engaged Milliman to perform consulting services as described in the letter dated August 4, 2011 and attached hereto. The parties agree that these terms and conditions will apply to all current and subsequent engagements of Milliman by Company unless specifically disclaimed in writing by both parties prior to the beginning of the engagement. In consideration for Milliman agreeing to perform these services, Company agrees as follows.

1. **BILLING TERMS.** Company acknowledges the obligation to pay Milliman for services rendered, whether arising from Company's request or otherwise necessary as a result of this engagement, at Milliman's standard hourly billing rates for the personnel utilized plus all out-of-pocket expenses incurred. Milliman will bill Company periodically for services rendered and expenses incurred. All invoices are payable upon receipt. Milliman reserves the right to stop all work if any bill goes unpaid for 60 days. In the event of such termination, Milliman shall be entitled to collect the outstanding balance, as well as charges for all services and expenses incurred up to the date of termination.

2. **TOOL DEVELOPMENT.** Milliman shall retain all rights, title and interest (including, without limitation, all copyrights, patents, service marks, trademarks, trade secret and other intellectual property rights) in and to all technical or internal designs, methods, ideas, concepts, know-how, techniques, generic documents and templates that have been previously developed by Milliman or developed during the course of the provision of the Services provided such generic documents or templates do not contain any Company Confidential Information or proprietary data. Rights and ownership by Milliman of original technical designs, methods, ideas, concepts, know-how, and techniques shall not extend to or include all or any part of Company's proprietary data or Company Confidential Information. To the extent that Milliman may include in the materials any pre-existing Milliman proprietary information or other protected Milliman materials, Milliman agrees that Company shall be deemed to have a fully paid up license to make copies of the Milliman owned materials as part of this engagement for its internal business purposes and provided that such materials cannot be modified or distributed outside the Company without the written permission of Milliman.

3. **LIMITATION OF LIABILITY.** Milliman will perform all services in accordance with applicable professional standards. The parties agree that Milliman, its officers, directors, agents and employees, shall not be liable to Company, under any theory of law including negligence, tort, breach of contract or otherwise, for any damages in excess of three times the professional fees paid to Milliman with respect to the work in question or $3,000,000, whichever is less. In no event shall Milliman be liable for lost profits of Company or any other type of incidental or consequential damages. The foregoing limitations shall not apply in the event of the intentional fraud or willful misconduct of Milliman.

4. **DISPUTES.** In the event of any dispute arising out of or relating to the engagement of Milliman by Company, the parties agree that the dispute will be resolved by final and binding arbitration under the Commercial Arbitration Rules of the American Arbitration Association. The arbitration shall take place before a panel of three arbitrators. Within 30 days of the commencement of the arbitration, each party shall designate in writing a single neutral and independent arbitrator. The two arbitrators designated by the parties shall then select a third arbitrator. The arbitrators shall have a background in either insurance, actuarial science or law. The arbitrators shall have the authority to permit limited discovery, including depositions, prior to the arbitration hearing, and such discovery shall be conducted consistent with the Federal Rules of Civil Procedure. The arbitrators shall have no power or authority to award punitive or exemplary damages. The arbitrators may, in their discretion, award the cost of the arbitration, including reasonable attorney fees, to the prevailing party. Any award made may be confirmed in any court having jurisdiction. Any arbitration shall be confidential, and except as required by law, neither party may

disclose the content or results of any arbitration hereunder without the prior written consent of the other parties, except that disclosure is permitted to a party's auditors and legal advisors.

5. **CHOICE OF LAW.** The construction, interpretation, and enforcement of this Agreement shall be governed by the substantive contract law of the State of New York without regard to its conflict of laws provisions. In the event any provision of this agreement is unenforceable as a matter of law, the remaining provisions will stay in full force and effect.

6. **NO THIRD PARTY DISTRIBUTION.** Milliman's work is prepared solely for the internal business use of Company. Milliman's work may not be provided to third parties without Milliman's prior written consent. Milliman does not intend to benefit any third party recipient of its work product, even if Milliman consents to the release of its work product to such third party.

7. **CONFIDENTIALITY.** Any information received from Company will be considered "Confidential Information." However, information received from Company will not be considered Confidential Information if (a) the information is or comes to be generally available to the public during the course of Milliman's work, (b) the information was independently developed by Milliman without resort to information from the Company, or (c) Milliman appropriately receives the information from another source who is not under an obligation of confidentiality to Company. Milliman agrees that Confidential Information shall not be disclosed to any third party.

MILLIMAN, INC.

By: _____

Name: Courtney R. White

Title: Consulting Actuary

Date: August 4, 2011

LOUISIANA HEALTH COOPERATIVE, INC.

By: _____

Name: Terry S Shilling

Title: Chief Executive Officer

Date: August 15, 2011