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
	:	19TH JUDICIAL DISTRICT COURT
versus	:	
GROUP RESOURCES INCORPORATED, MILLIMAN, INC., BUCK GLOBAL, LLC. AND IRONSHORE SPECIALTY COMPANY	:	PARISH OF EAST BATON ROUGE
	:	STATE OF LOUISIANA

FIFTH 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 FIFTH 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
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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.

TPA Defendant

a. **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.

b. **IRONSHORE SPECIALTY INSURANCE COMPANY** ("Ironshore"), a foreign insurer, doing business in the State of Louisiana, who issued an applicable policy or policies to GRI that provide coverage for the claims asserted herein.

11.

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 GLOBAL, LLC f/k/a 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.

DEFINED TERMS

12.

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

1. "**TPA Defendant**" shall refer to and mean the third party administrators hired by LAHC to oversee, manage, and otherwise operate LAHC; specifically: GRI and its insurer, Ironshore.

2. **"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 Global, LLC ("Buck").

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

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

FACTUAL BACKGROUND

13.

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.

14.

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

$13,176,560, 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.

15.

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.

16.

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.

17.

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.

18.

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.

19.

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 at least tens of millions of dollars

20.

As set forth herein, Defendants are liable to Plaintiff for all compensatory damages caused by their actionable conduct. Plaintiff makes no claim for post-Receivership administrative expenses or attorneys' fees.

CAUSES OF ACTION

Count One: Breach of Contract (Against GRI, the TPA Defendant)

21.

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

22.

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.

23.

In or before 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 to the First Supplemental, Amended, and Restated Petition for Damages and Request for Jury Trial as "Exhibit 2A" was and is a true and correct copy of the Delegation Agreement between LAHC and GRI effective August 20, 2014.

24.

Under the terms of the Agreement, GRI 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."

25.

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.

26.

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 $1,056,876.24;

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

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

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

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

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

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

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

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

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

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

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

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

s. Failed to invoice subscribers accurately when APTC changed;

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

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

v. Failed to cancel members after passive enrollment;

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

x. Failed to pay interest on claims to providers;

y. Failed to pay claims within the contractual timeframes;

z. Failed to adjust claims after retroactive disenrollments;

aa. Failure to examine claims for potential subrogation

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

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

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

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

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

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

hh. Paid claims for members that never effectuated;

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

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

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

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

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

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

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

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

qq. Failed to submit correct Taxpayer Identification Numbers associated with 1099s, resulting in IRS penalties and fines of $37,700.

27.

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.

28.

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.

Count Two: Gross Negligence and Negligence
(Against GRI, the TPA Defendant)

29.

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

30.

GRI 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.

31.

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

32.

GRI had a duty to perform its obligations in a reasonable, competent, and professional manner.

33.

GRI breached its 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.

34.

GRI breached its duties in that it negligently and wholly failed to perform its obligations in a reasonable, competent, and professional manner.

35.

GRI was grossly negligent in that it 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.

36.

GRI was 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.

37.

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

Count Three: Professional Negligence, Gross Negligence And Breach of Contract (Against the Actuary Defendants)

38.

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

Milliman

39.

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

40.

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).

41.

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."

42.

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.

43.

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.

44.

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.

45.

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 compromised its independence as an actuary and thereby breached its duty to LAHC.

46.

Milliman served as the actuary for not only LAHC, but for the vast majority of the other, 23 CO-OP's originally created under the ACA around the country. To date, at least 19 of the 23 CO-Ops have ceased operation. Upon information and belief, Milliman used this same financing model (i.e., conditioning payment upon approval by the federal government) with all CO-OP's)who hired Milliman to do actuarial work.

47.

The terms of the Agreement between LAHC AND Milliman (AND Millimand tnhe the other CO-OPscreated an improper incentive for Milliman to convince federal officials to approve and fund the project. Approval and funding was the only way Milliman could recover its fee for the initial feasibility study and business plan, and also ensure future fees for the provision of additional actuarial services to LAHC and the other similarly situated CO-OPs around the nation. The improper financial motivation compromised Milliman's objectivity and independence in certifying the feasibility study and business plan.

48.

Milliman did not disclose its financial interest in LAHC (and the other CO-OPs) receiving federal funding approval or its potential conflict of interest to CMS, nor did Milliman disclose and describe the implications of its financial interest and potential conflict to LAHC

49.

Percept 7 of the American Academy of Actuaries (AAA) code of professional conduct provides that when a conflict of interest exists, as it does here, Milliman should disclosure any such conflict and advise all interested parties that it cannot act fairly in an unimpaired way.

50.

According to ASOP 41 regarding the professional standard for communications by actuaries like Milliman, Section 3.4.2 provides that Milliman should have disclosed this conflict of interest in their feasibility study so that any reader of the study would know that Milliman was impaired.

51.

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 $13,176,560 to LAHC, and a Solvency Loan of $52,614,100, plus approximately $13.5 million in penalties and interest to date, to LAHC. In a very real sense, Milliman is responsible for the existence of LAHC and all resulting compensatory damages.

52.

Because Milliman provided a pro forma, cookie-cutter analysis of each CO-OP's financial condition and viability, as opposed to undertaking a detailed, market / state specific analysis for each and every individual CO-OP like LAHC, Milliman grossly deviated from acceptable actuarial practice. By using essentially the same methodology and analysis in each of the approximately 18 CO-OP's which Milliman compiled the feasibility studies for submission to the federal government, Milliman grossly breached its professional duty of care owed to LAHC and the other CO-Ops who contracted with Milliman to do this essential work.

53.

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.

54.

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.

55.

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.

56.

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.

57.

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.

58.

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.

59.

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.

60.

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.

61.

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.

62.

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.

63.

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.

64.

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."

65.

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.

66.

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

67.

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.

68.

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.

69.

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."

70.

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.

71.

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.

72.

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.

73.

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.

74.

As alleged in detail herein, the conduct of Milliman went way beyond simple negligence. Milliman's substandard conduct constitutes gross negligence, if not a conscious disregard for the best interests of LAHC, its members, providers, and creditors. But for Milliman's gross negligence, most of LAHC's substantial, compensatory damages would have been avoided.

Buck

75.

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

76.

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 Patrick C. 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.

77.

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.

78.

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.

79.

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.

80.

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.

81.

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.

82.

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.

83.

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.

84.

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."

85.

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.

86.

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.

87.

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.

88.

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."

89.

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.

90.

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.

91.

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.

92.

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.

93.

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."

94.

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.

95.

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).

96.

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.

97.

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.

98.

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.

99.

As alleged in detail herein, the conduct of Buck went way beyond simple negligence. Buck's substandard conduct constitutes gross negligence, if not a conscious disregard for the best interests of LAHC, its members, providers, and creditors. But for Buck's gross negligence, most of LAHC's substantial, compensatory damages would have been avoided.

Count Four: Negligent Misrepresentation
(Against the Actuary Defendants)

100.

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

Milliman

101.

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

102.

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

103.

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

104.

In Milliman's reports concerning LAHC's funding needs and premium rates, Milliman negligently misrepresented the actual funding needs and premium rates of LAHC. Milliman's negligent misrepresentations regarding LAHC's actual funding needs and premium rates were made to LAHC. LAHC relied upon these negligent misrepresentations to its detriment.

105.

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.

106.

As alleged in detail herein, the conduct of Milliman went way beyond simple negligence. Milliman's substandard conduct constitutes gross negligence, if not a conscious disregard for the best interests of LAHC, its members, providers, and creditors. But for Milliman's gross negligence, most of LAHC's substantial, compensatory damages would have been avoided.

Buck

107.

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

108.

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

109.

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

110.

In Buck's reports concerning LAHC's funding needs and premium rates, Buck negligently misrepresented the actual funding needs and premium rates of LAHC. Buck's negligent misrepresentations regarding LAHC's actual funding needs and premium rates were made to LAHC. LAHC relied upon these negligent misrepresentations to its detriment.

111.

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.

112.

As alleged in detail herein, the conduct of Buck went way beyond simple negligence. Buck's substandard conduct constitutes gross negligence, if not a conscious disregard for the best interests of LAHC, its members, providers, and creditors. But for Buck's gross negligence, most of LAHC's substantial, compensatory damages would have been avoided.

Count Five: Breach of Fiduciary Duty
(Against GRI and the Actuary Defendants)

GRI

113.

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

114.

The contract between GRI and LAHC created an agency (mandate) relationship, with GRI acting as the agent on behalf of LAHC, the principal. As an agent, GRI inherently owed fiduciary duties to LAHC, its principal.

115.

LAHC placed substantial faith, confidence, trust, and reliance on the work done by GRI for LAHC, and the advice and representations of GRI. This resulted in GRI owing LAHC fiduciary duties, including duties of candor, honesty, good faith, and to avoid any conflict of interest or potential self-dealing.

116.

As LAHC's agent, GRI handled and managed the assets of LAHC (e.g. premiums and funds used to pay providers, etc.) and was heavily involved in the day-to-day administration of LAHC. Because GRI had and exercised discretionary authority and/or had discretionary control regarding the management of LAHC, including management or disposition of LAHC's assets, GRI owed a fiduciary duty to LAHC. Because GRI had discretionary authority and/or discretionary responsibility regarding the administration of LAHC, GRI owed a fiduciary duty to LAHC.

117.

GRI breached its fiduciary duties by, among other things, engaging in that specific conduct alleged in detail in Paragraphs 21-28, *supra*.

118.

GRI's breaches of fiduciary duty proximately caused compensatory damage to LAHC, policyholders, and creditors, causing tens of millions in damages.

Milliman

119.

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

120.

Because it was a start-up insurance company with no access or ability to confirm Milliman's confidential actuarial guidelines and protocols, LAHC placed substantial faith, confidence, trust, and reliance on the advice and representations of Milliman. This resulted in Milliman owing LAHC fiduciary duties, including duties of candor, honesty, good faith, and to avoid any conflict of interest or potential self-dealing.

121.

LAHC developed a great deal of trust and confidence in the work performed by Milliman. The very existence of LAHC depended upon Milliman's feasibility study submitted to the federal government. The soundness of Milliman's analysis would determine whether LAHC would ever write policies or operate as a CO-OP under the ACA. LAHC relied upon Milliman's confidential actuarial work to its grave detriment.

122.

Milliman owed fiduciary duties to LAHC.

123.

There were also much wider ramifications for Milliman than just LAHC. Milliman had touted the other start-up CO-OPs and touted the strength of its Confidential Guidelines. Milliman secured engagements with the vast majority of the other start-up CO-OPs and played an instrumental role in those CO-OPs securing millions in federal funds and first-year rate approval.

124.

If Milliman had revealed the true financial condition of LAHC, it would have cast doubt on Milliman's work for the other companies, many of which were also at varying stages of financial distress.

125.

Today, only about four of the 23 CO-OPs remain, and they are under varying degrees of financial distress and regulatory oversight. The remaining 19 were put under some form of regulatory action (e.g., supervision or liquidation) and ultimately closed.

126.

Milliman breached their fiduciary duties by, among other things engaging in that conduct specifically pled at paragraphs 39-74, *supra*, and:

a. Failing to disclose Milliman's conflict or potential conflict of interest caused by Milliman's financial stake in LAHC securing federal funding approval.

b. Putting its own interest ahead of LAHC's in order to protect Milliman's reputation throughout the healthcare industry, as well as its lucrative financial relationships with the other CO-OPs.

c. Failing to be honest, forthright, and candid with LAHC and CMS that Milliman had substantially underpriced some of LAHC 's health plans.

d. Failing to be honest, forthright, and candid with LAHC and CMS about the risks associated with the underpriced plans.

e. Once LAHC started covering claims, and the risks associated with the underpriced plans began to come to fruition, resulting in alarming financial losses and trends, Milliman failed to be honest, forthright, and candid with LAHC and CMS about the true and accurate financial condition of the company.

f. Failing to timely advise LAHC and CMS through accurate projections and actuarial certifications, of the financial ramifications associated with LAHC's underpriced plan rates.

127.

Milliman's breaches of fiduciary duty proximately caused compensatory damage to LAHC, policyholders, and creditors, causing tens of millions in damages.

Buck

128.

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

129.

Buck owed fiduciary duties to LAHC.

130.

Because it was a relatively new insurance company with no access or ability to confirm Buck's confidential actuarial guidelines and protocols, LAHC placed substantial faith, confidence, trust, and reliance on the advice and representations of Buck. This resulted in Buck owing LAHC fiduciary duties, including duties of candor, honesty, good faith, and to avoid any conflict of interest or potential self-dealing.

131.

Buck breached its fiduciary duties by, among other things, engaging in that specific conduct alleged in detail in Paragraphs 75-99, *supra*.

132.

Buck's breaches of fiduciary duty proximately caused compensatory damage to LAHC, policyholders, and creditors, causing tens of millions in damages.

133.

Ironshore issued an applicable policy or policies to GRI that provide coverage for the claims asserted against GRI herein; as such, Ironshore is jointly and severally liable with GRI to the extent of the policy limits of any such policy.

DAMAGES

134.

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

135.

The compensable damages caused by the 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 payments, bonuses, profits, benefits, and other compensation inappropriately obtained by them;

g. damages in the form of all excessive administrative, operational, and/or management expenses incurred by LAHC prior to Receivership 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 other compensatory and equitable damages allowed by applicable law.

PRESCRIPTION AND DISCOVERY OF TORTIOUS CONDUCT

136.

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.

137.

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.

138.

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.

139.

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

140.

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

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, James J. Donelon, Commissioner of Insurance for the State of Louisiana in his capacity as Rehabilitator of Louisiana Health Cooperative, Inc., through his duly appointed Receiver, Billy Bostick, prays and demands that the following Defendants named herein, Group Resources Incorporated, Milliman, Inc., Buck Global f/k/a Buck Consultants, LLC, and Ironshore Specialty Insurance Company, be cited to appear and answer, and that upon a final hearing of the cause, judgment be entered against Defendants and in favor of Plaintiff for all compensable damages in an amount reasonable in the premises, including:

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

b. all fees, expenses, and compensation of any kind paid by LAHC to Defendants, GRI, Milliman, and Buck;

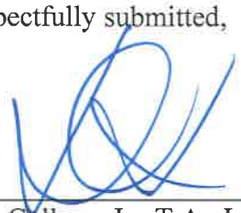
c. all recoverable costs and litigation expenses incurred herein;

d. all judicial interest;

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

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

Respectfully submitted,



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CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing has been furnished via e-mail and U.S. Mail, postage prepaid, to all counsel of record as follows, this 1st day of April, 2021, in Baton Rouge, Louisiana.

W. Brett Mason
Michael W. McKay
Stone Pigman
301 Main Street, #1150
Baton Rouge, LA 70825

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Justin Kattan
Catharine Luo
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Reid Ashinoff
DENTONS US
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J. E. Cullens, Jr.

PLEASE SERVE THE FOLLOWING DEFENDANT WITH THE PETITION FOR DAMAGES AND JURY DEMAND *AND* FIRST SUPPLEMENTAL, AMENDING AND RESTATED PETITION *AND* SECOND SUPPLEMENTAL, AMENDING AND RESTATED PETITION, *AND* THIRD SUPPLEMENTAL, AMENDING AND RESTATED PETITION, *AND* FOURTH SUPPLEMENTAL, AMENDING AND RESTATED PETITION, *AND* FIFTH SUPPLEMENTAL, AMENDING AND RESTATED PETITION AS FOLLOWS:

IRONSHORE SPECIALTY INSURANCE COMPANY
Through its agent for service of process:
The Louisiana Secretary of State
8585 Archives Avenue
Baton Rouge, LA 70809