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MONTANA FIRST JUDICIAL DISTRICT COURT
LEWIS & CLARK COUNTY

DANA ROLAN, on her own behalf and on behalf of the class she represents, Plaintiffs, vs. NEW WEST HEALTH SERVICES, DARWIN SELECT INSURANCE COMPANY and ALLIED WORLD ASSURANCE COMPANY and DARWIN NATIONAL ASSURANCE COMPANY, Defendants.	Cause No. DDV 2010-91 Honorable Christopher D. Abbott **PLAINTIFFS' BRIEF IN SUPPORT OF MOTION TO AMEND**

COME NOW Dana Rolan and the Class she represents and supports her Motion to Amend and supplement the Complaint as follows:

A. BACKGROUND

Thirteen years ago, Dana Rolan, a sixteen-year-old Capital High student, was seriously and permanently injured in an auto accident. Her medical bills alone exceeded $100,000. Her health insurer, New West Health Services, however, refused to pay the bills, forcing her to file this lawsuit. She included a class action

since it appeared New West was doing the same thing to other people. She asked for restitution of her benefits. She also requested compensatory and punitive damages under Montana's Unfair Settlement Practices Act, §§33-18-201, *et.seq*. because New West was violating well-settled law in refusing to pay her bills, forcing her to sue.

The case proceeded in an expected fashion. After a few years of discovery and motion practice, the District Court in 2012 held New West liable and ordered restitution of benefits to both Rolan and the Class. DN 49. The Court based its decision on Montana's "made-whole" law, which provides insurers, including health insurers, like New West, cannot avoid paying benefits unless and until the injured insureds, like Ms. Rolan, have been full compensated for all tort damages.

New West appealed, but in 2013, the Montana Supreme Court affirmed. *See, Rolan v. New West Health Services*, 2013 MT 220. They cited to *Blue Cross Blue Shield v. State Auditor,* 2009 MT 318 where they had held the made-whole law had been settled Montana law since the 1970s and had been codified into law regarding health insurers since the early 1990s. They remanded to pay the claims.

Thus, the case was over in 2013. So how is it almost a decade later that the litigation continues and no one has yet been paid a red cent? The delay makes a mockery of the canon that "justice delayed is justice denied." On its face, it

violates the fundamental constitutional guarantee that all persons are entitled to a speedy remedy in the courts of Montana. Art II, §16, MONT. CONST. How could this happen?

The answer is set forth in Rolan's proposed Third Amended Complaint, attached hereto. It alleges and documents the endless delay was caused by the acts and omissions of New West's liability carrier, Allied World. Its litigation strategy, concealments and deceit towards both its insured, New West, and Rolan and the Class have been the proximate cause of all the delay.

The Unfair Settlement Practices Act at §33-18-201, MCA contains several settlement duties which Allied violated to the detriment of both its insured, New West, and the claimants, Rolan and the Class. One duty is to fairly, promptly and equitably settle claims when liability is reasonably clear. Moreover, in determining whether liability is reasonably clear, the insurer must consider all "available information."

When Rolan was first injured in 2007, the law was already reasonably clear that Rolan's claims must be immediately paid. The Montana Supreme Court has on at least two occasions, characterized it as "well settled." The *State Auditor* decision, *supra*, states the "made-whole" law has been public policy since the 1970s and was codified into law against health insurers in the early 1990s. Yet,

Allied has failed to pay Rolan's claims 15 years later and basically ignored every attempt she made to settle.

After the Montana Supreme Court ruled in favor of Rolan in 2013, the defense lawyer informed Allied World in writing that liability to Rolan and the Class was clear and therefore, Allied should at least pay Rolan's claims if, for no other reason, than to decrease New West's exposure to punitive damages for delaying payment. Allied made no offer.

Instead, Allied decided to go for a long shot: It would argue the District Court's Order and the Montana Supreme Court's opinion in favor of Rolan were void. It would make a contention that all claims were covered under federal ERISA law and therefore, Montana's insurance laws were preempted. It had never raised this defense in the previous four years of litigation and in fact, New West had testified ERISA did not apply. But Allied would raise the defense anyway to derail the duty to pay.

The ERISA defense was characterized as our "only hope." When it was raised in 2013, Allied had found no documents to support it. The ones it located had "insurance" written all over them and so the defense stated, we don't want to provide those to the Court (She might get the impression the insurance laws apply

to New West after all). So, the defense directed New West to find some more documents.

Without knowing whether or not ERISA applied, the defense plowed ahead with its defense. It waited a couple of years to conduct further research and when it did, it found out its position was "tenuous" at best. The defense notified Allied the well-settled majority of courts, including those in the Ninth Circuit and the United States Supreme Court had already ruled that plans like Rolan's were not preempted by ERISA. Rather, insurers, like New West, were still required to follow state insurance laws—including the "made-whole" laws and the Unfair Settlement Practices Act. They were going to lose, but as stated in the correspondence: "We are going to continue to fight this battle."

The end came in 2017. The Montana Supreme Court held New West had no right to raise ERISA in the first instance, setting forth how it had effectively killed Rolan's and the Class's lawsuit. *Rolan II*, 2017 MT 270.

All was not lost, however. After finally conducting the research showing how "tenuous" the ERISA defense was, Allied came up with still another way to avoid its long over-due duty to pay. It would start claiming there was no insurance coverage. This would leave its insured, New West, high and dry and Rolan and the Class with little chance to receive compensation, but it would proceed anyway.

The "no-coverage" position came as a surprise to everyone. Both New West and Rolan stated Allied had been admitting full coverage for years. Its first coverage letter to New West in 2010 indicated there was full coverage. Shortly after the Supreme Court ruled in favor of Rolan in 2013, New West had written Allied asking for verification that the 2010 coverage letter was meant to indicate full coverage. Allied decided not to reply, which in itself, is a violation of the Unfair Settlement Practices Act, *supra.* Now, however, seven years into the lawsuit and seemingly when everything had been litigated, Allied asserts its secret "no-coverage" position. By then, New West had gone out of business and had no way to pay. As defense counsel informed Allied, My best estimate is that this could easily be in excess of several million dollars in damages." Without insurance, the outcome would "break the business."

The Unfair Settlement Practices Act prohibits liability carriers from doing such things as misleading the insured about coverage; providing inaccurate information when asked about coverage and from failing to "promptly providing a reasonable explanation" about coverages available to pay claims. *See*, §33-18-201, *supra.* Here, Allied had been misleading New West since the inception of the litigation in 2010. Then, in 2017, it disclosed its secret "no-coverage" position.

Allied's conduct described above, violates more than its UTPA duties. It constitutes deceit and, at least, constructive fraud. It certainly violates the

disclosure duties of a fiduciary which Allied is under Montana law. It is a gross and deliberate disregard of the rights of others and therefore, cries out for punitive damages.

Rolan and the Class are also entitled to the protections of the UTPA, §33-18-201, *supra.* They, too, are entitled to compensatory and punitive damages for all the things Allied has put them through. Therefore, the Third Amended Complaint includes their claims against Allied.

We've been fighting over coverage since 2017. Out of business, New West entered into a preliminary settlement whereby it paid $250,000 and assigned all its claims against Allied to obtain the rest. Without the insurance coverage, however, Rolan and class members will, at best, get paid a few pennies on the dollar. The Court re-certified the class. Notices have been sent out to try to find class members—a daunting task given the 12-year delay.

The District Court estopped Allied from raising the coverage issues, but the Montana Supreme Court held the evidence was at least currently insufficient to grant a summary judgment as a matter of law.

Much remains to be done, including obtaining a final settlement after a "Fairness Hearing," allowing the Class to object. The insurance issues, including

the claims in this proposed Amended and supplemented Complaint, need to be resolved.

The Complaint should be approved under the following law and rationale.

B. THE AMENDMENT SHOULD BE APPROVED AS IT SERVES THE ENDS OF JUSTICE.

Montana Rule of Civil Procedure 15 governs motions to amend and supplementing the proceedings. It provides, "a party may amend and supplement its pleadings at any time." The opposing party is entitled to object, but the Court "should freely give leave [to amend] when justice so requires." The courts, including Montana courts have interpreted this Rule liberally. Even in "doubtful cases, the doubt will be resolved in favor of the amendment." 61 CJS Pleadings, §341. "The policy favoring the resolution of cases on their merits creates a virtual presumption that a court must grant leave where no good cause appears to the contrary." *Id*. at §340. *See also*, *Moore's Federal Practice*, §15.02. Amendments are denied only in cases where there is "undue" surprise or "undue" prejudice to the opposing party. *E.g.,* 161 and 61 AM JUR 2d Pleadings, §722.

Applied here, "justice" requires this amendment. Unless the constitutional guarantee to a speedy remedy is a dead-letter, justice demands that Allied stand trial. The allegations in the Amended Complaint are documented by previous undisclosed communication between Allied and the defense, showing multiple

violations of legal duties—perhaps some of them *per se* violations—which demand resolution given the harm they have caused to the parties and the fair and proper administration of justice. At 13 years and counting, this case has to be one of the longest in the history of the state—if not the longest—and there exists ample reason to believe it is caused by the bad faith of Allied. There is certainly more than an ample presumption in favor of the amendment and therefore, it must be granted.

Moreover, Allied is hard put to claim "undue" surprise or "undue" prejudice. Both its insured and Rolan stated that it would be sued for this misconduct. The documents attached to the proposed complaint certainly indicate Allied knew exactly what it was doing.

C. RELATING BACK

Rule 15(c), *supra* states, "An amendment to a pleading relates back to the date of the original pleading when… The amendment asserts a claim or defense that arose out of the conduct, transaction or occurrence set out – or attempted to be set out – in the original pleading."

Here, the claims "relate back." The entire lawsuit essentially pertains to Allied's duty to pay the claims of Rolan and the Class. Allied's fingerprints are all over the tactics used to cause this extraordinary and ongoing delay. The Unfair

Settlement Practices Act recognizes insurers, like Allied, can and do assert dominate control over litigation, and therefore, have a duty to proceed in good faith. Insurance is certainly integral to the "transaction or occurrence" involved in the suit. That is why M. R. Civ. P. 26 expressly authorizes discovery of sources of insurance to pay claims. It is also why New West received the 2010 coverage letter and asked for its verification in 2013. It took until 2017 for Allied to provide a response and that has made a great difference.

Since the claims of New West and Rolan related back, the statute of limitation certainly has not run.

The only conceivable argument is that under the UTPA, third parties like Rolan and the Class cannot sue until after they have a settlement. Here, however, the settlement is not final. The Court must hold a Fairness Hearing and if the Class does not object, approve a final settlement. We submit, however, the Court can still approve the Third Amended Complaint with orders that it need not be answered until after final settlement is achieved. That, however, will not prevent discovery based upon New West's claims against Allied.

D. REMEDY REQUESTED

For all the above reasons, the Court should order that the Third Amended Complaint may be filed. If the Court deems Rolan's and the Class's claims are

premature, then discovery can still proceed on New West's claims with the understanding that Rolan can proceed as the settlement has been approved.

DATED this 26th day of May, 2022.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I served true and accurate copies of the foregoing document upon counsel of record by the following means:

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DATED this 27th day of May, 2022.

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MONTANA FIRST JUDICIAL DISTRICT COURT
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DANA ROLAN, on her own behalf and on behalf of the class she represents and as Assignees of claims of NEW WEST HEALTH SERVICES, Plaintiffs, vs. NEW WEST HEALTH SERVICES, DARWIN SELECT INSURANCE COMPANY and ALLIED WORLD ASSURANCE COMPANY and DARWIN NATIONAL ASSURANCE COMPANY, Defendants.	Cause No. DDV 2010-91 Honorable Christopher D. Abbott **PLAINTIFFS' THIRD AMENDED COMPLAINT AND REQUEST FOR JURY TRIAL**

Dana Rolan and the Class she represents reallege and state all they have stated in the previous Complaints and for their Third Amended Complaint against Defendant Allied World Assurance Company, further allege and state:

I. DESCRIPTION OF THE PARTIES

1. At times relevant to this suit, Dana Rolan ("Rolan") was insured for medical costs through New West Health Services ("New West"). She represents the certified class against New West ("Class"). The class action has been settled, but the interim settlement is not "final" until a Final Fairness Hearing is held to allow class members to object and the Court to grant final approval or disapproval.

2. At times relevant to this suit, New West has been a health insurer subject to the insurance laws of Montana. One of these state laws is the Montana "made-whole" law. It forms the primary legal reason why New West has been held liable for paying monetary restitution to Rolan and the Class.

3. At times relevant to this suit, Allied World Assurance Company ("Allied") has insured New West under an E & O policy with a $3,000,000 aggregate limit. For the first seven years of this litigation, Allied led both New West and Rolan to believe $3,000,000 in insurance coverage existed to pay restitution to Rolan and the Class. Then in 2016, Allied changed its position, deciding to deny any coverage existed at all. To do this, it asserted coverage defenses it had not previously raised. This is one of the reasons why Rolan and New West are making this Third Amended Complaint, which raises claims that Allied has violated both statutory and common law duties throughout this lawsuit.

These violations have resulted in over a decade of delay in resolving this case and must be addressed so the case does not continue years into the future.

II. NEW WEST'S FIRST-PARTY CLAIMS AGAINST ALLIED

As assignee of claims New West has against Allied, Rolan and the Class reallege and state all that appears in prior Complaints. They further allege and state that Allied has committed several violations of its duties under Montana law toward its insured New West over the past 13 years of this lawsuit. As alleged below, this has been a course of conduct spanning back to before Rolan filed this lawsuit in 2009.

A. INITIAL UNLAWFUL CONDUCT 2008-2011

4. On November 16, 2007, a 16-year-old Capital High student named Dana Rolan was seriously injured in an automobile collision. She incurred over $100,000 in medical costs due to head, back and pelvic injuries. Her sinus cavity was caved in. Her teeth were broken. She lost consciousness and suffered amnesia. There was a fracture through her hip joint. An intervertebral disc was herniated. The sacrum was traumatically bent and fractured completely around the bony connection with the spine. The damage to the sacrum progressed to cauda equina syndrome, requiring extensive and complicated surgeries, including the surgical implantation of plates and screws to fuse the spine to the hip.

5. The collision and resulting injuries were the admitted legal fault of Tyler Stephens. He had liability insurance that covered all types of tort damages through Unitrin Service Group.

6. As Ms. Rolan's medical insurer at the time, New West had a legal duty to promptly pay her medical costs as they arose. Contrary to this law, New West chose to avoid this duty by requiring Mr. Stephen's liability carrier, Unitrin, to pay the medical costs as part of tort damages. As a result, most of Rolan's $100,000-plus medical bills were paid by Unitrin, rather than New West.

7. New West's avoidance of payment violated Montana's well-settled "made-whole" law. This law requires health insurers, like New West, to promptly pay medical costs incurred by insureds, such as Dana Rolan, when they have been injured through the legal fault of other people, like Mr. Stephens. The health insurer is not allowed to avoid liability for prompt payment on the ground the tortfeasor's insurer is also required to pay medical costs as part of tort damages. It is only when, and if, the injured person has been fully compensated for all tort damages, plus litigation costs, that a health insurer can share in the insured's tort recovery through any type of subrogation. If, however, the insured has not been fully compensated, then the health insurer is not entitled to any reimbursement or subrogation at all. Besides being part of Montana common and statutory law for

decades, this law has fundamental constitutional significance. *Oberson v. Federated Ins.*, 2005 MT 329.

8. Applying the made-whole law here, New West clearly violated Rolan's rights by deciding to avoid payment of her medical costs on the excuse Unitrin should pay them as part of tort damages. Ms. Rolan has never been made whole. Besides the fact that Unitrin's insurance was too low to pay for her considerable acute and permanent injuries, she also had to pay litigation costs to achieve a settlement. Yet, New West illegally avoided paying over $100,000 of Ms. Rolan's medical bills--never even performing the required "made-whole" analysis.

9. This failure continues to this day. Still now, 15 years after the bills were incurred, neither New West nor Allied has paid a single penny of the compensation they owe. Nor have they paid any member of the Class. Allied, especially, has made a mockery of the fundamental constitutional guarantee to a speedy remedy in the courts of Montana. Its attitude and conduct mock the well-known canon that "justice delayed is justice denied."

10. For over a year in 2007-2008, Rolan, through her parents, tried to resolve her insurance claims without the assistance of counsel. She was unaware New West was violating her made-whole rights. She was struggling both

physically and emotionally. Her parents had no significant understanding of the law and were trusting New West to comply with the law.

11. Overwhelmed, Ms. Rolan hired counsel in 2009. It was then she learned New West had been violating her made-whole rights by failing to pay her medical bills.

12. It was also in 2009 that the Montana Supreme Court resolved even unreasonable doubts that health insurers, like New West, are subject to Montana's made-whole laws. In *Blue Cross v. State Auditor,* 2009 MT 318, the Montana Supreme Court held health insurers, like all other insurers in Montana, were subject to the made-whole law. In doing so, it noted that the made-whole law has been part of Montana law since the 1970s and was codified by the legislature with regard to health insurers since the early 1990s.

13. For the better part of 2009, Ms. Rolan, through counsel, made concerted efforts to prevail on New West to comply with its made-whole duties. Her letters went from assuming New West had simply overlooked the requirement; to explaining the clear made-whole laws to New West; to informing New West its excuses were meritless, given the clearness of the law. Finally, Rolan informed New West suit would be filed if her benefits were not paid in full by the end of January 2010.

14. New West's responses ranged from not answering at all to providing unmerited excuses. Just before Rolan was forced to sue, New West unreasonably offered her only 30 cents on the dollar.

15. Rolan rejected New West's unreasonable settlement offer and filed suit on January 29, 2010. She requested a declaratory judgment that New West was violating her made-whole rights. She requested restoration of medical benefits not paid, as well as coverage of her attorney fees and costs.

16. Ms. Rolan's Complaint also stated New West had violated several of its duties under the Unfair Trade Practices Act, § 33-18-201, MCA, including, but not limited to, the duty to effectuate a prompt, fair and equitable settlement when liability was reasonably clear. Since it was reasonably clear in 2009 (and thereafter) it had violated Ms. Rolan's made-whole rights, New West was responsible for both compensatory and punitive damages. *See,* Complaint, DN 1.

17. Given the way she had been mistreated, Rolan suspected others had been similarly mistreated. Therefore, her Complaint also included class action claims for all New West insureds whose made-whole rights had been similarly violated.

18. After filing her Complaint, Ms. Rolan continued to request a prompt settlement, but New West did not respond. Recently uncovered documents show

Allied was promptly made aware of Rolan's attempts to resolve the dispute with its insured, New West. Allied, however, did nothing.

19. Shortly after the suit was filed, New West provided Allied with a copy of the Complaint and tendered the defense. Ten days later, on February 19, 2010, Allied responded through its senior claims' analyst, Joseph Sappington. He provided a detailed 10-page single-spaced coverage letter, indicating an E & O policy covered New West for Rolan's and the Class's claims up to $3,000,000 in aggregate limits. He carefully listed and explained several specific policy exclusions, none of which precluded any coverages for the allegations in the Complaint. He then concluded:

> As the Complaint includes allegations sounding in a **Managed Care Activity**, and the allegations were apparently first made against an **Insured** in writing during the **Policy Period**, the conditions precedent to the Insuring Agreement appear to be satisfied. Accordingly, the MCEO Policy provides for a Per **Claim** Limit of Liability of $1,000,000 and a Maximum Aggregate Limit of Liability of $3,000,000 subject to a $50,000 retention applicable to **Loss**, including **Defense Expenses**, for each **Claim**.

20. Nowhere in this letter did Sappington state Class claims were not covered or were only partially covered. Nowhere did he state or even imply that Allied was denying ***any*** coverages which it started doing over a half a decade later. Nowhere did he even mention the policy exclusions Allied would later claim precluded coverage.

21. Based on Sappington's coverage letter, New West concluded it had full coverage under the E & O policy for Rolan's claims up to $3,000,000 aggregate claims limit. Rolan, as well, was misled into believing full coverage existed. Had either known Allied was secretly claiming no coverage existed, they both would have resolved this lawsuit immediately, rather than engaging in over a decade of litigation when no insurance money purportedly existed to provide compensation.

22. Sappington's letter also indicated that since coverage existed, Allied was assuming control of the defense and would hire the Browning firm in Helena, Montana to defend. It required Browning to agree to its policy setting forth joint duties purportedly designed to "achiev[e] the best results for [the] insured in an efficient and cost-effective manner." Both Allied and its chosen attorney must:

(1) Work closely together and communicate with each other;

(2) Identify and address any potential conflicts of interest between New West and Allied;

(3) Make settlement offers to bring "an early resolution of lawsuits …;" and

(4) Share all information with each other and the insured through frequent written reports so everyone, especially the insured, is kept informed of all significant events, including those affecting liability and damages; settlement and updates in the litigation plan.

23. On May 25, 2011, the Browning firm provided Allied with a litigation plan. It stated defending New West in ongoing litigation would most likely cost over $300,000. It informed Allied that Rolan would probably prevail, given the decision in *Blue Cross v. State Auditor*, *supra*, that health insurers were, in fact, subject to Montana's made-whole laws.

24. Even with this information, Allied made no attempt to resolve Ms. Rolan's claims. This failure violated several of its settlement duties under the Unfair Trade Practices Act, *supra.* First, it violated Allied's duty "to acknowledge and act reasonably promptly upon communications with respect to claims." §201(2). Both before and after Ms. Rolan had filed suit, she had made multiple offers to settle. Allied, which controlled the defense, neither acknowledged these settlement offers, nor acted reasonably promptly upon their communication.

25. Allied World also violated its duty to "conduct[] a reasonable investigation *based* ***upon all available information***, [before] refus[ing] to pay claims." §201(4), *supra* (emphasis added). Thus, Allied cannot delay paying a claim on the ground it did not know the "available information" showed liability and recovery were reasonably clear. Here, the made-whole laws were clear and well settled. Rolan had provided the medical bills which Unitrin had paid and New West had avoided. Therefore, its duty to pay claims was at hand and any delay violated Montana's Unfair Settlement Practices Act.

26. Allied's failure to settle Rolan's claims immediately also violated the UTPA duty to "attempt in good faith to effectuate prompt, fair and equitable settlement of claims in which liability has become reasonably clear." §201(6). The available information showed "liability had become reasonably clear," but Allied did not even respond to the multiple settlement offers Rolan made both before and after filing suit. It took seven years for Allied to make an offer and it was $50,000 to pay Rolan's claims which, with interest, was approaching $200,000, and pay the Class claims which likely were in the millions. This is not to mention the real emotional distress the delays have caused to partially disabled Ms. Rolan nor payment of her attorney fees which is required in any suit for declaratory judgment on insurance coverage. These additional losses were caused by Allied's illegal decision to delay instead of pay.

27. Allied World also violated its fiduciary duties under Montana law:

> "Any breach of duty [by an insurer] which, without an actual fraudulent intent, gains an advantage … by misleading [the insured] to [its] prejudice," is a violation of the insurer's" fiduciary duty. This is because the insurer is "bound to act in the highest good faith" and cannot gain "any advantage …over the [insured] by the slightest misrepresentation [or] concealment … of any kind." *Tynes v. Bankers Life Co.,* 224 Mont. 350, 730 P.2d 1115, 1124, 1126 (1987).

According to Allied's ***current*** position in this lawsuit, there never was any coverage of Rolan's or the Class's claims. From 2009 into 2017, however, Allied

led both New West and Rolan to believe full $3,000,000 in coverage existed for the claims. Allied's concealment of its "no-coverage" position, therefore, constitutes a breach of the fiduciary duty, since it, at a minimum, is more than even a "slight[] misrepresentation or concealment." *Tynes, supra*. Had Allied properly informed New West no coverage existed in 2009, rather than waiting until 2017, New West would have taken a different course of action than the years upon years of stressful and expensive litigation.

28. Allied also violated its self-imposed duties. Specifically, the joint-duty agreement it imposed on the Browning firm required that Allied make settlement offers to bring "an early resolution of lawsuit[]" so as to "achiev[] the best results for [the] insured in an efficient and cost-effective manner." Allied's failure to settle Rolan's claims immediately when the available information showed liability and damages were clear did not provide an "efficient and cost-effective" result. Rather, it created over a decade of expensive, stressful and unnecessary litigation.

29. Allied's conduct also violated its self-imposed duty to "***identify and address***" the clear "conflict of interest" that existed because Sappington's 2009 coverage letter indicates full $3,000,000 in coverage existed, but Allied's undisclosed position was that no coverage existed. The non-disclosure was the difference between New West settling this case promptly for a little over $100,000

to a decade of unnecessary litigation resulting in hundreds of thousands of dollars in litigation costs, plus over a million-dollar obligation to Rolan and the Class.

30. Allied also violated its joint duty to share information which affected "liability and damages [and] settlement." If no coverages existed, as Allied started arguing in 2017, it needed to disclose this because it affects "liability and damages" and certainly "settlement." The failure to share its "no-coverage" position with New West for several years defeated the agreement's purpose of providing the "best results for [the] insured in an efficient and cost-effective manner."

31. Allied's violation of its own agreement was negligent, intentional and a flagrant disregard of the interests of its insured, New West. It is also evidence showing Allied deliberately violated its duties and therefore, punitive damages are appropriate.

32. In addition, Allied's conduct constitutes constructive fraud. This occurs when Allied, without actual fraudulent intent, gains an advantage over New West by misleading it to its prejudice. By withholding its secret intention to deny coverage until 2017, Allied has committed constructive fraud. *See*, §28-2-406, MCA.

33. In addition, Allied's acts and omissions constitute deceit. Deceit is (1) the suggestion as a fact of that which is not true by one who does not believe it to be true; or (2) the suppression of a fact by one who is bound to disclose it or who gives information of other facts that are likely to mislead for want of communication; or (3) any other act without actual intent deceives. §27-1-712, MCA. Here, Allied led New West to believe its personal assets were protected by insurance up to $3,000,000 and suppressed the fact that it was secretly taking the position no coverage existed. Then, over seven years later—after much had unnecessarily been lost or paid for—Allied announced there never was any coverage in the first place. New West relied and acted on this misleading information to its prejudice and damage. Allied "suppressed" its true position.

34. In addition, Allied's acts and omissions constitute actual fraud under §28-2-405, MCA. Fraud is committed when one suggests as fact that which is not true to a person who believes it to be true. It is also "the suppression of that which is true by one having knowledge or belief of the fact." It also includes other acts fitted to deceive. Here, Sappington's letter, at a minimum, suggested as fact that $3,000,000 in coverage existed. Eight years later, however, Allied announced no coverages existed. This constitutes fraud.

35. As a result of Allied's unlawful acts and omissions, as described above, New West has been damaged, which damages include, but are not limited to, the following:

(a) All expenses New West has incurred caused by Allied's misconduct. Had New West known in 2010, Allied was denying all coverages, it would have settled Rolan's claims immediately for $100,000 of its own money. It would not have rationally engaged in protracted and expensive litigation which, according to the Browning firm, would cost over $300,000 in attorney fees and where it was more than reasonably clear Rolan and the Class would ultimately prevail, resulting in a multi-million-dollar exposure to personal assets.

(b) Damages to New West's business and goodwill caused by the unnecessary, expensive and protracted litigation, including diminishment in the value of New West's goodwill and assets when it sold the business in 2017.

36. In addition, Allied's conduct qualifies for punitive damages because it constitutes actual malice and fraud as those terms are defined under §27-1-221, MCA. It was a deliberate disregard of its insured's rights and interests.

B. ONGOING ILLEGAL CONDUCT 2012-2013

37. It took from 2009 into 2012 for Rolan and the Class to conduct discovery and obtain a declaratory judgment that New West violated Montana's

made-whole laws and thereby, owed Rolan and the Class restitution. On April 26, 2012, the District Court granted this relief. DN 49. New West unsuccessfully appealed. On August 6, 2013, the Montana Supreme Court affirmed the District Court. *Rolan v. New West*, 2013 MT 220 (*Rolan I*). Seemingly, liability and the duty to pay was now absolutely clear. Allied, however, made no attempt to settle despite Rolan's ongoing requests for settlement. Instead, it did the following.

38. On August 27, 2013, Garlington, Lohn and Robinson ("GLR") took over from the Browning firm. On October 8, 2013, the GLR attorney gave Allied his written evaluation based upon a full review of the evidence, the pleadings and the status of Montana law. Exhibit 1. He informed Allied both liability and the duty to pay were reasonably clear. Pertinent excerpts from his letter follow:

39. Liability was clear:

> The concern here is that Montana requires an insurer to undertake a made whole analysis prior to subrogation and the subrogation can only occur if the claimant has been "made whole." … Even though an insurer is not filing a claim to recover an amount paid (as in traditional subrogation), the insurer is withholding payment of an amount due under a policy because of the liability of a third party. It does so without a made whole analysis, which is in violation of Montana's laws.
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> ….
>
> As an aside, I should note that almost whenever a made whole analysis of a claimant is done, it inevitably reveals that the claimant is not made whole

> because there is always attorneys' fees unpaid, more emotional distress, lost wages that have not been covered, etc.

40. This clear law directly applied to Rolan's situation:

> Ms. Rolan's auto accident took place on November 16, 2007. So, it was approximately 2 years before the *State Auditor* case was decided. But unfortunately, given the nature of the decision, it is read to have applied existing Montana law, not to have changed the law, for the made whole doctrine evolved in Montana during the mid-1970s. ***So, the rule from State Auditor applies to the present case. This means that New West cannot withhold payment simply because the medical bills were paid by a third party insurer … [It] would not appear as though any exception applies.***

(Emphasis added.)

41. The evaluation indicated restitution, damages and costs would be considerable and, at the very least, clearly implicated the $3,000,000 aggregate limits. A considerable risk of punitive damages existed, given the nature of the insured's misconduct toward Ms. Rolan:

> ***We believe that New West will be liable in the present case for all amounts withheld from the treatment of Ms. Rolan. From our review, this would appear to be approximately $110,000 (plus interest at 10% per annum).***
>
> ***In addition, the case is certified as a class action***. Documents I have reviewed indicate that New West has identified another $200,000 (plus interest) that would be liable to other class members.
>
> ***Because the case was brought as a declaratory judgment action, they will most likely have to pay the Plaintiffs' attorneys' fees, as well.***
>
> ***The case also has significant concerns regarding potential punitive damages, as well.*** This would be under the Unfair Claims Practices Act,

> basically for malice. I see two issues here. The first has to do with New West's failure to respond to the initial letters of Erik Thueson in a timely manner. In sum, he wrote to them on several occasions over a period of many months before New West ever responded. The second concern arises because New West did not cure the issue once it had notice of the September 2009 State Auditor decision. Once it became aware of that case, arguably, it had the obligation to go back and to make payments on all of the non-ERISA cases where it had applied the COB provision.

42. Further delay in paying Ms. Rolan's claims would only increase the punitive damage exposure of New West:

> ***Indeed, that conduct and failure to cure continues to this day.*** At the deposition of New West Claims Manager Katherine Bahrman, opposing counsel asked her why these amounts have still not been paid. The only reason she proffered was because the bills/claims from Ms. Rolan had not really been submitted. Given that we have all of these records as part of the lawsuit, the response appears a bit disingenuous, at the least.
>
> The only other rationale as to why New West has not yet paid Ms. Rolan the $110,000 plus interest is because it is waiting for the outcome of the Diaz case. … T]he present context, it seems very unlikely that the Diaz decision will do anything other than confirm the application of the State Auditor rule as it applies to insurers, like New West.
>
> ***At a minimum, it would seem that New West should be prepared to make the payment to Ms. Rolan once the Diaz decision is announced (presuming it affirms the State Auditor case). Should it fail to do so, the ramifications for a punitive damages award at trial will be enormously increased.***

43. In addition, it was at least reasonably clear Allied would also pay Class damages:

> ***The other concern is the "unidentified" class members. Most likely, New West has other customers where it never even received claims because the liability insurance was paying the medical bills.*** … These claims would go back for 8 years before the Complaint was filed (i.e., back to January 2003).

(Emphasis added.) In point of fact, it was absolutely clear this would occur because New West had already admitted under oath in depositions it was systematically doing the same thing to others and had even had a list of hundreds of people who had lost benefits through this procedure.

44. The evaluation stated it was unlikely anything could be done to prevent this outcome: The "***only hope***" would be to "explore ***possible*** ERISA preemption," although it was unlikely to succeed. "So, in the present case, it would not appear as though any exceptions apply to the made-whole law." Furthermore, GLR informed Allied it was highly likely New West would be estopped from raising an ERISA defense. The defense had not been raised in the previous four years. Allied would be raising it only after both the District Court and Montana Supreme Court had ruled on liability and damages.

45. One of the hurdles was that the established evidence made it unlikely an ERISA defense would fly. For one thing, New West, through its Rule 30(b)(6) designated representative, had already testified ERISA did not apply. The New West representative also testified that New West self-recognized it had to follow Montana's made-whole laws, albeit after denying and perhaps because of Rolan's

claim. Her only excuse for not paying Rolan was that her bills had not yet been submitted to New West. As GLR wrote in his 2013 evaluation, this excuse was "disingenuous" because New West had all of Rolan's medical bills.

46. Moreover, New West's designated representative provided testimony that showed Rolan and the Class were still entitled to recovery—even if ERISA technically applied. She testified New West was the "insurer" for Rolan's employer plan. New West was receiving a "premium" from Rolan's employer plan and simply paying out medical benefits. It was not merely administering an employer's plan where the employer was paying the medical bills. This distinction is legally critical. It is well-settled law that a health insurer, which is paid a premium by an ERISA employer to pay the medical bills, remains subject to state insurance laws—here, the Montana "made-whole" law. It is only in those cases where the insurance company is simply administering a plan for an employer which is paying the medical bills itself that ERISA preempts state law. Here, New West accepted premiums from the employer to pay medical bills and therefore, New West had to follow state law and was not protected by ERISA.

47. With this information available, the GLR lawyer advised Allied it had two choices:

(1) Immediately settle with Rolan and conceivably the Class (This would, of course, be consistent with Allied's obligations under the UTPA. As the GLR lawyer explained, failure to promptly settle would expose New West *"for a punitive damages award at trial [which would] be enormously increased."*); or

(2) Continue to delay and deny by raising the "only hope" ERISA defense (which would create additional costs and stressful litigation).

48. Allied chose the second choice. It moved to amend its Answer to add its "only hope" ERISA defense. It did this despite the fact it had no documents at the time supporting the contention New West's plan was under ERISA. The documents it had stated the plan was "insurance" and therefore, "we did not want to present these to the Court." By choosing this course, Allied caused years of unfair prejudice, damages and costs to everyone involved, except for itself. This violated the UTPA §33-18-201(4) duty to pay claims when a reasonable investigation based upon all available information shows the claims are valid. It also violated the duty to "attempt in good faith to effectuate a prompt, fair and equitable settlement of claims in which liability had become reasonably clear." The available information, as provided to Allied by the GLR lawyer, showed on its face liability and the duty to pay were both reasonably clear. The fact that Allied would disregard this information and continue the lawsuit showed an enormous disregard

for the rights of others and thereby creates the need for punitive damages. Allied's misconduct is a classic example of why the legislature believed the UTPA was necessary: "Justice delayed is justice denied" and "[p]ublic policy call[s] for a meaningful solution." *Klaudt v. Flink,* 202 Mont. 247, 253 (1983).

49. Allied's ongoing course of conduct constituted fraud, deceit and constructive fraud. It also violated the duties set forth in Allied's written rules to conduct the lawsuit to "achiev[e] the best results for [the] insured in an efficient and cost-effective manner."

C. ONGOING UNLAWFUL CONDUCT: REFUSING TO DIVULGE SECRET "NO-COVERAGE" POSITION WHEN ASKED IN 2013.

50. In 2013, New West hired attorneys from the Crowley Fleck law firm to verify the full $3,000,000 aggregate limits covered Rolan's and the Class's claims which had been approved by the Montana Supreme Court a few months earlier.

51. On September 30, 2013, Ian McIntosh of the Crowley firm wrote a letter to Allied's senior claims analyst Sappington, requesting coverage be acknowledged and verified:

> ***Pursuant to your letter dated February 18, 2010, it appears that you agree there is coverage under the MCEO policy, unless New West committed willful misconduct or willfully violated a state law. Please contact me to confirm this.*** As I am sure you are aware, in Montana, an insurer is required to acknowledge and act reasonably promptly upon communications. Mont.

> Code. Ann. § 33-18-201(2). Please contact me at your earliest convenience to discuss New West's insurance coverage under the MCEO policy."

Exhibit 2. Allied chose not to comply with its duty to respond: Sappington never responded to the letter. When the Crowley lawyers telephoned him, Sappington did not inform them of Allied's undisclosed "no-coverage" position.

52. In addition to violating UTPA, §33-28-201(2), as cited in McIntosh's letter, Allied's decision to conceal its "no-coverage" position constituted fraud, constructive fraud and deceit as described above. It also violated Allied's fiduciary duty and self-imposed disclosure duties in its agreement with the lawyers chosen to conduct the defense.

53. Allied's ongoing unlawful conduct further contributed to New West's damages, showing further evidence of malice, fraud and a disregard for the interests of its insured, New West. Thus, punitive damages are appropriate.

D. ONGOING UNLAWFUL CONDUCT THROUGH 2017

54. From 2013 through 2017, Allied continued to refuse to effectuate a prompt, fair and equitable settlement. It also continued to conceal its "no-coverage" position. Had New West known of Allied's undisclosed position, it would never have consented to continue the litigation by asserting an ERISA defense which was unlikely to succeed. To do so meant New West would

eventually have to satisfy Rolan's and the Class's considerable claims out of its own pocket. The unlikely ERISA defense, moreover, ultimately was unsuccessful, although it caused several more years of additional expense and resource-draining delay.

55. When Allied moved to amend to include an ERISA defense, Rolan correctly asserted estoppel because the defense should have been raised years before. The Supreme Court had already affirmed the District Court's determination that New West was liable and owed Rolan and the Class. It was time to pay—not to start the litigation over again. Moreover, New West had already testified Rolan's employer was paying premiums to New West to pay medical benefits. Thus, it still was subject to Montana's insurance laws even if the plan was under ERISA. *See*, DN 70.

56. Nevertheless, the District Court granted Allied's motion to assert an ERISA defense on May 6, 2015. At the same time, the Court recognized the injustice of its decision:

> "Rolan's counsel began inquiring about the ERISA issue as early as March 2009 and apparently received no clear response …. [New West official], Katherine Bahrmann stated at her deposition 'that the plan was "not [a] properly constituted ERISA plan [and it] …was not intended to be.' … New West's answer and amended answer [to the complaint] admitted the Rolan health plan was subject to the Montana Insurance Code [not federal law under ERISA]. No ERISA related defense was asserted…."

> "[T]here is no reasonable explanation in the record as to why the preemption defense was not raised until years after commencement of this litigation…."
>
> [New West's failure to timely assert an ERISA defense] "is tantamount to requiring Rolan to address defenses that become, in effect, frivolous."

DN 101, pp. 4, 12-13. The Court recognized New West's belated defense had caused "four years of delay." *Id*.

57. New West then had the Court remove the case to federal court on the ground ERISA was a federal question. Rolan did not have the opportunity to appeal this admitted unjust decision to the Montana Supreme Court.

58. The removal to federal court caused over another year of delay. On February 29, 2016, however, Federal Judge Lovell held the District Court had erred: The case did not need to be removed to federal court. Montana had concurrent jurisdiction. Judge Lovell was perplexed by the decision to allow the belated defense that ERISA applied: The defense had caused "inexplicable confusion over whether its own plan was or was not an ERISA plan." Exhibit 3.

59. Although not necessary to his decision to remand, Judge Lovell also recognized it was unlikely New West's health insurance plan was covered under ERISA:

> ***St. Peter's plan is fully insured, so that state insurance laws are generally applicable*** due to ERISA's Savings Clause … The Supreme Court's test for deciding in the first instance whether a state insurance law is protected by

> the Savings Clause is (1) whether the state law is "specifically directed toward entities engaged in insurance", and (2) whether the state law "substantially affects the risk pooling arrangement between the insurer and the insured." *Kentucky Ass'n of Health Plans v. Miller,* 538 U.S. 329, 341-42,123 S. Ct. 1471, 155 L.Ed.2d 468 (2003).

Id. at 21-22. Applied, here, New West is by definition an "entit[y] engaged in insurance and therefore, the first requirement for the Montana made-whole laws exists. The second and final requirement is also satisfied since subrogation or the lack of it "affects the risk pooling arrangement." Thus, Judge Lovell's opinion shows on its face that Allied's "last hope" ERISA defense was meritless.

60. Instead of following its duty to settle because liability was at least reasonably clear based on the available information, Allied decided to keep pushing its ERISA defense. This caused additional years of delay.

61. On March 11, 2016, the defense and Allied conferred: The defense counsel had talked with Rolan's counsel who informed him: "we have enough experience in these types of cases that we know where it's going – implying that he's going to win, as he has on these other made-whole cases." Instead of seeking settlement, however, the plan was to ***"start*** researching" the "determinative [ERISA] issue immediately." If "we think we will lose [a] motion to dismiss on ERISA grounds, we should "mediate the case." Exhibit 4. GLR, however, pointed

out that Judge Lovell's decision indicated New West was subject to Montana's made-whole laws, providing a copy of the opinion.

62. Then followed months of ERISA research by the defense---which given its UTPA duties---should have been performed before asserting ERISA as a defense. This research only verified ERISA would not fly. Nevertheless, Allied and the defense decided to "continue the battle," rather than comply with Montana's laws against unfair settlement practices.

63. On June 2, 2016, GLR informed Allied:

> The more we dig into the merits of the matter, the more I'm concerned we are going to lose this battle on ERISA preemption of the state law claims. …

It was unlikely the ERISA defense would fly because:

> In my continuing review of the law in this area and in searching for law review articles on point, I discovered an industry article that does a decent job of summarizing the law in this area. A copy is attached for your review. One paragraph sums up the concern nicely, stating:
>
> ***"State subrogation law will generally be preempted to a self-funded plan, but state subrogation law will generally apply to insurance provided by an unfunded Plan."***

Id. New West had "unfunded plans." Therefore, liability was at least reasonably clear.

64. Another problem making liability reasonably clear was that New West's plans stated it would follow Montana's made-whole laws: "the New West plan has language to the effect that 'we won't subrogate until you have been

made whole.'" *Id.* Thus, even if ERISA applied, this language meant the made-whole laws still applied.

65. Despite stating a few months earlier they would seek settlement if the research went against them, Allied and the defense decided, "We are going to continue to fight this battle." Exhibit 5.

66. Allied and its defense decided to double down. On September 1, 2016, GLR reported to Allied: "I must say I feel as though the case law on ERISA is ultimately against us. Although there is some authority for doing an independent review and applying preemption under Section 502 of ERISA, ***the great bulk of the case law*** does the analysis under Section 514 of ERISA. ***If you do so, the Montana law on the made-whole rule is "saved" from preemption under the savings clause*** because the New West plan at issue was a fully insured plan (and not a self-insured plan)." The evaluation referred Allied to a 1999 U.S. Supreme Court decision which was "pretty much on point." It held the ERISA plan was not preempted by federal law. *Id.* Exhibit 6.

67. Rather than seek settlement, they would plow ahead with their position the entire case should be dismissed on ERISA preemption: "The district court judge [would be] rather happy to have the case get reviewed and be off

their docket for a year or so. The problem of course is that a review by the Supreme Court does not carry with it a better chance of success." *Id.*

68. Despite the fact that the available information continued to show liability and damages were reasonably clear, Allied chose again not to seek settlement, but to press on. This was temporarily successful. Despite the law to the contrary, the defense was able to get the District Judge to dismiss both Rolan's and the Class's claims on the ground of ERISA preemption. This would cause further delay, but ultimately it was reversed by the Montana Supreme Court.

69. Rolan and the Class appealed and submitted their brief. Because the ERISA defense was so "tenuous," Allied authorized GLR to retain attorneys expert in the field of ERISA preemption. Alas, these legal experts agreed the defense's position was "tough:"

> **The traditional and correct analysis of the situation takes us to Section 515 [of ERISA which] … ultimately means that the claim is most likely not preempted**.

GLR email to Allied, dtd April 26, 2017, Exhibit 7. Rather than following a duty to seek settlement, the defense and Allied decided to push on.

70. The result proved to be predictable. On November 7, 2017, the Montana Supreme Court reversed, holding New West should never have been allowed to raise the ERISA defense in the first place:

> ¶17 Initially, the District Court failed to conduct an inquiry into whether Rolan and the class she represents would be prejudiced. The District Court failed to determine if undue delay, ***bad faith or dilatory motive*** on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party by allowance of the amendment, or futility of the amendment existed.
>
> ….
>
> ¶21 There are no extraordinary circumstances in this case that would warrant granting New West's motion to amend. Rolan and the class argued that they would be substantially prejudiced by allowing New West to amend its answer to include the affirmative defense of ERISA preemption. Rolan and the class cite to three specific reasons prejudice would occur: (1) the length of the delay, (2) the parties have conducted extensive discovery, and (3) the case has already been appealed to the Montana Supreme Court for class certification based on state law claims. Conversely, New West has not offered any reasonable justification for the delay.
>
> ….
>
> ¶22 …. ***[H]ad the District Court conducted a proper inquiry into undue prejudice, we conclude the class certification would have been the dispositive issue. Rolan and the class were certified as a class based only on state law claims. Allowing New West to amend to include ERISA preemption would effectively destroy the class….New West's amendment could de-certify the class, forcing Rolan and the class to either seek re-certification based on ERISA claims or proceed alone, ten years after Rolan's injury and more than seven years after she filed suit.*** The District Court failed to consider the effect of the amendment on the class. We conclude that Rolan and the class she represents would be unduly prejudiced by allowing New West to amend.

Rolan v. New West, 2017 MT 270 (emphasis added). Thus, assertion of the ERISA defense in 2013, itself, was "bad faith" which should provide a remedy here. Essentially, the Montana Supreme Court told Allied the same thing GLR's 2013 evaluation told it: An ERISA defense was highly unlikely to succeed; it would "destroy the class …forcing Rolan and the Class to either seek re-certification based on ERISA claims or proceed alone, ten years after Rolan's injury and more

than seven years after she filed suit." Allied, unfortunately, succeeded in doing just that.

71. Allied's conduct during this period was an ongoing course of misconduct. It violated the same duties of the UTPA; its fiduciary duties and committed what is defined as fraud, constructive fraud and deceit. It violated Allied's self-imposed duty to conduct the defense in a manner that sought prompt settlement to "achiev[e] the best results for [the] insured in an efficient and cost-effective manner." In the process, it "effectively "destroy[ed] the Class" as stated by the Supreme Court, *supra*. As such, it caused inexcusable ongoing and further damage to everyone involved—including its own insured.

E. ALLIED FINALLY REVEALS ITS "NO-COVERAGE" POSITION.

72. It was after GLR informed Allied, the ERISA defense was "tenuous" that Allied began denying all coverages. Because New West had announced it was going out of business, Rolan requested a show cause hearing to assure assets continued to exist to pay her and the Class. On October 5, 2016, GLR wrote Allied, "As part of our response to the court, we are going to advise [the judge] that New West has insurance in the case."

73. Allied responded: "We issued a reservation-of-rights letter [in 2010] with respect to this matter, and our position is that there is no indemnity obligation under the policy." This is a misrepresentation. As discussed above, the 2010 Sappington letter states nothing of the sort. It indicated full coverage up to $3,000,000 exists. **Nowhere** does it state "there is no indemnity obligation under the policy." Further, in 2013, when New West's coverage counsel requested that Allied verify the policy provided $3,000,000, Allied had refused to respond in violation of its duties under UTPA, §201(1), (2) and (14).

74. GLR emailed back to Allied that New West had been misled:

> I conferred with New West and its day-to-day legal counsel to convey your response (below) on how there is no indemnity in the case (highlighted in yellow). I was told that New West's counsel looked into this earlier and conferred with Joe Sappington on the issue. They provided me with the attached correspondence on the subject. As you can see, their letter to Joe indicates that there is coverage "under the MCEO policy unless New West committed willful misconduct or willfully violated a state law." From their perspective, when he replied, "Sappington did not disagree with our analysis." Thus, it is their understanding that there is indemnity for this claim under the MCEO policy.

Exhibit 8. This mattered not to Allied. It continued to deny all coverages.

75. This forced New West to retain coverage counsel Gary Zadick. On November 2, 2016, Zadick wrote Allied its denial of coverages "is directly contrary to Allied World's reservation-of-rights letter of February 18, 2010 in which Mr. Sappington acknowledged there would be coverage except only to the

extent of any conduct that would fall within Exclusion A [for willful acts]." It also contradicted Allied's conduct in 2013, when coverage attorney McIntosh informed Allied in writing that New West was under the impression full coverage existed and Allied said nothing. It was too late now to raise a coverage defense and if Allied tried, it should be estopped. Exhibit 9.

76. On March 29, 2017, just before a court-ordered mediation, GLR provided Allied with another evaluation. It informed Allied that New West would lose the case if ERISA was not preempted. It stated:

> ***The ERISA preemption defense in this case is tenuous***. … We were able to convince the District Court to ignore the Section 514 analysis under ERISA [which showed ERISA did not apply] and keep her focus on Section 502 and "complete preemption." Frankly, there are not many cases that support this interpretation of the law. Thus, we believe there is a better than a 50% chance that the Montana Supreme Court will reverse this decision and find ERISA does not preempt Plaintiff's claims.

Exhibit 10. Concerning the harm to New West if this occurred, the evaluation stated:

> New West told me it could "break the company." Part of the problem is that we will not know the amount of the claims until the notices are sent out and the class members respond by submitting their claims to the company. My best estimate is that this could easily be in excess of several million dollars in damages.

Id. This seems prescient, since New West did go out of business. In addition, Allied's decision to deny coverage had created:

> There is also exposure to New West for damages to the individual Plaintiff and the class for claims of bad faith. This could be in the form of emotional distress, payment of interest on claims and punitive damages.

77. The exposure to punitive damages was high:

> Rolan's counsel had written to New West] on several occasions over a period of many months before New West ever responded. The second concern arises because New West did not cure the issue once it had notice of the September 2009 State Auditor decision or the 2013 Diaz decision, both of which held that COB provisions without a made whole analysis were in violation of the law. Once it became aware of that case, arguably, it had the obligation to go back and to make payments on all of the non-ERISA cases where it had applied the COB provision. Indeed, ***New West has never paid the claims of Ms. Rolan, which alone total approximately $110,000, plus interest dating back for nearly a decade. Thus, there is a significant potential of exposure to New West for liability in this arena, should the ERISA defense fail.***

Id. (emphasis added). Still further, the almost certain reversal would mean New West would be liable for hundreds of thousands of dollars in Rolan's attorney fees. *Id*.

78. The GLR evaluation recommended the following: "[I]f we could get rid of Rolan's individual claim and the class action claims for $1,000,000, I think it would be money well spent and I would recommend such a settlement."

79. On April 4, 2017, the parties attended the mediation. It was unsuccessful. Despite the evaluation and recommendations of GLR to at least offer $1,000,000, Allied brashly offered $50,000.

80. On April 6, 2017, Rolan's attorney wrote Allied's counsel. He explained he, too, concluded Sappington's 2010 coverage letter acknowledged full coverages existed. He wanted to know the grounds Allied was using to now deny the coverages and to offer only $50,000. *See* DN 220, Attachment 3.

81. Allied's attorney refused to respond to these inquiries. He wrote, "Our position remains the same as that expressed at the time of the mediation." He represented he did not have to disclose the reasons why Allied was denying coverage because: "I think the rule requiring an insurer to provide an explanation exists at the prelitigation stage" and therefore, he would not divulge Allied's bases for denying coverage. *Id.* The UTPA, however, applies at all times the claim is outstanding—especially where, as here, liability and damages had been reasonably clear for a decade. His response on behalf of Allied was a violation of the duty "to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement." §33-18-201(14), *supra*.

82. On November 7, 2017, the Montana Supreme Court held the defense should have been estopped from raising ERISA in the first place. *Rolan III* (discussed in ¶ 70 *supra*.) Even after this, Allied made no attempt to resolve the case fairly, promptly or equitably in violation of the UTPA, §33-18-201, MCA.

83. Allied's conduct, as described above, continued to violate the UTPA; its fiduciary duties and its obligation to avoid fraud, constructive fraud and deceit. Allied also violated its self-imposed duty to conduct the litigation so as to minimize its insured's exposure and to bring about a prompt and economical resolution. As the Montana Supreme Court stated in its decision, pursuing the belated ERISA defense "effectively destroy[ed] the class," requiring litigation "to start all over again." Allied's long and continuing course of misconduct underscores the need for punitive damages in addition to compensatory damages.

F. ONGOING MISCONDUCT 2018-2019

84. On March 23, 2018, Rolan made Allied a party, serving a Complaint requesting a declaratory judgment that $3,000,000 in coverage applied. New West's Answer stated Allied should be estopped from denying coverage, given its decision to conceal its "no-coverage" denial from 2010 into 2016.

85. On April 25, 2018, Allied answered Rolan's Complaint. It again denied any coverage existed. It counter-claimed against Rolan and the Class, raising coverage defenses which had not been identified let alone discussed in the Sappington 2010 coverage letter or at any time afterwards.

86. Allied also asserted several frivolous defenses, given the information it had at the time. It misrepresented that, "At all times pertinent to this litigation, New West possessed, among other defenses, a reasonable basis in law and fact to

assert that it was not obligated to pay." That is not true. By 2009, it was beyond legitimate debate that the "made-whole" law applied. Under the UTPA, *supra,* Allied had UTPA duties to know this was the law. In 2013, the GLR evaluation informed Allied the law was clear. Moreover, it explained that the longer Allied refused to pay, the higher its insured, New West's exposure to punitive damages would be at trial. *See*, 2013 evaluation, *supra*.

87. A related frivolous defense in Allied's Answer was "New West was … reasonable in its legal position that it did not owe payment to Plaintiff and her Class plan benefits under circumstances where a tortfeasor insurer had already paid the medical bills demanded from New West." This is not only directly contrary to the GLR 2013 evaluation, it is contrary to the Montana Supreme Court's multiple pronouncements the made-whole laws have been well-settled long before 2009. Allied's defense is also directly contrary to long settled ERISA law which recognizes that if the health insurer is merely accepting a premium from an employee (ERISA plan or not), the health insurer is still subject to the state's insurance laws—not ERISA. It is also contrary to the testimony of New West's designated representative years before that Rolan's plan was not subject to ERISA. Finally, it is contrary to New West's plan language which states New West will abide by Montana's made-whole laws. *See,* discussions, *supra.*

88. Another frivolous defense was that ERISA was "timely asserted." This is contrary to the pronouncement of every court which had considered the issue, including the Montana Supreme Court's express findings just a few months earlier that the ERISA defense was tardy and should never have been allowed in the first place. *Rolan v. New West*, 2017 MT 270, ¶22.

89. Along with the Second Amended Complaint, *supra*, Rolan had served Allied with written discovery requests to identify and produce all information in any way related to the coverage issues. To this day, Allied has failed to provide this information, contending none exists. This is incorrect: All liability insurers require adjusters to maintain careful records of all material events and discussions. Therefore, it is almost certain the adjusters assigned to Rolan's case have such documents. They will contain evidence concerning, for instance, Allied's reaction and strategy when coverage attorney requested Allied to acknowledge that full $3,000,000 coverage existed.

90. On July 5, 2018, and without responding to Rolan's discovery requests, Allied moved for summary judgment. It contended the "related-claims" provision in the E&O policy excluded the $3,000,000 aggregate coverage, which exclusion had not been mentioned in Sappington's 2010 coverage letter. DN 186, 187.

91. New West filed a cross-motion for summary judgment to estop Allied from denying coverages. Rolan joined in. She also contended Allied's summary judgment motion was premature and should be allowed only after it provided its coverage-related documents through discovery. DN 190, 192.

92. On July 16, 2018, class counsel expressed his frustration to the District Court:

> The need for this Court's concerted assistance cannot be overemphasized. The defense's tendencies towards delay are manifest. This Court required the defense to pay plaintiffs' counsel's partial attorney fees and costs for the four years of delay created by the belated ERISA defense. Judge Lovell did not sanction the defense, but made it clear the delay in removal was inexcusable under federal law and that this Court should have retained concurrent jurisdiction. The Supreme Court sanctioned the defense on remand, holding its long delays estopped it from raising the ERISA defense. Then, in 2018, we return to the District Court and here we go again.

DN 189, p. 10.

93. On October 24, 2018, the District Court held Allied was estopped from denying coverage on the $1,000,000 single claim limit. DN 330. She also stated Allied had "admit[ed] coverage under the $1 million single-limit of the MCEO policy." DN 330, p. 11.

94. On January 17, 2019, Allied filed a second motion for summary judgment, this time alleging the "loss" provision in the MCEO policy precluded all coverages. Again, this was not a coverage defense mentioned in Sappington's 2010 coverage letter or thereafter for several years.

95. On April 19, 2019, the District Court denied Allied's motion on the ground the "loss" exclusion defense lacked merit. She recognized the Class had been severely prejudiced by Allied's delays: "The chance of individuals being found, and their eligibility verified, becomes more remote as the years pass." DN 273.

96. On January 27, 2020, the District Court approved a "preliminary settlement" between Rolan and the Class and the by now defunct New West. It required New West to pay a quarter of a million dollars into a trust for the benefit of the Class. It also required New West to assign to Rolan and the Class all claims it had against Allied World. Given Dana Rolan's sacrifices throughout the 10-year litigation, she would be paid a $50,000 incentive award. DN 284.

97. On April 24, 2020, the District Court approved Allied's motion to interplead the $1,000,000 single-limit coverage into court without admitting liability. Allied interpleaded only $738,600, claiming New West was responsible for paying $261,400 of the litigation costs out of the $1,000,000 coverage limit. This was on top of the $100,000 to $200,000 New West paid before the coverage would even kick in. In effect, New West was paying for years of delay caused by Allied's illegal settlement practices. Rolan and the Class were paying for Allied's delays, since it caused the coverage to go from $1,000,000 to less than $750,00.

98. Three days later on April 27, 2019, the District Judge certified her coverage and estoppel decision to the Montana Supreme Court for interlocutory review.

99. The events described above display ongoing illegal conduct by Allied which further damaged its insured and, for that matter, Rolan and the Class. UTPA violations included:

(1) "Misrepresenting pertinent facts" under §201(1);

(2) Failing to acknowledge and act reasonably prompt" under §201(2);

(3) Failing to "adopt and implement reasonable standards for the prompt investigation of claims under §201(3);

(4) Neglecting to settle in good faith by effectuating a prompt fair and equitable settlement under §201(6);

(5) "Compelling [its] insured [New West] to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amount ultimately recovered" under §201(7); and

(6) Failing "to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement." §201(14).

100. This ongoing misconduct also constitutes breaches of fiduciary, fraud, constructive fraud and deceit duties. It also violated Allied's self-imposed duty to resolve claims in a prompt and inexpensive manner.

G. MONTANA SUPREME COURT PROCEEDINGS 2019-2022

101. There are insufficient funds to provide restitution to the Class and pay for other losses. To date, $109,721 has been paid to the administrator and another $32,339.04 is currently due. Further administration costs will probably reach or exceed this amount for additional notices to the Class, including their notice to object to the settlement at a Final Fairness Hearing and for administration of their individual claims. In addition, the Court approved a $50,000 incentive award to Rolan, which amount is currently before the Court for payment (Rolan's individual restitution now exceeds $200,000 counting over a decade of interest). Class counsel has not been paid for his 14 years of work on the case, which fees now easily exceed the entire amount in trust. None of this would have occurred if Allied had not asserted a near frivolous ERISA defense and then, after that was going to fail, disclosed its "no-coverage" defense.

102. On January 4, 2022, the Supreme Court reversed the District Court's coverage rulings in part. *Rolan v. New West and Allied World*, 2022 MT 1 (*"Rolan III").* It affirmed the District Court's holding that the "loss" provision in Allied's E & O policy did not preclude coverage.

103. The Supreme Court reversed on estoppel. The current record failed to show undisputed "clear and convincing evidence" the six elements of estoppel applied as a matter of law. Specifically, it had not been established through

undisputed clear and convincing evidence that Allied "acquiesced" to New West's understanding the $3,000,000 limit applied." *Id.* at ¶26.

104. The Supreme Court repeated its longstanding position on the made-whole laws:

> It is ***well settled*** in Montana law, that notwithstanding the terms of a contract, an "insured is entitled to be made whole for his entire loss and any costs of recovery, including attorney's fees, before the insurer can assert its right of legal subrogation . . . ." *Swanson v. Hartford Ins. Co.,* 2002 MT 81, ¶ 18, 309 Mont. 269, 46 P.3d 584 (quoting *Skauge v. Mountain States Tel. & Tel. Co.,* 172 Mont. 521, 528, 565 P.2d 628, 632 (1977)). The made-whole doctrine does not stem from the terms of a contract but rather is "provided by the equitable principles inherent in the *Skauge* ruling." *Swanson,* ¶ 20 (quoting *DeTienne Assocs. L.P. v. Farmers Union Mut. Ins. Co.,* 266 Mont. 184, 190, 879 P.2d 704, 708 (1994)).
>
> ….
>
> This class settlement is not an amount due under a contract, rather it covers the class's damages stemming from New West's failure to fulfill its made-whole duty—under Montana law and independent of the terms of the Policy. The class recovery at issue here stems not solely from New West's failure to pay amounts owed under contract, but under the fundamental tenet in Montana law that an "insurer has been paid for the assumption of the liability for the claim, and that where the claimant has not been made whole, equity concludes that it is the insurer which should stand the loss, rather than the claimant." *Zacher v. Am. Ins. Co.,* 243 Mont. 226, 230-31, 794 P.2d 335, 338 (1990). The class recovery thus does not amount to expectancy damages from a mere breach of contract, but from ***New West's violation of settled Montana law.***

Id. at ¶¶33-34 (emphasis added). This finding lays to rest Allied's frivolous contention that New West's duty to pay was unclear in 2009 or thereafter.

105. The Court remanded to the District Court "for further proceedings consistent with this Opinion." Rolan will either request a jury trial and/or summary judgment on estoppel depending on what further discovery discloses, including what Allied's unproduced file shows.

III. INDIVIDUAL THIRD-PARTY UTPA CLAIM OF DANA ROLAN

Plaintiff Dana Rolan repleads all that is stated above and in prior Complaints and hereby further alleges and states:

A. MISREPRESENTING INSURANCE COVERAGE

106. In 2011, Rolan served New West a discovery request to reveal and produce information concerning the amount of insurance which existed to cover Rolan and the Class claims. The defense provided an Errors and Omissions Policy with Allied that expressly covered "class actions" up to the $3,000,000 aggregate policy limits. Based on this information, Rolan believed from the beginning that $3,000,000 in coverage existed to pay Rolan's and the Class's claims. Had the defense informed her no coverage existed, as Allied contended six years later, Rolan would have immediately settled her individual claim for a little over $100,000. She would not have pursued the class action. It would have been fruitless if no insurance existed. She would, therefore, have been paid in 2011, rather than being subjected to 12 more years of litigation and still, to this day, remain uncompensated.

107. Assuming New West is a minimally rational business, it, too, would have settled rather than risk years of litigation; higher exposure to punitive damages and pre-judgment interest; hundreds of thousands of dollars in litigation costs and the loss of goodwill that has occurred over the past 12 years.

108. As a matter of Montana law, Allied controlled the defense of this action. As a matter of fact, it controlled the defense by creating joint duties between itself and defense counsel to coordinate their efforts to "achieving the best results for [the] insured in an efficient and cost-effective manner." Browning was sending its responses to discovery to Allied in compliance with this agreement and therefore, Allied is jointly responsible for providing Rolan a policy during discovery which on its face, stated class actions were covered by $3,000,000 aggregate coverage.

109. By providing a policy stating class actions were covered to $3,000,000, Allied violated its duties under the Unfair Settlement Practices Act, *supra.* This includes:

(1) "Misrepresenting pertinent facts or insurance policy provisions related to the coverages at issue." §201(1);

(2) "Failure to … implement reasonable standards for the prompt investigation of claims arising under insurance policies. §201(3). The joint

agreement with defense counsel provides a reasonable standard, but Allied did not implement it.

110. As a result of the violations of the law, Allied has caused enormous mental distress and financial losses for Rolan, including the complete loss, thus far, of over $100,000 in medical benefits. Allied is also liable for interest thereon; attorney fees unnecessarily incurred for the last 11 years; mental distress and frustration; and all other damages sustained. It is also liable for reckless and malicious conduct necessitating punitive damages.

B. AN ONGOING COURSE OF ILLEGAL CONDUCT THROUGHOUT THE LAWSUIT

111. Allied's conduct throughout this 13-year litigation has failed to comply with several UTPA duties.

112. An insurer is required to make a good faith, prompt, fair and equitable settlement when liability has become reasonably clear. §201(6), *supra*. Allied chose to ignore this duty several times. In 2009, the made-whole duty to pay Rolan was not only reasonably clear, but abundantly clear. GLR explained this to Allied in its 2013 evaluation. New West, itself, admitted as much through the testimony of its designated representative close to a decade before. As the Montana Supreme Court stated in *Rolan III*, *supra,* "The class recovery [arises] from ***New West's violation of settled Montana law.***"

113. Allied failed in its duty by "misrepresent[ing] pertinent facts or insurance policy provisions relating to coverages at issue. §201(1), *supra.* Among other things, it misrepresented it had no duty to pay because liability was not reasonably clear—contradicting the well-settled law and the evaluation of defense counsel. More often than not, it would not even respond to Rolan's offer to settle. And on the two occasions it responded over the 12 years of this litigation, it offered .30 on the dollar and $50,000 for settlement of both Rolan's and the Class's claims.

114. Allied failed to "acknowledge and act reasonably promptly upon communications with respect to claims." §201(3). Rolan made several offers to settle throughout this lawsuit. Allied made no response or counteroffer until 2017, where it offered $50,000 for both Ms. Rolan's and the Class's claims at a court-ordered settlement mediation—this at a time when its defense attorney recommended at least a $1,000,000 offer. When asked to divulge the reason for this paltry offer, Allied's counsel informed Rolan's counsel he did not have to. This conduct not only requires compensatory damages, but its deliberate nature requires punitive damages.

115. Allied failed in its duty to "conduct a reasonable investigation based upon all available information" before "refus[ing] claims." §301(4). Allied has frivolously contended throughout this 13-year lawsuit that liability has not been

reasonably clear and therefore, it had no duty to settle with Rolan or the Class. Over and over again, the evidence and law showed its position was clearly wrong, but Allied always chose to litigate rather than settle.

116. Allied failed in its duty to "affirm or deny coverage of claims within a reasonable time after proof of loss statements." As stated in the GLR 2013 evaluation, Rolan had submitted proof of her losses in 2009, consisting of copies of the $100,000+ bills New West was legally required to pay. Nevertheless, no effort was made to resolve Rolan's claims—a deficiency still existing 13 years later.

117. Allied failed to "promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement." §201(14). From 2009 to 2017, Allied provided no explanation for denying either Rolan's or the Class's claims. It made no compromise offer until the 2017 settlement conference when it offered $50,000, but refused to provide an explanation for it.

118. Allied's flagrant and multiple violations throughout this decade-plus time period subjects it to both compensatory and punitive damages.

IV. CLASS CLAIMS AGAINST ALLIED

Rolan and the Class reallege and state all that is stated above and for the Class claims against Allied, hereby allege and state.

119. Under M. R. Civ. P. 23, a class of similarly-situated people may bring a class action if four pre-requisites are satisfied:

(1) The class must be so numerous that joinder is impractical. The District Court has already answered this in the affirmative when it certified the class. New West's records show this requirement is satisfied.

(2) There is a question of law or fact common to class members. All members of the Rolan Class have a question of law and fact in common: Is Allied accountable for damages incurred because of Allied UTPA violations throughout this lawsuit? By violating its duties towards Rolan, Allied violated its duties toward the similarly-situated Class.

(3) The claims of the representative (Rolan) must be typical of the Class. Here, they are virtually identical. Virtually all of Allied's UTPA violations were committed against both Rolan and the Class.

(4) The representative parties will fairly and adequately protect the interests of the Class. Rolan is currently the class representative and her adequacy has already been approved by the Court. Should another class member assume the duties of the representative, the Court can reconsider the issue at that time.

Therefore, all four requisites have been satisfied as a matter of law.

120. The Class requests certification pursuant to Rule 23(b)(3). Both requirements of this form of class action are satisfied:

(1) The questions of law and fact common to class members predominate over any questions affecting only individual members. The predominate issue, here, is whether or not Allied violated the UTPA rights of all class members during this lawsuit. The affect on all individual members is the same: They have been deprived of their rights though the delays caused by Allied's misconduct.

(2) The class action is superior to other available methods to fairly and efficiently adjudicate the controversy. The alternative to this class action would be individual suits by class members, who probably number in the hundreds. Such an alternative is obviously impractical and would cause a huge expenditure of judicial resources. Moreover, management of the class action would be relatively simple. The Court can order that Rolan's individual claims and damages, including punitive damages, be tried as soon as possible after discovery is completed. The liability holding will then collaterally estop Allied from retrying liability in the other class cases. The individual class members can then use the liability holding to either settle with Allied or, if they desire, separately sue for their individual damages. The Class's separate settlement and trials would fall outside the class action. Application of Rolan's judgment against Allied to the Class's claims would simplify them significantly.

V. RELIEF IS REQUESTED

(1) Jury trials on all triable issues.

(2) Judgment for all compensatory and punitive damages due to Allied's multiple illegal acts against New West.

(3) Judgment for all compensatory and punitive damages due to Allied's multiple illegal acts against Dana Rolan individually, including but not limited to, damages for her mental anguish.

(4) Class certification to determine Allied's liability for compensatory and punitive damages due to its illegal conduct throughout this suit.

(5) An order that the liability determination and judgment for Rolan shall collaterally estop Allied from challenging liability in suits or settlements brought by class members.

(6) Any other relief the Court deems necessary and appropriate, including attorney fees and costs incurred by Rolan and the Class in seeking this relief.

DATED this _____ day of May, 2022.

THUESON LAW OFFICE

_____

ERIK B. THUESON
58 South View Road
Clancy, MT 59634

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I served true and accurate copies of the foregoing document upon counsel of record by the following means:

Robert Lukes Garlington, Lohn & Robinson 350 Ryman St, PO Box 7909 Missoula MT 59807-7909 *Attorneys for New West Health*	□ U.S. Mail □ Federal Express □ Hand-Delivery ☒ E-mail rclukes@garlington.com
Randall Nelson Nelson Law Firm 2619 St. Johns Ave, Ste E Billings MT 59102 *Attorneys for Allied World*	□ U.S. Mail □ Federal Express □ Hand-Delivery ☒ E-mail rgnelson@nelsonlawmontana.com
Gary Zadick Ugrin, Alexander, Zadick #2 Railroad Square, Ste. B PO Box 1746 Great Falls, MT 59403 *Attorneys for New West Health*	□ U.S. Mail □ Federal Express □ Hand-Delivery ☒ E-mail gmz@uazh.com
Martha Sheehy Sheehy Law Firm PO Box 584 Billings MT 59103-0584 *Attorneys for Allied World*	□ U.S. Mail □ Federal Express □ Hand-Delivery ☒ E-mail msheehy@sheehylawfirm.com

DATED this _____ day of May, 2022.

_____
Elayne M. Simmons
elayne@thuesonlawoffice.com

ERIK B. THUESON
58 South View Road
Clancy, MT 59634
Telephone: (406) 459-1792
ethueson@gmail.com
Attorney for Plaintiffs

MONTANA FIRST JUDICIAL DISTRICT COURT
LEWIS & CLARK COUNTY

DANA ROLAN, on her own behalf and on behalf of the class she represents, Plaintiffs, vs. NEW WEST HEALTH SERVICES, DARWIN SELECT INSURANCE COMPANY and ALLIED WORLD ASSURANCE COMPANY and DARWIN NATIONAL ASSURANCE COMPANY, Defendants.	Cause No. DDV 2010-91 Honorable Christopher D. Abbott **PLAINTIFFS' EXHIBITS TO THIRD AMENDED COMPLAINT**

INDEX TO EXHIBITS

From: Sappington, Joseph
To: Robert C. Lukes
Cc: "kheaney@crowleyfleck.com"; "imcintosh@crowleyfleck.com"
Subject: Re: Rolan v. New West - Montana case
Date: Tuesday, October 8, 2013 6:57:42 PM

Bob- Thanks very much for this very helpful review. I agree that the ERISA issue should be investigated and hopefully we can act on it as a defense to the matter.

Joe

EXHIBIT 1

From: Robert C. Lukes [mailto:rclukes@GARLINGTON.COM]
Sent: Tuesday, October 08, 2013 04:07 PM
To: Sappington, Joseph
Cc: 'Kevin P. Heaney' <kheaney@crowleyfleck.com>; 'Ian McIntosh' <imcintosh@crowleyfleck.com>
Subject: RE: Rolan v. New West - Montana case

Joe,

I have completed my initial review of materials in the *Rolan* case. This includes all pleadings, discovery, documents produced and depositions. I write to provide you with my initial thoughts and evaluation on the case.

These cases all arose in conjunction with the Montana Supreme Court's determination in the matter of *State Auditor v. Blue Cross Blue Shield*, see http://www.crowell.com/pdf/ManagedCare/Blue-Cross-Blue-Shield-of-Montana_v_Montana-State-Auditor.pdf. That case was decided in September of 2009. Although the decision strictly involved the denial by the State Auditor of proposed language for a health insurance policy, the ruling has been read much more broadly. These cases all concern the application of provisions concerning the "coordination of benefits," or COB. In simple terms, COB determines which policy is primary and which is secondary in a situation where there are multiple policies from insurers having an obligation to pay. The particular situation in these cases arises when there is a liability policy that has an obligation to pay a medical expense arising out of a tortfeasor's conduct. It is typically an auto policy, but the same analysis would apply to a premises liability policy. These COB provisions typically specify that in these situations, the health insurance will be secondary and will only pay in the event the liability coverage does not pay.

The concern here is that Montana requires an insurer to undertake a made whole analysis prior to subrogation and the subrogation can only occur if the claimant has been "made whole." For discussion of this concept, I will attach hereto our "opening brief" which was recently filed in the matter of *Diaz v. State of Montana*, which touches on these principles. As you may know, *Diaz* is seen as the leading case where certain critical issues will be decided that are relevant to a number of other cases involving COB. What arguably changed in Montana law in the *State Auditor* case is that our Supreme Court interpreted the application of a COB provision in conjunction with payment from a liability carrier to constitute a form of subrogation. In legal parlance, it is now referred to as a type of *de facto subrogation.* Even though an insurer is not filing a claim to recover an amount paid (as in traditional subrogation), the insurer is withholding payment of an amount due under a policy because of the liability of a third party. It does so without a made whole analysis, which is in violation of Montana's laws. As an aside, I should note that almost whenever a made whole analysis of a claimant is done, it inevitably reveals that the claimant is not made whole because there is always attorneys' fees unpaid, more emotional distress, lost wages that have not been covered, etc. Although somewhat debatable, this area of the law in Montana appears to have been established by the *State Auditor* case, i.e., an insurance company cannot apply a COB provision in this situation. Naturally, Plaintiffs' counsel will insist this has always been the law in Montana, but it was just finally enunciated in the *State Auditor* case. We strongly suspect that *Diaz* decision as anticipated from our Supreme Court will confirm the substance of the same.

In the *State Auditor* case, the situation with BCBS had to do with policies that were to be offered by BCBS for sale. So in the context of a health insurance company selling a policy, application of the COB provision violates Montana law. One issue in this context which has not yet been decided is whether the *State Auditor* rule should also apply to public entities that are not insurance companies. You can see our presentation of this issue in the *Diaz* briefing, attached, wherein we argue that the rule on *de facto subrogation* which was created should not apply to public entities. As noted therein, we are currently defending such cases not only on behalf of the State of Montana, but also for the Montana University System and a case brought indirectly against Lincoln County, by one of its employees.

In many ways, the facts of the present case are very similar to the other cases I have going on in this area of the law. We have a situation where Ms. Rolan was injured in a car accident and the tortfeasor's insurance (Unitrin) paid for the medical expenses. Although the New West policy provided coverage, under the COB provision, it was secondary and thus, withheld payments or in a number of circumstances, made payments and these were returned by the physicians/hospitals as duplicative of payments received from Unitrin. Ms. Rolan's auto accident took place on November 16, 2007. So, it was approximately 2 years before the *State Auditor* case was decided. But unfortunately, given the nature of the decision, it is read to have applied existing Montana law, not to have changed the law, for the made whole doctrine evolved in Montana during the mid-1970s. So, the rule from *State Auditor* applies to the present case. This means that New West cannot withhold payment simply because the medical bills were paid by a third party insurer.

The question remains whether there is any exception to this general rule which might apply. In *Diaz* and the other cases I am currently handing, an exception arguably exists because these are public entities funded by taxpayer dollars and there is some question as to whether the *State Auditor* rule which was adopted in the context of Title 33 insurance company should apply. Another exception that can apply to these claims is for employee benefit health plans, as these are typically governed and by federal laws under ERISA. Although this issue has not been litigated yet in Montana, the general belief is that ERISA would preclude application of Montana's unique laws on subrogation.

So, turning to the present case, it would not appear as though any exception applies. The health insurance at issue from New West arose from the employment of the Plaintiff's mother, Charma Rolan. She is an employee of St. Peter's Hospital. As part of her employment, Charma Rolan receives health insurance in a plan from New West. From what we have learned to date, it would appear as though St. Peter's Hospital takes the position that its benefit plans are non-ERISA plans, because of St. Peter's connection to the church. Although we have not yet researched the issue, Kevin Heaney at the Crowley firm has turned up these discussions on the subject which are very interesting.

See
http://blog.fraplantools.com/new-lawsuits-allege-catholic-hospital-plans-not-church-plans/

http://www.erisaexchangeblog.com/2013/04/29/class-action-lawsuits-target-hospital-church-plans/

http://www.mondaq.com/unitedstates/x/174370/Employee+Benefits+Compensation/The+ERISA+Church+Plan+ExceptionThe+Courts+Throw+A+Curvehttp://www.dol.gov/ebsa/programs/ori/advisory95/95-07a.htm#f3. This last DOL opinion is most interesting.

Although not yet developed, this investigation into a possible preemption by ERISA seems to be our only avenue in the case to avoiding liability. Unless there is some drastic revision of the *State Auditor* rule by our Supreme Court in the *Diaz* decision (anticipated no later than Spring 2014), we believe that New West will be liable in the present case for all amounts withheld from the treatment of Ms. Rolan. From our review, this would appear to be approximately $110,000 (plus interest at 10% per annum). In addition, the case is certified as a class action. Documents I have reviewed indicate that New West has identified another $200,000 (plus interest) that would be liable to other class members. Because the case was brought as a declaratory judgment action, they will most likely have to pay the Plaintiffs' attorneys' fees, as well.

The case also has significant concerns regarding potential punitive damages, as well. This would be under the Unfair Claims Practices Act, basically for malice. I see two issues here. The first has to do with New West's failure to respond to the initial letters of Erik Thueson in a timely manner. In sum, he wrote to them on several occasions over a period of many months before New West ever responded. The second concern arises because New West did not cure the issue once it had notice of the September 2009 *State Auditor* decision. Once it became aware of that case, arguably, it had the obligation to go back and to make payments on all of the non-ERISA cases where it had applied the COB provision. Indeed, that conduct and failure to cure continues to this day. At the deposition of New West Claims Manager Katherine Bahrman, opposing counsel asked her why these amounts have still not been paid. The only reason she proffered was because the bills/claims from Ms. Rolan had not really been submitted. Given that we have all of these records as part of the lawsuit, the response appears a bit disingenuous, at the least. The only other rationale as to why New West has not yet paid Ms. Rolan the $110,000 plus interest is because it is waiting for the outcome of the *Diaz* case. Remember, the primary issue in *Diaz* is whether the State of Montana should be treated as a Title 33 insurer under Montana law for the application of the *State Auditor* rule. Again, in the present context, it seems very unlikely that the *Diaz* decision will do anything other than confirm the application of the *State Auditor* rule as it applies to insurers, like New West. At a minimum, it would seem that New West should be prepared to make the payment to Ms. Rolan once the *Diaz* decision is announced (presuming it affirms the *State Auditor* case). Should it fail to do so, the ramifications for a punitive damages award at trial will be enormously increased.

The other concern is the "unidentified" class members. Most likely, New West has other customers where it never even received claims because the liability insurance was paying the medical bills. Under the class action definition adopted by the Court in this case, as approved in the recent Supreme Court order, these unidentified individuals are part of the class. In *Diaz,* the Plaintiffs have just taken steps to try and identify such individuals (see discovery attached, as recently submitted to BCBS). I suspect we shall see similar discovery in *Rolan* in the near future. Exactly how many such class members there are in *Rolan* and the potential liability remains completely unknown. These claims would go back for 8 years before the Complaint was filed (i.e., back to January 2003).

I think we need to quickly explore the possible ERISA exemption, as that would appear to be just about the only hope in avoiding liability in the case. It may be that once we complete our analysis of the ERISA preemption, we either move towards a settlement conference or alternatively, motions to amend our answer and a motion for summary judgment based on the ERISA preemption.

Please let me know your thoughts in this regard.

Thanks,
Bob Lukes

10-8-13

CROWLEY | FLECK PLLP
ATTORNEYS

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EXHIBIT
2

September 30, 2013

VIA E-MAIL & U.S. MAIL
Joseph Sappington, Esq.
Senior Claims Analyst
Allied World National Assurance Co.
9 Farms Springs Rd.
Farmington, CT 06032

Re: Insured: New West Health Services
Insurer: Darwin Select Insurance Co.
Policy No.: 0303-5534 (MCEO Policy)
Policy Period: 04/01/2009 to 04/01/2010
Policy Limit: $1,000,000 for each Claim made in the Policy Period and $3,000,000 in the aggregate for all Claims
Retention: $50,000
Subject: Rolan, Dana
Darwin Ref. No.: 2010000725

Dear Mr. Sappington:

As I indicated in my voicemail to you on September 17, 2013, we represent New West Health Services. I called you to discuss New West's insurance coverage in the Dana Rolan matter. More specifically, I called to discuss coverage under the Managed Care Organization Errors and Omissions Liability Policy (the "MCEO Policy"). The MCEO Policy is policy number 0303-5534 and the Darwin reference number is 2010000725.

Pursuant to your letter dated February 18, 2010, it appears that you agree there is coverage under the MCEO policy, unless New West committed willful misconduct or willfully violated a state law. Please contact me to confirm this.

The MCEO policy also apparently includes defense expenses as part of the policy limits. Thus, to determine the amount of coverage New West has remaining, please provide me with a detailed report of the defense expenses paid to date, and please confirm the remaining policy limits.

Please also provide me with a certified copy of the MCEO policy.

As I am sure you are aware, in Montana, an insurer is required to acknowledge and act reasonably promptly upon communications. Mont. Code Ann. § 33-18-201(2). Please contact me at your earliest convenience to discuss New West's insurance coverage under the MCEO policy.

Sincerely,

CROWLEY FLECK PLLP

Ian McIntosh

IM/wma

cc: Angela Huschka (via e-mail)

Exhibit 2-2

elayne@thuesonlawoffice.com

From: Robert C. Lukes <rclukes@GARLINGTON.COM>
Sent: Friday, March 11, 2016 11:20 AM
To: Querijero, Michelle
Subject: RE: Rolan v. New West Serv., your file 2010000725

EXHIBIT 4

Michelle,

We received an enquiry today from Plaintiff's counsel, Erik Thueson. Given the case is now moving back to state court, he's proposing that we try to mediate a settlement. He says "we have enough experience in these types of cases that we know where it's going" -- implying that he's going to win, as he has on these other made-whole cases.

The problem with his notion that he's going to win this case is that none of our other cases are under ERISA. Although the court found jurisdiction was not proper in federal court, it is now adamantly clear that ERISA applies to the case. The question now refined is whether Montana's made-whole law is still viable under ERISA's "Saving's Clause." I will copy the portion of the opinion discussing this issue at the base of this email – that starts on Page 22 of the opinion.

We are going to start researching this issue immediately. Although we have done a lot of analysis of ERISA's preemption to date, it was not really focused on this narrow question. And I think this issue will be determinative in the case. Here's what I think we should do. First, we should conclude our research on this question. Then, depending upon the results of this research, we should either: (A) submit a motion to the court on the question; or (B) mediate the dispute. In other words, if we think we will lose the motion, we should mediate the case.

Please let me know your thoughts in this regard and if you have any objection to this direction.

Thanks,
Bob Lukes

PG. 22 of Opinion

EXHIBIT
3

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
HELENA DIVISION

DANA ROLAN,

Plaintiff,

vs.

NEW WEST HEALTH SERVICES,

Defendant.

CV 15–51–H–CCL

ORDER

Before the Court is Plaintiff Dana Rolan's Motion to Remand all or part of this case to Montana state district court. The motion is opposed. Plaintiff requests a hearing on the motion, but the Court has determined that the motion is suitable for decision without oral argument.

Background

Plaintiff Dana Rolan ("Rolan") is a beneficiary of her mother's group health plan, which is provided by her mother's employer, St. Peter's Hospital. The New

West Health Plan ("the Plan") is fully-insured by Defendant New West Health Services ("New West"). Rolan was involved in an automobile accident that resulted in her serious injuries requiring medical treatment.

Plaintiff provides a summary of factual background and the state court case history in her Amended Complaint. The automobile accident occurred on November 16, 2007, near Townsend, Montana. Medical expenses were approximately $120,000. The tortfeasor possessed liability insurance through Unitrin Services Group, which accepted responsibility for the accident and paid medical bills of approximately $100,000. However, Rolan had asked *her* health insurer carrier, New West, to pay her medical bills. Rolan alleges that New West either directed Unitrin to pay Rolan's medical bills or to reimburse New West for its payment of Rolan's medical bills (or both). Rolan further alleges that New West did not first determine whether Rolan had been made whole for the entirety of her damages as required by M.C.A. 33-30-1102(4).

In February 2010, Rolan filed suit in the First Judicial District, alleging that New West violated her made-whole rights under Montana law. She sought

restitution of approximately $100,000 in medical benefits that she asserts should have been paid by New West, and compensatory and punitive damages for unfair claims settlement practices. New West answered the complaint and did not defend under ERISA. New West "officials then stated in deposition testimony that the plan was not an ERISA plan." (Doc. 8, Amended Compl. at 3, ¶ 6.) On May 4, 2012, the state district court certified a class action of non-ERISA plan members "whose claims are determinable solely by state law." (Doc. 8, Amended Compl., at 3, ¶ 8.) New West appealed that decision to the Montana Supreme Court, which affirmed the district court's certification order. *Rolan v. New West*, 307 P.3d 291, 371 Mont. 228 (Mont. 2013). According to Rolan, "[o]n October 23, 2013, over three and a half years into the lawsuit and six years since Rolan was deprived of her liability insurance, New West changed its position. It moved to amend its Answer to allege the plan in question was an ERISA plan after all and that therefore, the action is preempted under federal law." (Doc. 8, Amended Compl., at 4, ¶ 9.) The state district court granted New West's motion to amend its Answer. On May 5, 2014, New West moved for summary judgment, "arguing that

state courts have no jurisdiction over ERISA plans." (Doc. 8, Amended Compl., at 4, ¶ 11.) According to Plaintiff's Amended Complaint,

> [o]n May 6, 2015, the state district court granted New West's motion for summary judgment in part. It held that Rolan was enrolled in an ERISA plan and that the state court lacked jurisdiction to adjudicate ERISA claims. The Court recognized New West's ERISA plans, like Rolan's, which were not self-funded, are subject to Montana's made-whole laws. It held Rolan had a right to amend her Complaint to recast claims as ERISA claims and then her amended claims would be removed to federal court. The Court did not rule on Rolan's position that members of the certified class, who were in non-ERISA plans, continued to have state law claims. The Court held New West was responsible for Rolan's attorney fees and costs incurred over the four plus years in which New West had misrepresented that Rolan's plan was non-ERISA and governed by Montana law.

(Doc. 8 at 4-5, ¶ 12.) Rolan filed an Amended Complaint, now stating both state law claims and ERISA claims. On the same day Rolan filed her Amended Complaint, New West filed its removal papers, all within 30 days after the state district court ruling.

Removal of the Amended Complaint

New West removed Plaintiff's Amended Complaint to this Court pursuant to the Court's original jurisdiction under the Employee Retirement Income

Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq.

Plaintiff's Amended Complaint (Doc. 8) states the following claims:

1. Count I, "Individual State Law Claim" asserts that New West violated Montana's statutory made-whole law, which provides that no subrogation can occur until after the insured has determined that the injured claimant has been fully compensated for her injuries.[1][2] Rolan asserts that New West did not perform a made-whole analysis before avoiding payment of benefits. Rolan cites the ERISA Savings Clause that exempts state insurance laws from ERISA express preemption. Rolan asserts that New West has an independent duty to abide by Montana made-whole laws and that complete preemption under ERISA is therefore inapplicable.

2. In Count II, Rolan asserts that she is currently the class representative of a certified class alleging that New West violated

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[1] "33-30-1101. Subrogation rights. A hospital or medical service plan contract issued by a health service corporation may contain a provision providing that, to the extent necessary for reimbursement of benefits paid to or on behalf of the insured, the health service corporation is entitled to subrogation, as provided for in 33-30-1102, against a judgment or recovery received by the insured from a third party found liable for a wrongful act or omission that caused the injury necessitating benefit payments." M.C.A. § 33-30-1101 (2015).

[2] 33-30-1102. Notice–shared costs of third-party action–limitation. ... (4) The health service corporation's right of subrogation granted in 33-30-1101 may not be enforced until the injured insured has been fully compensated for the insured's injuries." M.C.A. § 33-30-1102 (2015).

their made-whole rights and entitling them to the same relief. A Certification Order issued by the First Judicial District Court is attached to the Amended Complaint. It alleged that New West either permitted or forced tortfeasors and their insurance companies to pay medical bills for the class, rather than New West, all without any attempt by New West to make any made-whole determination.

3. In Count III, Rolan sets forth a subclass of members who are in non-ERISA plans and asserts state law remedies under the Unfair Settlement Practices Act ("UTPA"), M.C.A. §§33-18-201, et seq., for this subclass. Count III alleges that New West violated the requirement that it promptly, fairly and equitably pay claims and conduct a reasonable investigation of claims. This subclass of state claims is asserted to be remedied by punitive damages upon a jury finding of malice or fraud.

Rolan groups the following counts under the subtitle "Concurrent Jurisdiction Alternative Claims."

4. In Count IV, Rolan asserts an "Individual ERISA Payment Claim," seeking concurrent jurisdiction by the state district court pursuant to § 502(a)(1)(B) of ERISA.[3] Rolan states that she is

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[3] "§ Civil Enforcement.
(a) Persons Empowered to Bring a Civil Action. A civil action may be brought–
(1) by a participant or beneficiary–
(A) for the relief provided for in subsection (c), or
(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future

entitled to payment of benefits and clarification of her rights to benefits. Rolan seeks her benefits, interest thereon, attorney fees and costs.

5. In Count V, Rolan asserts a "Class Action ERISA Payment Claim." This count alleges on behalf of all class members paying premiums to ERISA plans that New West violated their made-whole rights and they are therefore entitled to ERISA benefits, interest, and attorney fees and costs. Plaintiff points out that this claim can be resolved by state courts pursuant to concurrent jurisdiction provided by ERISA.[4]

The next group of counts is under the subtitle "Alternative Claims Recast as ERISA Claims." Rolan states that, in compliance with the state district court's Order of May 6, 2015," she is recasting all her claims as ERISA claims, pleading

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benefits under the terms of the plan; . . . .
29 U.S.C. § 1132.

[4] "1329(e) Jurisdiction.
(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.
29 U.S.C. § 1329(e)(1).

in the alternative:

> 6. In Count VI, Rolan asserts that she is owed over $100,000 in ERISA benefits, with interest dating back to when the benefits should have been paid to her in 2007, and attorney fees and costs.
>
> 7. In Count VII, Rolan asserts that a class should be certified pursuant to Fed. R. Civ. P. 23 for all members of ERISA New West plans funded by premiums (*i.e.*, not self-insured plans).
>
> 8. Count VII seeks equitable relief pursuant to either 502(a)(1)(B) for payment of benefits and/or 502(a)(3) for payment of restitution, plus interest and attorney fees and costs. Rolan is to be the class representative when this class is certified by this Court.

Motion for Remand

Both in her Motion for Remand[5] and in her Amended Complaint, Plaintiff seeks relief in the form of a remand to state court "on the ground that ERISA preemption does not apply." (Doc. 8, Amend. Compl. at 16, ¶¶ 56-57.) Plaintiff believes that either all of her original claims (Counts I through III) or some

[5] "Since there is neither express nor complete preemption, the state court has full jurisdiction over all state law claims that New West violated the made-whole laws. Therefore, the case should be remanded in its entirety." (Doc. 4, Pl.'s Brief in Supp. at 7.)

(alternative Counts IV (Rolan's individual ERISA claim) and V (ERISA class action)) of the counts should be remanded. If the case is to stay in federal district court, however, Plaintiff intends to proceed under Counts VI (Rolan's individual ERISA claim) and VII (ERISA class action).

ERISA Benefit Claims

ERISA provides that both federal and state district courts have concurrent[6]

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[6] § 1132. Civil enforcement.

...

(e) Jurisdiction. (1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this title brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 101(f)(1). State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

...

(f) Amount in controversy; citizenship of parties. The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

29 U.S.C. §§ 1132(e)-(f).

jurisdiction over a beneficiary's claims "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan...." ; ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B); ERISA § 502(e)(1), 29 U.S.C. § 1132(e)(1). Besides recovery of benefits under § 1132(a)(1)(B), ERISA remedies under § 502(a) can include an injunction, other equitable relief, and attorney fees and costs. 29 U.S.C. § 1132(a)(3), (g).

ERISA Preemption
(Complete/Express and Conflict/Obstacle)

In this case, Rolan's original Complaint filed in state district court only asserted state law claims, not ERISA claims. Generally, such a case lacks federal question jurisdiction. However, under the artful pleading doctrine, which is an exception to the well-pleaded complaint rule, if a plaintiff's state law claims are completely, or expressly, preempted by § 514(a) of ERISA,[7] the complaint "is

[7] "(a) Supersedure; effective date. . . . the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate

converted from 'an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule.'" *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 945 (9th Cir. 2009) (quoting *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 65, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987)). This is so because, in *Metro. Life*, 481 U.S. at 65, the Supreme Court held that when a suit composed of state law claims "relates to" an ERISA plan within the meaning of ERISA § 514(a), the suit is *necessarily* federal because Congress intended to occupy the field of employee benefits law. Congress announced its intent to completely occupy the field of employee benefit plans when it enacted ERISA 514(a) [29 U.S.C. § 1144(a)], providing that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

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to any employee benefit plan described in section 4(a) [29 USCS § 1003(a)] and not exempt under section 4(b) [29 USCS §1003(b)]. This section shall take effect on January 1, 1975. 29 U.S.C. § 1144(a).

Express/Complete Preemption

Under the complete preemption doctrine, these state-law claims are deemed to "arise under" federal law and on that basis may be removed to federal court despite their presentation as state claims. *Metro. Life*, 481 U.S. at 64-65 (announcing complete preemption doctrine under ERISA). When state law claims are thus preempted, a federal claim is substituted in its place. *See Moore-Thomas v. Alaska Airlines, Inc.*, 553 F.3d 1241, 1244 (9th Cir. 2009). To determine if Rolan's claims are completely preempted, we must determine whether her claims relate to an employee benefit plan within the scope of ERISA's civil enforcement provision, which is ERISA § 502(a)(1)(B). 29 U.S.C. § 1132(a)(1)(B). "If a complaint alleges only state-law claims, and if these claims are entirely encompassed by § 502(a), that complaint is converted from 'an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule.'" *Marin Gen. Hosp.*, 581 F.3d at 945 (quoting *Metro. Life*, 481 U.S. at 65-66). "Congress had 'clearly manifested an intent to make causes of action within the scope of the civil enforcement provisions of § 502(a) removable

to federal court." *Id.* (quoting *Metro. Life*, 481 U.S. at 66).

The two-part test provided by the Supreme Court in *Aetna Health Inc. v. Davila*, 542 U.S. 200, 124 S.Ct. 2488, 159 L.Ed.2d 312 (2004), is explained as follows:

> [W]here the individual is entitled to coverage only because of the terms of an ERISA-regulated employee benefit plan, and where no legal duty (state or federal) independent of ERISA or the plan terms is violated, then the suit falls "within the scope of" ERISA § 502(a)(1)(B). In other words, if an individual, at some point in time, could have brought his claim under ERISA 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is completely pre-empted by ERISA 502(a)(1)(B).

542 U.S. at 210 (citation omitted). The court should examine the factual allegations, the statute(s) upon which the state law claim is founded, and the plan document. *Id.* at 211. The labels utilized by the plaintiff are immaterial. *Id.* at 214-15. Under this test, complete preemption is triggered if (1) "an individual, at some point in time, could have brought [the] claim under ERISA 502(a)(1)(B)," and (2) "where there is no other independent legal duty that is implicated by a defendant's actions." *Id.* at 210.

In *Marin General Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 946, 950 (9th Cir. 2009), the Ninth Circuit analyzed whether complete preemption supported defendant's removal by applying the *Davila* two-part test to plaintiff's state law claims. In *Marin*, the plaintiff hospital asserted state-law claims for breach of contract, negligent misrepresentation, and quantum meruit in state court against an ERISA plan administrator. The factual allegations included an allegation that a hospital employee had telephoned the plan administrator to confirm that ERISA health insurance benefits were available to a prospective patient. The plan administrator's employee orally verified the patient's coverage *and* promised to pay 90% of the patient's medical expenses, which eventually totaled $178,926. Instead of paying 90% as allegedly promised, the plan administrator paid only 26% of the expenses. The district court ruled that the hospital's remedy was by means of an ERISA claim, eventually dismissing the hospital's complaint. On appeal, the Ninth Circuit panel reversed, concluding that the oral promise allegedly made by the plan administrator was an independent legal basis giving rise to a duty to pay the hospital, and one that was completely

independent of the ERISA benefit plan.

In *Aetna Health Inc. v. Davila*, 542 U.S. 200, 215, 124 S.Ct. 2488, 159 L.Ed.2d 312 (2004), the Supreme Court considered whether plaintiffs could bring state claims under the Texas Health Care Liability Act ("THCLA") for their plans' refusal to provide requested medical services as had been recommended by their physicians. The Court noted that upon denial of benefits, plaintiffs could have paid for the services themselves and then filed a federal suit pursuant to ERISA to claim benefits or plaintiffs could have immediately sought a preliminary injunction. *Id.* at 211. In asserting the violations, the plaintiffs specifically cited two statutes in the THCLA that set forth the duty of ordinary care owed to an insured by a health insurance carrier or health maintenance organization. The plaintiffs argued that "this duty of ordinary care arises independently of any duty imposed by ERISA or the plan terms... [so that] any civil action to enforce this duty is not within the scope of the ERISA civil enforcement mechanism." *Id.* at 212.

However, the Supreme Court rejected this argument, stating that the

statutory duty applicable under the THCLA did "not arise independently of ERISA or the plan terms." *Id.* Instead, any liability created by the THCLA would exist *"only* because of petitioners' administration of ERISA-regulated benefit plans. [The plan administrators'] potential liability under the THCLA in these cases, then, derives entirely from the particular rights and obligations established by the benefit plans." *Id.* at 213.

In *Davila* the Supreme Court also compared those facts to *Caterpillar Inc. v. Williams*, 482 U.S. 386, 107 S.Ct. 2425, 96 L.Ed.2d 318 (1987), wherein a state law claim was not preempted by the Labor Management Relations Act ("LMRA") § 301 because the state claim was based on breach of an individual employment contract, not the similar breach of a collective-bargaining agreement. Similarly, the Court compared the *Davila* facts to those in *Allis Chalmers Corp. v. Lueck*, 471 U.S. 202, 217, 105 S.Ct. 1904, 85 L.Ed.2d 206 (1985), a state-law bad-faith insurance claim that was preempted by LMRA § 301 because "the *duties imposed* and *rights established* through the state tort . . . derive[d] from the rights and obligations established by the contract." *Lueck*, 471 U.S. at 217 (emphasis added).

Similarly, in this case, New West's duty to pay benefits and Rolan's right to the payment of benefits derive not from an independent state law but from the ERISA plan itself. Montana's made-whole statute, standing alone, does not entitle Rolan to benefits; it is the ERISA plan that entitles Rolan to benefits. That Montana statute merely provides one basis for interpreting the ERISA plan. Similarly, the gravamen of any violation of Montana's Unfair Settlement Practices Act, §§ 33-18-201, M.C.A., *et seq.*, would be the failure to "promptly, fairly and equitably pay" Rolan's claim for benefits under the ERISA plan. Essentially, the rights claimed pursuant to Montana law are dependent upon the existence of the ERISA plan and not independent from it. Rolan's citation to *Wurtz v. Rawlings Co., LLC,* 761 F.3d 232 (2nd Cir. 2014), is unavailing because, in that case, the plaintiffs were not seeking benefits under ERISA at all but merely attempting to protect their tort settlements from the insurer's claim for reimbursement.

Therefore, Rolan's state causes of action fall within the scope of ERISA 502(a)(1)(B) (*i.e.,* a claim for benefits under an ERISA plan without a legal right independent of the ERISA plan), and are therefore completely preempted by

ERISA and removable to federal district court.

Conflict/Obstacle Preemption

General state laws may be preempted even if they do not "relate to" an employee benefits plan, such as when they provide additional remedies for conduct violating ERISA. A state law is an obstacle to ERISA and therefore preempted if it "duplicates, supplements, or supplants" ERISA's civil enforcement remedies, because such a law conflicts with congressional intent to make ERISA's enforcement mechanism exclusive. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 2009 (2004); *see also Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 51-54 (1987). This is generally known as conflict or obstacle preemption.

In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987), for example, the plaintiff asserted a common-law action seeking emotional distress and punitive damages for bad-faith insurance claims processing (as does Rolan in this case), but the Supreme Court held that such remedies not found in ERISA are pre-empted. "The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if

ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 144 (quoting *Mass Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)) (1990)). Using state law to supplement ERISA remedies would pose an obstacle to ERISA's policy choices, and the Supreme Court referred to this type of preemption as "conflict preemption." *Ingersoll-Rand*, 498 U.S. at 486.

In addition, because one of the main objectives of ERISA was interstate uniformity in the federal regulation of employee benefit plans, state statutes setting specified procedures for claim processing, such as a New Jersey statute prohibiting offsetting worker compensation payments against pension benefits in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 101 S.Ct. 1895, 68 L.Ed.2d 402 (1981), have been set aside because they are an obstacle to uniform plan administration. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987) ("The employer therefore was required to accommodate conflicting regulatory schemes in devising and operating a system for processing claims and paying benefits–precisely the burden that ERISA pre-emption was intended to avoid."). The Court in *Fort*

Halifax described the underlying policy as follows:

> It is thus clear that ERISA's pre-emption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Pre-emption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations. See, *e.g.*, H.R.Rep. No. 93-533, p. 12 (1973), U.S. Code Cong. & Admin. News 1974, pp. 4639, 4650 ("[A] fiduciary standard embodied in Federal legislation is considered desirable because it will bring a measure of uniformity in an area where decisions under the same set of facts may differ from state to state.").

Id. at 11.

Insurance Savings Clause

This does not necessarily mean, however, that the Montana statutes asserted by Rolan are without effect as to the New West plan at issue. The Montana statutory limitations on insurance subrogation could either be impliedly preempted by ERISA by means of conflict/obstacle preemption (either as to substantive law or remedies) or, on the other hand, might be protected by ERISA's Savings Clause

and applied to interpret the plan during the review of Rolan's benefit claim.[8]

Generally speaking, self-funded ERISA plans are protected from state insurance laws by the "Deemer Clause," 29 U.S.C. 1144(b)(2)(B), ERISA 514(b)(2)(B). In this case, however, the St. Peter's plan is fully insured, so that state insurance laws are generally applicable due to ERISA's Savings Clause, although conflict/obstacle preemption may still be applied to state insurance laws.[9]

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[8] ERISA's Savings Clause provides that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. 1144(b)(2)(A); ERISA 514(b)(2)(A).

[9] The Savings Clause thus permits state insurance laws to apply to fully-insured plans, so the Savings Clause "leaves room for complementary or dual federal and state regulation," but nevertheless ERISA may still pre-empt a state insurance law if "the two regimes cannot be harmonized or accommodated." *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 98 (1993) (citing the federal Supremacy Clause). Discussing the Savings Clause, the Supreme Court states that "[s]tate law governing insurance generally is not displaced, but "'where [that] law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress' federal preemption occurs." *Id.* at 99 (quoting *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984)). Two Supreme Court cases involving insurance claims handling laws protected by the Savings Clause both demonstrate that the Court continued its preemption review despite the Savings Clause to decide that the laws did not undermine ERISA's

The Supreme Court's test for deciding in the first instance whether a state insurance law is protected by the Savings Clause is (1) whether the state law is "specifically directed toward entities engaged in insurance", and (2) whether the state law "substantially affects the risk pooling arrangement between the insurer and the insured." *Kentucky Ass'n of Health Plans v. Miller*, 538 U.S. 329, 341-42, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003) (making a "clean break from the McCarran-Ferguson factors"); *Standard Ins. Co. v. Morrison*, 584 F.3d 837, 842 (9th Cir. 2009). This Court need not decide today whether Rolan's central claim for ERISA plan benefits (predicated on Montana's limitation on subrogation, M.C.A. § 33-30-1102(4)), meets this test for enforceability under the Savings Clause as that crucial issue has not been briefed by the parties and is not

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objectives. *See UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 377 (1999) ("[T]he [state] notice-prejudice rule complements rather than contradicts" ERISA's claims-handling rules and thus provides the "relevant rule of decision" for plaintiff's benefits claim); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 375-80, 384-86, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002) (noting that the state insurance law did not attempt to supplement or supplant ERISA remedies and recognizing "a limited exception from the savings clause for alternative causes of action and alternative remedies....").

determinative of the remand motion.

Removal Pursuant to 28 U.S.C. § 1141 & § 1146

An action is removable to federal court if the claims could have originally been filed in federal court. 28 U.S.C. § 1441(a). Defendants must show by a preponderance that removal is proper. *Gaus v. Miles, Inc.*, 980 F.2d 564, 566 (9th Cir. 1992) (citation omitted). Any doubts about the propriety of removal should be resolved in favor of remand. *Id.*

Having already determined that this Court has concurrent subject matter jurisdiction over Rolan's ERISA claims, the Court next considers whether removal is proper in this case from a procedural standpoint. Prior to removal, this case was litigated in state court for four years, including one interlocutory appeal to Montana's Supreme Court. Given that the Court believes that the case was removable from the very first filing, the Court must determine whether a four-year delay in removal is timely. Specifically, the Court must apply section §1446(b)(1) of Title 28, which provides that removal must occur within 30 days after formal

service of process on the removing defendant. *Murphy Bros. v. Michetti Pipe Stringing, Inc.*, 526 U.S. 344, 347-48, 354 (1999). Section 1446(b) also provides that, *in a case that was not initially removable*, the removal must be accomplished within thirty days "after receipt by the defendant, through service or otherwise, of a copy of an amended pleading, motion, order or other paper from which it may first be ascertained that the case is one which is or has become removable...." 28 U.S.C. § 1446(b)(3) (emphasis added).

In the instant case, the delay in removal appears to have multiple underlying causes. First, there was New West's inexplicable confusion over whether its own plan was or was not an ERISA plan. Then, after learning in 2013 that the plan at issue was an ERISA plan (and after the Montana Supreme Court affirmed the district court's class certification), New West busied itself in state court litigation. According to Plaintiff's amended complaint, on October 23, 2013, (over three years into the state court litigation), New West informed the state district court that the plan was in fact an ERISA plan subject to federal preemption. (*See* Doc. 8, Amended Complaint, § 9.) Instead of filing for removal within 30 days, however,

New West filed a motion to amend its answer to assert ERISA preemption. The state district court granted New West's motion to amend, and thereafter New West still did not remove but instead moved for summary judgment on jurisdictional grounds. New West did not file for removal until after May 2015, when the state district court (1) granted partial summary judgment to New West, (2) held that it lacked jurisdiction to adjudicate Rolan's ERISA claims, and (3) instructed Rolan to amend her complaint to recast her claims under ERISA to permit removal to federal district court.

However, under the artful pleading doctrine and the exception provided by complete preemption under ERISA, Rolan's complaint was removable from its first filing. Certainly, by October 2013, when New West apparently realized that the employee welfare plan was an ERISA plan, New West should have then understood that it could remove Rolan's complaint to federal court. The fact that New West waited almost two years to file for removal causes this Court to question whether New West should be precluded from such an untimely removal under an estoppel or waiver theory.

A similar circumstance was considered in *Cantrell v. Great Republic Ins. Co.*, 873 F.2d 1249 (9th Cir. 1989). In that case, the plaintiff filed a state court action alleging breach of the implied covenant of good faith and fair dealing and wrongful denial of the existence of an insurance contract. The plaintiff alleged that she had obtained through her employer a group health insurance policy, but that the defendant insurer later rescinded the insurance policy on the basis of "unadmitted medical history" (but allegedly to avoid paying her claims for benefits).

The plaintiff in *Cantrell* filed her original complaint in October 1985, against Great Republic Ins. Co.,but the Great Republic *Life* Insurance Company (a Washington corporation) answered the complaint in January 1986. The same defense counsel represented both entities. In May of 1986, Great Republic Ins. Co. admitted that it had issued a "certificate of insurance . . . for group medical expense insurance coverage to plaintiff." In June of 1986, Great Republic *Life* Ins. Co. admitted that a specified numbered certificate of insurance had been issued for the plaintiff on a date certain in 1981. Over a year later, in September,

1987, plaintiff sent a proposed amended complaint not changing her claims but naming Great Republic *Life* Ins. Co. as a defendant and adding herself as administrator of her daughter's estate. Counsel for both insurance carrier entities declined to stipulate to the filing of the amended complaint, so plaintiff filed a motion for leave to amend, which was granted on October 21, 1987. On November 20, 1987, both defendants filed their removal papers in federal district court citing the district court's original jurisdiction under ERISA. The defendants asserted that the removal was timely (within the 30-day removal period) because of the addition of new parties in the amended complaint. Plaintiff filed for remand back to state court asserting that there was no federal original jurisdiction, but the remand motion was denied by the federal court because ERISA preemption overcame plaintiff's artful pleading of state causes of action.

On appeal, the Ninth Circuit panel agreed that the district court had original jurisdiction pursuant to ERISA over plaintiff's state claims and that therefore her action was removable. However, the panel reversed the district court's denial of remand, deciding that the removal was untimely because it was "clear that

Cantrell's *original* complaint was removable." *Cantrell*, 873 F.2d at 1253 (emphasis in original). The original complaint was filed on October 8, 1985, and the removal papers were filed on November 20, 1987, far in excess of the thirty-day removal period set by 28 U.S.C. § 1446(b). The panel noted that there was no evidence that the defendant insurers were ignorant of the ERISA component prior to the filing of the amended complaint. *Id.* at 1256. In fact, in their brief opposing remand, the defendant insurers asserted that no discovery was needed to show that this was an ERISA claim on an ERISA plan. *Id.* at 1255, n.11. The Ninth Circuit panel simply could not accept that defendants were entitled to "have it both ways–to permit them to remove the action on the basis of ERISA preemption but excuse them from compliance with the thirty-day removal period...." *Id.* at 1255. The panel concluded that by their long delay the defendant insurers had waived their right to remove the ERISA case from state court.

Similarly, here, four years elapsed between the filing of the original complaint in state court and the filing of the removal papers. In between those two points, there was a class certification and an interlocutory appeal to the Montana

Supreme Court. Certainly, New West had access to the plan documents from the outset. At some point in the litigation, New West decided that the case should be governed by ERISA, and New West began to brief and argue motions to that effect, *years* before New West filed its removal papers. However, the case did not become removable because the state district court ordered Rolan to amend her complaint to rewrite her claims under ERISA. The case became removable when Rolan filed her initial complaint stating claims that were preempted by ERISA, and that fact was easily ascertainable by New West. Certainly, by the time that New West began asserting ERISA arguments to the state district court, New West had ascertained that the case was removable, so there is no mistake of fact argument available here. In any event, section 1446(b)(3) makes clear that a case may be removed during its pendency in state court *only* "if the case stated by the initial pleading is *not* removable...." 28 U.S.C. 1446(b)(3) (emphasis added). "Changes to a complaint that creates a new basis for removal do not undo the original waiver.... [and] subsequent events do not make it 'more removable' or 'again removable.'" *Samura v. Kaiser Foundation Health Plan, Inc.*, 715 F.Supp.

970, 972 (N.D. Calif. 1989) (quoting *Hubbard v. Union Oil Company*, 601 F.Supp. 790, 795 (S.D. W.Va. 1985)). Certainly, the amended complaint did not change the nature of Rolan's original claims for removal purposes.

In this case, and because the removal statutes are strictly construed against removal, the Court finds that New West's removal was untimely and remand is warranted. However, because New West was instructed to remove the case by the state court, the Court will not award fees and costs against it.

This remand order may be appealable to the Court of Appeals for the Ninth Circuit pursuant to 28 U.S.C. § 1291 and *Pelleport Investors, Inc. v. Budco Quality Theatres, Inc.*, 471 F.2d , 273, 276-78 (9th Cir. 1984). Accordingly,

IT IS HEREBY ORDERED that Plaintiff Rolan's Motion for Remand is GRANTED, and Plaintiff's Motion for Hearing is DENIED. The Clerk shall mail the clerk of the First Judicial District, Lewis and Clark County, a certified copy of this remand order.

Dated this 29th day of February, 2016.

CHARLES C. LOVELL
SENIOR UNITED STATES DISTRICT JUDGE

elayne@thuesonlawoffice.com

From:	Robert C. Lukes <rclukes@GARLINGTON.COM>
Sent:	Thursday, June 2, 2016 4:32 PM
To:	Querijero, Michelle
Subject:	RE: Rolan v. New West Serv., your file 2010000725
Attachments:	ERISA- article.pdf

EXHIBIT 5

Michelle,

We've been working on our SJ brief and the response to Plaintiff's motion for 'orders post remand.' The more we dig into the merits of the matter, the more I'm concerned we are going to lose this battle on ERISA preemption of the state law claims. They are so many twists and turns in the ERISA analysis it is just remarkable. But ultimately, I believe it comes down to a few things, all of which seem to work against us.

If a health benefit plan is self-funded, then most of the state claims can be preempted. But the New West plan at issue is a self-insured plan and it is therefore, it is not self-funded. There is also some case law out there under ERISA discussing that if a plan excludes application of the made whole doctrine, this can be successful in avoiding these claims. However, the New West plan has language to the effect that "we won't subrogate until you have been made whole," which is just the opposite.

In my continuing review of the law in this area and in searching for law review articles on point, I discovered an industry article that does a decent job of summarizing the law in this area. A copy is attached for your review. One paragraph sums up the concern nicely, stating:

State subrogation law will generally be preempted from applying to a self funded Plan, but state subrogation law will generally apply to insurance provided by an unfunded Plan.

In the terms used above, this is a self-insured plan, so it is 'an unfunded Plan.'

We are going to continue to fight this battle, but I wanted to let you know this most recent development in our analysis. Please let me know if you have any questions in this regard.

Thanks,
Bob Lukes

Exhibit 5-1

Lukes-756

6-2-16

Robert C. Lukes

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From: Robert C. Lukes <rclukes@GARLINGTON.COM>
Sent: Thursday, September 1, 2016 1:41 PM
To: Querijero, Michelle
Subject: RE: Rolan v. New West - your file 2010000725
Attachments: UNUM Life Ins. Co. of Am. v. Ward_ 526 U.S. 358.docx

EXHIBIT 6

Michelle,

The hearing on all motions before Judge Seeley in the Rolan case was yesterday in Helena, MT. It went as well as could be expected. GLR Associate Emma Mediak addressed the Plaintiff's motion on trying to amend the complaint to bring a new claim against New West for damages arising from its delay in asserting the ERISA defense. I addressed all the other issues, including the main issue of preemption under ERISA.

The judge did not ask many questions, which was quite different than what I recall from last time. Although the argument went for nearly two hours, she only had a handful of questions for counsel. It was impossible to tell which way she was leaning.

I must say I feel as though the case law on ERISA is ultimately against us. Although there is some authority for doing an independent review and applying preemption under Section 502 of ERISA, the great bulk of the case law does the analysis under Section 514 of ERISA. If you do so, the Montana law on the made whole rule is "saved" from preemption under the savings clause because the New West plan at issue was a fully insured plan (and not a self-insured plan). Although there are cases all over the board, the great bulk of the cases analyze the situation under 514.

I will attach an example. This is pretty much on point and it is from the US Supreme Court in 1999. (See UNUM Life case). This case is about whether California's notice prejudice rule is preempted by ERISA. As you will see, it was not preempted.

If we lost the ERISA motion in the Rolan case, we will have to consider an appeal to the MT Supreme Court. I don't think the mere denial of our summary judgment motion constitutes a 'final adjudication' of the case, so I don't think we will have an automatic right of appeal. But, we could move for certification of the question to the MT Supreme Court under Rule 54. I've been successful with those motions before, as often, the district court judge is rather happy to have the case get reviewed and be off their docket for a year or so. The problem of course is that a review by the Supreme Court does not carry with it a better chance of success. Although we have a decent argument, it is not a great one. And I suspect the

complex case law on the subject will get much closer scrutiny as part of any such appellate review.

If this was not certified as a class action, we would be looking to settle the case. Unfortunately, that aspect makes it very difficult. I know opposing counsel Erik Thueson would not accept anything less for the class members other than full compensation and 10% interest for the amounts owed. Despite efforts to try and elicit the amount that might be at issue from New West, they have not been very responsive. I will make another request again today.

I looked at the history of time involved by the court on the last main order on ERISA. The judge's order was approximately 4 months after our oral argument. I suspect that is about the time frame we will have to wait before we get an order from the judge.

In the meantime, if you have any questions, please let me know.

Thanks,
Bob Lukes

9-1-16

Robert C. Lukes

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elayne@thuesonlawoffice.com

From: Robert C. Lukes <rclukes@GARLINGTON.COM>
Sent: Wednesday, April 26, 2017 2:13 PM
To: Querijero, Michelle
Subject: RE: Rolan v New West. Montana file: 2010000725
Attachments: RCL to Renigar consulting agreement on ERISA preemption.pdf

EXHIBIT 7

Michelle,

I wanted to provide you with an update in the *Rolan* case.

As we discussed, we have retained attorneys Paul Ondrasik and Gwen Renigar as consultants on the ERISA issue. A copy of the consulting agreement with them is attached. They agreed to lower their fees somewhat for us, but they are still high. We limited their work to 10 hours of attorney time.

A few weeks ago, I provided Paul and Gwen a number of documents to review. Yesterday, we had a phone conference to discuss the case, ERISA preemption and our best strategy. Although they had some helpful ideas on our response, they agree the position is tough. The traditional and correct analysis of the situation takes us to Section 514 and because of the 'Deemer Clause' and our status as a not being self-funded ultimately means that the claim is most likely not preempted. Regardless, they did have some good ideas on how to present certain issues and a few cases that may be helpful, so I think this is definitely worth it.

We have an extension to file our Answer Brief with the Montana Supreme Court until May 20. I've done a lot of work on it already, but now I am going to go back to revise some items and then add more of what Paul and Gwen had to offer. Upon completion, we will provide you with a copy of the same. In the meantime, if you have questions, please let me know.

Thanks,
Bob Lukes

4-26-17

Robert C. Lukes

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Exhibit 7-2

Lukes-1031

elayne@thuesonlawoffice.com

EXHIBIT 8

From: Robert C. Lukes <rclukes@GARLINGTON.COM>
Sent: Friday, October 7, 2016 11:04 AM
To: Querijero, Michelle
Subject: RE: Rolan v. New West - your file 2010000725
Attachments: 20130930153558052.pdf; RE: Rolan v. New West; Ref. No. 2010000725

Michelle,

I conferred with New West and its day-to-day legal counsel to convey your response (below) on how there is no indemnity in the case (highlighted in yellow). I was told that New West's counsel looked into this earlier and conferred with Joe Sappington on the issue. They provided me with the attached correspondence on the subject. As you can see, their letter to Joe indicates that there is coverage "under the MCEO policy unless New West committed willful misconduct or willfully violated a state law." From their perspective, when he replied, "Sappington did not disagree with our analysis." Thus, it is their understanding that there is indemnity for this claim under the MCEO policy.

I am obviously not in a place to get into the middle of this dispute, assuming that there is a dispute on this issue. I just pass this information on for your consideration.

Thanks,
Bob Lukes

10-7-16

Robert C. Lukes

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From: Querijero, Michelle [mailto:Michelle.Querijero@awac.com]
Sent: Wednesday, October 05, 2016 2:28 PM

To: Robert C. Lukes
Subject: RE: Rolan v. New West - your file 2010000725

Correct. Remember, though, pursuant to the reservation of rights we issued, there is no indemnity coverage on the policy, so that $900K+ is for defense expenses. I emailed the Insured to ask if it's ok to send you a copy of the coverage letter if you think that would help. Please let me know if there are questions. Happy to have a call if that's easier.

Michelle L. Querijero, Esq. | Senior Claims Analyst
Allied World Insurance Company | www.awac.com
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1690 New Britain Ave., Suite 101 | Farmington, CT | 06032
T. 860.284.1496 | F. 860.284.1497 | michelle.querijero@awac.com

---

From: Robert C. Lukes [mailto:rclukes@GARLINGTON.COM]
Sent: Wednesday, October 05, 2016 4:25 PM
To: Querijero, Michelle
Subject: RE: Rolan v. New West - your file 2010000725

Michelle,

But payment by the insured of the self-insured retention does not reduce the coverage, right ? So New West would still have about $907,500 left in coverage ?

Bob

Robert C. Lukes
Garlington, Lohn & Robinson, PLLP
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Missoula, MT 59807-7909
Phone: (406) 523-2500

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From: Querijero, Michelle [mailto:Michelle.Querijero@awac.com]
Sent: Wednesday, October 05, 2016 2:06 PM
To: Robert C. Lukes
Subject: RE: Rolan v. New West - your file 2010000725

Hi Bob—

Good point. The file notes reflect bills going back to 2009. However, there is a $50,000 self-insured retention on the file, so that means that New West would have paid the first $50K, and the remaining $74K has been paid by Allied World.

There are two pending invoices in the amount of $17,747.00 that have not yet been paid and which should be added to that $74K. That would bring the total that needs to be paid under the policy to $92,457.23.

Exhibit 8-2

That would be $142,457.23 total defense costs, if you include the $50K self-insured retention.

Thanks,
Michelle

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Please consider the Environment before printing this email

From: Robert C. Lukes [mailto:rclukes@GARLINGTON.COM]
Sent: Wednesday, October 05, 2016 3:56 PM
To: Querijero, Michelle
Subject: RE: Rolan v. New West - your file 2010000725

Michelle,

Does that amount include payments to the prior law firm, Browning Kaleczyc Berry and Hoven ? Given the case has been going on for more than six years, $74,000 does not sound like much in legal fees. Are you sure that is correct ?

Thanks
Bob

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From: Querijero, Michelle [mailto:Michelle.Querijero@awac.com]
Sent: Wednesday, October 05, 2016 1:45 PM
To: Robert C. Lukes
Subject: RE: Rolan v. New West - your file 2010000725

Hi Bob—

Thanks for the update.

Exhibit 8-3

Re: the policy: This is an eroding policy, as you mentioned, so defense costs are within limits. The Limit of Liability is $1 million, and we have paid out a total of $74,710.23 in defense costs as of today. We issued a reservation of rights letter with respect to this matter, and our position is that there is no indemnity obligation under the policy.

Please let me know if there are questions.

Thanks,
Michelle

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Please consider the Environment before printing this email

From: Robert C. Lukes [mailto:rclukes@GARLINGTON.COM]
Sent: Wednesday, October 05, 2016 2:14 PM
To: Querijero, Michelle
Subject: RE: Rolan v. New West - your file 2010000725

Michele,

We are going to prepare our response to this motion. In the meantime, Plaintiff has already filed a 'supplemental' brief, a copy of which is attached. Although the plaintiff's counsel is ranting and raving about the situation, there is not really any new substance therein.

As part of our response to the court, we are going to advise her that New West has insurance in the case. I see it is a cannibalizing policy. Can you let me know how much is left on the limits in the case ?

Thanks,
Bob Lukes

10-5-16

Robert C. Lukes

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* *

From: Querijero, Michelle [mailto:Michelle.Querijero@awac.com]
Sent: Monday, October 03, 2016 9:15 AM
To: Robert C. Lukes
Subject: RE: Rolan v. New West - your file 2010000725

That's news to me also. Maybe Thueson will be less interested in pursuing.

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Please consider the Environment before printing this email

From: Robert C. Lukes [mailto:rclukes@GARLINGTON.COM]
Sent: Friday, September 30, 2016 11:07 AM
To: Querijero, Michelle
Subject: RE: Rolan v. New West - your file 2010000725

Michelle,

I just received the attached documents from Plaintiffs' counsel. As you can see, it has to do with New West Health Insurance closing shop at the end of this year. I had heard nothing about this from our client, so it was news to me. In sum, the Plaintiffs motion seeks an injunction to prevent the destruction of evidence and would require New West to post a bond to cover potential payments to claimants in the case.

I'm going to try to set up a call with New West and its primary attorneys for later today to discuss the situation. Just because a company is going out of business does not mean its records will be destroyed. Thus, I believe the motion is unfounded. Regardless, we shall have to prepare a response to the motion.

The motion on ERISA preemption remains pending with the court. I will keep you informed as this new situation develops. Please let me know if you have any questions in this regard.

Thanks,
Bob Lukes

9-30-16

Robert C. Lukes

Exhibit 8-5

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ROGER T. WITT
GARY M. ZADICK
JAMES R. ZADICK

NEIL E. UGRIN
1945 - 2007

November 2, 2016

File No.: NE41-03

Via Email Only: michelle.querijero@awac.com

Michelle L. Querijero
Senior Claims Analyst
Allied World Insurance Company
1690 New Britain Ave., Suite 101
Farmington, CT 06032

EXHIBIT
9

Re: Rolan v. New West
Claim #: 2010000725

Dear Ms. Querijero:

I am counsel for your insured New West with respect to coverage for New West under the Allied World MCEO policy. A reservation of rights letter was issued on February 18, 2010 by Joseph Sappington on behalf of Allied World. I have attached a copy for your convenience.

In the reservation of rights letter, Mr. Sappington advised Allied was assuming the defense of New West. With respect to the MCEO policy Mr. Sappington acknowledged that the conditions precedent "appear to be satisfied." February 18, 2010, page 4 of 10. Mr. Sappington raised Exclusion A – willful misconduct, willful violation or gaining a profit which the insured was not legally entitled. Pursuant to the policy endorsements and the law of Montana, these determinations are made in the underlying action. As you are aware, the Complaint alleges additional conduct that would constitute a "wrongful act" and would be covered.

There has been no supplemental reservation of rights issued. However, Ian McIntosh, on behalf of your insured New West, wrote to Mr. Sappington on September 30, 2013 confirming his understanding that New West was covered except to the extent of any willful misconduct or willful violation of state law. Mr. McIntosh and Kevin

Heaney of New West also spoke with Mr. Sappington and he confirmed to them that those were the only grounds upon which Allied World was contesting coverage.

Of course, it is far too late to assert any additional ground for challenging coverage. Allied World has been defending the case for six years under the February 18, 2010 reservation of rights. Allied World would be estopped to raise any additional defenses at this late date.

Your insured is concerned, however, because of a comment you made in an email to defense counsel Robert C. Lukes of October 5, 2016 in which you stated: "We issued a reservation of rights letter with respect to this matter, and our position is that there is no indemnity obligation under the policy." This comment is directly contrary to Allied World's reservation of rights letter of February 18, 2010 in which Mr. Sappington acknowledged that there would be coverage except only to the extent of any conduct that would fall within Exclusion A. Proof of "willful violation of law, willful misconduct, fraudulent conduct, criminal or malicious conduct" is a very high burden and it is very likely that there will be coverage and that there will not be proof of willful conduct or fraudulent conduct.

I also remind you that Allied World owes a fiduciary responsibility to its insured to protect it and to place its interests at least as high as its own even when defending under a reservation of rights.

Therefore, New West expects that Allied World will continue to provide a defense and indemnify New West with respect to any recovery that is not within the scope of the very stringent limitations of Exclusion A. I further request that I be included on all correspondence between Allied World and defense counsel.

Lastly, please advise me whether Allied World has separated its file between coverage and defense. Based upon the email correspondence, it is my assumption that you are overseeing both the defense and coverage of the litigation on behalf of Allied World. I look forward to your prompt response.

Sincerely,

UGRIN, ALEXANDER, ZADICK & HIGGINS, P.C.

Gary M. Zadick

GMZ/ajc
Enclosure

cc: Robert C. Lukes

ALLIED WORLD
ASSURANCE COMPANY

Joseph Sappington, Esq.
Senior Claims Analyst

V (860)284-1724
F (860)284-1725
E Joseph.Sappington@awac.com

VIA E-MAIL ahuschka@nwhp.com

February 18, 2010

To: Angela Huschka
New West Health Services
130 Neill Ave.
Helena, MT 59601

Re:

Insured:	New West Health Services
Insurer:	Darwin Select Insurance Company
Policy No.:	0303-5534 (MCEO Policy)
Policy Period:	04/01/2009 to 04/01/2010
Policy Limit:	$1,000,000 for each Claim made in the Policy Period and $3,000,000 in the aggregate for all Claims
Retention:	$50,000
Subject:	Rolan, Dana
Darwin Ref. No.:	2010000725

Insured:	New West Health Services
Insurer:	Darwin National Assurance Company
Policy No.:	0303-5533 (HCDO Policy)
Policy Period:	04/01/2009 to 04/01/2010
Policy Limit:	$1,000,000 for each Claim made in the Policy Period and $3,000,000 in the aggregate for all Claims
Retention:	$50,000[1]
Subject:	Rolan, Dana
Darwin Ref. No.:	2010000750

Dear Ms. Huschka:

I am writing on behalf of Allied World National Assurance Company, claims manager for Darwin National Assurance Company ("DNA") with respect to the referenced Health Care Organization Directors and Officers Liability Insurance Policy Including Employment Practices Liability Coverage Policy (the "HCDO Policy") and Darwin Select Insurance Company ("DSI") in respect to the Managed Care Organization Errors and Omissions Liability Policy (the "MCEO

[1] Applies to Insuring Agreement B(1) & (2).

Exhibit 9-4

Policy") (HCDO Policy and MCEO Policy collectively, the "Policies"; DSI and DNA collectively "Darwin"). This letter provides you with a summary of coverage under the above Policies in connection with the above referenced action. We previously acknowledged receipt of this matter on February 11, 2010.

This letter will refer to certain allegations asserted by the plaintiff. We recognize that such allegations are unsubstantiated contentions at this time. We cite the allegations only for analytical reasons. Nothing in this letter is intended to suggest or imply that the allegations have any legal or factual merit.

This letter does not modify any of the terms and conditions of the Policy. Please note that the words that appear in **bold** print below are defined in the Policy.

SUMMARY OF FACTS

We have reviewed the Complaint (the "Complaint") captioned, *Dana Rolan v. New West Health Services*, filed on or about January 26, 2010 in the Montana First Judicial District Court, Lewis & Clark County (the "Action"). This summary of facts is based on the allegations contained in the Complaint.

Plaintiff, a resident of Montana, brings the Action on behalf of herself and on behalf of those similarly situated. The Plaintiff claims that she suffered injuries caused by the legal fault of others and has not been made whole. It is further alleged that the Defendant has avoided payment of medical bills that they are allegedly contractually obligated to pay by claiming the medical costs are the responsibility of those at fault. The Plaintiff alleges that Defendant's failure to pay benefits violates Montana's constitution, statutory law, common law and established public policy. More specifically, the Plaintiff alleges that the Defendant's actions violate Montana's "made whole" law which is enumerated in MCA §33-18-201, *et seq.*

Plaintiff Rolan alleges that that in November 2007 she was severely injured as a result of a motor vehicle collision. The person who negligently caused the accident was insured by Unitrin Services Group. It is alleged that Unitrin paid medical costs of approximately $100,000 directly to the Plaintiff's medical providers under its liability policy. Allegedly, upon demand by the Plaintiff, defendant New West declined to pay the benefits because the tortfeasor's liability carrier, Unitrin, had advance paid medical costs. Plaintiff claims that New West illegally reduced the Plaintiff's insurance coverage by approximately $100,000 in violation of "made whole" obligations. By allegedly violating Montana's "made whole" laws, Plaintiff claims that the Defendant was unjustly enriched at the Plaintiff's expense.

It is alleged that the conduct of the Defendant violates MCA §§33-18-201 *et seq.* which prohibits failures to pay claims on a variety of grounds, including but not limited to breach of the insurance contract, and by asserting denials or failing to pay claims due to the existence of third party liability when the defendants allegedly knew there existed no reasonable or lawful ground for doing so given Montana's "made whole" laws. Lastly, the Plaintiffs allege that the Defendants violated MCA §§33-18-201 *et seq.* sounding in unfair trade practices.

The Complaint further sets forth actions for class certification, declaratory relief and payment, and other class claims for payment and breach of contract and similar Montana statutes as those referred to above. Plaintiffs seek both monetary damages, punitive damages, attorneys' fees and costs.

SUMMARY OF COVERAGE UNDER THE MCEO POLICY

The Insuring Agreement to the MCEO Policy (§ I) states that the **Underwriter** will pay on behalf of any **Insured Loss** which the **Insured** is legally obligated to pay as a result of a **Claim** that is first made against the **Insured** during the **Policy Period** or during any applicable Extended Reporting Period. New West Health Services ("New West") is an **Insured Entity** and is therefore an **Insured** under the MCEO Policy. (Definitions §§ IV(G), (H)).

"**Claim**" is defined in Definitions § IV(C) as any written notice received by any **Insured** that a person or entity intends to hold an **Insured** responsible for a **Wrongful Act** which took place on or after the retroactive date listed in ITEM 7 of the Declarations. In clarification and not in limitation of the foregoing, such notice may be in the form of an arbitration, mediation, judicial, declaratory or injunctive proceeding. A **Claim** will be deemed to be made when such written notice is first received by any **Insured**.

"**Wrongful Act**" is defined as

> (1) any actual or alleged act, error or omission in the performance of, or any failure to perform a **Managed Care Activity** by any **Insured Entity** or by any **Insured Person** acting within the scope of his or her duties or capacity as such;
>
> (2) any actual or alleged act, error or omission in the performance of, or any failure to perform, **Medical Information Protection**, by an **Insured Entity** or by any **Insured Person** acting within the scope of his duties or capacity as such; and
>
> (3) any **Vicarious Liability** for:
>
> > (a) the performance of, or any failure to perform:
> >
> > > (i) a **Managed Care Activity**;
> > >
> > > (ii) **Medical Information Protection**;
> >
> > (b) the rendering of, or failure to render, **Medical Services**; provided, that **Wrongful Act** shall not include any **Insured's** actual or alleged direct liability for the rendering of, or failure to render, **Medical Services**; or

> (c) any actual or alleged **Sexual Activity**; provided, that **Wrongful Act** shall not include any **Insured's** actual or alleged direct liability for any **Sexual Activity**.

(Definitions §IV(W).

The definition of "**Managed Care Activity**" means any of the following services or activities: **Provider Selection**; **Utilization Review**; advertising, marketing, selling, or enrollment for health care or workers' compensation plans; **Claim Services**; establishing health care provider networks, reviewing the quality of **Medical Services** or providing quality assurance; design and/or implementation of financial incentive plans; wellness or health promotion education; development or implementation of clinical guidelines, practice parameters or protocols; triage for payment of **Medical Services**; and services or activities performed in the administration or management of health care plans or workers' compensation plans. (Definition § IV(K)).

Specifically, "**Utilization Review**," is defined to mean "the process of evaluating the appropriateness or necessity of **Medical Services** for purposes of determining whether payment or coverage for such **Medical Services** will be authorized or paid for under any health care plan, but only if performed by an **Insured**" and "**Claim Services**" is defined to mean "the submission, handling, investigation, payment or adjustment of claims for benefits or coverages under health care or workers' compensation plans." (Definition § IV(U), (D)).

As the Complaint includes allegations sounding in a **Managed Care Activity**, and the allegations were apparently first made against an **Insured** in writing during the **Policy Period**, the conditions precedent to the Insuring Agreement appear to be satisfied. Accordingly, the MCEO Policy provides for a Per **Claim** Limit of Liability of $1,000,000 and a Maximum Aggregate Limit of Liability of $3,000,000 subject to a $50,000 retention applicable to **Loss**, including **Defense Expenses**, for each **Claim**.

Under the MCEO Policy the **Underwriter** has the right and duty to defend any **Claim** made against any **Insured** which is covered by this MCEO Policy even if the allegations of such **Claim** are groundless, false or fraudulent. (Insuring Agreement § I). In addition and pursuant to the MCEO Policy, the amount stated in ITEM 3(a) of the Declarations shall be the maximum aggregate Limit of Liability of the **Underwriter** for all **Loss**, including **Defense Expenses**, resulting from all **Claims** for which this MCEO Policy provides coverage, regardless of the number of **Claims**, the number of persons or entities included within the definition of **Insured**, or the number of Claimants. (Conditions § III(A)(1)). Further, "The obligation of the **Underwriter** to pay **Loss**, including **Defense Expenses**, will only be in excess of the applicable retention set forth in ITEM 4 of the Declarations." (Conditions § III(A)(3)).

Note also that under the MCEO Policy, no **Insured** may incur any **Defense Expenses** or admit liability for or settle any **Claim** without the **Underwriter's** written consent. (Conditions § III(D)(1)). The **Underwriter** will have the right to make investigations and conduct negotiations and, with the consent of the **Insureds**, enter into such settlement of any **Claim** as the

Underwriter deems appropriate. If the **Insureds** refuse to consent to a settlement acceptable to the claimant in accordance with the **Underwriter's** recommendation, then subject to the **Underwriter's** maximum aggregate Limit of Liability set forth in ITEM 3(a) of the Declarations, the **Underwriter's** liability for such **Claim** will not exceed:

(a) the amount for which such **Claim** could have been settled by the **Underwriter** plus **Defense Expenses** up to the date the **Insureds** refused to settle such **Claim** (the "Settlement Amount"); plus

(b) sixty percent (60%) of any **Loss** and/or **Defense Expense** in excess of the Settlement Amount incurred in connection with such **Claim**. The remaining forty percent (40%) of **Loss** and/or **Defenses Expenses** in excess of the Settlement Amount will be carried by the **Insured** at its own risk and will be uninsured.

In addition, pursuant to Conditions § III(B)(1), if during the **Policy Period** or any applicable Extended Reporting period, any **Claim** is first made against any **Insured**, the **Insureds** must, as a condition precedent to any right to coverage under this Policy, give the **Underwriter** written notice of such **Claim** as soon as practicable thereafter and in no event later than:

(a) with respect to a **Claim** made during the **Policy Period**, ninety (90) days after the end of the **Policy Period**; or

(b) with respect to a **Claim** made during an Extended Reporting Period, ninety (90) days after such **Claim** is first made.

Further, pursuant to Conditions § III(D)(2) the **Underwriter** will have no obligations to pay **Loss**, including **Defense Expenses**, or to defend or continue to defend any **Claim** after the **Underwriter's** maximum aggregate Limit of Liability, as set forth in ITEM 3(a) of the Declarations, has been exhausted by the payment of **Loss**, including **Defense Expenses**. If the **Underwriter's** maximum aggregate Limit of Liability, as set forth in ITEM 3(a) of the Declarations, is exhausted by the payment of **Loss**, including **Defense Expenses**, the premium will be fully earned.

As we are assuming New West's defense in this matter I will be in contact with you shortly to discuss the retention of Kimberly Beatty and Leo Ward of Browning, Kaleczyc, Berry & Hoven as counsel.

Given the allegations in the Complaint, please appreciate the potential implication of the following MCEO Policy provisions, which may operate to limit or preclude coverage in this matter.

The MCEO Policy stipulates that, except for **Defense Expenses**, the **Underwriter** shall not pay **Loss** for any **Claim** brought about or contributed to by:

(1) any willful misconduct or dishonest, fraudulent, criminal or malicious act, error or omission by any **Insured;**

(2) any willful violation by any **Insured** of any law, statute, ordinance, rule or regulation; or

(3) any **Insured** gaining any profit, remuneration or advantage to which such **Insured** was not legally entitled.

Determination of the applicability of Exclusion A may be made by an admission or final adjudication in a proceeding constituting a **Claim**, or in a proceeding separate from or collateral to any proceeding constituting a **Claim**. (Exclusions § II(A) as amended by Endorsement No. 6).

Section II Exclusions § (C)(6), sets forth that the **Underwriter** shall not pay any **Loss**, including **Defense Expenses**, for any **Claim** for any actual or alleged express or assumed liability of any **Insured** under an indemnification agreement; provided, that this EXCLUSION (C)(6) shall not apply to any tort liability that would have attached to the **Insured** in the absence of such agreement and is otherwise insured under the Policy.

Section II Exclusions § (C)(7), sets forth that the **Underwriter** shall not pay any **Loss**, including **Defense Expenses**, for any **Claim** based upon, arising out of, resulting from, or in any way involving any actual or alleged:

(a) failure to obtain, implement, effect, comply with, provide notice under or maintain any form, policy, plan or program of insurance, stop loss or provider excess coverage, reinsurance, self-insurance, suretyship or bond.

(b) commingling or mishandling of funds with dishonest intent;

(c) failure to collect or pay premiums, commissions, brokerage charges, fees or taxes.

The MCEO Policy defines **Loss** as **Defense Expenses** and any monetary amount which an **Insured** is legally obligated to pay as a result of a **Claim**; including punitive, exemplary or multiplied damages ("Punitive Damages") awarded in connection with any **Claim** covered by this Policy, other than **Claims** for **Antitrust Activity**, and only if such Punitive damages are insurable under applicable law. law.[2] **Loss**, however, does not include:

1) fines, penalties, or taxes and punitive, exemplary or multiplied damages provided that:

(a) if punitive, exemplary or multiplied damages (hereafter referred to as "Punitive Damages") are awarded in connection with any **Claim** covered by this Policy, other than **Claims** for **Antitrust Activity**, the maximum

[2] Endorsement No. 7 to the Policy discusses which jurisdiction's law shall apply when determining the insurability of Punitive Damages.

amount payable by the **Insurer** attributable to Punitive Damages for any **Claim**, or in the aggregate for all **Claims**, is $3,000,000. This Punitive Damages Limit of Liability is part of, and not in addition to, the aggregate Limit of Liability indicated in ITEM 3(a) of the Declarations; and

(b) if fines, penalties or Punitive Damages are awarded in connection with any **Claim** for **Antitrust Activity**, the maximum amount payable by the **Insurer** is the amount indicated in ITEM 3(b) of the Declarations. This Antitrust Limit of Liability is part of, and not in addition to, the aggregate Limit of Liability indicated in ITEM 3(a) of the Declarations; and

(c) the coverage described in subparagraphs (a) and (b) above shall apply unless prohibited by law;

2) fees, amounts, benefits or coverage owed under any contract with any party including providers of health care services, health care plan or trust, insurance or workers' compensation policy or plan or program of self-insurance;

3) non-monetary relief or redress in any form, including without limitation the cost of complying with any injunctive, declaratory or administrative relief; or

4) matters which are uninsurable under applicable law,

(Definitions § IV(J) as amended by Endorsement No. 5).

Note that pursuant to Conditions § III(G)(1), the MCEO Policy shall be excess of and shall not contribute with:

(a) any other insurance or plan or program of self-insurance, unless such other insurance or self-insurance is specifically stated to be in excess of this Policy; and

(b) any indemnification to which an **Insured** is entitled from any entity other than another **Insured**.

This Policy shall not be subject to the terms of any other policy or insurance or plan or program of self-insurance.

Accordingly, please immediately (1) advise whether there are any other insurance policies available to respond to the allegations in this matter; (2) advise what steps have been taken to secure coverage on behalf of the **Insured** under any other potentially applicable insurance policy; and (3) send us a copy of the coverage position(s) issued by any other insurance carrier(s) in connection with this matter. We expressly reserve all rights with respect to any and all other insurance and indemnification.

In addition, Conditions § III(G)(2), if any other policy or policies issued by the Underwriter or any of its affiliated companies, or by any predecessors or successors of the Underwriter or its affiliated companies, shall apply to any **Claim**, then the aggregate limit of liability with respect to all **Loss** under this Policy and all covered loss under such other policies shall not exceed the highest applicable limit of liability, subject to its applicable deductible or retention, that shall be available under any one of such policies, including this Policy. This Condition (G)(2) shall not apply with respect to any other policy which is written only as specific excess insurance over the Limit of Liability of this Policy.

SUMMARY OF COVERAGE UNDER THE HCDO POLICY

After reviewing the foregoing materials in conjunction with the HCDO Policy, we regret to inform you that for the following reasons, there does not appear to be any coverage available for this matter under the HCDO Policy.

The Insuring Agreement to the HCDO Policy (§ I(B)(2)) states that the **Insurer** will pay on behalf of an **Insured Entity Loss** from **Claims** first made against an **Insured Entity** during the **Policy Period** for **Wrongful Acts**. New West Health Services ("New West") is identified in the HCDO Policy as the **Parent Corporation** and is therefore both an **Insured Entity** and an **Insured** under the HCDO Policy. **Insured Entity** means the **Parent Corporation** and any **Subsidiary** created or acquired on or before the Inception Date in ITEM 2(a) of the Declarations. (Policy II(H)).

"**Claim**" is defined in § II(B) of the HCDO Policy in relevant part as (1) any written demand for monetary relief; or (2) any civil proceeding in a court of law or equity, which is commenced by the filing of a complaint, motion for judgment or similar proceeding. Section II(Z)(5) of the HCDO Policy defines **Wrongful Act** as including "any other actual or alleged act, error, omission, misstatement, misleading statement or breach of duty by any **Insured Entity**".

As the Complaint is a written demand for monetary damages and is a civil proceeding, was first made against an **Insured Entity** during the **Policy Period**, and is based, in part, on the actions of an **Insured Entity**, the conditions precedent to the Insuring Agreement appear to be satisfied. However, certain specific exclusions to the HCDO Policy preclude coverage for this **Claim** in its entirety.

Exclusion III(C)(5) provides:

> C. This Policy shall not provide coverage for any **Claim** based upon, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving:
>
> (5) any actual or alleged act, error or omission in the performance of, or failure to perform, **Managed Care Organization Business Activities** by any **Insured** or by any individual or entity for whose acts, errors or omissions an **Insured** is legally responsible, except that this Exclusion

C(5) shall not apply to **Claims** for **Provider Selection Practices** performed solely for an **Insured Entity**, and provided that the **Insured Entity** is not a **Managed Care Organization.**

"**Managed Care Organization Business Activities**" means "services or activities performed in the administration or management of healthcare plans; **Provider Selection Practices, Utilization Review**; case management; disease management; advertising, marketing or selling healthcare plans or healthcare insurance products; handling, investigating, or adjusting claims for benefits or coverages under healthcare plans; establishing healthcare provider networks; and reviewing the quality of **Medical Services** or providing quality assurance." (Policy §II(N)). "**Utilization Review**" means "the process of evaluating the appropriateness, necessity, or cost of Medical Services for purposes of determining whether payment or coverage for such Medical Services will be authorized or paid for under any health care plan. **Utilization Review** shall include prospective review of proposed payment or coverage for Medical Services, concurrent review of ongoing **Medical Services**, and retrospective review of already rendered **Medical Services** or already incurred costs." (Policy §II(X)).

The allegations in the Complaint indicate that the **Claim** arises from and is directly related to New West's conduct of **Managed Care Organization Business Activities**, including but not limited to, **Utilization Review** services, handling, investigating or adjusting claims for benefits or coverages under healthcare plans. As such, there is no coverage for the **Claim** under the HCDO Policy.

As it appears that there is no coverage for this **Claim** in its entirety under the HCDO Policy, we are not providing any additional comment regarding other coverage issues that may exist with respect to this **Claim.** If you possess any additional information that you believe would bear on coverage in this matter, please forward that information to me at your earliest convenience.

DNA's position with respect to this matter is based on the information provided to date, and is subject to further evaluation should additional information become available. DNA continues to expressly reserve all rights and defenses under the HCDO Policy, and available at law and in equity, with respect to this matter, including but not limited to, the right to assert additional terms and conditions of the HCDO Policy which may become applicable as new information is learned, and the right to deny coverage for this matter on additional and/or alternative bases.

CONCLUSION

Please keep us advised of any significant developments in this matter, and send us copies of significant motions, pleadings, orders, correspondence and other documents.

Darwin National Assurance Company and Darwin Select Insurance Company respectfully reserve all of their rights and defenses under the Polices and available at law with respect to this matter.

Please feel free to contact me if you have any questions.

Very truly yours,

Joseph Sappington

elayne@thuesonlawoffice.com

From: Robert C. Lukes <rclukes@GARLINGTON.COM>
Sent: Wednesday, March 29, 2017 10:10 AM
To: Querijero, Michelle
Subject: insured: New West; claimant: Rolan; your file: 2010000725

EXHIBIT 10

Michelle,

In response to your inquiry (below), please let this email memo serve as a report on the upcoming mediation and the recommended settlement value for the case.

There are two issues before the Montana Supreme Court on appeal in this case. The first is the ERISA preemption. The second is Plaintiff's request for additional fees or sanctions. The first issue is much more significant, as a reversal would essentially mean that New West would lose the case. The second issue if reversed would result in an additional cash award to Plaintiffs, but by comparison, the amount at issue is relatively minor. We will discuss these issues in turn, below.

FIRST ISSUE – ERISA PREEMPTION

This case is certified as a class action under Rule 23. Although the number of class members remains uncertain, it is estimated to be somewhere in excess of 40,000 individuals. If we lose the ERISA preemption defense, notices would have to be sent out to all individuals insured by New West dating back to January 26, 2002. As there is no other viable defense in the case to liability, upon receipt of claims from the class members, the claims would have to be processed and paid.

The ERISA preemption defense in this case is tenuous. The brief filed by Plaintiff to the Supreme Court is a much better presentation of the issue as compared with its submissions to the District Court. We suspect Erik Thueson had someone else draft the brief, presumably, Jim Hunt, who is co-counsel with Thueson in the *Diaz* case. We were able to convince the District Court to ignore the Section 514 analysis under ERISA and keep her focus on Section 502 and "complete preemption." Frankly, there are not many cases that support this interpretation of the law. Thus, we believe there is a better than a 50% chance that the Montana Supreme Court will reverse this decision and find ERISA does not preempt Plaintiff's claims.

The amount of damages that must be paid out to class members remains uncertain, at best. In my prior discussions on damages with New West, they were unable to pinpoint damages with any certainty. However, New West told me it could "break the company." Part of the problem is that we will not know the amount of the claims until the notices are sent out and

the class members respond by submitting their claims to the company. My best estimate is that this could easily be in excess of several million dollars in damages.

There is also exposure to New West for damages to the individual Plaintiff and the class for claims of bad faith. This could be in the form of emotional distress, payment of interest on claims and punitive damages. I see two sub-issues here. The first has to do with New West's failure to respond to the initial letters of Erik Thueson in a timely manner. In sum, he wrote to them on several occasions over a period of many months before New West ever responded. The second concern arises because New West did not cure the issue once it had notice of the September 2009 *State Auditor* decision or the 2013 *Diaz* decision, both of which held that COB provisions without a made whole analysis were in violation of the law. Once it became aware of that case, arguably, it had the obligation to go back and to make payments on all of the non-ERISA cases where it had applied the COB provision. Indeed, New West has never paid the claims of Ms. Rolan, which alone total approximately $110,000, plus interest dating back for nearly a decade. Thus, there is a significant potential of exposure to New West for liability in this arena, should the ERISA defense fail.

One issue we will be faced with at the mediation is Erik Thueson's apparent inability to compromise the claims of class members. Thus, we anticipate he will say that he cannot accept any offer now because he does not know the extent of the claims without first sending out notices to class members. The only thing that might change his historical stance is New West's current financial status. It is basically winding down and going out of business. If he had an offer from New West's insurer, I suppose there is some possibility he might accept it because he knows New West will not have the ability to pay. Ultimately, if we could get rid of Rolan's individual claim and the class action claims for $1,000,000, I think it would be money well spent and I would recommend such a settlement.

ISSUE TWO -- ADDITIONAL FEES/SANCTIONS

On this issue, I think it is unlikely that the Supreme Court will reverse this issue, given the discretion typically provided to the District Court on such issues. I would estimate there is only a 15% chance of it being reversed. If it is reversed, it is possible that the Court might award Plaintiff's counsel all fees. I would estimate those to be a maximum of $200,000 in addition fees. Given the low chance of success for Plaintiff on this issue, I would not pay more than $10,000 to settle this issue.

CONCLUSION

Please let me know if questions remain in this regard. If you could let me know the extent of my authority to settle prior to the mediation, that would be great. But if not, we will be in touch by phone.

Thanks,
Bob Lukes

3-29-17

Robert C. Lukes

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From: Querijero, Michelle [mailto:Michelle.Querijero@awac.com]
Sent: Monday, March 27, 2017 3:15 PM
To: Robert C. Lukes
Subject: Insured: new West; claimant: Rolan

Hi Bob—

I need to report on this mediation. Could you please let me know what your recommended settlement value is for the mediation under these circumstances? If you want to break it into the two parts (class claim and fees) as we discussed the other day, that's fine; whatever is easiest to you.

Thanks,
Michelle

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