IN THE COURT OF COMMON PLEAS OF PHILADELPHIA COUNTY
FIRST JUDICIAL DISTRICT OF PENNSYLVANIA
CIVIL TRIAL DIVISION

AETNA, INC.	:	May Term 2003
Plaintiff,	:	
	:	No. 03076
v.	:	
	:	Commerce Program
LEXINGTON INS. CO, et al.	:	
	:	Control Nos.: 051137, 070720, 070761,
Defendants.	:	090005, 090052, 090072, 090105, 090106,
	:	090123, 090530

ORDER

AND NOW, this 2ND day of May, 2006, upon consideration of the Cross-Motions for Summary Judgment of Aetna, Inc. ("Aetna")(Nos. 051137 and 090105), Certain Underwriters at Lloyds' ("Lloyd's") (No. 070720), Liberty Mutual Insurance Co. ("Liberty") (Nos. 070761 and 090052), Fireman's Fund Insurance Co. of Ohio ("Fireman's") (No. 090005), RLI Insurance Co. ("RLI") (No. 090072), Executive Risk Specialty Insurance Co. ("ERSIC") (No. 090106), Lexington Insurance Co. ("Lexington") and National Union Fire Insurance Co. of Pittsburgh, Pa. ("NUFIC")(No. 090123), and Steadfast Insurance Co. ("Steadfast") (No. 090530), the responses thereto, the briefs in support and opposition, and all other matters of record, and in accordance with the Opinion filed contemporaneously herewith, it is hereby **ORDERED** as follows:

1. Aetna's Motion for Summary Judgment regarding coverage is **DENIED**;

2. Defendants' Motions are **GRANTED**; and

3. Aetna's claims against all defendants are **DISMISSED** in their entirety.

4. Since the claims against all defendants have been dismissed, Lloyd's, ERSIC's and RLI's counterclaims against Aetna, and Aetna's Motion for Summary Judgment regarding those counterclaims, are **DISMISSED** as **MOOT**.

BY THE COURT,

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HOWLAND W. ABRAMSON, J.

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	:	090530

OPINION

In the present action, Aetna, Inc. ("Aetna")[1] seeks approximately $200 million in coverage from certain of its excess insurers for the costs it incurred in connection with the defense and settlement of consolidated class actions brought on behalf of several nationwide classes of healthcare providers ("HCPs").[2] The policies under with Aetna seeks coverage are "claims made" professional liability policies (the "Policy" or "Policies").[3] Aetna argues that,

[1] Aetna is an insurance company. The costs for which Aetna claims coverage in this action arise out of its operation of healthcare insurance plans, such as HMO, PPO and POS plans.

[2] Mangieri v. CIGNA, No. 99-3254 (N.D. Ala.) ("Mangieri") was the first of the consolidated class actions filed. However, when Mangieri and the subsequently filed class actions were consolidated by the Panel on Multi-District Litigation, another class action, Shane v. Humana, No. 00-1334 (S.D. Fla.) ("Shane"), was designated as the lead case in the managed care provider multi-district class action litigation (the "Provider MDL").

Aetna and the Provider MDL classes settled on May 21, 2003, after the trial court issued an Order certifying the class(es). *See* In re Managed Care Litigation, 209 F.R.D. 678 (S. D. Fla. 2002), which was affirmed in part and reversed in part (after Aetna's settlement) in Klay v. Humana, Inc., 382 F.3d 1241 (11th Cir. 2004).

[3] "In a 'claims-made' policy, the liability insurance coverage is effective if the negligent or omitted act is discovered and brought to the attention of the insurance company during the period of the policy, no matter when the act occurred." Appleman on Insurance § 130.1 (2d ed. 2005). A "claims-made" policy differs from an "occurrence" policy. "In the 'occurrence' liability insurance policy, the insured event triggering coverage is the 'occurrence' itself. Once the 'occurrence' happens, liability insurance coverage attaches even though the claim may not be made for some time thereafter." *Id.*

since the claims in the Provider MDL were filed against Aetna in 2000, its year 2000 Policy[4] should cover the costs Aetna incurred in connection with the Provider MDL. The defendants who insured Aetna under the 2000 Policy (the "2000 Insurers") argue that the Provider MDL claims are not covered under the express language of the 2000 Policy. As a result, Aetna seeks, in the alternative, to recover the costs it incurred in the Provider MDL under its year 1999 Policy.[5]

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[4] The Professional Liability Policies that Aetna had in place for 2000 are as follows:

Insurer Name	Type of Policy	Amount of Coverage	Party Status
Lexington Insurance Co. ("Lexington")	Primary	$500,000/Claim $1 Million/Aggregate	Defendant
National Union Fire Insurance Co, of Pittsburgh, PA ("NUFIC")	Excess	$2.5 Million/Claim $29 Million/Aggregate	Defendant
NUFIC	Excess	$30 Million	Defendant
Certain Underwriters, Lloyd's, London ("Lloyd's")	Excess	$20 Million	Defendant
Executive Risk Specialty Insurance Co. ("ERSIC")	Excess	$25 Million	Defendant
Starr Excess International ("Starr")	Excess	$25 Million	Not a Party
Lloyd's	Excess	$50 Million	Defendant
RLI Insurance Co. ("RLI")	Excess	$25 Million	Defendant
Liberty Mutual Insurance Co. ("Liberty")	Excess	$50 Million	Defendant
Chubb Atlantic Indemnity Ltd. ("Chubb")	Excess	$25 Million	Not a Party

"A wholly-owned subsidiary of Aetna reinsured 100% of the losses under [the Lexington Primary Policy and the NUFIC Excess Policy], and the coverage provided by these policies effectively served as a mechanism for administering a $3 million deductible in Aetna's coverage." Aetna Motion for Summary Judgment, p. 2, n. 3.

The 2000 Excess Policies are all "follow form" policies, in that they incorporate by reference the terms of the Primary Policy. In addition, several of the Excess Policies contain additional exclusions or requirements above and beyond those contained in the Primary Policy. For purposes of this Opinion, all references to the terms of 2000 Policy are to those of the Primary Policy unless specifically stated otherwise.

[5] The Professional Liability Policies that Aetna had in place for 1999 are as follows:

Insurer Name	Type of Policy	Amount of Coverage	Party Status
Columbia Casualty Co. ("Columbia")	Primary	$500,000/Claim $1 Million/Aggregate	Not a Party
Continental Casualty Co. ("CNA")	Excess	$1.5 Million/Claim $11 Million/Aggregate	Not a Party
CNA	Excess	$30 Million	Not a Party
Lloyd's	Excess	$25 Million	Defendant
ERSIC	Excess	$30 Million	Defendant
Steadfast Insurance Co. ("Steadfast")	Excess	$15 Million	Defendant
Fireman's Fund Insurance Co. of Ohio ("Fireman's")/Lloyd's	Excess	$25 Million	Defendant
Reliance Insurance Co. ("Reliance")	Excess	$25 Million	Not a Party

I. The Applicable Terms of the 1999 and 2000 Policies.

The interpretation of the terms of a contract, including an insurance contract, is a matter of law for the court. *See* Madison Const. Co. v. Harleysville Mut. Ins. Co., 557 Pa. 595, 606, 735 A.2d 100, 106 (1999); Galgano v. Metropolitan Property and Casualty Ins. Co., 267 Conn. 512, 519, 838 A.2d 993, 997 (2004).[6] "The intent of the parties to a written contract is deemed to be embodied in the writing itself; when the words are clear and unambiguous, the intent is to be gleaned exclusively from the express language of the agreement." Delaware County v. Delaware County Prison Employees' Independent Union, 552 Pa. 184, 189, 713 A.2d 1135, 1137 (1998). *See* Galgano, 267 Conn. at 519, 838 A.2d at 997.

The 1999 Policy contains the following language which defines and limits the coverage provided:

> Subject to the Limits of Liability, the Company will pay on behalf of the insured the loss which the insured shall be legally obligated to pay because of claims if legal liability for such loss arises out of an alleged act, error or omission in connection with the performance of professional services, provided always that:
>
> A. claim is first made against the insured during the Policy Period[7] on account of such act, error or omission;

As in Policy Year 2000, a wholly-owned subsidiary of Aetna reinsured 100% of the losses under the first two 1999 policies (i.e. Columbia's and CNA's), so the coverage provided by these policies effectively served as a mechanism for administering a $2 million deductible in Aetna's coverage.

The 1999 Excess Policies are also "follow form" policies, but some of them contain additional exclusions or requirements above and beyond those contained in the Primary Policy. For purposes of this Opinion, all references to the terms of 1999 Policy are to those of the Primary Policy unless specifically stated otherwise.

[6] Since Aetna is based in Connecticut, the law of Connecticut is arguably applicable to the claims raised in this action. However, under Pennsylvania choice of law rules, "[a] choice of law problem is not presented, . . . unless the determination of the case on the merits would vary according to which related jurisdiction supplies the governing internal substantive law. A choice of law problem does not exist here since courts in Pennsylvania and [Connecticut] apply the same standards when interpreting insurance policies." Reubush v. St. Paul Fire & Marine Ins. Co., 1986 U.S. Dist. LEXIS 18768, *3-4 (E. D. Pa. Oct. 22, 1986). The court will cite to the law of both states in this Opinion.

[7] The "Policy Period" for the 1999 Policy runs from January 1, 1999 to January 1, 2000. *See* Aetna's Complaint, Ex. K, p. 1. The Policy also includes a 90 day Extended Reporting Period under which "a claim first made during the Extended Reporting Period will be deemed to have been made on the last day of the Policy Period, provided that the claim is for loss that happened before the end of the Policy Period and after the Retroactive Date." *Id*. at p. 15.

B. such act, error, or omission happens subsequent to the Retroactive Date[8] specified in the Declarations; and

C. the insured reports the claim to the Company in writing, as otherwise provided in this Policy.

A claim shall be considered to be first made against the insured when the Corporate Risk Management Department ["CRMD"] of the insured first becomes aware of such claim or when the insurer is notified in writing by the [CRMD] of the insured of a specific circumstance involving a particular person which is likely to result in a claim.

Complaint, Ex. K, p. 2. "Claim" is defined under the 1999 Policy as:

1. any written demand for monetary damages,

2. any civil proceeding commenced by the service of a complaint or similar pleading,

3. any formal administrative, regulatory or arbitration proceeding commenced by the filing of a notice of charges, formal investigative order or similar document

against any Insured for an act, error or omission in connection with the performance of professional services by the Insured, including any appeal from such proceeding.

All claims of all persons arising out of the same act, error or omission or series of acts, errors or omissions shall be one claim and shall be deemed to have been made at the time the first of those claims is made against any insured.

Id., Ex. K, p. 6.

The 2000 Policy contains similar language which defines and limits the coverage provided.

Subject to the Limits of Liability, the Company will pay on behalf of the insured the loss which the insured shall be legally obligated to pay because of claims if legal liability for such loss arises out of an alleged act, error or omission in connection with the performance of professional services, provided always that:

[8] The 1999 Policy provides coverage for claims made during the Policy Period arising out of prior acts committed by Aetna Health Plans after January 1, 1976 , by U.S. HealthCare after October 1, 1996, by Health Lines after January 1, 1986, by NYLCare after July 16, 1998, by Corporate Health Administrators after February 28, 1997, and by Prudential HealthCare after August 6, 1999. *See* Aetna's Complaint, Ex. K, pp. 1, 17-18.

A. claim is first made against the insured during the Policy Period[9] on account of such act, error or omission;
B. such act, error, or omission happens subsequent to the Retroactive Date[10] specified in the Declarations; and
C. the insured reports the claim to the Company in writing within the policy period or within 90 days following the expiration of the policy period.

A claim shall be considered to be first made against the insured when the [CRMD] of the insured first becomes aware of such claim.

Id., Ex. A., p. 3. "Claim" is defined under the 2000 Policy as

1. any written demand for injunctive or equitable relief, monetary damages or services.

2. any institution of an arbitration proceeding or the commencement of a civil proceeding by the service of a complaint or similar pleading,

against any insured for an act, error or omission in connection with the performance of professional services by the insured, including any appeal from such proceeding.

claim shall also mean administrative and disciplinary proceedings and criminal charges brought against an insured relating to professional services.

All claims of all persons arising out of the same act, error or omission or series of related acts, errors or omissions resulting from the same loss[11] shall be one claim and shall be deemed to have been made at the time the first of those claims is made against any insured.

Id., Ex. A, p. 6.[12]

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[9] The "Policy Period" for the 2000 Policy runs from January 1, 2000 to January 1, 2001. *See* Aetna's Complaint, Ex. A, p. 1.

[10] The 2000 Policy sets forth the same Retroactive dates for Aetna, its predecessors, and its subsidiaries as did the 1999 Policy. *See id.*

[11] The phrase "resulting from the same loss" is not contained in the comparable provision of the 1999 Policy. However, the parties do not argue, and the court does not find, that it changes the definition of "Claim" significantly for purpose of this court's analysis. At most, it means that all claims resulting from the same loss should be treated as one.

[12] In addition, the "Exclusions" section of the 2000 Policy provides that:

The insurance afforded by the Policy shall not apply to any liability arising out of . . . any act, error or omission which was known to the [CRMD] of the named insured prior to January 1, 2000 and which was, or should have been reported under any policy in effect prior to January 1, 2000.

The parties do not argue, and the court does not find, that any of the above quoted language is ambiguous.[13] "Words of common usage in an insurance policy are to be construed in their natural, plain and ordinary sense, and [the court] may inform [its] understanding of these terms by considering their dictionary definitions." Madison Const. Co. v. Harleysville Mut. Ins. Co., 557 Pa. 595, 608, 735 A.2d 100, 108 (1999). *See* R.T. Vanderbilt Co., Inc. v. Continental Cas. Co., 273 Conn. 448, 463, 870 A.2d 1048, 1059 (2005). For purposes of the court's analysis of the Provider MDL claims, the definitions of the word "series" as used in both Policies and of the word "related" as used in the 2000 Policy are important.

"Series" "refers to like, related, or identical things arranged or occurring in order." The American Heritage Dictionary, p. 1648 (3rd Ed. 1992). *See* Highwoods Properties, Inc. v. Executive Risk Indemnity, Inc., 407 F.3d 917, 924 (8th Cir. 2005) ("A 'series' is 'a number of things or events of the same class coming one after another in special or temporal succession.")[14] "Related" is defined as "being connected; associated." The American Heritage Dictionary, p. 1523 (3rd Ed. 1992). "Related" also means "standing in relation; connected; allied; akin." Black's Law Dictionary, p. 1288 (6th Ed. 1990). *See* Continental Cas. Co. v. Wendt, 205 F.3d 1258, 1263 (11th Cir. 2000) ("The plain meaning of the word 'relate' is 'to show or establish a logical or causal connection between'").

Aetna's Complaint, Ex. A, p. 4.

[13] Aetna argues that the *contra proferentem* rule should be applied and that the language of the Policies should be read in Aetna's favor since it is the insured. However, this rule only applies where the language at issue is ambiguous, so it is not applicable here. *See* Madison Const. Co. v. Harleysville Mut. Ins. Co., 557 Pa. 595, 606, 735 A.2d 100, 106 (1999); Galgano v. Metropolitan Property and Casualty Ins. Co., 267 Conn. 512, 519, 838 A.2d 993, 997 (2004). Furthermore, it is not clear that this rule applies where the insured is a sophisticated insurance company that drafted and negotiated the terms of the policy at issue.

[14] The 1999 Policy does not expressly require that the acts in the "series" be "related." However, given the above definitions of "series," by requiring the acts to be serial, the 1999 Policy necessarily requires that they be related or similar, just as the 2000 Policy does.

In light of the definitions of "series" and "related," the terms of the Policies are clear. If the claims in the Provider MDL arise out of acts, errors, or omissions, or out of a series of related acts, errors, or omissions that served as the basis for claims in actions filed prior to the Policy Period (the "Prior Actions"), then they should be treated as one claim that was first raised prior to the Policy Period. In other words, if the acts on which the Provider MDL claims are based are the same or similar to the acts on which claims filed in Prior Actions are based, then the Provider MDL claims are not covered by the Policies.

It does not matter if the claims in one action are for violation of RICO and in another they are for violation of a consumer protection statute or the common law, so long as the underlying acts complained of are the same. Differences in the applicable law do not cause claims to be treated as separate and distinct under the Policies; instead, only differences in the underlying facts alleged can give rise to separate claims.[15] *See* Universal Teleservices Arizona, LLC v. Zurich American Ins. Co., 2004 Phila Ct. Com. Pl. LEXIS 88 * 13 (Mar. 4, 2004)[16] ("the pending and prior litigation exclusion looks to the underlying facts rather than the legal theories pled."); Bensalem Township v. International Surplus Lines Ins. Co., 1992 U.S. Dist. LEXIS 8243 *5 (E.D. Pa. June 15, 1992) ("The actual language of the policy . . . looks to underlying facts and not the characterization of those facts in legal pleadings").[17] *See also* Gateway Group Advantage, Inc. v. McCarthy, 300 F.Supp.2d 236, 243 (D. Mass. 2003) ("The fact that the same

[15] Jurisdictional differences are likewise irrelevant. For instance, if one action is brought in Texas, based on Texas law, on behalf of a Texas class, and another is brought in Illinois, based on Illinois law, on behalf of an Illinois class, and yet another is brought in Florida, based on federal law, on behalf of a nationwide class, the claims in such actions may be treated as one if they are all based on the same wrongful acts allegedly committed by Aetna.

[16] The trial court's opinion in Universal Teleservices was affirmed on appeal at 879 A.2d 230 (Pa. Super. 2005).

[17] The trial court's decision in Bensalem was reversed on other grounds on appeal at 38 F.3d 1303 (3d Cir. 1994). On remand, the trial court noted that the appellate court "agreed with our analysis of the policy's plain language," and dismissed the case. 1995 U.S. Dist. LEXIS 6329 *1, 41. This dismissal was affirmed on appeal at 77 F.3d 461 (3d Cir. 1996).

[allegedly wrongful acts] may give rise to claims by different claimants, and may give rise to different causes of action based on the laws of different states does not prevent the claims from being 'related' under the clear terms of the policy.")

II. The Allegations in the Provider MDL Complaints.

The 1999 and 2000 Insurers argue that the claims made in the Provider MDL relate back to claims made in Prior Actions. Therefore, the court must look first at the Provider MDL Complaint(s), and then compare those allegations to the allegations of the Complaints filed in the Prior Actions to determine if the claims made in the Provider MDL were first made in 2000, in 1999, or in some earlier year.

In Shane,[18] the lead case in the Provider MDL, the class plaintiffs based their RICO and state law claims on allegations that Aetna routinely and improperly engaged in the following wrongful acts:

A. Denied coverage and refused to pay the HCPs' claims for reimbursement on economic grounds without regard to whether the health care services rendered were medically necessary or not (hereinafter "Denied Coverage").

B. Delayed payment of the HCPs' claims for reimbursement for significant periods of time (hereinafter "Delayed Payment").

C. Diminished the amounts it paid on the HCPs' claims for reimbursement (hereinafter "Reduced Payment").

D. Decertified, terminated its contracts with, or otherwise refused to do business with HCPs without cause, thereby effectively denying them access to patients insured by Aetna (hereinafter "Blacklisted HCPs").

[18] Shane was filed in January, 2000 on behalf of a nationwide class of HCPs who treated patients insured by Humana from 1990 onward. An Amended Complaint, in which Aetna (and other insurers) were named as defendants, was filed in June, 2000.

E. Unilaterally amended its contracts with HCPs to their detriment, refused to negotiate terms with them, refused to provide information to them regarding its pricing and policies, and failed to provide a mechanism for review of its decisions (hereinafter "Dictated Terms").

F. Concealed its improper processing, denial, and reduction of the HCPs' claims (hereinafter "Concealed Activities").

G. Engaged in actuarial manipulation of the capitation system[19] to underpay doctors pursuant to their Capitation Agreements by:

1. Failing to pay for enrolled patients until each patient first seeks medical care;

2. Failing to pass along pharmaceutical company rebates to pharmacy risk pools; and

3. Falsifying year end statements to avoid making incentive payments to HCPs.

(hereinafter "Manipulated Capitation Payments").

H. Coordinated its wrongful activities with other defendants through trade organizations and the use of uniform guidelines, systems, and forms (hereinafter "Formed Industry Enterprise").

[19] Aetna apparently entered into Capitation Agreements with certain HCPs under which it paid the HCPs a fixed amount based on the number of patients insured by Aetna, rather than on the services actually provided to such patients by the HCPs.

Similarly, in Mangieri,[20] the first of the class actions filed in the Provider MDL,[21] the plaintiffs based their RICO and state law claims on allegations that Aetna engaged in the following wrongful acts:

A. Denied Coverage.

B. Delayed Payment.

C. Blacklisted HCPs.

D. Dictated Terms.

E. Retained discretion to remove prescription medicines from its covered list based on financial rather than medical considerations (hereinafter "Dropped Drugs").

D. Provided incentives and disincentives to HCPs to limit hospitalizations, emergency care, referrals to specialists, and the use of other health services (hereinafter "Discouraged Use of Services").

E. Penalized HCPs for discussing Aetna's reimbursement practices, coverage, and non-covered treatments with patients (hereinafter "Enforced Gag Rule").

F. Coordinated its wrongful activities among its subsidiaries and related companies (hereinafter "Formed Aetna Enterprise").

III. The Allegations In The Prior Actions.

Defendants argue that all of the wrongful acts alleged in the Provider MDL were the subject of Prior Actions,[22] so they are not covered under the 1999 and 2000 Policies. In order to determine whether there is coverage under either Policy, the court must review the Complaints

[20] Aetna relies upon the allegations contained in the Shane Complaint when arguing for coverage, but several defendants rely upon the allegations of the Mangieri Complaint when arguing against coverage. The court will err on the side of caution and consider the claims raised in both actions, to the extent that they differ.

[21] Mangieri was filed in 1999, but service was not made against Aetna until January, 2000.

[22] The court does not reference all of such Prior Actions in this Opinion because many of them are, for the court's purposes, duplicative of one another.

filed in the Prior Actions to determine whether the wrongful acts at issue in them are the same as, or related to, those alleged in the Provider MDL.

Ford v. NYLCare Health Plans of the Gulf Coast, Inc., No. H-96-1564 (S.D. Tex.) ("Ford") is the earliest action on which defendants rely. Ford was filed in May, 1996, on behalf of a class of specialized HCPs who contracted with Aetna (and other insurers) in Texas. In Ford, the class plaintiffs alleged that Aetna engaged in the following wrongful acts:

A. Denied Coverage.

B. Delayed Payment.

C. Reduced Payment.

D. Blacklisted HCPs.

E. Discouraged Use of Services.

State of Texas v. Aetna U.S. Healthcare, Inc. No. 98-13972 (Travis Co., Tex.) ("Texas") is the next action that was filed against Aetna. Texas was filed in December, 1998, by the Texas Attorney General on behalf of patients insured by Aetna in Texas. In Texas, the plaintiff alleged that Aetna engaged in the following wrongful acts:

A. Denied Coverage.

B. Delayed Payment.

C. Discouraged Use of Services.

D. Dropped Drugs.

E. Enforced Gag Rule.

IV. A Comparison Of The Allegations In The Provider MDL And The Prior Actions.

Upon review of the allegations in the actions filed prior to Shane/Mangieri, it is clear that all but a few of the acts complained of in the Provider MDL were the subject of Prior Actions.

A. Many Of The Claims In The Provider MDL Are Based On the Same Acts That Served As The Basis For the Claims In Prior Actions.

The allegation that Aetna improperly Denied Coverage for economic rather than medical reasons was first raised in Ford, in 1996. Therefore, under the terms of the 1999 and 2000 Policies, all claims based on the allegation that Aetna improperly Denied Coverage must be deemed to have been first made in 1996. As a result, such claims are not covered by either the 1999 or the 2000 Policies. Similarly, the allegations that Aetna improperly Delayed Payment of claims, Blacklisted HCPs, and Discouraged Use of Services were first raised in Ford, in 1996, so they are not covered by either the 1999 or the 2000 Policy.[23]

Claims based on allegations that Aetna Dropped Drugs and Enforced a Gag Rule against HCPs were not made in Ford, but they were made in Texas. Therefore, under the terms of the 1999 and 2000 Policies, claims based on those allegations are deemed first made in 1998, and they are not covered under either Policy.

B. Several Of The Claims In The Provider MDL Are Based On Acts That Are Related To, And/Or Part Of A Series Of, Acts That Served As The Basis For Claims In The Prior Actions.

Some of the wrongful acts alleged in the Provider MDL are not exactly the same as the acts that serve as the basis for the claims in the Prior Actions. However, under the 1999 Policy, if the acts alleged in the Provider MDL and the acts alleged in the Prior Actions formed part of a "series," then the Provider MDL claims based on such serial acts are not covered. Similarly, if the acts alleged in the Provider MDL and the acts alleged in the Prior Actions formed part of a "series" of "related" acts, the claims in the Provider MDL based on such serial related acts are not covered under the 2000 Policy.

[23] Claims based on allegations that Aetna Blacklisted HCPs and Discouraged Use of Services were also raised in 1997 in Ehlmann v. Kaiser Foundation Health Plan of Texas, No. 4:97-CV-264-Y (N.D. Tex.)

The allegation that Aetna improperly Reduced Payment of claims was first raised in 1996, in Ford, although the allegations in Ford are less specific than those in Shane. However, even if the Ford claims are not based on precisely the same acts as the Shane claims, they are clearly based on the same series of related acts. In Ford, plaintiffs claimed that Aetna (and other defendants) "systematically pay far less that the customary charges that they promise to pay and, in repeated cases, pay for only a portion of the medical services actually provided." Ford Complaint, ¶18. By the time Shane was filed, the plaintiffs had names for the specific practices that Aetna utilized to reduce the payments it made:

1. "Downcoding" by which Aetna "chang[ed] the code assigned to a particular service [performed by an HCP] to a less expensive one;"
2. "Bundling" by which Aetna "combined the codes of two or more procedures into one" which was less expensive than the two added together would have been; and
3. "Refusal to Recognize Modifiers" by which Aetna ignored modification codes submitted by HCPs "which indicate the degree of multiplicity, complexity or difficulty of the evaluation or procedure" for which reimbursement is requested.

Shane Complaint, ¶¶87-88. Clearly, the acts alleged in Ford regarding Reduced Payment are part of a series of acts substantially related to the more detailed acts alleged in Shane. Therefore, the Provider MDL claims based on allegations of Reduced Payment must be deemed to have first been made in 1996, and they are not covered by either the 1999 or the 2000 Policy.

The allegations that Aetna unilaterally Dictated Terms to the HCPs were not made until 1999,[24] so they are not covered by the 2000 Policy. However, they are not covered under the 1999 Policy either because Aetna's alleged Dictation of Terms is necessarily part of a series of

[24] Such allegations were raised in Maio v. Aetna, Inc., No. 99-CV-1969 (E.D. Pa.) ("Maio"), and O'Neil v. Aetna, Inc., No. 2:99-CV-284 (S.D. Miss.) ("O'Neil"), in addition to Mangieri.

related acts in which Aetna allegedly wielded its overbearing market influence improperly to limit its obligations and the HCPs' rights under the contracts between them. The other acts in this series include Blacklisting HCPs and Enforcing Gag Rules.

Furthermore, Aetna's alleged Dictation of Terms enabled it to engage in other wrongful acts, namely Delaying Payment, Reducing Payment, and Denying Coverage. In other words, the Dictation of Terms was a means to an end, and it must be viewed as part of an alleged course of conduct aimed at limiting the amounts that Aetna had to pay out on claims submitted by the HCPs. Since claims based on the other wrongful acts in this series were first alleged in 1996 and 1998, the related claims based on the alleged improper Dictation of Terms must be deemed to have been first made then, and not in 1999. *See* Highwoods Properties, Inc. v. Executive Risk Indemnity, Inc., 407 F.3d 917, 924-5 (8th Cir. 2005) (Where "the alleged deceptive and harmful actions occurred through the promulgation of several related documents issued in temporal succession, building on one another and resulting in the accomplishment of [a] merger," two actions based on different incomplete and deceptive communications in connection with the merger were "related" and part of a "series"); Continental Cas. Co. v. Wendt, 205 F.3d 1258, 1264 (11th Cir. 2000) ("Though clearly this course of conduct involved different types of acts, these acts were tied together because all were aimed at a single particular goal" which was to promote investment in an improper investment scheme.) Likewise, Aetna's alleged Concealment of its other wrongful Activities from the HCPs is clearly part of a series that included the wrongful activities that were concealed. Therefore, the claims based on Aetna's Concealed Activities relate back to the claims in the Prior Actions that are based on the wrongful activities concealed.

The allegations that Aetna Formed an Aetna Enterprise in violation of RICO were first made in Mangieri in 1999.[25] The allegations that Aetna Formed an Industry Enterprise were first made in Shane, in 2000. However, these concerted acts are clearly part of a series of acts related to the wrongful acts allegedly committed by Aetna individually. For instance, the allegation that Aetna Denied Coverage in concert with its subsidiaries or with other entities in the same industry necessarily is related to, and/or part of series with, the claim that Aetna alone Denied Coverage. As a result, the concerted action claims involving Denial of Coverage must be deemed to have been first made in 1996 when the first Denied Coverage claims were made. Likewise, the allegations that Aetna committed other wrongful acts as part of one or more conspiracies must be deemed to relate back to the first instance in which Aetna is alleged to have committed such wrongful acts alone.

C. Only A Few Of The Claims Raised In The Provider MDL Are Not Based On Acts That Served As The Basis For Claims Made In Prior Actions.

The allegations in Shane that Aetna improperly Manipulated Capitation Payments are the only allegations that were not made in any of the Prior Actions. Furthermore, the act of Manipulating Capitation Payments is not clearly part of a series of related acts that includes the acts alleged in the Prior Actions. Therefore, claims based on the allegation that Aetna Manipulated Capitation Payments must be deemed first made in 2000, and they may be covered

[25] These allegations were also made in Maio and O'Neil, in 1999.

under the 2000 Policy, [26] if they are not otherwise excluded as discussed later. [27]

IV. The Applicable Exclusions Under the Policies.

As set forth above, the claims in Shane that were based on allegations that Aetna Manipulated Capitation Payments may fall within the coverage of the 2000 Policy. However, the Insurers argue that such claims fit within the exclusionary language of the 2000 Policy, so that they need not pay the costs and expenses associated with those claims.[28] The relevant exclusion provisions of the 2000 Policy are as follows:

> The insurance afforded by the Policy shall not apply to any liability arising out of the following:
>
> * * *

[26] The claims in Shane were first asserted against Aetna in June, 2000. Therefore, they fall within the Policy Period of the 2000 Policy, but not the 1999 Policy Period or the Extended Reporting Period under the 1999 Policy. *See* Aetna's Complaint, Ex. K, p. 15.

[27] If this court were to find that one or more claims raised in the Provider MDL were covered by either the 2000 or 1999 Policy, Aetna would then be in the unenviable position of having to prove what portion of the settlement and defense costs, if any, was attributable to the covered claims.

> While it appears that Pennsylvania Courts have not spoken on the issue, . . . they would most likely place the burden on the plaintiff to prove that portion of the settlement amount [that is covered under the Policy]. This also comports with the general notion that the plaintiff has the burden of proving its case. In addition, the plaintiff is the party to this matter that settled the [underlying] case and is in a better position to prove what part of the settlement amount represents the settlement of claims [covered under the Policy.]

John Hancock Healthplan of Pennsylvania, Inc. v. Lexington Ins. Co., 1990 U.S. Dist. LEXIS 2450 *8 (E.D. Pa. Mar. 6, 1990) (the policy at issue was a Directors' & Officers' Liability Policy, so the Policy covered only the portion of the settlement amount that arose out of claims asserted against plaintiff's directors and officers and not the portion that arose out of claims asserted against plaintiff). *See* Int'l Commun. Materials v. Employer's Ins., 1996 U.S. Dist. LEXIS 21825 (W.D. Pa. 1996) (where the insured negotiated the settlement, the insured "must bear the burden of apportioning the settlement payment between covered and noncovered damages.") *See also* Continental Casualty Co. v. Canadian Universal Ins. Co., 924 F.2d 370 (1st Cir. 1991) (the burden was on the insured to produce the evidence at trial to enable the trial court to determine what portion of the settlement was allocable to covered damages and attorneys fees and what portion was not); RML Corp. v. Assurance Co. of America, 60 Va. Cir. 269, 271 (2002)("the plaintiff [insured] has the initial burden to prove how much of the settlement was for claims covered by the policy.") On the facts proffered by the parties in support of their Motions for Summary Judgment, the court does not see how Aetna could sustain this burden.

[28] Aetna makes much of the fact that the Insurers bear the burden of proving the applicability of any exclusions. *See* Madison Const. Co. v. Harleysville Mut. Ins. Co., 557 Pa. 595, 605, 735 A.2d 100, 106 (1999); Souper Spud, Inc. v. Aetna Casualty & Surety Co., 5 Conn. App. 579, 585, 501 A.2d 1214, 1217 (1985). However, where, as here, the terms of an exclusion clearly apply to the undisputed facts, that burden is easily met.

D. payment obligations imposed or assumed by the insured as a carrier, insurer, reinsurer, benefit plan, third party payor or under a service agreement, provider contract or purchase agreement;

Aetna's Complaint, Ex. A, p. 4. The allegations that Aetna Manipulated the Capitation Payments concern its failure to pay amounts that it was required to pay to the HCPs under their Capitation Agreements with Aetna. Therefore, the claims based on such allegations clearly constitute an attempt to impose liability on Aetna based on payment obligations that Aetna assumed under provider contracts. As such, any settlement and defense costs arising out of the allegations that Aetna Manipulated Capitation Payments are excluded from coverage under the 2000 Policy.[29]

V. The Insurers Do Not Have A Duty To Pay Aetna's Defense Costs Incurred In Connection With The Non-Covered Claims.

Aetna argues that even if it is not entitled to be indemnified for any of its settlement costs under the 1999 and 2000 Policies, it is still entitled to its costs of defending the Provider MDL. Normally, where an insurer has a duty to defend the insured, and the Complaint against the insured raises both covered and non-covered claims, "the insurer has a duty to defend until such time that the claim is confined to a recovery that the policy does not cover." General Accident Ins. Co. v. Allen, 547 Pa. 693, 706, 692 A.2d 1089, 1095 (1997). *See* Petro v. K-Mart Corp., 1998 Conn. Super. LEXIS 476 *8 (Feb. 24, 1998). In other words, the insurer must pay the costs

[29] The 2000 Policy further provides that "the Company shall have no obligation to indemnify the insured for any judgment or settlement comprised of restitution, revenues or profits of the insured that it is obligated to disgorge or pay to others." Aetna's Complaint, Ex. A, p. 8. Therefore, to the extent that Aetna's "loss" included the restitution of amounts that it was contractually obligated to pay the HCPs, such loss would not be covered under the 2000 Policy.

The claims in the Provider MDL based on allegations that Aetna improperly Denied Coverage, Delayed Payment, and Reduced Payment would also be excluded by these two provisions of the 2000 Policy, if they did not fall outside the scope of coverage due to the fact that they relate back to claims raised in the Prior Actions.

of defense until there are no covered claims left in the underlying action.[30] However, in this case the 1999 Insurers had no duty to defend Aetna. The 1999 Policy expressly provides that:

> The Company shall not be called upon to assume charge of the settlement or defense of any claim or suit brought, or proceeding instituted against the insured. The Company shall, however, have the right to associate with the insured in the investigation, defense and control of any claims; in such event the insured shall cooperate fully with the Company.

Aetna's Complaint, Ex. K, p.2. Similarly, the 2000 Policy provides that:

> The Company shall not be called upon to assume charge of the settlement or defense of any claim or suit brought, or proceeding instituted against, the insured. The Company shall, however, have the right to associate with the insured in the investigation and defense of any claim; in such event the insured shall cooperate fully with the Company. The insured shall have the right to select and maintain counsel of its choosing.

Id., Ex. A, p. 2.[31] These provisions were negotiated between the parties;[32] they are not boilerplate provisions in a form contract supplied by the insurer, as in many other cases. Aetna, unlike many insureds, is a sophisticated insurer in its own right, and it may be presumed to understand the import of the defense rights it retained for itself. Furthermore, it makes sense for Aetna to have retained such rights because it, through captive subsidiaries and a self-insured retention, acted as the primary insurer of its own risk under the Policies. The defendants are simply excess insurers who retained a right to observe and participate in Aetna's defense in order

[30] As set forth in the previous sections of this Opinion, there was no coverage for the claims raised in the Provider MDL, so there could be no duty to defend either.

[31] The first NUFIC 2000 Excess Policy, which Aetna's captive subsidiary reinsured, provides that "with respect to claims covered by this Policy, but not by the underlying insurance specified in the Declarations due to exhaustion of any per claim or aggregate limits of liability by reason of payments made solely thereunder, the Company shall have the right and the duty to defend any suit brought against the insured seeking losses covered by this Policy . . ." Aetna Complaint, Ex. B. However, as set forth previously, the Provider MDL claims were not covered by the Policy, so this duty to defend did not arise. If such a duty had arisen, then presumably Aetna's reinsuring subsidiary would have had to assume it. The second NUFIC 2000 Excess policy, which was not reinsured, contains an endorsement expressly disavowing any duty to defend, just as the Primary Policy did. *See id.* Ex. C.

[32] The 2000 Insurers claim that the 2000 Policy was drafted by Aetna, although Lexington suggested some "refinements" as well. At any rate, Aetna did not merely accede to its insurers' form agreement.

to protect their own interests as excess insurers. In doing so, defendants did not obligate themselves to defend Aetna.

Instead of a duty to defend, the Insurers had only a duty to indemnify Aetna for its "loss," which in 1999 was defined to include "defense of claims and other claims expense" and in 2000 was defined to include "claims expenses[33] incurred in the defense of a claim." Compare *id*., Ex. K, pp. 9-10 with *id*., Ex. A, p. 8. As set forth in the previous sections of this Opinion, the duty to indemnify is limited to claims that are covered under the Policies. Since none of the claims in the Provider MDL are covered under the 1999 and 2000 Policies, the 1999 and 2000 Insurers need not pay the defense costs associated with such non-covered claims.

CONCLUSION

For all the foregoing reasons, Aetna's Motion for Summary Judgment is denied, and the 1999 Insurers' and the 2000 Insurers' Motions for Summary Judgment are granted. Aetna's claims against both sets of Insurers, in which it demands coverage for the defense and settlement costs that it incurred in connection with the Provider MDL, are dismissed. Although this may initially seem like a harsh result, it is dictated by the unambiguous terms of the Policies. The court also believes that this result furthers the purpose for which liability insurance exists.

Liability insurance is intended to spread an individual's unforeseen (or at least unpreventable) risk among a pool of willing participants; it is not intended to alleviate the individual's obligation to behave rationally and to be risk averse. Once an insured becomes aware that it is engaging in behavior that may result in a loss, it should adjust its behavior to

[33] "Claims Expenses" is defined under the Policy to include the defense costs that Aetna seeks here. *See* Aetna's Complaint, Ex. K., p. 6.

avoid the loss. In other words, once Aetna became aware, through the filing of Ford,[34] Texas, and various other Prior Actions, that some of its Managed Care activities were actionable, it should have objectively assessed its exposure and modified its behavior[35] to avoid such potential liability. It should not have waited to get caught in the Provider MDL and then try to make its insurers share in its (by then) foreseeable and preventable loss.

BY THE COURT,

HOWLAND W. ABRAMSON, J.

[34] Aetna apparently prevailed in Ford. However, even an unsuccessful lawsuit should give an insured pause and cause it to scrutinize the behavior complained of more closely.

[35] Not all loss can be avoided and not all risky behavior can be modified. However, the behavior that Aetna allegedly engaged in could be altered, as demonstrated by the fact that Aetna promised to change certain of its Managed Care business practices as part of the settlement of the Provider MDL.