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

EXECUTIVE RISK INDEMNITY INC., Plaintiff,	:	November Term 2004
v.	:	No. 1495
CIGNA CORPORATION, Defendant.	:	COMMERCE PROGRAM
	:	Control Number 031399/021670

ORDER

AND NOW, this 19TH day of March 2008, upon consideration of the parties respective Motions for Summary Judgment, all responses in opposition, after oral argument and in accord with the attached Memorandum Opinion, it hereby is ORDERED that

1. Plaintiff Executive Risk Indemnity Inc.'s Motion for Summary Judgment is Granted and judgment is entered in Executive Risk Indemnity Inc.'s favor and against Cigna Corporation.
2. Defendant Cigna's Motion for Summary Judgment is Denied.

BY THE COURT,

_____
MARK I. BERNSTEIN, J.

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

EXECUTIVE RISK INDEMNITY INC., Plaintiff,	:	November Term 2004
v.	:	No. 1495
CIGNA CORPORATION, Defendant.	:	COMMERCE PROGRAM
	:	Control Number 031399/021670

OPINION

This is an insurance coverage dispute between Executive Risk Indemnity Co. ("Executive Risk"), an insurer and Cigna Corporation ("Cigna"), an insured who operates and administers managed care organizations throughout the United States. Cigna submitted a claim to Executive Risk for indemnification for settlement funds including attorney fees and defense costs paid in a Managed Care Class Action. Executive Risk denied coverage for the claim. All parties have now filed cross motions for summary judgment.

I. Cigna's Claim Review Process

Cigna enters into contractual agreements with designated physicians ("Providers") to treat individual members or those employed by organizations that have chosen Cigna to serve as administrator of a self funded third party health plan ("Subscribers"). Pursuant to these obligations, Cigna is required to pay providers for covered or medically necessary health services rendered to subscribers. Providers are required to submit standard coded claim forms. The most commonly used form is the American Medical Association's HCF/CMS-1500. This form requires providers to complete data fields for processing and reviewing of the payment request. The HCFA/CMS -1500 form

incorporates the American Medical Association's coding procedures which are copyrighted designations for physician services. The codes submitted are used by Cigna to assign reimbursement value for services provided.

From 1989 to August 1996, Cigna processed and audited only those claim forms which were in excess of $500.00 in billed charges. Cigna used the McKesson Corporation's ClaimCheck claim editing protocol to audit these claims.

In August 1996, Cigna automated the Claim Check software and began to audit all physician claim forms submitted for payment. As part of this automation process, Cigna's in house analyst lost the ability to override ClaimCheck or to make modifications. Following automation, Cigna withheld payments from physicians in the hundred of millions of dollars.

II. The Weiss Class Action Complaint

In February 1996, Michelle Weiss filed a class action complaint in the Southern District of New York against Cigna on her own behalf and on behalf of all participants and beneficiaries in employee welfare benefit plans through which healthcare coverage was provided by Cigna. That lawsuit alleged that Cigna as an ERISA fiduciary breached its duties of loyalty, good faith and fair dealing by (1) interfering with and usurping the role of the physician (2) providing physicians with financial bonuses if referral and hospitalizations rates were below average level and (3) specifying that any services not authorized in the HMO "Program Requirements" would be reimbursed only if Cigna's authorization was obtained prior to performance of the service.[1] The complaint further alleges that Cigna breached its fiduciary duty by manipulating the use of capitation

[1] Exhibit "38" to Executive Risk's Motion for Summary Judgment -Weiss complaint p. 3.

payments[2] to reduce treatment by withholding a portion of payments to take into account medical costs and by interfering with a patient's right to informed consent by penalizing providers for discussing Cigna's reimbursement practices, coverage and non covered treatments with patients. Ms. Weiss claims were dismissed on preemption grounds and withdrawn.

III. The Managed Care Litigation

A. The Subscriber Litigation

In November 1999, Bobby Pickney, a Cigna subscriber through his employer, instituted a class action lawsuit in the District Court for the Southern District of Mississippi against Cigna and its subsidiaries. That lawsuit sought relief pursuant to Racketeer Influenced and Corrupt Organizations Act ("RICO")[3] and the Employment Retirement Income Security Act ("ERISA")[4]. Pickney's lawsuit arose from Cigna's systematic and intentional concealment from health plan members of accurate information about when health care would be provided, when claims would be approved and what criteria and procedures were actually used to determine the extent and type of their coverage. On September 26, 2002, the Southern District of Florida denied class certification for the Subscriber Track Lawsuits and on May 14, 2003, the Subscriber Track Litigation was dismissed.[5]

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

[3] 18 U.S. C. §§ 1961-68.

[4] Section 502 of 29 U.S. C. § 1132.

[5] Cigna settled the individual claims of the named subscriber plaintiffs for a total of $9,000.00.

B. The Provider Litigation

On December 7, 1999, Eugene Mangieri, M.D. instituted a class action on behalf of himself and a class of physicians compensated by Cigna for services provided to members of Cigna's HMO plans from 1978 to 1999. The complaint alleged that Cigna aggressively implemented systemic internal policies which discouraged the providers from delivering necessary medical services, limited or denied providers ability to deliver medical services based upon cost criteria more restrictive than medical necessity, interfered with the medical judgment of providers by substituting the judgment of claims reviewers without medical training and without regard to medical needs. On April 17, 2000, In re Managed Care Litigation, MDL 1334 was created by order of the Judicial Panel on Multidistrict Litigation ("MDL Panel"). On October 23, 2000, the Mangieri case was transferred by the Multi District Litigation Panel to the United States District for the Southern District of Florida.

On July 15, 2002, Charles B. Shane, M.D. instituted suit on his own behalf and on behalf of other providers against Cigna in the Southern District of Florida, the Miami Division. That lawsuit alleged that Cigna systematically denied, delayed and diminished the payments due doctors for the medically necessary services rendered to the subscribers. The complaint alleged that Cigna implemented a systematic claim process to manipulate codes contained in the claim forms submitted by the providers by downcoding[6] and bundling[7] allegedly cheating doctors out of payment for services rendered.

[6] "Downcoding" is a process in which the codes submitted by the physicians on the claim forms are changed during the review process to less expensive one.

[7] "Bundling" occurs when codes for two or more procedures are combined into one.

The Provider Track Lawsuits were certified and consolidated for trial. The court conditionally certified a class and two subclasses defined as:

> The Global Class: All medical doctors who provided services to any person insured by any Defendant from August 4, 1990 to September 30, 2002.
>
> National Subclass: Medical doctors who provided services to any person insured by a Defendant, when the doctor has a claim against such Defendant and is not bound to arbitrate the claim.
>
> California Subclass: Medical doctors who provided services to any person insured in California by any Defendant when the doctor was bound to arbitrate the claim being asserted.

On July 11, 2002, the Shane Complaint became the lead case in the MultiDistrict Litigation.

C. The Kaiser Litigation

On May 26, 2000, Timothy N. Kaiser, M.D. and Suzanne LeBel Corrigan, M.D. filed a single count breach of contract complaint as a class action in Madison County, Illinois against Cigna alleging the same misconduct as that alleged in the Provider class action. From May 26, 2000, the date the lawsuit was initiated to November 22, 2002, the Kaiser action was litigated and defended as a breach of contract action. On November 22, 2002, the Kaiser plaintiffs amended their complaint to include allegations of RICO, conspiracy, violation of the prompt pay statutes and ERISA. The amended complaint also changed the class definition to encompass the entire class the Florida court certified on September 26, 2002.

On November 25, 2002, Cigna removed the action to the United States District Court for the Southern District of Illinois. On November 26, 2002, Cigna and the Kaiser plaintiffs filed a settlement agreement for all the claims in all jurisdictions and a motion requesting preliminary approval of the settlement and conditional certification of

a settlement class. That motion failed to reveal that the requested class encompassed a class certified in Florida or that an injunction hearing was pending in Florida to enjoin the settlement. On December 12, 2002, Judge Moreno, in Florida, enjoined Cigna from proceeding with the proposed settlement that had been preliminary approved in the Kaiser case.[8] On February 21, 2003, the MDL Panel issued an order transferring the Kaiser case to the United States District for the Southern District of Florida to become part of In re Managed Care Litigation.

Cigna settled the Managed Care Litigation on September 2, 2003. The Settlement Agreement which consisted of 149 pages contained very specific criteria for payment to class members. As part of the settlement, Cigna agreed to injunctive relief and business practice changes[9] as well as $140 million which Cigna agreed to cap at $135 million for purposes of this coverage dispute. The cash component of the settlement was to be paid as follows:

Cigna Charitable Foundation:	$15 million
Category A Settlement Fund:	$30 million
Claim Distribution Fund: Category One Category Two Medical Necessity	$40 million
Plaintiffs' Counsel Fees:	$55 million.

The settlement was approved on January 30, 2004.

[8] In rendering its decision, the court said "This court is well aware of the strong public interest favoring settlements. However, it cannot turn a blind eye to the underhanded maneuvers Cigna took to obtain this settlement. Cigna snookered both this court and Judge Murphy in Illinois in an obvious attempt to avoid this Court's jurisdiction. Cigna settled the claims of this Court's Plaintiff class and yet seeks approval from another judge in Illinois without informing that judge, apparently, of the proceedings in this case."

[9] Cigna is not seeking coverage for the injunctive relief and business practice changes.

On April 28 and May 5, 2004, Cigna requested reimbursement from Lloyds of London (hereinafter Lloyds) and its excess insurers for the settlement funds of $135 million settlement and $39 million in defense costs[10] in the Managed Care Litigation.

IV. Insurance Policies

Lloyds was Cigna's primary professional liability insurer for the policy period of March 30, 1999 through March 30, 2002 and provided the first layer of "non-captive" professional liability insurance coverage to Cigna. The Lloyds policy of insurance contained a $50 million liability limit subject to a self insured retention of $5 million per claim.

Cigna purchased additional liability insurance coverage from a group of insurers that included Executive Risk. These insurers provided an additional $50,000,000 in coverage for "Professional Liability" claims. Executive Risk provides $10,000,000 of that amount. The Executive Risk policy is a "follow form" policy, which incorporates by reference the terms of the Lloyd Policy. Executive Risk did not issue any separate excess policy form or add any additional terms, conditions or exclusions to those set forth in the Lloyd's policy. [11]

Cigna provided notice of the Multidistrict Litigation to its insurers in March 2000. On September 4, 2003, Cigna reached a settlement with the Providers and demanded that Lloyds' excess carriers including Executive Risk pay Cigna's defense costs associated with the Subscriber Litigation and the Provider Litigation and indemnify Cigna for costs associated with settlement of the Provider Litigation.

---

[10] Although Cigna was unable to provide a definite amount of defense costs during the litigation, Cigna in its motion for summary judgment claims $39 million.

[11] All references to the policy are to the Lloyd policy.

On May 11, 2004, the First Excess Layer Insurers collectively issued a coverage analysis and reservation of rights letter to Cigna denying coverage for the claims presented in the Multidistrict Litigation. On June 18, 2004, Lloyds also denied coverage. On October 19, 2004, Cigna informed the First Excess Layer Insurers that it had settled with Lloyds and that the policy issued by Lloyds had been fully tendered. On November 9, 2004, Cigna settled with four of the First Excess Layer Insurers AESIC, Gulf, Steadfast and Travelers.

V. Executive Risk's claim

Executive Risk denied Cigna coverage for the settlement entered into in the Managed Care Litigation and filed this lawsuit on November 12, 2004. Specifically, Executive Risk alleges that Cigna is not entitled to coverage because the misconduct alleged against Cigna in the Subscriber and Provider Track class actions relate to activities which accrued before the policy term and is therefore not insurable; that Cigna knew of the underlying misconduct that instigated and materialized before Cigna purchased its excess insurance with Executive Risk; that Cigna' repayment in the Shane/Kaiser Settlement of the money it withheld from the provider plaintiff's is not a Loss but is restitution or disgorgement of ill gotten gains uninsurable as a matter of law; and finally that Cigna's settlement of the Provider Litigation is barred under the exclusions in the policy precluding payment for Cigna's contractual liability or for liability as an insurer or benefits administrator. Executive Risk further claims that Cigna's insurance claim fails because Cigna has not provided any allocation regarding what portion of its claim applies to covered as opposed to non-covered loss.

VI. Cigna claims

Cigna, on the other hand, argues that it has proven covered losses in the amount of $174,000,000[12] of which Executive Risk must pay its policy limits of $10,000,000. Cigna concedes that it is not entitled to coverage for the injunctive relief or the business practice changes addressed in the Settlement Agreement. Cigna also concedes that unless its covered loss exceeds $65,000,000 the primary coverage has not been fully depleted and it is not entitled to any compensation by Executive Risk.

DISCUSSION

I. Applicable Policy Provisions

The relevant policy provisions are:

> If during the Policy Period or the Extended Reporting Period, if applicable, any **Claim** is made against the Assured for Wrongful Acts in the performance of **Professional Services** by or on behalf of the Assured or by persons for whose **Wrongful Acts** the Assured is legally responsible (including but not limited to employees acting within the scope of their employment and agents of [Cigna]), Underwriters agree to pay on its behalf **Loss** resulting from such Claim. [13]

The term "Claim" is defined as a "civil, criminal, administrative or regulatory proceeding or inquiry initiated against any of the Assureds which is commenced by the filing of a complaint or similar pleading, notice of charges, formal investigative order, indictment or similar document."

"Wrongful Acts" is defined to include "any actual or alleged error, misstatement, misleading statement, act, omission, neglect or breach of responsibility, obligation or

[12] This sum represents $135,000,000 for the settlement of the Managed Care Litigation and $39,000,000 in defense costs.

[13] Insuring Agreement V of the Primary Policy.

duty or negligent act by any Directors and/or Officers in their capacities as such or by the Entity or Assured."

"Professional Services" is defined as "those services performed by Assured for or on behalf of a customer or client of such Assured pursuant to an agreement between such customer and such Assured for a fee, commission, remuneration or other consideration which inured to the benefit of the Assured." "Professional Services" also includes "operation as a managed care organization, including health care cost review, peer or utilization review, claims handling, marketing, administration or management of services by or on behalf of the Assured."

The term "Loss" is defined to include "damages, settlements, judgments, awards and Defense Costs incurred by any of the Assureds," and "Defense Costs" includes "reasonable and necessary fees, costs and expenses incurred by the Assures in defense, investigation, adjustment or appeal of any Claim.[14]

II. The Provider and Subscriber Track Cases do not involve a common nexus of facts and circumstances that relate back to an action that preceded the Executive Risk policy period.

Before discussing the questions of insurance coverage and exclusions, the court will first address the notice issue. Executive Risk maintains that it is entitled to summary judgment because the allegations that made up the Provider and Subscriber Track cases that Cigna defended and ultimately settled are "Interrelated Wrongful Acts" that share a "common nexus" of facts and circumstances and place Cigna's claim into a prior policy period. In support of its position Executive Risk relies upon the following policy provision:

[14] Lloyd's policy p. 43, 47.

> More than one Claim involving the same Wrongful Act or Interrelated Wrongful Acts shall be considered as one Claim, which shall be deemed to have been made on the date the notice of the first such Claim was given.[15]

"Interrelated Wrongful Acts" is defined as

> Wrongful Acts which have as a common nexus any fact, circumstance, situation, event, transaction or series of facts, circumstances, situations, events or transactions, including any such fact circumstance, situation, event, transaction or series of facts, circumstances, situations, events, or transactions under the Financial Institution Fidelity Bond.[16]

It is the duty of the court to interpret the terms of an insurance contract.[17] Ascertaining the intent of the parties as manifested by the language of the written instrument is the goal of interpreting the contract. A term is ambiguous, "if and only if it is reasonably or fairly susceptible of different constructions and is capable of being understood in more senses than one and is obscure in meaning through indefiniteness of expression or has a double meaning…a contract is not rendered ambiguous by the mere fact that the parties do not agree on the proper construction."[18]

Analysis of the applicable policy provisions together with the factual allegations of the Weiss complaint and the Provider and Subscriber complaints reveals that these complaints do not constitute "Interrelated Wrongful Acts". In fact, few similarities exist between the Weiss complaint and the claims for which coverage is sought herein. Weiss, a participant in an employee welfare benefit plan, sought injunctive and declaratory relief for what she alleged to be poor treatment of her infant daughter's kidney disorder due to

[15] Lloyd's policy p. 31, paragraph 4.

[16] Glossary of Terms Applicable to all Policies, par 13 (p. 42).

[17] Standard Venetian Blind Co. v. Am. Empire Ins. Co., 503 Pa. 300, 469 A.2d 563, 566 (1983).

[18] Bohler-Uddeholm Am., Inc. v. Ellwood Group, Inc., 247 F.3d 79, 93 (3d Cir. 2001).

Cigna's referral policy and provision of financial incentives to providers. Weiss complained that individuals at Cigna made medical decisions rather than the patient's primary care physician. The Weiss complaint was filed six months before Cigna automated the use of Claim Check, does not reference Claim Check or any other claims processing software. The Weiss claims were dismissed on preemption grounds and the remainder was withdrawn.

In contrast, the plaintiffs in the Provider Managed Care Litigation were physicians who claimed they provided appropriate care but that Cigna misrepresented and failed to disclose aspects of its billing practices and automated claim processing policies and procedures. The litigation focused on Cigna's use of ClaimCheck. The Managed Care Litigation alleged that Cigna along with other major managed care organizations constituted a "Managed Care Enterprise" that engaged in racketeering. The Managed Care Litigation alleged that Cigna and other managed care organizations violated RICO and made representations about the automated claim processing and payment procedures. The Managed Care litigation sought injunctive relief and payment for unreinbursed proper claims.

The Weiss complaint and the Provider Managed Care Litigation allege different wrongs to different people. The injuries suffered by the respective plaintiffs are distinct and not "interrelated". Executive Risk's interpretation of the term "Interrelated Wrongful Acts" is so broad as to produce failures of coverage whenever any standard policies, practices, procedures, systems or designs, even when totally proper, are the subject of a lawsuit or even a claim letter if the insured had notified its carrier of a claim. Executive Risk's interpretation finds interrelatedness no matter how ill-founded the claim,

irrespective of any proof of any liability and regardless of the final result. This provision certainly does not encompass every conceivable claim including those that are attenuated or unusual into a single claim. A degree of relatedness exists among any claims brought against an insured in the managed care arena.

The Connecticut Superior Court[19] faced a similar question. That court analyzed the relatedness of claims by considering the following factors: whether the parties are the same; whether the claims arise from the same transaction; whether the alleged acts occurred at the same time; and whether there is a common scheme or plan.[20] These same factors are to be considered by a Pennsylvania Court. The Weiss and Provider Managed Care Litigation do not involve an "Interrelated Wrongful Act".[21] The parties are not the same, there were different transactions, and the wrongful acts were not contemporaneous. There was no common scheme or plan between the allegations of Weiss and those of the Provider Managed Care Litigation. The Weiss and the Provider Managed Care Litigation are not Interrelated Claims and Executive Risk's Motion for Summary Judgment on this basis is Denied.

Neither is the Subscriber Managed Care Litigation an "Interrelated Wrongful Act". Although the plaintiffs in the Subscriber Managed Care Litigation were the same type of plaintiff, namely, participants in the healthcare plans offered by Cigna, the complaints alleged different transactions, the wrongful acts were not contemporaneous and there was no common scheme or plan.

---

[19] Southridge Capital Management, LLC v. Twin City Fire Insurance Company, 2006 Conn. Super. LEXIS 2754 (2006).

[20] Id.

[21] By Executive Risk's interpretation any challenge to a hospital's standard policies or procedures no matter how ill-founded could impair insurance coverage decades later.

The Subscriber Managed Care Litigation was filed by Bobby Pickney, an enrollee of a Cigna health plan administered by his employer who filed the action on his own behalf and on behalf of all others similarly situated. Pickney alleged that Cigna engaged in a fraudulent scheme designed to induce plaintiff to enroll in its plans and continue its membership by misrepresenting its commitment to improve healthcare, engaging in a policy of limiting medical services and claims, misrepresenting the independence of the physicians and developing a policy to limit the delivery of quality healthcare services.

The Pickney complaint did not identify any specific healthcare claim in which Cigna failed to provide healthcare but rather broadly alleged contract claims, RICO violations and breach of fiduciary duty claims under ERISA. These claims are not "Interrelated Wrongful Acts". Executive Risk's Motion for Summary Judgment as it pertains to the Subscriber Managed Care Litigation is denied.[22]

III. The Executive Risk Policy Excludes Cigna's Claim for the Managed Care Litigation.

The court must decide whether the Managed Care Litigation qualifies for coverage under the policy. According to the terms of the policy:

> If during the Policy Period, or the Extended Reporting Period, if applicable, any **Claim** is made against [Cigna] for Wrongful Acts in the performance of **Professional Services** by or on behalf of [Cigna] or by persons for whose **Wrongful Acts** the assured is legally responsible (including but not limited to employees acting within the scope of their employment and agents of [Cigna], Underwriters agree to pay on its behalf **Loss** resulting from such Claim. [23]

The term "Loss" is defined as follows:

---

[22] Since the claims in the Weiss action and the claims in the Managed Care Litigation are not "Interrelated Wrongful Acts", the Managed Care Litigation was clearly not a known loss. This aspect of Executive Risk's motion for summary judgment is also denied.

[23] Insuring Agreement V of the Primary Policy.

> "Loss" means damages, settlements, judgments, awards and defense costs incurred by any of the Assureds, but shall exclude (except as respects Defense Costs):
>
> (a) direct tax obligations of the Assured;
> (b) amounts for which there is no legal recourse against the Assureds;
> (c) matters deemed uninsurable by law;
> (d) criminal or civil fines or penalties imposed by law; or
> with respect to any of the matters under subsections (f) through (i) of the definition of Claim, the over-payment or monies back to the government except where loss consists partly of fines and penalties and partly of over-payment of monies, in which case Underwriters will pay 50% of such loss, including Defense Costs.[24]

Clearly, the managed care settlement is covered by the language of the policy. Executive Risk maintains that all of Cigna's payment obligations to physicians under the Settlement Agreement for medically necessary services rendered are excluded by the contract and benefits exclusion because this liability is exclusively for money owed based on direct contractual relationships with a physician or on Cigna's status as an insurer or health-plan administrator.

The "Contract and Benefits Due" exclusion provides:

> C. Exclusions
>
> In addition to the common exclusions applicable to all Insuring Agreements, Underwriters shall not be liable to pay any Loss under this Insuring Agreement in connection with any Loss under this Insuring Agreement made against the Assured:
>
> ***
>
> 4. for liability of the Assured under contract or agreement, except liability which would have attached to the Assured even in the absence of such contract or agreement;
>
> 7. for benefits, coverage or amounts due or allegedly due including any amount representing interest thereon, from the Assured as:

[24] Glossary of Terms par. 17 p. 43.

(c) an insurer or reinsurer, under any policy or contract or treaty of insurance, reinsurance, suretyship, annuity, or endowment, or
(d) an administrator under any employee welfare benefit plan;[25]

Cigna concedes that contract claims are not covered losses because of this exclusion. However, Cigna argues that the contract exclusion does not apply because C 4 is a limitation on the contract exclusion. Cigna claims that liability "would have attached to [Cigna] even in the absence of such contract or agreement" because the complaints allege claims for RICO.

Generally, "If the complaint against the insured avers facts that would support a recovery covered by the policy, then coverage is triggered and the insurer has a duty to defend until such time that the claim is confined to a recovery that the policy does not cover."[26] In this case however, the court does not have to theorize, litigate or surmise what claims were settled and paid because the Settlement Agreement is quite specific. To receive any of the "Claim Distribution Fund" proceeds a claimant must demonstrate a contract claim made by the claimant to Cigna acting as either an "insurer" or an "administrator".

A review of the Kaiser, Shane and Mangieri complaints reveals that the litigation focused on Cigna's contractual breaches in delaying, diminishing and denying legitimate claims for payment pursuant to (1) provider contracts with physicians; (2) capitation (or lump-sum) contracts with physicians; (3) third party administration contracts with employers; and (4) insurance contracts with Cigna members.

[25] Lloyd's policy p. 18-19 Exclusion C.

[26] General Accident Ins. Co. of America v. Allen, 547 Pa. 693, 706, 692 A.2d 1089, 1095 (1997).

The Kaiser litigation exclusively raised contractual liability under its physician PPO contract. The classes that were certified by the State Court in Madison County and by the Federal Court in the District of Illinois after the case was removed presented only contract claims. The State Court certified the following class:

> Physicians… who from May 26, 1990 to present, (1) executed a Preferred Provider Organization (PPO) fee for services agreement with Cigna; (2) submitted claims for covered services and/or supplies pursuant to said agreement; and (3) whose claims were audited by Cigna's ClaimCheck computer software program prior to any payment.[27]

After the Kaiser case was removed to Federal Court, the District of Illinois certified the following class:

> All physicians, physician groups, hospitals, facilities, ancillary providers, and other health care practitioners, entities or providers, who at any time from January 1, 1996 through the present:
>
> A. Provided health care services or supplies to participants in or beneficiaries of health plans (including Medicare HMO Plans) whose benefits were insured or administered by Cigna Health Care; and
>
> B. Submitted claims to Cigna HealthCare for such services or supplies on a fee-for-service basis either:
>
> 1. as a participating provider pursuant to a Managed Care Agreement or another contract; or
>
> 2. on the basis of an assignment of health plan benefits i.e. as a non-participating provider.

In the Shane complaint, the lead MDL Provider case, the action was based on Cigna's obligations to the providers under Cigna's contractual duties to the providers and third parties for whom Cigna administered benefits. The class certified by the MDL panel was defined as:

[27] Exhibit "68" Kaiser State Court Certification Order dated March 29, 2001 attached to Executive Risk's Motion for Summary Judgment.

> The Global Class: All doctors who provided services to any person insured by any Defendant from August 4, 1990 to September 30, 2002.
>
> National Subclass: Medical doctors who provided services to any person insured by a Defendant, when the doctors has a claim against such Defendant and is not bound to arbitrate the claim.[28]

The contract and benefits exclusion is clear and unambiguous. By its terms it excludes coverage for Cigna's liability arising from any contracts except that liability which would have attached in the absence of a contract with the Providers and Subscribers. It also excludes coverage for Cigna's liability arising from benefits, coverage or amounts due from Cigna as an insurer under any contract of insurance or administrator under any employee welfare benefit plan. This is exactly the claims which Cigna settled.

Providers seeking compensation under the Settlement Agreement are required to submit Proof of Claim forms with documentation that they were denied payment for professional services rendered by the providers. The documentation was to consist of the following:

> …A copy of the relevant Cigna HealthCare's Remittance Form showing that payment was denied by Cigna Healthcare for one or more Category One Codes under the circumstances and within the date of service limitations…shall constitute adequate documentation …Alternatively, …, a copy of the Class Member's HCFA 1500 form…or other claim form showing that Category One Codes were originally submitted to Cigna HealthCare for payment under the circumstances and within the date of service limitations.[29]

Category Two Compensation requires the submission of the following with each Proof of Claim:

---

[28] Exhibit 14 Volume II to Executive Risk's Motion for Summary Judgment p. 2.

[29] Id. at p. 91 section 8.(c)(i) Form of Application; Time for Submission; Documentation Required.

(a) documentation evidencing that, with respect to the underlying Fee for Service Claim concerned, (i) they were denied payment, in whole or in part; (ii) they received reduced payment, including payment for a different billing code than the one(s) billed, for one or more CPT ® codes(s) or HCPCS Level II Codes(s); or (iii) they received a reduced payment based upon the application of Multiple Procedure Logic; and (b) a complete copy of the Clinical Information generated in connection with the Class Members' services on the specific date of service concerned. A copy of the relevant Cigna HealthCare Remittance form showing that payment was denied on the CPT®Codes or HCPCS Level II Codes in question, in whole or in part, shall constitute adequate documentation for purposes of requirement (a) above unless the Settlement Administrator determines that the records are false or fraudulent. In the event that the Class Member cannot locate the Cigna HealthCare Remittance Form applicable to a given Fee for Service Claim, the Class Member may submit copies of internal accounting records (such as printouts of accounts receivable records or paid account records) provided those records show, as to the underlying Fee for Service Claim and specific date of service concerned, all CPT® Codes or HCPCS Level II Codes which were submitted to Cigna HealthCare for payment on the Fee for Service Claim in question, then the Class Member may supplement the internal accounting records with additional documentation for that Fee for Service Claim, such as the HCFA 1500 form (now known as CMS 1500). [30]

Documentation is also required when filing a Proof of Claim for Medical Necessity Denial Compensation[31].

A single Proof of Claim may be used to seek multiple requests for Medical Necessity Denial Compensation under this Agreement provided adequate documentation concerning each of the affected Fee for Service Claims is included. Physician Groups and Physician Organizations may submit Proof of Claims on behalf of Physicians employed by or otherwise working with them at the time that the claims are made…provided however the Class Member who or which submits the Proof of Claim Form must be the Physician …who or which originally submitted the

[30] Section 8.3 (d) (ii) Documentation Required, p. 100.

[31] Medical Necessity Denial arises when a physician designated by Cigna, nurse or other health care professional acting for a medical director approves or denies a health care service or supply as being Medically Necessary makes. Exhibit "26" Settlement Agreement p. 49. Providers were permitted to submit Proofs of claims to have the decisions reevaluated.

> claim and must use the same tax identification number as was used on the original claim when submitting the Proof of Claim….[32]
>
> (b) Class Members filing Proofs of Claims for Medical Necessity Denial Compensation shall include with their Proof of Claim Forms: (a) documentation evidencing that they submitted Fee for Service Claims for payment to Cigna Healthcare for services or supplies provided to Cigna HealthCare Member, and were thereafter denied payment for one or more CPT®codes or HCPCS Level II Codes due to Cigna HealthCare's determination that the medical services, procedures or supplies correspond to such codes were either not Medically Necessary or were experimental or investigational; and (b) a complete copy of the Clinical Information generated in connection with the Class Member's services.[33]

Under the settlement agreement, Providers, Subscribers or Companies for whom Cigna administered benefits could receive settlement funds only if they demonstrated that they had not received all monies due them under their contractual arrangements with Cigna. The settlement only paid for claims in the Managed Care Litigation for breach of contract or claims associated with administering a health plan.

Although, the Shane complaint and later the Kaiser complaint as amended on November 22, 2002, alleged claims for RICO, all payments in settlement were the direct result of Cigna's breaches of its provider contracts with physicians, capitation contracts with physicians, third party administration contracts with employees on insurance contracts with Cigna members. Cigna's claim for the managed care litigation settlement is excluded from coverage under the contracts and benefits exclusion under the policy.

[32] Id. at p. 114.

[33] Id. p. 114-115.

IV. Cigna is not entitled to recover attorney fees and defense costs associated with the Managed Care Litigation.

Cigna seeks coverage for $55 million in attorneys' fees paid in the Settlement of the Managed Care Litigation and $39 million in defense costs which it incurred in the litigation. Cigna argues that the attorney fees and the defense costs are covered claims since they arise from the RICO claims and therefore constitute a loss under the policy. RICO claims and the defense costs related thereto are covered under the policy, however the claims seeking injunctive relief are not a covered claim under the policy.

Under Pennsylvania Rule of Civil Procedure 1035.2, the party responding to a summary judgment motion has a significant burden. If the record on which the motion is submitted does not contain sufficient evidence of facts essential to the non-moving party's cause of action or defense, the non-moving party must produce evidence by way of affidavit, admissions, answers to interrogatories or depositions. Here, absent from the record is any evidence explaining how the attorney fee and defense costs were incurred. No duty to defend existed in the Kaiser action until the complaint was amended to include the RICO claim three days before settlement. Obviously, any attorney fee or defense costs incurred prior to that amendment cannot constitute a covered claim. The Kaiser litigation was actively litigated for over two years. The Mangieri litigation was merged into the Shane litigation. No evidence has been presented detailing the legal activity beyond the pleadings in Shane. Were the court to presume that one third of the legal fees were incurred due to the Kaiser litigation three days before settlement, then the total legal fees and cost including defense costs would be $31.1 million and the total

claim recoverable would not exceed $62.7 million.[34] As previously stated unless the covered claims against Executive Risk exceeds $65 million no indemnification is owing.

Without any supporting evidence, speculation and conjecture about how much attorney fees and costs is attributable to non-covered claims in Kaiser cannot withstand summary judgment. Accordingly, Executive Risk's motion for summary judgment is granted.

CONCLUSION

Plaintiff Executive Risk Indemnity Inc.'s Motion for Summary Judgment is granted and judgment is entered in Executive Risk Indemnity Inc.'s favor and against Cigna Corporation. Defendant Cigna's Motion for Summary Judgment is Denied.

BY THE COURT,

_____

MARK I. BERNSTEIN, J.

[34] Of course if the attorney fee and costs in Kaiser were 50% of all, the total potential claim would be not more than $47,000,000. The court has no basis to make any reasoned judgment.