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

AMERISOURCEBERGEN CORP., et al,	:	
	:	**MARCH TERM, 2011**
Plaintiffs,	:	**No. 02679**
	:	
v.	:	
	:	
ACE AMERICAN INSURANCE COMP.,	:	
	:	**Control No.'s 12101128, 12125052**
	:	
Defendant.	:	

OPINION

By: Honorable Albert John Snite, Jr.

This is a professional liability insurance coverage dispute seeking "Claims Expenses," in excess of $17,600,000.00. Before the court are Plaintiffs' Partial Motion for Summary Judgment and Defendant's Motion for Summary Judgment.

PROCEDURAL HISTORY

AmerisourceBergen (hereinafter "Amerisource") filed its complaint against ACE American Insurance Company (hereinafter "Ace") on April 5, 2011, for breach of a professional liability insurance contract, as well as allegations that Ace acted in Bad Faith in violation of Pennsylvania's Insurance Bad Faith Statute, 42 Pa. C. S. §8371.

Ace filed a Motion for Judgment on the Pleadings on August 17, 2011.[1] Amerisource filed an Answer in Opposition thereto on September 26, 2011. Ace filed a Reply in Support on October 3, 2011.

On November 16, 2011, Judge Bernstein issued an Order and Opinion denying the Motion for Judgment on the Pleadings.

On October 12, 2012, Ace filed a Motion for Summary Judgment.[2]

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[1] Control no. 11082292.
[2] Control no. 12101128.

Amerisourcebergen Corporation Etal Vs Ace Am-OPFLD

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On December 7, 2012, Amerisource filed a Motion for Partial Summary Judgment.[3] On January 14, 2013, Ace filed its response in opposition to Amerisource's Motion for Partial Summary and Reply in Support of its Motion for Summary Judgment, as directed by this court's briefing schedule.

Oral argument was held on March 28, 2013.

On April 9, 2013, I denied both motions for summary judgment.

On May 7, 2013, Ace filed a Motion for Reconsideration of this court's April 9, 2013 Order, and alternatively sought amendment to the court's Order to certify it for interlocutory appeal. On May 23, 2013, Amerisource filed its Answer to Motion for Reconsideration.

On June 6, 2013, I granted the Motion for Reconsideration, and vacated the portion of the April 9, 2013 Order denying all motions for summary judgment.

FACTUAL HISTORY

Amerisource services healthcare providers and pharmaceutical manufacturers in the pharmaceutical supply chain by providing drug distribution services and clinical education, marketing, and business resources.[4] Amerisource provides purchase and distribution information and business support and consulting services to its customers, as well as reimbursement services to its customers.

Ace initially provided Amerisource its secondary "Excess Liability Insurance Policy" for the policy period of May 1, 2006 to May 1, 2007, under No. XEO G21684107 001 (the "2006 Policy"). During this period, St. Paul-Travelers Insurance Company provided Amerisource's primary "enterprise-wide" policy. The parties disagree whether the policy issued by Ace after the 2006 Policy period was a renewal or replacement, as discussed further *infra*.

For the policy period of May 1, 2007 to May 1, 2008, Ace issued the "Digital Technology & Professional Liability Insurance Policy," under No. EON G21683498 001 (the "2007 Policy"), which was its first "primary" coverage policy. The "Digital Technology & Professional Liability Insurance Policy," No. EON G21683498 002, issued by Ace to

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[3] Control no. 12125052.

[4] Amer. Mot. Summ. J. ¶ 12.

Additional Citations are as follows: "Amer. Resp. ¶ __" refers to Amerisource's Response to ACE's Motion for Partial Summary Judgment, Plaintiffs' Motion for Partial Summary Judgment; "ACE Resp. ¶ __" refers to Ace's Response to Plaintiffs' Motion for Partial Summary Judgment.

Amerisource for the policy period of May 1, 2008 to May 1, 2009 (the "2008 Policy"), is a renewal or replacement of the 2007 Policy. The "Digital Technology & Professional Liability Insurance Policy," under No. EON G21683498 003, issued by Ace to Amerisource for the policy period of May 1, 2009 to May 1, 2010 (the "2009 Policy") is a renewal or replacement of the 2008 Policy.[5]

Amerisource currently seeks coverage for legal defense costs it incurred in a Relator Action (the "Relator Action/Massachusetts Litigation"), filed as a *qui tam* action in Massachusetts,[6] alleging violations of the federal False Claims Act and various related state laws.[7] The Relator Action, filed under seal, was provided to the United States government on June 13, 2006.

The Massachusetts Plaintiffs allege that Amerisource defendants (Plaintiffs here) conspired with Amgen to falsely inflate the average sales price ("ASP") of the injectable prescription drug Aranesp, which systematically caused the submission of false Medicare claims.[8] The "scheme" was fostered by providing healthcare providers kickbacks, in violation of

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[5] As I have concluded, *infra*, "primary" coverage by Ace started in May 2007, and was renewed on an annual basis thereafter for all times relevant to this case.

[6] The False Claims Act contains a *qui tam* provision wherein private citizens ("relators") may file actions on behalf of the federal government. 31 U.S.C.A. §§ 3729-3733. When a relator files a *qui tam* action, it must provide the government with a sealed complaint, after which the government has sixty days to review the allegations and decide whether or not to intervene and proceed with litigation. 31 U.S.C.A § 3730(b)(2). Additionally, "[t]he defendant shall not be required to respond to any complaint filed under this section until 20 days after the complaint is unsealed and served upon the defendant pursuant to Rule 4 of the Federal Rules of Civil Procedure." Id. at (b)(3).

[7] Filed in United States of America ex rel. Kassie Westmoreland, et al. v. Amgen, Inc. et al., No. 06-10972-WGY in the United States District Court for the District of Massachusetts. See U.S. ex rel. Westmoreland v. Amgen, Inc., 812 F. Supp. 2d 39 (D. Mass. 2011).

[8] Westmoreland, 812 F.Supp.2d at 42-43. According to the Massachusetts Complaint, Aranesp is an injectable prescription drug developed and manufactured by Amgen, which was marketed by all Amerisource defendants. Aranesp is approved by the FDA to treat anemia in certain patients. Mass. Fourth Am. Comp. ¶ 3. Aranesp is distributed by Amgen in single dose vials and single dose pre-filled syringes containing liquid with a predetermined concentration of the drug. Id. ¶ 12. Amgen distributes the drug in vials or syringes that contain different amounts of the drug. Id. ¶ 114. Although single-dose vials of Aranesp contemplate that a 1.0 ml injection will be administered to the patient, the actual volume of liquid solution in the vial *exceeds* 1.0 ml, and this excess is known as "overfill." Id. ¶ 116. Aranesp overfill has value because Aranesp purchasers are charged for the drug based on the *labeled* concentration and dosage. Overfill is not reflected on the label and purchasers are *not* charged for the overfill that they receive-- *i.e.*, they do not pay for the extra micrograms of drug that are present in the overfill. Id. ¶ 140. Under the alleged unlawful marketing scheme, Aranesp vials contained more overfill than was required to provide the labeled dose and "hold up volume" ("HUV"), so defendants were able to induce medical providers to submit claims to Government Health Care Programs for the free Aranesp overfill. Id. ¶145. During the time the Relator was employed by Amgen, she learned that Amgen Professional Sales

the Medicare and Medicaid Patient Protection Act, as amended by 42 U.S.C. §§ 1320a-76(b).[9] The Massachusetts Complaint alleges that defendants conspired to encourage medical providers to purchase Aransep based on representations of the profits that the providers could realize from submissions of inflated Aranesp-related claims to Medicare.[10] Insofar as the providers falsely certified to the Government that they received no kickbacks, their Medicare billings were false claims under the False Claims Act.[11]

Although disputed to some extent, sometime in December 2008 to February 2009, Amerisource may have acquired certain pieces of information through possible "back channel" sources that a *qui tam* action was pending.[12]

On February 11, 2009, Amerisource obtained a redacted version of the (unserved) First Amended Complaint through download from PACER. On that same day, Amerisource received another copy of the redacted version of the sealed First Amended Complaint from counsel for Amgen.[13]

Amerisource disclosed the Massachusetts litigation to Ace, by letter dated July 8, 2009. In the July 8, 2009 letter, Amerisource stated that the complaint was "sealed" and asserted there was not yet a "claim" under the Policy (thus it presented its notice as "provisional").[14] Ace acknowledged the notice, by letter of July 22, 2009, which reserved all rights.[15] Ace again reserved "all rights and defenses" on August 13, 2009, by letter, and provisionally acknowledged the view that the matter did not yet appear to be a "claim."[16] Ace's August 13, 2009 letter requested that Amerisource provide a full summary of the facts and circumstances and other related documents and information to help Ace evaluate the matter.[17]

Representatives (PSR's) would advocate to customers the increased profits that could be made if the customers were to seek reimbursement for the "overfill micrograms" of Aranesp in the single-does vials that they had purchased. Id. ¶ 164.

[9] Ace Mot. Summ. J. ¶ 79-92.

[10] Mass. Fourth Am. Comp. ¶ 12.

[11] Westmoreland, 812 F.Supp. 2d at 55-56,60.

[12] In my final analysis this is not important, because I have found no "claim" was ever made before the Policy period.

[13] Amer. Resp. ¶ 20. Apparently, a redacted version of the sealed and unserved First Amended Complaint was made available on PACER due to action by the U.S. attorney.

[14] Ace Mot. Summ. J. ¶ 60-61.

[15] Id. ¶ 62.

[16] Id. ¶ 63.

[17] Id. ¶65.

On October 30, 2009, Amerisource's Vice President of Risk Management, Walter J. Hope, contacted Ace's lead claim handler, Michael Fried, Esquire, and informed him that the Relator's Second Amended Complaint "has been unsealed and unredacted but not yet served."[18] On November 3, 2009, Mr. Hope followed up and provided additional information to Mr. Fried regarding the Relator Action. Mr. Hope immediately provided copies of the unredacted, unsealed, and unserved complaints in the Massachusetts Litigation once those complaints were made available on PACER (Public Access to Court Electronic Records).[19]

The Relator filed her Third Amended Complaint on December 17, 2009,[20] with which service was effected upon Amerisource by its filing a waiver of service form on January 5, 2010.[21]

On January 14, 2010, Marsh USA (a risk management firm), on behalf Amerisource, sent Ace a Notice of Claim.[22] Ace responded that and advised that it would evaluate coverage, and in the following weeks, the parties repeatedly conferred regarding the insurance claim.[23]

On April 5, 2010, Ace phoned Amerisource to personally advise that Ace had concluded the claim was not covered, and sent a denial letter dated April 5, 2010.

Amerisource filed its current complaint on April 5, 2011, for breach of the professional liability insurance contract. Both parties filed motions for summary judgment in October and December 2012.

Ace asserts that four provisions of the Policy independently warrant judgment. The first provision requires that the "Claim" be first made within the policy period. Ace also relies on three policy exclusions—L, Q, and Y— to independently preclude coverage.

First, Policy Exclusion L ("Prior or Pending Litigation"), provides exclusion of any Claim:

> L. alleging, based upon, arising out of, or attributable to:
> 1. <u>any prior or pending litigation,</u>[24] **Claims,** demands, arbitration, administrative or regulatory proceeding or investigation filed or

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[18] Amer. Resp. ¶ 66.
[19] <u>Id.</u>
[20] It is contested by Ace that the Third Amended Complaint was <u>served</u> upon Amerisource on this date. Amerisource asserts that it was served on that date though the waiver of service. Amer. ¶1.
[21] Amer. Resp. to Mot. for Reconsideration Memo. p. 7.
[22] Ace Mot. Summ. J. ¶ 69. This letter is a "First Report of a Professional Liability Loss." Exh. 64, Ace Mot. Summ. J.
[23] <u>Id.</u> ¶ 70.
[24] Underline emphasis added.

> commenced on or before the earlier of the effective date of this **Policy** or the effective date of any policy issued by the **Insurer** of which this **Policy** is a continuous renewal or a replacement, or alleging or derived from the same or substantially the same fact, circumstance or situation underlying or alleged therein;

Second, Policy Exclusion Y ("False, Deceptive or Unfair Business Practices"), provides, in relevant part, exclusion for any Claim:

> Y. alleging, based upon, arising out of or attributable to any false, deceptive or unfair business practices or any violation of consumer protection laws.

Third, Policy Exclusion Q ("Inaccurate Description of the Price of Goods"), provides exclusion for any Claim:

> Q: alleging, based upon, arising out of or attributable to the inaccurate, inadequate, or incomplete description of the price of the goods, products, the disclosure of fees, the failure to meet deadlines, or as a result of the **Insured's** cost guarantees, cost representations, contract prices, pricing guarantees or estimates of probable costs or cost estimates being exceeded, or any guarantee or promise of costs savings, return on Investment, or profitability.

In granting Ace's Motion for Reconsideration of the April 9, 2013 Order that denied all summary judgment motions, I re-reviewed both motions to re-determine what facts are without controversy and the resulting rulings of law.

I am granting summary judgment in favor of Ace, finding that there are no disputed genuine issues of material fact, and judgment is warranted in favor under Exclusions L and part of Y.

DISCUSSION

Summary judgment should be granted "if the pleadings, depositions, answers to interrogatories and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law."[25]

It is well established that the interpretation of an insurance policy is a question of law. The primary goal in interpreting a policy is to ascertain the parties' intentions as manifested by the policy's terms. Where an insurer relies on an exclusion as the basis for its denial of coverage

[25] Pa. R. C. P. 1035(b).

and refusal to defend, the insurer has asserted an affirmative defense and, accordingly, bears the burden of proving such defense.[26]

The Policy here is a "claims made" policy. In order for an exclusion to apply, a "Claim" must be made during the Policy period.

a. **The applicable Policy period began on May 1, 2007.**

Whether one policy has renewed another is an issue courts determine as a matter of law by examining contracts.[27] Ace's 2006 excess policy bears a different prefix (i.e. "XEO") than the 2007-2009 policies (i.e. "EON"), and the 2006 policy uses the suffix "001". The 2007 through 2009 policies, alternatively, bear the suffix "001," "002," and "003," respectively.

The 2006 excess Policy only applied to a claim in excess of $21 million, and was secondary to the St. Paul-Travelers' primary policy. The 2007 Policy was then the primary Policy that used, for the first time, the 38-page Digitech Policy.

The 2007 policy application is a long-form, initial application, evidenced by its questions regarding which coverages Amerisource is "applying" for.[28] The 2008 and the 2009 applications, but not the 2007 application, state that they are "renewal" applications and omit any question regarding the coverages for which Amerisource is applying.

As such, it is clear that the 2007 Policy is not a renewal of the 2006 Policy, and the applicable start date for the Policy period is May 1, 2007.

b. **A "Claim" was not made until service was effected upon Amerisource, which was within the Policy period.**

A claim must be made during, and not prior to, the policy period, which began on May 1, 2007. "Claim" is defined under the policy as:

> E. **Claim** means:
> 1. with respect to Insuring Agreements A, B, C, D, and G:
> a. a written demand against any **Insured** for monetary or non-monetary damages;
> b. a civil proceeding against any **Insured** seeking monetary damages or non-monetary or injunctive relief, commenced by the service of a complaint or similar pleading; or
> c. an arbitration proceeding against any **Insured** seeking monetary damages or non-monetary or injunctive relief;

[26] Madison Const. Co. v. Harleysville Mut. Ins. Co., 735 A.2d 100, 106 (Pa. 1999) (citations omitted).
[27] The parties fail to materially distinguish between replacement and renewal. My analysis concerns excess and primary coverage.
[28] ACE Resp. ¶ 111.

2. also, with respect to Insuring Agreements C and D only, a **Regulator Proceeding;**
3. with respect to Insuring Agreement E, a written report by the **Insured** to the **Insurer** of a failure by the **Insured** or by an independent contractor, for which the **Insured** is legally responsible to properly handle, manage, store, destroy or otherwise control **Personal Information.**
4. with respect to Insuring Agreement F, a **Network Extortion Threat;**

Under the definition of "Claim," there must be either (1) a monetary written demand, (2) a civil proceeding commenced by service of a complaint, or (3) an arbitration proceeding. Number three (II.E.1.c), an arbitration proceeding, is not currently at issue to preclude coverage.

i. **A written demand seeking monetary or non-monetary damages is <u>not</u> synonymous with filing a complaint.**

Ace argues that Section II.E.1.a, a written demand under the definition of "claim," applies to preclude coverage. Ace argues that a "written demand for monetary damages" occurred upon the filing of the complaint in June 2006, wherein Amerisource is named as a defendant. As such, this would be a "claim" before the start of Ace's first period of primacy coverage in May 2007.

There are two problems with this argument. First, I would hesitate to equate a sealed complaint with a "written demand." The earliest such a complaint could be a considered a "written demand for money damages" would be upon its unsealing. In this case that would be on February 11, 2009, the date the First Amended Complaint was viewable on PACER. This would be clearly within the May 2008 primary coverage period.

Secondly, and more importantly, in reviewing the policy it is clear that Section II.E.1.<u>b</u> (a civil proceeding) applies, as this case involves a complaint in a civil proceeding, and not Section II.E.1.<u>a</u> (a written demand). Ace's argument that II.E.1.a applies is inconsistent with Pennsylvania rules of contract interpretation, where a specific term, such as "civil proceeding" takes precedence over a general term, such as a "written demand."

Ace's interpretation would render section II.E.1.b completely meaningless in this instance. While the First Amended Complaint contains language of "claim" and making "demand," this is so clearly a "civil proceeding" and not a "written demand" under the terms of the Policy.

Although Amerisource had been provided a copy of the redacted First Amended Complaint prior to May 1, 2009, this does not qualify as a written demand under the Policy as to signal exclusion.

ii. **A civil proceeding against Amerisource was commenced by service during the policy period.**

Clearly and unambiguously, under Section II.E.1.b, a civil proceeding is commenced by the service of a complaint.

On December 17, 2009, the Relator and Intervening Plaintiff filed the Third Amended Complaint, and Amerisource asserts it was served with original process pursuant to the Federal Rules of Civil Procedure.[29]

On January 5, 2010, waiver of service forms were filed in the Relator Action by Amerisource. Under the Federal Rules of Civil Procedure, when the plaintiff files a waiver, proof of service is not required and these rules apply as if a summons and complaint had been served at the time of filing the waiver. [30]

Therefore, a "claim" was made, by either interpretation of "service," within the policy period that began May 1, 2009 (as a renewal of the 2007 Policy) – either by Amerisource being formally listed and served in the Third Amended Complaint in December 2009, or by the waiver service forms in January 2010.

As such, I am finding as a matter of law, that Ace's contention in its Motion that a "claim" was made prior to the Policy is incorrect, and that a claim was made within the policy period.

Under the Policy, first a "claim" must be made during the policy period, and then one turns to any exclusions.

c. **Exclusion L (Prior or Pending Litigation) precludes coverage, as there was prior or pending litigation at the time the claim was made.**

Exclusion L precludes coverage under a variety of situations. Namely, claims alleging, based upon, arising out of, or attributable to: (1) any prior or pending litigation, (2) claims, (3) demands, (4) arbitration, (5) administrative or regulatory proceeding or investigation, filed or commenced on or before the earlier date of the effective date of the Policy, or the effective date

[29] Amer. ¶ 66. Ace contests this, continuing to argue that litigation commenced in June 2006, without explaining why the service requirement should be ignored.
[30] Fed. R. Civ. P.4(d)(4) (emphasis added).

of any policy issued by the Ace of which the Policy is a continuous renewal or a replacement, or alleging or derived from the same or substantially the same fact, circumstance or situation underlying or alleged therein.

i. **The 2007 policy is not a renewal or replacement of the 2006 policy, and the operative date for Exclusion L is May 1, 2007.**

As discussed *supra*, the effective date for Exclusion L is May 1, 2007, and thus a "claim" was made during (and not on or before) the date of the Policy.

ii. **However, there was prior or pending litigation.**

As to the first part of Exclusion L, excluding a claim "alleging, based upon, arising out of, or attributable to any prior or pending litigation," there was in fact prior or pending litigation in the Massachusetts *qui tam* litigation, filed on June 5, 2006. As discussed above, May 1, 2007 is the operative date for Exclusion L.

Ace argues properly that the law entitles it to summary judgment based on this exclusion. "Prior or pending litigation" is not defined within the policy – as opposed to "Claims" that is specifically defined – and as such, the provision is subject to interpretation by this court.

The Massachusetts Litigation commenced by filing on June 5, 2006, alleging that all Amerisource Defendants were liable for violations of the False Claims Act. Indeed, litigation was pending upon the filing of the complaint. False Claims Act litigation is commenced by a relator's filing of the action on behalf of the government.[31]

Litigation can commence by the filing of a unserved *qui tam* complaint before any service of the complaint, within the meaning of Exclusion L. This is demonstrated by the fact that "prior or pending litigation" is wholly separate, separated by a comma to denote distinction, from "Claims," "demands," "arbitration," or "administrative or regulatory proceeding or investigation." Each of these provides distinct situations within Exclusion L.

"Claims" is specifically defined within the Policy; "litigation" is not. The "Claim" definition, as discussed above, provides three situations: a written monetary demand, a civil proceeding commenced by service, or an arbitration proceeding. Because "claim" is defined to include "a civil proceeding," and prior or pending litigation is enumerated separately under Exclusion L, it is clear that these are two distinct situations under Exclusion L.

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[31] See U.S. ex. Rel. Repko v. Gurthrie Clinic, 557 F. Supp. 2d 522, 524 (M.D. Pa. 2008).

I am finding that the "prior or pending" exclusion applies to prior or pending litigation even if not served on the insured, including a *qui tam* False Claims lawsuit that has not been disclosed to the Insured.[32] The Eleventh Circuit likewise rejected an insured's argument that because it had not been served with any pleadings in the *qui tam* action that it was not a "pending proceeding."[33]

Exclusion L is plainly triggered by the commencement of the Massachusetts Litigation in June 2006, when the complaint was filed, docketed, and given a case number, despite service not having occurred at that point. "Prior or pending litigation" under the Policy does not require service, instead, a "Claim" made with respect to a civil proceeding does require service.

Amerisource argues that "litigation" cannot commence without service being made. The cases cited for this proposition are distinct, as support for attaining personal jurisdiction over the defendant.[34] Here, however, litigation, for purposes of the policy exclusion, can commence without service, as a "Claim" was not yet made, and there is no dispute to assertion of jurisdiction over Amerisource at the time of the filing of the 2006 complaint.

Simply stated, with respect to the facts of this case, a "claim" is either a written demand, or a filed and served civil proceeding. Pending litigation is a civil pleading that has been docketed, but not necessarily served.

The policy does not cover losses wherein no written demand has been made and civil litigation has been docketed but not yet served. This occasional, but by no means extraordinary situation must be foreseen by insureds, especially those who are changing carriers.[35]

d. **Exclusion Y (False, Deceptive or Unfair Business Practices) also applies to preclude coverage.**

Exclusion Y precludes claims arising from or alleging "false deceptive or unfair business practices or any violation of consumer protection laws" (emphasis added). Pennsylvania courts

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[32] See HR Acquisition I Corp. v. Twin City Fire Ins. Co., 547 F.3d 1309, 1317 (11th Cir. 2008) (finding that a lawsuit, for purposes of a "prior litigation" exclusion, is "pending" when it names the insured and is properly filed, docketed, and given a case number).

[33] Id.

[34] See e.g., Omni Capital Int'l., Ltd. v. Rudolf Wolff & Co., Ltd. 484 US 97, 104 (1987).

[35] For example, there could be a "pending but unserved proceeding" exception to the "pending litigation" exclusion. These foreseeable circumstances must be specifically bargained for when an insured changes primary carriers.

look to the language of the insurance policy themselves to compare with the underlying allegations in the complaint, to determine an insurer's duty.[36]

This exclusion precludes coverage for the Massachusetts Litigation that was brought under the False Claims Act, which operates to penalize false or deceptive practices that cause Medicare fraud.

The Massachusetts Litigation against Amerisource concerns Medicare reimbursement for the drug "Aranesp," manufactured by Amgen, Inc., a pharmaceutical company. The Massachusetts Litigation alleges that all Amerisource defendants conspired to get false claims paid by Medicare by encouraging providers to submit claims for payment by Medicare for the value of excess product, or "overfill," contained in the vials of Aranesp, but not included in Aransep's average sales price ("ASP").[37] This scheme allegedly provided healthcare providers kickbacks, in violation of the Medicare and Medicaid Patient Protection Act, as amended by 42 U.S.C. §§ 1320-a-76(b). The complaint states that as providers falsely certified to the Government that they received no kickbacks, the Medicare billings were false claims under the False Claims Act and Anti-Kickback Statute.[38]

Each count in the Massachusetts Litigation alleges that Amerisource is liable under the False Claims Act, on the premise of false or deceptive practices resulting in Medicare Fraud. The allegations in the Massachusetts Litigation describe the false, deceptive and unfair practices in which it is alleged that Amerisource engaged. Specifically, "Defendants have conspired with each other, with providers and others to defraud both governmental (federal and state) and private health insurance programs by encouraging Aranesp purchasers to seek reimbursement for the additional micrograms of Aransesp contained in the overfill. . . ."[39]

As such, the underlying allegations plainly describe false, deceptive and unfair business practices. Exclusion Y, which applies to any claim alleging "false, deceptive or unfair business practices" precludes Amerisource's insurance claim. By including excess overfill in its sales and counseling its clients how to overbill, Amerisource's business practice was false and deceptive.

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[36] Kvaerner Metals Div. of Kvaerner U.S., Inc. v. Commercial Union Ins. Co., 589 Pa. 317, 331, 908 A.2d 888, 896-97 (2006).
[37] Westmoreland, 812 F. Supp. 2d at 42-43.
[38] Id. at 55-56.
[39] Mass. Fourth Am. Comp. ¶ 158; see also Westmoreland, 812 F. Supp. 2d at 50-54.

In addition to excluding "false, deceptive or unfair business practices," Exclusion Y separately – as denoted by "or" – may also bar any Claim alleging any "violation of any consumer protection law."

The Massachusetts Litigation alleges violations of the Medicare and Medicaid Patient Protection Act.[40] However, this cannot be recognized as a "consumer protection law." The False Claims Act violations alleged in the Massachusetts Litigation are in connection with violations of the Medicare and Medicaid Patient Protection Act of 1987, as amended by 42 U.S.C. §§ 1320a-7b(b). The provided authority has not shown that the purpose of the Act, which is to protect the government from fraud, is a "consumer" protection law.

"Consumer" is specifically defined under the Consumer Protection Law of the Pennsylvania Unfair Trade Practices and Consumer Protection Act, as one who may bring an action: "Any person who purchases or leases goods or services primarily for personal, family or household purposes and thereby suffers any ascertainable loss of money or property, real or personal, as a result of the use or employment by any person of a method, act or practice declared unlawful . . ."[41] The government cannot be considered a consumer here.

Ace's cited authority has not sufficiently demonstrated that a "patient" is necessarily the same as a "consumer," under any definition.[42] The Medicare and Medicaid Patient Protection Act, also known as the Anti-Kickback Statute, was amended in 1977, and in doing so, Congress noted that the purpose and background of the bill of the Anti-Kickback Statute was to combat fraud and abuse in medical settings:

> In whatever form it is found, however, fraud in these health care financing programs adversely impacts on all Americans. It cheats taxpayers who must ultimately bear the financial burden of misuse of funds in any government-sponsored program. It diverts from those most in need, the nation's elderly and poor, scarce program dollars that were intended to provide vitally needed quality health services.[43]

[40] See, e.g., Mass. Fourth Am. Comp. ¶ 10.
[41] 73 Pa. Stat. Ann. § 201-9.2 (emphasis added).
[42] Amerisource provided Aranesp to prescribing physicians, not patients.
[43] H.R. REP. 95-393, H.R. REP. 95-393, 44, 1977 U.S.C.C.A.N. 3039, 3047.

When the statute was further amended in 1987, it was noted: "With this legislation, the Secretary of Health and Human Services will have clear authority to protect patients from incompetent providers."[44]

Ace cites Baglio v. Baska,[45] to support its proposition that the Medicare and Medicaid Patient Protection Act was enacted to ensure patients (being individual healthcare consumers) are protected from inadequate and inappropriate medical products and services. However, the court is not convinced that Baglio applies to the situation at hand, as Baglio additionally states: "Medicare and Medicaid fraud is perpetrated upon the United States government. . . . In other words, violations cause harm to the federally-funded programs and to those who use such programs. Dr. Baglio, as a physician and laboratory director, could not have been harmed even if such fraud had occurred."[46] Although this court agrees that the Anti-Kickback Statute was enacted to address fraud and abuse within the Medicare and Medicaid systems, and to protect patients' best medical interests, is not clear under the statute and case law that patient necessarily means consumer, under federal or Pennsylvania consumer protection laws.

Ace additionally cites a law review article, suggesting that the "Medicare Anti-Kickback Statute and Stark Amendments, serve both consumers and patients."[47] This uncited proposition, however, is discounted earlier in the article itself in its specific distinguishing of consumers and patients, as well as how their concerns differ, specifically in managed care contracts.

Again, the court finds this unconvincing as support for Ace's insistence that patient means consumer, specifically for purposes of a consumer protection law; especially when the principal support for such a proposition is congressional oratory, as opposed to the exact issues addressed in the legislation. The legislation does not protect patients as consumers, *per se*; only indirectly as general beneficiaries of any governmental program.

i. **The Massachusetts Litigation alleges that all defendants "conspired" to commit such fraud.**

Amerisource takes the position that even if this exclusion *could* apply, the allegations in the Massachusetts Litigation do not apply as against Amerisource, but only against third-parties

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[44] 133 Cong. Rec. H6809-01, p. 18 (daily ed. July 30, 1987) 1987 WL 943548.
[45] 940 F. Supp. 819, 834 (W.D. Pa. 1996).
[46] Id. at 834.
[47] Wendy K. Mariner, *Standards of Care and Standard Form Contracts: Distinguishing Patient Rights and Consumer Rights in Managed Care*, 15 JCHLP 1 * 16 (1998).

not involved in this litigation. This argument plainly ignores the language in the complaint that all defendants conspired to do such actions.

e. **Exclusion Q (Inaccurate Description of the Price of Goods) does not apply, as already determined by the Massachusetts District Court.**

Exclusion Q excludes claims "alleging, based upon, arising out of or attributable to the inaccurate, inadequate description of the price of goods, products or services . . . ." The Massachusetts Litigation alleges that Amerisource conspired to inflate the average sales price of Aranesp:

> Defendants have conspired with each other, and with providers and others to defraud both governmental (federal and state) and private health insurance programs by encouraging Aranesp purchasers to seek reimbursement for the additional micrograms of Aranesp contained in the overfill. This overbilling is improper for a number of reasons, including . . . [48]

A further allegation is, "Defendants [including Amerisource] knew that the asserted value of the Aranesp overfill was material to the amount that medical providers paid for Aranesp and would affect the sales price data of Aranesp."[49]

In an order dated August 25, 2011, the District Court of Massachusetts granted Amgen's Motion for Partial Summary Judgment as to Count IV of the Fourth Amended Complaint insofar as it alleged that Amgen artificially inflated the Average Sales Price of Aranesp.[50] The District Court then issued an opinion to explain its ruling. In its opinion, the District Court explained:

> Because the ASP [average sales price] calculation does not include overfill and because Amgen followed this methodology in calculating Aransep's ASP, the Court need not address the Relator's additional arguments that Amgen had a legal duty to report its assumption that overfill was not included in the ASP calculation and that Amgen failed to meet this duty. Even if Amgen failed to comply with a reporting obligation, such failure could not have resulted in an artificially inflated ASP because [Centers for Medicare and Medicaid Services] CMS has confirmed the validity of the "assumption" that overfill is not a factor in the ASP calculation. . . . The Relator again mistakenly conflates the fraud Amgen allegedly committed in urging providers to seek reimbursement for free overfill with an alleged, but unproven, impropriety in its ASP.[51]

In granting Amgen's motion for partial summary judgment, the Massachusetts District Court effectively ruled that because Amgen did not include overfill in calculating its drug's ASP,

[48] Mass. Fourth Am. Comp. ¶ 158.
[49] Id. ¶ 354.
[50] Westmoreland, 812 F. Supp. 2d at 45.
[51] Id. at 71-72 (emphasis added).

it correctly calculated ASP in seeking Medicare reimbursement for the drug.[52] Exclusion Y cannot bar coverage as the allegations do not contain "inaccurate description of the price of goods [or] products."

f. **Amerisource's claim for Bad Faith under 42 Pa. C. S. 8371 fails, as it has been judicially determined that Ace correctly denied coverage.**

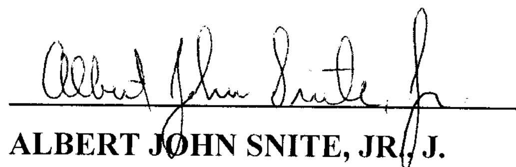
Amerisource also asserted a statutory bad faith claim against Ace based on its denial of coverage. In order to succeed with a bad faith claim, Amerisource must prove by clear and convincing evidence that Ace (1) did not have a reasonable basis for denying benefits under the insurance policy, and (2) knew or recklessly disregarded their lack of a reasonable basis in denying the claim.[53] Amerisource claims that Ace's bases for denying coverage were not reasonable, and claims handling was conducted in bad faith. Because this court has determined that an exclusion applies, this claim fails.[54]

CONCLUSION

Because Ace has demonstrated that policy exclusions L and Y both independently preclude coverage, I am finding that Ace's motion for summary judgment must be granted. Under the terms of the policy and the exclusions, the Claim made was outside the scope of the Policy. Amerisource's motion for summary judgment is denied, Ace's motion for summary judgment is granted, and the complaint is dismissed.

BY THE COURT:

DATE: July 16, 2013



ALBERT JOHN SNITE, JR., J.

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[52] Id.
[53] Condio v. Erie Ins. Exch., 899 A.2d 1136, 1142-43 (Pa. Super. 2006).
[54] See Frog, Switch & Mgf., Co. v. Travelers Ins. Co., 193 F.2d 742 (3d Cir. 1999).