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

JOHN R. GREGG, M.D. and VINCENT J. DiSTEFANO, M.D., on behalf of themselves and all others similarly situated, Plaintiffs, v. INDEPENDENCE BLUE CROSS, *et. al*. Defendants.	December Term, 2000 No. 03482 Control Nos. 081034, 080860 080890, 080891
ROBERT P. GOOD, M.D., on behalf of himself and all others similarly situated, Plaintiffs, v. INDEPENDENCE BLUE CROSS, *et. al*. Defendants.	December Term, 2002 No. 00005 **(Lead Case)** Control Nos. 081034, 080860 080890, 080891
PENNSYLVANIA ORTHOPAEDIC SOCIETY, on behalf of its members and all other similarly situated individuals, Plaintiffs, v. INDEPENDENCE BLUE CROSS, *et. al*., Defendants.	December Term, 2002 No. 00002 Control Nos. 081034, 080860 080890, 080891

O R D E R

AND NOW, this 22nd day of April, 2004, upon consideration of Plaintiffs' Motion for Final Approval of the Settlement (Control No. 081034) ("Motion for Final Approval") (which includes a Motion for Certification of a Settlement Class), all Objections and

opposition thereto, the plaintiffs' and defendants' opposition to those Objections, Plaintiffs' Reply In Support of Motion for Final Approval of Settlement, the testimony at the hearing conducted on August 21-22, 2003, the argument held on November 19, 2003, the proposed findings of fact and conclusions of law submitted by plaintiffs, defendants and objectors, and all matters of record, it is **ORDERED** that the Motion for Certification of a Settlement Class is **Granted**, that the Motion for Final Approval is **Granted,** and that all Objections, including those listed below, are **Overruled**:

(a) Objections of Martin D. Trichtinger, M.D., William W. Lander, M.D., Nancy S. Roberts, M.D., Beverly K. Dolberg, M.D. and the Pennsylvania Medical Society to Proposed Class Action Settlement;

(b) Objections of Kutztown Family Medicine, P.C. and Natalie M. Grider to Proposed Class Action Settlement;

(c) Objections of Rosalind Kaplan, M.D. to Proposed Class Action Settlement;

(d) Objections of Louis P. Bucky, M.D. to Proposed Class Action Settlement;

(e) Objections of Robert B. Sklaroff and Physician Providers of the University of Medicine and Dentistry – Robert Wood Johnson Medical School to Proposed Class Action Settlement;

(f) Objections of Terrence R. Malloy, M.D. on behalf of the Certified Class of New Jersey Providers to Proposed Class Action Settlement;

(g) Objections of Joseph Fallon, M.D., Medical Society of the State of New York, South Carolina Medical Association and Tennessee Medical Association to Proposed Class Action Settlement;

(h) Objections of Pennsylvania Psychiatric Society and Dr. John Yardumian to

Proposed Class Action Settlement; and,

(i) Objections of American Medical Association to Proposed Class Action Settlement.

FURTHER, upon consideration of the fact that three open motions are no longer pertinent, it is **ORDERED** that: (1) American Medical Association's Motion for Leave to File an Amicus Curiae Memorandum Regarding Proposed Settlement is **marked moot,** (2) the plaintiffs' Motion in Limine to Preclude and/or Limit the Objections of Louis P. Bucky, M.D. (Control No. 080890), is **marked moot**, (3) the plaintiffs' Motion in Limine to Preclude Non-Class Members from Objecting (Control No. 080891), is **marked moot**.

FURTHER, upon consideration of Defendants' Motion To Invalidate Opt-outs, For Approval Of Corrective Notice and a New Opt-out Period For Certain Class Members, and to Temporarily Restrain Communications Concerning the Class Action Settlement (Control No. 080860) ("Motion to Invalidate Opt-outs"), in which Class Representatives, the Pennsylvania Orthopaedic Society, Robert P. Good, M.D., John R. Gregg, M.D., and Vincent J. DiStefano, M.D. (collectively "Class Representatives"), and their counsel join, all opposition thereto, the argument held on November 19, 2003, and all matters of record, it is **ORDERED** that the Motion to Invalidate Opt-outs is **Granted**.

It is further **ORDERED** that:

1. All opt-outs submitted to date, including those identified in Exhibit(s) A-C to the Motion to Invalidate Opt-outs, are stricken, invalidated and declared void.

2. All class members who submitted, or are identified in, a timely opt-out ("Affected Class Members") remain in the Class Action Settlement ("CAS"), subject to the paragraphs that follow. The 267 group opt-outs are deemed to be included.

3. The parties are required to disseminate the correspondence and notice in the form attached hereto as Exhibit A ("Notice") on the following web pages not later than April 26, 2004: www.ibx.com and www.paorthosociety.com. The parties shall also disseminate the Notice, or a summary thereof, via publication in the Philadelphia Inquirer on or before May 5, 2004, and on the Internet via www.businesswire.com or other similar Internet news distribution service by April 26, 2004.

4. Independence Blue Cross is required to disseminate the Notice via U.S. mail not later than May 7, 2004, to any and all Affected Class Members. Any and all class members who submitted an untimely opt-out shall not be entitled to receive Notice.

5. All persons to whom the Notice is sent shall have another opportunity to opt-out of the class ("Second Opt-out"). The Second Opt-out Period shall end on June 9, 2004. Requests to opt-out must be post-marked no later than June 9, 2004.

6. Effective immediately upon entry of this Order, and continuing thereafter until midnight, June 9, 2004, the New Jersey Lawyers[1], medical societies/associations, including, but not limited to, the Pennsylvania Medical Society (hereinafter "PMS") and the Medical Society of New Jersey (hereinafter, "MSNJ"), and each of their partners, shareholders, attorneys, employees, agents, servants, representatives, members and

[1] The New Jersey Lawyers shall include the following: Edith M. Kallas, Esquire, and the law firm of Milberg, Weiss, Bershad, Hynes & Lerach, LLP ("Milberg Weiss"); Frank Morris, Esquire, and the law firm of Morris and Morris, LLC; Donna Siegel Moffa, Esquire, and the law firm of Trujillo Rodriguez & Richards, LLC; and Kenneth J. Gogel, Esquire, and the law firm of Gogel & Gogel.

all others acting by or through them and/or on their behalf are enjoined from communicating directly or indirectly or through or in concert with others with, or in any manner intended to reach, class members about the Class Action Settlement unless the communication is first approved by this court.

7. Upon further application by defendants, class counsel or other affected parties to the CAS, the court shall consider whether the New Jersey Lawyers and/or others should pay fees and costs reasonably incurred by defendants, class counsel or other affected parties in connection with responding to and/or remedying the improper communications with class members, including, but not limited to, fees and costs incurred in connection with (a) addressing and remedying the misuse of the AmeriHealth name in communications with class members, (b) preparing and filing the Motion to Invalidate Opt-outs, and (c) preparing, disseminating and mailing the new Notice.

BY THE COURT,

_____

ALBERT W. SHEPPARD, JR., J.

April 22, 2004

Re: Pennsylvania Orthopaedic Society, *et. al.* v. IBC, *et. al*.
December Term, 2002, No. 0002

Robert P. Good, M.D., *et. al.* v. IBC, *et. al.*
December Term, 2002, No. 0005

John R. Gregg, M.D., *et. al.* v. IBC, *et. al.*
December Term, 2000, No. 03482

Dear Class Member,

This Court is presently handling the class actions and settlements in the above-captioned matters. On June 19, 2003, this Court ordered that notice concerning this class action and settlement be given to class members. Any class member who wished to be excluded from the class had to file an exclusion request with the law firms of Berger & Montague or Billet & Connor by August 1, 2003. According to the records reviewed by this Court, you filed such an exclusion request.

This Court has now determined that during the first notice and opt-out period -- from June 19, 2003 through August 1, 2003 -- while there may have been some communications about the settlement that were fair and accurate, there were a significant number of misleading and inaccurate communications with class members by various plaintiffs' attorneys and law firms opposing the settlement. These plaintiffs' attorneys and law firms were not appointed by the Court to represent class members in these class actions and settlements. State, county and other medical associations also made misleading and inaccurate statements. The misleading and inaccurate communications, which included both direct mailings, faxes, websites, and website links, urged class members to file forms excluding themselves from the class. These communications were not authorized by the Court and the Court has found that they are likely to have influenced many decisions to file exclusion requests.

Because of these faulty communications to class members, this Court has ordered that original exclusion requests (including yours) are void, and has ordered a second notice and opt-out period for class members who filed those exclusion requests. **Accordingly, you must file a second exclusion request if you still want to be excluded from this class action and settlement.**

You should also note that, based on testimony of witnesses and submissions and objections in a lengthy fairness hearing conducted on August 21-22, 2003, this Court approved the settlement as fair and reasonable to the class as a whole. A copy of the Court's April 22, 2004 Findings of Fact, Discussion and Conclusions of Law, and Order

are available on the court's website, http://courts.phila.gov/opinions.html (select Commerce Program from dropdown menu). This decision will be subject to appeal, and is not final until all appeals, if any, are resolved. You should also note that there were a number of objections to the settlement during the course of the hearing. The Court considered the objections but did not find them meritorious. However, you may find some of the objections apply to your individual circumstances. You are free to consider these objections as well as the Court's approval of the settlement in making your decision of whether or not to request exclusion from the class.

Also enclosed are the new Court-approved notice materials explaining this class action and the settlement. You should read all of these materials carefully before deciding how to proceed. If, after reading the enclosed materials, you decide that you wish to remain in the class, you need do nothing more at this time. If you decide that you wish to exclude yourself from the class, you must once again sign and return to class counsel a letter requesting your exclusion from the class in accordance with the opt-out procedures mailed with the notice and that are also enclosed herewith. To be effective, the exclusion request must be sent by U.S. first class mail and postmarked by the U.S. postal service (and not by any privately owned and/or operated postage meters) no later than June 9, 2004 and signed by you. Individuals must sign the exclusion requests personally.

You should also be aware that the Court has temporarily restrained communications with class members concerning the Pennsylvania Class Action Settlement unless a proposed communication is approved by the Court. The Court has done so to provide class members with the opportunity to decide whether to participate in the settlement free of any further improper communications. If you receive any communications concerning the Class Action Settlement, you are asked to report it to class counsel, who are identified in the attached notice materials. Please note the Court has not restrained communications from or with your class counsel.

If you have any questions about this letter, the enclosed notice materials, or this class action and settlement, you should contact your own attorney, or the Court-appointed attorney for the class. Class counsel's names and addresses are included in the enclosed notice materials.

/AWS
Albert W. Sheppard, Jr.
Judge, Commerce Program
Court of Common Pleas
Philadelphia County

IN THE COURT OF COMMON PLEAS OF PHILADELPHIA COUNTY

FIRST JUDICIAL DISTRICT OF PENNSYLVANIA

CIVIL TRIAL DIVISION

JOHN R. GREGG, M.D. and VINCENT J. DiSTEFANO, M.D., on behalf of themselves and all others similarly situated,	:	December Term, 2000
	:	No. 03482
Plaintiffs,	:	
v.	:	
INDEPENDENCE BLUE CROSS, *et. al*.	:	
Defendants.	:	
ROBERT P. GOOD, M.D., on behalf of himself and all others similarly situated,	:	December Term, 2002
	:	No. 00005
	:	**(Lead Case)**
Plaintiffs,	:	
v.	:	
INDEPENDENCE BLUE CROSS, *et. al*.	:	
Defendants.	:	
PENNSYLVANIA ORTHOPAEDIC SOCIETY, on behalf of its members and all other similarly situated individuals,	:	December Term, 2002
	:	No. 00002
Plaintiffs,	:	
v.	:	
INDEPENDENCE BLUE CROSS, *et. al*.,	:	
Defendants.	:	

SECOND NOTICE OF CLASS ACTION SETTLEMENT

TO: ALL PROVIDERS WHO SUBMITTED CLAIMS FOR REIMBURSEMENT TO INDEPENDENCE BLUE CROSS, QCC INSURANCE COMPANY, KEYSTONE HEALTH PLAN EAST, INC., AMERIHEALTH HMO, INC., AMERIHEALTH, INC., AMERIHEALTH HMO, INC. NEW JERSEY OR AMERIHEALTH INSURANCE COMPANY OF NEW JERSEY (collectively "INDEPENDENCE BLUE CROSS") BETWEEN JANUARY 1, 1993 AND THE DATE OF FINAL JUDICIAL APPROVAL OF THE CLASS ACTION SETTLEMENT.

PLEASE READ THIS ENTIRE NOTICE CAREFULLY. YOUR RIGHTS MAY BE AFFECTED BY THE PROPOSED SETTLEMENT OF THIS CLASS ACTION.

This Second Notice of a class action settlement is given pursuant to Pennsylvania Rules of Civil Procedure 1712(c) and 1713(a). The purposes of this Notice are to (1) inform you that the Court has approved a settlement between the Pennsylvania Orthopaedic Society, Provider Class Representatives, and Independence Blue Cross, its subsidiaries, affiliates and related entities ("Independence Blue Cross"), and determined that is fair and reasonable to the class as a whole; and (2) advise you that the Court, as a result of unauthorized, misleading and inaccurate communications that urged you to opt-out of the settlement, has required that you receive this court-approved Second Notice and once again decide whether you wish to participate in the settlement. **IF YOU WISH TO PARTICIPATE IN THE SETTLEMENT, YOU ARE NOT REQUIRED TO DO ANYTHING**.

FAIRNESS HEARING APPROVING SETTLEMENT

The Court, based on the testimony of witnesses, submissions and objections in a lengthy fairness hearing conducted on August 21-22, 2003, approved a settlement of these actions as fair and reasonable to the class as a whole. A copy of the Court's April 22, 2004 Findings of Fact, Discussion and Conclusions of Law, and Order approving the

settlement are available on the court's website, http://courts.phila.gov/opinions.html (select Commerce Program from dropdown menu).

The approved Settlement is between Independence Blue Cross and a class of all Providers (e.g., all physicians, health care providers, group practices and/or any individual or group) who submitted claims for payment or reimbursement for medical services, procedures and/or products to Independence Blue Cross at any time during the period January 1, 1993 to the date of Final Judicial Approval, and who have been, claim to have been, and/or may have been denied payment or reimbursement or have, claim to have, and/or may have received reduced payment or reimbursement, including but not limited to, all claims for downcoding and/or bundling. The term "Providers" does not include hospitals. This litigation challenged certain Independence Blue Cross policies and procedures in the areas of payment, reimbursement, fee disclosure, claims processing and dispute resolution.

As part of the approved Settlement, Independence Blue Cross has agreed to address providers' concerns, simplify and streamline the reimbursement process for providers, and will result in additional reimbursement to providers, with an estimated financial impact in excess of $40 million in additional claims payments to providers over the next two years following Final Judicial Approval. Under the agreement, IBC will:

- Disclose to providers the standard fee schedules, and changes in fee schedules, that are applicable to the provider's specialty,
- Disclose policies or procedures that may impact the payment or reimbursement that a provider receives for services rendered,
- Process claims in accordance with established standards in various areas, including multiple surgery, radiologic guidance during a procedure, and certain claim specific modifiers used in billing,

- Replace the Independent Procedure designation with the separate procedure designation of the Current Procedural Terminology, and
- Establish a formal resolution process for provider payment disputes.

The changes in payment processing and dispute resolution will be continued for a period of two years from the date of Final Judicial Approval, with a phase in over that time period. IBC shall not be required to continue to provide disclosure after two years to the extent the Court finds that doing so would be inconsistent with IBC's business requirements or any controlling authority or requirement, including administrative, governmental or judicial authorities or requirements.

You may access further information about the settlement at www.ibx.com or www.paorthosociety.org or use the resources described below.

There were a number of objections to the settlement during the course of the fairness hearing. As set forth in the Findings of Fact, Discussion and Conclusions of Law, found at http://courts.phila.gov/opinions.html (select Commerce Program from dropdown menu) the Court considered these objections but did not find them meritorious. However, you may find some of the objections apply to your individual circumstances. You may consider these objections as well as the Court's approval of the settlement in making your decision of whether or not to participate in the settlement.

CORRECTIVE ACTIONS TAKEN BY THE COURT

If you received this Second Notice, then the Court has determined that your decision to opt-out of the settlement may have been improperly affected by misleading and inaccurate communications concerning the settlement from certain plaintiffs' lawyers (who were not class counsel in these lawsuits), their law firms and state medical societies. Because of these faulty communications to class members, this

Court has ordered that original exclusion requests (including yours) are void, and has ordered a second notice and opt-out period for class members who filed those exclusion requests. **Accordingly, you must file a second exclusion request if you still want to be excluded from this class action and settlement.**

You should also be aware that the Court has temporarily restrained communications with class members concerning the settlement and/or communications that urge them to opt-out. The Court has done so to provide class members with the opportunity to decide whether to participate in the settlement free from any further improper communications. If you receive any communications about the settlement other than this Notice packet, you are asked to report it to your class counsel in these Pennsylvania actions, who are identified below:

Jerome M. Marcus
Jonathan Auerbach
Berger & Montague, PC
1622 Locust Street
Philadelphia, PA 19103-6365
Fax: (215) 875-4604
Fax: (215) 875-5707
Class Counsel

and

David S. Senoff, Esquire
Billet & Connor, P.C.
2000 Market Street, Suite 2803
Philadelphia, PA 19103
Fax: (215) 496-7505
Class Counsel

RELEASE, OPT-OUT PROCEDURE AND EFFECT OF FAILURE TO OPT-OUT

As set forth above, class members who receive this Notice will have the opportunity to opt-out of the settlement. Absent taking such actions, **ALL CLASS MEMBERS SHALL BE BOUND BY THE SETTLEMENT AND ALL ORDERS OF THE COURT RELATING TO THE SETTLEMENT. YOU SHALL BE DEEMED CONCLUSIVELY TO HAVE SETTLED, RESOLVED AND RELEASED ANY AND ALL CLAIMS YOU MAY HAVE AGAINST INDEPENDENCE BLUE CROSS AND ALL OTHER RELEASED PARTIES ARISING FROM OR RELATED TO PAYMENT OR REIMBURSEMENT TO PROVIDERS OR COVERAGE FOR ANY AND ALL SERVICES, PROCEDURES, AND/OR PRODUCTS RENDERED OR PROVIDED BY SUCH PROVIDERS ON OR BEFORE JUNE 11, 2003, INCLUDING BUT NOT LIMITED TO ANY AND ALL CLAIMS THAT WERE BROUGHT OR COULD HAVE BEEN BROUGHT IN THE LITIGATION.**

Should anyone wish to opt-out, the class member must sign and return to Class Counsel identified above a letter requesting your exclusion from the class in accordance with the Opt-out Procedures mailed with this notice. This request to opt-out must be sent U.S. first class mail and **POSTMARKED BY THE U.S. POSTAL SERVICE (AND NOT BY ANY PRIVATELY OWNED AND/OR OPERATED POSTAGE METER) NO LATER THAN JUNE 9, 2004** (the expiration of the Opt-out Period). The opt-out request must be signed by you and include: your name, current office address, provider number, telephone number, and a statement that you wish to be excluded from the settlement. You may not opt-out on behalf of others. All persons wishing to opt-out must sign their own opt-out form and comply with the opt-out procedures.

This Notice is not the Class Action Settlement Agreement and merely provides information regarding the settlement. The Class Action Settlement Agreement controls the rights, interests and obligations of the parties. If you have any questions regarding this Notice, the Opt-out Procedure or the Class Action Settlement Agreement, you may contact Class Counsel, as described above. If you do not follow the procedures and deadlines that are described in this notice, you may lose legal rights significant to you, including, but not limited to, the right to opt-out of the settlement.

EXAMINATION OF PAPERS

This notice is a summary and does not describe all details of the proposed settlement with Independence Blue Cross, the Settlement Agreement or the proceedings in the action generally.

For complete information or if you wish to discuss this action or have any questions concerning this Notice or rights or interests with respect to these matters, please contact Class Counsel:

By Telephone:	**1-866-462-4120**
Or, Write to:	**Jerome M. Marcus, Esq.** **Jonathan Auerbach, Esq.** **Berger & Montague, PC** **1622 Locust Street** **Philadelphia, PA 19103-6365** **or** **David S. Senoff, Esq.** **Billet & Connor, P.C.** **2000 Market Street, Suite 2803** **Philadelphia, PA 19103**
Or, Visit:	**www.ibx.com** **www.paorthosociety.org**

In addition, you may review complete files of papers submitted in this case at the Office of the Prothonotary**,** Philadelphia County Court of Common Pleas, Room 278 City Hall, Philadelphia, PA 19107.

Dated: April 22, 2004

CLASS MEMBER OPT-OUT PROCEDURE

If you are a member of the Class and wish to remain in the Class, YOU NEED NOT DO ANYTHING. You are not being sued and you do not need to appear in court. If you do nothing, you will be included in the proposed settlement and be entitled to pursue its benefits, but will be giving up your individual right to pursue any and all claims against Independence Blue Cross, its subsidiaries, affiliates and related entities.

If you do not wish to remain in the Class, or accept the proposed settlement, you can opt-out by mailing a letter, postage prepaid, to Class Counsel at the addresses listed below:

	Jerome M. Marcus, Esquire Jonathan Auerbach, Esquire Berger & Montague, PC 1622 Locust Street Philadelphia, PA 19103-6365 **Class Counsel** and David S. Senoff, Esquire Billet & Connor, P.C. 2000 Market Street, Suite 2803 Philadelphia, PA 19103 **Class Counsel**

Your letter must include the following information:

- Full name
- Current Office Address
- Provider Number
- Telephone Number
- Statement that you wish to be excluded from the class action lawsuits
- Your signature

You must save a copy of the completed letter for your records. **YOUR REQUEST MUST BE SENT U.S. FIRST CLASS MAIL AND POSTMARKED BY THE U.S. POSTAL SERVICE (AND NOT BY ANY PRIVATELY OWNED AND/OR OPERATED POSTAGE METER) NO LATER THAN JUNE 9, 2004** (the expiration of the Opt-out Period).

You may not opt-out on behalf of others. All persons wishing to opt-out must sign their own opt-out form and comply with the opt-out procedures.

If you have any questions or concerns regarding this procedure and how it affects your rights you should contact Class Counsel.

FINDINGS OF FACT, DISCUSSION AND CONCLUSIONS OF LAW

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

JOHN R. GREGG, M.D. and VINCENT J. DiSTEFANO, M.D., on behalf of themselves and all others similarly situated,	:	December Term, 2000
	:	No. 3482
Plaintiffs,	:	Control Nos. 081034, 080860
v.	:	
INDEPENDENCE BLUE CROSS, *et. al*.	:	
Defendants.	:	
ROBERT P. GOOD, M.D., on behalf of himself and all others similarly situated,	:	December Term, 2002
	:	No. 0005
Plaintiffs,	:	**(Lead Case)**
	:	Control Nos. 081034, 080860
v.	:	
INDEPENDENCE BLUE CROSS, *et. al*.	:	
Defendants.	:	
PENNSYLVANIA ORTHOPAEDIC SOCIETY, on behalf of its members and all other similarly situated individuals,	:	December Term, 2002
	:	No. 0002
Plaintiffs,	:	Control Nos. 081034, 080860
v.	:	
INDEPENDENCE BLUE CROSS, *et. al*.,	:	
Defendants.	:	

FINDINGS OF FACT, DISCUSSION AND CONCLUSIONS OF LAW

INTRODUCTION

In these three pending class action cases (consolidated for the purpose of the proposed settlement), the plaintiffs, Dr. John R. Gregg, Dr. Robert P. Good, Dr. Vincent J. DiStefano and the Pennsylvania Orthopaedic Society, on behalf of themselves and all others similarly situated, and the defendants, Independence

Blue Cross, QCC Insurance Company, Keystone Health Plan East, Amerihealth HMO Inc. and Amerihealth Inc., ask this court to give final approval of the class certification for purposes of settlement and render final approval of their Class Action Settlement.

The named individual plaintiffs are orthopedic surgeons who provide medical care to patients who subscribe to health plans issued by the defendants. The named defendants are health insurance companies or health maintenance organizations which own, operate, underwrite and/or administer health insurance plans, such as preferred provider organizations (PPOs), point of service health plans (POs) and health maintenance organizations (HMOs).

The cases involve a dispute between a class of health care providers and health insurers regarding what reimbursement is appropriate for medical care provided to patient subscribers. These cases implicate a larger issue, however, which is the potential dangers of the intertwined relationship between the medical care reimbursement and the medical care delivery systems. Managed care, as defined by one expert witness, is "the merger of the payment and delivery mechanisms in order to manage patients' and physicians' access and cost of care." Tr. 8/22/03, p. 563. The evidence reveals that the existing merger of the payment and delivery systems in managed care potentially leads to results such as physicians making medical care decisions based, in part, on their reimbursement by health insurers[2], and physicians leaving the geographic area

[2] Dr. Linda Peeno, an expert witness, described this possibility as "the replacement of clinical logic in taking care of patients with a financial logic." Tr. 8/22/03, p. 569.

or their careers to avoid the financial burdens they endure.[3] Thus, these cases highlight the effects of managed care on health insurers, health care providers, and ultimately, patients, and arguably on our society as a whole.

The plaintiffs make the following specific claims: They assert that the defendants have improperly denied reimbursement and/or improperly reduced the appropriate amount of reimbursement due to plaintiffs for medical care provided to subscribers of defendants' health plans. Plaintiffs contend that the defendants practice "downcoding," which plaintiffs define as a situation where:

> defendants wrongfully disregard the CPT code [the American Medical Association's Physicians' Current Procedural Terminology coding[4]] submitted by plaintiffs and unilaterally and arbitrarily modify the CPT code to an inapplicable code which establishes a lower reimbursement rate.[5]

Plaintiffs also assert that the defendants practice "bundling," which plaintiffs define as the circumstance when:

> defendants fail to reimburse plaintiffs for two or more separate procedures performed simultaneously on the same patient [and instead,] either reimburse plaintiffs for the less expensive procedure and fail to reimburse plaintiffs for the more expensive procedure, or [ ] reimburse fully for one procedure and partially reimburse plaintiffs for the subsequent procedures at amounts below the contracted amount."[6]

In addition to the denial and reduction of reimbursement, the plaintiffs assert claims based on the defendants' non-disclosure of reimbursement policies, the

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[3] Dr. Gregg opined that "doctors are going to be just pouring out of this state faster and faster and we're going to lose medicine in Pennsylvania." Tr. 8/21/03, p. 71.

[4] Current Procedural Terminology (CPT) coding refers to proprietary codes of the American Medical Association. Tr. 8/21/03, p. 367. Each of the CPT codes correlates to a particular medical service. Many of the codes are five digits, although some of the codes are two digits and are known as "modifiers." A modifier is used in conjunction with a five digit code to identify further information about the type of medical service provided.

[5] Gregg Complaint, ¶¶ 25-26; Good Complaint, ¶¶ 24-25; Pennsylvania Orthopaedic Society Complaint, ¶¶ 21-22.

[6] Gregg Complaint, ¶¶ 25, 27; Good Complaint, ¶¶ 24-26; Pennsylvania Orthopaedic Society Complaint, ¶¶ 21, 23.

absence of procedures to correct improper claim resolution and the defendants' failure to adhere to applicable reimbursement schedules.

These claims constituted the targeted objectives of the litigation and subsequent settlement negotiation. For over six months, the parties negotiated a settlement of the three cases, and in June 2003, presented a Class Action Settlement Agreement (or "Class Action Settlement") to the court.

Upon consideration of the Motion for Final Approval of the Settlement, the objections to the settlement, the plaintiffs' and defendants' opposition to those objections, plaintiffs' Reply In Support of Motion for Final Approval of Settlement, the testimony at the hearing conducted on August 21 and 22, 2003, the argument held on November 19, 2003, the proposed findings of fact and conclusions of law submitted by plaintiffs, defendants and objectors, and all matters of record, the court **grants** plaintiffs' Motion for Certification of a Settlement Class, **grants** plaintiffs' Motion for Final Approval of the Settlement, and **overrules** all of the outstanding objections to both Motions.

In addition, upon consideration of the defendants' Motion to Invalidate Opt-outs, for Approval of Corrective Notice to Certain Class Members, and to Temporarily Restrain Communications Concerning the Class Settlement ("Motion to Invalidate Opt-outs"), the plaintiffs' support of that Motion, all opposition thereto, including objectors' memoranda, the testimony at the hearing conducted on August 21-22, 2003, the argument presented to the court on November 19, 2003, and all matters of record, the court **grants** the Motion to Invalidate Opt-outs, **orders** a second notice to be disseminated to certain class members and

temporarily restrains communications to the Settlement Class regarding the Class Action Settlement.

FINDINGS OF FACT

The Three Cases

1. On December 29, 2000, Drs. John R. Gregg and Vincent J. DiStefano filed a praecipe to issue a writ of summons in Gregg v. Independence Blue Cross, December Term, No. 03482 (Pa. Com. Pl., Phila.). On January 30, 2001, the plaintiffs filed a Complaint. After a round of preliminary objections, on July 6, 2001, the plaintiffs filed an Amended Complaint. The defendants then filed another round of preliminary objections to the Amended Complaint which the court overruled.

2. By Order dated June 24, 2002, the court allowed plaintiffs to amend the Amended Complaint to include class action allegations. The plaintiffs filed a Second Amended Class Action Complaint on July 2, 2002, alleging breach of contract, unjust enrichment, tortious interference with contract and seeking injunctive relief.

3. Dr. Gregg is an orthopedic surgeon who practices medicine in Pennsylvania and New Jersey. Ex. P-1 (Curriculum Vitae of Dr. Gregg); Tr. 8/21/03, pp. 36-39; Compl., ¶ 1.

4. Dr. DiStefano is also an orthopedic surgeon who practices medicine in Pennsylvania. Compl., ¶ 2.

5. For over ten years, Drs. Gregg and DiStefano have provided medical care to patients who subscribe to the defendants' health insurance

plans. Compl., ¶ 22.

6. Drs. Gregg and DiStefano each entered into a Professional Provider Agreement with the defendants to become contracted providers. Compl., Ex. A.

7. On August 12, 2002, the defendants filed an Answer and New Matter to the plaintiffs' Second Amended Class Action Complaint.

8. On October 1, 2002, the plaintiffs filed a motion for class certification which sought to certify a class of orthopedic physicians.

9. On October 2, 2002, the plaintiffs filed a motion for partial summary judgment.

10. On November 5, 2002, the defendants filed a motion for judgment on the pleadings.

11. Meanwhile, on December 2, 2002, Dr. Robert Good filed a Class Action Complaint in Good v. Independence Blue Cross, December Term, No. 00005 (Pa. Com. Pl., Phila.), alleging breach of contract, unjust enrichment, tortious interference with contract and seeking injunctive relief.[7]

12. Dr. Good is an orthopedic surgeon who treats patients insured by the defendants. Compl., ¶¶ 1, 10. Dr. Good entered into a Professional Provider Agreement with the defendants. Compl., Ex. A.

13. Also on December 2, 2002, the Pennsylvania Orthopaedic Society filed a Class Action Complaint in Pennsylvania Orthopaedic Society v. Independence Blue Cross, December Term, No. 00002 (Pa. Com. Pl., Phila.),

[7] On December 30, 2002, the defendants filed preliminary objections to the Good Complaint. These preliminary objections were never ruled upon because of intervening settlement negotiations.

alleging injunctive relief.[8] / [9]

14. The Pennsylvania Orthopaedic Society is a non-profit corporation and professional organization of orthopedic surgeons in Pennsylvania. Compl., ¶ 1.

15. Gregg v. Independence Blue Cross, Good v. Independence Blue Cross, and Pennsylvania Orthopaedic Society v. Independence Blue Cross are collectively referred to in this Opinion as "Litigation."

16. Counsel for the plaintiffs in the Litigation next filed a motion to consolidate Gregg, Good and Pennsylvania Orthopaedic Society.

17. The plaintiffs' claims in this Litigation involve "improper payment practices to health care providers, including bundling inconsistent with generally accepted standards, and the use of undisclosed payment policies to reduce or deny payment for services rendered; defendants' refusal to disclose the fee schedules pursuant to which health care providers provide services to defendants' insureds; and the inability on the part of health care providers to enforce their rights by virtue of their inability to hold defendants accountable for violations of their obligations to such providers." Pltfs' Motion for Final Approval of the Settlement ("Motion for Approval"), p. 11.

18. In pressing and defending against the claims in this Litigation, the parties engaged in hard-fought discovery. The court's records indicate that in less than one year's time, between November 2002 and September 2003, the

[8] The Pennsylvania Orthopaedic Society had previously filed a petition to intervene in the Gregg case. By Order dated June 26, 2002, the court denied the petition.

[9] As in the Good case, on December 30, 2002, the defendants filed preliminary objections to the Pennsylvania Orthopaedic Society case. These preliminary objections were never ruled upon because of intervening settlement negotiations.

parties filed at least seven discovery motions.

19. According to plaintiffs' counsel, the parties took and responded to discovery for approximately eighteen months. Pltfs' Proposed Findings of Fact and Conclusions of Law, p. 6. Plaintiffs' counsel states that they "reviewed and analyzed thousands of pages of non-public documents produced by defendants" and "deposed defendants' personnel regarding [their] policies." Motion for Approval, p. 22.[10]

20. According to plaintiffs' counsel, the scope of discovery and investigation regarding the insurance claims covered many fields of medicine other than orthopedics, including endocrinology, cardiology, oncology, family practice medicine (with respect to both capitation[11] and indemnity health insurance plans), anesthesiology, obstetrics and gynecology, pulmonology, surgery, gastroenterology, neurology, psychology and chiropractics. Tr. 8/21/03, pp. 16-17. Plaintiffs' counsel interviewed doctors, as well as their office staff, in these various fields, to discover how the defendant thwarted Providers' efforts to be properly reimbursed. Tr. 8/21/03, pp. 17-18; Motion for Approval, p. 22.

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[10] Because of our paperless discovery system, the court is unable to verify the document requests, interrogatories and depositions which were not the subject of a discovery motion. The court recognizes, however, that attorneys owe a duty of candor to the court and thus, the court relies on the integrity of counsel regarding these discovery assertions. Pa. R. Prof. Conduct, Rule 3.3.

[11] Capitation refers to a contractual payment arrangement whereby an insurer pays a monthly fee to a Provider for all of the services the Provider might give to a group of patients who subscribe to that health insurer. Tr. 8/21/03, pp. 167, 172. The capitated rates are generally calculated based on formulas which take the age and sex of patients, but not their health, into account. Tr. 8/22/03, p. 575. However, insurers and Providers negotiate capitated rates when they enter into capitated payment agreements. Tr. 8/22/03, p. 576. Providers who are reimbursed on a capitated basis are still eligible to submit reimbursement claims for certain services and procedures which qualify as "bill above" codes, i.e. claims above the capitated amount. Tr. 8/21/03, p. 172. Also, Independence Blue Cross' capitation program applies to HMOs only; there are no capitation agreements for PPO work. Tr. 8/21/03, p. 100.

The Class Action Settlement Agreement

21. For over six months, counsel for the parties negotiated a settlement of the Litigation. Tr. 8/21/03, pp. 8, 20.

22. On June 18, 2003, plaintiffs and defendants jointly moved for preliminary approval of the Class Action Settlement.

23. A copy of the Class Action Settlement Agreement is attached as Exhibit A to the Motion for Approval and is also found at Ex. D-11.

24. The Class Action Settlement Agreement defines "Providers" as:

> Any and all physicians, health care Providers, group practices and/or any individual or group that (1) provides, or provided at any time during the period January 1, 1993 to the date of Final Judicial Approval, medical services, procedures and/or products to an individual who has, or had at any time through the date of Final Judicial Approval, health insurance through Independence Blue Cross and/or any Released Party or (2) submitted at any time during the period January 1, 1993 to the date of Final Judicial Approval, a claim for payment or reimbursement for any medical services, procedures and/or products to Independence Blue Cross and/or any Released Party. As used herein, Providers shall also refer to any association of Providers, including any medical or professional association of any kind. The term 'Providers' shall not include hospitals.

Motion for Approval, Ex. A, § I(F).

25. The Class Action Settlement Agreement establishes the following categories of relief to Providers:

- disclosure to Providers of the standard fee schedules, and changes in fee schedules, that are applicable to the Provider's specialty;
- disclosure to Providers of all policies or procedures that may impact the payment or reimbursement that a Provider receives for services rendered;
- processing of claims in accordance with established standards in

various areas, including multiple surgery, radiologic guidance during a procedure, and eleven claim specific modifiers used in billing thousands of codes;

- replacement of the Independent Procedure designation with the Separate Procedure designation of the American Medical Association's Current Procedural Terminology ("CPT"); and
- establishment of a formal resolution process for Provider payment disputes.

Motion for Approval, Ex. A.

26. According to the Class Action Settlement Agreement, the class representatives (Drs. Gregg, DiStefano and Good) would be eligible to receive up to $20,000 in incentive payments, subject to this court's approval. Motion for Approval, Ex. A, § III(G).

27. Also according to the Class Action Settlement Agreement, counsel for the class may apply for attorneys' fees and costs of up to $5 million. Motion for Approval, Ex. A, § VI.[12]

28. According to Section IV.C of the Class Action Settlement Agreement, the defendants possess the option to withdraw from the settlement for a period of twenty days following the expiration of the opt-out period if more than six percent of the Settlement Class timely and properly opt-out of the settlement. In that event, the Class Action Settlement Agreement would be void.

[12] On June 18, 2003, the court granted plaintiffs' Motion for Appointment of Lead Counsel. Jerome M. Marcus, Esquire and Jonathan Auerbach, Esquire of Berger & Montague, P.C., and David S. Senoff, Esquire of Billet & Connor, P.C. were appointed as co-lead counsel for the plaintiff class.

(By Order dated August 20, 2003, upon a joint motion, the court extended the time for the defendants to exercise this withdrawal right. See Finding of Fact, ¶ 174.)

29. On June 19, 2003, the court granted preliminary approval of the Class Action Settlement Agreement and ordered that the Gregg, Good and Pennsylvania Orthopaedic Society cases be consolidated and conditionally certified as class actions for the purpose of settlement only. Ex. D-17.[13] / [14]

30. The June 19, 2003 Order adopts the same definition of "Settlement Class" as in the Class Action Settlement Agreement:

> All Providers (1) who submitted claims for payment or reimbursement to Independence Blue Cross and/or any Released Party for medical services, procedures and/or products and (2) who have been, claim to have been, and/or may have been denied payment or reimbursement or have, claim to have, and/or may have received reduced payment or reimbursement on such claims. The Settlement Class includes, but is not limited to, all claims by Providers for downcoding and/or bundling, however described or characterized.

Motion for Approval, Ex. A, § II(A). The June 19, 2003 Order also adopts the same definition of "Providers" as the Class Action Settlement Agreement. See Finding of Fact, ¶ 24.

Notice of the Class Action Settlement Agreement

31. The court approved a Notice of the Class Action Settlement Agreement and ordered that it be sent to the Settlement Class by U.S. mail, as well as published on the websites of Independence Blue Cross and the

[13] The court later amended the June 19, 2003 Order to include instructions regarding publication of the notice of the proposed class action settlement. The remaining provisions of the June 19, 2003 Order were to remain in full force and effect.

[14] The court designated Good v. Independence Blue Cross, December 2002, No. 00005 (Pa. Com. Pl., Phila.) as the lead case.

Pennsylvania Orthopaedic Society, in The Philadelphia Inquirer and on an Internet news distribution service. Ex. D-18; See also Motion for Approval, Ex. A, Tab C (Notice).

32. On June 19, 2003, the Notice was published on www.prnewswire.com.

33. On June 20, 2003, the Notice was published on the websites of Independence Blue Cross and the Pennsylvania Orthopaedic Society.

34. On June 27, 2003, the Notice was published in The Philadelphia Inquirer. Ex. D-49.

35. By June 27, 2003, the Notice was sent by U.S. mail to the class members. Ex. D-45; Ex. D-50.

36. A total of 32,641 Notices were mailed, which covered approximately 34,422 Providers. Ex. D-45.

37. The Notice was mailed to each class member who was a participating Provider as of June 5, 2003, in Pennsylvania, New Jersey, Delaware, Maryland and New York. Ex. D-45.

38. The Notice was mailed to every participating Provider at each office location of every group where that Provider was associated. Ex. D-45.

39. The Notice was mailed to every Integrated Delivery System which had a contract with Independence Blue Cross or its affiliates, and to Independent Physician Associations. Ex. D-45.

40. According to Cynthia O'Neill, a Senior Business Analyst for Professional Networks at Independence Blue Cross, it was not possible to

generate an accurate list of former Providers. Ex. D-45 (Supplemental Certification).

41. As stated in the Notice, the class members could choose to opt-out of the Class Action Settlement Agreement. The court-approved deadline for filing opt-outs and objections was August 1, 2003. Ex. D-18.

Communications With the Settlement Class by Non-Parties

42. Only 10 opt-out forms were received with a postmark date of July 11th or earlier. Ex. D-37; Tr. 11/19/03, pp. 28-29.

43. 7,293 opt-outs were submitted.[15] Ex. D-29, ¶ 4.

44. Of the 7,293 opt-outs, 4,873 of them (or 67 percent) used a form which Providers had received either from attorneys representing plaintiffs in a New Jersey class action styled Zakheim v. AmeriHealth HMO, Inc., No. CAM-L-6235-00 (Super. Ct. of NJ, Camden Cty.), or the Medical Society of New Jersey ("MSNJ"), or the Pennsylvania Medical Society. Ex. D-29, ¶ 11; Ex. D-34; Tr. 11/19/03, p. 31.

45. The Zakheim action alleges that AmeriHealth has breached its standardized contracts with New Jersey physicians by failing to respond to claims for reimbursement within the time period required by the contracts. The New Jersey Court appointed the lawfirms of Morris and Morris LLC and Milberg Weiss Bershad Hynes & Lerach LLP[16] as counsel for the plaintiff class.

[15] The 7,293 opt-outs include 7,026 individual class members who opted-out, and 267 groups which opted-out. Ex. D-29.

[16] The Milberg Weiss firm also represented the MSNJ in a case styled MSNJ v. AmeriHealth HMO, Inc., NO. C-66-02 (Super. Ct. of NJ, Mercer Cty., May 8, 2002), which alleged, among other things, that AmeriHealth improperly denied reimbursement to physicians for medically necessary services by bundling and downcoding claims. On January 20, 2004, the New Jersey Court granted the defendants' motion to dismiss the Complaint. In addition, the MSNJ submitted

46. Malloy v. AmeriHealth HMO, Inc., No. CAM-L-891-01 (Super. Ct. of NJ, Camden Cty.), is another New Jersey class action which alleges that AmeriHealth has improperly reduced and/or denied reimbursement to physicians through its automated claims processing. The New Jersey Court appointed the lawfirms of Trujillo Rodriguez & Richards, LLC and Gogel & Gogel as counsel for that plaintiff class.

47. On December 21, 2002, Zakheim and Malloy were consolidated for pre-trial purposes.[17]

48. Class members in Zakheim and Malloy also qualify as members of the Settlement Class in this Litigation. If those class members were to stay in the Settlement Class in this Litigation, they would release their claims in Zakheim and Malloy. See New Jersey Objectors' Memorandum of Law In Opposition to Motion to Invalidate Opt-outs, Ex. 6 (Notice to Class in Zakheim and Malloy) and Ex. 9, Tab H.

49. The New Jersey Counsel in Zakheim hired a class action administration firm, The Garden City Group, to send a letter dated July 11, 2003 and an opt-out sample form, to all members of the certified classes in Zakheim and Malloy, all of whom were also members of the settlement class in the Litigation in this court. Ex. D-12; See also Ex. P-2; Tr. 8/21/03, pp. 340-41, 348.

50. The July 11th correspondence contained letterhead which stated: "AmeriHealth HMO, Inc. – New Jersey." Ex. D-12; Ex. Morris-1 (Affidavit of Neil

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Footnote 16 continued -
an affidavit in support of the plaintiffs' motion for class certification in Zakheim. See New Jersey Objectors' Opposition to Defs' Motion to Invalidate Opt-outs, Ex. 3, ¶¶ 3-4.

[17] The court refers to the lawyers and lawfirms appointed for plaintiffs in Zakheim and Malloy as "New Jersey Counsel" or "New Jersey Lawyers," unless otherwise specified.

Zola, Chief Operating Officer of The Garden City Group); Ex. Morris-2 (Affidavit of Maria Baker, Director of Operations of The Garden City Group); Tr. 8/22/03, p. 487.

51. The July 11th correspondence was sent in an envelope which stated as its return address "AmeriHealth HMO, New Jersey – Class Action Settlement, P.O. Box 9000-6126, Merrick, New Jersey." Ex. D-12; Ex. Morris-1; Ex. Morris-2; Tr. 8/22/03, p. 513.

52. Along with defendant Independence Blue Cross, AmeriHealth HMO, Inc. would be released if the Class Action Settlement in this Litigation is approved and the defendants do not exercise their withdrawal right. See Finding of Fact, ¶ 100 (AmeriHealth HMO, Inc. is defined as a "Released Party".) **Neither AmeriHealth HMO, Inc. nor its counsel authorized the July 11th correspondence.**

53. The July 11th correspondence **was not authorized by this court**.

54. Although the New Jersey Court permitted New Jersey Counsel to mail a letter to class members in Zakheim and Malloy, the New Jersey Court was not made aware that the letter would be on AmeriHealth letterhead in an envelope with an AmeriHealth return address. Ex. K-2; Ex. D-63; Tr. 8/21/03, pp. 346, 416-17, 509, 515-17, 519. Language regarding the Class Action Settlement contained in the July 11th letter was first proposed to the New Jersey Court by Donna Siegel Moffa, Esquire of the Trujillo firm in a proposed Notice to the class in Zakheim and Malloy. See New Jersey Objectors' Memorandum of Law In Opposition to Motion to Invalidate Opt-outs, Ex. 9, Tab C. The New Jersey Court

included this language in the Notice it approved by Order dated June 24, 2003. Id. at Ex. 9, Tab E; See also Ex. D-42 (Transcript of June 24, 2003 hearing before the New Jersey Court). However, the New Jersey Court, sua sponte, subsequently removed this language in the revised Notice it approved by Order dated July 7, 2003. Id. at Ex. 9, Tab H. The New Jersey Court allowed the New Jersey Counsel to send a letter to the class in Zakheim and Malloy. See Ex. D-63 (Letter by New Jersey Court to New Jersey Counsel). In sending the July 11th letter, the New Jersey Counsel included language which had been removed by the New Jersey Court in its July 7, 2003 revised Notice.

55. Mr. Morris testified that the firms of Morris and Morris, LLC, Milberg Weiss Bershad Hynes & Lerach LLP, Gogel & Gogel, and Trujillo Rodriguez & Richards, LLC received a copy of the final form of the July 11th correspondence with the AmeriHealth HMO, Inc. letterhead before it was mailed to the class members. Tr. 8/22/03, pp. 494-95; Ex. D-12.

56. The New Jersey Counsel did not provide a copy of the July 11th letter to the defendants in this Litigation. Tr. 8/22/03, p. 515.

57. Mr. Morris testified that the July 11th letter should have read ""AmeriHealth HMO, Inc. – New Jersey Litigation," and that it was a mistake not to include the word "Litigation." Tr. 8/22/03, pp. 504-06.

58. Furthermore, the July 11th letter stated: "The Pennsylvania Class Action Settlement provides no relief for 'slowpay' or untimely claims review and processing by AmeriHealth, but does seek to dismiss and release all claims you may have for any untimely claims response and/or payment, including all interest

owed on any claims." Ex. D-12.

59. The July 11th letter stated: "The Pennsylvania Class Action Settlement provides no significant relief for AmeriHealth's claims review processes, but does seek to dismiss and release all your payment claims, including claims based on alleged bundling, downcoding and other wrongful practices which affect all physicians." Ex. D-12.

60. The July 11th letter also stated: "The Pennsylvania Class Action Settlement does not require AmeriHealth to make any cash payment at all to physicians in return for the universal release of all claims." Ex. D-12.

61. The July 11th letter listed New Jersey Counsel as persons to contact if the recipients had questions, but failed to list counsel in this Litigation for questions relating to the Class Action Settlement Agreement. Ex. D-12.

62. In addition, the July 11th letter stated that members of the classes could go to a website "for additional information about the New Jersey Class Actions or the proposed Pennsylvania Settlement…." Ex. D-12. That website, which became operational on July 16, 2003, stated, "Welcome to the AmeriHealth HMO, New Jersey Webpage" and also included a header stating, "AmeriHealth HMO, New Jersey."

63. The website's "title" and header were not changed until July 18, 2003, upon the defendant's demand to the New Jersey Counsel that the **unauthorized** use of AmeriHealth HMO, Inc.'s name cease immediately. Ex. D-22; Ex. D-52; Tr. 8/22/03, pp. 496-97, 506, 525; Affidavit of Patrick F. Morris to Correct Testimony Given at the Final Settlement Hearing on August 22, 2003

("Morris Affidavit"), ¶ 6; Supplemental Affidavit of Maria Baker, ¶ 4.

64. The website's title was changed from "Welcome to the AmeriHealth HMO, New Jersey Webpage" to read "Welcome to the New Jersey certified classes web page for the actions against AmeriHealth HMO, Inc." Morris Affidavit, ¶ 4.

65. Between July 16, 2003 and July 18, 2003, while the title still read ""Welcome to the AmeriHealth HMO, New Jersey Webpage," the website received 855 hits. Ex. Morris-2, ¶ 7.

66. The website stated: "After a thorough analysis of the proposed Pennsylvania settlement, the Medical Society of New Jersey recommends that its members opt-out of the Pennsylvania settlement . . . . To link to the Medical Society of New Jersey webpage, click here www.msnj.org."

67. The website also compared the terms and impact of the Class Action Settlement with a then-proposed settlement in an unrelated case, In re Managed Care Litigation Class Plaintiffs v. Aetna, Inc. and Aetna-US Healthcare, Inc., MDL No. 1334 (S.D.Fl. 2003) ("the Aetna case"), in which the Milberg Weiss firm represented the plaintiffs. Ex. D-22, pp. 32-52.[18]

68. The website also provided an opt-out form for members of the Settlement Class to use. Ex. D-22, p. 57.

69. No corrective notice was mailed to the recipients of the July 11th correspondence. Tr. 8/22/03, pp. 491, 496-98; Ex. D-33.

70. Dr. Gregg, as an AmeriHealth Provider, received a copy of the July

[18] The Aetna Settlement Agreement is found at Ex. D-20. Judge Federico A. Moreno of the Southern District of Florida Court approved the Aetna Settlement on October 24, 2003.

11th correspondence. At the time Dr. Gregg received the letter, he thought it was from AmeriHealth and that lawyers from AmeriHealth were advising him to opt-out of the Class Action Settlement Agreement. Tr. 8/21/03, pp. 49-50, 80.

71. Dr. Gregg spoke to over one hundred Providers regarding the Class Action Settlement Agreement. Tr. 8/21/03, pp. 52-53. Dr. Gregg testified that the Providers told him that they were confused about whether they should opt-out of the Class Action Settlement or not because they received communications advising them to opt-out. Tr. 8/21/03, p. 53.

72. In the end, 2,010 individual Providers who received the July 11th correspondence opted-out. Ex. D-29, ¶ 10.

73. In addition, the MSNJ's website, www.msnj.org, urged physicians to opt-out of the Class Action Settlement and provided an opt-out form. Ex. D-3.

74. The MSNJ website stated: "Following in the wake of this physician-friendly settlement [in the Aetna case] is a proposed settlement of Pennsylvania Class actions against Independence Blue Cross (IBC). Because of the relationship between IBC and AmeriHealth HMO, and because many physicians participate in both of these insurer networks, the Pennsylvania Settlement could preclude the agreement that MSNJ is working on [in the Aetna case]. **MSNJ urges physicians to opt-out of this proposed AmeriHealth/IBC Settlement by August 1. Not only are the terms of the settlement wholly inadequate, it will set a dangerous precedent for the remaining HMO lawsuits**." Ex. D-3, p. 6 (bold in original).

75. If a reader of the MSNJ website clicked on options for further

information, the website continued: “The Settlement fails to address wrongful practices relating to: medical necessity, reimbursement of claims (such as automatic downcoding and improper application of global periods); failure to pay claims in a timely manner; contracting issues (including, among other things, unilateral changes to material terms of the contract and prohibition on all products clauses); and administrative burdens. Nevertheless, all claims relating to these wrongful practices will be released.” Ex. D-3, p. 10.

76. The MSNJ website further stated: “Despite IBC’s claim to the contrary, the settlement fails to provide any meaningful relief in the areas of improper bundling, failure to recognize modifiers, disclosure of fee schedules and inadequate appeals processes. Nevertheless, all claims relating to these wrongful practices will be released.” Ex. D-3, p. 10.

77. The MSNJ website further stated: “Although IBC claims that its settlement provides relief in the four limited areas: ‘independent procedure being replaced by separate procedure designation’; ‘radiologic guidance during a procedure’; ‘multiple surgery reduction’; and ‘specific modifiers’, it has not agreed to a set of coding rules to be applied to these areas.” Ex. D-3, p. 10.

78. The MSNJ website also stated: “. . . [T]he reality is that IBC has only agreed to disclose ‘the standard fee schedule relevant to each provider’s applicable specialties.’ Thus, it appears that only disclosure of standard fee schedules pertaining to specialty codes will be ‘disclosed.’” Ex. D-3, p. 12.

79. The MSNJ website also compared the terms and impacts of the Class Action Settlement with the settlement in the Aetna case. Ex. D-3, pp. 6,

13-30.

80. The MSNJ also sent to its members a facsimile, entitled "Be Wary of Proposed AmeriHealth/IBC Settlement," dated July 13, 2003, stating: "The Proposed Pennsylvania Class Action Settlement:

- Provides no relief from alleged wrongful practice relating to medical necessity, failure to pay claims in a timely manner, administrative burdens and contracting issues by AmeriHealth, but does seek to dismiss and release all claims you may have against AmeriHealth or IBC.
- Provides no significant relief for AmeriHealth's claims payment processes, but does seek to dismiss and release all your payment claims, including claims based on alleged improper bundling, downcoding, failure to pay modifiers and other allegedly wrongful practices that affect all physicians.
- Does not require AmeriHealth to make any cash payment to physicians in return for the universal release of all claims.

The Aetna settlement should serve as a benchmark for resolution of other lawsuits against managed care companies. MSNJ opposes anything less." Ex. D-22, p. 4 (underlining in original).

81. The MSNJ website states that it has more than 8,000 members. Ex. D-21.

82. Like the MSNJ, the Pennsylvania Medical Society ("PMS") discussed the Class Action Settlement on its website, www.pamedsoc.org, urged physicians to opt-out and provided an opt-out form. Ex. D-2, p. 20; Ex. D-25.

83. The PMS website stated, in part: "Many see the settlement as

lowering the bar for future settlements; it may adversely affect terms that can be negotiated in other cases against other health plans." Ex. D-25, p. 9. PMS also made this statement in a facsimile sent to physicians on July 25, 2003. Ex. D-25, p. 29.

84. The PMS website also stated: "Dispute resolution process: The dispute resolution process is mandatory and internal. The details are not yet available. It is clear, however, that it does not cover such issues as medical necessity." Ex. D-25, p. 9. The website was later updated to say: "IBC will provide physicians an internal claims appeals mechanism that will be 'mandatory' for all physicians in the IBC network." Ex. D-25, p. 24. PMS also made this statement in a facsimile sent to physicians on July 25, 2003. Ex. D-25, p. 29.

85. The PMS website also stated: "Impairment of an antitrust action – As discussed, the scope of the release is extremely broad. Physicians should not be barred from bringing claims for future wrongs (after June 11, 1993) – for example, a claim that IBC engaged in post settlement conduct abusing monopsony power." Ex. D-25, pp. 15, 39.

86. The PMS website states that it has over 20,000 members. Ex. D-26.

87. Many smaller medical societies for various New Jersey counties also communicated with their members about the Class Action Settlement and encouraged them to opt-out. Ex. D-27.

88. One example of a communication is a memorandum from The Ocean County Medical Society of New Jersey entitled "Beware of Trojan Horses:

The Proposed AmeriHealth/IBC Settlement is not as it appears," which stated: "As you know in May, MSNJ reached a settlement with Aetna in a national class action suit . . . . [T]he PA Settlement could preclude the agreement that the Medical Society of New Jersey has procured."[19] Ex. D-27, p. 7.

89. Also, medical societies for various Pennsylvania counties also communicated with their members about the Class Action Settlement and encouraged them to opt-out. Ex. D-28.

90. Some of these Pennsylvania medical societies sent communications repeating statements by the Pennsylvania Medical Society. For example, the Pennsylvania College of Emergency Physicians sent a facsimile on July 25, 2003 stating: "Many see the settlement as lowering the bar for future settlements." Ex. D-28, p. 3; Ex. D-25, p. 9.

Opt-outs

91. The Notice to class members to opt-out of the Class Action Settlement Agreement required the signature of a Provider wishing to opt-out. Ex. D-18.

92. As mentioned previously in this Opinion, 7,293 non-duplicative opt-outs were submitted. Ex. D-29, ¶ 4.

93. 313 of the opt-outs were post-marked or sent after the August 1, 2003 deadline. Ex. D-29, ¶ 8.

94. 267 "groups" attempted to opt-out by these means: (1) an entity, practice or group, on its own behalf and/or on behalf of others, or (2) by an individual on behalf of an entity, practice or group, or (3) by an individual on

[19] The defendants in this Litigation are not parties in the Aetna case.

behalf of other individuals who did not sign the opt-out. Ex. D-29, ¶ 5.

95. Of those 267 "groups," 190 were submitted by or on behalf of groups that have no group contract with defendants and/or on behalf of individual providers who either have their own individual contract with the defendants or who do not contract with defendants at all. Ex. D-29, ¶ 6. In addition, 9 opt-outs were signed by only one provider on behalf of other providers who did not sign the opt-out forms. Ex. D-29, ¶ 6. Together, these 199 opt-outs sought to opt-out approximately 1,580 Providers. Ex. D-29, ¶ 7.

96. 601 of the opt-outs submitted failed to list provider numbers. Some of those 601 opt-outs indicated that they were non-participating providers. Ex. D-29, ¶ 8.

Fairness Hearing & Testimony Explaining
the Class Action Settlement Agreement

97. On August 21 and 22, 2003, the court conducted a fairness hearing on the Class Action Settlement Agreement.

98. At the hearing, the parties submitted a Joint Statement clarifying the Release in the Class Action Settlement Agreement. Ex. Court-1; Tr. 8/21/03, pp. 24-27, 33. The Joint Statement explains the scope of the claims released, the meaning of pending claims which would not be released, and the meaning of Released Parties. Ex. Court-1; Tr. 8/21/03, pp. 25-33.

99. Regarding the scope of claims released, the Joint Statement provides:

> As provided in the first paragraph of the Settlement Agreement, the intent of the Release in this case is to bar any and all claims against Independence Blue Cross and all other Released Parties arising from or

related to payment or reimbursement to Providers or coverage for any and all services, procedures, and/or products rendered or provided by such Providers on or before June 11, 2003, including but not limited to any and all claims that were brought or could have been brought in the Litigation.

Ex. Court-1, ¶ 1.

100. The Joint Statement identifies the Released Parties as:

Independence Blue Cross and each of the following affiliates, including any predecessors in interest to each of the following affiliates:

Independence Blue Cross;
AmeriHealth HMO, Inc. (old Delaware Valley HMO, Inc.);
AmeriHealth Health Plans, Inc.;
Keystone Health Plan East, Inc.;
QCC Insurance Company d/b/a AmeriHealth Insurance Company d/b/a Blue Cross and Blue Cross and Blue Shield of the USVI (old name was Q-Care Insurance Company);
AmeriHealth, Inc. (formerly Q.C.C., Inc. in 1993);
AmeriHealth Insurance Company of New Jersey;
AmeriHealth Insurance Plans, Inc.;
Vista Health Plan, Inc.;
HealthCare Delaware, Inc.;
Keystone Health Systems, Inc.;
AmeriHealth Integrated Benefits, Inc.

Ex. Court-1, ¶ 4.

101. The Joint Statement also clarifies the meaning of pending claims as described in Section IV(B) of the Class Action Settlement Agreement. The parties agreed to include the following language in Section IV(B):

This Release shall not eliminate a claim of a Provider for any services rendered after June 11, 2003. This Release also shall not eliminate a claim of a Provider where the Provider can establish that: (1) the Provider submitted a request for reimbursement to IBC about which he or she received a written communication from IBC between May 1, 2003 and June 19, 2003; and (2) the Provider submitted a written communication to IBC on or before June 19, 2003, disputing a particular identifiable claim in the specific written communication he or she received between May 1, 2003 and June 19, 2003; and (3) the written communication was not responded to by IBC as of August 21, 2003.

Ex. Court-1, ¶ 3.

102. Several witnesses testified at the fairness hearing. Gerald W. Peden, M.D. and John D. Ladley, F.S.A., M.A.A.A. testified in support of the class action settlement, as did Dr. Gregg, Steven J. Scherf, CPA/AVB, CFE, CVA, DABFA and Linda Peeno, M.D. The court found credible the testimony of Dr. Peden, Mr. Ladley, Dr. Gregg, Mr. Scherf and Dr. Peeno. Edith M. Kallas, Esquire and Patrick F. Morris, Esquire, attorneys representing Objectors, testified regarding communications to class members, among other issues.[20] The defendants also presented the certifications of Jeffery A. Dailey, Esquire, Suzanne M. Sweeney, Esquire, Cynthia O'Neill, Evie Mayo and Anna Dickerson.

103. Dr. Gregg testified that in his years of practice as a doctor, he never had a fee schedule from Independent Blue Cross. Tr. 8/21/03, p. 47.

104. Dr. Gregg testified that he initiated the Gregg case because he discovered that over a period of four years, the defendant had denied over $500,000 in reimbursement payments to Dr. Gregg. Tr. 8/21/03, pp. 39-46, 71. Dr. Gregg thought he was entitled to the denied reimbursement and could not identify a consistent set of rules which would provide a basis for defendant to grant or deny reimbursement. Tr. 8/21/03, pp. 39-46. In addition, Dr. Gregg testified that other than leaving voicemail messages for the defendants' representatives regarding claims which had been denied, Dr. Gregg had no method of recourse to get his denied claims paid. Tr. 8/21/03, pp. 39-46.

105. Gerald Q. Peden, M.D., a medical director employed by

[20] This court does not include here further findings regarding the testimony of Mr. Morris and Ms. Kallas because it deemed their testimony evasive and, in important respects, not credible.

Independence Blue Cross, oversees the defendants' policy unit, has analyzed the various aspects of the Class Action Settlement Agreement, and has investigated the systems necessary to implement the policy changes as a result of that agreement. Tr. 8/21/03, pp. 86-87. Dr. Peden will serve as the medical director on the defendants' dispute resolution panel for the second level of a Provider's appeal. Tr. 8/21/03, pp. 88-89.

106. Dr. Peden testified regarding the categories of relief provided by the Class Action Settlement Agreement.

Disclosure

107. The first category of relief relates to disclosure of information to Providers to reduce their administrative burden in their attempts to obtain reimbursement from the defendant. Tr. 8/21/03, pp. 100-01.

108. Dr. Peden testified that the defendant will publish a manual which will explain the defendants' policy relating to codes. Tr. 8/21/03, p. 94. The manual is to be released in the beginning of 2005. Tr. 8/21/03, p. 94.

109. Dr. Peden testified that the defendant will also publish quarterly newsletters to notify Providers of recent policy relating to codes. Tr. 8/21/03, p. 94. The first newsletter was to be published in the fall of 2003. Tr. 8/21/03, p. 94.

110. Another aspect of disclosure will be the defendants' publication of fee schedules through a password-protected website. Tr. 8/21/03, p. 95. Participating Providers will have the password, and will be able to enter a code and obtain the standard fee which would be reimbursed in connection with that

code. Tr. 8/21/03, pp. 95, 166. Moreover, any participating Provider will be able to obtain the standard fee for any code, not just the codes pertinent to the field in which that Provider practices. Tr. 8/21/03, pp. 153-54.

111. In addition, Dr. Peden testified that the defendant has already and will continue to publish medical policy information on its website with access to the public. Tr. 8/21/03, p. 95. The medical policy information will contain the defendants' coverage position on medical technology such as new drugs, new devices and new procedures. Tr. 8/21/03, p. 95. The defendant will update the on-line medical policy information on a weekly basis. Tr. 8/21/03, p. 96-98.

112. Furthermore, Dr. Peden testified that the defendant will implement a web-based pre-adjudication tool for Providers to find out what the claim adjudication would be for hypothetical codes, modifiers and patient information. Tr. 8/21/03, pp. 98-99. This pre-adjudication tool is run by software called Clear Claim Connection for which the defendant has contracted until sometime in 2007. Tr. 8/21/03, pp. 98-99.

113. Dr. Peden testified that all of the disclosure changes pursuant to the Class Action Settlement Agreement will benefit all Providers, including those with capitated fee arrangements. Tr. 8/21/03, pp. 99, 138. Because the defendant does not have any Providers with a pure capitation arrangement, even capitated Providers have certain codes which they are permitted to bill, above capitation, and therefore, the disclosure of code information would benefit them. Tr. 8/21/03, p. 100.

114. The Class Action Settlement provides that the disclosure changes

will continue for a two year period from the date of Final Judicial Approval, with a phase in over that time period. Ex. D-11, § III(E). The projected timeline for disclosure changes to be implemented are set forth in Ex. D-6. The Class Action Settlement further states that: "IBC shall not be required to continue to provide disclosure after two years to the extent the Court finds that doing so would be inconsistent with IBC's business requirements or any controlling authority or requirement, including administrative, governmental or judicial authorities or requirements. . . . Notwithstanding the foregoing, from and after the close of the two year period, the form of IBC's disclosure . . ., if any, shall be within its sole discretion." Ex. D-11, § III(E).

Claims Processing

115. The second category of relief provided by the Class Action Settlement Agreement relates to claims processing changes which are set forth in Defendants' Exhibit D-13. Tr. 8/21/03, p. 104.

116. As to the claims processing change details, Dr. Peden testified that the defendant will replace Independent Procedure (codes eligible for reimbursement when they are the only code submitted on a claim) with CPT's definition of Separate Procedure (codes for separate procedures are generally portions of another procedure, but even when they are performed alone, they are eligible for reimbursement). Tr. 8/21/03, pp. 106-08.

117. Dr. Peden testified that when the defendant receives a claim with a code along with another code for Radiological Guidance and/or Supervision of a Procedure, the defendant will allow each code to be billed and paid. Tr. 8/21/03,

pp. 112-13. Providers other than radiologists use radiologic guidance. Tr. 8/21/03, p. 113. In addition, capitated Providers would benefit from this claims processing change because they could still bill the radiological supervision and interpretation despite their capitation arrangement. Tr. 8/21/03, p. 113.

118. The next claims processing change provided by the Class Action Settlement Agreement is Add-On Codes which are codes, as defined by CPT, used for an additional level of service in connection with a procedure. Tr. 8/21/03, p. 116. Dr. Peden explained that Add-On Codes could be used, for example, for procedures for each additional level of the spine in connection with spine surgery. Tr. 8/21/03, pp. 116-17. The defendant will reimburse 100% of the Add-On Code. Tr. 8/21/03, p. 117.

119. Dr. Peden testified that the defendant will change its policy with respect to Modifier 51 Exempt Codes as well. Tr. 8/21/03, p. 117. These codes are designed to describe a procedure with multiple services, such as a complete ultrasound. Tr. 8/21/03, p. 117-18. Providers would use these codes rather than billing each component of the procedure which, in the past, would have been paid at a reduced rate. Tr. 8/21/03, p. 118.

120. Dr. Peden testified that the defendant will also reimburse claims using Modifier 25 (Significant, Separately Identifiable E/M Service by Same Physician on Same Day of Procedure or Other Service). Tr. 8/21/03, p. 119. Providers use this modifier to claim reimbursement for an evaluation and management service in connection with a procedure. Tr. 8/21/03, p. 119-20. For example, a psychiatrist may use Modifier 25 if he evaluates a patient along with

performing an electromyogram. Tr. 8/21/03, pp. 127-28. Also, a family doctor may use Modifier 25 when he evaluates a patient during the same office visit that he performs a procedure on that patient. Tr. 8/21/03, p. 170.

121. Dr. Peden testified that the Modifier 25 claims processing change was already put into effect as a show of good faith for the Class Action Settlement Agreement. Tr. 8/21/03, pp. 210-11.

122. Dr. Peden further testified that Modifier 25 will not benefit Providers with capitated arrangements with the defendant because the evaluation services are included in the payment which the capitated Provider receives. Tr. 8/21/03, pp. 175-76.

123. Another claims processing change provided by the Class Action Settlement Agreement is the reimbursement of Modifier 50 (Bilateral Procedure) which allows a Provider to be paid for a procedure performed on both sides of a patient's (otherwise known to the defendant as a member) body. Tr. 8/21/03, p. 120-21. For example, Dr. Peden testified that a dermatologist might use Modifier 50 to describe a procedure to remove skin lesions. Tr. 8/21/03, p. 121.

124. Dr. Peden testified that the Modifier 51 code (Multiple Procedures) indicates that the procedure being billed is a multiple procedure and that each part of the multiple procedure should be paid. Tr. 8/21/03, pp. 121-22. The Modifier 51 code can be used in connection with thousands of codes. Tr. 8/21/03, p. 122.

125. In addition, Dr. Peden testified that when the defendant receives a claim which employs Modifier 59 (Distinct Procedural Service), together with a

code which is considered a Separate Procedure, the defendant will reimburse the Provider for both the Separate Procedure as well as the other procedure. Tr. 8/21/03, pp. 109-11. Providers will be able to use Modifier 59 to indicate that two procedures which are not generally billed together should, nonetheless, each be reimbursed. Tr. 8/21/03, p. 123.

126. Dr. Peden testified that Modifier 59 is applicable to the majority of CPT codes and is allowed to be billed with codes other than procedures. Tr. 8/21/03, pp. 123, 138-39.

127. Dr. Peden testified that the use of Modifier 59 will benefit capitated Providers. Tr. 8/21/03, pp. 176, 179.

128. Another claims processing change will involve Modifier 62 (Two Surgeons). Where a procedure requires more than one surgeon, each surgeon can submit his/her claim for reimbursement with Modifier 62 which allows the claims to be reimbursed without a reduction which would have occurred absent Modifier 62. Tr. 8/21/03, pp. 123-24.

129. Modifier 66 (Team Surgery) will allow multiple surgeons who perform procedures on a single patient, as might happen in “team surgery,” to submit their claims for reimbursement without a reduction which would have occurred absent Modifier 66. Tr. 8/21/03, p. 125.

130. Dr. Peden testified that some Provider groups will benefit more from the claims processing changes than other Provider groups based on the fact that the claims reimbursement relies on codes, and some Provider groups use more codes for the type of care that they give. Tr. 8/21/03, pp. 137, 190. As

Dr. Peden put it, "[P]rocedurally based providers have more to choose from to bill than nonprocedurally based providers." Tr. 8/21/03, p. 137. On the other hand, Dr. Peden testified that the claims processing changes will benefit all Providers, not just orthopedic surgeons. Tr. 8/21/03, p. 127. For example, all fee for service Providers will be able to use Modifier 25 and Modifier 59 for reimbursement of their claims, and all capitated Providers will be able to use Modifier 59. Tr. 8/21/03, pp. 127, 138, 176, 179.

131. The Class Action Settlement provides that the claims processing changes will continue for a two year period from the date of Final Judicial Approval, with a phase in over that time period. Ex. D-11, § III(B) and (E). The projected timeline for claims processing changes to be implemented are set forth in Ex. D-6.

Dispute Resolution

132. The third category of relief provided by the Class Action Settlement Agreement relates to a new, two-level dispute resolution process.

133. If a Provider receives a response from the defendant with which the Provider disagrees, the Provider may appeal that response by submitting the dispute to the defendants' Inquiries Unit. Tr. 8/21/03, p. 133.

134. The Inquiries Unit is staffed by claims examiners who will determine if a particular claim was processed correctly or incorrectly. Tr. 8/21/03, p. 133.

135. The defendants' Inquiries Unit staff is not in any way compensated based on the number of claims they deem to have been processed correctly or incorrectly. Tr. 8/21/03, p. 133.

136. For the first level of dispute resolution, the Provider would submit the disputed Explanation of Benefits form, an explanation of why the Provider disagrees with the defendant, a proposal of an alternative method of payment on the claim, and supporting documentation. Tr. 8/21/03, p. 133.

137. The defendant would have thirty days to respond to the Provider. Tr. 8/21/03, pp. 135-136.

138. If a Provider disputes the Inquiry Unit's response, the Provider may submit the dispute to the defendants' three-member panel composed of a medical director or doctor and two internal employees not involved in claims processing. Tr. 8/21/03, pp. 134-35. This is the second level of dispute resolution.

139. The defendant would then have forty-five days to respond to the Provider. Tr. 8/21/03, pp. 135-36.

140. Dr. Peden testified that all Providers are eligible to participate in this dispute resolution process provided by the Class Action Settlement Agreement, and therefore it will benefit all Providers. Tr. 8/21/03, pp. 136, 138.

141. In addition, if after the dispute resolution process, a Provider remains unsatisfied with the outcome of the dispute, a Provider may still file a lawsuit against the defendant. Tr. 8/21/03, p. 136; Tr. 8/22/03, pp. 461-62.

142. The Class Action Settlement provides that the dispute resolution changes will continue for a two year period from the date of Final Judicial Approval, with a phase in over that time period. Ex. D-11, § III(C) and (E). The projected timeline for dispute resolution changes to be implemented are set forth

in Ex. D-6. The Class Action Settlement further states that: ". . . from and after the close of the two year period, the form of IBC's . . . dispute resolution, if any, shall be within its sole discretion." Ex. D-11, § III(E).

Value of Class Action Settlement Agreement

143. At the fairness hearing, the defendant relied on the testimony of John Ladley, a consulting actuary partner at Ernst & Young who concentrates on health and life insurance company consulting. Tr. 8/21/03, pp. 238-39; Ex. D-62.

144. Mr. Ladley collected data from the defendant and performed an analysis to evaluate the value of additional payments due to the claims processing changes provided by the Class Action Settlement Agreement. Tr. 8/21/03, pp. 242-50. Mr. Ladley and his staff prepared an Impact Analysis to reflect the analysis and conclusion. Tr. 8/21/03, p. 251; Ex. D-54.

145. Mr. Ladley concluded that to a reasonable degree of actuarial certainty, the value of the claims processing changes provided by the Class Action Settlement Agreement is in the range of $53.8 to $63.8 million. Tr. 8/21/03, pp. 259-60, 264; Ex. D-54. The range indicates a more conservative or less conservative view of how many claims will continue to be denied. Tr. 8/21/03, p. 264. Mr. Ladley's best estimate of the value is the midpoint of that range, namely $59 million. Tr. 8/21/03, pp. 260, 265.

146. In his analysis, Mr. Ladley did not place any monetary value on the dispute resolution process provided by the Class Action Settlement Agreement. Tr. 8/21/03, p. 263.

147. In addition, Mr. Ladley did not factor into his analysis the cost to the

defendant in making the claims processing changes. Tr. 8/21/03, p. 261.

148. The plaintiffs relied on the testimony and work of Stephen Scherf, a certified forensic accountant at Parente Randolph. Ex. P-3; Ex. P-4; Ex. P-5; Tr. 8/21/03, pp. 422-25.

149. Mr. Scherf concluded that to a reasonable degree of forensic accounting certainty, the value of the Class Action Settlement Agreement is in excess of $40 million. Ex. P-4; Ex. P-5; Tr. 8/21/03, pp. 427-30, 432, 440.

150. Mr. Scherf tested the analysis and conclusions of Mr. Ladley, and based on this examination, testified that the value which Mr. Ladley assigned to the Class Action Settlement was reasonable. Tr. 8/21/03, pp. 436-37. However, Mr. Scherf made more conservative assumptions than Mr. Ladley in the assessment of the settlement's value. Tr. 8/21/03, p. 436.

151. Like Mr. Ladley, Mr. Scherf did not factor into his analysis the cost to the defendant in making the claims processing changes. Tr. 8/21/03, p. 438.

152. Except to the limited extent implicated by Dr. Stephen Foreman's report (Ex. PMS-2, p. 4), the objectors did not present testimonial evidence estimating the value of the claims processing changes.[21]

153. Dr. Linda Peeno, a medical doctor who is currently a health care consultant, also testified for the plaintiffs regarding the value of the Class Action Settlement Agreement's terms. Ex. P-7 (Curriculum Vitae of Dr. Peeno); Tr. 8/22/03, pp. 535-40.

[21] The Foreman report focuses primarily on the objectors' argument that the proposed settlement would result in an unfairly weighted spectrum of benefits, depending upon a given Provider's practice; for example, primary care specialties compared with non-primary care specialties. Ex. PMS-2.

154. Dr. Peeno testified that in her opinion, the claims processing changes will encourage physicians to use their best clinical logic in treating patients without financial sacrifice. Tr. 8/22/03, pp. 569-70. According to Dr. Peeno, claims processing prior to the Class Action Settlement Agreement has encouraged physicians to treat patients in a way which would best guarantee reimbursement from the defendant to the physicians. Tr. 8/22/03, pp. 569-70. Dr. Peeno explained, for example, that a physician has had to choose between performing two procedures on a patient under the same anesthesia and not being reimbursed for both procedures versus causing the patient to undergo anesthesia twice and being reimbursed for both procedures. Tr. 8/22/03, pp. 569-70.

155. Dr. Peeno testified that in her opinion, the dispute resolution process will be beneficial to physicians because it will create an opportunity to resolve physicians' claims fairly. Tr. 8/22/03, pp. 570-71.

156. Dr. Peeno also testified that in her opinion, the defendants' disclosure of payment policies and fee schedules is a "radical paradigm shift" because it has been the lack of disclosure which has prevented physicians from knowing how to take care of patients within the context of financial reimbursement and maximize their practices' profit. Tr. 8/22/03, pp. 573-74.

157. In addition, Dr. Peeno testified that the terms of the Class Action Settlement Agreement will benefit physicians with capitated fee arrangements because it will disclose fee schedules and payment policies and will allow physicians to more accurately code and keep track of the cost of services which

they provide to capitated patients. The physicians will be able to analyze whether the capitated fee they receive for each patient is too little given their record of the actual value of services provided. With this information, physicians will be able to better negotiate a fair capitated fee arrangement with the defendant. Tr. 8/22/03, p. 575-77, 605-06, 612.

Objections to Class Action Settlement Agreement

158. Certain individuals, practice groups and professional societies filed objections to the final approval of the Class Action Settlement.

159. Specifically, a total of eighteen objections were filed, which included nine individual Providers[22], one individual Provider attempting to represent a class of physicians[23], one group Provider[24], one practice group[25], and six professional societies[26]. Only eight of these eighteen objections are proper.

160. Drs. Sklaroff, Malloy, and Fallon, as well as the Physician Providers of the University of Medicine and Dentistry -- Robert Wood Johnson Medical School opted out of the Settlement prior to filing objections. Ex. D-1; Ex. D-47; See also Objection of Certified Class of New Jersey Providers to Proposed Settlement, p. 1 ("Dr. Malloy has opted-out of this class in his individual capacity"); Tr. 8/21/03, p. 4 (Dr. Sklaroff admitted that he opted-out).

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[22] The nine individual Providers are: Natalie M. Grider, M.D., Rosalind Kaplan, M.D., Louis P. Bucky, M.D., Joseph Fallon, M.D., Martin Trichtinger, M.D., William Lander, M.D., Nancy Roberts, M.D., Beverly Dolberg, M.D. and Robert Sklaroff.

[23] The individual Provider attempting to represent a class of physicians is Terrence R. Malloy, M.D.

[24] The group Provider is Physician Providers of the University of Medicine & Dentistry – Robert Wood Johnson Medical School.

[25] The practice group is Kutztown Family Medicine.

[26] The professional societies are: American Medical Association, Pennsylvania Psychiatric Society, Medical Society of the State of New York, South Carolina Medical Association, Tennessee Medical Association, and the Pennsylvania Medical Society.

161. Dr. Fallon subsequently filed a Motion to Revoke Opt-out to Proposed Settlement to which the defendants filed their opposition. On September 15, 2003, the court denied the Motion of Joseph Fallon, M.D. to Revoke his Opt-out to the Class Action Settlement.

162. Dr. Malloy is the certified class representative of the class in Malloy, and in his objection in this Litigation, he purports to represent the entire class in Malloy.

163. Mr. Trujillo and Ms. Kallas claimed to represent Dr. Bucky at the fairness hearing. However, no one presented a signed authorization by Dr. Bucky for such representation, and no attorney filed an entry of appearance on behalf of Dr. Bucky. Dr. Bucky also failed to state in his objection that he wanted to appear at the fairness hearing, as the Notice required. Tr. 8/21/03, p. 223.

164. Objector Rosalind Kaplan, M.D. graduated from medical school in 1987 and is licensed to practice medicine in Pennsylvania through November 2004. Tr. 8/22/03, pp. 529-30.

Testimony of Objectors at the Fairness Hearing

165. Counsel for objector Kutztown Family Medicine, P.C., called two witnesses to testify at the fairness hearing.

166. Christiana Eshbach, a billing manager for Kutztown Family Medicine, P.C., testified that most of the work for which that practice bills is capitated and therefore, the practice receives a monthly payment for most of their patients, regardless of whether the practice provides services to those patients. Tr. 8/21/03, pp. 281-82, 289. George Raymond, the operations manager for

Kutztown Family Medicine, P.C., testified that for the practice's capitated work, he did not foresee any benefit from the Class Action Settlement Agreement. Tr. 8/21/03, pp. 293-94.

167. When Kutztown Family Medicine, P.C. provides a service for an Independence Blue Cross Preferred Provider Organization ("PPO") patient, however, then the practice bills the defendant on a fee for service basis. Tr. 8/21/03, pp. 288-89.

168. Both Ms. Esbach and Mr. Raymond testified that the claims processing changes provided by the Class Action Settlement Agreement will benefit Kutztown Family Medicine, P.C. in its fee for service billing. Tr. 8/21/03, pp. 289-90, 293-94, 305.

169. Objector Martin D. Trichtinger, M.D., an internist, testified that he did not foresee any benefit from the Class Action Settlement Agreement with respect to capitated fee arrangements, which constitutes the majority of his practice. Tr. 8/21/03, pp. 313, 323. Dr. Trichtinger testified, however, that he has not seen the list of bill-above codes which the defendant is publishing and which he could use to bill over and beyond the capitated services. Tr. 8/21/03, pp. 326-27; See n.5, *supra*.

170. Dr. Trichtinger further testified that no benefit would result from the Class Action Settlement Agreement with respect to services he typically provides as a specialist because he already is paid for those services. Tr. 8/21/03, p. 313.

171. Dr. Trichtinger is the Vice-Speaker of the Pennsylvania Medical Society whose Board of Trustees oppose the Class Action Settlement

Agreement. Tr. 8/21/03, pp. 315, 317.

Motion to Invalidate Opt-outs and Other Submissions

172. On August 20, 2003, the defendants filed their Opposition to Objections to the Class Action Settlement, as well as a Motion to Invalidate Opt-outs, for Approval of Corrective Notice to Certain Class Members, and to Temporarily Restrain Communications Concerning the Class Settlement ("Motion to Invalidate Opt-outs").

173. The plaintiffs joined defendants' Motion to Invalidate Opt-outs. See Pltfs' Praecipe to Join, dated September 10, 2003, and the Order approving the praecipe, dated September 11, 2003; Tr. 8/22/03, p. 639.

174. Also on August 20, 2003, upon a joint motion by the parties, the court granted the defendants an extension of time to exercise its withdrawal rights pursuant to Section IV.C of the Class Action Settlement Agreement. The time is extended to the later of (1) twenty days after the close of any subsequent opt-out period ordered by the court should the court grant the defendants' Motion to Invalidate Opt-outs or (2) five days after the court's denial of the defendants' Motion to Invalidate Opt-outs.

175. The plaintiffs also filed a Motion in Limine to Preclude Non-Class Members from Objecting.

176. Several individuals and entities submitted Proposed Findings of Fact and Conclusions of Law to the court, including (1) the plaintiff class representatives Pennsylvania Orthopaedic Society, Dr. Robert P. Good, Dr. John R. Gregg and Dr. Vincent J. DiStefano, on behalf of themselves and all others

similarly situated, (2) the defendants, (3) objectors Martin D. Trichtinger, M.D., William W. Lander, M.D., Nancy S. Roberts, M.D., Beverly K. Dolberg, M.D., and the Pennsylvania Medical Society, (4) objectors Kutztown Family Medicine, P.C. and Natalie M. Grider, M.D., and (5) objector Rosalind Kaplan, M.D.

DISCUSSION

Pennsylvania law requires that a class action may not be settled without a hearing and court approval. Pa.R.Civ.P. 1714(a). On August 21 and 22, 2003, this court conducted a hearing on the Motion for Final Approval of the Class Action Settlement. Based upon the criteria enunciated by the Pennsylvania Supreme Court, the testimony, the exhibits and the arguments presented at the hearing, as well as the parties' and objectors' written submissions, the court has determined: (1) that the Settlement Class should be certified, (2) that the Class Action Settlement is entitled to the presumption that it is fair, (3) and that the Class Action Settlement should be approved. Admittedly, the Class Action Settlement does not secure every remedy desired by the plaintiffs or the objectors, but it achieves relief which falls within the range of reasonableness, and should be approved.

The Class Is Certified for Settlement

As a threshold matter, the court must determine that it is appropriate to certify the class for the purpose of settlement pursuant to Pa.R.Civ.P. 1710. On June 19, 2003, upon consideration of the Joint Motion for Preliminary Approval of the Class Action Settlement Agreement, this court conditionally certified the class for the purpose of settlement. See Finding of Fact, ¶ 29. Now, the court finds

that the same class which was conditionally certified for settlement should be certified for final approval of settlement.

The June 19, 2003 Order defines the "Settlement Class" as:

> All Providers (1) who submitted claims for payment or reimbursement to Independence Blue Cross and/or any Released Party for medical services, procedures and/or products and (2) who have been, claim to have been, and/or may have been denied payment or reimbursement or have, claim to have, and/or may have received reduced payment or reimbursement on such claims. The Settlement Class includes, but is not limited to, all claims by Providers for downcoding and/or bundling, however described or characterized.

Motion for Approval, Ex. A, § II(A).

Rule 1702 of the Pennsylvania Rules of Civil Procedure sets forth five prerequisites for the certification of a class:

> One or more members of a class may sue or be sued as representative parties on behalf of all members in a class action only if:
> (1) the class is so numerous that joinder of all members is impracticable;
> (2) there are questions of law or fact common to the class;
> (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class;
> (4) the representative parties will fairly and adequately assert and protect the interests of the class under the criteria set forth in Rule 1709;
> (5) a class action provides a fair and efficient method for adjudication of the controversy under the criteria set forth in Rule 1708.

Pa.R.Civ.P. 1702.

The first prerequisite of numerosity tests whether "the number of potential individual plaintiffs would pose a grave imposition on the resources of the court and an unnecessary drain on the energies and resources of the litigants should plaintiffs sue individually." Baldassari v. Suburban Cable TV Co., Inc., 808 A.2d 184, 190 (Pa. Super.) (citations omitted), *appeal denied*, 573 Pa. 694, 825 A.2d 1259 (2002). The plaintiff seeking class certification "need not plead or prove the

actual number of class members, so long as he is able to define the class with some precision and provide sufficient indicia to the court that more members exist than it would be practicable to join." Baldassari, 808 A.2d at 190 (quotations omitted), citing Janicik v. Prudential Ins. Co. of America, 305 Pa. Super. 120, 132, 451 A.2d 451, 456 (1982).

Thousands of Providers qualify as class members under the definition set forth in the court's June 19, Order and Section II.A of the Class Action Settlement Agreement. See Finding of Fact, ¶ 30. Approximately 34,422 Providers in Pennsylvania, New Jersey, Delaware, Maryland and New York were mailed Notices of the Class Action Settlement. Ex. D-45. The number of potential individual plaintiffs is sufficiently plentiful for this prerequisite to be met.

Next, the court must determine whether the plaintiffs' claims present "questions of law or fact common to the class." Pa.R.Civ.P. 1702(2). Our Superior Court has explained the commonality prerequisite as follows:

> The common question of fact means precisely that the facts must be substantially the same so that proof as to one claimant would be proof as to all. While the existence of individual questions essential to a class member's recovery is not necessarily fatal to the class, there must be a predominance of common issues shared by all class members which can be justly resolved in a single proceeding. Moreover, claims arising from interpretations of a form contract generally give rise to common questions.

Baldassari, 808 A.2d at 191 (quotations and citations omitted). Furthermore, "'class actions may be maintained even when the claims of members of the class are based on different contracts' so long as 'the relevant contractual provisions raise common questions of law and fact and do not differ materially.'" Janicik, 305 Pa. Super. at 133, 451 A.2d at 457 (citations omitted).

All class members are health care providers who have provided medical services or who have performed medical procedures for patients who are insured by the defendants. All class members have also submitted claims to the defendants for payment for the medical services or medical procedures provided. All class members have been denied reimbursement on a claim, or have been reimbursed an improperly reduced amount. The factual and legal issues in this Litigation relating to the defendants' reimbursement policies (including alleged downcoding and bundling), the lack of disclosure of those policies and fee schedules, and the absence of any meaningful way to appeal an improperly resolved claim, are common to all of the class members. Therefore, the commonality requirement is met.

The third prerequisite to evaluate is whether the claims or defenses of the representative parties are typical of the claims or defenses of the class. Pa.R.Civ.P. 1702(3). Regarding this analysis, our Superior Court has stated:

> This factor requires that the class representative's overall position on the common issues is sufficiently aligned with that of the absent class members to ensure that his pursuit of his own interests will advance those of the proposed class members.

Baldassari, 808 A.2d at 193, citing D'Amelio v. Blue Cross of Lehigh Valley, 347 Pa. Super. 441, 458, 500 A.2d 1137, 1146 (1985) and Janicik, 305 Pa. Super. at 134, 451 A.2d at 457.

The representative parties' positions are typical of the class members' claims because the representative parties have been denied reimbursement and have received improperly reduced reimbursement for medical care they have provided patient subscribers. Indeed, Dr. Gregg testified that over the course of

four years during the 1990s, he determined that the defendant paid him only twenty-six to thirty percent of what he had been reimbursed previously, for the same amount of work. Tr. 8/21/03, pp. 40-41. Thus, the interests of the class representatives in obtaining greater reimbursement, disclosure of payment policies and a vehicle to appeal improperly resolved claims are aligned with the other health care providers of the class. This requirement of typicality is satisfied.

The court next evaluates whether the representative parties will fairly and adequately assert and protect the interests of the class under the criteria set forth in Rule 1709. Pa.R.Civ.P. 1702(4). Rule 1709's criteria are:

> (1) whether the attorney for the representatives parties will adequately represent the interests of the class,
> (2) whether the representative parties have a conflict of interest in the maintenance of the class action, and
> (3) whether the representative parties have or can acquire adequate financial resources to assure that the interests of the class will not be harmed.

Pa.R.Civ.P. 1709.

Counsel who have litigated on behalf of the representative parties have and will continue to adequately represent the interests of the class. "Generally, until the contrary is demonstrated, courts will assume that members of the bar are skilled in their profession." Janicik, 305 Pa. Super. at 136, 451 A.2d at 458 (citation omitted). "Courts may also infer the attorney's adequacy from the pleadings, briefs, and other material presented to the court, or may determine these warrant further inquiry." Janicik, 305 Pa. Super. at 136, 451 A.2d at 459 (citations omitted).

Jerome Marcus, Esquire and Jonathan Auerbach, Esquire of Berger & Montague, P.C., a lawfirm well-known for its handling of complex and class action litigation, have obtained specific experience in litigating health insurance cases over the past five years. At the fairness hearing, Mr. Marcus described that in 1999, Berger & Montague, P.C. litigated a case in the Third Circuit United States Court of Appeals relating to Independent Blue Cross Keystone HMO's physician financial incentives. Tr. 8/21/03, p. 10. A few years later, Berger & Montague, P.C. litigated a case regarding the alleged abuse of Independence Blue Cross' nonprofit status. Tr. 8/21/03, p. 10. In addition, Berger & Montague, P.C. litigated a case with co-counsel on behalf of providers alleging bundling and downcoding claims. Tr. 8/21/03, p. 11; Ex. D-39.

More generally and significant for the success of any case, no matter what the topic area, Mr. Marcus, Mr. Auerbach, and David Senoff, Esquire of Billet & O'Connor, P.C. are highly experienced, capable and tenacious litigators. See Motion for Approval, Ex. C (Profile of Berger & Montague, P.C.). In addition, the objectors have failed to present any compelling evidence challenging the competence of plaintiffs' counsel. Furthermore, the numerous pleadings and their content and the frequent and competent arguments before this court demonstrate that plaintiffs' counsel have more than adequately represented the interests of the class.

Next, there is no indication that any of the representative parties have a conflict of interest in the maintenance of the class action. "Because of the difficulty of proving a negative, courts have generally presumed that no conflict of

interest exists unless otherwise demonstrated, and have relied upon the adversary system and the court's supervisory powers to expose and mitigate any conflict." Janicik, 305 Pa. Super. at 136-37, 451 A.2d at 459 (citations omitted). The court, therefore, presumes the lack of a conflict of interest.

The court also believes that the class representatives have and will represent the class fairly and adequately. The court has considered Dr. Gregg's testimony that he initiated his case because he was sufficiently frustrated with the defendants' reimbursement policies. The court believes that Dr. Gregg has, from the beginning, acted in furtherance of health care providers' interests:

> I brought the suit against them out of total frustration. When I first went into practice in the late '70s, Blue Cross-Blue Shield Insurance Company was a partner in helping us take care of people. They paid for people who bought insurance and we took care of them, and they paid us reasonable and they were a very easy company to deal with. And then as time went on, through the '90s, they turned into a nefarious black box for not only the consumer but for the doctor. And my initiation into the financial aspects of this occurred in the mid-90s when my accountant told me – I was working six days a week, 12 hours a day – that I was going bankrupt.

Tr. 8/21/03, pp. 39-40; See also Tr. 8/21/03, pp. 41-42. When asked whether he would obtain the benefits of the litigation, Dr. Gregg responded:

> I don't know whether I'll last four more years practicing, but [ ] I decided that I would subjugate, you know. I don't want to seem like a saint, I'm not a saint, but I decided for the better good that we had to do something and it was in the best interest of medicine because we wouldn't have – doctors are going to be just pouring out of this state faster and faster and we're going to lose medicine in Pennsylvania the way things are going. It's very sad.

Tr. 8/21/03, p. 71. Dr. Gregg also testified that Dr. DiStefano was willing to initiate the lawsuit with him because he's "older like [Dr. Gregg]" and unlike Dr. Gregg's other partners, did not fear retaliation. Tr. 8/21/03, p. 46. These

motivations indicate an attitude on the part of the class representatives to act fairly and adequately for the members of the class, without any conflict of interest. The court notes that Dr. Gregg was credible, and impressed the court as a decent and caring man of substance and integrity.

In addition, the requirement that the representative parties have adequate financial resources to assure that the interests of the class will not be harmed is met. Plaintiffs' counsel have advanced the costs and expenses of the Litigation. See Motion for Approval, p. 46. Where an attorney for a class representative ethically advances costs and expenses to the representative, the adequate financing requirement of the certification test is met. Weinberg v. Sun Co., Inc., 740 A.2d 1152, 1171 (Pa.Super. 1999), *aff'd in part and rev'd in part on other grounds*, 565 Pa. 612, 777 A.2d 442 (2001).

The final prerequisite for class certification is whether a class action provides a fair and efficient method for adjudication of the controversy under the criteria set forth in Rule 1708. Rule 1708 provides a series of factors to consider, and according to our Superior Court, "they are not exclusive and their importance may vary according to the circumstances." Pa.R.Civ.P. 1708; Janicik, 305 Pa. Super. at 141, 451 A.2d at 461 (citations omitted). Rule 1708 states:

> (a) Where monetary recovery alone is sought, the court shall consider
> (1) whether common questions of law or fact predominate over any question affecting only individual members;
> (2) the size of the class and the difficulties likely to be encountered in the management of the action as a class action;
> (3) whether the prosecution of separate actions by or against individual members of the class would create a risk of
> (i) inconsistent or varying adjudications with respect to individual members of the class which would

confront the party opposing the class with incompatible standards of conduct;

(ii) adjudications with respect to individual members of the class which would as a practical matter be dispositive of the interests of other members not parties to the adjudications or substantially impair or impede their ability to protect their interests;

(4) the extent and nature of any litigation already commenced by or against members of the class involving any of the same issues;

(5) whether the particular forum is appropriate for the litigation of the claims of the entire class;

(6) whether in view of the complexities of the issues or the expenses of litigation the separate claims of individual class members are insufficient in amount to support separate actions;

(7) whether it is likely that the amount which may be recovered by individual class members will be so small in relation to the expense and effort of administering the action as not to justify a class action.

(b) Where equitable or declaratory relief alone is sought, the court shall consider

(1) the criteria set forth in subsections (1) through (5) of subdivision (a), and

(2) whether the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making final equitable or declaratory relief appropriate with respect to the class.

(c) Where both monetary and other relief is sought, the court shall consider all the criteria in both subdivisions (a) and (b).

Pa.R.Civ.P. 1708. "In determining fairness and efficiency, the court must balance the interests of the litigants, present and absent, and of the court system." Janicik, 305 Pa. Super. at 141, 451 A.2d at 461 (citations omitted). This court determines that certifying the action as a class action for settlement is fair and efficient based on the eight factors analyzed below.

First, common questions of law or fact predominate over any question affecting only individual members. As discussed previously, the common questions of law and fact involve the defendants' reimbursement policies

(including alleged downcoding and bundling), the lack of disclosure of those policies and fee schedules, and the absence of a meaningful way to appeal an improperly resolved claim. These common questions predominate over any individual questions, such as the exact dollar amount of reimbursement each health care provider has been denied.

Second, the size of the class and the difficulties likely to be encountered in the management of the action as a class action are not insurmountable. Since the class was conditionally certified, there has been no indication that the size of the class has been problematic. In addition, because this certification is for the purpose of settlement rather than a continuation of the litigation through trial, there will be little need for further management of the class action.

Third, the prosecution of separate actions by individual health care providers would create a risk of inconsistent adjudications. This is especially so because individual health care providers could bring these claims in various courts, inside and outside this Commonwealth. As our Superior Court recognized, "[c]ourts may, and often do, differ in resolving similar questions presenting issues of law or fact." Janicik, 305 Pa. Super. at 143, 451 A.2d at 462. Inconsistent adjudications would potentially create great difficulties for the defendants in reimbursing health care providers, as well as for other health care providers whose similar claims might be harmed by preceding adjudications.

Fourth, although other plaintiffs have brought litigation against the defendants involving many of the same issues, this factor, in and of itself, does not preclude certification of this class for settlement purposes.

Fifth, this court is an appropriate forum for the litigation of the claims of the entire class. The defendants are based or do business in Philadelphia County. Also, the court has jurisdiction over the class members who reside in Pennsylvania as well as those class members who submit to the court's jurisdiction.

Sixth, in view of the complexities of the issues and the expenses of litigation, generally speaking, the separate claims of individual class members would not support separate actions. There may be other health care providers like Dr. Gregg who lost a substantial amount of money over a period of time based on the lack of sufficient reimbursement by the defendants. These health care providers' damages might support separate actions, and perhaps that is the reason why some individuals opted-out of this settlement. The ability to bring a lawsuit against the defendants, however, would require substantial financial resources. Even if some individual health care providers were able to persuade firms like Berger & Montague, P.C. to take their cases on a contingency fee basis, there would be many providers left without willing counsel or financial resources to bring their claims. These claims, in addition to all of the smaller damage claims of other providers, would likely go unlitigated – an obviously unfair result.

Regarding the seventh factor, the plaintiffs state that "while the amounts at issue in this case for each claimant are not insubstantial, the fact remains that those amounts will not justify the expenditure of the sums it will take to try this case if Defendants insist on litigating each of their defenses." Motion for

Approval, p. 50. The parties urge this court to approve the Class Action Settlement, however, and thus, the expenses of litigating hopefully will not have to be incurred.

Because the plaintiffs also seek non-monetary relief, the court considers the eighth factor which is whether the defendant has acted on grounds generally applicable to the class, making final equitable or declaratory relief appropriate with respect to the class. According to the Class Action Settlement, the defendants will make disclosures in the form of policies and fee schedules to all class members, and provide a dispute resolution process for all. Thus, this factor weighs in favor of certifying the class to obtain the benefits of settlement.

Upon consideration of the prerequisites of Rules 1702, 1708 and 1709 of the Rules of Civil Procedure, the court certifies these three consolidated cases as class actions for the purposes of settlement only. The court incorporates the definitions of "Settlement Class" and "Providers" set forth in its June 19, 2003 Order[27] (and the Class Action Settlement Agreement).

The Presumption That the Settlement is Fair

Our Supreme Court has instructed that "settlements are favored in class action lawsuits." Dauphin Deposit Bank and Trust Co. v. Hess, 556 Pa. 190, 197, 727 A.2d 1076, 1080 (1999). Based on this principle, and under certain circumstances, the settlement in a class action lawsuit is entitled to the initial

[27] The class is defined as "All Providers (1) who submitted claims for payment or reimbursement to Independence Blue Cross and/or any Released Party for medical services, procedures and/or products and (2) who have been, claims to have been, and/or may have been denied payment or reimbursement or have, claim to have, and/or may have received reduced payment or reimbursement on such claims. The Settlement Class includes, but is not limited to, all claims by Providers for downcoding and/or bundling, however described or characterized." See June 19, 2003 Order; Motion for Approval, Ex. A, II.A.

presumption that it is fair. The circumstances to establish this presumption are:

(1) That the settlement has been arrived at by arm's-length bargaining;
(2) That sufficient discovery has been taken or investigation completed to enable counsel and the court to act intelligently;
(3) That the proponents of the settlement are counsel experienced in similar litigation; and
(4) That the number of objectors or interests they represent is not large when compared to the class as a whole.

Milkman v. American Travellers Life Insurance Co., No. 3775 June Term 2000, 2002 WL 778272, *5 (Pa. Com. Pl., Phila., April 1, 2002), citing Herbert B. Newberg and Alba Conte, 2 Newberg on Class Actions §11.41 (3d ed. 1992) (further citations omitted).

Here, each of the four criteria for a presumption of fairness is satisfied. Counsel for the parties negotiated for over six months, starting in December 2002 and finishing around May 2003, before reaching the proposed settlement. Tr. 8/21/03, pp. 8, 20. It was not until June 19, 2003, that the parties jointly moved for preliminary approval of the Class Action Settlement Agreement.

As for discovery, the record itself does not reveal the true extent of the discovery served and pursued by the parties, in that the Pennsylvania Rules of Civil Procedure do not require the filing of discovery pleadings. Nonetheless, the plaintiffs in the Gregg case did attach certain discovery to their Motion for Partial Summary Judgment and their Motion for Class Certification.[28] See Motion for Partial Summary Judgment in the Gregg case, Exs. 2 (D000001-D000605), 4 (Deposition Transcript of Todd Stanton, Senior Director Provider Programs at

[28] The plaintiffs' Motion for Partial Summary Judgment and Motion for Class Certification were originally filed under seal. However, the court removed the seal and announced in open court to counsel at the fairness hearing, including counsel for the objectors, that all filings and their attached exhibits, including discovery, were available for inspection.

Independence Blue Cross), 6; See also Motion for Class Certification in the Gregg case, Exs. 3-7.

Further, this court was frequently involved with the discovery process to the extent that counsel requested court intervention in discovery disputes. Finding of Fact, ¶ 18. In fact, in one such discovery dispute, the court itself requested second supplemental interrogatory responses from the defendant. Motion for Class Certification in the Gregg case, Ex. 6 (Def's Response to Second Supplemental Interrogatories). Based on its own involvement, this court can attest that the parties vigorously pursued discovery.

Next, the requirement that counsel for the proponents be experienced in similar litigation, is also satisfied. The court here incorporates its previous discussion (in the section relating to class certification) of the skills, experience and excellent work of Mr. Marcus, Mr. Auerbach and Mr. Senoff. Furthermore, in that the defendants supported the proponents' Motion to approve the settlement, the court takes into account the experience and fine work done by counsel for the defendants.

Finally, the prerequisite of whether the number of objectors or interests they represent is not large when compared to the class as a whole is fulfilled. As stated, nine individual Providers, one individual Provider attempting to represent a class of physicians, one group Provider, one practice group, and six professional societies filed objections to the Class Action Settlement. Not all of these objections were appropriate, however. Only eight objections were properly before the court.

Drs. Sklaroff, Malloy, and Fallon, as well as the Physician Providers of the University of Medicine and Dentistry -- Robert Wood Johnson Medical School, lack standing to object because they opted-out of the Class Action Settlement Agreement prior to filing objections. Ex. D-1; Tr. 8/21/03, p. 4; See In re Vitamins Antitrust Litigation, No. 99-197 TFH, 2000 WL 1737867, *5 (D.D.C. March 31, 2000) (citations omitted) ("It is firmly established in this Circuit, and elsewhere, that class members who opt-out of the class and are thus not parties to the settlement lack standing to object to the settlement.")[29]; See also In re Integra Realty Resources, Inc., 262 F.3d 1089, 1102 (10th Cir. 2001); Root v. Ames Department Stores, Inc., 989 F.Supp. 274, 275 (D.Mass. 1997) (holding that a potential class member lacked standing to object to a settlement because she had not "opted-in."); In re Sunrise Securities Litigation, 131 F.R.D. 450, 459 (E.D.Pa. 1990) ("As a general rule, only class members have standing to object to a proposed class settlement.").

Dr. Fallon and Dr. Malloy have slightly more complicated circumstances but still lack standing to object. After having opted-out of the settlement, Dr. Fallon filed a motion to revoke his opt-out. However, by Order dated September 15, 2003, the court denied Dr. Fallon's motion. Finding of Fact, ¶ 161. Thus, Dr. Fallon's opt-out remains effective and precludes him from objecting to the Class Action Settlement. Dr. Malloy similarly lacks standing to object as he opted-out of the settlement in his individual capacity prior to filing his objection on behalf of

[29] Federal court decisions have persuasive value in Pennsylvania courts, though their authority is not binding. Hutchison v. Luddy, 763 A.2d 826, 837 n.8 (Pa.Super. 2000); In re Insurance Stacking Litigation, 754 A.2d 702, 705 n.6 (Pa.Super. 2000); McMonagle v. Allstate Ins. Co., 460 Pa. 159, 167, 331 A.2d 467, 471-72 (1975).

the class in Malloy v. Amerihealth HMO, Inc., Docket No. L-891-01 in the Superior Court of New Jersey, Law Division, Camden County. Ex. D-1. Dr. Malloy cannot object on a representational basis because he is not permitted to object himself.[30] / [31]

The medical societies which objected – the American Medical Association, the Pennsylvania Psychiatric Society, the Pennsylvania Medical Society, the Medical Society of the State of New York, the South Carolina Medical Association and the Tennessee Medical Association – also lack standing to object to the proposed settlement. Associations have standing in a class only when (a) their members would otherwise have standing to sue; (b) the interests the association seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members. Hunt v. Washington State Apple Advertising Comm'n, 432 U.S. 333, 343 (1977); See also Pennsylvania Chiropractic Ass'n v. Independence Blue Cross, 2001 WL 1807781, *16 (Pa. Com. Pl. Phila.) (citations omitted), *recons. denied*, 2001 WL 1807984, *2 (Pa. Com. Pl. Phila. 2001) (association plaintiffs lacked standing to sue because their claims required individual participation of the associations' members in order to resolve the matter); But see

[30] The defendants also point out that Dr. Malloy could not properly object on behalf of the class in the Malloy action because the individual class members have a right to opt-out or object in their individual capacities in this Litigation. Defs' Brief In Opposition to Objections to Class Settlement, p. 4; See Hanlon v. Chrysler Corp., 150 F.3d 1011, 1024-25 (9th Cir. 1998) (holding that the decision to object or opt-out of a settlement is an individual one and may not be made by a potential class member who attempted to opt-out on behalf of all class members in another similar lawsuit), citing Newberg and Conte, 3 Newberg on Class Actions, § 16.16 at 90 (3d ed. 1992).

[31] In addition, Drs. Sklaroff, Malloy, and Fallon, as well as the Physician Providers of the University of Medicine and Dentistry -- Robert Wood Johnson Medical School have not proven that they are prejudiced by the settlement, i.e. that the settlement deprives them of a legal claim or cause of action.

Pennsylvania Psychiatric Society v. Green Spring Health Servs., 280 F.3d 278, 286 (3d Cir. 2002) (on a motion to dismiss, the Court held that the medical association plaintiff possessed standing to proceed because the pleadings, accepted as true, established the requirements for associational standing).

The third prong of this associational standing (the "Hunt") test presents the greatest difficulty for the medical societies. The medical societies seek relief from the defendants based on the assumption that every member of each of the medical societies provides medical services or procedures to patients who have health insurance through Independence Blue Cross and/or any Released Party in this Litigation, and that every member has a basis for claiming reimbursement from the defendants. There is no evidence in the record that each of the medical societies' members would be in a position to obtain reimbursement from the defendants. Thus, the claims asserted and the relief requested would require the participation of the individual members of the medical societies.

At least one objector argued that it would be inconsistent for this court to allow the Pennsylvania Orthopaedic Society to be a plaintiff in one of the three cases in this Litigation, yet find that the medical society objectors lack standing because they fail to meet the third prong of the Hunt analysis. The argument lacks merit in that this court has not permitted this inconsistency. In the Order denying the Pennsylvania Orthopaedic Society's petition to intervene in the Gregg case, the court stated, in part:

> Similar to Pennsylvania Chiropractic Association, [*supra*,] the Pennsylvania Orthopaedic Society is not in contractual privity with any of the defendants and therefore lacks standing to sue on behalf of its members. Further, the claim for injunctive relief is tied into the breach of

> contract claim which requires the individual participation of the members even if, otherwise, an association may pursue an injunction on behalf of its members.

See Order dated June 26, 2002 in Gregg case.

Subsequent to the denial of its petition to intervene, the Pennsylvania Orthopaedic Society filed its Class Action Complaint to which the defendants filed preliminary objections based on lack of standing and prior pending action. The court never addressed these preliminary objections, however, because of the pending settlement negotiations. In fact, these preliminary objections constitute one of the risks to plaintiffs of continuing litigation. Thus, when issues have been ripe for review, the court has applied the association standing test of Hunt to the plaintiff and objectors alike.[32]

Failure of one prong of the associational standing test is sufficient to deny the medical societies' standing to object to the settlement. Class Plaintiffs v. City of Seattle, 955 F.2d 1268, 1286 n.13 (9th Cir. 1992). Nevertheless, the court notes that the medical society objectors failed to present evidence linking their organizational purposes with the interests of the class members. In Class Plaintiffs, the Ninth Circuit Court of Appeals held that an organization lacked standing to appeal on behalf of class members it attempted to represent because the organization did not introduce into evidence any "certificate of incorporation, organizational constitution, or other relevant material" to establish on the record

[32] The defendants contend that the medical societies lack standing to object for an additional reason, namely, that some of the medical societies' members chose to opt-out of the Class Action Settlement. Defs' Brief in Opposition to Objections to Class Settlement, p. 6 n.5. Without more evidence in the record, the court is unable to verify which of the medical society members have opted-out. Generally, however, these medical societies could not object on behalf of members who lack standing to do so themselves. The medical societies fail to assert that all of their members chose to stay in the Settlement Class.

that the interests it sought to protect were germane to its organizational purpose. Class Plaintiffs, 955 F.2d at 1286. Similarly, the medical societies would have this court assume, absent proof, that the interests they seek to protect are germane to their organizations' purposes. Although there is perhaps room for leniency, this court is unpersuaded to make any assumptions in a case where the medical society objectors still fail the third prong of the Hunt test.

In addition to being precluded from objecting on behalf of their members, the medical society associations may not properly object for themselves. Only class members have standing to object to a settlement. See In re Sunrise Securities Litigation, 131 F.R.D. at 459. The associations do not qualify as part of the Settlement Class because they are not Providers, as defined by the court's June 19, 2003 Order preliminarily approving the Class Action Settlement. Generally, at some point between January 1, 1993 and the date of Final Judicial Approval, Providers must have rendered medical services, procedures and/or products to an individual insured by the defendants, or submitted a claim for reimbursement to the defendants. At least two of the medical societies, the Pennsylvania Medical Society and the Pennsylvania Psychiatric Society, have admitted that they are not class members. See Defs' Brief in Opposition to Objections to Class Action Settlement, Ex. B; Objection of Pennsylvania Psychiatric Society, ¶ 4, n.1. Thus, the medical society objectors cannot properly object in any capacity.

After subtracting the improper objections, only eight Objectors remain.[33] These Objectors, and the interests they represent, amount to only a relative few when compared to the class as a whole. In sum, this court finds that the Class Action Settlement is entitled to an initial presumption of fairness.

The Settlement Falls Within the Range of Reasonableness

The Pennsylvania Supreme Court has held that seven factors should be considered to determine whether a class action settlement should be approved: (1) the risks of establishing liability and damages; (2) the range of reasonableness of the settlement in light of the best possible recovery; (3) the range of reasonableness of the settlement in light of all of the attendant risks of litigation; (4) the complexity, expense and likely duration of the litigation; (5) the state of the proceedings and the amount of discovery completed; (6) the recommendations of competent counsel; and (7) the reaction of the class to the settlement. Dauphin Deposit Bank and Trust Co., 556 Pa. at 197, 727 A.2d at 1079-80, citing Buchanan v. Century Fed. Sav. and Loan Ass'n, 259 Pa. Super. 37, 46, 393 A.2d 704, 709 (1978); Cf. In re The Prudential Ins. Co. of America Sales Practices Litig., 148 F.3d 283, 323 (3d Cir. 1998); Girsh v. Jepson, 521 F.2d 153, 157 (3d Cir. 1975).

Risks of Establishing Liability and Damages

To appraise the risks of establishing liability and damages, a court should avoid conducting a trial on the plaintiffs' claims. See Newman v. Stein, 464 F.2d 689, 691-92 (2nd Cir. 1972) (citations omitted). Our Superior Court has

[33] The eight remaining Objectors are: Natalie M. Grider, M.D., Rosalind Kaplan, M.D., Louis P. Bucky, M.D., Martin Trichtinger, M.D., William Lander, M.D., Nancy Roberts, M.D., Beverly Dolberg, M.D. and Kutztown Family Medicine.

instructed, “In evaluating the likelihood of success, the lower court should not attempt to resolve unsettled issues or legal principles.” Buchanan, 259 Pa. Super. at 49, 393 A.2d at 710 (citations omitted). In Buchanan, the Superior Court admonished the lower court for reviewing the merits of the plaintiffs’ claims as though the case were being decided on a motion for summary judgment. Buchanan, 259 Pa. Super. at 50, 393 A.2d at 711.

At the same time, however, our Superior Court has held that:

> The court should . . . attempt to make a reasonable estimate of the probability of success. In most cases, the resolution of this question will present a delicate balancing problem for the lower court. It is obvious, however, that the lower court must proceed further than a mere determination that a cause of action has been stated sufficiently to withstand preliminary objections.

Buchanan, 259 Pa. Super. at 49, 393 A.2d at 710 (citations omitted). Thus, the court’s task of making a reasonable estimate of the probability of success should be more rigorous than simply finding that the plaintiffs’ claims would withstand preliminary objections, but not as overreaching as to find that a hypothetical motion for summary judgment on the plaintiffs’ claims would be granted in favor of the plaintiffs.

Although the plaintiffs in this Litigation contend their claims are meritorious, they admit several risks in establishing liability and damages. Motion for Approval, p. 10. First, plaintiffs acknowledge, and this court agrees, that they would have to prove that the defendants owed certain contractual obligations relating to reimbursement and disclosure, and that that proof would be far from risk-free. They admit that:

> To prove these claims, plaintiffs would have the heavy burden of demonstrating that the defendants actually had contractual obligations to do as the Complaints allege they should have done; that defendants breached those obligations; and that it is possible to measure the amount by which health care providers have been damaged by these breaches. To establish their right to the injunctive relief sought in the Complaints relating to bundling practices, plaintiffs would have to establish that defendants have a legal duty to calculate payments due according to nationally recognized standards even when such standards have not been adopted – and may have been expressly rejected – by defendants. To establish their right to disclosure of fee schedules, payment policies, and medical policies, plaintiffs would have to establish that defendants have a legal duty to provide such information, notwithstanding defendants' contention that much of that information is confidential. To establish their right to a dispute resolution procedure, plaintiffs would have to establish that defendants have a legal duty to create, and abide by, a duty of the kind created by the Settlement.

Motion for Approval, p. 11.

Even the Pennsylvania Medical Society, which filed an objection to the Class Action Settlement, has acknowledged that "[a]ny party pursuing litigation against IBC would need to overcome significant obstacles, including the factual issue as to whether IBC has discretion under its provider agreement to engage in the challenged practices." Ex. D-44 at Tab 62, p. 7. Certainly, the plaintiffs' success at trial would hinge on establishing that the defendants had no discretion in bundling and downcoding claims, keeping claims processing policies secret, and maintaining the confidentiality of fee schedules. Proof of these contractual obligations entails significant risk.

Furthermore, if the issue of contractual liability required evidence of the defendants' course of conduct, then Solomon v. U.S. Healthcare Systems of Pa., Inc., 797 A.2d 346, 350 (Pa.Super.), *appeal denied*, 570 Pa. 688, 808 A.2d 573 (2002), would present an additional risk in establishing liability and retrospective

damages.[34] In Solomon, the physician plaintiffs brought a contractual claim, among others, against a health insurer for denying and/or delaying payment for medical services which the plaintiffs provided to the insurer's subscribers. Upon a motion for summary judgment, Judge Levin of this court found in favor of the defendants and dismissed the plaintiffs' contractual claim. The Superior Court affirmed. Significantly, the Superior Court held that with respect to the claim that the insurer improperly delayed in paying plaintiffs, the "parties' longstanding course of performance was relevant to a determination of whether the parties intended to impose such an obligation [to pay the plaintiffs within a certain time period or to pay interest on the plaintiffs' claims]." Solomon, 797 A.2d at 350. The parties' course of performance demonstrated the parties' intent, and plaintiffs failed to prove that the insurer's alleged delay violated the agreement.

Similarly, here, the defendants' longstanding course of conduct would be an obstacle to proving that the defendants have obligations relating to disclosure, downcoding, bundling and dispute resolution. If the defendants' course of performance were considered, then the evidence would show that the "[d]efendants' policy has for years been to utilize the bundling practices at issue," that "defendants have maintained a constant course of conduct with respect to disclosure of payment policies, consistently reserving to itself the right to determine what policies are disclosed and which are not, and how, when and to whom they are disclosed," and that defendants "have not ever had a dispute resolution procedure of the kind established by this Settlement." Motion for

[34] See Motion for Approval, p. 12; Defs' Proposed Findings of Fact and Conclusions of Law, p. 33.

Approval, p. 12.

Further, the plaintiffs would face considerable risks in establishing retrospective damages on a class-wide basis. The plaintiffs contend that "[d]efendants have throughout this case made clear their intention to review damage claims on a doctor-by-doctor basis" and "claimed an intention, and a right, to assert any set-offs available to them by virtue of any overpayments." Motion for Approval, p. 16. This court believes that if this case were to proceed to trial, the defendants would insist on such evidence to prove retrospective damages, and there would be a basis for such insistence. Although not impossible to achieve, the costs in time and money to acquire this proof would be astronomical, and the results would be far from risk-free.

In addition, absent this settlement, the court agrees that the plaintiffs may not be able to establish that defendants must prospectively process Providers' claims in accordance with the standards the Class Action Settlement Agreement requires. Motion for Approval, pp. 16-17. If the plaintiffs were to demonstrate only their entitlement to disclosure of the defendants' payment policies in use prior to the Class Action Settlement Agreement, then the defendants might avoid being compelled to change their claims processing in the future to use the more forthcoming standards required by the settlement.

Beyond proving the elements of their claims and damages, the plaintiffs would also have to overcome several defenses, including:

> the fact that mere submission of a code for a service rendered does not automatically entitle a Provider to reimbursement for that service; the fact that defendants disclose and communicate to Providers the level, and reasons for the level, of reimbursement on claims; the course of dealing,

> custom and trade usage, and accord and satisfaction with respect to Providers' acceptance of such reimbursement; and issues of waiver, estoppel and statute of limitations.

Defs' Proposed Findings of Fact and Conclusions of Law, p. 32.

The anticipated defense which would present particular risk to plaintiffs would be that a Provider has waived his right to appeal a claim because he failed to pursue further reimbursement after having received an explanation of reimbursement. It is not inconceivable that, just as in the experience of Dr. Gregg, many Providers simply acquiesced to the reimbursement provided by the defendants, rather than aggressively pursuing additional reimbursement, because attempts to discuss a claim's resolution with the defendants have been, as Dr. Gregg described, like engaging in combat with a "nefarious black box." Tr. 8/21/03, pp. 40-41, 55.

The fact that the plaintiffs filed a Motion for Partial Summary Judgment in Gregg does not necessarily indicate a decrease in the amount of risk they would face at a trial. The defendants were not obliged to respond to the Motion for Partial Summary Judgment because of intervening settlement negotiations. However, had litigation continued, the defendants would surely have raised genuine issues of material fact precluding the grant of the motion. Also, if the case proceeded, the court would need to address the defendants' preliminary objections to the class action complaints in Good and Pennsylvania Orthopaedic Society. There is no guarantee that the preliminary objections would be overruled, especially with respect to the objection that the Pennsylvania Orthopaedic Society lacks associational standing to bring claims on behalf of its

members. Therefore, at virtually every level, including preliminary objections, certification, summary judgment, proof of liability, and proof of damages, the plaintiffs' case would be rife with risk.

Range of Reasonableness of Settlement in Light of Best Possible Recovery and in Light of All Attendant Risks of Litigation

The next two factors require the court to analyze the range of reasonableness of the settlement in light of the best possible recovery as well as all of the attendant risks of litigation. In this regard, "a court must 'examine what the potential rewards (or downsides) of litigation might have been had class counsel decided to litigate the claims rather than settle them' and balance 'the likelihood of success if the case were taken to trial against the benefits of immediate settlement.'" Milkman, 2002 WL 778272, at *13, citing In re Safety Components, Inc. Sec. Litig., 166 F.Supp.2d 72, 89 (D.N.J. 2001) (citations and quotation marks omitted). Our Superior Court has directed that "judges should analyze a settlement in terms of a 'range of reasonableness' and should generally refuse to substitute their business judgment for that of the proponents." Buchanan, 259 Pa. Super. at 47, 393 A.2d at 709, citing Newberg, 3 Newberg on Class Actions, § 5610b (1977).

The considerable risks likely to be encountered by the plaintiffs have been discussed. Without deciding issues of law appropriate for trial, the court concludes that the plaintiffs' likelihood of success would be uncertain, especially with respect to proving that the defendants have been and are obliged to reimburse physicians according to certain payment policies and fee schedules. The court further concludes that the likelihood of establishing that the defendants

must disclose their payment policies and provide a dispute resolution process would be doubtful. With the burden of proof on the plaintiffs, theirs would be an uphill battle.

The benefits of settling the Litigation now, and avoiding those risks, include:

- disclosure to Providers of the standard fee schedules, and changes in fee schedules, that are applicable to the Provider's specialty;
- disclosure to Providers of all policies or procedures that may impact the payment or reimbursement that a Provider receives for services rendered;
- processing of claims in accordance with established standards in various areas, including multiple surgery, radiologic guidance during a procedure, and eleven claim specific modifiers used in billing thousands of codes;
- replacement of the Independent Procedure designation with the Separate Procedure designation of the American Medical Association's CPT codes; and the
- establishment of a formal resolution process for Provider payment disputes.

Motion for Approval, Ex. A; Findings of Fact, ¶¶ 107-114 (Disclosure), ¶¶ 115-131 (Claims Processing Changes), ¶¶ 132-142 (Dispute Resolution).

The proponents have presented testimony which estimates the financial value of the claims processing changes. According to Mr. Scherf's analysis, the value of these changes is in excess of $40 million. Ex. P-4; Ex. P-5; Tr. 8/21/03, pp. 427-30, 432, 440. According to Mr. Ladley's Impact Analysis, the value of

these changes ranges between $53.8 to $63.8 million. Ex. D-54; Tr. 8/21/03, pp. 259-60, 264. The court finds these analyses credible. Thus, the benefits of the claims processing changes alone are valued, at a minimum, as $40 million.

Underlying all of these changes to the defendants' system of reimbursement to Providers lies the very real benefit of certainty. Dr. Gregg's investigation of what the defendants paid him over a four year period during the 1990s led him to recognize that the defendants "pay you [a Provider] bizarre sums of money, it changes from week to week and company to company….You couldn't understand what was going on." Tr. 8/21/03, pp. 40-41. For Providers like Dr. Gregg, the disclosure of fee schedules and payment policies required by the Class Action Settlement will ensure that Providers will have the information necessary to know how the defendants should operate, according to the defendants' own rules. This court submits that this result is invaluable and cannot be over-estimated in its salutary effect for class members.

With the Class Action Settlement's changes, Providers will be able to understand how to provide medical care to patients within the financial context of being reimbursed fairly. Tr. 8/22/03, p. 574. Important in this court's estimation, Dr. Peeno testified that the secrecy of the defendants' policies, in effect, has prevented Providers from maximizing the profits from their medical practices.

> [Secrecy] is the best tool a managed care company has to create all the roadblocks. I mean, you create rules that nobody knows about, you change the rules whenever it suits you without any kind of disclosure, you apply the rules whimsically or not at all or sometimes whatever you want to do, and I think it's not having . . . the knowledge that you need to be able to run your own business and then also to take care of the patients within the . . . financial context that you're being subjected to as a result.

Tr. 8/22/03, p. 574. This Class Action Settlement will give Providers the knowledge to generate more effectively income through their medical practices. It is submitted that this aspect of the settlement, in and of itself, will benefit not only the Providers, but their patients and our society as a whole.[35]

Even Providers reimbursed pursuant to capitation agreements stand to benefit from the Class Action Settlement because the codes for which they can bill above the capitated rates will be disclosed to them. Tr. 8/2103, pp. 113, 176, 179. In addition, when those Providers negotiate their next capitation agreements, they will know the actual value of the medical services they provide and whether the proposed capitated rate is sufficient in light of that value. Tr. 8/22/03, pp. 576-77, 605-06, 612.

Finally, patient care stands to benefit from the changes required by the Class Action Settlement. Dr. Peeno testified that the defendants' payment policies have promoted a system whereby Providers have been encouraged to treat patients in a manner which would increase the likelihood of reimbursement. Tr. 8/22/03, pp. 569-70. A Provider's financial considerations and patient care considerations do not always jive, however. Dr. Peeno gave the example of when a Provider has chosen to perform two medical procedures at different times, rather than under the same anesthesia, because the Provider would be more likely to be sufficiently reimbursed for both procedures than if they were performed at the same time. Tr. 8/22/03, pp. 569-70. In this way, these claims processing changes will benefit patient care. Again, this court believes that as a

[35] The court acknowledges that the settlement speaks of this "certainty" for a prospective period of only two years. One can hope that the defendants will later recognize the beneficial nature of this system in terms of the duration of its implementation.

result society itself benefits.

Admittedly, the benefits of the proposed settlement do not blanket all of the remedies and relief to which the plaintiffs claim they are entitled. As an example, and as some Objectors argued, the Class Action Settlement does not give Providers retrospective damages for unreimbursed claims. The Class Action Settlement does, however, achieve substantial benefits, especially in light of the risks, and potential downsides, the plaintiffs would face if they proceeded to trial instead. Thus, the comparison of risks of trial versus benefits of settlement indicate that the Class Action Settlement falls in the range of reasonableness.

Complexity, Expense and Likely Duration of the Litigation

The next factor in this analysis is the complexity, expense and likely duration of the litigation. The court recognizes that the issues in this Litigation are complex relative to other commercial cases. Proof relating to the thousands of medical codes would require expert knowledge and understanding. In addition, if the plaintiffs' damages at trial were based in part on individual Provider's claims, such proof would surely be a difficult feat. The very able counsel for the defendants could be relied upon to present the most intelligent of defenses. The expense for plaintiffs, and their counsel, would predictably increase. Keep in mind that the Gregg case has been in litigation for three years already. Motion for Approval, p. 19. The cases would take some time to get to trial, and even after trial, more time would accumulate due to the appeal process. The complex nature, the high expense and the likelihood of years' passing

without final resolution weigh in favor of settlement. See In re The Prudential Ins. Co. of America Sales Practices Litig., 148 F.3d at 318.

State of the Proceedings and Amount of Discovery Completed

Next, the court considers the state of the proceedings and the amount of discovery completed to determine whether counsel had a good understanding of the claims and their likelihood of success before agreeing to a proposed settlement. Milkman, 2002 WL 778272 at *18, citing In re General Motors Corp. Pick-up Truck Fuel Tank Products Liability Litigation, 55 F.3d 768, 813 (3rd Cir. 1995).

Counsel in the Gregg case have been litigating for approximately three years. According to plaintiffs' counsel, they have engaged in discovery for approximately eighteen months and have analyzed thousands of pages produced by the defendants. Motion for Approval, p. 22. The court's own records indicate that just for the period between November 2002 and September 2003, the parties filed at least seven discovery motions. In addition, counsel has described to the court how the plaintiffs' investigation has covered many different practice areas. Tr. 8/21/03, pp. 16-17. Further, plaintiffs filed a Motion for Partial Summary Judgment just prior to the parties beginning settlement negotiations, and to have done so, indicates to this court a certain preparedness relating to discovery and issues of law (notwithstanding that the court makes no findings as to the merits of that motion). Finally, the parties' settlement was not reached overnight. The parties negotiated the Class Action Settlement for approximately six months. Finding of Fact, ¶ 21. Therefore, based on the discovery, the pre-

trial motion, and the prolonged settlement negotiation, the court is persuaded that class counsel appreciated the merits of the Litigation's claims before consenting to the Class Action Settlement.

Recommendations of Competent Counsel

The court must also consider the recommendations of competent counsel in evaluating the reasonableness of the settlement, and those recommendations are given substantial weight. Milkman, 2002 WL 778272 at *19, citing Williams v. Vukovich, 720 F.2d 909, 922-23 (6th Cir. 1983) (further citations omitted). The Superior Court has warned that although a judge must take care that there is no collusion between the proponents of the proposed class action settlement, if no indicia of collusion are present, and where there was extensive, adversarial discovery, then "the recommendations and opinions of counsel are entitled to substantial consideration." Buchanan, 259 Pa. Super at 56 n.21, 393 A.2d at 714 n.21. In yet another case, the Superior Court stated that "the opinion of experienced counsel is entitled to considerable weight." Fischer v. Madway, 336 Pa. Super. 289, 297, 485 A.2d 809, 813 (1984) (citations omitted).

Plaintiffs' counsel and defense counsel negotiated at arms-length and in good faith for over six months to reach the Class Action Settlement Agreement. This court was involved in certain of these negotiations. There is no indication of collusion between plaintiffs' counsel and defense counsel. Absent collusion, and given the class-action experience of both plaintiffs' counsel and defense counsel, this court accords substantial consideration to counsels' recommendations to

approve the settlement.[36]

Reaction of the Class to the Settlement

The final factor to be evaluated is the reaction of the class to the Class Action Settlement. "It has been stated that a class's reaction is perhaps the most significant factor to be weighed in considering its adequacy…." Milkman, 2002 WL 778272 at *20, citing In re Microstrategy, Inc. Sec. Litig., 150 F.Supp.2d 896, 906 (E.D.Va. 2001) (further citation omitted). "The purpose of examining the reaction of the class to the proposed settlement is to gauge whether members of the class support the settlement." Milkman, 2002 WL 778272 at *20 (quotations and citation omitted). But, the existence of resistance to the settlement among class members, even from a named plaintiff, does not preclude approval of a settlement. Milkman, 2002 WL 778272 at *20, citing Brotherton v. Cleveland, 141 F.Supp.2d 894, 906 (S.D.Ohio 2001) (further citations omitted).

Overall, the great majority of Providers chose to remain in the Settlement Class to take advantage of the benefits of the Class Action Settlement. The plaintiffs admit that a "substantial minority of the class has opted-out of the Settlement," and they believe that many of these opt-outs resulted from the dissemination of the disingenuous July 11th letter and other materials which specifically encouraged opt-outs. Motion for Approval, p. 24. Like the plaintiffs, the defendants contend that many of the opt-outs were produced by a concerted campaign to "foment opt-outs." Tr. 11/19/03, p. 13.

[36] This court has been completely and continually impressed with the lawyering of the attorneys involved. The court believes that the litigants are fortunate to have such excellent attorneys representing them.

A brief exposition and statistical analysis is set forth here to assist the reader in placing the magnitude of the "opt-out" issue in perspective.

With the understanding that due to the complexity of this marketplace and the permutations possible, it is impossible to quantify the situation with certainty. But, a number of pertinent parameters can be deduced. The Certification of Jeffrey Dailey sets forth the figures discussed.[37]

A total of 32,641 Notices were sent to approximately 34,422 Providers. There were 7,293 total opt-outs. Of these 512 were improper (313 – after deadline; 190 – no contract with defendants; 9 – signature discrepancies; a total of 512). Thus, after subtracting 512, 6,781 proper opt-outs were submitted.

Of the 7,293 opt-outs, there were 267 "group" opt-outs submitted. But, only 68 of them were proper. (See Ex. D-29, ¶¶ 6-7 - - explaining that 199 were improper for various reasons). It should be recognized that the 68 appropriate group opt-outs must be dealt with carefully. A "group" can consist of perhaps two or three Providers or as many as 100 or more Providers. This means then that we should consider two approaches - - a "group" deemed as one entity, or an analysis of the opt-outs on an "individual opt-out" basis only.

Subtracting the 267 (group) from the 7,293 (total) gives us a value of 7,026 individual opt-outs. It has been estimated that the number of Providers in the 267 group opt-outs total approximately 6,100. Further, the 199 group opt-outs deemed faulty include an estimated 1,580 Providers.

[37] Ex. D-29.

Thus, the maximum value of the range of estimated opt-outs would equal:

7026 Individuals
+ 6100 Doctors in 267 groups
13126
- 1580 Doctors in 199 groups (deemed faulty)
11526 Total opt-outs

Based upon 34,422 total Providers, the maximum percentage of opt-outs would be:

11526 ÷ 34422 = 33.4 percent

The minimum value of the range would equal:

7293 total opt-outs
- 512 deemed improper
6781 total of proper opt-outs

and: 6781 ÷ 34422 = 19.7 percent

In summary then, the estimated range of opt-outs would be between 19.7 percent and 33.4 percent based upon 34,422 Providers receiving notice.

However, these values would in reality, be less because the actual number of Providers would exceed 34,422, in that that number does not include non-participating Providers. It is likely that the increase in the total (34,422) could be significant, but, nonetheless, impossible to quantify. (See Tr. 11/19/03, pp. 130-33).

This court submits that between 19% and 33% of all Providers opted-out. See Ex. D-29. To conclude, this court feels comfortable suggesting that presently the number of doctors who opted-out range between 1 in 5 (20%) and 1 in 3 (33 1/3%).

The number of Providers who remained in the Settlement Class but who filed objections equal an insignificant minority. Of the eighteen objections filed,

the court has determined that only eight objections were properly filed. Based on the court's analysis of the substance of these objections, these objections fail to present a sufficient basis to reject the Class Action Settlement.

Objections regarding the settlement's impact on different practice groups

Some objectors argue that the Class Action Settlement is unfair because the claims processing changes will disproportionately benefit different physician practice groups, with procedure-oriented specialists, such as orthopedic surgeons benefiting the most, and service-oriented physicians, such as primary care physicians, obstetricians-gynecologists and psychiatrists, benefiting the least.[38]

As the objectors point out, the type of medical practice is key to understanding the disparity. Some physicians, by the very nature of their medical practices, perform more procedures. Other physicians provide more service-related patient care. For example, the nature of an orthopedic surgeon's medical practice differs from that of a family doctor. The significant upshot of this difference is that the nature of the medical services a Provider renders, dictates what CPT codes the Provider may use to claim reimbursement. Some of the claims processing changes in the Class Action Settlement affect CPT codes used to bill procedures, such as surgeries or radiological guidance, whereas some of the claims processing changes affect CPT codes used to bill for services. Not all Providers will benefit equally from all of the claims processing changes because not all Providers will be able to claim reimbursement for every

[38] See Objections of Martin D. Trichtinger, M.D., et. al., ¶¶ 13-19; 39-41; See Objections of Kutztown Family Medicine, P.C., et. al., ¶ 36 (and Amended Objections of Kutztown Family Medicine, P.C., et. al., ¶ 20).

affected CPT code. As Dr. Peden put it, "[P]rocedurally based providers have more to choose from to bill than nonprocedurally based providers." Tr. 8/21/03, p. 137.

The court does not find this phenomenon unfair for several reasons. First, any disparity does not arise from the settlement itself, but rather, from the nature of the practices of the Providers. As it turns out, the Providers who have chosen procedurally-based practices have also lost more money in terms of reimbursement than had they chosen non-procedurally-based practices. Thus, the disparity cuts both ways; the claims processing changes will benefit more those who have allegedly lost more and will benefit less those who have lost less.[39]

Second, as the Objectors have admitted, a class action settlement is not required to benefit all class members equally.[40] The applicable standard for approving the Class Action Settlement is the analysis established by the Pennsylvania Supreme Court in Dauphin Deposit Bank and Trust Co., 556 Pa. at 197, 727 A.2d at 1079-80. The last prong of the Dauphin analysis examines the reaction of the class to the settlement, and thus, tests whether a majority of the class finds that the benefits of the settlement to be outweighed by the drawbacks. Thus, the question of whether a disparity exists is not the correct standard for judging whether a class action settlement should be approved.

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[39] The objectors attempted to show the impact of the claims processing changes on different practice groups through the affidavit and report of Stephen Foreman, J.D., M.P.A. Ex. PMS-2. Defense counsel did point out, however, that Mr. Foreman's report shows that all Providers in the Settlement Class will receive some benefit. Tr. 11/19/03, p. 139. Notwithstanding this affidavit and report, the court does not find that any disparity among practice groups precludes the approval of the Class Action Settlement.

[40] See Proposed Findings of Fact and Conclusions of Law of Objectors Martin D. Trichtinger, M.D., et. al., p. 30.

In addition, based on the evidence of record, the court finds that all members of the Settlement Class will reap some benefit. For example, all fee for service Providers will be able to use Modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by Same Physician on Same Day of Procedure or Other Service) and Modifier 59 (Distinct Procedural Service) for reimbursement of their claims, and all capitated Providers will be able to use Modifier 59. Tr. 8/21/03, pp. 127, 138, 176, 179. Ms. Esbach and Mr. Raymond, witnesses for objector Kutztown Family Medicine, P.C., acknowledged that the claims processing changes will benefit that practice in its fee for service billing. Tr. 8/21/03, pp. 289-90, 293-94, 305. Dr. Trichtinger, whose practice is mostly reimbursed based on capitated fee arrangements, testified that he had not seen the list of bill-above codes which he will be able to use to bill over and beyond the capitated services. Tr. 8/21/03, pp. 320, 326-27. Aside from the claims processing changes, the dispute resolution process will benefit all Providers, no matter what the nature of their medical practice. Ex. D-11, § III(C); Tr. 8/21/03, pp. 136, 138. Also, as discussed above, the disclosure of code information will benefit all Providers, including capitated Providers. Ex. D-11, § III(A); Tr. 8/21/03, pp. 99-100, 138, 573-77, 605-06, 612.

If a Provider felt that these benefits were not sufficient based on a disparity among practice groups, that Provider had an opportunity to opt-out.

Further, the court does not find undue prejudice in the fact that the three cases began on behalf of orthopedic surgeons, and later were prosecuted on behalf of all Providers. Counsel for the objectors argue that plaintiffs' counsel

became conflicted in their representation because they stand to earn a fee based on their all-Provider representation, yet they failed to prosecute the interests of an all Provider class. Tr. 11/19/03, pp. 50-52. Absent any evidence to support the objectors' arguments, the court does not believe that the fact that the scope of the Settlement Class expanded indicates that plaintiffs' counsel was conflicted in its representation or that the settlement terms prejudice physicians in practice groups other than orthopedic surgery.[41]

Objections regarding "slow pay" claims

The court next addresses objections regarding "slow pay" claims.[42] Notwithstanding the court's determination that the objections of the medical societies and Dr. Fallon are improper, the court addresses these objections in an effort to allow them the benefit of the court's thoughts on this issue.

A "slow pay" claim refers to a claim which alleges that the defendants failed to reimburse a Provider's claims in a timely way, thereby violating the time limit provisions of the Professional Provider Agreement at issue. New Jersey Counsel in Zakheim (the same lawyers responsible for the inappropriate July 11th correspondence) represent a certified class of New Jersey physicians in a lawsuit against AmeriHealth (a defendant in this Litigation), alleging that AmeriHealth failed to reimburse Dr. Zakheim and the rest of the class timely according to their Professional Provider Agreements.

[41] In addition, the court rejects the objection that the Class Action Settlement's value is illusory. As discussed supra, the value has been estimated to be at least $40 million, and perhaps as much as $63.8 million. See Ex. D-54; Ex. P-4; Ex. P-5. The court finds this range of estimated value to be credible.

[42] See Memorandum of Law In Support of Objections of Joseph Fallon, et. al., pp. 24-34.

In their objection, New Jersey Counsel, on behalf of the medical societies and Dr. Fallon, argue that the named plaintiffs in this Litigation lack authority to represent the class in "slow pay" claims, and cannot release "slow pay" claims. In addition, the objection argues that the Class Action Settlement provides no relief for "slow pay" claims, yet the class members will have released those claims. The issue underlying this objection is that if the Zakheim and Malloy class members stay in the Settlement Class in this Litigation, rather than opting-out, and the court gives final approval to the Class Action Settlement, then they will have released their claims in those lawsuits.

The "slow pay" objection fails for several reasons. First, Drs. Gregg, DiStefano and Good have standing to pursue slow pay claims. Their Professional Provider Agreements, attached to their complaints, require that the defendants pay "clean" claims within thirty days. Those contracts state:

> Unless the claim is disputed, Independence shall make payment on each of the Provider's clean, completed, accurate and timely submitted claims for Covered Services rendered to a Beneficiary, within thirty (30) days of receipt of each such claim or within the time required by applicable State, federal law or regulation or such other period of time as set forth in the applicable Benefit Program Exhibit to this Agreement.

Gregg Compl., Ex. A, § III, 3.2(b); Good Compl., Ex. A, § III, 3.2(b).

Moreover, the complaints in Gregg and Good specifically bring "slow pay" claims. The complaints set forth the language of 3.2(b) and then continue:

> Accordingly, once a provider submits a clean, complete, and accurate claim in the defendants' proper format, defendants are obligated to pay the provider the applicable amount for the particular service rendered based upon the applicable reimbursement schedule.

Gregg Compl., ¶¶ 33, 62; Good Compl., ¶¶ 33, 62.

> All of the claims at issue herein submitted . . . were 'clean,' 'complete' and 'accurate' claims in a format approved by defendants.

Gregg Compl., ¶ 37; Good Compl., ¶ 37.

> None of the claims performed . . . at issue herein were 'disputed' by defendants.

Gregg Compl., ¶ 40; Good Compl., ¶ 40.

> By failing to fully and properly reimburse plaintiffs for the claims at issue herein, defendants breached the provider agreement and the reimbursement provisions of said provider agreement.

Gregg Compl., ¶ 64; Good Compl., ¶ 64. At his deposition, Dr. Gregg identified "slow pay" as a claim encompassed in his breach of contract allegations. Defs' Brief in Opposition to Objections, Ex. I, p. 2. To this court, as well, these allegations constitute "slow pay" claims.

Because the "slow pay" claims exist in this Litigation, it is not improper for the Class Action Settlement's Release to include them. The objectors contend that the relief is insufficient given the alleged value of the "slow pay" claims in the Zakheim case. This court believes nonetheless, that the relief provided by the Class Action Settlement is fair and reasonable. The court believes that the dispute resolution process with its stated time frames and the fact that the defendants will be publishing covered codes should, to an acceptable extent, remedy the late pay problem.

Objections relating to retired providers and no retrospective relief

One objector, Dr. Kaplan, argues that the Class Action Settlement unfairly prejudices her because it does not grant retrospective financial damages.[43] Dr. Kaplan contends that she is no longer a Blue Cross Provider, and therefore, the

[43] See Objections of Rosalind Kaplan, M.D., pp. 3-5.

only relief she would benefit from would be retrospective relief. Tr. 11/19/03, p. 16. Dr. Kaplan argues that she will be releasing her claims of damages (from a period of more than ten and a half years) without gaining any benefit, and that this constitutes a denial of due process. Tr. 11/19/03, p. 17; Kaplan Proposed Findings of Fact and Conclusions of Law, pp. 3, 7-8. Additionally, Dr. Kaplan maintains that she did not receive mailed notice of the Class Action Settlement, and this also constitutes a denial of due process. Tr. 11/19/03, pp. 17-20.

The court rejects these objections as not persuasive. If Dr. Kaplan believes that the Class Action Settlement provides her no relief given her personal situation, then she should have opted-out, as she was given an opportunity to do. She makes no argument that she did not know about the Class Action Settlement in time to opt-out. In fact, ironically, her lawyer did not know how Dr. Kaplan originally found out about the settlement. Tr. 11/19/03, p. 20. As discussed later, individual notice is not required by the Pennsylvania Rules of Civil Procedure or due process in all circumstances.

Moreover, the lack of retrospective relief does not render the Class Action Settlement prejudicial. In the case of In re IKON Office Solutions, Inc. Sec. Litig., 209 F.R.D. 94 (E.D.Pa. 2002), cited to the court by the plaintiffs and defendants, the Eastern District Court of Pennsylvania approved a class action settlement which provided future benefits but no retrospective relief. The Court approved the settlement notwithstanding its recognition that of the over 51,000 class members, 18,934 individuals are “no longer participants in the Plan and thus will not benefit from the structural changes to the plan.” Id. at 102.

In addition, class action settlements are not required to benefit all class members equally. In Milkman, Judge Herron of this court acknowledged that in that settlement, "it is predicted that at least 745,125 Class Members out of a Class of 762,235 (97.8 percent) will not actively participate in the Settlement and thus will not benefit from the Settlement in any way." Milkman, 2002 WL 778272, *7 n.28. Similarly in this case, Providers who have not and choose not to make claims for reimbursement from defendants will not benefit in the same way that Providers who do make such claims. Having stayed in the class and remaining licensed to practice medicine, however, Dr. Kaplan could choose to care for patients again, submit claims to the defendants, and enjoy the benefits of the new disclosures, claims processing changes and dispute resolution.

Objections relating to Providers with capitated agreements

Certain objectors, Dr. Grider and Kutztown Family Medicine, P.C., contend that the Class Action Settlement is prejudicial because it fails to benefit capitated providers.[44] This objection, too, is unpersuasive and rejected.

Initially, the court notes that just like Dr. Kaplan, Dr. Grider and Kutztown Family Medicine, P.C. could have opted-out and retained their capitation claims against the defendants, but they chose to stay in the Settlement Class and release their claims. Dr. Grider's counsel acknowledged this opt-out opportunity. Tr. 11/19/03, pp. 73-74.

Moreover, capitated Providers will benefit from the Class Action Settlement in several ways. First, because the defendants do not have any

[44] See Objections of Kutztown Family Medicine, P.C., et. al., ¶¶ 11-19, 36 (and Amended Objections of Kutztown Family Medicine, P.C., et. al., ¶¶ 7-8, 20.

Providers with a pure capitation arrangement, even capitated Providers have certain codes which they are permitted to bill, above capitation, and therefore, the disclosure of code information for bill-aboves will benefit them. Tr. 8/21/03, pp. 99, 100, 138. Second, capitated Providers will benefit from claims processing changes regarding Radiological Guidance and/or Supervision of a Procedure and Modifier 59 (Distinct Procedural Service) Tr. 8/21/03, pp. 113, 176, 179. Third, in the event of a disputed claim, the dispute resolution process will benefit all Providers, including capitated Providers. Fourth, capitated Providers who, in addition to HMO work, also care for patients insured by a PPO stand to receive all of the benefits of the Class Action Settlement with respect to those PPO claims. Tr. 8/21/03, p. 100.

Furthermore, defendants' disclosures will benefit capitated providers in another, albeit more indirect, way. As Dr. Peeno testified, the disclosure of fee schedules and payment policies will benefit capitated Providers because it will allow them to more accurately code and keep track of the cost of services which they provide to capitated patients. As a result, capitated Providers will be able to analyze whether the capitated fee they receive for each patient is too little given their record of the actual value of services provided. With this information, capitated Providers will be able to better negotiate a fair capitation fee arrangement with the defendant. Tr. 8/22/03, pp. 575-77, 605-06, 612.

It should be noted that capitated Providers have not been damaged by reimbursement policies, like bundling, to the same extent that non-capitated Providers have been. This is so because most of the reimbursement which

capitated Providers receive is based on an agreed-upon monthly fee, rather than on separately claimed codes. Therefore, any disparity in the effects of the claims processing changes on capitated providers should be viewed within the context of how capitated Providers have also been somewhat insulated from the reimbursement policies challenged by this Litigation.

Objections relating to the release

Next, several objectors argue that the release in the Class Action Settlement Agreement is overbroad, covers future claims and is ambiguous as to what types of claims it covers.[45]

The language of the release is found in Section IV(B) of the Class Action Settlement Agreement. Ex. D-11, § IV(B).

> Upon Final Judicial Approval of this Settlement, the Settlement Class Members, on behalf of themselves and any present and former agents, . . . ("Releasors"), hereby discharge and release IBC and the Released Parties, . . . ("Releasees"), from any and all rights, claims, causes of action, suits, debts, liabilities, losses, damages, actions, judgments, obligations, attorneys' fees, expenses, indemnities, subrogations, duties, demands, controversies or liabilities of every kind and nature whatsoever, however styled, whether at law or in equity, including but not limited to, any and all claims for monetary damages, restitution, unjust enrichment, disgorgement, injunction or arbitration, however styled, whether known or unknown, matured or unmatured, foreseeable or unforeseeable, suspected or unsuspected, fixed or contingent, and whether or not asserted, threatened, or litigated, which the Releasors now have, ever had, or in the future may have individually, representatively or in any other capacity against the Releasees for, upon, or by reason of, any matter, cause or thing whatsoever *from the beginning of time to the date of this Agreement,* including but not limited to, any all Settled Claims, and any and all claims arising out of, relating to or in any way connected with the Litigation or that have been asserted or could have been asserted in the Litigation.

[45] See Objections of Martin D. Trichtinger, M.D., et. al., ¶¶ 31-35; See also Memorandum of Law In Support of Objections of Joseph Fallon, et. al., pp. 20-22.

> Provided, however, that this Release shall not eliminate any Physician's right to be compensated for services performed before the date of Final Judicial Approval for which either (1) a request for reimbursement is pending at the date of Final Judicial Approval or (2) a request for reimbursement has not yet been submitted but may still be submitted timely under the parties' agreement i.e. within 60 days of the date of service. A request for reimbursement is pending if it has been submitted to a Released Party but has not yet been processed. This Release shall not eliminate any physician's right to specifically dispute a particular claim adjudicated within 60 days prior to Final Judicial Approval.
>
> . . .

Ex. D-11, § IV(B)(1) (emphasis added).

That Class Action Settlement was subsequently supplemented by a Joint Statement which provides:

> As provided in the first paragraph of the Settlement Agreement, the intent of the Release in this case is to bar any and all claims against Independence Blue Cross and all other Released Parties arising from or related to payment or reimbursement to Providers or coverage for any and all services, procedures, and/or products rendered or provided by such Providers on or before June 11, 2003, including but not limited to any and all claims that were brought or could have been brought in the Litigation.

Ex. Court-1, ¶ 1. The Joint Statement further explained:

> This Release shall not eliminate a claim of a Provider for any services rendered after June 11, 2003. This Release also shall not eliminate a claim of a Provider where the Provider can establish that: (1) the Provider submitted a request for reimbursement to IBC about which he or she received a written communication from IBC between May 1, 2003 and June 19, 2003; and (2) the Provider submitted a written communication to IBC on or before June 19, 2003, disputing a particular identifiable claim in the specific written communication he or she received between May 1, 2003 and June 19, 2003; and (3) the written communication was not responded to by IBC as of August 21, 2003.

Ex. Court-1, ¶ 3.

The Joint Statement, when read in conjunction with the Class Action Settlement Agreement, moots the objections regarding the release. The scope

of the release is unambiguous. The release bars all claims from the beginning of time until the date of the Class Action Settlement Agreement, June 11, 2003, with the stated exceptions. Specifically, however, the release targets those claims "arising from or related to payment or reimbursement to Providers or coverage for any and all services, procedures, and/or products rendered or provided by such Providers on or before June 11, 2003, including but not limited to any and all claims that were brought or could have been brought in the Litigation." Ex. Court-1, ¶ 1. Importantly, the release does not bar future claims arising after June 11, 2003. Ex. D-11, § IV(B)(1); Ex. Court-1, ¶ 3.

Moreover, the court finds that the release, despite its broad scope, is the consideration which the defendants found necessary to agree to the Class Action Settlement. Given that the Class Action Settlement has been valued to be at least $40 million, and up to $63.8 million, the court does not find the scope of the release to be so unjustified as to preclude approval of the proposed settlement.[46]

Objections relating to alleged procedural inequities

Some objectors maintain that certain procedural inequities prejudiced them.[47] The first alleged procedural inequity is the fact that the parties filed certain pleadings under seal. This objection is without merit, however, because as soon as the class was conditionally certified, the court lifted the seal. The court announced to all parties and objectors in open court that everyone should

[46] Furthermore, the Notice provided to the Settlement Class highlighted the broad scope of the release. The Notice stated, in bolded capital letters that if you remain in the class, "You shall be deemed conclusively to have settled, resolved and released any and all claims you may have . . . ." Ex. D-18. Therefore, the Settlement Class was warned of the scope of the release and was sufficiently advised regarding how to opt-out.

[47] See Objections of Martin D. Trichtinger, et. al., ¶¶ 7-12; Proposed Findings of Fact and Conclusions of Law of Objectors Martin D. Trichtinger, *et. al*., pp. 36-39.

feel welcome to review the pleadings which were and have been located in chambers. In fact, counsel for these objectors acknowledge that they were able to review the documents which had been under seal.[48] Thus, the court does not accept that there existed any inequity or prejudice which would warrant not approving the Class Action Settlement.

The second asserted procedural inequity is the court's denial of certain objectors' discovery against the parties prior to the fairness hearing. It is unnecessary to analyze the objectors' discovery requests as though this was a motion for reconsideration. However, the court notes that it is within its discretion whether to grant or deny discovery requests by objectors, and objectors do not have an absolute right to discovery. See Milkman, 2002 WL 778272, *22 (citations omitted); See also In re Amsted Industries, Inc. Litig., 521 A.2d 1104, 1107 (Del.Ch. 1986). The court also observes that notwithstanding the denial of discovery, a review of the transcripts of August 21 and 22, and November 19, 2003, reveals that counsel for the objectors were very well prepared to present their arguments.[49]

Objections regarding notice to the class

Some objectors argue that the parties failed to properly disseminate the Notice of the Class Action Settlement to class members thereby violating this court's June 19, 2003 Order and due process, and in addition, that the substance

[48] See Proposed Findings of Fact and Conclusions of Law of Objectors Martin D. Trichtinger, *et. al*., p. 37; Tr. 11/19/03, pp. 55-56 (Peter Hoffman, Esquire, acknowledged that someone came to the court's chambers on three occasions to copy pleadings filed in this Litigation.)

[49] The discovery obtained by the parties was not wholly inaccessible to the objectors either. Discovery was attached to some of the pleadings, and at least one attorney for objectors admitted that defendants' counsel allowed him to review discovery relating to opt-outs. Tr. 11/19/03, p. 40.

of the Notice violated due process.[50] Again, although some of these objectors lack standing, the court discusses these arguments to quell any concern that due process was violated.

Rule 1712(b) of the Rules of Civil Procedure establishes the procedure for notice to a class:

> The court may require individual notice to be given by personal service or by mail to all members who can be identified with reasonable effort. For members of the class who cannot be identified with reasonable effort or where the court has not required individual notice, the court shall require notice to be given through methods reasonably calculated to inform the members of the class of the pendency of the action. Such methods may include using a newspaper, television or radio or posting or distributing through a trade, union or public interest group.

Pa.R.Civ.P. 1712(b). In addition, Rule 1712(c) states, in part:

> The court may require a defendant to cooperate in giving notice by taking steps which will minimize the plaintiff's expense including the use of the defendant's established methods of communication with members of the class . . .

Pa.R.Civ.P. 1712(c). Thus, Rule 1712 does not require personal individual notice, but rather, allows a court discretion. See Pa.R.Civ.P. 1712, 1977 Explanatory Comment ("Rule 1712 relaxes the rigid requirement of personal individual notice required by Eisen v. Carlisle and Jacquelin, 417 U.S. 156, 40 L.Ed.2d 732, 94 S.Ct. 2140 (1974).").

Our Pennsylvania Superior Court has cited the due process standard enunciated by the United States Supreme Court:

> [T]o bind an absent plaintiff concerning a claim for money damages or similar relief at law, [a forum state] must provide minimal procedural due process protection. The plaintiff must receive notice plus an opportunity to

[50] See Objections of Martin D. Trichtinger, M.D., et. al., ¶¶ 28-30; Objections of Rosalind Kaplan, M.D., pp. 5-8; See also Memorandum of Law In Support of Objections of Joseph Fallon, et. al., pp. 16-19.

> be heard and participate in the litigation, whether in person or through counsel. The notice must be the best practicable, reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections. The notice should describe the action and the plaintiffs' rights in it. Additionally, we hold that due process requires at a minimum that an absent plaintiff be provided with an opportunity to remove himself from the class by executing and returning an "opt-out" or "request for exclusion" form to the court.

Prince George Center, Inc. v. U.S. Gypsum Co., 704 A.2d 141, 148 (Pa. Super. 1997), *appeal denied*, 557 Pa. 640, 732 A.2d 1210 (1988), *cert. denied*, 528 U.S. 810 (1999), citing Phillips Petroleum Co. v. Shutts, 472 U.S. 797, 811-12 (1985).

In this case, the court's June 19, 2003 Order instructed the parties as follows:

> It is further ORDERED that the parties are required to disseminate the notice on the following web pages not later than June 20, 2003: www.ibx.com and www.paorthosociety.com. The parties shall also disseminate the notice, or a summary thereof, via publication in the Philadelphia Inquirer on or before June 25, 2003, and on the Internet via www.businesswire.com or other similar Internet news distribution service by June 20, 2003.
>
> It is further ORDERED that Independence Blue Cross is required to disseminate notice to the class via U.S. mail not later than June 30, 2003, as set forth in the Class Action Settlement Agreement.

See Order, dated June 19, 2003. Subsequently, the court amended the June 19, 2003, only insofar as the court permitted the parties until July 1, 2003 to disseminate the Notice, or a summary thereof, via publication in The Philadelphia Inquirer. In addition, the Class Action Settlement Agreement specified that Independence Blue Cross would disseminate the Notice in a normal mailing to the Settlement Class Members. Motion for Approval, Ex. A, § V(B)(1).

Contrary to the objector's assertions, the parties complied with the court's June 19, 2003 Order. Independence Blue Cross sent a Notice to each Provider via U.S. mail within the specified timeframe. Ex. D-45; Ex. D-50. Specifically, if the Provider constituted a group entity, then that Provider was sent the Notice, rather than the individual physicians who do not contract with the defendants.[51] The recipient Providers were the individuals or groups which could be identified with reasonable efforts. In all, Independence Blue Cross mailed a total of 32,641 Notices. Ex. D-45; Ex. D-50. In addition to mailed notice to each Provider, the notice was published through an internet news distribution service, on the web pages of the Pennsylvania Orthopaedic Society and Independence Blue Cross, and in The Philadelphia Inquirer. Ex. D-49; See Findings of Fact, ¶¶ 32-36.

Moreover, starting after June 19, 2003, there has been substantial publicity about the Class Action Settlement, such as articles in The Philadelphia Inquirer, The Philadelphia Business Journal, The Pittsburgh Post-Gazette, Physician's News Digest, American Medical News, Managed Care Week, Modern Physician, Modern Healthcare, Mealey's Litigation Report, and Bureau of National Affairs publications. See Ex. D-5; Defs' Brief In Opposition to Objections to Class Action Settlement, Ex. E.

In addition to the efforts of the parties in this Litigation to disseminate the Notice, medical societies and interested lawyers have sent mailings and faxes and put up information on websites to opine on the Class Action Settlement

[51] For example, Independence Blue Cross sent the objector University of Medicine and Dentistry – Robert Wood Johnson Medical School a notice, but did not send notices to individual doctors who practice there but who do not contract with the defendants. That entity, in fact, received notice and filed an opt-out. Ex. D-1.

Agreement. Ex. D-3 (MSNJ website); Ex. D-4 (Medical Society of the State of New York website); Ex. D-12 (July 11th Correspondence from New Jersey Counsel in Zakheim); Ex. D-25 (Pennsylvania Medical Society communications); Ex. D-27 (New Jersey County and Specialty Medical Society communications); and Ex. D-28 (Pennsylvania County and Specialty Medical Society communications). The communications pertinent to this case have been extensive and have run unchecked.[52]

Based upon a fair reading of all the facts, the court finds that the dissemination of Notice complied with due process and its June 19, 2003 Order.[53]

The objection also asserts that the substance of the Notice violated due process. To review this objection, the court relies on our Superior Court's instructions regarding the requirements for a class action notice:

> Notice in a class action suit must present a fair recital of the subject matter and proposed terms and inform the class members of an opportunity to be heard. It may consist of a very general description of the proposed settlement, including a summary of the monetary or other benefits that the class would receive and an estimation of attorneys' fees and other expenses. The notice need not provide a complete source of settlement information, and class members are not expected to rely upon the notices as such.

Fischer v. Madway, 336 Pa. Super. 289, 293-94, 485 A.2d 809, 811 (1984) (quotations and citations omitted).

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[52] The court suggests that Dr. Fallon's counsel exhibit real chutzpah to complain that the notice was inadequate while at the same time they were principal actors in sending the "ugly" July 11th letter.

[53] Furthermore, the court does not find the notice unreasonable because it was disseminated during the summer or because the opt-out period lasted for approximately one month, as suggested by one objector. See Objections of Rosalind Kaplan, M.D., p. 8.

The objection specifically contends that the notice failed to satisfy due process because it did not state that "the proposed settlement intends to release medical associations' claims." Memorandum of Law In Support of Objections of Fallon and Medical Societies, p. 19. This objection is unsuccessful because, in fact, the release of the Class Action Settlement only releases individuals or groups which have provided medical care to those who are insured by the defendants, or which have submitted claims for medical care rendered to those insured by the defendants. See Motion for Approval, Ex. A, § I(F) (definition of "Provider"). An association, such as a medical society, which has not provided medical care and has not submitted claims for reimbursement for medical care it provided, is not released by the Class Action Settlement. Therefore, no due process violation occurred by the absence of an untruth. The court notes, in addition, that it approved the Notice to be disseminated to the Settlement Class and found it to be informative, clear and fair.

Objection relating to proposed fee award to class counsel

Some objectors contend that class counsel do not deserve the proposed fee award.[54] According to the Class Action Settlement Agreement, counsel for the class may apply for attorneys' fees and costs up to $5 million. Ex. D-11, §VI. Plaintiffs' counsel, however, has not yet filed a fee petition. Moreover, the court's approval of the Class Action Settlement does not automatically approve any fee request. Therefore, the court declines to address this premature objection.

[54] See Proposed Findings of Fact and Conclusions of Law of Objectors Martin D. Trichtinger, *et. al.*, pp. 39-41.

In summary, the objections filed do not persuade the court to find the settlement inadequate or unfair. Although this Opinion is dedicated to discussing the objections at length, the fact is that a insignificant minority of class members objected. Although a significant minority of class members opted-out, the vast majority of Providers neither opted-out, nor objected. Instead, they chose to remain in the Settlement Class to enjoy the benefits of the defendants' disclosure, claims processing changes and dispute resolution process. The reaction of the class, as it stands, indicates that the Class Action Settlement should be approved.[55]

Based on the analysis of the seven Dauphin factors, and especially considering the risks which the plaintiffs would face in establishing liability and damages at a trial, the relief which the plaintiffs would achieve through settlement, and the recommendations of counsel, the court renders final approval to the Class Action Settlement.

The Motion to Invalidate Opt-outs is Granted

In addition to the Motion for Final Approval of the Settlement, the defendants filed a Motion to Invalidate Opt-outs which the plaintiffs joined and support. The Movants argue that the New Jersey Counsel, the New Jersey Medical Society, the Pennsylvania Medical Society and various other medical societies in New Jersey and Pennsylvania engaged in a campaign of false and misleading communications to solicit Providers to opt-out of the Class Action Settlement. The Movants further contend that the misleading communications

[55] Later in this Discussion, the court grants a second opt-out period to all those who previously, timely opted-out. At the conclusion of the second opt-out period, the number of opt-outs will either remain the same or will have decreased.

were highly effective in procuring opt-outs.

The Movants request that the court invalidate all timely opt-outs, and order a second Notice and opt-out period for the members of the Settlement Class which had timely opted-out in the first opt-out period. The Movants also request that the court temporarily restrain communications to the class members regarding the Class Action Settlement during the second opt-out period and order that all communications during that time must be approved by this court prior to dissemination. In addition, the Movants seek an order that, upon further application to the court, the court will consider whether the New Jersey Counsel and/or others should pay defendants and other affected parties fees and costs reasonably incurred in remedying the misuse of the AmeriHealth name, preparing and filing the Motion to Invalidate and responding to misleading communications regarding the Class Action Settlement.

The objectors, on the other hand, contend that Providers who opted-out did so because they informed themselves about the Class Action Settlement, and decided that it was inadequate. The objectors argue that none of the communications were misleading and therefore, the relief sought by the Movants is not justified and would infringe on speech protected by the First Amendment. The court heard argument on the Motion to Invalidate Opt-outs on November 19, 2003.

The consequences of the Motion to Invalidate Opt-outs are significant in that the defendants retained a right to withdraw from the Class Action Settlement for a period of twenty days following the expiration of the opt-out period if more

than six percent of the Settlement Class timely and properly opt-out of the settlement. Ex. D-11, § IV(C)(1). By Order dated August 20, 2003, upon a joint motion, the court extended the time for the defendants to exercise this withdrawal right. See Finding of Fact, ¶ 174. If the defendants do exercise this withdrawal right, the Class Action Settlement Agreement will be void.

This court is authorized and bound to enter appropriate orders to protect the members of the class and to ensure the fair conduct of the class action. See Pa.R.Civ.P. 1713(2), (4), (6); See also Georgine v. Amchem Products, Inc., 160 F.R.D. 478, 489 (E.D. Pa. 1995), citing Gulf Oil Co. v. Bernard, 452 U.S. 89, 100 (1981). One of the court's obligations in a class action is to ensure that "class members' decisions to participate or to withdraw be made on the basis of independent analysis of their own self interest." Georgine, 160 F.R.D. at 490 (citations omitted). The Third Circuit Court held that it is not only "[a] district court's duty and authority under Rule 23(d) to protect the integrity of the class and the administration of justice generally . . . [against] communications that mislead or otherwise threaten to create confusion and to influence the threshold decision whether to remain in the class," but also against "communications that seek or threaten to influence [a] choice of remedies." In re School Asbestos Litig., 842 F.2d 671, 683 (3d Cir. 1988).

The court's intervention of invalidating opt-outs is justified where the court finds that the misleading communications have "frustrated [the] Court's purposes." Georgine, 160 F.R.D. at 497. Misleading information hinders what the court is obligated to protect, i.e. the ability of class members to make an

informed and independent choice as to whether to stay in or opt-out of a class action. As the Eastern District of Pennsylvania Court stated:

> Misleading communications to class members concerning litigation pose a serious threat to the fairness of the litigation process, the adequacy of representation and the administration of justice generally. In re School Asbestos Litig., 842 F.2d 671, 680 (3d Cir. 1988). "Unsupervised, unilateral communications with the plaintiff class sabotage the goal of informed consent by urging exclusion on the basis of a one-sided presentation of the facts, without opportunity for rebuttal. The damage from misstatements could well be irreparable." Kleiner v. First National Bank of Atlanta, 751 F.2d 1193, 1203 (11th Cir. 1985).

Georgine, 160 F.R.D. at 490.

The determination of whether the court should order the invalidation of opt-outs requires the court to analyze (1) whether the communications at issue are misleading and (2) whether the misleading communications made it likely that the class members who received the communications were unable to make an informed and independent decision to opt-out of the Settlement Class. Georgine, 160 F.R.D. at 490.

Incomplete communications can be just as misleading as affirmative falsehoods. For example, the Court in Georgine found that the absence of information identifying the drafters of the communications and their personal interests misled the recipients by not cautioning them to analyze the motivations of the drafters. Georgine, 160 F.R.D. at 492, 494-496. Also, that Court held that "one-sided attacks" which did not explain the settlement's benefits, but focused only on the settlement's downsides, compounded the adverse effects to the class members. Georgine, 160 F.R.D. at 496.

Furthermore, the court is not required to find that the misleading communications soliciting opt-outs led to actual opt-outs. The Court in Georgine stated: "A remedy is appropriate if the communications at issue create a 'likelihood' of abuse, confusion, or an adverse effect on the administration of justice." Georgine, 160 F.R.D. at 498, citing In re School Asbestos Litig., 842 F.2d at 683. That Court further stated that "the extent of harm resulting from a campaign to solicit opt-outs cannot be quantified with any precision, and hence the Court must make its best estimate, taking into account the likely effect of the solicitation program based on its nature." Georgine, 160 F.R.D. at 498 (quotations and citations omitted).

Here, regrettably, this court finds that communications sent by certain lawyers and medical associations to members of the Settlement Class were, indeed, false, misleading and confusing. The ways in which the communications were misleading can be grouped into the following categories: (1) the communications gave false impressions of the scope of the relief provided by the Class Action Settlement, (2) the communications gave false impressions of the scope of the release, (3) the communications made misleading comparisons to the settlement in the Aetna case, (4) the communications failed to inform the class members of the pecuniary interests of the drafters of those communications, (5) some of the communications falsely represented that they were from AmeriHealth, one of the parties to the Class Action Settlement, and (6) the communications failed to include the Notice approved by this court and failed to provide the contact information for counsel in this Litigation.

First, the communications gave false impressions of the scope of the relief provided by the Class Action Settlement. For example, the July 11th letter from New Jersey Counsel misled class members into thinking that they would receive nothing for their release of claims. The July 11th letter stated: "The Pennsylvania Class Action Settlement provides no significant relief for AmeriHealth's claims review processes, but does seek to dismiss and release all your payment claims, including claims based on alleged bundling, downcoding and other wrongful practices which affect all physicians." Ex. D-12. Meanwhile, the July 11th letter makes absolutely no mention of any of the benefits of the Class Action Settlement's terms. As the court in Georgine characterized similar communications, this constitutes a "one-sided attack." Georgine, 160 F.R.D. at 496.

A further example of a misleading communication which neglected to explain the relief afforded by the Class Action Settlement is the MSNJ website which stated: "The Settlement fails to address wrongful practices relating to: medical necessity, reimbursement of claims (such as automatic downcoding and improper application of global periods); failure to pay claims in a timely manner; contracting issues (including, among other things, unilateral changes to material terms of the contract and prohibition on all products clauses); and administrative burdens. Nevertheless, all claims relating to these wrongful practices will be released." Ex. D-3, p. 10. In addition, the MSNJ website stated: "Despite IBC's claim to the contrary, the settlement fails to provide any meaningful relief in the areas of improper bundling, failure to recognize modifiers, disclosure of fee

schedules and inadequate appeals processes. Nevertheless, all claims relating to these wrongful practices will be released." Ex. D-3, p. 10. These communications misrepresent the Class Action Settlement's terms, and ignore the disclosure, claims processing and dispute resolution changes.

When compared to the July 11th letter and the MSNJ communications, the PMS communications made more of an attempt to acknowledge that the Class Action Settlement achieves benefits for Providers. But, nonetheless, they were misleading in their analyses. For example, the PMS website stated: "Dispute resolution process: The dispute resolution process is mandatory and internal. The details are not yet available. It is clear, however that it does not cover such issues as medical necessity." Ex. D-25, p. 9. The website was later updated to say: "IBC will provide physicians an internal claims appeals mechanism that will be "mandatory" for all physicians in the IBC network." Ex. D-25, p. 24. PMS also made this statement in a facsimile sent to physicians on July 25, 2003. Ex. D-25, p. 29. What PMS failed to say is that if a Provider exhausts the two-step dispute resolution process, then the Provider still has an opportunity to bring a lawsuit. The PMS communications falsely imply that the defendants' dispute resolution process is the only way in which Providers could appeal their claims.

Some communications briefly hinted at a benefit of the Class Action Settlement but misconstrued it. For example, the MSNJ website stated with respect to disclosure: "[T]he reality is that IBC has only agreed to disclose 'the standard fee schedule relevant to each provider's applicable specialties.' Thus, it appears that only disclosure of standard fee schedules pertaining to specialty

codes will be 'disclosed.'" Ex. D-3, p. 12. The MSNJ communication failed to explain that all Providers in the Settlement Class will be able to obtain the standard for any code, not just "specialty" codes. Tr. 8/21/03, pp. 153-154. The MSNJ communication also failed to inform its readers that IBC will disclose fee schedules and claim adjudication information in quarterly newsletters, a manual, on its password-protected website and through a web-based pre-adjudication tool. Tr. 8/21/03, pp. 94-95, 98-99.

Similarly, the MSNJ website hinted at claims processing changes, but inadequately and unfairly described them, when it stated: "Although IBC claims that its settlement provides relief in the four limited areas: 'independent procedure being replaced by separate procedure designation'; 'radiologic guidance during a procedure'; 'multiple surgery reduction'; and 'specific modifiers', it has not agreed to a set of coding rules to be applied to these areas." Ex. D-3, p. 10. This communication failed to describe approximately how many codes will be affected by the claims processing changes, fails to identify specifically which codes will be affected, fails to explain how the defendants will pay claims differently as compared to the past, and fails to explain that IBC will be using CPT codes (or, if IBC later chooses, codes from relevant Professional Association Coding manuals, or Medicare's codes (See Ex. D-11, § IIIA)).

Some of the communications failed to indicate that the Class Action Settlement had any financial value to class members. For example, the July 11th letter stated: "The Pennsylvania Class Action Settlement does not require AmeriHealth to make any cash payment at all to physicians in return for the

universal release of all claims." It is true that the Class Action Settlement does not provide retrospective cash payments. However, the July 11th letter failed to clarify this issue, and instead falsely implied that the Class Action Settlement's terms have no financial value whatever. It was not necessary for New Jersey Counsel to obtain an expert to provide a financial valuation of the terms in order for New Jersey Counsel to know that the claims processing changes will have a positive financial value to Providers.

The second category of how certain communications were misleading concerns the scope of the Class Action Settlement's release. For example, the PMS website stated: "Impairment of an antitrust action – As discussed, the scope of the release is extremely broad. Physicians should not be barred from bringing claims for future wrongs (after June 11, 1993) – for example, a claim that IBC engaged in post settlement conduct abusing monopsony power." Ex. D-25, pp. 15, 39. This communication is not only confusing; it falsely implies that the release prohibits future claims which arise after June 11, 2003, the date of the Class Action Settlement Agreement. See Ex. D-11, § IV(B)(1); Ex. Court-1, ¶ 3. In fact, although the court recognizes that the release is broad, the release does not bar future claims arising after June 11, 2003.

The third category of misleading communications deceives by comparing this Class Action Settlement to the settlement in the Aetna case. The MSNJ, the PMS and medical societies from counties in New Jersey and Pennsylvania all stated in communications to their members that the Class Action Settlement in this Litigation is inferior to the then-proposed settlement in the Aetna case which

serves as a "benchmark" for actions against managed care companies, and that the Class Action Settlement "lowers the bar for future settlements." Ex. D-22, p. 4; Ex. D-25, pp. 9, 29; Ex. D-27, p. 7; Ex. D-28, p. 3; Ex. D-25, p. 9. This court does not find the comparison of the Aetna case relevant to this Litigation or the proposed settlement. In fact, it deems it totally unfair. None of these communications (1) advised class members that the defendants in this Litigation are different from the defendants in the Aetna case, (2) identified what the claims were in the Aetna case, or (3) explained what the risks of proving liability and damages were in the Aetna case as compared to the risks of proving liability and damages in this Litigation. Thus, aside from being irrelevant, the Aetna comparison is woefully inadequate and plainly unfair. In addition, the communications misled by implying that if a class member opts-out, he or she will obtain superior relief later. Of course, there is no guarantee, much less a likelihood, of superior relief being realized at a later date.

The fourth category of misleading communications fails to inform the class members that they were drafted by lawyers with pecuniary interests in maximizing the number of opt-outs from the Class Action Settlement. If the class members in this Litigation decided to remain in the Settlement Class, they would, effectively, release their claims in the Zakheim and Malloy actions. See New Jersey Objectors' Memorandum of Law In Opposition to Motion to Invalidate Opt-outs, Ex. 6. In that instance, the lawyers who represent the plaintiff classes in Zakheim and Malloy would lose members of those classes, and their contingency fees would be jeopardized. Thus, when the New Jersey Counsel failed to state

in the July 11th letter or in the website posted July 16, 2003 that they had a pecuniary interest in urging opt-outs, they misled class members.

In addition, the MSNJ communications failed to disclose MSNJ's own lawsuit and its support of the Zakheim action. MSNJ, represented by the Milberg Weiss firm, had brought the case of MSNJ v. AmeriHealth HMO, Inc., No. C-66-02 (Super. Ct. of NJ, Mercer Cty., May 8, 2002) (dismissed on January 20, 2004), alleging improper denial of reimbursement to physicians. The MSNJ also lent support to the plaintiff class in Zakheim by submitting an affidavit in support of the plaintiffs' motion for class certification. See New Jersey Objectors' Opposition to Defs' Motion to Invalidate Opt-outs, Ex. 3, ¶¶ 3-4. Just as in Georgine, where the Court found it disturbing that a communication from counsel for objectors failed to disclose that they represented objectors, this court finds the lack of disclosure regarding MSNJ's positions misleading in that class members likely thought that the communications were made by "neutral observers." Georgine, 160 F.R.D. at 492.[56] / [57]

The fifth category of misleading communications concerns deception by falsely representing that they were authored by AmeriHealth, one of the parties to the Class Action Settlement. The July 11th letter and the website posted on July 16, 2003, referred to in the July 11th letter, both identified themselves as being

[56] The defendants also allege that the July 11 letter failed to disclose that the Milberg Weiss firm potentially stood to earn a portion of a $50 million fee in the settlement of the Aetna case. Memorandum In Support of Motion to Invalidate Opt-outs, pp. 4-5. The Milberg Weiss firm denies the allegations. New Jersey Objectors' Opposition to the Motion to Invalidate Opt-outs, p. 32. The court makes no findings concerning this alleged pecuniary interest. The court, does however, suggest that the reader may want to "think about it."

[57] The court in In re McKesson HBOC, Inc. Securities Litig., 126 F. Supp.2d 1239 (N.D.Cal. 2000) found solicitations to opt-out of a class action to be deceptive. As it turns out, the Milberg Weiss firm had made solicitations in that case, but agreed to cease its efforts when the lead plaintiff moved for an injunction. Id. at 1242.

from AmeriHealth. The letterhead on the July 11th letter stated: "AmeriHealth HMO, Inc. – New Jersey." Ex. D-12. The return address for the July 11th letter's envelope said: "AmeriHealth HMO, New Jersey – Class Action Settlement." Ex. D-12. The website's title stated: "Welcome to the AmeriHealth HMO, New Jersey Webpage," and the website's header stated: "AmeriHealth HMO, New Jersey." Ex. D-22. **This identifying information was not authorized by AmeriHealth or its counsel.** A class member reading the July 11 letter and the July 16 website would reasonably conclude that AmeriHealth was responsible for those communications and was discouraging class members from staying in the Class Action Settlement it negotiated.

This court holds the New Jersey Counsel responsible for the July 11th letter and July 16 website. Mr. Morris testified that the New Jersey Counsel received a copy of the final form of the July 11th correspondence with the AmeriHealth HMO, Inc. letterhead before it was mailed to the class members. Tr. 8/22/03, pp. 494-95. Therefore, New Jersey Counsel had ample opportunity to correct the letterhead. The same is true for the website. However, even when the inaccuracies were apparent and public, New Jersey Counsel failed to send any corrective notice to the July 11th letter to explain that the correspondence did not come from AmeriHealth HMO, or to correct statements relating to the effect of the Class Action Settlement Agreement. Tr. 8/22/03, pp. 491, 496-98; Ex. D-33. This court submits that this conduct of counsel approaches, if not reaches, the fields of fraud.

Finally, the sixth category of misleading information relates to communications failing to provide class members with the contact information of counsel in this Litigation and failing to include the Notice approved by this court. The July 11th letter, for example, listed New Jersey Counsel as persons to contact if the recipients had questions, but failed to list counsel in this Litigation for questions relating to the Class Action Settlement Agreement and failed to include the Notice. Ex. D-12. New Jersey Counsel neglected to supply class members with an uncomplicated way of discovering the information from the court and the lawyers responsible for the Class Action Settlement. The fact that the July 11th letter also stated that the class members should "educate" themselves about the Class Action Settlement does not remedy the court's concern. Ex. D-12. In Georgine, the court noted that a communication was "underhanded because it encourage[d] recipients to make decisions to opt-out of the class without the benefit of the Court-approved notice materials." Georgine, 160 F.R.D. at 492 n.17. Similarly, the July 11th letter and other similar communications unfairly obstructed the court's ability to ensure that class members receive only accurate and even-handed communications.

In their defense, New Jersey Counsel contend that the communications were clearly offering their opinions, not statements of fact. New Jersey Objectors' Opposition, p. 22. The court rejects this argument. The communications' statements are convincingly misleading because they give the impression of stating fact about what the Class Action Settlement achieves and what it does not achieve. See Georgine, 160 F.R.D. at 491 n.14.

In addition, New Jersey Counsel argue that their July 11th letter was authorized by the New Jersey Court in Zakheim and Malloy. Although the New Jersey Court permitted New Jersey Counsel to mail a letter to class members, the New Jersey Court was not made aware that the letter would be on AmeriHealth letterhead in an envelope with an AmeriHealth return address. Ex. K-2; Ex. D-63; Tr. 8/21/03, pp. 346, 416-17, 509, 515-17, 519. Therefore, the court finds it disingenuous and unprofessional to shift the blame to the New Jersey Court.

Based on the court's findings that the communications at issue are misleading, the next question is whether the misleading communications made it likely that the class members who received the communications were unable to make an informed and independent decision to opt-out of the Settlement Class. The answer is that this court finds a strong likelihood that the communications misled class members and caused them to file opt-outs. Think about it!

With respect to the influence of the misleading communications, the facts are as follows: Only 10 opt-out forms had been received with a postmark date of July 11th or earlier. Ex. D-37; Tr. 11/19/03, pp. 28-29. Therefore, before the July 11 letter, the vast majority of the class members had not opted-out. Then, the July 11th letter was sent to the entire class in the Zakheim action and the Malloy action, i.e. thousands of class members in this Litigation. Tr. 8/21/03, pp. 340-41. Even if the court were to assume that most opt-outs would be received closer to the August 1, 2003 deadline, the forms on which the class members opted-out indicate the influence of the misleading communications. Of the 7,293

opt-outs submitted, 4,873 of them (or 67 percent) used a form which Providers had received from New Jersey Counsel in the July 11th correspondence, the MSNJ, or the Pennsylvania Medical Society. Ex. D-29, ¶ 11; Ex. D-34; Tr. 11/19/03, p. 31. The opt-out forms which 67 percent of the opt-outs used, were included in the misleading communications. In all, 2,010 individual providers who received the July 11th correspondence opted-out. Ex. D-29, ¶ 10. Based on these statistics, the court finds a strong likelihood that the misleading communications greatly influenced the Settlement Class.

The court also finds that the likelihood that the misleading communications were effective in procuring opt-outs is indicated by the communications' wide distribution. The Pennsylvania Medical Society claims 20,000 members, and the Medical Society of New Jersey claims 8,000 members. Ex. D-26; Ex. D-21. The July 11th letter was sent to the class in Zakheim and the class in Malloy, totaling thousands of class members. Tr. 8/21/03, pp. 340-41. Therefore, when the lawfirms and medical societies communicated by facsimile, letter and website, they communicated to thousands of class members. The court also acknowledges the possibility of, but cannot begin to account for, redistribution of the misleading communications, which would only increase their influence.

The greatest indicator that the misleading communications likely caused a high percentage of opt-outs is that counsel received 7,293 opt-outs. Without having to find that the communications actually procured opt-outs, the court finds that there is a strong likelihood that class members were misled by the communications discussed *supra*, and in their confusion, opted-out.

Based on these findings, the court must decide what remedy is appropriate to counteract the effects of the misleading communications. "The initial consideration in determining the appropriate remedy is the degree of harm caused by the improper conduct." Georgine, 160 F.R.D. at 498, citing Kleiner, 102 F.R.D. 754, 772 (N.D. Ga. 1983), *aff'd in part, vacated in part, and rev'd in part*, 751 F.2d 1193 (11th Cir. 1985). Here, the misleading communications obstructed the court's efforts to ensure that class members receive only accurate information so that they could make informed and independent decisions whether to stay in or opt-out of the Class Action Settlement. This court finds that the disappointing conduct of New Jersey Counsel and the medical societies had an effect here that cannot be countenanced.

In similar circumstances, other courts have ordered a new notice and new opt-out period for those who had previously opted-out of a class. See Georgine, 160 F.R.D. at 518-520; In re McKesson HBOC Inc. Securities Litig., 126 F. Supp.2d at 1246; Impervious Paint Indus., Inc. v. Ashland Oil, 508 F. Supp. 720, 724 (W.D.Ky.) *appeal dismissed*, 659 F.2d 1081 (6th Cir. 1981). In addition, Rule 1713 of the Pennsylvania Rules of Civil Procedure supports the court's authority to enter an appropriate order to remedy the influence of the misleading communications. Pa.R.Civ.P. 1713(2), (4), (6).[58]

[58] At the November 19, 2003 argument, Mr. Trujillo asserted that the relief sought by the Motion to Invalidate Opt-outs should be denied because, in part, this court must give full faith and credit to the New Jersey Court's allowance of the July 11th letter. Tr. 11/19/03, pp. 104-08; See Finding of Fact, ¶ 54; Ex. D-63. Article IV, §1 of the United States Constitution provides that: "Full Faith and Credit shall be given in each State to the . . . judicial Proceedings of every other State." This full faith and credit requirement applies only to final orders, however. Clark v. Clark, 714 A.2d 427, 430 (Pa. Super. 1998); Schoenfeld v. Marsh, 418 Pa. Super. 469, 475, 614 A.2d 733, 736 (1992); See also Thompson v. Thompson, 484 U.S. 174, 180 (1988). Neither Mr. Trujillo nor anyone else has presented this court with a final Order from the New Jersey Court authorizing the

This court, without hesitation or reservation, feels obliged to remedy the situation by invalidating the opt-outs and ordering a new opt-out period. Unfortunately, the facts warrant such a remedy. The court approves the Notice set forth in its Order to be sent to all those who submitted, or are identified in, a timely opt-out ("Affected Class Members"). The Affected Class Members will have an opportunity to opt-out of the Settlement Class again, if they so choose.

The untimely opt-outs, i.e. those which were submitted with a postmark date later than August 1, 2003, will not receive the new Notice and will not receive another opportunity to opt-out. The misleading communications, although deceptive in so many ways, did not mislead class members about the August 1, 2003 opt-out deadline. Therefore, the untimely opt-outs cannot be blamed on misleading communications. In addition, the court declines to conduct mini-trials regarding whether each untimely opt-out can fairly be excused.

Of the 267 opt-outs, 190 were "submitted on behalf of groups that have no group contract with defendants and/or on behalf of individual providers who either (a) have their own individual contract with defendants, or (b) do not contract with defendants at all." Ex. D-29, ¶ 6. "Nine additional opt-outs were signed by only one provider attempting to opt-out for other providers without obtaining the other providers' signatures on the opt-out form." Ex. D-29, ¶ 6. The 199 opt-outs are thus considered ineffective and the class members they represent remain in the Settlement Class. However, the court recognizes that arguably these groups intended to opt-out, and the participating class members

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Footnote 58 continued -
deceptive contents of the July 11th letter. Thus, the full faith and credit argument fails.

represented by these groups have a right to choose to opt-out or not. See Hanlon, 150 F.3d at 1024-25. Thus, all of the 267 group opt-outs (**which includes the 199**) will receive the new Notice and are granted another opportunity to opt-out. The court recognizes that as to some of these recipients a second attempt to opt-out will not be operative. But, in fairness, the court decides to err on the side of caution.

Some objectors suggest that if the court decides that corrective notice is necessary, which the objectors deny, they argue that the proper remedy would be to allow Providers who opted-out to withdraw their opt-outs, rather than being given an opportunity to opt-out again. Memorandum of Law In Support of the Response of Objectors Martin D. Trichtinger, M.D., *et. al.*, p. 21 n.18. This remedy, however, would place the burden on those who opted-out to affirmatively withdraw, rather than having them start in the Settlement Class. This would, in the court's judgment, unfairly disadvantage the parties in this Litigation.

In the Motion to Invalidate, the Movants further request that the court temporarily restrain communications concerning the Class Action Settlement during the second opt-out period and order that all communications to class members must be reviewed by the court prior to dissemination. The objectors contend that their First Amendment rights will be impinged by such a restriction on speech. "To survive constitutional scrutiny, a content-based limitation on speech must further a compelling interest and be narrowly tailored to serve that interest." Georgine, 160 F.R.D. at 514-15 (citations omitted). "When

governmental action implicates First Amendment rights, the Court must balance those interests against the governmental interest in limiting the activity in question." Georgine, 160 F.R.D. at 512 (citations omitted).

In similar scenarios, as here, courts have found good cause to restrict speech to class members based on four criteria: "the severity and likelihood of the perceived harm; the precision with which the order is drawn; the availability of a less onerous alternative; and the duration of the order." Hampton Hardware, Inc. v. Cotter & Co., Inc., 156 F.R.D. 630, 633 (N.D.Tex, 1994), citing Kleiner, 751 F.2d at 1206 (further citations omitted). One federal court instructed that: "[a]ctual harm need not be proven to justify an order limiting class contacts. Rather, an order limiting contacts is justified upon a finding of 'a likelihood of serious abuses.'" Hampton Hardware, Inc., 156 F.R.D. at 633, citing In re School Asbestos Litig., 842 F.2d at 671 (further citations omitted).

Here, the Movants request that the court restrain communications to the class members regarding the Class Action Settlement for the period of time during which Affected Class Members will be able to opt-out. Even assuming that this restraint would impinge upon the First Amendment rights of the speakers, the limitation on speech would also further the compelling interest of ensuring that the class members' decisions to participate or to opt-out are made "on the basis of independent analysis of their own self interest." Georgine, 160 F.R.D. at 490. In general, the limitation on speech will promote the court's interest to "protect the integrity of the class and the administration of justice" against misleading communications. In re School Asbestos Litig., 842 F.2d at

683. Given our experience in the first opt-out period, this court does not take these interests lightly and finds that the harm, absent a temporary restraint on speech, would present a likelihood of serious abuse.

In addition, the remedy is narrowly tailored to serve the court's compelling interest. The temporary restraint on speech would be limited in duration and would last only throughout the second opt-out period. It would be limited with regard to scope in that only communications relating to the Class Action Settlement would be restricted. It would also be limited in that the restraint would allow communications to be disseminated to the class members during the second opt-out period so long as they were first approved by this court. The court cannot discern a less onerous alternative which would prevent the types of abuses which occurred during the first opt-out period. Therefore, the court does not find that the temporary restraint on speech violates the First Amendment.

Finally, the Movants seek an order that, upon further application, the court will consider whether the New Jersey Counsel and/or others should pay defendants and other affected parties fees and costs reasonably incurred in remedying the misuse of the AmeriHealth name, preparing and filing the Motion to Invalidate and responding to misleading communications regarding the Class Action Settlement. The court deems this request appropriate and will consider this payment of fees and costs upon further application.

CONCLUSIONS OF LAW

1. Upon consideration of the prerequisites of Rules 1702, 1708 and 1709 of the Pennsylvania Rules of Civil Procedure, the court certifies these three consolidated cases as class actions for the purposes of settlement only. The court incorporates the definitions of Settlement Class and Providers set forth in its June 19, 2003 Order[59] (and the Class Action Settlement Agreement).

2. The court's analysis of the factors enunciated in Dauphin Deposit Bank and Trust Co. v. Hess, 556 Pa. 190, 727 A.2d 1076 (1999), dictates that the Class Action Settlement falls within a range of reasonableness, such that it is appropriate for approval.

3. The objections to the Class Action Settlement do not preclude its approval by this court.

4. The court renders final approval of the Class Action Settlement.

5. The court finds that certain communications relating to the Class Action Settlement by New Jersey Counsel, the Medical Society of New Jersey and the Pennsylvania Medical Society (1) "frustrated the court's purposes" of ensuring that class members make an informed and independent choice as to whether to stay in or opt-out of the Class Action Settlement, (2) misled class members by focusing only on what the settlement does not achieve, rather than also informing class members what the settlement does achieve, thereby

[59] The class is defined as "All Providers (1) who submitted claims for payment or reimbursement to Independence Blue Cross and/or any Released Party for medical services, procedures and/or products and (2) who have been, claims to have been, and/or may have been denied payment or reimbursement or have, claim to have, and/or may have received reduced payment or reimbursement on such claims. The Settlement Class includes, but is not limited to, all claims by Providers for downcoding and/or bundling, however described or characterized." See June 19, 2003 Order; Motion for Approval, Ex. A, II.A.

constituting a "one-sided attack," (3) misled class members by not divulging the pecuniary interests of certain of the major players involved in disseminating these misleading communications, (4) misled class members by not fairly describing and by misconstruing the terms of the settlement and (5) creating "a 'likelihood' of abuse, confusion or an adverse effect on the administration of justice." See Georgine, *supra*.

6. The court grants the Motion to Invalidate Opt-outs.

7. As more specifically set forth in the court's Order, a second Notice shall be disseminated to Affected Class Members, and they will have a second opportunity to opt-out of the Class Action Settlement.

8. If after the second opt-out period, the Class Action Settlement is accepted by the parties, and the defendants do not exercise their withdrawal right, the Litigation, namely Gregg v. Independence Blue Cross, December Term, No. 03482 (Pa. Com. Pl., Phila., Dec. 29, 2000), Good v. Independence Blue Cross, December Term, No. 00005 (Pa. Com. Pl., Phila., Dec. 2, 2002), and Pennsylvania Orthopaedic Society v. Independence Blue Cross, December Term, No. 00002 (Pa. Com. Pl., Phila., Dec. 2, 2002), will be dismissed with prejudice.

9. If after the second opt-out period, the Class Action Settlement is accepted by the parties, and the defendants do not exercise their withdrawal right, all members of the class shall be bound by the Class Action Settlement, including, but not limited to, its terms regarding the release of Settled Claims

against the Released Parties.[60]

10. The court retains original jurisdiction over the second opt-out period and the Class Action Settlement Agreement, including its administration, supervision, interpretation and enforcement, as well as its provisions relating to attorneys' fees.

BY THE COURT,

ALBERT W. SHEPPARD, JR., J.

Date: April 22, 2004

[60] See Motion for Approval, Ex. A, IV.B (Release); See also Ex. Court-1, ¶ 4 (Released Parties).