IN THE SUPERIOR COURT OF THE STATE OF DELAWARE

IN AND FOR NEW CASTLE COUNTY

EXECUTIVE RISK SPECIALTY INSURANCE CO., Plaintiff,	)	
v.	)	C.A. No. 09C-09-027 JOH
FIRST HEALTH GROUP CORP., and THE FIRST HEALTH SETTLEMENT CLASS, Defendants,	)	
and	)	
RLI INSURANCE CO., HOMELAND INSURANCE CO. OF NEW YORK, and CHARTIS SPECIALTY INSURANCE COMPANY f/k/a AMERICAN INTERNATIONAL SPECIALTY LINES INSURANCE COMPANY, Nominal Defendants.	)	
FIRST HEALTH GROUP CORP., Cross-Plaintiff,	)	
v.	)	
RLI INSURANCE CO., HOMELAND INSURANCE CO. OF NEW YORK, and CHARTIS SPECIALTY INSURANCE COMPANY f/k/a AMERICAN INTERNATIONAL SPECIALTY LINES INSURANCE COMPANY, Cross-Defendants.	)	

Date Submitted: February 5, 2013
Date Decided: May 7, 2013

Upon Consideration of the Defendant, First Health Settlement Class' Motion for Partial Summary Judgment. ***DENIED.***

Upon Consideration of the Cross-Defendant, Chartis Specialty Insurance Company's Motion for Partial Summary Judgment. ***GRANTED.***

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Timothy J. Houseal, Esquire, and William E. Gamgort, Esquire, of Young, Conaway, Stargatt & Taylor, LLP, Wilmington, Delaware; Of Counsel: Matthew J. Fink, Esquire, and Charles A. Hafner, Esquire, of Bates, Carey, Nicholaides, LLP, Chicago, Illinois. Attorneys for Chartis Specialty Insurance Company f/k/a American International Specialty Lines Insurance Company.

Herlihy, Judge

Introduction

Cross Motions for partial summary judgment are before the Court on this insurance coverage case. The underlying dispute originates from a Louisiana law regulating Preferred Provider Organizations ("PPO") and payment for workers' compensation medical expenses. Such organizations, in order to have their reduced fees accepted, must provide notice in one of two ways to health care providers; neither was done in this case. Failure to provide the requisite notice triggers the imposition of certain financial obligations as set out in the law. It is undisputed that violations occurred and financial obligations, as set out in the law were imposed. The issue is whether those statutorily designated obligations are covered.

The Court holds that they are not covered obligations. Accordingly, the Settlement Class' motion for partial summary judgment is DENIED and Chartis' motion for partial summary judgment is GRANTED.

Factual and Procedural Background

A. Louisiana's Preferred Provider Organizations Act

The coverage dispute in this matter revolves around a Louisiana statute and the insurance contract, which are closely intertwined. The Court will first address the statute.

A PPO is statutorily defined as a group of medical providers which agree to provide medical services to subscribers of an insurance carrier at reduced rates.[1] PPOs were developed and are used to allow employers and insurance companies to offer health

[1] La. R.S. 40:2202(5)(a).

care services at reduced rates through a network of preferred providers. Following the advent of PPO networks, some managed care organizations began taking unfair advantage of health care providers. On occasion, providers learned that they were being reimbursed at reduced rates even though they had never agreed to participate in a PPO network.

The legislature in Louisiana set out to remedy this problem by enacting statutes that allow intermediaries to take advantage of the benefits of PPO networks, while eliminating the unfair practices to healthcare providers.[2] Its response is found in title 40, Chapter 12 of the Louisiana Revised Statutes which regulates the operation of PPO networks in what is known as the "PPO Act" or also the "Any Willing Provider Act." It was enacted in 1984 in an attempt to help reduce health care costs, but also to protect health care providers. It includes notice provisions that only allow reimbursement at the lower negotiated rates if notice is given in either one of two ways, one where a patient presents a benefit card at the time of service that identifies the discount to be taken:

> A preferred provider organization's alternative rates of payment shall not be enforceable or binding upon any provider unless such organization is clearly identified on the benefit card issued by the group purchaser or other entity accessing a group purchaser's contractual agreement or agreements and presented to the participating provider when medical care is provided….[3]

Alternatively, in the event that a benefit card is not issued or utilized by a group purchaser, injured employee or other entity, "written notification [to the provider] shall

[2] La. R.S. 40:2203.1.

[3] La. R.S. 40:2203.1(B).

be required of any entity accessing an existing group purchaser's contractual agreement or agreements at least thirty days prior to accessing services through a participating provider under such agreement or agreements."[4]

The statute also provides for financial consequences in the event a PPO fails to comply with these mandatory notice provisions:

> Failure to comply with the [notice provisions] of this Section shall subject a group purchaser to damages payable to the provider of double the fair market value of the medical services provided, but in no event less than the greater of fifty dollars per day of noncompliance or two thousand dollars, together with attorney fees to be determined by the court.[5]

B. The Parties

First Health Group Corporation ("First Health") issued and underwrote medical service plans, including several Preferred Provider Organization ("PPO") networks. It also develops comprehensive hospital and professional provider networks, which in turn, offer reduced cost health care services to employers, insurance carriers, and other payor clients. It owned and operated one such PPO network in Louisiana that is relevant to this litigation. First Health contracted with numerous health care providers in Louisiana to participate in the Louisiana PPO network. As part of the agreements with First Health, the health care providers contracted to provide medical services at discounted rates. Those agreements also required that health care providers remit invoices for medical

[4] La. R.S. 40:2203.1(B)(5).

[5] La. R.S. 40:2203.1(G).

services to the payors directly, rather than First Health. Under the PPO agreements, the payors were responsible for payment of covered amounts to the health care providers.

Plaintiff, Executive Risk Specialty Insurance Company ("Executive Risk") issued primary Managed Care Organization Errors & Omissions ("E & O") Policy No. 8166-5219 to First Health (the "Primary Policy"). Additionally, RLI Insurance Company ("RLI"), Homeland Insurance Company of New York ("Homeland") and American International Specialty Lines Insurance Company, now known as Chartis Specialty Insurance Company ("Chartis") issued excess E & O Policies to First Health.

In April 2004, a group of Louisiana health care providers sued First Health and others, alleging violations of Louisiana's PPO Act. In that action, titled *Gunderson v. F.A. Richard & Associates, Inc.*, the class of plaintiff health care providers (the "*Gunderson* Class") alleged that the defendants violated the PPO Act by failing to provide notice to health care providers prior to payors remitting payment at contractually agreed discounted rates for services rendered to workers' compensation patients. The *Gunderson* Class is a class of Louisiana medical service providers – doctors, hospitals, physical therapists, and chiropractors – who contracted with First Heath to accept the discounted reimbursements for services regarding workers' compensation. The *Gunderson* Class sought statutory damages and attorneys' fees for the defendants' failure to comply with the notice provisions. First Health settled that judgment in the *Gunderson* Court and assigned its insurance rights to the *Gunderson* Class.

After First Health sought coverage for the judgment arising from the action the *Gunderson* Court, Executive Risk filed this action seeking a declaration that it has no duty to indemnify First Health, regarding the judgment in Louisiana.

C. The *Gunderson* Action

The *Gunderson* Class moved for partial summary judgment on the claims asserted against First Health based on its undisputed violation of the notice provisions of the PPO Act. In support of its motion, it produced the testimony of Lester Langley, Jr., a certified public accountant, who calculated that there had been 130,931 individual violations of the PPO Act for underpayment without the statutorily-required notice. The calculation was based on data produced by First Health exhibiting every occurrence since January 1, 2001 where a payor in First Health's network was entitled to discount a *Gunderson* Class member's bill. Then, the *Gunderson* Class' accountant simply multiplied the number of bills, 130,931, by the $2,000 minimum per-violation award for a total of $261,862,000.

The court entered a partial judgment against First Health in the amount of $261,862,000.[6] The order stated that "judgment is hereby rendered against [First Health] in the amount of $261,862,000.00 together with legal interest thereon, in favor of the [*Gunderson* Class]."[7] That court calculated the amount of the judgment using the statutory formula of $2,000 per violation for 130,931 bills for which First Health had not provided the required notice. The aggregate monetary amount of the discounts taken

[6] Cross-Defs.' Mot. Summ. J., Ex. M.

[7] Cross-Defs.' Mot. Summ. J., Ex. M.

without proper notice is not known and was not used in calculating the judgment against First Health, nor was the fair market value established of the medical services provided.

First Health appealed that judgment to the Louisiana Court of Appeal.[8] Among other arguments, its contentions asserted that the *Gunderson* Court erred in granting the *Gunderson* Class' motion for partial summary judgment on the issue of partial, undisputed damages. The appeals court held that the evidence presented by the *Gunderson* Class, including the testimony of the certified public accountant who calculated the damages, was sufficient to make a *prima facie* case with regard to the issue of partial damages, and First Health's evidence in opposition was insufficient to show the existence of a material issue of fact.[9] Accordingly, the court held that the district court correctly granted the motion for partial summary judgment.[10]

Thereafter, First Health sought discretionary leave to appeal to the Louisiana Supreme Court. While the petition for leave to appeal was pending, First Health settled the class action with the *Gunderson* Class for $150,500,000. Along with the agreement to pay the settlement amount, First Health assigned its rights to receive payments under the E & O insurance policies to the *Gunderson* Class (hereinafter the "Settlement Class).

[8] *Gunderson v. F.A. Richard & Assoc.*, 44 So.3d 779 (La. App. 2010).

[9] *Id.* at 786.

[10] *Id.* at 789.

The Louisiana district court approved the settlement and entered a final order and judgment against First Health.[11]

D. Complaint for Declaratory Judgment filed in this Court

After approval of the settlement agreement, Executive Risk filed this declaratory judgment action in this Court on September 2, 2009, seeking an order that it had no duty to indemnify First Health for any portion of the $150.5 million judgment and attorneys' fees under the terms of the E & O Policy. Executive Risk also filed this suit against First Health and named the Excess Insurers – RLI, Homeland and Chartis -- as additional "nominal" defendants. First Health filed a counterclaim against Executive Risk and crossclaims against the Excess Insurers seeking coverage under the E & O policies.

During discovery in February 2012, Executive Risk entered into a settlement agreement with First Health and the Settlement Class. Specifically, the agreement resulted in the payment of First Health's defense costs and a settlement with First Health and the Settlement Class, thereby resolving the claims related to the Primary Policy and the Executive Risk excess policy. In addition, the Settlement Class, consisting of the *Gunderson* Class in the *Gunderson* action, was added as a party in this case.[12] The Settlement Class is now the real party in interest as the assignee of First Health's rights to recover under the E & O Policies. Based on the settlement agreement between Executive

[11] *Gunderson v. Richard & Assoc., Inc. et. al*, No. 2004-2417 (14th Judicial D.C. Parish of Calcasieu, State of La. May 27, 2011) (Final Order and Judgment) (Wyatt, J.).

[12] Cross-Defs.' Mot. for Summ. J., Ex. N, pp. 27-29.

Risk, First Health and the Settlement Class, the Excess Insurers were left disputing coverage.

The Settlement Class and the Excess Insurers filed cross motions for summary judgment. Then, after moving for summary judgment, the Settlement Class settled all claims with RLI and Homeland. As a result of those settlements, the only claims remaining for decision by this Court are between the Settlement Class and Chartis.

E. The Executive Risk Primary E & O Policy and Chartis Excess Policy

Executive Risk issued the primary managed care errors and omissions ("E & O") policy (the "Primary Policy") to First Health. The Primary Policy covers "any Loss which the Insured is legally obligated to pay as a result of any Claim that is first made against the Insured during the Policy Period…."[13] The policy defines "Loss" as:

> Defense Expenses and any monetary amount which an Insured is legally obligated to pay as a result of a Claim. Loss shall include, up to the amount listed in ITEM 3(b) of the Declarations (which sum shall be part of and not in addition to the Limit of Liability stated in ITEM 3(a) of the Declarations), any fines assessed, penalties imposed, or punitive, exemplary or multiplied damages awarded in Claims for Antitrust Activity, but only if such fines, penalties or punitive, exemplary or multiplied damages are insurable under applicable law. This paragraph shall be construed under the applicable law most favorable to the insurability of such fines, penalties, and punitive, exemplary or multiplied damages. Loss shall not include:
>
> (1) except as expressly set forth above, fines, penalties, taxes, and punitive, exemplary or multiplied damages[.][14]

"Loss" also includes penalties for "Antitrust Activity," which the policy defines as:

[13] Cross-Defs.' Mot. Summ. J., Ex. A, p. 1, ¶ I (emphasis removed).

[14] Cross-Defs.' Mot. Summ. J., Ex. A, p. 3, ¶ II(J).

> Any actual or alleged: price fixing; restraint of trade; monopolization; unfair trade practices; or violation of the Federal Trade Commission Act, the Sherman Act, the Clayton Act or any other federal statute involving antitrust, monopoly, price fixing, price discrimination, predatory pricing or restraint of trade activities, or of any similar provision of any federal, state or local statute, rule or regulation or common law.[15]

The Primary Policy initially excluded from the definition of "Loss" coverage for punitive or exemplary damages, but First Health and Executive Risk added Endorsement Number 7, which specifically stated that coverage includes amounts for punitive or exemplary damages.[16] Thus, the policy contains a broad definition of covered losses, a separate provision defining included antitrust activity, and an endorsement providing for coverage of certain punitive and exemplary damages.

First Health also obtained four layers of excess coverage through additional excess policies (the "Excess Policies") for claims that exceeded the limits of the Primary Policy. Executive Risk, RLI, Homeland and Chartis issued the Excess Policies to First Health. The Excess Policies are "follow form" and all provide for coverage, therefore, under the

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[15] Cross-Defs.' Mot. Summ. J., Ex. A, p. 1, ¶ II(A).

[16] The relevant portions of endorsement no. 7 provide:

> (1) The term "Loss," as defined in Section II Definitions (J) of the Policy, is amended to include . . . any punitive or exemplary damages where insurable under applicable law.
> (2) Section II Definitions (J)(1) of the Policy is amended to read in its entirety as follows: "(1) except as expressly set forth above, fines, penalties, taxes or multiplied damages[.]"
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> Cross-Defs'. Mot. Summ. J., Ex. A, Endorsement No. 7, p. 1.

same terms, conditions, exclusions, and limitations as the Primary Policy.[17] Chartis' Excess Policy provides class action policy limits of $10 million.

Parties' Contentions

Chartis and the Settlement Class have each moved for partial summary judgment. Chartis seeks an order declaring that it has no duty to provide coverage under the excess E & O policy it issued to First Health. Conversely, First Health agrees that there are no genuine issues of material fact and submits it is entitled to partial summary judgment on the issue of whether the Chartis policy covers the judgment in the *Gunderson* action. Both parties agree that this case is ripe for partial summary judgment on the issue of coverage because the only issue remaining involves interpretation of the Chartis excess policy, which is purely a question of law.

The Settlement Class raises several arguments in support of its motion. First, it contends that the judgment against First Health was not an excluded penalty under the express language of the E & O policies. In support of this contention, it points to a ruling in the *Gunderson* action where the Louisiana court held that the award was not a penalty

[17] Cross-Defs' Mot. Summ. J., Ex. B, p. 1 ("The Insurer shall provide the Insureds with insurance during the Policy Period excess of the Underlying Limit. Coverage hereunder shall attach only after the insurers of the Underlying Insurance shall have paid in legal currency the full amount of the Underlying Limit for such Policy Period. Coverage hereunder shall then apply in conformance with the terms and conditions of the Primary Policy and, to the extent coverage is further limited or restricted thereby, the terms and conditions of any other Underlying Insurance, except as otherwise provided herein. In no event shall this Policy grant broader coverage than would be provided by any of the Underlying Insurance; Ex. C, Homeland 000014 ("This Policy will apply in conformance with, and will follow the form of, the terms, conditions, agreements, exclusions, definitions and endorsements of the Underlying Insurance…"); Ex. D, CSIC 00205 ("This policy shall provide the Insureds and the Company with coverage in accordance with the same terms, conditions, exclusions and limitations of the Followed Policy…").

under the statute, but was for (statutory) "damages" for violations of the notice provision. The Settlement Class argues that if the legislature wanted to impose a penalty, it would have called it such. Alternatively, the Settlement Class asserts that the judgment against First Health is a covered loss even if this Court finds it to be a penalty because the amounts were awarded because of antitrust activity. Third, even if the amount is not covered under the policies as a penalty or antitrust activity, it states that it is specifically covered as punitive and exemplary damages. Finally, the Settlement Class claims that, if nothing else, the policies provide coverage for the attorneys' fees awarded in the *Gunderson* action.

Chartis agrees with the Settlement Class that the only remaining issue in this declaratory judgment action involves coverage under the policies; however, it contends that the policies did not provide coverage for the amounts in the judgment entered against First Health. It claims the judgment entered against First Health in *Gunderson* constitutes a penalty that is excluded from coverage under the Primary Policy, and therefore, the its excess policy. In support of this argument, it points out that the statutory "damages" are not related to the actual damages suffered and, as such, constitute a penalty.

In addition, Chartis identifies numerous instances in the record from the *Gunderson* action where the Settlement Class specifically referred to the amounts awarded as penalties, not damages. Next, it claims that the provision providing coverage for punitive damages is not ambiguous and does not provide coverage for the amounts at issue here. Chartis states the Settlement Class did not receive an award of punitive damages so the policy coverage for punitive damages does not apply. Asserting that the

claims in the *Gunderson* action were not for antitrust activity, it notes that the policy provisions providing coverage for antitrust violations do not require coverage for the *Gunderson* judgment. And finally, in opposition to the Settlement Class' argument that the awards of attorneys' fees are covered by the policy, Chartis points out that no separate award of attorneys' fees was entered against First Health. Therefore, this Court should not address that claim, as it was not raised in prior pleadings and should be deemed waived.

Applicable Standard

Summary judgment may only be granted where there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law.[18] Where the Court is faced with cross motions for summary judgment, it will not grant summary judgment for one party unless no genuine issue of material fact exists and that party is entitled to judgment as a matter of law.[19] Neither party has presented or argued that any genuine issue of material fact remains to be determined. The sole issue only involves interpretation of an insurance contract, which is a legal determination, making summary judgment appropriate on the present record.[20]

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[18] *Wilson v. Joma, Inc.*, 537 A.2d 187 (Del. 1988).

[19] *Wygant v. Geico General*, 27 A.2d 553, 2011 WL 3586488, at *1 (Del. Aug. 16, 2011).

[20] *Gallaher v. USAA Cas. Ins. Co.*, 2005 WL 3062014, at *1 (Del. Super. Nov. 14, 2005).

Discussion

A. Contract Interpretation

This dispute requires this Court to determine whether the Primary Policy, and therefore, the Chartis excess E & O Policy, provided coverage for the judgment against First Health in the *Gunderson* action. The Primary Policy does not contain a choice of law provision. Both parties remaining in this case agree that Delaware law should be applied in construing the relevant policies because there is no conflict among Delaware law and other jurisdiction's laws that would potentially apply to this case. As such, regardless of which jurisdiction's laws are applied, the outcome will remain the same. Delaware precedent supports applying Delaware law when there is no conflict between Delaware law and another potentially-applicable jurisdiction's laws.[21]

Under Delaware's well-established principles of insurance contract interpretation, an insured has the initial burden to prove that a claim is covered under the terms of a policy.[22] Once the insured has met that initial burden, the insurer then has the burden to prove that the policy's exclusions apply removing the claim from coverage.[23] Clear and unambiguous language in an insurance policy must be given its usual and ordinary

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[21] *Deuley v. DynCorp Intern., Inc.*, 8 A.3d 1156, 1161 (Del. 2010) (quoting *Berg Chilling Sys., Inc. v. Hull Corp.*, 435 F.3d 455, 462 (3d Cir. 2006)).

[22] *State Farm Fire and Cas. Co. v. Hackendorn*, 605 A.2d 3, 7 (Del. Super. 1991) (citing *New Castle County v. Hartford Accident and Indemnity Co.,* 933 F.2d 1162, 1181 (3d Cir. 1991)).

[23] *Deakyne v. Selective Ins. Co. of America*, 728 A.2d 569, 571 (Del. Super. 1997); *Hackendorn*, 605 A.2d at 7.

meaning by the Court.[24] Where no ambiguity exists in the terms of a policy, Delaware courts will not "destroy or twist policy language under the guise of construing it."[25] Creating an ambiguity where none exists could effectively create a new contract with rights, liabilities, and duties to which neither party agreed.[26] "[A]n insurance contract is not ambiguous simply because the parties do not agree on the proper construction."[27] A court will only find an ambiguity where the contract language permits two or more reasonable interpretations.[28]

As the initial burden is on the insured to show coverage, the Settlement Class -- as the assignee of the insured -- must establish that the Primary Policy provides coverage for claims related to the *Gunderson* settlement. To do this, the Settlement Class points to the Primary Policy's Insuring Agreement, which contains a broad definition of covered losses as "any Loss which the Insured is legally obligated to pay as a result of any Claim that is first made against the Insured during the Policy Period[.]"[29] To ascertain coverage under the policy, the Court must determine if the *Gunderson* settlement falls within the

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[24] *Rhone-Poulenc Basic Chemicals, Co. v. American Motorists Ins. Co.*, 616 A.2d 1192, 1196 (Del. 1992) (citing *Johnston v. Talley Ho, Inc.*, 303 A.2d 677, 679 (Del. Super. 1973)).

[25] *Id.* (citation omitted).

[26] *Hallowell v. State Farm Mut. Auto Ins. Co.*, 443 A.2d 925 (Del. 1982).

[27] *O'Brien v. Progressive Northern Ins. Co.*, 785 A.2d 281, 288 (Del. 2001) (citing *Rhode-Poulenc*, 616 A.2d at 1196).

[28] *Hackendorn*, 605 A.2d at 7.

[29] Cross-Defs.' Mot. Summ. J., Ex. A, p. 1, ¶ I. Capitalized terms not defined in this Opinion are given the meaning ascribed to them in the Primary Policy.

meaning of "Loss," which is defined in the Primary Policy in Section II, containing definitions.

The analysis begins with the definition of "Loss." It contains four sentences, each of which must be considered. The first broadly defines the coverage provided as "Defense Expenses and any monetary amount which an insured is obligated to pay as a result of a Claim."[30] The second sentence specifically states that "Loss" includes "fines assessed, penalties imposed, or punitive, exemplary, or multiplied damages" that are *related to* "Claims for Antitrust Activity."[31] The third contains a general statement that claims for Antitrust Activity should be construed under the applicable law most favorable to the insurability of such amounts.[32] Finally, the last sentence of the definition contains a list of certain exclusions from the definition of "Loss."[33] One such exclusion relevant to this case states that "fines, penalties, taxes, and punitive, exemplary or multiplied damages" not related to Antitrust Activity are excluded from the definition of "Loss."[34] In sum, the definition contains a broad description of what is covered, specifically

[30] Cross-Defs.' Mot. Summ. J., Ex. A, p. 3, ¶ II(J).

[31] *Id.*

[32] *Id.*

[33] The Primary Policy also contains a separate section listing "Exclusions." Despite the existence of a section specifically listing exclusions, the Court finds that the definition of "Loss" also contains exclusions. The Court reaches this conclusion because the first sentence of the definition of "Loss" begins with a broad and inclusive description of what is covered under the policy and, in the fourth sentence, attempts to limit what is covered.

[34] Cross-Defs.' Mot. Summ. J., Ex. A, p. 3, ¶ II(J)(1).

provides that Antitrust Activity is covered, and then attempts to rein in the broad grant of coverage through specific exclusions.

Turning first to the Settlement Class' burden, the Court must determine if the amounts awarded in *Gunderson* are a monetary amount that First Health was obligated to pay as a result of a "Claim." Where a capitalized term is used, the Court must give that term the meaning set forth in the Policy. "'Claim' means any written notice received by any Insured that a person or entity intends to hold an Insured responsible for a Wrongful Act."[35] Wrongful Act, in turn, means "any actual or alleged act, error or omission in the performance of, or any failure to perform, a Managed Care Activity by any Insured Entity or by any Insured Person acting within the scope of his or her duties or capacity as such[.]"[36] Managed Care Activity consists of the following services or activities:

> Provider Selection; Utilization Review; advertising, marketing, selling, or enrollment for health care or workers' compensation plans; Claim Services; establishing health care provider networks; reviewing the quality of Medical Services or providing quality assurance; design and/or implementation of financial incentive plans; wellness or health promotion education; development or implementation of clinical guidelines; practice parameters or protocols; triage for payment of Medical Services; and services or activities performed in the administration or management of health care or workers' compensation plans.[37]

The amounts awarded in *Gunderson* fall within the definition of "Loss." The *Gunderson* judgment resulted from First Health's undisputed failure to comply with statutory notice provisions before the payor clients reimbursed health care providers at

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[35] Cross-Defs' Mot. Summ. J., Ex. A, ¶II(C) (emphasis removed).

[36] *Id.* at ¶ II(V)(1) (emphasis removed).

[37] *Id.* at ¶ II(K) (emphasis removed).

contractually agreed upon discounted rates. It is undisputed that First Health's action (or inaction) is an error or omission in the performance of, or failure to perform, a Managed Care Activity, making it a Wrongful Act. The Wrongful Act became a Claim, at the very latest, when First Health was served with the complaint in the *Gunderson* action. Because Claims are afforded broad coverage under the definition of Loss, the Settlement Class has satisfied its initial burden to show that the *Gunderson* judgment is covered under the policy. Now, the burden shifts to Chartis to prove that the policy excludes coverage for the amounts the Settlement Class seeks.

B. The Amounts Awarded in Gunderson Are Not Covered Under the Plain Meaning of the Policy

Chartis claims the amounts awarded to the Settlement Class in the *Gunderson* action were a penalty and are therefore, specifically excluded from the definition of Loss. The Settlement Class disagrees and argues that those amounts were for damages, which amount to a covered Loss. Notably, neither party has stated that the definition of Loss is ambiguous or that its exclusion for "fines, penalties or multiplied damages" should not be given its plain meaning. Instead, the crux of this dispute concerns whether the amounts awarded in the *Gunderson* action were for damages or a penalty.

In considering whether the judgment awarded in the *Gunderson* action is covered under the Primary Policy at issue, the Court must apply the plain meaning of the terms "fines, penalties, or multiplied damages."[38] It is well-settled in Delaware that, in ascertaining the meaning of words not defined in a contract, courts "look to dictionaries

[38] *See O'Brien v. Progressive Northern Ins. Co.*, 785 A.2d 281, 288 (Del. 2001).

for assistance in determining the plain meaning of terms which are not defined in a contract."[39] "This is because dictionaries are the customary reference source that a reasonable person in the position of a party to a contract would use to [discern] the ordinary meaning of words not defined in the contract."[40]

The word "penalty" is defined as follows:

> Punishment imposed on a wrongdoer, usu. in the form of imprisonment or fine; esp., a sum of money exacted as a punishment for either a wrong to the state or a civil wrong (as distinguished from compensation for the injured party's loss). ● Through usu. for crimes, penalties are also sometimes imposed for civil wrongs.[41]

Black's goes on to define a "civil penalty," as a "fine assessed for a violation of a statute or regulation and a "statutory penalty," which is a "penalty imposed for a statutory violation; esp., a penalty imposing automatic liability on a wrongdoer for violation of a statute's terms without reference to any actual damages suffered."[42] Thus, a statutory penalty must: "(1) impose automatic liability for a violation of its terms; (2) set forth a predetermined amount of damages; and (3) impose damages without regard to the actual damages suffered by the plaintiff."[43]

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[39] *Lorillard Tobacco Co. v. Am. Legacy Found.*, 903 A.2d 728, 738 (Del. 2006) (citing *Northwestern National Ins. Co. v. Esmark, Inc.*, 672 A.2d 41, 44 (Del. 1996)).

[40] *Id.*

[41] BLACK'S LAW DICTIONARY 1247 (9TH ED. 2009).

[42] BLACK'S LAW DICTIONARY 1247 (9TH ED. 2009).

[43] *Landis v. Marc Realty*, 919 N.E.2d 300, 307 (Ill. 2009) (citing *McDonald's Corp v. Levine*, 439 N.E.2d 475, 480 (Ill. App. Ct. 1982)).

The Court concurs with the parties that Delaware law applies to the interpretation of the insurance contract in this case. It is, however, necessary to apply Louisiana law to the interpretation of the statute concerning remedies, as it is now a matter of statutory interpretation under Louisiana law.

The Louisiana statute in this case, La. R.S. 40:2203.1(G), guarantees recovery to the provider, if a PPO fails to comply with mandatory notice requirements of La. R.S. 40:2203.1(B). In the event that a PPO fails to give the requisite notice as provided in the statute, the provider is entitled to "double the fair market value of the medical services provided, but in no event less than the greater of fifty dollars per day of noncompliance or two thousand dollars . . . ."[44] The focus of the analysis is on the language after "but in no event less than . . . ."

Chartis cites to *Landis v. Marc Realty* for the proposition that the amounts awarded in section 40:2203.1(G) fall within the plain meaning of penalty. In *Landis*, the Supreme Court of Illinois held that a statute set forth in the Chicago Residential Landlord and Tenant Ordinance for the benefit of tenants, constituted a statutory penalty.[45] The court reasoned that an automatic liability was imposed by a statutory provision stating that, "where a landlord fails to comply with the statutory provision, [regarding the timely return of security deposits] the tenant 'shall be awarded' damages in an amount equal to

[44] La. R.S. 40:2203.1(G).

[45] 919 N.E.2d 300, 307 (Ill. 2009).

two times the security deposit plus interest."[46] Further, the court held that the term "shall" within the statute, suggests that the award to plaintiff is automatic, or mandatory.[47] Thus, the Court held that "because [the statutory provision] imposes automatic liability for a violation of its terms, sets forth a predetermined amount of damages, and imposes liability regardless of plaintiffs' actual damages, the provision is a 'penalty' within the meaning of [the] section []."[48]

Based on the language set forth in La. R.S. 40:2203.1(G), and the reasoning of the *Landis* court, the remedy available for noncompliance of La. R.S. 40:2203.1(B), satisfies the definition of a penalty, specifically a statutory penalty. Like in *Landis*, the term "shall" as set forth in La. R.S. 40:2203.1(G), suggests that the amount payable to the provider for failure to comply with the notice requirements is automatic, or mandatory. Further, the remedy at issue imposed in the *Gunderson* action is a statutory penalty because the provision imposes automatic liability on a PPO for violation of La. R.S. 40:2203.1(B), without reference to any damages actually suffered. Instead, the statute imposes a monetary amount that has no correlation to the amount of actual damages suffered. More importantly, in this case, the record shows that the actual losses in medical expenses were approximately $20 million,[49] which is substantially lower than the $261 million judgment rendered. Thus, the *Gunderson* settlement constitutes "fines,

[46] *Id.* (citing Chicago Municipal Code § 5-12-080(f)).

[47] *Id.*

[48] *Id.* at 308.

[49] Cross-Defs.' Mot. for Summ. J., Ex. S, p. 2, ¶8.

penalties, or multiplied damages" which are not recoverable under the Primary Policy's definition of "Loss."

Additionally, Chartis relies on *Indian Harbor Ins. Co. v. Bestcomp, Inc.*,[50] in support of its argument that the settlement in *Gunderson* does not constitute a "Loss" under the Primary Policy. In that case, which is remarkably similar to the case before this Court, a United States District Court in Louisiana was presented with a coverage dispute regarding La. R.S. 40:2203.1(G), the same statutory provision at issue here. In July 2009, Indian Harbor issued a professional liability insurance policy to a subsidiary of Bestcomp. The policy provided coverage for damages and claim expenses in excess of the deductible that Bestcomp was legally obligated to pay between the policy period. Damages were defined as a "duty to defend any claim against the Insured even if any of the allegations of the claim [were] groundless, false or fraudulent."[51] The policy did not cover "[f]ines [and] penalties" and "the multiplied portion of any multiplied awards."[52]

Like First Health, Louisiana medical providers, as a class, sued Bestcomp for failing to provide notice of discounts to workers' compensation medical bills for medical services as required by La. R.S. 40:2203.1(B).[53] In that suit, entitled *George Raymond Williams, M.D. v. BestComp, Inc.*, plaintiffs alleged that Bestcomp was a group purchaser that failed to comply with the notice requirements of La. R.S. 40:2203.1. Indian Harbor

[50] 2010 WL 5471005 (E.D. La. Nov. 12, 2010) *aff'd*, 452 F. App'x 560 (5th Cir. 2011).

[51] *Id.* at *1.

[52] *Id.*

[53] 2010 WL 5471005 at *1.

filed a declaratory judgment asserting it had no duty to defend or indemnify Bestcomp or to pay damages incurred under La. R.S. 40:2203.1(G).[54] Indian Harbor first moved for summary judgment arguing that the claims filed against Bestcomp and the damages requested were not covered, as the damages did not qualify as "compensatory sums" under the policy.[55] Indian Harbor further contended that Section 40:2203.1(G) damages were specifically excluded from the policy's definition of damages because they were penal in nature.[56] The class also moved for summary judgment arguing that the damages requested were covered under the policy because they qualified as "compensatory sums" and were not punitive in nature.[57]

The court in *Bestcomp* held that the damages under Section 40:2203.1(G) were excluded from the policy's definition of damages for several reasons. First, the court held that the damages did not qualify as "compensatory sums" as the amount "more than compensate[d] an injured party for losses incurred due to lack of notice."[58] Second, the court noted that the damages available under the statute were not compensatory because there was no correlation between the amount of damages and the discount applied.[59] Lastly, the court reasoned that section 40.2203.1(G) is "punitive in nature because its

[54] *Id.* at *2.

[55] *Id.*

[56] *Id.*

[57] *Id.*

[58] 2010 WL 5471005, at *5.

[59] *Id.*

purpose is to punish group purchasers for failure to provide notice of PPO discounts to health care providers."[60] Additionally, the court "[found] it significant that numerous courts [had] referred to the damages under 40.2203.1(G) as penalties."[61]

The Settlement Class disputes this reasoning and instead, argues that, based on the language set forth in La. R.S. 40:2203.1(G), the Louisiana legislature did not intend that the language regarding "damages" set forth in the statute to be transformed into "penalties." In support of this contention, it cites to *International Harvester Credit Corp. v. Seale*, where the Louisiana Supreme Court held that statutory damages are only construed as penalties where the language in the statute is specifically stated as such.[62] "The term 'damages,' unmodified by penal terminology such as 'punitive' or 'exemplary,' has been historically interpreted as authorizing only compensation for loss, not punishment."[63] Furthermore, "[u]nder Louisiana law, punitive or other 'penalty'

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[60] *Id.* at *6.

[61] *Id. (*citing *Liberty Mut. Ins.,* 2009 WL 259589, at *1 (W.D. La. Feb. 3, 2009); *Isle of Capri Casinos, Inc. v. COL Mgmt*, 2009 WL 691167, at *1 (W.D. La. Mar. 16, 2009); *Cent La. Ambulatory Surgical Ctr., Inc. v. Rapides Parish School Bd.*,2010 WL 4320487, at *3 (La.App. 3 Cir. 11/3/10); *Gunderson v. F.A. Richard & Assocs.*, 2010 WL 2594287, at *8 (La.App. 3 Cir. 4/30/10); *Touro Infirmary v. American Maritime Officer*, 34 So.3d 878, 881 (La.App. 4 Cir. 1/7/10); *Touro Infirmary v. Am. Mar. Officer*, 24 So.3d 948, 955 (La.App. 4 Cir. 11/9/09)).

[62] 518 So.2d 1039 (La. 1988).

[63] *Id.* at 1041 (citing *Vincent v. Morgan's La. T.R. & S. Co.*, 74 So. 541, 549 (La. 1917)).

damages are not allowable unless expressly authorized by statute."[64] If a statute, however, authorizes "the imposition of a penalty, it is to be strictly construed."[65]

This Court is not persuaded by the Settlement Class' argument regarding legislative intent. On June 8, 1999, the Senate Insurance Committee met in Baton Rouge, Louisiana to discuss, among other topics, House Bill 1072 which prohibits certain practices by health care providers.[66] The meeting minutes reveal that the legislature borrowed the language from Title 22 when enacting Section 40:2203.1(G). In that Title 22 statute, an insured was permitted to recover a "penalty" equal to double the value of any insurance benefits not paid, together with attorney's fees. In the event of a violation, the statute states the following:

> Failure to comply with the provisions of this Section shall subject the insurer to a *penalty* payable to the insured of double the amount of the health and accident benefits due under the terms of the policy or contract during the period of delay, together with attorney fees to be determined by the court.[67]

The Legislature specifically drafted Section 40:2203.1(G) based on Title 22 of the Louisiana Revised statutes.[68] That statutory provision explicitly uses the term penalty when referring to consequences for failing to comply with the provisions of La. R.S. 22:1821(A). "When the law is clear and unambiguous and its application does not lead to

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[64] *Id.* (citing *Ricard v. State*, 390 So.2d 882 (La. 1980)).

[65] *Id.* (citing *State v. Peacock*, 461 So.2d 1040, 1044 (La. 1980)).

[66] Cross-Defs.' Mot. Summ. J., Ex. R, p. 2.

[67] La. R.S. 22:1821(A) (emphasis added).

[68] *See* Cross-Defs.' Mot. Summ. J., Ex. R., p. 2.

absurd consequences, the law should be applied as written and no further interpretation may be made in search of the intent of the legislature."[69]

Here, the intent of the Legislature is ambiguous because the meeting minutes regarding Senate Bill 1072 are not consistent to the language set forth the Any Willing Provider Act. While the minutes explicitly state that Section 40:2203.1(G) would "track the requirements the legislature had adopted under Title 22 for paying their claims timely,"[70] as set forth in Title 22, in the event of a violation, Section 40:2203.1(G) refers to "damages" while Title 22 refers to a "penalty." Furthermore, the word "penalty" does not appear in Section 40:2203.1(G). Thus, based on the ambiguity present in discerning the Legislature's intent at the time of enacting Section 40:2203.1(G), this Court is not persuaded by the Settlement Class' argument regarding the intent of the Louisiana legislature in enacting Section 40:2203.1(G).

The Settlement Class additionally relies on the *Gunderson* trial judge's bench ruling in the underlying *Gunderson* decision in the Fourteenth Judicial District Court on July 20, 2007. In that case, defendant F.A. Richard & Associates ("F.A. Richard") settled, thereby paying the *Gunderson* Class $10 million. In connection with the F.A. Richard settlement, its insurance company, Columbia Casualty argued that its insurance policy did not provide coverage from penalties and thus, claims brought under La. R.S. § 40:2203.1(G) were excluded from coverage. The trial court was faced with identical

[69] *Pepper v. Triplet*, 864 So.2d 181, 193 (La. 2004).

[70] Cross-Defs.' Mot. Summ. J., Ex. R, p. 2.

argument on summary judgment as this Court is now. After hearing the motions for summary judgment, the trial judge ruled from the bench as follows:

> As I indicated before I left for lunch[,] I was going to attempt to make a decision regarding the motions that were heard this morning in the matter of the Third Party Demand and the Motion for Summary Judgment by FARA as it addressed Columbia.
>
> This Court has considered the information, reviewed the evidence that was submitted, looked over the documents that have been submitted, rehashed the arguments that have been made and has come to a decision.
>
> After all is said and done[,] I believe that the basis of what we've got [sic] here[,] we must go back to where we all started these many years ago, and that's Revised Statute 40:2203.1 Section G, which reads in pertinent part[,] ["]Failure to comply with the provisions of this section shall subject a group purchaser to damages payable to the provider of double the fair market value of the medical service provided but in no event less than the greater of $50 per day of noncompliance or $2000 together with attorney's fees to be determined by the Court.["]
>
> Much ado has been made about what that constitutes, and what this Court determines it is. And what, if any, does it mean as it relates to fines, penalties, pecuniary damage.
>
> This Court notes from *a very basic standpoint* that it makes no mentions of fines or penalties. So in my mind, again, just going back to square one here, that I believe from a very basic standpoint that damages are covered by the Columbia policy. No one is arguing that point.
>
> Now, as to whether or not the quote, "damages" being sought by the plaintiffs are in fact civil fines and penalties this Court is of the position that they are not.
>
> Civil fines and penalties[,] in my feeling[,] connote and/or imply payment to someone other than the plaintiff in a compensatory or damage suit other than what we have before us at this time.
>
> For instance, if part or partial of the settlement or the agreement by FARA [F.A. Richard] was to pay not only the medical service provider something, plus pay someone else some fines and penalties, then I think we have fines and penalties.

> Payment of the agreed amount [of the settlement] at this time is to plaintiffs to compensate them for the failure of FARA to abide by the notice requirements of Louisiana Revised Statute 40:2203.1.
>
> Accordingly, pursuant to the evidence [] argument, documents submitted and reviewed by this Court, this Court finds that the policy of insurance provided by Columbia provides coverage for this claim and accordingly[,] the Motion for Summary Judgment is granted.[71]

Following the bench ruling, the court designated the judgment as final and immediately appealable under La. Code Civ. P. art. 1915(B).[72]

Defendant, First Health, appealed that decision granting the *Gunderson* Class' motion for summary judgment and denying defendant's motion for summary judgment.[73] In its appeal, among other contentions,[74] "First Health assert[ed] that the trial court erred in granting [p]laintiffs' motion for partial summary judgment on the issues of the applicability of La. R.S. 40:2203.1 to First Health and on the issue of partial, undisputed

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[71] Settlement Class' Mot. Summ. J., Ex. E, pp. 86-88.

[72] *Gunderson v. F.A. Richard & Assoc.*, 44 So.3d 779, 782 (La. Ct. App. Aug. 25, 2010).

[73] *Gunderson*, 44 So.3d at 781.

[74] First Health argued the following in its appeal: (1) its appeal of the trial court's denial of its motion to decertify the Gunderson Class divested the court of jurisdiction to hear the motions for summary judgment; (2) the trial court erred in denying its motion for summary judgment because most First Health provider agreements require application of California or Illinois law; (3) the trial court erred in proceeding with summary judgment where the U.S. District Court for the Western District of Louisiana had issued injunctions prohibiting the class representatives from pursuing their own claims against First health; (4) the Gunderson Class' cause of action has prescribed because the prescriptive period is one year rather than ten years applied by the trial court; (5) La. R.S. 40:2203.1 is unconstitutionally vague and its damage provision violates due process; (6) the trial court erred in granting the Gunderson Class' motion for partial summary judgment on the issues of the applicability of section 40.2203.1 to First Health and on the issue of partial, undisputed damages; and (7) the trial court erred in designating the damages portion of its judgment as final under La. Code Civ. P. art. 1915(B).

damages."[75] The specific issue of whether the payment for lack of notice was damages or a penalty was, however, not appealed. While the Louisiana Third Circuit Court of Appeals affirmed, referring to the amount awarded as "statutory damages," the specific issue present in this case was not addressed in its opinion.[76]

Respectfully to the trial court in Louisiana, this Court's review of the insurance policy reveals that the damages under section 40.2203.1(G) are excluded under the policy's definition of Loss. Based on the arguments presented by both parties, the *Bestcomp* decision is persuasive to the situation currently before the Court. While the policy provision in *Bestcomp* differs slightly from the policy provision applicable in this case, the Court finds that the damages under section 40.2203.1(G) are excluded from coverage under the policy as a statutory penalty. The amount under the statute more than compensates an injured party for losses sustained for a lack of notice. Additionally, "[S]ection 40.2203.1(G) is punitive in nature because its purpose is to punish group purchasers for failure to provide notice of PPO discounts to health care providers."[77] Further, like the *Bestcomp* court, this Court also finds it significant that other courts have referred to the specific statutory provision as imposing a "penalty."[78] Thus, under the

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[75] *Id.* at 785.

[76] *Gunderson v. F.A. Richard & Assoc.*, 977 So.2d 1128 (La. App. 3d Cir. Feb. 27, 2008).

[77] 2010 WL 5471005 at *6 (citing *Gunderson v. F.A. Richard & Assocs.*, 44 So.3d 779, 783 (La.App. 3 Cir. 6/30/10) (finding that "[t]he mandatory provisions of this statute evidence a strong public policy in favor of notice to health care providers that a PPO discount may be taken").

[78] *See Cent. La. Ambulatory Surgical Ctr., Inc., v. Rapides Parish Sch. Bd.*, 68 So.3d 1041, 1045 (La. App. 3d. Cir. Nov. 3, 2010) (noting that "the panel reversed its position on the

plain meaning of the policy, the amount is excluded as "fines, penalties [] or multiplied damages" and is not covered.

C. The Gunderson Settlement Does Not Constitute Antitrust Activity Under the Policy Language

Alternatively, the Settlement Class argues that even if this Court characterizes the claims in the *Gunderson* matter as a penalty, the claims fall within the purview of "Antitrust Activity" under the Primary Policy. It contends the pricing differential applied to First Health, without proper notice requirement, constitutes "Antitrust Activity" either as unfair trade practice, price discrimination, or predatory pricing. In opposition, Chartis asserts that the Settlement Class did not allege any Antitrust claims or theories against First Health and therefore, the "Antitrust Activity" language set forth in the policy is not implicated.

The five types of "Antitrust Activity" claims enumerated in the policies are as follows: (1) price fixing; (2) restraint of trade; (3) monopolization; (4) unfair trade practices; or (5) violation of the Federal Trade Commission Act, the Sherman Act, the

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penalty and attorney fee award based on failure of the defendants to comply with the notice requirements of La. R.S. 40:2203.1"); *Gray Ins. Co. v. Concentra Integrated Servs.*, 2010 WL 5298763, at n.4 (N.D. La. Aug. 24, 2010) (stating that "a violation of La. R.S. 40:2203.1 carries a statutory penalty); *Gunderson v. F.A. Richard & Assoc.*, 44 So.3d 779, 782, 789-91 (La. Ct. App. 2010) (declining to adopt a comparative fault argument as "applied to a penalty for statutory violation" and describing the remedy as recovering "penalties under the statute"); *Touro Infirmary v. Am. Maritime Officer*, 24 So.3d 948, 951 (La. Ct. App. 2009) (holding that the penalty provisions of section 40:2203.1(G) applied to group purchasers only); *Liberty Mutual Ins. Co. v. Gunderson*, 2009 WL 259589, at *1 (W.D. La. Feb. 3, 2009) (noting that section 40:2203.1(G) "provides for penalties of fifty dollars per day of noncompliance together with attorneys fees determined by the court"); *Isle of Capri Casinos, Inc. v. COL Mgmt.*, 2009 WL 691167, at *1 (W.D. La. Mar. 16, 2009) (referring to the remedy under section 40:2203.1 as penalties and noting that such penalties amounted to "twice the bill it charges or $50.00 per day, per claim, plus attorney's fees").

Clayton Act, or other similar provision of any federal, state, or local statute, rule, regulation, or common law.[79] The Settlement Class bears the burden of showing that the asserted claims fit within the definition of "Antitrust Activity" under the policies.[80]

The gravamen of the *Gunderson* Petition was that First Health discounted payments to participating providers without the proper notice, in violation of La. R.S. 40:2203.1. Specifically, the petition alleged, "[n]otwithstanding the [] statutory requirements for payment of bills and charges under the Louisiana Workers' Compensation Act, the Group Purchaser Defendant Class routinely and systematically reimburses health care providers at rates below those mandated by LA R.S. 23:1203(B) pursuant to [PPO] contracts governed by the provisions of LA R.S. 40:2203.1, et. seq."[81] Further, the Petition alleged that the defendants' activities included: "(1) an inability on the part of participating providers to determine whether their rates [were] being reduced below that mandated by the State . . . prior to rendering service, (2) an inability on the part of participating providers to determine what extent their rates [were] being reduced prior to rendering service, and (3) payment to participating providers below that mandated by the State . . ."[82]

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[79] Cross-Defs.' Mot. Summ. J., Ex. A, p. 1, ¶ (II)(A).

[80] *See, e.g., E.I. duPont de Nemours & Co. v. Allstate Ins. Co.*, 693 A.2d 1059, 1061 (Del. 1997).

[81] Class' Mot. for Part. Summ. J., Ex. B, Pet., at ¶ VIII.

[82] *Id.* Pet., ¶ X.

The Supreme Court of Delaware has held that "the terms of an insurance contract are to be read was a whole and given their plain and ordinary meaning."[83] Furthermore, Delaware recognizes the principle of *ejusdem generis*, which stands for the proposition that "where general language follows an enumeration of persons or things, by words of a particular and specific meaning, such general words are not to be construed in the widest extent, but are to be held as applying only to persons or things of the game general kind or class as those specifically mentioned."[84] In reading the definition of "Antitrust Activity" as a whole, it exists when an Insured is sued for anti-competitive conduct, or injury to the marketplace.[85]

The Settlement Class has not met its burden of showing the asserted claims fit within the definition of "Antitrust Activity" under the policies. It attempts to choose certain words from the "Antitrust Activity" policy provision in arguing that the claims fit within this broad provision. Specifically, the antitrust provisions of the policies have not been implicated, as First Health had not alleged any violations of antitrust claims or

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[83] *O'Brien v. Progressive Northern Ins. Co.*, 785 A.2d 281, 291 (Del. 2001).

[84] *Aspen Advisors v. United Artists Theater Co.*, 861 A.2d 1251, 1265 (Del. 2004).

[85] *See e.g., Saint Consulting GP. v. Endurance Am. Spec. Ins. Co.*, 2012 WL 1098429, at *3 (D. Mass. Mar. 30, 2012) (noting that, while an "antitrust" exclusion is broad, it only pertains to "anticompetitive conduct"); *Integra Telecom v. Twin City Fire Ins. Co.*, 2010 WL 1753210, at *5-6 (D. Or. Apr. 29, 2010) (holding that the term "unfair trade practices" was "limited to antitrust and anti-competitive violations because the terms that come before and after it are reasonably limited to antitrust or anti-competitive conduct."); *Cont'l Cas. Co. v. Multiservice Corp.*, 2009 WL 1788422, at *3 (D. Kan. June 23, 2009) (holding that an identical exclusion applied only to "claims based upon charges or violations of antitrust laws"); *Clinch v. Heartland Health*, 187 S.W.3d 10, 19 (Mo. Ct. App. Jan. 17, 2006) (stating that, "[b]ecause the purpose of antitrust laws is to protect competition and not individual competitors, an antitrust plaintiff must prove that a defendant's anti-competitive behavior injured consumers or competition in the relevant market").

theories. The claims in the *Gunderson* Petition did not pertain to antitrust law and claimed no anti-competitive injury to the market. Instead, the Settlement Class was a group of medical providers claiming lack of notice with regard to discounts applied to PPOs. Thus, the Court holds that coverage for the *Gunderson* settlement would not alternatively be covered as a Loss under the "Antitrust Activity" definitions set forth in the policies.

D. Chartis is Not Legally Obligated to Pay the Settlement Class' Attorneys' fees

The Settlement Class paid its attorneys 35% of the $150.5 million settlement in the *Gunderson* action out of the common fund doctrine. It argues that the attorneys' fees in the amount of $52.5 million paid in connection with the *Gunderson* action, meets the definition of "Loss" under the Primary Policy, as they are a "monetary amount which the insured is legally obligated to pay."[86] Thus, the attorneys' fees are covered under the definition of "Loss."

In opposition, Chartis contends the Settlement Class has waived the issue of coverage for attorneys' fees, as neither First Health, nor the Settlement Class has previously raised the issue in this case. Should the Court consider the argument regarding attorneys' fees, Chartis argues that the payment of $52.5 million in attorneys' fees is not a "Loss" to First Health, nor is it covered under First Health's liability policies at issue. Chartis submits that, based on the $261 million judgment entered against First Health, there was no mention in the judgment itself that it was liable for attorneys' fees.

[86] Cross-Defs.' Mot. Summ. J., Ex. A, P.3, ¶ II(J).

Instead, the Settlement Class had an obligation to pay its own attorneys' fees. Chartis further contends that the *Gunderson* trial court's approval of the Settlement Class' request to pay its attorneys 35% of the $150.5 million settlement should not change the nature of the settlement payment. That request was not followed by any specific language directing the payment of that amount for fees.

The Settlement Class relies on *UnitedHealth Group Inc. v. Hiscox Dedicated Corporate Member Ltd.*,[87] for the proposition that the claim for attorneys' fees was itself a claim for damages, regardless of whether the underlying claims resulting in the attorneys' fees were covered. In that case, plaintiff UnitedHealth Group, Inc., the Insured, agreed to settle two lawsuits – a class action filed in federal court in New Jersey and a potential action by the New York Attorney General's Office. Plaintiff filed suit seeking to compel its managed-care liability insurers to indemnify it for the settlement amounts, in addition to the attorney's fees and costs incurred in defending the actions. The insureds filed five motions to dismiss the complaint, which were referred to the magistrate judge. The magistrate judge recommended denying the motions in their entirety. The insurers objected to the magistrate judge's recommendation and thus, the district court of Minnesota conducted a *de novo* review of the magistrate's findings. The Court in *UnitedHealth* held that, while the underlying claims were not covered under the insurance policy, plaintiff's attorneys' fees expended regarding the uncovered claims were covered under the policy.

[87] 2010 WL 550991 (D. Minn. Feb. 9, 2010).

The Settlement Class additionally cites to *XL Specialty Ins. Co. v. Loral Space & Commuc'ns, Inc.*, where the Supreme Court, Appellate Division of New York held that attorneys' fees paid under the common fund doctrine in a derivative settlement were a covered "loss" under the policies.[88]

However, in *Bestcomp*, the court held that the attorneys' fees recoverable under section 40.2203.1(G) were excluded from coverage under the insurance policy, as they were "penal in nature."[89] As a basis for this holding, the court cited to various opinions of Louisiana courts finding that an award of attorneys' fees is punitive in nature. For example, in *Langley v. Petro Star Corp of La.*, the Supreme Court of Louisiana held that "[a]n award of attorney fees is a type of penalty imposed not to make the injured party whole, but rather to discourage a particular activity on the part of the opposing party."[90] Similarly, in *Texas Indus., Inc. v. Roach*, the Second Circuit Court of Appeal in Louisiana held that an attorneys' fees award was penal in nature and only favored in extenuating circumstances.[91] Likewise, in *Peyton Place, Condo. Assocs., Inc., v. Guastella*, the court held that an attorneys' fees award was not compensatory in nature, but instead, existed "to discourage a particular activity or activities on the part of the other party."[92]

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[88] 82 A.D.3d 108 (N.Y. App. Div. 2011).

[89] 2010 WL 5471005, at *7.

[90] 792 So.2d 721, 723 (La. 6/29/11).

[91] 426 So.2d 315, 317 (La.App.2d Cir. 1983).

[92] 18 So.3d 132, 136 (La.App. 5 Cir. 5/29/09).

As an initial matter, the issue of waiver is inapplicable to this case. It is well settled that that "[w]aiver is the voluntary and intentional relinquishment of a known right."[93] "It implies knowledge of all material facts and an intent to waive, together with a willingness to refrain from enforcing those [] rights" and "[t]he facts relied upon to prove waiver must be unequivocal."[94] A party claiming waiver must show the following elements: (1) a requirement or condition to be waived; (2) the waiving party's knowledge of such a requirement or condition; and (3) an intention on behalf of the waiving party to waive the requirement or condition.[95] Here, Chartis has not met the elements necessary to establish waiver of the attorneys' fees issue. Thus, as waiver has not properly been established, the Court will consider the Settlement Class' argument regarding attorneys' fees.

Generally, this Court has applied Delaware law concerning interpretation of insurance contracts. But, the Court believes it is consonant with its holding on coverage and the statute underlying this matter to employ Louisiana law to determine whether the Settlement Class is entitled to attorneys' fees.

This Court finds that the Settlement Class has not met its burden of proving that the attorneys' fees paid in the amount of $52.5 million to their own attorneys is covered as a "Loss" under the Policy. As assignee of First Health, the Settlement Class bears the

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[93] *Bantum v. New Castle County Vo-Tech Educ. Ass'n*, 21 A.3d 44, 50-51 (Del. 2011) (quoting *AeroGlobal Capital Mgmt., LLC v. Cirrus Indus., Inc*., 871 A.2d 428, 444 (Del. 2005)).

[94] *Id.*

[95] *Bantum*, 21 A.3d at 51 (internal citations omitted).

burden of proving that the payment of $52.5 million to its own attorneys is a covered "Loss" under the policies.

The specific terms of the settlement agreement of the Class Action between First Health and the Settlement Class included a payment of $150.5 million by First Health to the Settlement Class, plus an assignment of First Health's rights under its insurance policies. No portion of settlement agreement was apportioned to the payment of the attorneys' fees. Additionally, Executive Risk has paid, or will pay the entirety of the defense costs expended by First Health in connection with the Class Action.[96] Unlike the cases cited in support of payment of attorneys' fees, here, Executive Risk has already, or will pay all defense costs incurred by First Health with regard to the Class Action.

Furthermore, and importantly, in accord with the rationale of *Bestcomp*, *Langley*, *Texas Industries, Inc.* and *Peyton Place*, the attorneys' fees are punitive in nature, under Louisiana law, and exist merely to discourage group purchasers from failing to provide adequate notice of PPO discounts to health care providers. As assignee of First Health, the Settlement Class is not entitled to payment the attorneys' fees incurred by the Class. Such a payment is not covered under the policy as a Loss that Chartis is legally obligated to pay. Accordingly, the Settlement Class is not entitled to coverage for attorneys' fees paid in connection with this litigation.

[96] Cross-Defs.' Mot. Summ. J., p. 9, n. 5.

Conclusion

For the reasons stated herein, the *Gunderson* settlement is not a covered loss. Accordingly, the Settlement Class' motion for partial summary judgment is DENIED and Chartis' motion for partial summary judgment is GRANTED.

/s/ Jerome O. Herlihy

J.