IN THE COURT OF CHANCERY OF THE STATE OF DELAWARE

IN AND FOR NEW CASTLE COUNTY

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| IN RE CAREMARK INTERNATIONAL INC. DERIVATIVE LITIGATION | Consolidated Civil Action No. 13670 |

**CONFIDENTIAL -- FILED UNDER SEAL**

# PLAINTIFFS' BRIEF IN SUPPORT OF SETTLEMENT AND APPLICATION FOR AN AWARD OF ATTORNEYS' FEES AND EXPENSES

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## PRELIMINARY STATEMENT

Plaintiffs submit this brief in support of their application for approval of the proposed settlement of this consolidated derivative action and their application for an aggregate award of attorneys' fees and reimbursement of expenses of $1,025,000.[1]

In this litigation, plaintiffs charged that the directors of Caremark International, Inc. ("Caremark" or the "Company") breached their fiduciary duties to Caremark in connection with alleged violations by Caremark employees of various federal and state laws and regulations which, among other things, regulated or prohibited Caremark and other health care providers from paying remuneration or consideration in any form to anyone to induce the referral of Medicare and Medicaid patients. Beginning in August 1991, Caremark became the target of one of the largest medical fraud investigations in the history of the United States Department of Justice and the Office of the Inspector General ("OIG") of the Department of Health and Human Services ("HHS"). The ensuing scandal cost Caremark approximately $250 million in criminal and civil fines, penalties and settlements with governmental and private parties. Plaintiffs sued derivatively, claiming that Caremark's directors had recklessly and wrongfully exposed Caremark to the consequences of its employees' alleged wrongdoing.

The parties commenced settlement negotiations in May 1995. Plaintiffs' letter proposal of May 16, 1995 became the centerpiece of the parties' negotiations. See Exhibit 1 to the Affidavit of David C. Harrison, Esquire, filed simultaneously herewith.

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[1] Based upon their normal billing rates, to date plaintiffs' attorneys have spent over $710,000 of time in prosecuting this litigation and approximately $53,000 in out-of-pocket expenses.

The parties' negotiations led to an agreement in principle, as modified by a memorandum of understanding dated June 7, 1995. The parties executed a Stipulation and Agreement of Compromise and Settlement on June 28, 1996 (the "Settlement Agreement"), which is now before the Court.

The settlement was negotiated separate and apart from any relief sought by governmental agencies. The settlement resulted in remedial benefits to Caremark, described by Caremark's Chief Financial Officer as a "quantum leap" over the internal controls that Caremark had in place when the alleged misconduct by lower echelon employees took place. The settlement also will put to rest one of the most challenging and troubling periods in Caremark's history.

Pursuant to the Scheduling Order of July 2, 1996, notice of the proposed settlement and application for an award of attorneys' fees and reimbursement of expenses has been disseminated to almost 100,000 record and beneficial owners of Caremark stock. Notwithstanding the widespread publicity generated by the events which prompted this litigation, accompanied by high profile criminal and civil enforcement proceedings, to plaintiffs' knowledge only seven shareholders have written to the Court or to plaintiffs' counsel objecting to any part of the settlement or the fee and expense application. Plaintiffs will discuss these objections infra.

## STATEMENT OF FACTS

Caremark is a Delaware corporation headquartered in Northbrook, Illinois. It was created in November 1992 as a spin-off of a division of Baxter International, Inc. ("Baxter"). Caremark was a leader in the business of providing alternative site health care services,[2] including infusion therapy, growth hormone therapy, HIV/AIDS-related treatments and hemophilia therapy. In addition to this patient care segment, the Company provided managed care services, including prescription drug programs and the operation of multi-specialty group practices.

For the three full years since Caremark's 1992 spin-off, the Company has reported increased revenues, net income and earnings as follows:

| Year Ended Dec. 31 (in millions) | 1992 | 1993 | 1994 |
|---|---|---|---|
| Revenues | $1,461 | $1,783 | $2,426 |
| Net Income | 27.30 | 77.70 | 80.40 |
| Earnings Per Share | 0.39 | 1.06 | 1.08 |
| Shares Outstanding | 69.80 | 74.90 | 74.80 |

Caremark's patient care business segment historically accounts for the bulk of the Company's revenues with the home infusion business generating more than one-half of its revenues. Almost all of Caremark's patient revenues were derived from third-party payors including private insurers and federal and state Medicare and Medicaid

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2 Meaning health care provided at non-hospital sites, e.g., at home or in clinics.

reimbursement programs which are subject to extensive regulation. Such governmental regulations specifically prohibit Caremark's payment of remuneration in any form to anyone in order to induce the referral of Medicare and Medicaid patients (the "Anti-Referral Payments Law"). It is the alleged violation of these laws that were the subject of this litigation and the investigations and proceedings brought by governmental agencies.

In 1992, approximately 25% of Caremark's patient care revenues ($234 million), or 16% of total revenues, was attributable to payments received on behalf of Medicare and Medicaid patients. This amount increased to $249 million and $291 million, respectively, in 1993 and 1994. Loss of such business would have serious consequences to the Company.

Caremark typically retained hospitals, physicians and other health care professionals to provide services and advice to Caremark pursuant to a variety of employment, consulting, joint venture and service contracts. Caremark also entered into distribution agreements with drug manufacturers whose products could be distributed through Caremark's branches, and were suitable for administration in the alternate site setting. Under these arrangements, Caremark became the largest distributor of Protropin, a growth drug hormone manufactured by Genentech, Inc.

### A. Commencement of the Litigation

On August 4, 1994, a federal grand jury in Minnesota issued an indictment (the "Minnesota Indictment") charging, inter alia, that Caremark and three of its employees had violated the Anti-Referral Payments Law by making payments of over $1.1 million

to induce a Minneapolis physician to distribute Protropin. United States v. Brown et al., CR-4-94-95 (D. Minn.).

Five actions were subsequently filed in this Court and consolidated under the above caption (the "Derivative Action").[3] The Derivative Action named as defendants the thirteen Caremark directors: C.A. Lance Piccolo ("Piccolo"), James G. Connelly, III ("Connelly"), Thomas W. Hodson ("Hodson"), Raymond D. Oddi ("Oddi"), Peter F. Whitington, Blaime J. Yarrington, Ira Harris, Ralph W. Muller, Kenneth N. Pontikes, Vincent A. Calarco, Roger L. Headrick, Philip B. Rooney and Nancy G. Brinker (the "Director Defendants"). Three Director Defendants are officers of the Company: Piccolo, Chairman and Chief Executive Officer since August 1992; Connelly, President and Chief Operating Officer since August 1992; and Hodson, Senior Vice President and Chief Financial Officer since August 1992. Each of them was a senior executive at Baxter prior to the spin-off. Defendant Oddi, who heads the Audit and Ethics Committee, was also former Senior Vice President and Chief Financial Officer of Baxter. Caremark was named as a nominal defendant.

As part of derivative counsels' investigation, counsel discovered that Caremark was the subject of a government investigation which began in August 1991, when the

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[3] On August 8, 1994, another stockholder derivative action, captioned Brumberg v. Mieszala, No. 94 C 4798, was filed in the United States District Court for the Northern District of Illinois against Caremark, the Board of Directors of Caremark and three Caremark employees (the "Brumberg Action"). The Brumberg complaint alleged violations of the Racketeer Influenced Corrupt Organization ("RICO") laws and breaches of fiduciary duty, abuse of control, waste of corporate assets, constructive fraud, unjust enrichment and gross mismanagement. The Brumberg Action was stayed pending resolution of this action.

OIG-HHS served a subpoena on Caremark requiring the Company to produce, among other documents, contracts between Caremark and physicians known as "Quality Service Agreements" ("QSAs").[4] Caremark paid physicians fees under QSAs for monitoring Medicare and Medicaid patients under Caremark's care. As a result of the OIG initiative, Caremark announced that effective October 1, 1991, it would discontinue paying management fees to physicians for services to Medicare and Medicaid patients.

In March 1992, the Department of Justice joined the OIG investigation and commenced an inquiry into Caremark's financial relationships with doctors, hospitals, and health care providers. Representatives of several federal and state agencies, including a federal grand jury, also commenced separate investigations into Caremark's business practices. The OIG investigation and related governmental investigations ultimately encompassed a review of a wide variety of conduct attributed to Caremark, including whether:

- Caremark's financial relationships with health care providers were intended to induce patient referrals to the Company and thereby violated the Anti-Referral Payments Law;
- the Company's billing practices defrauded public and private health care payors;

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[4] In July 1991, the HHS issued "safe harbor" regulations which described the conditions whereby certain financial arrangements between health care service providers such as Caremark and patient referral sources such as physicians would not be considered violative of the Anti-Referral Payments Law. The regulations were narrowly drawn and therefore provided only limited guidance regarding the legality of many common agreements (including QSAs) used by Caremark and other providers.

- the Company's activities led to excessive and medically unnecessary treatments for patients;
- the Company improperly waived patient co-payment obligations; and
- the Company failed to keep adequate records at its pharmacies, as required by law.

Plaintiffs asserted that not only were Caremark's directors aware of the OIG probe as early as August 1991, but they also acknowledged the disastrous effect that fines, penalties and criminal convictions could have on Caremark's business. Indeed, in Caremark's Form 10-K for the year ended December 31, 1992, it was represented that:

> The OIG and the Department of Justice are investigating Caremark to determine whether Caremark's fee-for-service and other arrangements with physicians and hospitals violate the Medicare Referral Payments Law (the federal law prohibiting the payment of remuneration to induce the referral of Medicare and Medicaid patients) . . . . Civil penalties for violating the Medicare Referral Payments Law include exclusion from participation in the Medicare and Medicaid program. Criminal penalties could include fines of up to $25,000 per violation or up to five years imprisonment, or both, subject to increases under the Federal Organizational Sentencing Guidelines. If imposed, such penalties could have a material adverse effect on Caremark's business. The outcome of this investigation is not presently determinable. Growth in sales slowed following initial publicity related to this investigation as well as reported investigations of others. Based on these changes and discussions with customers, Caremark believes that this publicity has adversely affected revenues from certain patient care services and may continue to do so. (Emphasis supplied.)

Plaintiffs also noted that the Director Defendants did not deny the merits of the OIG investigation, but instead, acknowledged in the 1992 Form 10-K:

> No assurance can be given that the OIG or the United States Department of Justice will not seek a determination that Caremark's past or current policies and practices regarding contracts and relationships with health care providers violate the Medical Referral Payments Law, and no assurance can be given that Caremark's interpretation of these laws will prevail if challenged. A determination that contracts and relationships entered into by Caremark violate the Medicare Referral Payments Law could have a material adverse effect on the business of Caremark.[5] (Emphasis supplied.)

In essence, plaintiffs complained that Caremark's directors had exposed the Company to potential sanctions for illegal conduct by its employees which could have disastrous consequences to the Company's resources and its future, including exclusion from participation in the Medicare and Medicaid programs.

On September 14, 1994, defendants moved to dismiss plaintiffs' initial complaint pursuant to Chancery Court Rules 12(b)(6) and 23.1. In their brief, defendants argued, among other things, that the complaint failed to comply with the requirements for pleading demand futility under Rales v. Blasband, Del. Supr., 634 A.2d 927 (1993), and also that Caremark's charter provisions, authorized by 8 Del.C. § 102(b)(7), protected Caremark's directors against liability for money damages for duty of care claims.

### B. New Revelations of Alleged Misconduct -- The Amended Complaint, Second Amended Complaint and Third Amended Complaint

On October 28, 1994, plaintiffs filed an amended complaint (the "Amended Complaint") which supplemented and amplified the substantive allegations of their initial

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[5] Similar disclosures regarding the OIG investigation were made in Caremark's 1992 and 1993 Annual Reports and in quarterly reports on Form 10-Q for the periods ending March 31,

pleadings. The Amended Complaint alleged that on September 21, 1994, a federal grand jury in Columbus, Ohio issued an indictment (the "Ohio Indictment") charging an osteopathic doctor with receiving $134,600 in kickbacks for referring patients to an unidentified provider of health care services from 1991 through September 1994 in violation of the Anti-Referral Payments Law. U.S. v. Neufeld, No. CR-2-94-144 (S.D. Ohio). Media sources, including the Wall Street Journal, Financial World, and Modern Healthcare, universally reported that the "unnamed company" that made the referral payments to the physician who was indicted was Caremark.

The Amended Complaint further alleged that Caremark was involved in a scheme of paying $3 million in illegal kickbacks to doctors affiliated with the University of Minnesota and an overbilling and kickback scheme with two doctors and a pharmacy in Atlanta, Georgia, which was the subject of a civil RICO lawsuit filed by an Atlanta AIDS patient captioned Booth v. Rankin Civ. No. E-2758 (Super. Ga. Fulton Cty.) (the "Atlanta Lawsuit"). The Amended Complaint charged the Director Defendants with encouraging or countenancing the unlawful kickback schemes, fraudulent billing practices and other illegal or improper activities, misrepresenting to the public that corrective measures were being taken, intentionally failing to implement adequate protective procedures, failing to supervise employees adequately, recklessly exposing the Company to losses, and failing to fire or sue those persons directly responsible for the illegal conduct.

On November 18, 1994, defendants moved to dismiss the Amended Complaint pursuant to Rules 12(b)(6) and 23.1. This motion was mooted when plaintiffs served their second amended complaint on January 3, 1995 (the "Second Amended

Complaint"), following additional public revelations of alleged misconduct. The new claims dealt with an expanded investigation into Caremark's operations in Michigan relating to the submission of allegedly false and inflated bills to insurers (including the federal and state Medicaid programs) for Caremark's home infusion therapies and Caremark's policy of waiving patient co-payments in order to induce patients to continue therapy treatments. The Second Amended Complaint also alleged that the federal government was investigating the head of Caremark's Detroit office for allegedly paying kickbacks to doctors in exchange for patient referrals; and that the Federal Trade Commission had begun an examination of Caremark's contractual alliances with drug companies.

On January 13, 1995, the Director Defendants and Caremark moved to dismiss the Second Amended Complaint pursuant to Rules 12(b)(6) and 23.1.

On January 29, 1995, Caremark announced an agreement to sell its home infusion business for approximately $310 million in cash and securities to Coram Health Care Company ("Coram"). The agreement provided that Caremark would remain liable for penalties and fines resulting from the OIG and related state law investigations. Baxter had purchased the home infusion business in 1987 for $586 million.

On April 11, 1995, plaintiffs filed their opposition brief to defendants' motion to dismiss, and concurrently filed a third amended and supplemental derivative complaint (the "Third Amended Complaint"). The Third Amended Complaint included additional allegations with respect to the ongoing federal investigation against Caremark, adding that the investigations and indictments had caused the Company to incur huge legal bills

and to sell its home infusion business at a significant loss. The Third Amended Complaint also contained additional allegations with respect to the Atlanta Lawsuit and the alleged kickback arrangements between Caremark and several doctors in Atlanta.

### C. Settlement Negotiations

In May 1995, the parties first explored the possibility of settlement. As above noted, on May 16, 1995, plaintiffs presented a formal settlement proposal which encompassed both a monetary element (in the form of Caremark senior officers relinquishing stock options),[6] as well as the adoption and implementation of extensive remedial measures by Caremark senior management. (See Exhibit 1 to Harrison Affidavit.) Plaintiffs' demand was original with plaintiffs and did not copy or encompass any publicly available or known potential relief sought by any governmental agency.

Further communications during the next two weeks led to a full-day negotiating session on May 30, 1995, commencing at 10:00 a.m. and lasting to 7:30 p.m. at the offices of Richards, Layton & Finger. At that meeting, plaintiffs' proposals to settle the action were explored in detail. Negotiations continued all day, interspersed periodically with separate caucuses by the parties' respective counsel.

During this meeting, counsel for Caremark confirmed to plaintiffs' counsel Caremark's prior representations in numerous public filings that an adverse determination in the government proceedings or investigations could result in substantial

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6 Plaintiffs' settlement strategy reflected their assessment of the chances of recovering money damages from the Director Defendants in light of the "raincoat" provisions in Caremark's Certificate of Incorporation.

fines and penalties, the loss of Caremark's Medicare/Medicaid business, and adversely impact its reimbursement arrangements with private insurers. Caremark's counsel represented that if, in fact, there had been any wrongdoing, such wrongdoing had been carried out by lower echelon personnel, and that senior management and the directors were not implicated. As of that time, no director or senior officer had been named a defendant or an unnamed co-conspirator in any governmental litigation, and defendants' counsel represented to plaintiffs' counsel that none would be named. Plaintiffs' counsel were further advised that the Director Defendants had concluded that the conduct of the lower echelon employees put Caremark's Medicare/Medicaid business in jeopardy. Accordingly, the directors had instructed counsel representing Caremark in the government investigation, the Chicago-based firm of Winston & Strawn, to attempt to negotiate a global settlement of all pending investigations with the federal and state Medicare/Medicaid agencies, including the Department of Justice and the OIG. Caremark's counsel further advised plaintiffs' counsel that any such settlement would have to allow Caremark to continue to participate in federal and state reimbursement programs.

Plaintiffs' counsel were also advised that many of the remedial measures contained in their demand of May 16, 1995 were similar to the relief being discussed with the governmental agencies and, that since receipt of plaintiffs' demand, negotiations with derivative counsel and the governmental agencies had proceeded on parallel but separate tracks. Plaintiffs' counsel was also advised that restitution and fines had been discussed as part of the government settlement.

In light of defense counsels' representations (which they represented could and would be confirmed in discovery), plaintiffs withdrew their demand for monetary relief. Defendants, through counsel, however, expressed their willingness to adopt almost in its entirety the remedial relief plaintiffs proposed in their May 16, 1995 demand.

During the next several days, the parties negotiated the principal terms of a memorandum of understanding ("MOU"), which was subject to, among other things (i) appropriate confirmatory discovery conducted by plaintiffs' counsel; (ii) a formal settlement stipulation; and (iii) the approval of this Court following notice to the Caremark stockholders.[7]

**D. Terms of the Settlement**

At a special meeting on June 15, 1995, Caremark's Board of Directors approved the MOU and adopted the Resolutions called for by the MOU which were subsequently incorporated into the Settlement Agreement. (See July 15, 1995 Board minutes, Exhibit 2 to Harrison Affidavit.) These Resolutions read as follows:

> RESOLVED, that the settlement of the derivative litigation pending before the Delaware Court of the Chancery, styled In re Caremark International Inc. Derivative Litigation, Consol. C.A. No. 13670, on the terms set forth in the memorandum of understanding (the "Delaware MOU") is in the best interests of the Corporation and all of its stockholders, and the Corporation's attorneys are authorized to sign the

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[7] At no time during the meeting or at any time thereafter until June 1996, about one year later, were attorneys' fees discussed. The parties specifically deferred any such discussion on the question of attorneys' fees until after the parties had agreed on a final version of a settlement stipulation, to be entered after the completion of discovery.

Delaware MOU on behalf of the Corporation and to proceed with the proposed settlement of this lawsuit; and

FURTHER RESOLVED, that the Corporation and all of its employees and agents are prohibited from providing or paying any form of compensation (whether monetary or otherwise, whether in the form of a grant, monies for research or medical studies, or monitoring patients) to any doctor, pharmacy, hospital, health care maintenance organization, or any joint venture in which the Corporation or any employee thereof is a principal, in exchange for the referral of a patient to a Corporation facility or a Corporation service, for which reimbursement may be sought from Medicare, Medicaid or any similar state reimbursement program; and

FURTHER RESOLVED, the Corporation and all of its employees and agents are prohibited from providing or paying any form of compensation (whether monetary or otherwise, whether in the form of a grant, monies for research or medical studies, or monitoring patients) to any doctor, pharmacy, hospital, health care maintenance organization, or joint venture in which the Corporation or any employee thereof is a principal, in exchange for the prescription of drugs marketed or distributed by the Corporation, for which reimbursement may be sought from Medicare, Medicaid or any similar state reimbursement program; and

FURTHER RESOLVED, the Corporation and all of its employees and agents are prohibited from payment or splitting of fees with physicians, joint ventures, any business combination in which the Corporation maintains a direct financial interest, or other health care providers with whom the Corporation has a financial relationship or interest, in exchange for the referral of a patient to a Corporation facility or a Corporation service, for which reimbursement may be sought from Medicare, Medicaid or any similar state reimbursement program; and

FURTHER RESOLVED, that the board shall discuss at a meeting of the full board, on a semi-annual basis all material changes in government health care regulations relevant to the Corporation since the proceeding semi-annual meeting

and their effect on the Corporation's relationship with various health care providers, and the board shall establish a written record of such discussions; and

FURTHER RESOLVED, that the Corporation's officers are directed to remove all Corporation personnel from any health care facility or hospital who have been placed in said facility for the purpose of providing remuneration to said facility in exchange for the referral of a patient to a Corporation facility or a Corporation service, for which reimbursement may be sought from Medicare, Medicaid or any similar state reimbursement program; and

FURTHER RESOLVED, that prior to the commencement of treatment by the corporation of any patient, the Corporation shall make a written disclosure to each patient who is referred to a Corporation facility or for Corporation services, of any financial relationship between the Corporation and the health care professional or provider who made the referral; and

FURTHER RESOLVED, that in order to enforce and effectuate the above policies, the board thereby establishes a committee of the board called the compliance and ethics committee, which will consist of four directors (including at least two non-management directors); and

FURTHER RESOLVED, that the compliance and ethics committee shall meet a minimum of four times per year, shall establish procedures to ensure the above newly adopted policies are enforced, and shall generally oversee the Corporation's financial arrangements with physicians and other health care professionals; and

FURTHER RESOLVED, that the compliance and ethics committee shall oversee, monitor and direct the business segments of the Corporation regarding the Corporation's policies with respect to compliance with federal and state "Referral Payment Laws," as described on pages 6-7 of the 1994 Form 10-K of the Corporation; and

FURTHER RESOLVED, that the corporate officer(s) responsible for each of the Corporation's business segments (including Pharmaceutical Services, Disease State

Management, Physician Practice Management and International), shall serve as the compliance officer for that business segment, and that each compliance officer will report orally on a semi-annual basis to the compliance and ethics committee, and annually, in writing, to the compliance and ethics committee, concerning that business segment's performance under the Corporation's compliance and ethics policies and the impact of changes in the federal and state "Referral Payment Laws" on the Corporation's arrangements with health care providers; and

FURTHER RESOLVED, that the compliance officer for each business segment, with the assistance of the Corporation's outside counsel, (a) will review all existing contracts and financial arrangements with physicians, hospitals, and other health care professionals and providers who refer or are in the position to refer patients to the Corporation or to prescribe prescription drugs marketed or distributed by the Corporation which relate to oncology, hemophilia or synthetic human growth hormone therapies, and (b) will approve, in advance, any new form contract adopted by that business segment which establishes a relationship between the Corporation and any person or entity which may refer a patient to a Corporation facility or service; and

FURTHER RESOLVED, that the compliance and ethics committee shall report on a semi-annual basis to the board concerning each business segment's performance under the Corporation's compliance and ethics policies and the impact of any changes in the federal and state "Referral Payment Laws" on the Corporation's arrangements with health care providers; and

FURTHER RESOLVED, that the board shall consider and, in its sole discretion, determine whether the Corporation should pursue any actions against third parties, including the Corporation's directors and officers liability insurance carriers, with respect to the matters arising out of the proposed settlements with the federal and state governments of various matters arising out of the investigation being conducted by the Office of the Inspector General of Health and Human Services, the U.S. Department of Justice and the related administrative proceedings, civil lawsuits and criminal

proceedings involving the Corporation (the "Proposed Settlements") or the Delaware derivative litigation; and

FURTHER RESOLVED, that the Corporation shall disclose in its annual report to the Corporation's stockholders for each of the calendar years 1995, 1996, and 1997, a summary of the procedures implemented and actions taken pursuant to these resolutions; and

FURTHER RESOLVED, that Article III entitled "Committees" of the bylaws of the Corporations, as amended and restated by the board of directors on December 14, 1993, is vacated and repealed, and Article III entitled "Committees" of the bylaws of the Corporation as amended and restated and as attached to these minutes as Exhibit A is hereby approved and adopted.[8]

## E. Caremark's Settlement with Several Government Agencies

On June 15, 1995, the Board also approved a comprehensive settlement with the government covering Caremark's business practices dating back to 1986. The government settlement included, inter alia, the payment of criminal and civil fines and penalties totaling $161 million, a guilty plea to two counts of mail fraud, and remedial

8 Exhibit A to the minutes is part of Exhibit 2 to the Harrison Affidavit.

measures to be implemented by Caremark.[9] No officers or directors of the Company were charged with wrongdoing in the Government settlement agreement.[10]

### F. Impact of the Derivative Action on Caremark's Compliance Programs

The Derivative Action directly produced the remedial measures set forth in the directors' resolutions adopted at the Board meeting on June 15, 1995. This point was underscored by Thomas W. Hodson, Senior Vice President, Chief Financial Officer and a member of the Caremark Board. Mr. Hodson testified, in part:

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[9] The governmental entities involved in the settlement included the Department of Justice, the OIG, the U.S. Veterans Administration, the U.S. Federal Employee Health Benefits Program, the Federal Civilian Health and Medical Program of the Uniformed Services, and related state agencies in all 50 states and the District of Columbia. Caremark's agreement with these entities contained several components: (i) a guilty plea by a subsidiary of the Company to two counts of mail fraud and the payment of criminal fines totaling $29 million in actions pending before federal courts in Ohio and Minnesota; (ii) civil settlement payments of $85.3 million to the federal government and $44.6 million to the states to resolve various claims relating to Company payment practices; (iii) the donation of $2 million to a grant program set up under the Ryan White Comprehensive AIDS Resources Emergency Act; (iv) the payment of $3.5 million to the federal government to resolve claims relating to alleged Company violations of the Controlled Substances Act; and (v) a compliance agreement with HHS.

[10] In response to the public announcement of Caremark's settlement with the government agencies, on July 25, 1995, a shareholder derivative complaint was filed against Caremark and seven of the Director Defendants, captioned Lenzen v. Piccolo, No. 95 CH 7118 (Circuit Court of Cook County, Ill.) (the "Lenzen Action"). The Lenzen complaint alleges that the Director Defendants breached their fiduciary duties by allegedly failing to oversee the Company's management, failing to exercise reasonable care to prevent the Company from engaging in criminal activity and causing the Company to incur the liabilities associated with the OIG investigation and the government settlement. If the settlement of this action is approved and the complaint dismissed, the Lenzen Action will be dismissed.

Q: Mr. Hodson, the board of directors approved this memorandum of understanding in connection with the proposed settlement of the Delaware derivative actions?

A: Yes, it did.

Q: And pursuant to the terms of the MOU -- I'll call it the MOU, the memorandum of understanding -- Exhibit A calls for the adopting by the board of a no payment for referrals policy. Following the signing of the MOU, did the board in fact adopt this payment for referrals policy?

A: Yes, we did.

Q. And the next page, the MOU calls for enforcement of the no payment for referral policy through, among other things, formation of a separate compliance and ethics committee. Has the board in fact formed a compliance and ethics subcommittee?

A. Yes, it did.

Q. And it -- MOU further calls for the board to establish procedures to ensure that the policies it adopted pursuant to the MOU are implemented and enforced. Can you tell me, has the board so established those procedures?

A. Yes, and it has made the -- this separate committee responsible for that action, along with the compliance officers at the company, which is me.

Hodson Tr. 122-123.

Mr. Hodson also testified that negotiations with derivative counsel were distinct from negotiations with the government:

Q: Now, the settlement of the derivative lawsuit, which was approved in a June 15th [board] meeting, was that negotiated separate from the government settlement by Caremark?

A: Yes. We had separate special counsel assigned to negotiate a settlement on this derivative action.

Hodson Tr. 124.

Mr. Hodson also testified as to the importance of establishing a separate Compliance Committee with each division head as compliance officer:

> Q: [W]as the July 25th meeting the meeting at which the board formed the compliance and ethics committee in accordance with the terms of the MOU?
>
> A: Yes. I believe that the committee was established at the June 15th meeting, and that the appointment of committee members was done at the [July] 25th meeting.[11]
>
> * * *
>
> Q: Can you tell me what changes were made in the charter as a result of the formation of [the compliance and ethics] committee?
>
> A: [T]he essence of the changes were with the formation of this compliance and ethics committee, what was formerly the audit and ethics committee ceded its responsibility for oversight of ethics, which was a secondary matter for that committee . . . to the compliance and ethics

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11 Similarly, director Oddi testified:

> Q. What was the motivating factor for splitting the committee and setting up a separate ethics and compliance committee?
>
> A. Probably the chief motivating factor was the memorandum of understanding that we entered into.
>
> Q. What litigation was that in?
>
> * * *
>
> A. The derivative litigation.

Oddi Tr. 68-69.

committee, which has a primary responsibility for these matters.

Q: So, now there is a single independent committee that just -- whose purpose is to deal with issues of compliance and ethics?

A: That's correct.

* * *

A: The company's chief executive officer designated the most senior operating executives in the business to be the compliance officers in order to put the greatest focus on this matter [compliance] in the businesses.

Hodson Tr. 131-134.

Hodson concluded that the compliance program adopted pursuant to the Settlement was a "quantum leap" for Caremark:

Q. So, its fair to state that this is a much more extensive and comprehensive program than Caremark had previously undertaken?

A: Yes. It's a quantum leap ahead of what we have done in the past.

Hodson Tr. 139.

Director Oddi similarly summarized the critical impact of the compliance program on Caremark's corporate governance practices as follows:

Q. So as a result of that litigation this committee was set up and is it your belief that this new ethics and compliance committee will better be able to deal with issues that, you know, either have arisen since it's been set up or will arise in the future with respect to this kind of conduct?

A. I think that is the case. The company has been -- as a result of that has been organized in a way where

every division of the company has been brought to a high level of convergence with the issues.

Every division has its own compliance officer. The compliance and ethics committee receives reports from those groups and we have enhanced some of the requirements. I think there has been another manual with more improvements subsequent to this.

Oddi Tr. 68-69.

### G. Confirmatory Discovery and the Private Payor Settlement

Following approval of the MOU by Caremark's directors, plaintiffs' counsel reviewed and analyzed more than 200,000 pages of documents produced by defendants in Chicago and New York.

Heated discovery disputes erupted after the initial production of documents. Substantial delays resulted because defendants redacted, as privileged, Board minutes and other relevant documents relating to the Board's conduct with respect to the OIG investigation and the government settlement. Defendants argued that selective disclosure to plaintiffs' counsel of these matters might constitute a waiver of attorney-client communications with respect to a pending federal securities class action and a state court action filed against Caremark on September 11, 1995 by Coram for breach of contract, fraud, and negligent misrepresentation relating to the sale of Caremark's home infusion business.[12] After extensive negotiations, defendants agreed to make

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[12] In re Caremark International, Inc., Case No. 94C 4751 (N.D.Ill.); Coram Healthcare Corp. v. Caremark, Inc., No. 972431 (Super. Ct. San Fran. Cty.).

additional production of documents which, in Caremark's view, did not waive the attorney-client privilege.

Plaintiffs' counsel then deposed Mr. Hodson, Caremark's Chief Financial Officer and a director who played an integral role in responding to the OIG investigation, and Mr. Oddi, the head of the Audit and Ethics Committee.

On March 19, 1996, in the midst of discovery, Caremark publicly announced that it had entered into a settlement with a number of private insurance companies (the "Private Payors") relating to essentially the same business practices involved in the OIG investigation.[13] Caremark agreed to pay a total of $98.5 million to the Private Payors to settle disputes dating back to 1986.

Plaintiffs' counsel immediately demanded additional document and deposition discovery to determine whether the Private Payor claims were based on the same practices complained of in the Derivative Action; whether the remedial measures embodied in the MOU were sufficient to address the purported conduct underlying the Private Payor claims; and whether to abandon or modify the proposed settlement in view of the settlement with the Private Payors.

Following the deposition of James G. Connelly III, Caremark's President and Chief Operating Officer, plaintiffs concluded that the Private Payor claims were in fact based

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[13] The Private Payors consist of Aetna Life Insurance Company, Connecticut General Life Insurance Company, CIGNA Employee Benefits Services, Inc., The Equitable Life Assurance Society of the United States, First Equicor Life Insurance Company, Massachusetts Mutual life Insurance Company, The MetraHealth Insurance Company, Metropolitan Life Insurance Company, Northwestern National Life Insurance Company, The Prudential Insurance Company of America, The Travelers Insurance Company, and Blue Cross and Blue Shield of Michigan.

on the same practices which led to the governmental investigations, the indictments described above and the institution of the Derivative Action. Correspondingly, plaintiffs concluded that the significant remedial measures embodied in the MOU and in the June 15, 1995 Board Resolutions directly and satisfactorily addressed those practices. Thus, there was no reason to abandon or modify the proposed settlement of the Derivative Action in light of the late-blooming Private Payor settlement, even though that settlement cost the Company $98.5 million. The parties thereupon proceeded to negotiate the terms of a formal settlement agreement.

## ARGUMENT

### I. THE SETTLEMENT SHOULD BE APPROVED AS FAIR, REASONABLE AND ADEQUATE

#### A. Standards for Approving a Settlement

Delaware has long favored the voluntary settlement of contested claims. See e.g., In Re Resorts International Shareholders Litig. Appeals, Del. Supr., 570 A.2d 259, 265-266 (1990); Nottingham Partners v. Dana, Del. Supr., 564 A.2d 1089, 1102 (1989); Polk v. Good, Del. Supr., 507 A.2d 531, 535 (1986); Neponsit Investment Co. v. Abramson, Del. Supr., 405 A.2d 97, 100 (1979); Rome v. Archer, Del. Supr., 197 A.2d 49, 53 (1964).

The Court's function in reviewing a class or derivative action settlement "is to consider the nature of the claim, the possible defenses thereto, the legal and factual circumstances of the case, and then to apply its own business judgment in deciding whether the settlement is reasonable in light of these factors." Barkan v. Amsted Industries, Inc., Del. Supr., 567 A.2d 1279, 1284 (1989), quoting Polk v. Good, supra, 507 A.2d at 535.

The "facts and circumstances" a court considers in assessing the overall fairness of a proposed settlement, include: (1) the probable validity of the claims; (2) the apparent difficulties in the enforcing the claims through the courts; (3) the delay, expense and trouble of litigation; (4) the amount of the compromise as compared with the amount

of collectibility of a judgment; and (5) the views of the parties involved. Polk v. Good, supra, 507 A.2d at 536.

Settlements are encouraged not only because they serve the interests of judicial economy, but because the litigants are in the best position to evaluate the strengths and weaknesses of their cases. In part, it is for this reason that courts do not try the case on the merits in considering a proposed settlement, but rather apply their business judgment to determine the reasonableness of the settlement. See e.g., Polk v. Good, supra, 507 A.2d at 536; Neponsit Investment Co. v. Abramson, supra, 405 A.2d at 100; Rome v. Archer, supra, 197 A.2d at 53.

Here, the parties have performed the "balancing" analysis described above, and after conducting an examination into the facts and applicable law relating to the matters at issue, and after considering the benefits to Caremark, the risks and costs of further litigation and the desirability of permitting the settlement to be consummated, have concluded that the negotiated terms and conditions of the settlement are fair, reasonable, adequate, and in the best interests of Caremark and its stockholders.

## B. Analysis of Claims

### (1) Threshold Issues -- Demand Futility; 8 Del.C. § 102(b)(7)

Under Delaware law, a pre-suit demand will be excused if plaintiff alleges particularized facts creating a reasonable doubt that (i) the directors are disinterested or independent; or (ii) the challenged transaction was otherwise the product of a valid exercise of business judgment. Aronson v. Lewis, Del. Supr., 473 A.2d 805, 814 (1984).

In this case, defendants asserted in their motions to dismiss each of plaintiffs' complaints and amended complaints that Aronson's two-part test is inapplicable because plaintiffs' claims did not involve the decision-making process by Caremark's directors, but rather a failure by the directors adequately to supervise the conduct of the Company's employees. Defendants argued that such claims are governed by Rales, where the Supreme Court held that Aronson should not apply "where the subject of the derivative suit is not a business decision of the board." Rales, 634 A.2d at 934.

Rales further explained that

> where directors are sued derivatively because they have failed to do something (such as a failure to oversee subordinates), demand should not be excused automatically in the absence of allegations demonstrating why the board is incapable of considering a demand. Indeed, requiring demand in such circumstances is consistent with the board's managerial prerogatives because it permits the board to have the opportunity to take action where it has not previously considered doing so.

Id. at 934, n. 9.

Plaintiffs countered that in Rales the Supreme Court noted that formal or specific board action was not required for application of the Aronson standards for determining demand futility. Instead, the Supreme Court required only a "conscious decision by directors to act or refrain from acting." Rales, 634 A.2d at 933, citing Aronson, 473 A.2d at 813 (emphasis supplied). Plaintiffs contended that they sufficiently alleged such a conscious decision by the Caremark Board to refrain from putting a stop to the alleged wrongdoing by Caremark's employees. Plaintiffs argued that defendants were on notice

of possible wrongdoing since at least August 1991; defendants acknowledged the materiality of the alleged misconduct, if proved, to Caremark's business; and the wrongdoing appeared to continue through 1994.[14] Needless to say, defendants hotly contested plaintiffs' contention that the Director Defendants "turned a blind eye" to the wrongdoing of subordinate employees. E.g., Hodson Tr. 126-128.

Defendants also relied heavily on the decision in Baxter International Inc. Shareholder Litigation, Del. Ch., 654 A.2d 1268 (1995), where this Court, applying Rales, dismissed a complaint for failing to adequately plead that demand was excused. Plaintiffs in Baxter charged the Baxter directors with failing to take corrective action to prevent Baxter employees from illegally overcharging a government agency, the Veterans Administration. Plaintiffs in Baxter, however, did not allege, as plaintiffs do here, that the directors had permitted practices known or suspected to be illegal to continue after the time they had to know such practices had occurred.

Plaintiffs also distinguished this case from Baxter because of the widespread notoriety of the events at issue, the alleged three-year continuation of the wrongdoing after the OIG subpoena, and the materiality of the wrongdoing, if proved, to the Company's business which, in this case, defendants explicitly acknowledged.[15] Compare

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[14] The Wall Street Journal reported on the August 4, 1994 announcement of the Minneapolis Indictment which was the first public disclosure of the results of the Justice Department's three-year investigation. Among other things, the article noted that federal authorities were planning to interview between 100 and 120 doctors who allegedly had received large payments from Caremark through 1994.

[15] Plaintiffs alleged that from the time they first took their Board seats, the Director Defendants were aware that (1) Caremark's "fee for services" arrangements with (continued...)

Freedman v. Braddock, Index No. 24708/92 (N.Y. Sup. Ct., May 17, 1993). Freedman was a derivative action against Citicorp's directors for their failure to supervise the activities of a mortgage subsidiary. The complaint alleged that Citicorp was given notice of the subsidiary's unsound lending practices and inadequate loan procedures by the Office of the Comptroller of the Currency, but had failed to take adequate steps to remedy the deficiencies. The Court, applying Delaware law, held that the complaint raised a reasonable doubt that the defendants' failure to act -- despite knowledge of the wrongdoing -- was the product of valid business judgment. Accord Decker v. Clausen, Del. Ch., C.A. No. 10684, Berger, V.C. (Nov. 6, 1989), slip op. at 8 (allegations that bank knew or should have known about problems with student loans, or made no effort to discover such problems, "could possibly be enough to create a reasonable doubt" under Aronson's second prong).

Plaintiffs have already expressed their concerns that the Director Defendants may well be insulated from liability for money damages -- even if plaintiffs were to prevail on the liability issues -- pursuant to Caremark's Certificate of Incorporation authorized by 8 Del.C. § 102(b)(7). As noted, these concerns persuaded plaintiffs to drop their demand for a monetary component in the settlement. Plaintiffs recognized that they would have a very difficult time persuading the Court that the enormity of the risks to

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[15](...continued)
physicians were being investigated by the federal government; (2) Caremark's exposure with respect to such arrangements was in the hundreds of millions of dollars; and (3) senior management had publicly committed to discontinuing such arrangements. Nevertheless, they permitted these business practices to continue on a nationwide basis, according to plaintiffs' allegations.

which Caremark was exposed by its employees' misconduct, including loss of its entire Medicare/Medicaid business, evidenced "bad faith" on the part of the managers of the Company who, after all, had no financial interest in the wrongdoing and no reason to harm Caremark.[16] Indeed, even the employees who directly engaged in the allegedly wrongful practices did so arguably to promote Caremark's business (with the expectation, of course, that they would personally benefit from increased compensation for their efforts).

**(2) The Merits**

While plaintiffs believe that their Third Amended Complaint would survive motion practice (although, of course, the outcome is hardly free from doubt), they recognize that that would be only one, early step in a challenging, difficult litigation. Success at trial is problematical, particularly with the distinct prospect that plaintiffs might not recover money damages against the Director Defendants even if plaintiffs established their liability. The linchpin of plaintiffs' legal arguments is founded on the pronouncements of the Delaware Supreme Court in Graham v. Allis-Chalmers Manufacturing Company, Del. Supr., 188 A.2d 125, 130 (1963):

> In the last analysis, the question of whether a corporate director has become liable for losses to the corporation through neglect of duty is determined by the circumstances. If he has recklessly reposed confidence in an obviously untrustworthy employee, has refused to neglected cavalierly to perform his duty as a director, or has ignored either willfully or through inattention obvious danger signs of

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[16] 8 Del.C. § 102(b)(7) does not exculpate directors who are guilty of "bad faith" from liability for money damages.

> employee wrongdoing, the law will cast the burden of liability upon him.

The Supreme Court also said that "directors are entitled to rely on the honesty and integrity of their subordinates until something occurs to put them on suspicion that something is wrong. If such occurs and goes unheeded, then liability of the directors might well follow . . . ." Id.

The Graham plaintiffs lost after trial because they did not prove that the Allis-Chalmers directors knew that the company's employees had violated federal law nor were there "any facts brought to the Directors' knowledge which should have put them on guard against such activities." 188 A.2d at 131.

In this case, unlike Graham, plaintiffs believe that the OIG subpoena in August 1991 put defendants on notice of possible employee misconduct which, if proved, would be material to Caremark and its business. Indeed, defendants' knowledge is evidenced in the Company's Securities and Exchange Commission filings and documents disseminated to shareholders. The question then becomes whether or not the directors blinded themselves, consciously or recklessly, to the fact that their subordinates may have continued the same allegedly wrongful practices through 1994. In this regard, plaintiffs' proof would focus on the pervasiveness of the alleged wrongdoing, that is, that the practices complained of extended throughout the Company such that the directors had to know about it after 1991.

The evidence supporting plaintiffs' claims is skimpy. Plaintiffs would rely upon documents such as a memorandum (admittedly predating the November 1992 spin-off), which shows that Caremark closely followed the correlation between patient referrals and

payments made by Caremark to physicians. The memorandum, entitled "Return on the Investment in Research Grants, An Analysis of Caremark, Inc.," tracks the amount paid in grants to seven researchers against the amounts they generated through referrals. The purpose of the memorandum was to determine "what sort of a return has there been in funding research to justify a [$1.6 million] investment." The memorandum, which includes 1990 research grant results, concludes that the researchers produced $10.7 million in revenues which represents "a return of $6.55 in revenue for every dollar invested by Caremark." The author also found a "tendency for researchers to increase his referrals of Caremark just prior to being awarded a grant." The memorandum includes bar charts showing referral revenues by physician, with Dr. Brown, the subject of the Minnesota Indictment, leading the group.[17] While Caremark's position is that the Company did not have a routine capability before 1993 to track referral revenue by physician (Hodson Tr. 106-07), the memorandum states that "revenue from patient referrals is relatively easy to measure." Defendants characterize the research grant memorandum as a "mystery" document whose author and recipients could not be identified after an exhaustive search. Hodson Tr. 103-104, 106.

Plaintiffs believe that the trial record would show that Caremark continued to make payments to physicians, including Dr. Brown, for "research grants" after issuance of the OIG subpoena in 1991. Indeed, the Minnesota Indictment covers a period from 1986 continuing into 1994. Also, while the amounts involved may have appeared relatively

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[17] Other internal documents question the continued payments to Dr. Brown because he "has not yet published any of the results obtained through this grant . . . [although Caremark] has paid him $409,000."

modest in light of Caremark's overall revenues, plaintiffs would argue that the potential loss of Caremark's Medicare/Medicaid business from even arguably minor violations of the Anti-Referral Payments Law made it imperative for the directors to pay close attention to Caremark's dealings with physicians. The defendants, of course, would contend that they did.

Another provocative issue deals with the directors' views (reasonable/ unreasonable) as to the legality of the practices which were attacked by the government. As heretofore noted, the regulations under the Anti-Referral Payments Law were narrowly drawn and provided only limited guidance about the legality of certain practices, some of which were common in the health care industry. It was certainly open to question whether the Quality Service Agreements were or were not proscribed. Also, it is noteworthy that on October 4, 1995, following close of the government's case-in-chief in the Minnesota Indictment, District Judge David Doty dismissed the indictments against the three defendant Caremark employees.

### C. The Settlement

The prospects for success or failure on the foregoing issues and other equally knotty ones persuaded plaintiffs to seek a settlement which provides immediate and concrete remedial benefits to Caremark and its shareholders to ensure to the fullest extent possible that the practices which appeared to infect an important part of Caremark's business were stopped, once and for all.

Pursuant to the settlement, the Board of Directors has reconstituted its committees to create a separate and independently-operated Compliance Committee which will

review both the overall and the individual business units' corporate integrity programs. Mr. Hodson acknowledged that, prior to the settlement, compliance issues were a "secondary matter" for the then-existing audit and ethics committee. By virtue of the settlement, the senior executive officer of each business segment (the "Compliance Officer") will be responsible for regularly reporting to the Compliance Committee regarding the practices and compliance of each individual unit's integrity program. Compliance Officers, with the assistance of outside counsel, will review existing contracts and approve all new form contracts with health care providers who provide, or are in a position to provide, referrals of patients to Caremark facilities or services. As Mr. Hodson testified, the remedial measures constitute "a quantum leap ahead of what we have done in the past," involving "the most senior operating executives in the business to be compliance officers to put the greatest focus on this matter in the businesses."

Pursuant to the settlement, the Board as a whole will be directly involved in the prophylaxis against future misconduct. The Board has implemented an explicit "No Payments For Referrals" policy which is designed to eliminate any future kickbacks to health care providers. The Board engages in a semi-annual review of the changes in the government health care regulations to insure that the impact of any amended regulation is understood and acted upon by Caremark. Caremark has also adopted a policy to inform all patients referred to Caremark of any financial relationship between Caremark and the health care provider who referred the patient.

The Delaware courts have frequently acknowledged the merit of non-monetary settlement benefits. E.g., Chrysler Corporation v. Dann, Del. Supr., 223 A.2d 384, 386

(1966) (benefits from modification of incentive compensation plan); Tandycrafts, Inc. v. Initio Partners, Del. Supr., 562 A.2d 1162, 1165 (1989) (benefits from "heightened level of corporate disclosure"); Rosen v. Smith, Del. Ch., C.A. No. 7863, Hartnett, V.C. (Sept. 18, 1985) (bylaw amendment); Polk v. Good, supra (modification of voting provisions in stock repurchase agreement); and Geller v. Tabas, Del. Supr., 462 A.2d 1078 (1983) (retention of independent financial consultant).

While plaintiffs would have liked to recover monetary benefits as part of the settlement (the surrender of directorial stock options seemed a likely vehicle), defendants adamantly refused. Nonetheless, plaintiffs agreed to the settlement and commend it to the Court for approval because the settlement in large measure achieves the kind of equitable relief, by agreement of the parties, which plaintiffs are convinced will materially benefit Caremark and its shareholders. The Caremark Board of Directors has expressly determined that the settlement is "in the best interests of the Corporation and all its stockholders." That judgment should be taken into account in passing upon the settlement. Krinsky v. Helfand, Del. Supr., 156 A.2d 90, 95 (1959).

For the foregoing reasons, plaintiffs respectfully submit that the settlement is fair, reasonable, adequate and in the best interests of Caremark and its shareholders and should be approved by the Court.

## II. THE OBJECTIONS TO THE SETTLEMENT AND FEE APPLICATION SHOULD BE REJECTED

While each of the objections is framed somewhat differently, they share common themes. Some of the objectors want the Caremark Board or Chief Executive Officer to resign. Others want the directors to personally foot the bill for the costs of litigation which resulted from questionable business practices of employees that the directors were charged with overseeing. Some of them assert that the government was responsible for the remedial measures which form the settlement consideration. Most of the objectors assert that the fee and expense request of plaintiffs' counsel is excessive.

Like objections often appear in settlements which involve remedial relief. It is undisputed that corporate directors have legal and fiduciary obligations imposed upon them; the claim here is that Caremark's directors failed to abide by those standards of conduct. Where, as in this case, a corporation engages in conduct that runs afoul of the law, the potential remedies are not limited to the payment of monetary compensation by the directors for damage already done to the corporation. There are also real and tangible benefits to be gained by the corporation and its stockholders in agreeing to put into place corrective measures that deter or prevent the alleged violations from occurring in the future. There are also real benefits in putting to rest troubling litigation that would deplete the company's resources, including managerial time and energies.

When this action was filed, there were widespread allegations of pervasive violations of the Anti-Referral Payments Law by Caremark personnel. And the alleged

misconduct occurred (and appeared to continue for three years) despite the legal and fiduciary obligations of the Director Defendants. There is nothing in the record to support the objectors' assumption that the corrective policies and procedures, which form the settlement consideration and which represent a "quantum leap" over the procedures Caremark previously had in place, would have been adopted by Caremark's Board of Directors in the absence of prosecution of this litigation. On the contrary, as previously described, the remedial relief the Board adopted in consideration for settling plaintiffs' claims was original with plaintiffs, was demanded by plaintiffs and negotiated at arm's length without knowledge of any proposals by the government.

It is certainly true that defendants also settled with the government and there is some overlap between the remedial portions of the instant settlement and the government settlement.[18] That does not render the settlement unfair. Defendants bargained for a global discharge of all litigation and claims arising from the practices which gave rise to the Company's tribulations. This litigation contributed materially to that global settlement. Compare In Re Amsted Industries Incorporated Litigation, Del. Ch., Cons. C.A. No. 8224, Allen, C. (Aug. 24, 1988).

For the foregoing reasons, plaintiffs respectfully submit that the objections should be rejected.

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[18] Important parts of the overall remedial measures, particularly with respect to the formation and workings of the Compliance Committee, are unique to the instant settlement.

## III. THE APPLICATION FOR FEES AND EXPENSES IS FAIR AND REASONABLE AND SHOULD BE GRANTED

Plaintiffs' counsel have applied for an aggregate award of attorneys' fees and reimbursement of expenses totalling $1,025,000 which Caremark has agreed to pay if awarded by this Court. Plaintiffs submit that their application is fair and reasonable given the complexity of the claims, the risks plaintiffs faced in prosecuting the litigation, and the results achieved by the efforts of plaintiffs' counsel.

### A. The Applicable Standards

In class and derivative actions, plaintiffs' counsel are entitled to an award of attorneys' fees and expenses where counsels' litigative efforts achieve a benefit for the corporation and its shareholders. Gottlieb v. Heyden Chem. Corp., Del. Supr., 105 A.2d 461 (1954); Allied Artists Pictures Corp. v. Baron, Del. Supr., 413 A.2d 876 (1980). The amount of such an award is committed to the sound discretion of the trial court, Sugarland Indus. Inc. v. Thomas, Del. Supr., 420 A.2d 142, 149-50 (1980), which has to determine what is reasonable under the circumstances. Krinsky v. Helfand, supra.

Plaintiffs' request for an award of attorneys' fees should be evaluated according to: (1) the benefits achieved in the action; (2) whether the fees are contingent; (3) the efforts of counsel; (4) the difficulty of the litigation; and (5) the standing and ability of counsel. Sugarland, supra, 420 A.2d at 149-50.

## B. The Efforts of Counsel in Achieving the Benefits

The benefit achieved is normally the factor given the greatest weight by the Delaware courts in determining the amount of a fee award. See Sugarland, supra, 420 A.2d at 152. Plaintiffs have already discussed the benefits and the reasons why those benefits are material to Caremark and its shareholders. The cases heretofore cited for the proposition that non-monetary benefits will support a settlement apply as well to the proposition that non-monetary benefits will support fee awards. E.g., Tandycrafts, supra; Polk v. Good, supra, Geller v. Tabas, supra; Chrysler Corporation v. Dann, supra.

By their very nature, the benefits cannot be quantified. Under these circumstances, this Court has employed a quantum meruit approach in valuing non-monetary benefits. In Re Diamond Shamrock Corporation, Del. Ch., Cons. C.A. No. 8798, Jacobs, V.C. (Sept. 14, 1988); Weinberger v. Nelson, Del. Ch., C.A. No. 7256, 10 Del.J.Corp.L. 352, Berger, V.C. (Nov. 9, 1984). Plaintiffs' counsel themselves used the quantum meruit approach in their totally arm's-length negotiations with defendants' counsel concerning this fee application. See Hensley v. Eckerhard, 461 U.S. 424, 437 (1983) ("Ideally, of course, the litigants will settle the amount of a fee"). By design, those negotiations did not begin until plaintiffs' attorneys had completed all their substantive work, except fine-tuning the settlement documents. The Harrison Affidavit accompanies this brief and shows that plaintiffs' counsel have spent over $710,000 of time, at normal billing rates, through August 14, 1996. With the exception of drafting this brief and the settlement papers, virtually all that time was expended before the fee negotiations took place. The fee application represents a very slight premium over normal billing rates to

take into account, among other things, the contingent nature of counsels' engagement in this litigation and, of course, the delay in receiving compensation while paying regular overhead and advancing the expenses of the litigation.

The services rendered by plaintiffs' counsel in obtaining the benefits achieved in this case required a high level of experience and expertise in stockholder litigation. Counsels' efforts included a comprehensive and continuing investigation of relevant facts both prior to and for several months following the commencement of the litigation as allegations of misconduct by Caremark employees publicly surfaced; the preparation of pleadings, including three amended complaints, and discovery requests; the exhaustive study and analysis of documents available in the public domain and more than 200,000 pages produced by defendants during discovery; preparation and research relating to Caremark's alleged kickback schemes; preparation for and conducting depositions; extensive discovery disputes and legal research regarding the scope of the attorney-client privilege and selective waiver thereof; intensive settlement negotiations; additional discovery following the announcement of the settlement of the Private Payor claims; the preparation of settlement papers; and, finally, the preparation of this brief.

As set forth in the Harrison Affidavit, plaintiffs' counsel have expended more than 2,300 hours in the prosecution and settlement of this litigation. Plaintiffs' counsel have also incurred more than $52,749 in out-of-pocket disbursements. See Exhibit 3 to Harrison Affidavit.

All of the time and disbursements were at risk because counsels' engagement was entirely contingent. It has long been recognized that an attorney is entitled to a larger fee when the fee is contingent than when it is fixed on a time or contractual basis. In determining fees, the fact that counsel's compensation is contingent upon success must be taken into account. Braun v. Fleming Hall Tobacco Co., Del. Supr., 93 A.2d 495, 496 (1952); Chrysler Corp. v. Dann, supra, 223 A.2d at 389.

Courts have recognized that, as a matter of fairness, an adjustment in an attorneys' fee award should be made to account for the risk involved in a contingent action. As the Court of Appeals for the Seventh Circuit explained:

> [W]hen attorneys' receipt of payment is contingent on the success of the litigation, reasonable compensation may demand more than the hourly rate multiplied by the hours worked, for that is exactly what the attorneys would have earned from clients who agreed to pay for services regardless of success. Thus, to account for the contingent nature of the compensation, a court should assess the riskiness of litigation.

Skelton v. General Motors Corp., 860 F.2d 250, 258 (7th Cir. 1988), cert. denied, 493 U.S. 810 (1989).

### C. Standing and Ability of Counsel

The skill, standing and ability of plaintiffs' counsel also are factors for the Court to consider in determining the amount of a reasonable fee award. Plaintiffs' counsel are some of the most experienced and successful firms in the field of corporate litigation and their reputations have been repeatedly and favorably noted by the courts before whom they have practiced.

The reputation and skill of opposing counsel may also be considered when determining an award of fees. Defendants here are represented by well-known counsel in Delaware and Chicago, who vigorously defended their clients. The fact that plaintiffs' counsel were able to obtain significant therapeutic benefits was due in large part to their own expertise and their ability to convince defendants that they would diligently and skillfully litigate the case absent a settlement which conferred real benefits on Caremark and its shareholders.

### D. Public Policy Considerations

Individuals wronged by violations of corporate law should have reasonable access to counsel with the ability and experience necessary to analyze and litigate complex cases. Such individuals rarely have the financial resources to pay customary fixed hourly rates for such services.

In complex derivative and class cases, able counsel for plaintiffs can only feasibly be retained on a contingent basis. A large segment of the public would be denied a remedy for violations of fiduciary duty by those entrusted with stewardship of public companies if contingency fees awarded by the courts did not fairly compensate plaintiffs' counsel for the services provided, the serious risk undertaken, and the delays normally occurring before compensation is received.

The complexity and societal importance of derivative litigation calls for the involvement of the most able counsel obtainable. To encourage first-rate attorneys of this caliber to represent plaintiffs on a contingent basis in this type of socially important litigation, attorneys' fees awarded should reflect this goal.

The courts of Delaware have recognized and adopted the foregoing considerations in the awarding of fees. For example, in Allied Artists, supra, 413 A.2d at 878, the Supreme Court stated as follows:

> The reason for allowing an award of attorneys' fees to plaintiffs' counsel where a defendant corporation takes steps to settle or moot a case and in so doing produces the same or similar benefit sought by the shareholder's litigation is to prevent frustration of the remedial policy of providing professional compensation for such suits when meritorious. This rule insures that, even without a favorable adjudication, counsel will be compensated for the beneficial results they produced, provided that the action was meritorious and had a casual connection to the conferred benefit. (Emphasis supplied.)

Accord, Tandycrafts, supra, 562 A.2d at 1165-1166.

* * *

Given the important benefits achieved by the settlement, the contingent nature of the litigation, the quality and extent of the services performed by plaintiffs' attorneys, the standing of counsel and public policy considerations, plaintiffs respectfully submit that their application for an award of $1,025,000, inclusive of expenses, is fair and reasonable and should be granted.

## CONCLUSION

For the foregoing reasons, plaintiffs respectfully submit that the proposed settlement should be approved in all respects and that plaintiffs' application for attorneys' fees and expenses should be granted in full.

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CERTIFICATE OF SERVICE

I, JOSEPH A. ROSENTHAL, hereby certify that on August 15, 1996, I caused copies of the foregoing Plaintiffs' Brief in Support of Settlement and Application for an Award of Attorneys' Fees and Expenses to be served by hand delivery upon the following:

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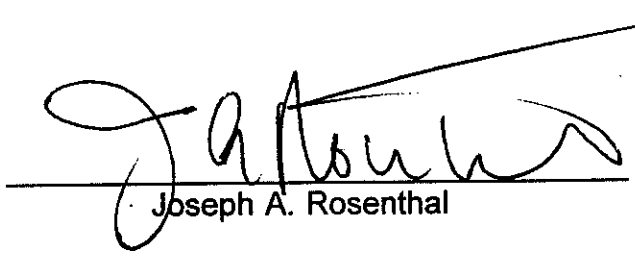

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