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The False Claims Act and Professional Liability Insurance Policies

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Introduction

Throughout the past decade, the federal False Claims Act has imposed billions of dollars in penalties upon corporations. Currently, the Act represents the fastest growing area of federal enforcement in the United States. Many targeted companies are insureds that have procured professional liability insurance policies. Insureds seeking coverage for costs and liabilities imposed by the Act increasingly have pursued recovery under these policies.

This article explains the unusual procedural features of False Claims Act litigation and how this may impact notification to insurers, as well as the scope of coverage under professional liability policies. The actions and practices of Government agencies in investigating and enforcing False Claim Act actions can be crucial for underwriting and claims evaluations. The article explains how these and other nuances of False Claim Act proceedings frequently implicate retroactive date clauses, the "Loss definition," Claims Made and Reported requirements, and the "Prior and Pending" and "Prior Knowledge" exclusions.

The False Claims Act: Substantive and Procedural Mechanics

The False Claims Act is a federal statute that financially penalizes anyone found to have caused a false claim to be submitted to the Government.[1] Thirty-two states have enacted similar statutes for false claims submitted to state governments. Under the federal FCA, violators are liable for a $5,500 - $11,000 penalty for each violation, plus a sum equal to three times the amount of the Government's loss.[2] During the last six years, the federal government, under the FCA, has recovered more than $22 billion from subject companies.[3] Targeted industries include healthcare, technology, defense contractors, financial institutions, government services, and the energy sector.

FCA actions often are referred to as "qui tam" actions, invoking a Latin phrase for one who sues "for the King as well as himself." A "qui tam" plaintiff sues on behalf of the United States ("the King") and herself, and is entitled to a percentage of any damages recovered. (The "qui tam" plaintiff is referred to as "the Relator"). The United States Attorney's Office is required to investigate qui tam actions, which therefore remain sealed and undisclosed to the public for an extended period – three or more years in many cases – after they are filed.

Accordingly, policyholders often do not know at first that they have been sued, though it is not uncommon, prior to unsealing, for the U.S. Attorney's Office to notify the policyholder it is under investigation to seek its cooperation. Notably, claims may arise long after "wrongful acts" began, given that the statute of limitations affords the Government three years to bring suit from the point at which it knew or should have known of the basis for an FCA action. Thus, if the Government could not have known the basis for an FCA action until ten years after the violations began, a suit might not be filed until thirteen years after the first "wrongful act."

A "claim" is statutorily defined in the FCA as a request or demand by someone for the U.S. to disburse funds or property, or for reimbursement of funds or property.[4] It can include

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causing another to make a claim, as well as actions to avoid or decrease obligations owed to the Government. Further, if a defendant certifies compliance with applicable regulations, such as statutes forbidding kickbacks, violation of that certification may subject an insured to FCA liability even if the claim it submits is otherwise valid.[5] This "false certification" liability, which subjects to liability numerous intermediaries who do not themselves submit claims to the Government, has been a fast-growing area for enforcement. In part because of this expansion of FCA liability, claims for Medicare or Medicaid reimbursement, which nearly always condition reimbursement on a certification that the claimant could not have accepted kickbacks or otherwise violated applicable regulations, have emerged as a fertile source of FCA liability. The Government's aggressive push to combat Medicare, Medicaid, and TRICARE (military health insurance) fraud is led by the interagency Health Care Fraud Prevention and Enforcement Action Team ("HEAT").

Threshold Questions Regarding Whether FCA are Claims Ensured Under Professional Liability Policies

Insurance claims to recover for losses on account of the FCA are a relatively recent concern, which has intensified during this century. Professional liability insurers who did not intend to cover such claims may take into consideration three threshold barriers to coverage: (i) public policy; (2) the "professional services" definition, and (3) the "Loss" definition.

Although FCA liability is imposed for fraudulent claims that have been submitted deliberately, or at least recklessly, no court has yet ruled that public policy forbids insuring against FCA-imposed losses. Furthermore, many large FCA insurance claims seek the cost of defense, rather than for fines paid on account of deliberate wrongdoing that has been admitted or proved. This is likely another reason why the "public policy" bar, which may preclude insurance coverage for knowing misconduct, has, so far, not stood in the way of insurance claims for FCA-imposed costs.

In contrast, the "professional services" definition has barred a significant number of FCA claims at the threshold. The "professional services" definition usually requires that the loss result from a "professional activity," rendered for "another," for a fee. Relatively few FCA losses arise in such circumstances. Billing the Government is not a "professional service." And a professional that submits false claims usually cannot be regarded as having done so while serving "another for a fee." Rather, the liability arises out of the professional's internal misconduct. In a leading case, an insured billed the Government for professional services it never provided.[6] The court, in upholding the insurer's declination, observed that the insured's offense "was not the actual level of services provided to [the Insured's] patients, but rather that [the Insured] billed for services it did not provide—namely, enhanced services." On the other hand, in a 2014 case, a court found the particular policy language at issue required no "causal connection" between the FCA violation and covered "professional services".[7] Overall, it is unusual for deficient professional services to proximately cause a false claim to the Government.

A related threshold defense to coverage is the "Loss" definition. The "Loss" definition frequently will exclude fines or penalties. The per-claim penalty of the Act is a fine or penalty. Similarly, the trebled damages provision of the FCA has been deemed to be of a penal character.[8] The "Loss" definition also may exclude claims for "disgorgement" of funds. As an FCA defendant is obligated to restore to the Government any sums the Government originally had granted to the defendant, the disgorgement exception to "Loss" often will be implicated. Many policies also exclude "fee"-related or billing disputes, which are the gravamen of many FCA actions.

Other Key Limitations on Coverage

In addition to raising issues under the "Professional Services" and "Loss" provisions, an FCA claim may raise multiple questions regarding "timing" issues. These include: (1) when was the Claim first made; (2) was the Claim timely reported; (3) did relevant acts precede the policy's retroactive date; (4) was there a prior or pending proceeding related to the Claim; (5) did the insured have "prior knowledge?" The unique features of the FCA create multifaceted timing issues that may drive whether policy coverage exists, and under which policy the claim is paid.

Liability under the FCA involves a number of noteworthy time lags. First, the Insured may not be sued until long after its wrongful acts occurred. Often, an FCA defendant has been engaging in the fraudulent practice as part of its business model, sometimes for decades. (Some corporate affiliates have been created for the sole purpose of facilitating submission of dubious claims to the Government). Because the wrongful acts are fraudulent, the injury ordinarily is unnoticed (outside the perpetrator) until the Government or the relator uncovers it. These schemes often extend across a long continuum, such that their commencement date is not always immediately evident to the insurer.

Second, and uniquely, the claim against the Insured likely will first be made "under seal." A complaint filed "under seal" ordinarily is not served on the defendant nor made available to the public on the court docket. This means that at the time that the claim has been made against the Insured, and indeed monetary recovery sought in a duly filed civil complaint, the insured may not be aware of the claim. Sometimes, the insured receives only a generic subpoena, and may assert it cannot ascertain whether there has been a "Claim" that it needs to report, even as a "notice of circumstances." These features of FCA claims do not defeat the operation of standard limitations on coverage, but they can present new or unusual claim scenarios, as discussed below.

The retroactive date clause, if there is one, can present a notable barrier to coverage, because it applies whether or not the Insured had relevant notice. And while Insureds have contended that retroactive dates do not bar misconduct that post-dates the retroactive date even if it commenced prior to that date, this is incorrect. The clause has been held to apply to a course of conduct that commenced prior to the retro date, even when most of the negligence post-dated the retro date.[9]

The "Claims Made" requirement presents a familiar threshold requirement for coverage, though in a distinct context where FCA claims, which may be made in secret (under seal), are concerned. Typical definitions of "Claim" require (1) a "written demand," (2) for money or services, (3) on account of a "Wrongful Act" committed by the insured. Some insureds sued under the FCA have contended that the initial filing of the complaint against them is not a "demand"

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because it was not served on them, and only was filed under seal. However, the act of a claimant filing an FCA complaint in federal court is difficult to characterize as anything other than a "written demand for damages." Courts in FCA cases have indicated that the filing of an FCA complaint in federal court, even under seal, is hardly a private act.[10]

A number of exclusions are implicated in FCA cases. The most noteworthy is the "Prior and Pending Exclusion." The Prior and Pending Exclusion, briefly summarized, precludes a claim arising out of circumstances alleged in any civil, administrative, or regulatory proceeding that commenced before the "continuity date." The "continuity date" is a term of art referring to a prior date specified in the declarations, or alternatively to a date defined in many policies as the date of inception of the first such policy written by the insurer of which the current one is a "continuous renewal." Thus, if the "continuity date" is January 1, 2011, and an action alleging a similar or related scheme was commenced against the Insured on April 15, 2010, the Prior and Pending Exclusion is implicated.

It is important to understand that a typical Prior and Pending Exclusion typically states that it applies to prior "administrative or regulatory proceedings or investigations." This is an oft-overlooked, but important limitation on coverage for FCA claims. As discussed above, service of an FCA civil action frequently is preceded by years of investigation by the Department of Justice. Such investigations may be in conjunction with, or themselves preceded by, investigations by the Office of the Inspector General, the Federal Bureau of Investigation, or the Department of Health and Human Services. Given that courts have deemed most arms of the Executive Branch, including the Department of Justice, to be "administrative" agencies, it is likely that any federal governmental investigation that precedes the "continuity date" implicates the Prior and Pending Exclusion. Discovering the existence of such investigations requires genuine depth of knowledge regarding the agencies' jurisdictions, operating practices, investigatory procedures, and record-keeping and retention protocols. For example, the OIG customarily marks the commencement of an investigation with an "Opening Investigative Memorandum," which may be non-confidential in part and obtainable via a Freedom of Information Act request.

In a recent case, the Prior and Pending Exclusion applied to bar coverage for a False Claim Act complaint that was filed in 2006, but was not provided to the insured until 2009.[11] The insured contended that the "continuity date" dated back to a 2006-07 follow form excess policy. The court, however, concluded that the policy at issue was a "continuous renewal" only of a 2007-08 policy within the same continuum of primary policies. Because the FCA complaint had been filed, even if not served, prior to that 2007-08 policy, the Prior and Pending Exclusion barred coverage. The court also rejected arguments by the insured (1) that a sealed FCA complaint is not a "pending" action until served on the insured, and (2) that the exclusion should not be applied to bar a claim the insured did not know of as of the "continuity date." The insurer successfully argued that notice to the insured of the complaint, while important under the "Prior Knowledge" exclusion, was not a requirement under the Prior and Pending Exclusion.

The Prior Knowledge Exclusion turns upon knowledge of circumstances that foreseeably may lead to a claim. Unlike the Prior and Pending Exclusion, no proceeding nor investigation need have preceded the "continuity date." Rather, "circumstances" that reasonably indicate the insured may be sued are sufficient, so long as these circumstances were known to the insured. When FCA claims are on the horizon, this frequently becomes evident to the insured via criticisms from employees, or by union leadership, public officials, or news media. In addition, regulators, often at the state or municipal level, may have communicated to the insured concerns regarding false claims violations or, equally significantly, predicate acts. In a number of cases I have handled, evidence was found that the insured's compliance officers had been informed many years prior of violations of the kind that ultimately led to the qui tam action.

Both the "Prior / Pending" and the "Prior Knowledge" exclusions traditionally have required a relationship between the prior action or circumstances and the ensuing legal action that forms the basis of the claim. The "commonality" between the prior action or circumstances (as the case may be) need not concern a common legal theory; most judicial decisions have focused more on common factual elements. Thus, if a prior law suit sought recovery for the insured allegedly having conspired to promote off-label usage of a drug, in violation of the Federal Drug and Cosmetic Act,[12] and the current one is styled as a False Claims Act action, the Prior / Pending exclusion may nonetheless apply if both actions allege a scheme involving common or significantly similar facts. Courts have, for example, deemed claims based upon a prior wrongful employment termination action "related" to later claims brought under a different legal theory when the wrongful termination was on account of the same facts as the later action.[13] Because the FCA carries its own provisions penalizing wrongful termination, it is not uncommon to encounter a wrongful termination claim when the insured also is subject to liability for the submission of false claims to the Government. In general, common victims or time frames have been pivotal in many cases, but may not be indispensable requirements.

Conclusion: The Distinct Challenge of FCA Exposures under Professional Liability Policies

A few policies on the market contain a False Claim Act exclusion, but most do not (though other exclusions, such as exclusions for "deceptive business practices" may apply).[14] This can in part be explained by the reluctance of insurers to add to what may already be a long list of exclusions in order to preclude claims that may seldom involve insured "professional services." Underwriters may be able to assess and mitigate against the risk of FCA liability by reviewing corporate securities filings provided to them, though some insureds, it should be noted, may not report ongoing investigations insofar as the insured believes information regarding the proceedings are sealed and confidential. The insistence of an insured upon institution of a remote "continuity date" has, in this author's experience, sometimes correlated with an appreciation on the Insured's part that it is subject to liability for FCA transgressions. Likewise, extreme narrowing of the persons whose "knowledge" matter for purposes of the Prior Knowledge Exclusion—i.e., confining the clause to knowledge of the General Counsel—has sometimes reflected a situation in which compliance officers have knowledge that would otherwise have triggered the exclusion. This is particularly true in the

pharmaceutical industry, where, according to federal regulatory guidance, the compliance officer has authority to report directly to the board of directors.[15] Overall, in defining and measuring FCA exposures successful insurers appreciate that false claims practices typically involve a long history of wrongful acts leading to non-public investigations and sealed legal proceedings prior to service of a publicly available civil complaint.

From the claims standpoint, because FCA claims may generate enormous defense costs, insurers may not find solace in "fraud" exclusions if, as is common, those exclusions do not bar defense costs absent a judgment or similar finding against the insured. Accordingly, the focus often needs to be on timing-related issues, with an eye toward whether the scheme currently alleged has a relevant antecedent. An insurer may have the ability to uncover such histories through independent investigations. Freedom of Information Act requests may not generate a substantive response for months, but ultimately can be high-yield, confirming when investigations commenced against the insured. Here, the advantage belongs to the claim professional possessing substantial depth of understanding, not merely of the substance of FCA liability, but also of the procedural nuances that differentiate the early stages of civil FCA proceedings from nearly all others.

Endnotes

1 31 U.S.C.S. §§ 3729-33.

2 31 U.S.C.S. § 3729.

3 http://www.justice.gov/opa/pr/justice-department-recovers-nearly-6-billion-false-claims-act-cases-fiscal-year-2014.

4 31 U.S.C.S. §3729.

5 *See Mikes v. Straus*, 274 F.3d 687, 700 (2d Cir. 2001).

6 *Zurich American*, 529 F.3d 916, 921-22.

7 *Esai, Inc. v. Zurich American Ins. Co.*, 2015 WL 113372 (D. N.J. 2015).

8 *U.S. v. Aleff*, 772 F.3d 508, 512 (8TH Cir. 2014).

9 *Cumberland County Guidance Center v. Scottsdale Ins. Co.,* 2011 WL 6260728 (N.J. Super. 2011).

10 *See United States ex rel. Schweizer v. Oce NV*, 577 F. Supp. 2d 169, 176 (D.D.C. 2008); *United States ex. rel. Durham v. Prospect Waterproofing, Inc.*, 818 F. Supp. 2d 64, 67 (D.D.C. 2011).

11 *AmerisourceBergen Corp., et al v. ACE American Ins. Co.*, 100 A.3d 283 (Pa. Super. 2014). The author represented the insurer in this matter both at the trial level and in obtaining affirmance before the appellate court.

12 21 U.S.C.A. §§ 331(a), 333(a)(1), 352 (f)(1).

13 *Pantropic Power Prods., Inc. v. Fireman's Fund Ins. Co.*, 141 F.Supp.2d 1336, 1371 (S.D. Fla. 2001).

14 *AmerisourceBergen Corp., et al v. ACE American Ins. Co.*, No. 002679 (Phila. Ct. Com. Pl. 2013), *aff'd on other grounds*, 100 A.3d 283 (Pa. Super. 2014).

15 OIG Compliance Guidance, 68 FED. REG. at 23733.

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settlements was immaterial.[18] As a result, the appeals court unanimously affirmed the lower court's order barring coverage for the settlement.[19] New York's appeals courts have recently gone out of their way to reaffirm that public policy forbids carriers from indemnifying disgorgement payments.[20]

Modern Trend: Parsing the Claim

More recently, courts have displayed a reluctance to follow *Level 3* and its progeny. When presented with a settlement that includes a disgorgement or restitution payment, courts have displayed a greater willingness to parse the settlement and find coverage for at least some portion of the sum. One recent case that typifies the trend is *U.S. Bank National Association v. Indian Harbor Insurance Company*, which was decided by the federal district court in Minnesota in December 2014.[21] An underlying consumer class had sued U.S. Bank, alleging that it unlawfully manipulated the order in which consumers' transactions posted to their accounts so as to maximize the amount of overdraft fees that the bank would earn. U.S. Bank settled the claims against it for $55 million, and then sought coverage for the amounts it expended to defend and to settle the suits.

The carriers took the position that U.S. Bank's settlement was outside of coverage because the settlement constituted restitution, and restitution is uninsurable as a matter of law.[22] The court disagreed, noting in its summary judgment ruling that the primary policy removed from the definition of "Loss" only any "profit or remuneration gained by [U.S. Bank] to which [it] is not legally entitled…as determined by a final adjudication in the underlying action."[23] Because there had been no "final adjudication," the court found that the settlement was covered "Loss."[24]

The *U.S. Bank* court's holding was precisely the danger that the *Level 3* court warned against. In *Level 3*, the court wrote:

> Level 3 acknowledges that if a judgment had been entered in the suit against it on the basis of a judicial determination that it had engaged in fraud, Federal would win; the policy so provides. It couples this acknowledgment with the inconsistent assertion that almost the entire purpose of D&O policies is to insure corporations and their officers and directors against claims of fraud. Pressed at argument concerning this inconsistency, it argued that the line runs between judgments and settlements. As long as the case is settled before entry of judgment, the insured is covered regardless of the nature of the claim against it. That can't be right….It would mean, as