The False Claims Act and Professional Liability Insurance Policies

By Richard C. Mason

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. 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. During the last six years, the federal government, under the FCA, has recovered more than $22 billion from subject companies. 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. It can include
Judicial Treatment of Coverage for Disgorgement and Restitution Settlements

By John D. Hughes and Alexander G. Henlin

Professional liability insurers are increasingly being asked to indemnify their insureds for settlements that are fairly characterized as disgorgement or restitution. Courts have struggled with whether such settlements are covered for at least the past 25 years. Unfortunately, decisions have come down on both sides with respect to whether such settlements are insurable.

Recent cases, however, suggest that, unless such settlements are clearly outside the scope of the policy’s insuring agreement—for example, if there is a carve-out in the policy’s definition of the term “Loss”—or are clearly excluded even prior to final adjudication, courts are more likely to find coverage. Accordingly, underwriters should consider that they may have to pay such settlements when calculating their proposed premiums.

Typical Policy Terms

A coverage analysis always begins with the policy’s insuring agreement. A typical D&O policy’s insuring agreement for entity coverage might provide:

The Underwriter will pay on behalf of the Insured:

All Loss for which the Insured becomes legally obligated to pay on account of any Claim first made against the Insured during the Policy Period or, if applicable, the Discovery Period, for a Wrongful Act which takes place during or prior to the Policy Period; provided, however, the Insured shall report such Claim to the Underwriter as soon as practicable….

The policy may then define the term “Loss” to mean anything from a combination of “[c]laim expenses and [d]amages” to “the total amount which [the insured] becomes legally obligated to pay on account of each Claim…in each Policy Period…made against [it] for Wrongful Acts…including, but not limited to, damages, judgments, settlements, costs, pre-judgment and post-judgment interest and Defense Costs.”

Management and professional liability policies also typically include various carve-outs from the definition of “Loss.” Some, for example, may except from the definition of “Loss” any “[m]atters which are uninsurable under the law pursuant to which this Policy is construed.” Others may except from the definition “taxes, civil or criminal fines or penalties” or “fees, commissions or charges” for professional services.

Virtually all liability policies then include a series of exclusions. Among the more common exclusions are personal profit exclusions, like this one from a lawyers’ professional liability policy:

[This policy] shall not apply to any Claim based upon, arising out of, attributable to, or directly or indirectly resulting from any insured having gained in fact any personal profit or advantage to which he or she was not legally entitled.

Another common exclusion is the dishonest acts exclusion, which may be phrased like this one:

[This policy] shall not apply to any Claim made against the Insured(s)…based upon or arising out of any deliberate, dishonest, fraudulent or criminal act or omission by such Insured(s), provided, however, such Insured(s) shall be protected under the terms of this policy with respect to any such Claim(s) made against them in which it is alleged that such Insured(s) committed any deliberate, dishonest, fraudulent or criminal act or omission, unless judgment or other final adjudication thereof adverse to such Insured(s) shall establish that such Insured(s) were guilty of any deliberate, dishonest, fraudulent or criminal act or omission.

The “final adjudication” language in the exclusion above is a common feature of many professional liability policies’ misconduct exclusions. As we shall see, in some cases, courts have seized on it to find that a particular settlement falls within the scope of coverage—or, at least, to declare that a particular component of a settlement is not specifically excluded from coverage.

Early Trend: No Coverage

Courts that first considered the question had little difficulty concluding that settlements that constituted disgorgement or restitution were uninsurable, as a matter a law. In Bank of the West v. Superior Court, for example, the California Supreme Court in 1992 held that a settlement resolving state-law unfair competition claims was uninsurable, because the only non-punitive monetary relief available under the California Unfair Business Practices Act was disgorgement of money that had been wrongfully obtained.

The court went on to state: “It is well established that one may not insure against the risk of being ordered to return money or property that has been wrongfully acquired. Such orders do not award ‘damages’ as that term is used in insurance policies.”

Summarizing similar holdings from
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Boston Event Builds on WLN’s Six-Year Legacy

By Maureen Mulligan and Carolyn Pearce

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The PLUS mission is to be “the global community for the professional liability insurance industry by providing essential knowledge, thought leadership and career development opportunities” for those in the profession. It is no secret that women remain under-represented in executive and leadership positions in the insurance industry. In a 2013 research study conducted by Saint Joseph’s University those numbers were quantified and the study showed that women held only 6 percent of C-suite positions, 8 percent of inside officer positions and 12.6 percent of board seats at the top 100 companies in the industry.

In order to provide thought leadership on the advancement of women in the profession and an opportunity for career development, in 2009 PLUS Foundation formed the Women’s Leadership Network. The goal of the WLN is twofold: to raise corporate awareness of the value of diverse leadership, and to provide women the opportunity to network and learn from business leaders in an effort to help them define and promote their own career paths. Filling that goal, the Women’s Leadership Network has hosted over a dozen events around the country, providing opportunities to network and learn from women who are leaders by virtue of their achievements. But these events are not just for women. In order to create diversity in the profession at entry points and at the executive level, both men and women need to be part of the discussion. The next time an event is held in your city PLUS Foundation encourages you to send a cross section of people from all levels of your company.

The most recent WLN event was held in Boston at the end of February. Despite the snowy winter and unpredictable weather, over 100 people attended the event featuring Joanne Chang speaking on “Career, Vision & the Confidence to Execute on It.” Ms. Chang is a former management consultant and honors graduate of Harvard College with a degree in applied mathematics and economics. She left the world of management consulting and created Boston’s Award winning Flour Bakery + Café and Myers + Chang restaurants. She led an engaging discussion on how to develop a vision for your career and to have the confidence to execute on it. The premise of her presentation was that nothing can be accomplished without a plan, combined with hard work to execute that plan. Her presentation reinforced the idea that to advance your own goals you need to have a vision today, not a plan for the future, and to be very strategic on the pursuit of your vision.

The first step, according to Ms. Chang, is to “create a vision.” In other words, she asked those attending the lecture
to figure out and articulate what they want to accomplish in their careers. Is your goal to be a top salesperson, preside over a division or business unit or be a CEO? Chang advocates being specific about your goals, writing them down and thinking in the present tense. After that is set, the next step is to “define the people who will help you get there.” No one advances alone. Find advisors, mentors, sponsors and role models who can be sounding boards and advocates to help you reach your goals. Some of these people will work with you and others may be outside advisors. Next, “get the confidence to pursue your vision.” Ms. Chang reminded the audience to push themselves to succeed and not be afraid to fail and learn from mistakes. Growth comes from taking risks and moving forward. She then advises you to “surround yourself with believers and give yourself constant pep talks.” Don’t get bogged down with people who are not supporting you in your goals. Reach out to find those who will give you support. Finally, “avoid pitfalls”. Leave your ego at the door and do not give up on the path to achieving your vision.

Providing tools for career advancement and professional development is part of the mission of the WLN, and Joanne Chang’s presentation on “Career Vision and the Confidence to Execute on It” provided another tool for the box. The presentation concluded with a great networking reception which gave women in the insurance industry from around New England a chance to connect. A special thanks goes out to PLUS New England Board members who organized the event, particularly Terri Pastori (Board Chair), Carolyn Pearce, Nancy Adams, Robert Moore and Tina Rothemich.

PLU S Executive Director Search

In the January 2015 issue of the PLUS Journal, PLUS announced the departure of our Executive Director. PLUS has engaged the executive search firm Vetted Solutions to conduct the search and is now accepting applications for the Executive Director role. Please review the job description on the PLUS or Vetted Solutions’ websites.

Contact Information

To express interest, or to submit confidential referrals, questions or comments, please contact the executive search firm, Vetted Solutions:

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To apply for this position, please click link below.

🌐 http://tinyurl.com/PLUSExecDr
The problem of diagnostic error has gotten more attention than ever over the last ten years in patient safety and medical literature. There are hundreds of articles on a problem that is both pervasive and persistent. The primary care specialties have been principally involved by virtue of the very nature of their practice.

But closed claim studies by the PIAA have shown that the problem occurs at a significant rate in surgical and other specialties as well. For example, in the time frame of 2008-2012, data from the PIAA Data Sharing Project (DSP) reported that of all the chief medical factors reported, diagnostic errors accounted for the second highest reason for claims and resulted in the highest average indemnity payments (See Exhibit 1). In closer review of the diagnostic error MPE claims reported to the DSP for this five-year period, radiologists were most often named in claims, and claims related to cancer were the top medical conditions (breast, lung, and colorectal cancer specifically). Obstetricians/gynecologists were reported to have the highest indemnity payments reported for diagnostic error. And diagnostic error in cardiac/ cardiorespiratory conditions saw the top number of claims reported for this time period followed by breast cancer, lung cancer, acute myocardial infarction/heart attack, and colorectal cancer (See Exhibit 3).

Health care delivery in the United States has increasingly shifted to a significant rate in surgical and other specialties as well. For example, in the time frame of 2008-2012, data from the PIAA Data Sharing Project (DSP) reported that of all the chief medical factors reported, diagnostic errors accounted for the second highest reason for claims and resulted in the highest average indemnity payments (See Exhibit 1). Additionally, surgical specialties were named in 9% of all closed claims reporting diagnostic error; hospitalists’ were named in 22%; advanced practice providers were reported in 24%. Non-surgical specialties (including primary care specialties) were reported in 31% of medical professional liability claims naming diagnostic error as the chief medical factor in the claim (See Exhibit 2). In closer review of the diagnostic error MPE claims reported to the DSP for this five-year period, radiologists were most often named in claims, and claims related to cancer were the top medical conditions (breast, lung, and colorectal cancer specifically). Obstetricians/gynecologists were reported to have the highest indemnity payments reported for diagnostic error. And diagnostic error in cardiac/ cardiorespiratory conditions saw the top number of claims reported for this time period followed by breast cancer, lung cancer, acute myocardial infarction/heart attack, and colorectal cancer (See Exhibit 3).
Calling All Authors!

Have you authored an article or thought about writing an article on a professional liability topic? Do you want to share it with the PLUS membership? If so, please send it to us and we’ll look at publishing it in the PLUS Journal.

It’s easy! You can either provide your article online through our website article submission area or email it to Lance Helgerson at lhelgerson@plusweb.org. Thanks for contributing to the PLUS Journal.

Exhibit 3

Cardiac/Cardiorespiratory arrest most prevalent by closed claims; Cancer conditions dominated top diagnostic error claims.

Endnotes

1 PIAA Data-Sharing Project, 2014.
Ken Stephens, RPLU is a busy man. As Western Territory Manager and Senior Vice President for Chubb Specialty Insurance he travels extensively and manages a large team of professional liability practitioners. Despite his hectic schedule Ken carved out time to complete his RPLU designation last year. Recently we spoke with him about the program, his experience with the PLUS Curriculum, and his advice for anyone considering the RPLU program.

PLUS: Earnig the RPLU designation is a tremendous accomplishment—what made you want to seek the designation?

Ken: Earning the RPLU designation has been a goal of mine for several years. In our ever changing and competitive landscape, I believe that one must go deep and wide in your chosen field of endeavor. However, other priorities, and life in general compelled me to delay. Recently Chubb reinvigorated its campaign to encourage underwriters to seek designations and continue to drive deep technical expertise, and asked senior leaders to encourage underwriters to enroll. The company also created an online community called The Chubb RPLU Cohort with participants and coaches sponsored by our learning and development group. That was my catalyst. How can I stress the importance of earning an RPLU to my staff if I hadn’t? So, I set out to fulfill my own goal while also hoping to be a role model for others.

PLUS: What is your opinion of the PLUS Curriculum?

Ken: The PLUS Curriculum is challenging but not overwhelming, if one allocates the appropriate time to study as the instructions outline. And although a few of the modules were more of a review, given my time in the industry, I learned something new in each module, or a different way of how I might present claims scenarios to brokers or newer underwriters.

PLUS: Did you have a favorite module? Why did you like it?

Ken: Wow… that’s a tough question. I’ve been in the industry for a while so I was quite familiar with each of the modules, but I have to admit the Professional Liability Reinsurance and the General Liability modules were the most intriguing because I was not as familiar with the inner workings of those lines of coverage.

PLUS: How long did it take you to complete the RPLU program?

Ken: 6 months. Yeah, I know… speedy. It wasn’t that I was so passionate about RPLU modules, as I was determined to finish prior to the conference in Las Vegas. Also, I’d challenged several of my underwriters who started before me to complete the program in that time frame as well, so my reputation for follow through, and some bragging rights, were at stake!

PLUS: How has earning your RPLU designation impacted your career in the industry?

Ken: The RPLU designation has not had an immediate effect on my career as much as it’s made me smarter relative to lines of coverage I was not as familiar with, and that is a benefit not only to me, but to the company I serve. Further, it has my broadened my perspective on the PLUS organization and its tremendous value in developing the future underwriters and brokers in our evolving industry.

PLUS: How did your employer support and encourage you as you pursued your RPLU?

Ken: Chubb not only encourages it’s underwriters to pursue the RPLU, but financially supports the costs of the modules and tests, and provides an incentive award after each passed exam. Additionally, upon earning the RPLU, Chubb pays for the employee to attend that year’s PLUS conference and RPLU conferment ceremony.

PLUS: Now that you’ve completed the RPLU designation what’s next?

Ken: This April I plan to go to AZ and do a tandem jump from a plane with some friends. Oh, you mean relative to professional liability education? I was impressed by Ross Hess, RPLU+ and...
the 23 completed modules and 22 corresponding exams he completed... Maybe that will be my next goal, but give me a few months to use up my new business cards with the current RPLU moniker.

PLUS: What advice would you give to someone considering pursuit of the RPLU designation?

Ken: Get started! Had I earned the designation earlier in my career, even with the great training that Chubb provides, I may have expanded into other specialty areas like Reinsurance or Med Mal. Also, recognizing that the professional liability field is quickly evolving and extremely competitive, this designation demonstrates that you’re seriously committed to your craft and distinguishes you among your peers.

PLUS: Any funny stories about the RPLU process or being an RPLU?

Ken: There were some days prior to a test that I either did not feel like studying or was dogged tired from business travel, but I would use that time to email some of my colleagues to encourage or challenge them to finish a module over a few holiday weekends. I also used my study time at the kitchen table with my teenage son to not only demonstrate that an “old dog can learn new tricks” but to show that one must stay focused. By the way, I’m still catching up on the prior season of a few favorite shows due to my focus on studying 3-4 nights a week. (Editor’s note: Both Game of Thrones and Ray Donovan are worth the wait!) Near the end, and due to my travel schedule, if a test date was not available at my home testing center I would scour the various cities where I was scheduled to travel to find a testing center and attempt to test there. What a sight carrying those huge modules on board my flights!

PLUS: What else would you like to share about the PLUS Curriculum or RPLU program?

Ken: The staff at the PLUS offices are friendly, helpful and patient, particularly Stephanie Johnson. I was really cutting it close getting the final test in prior to the cut-off for getting my name in the graduation pamphlet... and yes, that was important to me. The last week I called Stephanie repeatedly to advise that I was taking the final test and the grade would be in by the deadline. I don’t recommend that approach, but thanks to kind folks at PLUS I got my “name in the book.”

We thank Ken for participating in this interview. If you haven’t checked out the PLUS Curriculum and RPLU program recently take his advice and get started! Visit www.plusweb.org/rplu today. ☺️
PLUS and the PLUS Foundation recognize the value of diversity in the professional liability insurance industry's workforce, and support efforts to make the industry open to all interested individuals. To illustrate our commitment to creating a vibrant and inclusive industry, the PLUS Board of Trustees created a formal D&I Committee to explore ways to highlight diversity issues and attract a more diverse workforce going forward.

Members of the PLUS D&I Committee, Serge Adam, Esq. (Schuyler Roche & Crisham, P.C.), Christina L. Poore, RPLU (Travelers Bond & Specialty Insurance), Kristine Tejano Rickard (Protective Specialty), Chester D. White, RPLU (Aon Professional Services), and Trustees Anjali C. Das (Wilson Elser Moskowitz Edelman & Dicker), Corbette Doyle (Vanderbilt University) and Leib Dodell (ANV), are charged with keeping D&I considerations at the center of all that PLUS does. These efforts include attracting and promoting a more diverse roster of speakers at PLUS events, identifying subject matter experts with diverse backgrounds to work on PLUS educational products, and attracting the next generation of professional liability practitioners from a variety of backgrounds.

“In order to be the global community for the professional liability insurance industry, PLUS must reflect diversity of thought and perspectives,” stated Christina Poore, RPLU, committee member and account executive at Travelers.

“This commitment to diversity and inclusion helps us achieve our mission by sustaining membership growth and driving industry advancement.”

Perhaps the most visible project to date focuses on data collection and measurement. As part of our 2015 membership renewal program all members were asked to provide data to help PLUS measure the diversity of our industry at present. Specifically, members were asked to share their date of birth, gender and ethnicity to provide a snapshot of where our industry is, as well as provide a baseline for future analysis. A current snapshot of PLUS membership in these categories is illustrated in the charts below.

We appreciate all the members who have provided this information, and encourage those of you who did not share this information to reconsider. This data will only be used to provide general trends on employment and recruitment in the industry, and PLUS will not share, sell, or release this information in accordance with our existing privacy policy.

Watch the PLUS Journal for updates on the specific programs and initiatives from the PLUS D&I Committee in the coming months.

PLUS, and the industry as a whole, are stronger and more creative because of our commitment to diversity and inclusion. Together, we all drive professional liability forward.
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. 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; (ii) 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. 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.” 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. 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.

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”
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
filling 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
claim, 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. 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.

**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. 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. 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.” Because there had been no “final adjudication,” the court found that the settlement was covered “Loss.”

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

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**Endnotes**

5. OIG Compliance Guidance, 68 FED. REG. at 23733.
Level 3’s lawyer confirmed at argument, that if Level 3, seeing the handwriting on the wall, had agreed to pay the plaintiffs in the fraud suit all they were asking (a very large amount—almost $70 million), which they surely would not have done had there been no evidence of fraud (no rational defendant settles a nuisance suit for the full amount demanded in the complaint, unless the amount is trivial), Federal would still be obligated to reimburse Level 3 for that amount. And that would enable Level 3 to retain the profit it had made from a fraud. 25

In sum, the U.S. Bank decision elevates form over substance, finding coverage because there had been no “final adjudication,” notwithstanding that the point of the settlement was to resolve claims that U.S. Bank had received profit to which it was not entitled.

The U.S. Bank decision is hardly an outlier. In William Beaumont Hospital v. Federal Insurance Company, 26 the Sixth Circuit was asked to determine whether an antitrust settlement resolving claims that various Detroit-area hospitals had conspired to depress nurses’ wages was within the scope of coverage. The federal appeals court concluded that it was, relying upon a distinction between the hospitals’ retaining the nurses’ allegedly higher unpaid wages (which the court assumed it did) versus the hospitals’ unlawfully gaining possession of those wages (which the court concluded had not happened) to hold that there was nothing for the hospital to disgorge. 27

Similarly, in Genzyme Corporation v. Federal Insurance Company, 28 the First Circuit closely examined a shareholder class-action claim under a D&O policy. Remanding the case for further fact-finding, the appeals court noted that Massachusetts has only a limited public policy exception to the insurability of matters: coverage is proscribed only for “acts committed with the specific intent to do something the law forbids.” 29 The appeals court also stated that there is no Massachusetts case standing for the principle that restitution of ill-gotten gain is uninsurable—a sweeping pronouncement that the court immediately concluded was not relevant because the case before it did not involve any ill-gotten gain. 30

It is worth noting, too, that some courts have parsed settlements and found that at least some portion of the payment made by an insured falls within coverage. In The PNC Financial Services Group v. Houston Casualty Company, 31 another overdraft-fee case, the court found that those portions of the settlement that refunded improperly-charged fees to the consumer class fell within a carve-out to the definition of “damages.” 32 But, relying on the language of the carve-out, the court went on to hold that other portions of the settlement—including the fees paid to the consumers’ counsel and court costs—were not similarly removed from the definition of “damages,” with the result that the carrier was obligated to fund those components of the settlement.

Conclusions

Based on the foregoing, carriers can draw several salient conclusions. First, in the absence of either clear policy language that excludes coverage for payments that constitute either restitution or disgorgement, or explicit and controlling state law that bars such coverage, there appears to be a trend wherein courts are ruling that settlement payments fall within the scope of a professional liability policy’s coverage.

Second, while insurers do occasionally still prevail when they contend that a settlement payment is properly characterized as either disgorgement or restitution, that outcome is by no means as certain as it once was. The decision will depend on the exact language of the relevant insurance policy, and the controlling law of the appropriate jurisdiction.

Finally, the uncertainty created by the body of decisions should factor into the premiums that carriers charge to proposed insureds. Underwriters, too, should carefully review policies to ensure that they cover only what the insurer intends to insure.

Endnotes

2 See id., *15 (emphasis removed).
4 See id., *5.
9 See 2 Cal.4th at 1226.
10 See id.
11 See id., at 1269.
12 272 F.3d 908 (7th Cir. 2001).
13 See id., at 909.
14 See id., at 910.
15 See id., at 910-11.
17 68 A.D.3d 420, 889 N.Y.S.2d 575 (1st Dep’t 2009).
18 See id.
19 See id.
20 See J.P. Morgan Sec. Inc., note 8, supra.
21 See note 4, supra.
22 See id., at *5.
24 See id., at *18.
25 See Level 3, 272 F.3d at 911.
27 See 552 Fed. App’x at 499.
28 622 F.3d 62 (1st Cir. 2010).
29 See id., at 70.
30 See id.
32 See id., *10.
PLUS Board and Awards
Call for Nominations

The Nominations and Leadership Committee is seeking suggestions from PLUS members for potential candidates for the PLUS Board of Trustees and our distinguished annual awards. If you, as a PLUS member, feel that you or someone you know would be a good candidate for the PLUS Board or a deserving recipient of an award, please submit the potential candidate’s name, current employer and position, a list of contributions to PLUS, additional comments about the proposed candidate’s character and accomplishments, and whether the candidate is proposed as a Board nominee or an Award recipient to PLUS Executive Director Derek Hazeltine at dhazeltine@plusweb.org by May 5.

Board of Trustees
Trustees are elected to the Board for a term of three years, with terms staggered so that one-third of Trustee positions shall conclude each year. A number of factors are considered when evaluating candidates, including stature in the industry, company position, years in the business, past service to PLUS, and the current balance and composition of the Board (underwriters, brokers, attorneys, company representation, diversity, geography, etc.).

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Each year the Professional Liability Underwriting Society presents two awards at its Annual Conference.

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The PLUS Founders Award recognizes a PLUS member who has made lasting and outstanding contributions to PLUS and represents the spirit and dedication of individuals who have contributed selflessly to create, lead and improve the Society.

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PLUS staff will submit additional information about Trustee candidates and Award nominees to the Nominations and Leadership Committee. The Committee will consider all suggestions offered by PLUS members and hold meetings over the Summer to determine Trustee candidates to be listed on the ballot submitted to membership in late September and Award recipient recommendations to the Board, respectively.

PLUS will archive all information from this process, consider suggested candidates for other leadership positions within PLUS, and present information about them to the Nominations and Leadership Committee in subsequent years. 🌟

Thank you for your support and involvement in this process.
Calendar of Events

Chapter Events*

Canadian Chapter
- April 23, 2015 • Educational Seminar • Calgary, AB

Eastern Chapter
- April 23, 2015 • Spring Break Reception • New York, NY
- June 2015 • Educational Seminar • New York, NY

Hartford Chapter
- May 19, 2015 • Educational Seminar • Hartford, CT
- September 27, 2015 • PLUS Foundation Golf Outing • Location TBD

Mid-Atlantic Chapter
- April 2015 • Networking Reception • Philadelphia, PA
- May 2015 • Educational Seminar • Philadelphia, PA
- July 14, 2015 • PLUS Foundation Golf Outing • Location TBD

Midwest Chapter
- April 15, 2015 • Networking Reception • Indianapolis, IN
- May 6, 2015 • Educational Seminar • Chicago, IL
- May 2015 • Networking Reception • Cleveland, OH
- June 2015 • Educational Seminar • St. Louis, MO
- July 8, 2015 • PLUS Foundation Golf Outing • Chicago, IL

North Central Chapter
- Summer 2015 • Educational Seminar • Minneapolis, MN

Northwest Chapter
- May 14, 2015 • Educational Seminar with CPCU & RIMS • Seattle, WA

New England Chapter
- April 30, 2015 • Networking Reception • Boston, MA
- June 8, 2015 • PLUS Foundation Golf Outing • Cohasset, MA

Southeast Chapter
- April 20, 2015 • PLUS Foundation Golf Outing • Milton, GA
- May 20, 2015 • Educational Seminar • Fort Lauderdale, FL
- June 18, 2015 • Networking Reception • Atlanta, GA

Southern California Chapter
- June 2015 • Networking Reception • Los Angeles, CA

Southwest Chapter
- April 15, 2015 • Educational Seminar • Denver, CO
- May 7, 2015 • Educational Seminar & Networking Reception • Salt Lake City, UT
- May 8, 2015 • Educational Seminar (Luncheon Workshop) • Scottsdale, AZ
- Spring 2015 • Educational Seminar • Las Vegas, NV

Texas Chapter
- May 12, 2015 • PLUS Foundation “Top Golf” Outing • Houston, TX
- August 6, 2015 • Networking Reception • Austin, TX

International Events

2015 Medical PL & Professional Risk Symposium
- April 28 & 29, 2015 • Marriott Marquis • Atlanta, GA

Singapore Networking Event & Presentation
- May 14, 2015 • Singapore Cricket Club • Singapore

2015 Cyber Symposium
- September 17, 2015 • Sheraton Chicago Hotel & Towers • Chicago, IL

2015 PLUS Conference
- November 11-13, 2015 • Hilton Anatole • Dallas, TX

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