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Surveying Roughly a Decade's Worth of R&W Insurance Litigation – Three Cases in the Spotlight

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Representation and warranty (R&W) insurance, while not novel, is increasingly popular.[1] R&W insurance covers losses from a covered breach of certain contractual representations and warranties, typically those representations made about the business and the ability to enter into a transaction in connection with the sale of a business. One of the most frequent bases for an R&W insurance claim is a breach of the representations concerning a company's financial statements.[2] One or both parties may purchase R&W insurance to protect their reliance on the accuracy of the representations and warranties (though buyer-side R&W policies are more common than seller-side policies). A buyer or seller may be concerned that a counterparty may be unable, or unwilling, to adequately compensate for a breach of representations and warranties. In the event of a breach of a covered representation or warranty—subject to a retention and exclusions—an applicable insurance policy may compensate to some extent, potentially lowering a transaction's overall cost (in essence, the R&W insurance may substitute the insurer for the seller in such an indemnity structure).[3]

A survey of caselaw from roughly the past decade reveals that many cases have involved alleged breaches of contractual representations or warranties, but just three have been discovered that discuss R&W *insurance* at length in written decisions. Commentators suggest the scarcity of litigation reflects, at least in part, that R&W insurance disputes are often privately arbitrated instead.[4] In that context, these three reported cases are analyzed below.

Ratajczak v. Beazley Solutions Ltd., 870 F.3d 650 (7th Cir. 2017)

In *Ratajczak*, the Seventh Circuit addressed an appeal by seller-insureds who asserted that an R&W insurance policy obligated their insurer to indemnify seller-insureds in connection with a settlement concerning seller-insureds' alleged breaches of representations and warranties in a sale purchase agreement. Between 2006 and 2012, seller-insureds owned and controlled a manufacturer with a product that at least one customer used to make high-protein food for calves and young animals. Customers would gauge the product's protein levels by measuring the nitrogen found in the product. Seller-insureds allegedly added a cheap substitute to their product so the product would test artificially high in nitrogen and appear to have higher protein levels. Seller-insureds sold the company, were retained as employees, and continued this practice. Eventually, the buyer discovered the alleged fraud, fired the seller-insureds, and threatened suit with a draft complaint. A $10 million settlement was reached without insurer approval (before the complaint was filed). The insurer refused to indemnify the seller-insureds, who then sued for alleged breach of duty to indemnify. The district court granted summary judgment to the insurer, and seller-insureds appealed.

Seventh Circuit's Decision and Analysis

The Seventh Circuit held that seller-insureds failed to qualify for the R&W insurance coverage for two independent reasons: (1) seller-insureds' policy retention offset the sale contract's maximum damages for a non-fraudulent breach of a general warranty (whereas fraud was excluded from the policy's coverage); and (2) seller-insureds settled without the insurer's consent, which was required to obligate the insurers to pay out for the settlement under the policy.

The Seventh Circuit first determined that the R&W insurance policy covered losses for breach of contract but not for fraud. The court then found that, under the sale purchase agreement, there were two ways a breach of warranty claim could arise: (1) a false statement in a fundamental representation – "a list of specific representations made by seller company on which the buyer relied;" and (2) a false statement not included among the fundamental representations, which the court also referred to as a false statement in a "general warranty." However, the Seventh Circuit found that in the case of the latter – *i.e.*, if the false statement was in a general warranty and not a fundamental representation – then damages for which the seller-insureds were liable under the purchase agreement were contractually capped at $1.5 million. Moreover, the Seventh Circuit noted that seller-insureds carried a $1.5 million retention under the policy (similar to a deductible). The Seventh Circuit observed that the insurer had argued, and the district court had agreed, that if there had been any non-fraudulent breach of warranty, such false statement was not among the specifically listed fundamental representations, so damages were contractually limited at $1.5 million. The Seventh Circuit adopted the district court's holding that, because the cap matched the retention, no indemnification could be owed by the insurer.

The court noted that the draft complaint that the buyer sent to seller-insureds accused them of fraudulently concealing the addition of the cheap substitute in order to impact protein-test results, alleged that profits were artificially inflated, and did not specify a falsehood in a fundamental representation. Seller-insureds contended that the draft complaint should be liberally construed and the accusations *implied* a breach of fundamental representations, such as inaccuracy of books and records. The court rejected this argument, however, because the complaint was never filed. Moreover, the court observed that the draft complaint emphasized fraudulent statements and misleading omissions – and fraud was excluded from coverage. Still, the court acknowledged that the pleadings could be construed as negligent misstatements not subject to the fraud exclusion, but damages arising from such misstatements would have been contractually capped at $1.5 million as breaches of non-fundamental representations.

The court also held that indemnification was not required because under the policy the insurer was not bound by settlements it did not approve in advance. Seller-insureds argued that the insurer was required – and failed – to prove prejudice from delay in noticing the claim, citing Wisconsin law. The court, however, ruled that New York law governed the policy, under which the requirement of insurer settlement approval was "absolute."

Thus, the Seventh Circuit in *Ratajczak* held that seller-insureds lost on two separate bases: (1) a retention offset maximum damages for breach of a general warranty; and (2) insureds settled without insurer's consent.

Bobcat N. Am., LLC v. Inland Waste Holdings, LLC, Civil Action No. N17C-06-170 PRW CCLD, 2020 WL 5587683 (Super. Ct. Del. Sept. 18, 2020)

The second case yielding a court decision regarding R&W insurance, *Bobcat v. Inland Waste Holdings, LLC*, involved a policy that the court found might have covered fraudulent breaches. The court granted in part and denied in part sellers' motion for partial summary judgment, finding genuine disputes of material fact as to one of several claims.

Background

Plaintiff Bobcat North America, LLC (Buyer) purchased several waste-management companies from Defendants Inland Waste Holdings, LLC, Bart A. Begley, Montgomery M. Davison, and Robert A. Smith (Sellers) under a Unit Purchase Agreement (UPA). In connection with the UPA, the parties jointly "purchased a Buyer-Side [R&W] insurance policy from QBE Specialty Insurance Company, covering any of [Buyer's] losses from breaches by Sellers of their representations in the UPA, including fraudulent breaches (the 'QBE Policy')." The UPA provided two categories of potential claims against Sellers: (1) R&W insurance claims – which were defined as any claim for breach of a representation and warranty that is not classified as a non-R&W insurance claim; and (2) non-R&W insurance claims. Non-R&W insurance claims in turn included, as relevant: "(i) Claims related to any fraud or willful or knowing breach of any representation or warranty . . . (the 'Fraud Claims'); [and] (ii) Claims related to inaccuracies or breaches of any representation or warranty set forth in Section 3.12(c) (Environmental Matters) . . . " Sellers interpreted the QBE Policy to cover the "Fraud Claims" defined as non-R&W insurance claims under the UPA.

Buyer discovered inaccuracies in Sellers' UPA representations and warranties[5] and submitted a claim notice to QBE. Buyer filed for arbitration against QBE to enforce the policy, and QBE settled and agreed to pay Buyer $7.1 million. Buyer and Sellers agreed that the settlement was ambiguous on the apportionment of proceeds across Buyer's claims.

Buyer then filed suit against Sellers asserting claims for breach of contract, fraudulent inducement, negligent misrepresentation, indemnification, and declaratory relief. Sellers moved for partial summary judgment to dismiss all claims except declaratory relief. The court: (1) granted summary judgment on the fraudulent inducement claim because Buyer failed to plead separate fraud and contract damages; (2) held that the Court of Chancery had exclusive subject-matter jurisdiction over the negligent misrepresentation claim and allowed Buyer to seek dismissal without prejudice or transfer of that claim; (3) denied Sellers' request to dismiss a certain individual Defendant, a former senior employee at Sellers, finding him, as a matter of contract, potentially jointly and severally liable for any fraud or willful or knowing breach of a representation or warranty as well as finding a genuine issue of material fact as to his actual knowledge of alleged fraud; and (4) denied summary judgment on the breach-of-contract and indemnification claims, finding a genuine issue of material fact whether the QBE settlement payment covered claims for fraud, and the impact on Sellers' obligations to indemnify Buyer. This last holding regarding denial of summary judgment on the breach-of-contract and indemnification claims is analyzed in detail below.

Delaware Superior Court's Decision and Analysis on Breach-of-Contract and Indemnification

In defense against Buyer's breach-of-contract and indemnification claims, Sellers argued that the factual similarities underlying Buyer's insurance claims necessitated that the QBE settlement offset any damages Buyer recovered in litigation. Buyer responded that it had submitted R&W insurance claims to QBE and pursued only non-R&W insurance claims (as defined in the UPA) in the litigation. Particularly, Buyer asserted that its litigation claims were fraud claims or environmental matters that constituted non-R&W insurance claims not subject to liability limitations applicable to R&W insurance claims.

The court found that one reading of the transactional documents might be that the QBE policy covered fraud claims, but not environmental matters, and that Buyer could but was not required to submit fraud claims to QBE. In that case, Sellers argued, Buyer opted to submit its fraud claims to QBE.

The court then rejected Sellers' argument that the UPA required that the QBE settlement offset the fraud claims, a type of non-R&W insurance claim. The court found that the UPA did limit Sellers' indemnification obligations – that Buyer must first seek relief solely from QBE, and that Buyer then could seek 50% or 100% compensation on denied claims from Sellers depending on the representation breached, up to a $10 million QBE Policy cap – but only for R&W insurance claims. The court found no such limitations on Sellers' indemnification obligations for non-R&W insurance claims.

The court recognized the QBE settlement as silent on its allocation across Buyer's R&W insurance claims and found a genuine dispute of material fact whether or how the settlement proceeds should be allocated among Buyer's insurance claims, and the effect on any litigation award. The court acknowledged that Sellers and Buyer disputed whether the QBE payment was based, at least partly, on a fraud claim, pointing to contrary indications in the claim notice, settlement agreement, UPA, and arbitration demand. The court therefore also found a genuine issue of material fact whether the payment covered claims for fraud and denied summary judgment on the breach-of-contract and indemnification claims. Within months of the decision, and following briefing of a motion for judgment on the pleadings by Buyer, the parties jointly reported to the court that they had reached a global settlement, and the action was dismissed with prejudice.

Novolex Holdings, LLC v. Illinois Union Ins., Docket No. 655514/2019 (N.Y. Sup. Ct. Sept. 23, 2019) (ongoing)

Like the *Ratajczak* and *Bobcat* cases, *Novolex* concerns R&W insurance coverage for alleged breaches of representations and warranties. However, a written decision has not yet been issued. Notably, the court denied a motion to dismiss in an August 2020 oral ruling, and cross motions for summary judgment that were fully briefed in December 2021 remain pending. While many filings have been submitted under seal, public information is addressed here.

Background

Under an Equity Purchase Agreement (EPA), Novolex Holdings, LLC (Novolex) (Buyer) purchased The Waddington Group (TWG), a tabletop goods and food packaging products manufacturer, from Newell Brands, Inc. (Newell) (Seller). In the EPA, Seller made representations and warranties regarding the strength of customer relationships and lack of adverse changes to TWG's business. Buyer purchased an R&W insurance policy that had four different tiers of insurers providing layers of coverage. Allegedly, after the transaction closed, Buyer discovered that TWG's relationship with one of TWG's and Seller's largest customers deteriorated before closing due to Seller's mismanagement and realized that Seller had breached the EPA's warranties. Buyer alleges it lost approximately $267 million, well over policy limits of $150 million (in excess of a $17 million retention).

Buyer submitted an insurance claim. Insurers from the first, second, and fourth tiers of the R&W insurance policies paid on the claim. Defendants, insurers in the third-tier of the four-tier R&W insurance tower, refused to cover the losses. In its amended complaint, Plaintiff Buyer (Plaintiff) argues that the R&W insurance policy contains a materiality scrape (which is often contained in these policies), which assertedly reads the materiality qualifications out of the EPA's representations and warranties, such that the existence of breaches and the amount of losses are determined without giving effect to such materiality qualifications – for which Plaintiff allegedly paid higher premiums. [6] And, while non-party insurers from other tiers, including those higher in the insurance tower, paid, Defendants did not.

Plaintiff has asserted eight counts: one for declaratory judgment; six for breaches of the R&W insurance policy corresponding to six EPA warranties; and, upon amendment, one for breach of the implied covenant of good faith and fair dealing. Plaintiff seeks compensatory damages up to the policy limit for the difference in price it paid and TWG's actual worth, reasonable attorneys' fees, costs, expert fees, and pre- and post-judgment interest.

The court denied Defendants' motion to dismiss on the record at a hearing. [Dkt. 154, 159 at 17–18] The court indicated that its "initial reaction to [D]efendants' motion was that they were holding the plaintiff to a much higher standard than applies in a motion to dismiss which is whether they stated a claim, and [the court was] finding they have stated a claim for a variety of reasons . . . so [it was] not prepared to dismiss the causes of action yet." The court read the EPA's "Significant Customers and Suppliers" Warranty to have required Seller to inform Plaintiff if there were a change in the customer relationship "in some material way." The court "reiterate[d]" that "given the uncertainty as to future purchase orders with [the customer] or anyone else, for that matter, any of the major or significant material, it seem[ed at the motion to dismiss stage] to see this ['Significant Customers and Suppliers' Warranty] as a requirement that the seller let the plaintiff know if there is a change in the relationship."

Current Status

Cross motions for summary judgment are now pending. Plaintiff seeks partial summary judgment that four warranties were breached as a matter of law and that Plaintiff suffered damages exceeding policy limits. [Dkt. 377] Defendants filed an opposition under seal. [Dkt. 502]

On reply, Plaintiff argued that Defendants' opposition mischaracterized the EPA's representations and warranties and wrongly asserted that Defendants' contractual protections were narrowly tailored. [Dkt. 535] Plaintiff accused Defendants of attempting to rewrite the policy and abandon their obligations. Plaintiff also pointed out that the Delaware Superior Court, in a parallel action, rejected an argument that the representations and warranties in the EPA were accurate as of signing – an argument virtually identical to Defendants' in this matter. Plaintiff concluded its arguments by asserting that Defendants as a matter of law should lose at summary judgment regarding the four warranties and that Defendants fail to raise a genuine dispute on causation or damages.

Defendants' pending summary judgment motion and reply were filed under seal. [Dkt. 380, 528] According to Plaintiff's opposition, however, Defendants asserted that Plaintiff had not submitted any valid claims under the policy, which Plaintiff assailed as "baseless." [Dkt. 491] As noted above, Plaintiff argued that Defendants premised their faulty argument on a misunderstanding that the policy provided "only narrow protection, 'limited to the applicable, narrowly tailored representations and warranties in the EPA.'" Plaintiff called this "patently false," contending that the representations and warranties were not only "comprehensive," but the R&W insurance policies extended their scope by applying a materiality scrape and by not limiting the types of damages that constitute a "Loss."

Plaintiff further complained that Defendants' "treatment of the factual record [was] equally spurious." Plaintiff asserted that it intends to prove facts at trial that Defendants' misconduct amounts to bad faith and warrants punitive

damages. Plaintiff also argued that Defendants failed to meet their burden to show no genuine issue of material fact regarding Plaintiff's ability to establish the underlying breaches by Seller and TWG of any of the six warranties under the R&W insurance policies. Additionally, Plaintiff disputed Defendants' argument that the breaches did not proximately cause Plaintiff's loss and asserted that Plaintiff needed only to show that it suffered loss arising out of the breaches under the primary policy. Plaintiff closed by arguing that its losses, regardless, exceeded Defendants' coverage obligations, meaning that Defendants were liable to pay out in full.

Take-Aways

Any forthcoming R&W insurance decisions, in *Novolex* or otherwise, may be instructive. R&W insurance's popularity continues to grow and stakeholders stand to gain guidance from any publicly available new decisions. We will continue to monitor *Novolex*, as well as other R&W insurance decisions, for important developments and take-aways.

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[1] Marsh, 2021 US and Canada Transactional Risk Year In Review (Feb. 2022), at 6 (noting that Marsh alone "completed 999 distinct insurance placements on mergers and acquisitions last year – a 71% increase over 2020."), https://www.marsh.com/us/services/transactional-risk/insights/transactional-risk-report-2021/americas.html; *see also* Brian Gingold, Representation and Warranty Insurance – To Insure, or Not to Insure, That is the Question, Weil's Global Private Equity Watch (March 5, 2018) (noting growth in R&W insurance and that "[t]here are now more than 20 R&W insurers in the US and, according to market data, more than 1,400 policies were placed in 2017, representing tens of billions of dollars in coverage limits and roughly $1 billion in premiums."), https://privateequity.weil.com/features/representation-warranty-insurance-insure-not-insure-question/.

[2] *See* Atlantic Global Risk, 2021 Insights, at 30, https://www.atlanticgrp.com/documents/atlantic_global_risk_2021_insights_report.pdf.

[3] *See* R&W Insurance, Part I: Pros and Cons for Buyers, Weil's Global Private Equity Watch (May 27, 2015) (noting "R&W insurance serves to shift responsibility for most seller representations and warranties to a third-party insurance underwriter," while also noting such insurance may contain exclusions), https://privateequity.weil.com/insights/rw-insurance-part-pros-cons-buyers/; *see also* R&W Insurance, Part II: Pros and Cons for Sellers, Weil's Global Private Equity Watch (May 28, 2015) ("The key advantage of R&W insurance to sellers is limiting (or eliminating) their post-closing liability for breaches of reps and warranties made in the acquisition agreement."), https://privateequity.weil.com/insights/rw-insurance-part-ii-pros-cons-sellers/.

[4] Richard Harroch, A Guide To M&A Representations And Warranties Insurance In Mergers And Acquisitions, *Forbes* (Jan. 23, 2019) ("Since most representations and warranties insurance policies are subject to mandatory arbitration provisions, there is little published legal authority in this area."), https://www.forbes.com/sites/allbusiness/2019/01/23/guide-mergers-acquisitions-representations-warranties-insurance/?sh=7ea2a2e367f3; *see also* Brian Keeler, Representations and Warranties Insurance in M&A Transactions, *Bloomberg Law* (2020) (noting frequency of requirement in R&W insurance policies "to arbitrate any coverage or other disputes between the insurer and the insured. But arbitration proceedings can be (and usually are) kept confidential, unlike judicial proceedings…"), https://www.bloomberglaw.com/product/health/document/X4FN881O000000.

[5] These inaccuracies were not specified in the opinion and the cited portion of Buyer's brief was redacted.

[6] *See also* Daniel Avery, The 'Materiality Scrape' Provision, *Bloomberg Law* (2021), https://www.bloomberglaw.com/product/blaw/document/X5U6SUOG000000.

Recent Trends in Insurance Coverage & FCA Litigation

By Lori Pines, Blake Steinberg, and Emma Peplow

False Claims Act (FCA) litigation is on the rise. The Department of Justice (DOJ) opened 250 new investigations in 2020, the most since 1994.[1] Federal *qui tam* cases have also steadily increased since 2017, with 672 matters filed in 2020.[2] Additionally, the federal government has recently signaled willingness to use the FCA to combat fraud in the context of cybersecurity.[3] As such, companies and insurers that seek or offer coverage for FCA actions should be proactive about monitoring whether policies are up to date and provide the agreed-upon coverage for FCA liability.

The False Claims Act

The FCA prohibits fraud on the government and is particularly important for businesses and insurers to consider in light of how large individual recoveries under the FCA can be – such recoveries have exceeded $1 billion.[4] For example, to resolve FCA allegations, GlaxoSmithKline paid $2 billion in a 2012 settlement,[5] Johnson & Johnson paid $1.39 billion in 2013,[6] and Bank of America and Countrywide paid $1 billion in 2014.[7] In addition, businesses can be found liable not just for fraudulent statements to the government, but also for failing to comply with material requirements tied to receiving government funding.[8]

Both the Biden Administration and the DOJ have recently indicated that parties can expect FCA litigation to emerge in the cybersecurity context in the near future. President Biden signed an Executive Order on May 12, 2021 aiming to reduce data breaches and malicious cyber campaigns. The Order imposes new obligations on contractors who provide information and operational technology to the government, including obligations to collect and preserve data on cybersecurity threats, as well as to share relevant data with agencies with which they contract.[9] Similarly, in October 2021, the DOJ announced its own new Civil Cyber-Fraud Initiative, which aims to "combat new and emerging cyber threats to the security of sensitive information and critical systems."[10]

Parties that do business with the government – especially those in the technology and defense spaces – may therefore soon face litigation that not only imposes substantial attorneys' fees and costs, but also leads to significant liabilities in the form of settlement payments or unfavorable verdicts reflecting treble damages under the FCA.[11] Some insurance policies may cover claims in these contexts, but recent litigation has also revealed that coverage for FCA-related matters is by no means guaranteed.

Insurance Coverage for FCA Litigation, Generally

Some recent case law has rejected certain insurers' arguments that coverage for fraud-based FCA claims violates public policy. In *Astellas US Holdings v. Starr Indemnity & Liability*,[12] Astellas sought reimbursement from its insurance providers for a $100 million settlement payment it made to the government to resolve allegations that it violated the FCA by causing "the submission of false claims to federal government health care programs [] by facilitating payments to federal health care beneficiaries." In October 2021, the Northern District of Illinois decided cross-motions for summary judgment filed by Astellas and one of the insurers, determining that the settlement payment constituted a covered "Loss" under the applicable insurance policy, and that public policy did not bar coverage.

In determining that the payment constituted a covered Loss under the policy, the *Astellas* court emphasized that the FCA "allows only for civil penalties and compensatory damages, not for restitution." The court found that the intent of Astellas' settlement payment was not to give back the "net benefit of the unlawful scheme" (which would not have been insurable), but rather, the intent was to compensate the government for its monetary losses. The court also

noted that although the DOJ may have been able to pursue other claims beyond the FCA, such as unjust enrichment, the DOJ did not do so – "the primary focus of the DOJ's investigation and subsequent settlement was a violation under the FCA," which was insurable under Illinois law.

In addition, the insurer in *Astellas* argued, among other things, that allowing insurance coverage for losses stemming from fraud-based allegations was against Illinois public policy. The court, however, disagreed and held that losses incurred to address allegations related to fraud are insurable. In reaching its decision, the *Astellas* court considered a Delaware state case involving federal securities fraud in which the Delaware court had held that fraud-based claims were insurable under directors and officers (D&O) policies. The *Astellas* court found that case to be "instructive" for purposes of assessing whether the settlement payment in *Astellas* was insurable.[13]

Notice Requirements

When a company becomes the subject of an FCA investigation, a close reading of notice requirements and provisions in insurance policies regarding what constitutes a "Claim" for purposes of qualifying for coverage can inform the adequacy of notice to an insurer. Notably, compliance with notice requirements can be complicated because, among other reasons, FCA actions are often filed under seal.[14] 672 of the 922 FCA actions initiated in 2020 were *qui tam* cases, which must first be filed under seal.[15] Obligations to provide notice of litigation may be linked to policy provisions defining when a "Claim" has been deemed to be initiated for purposes of seeking coverage.[16] In interpreting policy language, some courts have held that allegations become claims for which insureds can seek coverage with initial court filings, even if a case remains under seal.[17]

Insurers and insureds can also negotiate specific notice requirements.[18] In *PAMC, Ltd. v. National Union Fire Insurance Co. of Pittsburgh*, the policyholder was required to provide notice to its insurer "as soon as practicable" once the policyholder's risk manager or general counsel "first bec[ame] aware of the Claim."[19] However, that policyholder was found to have failed to provide notice after receiving a subpoena and becoming aware that an FCA *qui tam* action had been filed against it. The policyholder, however, argued that a "Claim" was not initiated for notice purposes under the applicable policy until the DOJ's investigation concluded. The policyholder argued that even if the subpoena did trigger the notice obligations, the policyholder did not violate the notice requirements by failing to disclose the subpoena and *qui tam* action because the DOJ had requested that the policyholder not disclose the subpoena unless it received permission. However, the court disagreed and held in favor of the insurer. The *PAMC* court stated that insurance policies that require notice are regularly deemed unambiguous and are strictly construed according to their explicit terms.

As indicated above, in interpreting policy language, certain courts have held that allegations become claims for which insureds can seek coverage after initial court filings,[20] not necessarily when a company receives formal notice such as through service,[21] or through the unsealing of the suit.[22] In the case of PAMC's policy, the language was found to limit the triggering of notice obligations to when a specific official became aware of the claim. Even with such language, however, disputes might arise regarding whether coverage for FCA suits might possibly require disclosure upon receipt of communications regarding potential FCA allegations.

Notice obligations can also differ across policies and depending on the coverage being sought. In *SHH Holdings v. Allied World Specialty Insurance*,[23] the court found that SHH's failure to disclose an FCA investigative demand when applying for Employment Practices Liability (EPL) insurance did not preclude it from obtaining EPL coverage. SHH – which also applied for D&O coverage in the same application in which it applied for EPL coverage – argued that the application questions did not require it to disclose the FCA Civil Investigation Demand (CID). SHH argued that the FCA "claim could never be dragged into the D&O coverage period" and that it "did not intend coverage to apply to the [FCA] allegations." The court agreed with SHH.

Scope of Professional Services Liability

Through professional services liability (PSL) insurance, insurers may offer coverage of potential FCA liability to companies that engage in the business of skilled services, which includes industries that require specialized knowledge such as banking, healthcare, law, or accounting. Several recent decisions have involved the scope of what actions can be covered under PSL policies.

For example, in *IberiaBank v. Illinois Union Insurance*, the Fifth Circuit rejected coverage for policyholder IberiaBank's settlement with the government to resolve FCA allegations because IberiaBank's transactions with the government fell outside the scope of "professional services."[24] The insurance policy specified that professional services "must be performed pursuant to a written contract with such policyholder or *client* for consideration inuring to the benefit of [IberiaBank]." The court found that the settlement payment was not covered, in part because IberiaBank did not receive any consideration from the government, meaning the government was not IberiaBank's client under the applicable policy. In short, "IberiaBank [could not] procure coverage for a claim brought by the government on the basis of professional services rendered to IberiaBank's borrowers."

Additionally, the Fourth Circuit has indicated that, to be covered under PSL insurance, claims must arise out of the job requirements of a specialized profession.[25] Business, marketing, staffing, and operational decisions have been found to fall outside this scope.[26] However, if the conduct in question – though it is insufficient on its own to qualify as "professional services" – causes either the rendering or the failure to render professional services, it is likely to be insurable.[27] For example, in *Affinity Living Group, LLC v. StarStone Specialty Insurance*, the court allowed Affinity to obtain insurance coverage for an FCA lawsuit because the facility failed to render the professional services referenced in Medicaid reimbursement claims. The court, in interpreting the applicable policy's requirement that the claim "arise[] out of" a medical incident for coverage, noted that failure to render medical services constituted a covered "medical incident" and that the failure to render services "[bore] a causal relationship to the [false] billing," entitling Affinity to coverage.[28]

To recap, when assessing PSL insurance coverage, parties should review the policy carefully. In the context of FCA coverage matters, courts have addressed those actions that constitute the rendering of "professional services" and thus are insurable by PSL insurance. As indicated in *IberiaBank*, stakeholders should consider what, if any, specific language defines what qualifies as "professional services" and consider whether work falls within such a classification. For example, if the policy requires that consideration be exchanged for work to be considered "professional services" and eligible for PSL insurance, an assessment may consider whether such an exchange for consideration from the government occurred. Further, as indicated in the Fourth Circuit cases, an assessment may consider whether actions implicate exposure to potential FCA liability arising from the demands of a job that requires specialized knowledge or skill, or whether such actions constitute a peripheral business, marketing, or operational activity. If the former, the activity might be coverable under PSL insurance, whereas if the latter, the activity might not be.

Broad Exclusions & Denials of Coverage

Recent case law has also addressed issues concerning the broad denial of coverage for FCA matters, both in the context of policy drafting and coverage determination. According to some decisions, broad language in an insurance policy limiting coverage might be enforceable. In adjudicating coverage of an FCA claim, the Ninth Circuit in *Office Depot v. AIG Specialty Insurance* found an exclusion in an insurance policy that precluded coverage for any claim "alleging, arising out of or resulting, directly or indirectly, from any liability or obligation under *any contract or agreement* or out of any breach of contract" to be permissible,[29] but noted the "uncomfortable breadth" of the

exclusion. The court found that because the FCA suit was premised on Office Depot's contractual obligations, its losses in connection with the suit were not covered by the policy.

Courts in some cases have found policy language to reflect broad coverage exclusions and to be ambiguous, and have interpreted some such policy language in favor of coverage. For instance, in *Guaranteed Rate*, the court found that where the applicable policy did not define "Professional Services," the Professional Services "Exclusion must be interpreted narrowly in favor of coverage," and concluded that the Professional Services Exclusion did not apply to prevent coverage.[30] Separately, the insurer in *Guaranteed Rate* argued that a CID issued to the policyholder by the federal government in connection with FCA allegations did not constitute a "Claim" pursuant to the applicable insurance policy, despite the fact that the policy defined the term "Claim" to include "a civil, administrative or regulatory investigation against the Insured." The court, however, disagreed, finding that the policy language at issue in *Guaranteed Rate* was consistent with the language at issue in an earlier case where the court had also deemed a CID to constitute a "Claim" pursuant to an applicable insurance policy.

Takeaways

Stakeholders should consider the following when considering a new insurance policy:

When Negotiating Insurance Policies

- Consider the language in potential exclusions and what, if any, implications might follow from language that might limit or preclude coverage for liability arising out of "any contract or agreement."
- Assess the policy's notice requirement language, including whether language specifies that notice requirements are premised on when a specific individual becomes aware of a claim, or includes a particular definition of "claim" that specifies when the claim is considered initiated for purposes of the policy.
- Whether fraud exclusions exist for the policy that might be relevant to coverage for losses attributed to FCA fraud-related allegations.

Regarding Receipt of Information or Requests Relating to an Ongoing FCA Investigation:

- Consider whether the insured has provided early disclosure to the insurer. Assess whether CIDs served on a company might indicate an FCA investigation.
- Consider the allegations and whether they fall within the scope of policies.

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[1] DOJ, FRAUD STATISTICS – OVERVIEW (updated Jan. 14, 2021), https://www.justice.gov/opa/press-release/file/1354316/download.

[2] *Id.*

[3] Exec. Order No. 14028, 86 Fed. Reg. 26,633 (May 12, 2021), https://www.federalregister.gov/documents/2021/05/17/2021-10460/improving-the-nations-cybersecurity.

[4] 31 U.S.C. § 3729 (2018).

[5] DOJ, GLAXOSMITHKLINE TO PLEAD GUILTY AND PAY $3 BILLION TO RESOLVE FRAUD ALLEGATIONS AND FAILURE TO REPORT SAFETY DATA (JULY 2, 2012), https://www.justice.gov/opa/pr/glaxosmithkline-plead-guilty-and-pay-3-billion-resolve-fraud-allegations-and-failure-report.

[6] DOJ, JOHNSON & JOHNSON TO PAY MORE THAN $2.2 BILLION TO RESOLVE CRIMINAL AND CIVIL INVESTIGATIONS (Nov. 4, 2013), https://www.justice.gov/opa/pr/johnson-johnson-pay-more-22-billion-resolve-criminal-and-civil-investigations.

[7] DOJ, BANK OF AMERICA TO PAY $16.65 BILLION IN HISTORIC JUSTICE DEPARTMENT SETTLEMENT FOR FINANCIAL FRAUD LEADING UP TO AND DURING THE FINANCIAL CRISIS (Aug. 21, 2014), https://www.justice.gov/opa/pr/bank-america-pay-1665-billion-historic-justice-department-settlement-financial-fraud-leading.

[8] 31 U.S.C. § 3729 (2018).

[9] Exec. Order No. 14028, 86 Fed. Reg. 26,633 (May 12, 2021), https://www.federalregister.gov/documents/2021/05/17/2021-10460/improving-the-nations-cybersecurity.

[10] DOJ, DEPUTY ATTORNEY GENERAL LISA O. MONACO ANNOUNCES NEW CIVIL CYBER-FRAUD INITIATIVE (Oct. 6, 2021), https://www.justice.gov/opa/pr/deputy-attorney-general-lisa-o-monaco-announces-new-civil-cyber-fraud-initiative.

[11] 31 U.S.C. § 3729.

[12] *Astellas US Holdings, Inc. v. Starr Indemnity & Liability Co.*, No. 17-cv-08220, 2021 WL 4711503 (N.D. Ill. Oct. 8, 2021).

[13] *Id.* at *21-22 (discussing *RSUI Indem. Co. v. Murdock*, 248 A.3d 887 (Del. 2021)).

[14] *See PAMC, Ltd. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 2019 WL 666726 at *2 (C.D. Cal. Feb. 12, 2019); 31 U.S.C. § 3730(b)(2) (2018).

[15] DOJ, FRAUD STATISTICS – OVERVIEW, (updated Jan. 14, 2021), https://www.justice.gov/opa/press-release/file/1354316/download.

[16] *PAMC*, at 2019 WL 666726 at *1-2.

[17] *See Springstone, Inc. v. Hiscox Ins. Co., Inc.,* No. 20-6014, 2021 WL 4240779 at *2 (6th Cir. Sept. 17, 2021) (holding that under the applicable policy, a claim was "made" when it was filed); *AmerisourceBergen v. ACE American Ins. Co.*, 100 A.3d 283, 288-89, 291 (Pa. Sup. Ct. 2014) (precluding coverage for costs incurred in defending against an FCA *qui tam* action under a "Prior or Pending Litigation" exclusion, noting that litigation had been filed with the court prior to the applicable policy's effective date); *HR Acquisition I Corp. v. Twin City Fire Ins. Co.*, 547 F.3d 1309, 1317-19 (11th Cir. 2008) (precluding coverage under a "prior litigation" exclusion, and noting that for the exclusion to apply, the action need only be "pending" or "exist" – service need not have been made).

[18] *PAMC, Ltd. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 2019 WL 666726 (C.D. Cal. Feb. 12, 2019).

[19] *Id.* at *2.

[20] *See Springstone*, 2021 WL 4240779 at *2; *AmerisourceBergen v. ACE American Ins. Co.*, 100 A.3d 283, 288-89 (Pa. Sup. Ct. 2014); *HR Acquisition I Corp. v. Twin City Fire Ins. Co.,* 547 F.3d 1309, 1317 (11th Cir. 2008).

[21] *AmerisourceBergen v. ACE American Ins. Co.*, 100 A.3d 283, 288-89 (Pa. Sup. Ct. 2014).

[22] *Springstone*, 2021 WL 4240779 at *2.

[23] *SHH Holdings v. Allied World Specialty Ins. Co.*, 2020 WL 7385384 (N.D. Ohio, Dec. 16, 2020).

[24] *IberiaBank Corp. v. Illinois Union Ins. Co.*, 953 F.3d 339, 344 (5th Cir. 2020).

[25] *See Affinity Living Group, LLC v. StarStone Specialty Insurance Co.*, 959 F.3d 634, 639-43 (4th Cir. 2020); *see also Church Mut. Ins. Co. v. Lake Pointe Assisted Living, Inc.*, 517 F. Supp. 3d 467, 476-79 (E.D.N.C. 2021) (distinguishing *Affinity* and holding that business, marketing, and operational activities involved in running an adult care facility were "not the type of health-care professional service contemplated by the parties when the [] policy was issued," but ultimately finding that the policyholders were entitled to coverage for other reasons).

[26] *Church*, 517 F. Supp. 3d at 478-79.

[27] *Affinity*, 959 F.3d at 639-43.

[28] *Id.*

[29] *Off. Depot, Inc. v. AIG Specialty Ins. Co.*, 829 F.App'x 263, 263 (9th Cir. 2020) (emphasis added) (internal quotations omitted).

[30] *Guaranteed Rate, Inc. v. ACE Am. Ins. Co.*, No. CVN20C04268MMJCCLD, 2021 WL 3662269, at *4 (Del. Super. Ct. Aug. 18, 2021).

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