SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

HON. SALIANN SCARPULLA

PRESENT: _____ **PART** 39
Justice

Index Number : 650339/2011
CERTAIN UNDERWRITERS AT
vs.
HURON CONSULTING GROUP, INC.
SEQUENCE NUMBER : 006
SUMMARY JUDGMENT

INDEX NO. _____
MOTION DATE _____
MOTION SEQ. NO. _____

The following papers, numbered 1 to _____, were read on this motion to/for _____

Notice of Motion/Order to Show Cause — Affidavits — Exhibits _____ **No(s).** _____

Answering Affidavits — Exhibits _____ **No(s).** _____

Replying Affidavits _____ **No(s).** _____

Upon the foregoing papers, it is ordered that this motion is

motion and cross-motion are decided in accordance with accompanying memorandum decision.

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE FOR THE FOLLOWING REASON(S):

Dated: 4/16/14

_____, J.S.C.
HON. SALIANN SCARPULLA

1. **CHECK ONE:** ..... [X] CASE DISPOSED [ ] NON-FINAL DISPOSITION
2. **CHECK AS APPROPRIATE:** .....**MOTION IS:** [ ] GRANTED [ ] DENIED [ ] GRANTED IN PART [X] OTHER
3. **CHECK IF APPROPRIATE:** ..... [ ] SETTLE ORDER [ ] SUBMIT ORDER
[ ] DO NOT POST [ ] FIDUCIARY APPOINTMENT [ ] REFERENCE

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: IA PART 39

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CERTAIN UNDERWRITERS AT LLOYD'S LONDON SUBSCRIBING TO POLICY NO. QK0903325,

Plaintiffs,

v.

HURON CONSULTING GROUP, INC., HURON CONSULTING GROUP LLC and HURON CONSULTING SERVICES, LLC,

Defendants.

DECISION and ORDER
Index No. 650339-2011
Motion Seq. No. 06

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HON. SALIANN SCARPULLA, J.:

This is a declaratory judgment action brought by plaintiffs Certain Underwriters at Lloyd's London subscribing to Policy No. QK0903325 ("Underwriters") to determine their obligations under a professional liability policy to defend and indemnify defendants Huron Consulting Group, Inc. ("Huron"), Huron Consulting Group LLC and Huron Consulting Services, LLC (the "Huron entities") in connection with a False Claims Act lawsuit premised upon excessive Medicaid and Medicare billing, titled *United States of America, the State of New York Ex. Rel. Associates Against Outlier Fraud v. Huron Consulting Group, et al*, No. 09-01800 (SDNY) (the "Outlier Action"). Underwriters move for summary judgment. Huron opposes the motion and cross moved for summary judgment. Insofar as the underlying Outlier Action was dismissed while this motion was

pending, the only issue is whether Underwriters must reimburse Huron for approximately $2 million in defense costs, less the applicable deductible.

Background

The Policy

Underwriters issued to the Huron Entities a primary Professional and Technology Based Services, Technology Products, Computer Network Security, and Multimedia and Advertising Liability Insurance Policy, Policy No. QK0903325 (the "Policy"), with a claims-made-and-reported policy period of July 16, 2009 to July 16, 2010. The Policy provides limits of $10 million for each claim and in the aggregate, inclusive of Claims Expenses, subject to a deductible of $750,000 each Claim. The Policy defines "Insured" to include the Named Insured, Huron, and any Subsidiaries of the Named Insured, which include Huron Consulting Group LLC and Huron Consulting Services.

The Policy includes several insuring clauses which define the scope of coverage afforded to the Huron Entities. Insuring Clause A, "Professional Services or Technology Based Services Coverage," provides that Underwriters will:

> pay on behalf of any Insured: Damages and Claims Expenses, in excess of the Each Claim Deductible, which the Insured shall become legally obligated to pay because of any Claim first made against any Insured and reported in writing to the Underwriters during the Policy Period or Optional Extension Period (if applicable) arising out of any negligent act, error or omission, or any unintentional breach of contract, in rendering or failing to render Professional Services or Technology Based Services on or after the Retroactive Date set forth in the Schedule and before the end of the Policy Period by the Insured or by any person, or organization, including an

> independent contractor, for whose negligent act, error or omission or unintentional breach of contract the Insured Organization is legally responsible.

(Policy, Section I.A). Among the categories of services constituting "Professional Services" is "Health and Educational Consulting," defined as follows:

> Health and Educational Consulting, consisting of pharmaceutical and health plan consulting on operational, compliance and contracting issues related to federal healthcare programs, including federal healthcare contract consulting, medical cost containment consulting, operational and financial advisory and regulatory compliance services; health care consulting for providers and payors providing assessment and implementation solutions to reduce costs and increase effectiveness, higher education consulting providing operational consulting to colleges, universities, hospitals and academic medical centers in the areas of research administration; regulatory compliance, clinical research, technology planning and implementation and financial management and strategy.

(Policy, Section VI.V).

Under the Policy, a "Claim" is defined to include "a written demand received by any Insured for money or services, including the service of a suit or institution of arbitration proceedings" (Policy, Section VI.G.1). The Policy imposed upon Underwriters "the duty to defend . . . any Claim against the Insured seeking Damages which are payable under the terms of this Policy, even if any of the allegations of the Claim are groundless, false or fraudulent" (Policy, Section II.A.1). The parties agreed that Illinois law would govern any disputes under the Policy (Policy Section XXVI and Schedule to Policy).

The Policy also sets forth two exclusions that are relevant here. Exclusion "A" in the Policy provides that:

> The coverage under this Insurance does not apply to Damages, Penalties or Claims Expenses in connection with or resulting from any Claim, or to any Privacy Notification Costs: Arising out of or resulting from any criminal, dishonest, fraudulent or malicious act, error or omission committed by any Insured; however, this Policy shall apply to Claims Expenses incurred in defending any such Claim alleging the foregoing until such time as there is a final adjudication, judgment, binding arbitration decision or conviction against the Insured, establishing such criminal, dishonest, fraudulent or malicious conduct, or a plea of nolo contendere or no contest regarding such conduct, at which time the Named Insured shall reimburse the Underwriters for all Claims Expenses incurred defending the Claim and the Underwriters shall have no further liability for Claims Expenses.

(Policy, Section V.A). Exclusion "N" states:

> The coverage under this Insurance does not apply to Damages, Penalties or Claims Expenses in connection with or resulting from any Claim, or to any Privacy Notification Costs: Brought by or on behalf of the Federal Trade Commission, the Federal Communications Commission, or any federal, state, local or foreign governmental entity, in such entity's regulatory or official capacity.

The Outlier Action

The Outlier Action was filed in the United States District Court for the Southern District of New York (Rakoff, J.) under seal in February 2009 by relator Associates Against Outlier Fraud ("Relator"), an entity entirely owned by Steven Landgraber,

against Huron and other parties, including Empire Health Choice Assurance, Inc. ("Empire"). On March 18, 2011, the Relator filed a third amended complaint ("TAC"), which is the operative pleading in the Outlier Action.

The Outlier Action arises out of work performed by the Huron Entities and the consulting firm of Speltz & Weis ("S&W") on behalf of St. Vincent's Hospital ("St. Vincent's") in New York. St. Vincent's had retained S&W in 2004 to help reverse its failing finances. As concerns the Huron Entities, Relator asserts claims against them under the *qui tam* provisions of the Federal False Claims Act, 31 U.S.C. §§ 3729-33, ("FCA" or "False Claims Act" or "Act"), and the analogous False Claims Act of the State of New York ("NYS"), for submitting allegedly false and/or fraudulent reimbursement claims and statements to the United States and New York State in 2005 and 2006.

Medicare and Medicaid make supplemental payments to hospitals, called "outlier" payments, for in-patients whose costs of treatment are unusually high. Outlier payments are calculated by employing a ratio of "costs to charges" ("RCC"). If the RCC is higher than it should be, because it does not reflect recent increases in the hospital's charges, an over-reimbursement to the hospital may result. In 2003, CMS changed it regulations to require the use of updated RCCs in recognition that some healthcare providers were using the older ones to inflate their outlier payments.

The government contracts with insurance companies, known as "fiscal intermediaries" ("FIs") to administer the Medicare program. Hospitals such as St. Vincent's were required to submit their charges for patient treatments to an FI for approval. The FI was responsible for determining the correct RCC to be applied to each bill. For many years, including 2005 and 2006, Empire served as St. Vincent's FI and was required to monitor and approve or disapprove the hospital's outlier claims.

The TAC alleges that St. Vincent's increased its charges 75% in 2005 to take advantage of the increased outlier payments it would receive if the RCC in effect in 2003 was applied. It further alleges that hospital received hundreds of millions of dollars in additional payments in 2005 and 2006 due to its billing practices. The hospital's charges for that period on its Manhattan campus were seven times more than those billed in 2003-2004 and other locations experienced similar increases. As demonstrated by St. Vincent's actual RCC during 2005-2006, its charges increased disproportionately to its costs.

The TAC alleges that Huron managers knew that a repayment of some or all of the unlawfully received outlier funds might become necessary if the government discovered the outlier overpayments. Accordingly, under Huron's supervision, St. Vincent's calculated an estimate for the overpayments and allocated them to a "'liability' reserve account." The Relator alleges he was instructed to maintain a second set of non-public books order to keep track of the excess payments and to keep an accounting of what reimbursement might need to be made if the fraud was discovered. A letter was written

to Medicare advising the agency that the RCC might not be accurate and should be reviewed, but it drew no response and the overpayments continued.

The TAC further alleges that Empire facilitated the hospital's receipt of unjustified outlier payments by failing to monitor the charges and apply the proper RCC. It is additionally alleged that Empire acted fraudulently and with reckless disregard, authorizing payments from Medicare while ignoring CMS' warnings, applying the wrong RCC, and disregarding the exponential increase in outlier payments. Because of Empire's malfeasance, the Government made over $30 million in unjustified outlier payments. Relator alleges that Empire had sufficient and voluminous information to realize that it should have rejected the claims for payment, but overlooked the obvious anomalies in the hospitals charges and billing protocols.

On January 6, 2010, the United States provided notice that it declined to intervene in the case at that time but reserved the right to do so in the future should developments warrant. However, it demanded that the parties seek its prior written consent for any dismissal, settlement or discontinuance of the action, and that all pleading filed in the action be served upon it. The Court entered an order effecting the government's conditions on January 12, 2010.

By order dated March 13, 2013, the District Court dismissed the Outlier Action with prejudice. After reviewing a CMS decree in the Federal Register, the relevant sections of the Code of Federal Regulations, and Medicare's Provider Reimbursement Manual, Judge Rakoff stated:

> The Court concludes that not one of these provisions, nor all of them read together, establish a "proportionality" rule for charge adjustment. Nor do any of these provisions establish that submission of charges to Medicare when a facility's cost-to-charge ratio is stale is per se unreasonable and therefore false or fraudulent under the FCA. Moreover, discovery has, if anything, completely disproved the Complaint's allegations that relator's interpretation of these provisions is "universally recognized" or that it accords with some standardized practice. As for the Complaint's more sensational allegation that St. Vincent's maintained a surreptitious hidden ledger to track its "illicit" profits from outlier payments, discovery has established that St. Vincent's simply tracked its outlier as a potential liability and made the data available both to Empire and its auditor KPMG. There is, in sum, no law, rule, regulation, or fact rendering Huron's submission of outlier-producing bills under these circumstances false or fraudulent.

U.S. v Huron Consulting Group, Inc., 929 F. Supp. 2d 245, 254 (S.D.N.Y 2013) (citations omitted).

Discussion

A movant seeking summary judgment must make a *prima facie* showing of entitlement to judgment as a matter of law and offer sufficient evidence to eliminate any material issues of fact. *Winegrad v. New York Univ. Med. Ctr.*, 64 N.Y.2d 851, 853 (1985). Once a showing has been made, the burden shifts to the opposing party to demonstrate the existence of a triable issue of fact. *Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 324 (1986); *Zuckerman v. City of New York*, 49 N.Y.2d 557, 562 (1980).[1]

[1] The parties agreed that Illinois law would govern any disputes under the Policy. However, "[c]hoice of law provisions typically apply to only substantive issues." *Portfolio Recovery Assocs., LLC v. King*, 14 N.Y.3d 410, 416 (2010). "[P]rocedural matters are governed by the law of the forum," in this case New York. *Tanges v. Heidelberg N. Am., Inc.*, 93 N.Y.2d 48, 53 (1999). "As summary judgment is often

The Underwriters bases their motion for summary judgment and disclaiming coverage on three arguments: (1) the Policy does not cover FCA claims arising from the intentional and fraudulent Medicaid and Medicare billing practices alleged by the TAC; (2) the alleged billing practices did not fall within the meaning "Professional Services" as defined by the Policy; and (3) coverage is precluded by Exclusion N, because the FCA action was brought on behalf of governmental agencies in their regulatory or official capacities. None of these contentions has merit.

Under Illinois law, the interpretation of an insurance policy is governed by the general rules applicable to contracts. *Standard Mut Ins Co. v Lay,* 2013 IL 114617, 989 NE2d 591 (2013); *Hobbs v Hartford Ins Co. of the Midwest*, 214 Ill2d 11, 823 NE2d 561 (2005). The court's "primary objective is to ascertain and give effect to the intention of the parties, as expressed in the policy language." *Hobbs*, 214 Ill2d 11, 17. "In order to ascertain the meaning of the policy's language and the parties' intent, the court must construe the policy as a whole and take into account the type of insurance purchased, the nature of the risks involved, and the overall purpose of the contract." *Travelers Ins Co. v Eljer Mfg, Inc.*, 197 Ill2d 278, 292, 757 N.E.2d 481 (2001) (citations and internal quotations omitted).

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referred to as the 'procedural equivalent of a trial' (*Dykeman v Heht* 52 AD3d 767 [2d Dept. 2008]) and as a 'procedural device' (*Matter of Tradale CC*, 52 AD3d 900 [2d Dept. 2008], the Court will apply New York law with respect to the burdens applicable to the movant and opponent." *NEC Fin. Servs., Inc. v. First Fidelity Mtge. Group, Ltd*, 2009 NY Misc. LEXIS 5859, at *1-2 (Sup. Ct. Nassau Co. 2009).

The insurer's duty to defend arises when "the facts alleged in the underlying complaint fall within, or potentially within, the policy's coverage." *Pekin Ins Co. v Wilson,* 237 Ill2d 446, 455, 930 NE2d 1011, 1017 (2010). However, "the duty to defend does not require that the complaint allege or use language affirmatively bringing the claims within the scope of the policy." *Intern. Ins Co. v Rollprint Packaging Prods, Inc.*, 312 Ill App 3d 998, 1007, 728 NE2d 680, 683 (1st Dist 2000). Rather, a defense must be provided unless the facts pled in the underlying action "preclude any possibility of coverage." *Illinois Emcasco Ins Co. v Northwestern Nat Cas Co.,* 337 Ill App 3d 356, 785 NE2d 905, 910 (1st Dist 2003). This is true even if "only one of several theories of recovery alleged in the complaint falls within the potential coverage of the policy." *Valley Forge Ins Co. v Swiderski Electronics, Inc.*, 223 Ill 2d 352, 363, 860 NE2d 307, 315 (2006). The insurer may also consider facts alleged in other pleadings, *Pekin,* 237 Ill2d 446, 930 NE2d 1011, or true but unpled facts that may be in its possession. *Shriver Ins Agency v Utica Mut Ins Co.*, 323 Ill App 3d 243, 247, 750 NE2d 1253, 1256 (2d Dist 2001).

Where the policy language is unambiguous it will be applied as written, unless it contravenes public policy. *Hobbs*, 214 Ill2d 11, 17; *Menke v Country Mut Ins Co.*, 78 Ill.2d 420, 423, 401 N.E.2d 539, 541 (1980). Ambiguous language, however, will be construed against the insurer who drafted the policy. *Outboard Marine Corp. v Liberty Mut Ins. Co.*, 154 Ill2d 90, 607 NE2d 1204 (1992). An ambiguity exists where the language is subject to more than one reasonable interpretation, *id.*, but the court will not

strain to find an ambiguity where none exists. *McKinney v Allstate Ins Co.*, 188 Ill2d 493, 497, 722 N.E.2d 1125, 1127 (1999). "Although policy terms that limit an insurer's liability will be liberally construed in favor of coverage, this rule of construction only comes into play when the policy is ambiguous." *Menke*, 78 Ill 2d 420.

With respect to Underwriters' duty to defend, the only obligation at issue here, Exclusion A unambiguously requires the payment of Claims Expenses incurred in actions alleging criminal, dishonest, fraudulent or malicious conduct, until such time as the insured has been finally adjudicated to have engaged in such intentional wrongdoing. Underwriters nevertheless argues that this language must be disregarded under the rule that an exclusion may not "create coverage" where none exists within the insuring agreement. As coverage is only triggered in the first instance by a negligent act, omission or error, plaintiffs urge, Exclusion A may not be read to expand Huron's rights. This argument fails for several reasons.

First, Exclusion A does not "create coverage" for intentional wrongdoing. By its terms, an insured who is actually held to have engaged in such conduct will neither be indemnified for any resulting judgment, nor freed from defense expenses. The exclusion merely provides that the insurer will advance defense costs – subject to recoupment in full should the insured be adjudged liable for the prohibited acts. In the final analysis, only an insured who acts negligently will ultimately recover anything from the insurer.

Second, although there is a general rule against expanding coverage through an exclusion, or an exception to an exclusion, *see Knezovich v Hallmark Ins. Co.*, 2012 IL

App (1st) 111677, 975 NE2d 1165, 1172 (1st Dist 2012), *Continental Cas Co. v Donald T. Bertucci, Ltd.*, 399 Ill App 3d 775, 926 NE2d 833 (1st Dist 2010), *Stoneridge Dev Co. v Essex Ins Co.*, 382 Ill.App3d 731, 888 NE2d 633 (2d Dist 2008), the principle is not inflexible. The language of an exclusion may be employed to inform the court's determination of the scope of coverage, "in light of the overriding principle to construe the policy as a whole and the notion that a policy must not be interpreted in a manner that renders provisions of the contract meaningless." *Landmark Amer Ins Co. v NIP Group, Inc.*, 2011 IL App (1st) 101155, 962 NE2d 562 (1st Dist 2011) (citations and internal quotations omitted).

Exclusion A, read together with the Policy's promise to defend against even groundless, false or fraudulent claims, evinces an unambiguous intent to afford a defense (at least temporarily) for claims of intentional conduct. Indeed, any other interpretation of the Policy would render the exclusion's reference to Claims Expenses for criminal, dishonest, fraudulent or malicious acts, errors or omissions completely meaningless. This would "offend[] a well-settled principle of contract construction: a contract must not be interpreted in a manner that nullifies provisions of that contract." *Atwood v. St. Paul Fire & Marine Ins. Co.*, 363 Ill. App. 3d 861, 864 (2d Dist. 2006). *See also Cincinnati Ins. Co. v. Gateway Constr. Co.*, 372 Ill. App. 3d 148, 152 (1st Dist 2007) ("[a] policy must not be interpreted in a manner that renders provisions of the policy meaningless").

The cases relied upon by Underwriters on this point do not compel a different conclusion. In *Lyerla v Amco Ins Co.*, 2007 WL 2229867 (SD Ill 2007), the court

declined to examine an exception to an exclusion allowing for coverage for a subcontractor's work, where there was no threshold allegation of an "occurrence" or "property damage" under the policy. In *Executive Risk Indem, Inc. v Chartered Benefit Services, Inc.*, 2005 WL 1838433 (ND Ill 2005), the court held that an exclusion that permitted recovery for incidents of which the insured had some notice prior to the policy's renewal date, did not permit recovery where an actual claim had been made during the prior policy period. Neither case involved an exclusion or any other policy clause that directly and unambiguously defined the insurer's defense payment obligations with respect to the particular category of allegations at issue.

In view of this determination, the parties' extended discussion of whether the FCA claims fall within the Policy's negligence coverage is academic. Underwriters were required to pay the Claims Expenses incurred in defending allegations of both negligent and intentional conduct, and was entitled to reimbursement only if the *Outlier* plaintiff prevailed. As the Outlier action was dismissed with prejudice, with the court specifically finding that Huron's billing practices were not false or fraudulent, Underwriters remain liable for those expenses.

Furthermore, the FCA claims would be covered even if Exclusion A were inapplicable. "[A]lleged deliberate misconduct does not always bring a claim within an intentional conduct exclusion." *Cincinnati Ins Co. v American Hardware Mfrs Assoc*, 387 Ill App 3d 85, 113, 898 NE2d 216, 240 (1st Dist 2008). As Underwriters acknowledged at oral argument, an FCA claim may be based upon reckless disregard, *see*

31 U.S.C. § 3729(b)(1), which is "an extension of gross negligence" or an "extreme version of ordinary negligence." *U.S. v King-Vassel*, 728 F3d 707, 712-13 (7th Cir 2013). Such negligence may be found "when the actor knows or has reason to know of facts that would lead a reasonable person to realize that harm is the likely result of the relevant act." *King-Vassel*, 728 F3d 707, 713 (citations and internal quotations omitted). The FCA does not require an intentional lie to trigger liability, *U.S. ex rel. Plumbers & Steam. v C.W. Roen Const.*, 183 F.3d 1088, 1092 (9th Cir1999), and no proof of specific intent to defraud is necessary. *See* 31 § 3729(b)(1); *U.S. ex rel. Kreindler & Kreindler v United Technologies Corp.*, 985 F2d 1148, 1152 (2d Cir 1993). Accordingly, Underwriters' reliance on cases holding that FCA claims may not be founded upon "mere" negligence is misguided, as such claims can be based upon other, more heightened forms of negligence and thus fall within the coverage of the Policy.

Liberally construed, the factual allegations of the TAC are consistent with a negligence theory of reckless disregard. Although much of its language characterizes Huron's conduct as part of an intentional conspiracy, an alternate reading supporting the lesser showing of recklessness under the FCA is reasonable. As noted, the TAC alleges that Empire, not Huron, was ultimately responsible for calculating the correct charges to be billed to the government. Huron merely supplied the relevant data to Empire, and allegedly did so "openly," and there is no allegation that the information it supplied misrepresented the actual charges billed to patients. Although the TAC alleges that Huron employed a stale RCC, it also notes that the government was advised of this fact

and did not take any action. It further alleges that Empire had sufficient information to determine that the outlier claims should be denied. Accordingly, the TAC could reasonably be interpreted as asserting that Huron negligently failed to take steps to insure that Empire correctly submitted claims based on the data supplied, or negligently failed to insure that overpayments were returned.

More significantly, the TAC's allegations of fraud are ultimately premised upon Huron's reliance on an outdated RCC. However, as confirmed by Judge Rakoff, there is no law, rule or regulation defining what increase in charges is permissible, or what ratio of costs to charges is reasonable, or prohibiting the submission of charges to the government when an RCC is stale. *See Huron*, 929 F Supp 2d 245, 254; *Boca Raton Comm. Hosp., Inc. v Tenet Healthcare Corp.*, 238 FRD 679, 689 (SD Fla.2006) (denying class certification in part because "CMS has never taken a position on what level of overcharging is unlawful or unreasonable"). Accordingly, the TAC's repeated allegations that Huron was acting fraudulently fail as a matter of law, as Huron could not have intentionally violated standards which lacked any legal status or definition.

Steadfast Ins Co. v Caremark Rx, Inc., 359 Ill App 3d 749, 835 NE2d 890 (1st Dist 2005), relied on by Underwriters, does not control the outcome of this case. The *Caremark* court considered a complaint which alleged "a hidden scheme to deliberately convert a portion of the [ERISA] Plan's assets by conspiring with drug manufacturers in exchange for kickbacks." *Caremark Rx, Inc.*, 359 Ill App 3d 749, 758, 835 NE2d 890, 898 and found that no facts were alleged to support any theory of negligence. In contrast,

the TAC at issue here does set forth sufficient facts supporting a recklessness theory under the FCA. Moreover, as discussed above, a conclusion that Huron's conduct was intentional is legally foreclosed by the absence of any law defining its alleged wrongdoing.

Coverage is also not defeated by Exclusion N's bar against actions brought by or against government entities in their regulatory or official capacities. Although some courts have characterized *qui tam* actions under the FCA as being brought "on behalf" of the government, *see Vt Agency of Nat 'l Res v Stevens*, 529 US 765, 773-74 (2000); *Woods v Empire Health Choice, Inc.,* 574 F.3d 92, 97-98 (2d Cir. 2009); *United Seniors Assoc. v Philip Morris USA*, 500 F3d 19, 24 (1st Cir 2007), it is also true that "[*q*]*ui tam* relators pursue their claims essentially as private plaintiffs, except that the government may displace a relator as the party with primary authority for prosecuting an action." *U.S. ex rel. Kelly v Boeing Co.,* 9 F3d 743, 760 (9th Cir 1993). In this case, the government declined to participate as a party. Accordingly, construing the clause narrowly and in favor of the insured, the court finds that Exclusion N does not bar coverage in FCA actions which are pursued by private parties without government intervention.

This interpretation is bolstered by the exclusion's additional requirement that the government entity must be functioning in its official or regulatory capacity. While Underwriters argue that FCA actions further the government's regulatory and official objectives, that would be true of any action that could be brought on its behalf, and thus render the qualification illusory. Limiting the exclusion to actions in which the

government has an active, participatory role in enforcing its statutory rights, however, would draw a meaningful distinction between lawsuits that are brought in a regulatory or official capacity, and those that are not. At a minimum, this reading of the clause is a reasonable one, so even if the exclusion is ambiguous the interpretation favoring the insured should be adopted.

Although there is a dearth of case law on this particular issue, the decisions in which similar or analogous exclusions have been enforced are easily distinguishable. For example, in *Amer Cas Co. of Reading, Pennsylvania v FDIC*, 39 F3d 633 (6th Cir 1994), the court found that the action was brought "on behalf" of the FDIC even though that agency was not the party which commenced it. However, the policy contained additional language excluding "any type of legal action which such Agencies have the legal right to bring as receiver, conservator, liquidator or otherwise," thus specifically relieving the FDIC of any obligation to participate. Moreover, the policy did not contain the additional qualifying language here, mandating that the suit be brought in an official or regulatory capacity. *See also Pierce Food Service Equipment Co., Inc. v Amer Economy Ins Co.*, 2011 WL 10457851, *1-3 (2d Dist 2011) (policy exclusion for damages by reason of "[s]eizure or destruction of property by order of governmental authority" applied where property was damaged in the course of a search conducted pursuant to a warrant issued by a judge, notwithstanding insured's contention that warrant was based upon false statements that the property was stolen).

Finally, even if the Outlier action were in some sense brought "on behalf" of the government, and even had the government chosen to participate, that would not change the fact that it was *also* brought on behalf of the private plaintiff so as to trigger coverage of the entire action. The Policy defines a claim as a "demand for money or services" and the Relator demands damages for his own account under the FCA.

Underwriters' last contention, disputing that Huron's alleged negligence arose in connection with its rendering of professional services, merits little discussion. The Policy states that such services include health and educational consulting, which in turn includes operational and financial advisory and regulatory compliance services. The TAC alleges that Huron was required to render managerial and administrative services in connection with the hospital's turnaround and that the challenged billing practices clearly arose out of Huron's consultancy. These allegations fit squarely within the Policy's definition of professional services.

The cases cited by Underwriters to suggest otherwise are inapposite. In *Zurich American Ins. Co. v O'Hara Regional Center for Rehabilitation*, 529 F3d 916, 921-22 (10th Cir 2008), the defined services were "Professional Nursing or Medical Services." Because the alleged fraudulent reimbursement billing practices did not involve the rendering of nursing or medical care, the court rejected the hospital's coverage claim. *In Med Records Assocs, Inc. v Amer. Empire Surplus Lines Ins Co.*, 142 F3d 512 (1st Cir 1998), where the Policy described the professional services as "Medical Records Processor," but contained no definition of that term, the court found that the aspect of the

insured's work which involved copying and charging for medical records involved no particular skill or knowledge rising to the level of professionalism. Similarly, in *Horizon West Inc. v St. Paul Fire and Marine Ins. Co.,* 214 F Supp 2d 1074 (ED Cal 2002), relying on *Med Records Assocs*, the court, in the apparent absence of any policy provision defining the scope of the insured professional services, held that the mere submission of Medicare and Medicaid claims "constitute[d] anything other than ordinary activities achievable by those lacking the relevant professional training and expertise." *Horizon West,* 214 F Supp 2d 1074, 1079. In contrast, here the Policy expressly defines Huron's professional services, which clearly encompass the complex financial services out of which the claims arose.

Accordingly, the Huron Entities' motion for summary judgment is granted and Underwriters' motion is denied.

In view of the conclusions above regarding the availability of coverage under the Policy, it is unnecessary to address Huron's further argument that Underwriters are estopped from raising coverage defenses by virtue of its allegedly unreasonable delay in raising them.

In accordance with the foregoing it is

ORDERED, that the motion for summary judgment of Certain Underwriters at Lloyd's London Subscribing to Policy No. Qk0903325 is denied, and it is further,

ORDERED, that the cross motion for summary judgment of Huron Consulting Group, Inc., Huron Consulting Group LLC and Huron Consulting Services, LLC is granted, and it is further

ADJUDGED AND DECLARED that Certain Underwriters at Lloyd's London Subscribing to Policy No. Qk0903325 are obliged to pay defendants Huron Consulting Group, Inc., Huron Consulting Group LLC and Huron Consulting Services, LLC Claims Expenses in connection with the defense of the action titled *United States of America, the State of New York Ex. Rel. Associates Against Outlier Fraud v. Huron Consulting Group, et al*, No. 09-01800 (S.D.N.Y.).

Settle Judgment.

Dated: New York, New York
May 9, 2014

ENTER:

Saliann Scarpulla, J.S.C.