No. 21-3075

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

ASTELLAS US HOLDING, INC. and ASTELLAS PHARMA US, INC.,

Plaintiffs and Appellees,
v.

FEDERAL INSURANCE COMPANY,

Defendant and Appellant

On Appeal from the United States District Court
for the Northern District of Illinois
Case No. 17-cv-08220 Hon. Franklin U. Valderrama, District Judge

---

MOTION FOR LEAVE TO FILE BRIEF AS AMICUS CURIAE BY COALITION AGAINST INSURANCE FRAUD IN SUPPORT OF DEFENDANT-APPELLANT FEDERAL INSURANCE COMPANY AND URGING REVERSAL

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COALITION AGAINST INSURANCE FRAUD

MOTION FOR LEAVE TO FILE AMICUS BRIEF

1. Pursuant to Fed. R. App. P. 29, subd. (a), the Coalition Against Insurance Fraud ("Coalition") respectfully moves for leave to file the attached brief as amicus curiae in support of of the Defendant-Appellant, Federal Insurance Company ("Federal").

2. The Coalition is the only alliance in the country uniting, defending, and empowering the interests of consumers, government agencies, and insurers in combating insurance fraud. The Coalition is a consumer advocacy group representing the interests of consumers in the insurance marketplace. Founded in 1993, the Coalition's goals are to: (1) combat all forms of insurance fraud, (2) reduce costs for consumers, and (3) promote fairness and integrity in the insurance system. To this end, the Coalition has played an active role in advocating for laws, regulations, and policies that help detect, prevent, deter, and prosecute insurance fraud.

3. The Coalition works to promote public policies that help its constituents combat all forms of insurance fraud across the United States. The ongoing mission of the Coalition includes identifying court cases, such as the instant case, which present opportunities to create environments where insurance fraud can be countered successfully.

4. The Coalition has participated as amicus curiae addressing insurance fraud issues in the following courts: the Pennsylvania Supreme Court; the New York Court of Appeals; the Illinois Supreme Court; the Supreme Court of Washington State; the Florida Supreme Court; the Supreme Court of Texas; the

Supreme Court of Kentucky; the California Supreme Court; the Supreme Court of West Virginia; the Massachusetts Supreme Court; the Supreme Court of Colorado, the Supreme Court of New Jersey and the Supreme Court of Ohio. As a result, the Coalition is particularly well situated to explain the impact of the District Court on the fight against insurance and Medicare fraud.

5. The Coalition files this brief after considering this Court's opinions in *Voices for Choices v. Illinois Bell Tel. Co.*, 339 F.3d 542 (7th Cir. 2003) and *Ryan v. Commodity Futures Trading Comm'n*, 125 F.3d 1062 (7th Cir. 1997) and is requesting leave to file its brief as amicus curiae as it will assist this Court "by presenting ideas, arguments, theories, insights, facts, or data that are not to be found in the parties' briefs." *Voices for Choices*, 339 F.3d at 545. In fact, the Coalition has a unique perspective on this matter and is providing specific information that can assist the court beyond what the parties can provide. (*Id.*)

6. The Coalition's brief provides this Court with specific figures compiled by the Coalition regarding the billions of dollars involved in insurance and Medicare fraud. The brief also places the decision of the District Court in the context of the fight against insurance and healthcare fraud by the Federal Government, State governments and insurance companies. The Coalition's brief shows how the District Court's decision undermines the fight against insurance and healthcare fraud, and abandons established public policy to the benefit of fraudsters.

7. Although Federal's brief also considers the public policy aspect of the District Court's decision, the Coalition's brief places such policy in a national

context, and shows the impact of such decision on the fight against fraud at a national level.

8. The data and analysis provided by the Coalition's brief shows that insurance and healthcare fraud are massive multibillion operations, and that governmental agencies and insurance companies are struggling to prevent fraud or to prosecute and recoup the proceeds of fraudulent activity. The District Court's decision in this matter entirely undermines the position of federal and state governments and insurance companies in their onerous fight against insurance and healthcare fraud.

9. Pursuant to Fed. R. App. P. 29, subd. (a)(4)(E), the Coalition states that no party's counsel authored this brief in whole or in part. No party or party's counsel contributed money that was intended to fund preparing or submitting this brief. No other person contributed money that was intended to fund preparing or submitting this brief.

10. For the foregoing reasons, the Coalition respectfully requests leave to file the attached brief as amicus curiae in support of Federal

Respectfully submitted,

Dated: March 14, 2022

MANNING & KASS
ELLROD, RAMIREZ, TRESTER LLP

By: _____

Dennis B. Kass
David R. Ruiz (*Counsel of Record*)
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Coalition Against Insurance Fraud

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BRIEF OF AMICUS CURIAE COALITION AGAINST INSURANCE FRAUD IN SUPPORT OF DEFENDANT-APPELLANT FEDERAL INSURANCE COMPANY AND URGING REVERSAL

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APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No: 21-3075

Short Caption: Astellas US Holding, Inc. et al. v. Federal Insurance Co.

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party, amicus curiae, intervenor or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statements be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in the front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

☐ **PLEASE CHECK HERE IF ANY INFORMATION ON THIS FORM IS NEW OR REVISED AND INDICATE WHICH INFORMATION IS NEW OR REVISED.**

(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing item #3):

Coalition Against Insurance Fraud

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Manning & Kass, Ellrod, Ramirez, Trester, LLP

(3) If the party, amicus or intervenor is a corporation:

i) Identify all its parent corporations, if any; and

None

ii) list any publicly held company that owns 10% or more of the party's, amicus' or intervenor's stock:

Nove

(4) Provide information required by FRAP 26.1(b) – Organizational Victims in Criminal Cases:

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

Attorney's Signature: /s/ David R. Ruiz Date: March 14, 2022

Attorney's Printed Name: David R. Ruiz

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☑ **No** ☐

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APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

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(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

Attorney's Signature: /s/ Dennis B. Kass Date: March 14, 2022

Attorney's Printed Name: Dennis B. Kass

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☐ **No** ☑

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I. STATEMENT OF IDENTITY AND INTEREST

The Coalition Against Insurance Fraud ("Coalition") respectfully submits this Amicus Curiae Brief in support of the Defendant-Appellant, Federal Insurance Company ("Federal").

The Coalition is the only alliance in the country uniting, defending, and empowering the interests of consumers, government agencies, and insurers in combating insurance fraud. The Coalition is a consumer advocacy group representing the interests of consumers in the insurance marketplace. Founded in 1993, the Coalition's goals are to: (1) combat all forms of insurance fraud, (2) reduce costs for consumers, and (3) promote fairness and integrity in the insurance system. To this end, the Coalition has played an active role in advocating for laws, regulations, and policies that help detect, prevent, deter, and prosecute insurance fraud.

The Coalition works to promote public policies that help its constituents combat all forms of insurance fraud across the United States. The ongoing mission of the Coalition includes identifying court cases, such as the instant case, which present opportunities to create environments where insurance fraud can be countered successfully.

The Coalition has participated as amicus curiae addressing insurance fraud issues in the following courts: the Pennsylvania Supreme Court; the New York Court of Appeals; the Illinois Supreme Court; the Supreme Court of Washington State; the Florida Supreme Court; the Supreme Court of Texas; the Supreme Court of Kentucky; the California Supreme Court; the Supreme Court of West Virginia; the

Massachusetts Supreme Court; the Supreme Court of Colorado, the Supreme Court of New Jersey and the Supreme Court of Ohio.

This Appeal presents this Court an opportunity to correct the decision of the District Court ruling that an insurance company must provide coverage under an excess policy and indemnify its insured for part of the amount it paid to settle a claim for violations of the False Claims Act, 31 U.S.C. §§ 3729-3733, ("FCA") and the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, ("AKS") brought by the United States Department of Justice ("Department of Justice").

The Department of Justice's case against the insured, Plaintiffs-Appellees Astellas US Holding, Inc. and Astellas Pharma US, Inc. ("Astellas"), a pharmaceutical company, was based on a scheme by Astellas to use unlawful kickbacks to generate overuse of one of its drugs, which resulted in overpayments for the drug by the government's Medicare program. Astellas claimed that Federal, its insurer, should indemnify it for the portion of its fraudulently obtained proceeds that represents the amount paid by the Medicare program that Astellas had to return pursuant to the settlement between Astellas and the Department of Justice.

The District Court's ruling in favor of Astellas conflicts with the longstanding public policy against insuring acts of fraud. Under the District Court's decision, public policy considerations would prohibit insurance solely for proceeds of fraud that exceed the victim's own loss, but insurers would be forced to cover payments that represent money taken directly from the victims of fraud and returned to them as "damages" or "restitution."

The District Court's decision allowed Astellas to circumvent the public policy against insuring acts of fraud, and the ruling in fact, benefits fraudsters. The ramifications of affirming the District Court's holding will extend far beyond the individual parties in this litigation, including undermining the Department of Justice's ability to deter fraud through FCA settlements, and undermining the applicability of federal and state statutes enacted to curtail insurance fraud. Affirming this ruling will result, in many cases, in insulating perpetrators of fraud from any consequences for their wrongdoing; their fraudulent scheme(s) will either succeed and be profitable, or their insurers will be required to reimburse the fraudsters for proceeds that they are required to return to the victim. In other words, the District Court's ruling, if affirmed, will result in allowing fraudulent activities and schemes to be insured.

In short, under the ruling in Astellas, if a fraudster executes a successful scheme, it retains the proceeds. If a fraud scheme is discovered, and thus unsuccessful, the fraudster suffers no real consequences; it recovers from its insurance company the amounts it is required to repay to its victims. Under the district court's reasoning, the defrauder cannot lose.

Coalition's brief is filed after requesting leave of Court to do so in the concurrently filed motion for leave pursuant to Fed. R. App. P. 29, subd. (a)(2) and (3).

II. STATEMENT OF COMPLIANCE WITH FED. R. APP. OP. RULE 29

No party's counsel authored this brief in whole or in part. No party or party's counsel contributed money that was intended to fund preparing or submitting this brief. No other person contributed money that was intended to fund preparing or submitting this brief. Fed. R. App. P. 29, subd. (a)(4)(E).

III. SUMMARY OF ARGUMENT

Fraud should not be incentivized by the creation of a legal framework that forces insurance companies to defend or cover the consequences of the fraudulent acts of their insureds. However, this is exactly what the District Court's decision does by forcing Federal to indemnify Astellas for part of a settlement between Astellas and the Department of Justice that settled claims against Astellas under the False Claims Act and the federal Anti-Kickback Statute arising from Astellas's scheme to defraud the Medicare program.

Insurance fraud costs consumers about $80 billion per year,[1] and Medicare fraud likewise costs the United States government and taxpayers about $60 billion per year. Of the total fraud amounts experienced each year by insurance companies and the federal and state healthcare programs, only a small fraction are recovered through the application of anti-fraud statutes and the efforts of law enforcement and insurance companies' special investigation units.

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[1] The Coalition Against Insurance Fraud estimated in 1995 that insurance fraud costs consumers $80. The figure is currently being updated for release later this year. If only adjusted for inflation, using the U.S. Commerce Department calculator, the $80 billion figure would equal $142 billion today.

The District Court's opinion undermines these efforts. The focus seems to be on maximizing coverage under an insurance policy to the detriment to insurers, and ultimately their policyholders in the form of increased pressure on premium rates, and seems to ignore the perverse incentive it affords to insureds involved in fraud claims. The District Court fails to take into account that the only reason for a settlement between Astellas and the Department of Justice is that Astellas was caught defrauding the Medicare program to promote one of its pharmaceutical products in violation of the FCA and the AKS.

The District Court gives great weight to semantics, focusing on whether the ill-obtained amounts that Astellas had to return to settle the claim of fraud constitute "damages" or "restitution" and looking to artificial distinctions between whether the amounts returned were taken directly from the victims or were additional amounts exceeding the victims' loss. By artificially distinguishing between proceeds of fraudulent conduct taken directly from the victims and those that exceed the victims' own loss, the District Court's decision creates an avenue for individuals and entities involved in insurance and healthcare fraud to be insulated from the consequences of their wrongdoing and ensuring that their fraudulent activities are always profitable.

As the below analysis shows, the District Court's decision undermines the fight against insurance and healthcare fraud, and abandons established public policy to the benefit of fraudsters. Insurance agreements should not be interpreted to insure the ill-gained proceeds of individuals and entities involved in insurance and healthcare fraud.

IV. ARGUMENT

A. Insurance and healthcare fraud are a thriving multi-billion Dollar industry affecting consumers and taxpayers that must be curtailed

The Coalition has calculated that Insurance fraud steals at least $80 billion every year from American consumers.[2] At least 48 states make insurance fraud a specific crime, and 42 of them and the District of Columbia have an insurance fraud bureau.[3]

However, despite the multitude of anti-fraud statutes and regulations, and the efforts of law enforcement and insurance companies, insurance and healthcare fraud is thriving; it is difficult to prosecute and to recover the amounts fraudulently obtained.

As to the Medicare program, in 2018, Medicare fraud was estimated to cost about $60 billion every year.[4] In 2019, the United States Department of Health and Human Services, expected to recover only about $5.9 billion of those $60 billion from

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[2] Coalition against Insurance Fraud, *Fraud Statistics, Impact*. (Feb. 7, 2022) https://insurancefraud.org/fraud-stats/. The $80 billion estimate of insurance fraud was released by the Coalition Against Insurance Fraud in 1995. The figure is currently being updated for release later this year. If only adjusted for inflation, using the U.S. Commerce Department calculator, the $80 billion figure would equal $142 billion today.

[3] Coalition against Insurance Fraud, *Fraud Statistics, State and Federal Efforts to Investigate and Prosecute Insurance Fraud*. (Feb. 7, 2022) https://insurancefraud.org/fraud-stats/

[4] Joe Eaton, *Medicare Under Assault From Fraudsters*, AARP Bulletin, Mar. 30, 2018, https://www.aarp.org/money/scams-fraud/info-2018/medicare-scams-fraud-identity-theft.html.

fraud investigations involving Medicare, Medicaid, and other federal healthcare programs.[5]

For the fiscal year ending on September 30, 2021, the Department of Justice obtained more than $5.6 billion in settlements and judgments from civil cases involving Medicare/Medicaid fraud and false claims against the government.[6] Over $5 billion of the more than $5.6 billion in settlements and judgments recovered by the Department of Justice related to matters that involved the healthcare industry, including drug and medical device manufacturers, managed care providers, hospitals, pharmacies, hospice organizations, laboratories, and physicians.[7] Significantly, the $5 billion figure reflects only federal losses, and do not include the additional tens of millions of dollars for state Medicaid programs that the Department of Justice assisted the states in recovering.[8]For the fiscal year ending on September 30, 2020, the Department of Justice obtained more than $2.2 billion in settlements and judgments from civil cases involving Medicare/Medicaid fraud and false claims

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5 U.S. Department of Health and Human Services, Office of Inspector General, *OIG Fiscal Year 2019 Semiannual Report Reveals Taxpayers Could See Nearly $5.9 Billion Returned to Government* (2019), https://oig.hhs.gov/newsroom/news-releases/2019/sar.asp. *See also* U.S. Department of Health and Human Services, Office of Inspector General, *Semiannual Report to Congress April 1, 2019-September 30, 2019* (Aug. 2019), https://oig.hhs.gov/reports-and-publications/archives/semiannual/2019/2019-fall-sar.pdf

6 U.S. Department of Justice, Office of Public Affairs, *Justice Department's False Claims Act Settlements and Judgments Exceed $5.6 Billion in Fiscal Year 2021* (Feb. 1, 2022) https://www.justice.gov/opa/pr/justice-department-s-false-claims-act-settlements-and-judgments-exceed-56-billion-fiscal-year

7 *Id.*

8 *Id.*

against the government.[9] Over $1.8 billion of the more than $2.2 billion in settlements and judgments recovered by the Department of Justice relate to matters that involved the healthcare industry, including drug and medical device manufacturers, managed care providers, hospitals, pharmacies, hospice organizations, laboratories, and physicians.[10] Again, the $1.8 billion figure reflects only federal losses, and does not include the additional tens of millions of dollars for state Medicaid programs that the Department of Justice assisted the states in recovering.[11]

In 2020, it was reported that through the FCA, and its whistleblower provisions, the Department of Justice obtained more than $2.6 billion in whistleblower health settlements in 2019 out of at least $3 billion in whistleblower settlements overall.[12] These $2.6 billion relate to health care industry matters such as drug and medical device manufacturers, managed care providers, hospitals, pharmacies, hospice organizations, laboratories, and physicians. [13]

These figures tell a clear story: fraudsters are generally successful in their endeavors as a majority of them are able to abscond with their ill-gained proceeds,

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9 U.S. Department of Justice, Office of Public Affairs, *Justice Department Recovers Over $2.2 Billion from False Claims Act Cases in Fiscal Year 2020* (Jan. 14, 2021) https://www.justice.gov/opa/pr/justice-department-recovers-over-22-billion-false-claims-act-cases-fiscal-year-2020

10 *Id.*

11 *Id.*

12 U.S. Department of Justice, Office of Public Affairs, *Justice Department Recovers over $3 Billion from False Claims Act Cases in Fiscal Year 2019* (Jan. 9, 2020) https://www.justice.gov/opa/pr/justice-department-recovers-over-3-billion-false-claims-act-cases-fiscal-year-2019

13 *Id.*

and law enforcement is not able to recover all the amounts obtained by fraudulent means. Public policy should focus on curtailing these activities, and closing any avenues that allow fraudsters to thrive. Thus, the public policy *against* insuring the proceeds of fraudulent activities should be preserved, and no exceptions should be created based on semantic distinctions as occurred in the underlying decision.

B. The settlement payment should not be a covered loss as the settlement was entirely based on Astellas's fraudulent activity

The District Court's opinion requires Federal to cover part of the settlement payment despite confirmation that the crux of the Department of Justice's claim against Astellas was entirely predicated on Astellas's fraudulent activity that violated a series of federal anti-fraud statutes.

1. The District Court's opinion acknowledges that the settlement between the Department of Justice and Astellas was entirely based on Astellas's scheme to defraud Medicare and its violations of the FCA and the AKS

The District Court's opinion leaves no doubt that the Department of Justice's investigation and claim against Astellas were entirely predicated on Astellas's fraudulent activities in violation of the FCA and the AKS.

In fact, the District Court's decision provides the following details as to the Department of Justice's investigation and settlement agreement:

- The March 2016 subpoena duces tecum issued by the Department of Justice to Astellas sought documents relevant to the Department of Justice's investigation of "alleged 'Federal healthcare offenses' arising out of Astellas' charitable contributions to Charity PAPs." *Astellas US Holding, Inc. v. Starr Indem. & Liab. Co.*, No. 17-cv-08220, 2021 U.S. Dist. LEXIS 195236, p. *12 [2021 WL 4711503, p. *5] (N.D. Ill. Sep. 23, 2021).
- The September 2017 Civil Investigative Demand issued by the Department of Justice to Astellas was issued pursuant to the FCA "in the course of a[n] FCA investigation" of Astellas to determine whether it had caused the "submission of false claims to federal government health care programs, in violation of 31 U.S.C. § 3729, by facilitating payments to federal health care beneficiaries." *Astellas US Holding, Inc.,* 2021 U.S. Dist. LEXIS 195236, p. *13 [2021 WL 4711503, p. *5].
- The October 19, 2017 Tolling Agreement between the Department of Justice and Astellas specified that the Department of Justice was conducting a joint criminal and civil investigation of Astellas for conduct that included healthcare fraud and violations of the FCA and the AKS in connection to payments to the Charity PAPs. *Astellas US Holding, Inc.,* 2021 U.S. Dist. LEXIS 195236, p. *13 [2021 WL 4711503, p. *5].
- The April 25, 2019 Settlement with the Department of Justice described "Covered Conduct" as Astellas causing Medicare beneficiaries to submit

false claims for reimbursement to Medicare, and released Astellas "from any civil or administrative monetary claim" for the covered conduct under the FCA, the AKS, the Program Fraud Remedies Act, 31 U.S.C. §§ 3801-12, or "the common law theories of payment by mistake, unjust enrichment, and fraud." *Astellas US Holding, Inc.,* 2021 U.S. Dist. LEXIS 195236, p. *21 [2021 WL 4711503, p. *7].

- On the same day that the settlement was executed, the Department of Justice issued a press release stating, "As today's settlements make clear, the FBI will aggressively go after pharmaceutical companies that look to bolster their drug prices by paying illegal kickbacks — whether directly or indirectly — to undermine taxpayer funded healthcare programs, including Medicare[.]" *Astellas US Holding, Inc.,* 2021 U.S. Dist. LEXIS 195236, p. *19 [2021 WL 4711503, p. *7].

There is no doubt from these facts that the District Court was aware of the nature of the investigation and claim by the Department of Justice: Astellas was involved in Medicare fraud.

2. The FCA and the AKS are the primary tools for the Department of Justice to fight insurance and healthcare fraud and any settlement under them must be interpreted accordingly

Despite acknowledging that Astellas settled a matter involving Medicare fraud, in concluding that Astellas' settlement payment was "damages" and not

"restitution," and imposing an artificial distinction between amounts taken directly from the victims and additional amounts exceeding the victims' loss, the District Court obviates the nature and purpose of the FCA and the AKS.

The FCA imposes civil liability on any person who "knowingly presents, or causes to be presented" to the United States or its representatives "a false or fraudulent claim for payment or approval," 31 U.S.C. § 3729, subd. (a)(1) (2006–2015), or "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim," 31 U.S.C. § 3729, subd. (a)(1)(B) (2010–15). The FCA imposes civil penalties and treble damages as remedies for each violation. 31 U.S.C. § 3729, subd. (a)(1)(G).

The FCA is an anti-fraud statute that condemns fraud, but not negligent errors or omissions. *United States ex rel. Garst v. Lockheed–Martin Corp.*, 328 F.3d 374, 376 (7th Cir. 2003). In fact, the FCA is "the primary vehicle by the Government for recouping losses suffered through fraud." *United States v. Sanford-Brown, Ltd.*, 788 F.3d 696, 700–701 (7th Cir. 2015) (citing 31 U.S.C. § 3729 *et seq.*), reinstated and superseded on other grounds by *United States v. Sanford–Brown, Ltd*, 840 F.3d 445, 447 (7th Cir. 2016).

In turn, the AKS is designed to prevent Medicare and Medicaid fraud, including through the use of illegal remunerations as was the case here. The AKS expressly considers a felony punishable by a $100,000 fine or no more than 10 years in prison the knowing and willful offering or paying of any remuneration to induce a referral to obtaining business reimbursable under a federal health care program. 42

U.S.C. § 1320a-7b(b)(2). In this regard, the AKS was designed to help combat health care fraud. *United States v. Borrasi*, 639 F.3d 774, 781 (7th Cir. 2011).

According to the Health Resources and Services Administration, the Statute was enacted to "protect the Medicare and Medicaid programs from increased costs and abusive practices resulting from provider decisions that are based on self-interest rather than cost, quality of care or necessity of services." *United States v. Patel*, 778 F.3d 607, 612 (7th Cir. 2015) (quoting Health Res. & Serv. Admin., Program Assistance Letter 1995–10, Guidance on the Federal Anti–Kickback Law, available at http://bphc.hrsa. gov/policiesregulations/policies/pal199510.html.)

More importantly, as the District Court itself recognized, "a claim that includes items or services resulting from a violation of [the AKS] constitutes a false or fraudulent claim for purposes of [the FCA]." *Astellas US Holding, Inc.*, 2021 U.S. Dist. LEXIS 195236, p. *44 [2021 WL 4711503, p. *14].

Both the FCA and AKS contemplate penalties and fines for fraudulent activity, and their main purpose is to deter fraud. They must be interpreted to fulfill that purpose. In interpreting the Settlement Agreement as not being restitutionary in nature and artificially dividing the amounts paid between amounts taken directly from the victims and additional amounts exceeding the victims' loss, the District Court ignored the fraud deterrence purpose of these statutes.

3. Astellas's payment under the settlement agreement cannot be considered a loss within an insurance contract

No insurance policy is ever written to include disgorgement of fraudulently obtained proceeds within the definition of loss. *Scottsdale Indemnity Co. v. Village of Crestwood*, 673 F.3d 715, 717–18, 719–20 (7th Cir. 2012) (applying Illinois law). In fact, no state would enforce such an insurance policy if it were written as it basically would allow thieves to buy insurance against having to return money they stole. *Level 3 Communications, Inc. v. Federal Ins. Co.*, 272 F.3d 908, 910 (7th Cir. 2001). Therefore, fraud and its proceeds cannot be insured, and an insurance policy should never be interpreted as providing coverage for the return of property or money obtained fraudulently by merely labelling the amounts returned as "damages."

A claim to recover fraudulently obtained property or the profits made from appropriating the property is a claim for restitution. A claim for restitution is a claim that defendants have something that belongs of right not to them but to the plaintiffs. *Tull v. United States*, 481 U.S. 412, 424 (1987); *ConFold Pacific, Inc. v. Polaris Industries, Inc.*, 433 F.3d 952, 957–58 (7th Cir. 2006). On the other hand, a claim for damages is not based on defendants having something that belongs as a matter of right to plaintiffs. Instead, it is based on plaintiffs obtaining the monetary equivalent of harm done to them. *Level 3 Communications*, 272 F.3d at 910.

More importantly, as the 7th Circuit has recognized by agreeing in this regard with the 9th Circuit, the particular label used to refer to the relief obtained by the victim of fraud is not dispositive. *Ryerson Inc. v. Federal Ins. Co.*, 676 F.3d 610, 613

(7th Cir. 2012) (citing *Pan Pacific Retail Properties, Inc. v. Gulf Ins. Co.*, 471 F.3d 961, 966–69 (9th Cir. 2006)). The 9th Circuit was clear on this point: in deciding whether a certain remedy is insurable, the Court must look beyond the labels of the asserted claims or remedies. *Pan Pacific Retail Properties, Inc.,* 471 F.3d at 966–67 (citing *Bank of the West v. Superior Court*, 833 P.2d 545, 548-549 (Cal. 1992)).

Here, the labels used in the settlement agreement are not dispositive, and the concept of loss within the insurance agreement between Astellas and Federal must be interpreted in line with settled public policy that the proceeds of fraud are not insurable. Therefore, the payment under the settlement agreement must be considered restitutionary in nature and the distinction between amounts taken directly from the victims and additional amounts exceeding the victims' loss should not be considered for purposes of determining whether the amounts paid by Astellas are covered within the concept of loss. The amounts from the settlement agreement the district court considered to be covered under the policy are the proceeds of Astellas's fraudulent activity regardless of labels. Therefore, Federal should not be required to cover Astellas's settlement payment resulting from its fraudulent activity.

C. Public Policy Demands Reversing the District Court's Decision

The main issue for this Court to decide is whether the longstanding public policy against insuring the proceeds of fraudulent acts precludes insurance for Astellas's settlement returning to the government a portion of the proceeds of Astellas's fraud.

The District Court held that such public policy does not prohibit insurance for payments that represent money taken directly from the victims of fraud and returned to them. Instead, the District Court reinterpreted this public policy to only bar insurance for the disgorgement of additional profits obtained through fraud, but not for the amounts taken directly from the victims and later returned.

The District Court's narrow view of this longstanding policy should be rejected as it undermines the government and insurance companies fight against insurance and healthcare fraud, ignores the main purpose of the FCA, the AKS, and it opens the door for insuring fraud.

In fact, two articles published after the District Court issued its decision show the negative impact that it will have on public policy and the fight against insurance and healthcare fraud.

One article points out that although the Department of Justice is increasing the number of FCA investigations and actions, the "good news is that companies incurring legal fees defending against government investigations or negotiating settlements with regulators to resolve FCA claims may be able to look to D&O to mitigate those loses" after the District Court's decision in this case.[14] The article points out that after the trial Court decision alleged fraud is insurable and that since

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[14] Geoffrey B. Fehling, et al., Policyholder Win Highlights Key Issues to Maximize Coverage for False Claims Act Settlements, The National Law Review (Oct. 21, 2021) https://www.natlawreview.com/article/policyholder-win-highlights-key-issues-to-maximize-coverage-false-claims-act?fr=operanews

settlements are not final adjudications of government's claims, the conduct exclusion within the policy is not triggered.[15]

The other article points out the "far-reaching consequences" for corporate policyholders of the District Court's decision as it held that an FCA settlement qualified as insurable compensatory damages as opposed to uninsurable disgorgement.[16] The article points out how the District Court's decision has added "several important arrows to policyholders' quiver," including as to issues that "will inevitably arise in the future."[17]

Both articles point out how the Government's and the insurance companies' fight against insurance and healthcare fraud became more difficult after the District Court's decision. In short, the District Court's decision should be reversed so that fraudsters are not given new avenues to escape their day of reckoning.

The Seventh Circuit already has precedent supporting the fight against fraud and ensuring that an insurance company is not forced to insure fraud in its decision in *Level 3 Communications, Inc.*, 272 F.3d 908, and its progeny. The District Court failed to apply this precedent by misapplying authority from other jurisdictions. Such an attempt to circumvent precedent and to alter long-standing public policy should be reversed.

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[15] *Id.*

[16] Courtney Horrigan, et al., FCA Ruling Guides Insureds On Classifying Restitution Costs, Law360, (Oct 27, 2021) https://www.law360.com/articles/1435202/fca-ruling-guides-insureds-on-classifying-restitution-costs

[17] *Id.*

V. CONCLUSION

The District Court's decision should be reversed as it negatively impacts the fight against insurance and healthcare fraud spearheaded by the Department of Justice and insurance companies. The decision sets new avenues for fraudsters to pursue their activities while hampering the ability of insurers to prevent providing coverage for fraudulent activities.

Insurance and health fraud costs consumers and taxpayers billions of dollars per year, and even before the decision by the District Court, only a small fraction were recovered by enforcing anti-fraud statutes such as FCA and AKS, and the efforts of law enforcement and insurance companies' special investigation units.

The District Court's opinion undermines these efforts by seeming more concerned with maximizing coverage under an insurance policy to the detriment of insurers and to the benefit of insureds involved in fraud claims. Therefore, the District Court's opinion should be reversed.

Dated: March 14, 2022

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH RULE 32

1. This brief complies with the type-volume limitations of Fed. R. App. P.32, subd. (a)(7) and Circuit Rule 32, subd. (c) because this brief contains 4,540 words, excluding the parts of the brief exempted by Fed. R. App. P. 32, subd. (f).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32, subd. (a)(5) and Circuit Rule 32, sud. (b), as well as the type style requirements of Fed. R. App. P. 32, subd. (a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2016 in Century Schoolbook 12-point font.

Dated: March 14, 2022

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CERTIFICATE OF SERVICE

I hereby certify that on March 14, 2022, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the appellate CM/ECF system.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Dated: March 14, 2022

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