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The *Level 3* Legacy

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THE *LEVEL 3* LEGACY

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More than fifteen years have passed since the Seventh Circuit issued its landmark ruling in *Level 3* questioning the availability of D&O coverage for damages that are "restitutionary in character." *Level 3 Communications, Inc. v. Fed. Ins. Co.*, 272 F.3d 908, 910 (7th Cir. 2001). While not the first decision to conclude that coverage is barred for disgorgement or restitutionary-type payments, *Level 3* has arguably become the most well-known. In the ensuing years, courts have come to markedly different approaches on the insurability of damages that might be characterized as restitution or disgorgement. This paper posits that weaknesses in the *Level 3* court's reasoning contributed to what has become an unsettled area of law, and explains that recent decisions have begun to apply more rigorous textual analyses and thus are more likely to allow coverage for certain claims arguably involving disgorgement or restitution, at least absent specific contractual exclusions.

This paper proceeds in three sections. The first offers an analysis of the *Level 3* decision, identifying key aspects of the court's reasoning that led to a rule with unstable foundations. The second section discusses the varying approaches courts have taken following *Level 3* and illustrates how more recent decisions have narrowed *Level 3*'s application. The final section discusses four motivating factors driving courts to adopt a *Level 3*-type rule and identifies

specific D&O insurance policy language that is available on the market that addresses those motivations in a more precise and predictable manner than a *Level 3*-type analysis.

I. THE UNINSURABILITY OF RESTITUTIONARY PAYMENTS: THE *LEVEL 3* DECISION

Level 3 addressed insurance coverage for the settlement of an underlying securities fraud action. The corporate insured, Kiewit Diversified Group Inc. (later acquired by Level 3), through a subsidiary company, held a majority stake in a company and was alleged to have obtained the remaining shares from minority stockholders as a result of fraudulent representations by the subsidiary company and one of its directors. *Kiewit Diversified Grp. Inc. v. Fed. Ins. Co.*, 999 F. Supp. 1169, 1172 (N.D. Ill. 1998). The parent company, subsidiary, and director were named as defendants. *Id.* The stockholder-plaintiffs claimed that their stock "was far more valuable than the price reflected, and that they would not have sold their shares had" the defendants disclosed certain material information. Fed. Br., *Level 3*, 2001 WL 34106466, at * 4-5. The plaintiffs asserted causes of action for violation of federal securities laws, fraud, breach of fiduciary duty, and breach of contract. *Id.* at *4. The plaintiffs estimated their damages at $70 million; the parties settled after the first day of trial for $11.8 million. Level 3 Br., *Level 3*, 2001 WL 34106467, at *9-10; Fed. Ins. Co. Br. at *12.

Level 3's D&O insurer, Federal Insurance, refused to pay the settlement on various grounds, but the ground relevant here was based on the contention that the settlement was "not [a] covered 'Loss,' and was not insurable." Fed. Ins. Co. Br. at *14.

In a decision authored by Judge Richard Posner, the Seventh Circuit agreed with the insurer's position that allowing coverage for the securities fraud settlement would be akin to allowing coverage for theft and that the settlement could not be fairly characterized as a bona

fide "loss." As the court put it: "It's as if . . . Level 3 had stolen cash [from the shareholders] and had been forced to return it and were now asking the insurance company to pick up the tab." *Level 3*, 272 F.3d at 910.

The court's conclusion may have intuitive appeal to some, but close examination reveals that the ruling rests on a shaky foundation in at least three principal ways, each of which is discussed below.

A. The "Interpretive Principle" And Public Policy

The Seventh Circuit's opinion, in keeping with Judge Posner's pragmatic approach and colorful literary style, purports to cut to the heart of the matter without pausing to quote all of the potentially relevant policy language, to describe in detail the underlying lawsuit, or to mention anything about the governing state law. In this regard, the court's well-known 2001 ruling is similar to an earlier appeal heard by the same panel reversing a trial court ruling for the insurer on a different case-dispositive issue. *Level 3 Communications, Inc. v. Federal Ins. Co.*, 168 F.3d 956 (7th Cir. 1999). In that 1999 decision, the panel, per Judge Posner, mentioned but did not cite Nebraska law and ignored the "literal accuracy" of the insurer's position because it would be "too nutty to be tolerable as a contractual interpretation. . . ." *Id.* at 957, 959.

In addressing the insurability of restitutionary damages, the court grounded its ruling on the definition of "Loss," which it quoted as "the total amount which any Insured Person becomes legally obligated to pay . . . including, but not limited to . . . settlements." *Level 3*, 272 F.3d at 909. In fact, the definition in the policy, as quoted by the district court, referred to "the total amount which any insured person becomes legally obligated to pay *on account of each claim and for all claims in each policy period. . . made against them for wrongful acts for which coverage*

applies, including, but not limited to *damages*, *judgments*, settlements, *costs, and defense costs*," but not including "*matters uninsurable under the law*." *Level 3*, 1999 WL 675295 at *3 (italics highlighting words not quoted in the panel opinion). Rather than focus on the content of the entire definition, much less the portions partially quoted in the panel's opinion, the court homed in on the term "Loss" itself, applying what it called an "interpretive principle" by which it concluded that "a 'loss' within the meaning of an insurance contract does not include the restoration of an ill-gotten gain." *Level 3*, 272 F.3d at 910.

Interpreting the word "Loss" as the court did might be a valid approach where the word is used as a standalone term, but in *Level 3* the meaning of "Loss" was expressly prescribed by the definition provided in the policy rather than the defined term itself. That definition specifically encompassed "settlements" among "the total amount" the insurer was obligated to indemnify and thus on its face would capture a settlement of a securities lawsuit such as that in *Level 3*. The court did not attempt to reconcile its interpretation with the words in the definition.

A similar indifference to policy wording appears in the court's attempts to distinguish decisions going the other way. For example, the Seventh Circuit considered *Limelight Productions*, an Eleventh Circuit decision that found "no merit to the argument that ill-gotten profits are not damages covered by the insurance policies." *Limelight Productions, Inc. v. Limelite Studios, Inc.*, 60 F.3d 767, 769 (11th Cir. 1995). The *Level 3* court brushed this and similar decisions aside, concluding that, although the "facts were similar to those in the present case, [] the operative term in the insurance policy [in those cases] was 'damages' rather than 'loss' and so was broader." *Level 3*, 272 F.3d at 910. Actually, it was narrower. "Loss" as defined in Level 3's policy included, but was not limited to, "damages": "Loss" was defined as

"*the total amount* which any Insured Person becomes legally obligated to pay," and specifically included "*damages,* judgments, [and] settlements." Level 3 Br. at *12 (emphasis added). The court's opinion in *Level 3* replaced the word "damages" with ellipses when it quoted the policy's definition of "loss" as "the total amount which any Insured Person becomes legally obligated to pay . . . including but not limited to . . . settlements." *Level 3*, 272 F.3d at 908. Accordingly, its effort to distinguish the wording of the *Limelight* policy from Level 3's policy was unsupported.

A handful of decisions preceding *Level 3* adopted similar interpretive approaches, focusing on terms such as "loss" without regard to their prescribed policy definitions. In *Town of Brookhaven,* for instance, the policy defined "Loss" as "any amount which the Assureds . . . are legally obligated to pay a claimant on account of injuries or damages suffered by such claimant . . . and shall include damages, judgments, [and] settlements," while carving out matters "deemed uninsurable under the law." *Town of Brookhaven v. CNA Ins. Cos.*, No. CV-86-3569, 1988 WL 23555, *3 (E.D.N.Y. Feb. 24, 1988). The Town of Brookhaven was found to have distributed tax revenues to school districts "more slowly than required under" the county tax act; school districts sued to recover "the interest earned by the town during the period the town unlawfully withheld" the tax revenues from the school districts. *Id.* at *1, *3. The *Brookhaven* court dismissed the insurer's argument that public policy barred coverage, but nevertheless concluded that the definition of "Loss" in the policy was not broad enough to encompass what it characterized as "repayment" of funds the town was "never entitled to." *Id.* at *5-6, *3. The court reasoned that "[t]he broad language of the policy does not alter [the court's] conclusion" that the town did not suffer a "loss" because the "plain and ordinary meaning of loss . . . cannot be ignored, and the town simply cannot lose that to which it was not legally entitled." *Id.* at *5

(internal citations omitted). *See also Local 705 Int'l Broth. of Teamsters Health & Welfare Fund v. Five Star Managers, LLC*, 316 Ill. App. 3d 391, 396 (2000) (policy covered "ultimate net loss" defined as "the total sum which the insured shall become legally obligated to pay . . . including, but not limited to, damages, judgments, settlements, costs and claims expenses"; but holding that "[t]he plain and ordinary meaning of 'loss' cannot be ignored. [The insured] simply cannot lose that to which it was not legally entitled") (internal quotations omitted).

The *Level 3* court's interpretive approach aside, the panel appears to have been influenced by—without predicating its holding upon—the notion that, as a matter of public policy, amounts constituting "ill-gotten gains" or restitution are not insurable.[2] Indeed, the *Level 3* court cited a string of cases many of which, including the California Supreme Court's *Bank of the West* opinion, invoke a public policy rationale to preclude coverage for disgorgement and restitutionary-type payments:

> When the law requires a wrongdoer to disgorge money or property acquired through a violation of the law, to permit the wrongdoer to transfer the cost of disgorgement to an insurer would eliminate the incentive for obeying the law. Otherwise, the wrongdoer would retain the proceeds of his illegal acts, merely shifting his loss to an insurer.

Bank of the West v. Superior Court, 2 Cal. 4th 1254, 1269 (1992).

[2] The court makes clear that it is relying on contract text rather than public policy or unenforceability. *See Level 3*, 272 F.3d at 910 ("As the interpretive principle controls this case, we need not consider the issue of unenforceability, though the two issues are intertwined, since obviously an insurance policy wouldn't be presumed to have been drafted in such a way as to make it unenforceable."); *id.* at 911 ("An insured incurs no loss within the meaning of the insurance contract. . . ."). Although the Level 3 policy's definition of "Loss" excludes "matters uninsurable under the law," the panel neither quoted nor purported to rely on that aspect of the definition.

Thus, while courts adopting a *Level 3* analysis may pay homage to the idea of interpreting insurance policy language, more often than not the decisions are motivated by an unwillingness to allow insurance coverage where doing so would appear to insure fraud, reduce incentives to obey the law, or somehow allow a defendant to keep an apparent windfall.

B. Ignoring Exclusions And Equating Settlements With Determination Of Facts

The second questionable feature of *Level 3*'s analysis is the Seventh Circuit's refusal to apply the clear mandate of exclusionary provisions and a willingness to accept a settlement as essentially tantamount to a determination of liability.

In this regard, it is important to highlight two exclusions in the *Level 3* policy that might have been implicated by the facts in that case under certain circumstances. While the panel opinion alludes to the insured's concession that there would be no coverage if there had been a fraud judgment, the court did not cite or describe the policy's conduct exclusions. The first exclusion, to which the court was presumably alluding, barred coverage for loss:

> Arising from . . . any deliberately fraudulent act or omission or any willful violation of any statute or regulation by such Insured Person, if a judgment or other final adjudication . . . establishes such a deliberately fraudulent act or omission or willful violation.

Level 3 Br. at *24.

The second provision excluded losses from claims made against an Insured Person:

> based upon . . . such an Insured Person having gained in fact any personal profit, remuneration or advantage to which such an Insured Person was not legally entitled.

Id. at *18. The *Level 3* policy apparently had additional language making clear that this "profit" exclusion applied only to non-indemnifiable losses of directors and officers. *Id.* at *19.

Presumably referring to the fraud exclusion, the insured in *Level 3* acknowledged that coverage would be unavailable "if a judgment had been entered in the [securities] suit . . . on the basis of a judicial determination that [Level 3] had engaged in fraud," but contended that coverage existed for *settlements* resolving allegations of fraud. *Id.* at 911.[3] The Seventh Circuit disagreed, declaring that it "can't be right" that, "[a]s long as the case is settled before entry of judgment, the insured is covered regardless of the nature of the claim against it." *Id.* The court hypothesized that such a rule would incentivize an insured to simply agree to a settlement—even at the full amount demanded by plaintiffs—to avoid application of the exclusion, allowing the insured to "retain the profit it had made from a fraud." *Id.*

As sole support for this conclusion, the Seventh Circuit cited *Reliance Group Holdings, Inc. v. Nat'l Union Fire Ins. Co.*, a case involving coverage for a settlement of consolidated class action securities and derivative lawsuits under a policy that appears to have covered claims against only the directors and officers (and indemnified by the company), and not claims against the company itself. 188 A.D.2d 47, 52-35 (N.Y. App. Div. 1993) (quoting coverage grant for claims made against director and officers for wrongful acts of directors and officers). In that case, Reliance Group (and its subsidiaries, referred to collectively as Reliance Group) was alleged to have obtained so-called greenmail payments—profits gained by purchasing shares of a

[3] While the Seventh Circuit's opinion suggests that the fraud exclusion would apply to Level 3 if there were "a judicial determination that *it* had engaged in fraud," *Level 3*, 272 F.3d at 911 (emphasis added), in fact, the policy at issue—which antedated the era of widespread entity coverage—does not appear to have covered claims against the company in the first instance. *See e.g.*, *Level 3*, 1999 WL 675295 at *4 (referring to "the uninsured corporation" and applying the larger settlement rule to allow full coverage because there was an insured person named in the underlying action).

company, threatening a hostile takeover, and then selling the shares back to the target company at a premium in exchange for backing off the take-over. *Id.* at 50. Shareholders of the target company sued Reliance Group and a director for breach of fiduciary duty for allegedly abandoning a derivative action Reliance Group had initiated against the target company. *Id.* A preliminary injunction was granted (and upheld on appeal), imposing a constructive trust on Reliance Group's greenmail profits, the purposes of which the underlying courts described as "to prevent unjust enrichment," and allow the plaintiffs to "recover[ ] wrongfully acquired assets." *Id.* at 51. A settlement was eventually reached between Reliance Group, its director, and the shareholder-plaintiffs; Reliance Group then sought coverage for the entire settlement amount as an indemnified loss on behalf of the director. *Id.* at 51-52. The court refused to recognize coverage.

Much of the court's analysis was focused on the fact that the company itself was ordered to disgorge its "wrongfully acquired assets," which was not a loss to or on behalf of the insured director. *Id.* at 51; *see also id.* at 56 ("The D&O policy covers corporate indemnification of directors and officers for *their* incurred liability, not the corporation's own liability.") (emphasis in original). The *Reliance Group* court also referred to the restitutionary nature of the company's settlement payment. Specifically, the *Reliance Group* court held that the company did not suffer a loss as defined in the policy, in part because:

> It is well established that one may not insure against the risk of being ordered to return money or property that has been wrongfully acquired. Such orders do not award 'damages' as that term is used in insurance policies. *Bank of the West*, 2 Cal. 4th 1254 [(1992)]. . .

> The settlement of [the underlying] action . . . was essentially equivalent to a determination reached through agreement of the parties, that [the company] had been unjustly enriched in the amount of $21.1 million through its actions in connection with the [ ] takeover attempt. In other words, the determination of this appeal should not hinge on the circumstance that [the company] made restitution by way of settlement instead of in satisfaction of a judgment after trial.

Id. at 55.

In passing, the court noted that the policy contained an exclusion barring coverage for claims against insured persons "based upon or attributable to their gaining in fact of any personal profit or advantage to which they were not legally entitled." *Id.* at 57 n.2. The court observed that, had coverage been sought for non-indemnifiable loss, rather than under the "Company Reimbursement" portion of the policy, and had the director been made to disgorge profits he gained, the claim "would almost certainly be excluded." *Id.* That exclusion, however, did not apply to losses the company incurred by indemnifying its directors. *Id.* Rather than consider the asymmetrical structure of the exclusion as an indication of the intent of the parties to the policy, the *Reliance Group* court concluded that the existence of the profit exclusion under one coverage section "provide[d] a gloss in construing the intent of the policy with respect to the essential nature of the claims upon which coverage is contemplated." *Id.*

For present purposes, there are two fundamental problems in the *Level 3* and *Reliance Group* reasoning.

First, both courts ignore the limitations of the exclusions in the policies at issue, effectively rewriting the exclusions in the course of denying coverage. In *Level 3* the court believed that if "a judgment" established that the insured had engaged in fraud (or "stealing," as

the court would put it), the fraud exclusion would bar coverage. *Level 3*, 272 F.3d at 911. But when the Seventh Circuit refused to recognize coverage for the insured's *settlement* of the securities fraud suit, it ignored the "judgment or other final adjudication" requirement in the exclusion, effectively holding that a *settlement* resolving *allegations* of fraud was sufficient to trigger the exclusion. Similarly, both the *Level 3* and *Reliance Group* policies had provisions excluding losses attributable to an insured person "gaining in fact [ ] any personal profit or advantage to which they were not legally entitled." *Reliance Grp.*, 188 A.D.2d at 57 n.2. In both cases, however, the profit exclusion applied by its terms only to non-indemnified losses incurred by directors and officers and required a finding that the insured persons "in fact" obtained improper personal profits or advantages. Traditional contract interpretation principles would dictate that, where the parties used a provision in one section of the contract, but not in another, the parties are deemed to have intended the asymmetry. The *Reliance Group* court, however, took the presence of the exclusion in one section of the policy as indication that the parties intended the exclusion to apply to all coverage sections; again, effectively imposing its own terms in the policy. *See id.*[4]

Second, both courts seemed to equate a settlement with a tacit determination that the insured in fact engaged in the alleged wrongful conduct. As the *Reliance Group* court articulated: "The *settlement* of [the underlying] action . . . *was essentially equivalent to* a determination . . . that [the insured] had been unjustly enriched." *Id.* at 55 (emphasis added).

[4] As we shall see at pages 18-21 below, the First Circuit more recently reversed a district court's refusal to enforce a not dissimilar asymmetry and rejected a carrier's plea to deny coverage on *Level 3* type grounds. See *Genzyme Corp. v. Fed. Ins. Co.*, 622 F.3d 62 (1st Cir. 2010).

Arguably, the fact that a preliminary injunction was ordered and a temporary constructive trust imposed takes *Reliance Group* out of the realm of the typical settlement made prior to any findings of fact. The same cannot be said for *Level 3* where the parties settled after the first day of trial without any factual findings, judgment or other final adjudication. *Level 3*, 272 F.3d at 911. The *Level 3* court nevertheless reasoned that the insured's settlement was proof enough of wrongful conduct because the insureds "settled with the plaintiffs in the fraud suit for [a] not inconsiderable amount . . . after the trial had begun and much of the expense of defending the suit had therefore already been incurred." *Id.* The court also faulted the insured for making "no attempt to show that the fraud suit was groundless and the settlement merely an effort to avoid the expense of defending a nuisance suit." *Id.* at 911-12. In the court's view, a "rational defendant" would settle a law suit for a substantial sum only if there were truth to the allegations. *Id.* at 911.

Even aside from the fact that the settlement of the underlying securities action addressed in *Level 3* was for only seventeen percent of the plaintiffs' claimed damages, this analysis flips on its head the fundamental tenet that a settlement is not evidence of liability; parties enter into settlements (even for amounts exceeding nuisance value) for numerous reasons, many of which have nothing to do with the merits of the allegations. Indeed, virtually every securities action settles, for one reason or another. The *Level 3* decision comes close to accepting the insurer's position that, despite having a "final adjudication" requirement in the fraud exclusion, insurability does not depend on a finding of fraud, but instead is based the "nature of the claim" being settled. *Id.*; *see also* Fed. Reply Br. at *11 (whether underlying plaintiffs "were, in fact, defrauded makes no difference. . . . The determination of insurability . . . is based on whether the

claim that was settled was for the return of wrongfully-acquired property") (emphasis in original). Stated another way, under the reasoning of *Level 3,* a settlement resolving fraud allegations could be said to amount to a finding that the insured engaged in fraud.

Evidently recognizing the inherent incongruity of its reasoning, the *Level 3* court considered how it would deal with circumstances where an insured has "shown that the fraud suit was groundless, that there was no ill-gotten gain that insurance would enable it to keep." *Level 3*, 272 F.3d at 912. The court is at a loss to explain how its rule would apply: "We need not decide; and prudence is definitely the better part of valor here, since we can find no guidance on the point from cases or other materials." *Id.*

C. Focus On The General "Nature" Of The Claims And Remedy

The final aspect of note in *Level 3* is the focus the court places on determining the "nature" of the claims and remedies. For example, the court acknowledged that the underlying plaintiffs in *Level 3* did not request restitution or rescissory damages, but rather sought "standard damages relief" in a securities suit—"the difference between the value of the stock at the time of the trial and the price they had received for the stock from Level 3." *Level 3*, 272 F.3d at 910. Nevertheless, in the court's view, the damages were "restitutionary in character" because they sought "to divest the defendant of the present value of the property obtained by fraud, minus the cost to the defendant of obtaining the property." *Id.* at 910-11. Emphasizing the point, the court declared:

> How the claim or judgment order or settlement is worded is irrelevant. An insured incurs no loss within the meaning of the insurance contract by being compelled to return property that it had stolen, even if a more polite word than "stolen" is used to characterize the claim for the property's return.

Id. at 911.

Consequently, an insured may find itself out of luck where a court decides the underlying claims or remedies can be characterized as "restitutionary in character," even where the underlying plaintiff does not pray for restitution or assert claims for unjust enrichment, much less establish that wrongdoing occurred. This broad-brush approach dovetails with the *Level 3* court's belief that it is the "nature of the claim" that matters—not whether the claim is settled or adjudicated. In so ruling, the court failed entirely to address the fact that the individual insured director—who was indemnified by the company, therefore giving rise to the insurance claim—was not being asked to return an ill-gotten gain and was not even the defendant the court suggested had reaped the ill-gotten gain at issue. The loss complained of by the underlying plaintiffs was (ostensibly) a gain incurred by the corporate defendant, not by the individual defendant. Had the court focused on this basic fact, the court would have concluded that characterizing the settlement as restitution as to the individual defendant was inapt. And as we shall see, a rule that bars coverage for damages that are "restitutionary in character" is necessarily vague in application and invites litigants to test the outer boundaries of the concept.

II. THE LEGACY OF *LEVEL 3*: LACK OF UNIFORMITY AND RETRENCHMENT

As Section I demonstrates, the foundations of *Level 3* are questionable in many respects. The reasoning is inconsistent with accepted canons of contract interpretation, principles of freedom of contract, and the ability of parties to compromise disputes without admitting fault. It can hardly be surprising, then, that in the years following the *Level 3* decision, courts have come to markedly different positions on the insurability of disgorgement claims and restitutionary-type damages. Indeed, early insurer-successes following *Level 3* led insurers to advance *Level 3*

arguments in many types of cases in an attempt to expand its reach. Some of the more aggressive expansion efforts caused courts to adopt more rigorous analyses, focusing more on policy language and away from the stance against insurability of restitutionary-type damages seen in *Level 3*. The following sections offer an illustration of the varying approaches courts have adopted.

A. Adherence To *Level 3*

A number of courts have adopted the *Level 3* approach to coverage for restitutionary-type payments. For example, in *CNL Hotels & Resorts, Inc. v. Twin City Fire Ins. Co.*, 291 Fed. Appx. 220, 222 (11th Cir. 2008), the insured company, CNL, was alleged to have overvalued its stock by $8 a share in an offering. CNL also obtained shareholder approval for a merger through an allegedly misleading proxy statement and allegedly proposed to pay an excessive price for the target entity. *Id.* Class action shareholder suits ensued; one class of plaintiffs "sought a refund of $8 to compensate them for the difference between the price that they paid for the stock and the price at which" the stock was valued by an independent advisor. *Id.* CNL eventually settled this litigation for $35 million. A second class of shareholders alleged that CNL proposed to pay an excessive price for the target company; this litigation was resolved by restructuring the merger deal and paying plaintiffs' attorneys fees. *Id.*

Certain of CNL's excess insurers denied coverage and the Eleventh Circuit agreed, holding that the $35 million settlement "was restitutionary in nature." *Id.* at 223 (citing *Level 3*, 272 F.3d at 910). In so holding, the Eleventh Circuit was not persuaded that, because the underlying plaintiffs did not attempt to show fraud, the case fell outside *Level 3*'s ambit:

> The return of money received through a violation of law, even if the actions of the recipient were innocent, constitutes a restitution payment, not a "loss." It is immaterial whether CNL committed fraud. CNL received money directly from the Purchaser Class through the sale of shares, and CNL returned some of the money after the Purchaser Class alleged that the sale of shares by CNL violated the law.

Id. The Eleventh Circuit was equally unmoved by the fact that Section 11 (the statue under which the underlying lawsuit was brought) provides for an award of damages as measured by the loss to the plaintiff shareholder, because "in this appeal the loss to the plaintiff is equal to the gain of the defendant." *Id.* at 224.

As for CNL's payment of attorney's fees in connection with the excessive price proposed to be paid under the merger, the court held that the policy's so-called "bump up" exclusion "removes the payment from the definition of 'loss.'" *Id.* at 225. The bump-up carve-out to the definition of loss in that policy provided:

> In the event of a Claim alleging that the price or consideration paid or proposed to be paid in any transaction involving all or substantially all the ownership interest in or assets of an entity is inadequate or excessive, Loss with respect to such Claim shall not include any amount of damages, settlements or judgment representing the amount by which such price or consideration is effectively increased or decreased, or to any plaintiff's counsel fees and costs arising out of such Claim; provided, however, that this paragraph shall not apply to Claims Expenses incurred in the defense or appeal of such Claim.

CNL Hotels & Resorts, Inc. v. Houston Cas. Co., 2007 WL 1363757, at *2 (M.D. Fla. May 8, 2007).[5]

The Fifth Circuit also followed suit to *Level 3* in *TransTexas Gas Corp. v. U.S. Bank Nat'l Assoc.*, 597 F.3d 298 (5th Cir. 2010), a case addressing coverage for what was determined to be a fraudulent transfer under the Bankruptcy Code. In the underlying action, the trial court found (and the Fifth Circuit affirmed) that payments made to a company's CEO, who controlled the company and threatened litigation against it if his demands for severance payments were not met, were fraudulent transfers under the Bankruptcy Code. *See Nat'l Union Fire Ins. Co. of Pittsburgh, PA v. U.S. Bank*, 2008 WL 2405975, at *2 (S.D. Tex. June 11, 2008); *In re TransTexas*, 597 F.3d at 305-308. Consequently, the CEO was ordered to repay the amounts determined to be fraudulent transfers. *In re TransTexas*, 597 F.3d at 303. The company's insurer refused to indemnify the payment, arguing that it was not a "loss" within the meaning of the policy's definition of that term, which was defined to include "damages, settlements, [and] judgments," but excluded "matters which may be deemed uninsurable under the law." *Id.* at 309.

Taking its cue from *Level 3*, the Fifth Circuit sidestepped the issue of whether the policy's "profit or advantage" exclusion would bar coverage, and instead concluded that the insurer did not owe an indemnity obligation because "the return of funds due to a fraudulent transfer is in the nature of restitution." *Id.* at 311 n.5, 310. In so holding, the Fifth Circuit relied on *Level 3*, noting that it agreed with the *Level 3* court's "interpretation" that "a 'loss' within the

[5] The court ended up remanding the case for a determination as to whether the insurers had properly filed the endorsement adding the bump-up exclusion with the state's insurance regulator. *Id.*

meaning of an insurance contract does not include the restoration of ill-gotten gain." *Id.* (internal quotations omitted).[6]

B. Expansion of *Level 3* Precipitates Closer Scrutiny By Courts

Successes in *Level 3* and other courts may have emboldened insurers to press disgorgement and public policy uninsurability arguments to new extremes, leading courts to begin staking out the limitations of the doctrine that *Level 3* had left unattended.

Genzyme Corp. v. Fed. Ins. Co., 622 F.3d 62 (1st Cir. 2010), is one of the key decisions signaling a turning point in courts' willingness to go along with *Level 3*-type arguments. In that case, Genzyme exercised its option to exchange shares of a "tracking stock" for shares of general common stock in the company. *Id.* at 65. The price paid for the exchanged shares was determined by a formula set out in Genzyme's articles of organization and was based on the market value of the exchanged shares. *Id.* at 64-65. Following the share exchange, holders of the exchanged shares sued Genzyme and its officers and directors alleging the defendants artificially depressed the market value of the shares "so that Genzyme could fold the [division] into the General Division at an exchange rate that would be favorable to General Division shareholders," effectively favoring one class of noteholders over another. *Id.* at 66.

The lawsuit was settled, and Federal Insurance denied coverage arguing in the first instance that the settlement was not an insurable "loss" because it did not fall within the common meaning of the term, coverage was against public policy, and in the alternative, a bump-up

[6] The Fifth Circuit has an opportunity to revisit its holding in *TransTexas* when it decides *John M. O'Quinn, P.C. v. Lexington Ins. Co.*, No. 16-20224, a case that raises the issue of insurability of restitution in light of more recent Texas state case law.

exclusion in the policy applied. *Genzyme Corp. v. Fed. Ins. Co.*, 657 F. Supp. 2d 282, 287, 288 (D. Mass. 2009). The district court held that there was no coverage. Reversing in part and affirming in part, the First Circuit held that public policy did not bar coverage, but concluded that the bump-up provision applied to exclude that portion of the settlement attributable to claims made against the corporate entity defendant. A comparison of the district court and First Circuit's analyses is instructive.

On the question of whether the settlement constituted a "loss," the district court announced that it would "not attempt to make hairsplitting distinctions between the commonly understood meaning of the word 'loss' and the requirements of public policy," but would instead "use considerations of public policy to guide its inquiry into whether the Settlement Payment constitutes an insurance 'loss'"—an approach that mirrors that taken in *Level 3* but with a transparent acknowledgment of its methods. *Genzyme*, 657 F. Supp. 2d at 288. The district court then admitted that it was "hard to see how Genzyme received any material benefit from the Share Exchange that could be disgorged by a restitutionary remedy," and that, consequently, the case did "not fit comfortably within the existing case law holding that the mere return of an ill-gotten gain is uninsurable." *Id.* at 289-90. Undeterred, the court nevertheless viewed the company's conduct as of the type that cannot be insured: "Genzyme should not be able to divide the benefits of equity ownership among its shareholders one way, redistribute those benefits, and then demand indemnification from its insurer for the redivision." *Id.* at 291.

Reversing the district court, the First Circuit reviewed the requirements for implying a public policy bar to coverage and found "no basis in Massachusetts legislation or precedent for concluding that the settlement payment is uninsurable as a matter of public policy." *Genzyme*,

622 F.3d at 69. The appellate court also noted that an exception of the type proposed by the insurer "would have the effect of making it impossible to secure coverage for damages awards in routine securities litigation" where one class of shareholders alleges it was treated unfairly; "[i]f the parties wish to exclude such coverage, it is common to include limiting provisions" like the bump-up provision. *Id.* at 70. The First Circuit separately considered the argument that a *Level 3* rule—that "a restitutionary payment is not insurable"—applied. *Id.* The court held (without deciding that Massachusetts recognized the doctrine) that *Level 3* did not apply because "Genzyme obtained no identifiable asset in the share exchange and therefore the settlement payment cannot represent the restoration to the plaintiffs of some amount Genzyme had improperly taken and withheld." *Id.*

The First Circuit did affirm, in part, the district court's alternative finding, that the policy's bump-up provision applied. That provision read:

> [Federal] shall not be liable under Insuring Clause 3 [entity coverage] for that part of Loss, other than Defense Costs . . . which is based upon, arising from, or in consequence of the actual or proposed payment by any Insured Organization of allegedly inadequate or excessive consideration in connection with its purchase of securities issued by [any Insured Organization].

Id. at 72. Despite acknowledging that, on its face, the provision applied only to claims made against the company and not claims against directors or officers, the district court found its way to applying the exclusion to claims against the company *and* claims against the individual insureds. Channeling *Level 3* and *Reliance Group*, the district court appeared persuaded that "it makes little sense to allow a corporation to sidestep coverage limitation in its insurance policy through the simple expedient of claiming that a settlement payment was made to indemnify its

directors and officers." *Genzyme*, 657 F. Supp. 2d at 294; *see also id.* at 294-95 (reasoning that such an approach would encourage fraud by insured corporations, quoting *Reliance Group*).

The First Circuit disagreed, holding that "[o]n the face of the policy, the Bump-Up clause only applies to [entity coverage]" and thus "cannot bar Genzyme from seeking recovery" for amounts "it paid to indemnify its officers and directors." *Genzyme*, 622 F.3d at 73. The appellate court observed that the policy's allocation provision "specifically contemplate[d] a situation in which the Bump-Up clause" would bar coverage as to claims against the company, but not the insured individuals. *Id.* The First Circuit acknowledged that securities claims are often made against both the company and its directors and officers, but that "giving effect to the plain language of the policy does nothing to allow a corporation to sidestep" coverage limitations, but rather enforces the "express benefit of the insurance policy" for which the insured paid. *Id.* at 74 (internal quotations omitted).

As the sections below evidence, in many ways *Genzyme* set the stage for other courts to engage in more rigorous analyses and police the boundaries of any disgorgement-based arguments for denying coverage.

C. Trimming *Level 3*: Coverage Where The Insured Did Not Receive A Benefit

One of the rules coming out of *Genzyme* is that a case does not "fit within the framework of *Level 3*" where the insured "obtained no identifiable asset" and therefore, a settlement "cannot represent the restoration" of ill-gotten gains. *Genzyme*, 622 F.3d at 70. In *J.P. Morgan Securities Inc. v. Vigilant Ins. Co.*, 21 N.Y.3d 324, 336 (2013), the New York Court of Appeals

applied this principle where an insured's payment, "although labeled disgorgement . . . [does] not actually represent the disgorgement of [the insured's] own profits."

In that case, Bear Stearns entered into a settlement with the SEC under which it agreed to pay $160 million as "disgorgement." *Id.* at 330. The SEC issued an order detailing its findings that Bear Stearns had "willfully" violated federal securities laws by "facilitat[ing] a substantial amount of late trading and deceptive market timing" on behalf of its customers. *Id.* at 331 (internal quotations omitted). The insured acknowledged that it may be reasonable to preclude coverage for "disgorgement of its own ill-gotten gains," but argued that such a rule did not apply as to Bear Stearns because "the bulk of the disgorgement payment—approximately $140 million—represented the improper profits acquired by third-party hedge fund customers, not revenue that Bear Stearns itself pocketed." *Id.* at 333, 336. The New York Court of Appeals agreed. Distinguishing other cases where the "SEC's findings conclusively linked the disgorgement payment to improperly acquired funds in the hands of the insured," the court stated:

> In this case, in contrast, Bear Stearns alleges that it is not pursuing recoupment for the turnover of its own improperly acquired profits and, therefore, it would not be unjustly enriched by securing indemnity. The Insurers have not identified a single precedent, from New York or otherwise, in which coverage was prohibited where, as Bear Stearns claims, the disgorgement payment was (at least in large part) linked to gains that went to others.

Id. at 337 (internal quotations omitted).

D. Trimming *Level 3*: Coverage Where Neither The Claim Nor The Remedy Are Restitutionary In Nature

In other instances, courts have adopted *Genzyme*'s attitude of skepticism toward expansive views of what counts as "restitutionary in character." For example, in *William Beaumont Hosp. v. Fed. Ins. Co.*, 2013 WL 992552 (E.D. Mich. Mar. 13, 2013), Federal Insurance refused to cover a settlement resolving an antitrust suit against the insured hospital (coverage arose under an endorsement specially extending coverage to "Claims for Antitrust Activities"). The underlying suit was brought by registered nurses employed by hospitals in the Detroit area who accused the hospitals of conspiring to depress the nurses' compensation. *Id.* at *3. The nurses sued to "recover for the compensation properly earned by RNs . . . but unlawfully retained by [the] hospitals as a result of the conspiracy . . . ." *Id.* Federal argued that the insured's settlement payment was not within the policy's definition of "loss" and also was not in accord with the principle of *Level 3* that "coverage for restitution or disgorgement is uninsurable as a matter of public policy." *Id.* at *9.

The definition of "loss" under the policy in *Beaumont* in fact carved out the type of restitutionary claims that animated *Level 3*; that provision exempted from "loss":

> Solely with respect to any Claim based upon, arising from or in consequence of profit, remuneration or advantage to which an Insured was not legally entitled, the term Loss . . . shall not include disgorgement by any insured or any amount reimbursed by any Insured Person.

Id. at *5. But neither this specific carve-out nor the allegations claiming that the insured "unlawfully retained" benefits persuaded the district court that coverage was unavailable. Instead, the court concluded that the carve-out quoted above did not apply because the antitrust

suit arose under the Sherman Act, violation of which requires proof of concerted action among defendants that produces adverse anti-competitive effects that harms the plaintiff—the plaintiffs' claims did not depend on proving that the defendants obtained a "profit, remuneration or advantage to which [they were] not legally entitled." *Id.* at *6 (alterations omitted). The carve-out provision did not apply for the additional reason that the underlying plaintiffs did not seek disgorgement as a remedy. *Id.* at *7. The court noted that the plaintiffs did not include restitution in their prayer for relief and their damages expert computed damages based on "the difference between the actual earnings of the[] class members . . . and the 'but-for' earnings these RNs would have been paid in the absence of the alleged conspiracy"—a remedy that the court noted was intended to compensate the plaintiffs, not disgorge profits earned by the insured. *Id.* at *8.

Finally, the court rejected entirely the insurer's reliance on *Level 3* and the idea that a public policy rule barred coverage explaining that, the insurer "need not identify any sort of public policy basis for reading the Policy as excluding the remedy of disgorgement from its definition of 'loss'" because "the ***Policy itself*** makes this exclusion . . . ." *Id.* at *9 (emphasis in original). The court then reiterated its finding that the underlying suit did not involve claims or remedies that were "restitutionary in nature":

> While the [underlying] complaint makes passing reference to RN compensation "unlawfully retained" by the defendant hospitals, and while it is undoubtedly possible, as a matter of abstract, zero-sum economic theory, to assert that every additional dollar in wages the plaintiff RNs allegedly would have received but for the antitrust conspiracy alleged in this complaint is money unlawfully "withheld" or "retained" by the defendant hospitals, the Court concludes that it would stretch the notion of "disgorgement" beyond all accepted meaning in the law to say that this remedy is

> being pursued against the defendant hospitals in the [underlying] litigation.

Id. at *11.

E. Trimming *Level 3*: Coverage For Settlements Resolving Allegations Of Ill-Gotten Gains

Another way in which courts policed the boundaries is to allow coverage for *settlements* resolving allegations of fraud, unjust enrichment, or claims seeking restitutionary-type damages. Three recent cases have taken this approach.

In the first, *U.S. Bank National Assoc. v. Indian Harbor Ins. Co.*, a consumer class action was filed against U.S. Bank asserting breach of contract, unconscionability, conversion, and unjust enrichment. 68 F. Supp. 3d 1044, 1046 (D. Minn. 2014). The bank was alleged to have posted its customers' debit-card transactions in a manner so as to maximize the amount of overdraft fees assessed; the plaintiffs sought, *inter alia*, "return of the excess over draft fees, and damages." *Id.* When the bank sought coverage for a settlement it reached with the plaintiffs, its insurers denied coverage on grounds that "the settlement require[d] U.S. Bank to return unlawfully assessed overdraft fees . . ., returning something that one wrongfully took . . . constitutes restitution, and restitution is uninsurable." *Id.* at 1049.

The district court assumed without deciding that the governing law (Delaware) precluded "insurance coverage for restitution as a matter of public policy," the court nevertheless found coverage was available for the settlement. *Id.* at 1049. Critical to the court's analysis was recognition that the policy contained a profit exclusion barring coverage for:

> Loss in connection with any Claim . . . brought about or contributed in fact by any . . . profit or remuneration gained by [the

> insured] to which it is not legally entitled . . . as determined by a final adjudication in the underlying action.

Id. at 1047 (internal quotations omitted). The court reasoned that, if it "interpreted [the definition of Loss] to preclude coverage for a payment based on a settlement resolving claims for restitution, [the court] would nullify the [profit exclusion] that precludes coverage for a payment based only on a final adjudication determination that the claims warrant restitution." *Id.* at 1050. In an implicit rebuke of the *Level 3* approach, the *U.S. Bank* court "emphasize[d] that it will not automatically presume—as the Insurers do—that the settlement constitutes restitution because it resolved claims alleging ill-gotten gains and seeking disgorgement for those gains." *Id.* The court went on to explain:

> Not only does the clear policy language, and especially the [profit exclusion], prevent the Court from doing so. But the common-sense effect of a settlement does as well. If a settlement resolves claims alleging unlawful activity but excludes an admission of liability for the activity, it does not establish that the underlying allegations are true or false.

Id.

The court went on to distinguish other decisions in the *Level 3* line of cases and, in a final signal of its departure from the *Level 3* approach, rebuffed the suggestion that its ruling would incentivize insureds to settle rather than litigate the underlying lawsuits, concluding that the insurers "could have refused consent" to the settlement "or conditioned consent on an admission of liability for wrongdoing or a stipulation that the payment was restitution." *Id.* at 1053.

The Texas Court of Appeals came to a similar conclusion in *Burks v. XL Specialty Ins. Co.*, 534 S.W.3d 458 (Tex. Ct. App. 2015).[7] In the underlying proceeding, a bankruptcy plan agent sought to recover allegedly fraudulent transfers of money and stock to an insured CFO and sought to avoid obligations under a separation agreement to compensate the CFO. *Id.* at 460. The company's D&O insurer refused to fund the settlement, arguing that the settlement "represent[ed] uninsurable disgorgement or restitution." *Id.* at 467.

Echoing *U.S. Bank* and drawing a contrast with *TransTexas*, the Texas Court of Appeals refused to grant summary judgment to the insurer, reasoning that, while "[a] ***judgment*** ordering the repayment of a fraudulent transfer under the Bankruptcy Code may indicate that an insured has paid restitution or disgorgement," "the mere fact of settlement does not indicate admission of the allegations in a complaint" and the court would "not automatically presume . . . that the settlement constitutes restitution because it resolved claims alleging ill-gotten gains and seeking disgorgement of those gains." *Id.* at 167-68 (internal citations and quotations omitted). Notably, the court "assume[d] without deciding that disgorgement is 'uninsurable' in Texas," but cautioned that "[g]iven the strong policy in Texas favoring the right of parties to contract and the lack of any Texas authority holding that insuring against disgorgement is against public policy," it rendered "no opinion on the matter." *Id.* at 465 n.5.

Relying on *Level 3*, the insurer in *Burks* argued that it "can't be right" that a "judgment for disgorgement is uninsurable while a settlement is not." *Id.* at 469. As in *U.S. Bank*, the

[7] Following the Texas Court of Appeals's decision in *Burks*, the parties settled, leading the court to vacate its judgment. The court specifically ruled, however, that its opinion would not be withdrawn. *See Burks v. XL Specialty Ins. Co.*, 534 S.W.3d 470 (Mem.) (Tex. Ct. App. 2016).

Burks court did not agree with the logic of *Level 3*, asserting instead that "the sweeping *Level 3* decision has never been cited as authority by a Texas court, [and] even the Seventh Circuit acknowledged that not all settlements in satisfaction of claims alleging ill-gotten gains necessarily would be excluded from coverage." *Id.*

Finally, in *TIAA-CREF v. Illinois National Ins. Co.*, 2016 WL 6534271, at *3 (Super. Ct. Del. Oct. 20, 2016), the court determined that the insured was entitled to coverage for settlements resolving class action lawsuits alleging that the insured delayed processing its customers' withdrawal requests and failed to pay its customers gains earned on their accounts between the date the customer made the withdrawal order and the date when the transaction actually took place. Focusing on New York law, the Delaware court distinguished prior New York cases as involving SEC Orders that "conclusive[ly] link[ed]" "the insured's misconduct and the payment of monies." *Id.* at *12. By contrast, TIAA-CREF "settled, expressly denying any liability," consequently, the court found "no conclusive link between the settlements in the Underlying Actions and wrongdoing by TIAA-CREF that would render the settlement agreements uninsurable disgorgement." *Id.*

F. Rejecting The *Level 3* Public Policy Rationale

Several courts have rejected the idea that public policy bars coverage for payments that are restitutionary in nature.

For example, in *Cohen v. Lovitt & Touché, Inc.*, 308 P.3d 1196, 1198 (Ariz. Ct. App. 2013), underlying plaintiffs sued the owners of a ranch, alleging that the company violated state law requiring that all moneys collected as a "service" charge (*i.e.*, tips) be paid directly to the company's employees. The underlying lawsuit was settled for $16 million. In the coverage

action, the trial court determined that the underlying settlement payment was "restitutionary" and "uninsurable as a matter of public policy." *Id.* The Arizona Court of Appeals reversed, reasoning that such a "rule is categorical and would render losses from restitutionary payments uninsurable, regardless of the specific language of the agreement or the specific circumstances of the claim." *Id.* at 1199. The court noted that, "[s]uch an approach forecloses consideration of variation in contractual language which could substantially mitigate or even eliminate any public policy concerns" and has the potential to strip "well-intentioned directors and officers from the type of unforeseen losses" that are intended to be covered by insurance. *Id.* at 1200.

Similarly, in an earlier case, the court in *Virginia Mason Medical Center* dismissed arguments that a settlement was uninsurable where the insured agreed to "pay each class member a sum equal to the amount which that class member had paid" for an allegedly improper hospital charge. *Virginia Mason Medical Center v. Executive Risk Indem. Inc.*, 2007 WL 3473683 at *4 (W.D. Wash. Nov. 14, 2007) *aff'd*, 331 Fed. Appx. 473 (9th Cir. 2009). The court rejected the insurer's argument that "loss" had an "ordinary meaning" separate from the policy definition, and that the ordinary meaning did not include a "refund of funds that were not properly obtained." *Id.* at *3. The court explained that "[t]he Policy's definition of 'loss' clearly includes settlements resulting from claims alleging wrongful conduct" and "[d]isallowing coverage for the [] settlement on the grounds that the funds were wrongfully gained would render nonsensical the Policy's explicit coverage for settlements resulting from a wrongful act." *Id.* at *2-3. *See also Virginia Mason*, 331 Fed Appx. at 474 ("Executive Risk's reliance on the ordinary meaning of the term 'loss' is misplaced because the insurance policy specifically defines 'loss' to include payments made for damages caused by omissions and misleading statements.").

Similarly, the court was not persuaded by the insurer's arguments (which relied on *Level 3*) that the settlement was not covered because it was "restitutionary in nature." *Id.* The court explained that it "reject[ed] the Seventh Circuit's attempt to characterize the nature of a settlement," reasoning that "restitution . . . is awarded at the conclusion of litigation once culpability is allocated, while a settlement is a negotiated bargain between two parties who have foregone the right to a finding of culpability." *Virginia Mason*, 2007 WL 3473683 at *3. *See also Virginia Mason*, 331 Fed. Appx. at 474 ("The settlement reflected a compromise of asserted damages arising from the plaintiffs' non-disclosure claim in the underlying action, rather than disgorgement of unlawful gains.").

The *Virginia Mason* court also declined to apply a public policy bar to coverage, stating that the policy "insure[d] Virginia Mason for damages or settlements resulting from claims alleging wrongful acts," and that "vague public policy arguments should not limit express language in a policy." *Virginia Mason*, 2007 WL 3473683 at *4. *See also Virginia Mason*, 331 Fed. Appx. at 474 (noting "the lack of any Washington public policy militating against coverage under the policy").

Separately, the insurer contended that the settlement fell within the scope of the policy's fraud and profit exclusion, which the court quoted as applying to:

> Claims brought about or contributed to in fact (1) by any dishonest or fraudulent act or omission . . . or (2) by an Insured gaining any profit, remuneration or advantage to which such Insured was not legally entitled.

Virginia Mason, 2007 WL 3473683 at *4. The exclusion did not apply because, as the district court put it, "the phrase 'in fact' requires an entry of some pertinent factual finding" to trigger

the exclusion—a finding that the underlying court did not make and the insurer failed to present evidence that the insured's conduct triggered the exclusion. *Id.* at *5. *See also Virginia Mason*, 331 Fed. Appx. at 474 (affirming on the separate ground that the exclusion did not apply because the insured "did not return something to which it was not entitled").

Finally, in *Houston Casualty Co. v. Sprint Nextel Corp.*, 2010 WL 4852649 (E.D. Va. Nov. 22, 2010), an insurer, relying on the *Genzyme* district court decision, denied coverage for a securities class action settlement resolving allegations that the insured company and its directors and officers breached their fiduciary duties when they combined two different tracking stocks, allegedly undervaluing one of the stocks. The insurer argued, among other things, that the settlement did not constitute a loss because the company "incurr[ed] no loss of assets due to the recalibration, [and therefore] there is nothing for an insurer to indemnify" and because it was uninsurable as a matter of Kansas public policy. *Id.* at *4, 5.

As to the first argument, the district court dismissed the position, stating that "[t]he mere fact that a securities settlement results in a transfer from a corporation to a subset of its shareholders does not mean that the settlement fails to qualify as a 'loss' to the corporation." *Id.*

Nor did the court accept the insurers invitation to apply a public policy exception to coverage, observing that a court can recognize such an exception only if the rule is "so thoroughly established as a state of public mind so united and so definite and fixed that its existence is not subject to any substantial doubt." *Id.* But as the court pointed out, "[n]o Kansas statute prohibits insurance coverage for claims alleging that D&Os breached their fiduciary duties either generally or specifically in connection with the settling of an appropriate conversion ratio for the recombination of two tracking stocks." *Id.* Indeed, as the court astutely noted,

Kanas statutory law—like Delaware law—provides that a "corporation shall have power to purchase and maintain insurance on behalf of D&Os whether or not the corporation would have the power to indemnify such person against such liability. In other words, Kansas law expressly provides that even wrongdoing so severe as to be unindemnifiable by the corporation is nonetheless insurable under a D&O policy." *Id.* at *6 (internal quotations omitted).

III. A MORE SENSIBLE APPROACH: APPLYING THE POLICY AS WRITTEN

Thus far, the discussion in this paper has highlighted several problematic aspects of the *Level 3* court's analysis and has shown how the foundations of the *Level 3* doctrine have resulted in a lack of uniformity among courts concerning insurability of disgorgement and restitutionary-type claims.

This section identifies four rationales that appear to motivate courts to adopt *Level 3*-like rules. This section then describes different policy provisions currently available on the market that allow parties to address the *Level 3* rationales more precisely and with more certainty, relieving courts from having to engage in unmoored inquiries into the "nature" of a claim, settlement, or judgment.

A. Rationales Motivating The *Level 3* Doctrine

As the case survey above illustrates, there appear to be four principal rationales motivating courts to adopt *Level 3*-like rules.

Moral hazard. A frequently cited justification for adopting the *Level 3* doctrine is the potential for moral hazard if insurance coverage is recognized—that is, by indemnifying an insured for certain wrongful conduct, one risks removing the insured's incentive to follow the law. As the California Supreme Court explained: "[T]o permit the wrongdoer to transfer the

cost of disgorgement to an insurer would eliminate the incentive for obeying the law." *Bank of the West*, 2 Cal.4th at 1269.

Fraud and intentional violations of the law. A related rationale is the desire not to allow insurance for fraud or other intentionally illegal conduct. This rationale is prominent in *Level 3* itself. The relatively short *Level 3* opinion uses the word "stolen" no less than six times and "fraud" 16 times. The sentiment is clear enough: Insurance should not be used to indemnify a thief. *See Level 3*, 272 F.3d at 911 (allowing insured to collect insurance for settlement "would enable Level 3 to retain the profit it had made from a fraud").

You can't lose something that wasn't yours to begin with. Courts are also motivated by the common sense thinking that one simply does not suffer a "loss" by having to return something to which one never had ownership or entitlement, regardless of one's intent. *See Local 705 Int'l Broth. of Teamsters*, 316 Ill. App. 3d at 396 ("[The insured] simply cannot lose that to which it was not legally entitled.") (internal quotations omitted).

Insurance is not intended to fund the cost of doing business. In some of the cases where insurers have pressed "restitutionary in character" arguments to the extreme, sympathetic courts have justified a coverage denial on grounds that the insured is attempting to shift the cost of doing business on to its insurers. *See Genzyme*, 657 F. Supp. 2d at 291 ("Genzyme should not be able to divide the benefits of equity ownership among its shareholders one way, redistribute those benefits, and then demand indemnification from its insurer for the redivision.").

B. Available Policy Language To Address The *Level 3* Rationales

Whatever the merit of the underlying rationales for *Level 3* and its kin, modern professional and management liability policies have more precise tools at their disposal to

address those concerns. It is important not to lose sight of the fact that insurance coverage is almost always a matter of contract—if insurers are concerned with insuring certain types of conduct, or suspect their insureds may attempt to bypass an exclusion through a settlement, those "problems" can be solved by drafting, pricing, or declining to take on a risk. As the Arizona Court of Appeal recognized, "parties to an insurance contract are fully capable of drafting language that prohibits coverage when an insured has intentionally or recklessly acquired property in a wrongful fashion." *Cohen*, 233 Ariz. at 1200.

As an example, the following four policy provisions, when applied according to their terms, would substantially, if not entirely, address the four rationales outlined above and allow insurers to calibrate their coverage obligations to align with their risk tolerance for specific insureds.

Fraud and intentional violation of the law exclusions. Contemporary management and professional liability policies almost invariably contain exclusions that bar coverage for fraudulent or intentionally illegal conduct. One such exclusion that is widely available on the market precludes coverage for "deliberate criminal or deliberate fraudulent acts" of the insured, "if established by any final, non-appealable adjudication" in the underlying proceedings. Variations in language allow an insurer to broaden the scope of the exclusion, for instance, by including "deliberate violation of any statute, rule, or law"; by triggering the exclusion upon findings made in "any" underlying proceeding rather than "the" underlying proceeding; or by replacing the requirement of a determination in the underlying proceeding with an allowance for the insurer itself to prove deliberate fraud or criminal conduct. At the most extreme end, an insurer could entirely eliminate the need for a determination of fact as to whether the insured

engaged fraud, thereby potentially excluding even settlements that resolve allegations of fraud. The fact that most insurers are unable for commercial reasons to insist on such a broad exclusion should not eclipse the fact that such language is available.

Profit/financial advantage exclusions. Whereas fraud exclusions typically focus on the intentionally illegal conduct of the insured, insurers also have at their disposal profit exclusions that focus on financial benefits gained by the insured. A typical profit exclusion bars coverage for claims "arising out of, based upon or attributable to any remuneration, profit or other financial advantage to which the Insured was not legally entitled if established by any final, non-appealable adjudication in any underlying." Again, variations in the exclusionary language allow the parties to properly price the risk and gain certainty on the scope of coverage. For example, the exclusion can be written so to apply only where "the insured" against whom the claim is made is also "the insured" who allegedly gained a profit or advantage; by contrast, the exclusion might be written to apply to claims arising out of a profit gained by "any insured." Similarly, the exclusion can include the same variations in the final adjudication requirement discussed above. Finally, an insurer may choose to broaden or narrow the types of benefits—remuneration, profit, advantage—that trigger the exclusion.

"Bump-up" exclusions. Different versions of the bump-up exclusion available on the market address the stated concern that an insured is purportedly shifting the costs of a business transaction to its insurer, for example, where shareholders of a target company allege the insured entity paid too little to acquire the target. One example of a bump-up provision, taken from *Genzyme*, exempts from coverage (for claims against the company), "Loss, other than Defense Costs . . . which is based upon, arising from, or in consequence of the actual or proposed

payment by any Insured Organization of allegedly inadequate or excessive consideration in connection with its purchase of securities issued by [any Insured Organization]." *Genzyme*, 622 F.3d at 72. The bump-up provision can be modified so that it applies to claims of inadequate consideration in connection with the insured entity's purchase of securities issued by *any* company—not just the insured company. Other versions, expressly include plaintiffs' counsel fees within the scope of the carve-out.

Specificity in the definition of "loss." In addition to the finely-tuned exclusions discussed above, a more blunt tool is available to address the *Level 3* rationales: Insurers can negotiate express carve outs for disgorgement or restitution in the definition of "loss" or "damages" in their policies.

* * *

Beyond the four provisions highlighted above, there are several other policy terms—*e.g.*, retentions, consent rights, allocation provisions—that allow parties to an insurance contract to address and eliminate, to the extent they can through negotiations, the potential moral hazard and other public policy worries motivating *Level 3*-type rules.

IV. CONCLUSION.

Accepting that the underlying rationales motiving the *Level 3* doctrine may be understandable, the discussion above should make clear that the *Level 3* approach to addressing those concerns results in unpredictable application, often ignores clear policy language, and runs up against foundational principles of freedom of contract and settlement without admitting fault. Fortunately, policy terms are available to the parties that substantially address the concerns motivating the *Level 3* doctrine and which more clearly define the scope of the risk transfer.

Courts that find the *Level 3* doctrine compelling are better served by enforcing the terms of the insurance contract as bargained for by the parties—a rule that will result in more uniform decisions and will also promote the rationales on which *Level 3* is grounded.