THE SECOND CIRCUIT DECISION IN *UTICA MUTUAL v. MUNICH RE*: SOME CLARITY ON THREE FRONTS

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On July 29, 2021, the United States Court of Appeals for the Second Circuit issued its ruling on the appeal of Utica Mutual Insurance Company ("Utica") from the decision of the United States District Court for the Northern District of New York in the dispute between Utica and Munich Reinsurance America, Inc. ("MRAm"). The court affirmed the decision of the court below that MRAm had no obligation to reimburse Utica for approximately $2.7 million in defense expenses in addition to policy limits. *Utica Mut. Ins. Co. v. Munich Reins. Amer., Inc.*, 2021 U.S. App. LEXIS 22476 (2d Cir. July 29, 2021) (cited herein as "Opinion").[1]

Whenever the Second Circuit, perhaps the nation's leading court in commercial matters, visits the reinsurance arena, the entire industry must take notice. That is especially true here, as the *Utica v. MRAm* opinion brings a measure of clarity to three separate issues, all of which have larger ramifications for the industry generally. This article will summarize the ruling, analyze the

[1] Rubin, Fiorella, Friedman & Mercante, LLP represented MRAm both in the district court and the Second Circuit. The opinions expressed in this article, however, are solely those of the author and are presented for the general edification of the reader. They do not necessarily represent the views of MRAm or Rubin, Fiorella, Friedman & Mercante, LLP. Any application of the Second Circuit ruling to future cases must be done in light of all the facts and circumstances of the case, and this article does not constitute legal advice to be used in future cases.

holdings of the court, and offer some thoughts on the impact of this ruling on future reinsurance disputes.

The Second Circuit Decision

Utica issued primary and umbrella policies for over thirty years to Goulds Pumps ("Goulds"), a manufacturer whose products incorporated asbestos components. Through a series of facultative reinsurance certificates, MRAm reinsured the umbrella policies for certain years – 1973 being the relevant year here – but not the primary policies. Goulds ultimately became the target of lawsuits from thousands of persons claiming bodily injury from exposure to asbestos.

As issued, the 1973 umbrella policy covered expenses within policy limits. A retroactive 1974 endorsement, however, added expense coverage in addition to limits in connection with any "occurrence not covered by" the relevant primary policy. The primary policy here covered bodily injury claims of all types, without any exclusion for asbestos-related injuries.

The 1973 facultative reinsurance certificate issued by MRAm to Utica required MRAm to indemnify for "losses or damages which [Utica] is legally obligated to pay under the policy reinsured" (Paragraph 1). It also required MRAm to indemnify Utica for "allocated loss expenses incurred by [Utica]," with "allocated loss expenses" defined as "all expenses incurred in the investigation, adjustment and litigation of claims or suits."

Utica defended and indemnified Goulds against asbestos-related bodily injury claims for many years, but eventually coverage issues arose between them, including but not limited to a disagreement over whether the primary policies included aggregate limits. In early 2007, Goulds and Utica entered into a

Settlement Agreement resolving the coverage issues. With respect to the 1973 policy year, the Settlement Agreement provided, *inter alia*, that the primary policy incorporated an aggregate limit of $300,000, and that the umbrella policy provided coverage for defense expenses within limits.

Utica defended and paid bodily injury claims on behalf of Goulds that exhausted the $25 million aggregate limit of the 1973 umbrella policy. It billed MRAm for its $5 million share of that amount, and MRAm paid in full. Utica also billed MRAm for approximately $2.7 million in defense expenses which it claimed to have allocated to the 1973 umbrella policy, in addition to the limit. MRAm declined to pay that amount, and Utica sued MRAm in the Northern District of New York federal court.

Utica advanced three basic positions. *First*, it claimed that MRAm was liable for defense expenses in addition to limits because those expenses were covered by the 1973 umbrella policy that MRAm reinsured. According to Utica, indemnity payments exhausted the limit of the 1973 primary policy, and any injury claims still pending (or yet to be asserted) as of the date of exhaustion were "not covered by" the primary policy, thus triggering the "occurrence not covered by" provision in the umbrella policies, providing defense expense coverage in addition to limits. *Second*, Utica claimed that it allocated defense expenses to its 1973 umbrella policy in addition to limits pursuant to its good faith interpretation of the umbrella policy, and that MRAm is obligated to honor that allocation decision through the concept of Follow the Fortunes/Settlements – provisions that Utica argued should be implied into MRAm's certificates. *Third*, Utica claimed that MRAm was required to pay defense expenses in addition to limits pursuant to the facultative reinsurance certificate, regardless of the proper interpretation of the umbrella policy. Specifically, Utica argued that the certificate's requirement that

MRAm pay any defense expenses "incurred" by Utica created an independent obligation to pay such expenses, so long as they were incurred in the "investigation, adjustment and litigation of claims or suits."

Following a two-week trial, the federal district court ruled in favor of MRAm in a lengthy opinion. 381 F. Supp. 3d 185 (N.D.N.Y. 2019). Utica appealed to the Second Circuit. The Second Circuit affirmed, and rejected all three prongs of Utica's case.[2]

1. Interpretation Of The Umbrella Policy

The appellate court held that the umbrella policy unambiguously does not cover defense expenses in addition to limits. The court emphasized the fundamental purposes of an umbrella policy: to provide both excess coverage for occurrences covered by the primary policy ("vertical" coverage) and primary coverage for specified occurrences not covered by the primary policy ("horizontal" coverage). Opinion at 8 (all cites are to the LEXIS pagination). The court held that the 1974 endorsement, which by its terms applies only to "occurrences not covered by" the primary policy, related only to the horizontal, not vertical, coverage. *Id*. In doing so, the court relied on the language of the umbrella policy itself, without resort to extrinsic evidence.[3] It emphasized: (a) the policy's definition of the horizontal coverage as attaching when the "insurance afforded by [the primary policy] is inapplicable to the occurrence," and (b) the term of art

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[2] The Second Circuit opinion also decided an appeal brought by Century Indemnity Company from a verdict in favor of Utica on similar, but not identical, issues. The Second Circuit ruled in Century's favor and rejected Utica's arguments on grounds similar to those described below. This article will deal only with the MRAm action, except where noted.

[3] The District Court received extensive extrinsic evidence at trial.

"covered," which typically describes an occurrence that is within the scope of a policy. Opinion at 10-13.

The court specifically rejected Utica's contention that an occurrence is "not covered" for purposes of the umbrella policy once the applicable primary limit has been exhausted. Opinion at 12-13. The court held that while exhaustion cuts off the obligation to *pay* for liabilities as they arise, it does not abrogate the coverage itself. Opinion at 12. The court buttressed this holding by noting that Utica's interpretation effectively erases a portion of the policy language. If, as Utica contended, the defense expense coverage applied to both the vertical and horizontal coverage, it would have sufficed to say that the defense expense coverage applied to all occurrences, full stop. It would have been unnecessary to distinguish between occurrences covered and not covered by the primary policy. Opinion at 12-13.

2. Follow The Fortunes/Follow The Settlements

With regard to the Following concepts, the Second Circuit recognized that a reinsurer normally may not question allocation decisions made after a settlement between the cedent and the policyholder which is reasonable, in good faith and within the applicable policies. Opinion at 16. Nevertheless, the court rejected Utica's reliance on Follow the Fortunes/Follow the Settlements, on two separate and independent bases.

First, the court noted that the Goulds-Utica Settlement Agreement treated the 1973 umbrella policy as paying defense costs within limits.[4] Therefore, Utica's allocation of defense costs to the 1973 umbrella in addition to limits contradicted its own agreement with Goulds. As the court put it, Follow the Fortunes/ Settlements "assumes that the cedent's billing to its reinsurers is at least consistent with, and does not contradict, its performance of the settlement." Opinion at 16-17.

Second, the court held that Utica's allocation was "outside the terms of the 1973 umbrella policy," which, as already discussed, did not cover defense costs in addition to limits. The court held that the terms of the umbrella policy were incorporated into MRAm's facultative reinsurance certificate by virtue of a Follow Form clause and that Follow the Fortunes/Settlements may not be used to make a

[4] As discussed above, the Settlement Agreement included a provision that identified each umbrella policy and described the coverage of each umbrella. The provision specifically stated that the 1973 umbrella policy had an aggregate limit of $25 million and that the stated limit was eroded by defense expenses.

reinsurer liable for sums outside the express terms of the reinsurance contract. Opinion at 17-18.[5]

3. Interpretation of the Facultative Certificate

With regard to MRAm's alleged "independent obligation" under the reinsurance certificate to pay defense expenses even if not covered by the reinsured policy, the Second Circuit held that Utica's interpretation of the certificate violated the "contractual intent of facultative reinsurance," which is that the reinsurer's liability tracks that of the cedent. Opinion at 19-20. The court held that by virtue of the Follow Form provision in the reinsurance certificate, the terms of the umbrella policies were incorporated into the certificate, and those umbrella terms did not make Utica liable for defense expenses in addition to limits. Opinion at 19-20.

The court also squarely rejected Utica's contention that the concept of expenses "incurred" is not limited to what Utica is obligated to pay under the umbrella policy. Opinion at 20-21. The court pointed to the reinsurance certificate's many textual indications that MRAm's liability under the certificate is intended to be congruent with Utica's. Examples are the insuring clause ("losses

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[5] The MRAm facultative certificates did not contain any Following provisions. The District Court declined to imply a follow the settlements provision into those certificates either as a matter of law or fact (having heard expert testimony on whether such provisions are implied as a matter of reinsurance industry custom and practice). As respects MRAm, the Second Circuit affirmed the District Court's finding that the umbrella policy was unambiguous.

The follow the settlements discussion applied to the Century appeal, as Century's certificate did contain a follow the settlements provision. The Second Circuit found that a follow the settlements provision does not trump a follow form provision when dealing with a policy that unambiguously does not provide coverage.

or damages which [Utica] is legally obligated to pay under the policy reinsured"), the insolvency clause (reinsurance shall be payable to Utica or any statutory receiver "on the basis of the liability of [Utica] under the policy reinsured"), the declaration page (identifying the umbrella policy specifically as the policy reinsured) and the clause relating to calculation of expenses (the ratio of MRAm's liability for expenses is based on the ratio of its liability for loss "under the policy reinsured"). *Id*.

In sum, the court found that Utica's reading of the certificates would result in the reinsurers assuming more risk than Utica itself did when it underwrote the 1973 umbrella policy; an "absurd result" to be avoided. Opinion at 22.

An Analysis Of The Opinion

Federal appellate decisions do not always align with the expectations of the reinsurance community based on long-held understandings of contract language. A case in point is the Second Circuit opinion in *Bellefonte Reins. Co. v. Aetna Cas. & Sur. Co.*, 903 F.2d 910 (2d Cir. 1990), which was widely criticized by industry professionals and has been whittled away by subsequent decisions.[6] In *Utica v. MRAm*, however, the Second Circuit's decision is more in keeping with industry expectations. Moreover, its opinion clarifies the law on topics which have been somewhat controversial in the industry.

With regard to interpretation of the umbrella policy, the court's opinion formalizes the simple notion that a reference to occurrences "not covered by" the

[6] *Bellefonte* held, in highly simplified terms, that a facultative certificate stating a limit of liability, and providing that the reinsurer's liability for expenses was "subject to" the limit, imposed a hard cap on all liability, whether for indemnity or expense.

primary policy is to an occurrence within the horizontal, gap-filling coverage of the umbrella, rather than the vertical, excess coverage for claims exhausting the primary limit. The lynchpin of the decision is that an occurrence which exhausts the indemnity limit of the primary policy remains a "covered" occurrence. Simply because the primary insurer has no further duty to pay does not mean that the coverage of the primary policy is somehow abrogated. As one New York decision put it, as quoted by the Second Circuit: "the terms 'covered' and 'not covered' refer to whether the policy insures against a certain risk, not whether the insured can collect on an underlying policy."[7]

This coincides with the commonly-held industry belief that "coverage" is defined by the scope of the policy. Whether the primary policy limit has been exhausted goes to whether the insurance is "collectable," or perhaps "payable." It does not go to "coverage." If it did, one would be forced to the fanciful conclusion that an occurrence is "covered" when it happens (such that the policy must respond) but magically becomes "not covered" when the limit exhausts.

Nevertheless, the meaning of "not covered" has been surprisingly controversial when used in umbrella and excess policies. The casebooks are riddled with cases interpreting the phrase. While most rulings have held that the phrase unambiguously refers to occurrences outside the scope of the primary coverage,[8] a small minority has held that it encompasses occurrences as to which

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[7] *Pergament Distribs., Inc. v. Old Republic Ins. Co.*, 128 A.D.2d 760, 761 (2d Dep't 1987).

[8] *See, e.g., R.T. Vanderbilt Co. v. Hartford Acc. & Indem. Co.*, 156 A.3d 539 (Conn. App. 2017); *Treesdale, Inc. v. TIG Ins. Co.*, 681 F. Supp. 2d 611 (W.D. Pa. 2009); *Amer. Spec. Risk Ins. Co. v. A-Best Prods, Inc*., 975 F. Supp. 1019 (N.D. Ohio 1997).

the primary limit has been exhausted.[9] It will be difficult for courts to embrace, or for insureds or insurers to rely on, the minority view after *Utica v. Munich*, particularly if New York law applies.

With regard to Follow the Fortunes/Settlements, it is hardly surprising that the court held the reinsurer to be not bound by an allocation that was squarely inconsistent with the Settlement Agreement's own terms. Nor is it surprising that the court held the reinsurer to be not bound by an allocation that was squarely inconsistent with the umbrella policy language, as discussed above.[10]

The Second Circuit ruling brings welcome clarity to the issue of when a reinsurer will be required to defer to a cedent's allocation of a settlement. In *U.S. Fid. & Guar. Co. v. Amer. Re-Ins. Co.*, 20 N.Y.3d 407 (2013) ("USF&G"), the New York Court of Appeals held that an allocation need not be followed by a reinsurer simply because it is *consistent* with the cedent-policyholder settlement. Rather, the issue is whether the allocation is "objectively reasonable," in the sense of an allocation "that the parties to the settlement of the underlying insurance claims might reasonably have arrived at in arm's length negotiations if the reinsurance did not exist." *Id*. at 420. Thus, some might argue that if the allocation is *inconsistent* with the cedent-insurer settlement, it may still deserve deference, so long as it is "objectively reasonable." Some judicial decisions are cited for this very proposition. The Second Circuit now teaches us that this is not necessarily so, at

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[9] *See, e.g., In re Viking Pump, Inc*., 148 A.3d 633 (Del. 2016).

[10] That said, there is legal precedent to support the argument that a reinsurer may be bound even if a loss is not technically covered by the reinsured policy. The battleground in future disputes will be whether the policy language is truly susceptible to only one reasonable interpretation. If so, and it is found to unambiguously exclude coverage, then a follow the settlements provision will not salvage the reinsurance presentation.

least where the settlement contains an agreed policy allocation; if the reinsurance billing contradicts the settlement allocation, it is likely to receive no deference.[11]

It is interesting to note that the Second Circuit cited no prior authority to support its statement that deference to the cedent's allocation "assumes that the cedent's billing to its reinsurers is at least consistent with, and does not contradict, its performance of the settlement." This is at least a significant clarification of the law that expresses a rule never before stated explicitly.

Finally, with regard to the "independent obligation" point, the court recognized the fundamental concept in facultative reinsurance that the reinsurer's obligations are derived from and congruent with the cedent's obligations under the reinsured policy, unless specified to the contrary very clearly. The Second Circuit ruling is perhaps the strongest judicial statement of this principle yet made.

Once again, this is a point that coincides with common industry understanding. It is particularly gratifying that the court saw through to the essence of the issue where some other courts have not been so incisive.[12]

Some Thoughts On The Decision's Impact In Future Cases

[11] A reinsurance billing that is inconsistent with an allocation agreed between the insured and its insurer is, at least presumptively, one that has been made only because reinsurance exists.

[12] A much earlier federal district court opinion, *Employers Ins. Co. of Wausau v. American Re-Ins. Co.*, 256 F. Supp. 2d 923 (W.D. Wisc. 2003), held that a reinsurer could be liable for expenses (in that case, declaratory judgment expenses) beyond what the insurer was liable to pay under the policy reinsured. Utica relied on *Employers*, and even argued that MRAm should be collaterally estopped from arguing to the contrary, since the defendant in Employers was MRAm's predecessor-in-interest. The Second Circuit did not even deign to mention *Employers*, and the precedential value of that decision now appears to be nil.

The Second Circuit opinion is instructive, both in terms of the results reached on the three principal issues and the reasoning used by the court to get there. Indeed, all three prongs of the court's ruling will likely have precedential value.

The holding by the Second Circuit that will perhaps have the greatest impact is its holding that a cedent may not invoke Follow the Settlements to defend an allocation that contradicts the cedent's settlement with the policyholder. While this may seem simple and instinctual on some level, it has never been a proposition free from doubt, as discussed above. Indeed, as alluded to above, the decision in USF&G and others have routinely been cited as authorizing allocations that deviate from the settlement.

It is now open to reinsurers to question billings on the ground that they are inconsistent with an allocation agreed upon between the cedent and the insured. No longer can the cedent defend such a billing on the ground that it is reasonable and ought to be deferred to, notwithstanding the inconsistency; it must be consistent with any agreement reached with the policyholder. In effect, the Second Circuit has put the "Follow" back in Follow the Settlements – the cedent must be asking the reinsurer to follow the actual settlement reached with the policyholder, not a different (but allegedly reasonable) allocation.

Of course, it is possible to overstate the holding. The Second Circuit held that the allocation underlying Utica's billing to MRAm was not entitled to deference because it contradicted a very specific and unequivocal provision in the Utica-Goulds Settlement Agreement as to how the policies were to operate (*i.e.*, cover defense expenses within limits) and how much of the settlement was to be assigned to each policy. Absent such specific and unequivocal provisions in the settlement agreement with the policyholder, the Second Circuit's rationale would

probably not apply. Moreover, policyholder-cedent settlement agreements typically do not include allocations to implicated policies. The fact remains, however, that where there is such a provision, it will now foreclose the cedent from billing the reinsurer on some contradictory basis.

Reinsurers will also benefit from the court's holding – in rejecting the "independent obligation" point – that a facultative certificate imposes no liability on the reinsurer beyond that which the cedent assumed under the policy reinsured. This principle will be useful whenever cedents seek indemnification from reinsurers for any sums that an insurer is not obligated to pay under the reinsured policy.

One possible application of this point is in the area of declaratory judgment expenses. Declaratory judgment expenses are often billed to reinsurers under facultative certificates even though they are not required to be paid pursuant to the reinsured policy. Instead, they are paid of the cedent's own volition, in an effort to limit or eliminate its coverage obligations. The debate over coverage for declaratory judgment expenses under facultative certificates is likely to be reignited after the Second Circuit decision, based as it is on the concept that reinsurers are not liable for any obligations beyond the scope of the reinsured policy. At minimum, the decision balances out precedent that has found declaratory judgment expenses to be covered under such contracts, on the ground that such expenses are "incurred in the investigation and settlement of claims or suits."

Finally, the Second Circuit opinion regarding the interpretation of the umbrella policy will also be a useful precedent for insurers and reinsurers alike. As already discussed, the opinion definitively rejects the argument that an umbrella using "occurrence not covered by" as the triggering language for expense coverage provides such coverage in the vertical (exhaustion of primary) scenario. Moreover,

in reaching that result, the court took a practical and industry-savvy view of the purposes of umbrella coverage, which will be useful in future disputes where the scope or effect of umbrella coverage is at issue.