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50 States Of Grey Claims:

The 10 Most Significant Insurance Coverage Decisions Of 2012

Part 2

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(Cases are listed in the order decided)

Coming Soon to *Coverage Opinions*: 5th Annual *"Coverage for Dummies"*

Coverage cases demonstrate that sometimes people get in trouble by doing really dumb stuff. But they still know enough to seek insurance coverage. *"Coverage for Dummies"* is the annual look at several examples from the past year of attempts by individuals to secure insurance coverage for the frailty and imperfection of the human brain. Look for the 5th annual installment of "Dummies" in an upcoming issue of *Coverage Opinions*.

Peach Clobber: Georgia Supreme Court Hits Insurer For An Ineffective Reservation of Rights Letter - *Continued*

The Georgia Supreme Court ultimately held that Maxum had not reserved its right to assert the late notice defense and in fact had waived it. For that reason, there was coverage.

First, putting aside the substance of the reservation of rights letter, the court concluded that Maxum could not both deny coverage and reserve its right to assert additional defenses at a later date. "A reservation of rights is only available to an insurer who undertakes a defense while questions remain about the validity of the coverage." Whether an insurer can deny coverage, and reserve its right to assert additional defenses at a later date, is a question for another day. The dissent had some strong words about what it thought of the majority's determination that an insurer could not do so.

For purposes of what's important here, the court held that, even if Maxum had the legal ability to reserve its right to assert its late notice defense, Maxum nevertheless would have waived the defense for failing to adequately inform EWES of the basis for the defense. Explaining that a "reservation of rights is not valid if it does not fairly inform the insured of the insurer's position," the Court held that Maxum's letter was inadequate because the letter "did not unambiguously inform EWES that Maxum intended to pursue a defense based on untimely notice of the claim."

It is fair to say that insureds are entitled to be fairly informed of the reasons why an insurer, despite agreeing to provide a defense, may not have any obligation to provide coverage for any damage award. [But there should also be prejudice considerations before determining if there are consequences for the insured for the insurer failing to meet this standard.] That the Georgia Supreme Court discussed the adequacy of reservation of rights letters, in terms of a "fairly inform" standard, is why Hoover was selected as one of the year's ten most significant.

The court stated: "In order to inform an insured of the insurer's position regarding its defenses, a reservation of rights must be unambiguous. If it is ambiguous, the purported reservation of rights must be construed strictly against the insurer and liberally in favor of the insured. A reservation of rights is not valid if it does not fairly inform the insured of the insurer's position." (internal quotes and citations omitted).

This statement should serve as an important lesson to insurers when drafting reservation of rights letters. While the letter should cite the facts in detail and potentially relevant policy provisions, the important step is to then tie these together.

But to say, in this particular case, that Maxum's letter did not meet the "fairly inform" standard is just plain wrong. In addition to addressing the Employer's Liability Exclusion, Maxum's letter stated that "coverage for this matter may be barred or limited to the extent the insured has not complied with the notice provisions under the policy." While the court also looked at some aspects of how the notice provision was handled in the course of the coverage litigation, to say that this statement did not fairly inform the insured, in unambiguous terms, that breach of the notice provision was a potential basis for disclaimer, is hard to grasp.

Product Markdown Results In Free Coverage For Advertising Injury

Travelers Prop. Cas. Co. v. Charlotte Russe Holding, Inc., 144 Cal. Rptr. 3d 12 (Cal. App. Ct. 2012)

Sometimes a coverage decision is significant, but involves facts that are so unique that it is unlikely to have any real impact on the future coverage landscape – because there probably isn't any future coverage landscape. Charlotte Russe is not one of them. The circumstances in Charlotte Russe, involving a scenario that resulted in advertising injury coverage under a CGL policy, are quite common. So common, in fact, that they leave you wondering if the loss is even fortuitous.

The insured, Charlotte Russe Holding, entered into a contract with Versatile Entertainment, Inc., to become the exclusive sales outlet for Versatile's "People's Liberation" jeans and knits. This brand of denim apparel allegedly was a "premium," "high end" brand of clothing in which Versatile had "invested millions of dollars developing." Although Charlotte Russe had never before offered high-end apparel for sale,

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Product Markdown Results In Free Coverage For Advertising Injury

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Versatile agreed to make Charlotte Russe its exclusive sales outlet because Charlotte Russe "had promised to provide the investment and support necessary to 'promote the sale of premium brand denim and knit products in order to encourage [Charlotte Russe's] customers to purchase such premium products at a higher price point at its [Charlotte Russe] stores.'"

The clothing did not sell well, however, and Charlotte Russe began to "fire sale" the apparel at "close-out" prices. In response, Versatile filed two lawsuits against Charlotte Russe, alleging that the sale of the clothing "at severe discounts" violated the parties' contract and also resulted in "significant and irreparable damage to and diminution of the People's Liberation Brand and trademark." Versatile alleged damages for breach of contract, declaratory relief, fraudulent and negligent misrepresentation, and intentional interference with a contractual relationship. No causes of action were alleged for trade libel, slander, or disparagement.

Charlotte Russe sought defense coverage under its CGL policy for "personal and advertising injury," defined in part as "injury arising out of '[o]ral, written, or electronic publication of material that slanders or libels a a person or organization or disparages a person's or organization's goods, products or services." Charlotte Russe contended Versatile's discounting claims "involved disparagement." Travelers disagreed and denied coverage on the basis that "the reduction of a product's price is not ... a disparagement of that product." In the ensuing coverage action, the trial court granted Travelers summary judgment. The California Court of Appeal reversed.

In reversing, the Court of Appeal held that Versatile's allegation that the price markdown caused "significant and irreparable damage to and diminution of the People's Liberation Brand and trademark" was enough to implicate coverage. "Versatile's pleadings alleged that the People's Liberation brand had been identified in the market as premium, high-end goods; and that the Charlotte Russe parties had published prices for the goods implying that they were not. It therefore pled that the implication carried by the Charlotte Russe parties' pricing was false. That is enough."

The court further concluded that it could not "rule out the possibility" that someone might construe Versatile's complaint in a way to imply an implication of a disparagement claim--that the dramatic discounts at which the People's Liberation products were being sold communicated to potential customers the implication that the products were not premium, high-end goods. Thus, the court rested its conclusion of coverage on a wink-wink—that is, on a claim that was never made, but "could reasonably be read" in the pleading as being implied.

The Supreme Court of California declined to hear an appeal of the case, making it final, but the decision has had its share of criticism, no less than from another Division of the California Court of Appeal, itself. And the criticism came swiftly. In Hartford Cas. Ins. Co. v. Swift Distribution, Inc., issued just four months after Charlotte Russe, the California Court of Appeal distinguished Charlotte Russe from a case involving underlying patent and trademark claims from an insured's copycat product. But more than just distinguishing Charlotte Russe, the Swift court was harshly critical of it.

The Swift court stated: "We fail to see how a reduction in price—even a steep reduction in price—constitutes disparagement. Sellers reduce prices because of competition from other sellers, surplus inventory, the necessity to reduce stock because of the loss of a lease, changing store location, or going out of business, and because of many other legitimate business reasons. Reducing the price of goods, without more, cannot constitute a disparagement; a price reduction is not an injurious falsehood directed at the organization or products, goods, or services of another[.]"

Given how commonplace deep discounting in retail stores has become, the potential consequences of Charlotte Russe are readily apparent. Moreover, the court's blessing of coverage for implied disparagement has implications beyond simply the retail markdown context.

Leaking Like Progres-sieve?: What's Next For Insurers After The UIM Claim Heard 'Round The World?

Fisher v. Progressive, Md. Cir. Ct.

In my house, if my wife says something, it is true. And if her mother agrees, then it is written on stone tablets. I could dig up Aristotle and even he couldn't convince this duo otherwise.

That is not unlike what happened to Progressive Insurance in August, after Matt Fisher's Tumblr post contained this, well, not so subtle, headline: "My Sister Paid Progressive Insurance to Defend Her Killer In Court." That headline was false as a matter of insurance law. While Mr. Fisher's sister was a Progressive customer, who was tragically killed in an automobile accident, Progressive did not pay to defend the driver that killed her.

But once Mr. Fisher's post went viral – and boy did it ever – no amount of explanation of the truth, or lessons in insurance law, could change the message and all the negative consequences that came with it for Progressive. The company was powerless to stop the mayhem (oops, wrong insurer). The horse had left the barn. The toothpaste was out of the tube. Choose your cliché. All Progressive could do was pay Fisher and cut bait. And hope that people on Twitter would soon find something else to tweet about.

Fisher v. Progressive may seem a curious choice as one of 2012's ten most significant insurance coverage decisions. On one hand, it is a garden variety underinsured motorist claim. Not to mention that this is an article about the ten most significant coverage decisions of the year and the case offers no opinion. In that sense, while very important to the parties involved, the case has no significance whatsoever beyond them. For that matter, on its face the case is probably the least significant of all of the 120 that have been featured in this commentary over the past twelve years. [This is no disrespect whatsoever to the Fisher family. That statement was solely in terms of insurance law and the objectives that this article sets out to achieve.]

On the other hand, it could also be argued that Fisher v. Progressive is a hugely important coverage case and one of the most worthy of being included in a list of 2102's ten most significant (and maybe even beyond that). Whichever its legacy may be, Fisher's tale is one that all claims professionals should be aware of.

By way of very brief background, Matt Fisher's sister was killed in a car accident. A indisputable tragedy. The driver of the other vehicle was underinsured. Fisher's sister had underinsured motorist coverage with Progressive. Under Maryland law, to collect on an underinsured claim, the other driver must be at fault. So Fisher's family had to sue the other driver to prove fault in order to obtain payment under her underinsured policy. The other driver was insured by Nationwide, and Nationwide undertook the defense. However, Progressive participated in the other driver's defense as it had evidence that the other driver was not at fault. Hence, Fisher's brother's headline on his Tumblr post: "My Sister Paid Progressive Insurance to Defend Her Killer In Court." A Maryland jury ultimately decided in favor of Fisher and awarded $760,000. Progressive's share was $75,000.

Again, Fisher's headline was false because it was Nationwide, and not Progressive, that defended the other driver. And Progressive had the right to prove that the other driver was not at fault. Never mind. Fisher's story, fueled by that attention-grabbing headline, went viral – very viral. The niceties of Maryland insurance law were no match for the power of an internet story gone wild. Progressive took a beating in the court of public opinion – no matter what it did to explain its actions and its rights to take them. The story was featured on CNBC, "CBS This Morning" and Glenn Beck's radio show, as well as umpteen news sites. According to an analysis conducted at the request of Dow Jones Newswires, more than 1,000 people on Twitter claimed to have dropped Progressive as their insurer in a four-day period and 1,600 expressed a desire not to do business with them.

In addition to paying what it owed, Progressive also paid, according to Fisher's attorney "tens of thousands" more to settle with the Fishers over the way the company handled the claim.

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Leaking Like Progres-sieve?: What's Next For Insurers After The UIM Claim Heard 'Round The World?

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Huh. Say that again? How the company handled the claim? As in – by following Maryland law.

On one hand, the Fisher case is over. But is it really over? That's the question that Erik Holm of Dow Jones Newswires and the Wall Street Journal posed in an August 21st WSJ story. Calling the situation a "cautionary tale" for insurers, Mr. Holm asked: "Now, the question is whether Progressive's experience will prompt changes throughout the auto-insurance industry as more consumers use the internet to tell their side of the story when they feel they've been slighted by their insurers." Mr. Holm observed that "[e]ven when a company's actions are legal and done with the blessing of regulators, it can suffer reputational and financial harm when exposed to harsh cyber-invective."

If insurers overpaid on claims or paid claims that were not owed, simply because of the risk of one of them, every now and then, being wrongly blown out of proportion on account of a viral blog post, they would soon be unable to pay any claims. And then you'd really see a lot of negative blog posts. Nonetheless, an insurer's concern about being the next Progressive, in the next Mr. Fisher's blog post that goes viral, could cause an insurer to pay an otherwise uncovered claim. Just take a look at some of the public's comments posted on Progressive's website where it provided information on the case.

If Fisher v. Progressive can have this kind of impact, then it is one of the most significant coverage cases of the year, and even beyond that. It is one thing for an insurer to pay a claim because it fails to convince a court to accept its interpretation of policy language. That comes with the territory. But insurers do not bargain to pay otherwise uncovered claims because they must ignore their policy language. Insurers usually get vilified for allegedly not following the appropriate claims process. Here, they did so and still got vilified. It's a tough business.

Minnesota High Court: Mary Tyler More Disclosure Required To Insureds About Covered Versus Uncovered Claims

Remodeling Dimensions, Inc. v. Integrity Mutual Insurance Company, 819 N.W.2d 602 (Minn. 2012)

The November 14th issue of Coverage Opinions addressed the fact that, no matter how well a reservation of rights letter may be written, specifying what's covered and what's not, the underlying litigation may result in a verdict that does not specify the extent to which it represents this or that type of damage or the claims on which the relief is based. In this situation, often-times referred to as a "general verdict," the policyholder is likely to argue that, because the basis for the jury's verdict cannot be determined, it must be presumed that the entirety of the jury award represents covered claims and damages. Adding to the difficulty for insurers is that it cannot ask appointed defense counsel to seek special jury interrogatories which would go a long way toward solving this problem.

Some courts have accepted the policyholder argument that, if the insurer created the problem of an inability to allocate between covered and uncovered claims, it must therefore bear the consequences. In other words, if it cannot be determined which portion of a verdict is covered and which is not, then all of the damages will be considered covered. Or the insurer may have a difficult burden to prove covered versus uncovered damages.

While the facts of Remodeling Dimensions appear somewhat unique – the coverage dispute involves an underlying case in arbitration--a closer look shows that the decision's underlying principles have application to the issue of allocation of covered versus uncovered claims in the more traditional context. Being a supreme court decision, addressing an important coverage issue, on which existing case law is not abundant, it was

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Minnesota High Court: Mary Tyler More Disclosure Required To Insureds About Covered Versus Uncovered Claims - *Continued*

selected for this year's insurance best-of.

The case involved an underlying construction defect action. The insured, Remodeling Dimensions, Inc., entered into a construction agreement with the underlying plaintiff homeowners to build an addition to their home and to remove and reinstall a master bedroom window in the original part of the house. The construction agreement provided that disputes arising out of the work would be resolved by binding arbitration before the American Arbitration Association. After construction was com pleted, a dispute arose over the workmanship and quality of RDI's work. The homeowners commenced arbitration in July 2006.

RDI tendered the claim to its insurance carrier, Integrity Mutual, which accepted the defense and appointed defense counsel in early September 2006. On September 21, 2006, the AAA appointed an arbitrator for the case, and Integrity issued to RDI a reservation of rights letter the next day, stating that it questioned whether the underlying allegations were covered under the insurance policy and reserving its right to deny coverage notwithstanding the outcome of the arbitration.

On January 10, 2007, Integrity sent RDI a second letter requiring RDI to ensure that any arbitration award issued by the arbitrator was sufficiently detailed to identify damages that were covered and not covered under the policy. The letter stated: "The purpose of this correspondence is also to alert you of your duties in this matter. It will be up to you and your counsel to fashion an arbitration award form that addresses the coverage issues and your respective burden. If, for example, the arbitration award ultimately rendered makes it impossible to determine whether any of the damages awarded involve 'property damage' that occurred during the Integrity policy period, Integrity will not be responsible to indemnify an ambiguous award."

Following arbitration, the arbitrator awarded damages to the homeowners, but not in the detailed manner sought by Integrity. RDI's appointed attorney requested further breakdown of the award, which was refused on the basis that the request was untimely. The AAA's rules required that all such requests had to be made prior to appointment of the arbitrator.

Integrity subsequently denied coverage for the award, as it said it would, and RDI commenced suit against Integrity. Putting aside the lower court decisions, the Minnesota Supreme Court remanded the case for further factual findings on the basis that Integrity potentially waived its right to request a detailed arbitration award through its own delay. The court based its decision on bedrock principles involving an insurer's duty to defend; namely, that "when an insurer has a duty to defend a liability claim for which it questions coverage, the insurer must expressly inform its insured that it accepts defense of the claim subject to its right to later contest coverage of the claim based on facts developed at trial." An insurer that fails to make such a reservation of rights "is estopped from later denying coverage of the claim."

These principles, the court explained, equally applied to the issue at hand: "Previously, we have not had occasion to address whether an insurance company has a duty to disclose to its insured the availability of obtaining a written explanation of an arbitration award, and the appropriate remedy if it fails to do so. But our existing law on the failure of the insurer to notify its insured that its defense of a claim is made under a reservation of rights is relevant and helpful. We have held that an insurer that defends an insured, but provides no notice that the insurer reserves its right to contest coverage, is estopped from later denying coverage under the insurance policy, even if it acted in good faith. . . . We believe this estoppel rule is analogous to this situation."

Applying the estoppel rule, the court concluded that "when an insurer notifies its insured that it accepts the defense of an arbitration claim under a reservation of rights that includes covered and noncovered claims, the insurer not

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Minnesota High Court: Mary Tyler More Disclosure Required To Insureds About Covered Versus Uncovered Claims - *Continued*

only has a duty to defend the claim, but also to disclose to its insured the insured's interest in obtaining a written explanation of the award that identifies the claims or theories of recovery actually proved and the portions of the award attributable to each."

The insurer's failure to comply results in important consequences for the burdens of proving covered and uncovered damages: "Ordinarily, the insurer's disclosure should be made at or near the time the defense of the claim is accepted under a reservation of rights. When an insurer, however, fails to provide timely notice to the insured in this situation and the insured shows the conditions including prejudice to the insured are satisfied, then the insurer is estopped from claiming that the insured has the burden of proving allocation of the award. Instead, the burden shifts to the insurer to prove by a preponderance of the evidence that some part of the award is attributable to a noncovered claim. If the insurer meets this burden, both parties may present evidence and the district court must, as best it can, establish the allocation the arbitrator would have made if allocation had been requested. Alternatively, when an insured receives timely notice of its interest in a written explanation of the arbitration award, the insured bears the burden of proving allocation of the award in subsequent litigation with its insurer over coverage."

The court softened the potential harsh effects of this duty, however, by requiring the existence of certain conditions: "The duty we impose upon the insurer is conditioned upon the insured affirmatively showing that a written explanation of an award is available under applicable rules, the insurer had the opportunity to provide timely notice to the insured of the insured's interest in a written explanation of the award, and prejudice was caused by the failure of the insurer to provide such notice. Prejudice in this context means the inability of the insured to obtain a written explanation of an arbitration award caused by conduct of the insurer." The court then remanded the case for determination of whether these conditions existed to estop Integrity.

Narrow, Er, Leaking Window For Construction Defect Coverage

Ghilotti Brothers, Inc. v. American Safety Indemnity Company, No. 10–17231, 2012 WL 3745624 (9th Cir. Aug. 30, 2012)

Two page unpublished opinions from the Ninth Circuit (or any circuit – that was not meant as a Ninth Circuit ribbing) – with only one-half a page being relevant--are not usually the stuff of this annual review of the year's ten most significant coverage decisions. But Ghilotti Brothers, Inc. v. American Safety, despite its brevity and unpublished status (i.e., being relegated to the kid's table as judicial decisions go), speaks volumes on the subject of solutions that some insurers have adopted to address their huge exposure for construction defect claims.

There are several reasons why insurers have faced significant exposure for construction defect claims. One of them is that the continuous trigger has brought more of them, and more of their policies, to the settlement table. While those miniature Nestle Crunch bars and Swedish fish at JAMS may seem free, insurers have in fact paid handsomely for them.

The November 28th issue of *Coverage Opinions* addressed endorsements being employed by some insurers to minimize the impact of the continuous trigger on their experience for construction defect claims. These endorsements, going by such names as First Manifestation Endorsement, Claims in Progress Exclusion, Discovered Injury or Damage Exclusion and Prior Damages Exclusion, were essentially designed to preclude coverage for "bodily injury" or "property damage" that took place before the policy period, even if the insured did not know that injury or damage had taken place and even if the injury or damage was continuous or progressive. As a result, coverage is effectively limited to "bodily injury" or "property damage" that first takes place during the policy period.

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Narrow, Er, Leaking Window For Construction Defect Coverage - *Continued*

Based on a review of the case law in this area, as well as my first-hand experience, these endorsements, even if not operating as intended in every case, are serving to reduce the number of policies triggered for some construction defect claims.

And some endorsements even go one step further that the First Manifestation variety. Consider one called a Total Prior Work Exclusion that was at issue in Ghilotti Brothers. It added the following provision to a policy issued to an insured that performed construction work of some type: "[t]he 'occurrence' and resulting injury or damage must result, in its entirety, from 'your work' performed during the policy period of this policy. If 'your work' was performed in part during the policy period of this policy and in part before the policy period of this policy, any 'occurrence' and resulting injury or damage claimed to result from 'your work' will be deemed to have resulted, in its entirety, solely from 'your work' prior to the policy period of this policy[.]"

Under this endorsement, which the Ghilotti Brothers court found to be unambiguous, "[i]f work occurs in part prior to the policy period and some damage results from such work, that damage will not be covered by the policy." So in essence, in order to satisfy this requirement, the insured's work on a construction project must first commence during the policy period. Now consider this requirement in conjunction with the policy's likely additional requirement that "property damage" must occur during the policy period.

Because construction projects tend to take some time to complete (even small residential ones), the likelihood of an insured starting a project during the policy period, with property damage beginning to take place during that same policy period, may be small. And if the insured starts work on a project close to the end of the policy period, the window for potentially triggering coverage gets really small. And this outcome does not change even if the insured had consecutive coverage between the time that it commenced work on the project and when the property damage first took place. Compare this to policies issued to the insured, during this same consecutive period, that have First Manifestation type endorsements. In this scenario, one of those policies would likely be triggered (all other issues aside).

With the substance of the Ghilotti Brothers decision just about being able to fit on the back of an envelope – no, really – it is not worth discussing its specifics. Ghilotti Brothers was selected as one of the year's ten most significant because of the court's conclusion that the Total Prior Work Exclusion--which goes as far as I've seen in an effort by an insurer to reduce its construction defect exposure, short of an endorsement that reads "we do not cover construction defect"--was unambiguous.

Options exist for insurers to significantly reduce their exposure for the risks associated with construction projects. For commercial reasons, not all insurers will go down these roads. But some are in one form or another. Such policies may be issued to smaller size (read as, judgment proof) contractors, who need a liability policy to serve as their ducat to a job site, and are looking for the least expensive option. And since the general contractor is probably not reviewing its subcontractor's policy's terms and conditions, it may be the underlying plaintiffs that feel the biggest impact of these coverage limiting endorsements.

Opinion-aided: Court Opens Door To Policyholder Getting Its Hands On Outside Coverage Counsel's Opinion Letter

Barton Malow Company v. Certain Underwriters at Lloyd's of London, No. 10–10681, 2012 WL 4668868 (E.D. Mich. Oct. 3, 2012)

While the insurer prevailed before the Eastern District of Michigan in Barton Malow Co., the win was not without a price – an opinion that should cause some concern for insurers when it comes to maintaining coverage opinions secured from outside counsel as privileged. The decision opens the door for policyholders to potentially obtain the opinion letters prepared by outside coverage counsel.

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Opinion-aided: Court Opens Door To Policyholder Getting Its Hands On Outside Coverage Counsel's Opinion Letter - *Continued*

Given that such opinion letters may contain qualifications, policyholders have a significant incentive to obtain them. Even if such qualifications are legitimate, and they probably are, policyholder counsel would likely try to make hay out of them.

Barton Malow Company was involved in litigation with Lloyd's of London over coverage for an arbitration award arising out of the company's role as a construction manager for a University of Michigan project. Barton Malow sought to obtain certain unredacted reports prepared by a law firm that was hired by Lloyd's as coverage counsel before the litigation. Barton Malow maintained that the redacted reports were neither privileged nor subject to the work product doctrine. At the court's urging, Lloyd's produced to Barton Malow redacted portions of five reports prepared by its coverage counsel. After then producing the reports in unredacted form – again at the court's urging – Barton Malow sought to have three of the passages that Lloyd's wanted to keep redacted declared as non-privileged and not subject to the work product doctrine.

The Barton Malow court set out the following test for determining if communications by attorneys in the insurance claims process are subject to attorney-client privilege: "The communication itself must be primarily or predominantly of a legal character. The payment or rejection of claims is a part of the regular business of an insurance company. Consequently, reports which aid it in the process of deciding which of the two indicated actions to pursue are made in the regular course of its business. Merely because such an investigation was undertaken by attorneys will not cloak the reports and communications with privilege because the reports, although prepared by attorneys, are prepared as part of the regular business of the insurance company."

Despite setting out a seemingly broad test, for allowing communications by attorneys, in the insurance claims process, to be outside the scope of attorney-client privilege, the Barton Malow court held that the specific communications at issue were protected by attorney-client privilege: "A review of the selected passages shows that the communications were not the work of an attorney performing a function that was part of the regular course of Underwriter's insurance business. Importantly, the passages must be read in the context of the entire report, including the text appearing before and after the selected passages. In so doing, it is clear that the passages communicate legal advice from Underwriter's counsel regarding the extent, if any, to which Barton Malow's claim was covered. They show counsel's legal opinions regarding the scope of potential liability."

The lesson from Barton Malow is that, under its test, it is possible that the opinion from outside counsel may not be privileged. A concern for insurers in this regard should be the lack of guidance that the court provided in determining what's privileged and what's not. On one hand, the court stated that, because the payment or rejection of claims is part of the regular business of an insurance company, "reports which aid it in the process of deciding which of the two indicated actions to pursue are made in the regular course of business" and are not privileged. On the other hand, the court concluded that the specific passages at issue were protected by privilege because it was clear that they communicated legal advice regarding the extent, if any, to which the claim was covered.

On its face, and without any detailed guidance from the court, it can be imagined that the test for what qualifies as a "report which aided the insurer in the process of deciding which of the two indicated actions to pursue, and a report that communicated legal advice, regarding the extent, if any, to which the claim was covered, is not a bright line. One can imagine in camera reviews by courts to make this determination.

One take-away from the decision seems to be that insurers that employ outside coverage counsel should insist that counsel provide legal analysis to support its opinion. That seems obvious. But sometimes insurers simply seek a more

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Opinion-aided: Court Opens Door To Policyholder Getting Its Hands On Outside Coverage Counsel's Opinion Letter - *Continued*

cursory opinion from counsel, which could be argued to be a non-privileged report that aided the insurer in the process of deciding which of the two indicated actions to pursue.

For a significant decision from 2012 that also addressed the discovery of documents that one party believed were privileged, see the First Circuit's decision in Vicor Corp. v. Vigilant Ins. Co., 674 F.3d 1 (1st Cir. 2012), Here the court opened the door to an insurer potentially obtaining documents from its insured's defense counsel in underlying litigation, for the insurer's use to potentially disprove coverage in subsequent coverage litigation – and the claim was defended under a reservation of rights.