BERRY & MURPHY, P.C. V. CAROLINA CASUALTY INSURANCE CO.: MALPRACTICE LIABILITY INSURANCE IN THE TENTH CIRCUIT

American journalist and satirist, Ambrose Bierce, once referred to insurance as, "[a]n ingenious modern game of chance in which the player is permitted to enjoy the comfortable conviction that he is beating the man who keeps the table."[1] However, as insurance policies become increasingly complex, and new forms of liability insurance are created, policyholders can no longer feel comfortable with the idea that an insurance policy guarantees them coverage. Instead, "the man who keeps the table" has the luxury of feeling much more comfortable. In *Berry & Murphy, P.C. v. Carolina Casualty Insurance Co.*,[2] the Tenth Circuit interpreted a claims-made malpractice liability insurance policy in favor of Carolina Casualty Insurance Company,[3] resulting in a lack of coverage for Berry & Murphy, P.C.[4] and a windfall for Carolina Casualty.[5] In doing so, the court incorrectly interpreted the term "insured" as defined in the insurance policy,[6] did not adhere to established precedent in Colorado law,[7] and created a highly inequitable result. All attorneys covered by a claims-made malpractice liability insurance policy should take notice of the holding in *Berry & Murphy* due to its potentially damaging effects.

Part I of this Comment examines claims-made insurance policies and how they compare to occurrence policies, the various pitfalls insured parties face under this relatively recent form of coverage, how the judiciary has historically construed insurance policies, and the potential result of an insurance company's arbitrary refusal to defend or pay a claim. Part II summarizes the facts, procedural history, and the court's holding and analysis in *Berry & Murphy*. Part III analyzes *Berry & Murphy*, commends the court on its determination that the facts constitute a single claim, criticizes the majority for its interpretation of the term "insured," and examines the fallacies and potential negative consequences of the ruling. This Comment concludes by arguing that claims-made insurance policies must be written with more precise definitions of key terms, and that clearly defined precedent dictates favorable outcomes for insured parties when insurance companies fail to heed such advice.

1. AMBROSE BIERCE, THE DEVIL'S DICTIONARY 169 (Forum Books 1948) (1911).
2. 586 F.3d 803 (10th Cir. 2009) [hereinafter "Berry & Murphy"].
3. *Id.* at 816.
4. *Id.* at 815.
5. *Id.* at 816 (Lucero, J., dissenting).
6. *See id.* at 814–15 (majority opinion).
7. Ballow v. PHICO Ins. Co., 875 P.2d 1354, 1359 (Colo. 1993) (noting that ambiguous contractual provisions should be "construed against the insurer who drafted the policy and in favor of the insured" (citing Chacon v. Am. Family Mut. Ins. Co., 788 P.2d 748, 750 (Colo. 1990))).

I. BACKGROUND

A. Contrasting Occurrence and Claims-Made Insurance Policies

Historically, "insurance policies have been written on an occurrence basis, providing coverage for events that take place during the policy period . . . ."[8] Under an occurrence policy, the claim against the insured can come at any time, essentially providing unlimited prospective coverage for events occurring while the policy was in effect.[9] As the United States became more industrialized and insurance claims increased, insurance companies discovered that difficulties with the occurrence model were quickly arising.[10] In particular, due to the prospective nature of these policies, unanticipated lag time between occurrences and filing of claims created a "tail" in which the insurance companies could not predict the amount of money they would have to pay out, causing actuarial estimation problems.[11] For this reason, insurance companies sought to avoid liability by arguing that events leading to insurance claims did not take place during the policy period.[12] However, the judiciary was willing to broaden insurers' liability by developing three different theories that worked in favor of the insured.[13] As a result, insurance companies faced increased business costs,[14] which, in turn, were passed on to the insured.[15] A natural consequence of these increased rates was the insurer's inability to obtain such rates due to the unwillingness of the insured to pay a premium that approached the total recovery available.[16]

As insurers began to withdraw from the market due to financial instability,[17] carriers realized that a less expensive policy option would be needed to counteract the rising premiums of occurrence policies.[18] Claims-made policies began to emerge, and this narrower form of coverage began to replace occurrence policies in areas such as professional liability.[19] Claims-made policies provide retroactive coverage[20] for

8. *See* Carolyn M. Frame, *"Claims-Made" Liability Insurance: Closing the Gaps with Retroactive Coverage*, 60 TEMP. L.Q. 165, 165 (1987).

9. *Berry & Murphy,* 586 F.3d at 809 n.3 (citing 1 LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INSURANCE § 1:5 (3d ed. 1996)).

10. *See* Frame, *supra* note 8, at 169–70.

11. *Id.*

12. *Id.* at 170.

13. *Id.* at 170–71 (describing the manifestation theory, exposure theory, and triple trigger theory).

14. *Id.* at 171 ("Insurers were faced with inflation rates, escalating jury awards, and the general proliferation of claims. These factors increased the insurer's business costs because the premiums paid at the time of the occurrence were not sufficient to create the financial pool required to pay the 'tail' claim." (footnotes omitted)).

15. *See id.*

16. *Id.*

17. *Id.*

18. *See id.*

19. *Id.* at 177–79 (describing that the proliferation of claims-made policies in the area of professional liability is due, in part, to the policy's relative cost and coverage compared to occurrence policies).

claims that are made against the insured and reported during the policy period.[21] The notable difference between the occurrence policy and claims-made policy is that under a claims-made policy an insured can be indemnified for an event that occurred *before* the policy began, as long as the event is reported during the policy period.[22] Because the insurer's liability ends on a stated date, insurers are no longer exposed to the uncertainty of future claims by the insured, thereby allowing the insurers to calculate premiums with greater accuracy.[23]

B. Problems Associated With Claims-Made Policies

1. Notice-Prejudice Rule

Due to the strict notice and reporting requirements set forth in claims-made insurance policies, commentators have suggested that a more appropriate name for this type of policy should be "claims made and reported."[24] Because an insured party must become aware of the event giving rise to the claim *and* must report the claim within the policy period, limiting the name of this type of policy to claims-*made* seems misleading. The critical requirement of giving notice of a claim to the insurer within the policy period has led to what is commonly referred to as the "notice-prejudice" rule.[25]

This often-overlooked notice requirement[26] has led to litigation in instances where a claim is made against an insured shortly before the policy's coverage expired, not leaving a reasonable amount of time to give notice,[27] and in cases where an insured argues that circumstances made it impractical to give notice to the insurer.[28] However, in cases such as these, courts have been reluctant to add a judicially created "tail" to the end of a claims-made policy and have instead sided with insurance companies in showing "prejudice" when the insured fails to report the claim during the policy period.[29] Due to the inherent differences between occurrence policies and claims-made policies, courts have determined that the notice provision is an essential element of claims-made policies

20. Berry & Murphy, P.C. v. Carolina Cas. Ins. Co., 586 F.3d 803, 809 n.3 (10th Cir. 2009) (citing 1 RUSS & SEGALLA, *supra* note 9, at § 1:5).

21. Steven P. Garmisa, *Claims-Made Policies: Let the Lawyer Beware*, 78 ILL. B.J. 292, 292 (1990).

22. *See id.*

23. *Id.*

24. Reed Millsaps, *Avoiding the "Nightmares"—The "Notice-Prejudice" Rule and Claims Made Policies*, 28 No. 5 INS. LITIG. REP. 165, 165 (2006).

25. *See id.*

26. *Id.*

27. *E.g.*, Gulf Ins. Co. v. Dolan, Fertig & Curtis, 433 So. 2d 512, 513 (Fla. 1983).

28. *E.g.*, St. Paul Fire & Marine Ins. Co. v. Estate of Hunt, 811 P.2d 432, 433 (Colo. App. 1991).

29. *See, e.g.*, *id.* at 435; *Dolan*, 433 So. 2d at 515.

and have held that any judicial extension of the policy period would result in an un-bargained-for extension of coverage.[30]

In *Gulf Insurance Co. v. Dolan, Fertig & Curtis*,[31] the Florida Supreme Court noted the stark differences between occurrence and claims-made policies and cited economic ramifications as the basis for its decision that insurers must show "prejudice" under a claims-made policy.[32] As discussed above, the financial benefit conferred upon the insured in such a policy is a lower premium for comparable coverage.[33] However, this comes at the cost of a shorter reporting period.[34] The court refused to extend the reporting period beyond the end of the policy because it viewed this type of coverage as specifically bargained for between the insurer and the insured.[35] The philosophy of the *Dolan* court was "widely followed by other courts[,]"[36] with some courts extending the economic analysis beyond premium setting, [37] effectively solidifying the notice-prejudice rule.

2. Policy Language Ambiguities

Another problem facing claims-made insurance policies leading to increased litigation is ambiguities in policy language.[38] When insurance companies write policies that lack clear terminology, yet propose to enforce strict notice and reporting guidelines, the interpretation of whether or not an insured is covered often become contentious.[39]

In California, the word "may," in conjunction with the terms of when a claim can be set forth, has led to such an ambiguity.[40] In *Chamberlin v. Smith*, the California Court of Appeals followed precedent set in *Gyler v. Mission Insurance Co.* in determining that the language of the insurance policy was susceptible to two divergent interpretations.[41] The

30. *E.g.*, *Dolan*, 433 So. 2d at 515.

31. 433 So. 2d 512 (Fla. 1983).

32. *See id.* at 516. In a claims-made policy, unlike an occurrence policy, a claim will not arise after the expiration of the policy; therefore, due to this reduced underwriting risk, claims-made policies can be offered at a lower premium than occurrence policies. *Id.*

33. Millsaps, *supra* note 24, at 165.

34. *Id.*

35. *Dolan*, 433 So. 2d at 515.

36. Millsaps, *supra* note 24, at 165 (discussing the holdings of *Textron, Inc. v. Liberty Mut. Ins. Co.*, 639 A.2d 1358 (R.I. 1994) and *St. Paul Fire & Marine Ins. Co. v. Estate of Hunt*, 811 P.2d 432 (Colo. App. 1991) as examples of cases that have followed *Dolan*).

37. *See* St. Paul Fire & Marine Ins. Co. v. Estate of Hunt, 811 P.2d 432, 435 (Colo. App. 1991) (noting that the ability to accurately fix reserves leads to lower policy premiums); Hasbrouck v. St. Paul Fire & Marine Ins. Co., 511 N.W.2d 364, 368 (Iowa 1993) (noting that insurer prejudice allows for more accuracy in setting reserves).

38. *See* Garmisa, *supra* note 21, at 294.

39. *See, e.g.*, St. Paul Ins. Co. of Ill. v. Armas, 527 N.E.2d 921, 925 (Ill. App. Ct. 1988).

40. *See, e.g.*, Gyler v. Mission Ins. Co., 514 P.2d 1219, 1220–21 (Cal. 1973); Chamberlin v. Smith, 140 Cal. Rptr. 493, 497 (Ct. App. 1977).

41. *Chamberlin*, 140 Cal. Rptr. at 497–98 ("First, the phrase might limit coverage to a claim asserted within the policy period and exclude claims asserted afterward, making the words 'which may be' superfluous. Secondly, the phrase might be construed as extending coverage to any claim

pertinent language of the insurance policy read, "[T]o indemnify . . . against any *claim or claims* for breach of professional duty as Lawyers *which may be made against them* during the period set forth in the Certificate by reason of any negligent act, error or omission, whenever or wherever the same was or may have been committed . . . ."[42] The court dismissed the idea that there was unnecessary language in the policy and instead adopted a construction that provided coverage for an injury that took place during the policy period, even when the claim was made subsequent to the policy's expiration.[43] In ambiguous situations such as this, claims-made policies will likely lead to litigation due to the insurer's unwillingness to indemnify the insured[44] and the insured's rightful claim that ambiguities must be construed in their favor.[45]

While many insurance companies have eliminated the word "may" from their policies,[46] even "plain language" policies can be encumbered by ambiguities, leading to disagreements regarding the temporal requirements of notice.[47] For example, in *St. Paul Insurance Co. of Illinois v. Armas*,[48] the Illinois Appellate Court found that the plain language of a malpractice liability insurance policy, in conjunction with a cancellation form, resulted in an ambiguity that could conceivably allow an insured party to report a claim after the expiration of the policy period.[49] In this policy, which lacked a definitional section,[50] the insured was given no guidance in determining what constituted a loss—leading the court to determine that an ambiguity was created as to when a claim had to be reported.[51] The court held that the provisions created confusion, resulting from conflicting terms.[52] Accordingly, the court reversed the trial court's ruling, holding that summary judgment was inappropriate.[53] Such ambiguities in claims-made policies constitute another worrisome complication due to the increased potential for litigation and possibility that the insured will not receive the coverage they thought they had purchased.

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which arose and *could* have been asserted during the policy period, including claims not actually asserted until after the policy's expiration." (quoting *Gyler*, 514 P.2d at 1221)).

42. *Id.* at 497 (second alteration in original).

43. *Id.* at 502.

44. *See, e.g.*, *Chamberlin,* 140 Cal. Rptr. at 495.

45. *See id.* at 498 ("The general rule is that if coverage is available under any reasonable interpretation of an ambiguous clause of an insurance policy, the insurer cannot escape its obligations.").

46. Garmisa, *supra* note 21, at 294.

47. *Id.*

48. 527 N.E.2d 921 (Ill. App. Ct. 1988).

49. *See id.* at 925.

50. *Id.* at 924.

51. *Id.*

52. *Id.*

53. *Id.* at 925.

3. Avoidance of Liability

Due to the restrictive nature of claims-made policies, insurers typically require prospective policyholders to disclose whether they have knowledge of potential claims against them at the time the policy is instituted. This attempt by insurance companies to avoid coverage gives rise to problems regardless of the jurisdiction in which the policy is written and has been interpreted both in favor of and against insured parties.[54]

A series of Illinois state cases illustrate the courts' varying interpretations of whether a lack of disclosure on behalf of the insured at the onset of the claims-made policy is considered misrepresentation.[55] In *Great West Steel Industries v. Northbrook Insurance Co.*,[56] the court held that no misrepresentation had taken place when the insured failed to report a construction accident potentially related to steel it had manufactured because it believed it was not responsible for the accident.[57] Although the insured party was aware of the circumstances that might lead to a claim, it did not believe it was at fault and the court construed the policy language in their favor.[58]

In the malpractice liability context, courts have not been as forgiving when policyholders fail to report potential claims at the inception of the policy.[59] For example, in *Stiefel v. Illinois Union Insurance Co.*,[60] an attorney received a letter informing him of a potential malpractice lawsuit that would be filed against him six months before he took out a claims-made insurance policy.[61] Despite the argument that the attorney believed the claim had been abandoned, the court did not reach a conclusion consistent with *Great West Steel Industries* when the insurance company subsequently denied coverage after a lawsuit was filed against the insured within the policy period.[62] Instead, the court explained that the letter sent to the insured undoubtedly constituted notice of a potential malpractice suit, regardless of the fact that the lawsuit was not filed when the plaintiff claimed they would file it.[63] In contrast to the holding in *Stiefel*, an insurance company's attempt to avoid liability in similar circumstances was unsuccessful when an insured party denied knowledge of a potential claim even though they had received a letter similar to that

54. *See* Garmisa, *supra* note 21, at 296.
55. *Id.*; Great W. Steel Indus. v. Northbrook Ins. Co., 484 N.E.2d 847 (Ill. App. Ct. 1985); Stiefel v. Ill. Union Ins. Co., 452 N.E.2d 73 (Ill. App. Ct. 1983)).
56. 484 N.E. 2d 847 (Ill. App. Ct. 1985).
57. *Id.* at 853.
58. *Id.*
59. *See Stiefel*, 542 N.E.2d at 76.
60. 542 N.E.2d 73 (Ill. App. Ct. 1983).
61. *Id.* at 74–75.
62. *See id.* at 77.
63. *Id.*

in *Stiefel* four years before the policy term.[64] This departure from *Stiefel*'s holding indicates an increased potential for ambiguity in the interpretation of this temporal aspect of claims-made policy applications, giving rise to further complications with this type of insurance policy.

C. Insurance Policy Jurisprudence

When a dispute arises between an insurance company and a policyholder, Colorado law states that insurance policies should be interpreted based on the principles of contract law.[65] In construing the terms of the policy, courts must attempt to "promote the intent of the parties" as they would with any contract.[66] As evidenced by a multitude of insurance litigation, the intent of the parties is not always clear.[67] In the insurance context, courts seek to resolve disagreements about coverage and terminology used in a written instrument by determining intent based on the plain language of the instrument.[68] When the language is clear and unambiguous, courts should "not rewrite a contractual provision"[69] and must instead "give effect to the plain and ordinary meaning of its terms."[70]

When the language is unclear, however, and uncertainty arises, "courts should construe the policy in favor of the insured."[71] Although a mere disagreement between the insurance provider and policyholder does not give rise to an ambiguity, when the policy "is susceptible on its face to more than one reasonable interpretation" it is determined to be ambiguous.[72] Finally, in determining whether a policy is ambiguous on any point, courts "must evaluate the policy as a whole."[73]

D. Bad Faith on Part of Insurer

When an insurance company is held liable for a claim, state statutes may also allow insured parties to recover reasonable attorney fees, court

64. St. Paul Mercury Ins. Co. v. Statistical Tabulating Co., 508 N.E.2d 433, 436 (Ill. App. Ct. 1987) ("We also recognize that that foreseeability may have been diminished by the intervening time period between the last correspondence between the parties in April, 1980 and the filing of the complaint in February 1983. In our view, whether that period of silence lulled Stat-Tab into a false assurance that there were no prior errors which would give rise to a potential claim, thereby acting as a waiver of prior knowledge of potential claims, is a genuine issue of material fact which precludes entry of a summary judgment.").

65. *See* Carl's Italian Rest. v. Truck Ins. Exch., 183 P.3d 636, 639 (Colo. App. 2007) (citing Chacon v. Am. Family Mut. Ins. Co., 788 P.2d 748, 750 (Colo.1990)).

66. Cary v. United of Omaha Life Ins. Co., 108 P.3d 288, 290 (Colo. 2005).

67. *See, e.g.*, Bay Cities Paving & Grading, Inc. v. Lawyers' Mut. Ins. Co., 855 P.2d 1263 (Cal. 1993); Prof'l Solutions Ins. Co. v. Mohrlang, No. 07-cv-02481-PAB-KLM, 2009 WL 321706 (D. Colo. Feb. 10, 2009).

68. Parrish Chiropractic Ctrs., P.C. v. Progressive Cas. Ins. Co., 874 P.2d 1049, 1055 (Colo. 1994)

69. Wota v. Blue Cross & Blue Shield of Colo., 831 P.2d 1307, 1309 (Colo. 1992).

70. *Id.*

71. Republic Ins. Co. v. Jernigan, 753 P.2d 229, 232 (Colo. 1988).

72. Cary v. United of Omaha Life Ins. Co., 108 P.3d 288, 290 (Colo. 2005).

73. *Id.*

costs, and the covered benefits when an insurer's delay or refusal to pay a claim constitutes bad faith.[74] In Colorado, a first-party claimant in such an action may recover two times the covered benefit.[75] In the absence of a bad faith statute, an insured may typically only recover special damages for the insurance company's refusal to indemnify the loss or the actual amount due to the insured based on the loss.[76]

An insurance company's mere denial of a claim does not necessarily rise to the level of bad faith[77] and, although similar, states differ in the elements of this cause of action.[78] To establish a claim of bad faith in Colorado the plaintiff must have damages or loss, the defendant must have denied or delayed payment without reasonable basis for its action, and the defendant's unreasonable conduct must have been the cause of the plaintiff's damages or loss.[79] Because such statutes are penal in nature, they are to be strictly construed and the burden is on the insured seeking statutory recovery to prove arbitrariness or capriciousness on the part of the insurer for failing to pay a claim.[80] Insurance companies have been held liable for statutory penalties after acting in bad faith in a variety of circumstances,[81] including, among other things, denial of a claim on the grounds that a particular person was not within the coverage afforded by the policy.[82] Illustrating the contentiousness of such litigation, however, courts have also held to the contrary in cases involving similar factual circumstances.[83]

II. *BERRY & MURPHY, P.C. V. CAROLINA CASUALTY INSURANCE COMPANY*

A. Facts

Berry & Murphy, P.C. involves the interpretation of a claims-made insurance policy issued by Carolina Casualty[84] to the named insured "Timothy H. Berry, P.C."[85] The issue in this case stems from a series of disputes beginning with a personal injury lawsuit filed against Joseph Ciri on behalf of Oksana and William Burkhardt.[86] Seth Murphy, a co-shareholder with the law firm of Berry & Murphy, P.C., represented

74. 14 RUSS & SEGALLA, *supra* note 9, at § 207:1 (defining bad faith as "the arbitrary refusal of an insurance company to pay a valid claim").

75. COLO. REV. STAT. § 10-3-1116(1) (2008).

76. George L. Blum, Annotation, *What Constitutes Bad Faith on Part of Insurer Rendering It Liable for Statutory Penalty Imposed for Bad Faith in Failure to Pay, or Delay in Paying, Insured's Claim-Particular Grounds for Denial of Claim: Risks, Causes, and Extent of Loss, Injury, Disability, or Death*, 123 A.L.R. 5TH 259 § 2[a] (2004).

77. *Id.* at § 2[b].

78. *See* 14 RUSS & SEGALLA, *supra* note 9, at § 207:3.

79. COLO. JURY INSTR., 4TH (CIVIL) § 25:4 (2010).

80. Blum, *supra* note 76, at § 2[b].

81. *Id.* at § 2[a].

82. *Id.* at § 3[a].

83. *Id.* at § 3[b].

84. Berry & Murphy, P.C. v. Carolina Cas. Ins. Co., 586 F.3d 803, 805 (10th Cir. 2009).

85. *Id.* at 814.

86. *Id.* at 805.

the Burkhardts in this suit (the Ciri Lawsuit)—filed in January 2005.[87] In March 2006, Mr. Murphy left Berry & Murphy, P.C., taking the Ciri Lawsuit with him to his new firm, Richmond, Neiley, Sprouse, & Murphy, LLC.[88] Over the next several months, the court granted a motion to withdraw as counsel filed by Mr. Murphy and granted, without prejudice, a motion filed by the defendants to dismiss the lawsuit for failure to prosecute.[89] In November 2006, the court then granted a motion to reconsider the order dismissing the Ciri Lawsuit after the Burkhardts hired Cindy Tester as new counsel.[90] Due to various instances in which Mr. Murphy failed to comply with Colorado Rule of Civil Procedure 16.1,[91] which he did not opt out of, Ms. Tester sent a letter (the Tester Letter) to Mr. Murphy in January 2007 at his new place of employment informing him of a malpractice suit she planned to file on behalf of the Burkhardts.[92]

Of great importance to the case is the fact that the Tester Letter was sent only to Richmond, Neiley, Sprouse, & Murphy, LLC and not to Mr. Murphy's former co-shareholder, Timothy H. Berry.[93] Furthermore, Mr. Murphy followed the advice in the Tester Letter and provided his law firm's malpractice insurance carrier with notice of the claim.[94] Nearly a year later, in December 2007, the court granted a renewed motion to dismiss the Ciri Lawsuit,[95] which was followed by a legal malpractice claim (the Malpractice Lawsuit) filed on behalf of the Burkhardts against Mr. Murphy and Berry & Murphy, P.C., in the United States District Court for the District of Colorado.[96] The Malpractice Lawsuit alleged that Mr. Murphy and Berry & Murphy, P.C. "missed the deadline for filing notice to elect exclusion from Simplified Procedures pursuant to [Colorado Rule of Civil Procedure] 16.1 in the Ciri Lawsuit," and that both were "'negligent' and breached their 'fiduciary duty of loyalty' to the Burkhardts."[97] On July 23, 2008, Mr. Berry accepted service of the Malpractice Lawsuit and put Carolina Casualty on notice of the suit the same day.[98] Mr. Berry alleged that he first received knowledge of the

87. *Id.*
88. *Id.*
89. *Id.*
90. *Id.* at 806.
91. COLO. R. CIV. P. 16.1(a)(1) ("The purpose of [simplified procedure] is to provide maximum access to the district courts in civil actions; to enhance the provision of just, speedy, and inexpensive determination of civil actions; to provide the earliest practical trials; and to limit discovery and its attendant expense.").
92. *Berry & Murphy*, 586 F.3d at 806.
93. *Id.*
94. *Id.*
95. *Id.*
96. *Id.* at 807.
97. *Id.*
98. *Id.*

Malpractice Lawsuit at the time he was served and was unaware of the Tester Letter.[99]

B. Procedural Background

Plaintiffs Berry & Murphy, P.C. and Timothy H. Berry, P.C. filed suit to resolve a dispute with defendant Carolina Casualty regarding defendant's denial of coverage for the Malpractice Lawsuit.[100] Carolina Casualty denied coverage "on the grounds that the alleged malpractice claim was first made against an insured (i.e., Seth Murphy) prior to the inception of the insurance policy (i.e., via the Tester Letter), thereby falling outside the claims-made coverage of the policy."[101]

The plaintiffs and Carolina Casualty filed cross-motions for summary judgment before the district court, which granted Carolina Casualty's motion in its entirety.[102] The district court based its ruling on the fact that Mr. Murphy was an "insured" under the language of the insurance policy, that the Tester Letter constituted notice to the insured, and that the "burden" should not fall on Carolina Casualty for Mr. Murphy's failure to inform his former partner or firm of the claim.[103] As the prevailing party, Carolina Casualty was awarded costs.[104] On appeal, the Tenth Circuit reviewed the district court's decision *de novo* and applied the substantive law of Colorado, the forum state.[105]

C. The Majority Opinion

Writing for the majority, Judge Briscoe began her analysis by examining the language of the insurance policy at issue.[106] The claims-made policy contained the following "Insuring Agreement":

> This Policy shall pay on behalf of the *Insured* all *Damages* and *Claims Expense* that the *Insured* shall become legally obligated to pay, arising from any *Claim* first made against an *Insured* during the *Policy Period* and reported to the *Insurer* in writing during the *Policy Period* or within 60 days thereafter, for any *Wrongful Act,* provided that prior to the inception date of the first Lawyers' Professional Liability Insurance Policy issued by the *Insurer* to the *Named Insured,* which has been continuously renewed and maintained in effect to the inception of this *Policy Period,* the *Insured* did not know, or could

99. *Id.*
100. *Id.*
101. *Id.*
102. *Id.*
103. *Id.*
104. *Id.* at 807–08.
105. *Id.* at 808.
106. *Id.* at 808–10.

> not reasonable foresee that such *Wrongful Act* might reasonably be expected on the basis of a *Claim*.[107]

In analyzing this language and the policy's definitions of the terms "Claim,"[108] "Wrongful Act,"[109] "Related Wrongful Act,"[110] and "Notice of Claim and Multiple Claims,"[111] Judge Briscoe did not find any ambiguity and determined that the terms had "plain and ordinary meanings" that could be applied to the language of the policy.[112] Therefore, the majority found that the two essential inquiries were whether (1) the Tester Letter and Malpractice Lawsuit constituted a single claim[113] and (2) whether Mr. Murphy was an "insured" under the language of the policy.[114]

In deciding whether the Tester Letter and Malpractice Lawsuit should be considered as one "claim," the majority began by analyzing the policy's definition of "related wrongful act."[115] To support their position that the claim in the Tester Letter was not "logically or causally connected" to the claims made in the Malpractice Lawsuit, the plaintiffs argued that *Professional Solutions Insurance Co. v. Mohrlang*[116] should control.[117] In *Mohrlang*, the United States District Court for the District of Colorado was faced with a task similar to the one in the current dispute; to determine whether two malpractice claims were "related" by examining the policy's definition of "related acts or omissions."[118] Like

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107. *Id.* at 808–09.

108. *Id.* at 809 ("[A] written demand for monetary or non-monetary relief including, but not limited to, a civil, criminal, administrative or arbitration proceeding . . . . A *Claim* shall be deemed to have been first made at the time notice of the *Claim* is first received by any *Insured*." (internal quotation marks omitted)).

109. *Id.* ("[A]ny actual or alleged act, omission, or *Personal Injury* arising out of *Professional Services* rendered by an *Insured* or by any person for whose act or omission the *Insured* is legally responsible . . . ." (internal quotation marks omitted)).

110. *Id.* ("*Wrongful Acts* which are logically or causally connected by reason of any common fact, circumstance, situation, transaction, casualty, event or decision." (internal quotation marks omitted)).

111. *Id.* at 809–10 (stating in pertinent part: "(A) As a condition precedent to their rights under this Policy, an *Insured* shall give the *Insurer* written notice of any *Claim* as soon as practicable . . . . (C) All *Claims* based upon or arising out of the same *Wrongful Acts* or any *Related Wrongful Acts*, or one or more series of similar, repeated or continuous *Wrongful Act* or *Related Wrongful Acts*, shall be considered a single *Claim*. Each *Claim* shall be deemed to be first made at the earliest of the following times: 1. when the earliest *Claim* arising out of such *Wrongful Act* or *Related Wrongful Acts* is first made").

112. *Id.* at 810 (citing Carey v. United of Omaha Life Ins. Co., 108 P.3d 288, 290 (Colo. 2005) ("An insurance policy is ambiguous if it is susceptible on its face to more than one reasonable interpretation . . . . A mere disagreement between the parties concerning interpretation of the policy does not create an ambiguity. To determine whether a policy contains an ambiguity, we must evaluate the policy as a whole." (internal citations omitted))).

113. *Berry & Murphy*, 586 F.3d at 810.

114. *Id.* at 814.

115. *Id.* at 810–11.

116. No. 07–cv–02481-PAB-KLM, 2009 WL 321706 (D. Colo. Feb. 10, 2009).

117. *Berry & Murphy*, 586 F.3d at 811–12.

118. *Mohrlang*, 2009 WL 321706, at *3 (defining "related acts or omissions" as "all acts or omissions in the rendering of professional services that are temporally, logically or causally connected by any common fact, circumstance, situation, transaction, event, advice or decision").

the Tenth Circuit in the current case, the *Mohrlang* court found no ambiguity in the policy's terms.[119] The district court found that the claim against the attorney for breach of professional duties involving the sale of stock[120] and the second claim for breach of fiduciary duties of loyalty, disclosure, and candor involving the release of promissory notes[121] were not temporally, logically, or causally connected and were not related claims under the language of the policy.[122]

Refusing to adopt the result from *Mohrlang*, the majority distinguished the facts in the current case by using the district court's definition of "logically connected."[123] Because the Tester Letter faulted Mr. Murphy for not opting out of Rule 16.1 and the Malpractice Lawsuit "flows from Murphy's decision to proceed under Rule 16.1[,]" the court found the two claims logically connected.[124]

Both the plaintiffs and Carolina Casualty then discussed the California Supreme Court case, *Bay Cities Paving & Grading, Inc. v. Lawyers' Mutual Insurance Co.*,[125] which examined insurance policy term definitions specific to a "claims-based" legal liability policy.[126] The two alleged claims of malpractice in this case were an attorney's failure to serve a stop notice on a construction project's lenders and a failure to timely foreclose on a mechanic's lien.[127] Although it was argued that these were two separate claims, both warranting indemnification,[128] the California Supreme Court disagreed and treated them as a single claim.[129] Carolina Casualty argued that the reasoning employed in *Bay Cities* is applicable to the facts at hand and that the Tenth Circuit should reach a similar result.[130] The majority agreed with Carolina Casualty, stating that "it seems logical" to connect multiple acts of malpractice as "related" in this instance because a single client, the Burkhardts, suffered a single injury from a single attorney.[131]

The final argument made by Carolina Casualty regarding whether the Tester Letter and Malpractice Lawsuit constituted a single claim involved a Florida District Court of Appeals case in which "[t]he alleged

119. *Id.* at *9.
120. *Id.* at *2.
121. *Id.*
122. *Id.* at *13.
123. Berry & Murphy, P.C. v. Carolina Cas. Ins. Co, 586 F.3d 803, 812 (10th Cir. 2009) (citing *Mohrlang*, 2009 WL 321706, at *11 (defining "logically connected" as "connected by an inevitable or predictable interrelation or sequence of events")).
124. *Id.*
125. 855 P.2d 1263 (Cal. 1993).
126. *Berry & Murphy,* 586 F.3d at 812.
127. *Bay Cities*, 855 P.2d at 1264.
128. *Id.* at 1265.
129. *Id.* at 1266 ("[W]hen, as in this case, a *single* client seeks to recover from a *single* attorney alleged damages based on a *single* debt collection matter for which the attorney was retained-there is a *single* claim under the attorney's professional liability insurance policy.").
130. *Berry & Murphy*, 586 F.3d at 813.
131. *See id.*

acts of malpractice were the attorney's failure to name a hospital and each individual physician from that hospital as defendants in a medical malpractice lawsuit."[132] Despite the defendant's assertion that his attorney's failure to join several defendants is akin to multiple wrongful acts, and therefore multiple claims, the court held otherwise.[133] Using reasoning similar to *Bay Cities*, the court in *Eagle American Insurance Co. v. Nichols*[134] found that all of the attorney's acts of negligence led to a single injury on the part of the plaintiff.[135] Based on the arguments presented by Carolina Casualty and consideration of the *Bay Cities* and *Nichols* cases, the Tenth Circuit concluded that the Tester Letter and the Malpractice Lawsuit alleged "related wrongful acts" under the insurance policy and were therefore one "claim" for indemnification purposes.[136]

With the "single claim" dispute resolved, the court turned its attention to whether Mr. Murphy was an "insured" under the terms of the insurance policy.[137] The term "insured" had five distinct definitions within the policy, with the pertinent definition stating that "insured" means, "any individual or professional corporation who was a partner, officer, director, stockholder, or employee of the *Named Insured* or *Predecessor Firm,* but solely while acting within the scope of their duties on behalf of the *Named Insured* or *Predecessor Firm* . . . ."[138] Again, finding no ambiguity in the policy language, the court proceeded to analyze the language of this definition in two parts.[139]

The first limitation the definition required was that the individual "*was* a partner, officer, director, stockholder, or employee" of the named insured.[140] The court held it "undisputed" that Mr. Murphy was a co-shareholder in Murphy & Berry, P.C. and that he therefore fit this first requirement.[141]

The second limitation on the definition of "insured" was a much more crucial determination for the court to make and effectively became the decisive interpretation in this case.[142] In the court's analysis of the language, "but solely while acting . . . on behalf of the Named Insured," it stated:

> This clause, when read in context with the rest of this definitional subsection, cannot mean that an individual is an insured only while

132. *Id.* (citing Eagle Am. Ins. Co. v. Nichols, 814 So. 2d 1083, 1084 (Fla. Dist. Ct. App. 2002)).
133. *Nichols*, 814 So. 2d at 1085–87.
134. 814 So. 2d 1083 (Fla. Dist. Ct. App. 2002).
135. *Id.* at 1087.
136. *Berry & Murphy*, 586 F.3d at 814.
137. *Id.*
138. *Id.*
139. *Id.* at 814–15.
140. *Id.* at 814.
141. *Id.*
142. *See id.* at 815.

> acting on behalf of the named insured, but must mean that an individual is an insured only if the claim being made is related to that individual's duties on behalf of the named insured. Otherwise, no former employee of the named insured could ever be an "insured." If "insured" were interpreted to mean that an individual was an insured only while acting within the scope of business of the named insured, it would be paradoxical to define "insured" to include former employees-any individual "who *was* a partner, officer, director, stockholder, or employee of the Named Insured," Timothy H. Berry, P.C.[143]

The court then explained what it believed to be a "better" view of the definition of insured as including "an individual after he has left the law firm if the claim involves that individual's acts or omissions that occurred while at the law firm."[144] Because Mr. Murphy was an "insured" under the court's view of the definition and notice of the "claim" was given to Mr. Murphy as an insured before the policy period commenced, the court held that Carolina Casualty was under no duty to defend or indemnify the plaintiffs.[145] Without a duty to defend or indemnify a claim, the court held that the plaintiffs' claim failed and affirmed the judgment of the district court.[146]

D. The Dissent

Dissenting, Judge Lucero crafted a strongly worded response to the majority, arguing that, by denying Mr. Berry "the very coverage for which he paid premiums," Carolina Casualty received a windfall.[147] By redefining "notice" Judge Lucero asserted that the majority created an "escape hatch" for insurers, allowing them to promise coverage and collect premiums, yet avoid responsibility by failing to uphold their end of the insurance agreement and refusing to indemnify the insured.[148]

The focus of the dissenting opinion centered on the interpretation of the term "insured" and, ultimately, whether notice was given to an insured during the policy period.[149] Through the dissection, and piecing back together, of the policy's definition of insured, Judge Lucero interpreted the term in a more straightforward manner. By extracting the superfluous language unrelated to the facts in the current dispute, he found a better reading to be, "An individual . . . who was a . . . stockholder of the . . . Predecessor Firm is an insured, but solely while acting within the scope of their duties on behalf of the . . . Predecessor Firm."[150] Based on

143. *Id.* at 814–15.
144. *Id.* at 815.
145. *Id.*
146. *Id.*
147. *Id.* at 816 (Lucero, J., dissenting).
148. *Id.*
149. *Id.*
150. *Id.* at 818 (alterations in original) (internal quotation marks omitted).

the dissent's reading of Colorado's caselaw related to contract interpretation,[151] and careful evaluation of the definition of "insured" in the policy, Judge Lucero argued that Mr. Murphy was not an insured when he received notice of the Burkhardts' claim through the Tester Letter.[152]

By applying "the plain and ordinary meaning of [the definition's] terms,"[153] the dissent determined that a former employee, or stockholder in this instance, of a predecessor firm is *not* an insured when acting outside the scope of his duties on behalf of the firm.[154] In this instance, Mr. Murphy was no longer working for Berry & Murphy, P.C. when he received the Tester Letter, cannot be said to have been working on behalf of Berry & Murphy, P.C. at that time, and was therefore not an insured when notice was given to him.[155]

Continuing with its plain language interpretation of "insured," the dissent directly refuted the majority's obscuring of the definition.[156] In response to the majority's "paradoxical" argument,[157] Judge Lucero argued that interpreting the definition according to the words' plain meaning did not render it meaningless but instead made it consistent with what one might expect: that it is unlikely that a former stockholder can receive notice of a claim.[158] After outlining instances in which a former stockholder *can* receive notice sufficient to fulfill the requirement of a claim,[159] Judge Lucero reiterated the majority's careless disregard of Colorado caselaw.[160]

151. *Id.* at 817 (citing State Farm Mut. Auto. Ins. Co. v. Stein, 940 P.2d 384, 387 (Colo. 1997) (stating that Colorado courts construe insurance policies "to promote the intent of the parties"); Parrish Chiropractic Ctrs., P.C. v. Progressive Cas. Ins. Co., 874 P.2d 1049, 1055 (Colo. 1994) ("Where there is a written instrument, the intent of the parties is determined from the plain language of the instrument itself."); Wota v. Blue Cross & Blue Shield of Colo., 831 P.2d 1307, 1309 (Colo. 1992) (stating that courts should "not rewrite a contractual provision that is clear and unambiguous, but must give effect to the plain and ordinary meaning of its terms"); Republic Ins. Co. v. Jernigan, 753 P.2d 229, 232 (Colo. 1988) ("However, where there is ambiguity or uncertainty as to coverage, courts should construe the policy in favor of the insured.")).

152. *Berry & Murphy*, 586 F.3d at 818 (Lucero, J., dissenting).

153. *Id.* (citing *Wota*, 831 P.2d at 1309).

154. *Id.* at 818.

155. *Id.*

156. *Id.* at 816 ("In construing the policy's definition of 'Insured,' the majority opinion misapplies Colorado law. At a minimum, that definition is ambiguous as to whether a former stockholder is an insured for notice purposes.").

157. *Id.* at 815 (majority opinion) ("[I]t would be paradoxical to define 'insured' to include former employees . . . .").

158. *See id.* at 818 (Lucero, J., dissenting).

159. *Id.* ("Only if it is established that a former stockholder has given notice in fact to his previous employer may an issue of notice in this context be properly raised. . . . An individual can be both a former stockholder and acting on behalf of her former law firm in certain circumstances. An individual might semi-retire from the practice of law and renounce stockholder status, but take occasional cases on behalf of her former firm on a contract basis.").

160. *Id.* at 819 (citing Pub. Serv. Co. v. Wallis & Cos., 986 P.2d 924, 931 (Colo. 1999) (construing policy language in favor of the insured when it is "susceptible to more than one reasonable interpretation")).

In its conclusion, the dissent stated its belief that Mr. Murphy was not an insured at the time he received the Tester Letter, and that the claim was instead first made against an insured when Mr. Berry accepted service of the Burkhardts' complaint.[161] Because Mr. Berry accepted service on July 23, 2008, the claim was made within the policy period and the dissent would therefore reverse the district court's grant of summary judgment in favor of Carolina Casualty.[162]

III. ANALYSIS

In *Berry & Murphy, P.C.*, the Tenth Circuit properly interpreted established precedent in determining that the Tester Letter and Malpractice Lawsuit constituted a single claim, but the majority's interpretation of the term "insured" resulted in a holding that was not only inequitable, but one that could have potentially hazardous effects. By defining the term "insured" to include former employees in instances where the claim involves his acts or omissions while working at his former law firm, the court disregarded Colorado insurance jurisprudence, which, if followed, would have led to a different outcome. The Tenth Circuit has also given such individuals powerful discretion when receiving notice of a claim, leading to potentially damaging effects.

A. Interpretation of "Related Wrongful Acts"

Although not explicitly stated, the court's first determination of whether the Tester Letter and Malpractice Lawsuit constituted related wrongful acts was paramount.[163] Had the court reached the opposite conclusion it is almost certain that the Tenth Circuit would have had to reverse the district court's ruling. If the majority had determined that these were separate claims and adopted the appellant's arguments,[164] the court's subsequent analysis would have proceeded much differently by analyzing whether Mr. Berry, not Mr. Murphy, was an insured. Mr. Berry would therefore likely be entitled to coverage because the dispute over the term "insured" involved Mr. Murphy's status due to the court's finding that the Tester Letter constituted the first claim against the insured.[165]

Instead, the majority devoted the bulk of its opinion to carefully analyzing the arguments on both sides of the issue and interpreting the authority used by both Mr. Berry and Carolina Casualty.[166] Throughout

161. *Id.* at 819.
162. *Id.*
163. *Id.* at 810 (majority opinion) (stating that the first determination to be made is whether the Tester Letter and Malpractice suits are considered one claim, and failing to discuss the ramifications if they are determined not to be related wrongful acts).
164. Brief for Appellant at 21–24, Berry & Murphy, P.C. v. Carolina Cas. Ins. Co., 586 F.3d 803 (10th Cir. 2009) (No. 09-1004), 2009 WL 1064884.
165. *Berry & Murphy*, 586 F.3d at 814.
166. *Id.* at 810–14.

its discussion of these proffered cases, the Tenth Circuit chose not to restate or directly comment on the appellant's arguments and instead opted for a streamlined analysis that simply related the law and previous holdings to the facts at hand.[167] In finding the Tester Letter and Malpractice Lawsuit to constitute "related wrongful acts[,]" the court correctly interpreted *Mohrlang* and *Bay Cities*,[168] while refusing to accept the appellant's coherent but ultimately misguided arguments.[169]

1. The *Mohrlang* Decision

In focusing on *Mohrlang*'s recitation of the clear definitions set forth in Merriam-Webster's Collegiate Dictionary of "logically connected"[170] and "causally connected"[171] the majority properly distinguished Mr. Berry's argument. Because insurance contract cases are so fact-specific, and policies are written in vastly different ways, the court's reliance on the definitions set forth in *Mohrlang* allowed for a well-reasoned decision on this point.[172] Mr. Berry's argument that the Tester Letter and Malpractice Lawsuit were *not* logically connected because the failure to file disclosures was not a "predictable result" of proceeding under Colorado Rule of Civil Procedure 16.1 fell flat due to the appellant's misinterpretation of the definition of the term.[173] The court's search for a "predictable interrelation" rather than a "predictable result" is a more faithful reading of the definition and one that is certainly found in this instance. While Rule 16.1 adheres in principle to the disclosure guidelines of Rule 26,[174] Rule 16.1 also sets forth strict disclosure deadlines.[175] By failing to opt out of Rule 16.1, Mr. Murphy subjected himself to the timeframes dictated by the rule. Although failing to fulfill these requirements may not be a "result" of proceeding under Rule 16.1, as Mr. Murphy may have failed to make disclosures regardless of his course of action, this shortcoming is certainly "interrelated" to Rule 16.1 due to its setting of disclosure deadlines.[176]

167. *Id.* at 811–14.

168. *Id.*

169. Brief for Appellant, *supra* note 164, at 21–24.

170. Prof'l Solutions Ins. Co. v. Mohrlang, No. 07–cv–02481-PAB-KLM, 2009 WL 321706, at *11 (D. Colo. Feb. 10, 2009) (defining "logically connected" as "connected by an inevitable or predictable interrelation or sequence of events").

171. *Id.* (defining "casually connected" as "connected where one person or thing brings about the other").

172. *Berry & Murphy*, 586 F.3d at 812 (using the definitions of the terms "logically connected" and "causally connected" only in relation to the facts at hand).

173. *See* Brief for Appellant, *supra* note 164, at 22.

174. COLO. R. CIV. P. 16.1(k)(2) (stating that certain provisions of Rule 26 apply to disclosure of expert witnesses).

175. *Id.* ("Written disclosures of experts shall be served by parties asserting claims 90 days before trial; by parties defending against claims 60 days before trial; and parties asserting claims shall serve written disclosures for any rebuttal experts 35 days before trial.").

176. *Id.*

The court's failure to address the "causally connected" argument set forth by the appellant likely stems from the fact that such an analysis was unnecessary.[177] If the Tenth Circuit had applied the *Mohrlang* court's definition, it would have been difficult to find a causal connection between the Tester Letter and Malpractice Lawsuit. Any causal connection that may have existed between proceeding under Rule 16.1, as cited in the Malpractice Lawsuit, and Mr. Murphy's failure to make adequate disclosures, as mentioned in the Tester Letter, was certainly broken by a deliberate choice not to comply with the rule.[178] However, due to the operative word, "or" in the definition of "related wrongful acts" the court's determination that the Tester Letter and Malpractice Lawsuit were logically connected was sufficient to end this inquiry.[179]

2. The *Bay Cities* Decision

In an apparent attempt to add weight to its decision that only one claim had been made, the Tenth Circuit discussed a California Supreme Court case that was also construed in favor of Carolina Casualty.[180] The appellant's argument that "the Tester Letter and the Malpractice Lawsuit did not arise from the same underlying cause"[181] did not persuade the court to find multiple claims because of the straightforward language used in *Bay Cities*.[182] An attempt to argue that the *results* of Mr. Murphy's failures as set forth in the Tester Letter and Malpractice Lawsuit were different[183] was clearly out of line with the reasoning of the *Bay Cities'* court.[184] On this point, the appellant relied on the fact that the claim in the Tester Letter cites dismissal of the Ciri Lawsuit, and the Malpractice Lawsuit cites malpractice that did *not* lead to dismissal of the Ciri Lawsuit.[185] However, as the majority properly pointed out, the circumstances here included a single client, a single attorney, and a single claim for which Mr. Murphy was retained.[186] Regarding the result, it is also true that the Burkhardts suffered a single harm.[187] Again, the Tenth Circuit correctly applied persuasive authority despite the refusal to directly comment on the appellant's argument.

177. *Berry & Murphy*, 586 F.3d at 809 (defining "related wrongful acts" as logically *or* causally connected).

178. Brief for Appellant, *supra* note 164, at 19–21.

179. *Berry & Murphy*, 586 F.3d at 809 (defining "related wrongful acts" as logically *or* causally connected).

180. *Id.* at 812–13.

181. Brief for Appellant, *supra* note 164, at 28.

182. *Berry &* Murphy, 586 F.3d at 813 (discussing Bay Cities Paving & Grading, Inc. v. Lawyers' Mut. Ins. Co., 855 P.2d 1263, 1275 (Cal. 1993)).

183. Brief for Appellant, *supra* note 164, at 27–28.

184. *See Bay Cities*, 855 P.2d at 1266.

185. Brief for Appellant, *supra* note 164, at 27–29.

186. *Berry & Murphy*, 586 F.3d at 813.

187. *Id.* (agreeing that the single harm which the Burkhardts suffered was "the lost opportunity to recover some or all of their damages in the Ciri Lawsuit").

B. Interpretation of "Insured"

One difficulty faced by the court, and one potential reason for the stark difference between the majority and dissent's interpretations of the term "insured," is that the term's definition varies greatly depending on the type of insurance policy in which it is used.[188] To make matters more difficult, Colorado case law does not set forth a standard definition of "insured" as used in a malpractice liability insurance policy, which is likely due to the variable nature of insurance policies.[189] Additionally, the Colorado Revised Statutes do not provide any guidance because the term "insured" is omitted from the definitions section of Title 10, Insurance.[190] While "insurer" is defined,[191] along with twenty-seven other terms and phrases, the Colorado Legislature did not include a standard definition for "insured."[192]

Faced with these uncertainties, the majority proceeded to improperly craft a definition of this key term. While the Tenth Circuit should be commended for its threshold determination that the Tester Letter and Malpractice Lawsuit constituted a single claim, it should not be similarly lauded for its interpretation of the term "insured." After deciding that the Tester Letter constituted the initial claim, the appellant's right to indemnification hinged on whether Mr. Murphy was considered an insured under the language of the policy at the time he received the letter. In deciding that Mr. Murphy was in fact an insured, the majority created a class of insured individuals that was likely not anticipated by the appellant at the inception of the insurance policy.

1. The Majority's Definition

Mr. Murphy received the Tester Letter prior to the commencement of the insurance policy at issue.[193] Therefore, under the conditions of the claims-made agreement, Mr. Murphy's judicially created status as an insured caused the claim to be made outside the policy period,[194] foreclosing Berry & Murphy, P.C. from receiving indemnification.[195] In the majority's brief discussion of this important issue, the Tenth Circuit's

188. JOHN W. GRUND, J. KENT MILLER & GRADEN P. JACKSON, 7A COLO. PRAC., PERSONAL INJURY TORTS AND INSURANCE § 47.5 (2d ed. 2010).

189. *See generally id.*

190. COLO. REV. STAT. § 10-1-102 (2006).

191. *Id.* ("'Insurer' means every person engaged as principal, indemnitor, surety, or contractor in the business of making contracts of insurance.").

192. *See id.*

193. *See* Berry & Murphy, P.C. v. Carolina Cas. Insur. Co., 586 F.3d 803, 805–07 (10th Cir. 2009).

194. *Id.* at 806-07. By determining that Mr. Murphy was an "insured" under the language of the claims-made policy effective from February 6, 2008 to February 6, 2009, the court foreclosed Berry & Murphy, P.C.'s opportunity to report a claim during the policy period because Mr. Murphy had received the Tester Letter on January 10, 2007, constituting notice of the Malpractice Lawsuit. Because this notice came before the inception of the claims-made policy, the claim was not made during the policy period and Carolina Casualty avoided liability.

195. *Id.* at 815.

decision turns a blind eye to Colorado precedent and distorts the language of the insurance policy to fit the Court's ideals.

The majority begins its analysis of this topic by determining that there is no ambiguity in the policy's definition of insured.[196] However, after a short discussion of the definition's third subsection and its limitations, the court states what it believes to be a "better" view of the term "insured."[197] What the court appears to have done is rewrite the policy's definition. Colorado insurance law explicitly states that courts should "not rewrite a contractual provision that is clear and unambiguous,"[198] a point of law that the Tenth Circuit did not follow. In the majority's attempt to avoid calling the language ambiguous, which would have led to the court necessarily having to construe the policy in favor of the insured,[199] it instead implicitly decided there was an ambiguity by not only rewriting the language but by acknowledging that it is susceptible to more than one reading.[200] Through making these two points in its holding, the court creates a definition that is neither based on the clarity of the policy language, nor construed in favor of the insured. Instead, the court created a definition that protects Carolina Casualty and all other malpractice insurance policy providers from defending and indemnifying insured parties when a former employee receives notice of a claim.

2. The Dissent's Definition

In response to the majority's reading that was "wholly unmoored from the text of the policy and violates Colorado jurisprudence regarding insurance contract interpretation,"[201] the dissent proposed a reading of "insured" that is perfectly in-line with the policy's language.[202] Due to a lack of technical or specialized meaning in the words of the definition, the dissent agreed that "the plain and ordinary meaning" of the words should be adopted.[203] In determining that Mr. Murphy was *not* an insured at the time he received the Tester Letter,[204] the dissent made a proper determination without having to side-step Colorado law.[205] The dissent's

196. *Id.* at 814.

197. *Id.* at 815 ("In our opinion, the better view is that 'insured' is defined to include an individual after he has left the law firm if the claim involves that individual's acts or omissions that occurred while at the law firm.").

198. Wota v. Blue Cross & Blue Shield of Colo., 831 P.2d 1307, 1309 (Colo. 1992).

199. Republic Ins. Co. v. Jernigan, 753 P.2d 229, 232 (Colo. 1988).

200. *See Berry & Murphy*, 586 F.3d at 815 n.6. Although the court reiterates the belief that the language is clear and unambiguous, it proceeds to rebut the dissent's opinion that the majority is misapplying the term "insured" in various situations. *Id.*

201. *Id.* at 817 (Lucero, J., dissenting).

202. *See id.* at 818.

203. *Id.* (quoting *Wota*, 831 P.2d at 1309) (internal quotation marks omitted).

204. *Berry & Murphy*, 586 F.3d at 818 (Lucero, J., dissenting) ("Murphy is an insured for the purposes of certain acts (acts committed within the scope of his duties on behalf of his former firm) but not others (acts committed outside the scope of his duties). There is no dispute that Murphy was not acting on behalf of Berry & Murphy, P.C. when he received the Tester Letter; thus notice to him was not notice to an insured.").

205. *See id.* (determining that Mr. Murphy was not an insured).

clear logic[206] not only serves the best interest of public policy, it is also in line with Colorado insurance and contract jurisprudence.[207]

3. Additional Jurisprudence

Because insurance policies take on many forms, determining who is an "insured" under individual policies requires careful interpretation of the policy language. Typically, those named on the declarations page are considered "named insured" and coverage is extended to those individuals and entities.[208] However, beyond those qualified as named insured, discrepancies begin to arise when determining whom the policy covers.[209] In *Berry & Murphy*, the Tenth Circuit was not faced with a particularly unique challenge but nonetheless could have used decisions from the Appellate Division of the Superior Court of New Jersey as guidance.[210]

In *Jolley v. Marquess*,[211] the New Jersey Appellate Court was also faced with the task of interpreting the definition of "insured" in a claims-made malpractice liability policy, albeit under a set of circumstances distinguishable from *Berry & Murphy*.[212] In *Jolley*, Marquess was a former partner and employee of the law firm Marquess, Morrison, and Trimble, P.A. (MMT).[213] After leaving MMT, Marquess retained his title of "senior trial attorney" with MMT and continued to represent one of his former firm's clients on an insurance matter.[214] When a malpractice lawsuit was filed against Marquess, MMT's insurance carrier, Zurich,

206. *Id.* ("According to the majority, 'but solely while acting within the scope of their duties on behalf of' a predecessor firm 'cannot mean that an individual is an insured only while acting on behalf of' a predecessor firm. Yet that is precisely how 'Insured' is defined in the policy.").

207. *See* Wota v. Blue Cross & Blue Shield of Colo., 831 P.2d 1307, 1309 (Colo. 1992) ("An insurance policy is a contract and should be construed in accordance with general principles of contractual interpretation."); Heller v. Fire Ins. Exch., 800 P.2d 1006, 1008 (Colo. 1990) ("To ascertain whether certain provisions of an agreement are ambiguous, the language used must be examined and construed in harmony with the plain, popular, and generally accepted meaning of the words employed and with reference to all provisions of the document."); Terranova v. State Farm Mut. Auto. Ins. Co., 800 P.2d 58, 60 (Colo. 1990) ("In the absence of an ambiguity, an insurance policy must be given effect according to the plain and ordinary meaning of its terms."); Urtado v. Allstate Ins. Co., 528 P.2d 222, 223 (Colo. 1974) ("Considering the contract as a whole, we cannot say that it is ambiguous. Since it is not, this court may not rewrite it nor limit its effect by strained construction.").

208. John M. Palmeri & Franz Hardy, *Protecting Your Law Practice: Malpractice Insurance Basics*, COLO. LAW., Apr. 2005, at 45, 46.

209. *See* Jolley v. Marquess, 923 A.2d 264, 271 (N.J. Super Ct. App. Div. 2007) (interpreting whether or not a former employee is an insured); *See also* London, Anderson & Hoeft, Ltd. v. Minn. Lawyers Mut. Ins. Co., 530 N.W.2d 576, 578–79 (Minn. Ct. App. 1995) (determining that only named lawyers could be held liable for deductable).

210. *Jolley*, 923 A.2d at 264.

211. 923 A.2d 264 (N.J. Super Ct. App. Div. 2007).

212. *Id.* at 271.

213. *Id.* at 267.

214. *Id.* at 268. The distinguishing fact that Marquess retained his title of "senior trial attorney" does not defeat the fact that the New Jersey Appellate Court was faced with a nearly identical task as the 10th Circuit of interpreting the word "insured" in a claims-made malpractice liability insurance policy. *Id.*

denied coverage arguing that Marquess was not a named insured at the time any alleged malpractice may have occurred.[215] The *Jolley* court then had to determine if Marquess fit the definition of insured as stated in the policy.[216]

In determining that Marquess was in fact an insured,[217] the *Jolley* court analyzed policy language nearly identical to that in *Berry & Murphy*.[218] The provision at issue read, "[t]he unqualified word 'insured', whenever used in this policy means: . . . (d) any former partner, officer, director, or stockholder employee of the firm or predecessor firms named in the Declaration while acting solely in a professional capacity on behalf of such firms."[219] This is strikingly similar to the language in *Berry & Murphy*, with the greatest difference being the substitution of "within the scope of their duties" in the Carolina Casualty policy[220] for "solely in a professional capacity" in the Zurich policy.[221]

The *Jolley* court, unlike the majority in *Berry & Murphy*, determined that this subsection of the definition was ambiguous and focused on construing it in "conformity [with] public policy and principles of fairness."[222] With these principles in mind, the *Jolley* court construed the policy language in favor of Marquess—and to the detriment of the insurance company.[223] Stating that subsection (d) was limited to those former employees who are "representing a party who remains a client of the insured firm,"[224] the *Jolley* court made a ruling that was favorable to the insured in this case and that should have provided guidance to the Tenth Circuit in its attempt to interpret the policy language.

First, this seemingly plain language was determined to be susceptible to multiple interpretations,[225] just as the policy language in *Berry & Murphy* could have been determined to be ambiguous.[226] Had *Berry & Murphy* decided that the language was ambiguous in the same manner, established precedent may have forced a substantially different outcome.

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215. *Id.* at 269. While the argument in this case is opposite that of the argument in *Berry & Murphy*, in that the insurance company in *Jolley* is arguing that Marquess is *not* an insured, the fact still remains that both the New Jersey Appellate Court and the 10th Circuit were faced with nearly identical tasks in interpreting the term "insured" in claims-made malpractice liability insurance policies. *Id.*

216. *Id.* at 271.

217. *Id.* at 272–73.

218. *See id.* at 270–71.

219. *Id.* (emphasis omitted).

220. Berry & Murphy, P.C. v. Carolina Cas. Ins. Co., 586 F.3d 803, 814 (10th Cir. 2009).

221. *Jolley*, 923 A.2d at 271.

222. *Id.* at 272 (quoting Voorhees v. Preferred Mut. Ins. Co., 607 A.2d 1255, 1260 (N.J. 1992)).

223. *Jolley*, 923 A.2d at 273.

224. *Id.* at 272.

225. *See id.*

226. *See* Berry & Murphy, P.C. v. Carolina Cas. Ins. Co., 586 F.3d 803, 816–19 (10th Cir. 2009) (Lucero, J., dissenting). Multiple interpretations are evidenced by the fact that the dissent's interpretation deviated greatly from the majority. *Id.*

Second, the definition employed by the *Jolley* court could have guided the court in *Berry & Murphy*. If the majority interpreted the definition of insured in a similar manner to *Jolley* when it ruled that acting "solely in a professional capacity on behalf of such firms" is limited to instances where a former attorney is representing a party who remains a client of the insured firm,[227] Mr. Murphy surely would not have been considered an insured.

C. Practical Effects of Holding

By creating a class of insured individuals who are no longer partners or employees of a law firm, yet are still considered "insured" when they receive a claim based on acts or omissions that took place while employed at their former law firm,[228] the Tenth Circuit has created a situation in which law firms may not receive coverage for the premiums they are paying.[229] Based on this holding, the Tenth Circuit has developed disturbing precedent with potentially severe consequences for lawyers, law firms, and insurance companies alike. In the wake of this decision a potentially hazardous set of circumstances may arise when former employees are faced with the discretion to notify their former employer of a potential or actual claim.

In light of this holding, law firms are now at the mercy of their former employees when an injured client sends notice of a potential malpractice claim directly to the attorney who is being accused of malpractice, rather than to the law firm itself. As was seen in *Berry & Murphy*, the former employee is then faced with the sole decision of whether or not to tell his former law firm about the claim. Even when the former employee heeds the advice of the client and informs his insurance carrier of the potential lawsuit, the former law firm remains in great danger of being denied coverage.[230] In cases where an employee was fired from his position as an attorney, or decided to leave his law firm as a result of a bad business relationship with his employer, the Tenth Circuit now gives these individuals the power to vindictively withhold knowledge of a claim with the intention of financially damaging his former employer. By simply taking out an individual malpractice liability insurance policy upon leaving a law firm, former employees are able to rest assured that they will be covered in the event a claim is made against them but will also be able to take comfort in the idea that withholding information of a claim against their former employer will not affect them as an individual.

227. *Jolley*, 923 A.2d at 272.
228. *See Berry & Murphy*, 586 F.3d at 814–15.
229. *Id.* at 816 (Lucero, J., dissenting).
230. Although Mr. Murphy took the advice of the Tester Letter and put his malpractice insurance carrier on notice, Carolina Casualty nonetheless escaped liability. *See id.*

1. Curing the Effects

One possible remedy to this unfortunate outcome would be for courts to employ an "impossibility" doctrine in claims-made insurance policies. In *Gulf Insurance Co. v. Dolan, Fertig & Curtis*,[231] the Florida Supreme Court noted that "if an impossibility prevented notice being given to an insurer at the very end of the policy period, it may well be that an insured would be relieved of giving notice during the period of such impossibility."[232] Although that issue was not before the court, it held the possibility open for future cases.[233] It would certainly be in the best interest of insured parties if courts were to recognize the impossibility doctrine when a law firm does not receive notice of a claim within a policy period because notice was first given to a former employee. When situations such as this arise, courts could then look to when the insured law firm, rather than the former employee, received notice of the claim when determining whether a claim was made within the policy period. This recognition of impossibility would be in line with the idea set forth by the Florida Supreme Court but would extend to claims made before the policy period began, rather than notice given after the policy period expired.

An additional approach that can be taken to cure the outcome of *Berry & Murphy* is legislative intervention. In Colorado, claims-made insurance policies are subject to regulation by the Insurance Commissioner under Colorado Revised Statute § 10-4-419, Claims-made policy forms.[234] Within this statute, mandatory disclosures and alerts to the insured are set forth, including the following:

> (A) A description of the principal benefits and coverage provided in the policy;
>
> (B) A statement of the exceptions, reductions, and limitations contained in the policy;
>
> (C) A statement of the renewal provisions including any reservation by the insurer of a right to change premiums;
>
> (D) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions. [235]

Beyond these disclosures, § 10-4-419 requires that the policy include numerous additional definitions and provisions and governs vari-

231. 433 So.2d 512 (Fla. 1983).
232. *Id.* at 515 n.1.
233. *Id.*
234. COLO. REV. STAT. § 10-4-419 (2010).
235. *Id.*

ous other aspects of claims-made policies.[236] The term "insured," however, is not set forth in this statute, and insurers are not required to meet any statutory guidelines or follow any regulations when defining this important term in insurance policies.[237] An amendment to this statute requiring clear, unambiguous definitions of key terms such as "insured," and a requirement that such definitions be submitted and reviewed by the Insurance Commissioner would undoubtedly be in the best interest of public policy because such requirements would reduce or even eliminate the risk of litigation. While it may be impractical to list every person covered by the insurance policy as a named insured, all parties involved would benefit from a clearer understanding of exactly who is covered through the use of straightforward explanations of troublesome terms.

A final recommendation for curing the effects of this ruling is for lawyers and law firms to take a proactive approach with their insurance policies. Because the changing structure of a law firm has the ability to negatively impact insurance coverage,[238] partners and stockholders should inform their insurance company when attorneys are no longer employed with the firm. This simple step of informing an insurance company, or inquiring about potential ramifications, can put the carrier on notice that an employee is no longer a member of the firm, and the insured law firm can be confident that former employees who receive notices of claims will have no bearing over their malpractice insurance coverage.

IV. CONCLUSION

In *Berry & Murphy, P.C. v. Carolina Casualty Ins. Co.*, the Tenth Circuit properly construed the insurance policy's definition of "related wrongful acts" but improperly rewrote the definition of "insured" to fit the court's ideals. In doing so, the court failed to follow established Colorado precedent in its analysis and created a class of insured individuals who now carry a dangerous amount of discretion. All attorneys carrying malpractice liability insurance should understand the potential consequences of this ruling, and the judiciary and legislature should begin to take notice of alternative measures that can be taken to cure this inequitable result. It seems clear that when a court rewrites the definition of a term within an insurance policy, an ambiguity has arisen, and the beneficiary of such an ambiguity should be the insured.

236. *Id.* (including, but not limited to, definitions of events and conditions which trigger coverage, a provision that guarantees the ability to purchase an extended reporting period upon cancellation or nonrenewal, and mandatory submission of new claims-made policy forms to the Insurance Commissioner before such forms are used).

237. *See id.*

238. *See* Susan Saab Fortney, *Legal Malpractice Insurance: Surviving the Perfect Storm*, 28 J. LEGAL PROF. 41, 55 (2004).

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