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# Reasonable Expectations: Seeking A Principled Application

WILLIAM A. MAYHEW\*

## I. INTRODUCTION

Insurance contracts, the written policies of insurance, are, in the vast majority of cases,<sup>1</sup> clearly contracts of adhesion.<sup>2</sup> Adhesion contracts in both insurance and non-insurance cases have long vexed courts attempting to apply the traditional rules of contract law, which are classically based on the theory of freedom of contract with the terms of the agreement bargained for between the parties,<sup>3</sup> to the realities of the adhesion contract where virtually all of the terms of the contract are dictated and determined solely by one side. That is, the basic terms of the form contract are offered to one party on a strict take-it-or-leave-it basis.

In order to deal with the problems inherent in adhesion contracts

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1. It has been estimated that 99% of all contracts are on standard forms. Slawson, *Standard Form Contracts and Democratic Control of Lawmaking Power*, 84 HARV. L. REV. 529, 529 (1971).

2. Adhesion contracts in insurance mean that the insured receives a standard insurance policy without any ability to negotiate the terms. Where the terms are negotiated or could be negotiated, the insurance contract, though contained in a standard policy, is not truly a contract of adhesion. See Holmes, *A Contextual Study of Commercial Good Faith: Good-Faith Disclosure in Contract Formation*, 39 U. PITT. L. REV. 381 (1978), where the author points out that insurance contracts are adhesive for the following reasons: "the inequality of bargaining power and knowledge as between insurer and applicant, the technical character of the insurance contract, the fact that delivery of the policy often occurs after contract formation and premium payment, and the mass-standardized nature of insurance contracts." *Id.* at 397 (footnotes omitted). See also *Neal v. State Farm Ins. Co.*, 188 Cal. App. 2d 690, 694, 10 Cal. Rptr. 781, 784 (1961). Cf. *Ponder v. Blue Cross of S. Cal.*, 145 Cal. App. 3d 709, 719, 193 Cal. Rptr. 632, 637 (1983) (inability of insured to negotiate individual terms rendered insurance contract a contract of adhesion).

3. Holmes points out that insurance law never came within the classical law of contract. Holmes, *supra* note 2, at 393-95.

the courts have often turned to covert decisional methods that may go far beyond our concepts of fairness and reasonableness in protecting the interests of the drafting party. The courts have employed, perhaps the word should be misemployed, contractual rules of interpretation<sup>4</sup> or have applied some other doctrine such as estoppel, waiver,<sup>5</sup> public policy<sup>6</sup> or unconscionability<sup>7</sup> (where the decisions often turn on the status of the parties).<sup>8</sup> Neither the Restatement (Second)<sup>9</sup> nor the Uniform Commercial Code<sup>10</sup> provide any other workable, and at the same time, predictable solution.

It is not surprising to find the courts resorting to covert reasoning where the inquiry into the problems caused by adhesion contracts is narrowed solely to insurance disputes. In order to reach a desired result while applying classical contract rules the courts have often engaged in reasoning which is no more than makeweight. In fact, the real basis for the court's opinion in many insurance cases is neither in the opinion<sup>11</sup> nor does it appear beyond a slight reference.<sup>12</sup>

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4. Llewellyn, Book Review, 52 HARV. L. REV. 700, 702-703 (1939) (reviewing O. PRAUSNITZ, *THE STANDARDIZATION OF COMMERCIAL CONTRACTS IN ENGLISH AND CONTINENTAL LAW* (1937)); Kessler, *Contracts of Adhesion—Some Thoughts About Freedom of Contract*, 43 COLUM. L. REV. 629, 633 (1943).

5. For a general discussion of estoppel and waiver in insurance law, see 16 B. APPLEMAN, *INSURANCE LAW AND PRACTICE* §§ 9081-9090 (1981). See also Morris, *Waiver and Estoppel in Insurance Litigation*, 105 U. PA. L. REV. 925 (1957).

6. See, e.g., *Brown v. Blue Cross & Blue Shield*, 427 So. 2d 139 (Miss. 1983), where a husband and wife were seeking to recover maternity benefits under a group medical policy. The employer terminated the Blue Cross policy on February 1, 1976, and purchased another group medical policy for his employees that did not provide maternity benefits. The baby was born on July 13, 1976, while the successor policy was in force. The court justified coverage under the cancelled policy on the ground of undefined public policy. *Id.* at 141. See also Llewellyn, *supra* note 4, at 702-03.

7. See Lef, *Unconscionability and the Code — The Emperor's New Clause*, 115 U. PA. L. REV. 485 (1967).

8. Professor Spiegel Lef, in discussing equitable unconscionability, stated: Within the ambit of those factors of contract-procuring behavior which would result in a denial of specific performance, a bewildering number of permutations work to inform the chancellor's discretion. In these cases one runs continually into the old, the young, the ignorant, the necessitous, the illiterate, the improvident, the drunken, the naive and the sick, all on one side of the transaction, with the sharp and hard on the other. Language of quasi-fraud and quasi-duress abounds. Certain whole classes of presumptive sillies like sailors and heirs and farmers and women continually wander on and off stage. Those not certifiably crazy, but nonetheless pretty peculiar, are often to be found. And in most of the cases, of course, several of these factors appear in combination.

*Id.* at 531-33 (footnotes omitted).

9. See Murray, *The Standardized Agreement Phenomena in the Restatement (Second) of Contracts*, 67 CORNELL L. REV. 735, 782-84 (1981).

10. Lef, *supra* note 7, at 558-59; Hillman, *Debunking Some Myths About Unconscionability: A New Framework for U.C.C. Section 2-302*, 67 CORNELL L. REV. 1, 4 (1981).

11. See, e.g., *Galinko v. Aetna Casualty and Sur. Co.*, 432 So. 2d 179 (Fla. Dist. Ct. App. 1983) (decision saves lawyer from malpractice).

12. See, e.g., *Brown v. Blue Cross & Blue Shield*, 427 So. 2d 139 (Miss. 1983).

The use of covert methods by the courts to reach a desired decision in insurance disputes is often the result of the courts' discomfort with an express statement of the true basis for a decision. Courts often resort to covert methods for a variety of reasons: emotion,<sup>13</sup> desire to judicially regulate some aspect of the insurance industry,<sup>14</sup> perceived unfairness on the part of the insurer,<sup>15</sup> or the desire to implement judicial theories of wealth-spreading or wealth-redistribution.<sup>16</sup>

Though the problems caused by this covert means of judicial decision-making have been recognized for many years,<sup>17</sup> judges, with all their human frailties, have continued to rely on such covert methods<sup>18</sup> to reach results the court considers satisfying while at the same time avoiding the criticism that might well occur if the true reasoning of the decision were set forth. The obvious problem of this type of judicial approach is that such covert-based opinions are misleading.<sup>19</sup> Lawyers are trained to predict results based on past decisions. Lawyers are also trained to react to judicial decisions in a lawyer-like manner; thus, lawyers may rewrite contracts such as insurance policies to correct infirmities that the lawyer believes to be created by a particular decision. Where the perceived infirmity does not represent the true rationale, additional litigation may well result in not only additional appellate opinions but opinions that continue to base their decisions on covert methods. As a result, there is a marked diminution in the reliance that can be placed on that court's opinions in in-

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13. See, e.g., *id.*

14. See, e.g., *Crisci v. Security Ins. Co.*, 66 Cal. 2d 425, 426 P.2d 173, 58 Cal. Rptr. 13 (1967) (regulation of claims practices by imposing bad faith liability on insurance companies).

15. See, e.g., *Countryside Casualty Co. v. Grant*, 269 Ark. 526, 601 S.W.2d 875 (1980) (clear exclusion provision in an insurance contract became ambiguous when considered in relation to the purpose and circumstances surrounding the making of the contract, thereby providing coverage to the insured).

16. See, e.g., *Foremost Ins. Co. v. Putzier*, 102 Idaho 138, 627 P.2d 317 (1981) (the real reason for giving the insured apparently unlimited oral insurance appears to be that the individual defendant, a chef and entrepreneur, spoke English so poorly that communication with him was difficult).

17. See Llewellyn, *supra* note 4, at 702-03.

18. See, e.g., cases cited *supra* notes 11-16.

19. See Llewellyn, *supra* note 4, at 703. See also Holmes, *supra* note 2, at 398, where the author states:

Contract and insurance law have had to pay a high price in terms of uncertainty because of the felt duty to reconcile a fair result with freedom of contract, to maintain an artificial unity in contract law, and not to strip insurer's shields (albeit technical ones) against dishonest insureds, sentimental jurors and fickle judges. One result has been unnecessary litigation, because lawyers are encouraged to assert technical but irrelevant theories.

*Id.* at 398.

insurance disputes. There is additional disruption since this lack of predictability affects not only insurance companies but also insurance consumers. There are additional economic costs that will have to be passed on to the insurance consumer in higher policy costs plus the higher economic costs to society in general for uncompensated litigation costs incurred by government.<sup>20</sup>

The fact that insurance contracts are adhesive does not, by itself, make such contracts bad. In fact, the use of preprinted forms by the insurance industry is an absolute necessity.<sup>21</sup> The use of the form insurance policy allows for the standardization of risks and the resultant computation of premiums. Without the standardized contract of insurance, the attorneys fees and underwriting fees would render insurance impractical for probably most of the consumer market. Clearly, without standardization the costs of selling the policy, underwriting the risk and drafting the insurance contract would far exceed the actual costs of the risk-spreading element of the transaction.<sup>22</sup>

Insurance contracts may be more adhesive than most other commercial contracts since the insured generally has no power to alter the policy and often the insured will order insurance without reading or even being given the opportunity to read the actual policy terms. In the non-insurance situation, the terms of the adhesion agreement usually are contained somewhere in the document to be executed, though sometimes these terms are incorporated from the back of a form contract.

At the center of much of this judicial desire to employ unstated decisional reasons has been the marketing process by which insurance policies are sold. An additional factor is the courts' inability to fashion substantive law in the insurance area in a way that accurately reflects the true state of insurance marketing and insurance contract formation.<sup>23</sup> Policies of insurance are usually sold through insurance

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20. See Holmes, *supra* note 2, at 398-99. Numerous insurance opinions have chastised insurance companies for the cumbersome and technical language used in policies. A number of insurers have simplified their policy language only to find the simplification penalized by the courts. See generally Bragg, *Concurrent Causation and the Art of Policy Drafting: New Perils for Property Insurers*, 20 FORUM 385 (1985); Note, *Autopsy of a Plain English Insurance Contract: Can Plain English Survive Proximate Cause? — Graham v. Public Employees Mutual Insurance Co.*, 59 WASH. L. REV. 565 (1984). See also Farnham, *The Untimely Demise of Policy Defenses — New Property Policies and the I.S.O.*, 14 FORUM 177 (1977). For a recent and very good example, see the majority, concurring, and dissenting opinions in *Searle v. Allstate Life Ins. Co.*, 38 Cal. 3d 425, 696 P.2d 1308, 212 Cal. Rptr. 466 (1985).

21. See Rotkin, *Standard Forms: Legal Doctrine in Search of an Appropriate Body of Law*, 1977 ARIZ. ST. L.J. 599, 600 (1977); Kessler, *supra* note 4, at 631-32.

22. See Slawson, *supra* note 1, at 530-31.

23. Cf. Young, Lewis & Lee, *Insurance Contract Interpretation: Issues and Trends*, 625 INS. L.J. 71 (1975), where the authors state:

Decisions like these, while they may serve the judiciary's notion of justice and fair play, simply add to the confusion which already exists. Drafters are

agents. The so-called agent may in reality be a direct employee of the insurer, an agent who represents only that insurer, or an independent insurance broker who may represent any number of insurers. The prospective insured and the agent may reach agreement concerning only what is to be insured, the name or names to be listed as the named insured or named insureds, the insurance company on the risk, a general description of the insurance coverage, the dollar limits of the coverage and the premium cost. This may be done orally and is often done by telephone. The insured usually will not see the whole written contract, the insurance policy, with its detailed and specific provisions, many of which are cumbersome and heavy reading, until the policy is received by mail or delivered by the agent. In any event, there is usually a delay between the time the insured agrees to purchase the policy and the time the insured receives the actual policy, which contains terms dictated entirely by the insurer.<sup>24</sup>

The insurance contract does differ substantially from other adhe-

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invited to attempt new and probably more complex wording. Plaintiff's attorneys are encouraged to engage in further semantical hair-splitting to find ambiguities in unfavorable provisions. Furthermore, it is submitted, the labeling or non-labeling of the contract as one of "adhesion" is likely to have little influence upon the construction chosen by a court; in either event, words will purportedly be given their plain and usual meanings, and unclear or ambiguous words will be construed more strongly in favor of the insured. Perhaps the significance of the employment of the term "adhesion contract" is that certain associated "well-established" rules of construction are thereby raised, which rules grant to the courts greater latitude in detecting and protecting policyholders from unclear provisions. Possibly the use of the term can accurately be seen as no more than a symptom that a court is searching more diligently for an ambiguity. Some of the decisions, though, suggest that the judges, in insurance litigation, have assumed a discretion which goes beyond merely construing ambiguities, and a number of commentators have agreed that such an approach ought to be openly employed.

The courts have been urged to recognize the true nature of adhesion contracts and to adopt a multiple system of contract law wherein the meaning of freedom of contract ". . . must change with the social importance of the type of contract and with the degree of monopoly enjoyed by the author of the standardized contract." If the judiciary is to renounce the law of contracts as a basis for resolving insurance disputes, however, one must ask what guidelines are to be utilized in the formulation of decisions other than the court's unfettered notion of what is just in a given situation. Perhaps one answer would be the judicial adoption of a doctrine similar to the Uniform Commercial Code's "unconscionability" provision, whereby a judge is empowered to refuse to enforce a contract for the sale of goods or any part of such a contract upon a finding that the contract is unconscionable. Unconscionability has been found to exist where a party of superior bargaining strength used that strength to impose harsh or unfair provisions upon the weaker party, and, indeed, some courts have extended the doctrine to contracts which were not under the legislative purview of the Uniform Commercial Code.

*Id.* at 77 (footnotes omitted).

24. See Note, *A Common Law Alternative to the Doctrine of Reasonable Expecta-*

sive non-insurance contracts. By industry practice an insurance policy can usually be cancelled prior to its expiration date without the insured incurring untoward expenses or legal consequences. This right of cancellation on the part of the insured is a sufficient basis by itself for the courts to enforce against the insured a legal duty to read the policy,<sup>25</sup> notwithstanding the fact that most insureds simply will not take the time and make the effort.<sup>26</sup>

The courts have responded to this scheme of insurance contract formation in a number of ways. Several judicial tools are used by courts to covertly decide insurance cases and camouflage true reasons for the decision. These include misapplying the concepts of estoppel and waiver,<sup>27</sup> stretching to find ambiguities beyond a reasonable interpretation of the policy language<sup>28</sup> and applying vague expressions of public policy.<sup>29</sup>

As a result of the many problems caused by the perceived harshness of certain insurance policy provisions and the courts' desire to regulate,<sup>30</sup> the doctrine of reasonable expectations has evolved. The purpose of this article is to trace the history of the doctrine, to analyze its recent applications by the courts, and to explore the issue of whether the doctrine is being used as a covert tool. Lastly this article will suggest modifications in the application of the doctrine.

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*tions in the Construction of Insurance Contracts*, 57 N.Y.U. L. REV. 1175, 1180-81 (1982).

25. See, e.g., *Reserve Ins. Co. v. Pisciotto*, 30 Cal. 3d 800, 810, 640 P.2d 764, 769, 180 Cal. Rptr. 628, 633 (1982); *Hallowell v. State Farm Mut. Auto. Ins. Co.*, 443 A.2d 925, 928 (Del. Super. Ct. 1982). Cf. *Croteau v. John Hancock Mut. Life Ins. Co.*, 123 N.H. 317, 320, 461 A.2d 111, 113-14 (1983) (duty to read may be obviated if policy construction would dissuade a reasonable person).

26. See R. KEETON, BASIC TEXT ON INSURANCE LAW 351 (1971).

27. See *supra* note 5.

28. See *supra* note 4.

29. See, e.g., *Gray v. Zurich Ins. Co.*, 65 Cal. 2d 263, 419 P.2d 168, 54 Cal. Rptr. 104 (1966) (language of policy led insured to expect defense of third party suit); See also Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961, 969-72 (1970).

30. Cf. Keeton, *supra* note 29, at 966-67:

Insurance contracts continue to be contracts of adhesion, under which the insured is left little choice beyond electing among standardized provisions offered to him, even when the standard forms are prescribed by public officials rather than insurers. Moreover, although statutory and administrative regulations have made increasing inroads on the insurer's autonomy by prescribing some kinds of provisions and proscribing others, most insurance policy provisions are still drafted by insurers. Regulation is relatively weak in most instances, and even the provisions prescribed or approved by legislative or administrative action ordinarily are in essence adoptions, outright or slightly modified, of proposals made by insurers' draftsmen.

Under such circumstances as these, judicial regulation of contracts of adhesion, whether concerning insurance or some other kind of transaction, remains appropriate.

*Id.* at 966-67 (footnote omitted).

## II. THE EARLY HISTORY OF REASONABLE EXPECTATIONS DOCTRINE

The doctrine of reasonable expectations seems to have first developed as an interpretive tool used to resolve ambiguities in the insurance context. In *Gaunt v. John Hancock Mutual Life Insurance Co.*,<sup>31</sup> Judge Learned Hand used the doctrine as an interpretive tool and rejected a literal reading of the policy without expressly finding the provision in question ambiguous.<sup>32</sup> In *Gaunt*, the decedent signed an application for life insurance and gave the agent the full first premium. Both the application signed by the decedent and the receipt given the decedent by the agent provided that the policy would not be in force until approved by the insurer's home office though, once approved, the effective date of the policy would relate back to the successful completion of the required medical examination.<sup>33</sup>

*Gaunt* was examined twice and the insurer's home office medical staff medically approved the application. On the same day the home office approved and forwarded the application for final acceptance, *Gaunt* died and the application never received final approval.<sup>34</sup> In ruling in favor of the beneficiaries of the policy and rejecting a literal reading of the application and the receipt, Judge Hand stated:

[T]he ordinary applicant who has paid his first premium and has successfully passed his physical examination, would not by the remotest chance understand the clause as leaving him uncovered until the insurer at its leisure approved the risk; he would assume that he was getting immediate coverage for his money.<sup>35</sup>

The seminal case in the evolution of the doctrine of reasonable expectations in insurance law is *Kievit v. Loyal Protective Life Insurance Co.*<sup>36</sup> *Kievit* involved the purchase of an accident insurance policy. The issued policy was entitled "Form 92 — Time Accident Policy" and stated that the policy "Provides Indemnity for Loss of Time by Accidental Bodily Injuries, and for Loss of Life, Limb or Sight by Accidental Means to the Extent Herein Provided."<sup>37</sup> The policy went on to provide the plaintiff with monthly payments "against loss resulting directly and independently of all other causes

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31. 160 F.2d 599 (2d Cir.), *cert. denied*, 331 U.S. 849 (1947). The courts have long spoken of reasonable expectations in interpreting insurance contracts. *See, e.g.*, *Bird v. St. Paul Fire & Marine Ins. Co.*, 224 N.Y. 47, 120 N.E. 86 (1918).

32. 160 F.2d at 601-02.

33. The trial judge found that both the decedent and the agent intended coverage from the date of completion of the medical examination. *Id.* at 600.

34. *Id.*

35. *Id.* at 602.

36. 34 N.J. 475, 170 A.2d 22 (1961).

37. *Id.* at 477, 170 A.2d at 24.



from accidental bodily injuries. . . .”<sup>38</sup> In addition the policy excluded “disability or other loss resulting from or contributed to by any disease or ailment.”<sup>39</sup> While the policy was in force, the plaintiff was struck in the head by a board and became totally disabled.

At trial medical testimony indicated that plaintiff had either suffered from a psychiatric condition known as conversion hysteria caused by his head injury or that he suffered from pre-existing Parkinson’s disease.<sup>40</sup> The trial judge applied the wording of the policy literally and found that the plaintiff suffered from a pre-existing disease that precluded recovery under the policy.<sup>41</sup>

The New Jersey Supreme Court refused to base the *Kievit* decision on the presence or absence of an express clause denying benefits for loss caused or contributed to by either some disease or ailment, as had the lower appellate court.<sup>42</sup> To have done so would have resulted in a finding for the insurer since the policy contained such an exclusionary clause. Nor did the supreme court attempt to find or create some ambiguity in the policy in order to interpret the policy in favor of the insured. Rather, the court, in spite of the literal terms of the policy, based its decision as follows:

[T]he court’s goal in construing an accident insurance policy is to effectuate the reasonable expectations of the average member of the public who buys it; he may hardly be expected to draw any subtle or legalistic distinctions based on the presence or absence of the exclusionary clause for he pays premiums in the strong belief that if he sustains accidental injury which results (in the commonly accepted sense) in his disability he will be indemnified and not left empty-handed on the company’s assertion that his disability was caused or contributed to by a latent disease or condition of which he was unaware and which did not affect him before the accident.<sup>43</sup>

The underlying basis for the decision in *Kievit* seems to be the court’s recognition that Mr. Kievit was forty-eight years old when he purchased the policy and that to enforce the policy literally would result in insurance of little or no practical benefit due to the natural aging process of the human body. The court was also undoubtedly concerned with the financial impact on often destitute insureds in fighting denials of coverage by insurers, in light of the fact that *Kievit* was decided prior to the advent of the bad faith doctrine.

Two cases dealing with airline trip insurance policies, which both involved the same defendant insurer, are also of importance. The first is *Lachs v. Fidelity & Casualty Co.*,<sup>44</sup> where the decedent

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38. *Id.*

39. *Id.*

40. *Id.* at 479-80, 170 A.2d at 24-25.

41. *Id.* at 481, 170 A.2d at 25-26.

42. *Id.* at 488, 170 A.2d at 30 (citing *Mahon v. American Casualty Co.*, 65 N.J. Super. 148, 167 A.2d 191 (1961)).

43. *Kievit*, 34 N.J. at 488-89, 170 A.2d at 30.

44. 306 N.Y. 357, 118 N.E.2d 555 (1954).

purchased a policy of airline trip insurance from a vending machine placed in front of a non-scheduled airline counter from which the decedent then purchased a ticket after procuring the insurance. The policy specifically covered only flights on a "Civilian Scheduled Airline."<sup>45</sup>

The court's decision in *Lachs* that the insured was covered was not based on the ambiguity raised by the words "Civilian Scheduled Airline" in the policy. The real basis for the decision appears to be that the location of the vending machine was misleading to passengers on the non-scheduled flights. The insurer failed to give adequate notice of non-coverage not only to *Lachs*, but also to other non-scheduled airline passengers who had purchased insurance. The court held that *Lachs* was covered even though the literal terms of the policy did not provide passengers with coverage.<sup>46</sup> Though the court in *Lachs* did not base its decision on a theory of honoring the reasonable expectations of the insured by overriding the express terms of the policy (a theory which had not yet been clearly enunciated),<sup>47</sup> it is clear that the theory would have been applicable based on the misleading activity of the insurer.

The second case is *Steven v. Fidelity and Casualty Co.*<sup>48</sup> The decedent, Steven, purchased an airplane trip insurance policy. The policy set out in bold type the following words: "NOR FOR TRAVEL ON OTHER THAN SCHEDULED AIR CARRIERS."<sup>49</sup> The machine also provided an envelope for the mailing of the policy to his beneficiary. Using this envelope, Steven mailed the policy to his wife.<sup>50</sup> Though Steven had purchased a round-trip airline ticket on a scheduled airline, his return flight was delayed. A substitute flight on a charter aircraft was arranged. The charter crashed.<sup>51</sup>

The court found coverage partially because the decedent, by purchasing trip insurance, had a reasonable expectation that coverage would extend even to substitute transportation that might be required in an emergency. The court found that the policy did not sufficiently warn of non-coverage. In addition, the court pointed out that the insurer instructed Steven to mail the policy to his benefici-

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45. *Id.* at 363, 118 N.E.2d at 557.

46. *Id.* at 366, 118 N.E.2d at 559.

47. See *infra* notes 61-63 and accompanying text.

48. 58 Cal. 2d 862, 377 P.2d 284, 27 Cal. Rptr. 172 (1962).

49. *Id.* at 866, 377 P.2d at 286, 27 Cal. Rptr. at 174.

50. *Id.*

51. *Id.* at 867, 377 P.2d at 287, 27 Cal. Rptr. at 175.

ary before boarding the plane. Since the insurer furnished no duplicate to Steven, he could not have reviewed the policy language prior to taking the substitute charter flight.<sup>52</sup>

The next major case in the development of the doctrine is the landmark duty-to-defend case of *Gray v. Zurich Insurance Co.*<sup>53</sup> Dr. Gray was insured by the defendant under a comprehensive personal liability endorsement. The policy contained typical defense language and specifically excluded coverage for acts "caused intentionally by . . . the insured."<sup>54</sup> The underlying personal injury case against Dr. Gray alleged that he had "wilfully, maliciously, brutally and intentionally assaulted" the plaintiff. Dr. Gray claimed he acted in self-defense.<sup>55</sup>

The court found that the insurer had the duty to defend Dr. Gray. The court made the illogical finding that the policy's defense clause was ambiguous and "that the insured would reasonably expect a defense by the insurer in all personal injury actions against him."<sup>56</sup> In fact if read reasonably, an insured would expect just the opposite. The policy excluded coverage for intentional acts and reasonable reading of the policy should have clearly negated the insured's expectation of the insurer defending the suit.

It has been suggested that the court in *Gray* was mandating coverage for a defense because no such coverage was available in the marketplace and that the burden of defending the action was more appropriately placed on the insurer than the insured.<sup>57</sup> The more plausible explanation is that if the plaintiff had pleaded a negligence cause of action or later so amended his complaint (as allowed by California law),<sup>58</sup> the insurer would then have had to defend against the suit.<sup>59</sup>

### III. KEETON'S FORMULATION OF THE DOCTRINE

Probably the major impetus in moving the doctrine of reasonable expectations beyond that of solely an interpretative rule was the 1970 law review article by Professor, now Judge, Keeton.<sup>60</sup> Keeton pointed out that a number of judicial doctrines employed to regulate the adhesion contract could better be grouped under a heading of

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52. *Id.* at 877, 377 P.2d at 294, 27 Cal. Rptr. at 182.

53. 65 Cal. 2d 263, 419 P.2d 168, 54 Cal. Rptr. 104 (1966). See Note, *The Insurer's Duty to Defend Made Absolute: Gray v. Zurich*, 14 UCLA L. REV. 1328 (1967).

54. *Gray*, 65 Cal. 2d at 267, 419 P.2d at 170, 54 Cal. Rptr. at 106.

55. *Id.*

56. *Id.* at 278, 419 P.2d at 178, 54 Cal. Rptr. at 114.

57. See Abraham, *Judge-Made Law and Judge-Made Insurance: Honoring the Reasonable Expectations of the Insured*, 67 VA. L. REV. 1151, 1166 (1981).

58. *Gray*, 65 Cal. 2d at 277, 419 P.2d at 176-77, 54 Cal. Rptr. at 113.

59. *Id.* at 276-77, 419 P.2d at 176-77, 54 Cal. Rptr. at 112-13.

60. See Keeton, *supra* note 29.

"honoring reasonable expectations" and he formulated the doctrine as follows: "The objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations."<sup>61</sup> Keeton also theorized that the principle should incorporate the following propositions:

- 1) The language of the insurance policy should be interpreted as a layman would read the policy;<sup>62</sup>
- 2) If the insured's expectations were objectively reasonable, those expectations then should be protected even if a close and detailed study of the policy by the insured would have defeated those expectations;<sup>63</sup> and
- 3) If the policy language differed from "the reasonable expectations of a policyholder having an ordinary degree of familiarity with the type of coverage involved,"<sup>64</sup> the insurer could not rely on such policy language unless the insurer had given adequate notice to the insured prior to the selling of the policy.<sup>65</sup>

The most important aspect of Keeton's formulation was the recognition that courts were applying the concept of reasonable expectations as more than an interpretive tool. The idea that the enforcement of policy provisions might become discretionary or that the courts would use the doctrine of reasonable expectations as an unprincipled means of reaching decisions (as feared by some commentators),<sup>66</sup> was clearly not intended by Keeton. Keeton noted specifically that his formulation was not specific enough for courts in deciding particular cases.<sup>67</sup> Keeton also limited the area of expectations of the insured:

[T]he illustrations we have examined here involve expectations treated by policy language and structure and by marketing patterns and general practices. These are expectations shared by many and based on matters emanating from

61. *Id.* at 967. Professor Young, in 1981, restated the doctrine as it had evolved: "If the general design of a policy is in wide currency, no provision in a policy of that design precludes a given claim of loss unless a representative buyer of like policies would conclude that it does, upon a reasonably attentive reading of the policy in question." Young, *Insurance Policy Defenses: In Search of Restatement*, 34 ARK. L. REV. 507, 510 (1981) (emphasis in original).

62. Keeton, *supra* note 29, at 967.

63. *Id.* at 968-69.

64. *Id.* at 968.

65. *Id.*

66. See, e.g., Perlet, *The Insurance Contract and the Doctrine of Reasonable Expectation*, 6 FORUM 116 (1971); Squires, *A Skeptical Look at the Doctrine of Reasonable Expectation*, 6 FORUM 252 (1971).

67. Keeton, *supra* note 29, at 967.

a source relatively near the command center of the insurer's operational structure. It seems both appropriate and likely that the expectations principle identified here will be extended only to expectations of a somewhat common rather than exceptional character. . . .<sup>68</sup>

#### IV. THE MATURING OF THE DOCTRINE

The case of *Herzog v. National American Insurance Co.*,<sup>69</sup> was decided about the same time as the publication of the Keeton article. The context of the case was a declaratory relief action in which the issue raised was whether a homeowner's policy was to be considered a motor vehicle liability policy, thus providing coverage for an accident occurring three to five miles away from the insured premises, or strictly a homeowner's policy which limited coverage for vehicle-related accidents to those occurring on "the ways immediately adjoining" the insured premises.<sup>70</sup> The court noted that the phrase in question, though somewhat imprecise, could still be reasonably construed.

Rather than hold the imprecise language strictly against the insurer, thus perhaps finding in favor of coverage, the court looked at the reasonable expectations of both the insured and the insurer. The insurer's expectations were developed objectively by looking at the information sought by the insurer on the application and the small premium charge. From this, the court determined that the insurer did not contemplate extended automobile coverage.<sup>71</sup> The court also noted that customarily, automobile insurance was purchased by homeowners and that the premiums, commensurate with the risk, were much higher. As a result, the court found that the reasonable expectations of the insured did not encompass the limited motor vehicle coverage in a homeowner's policy being turned into a general automobile liability policy.<sup>72</sup> Thus, by seeking and determining the reasonable expectations of both parties the court used the doctrine to reject a concept that would have greatly expanded the policy limits available to victims of automobile accidents.

The court, in *Herzog*, was not faced with an issue of non-available coverage as it may have been in *Gray v. Zurich Insurance Co.*<sup>73</sup> since automobile insurance was readily available. It was not faced with any evidence of any unfair marketing or claims practices on the part of the insurer. The court correctly analyzed the case both from the standpoint of the insurer and insured in general. The court denied

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68. *Id.* at 973-74.

69. 2 Cal. 3d 192, 465 P.2d 841, 84 Cal. Rptr. 705 (1970).

70. *Id.* at 196, 465 P.2d at 842, 84 Cal. Rptr. at 706.

71. *Id.* at 197, 465 P.2d at 843, 84 Cal. Rptr. at 707.

72. *Id.*

73. 65 Cal. 2d 253, 419 P.2d 168, 54 Cal. Rptr. 104 (1966).

coverage rather than seeking to expand the policy in this one case to provide a greater pool of insurance for this one accident and at the same time, adding considerable expense to the insured public. This could occur through increased homeowner insurance premiums, and could possibly invite a rewrite of policy forms by insurers and a possible myriad of new litigation over the wording of the new language.

Following the Keeton article, the doctrine of reasonable expectations, advanced either as an interpretative tool or to avoid specific policy provisions, began to appear with great frequency in reported decisions<sup>74</sup> and in law reviews.<sup>75</sup> An analysis of several of the important cases since 1970 will illustrate the varied approaches used by the courts as the doctrine received greater emphasis.

In determining the enforceability of a burglary policy that required visible marks of forcible entry on the exterior of the building, the Iowa Supreme Court in *C & J Fertilizer, Inc., v. Allied Mutual Insurance Co.*,<sup>76</sup> voided the restrictive definition on three grounds: reasonable expectations, implied warranty and unconscionability. In determining the reasonable expectations of the insured, the court seemed to focus on both the subjective expectations of this particular insured and the objective expectations of a reasonable insured. For instance, the court zeroed in on the conversation between the insured and the agent prior to purchase of the policy. The agent stated that "there had to be visible evidence of burglary,"<sup>77</sup> without any reference to the actual wording of the policy. It should be pointed out that the agent's statement of the policy language, though incomplete, was not incorrect. The insured could not recall reading the definition of burglary after receiving the policy.<sup>78</sup>

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74. There are literally hundreds of reported cases that discuss the doctrine.

75. See, e.g., Abraham, *supra* note 57; Keeton, *Reasonable Expectations in the Second Decade*, 12 FORUM 275 (1976); Perlet, *supra* note 66; Squires, *supra* note 66; Young, *supra* note 61; Young, *Insurance Contract Interpretations: Issues and Trends*, 1975 INS. L.J. 71 (1975); Note, *Reasonable Expectations: The Insurer's Dilemma*, 24 DRAKE L. REV. 853 (1975); Note, *The Reconstruction of Insurance Contracts Under the Doctrine of Reasonable Expectations*, 18 J. MAR. L. REV. 155 (1984); Note, *Dobosz v. State Farm Fire & Casualty Co.: Representations in Insurance Advertising Brochure as Part of the Insurance Contract*, 17 J. MAR. L. REV. 969 (1984); Note, *The Doctrine of Reasonable Expectations in Massachusetts and New Hampshire: A Comparative Analysis*, 17 NEW ENG. L. REV. 891 (1982); Note, *A Common Law Alternative to the Doctrine of Reasonable Expectations in the Construction of Insurance Contracts*, 57 N.Y.U. L. REV. 1175 (1982); Note, *A Reasonable Approach to the Doctrine of Reasonable Expectations as Applied to Insurance Contracts*, 13 U. MICH. J.L. REF. 603 (1980).

76. 227 N.W.2d 169 (Iowa 1975).

77. *Id.* at 171-73.

78. *Id.* at 172-73.

As to objective expectations, the court appears to have concentrated on the fact that the policy definition of burglary was more restrictive than either the legal or lay definition.<sup>79</sup> In addition, though the court discussed this under the heading of unconscionability, the court apparently felt that the restrictive policy definition of burglary was not plain and conspicuous since it appeared in the definition section of the policy and not in the exclusions section.<sup>80</sup> It should be noted that the court never found the provision to be ambiguous.

The court in *C & J Fertilizer* apparently felt that a burglary had been sufficiently proven and that the definition of burglary, in the absence of adequate notice to the insured prior to purchase of the policy, was so overly restrictive as to negate a literal reading of the provision. Unfortunately, the court never truly considered whether the limitation was reasonable in terms of avoiding fraudulent claims,<sup>81</sup> thus benefitting all insureds as a class by lower premium costs. In addition, the court never considered whether the insured's expectations were those of a reasonable "policy holder having an ordinary degree of familiarity with"<sup>82</sup> burglary coverage. In fact, such definitional language was not uncommon in like policies.<sup>83</sup>

The *C & J Fertilizer* decision seemed to indicate that the Iowa Supreme Court would readily refuse to enforce policy provisions under the guise of reasonable expectations; however, such has not been the case. In *Chipokas v. Travelers Indemnity Co.*,<sup>84</sup> the issue raised was whether Travelers had a duty to defend on a professional liability policy issued to a lawyer sued for fraud where the policy specifically excluded fraudulent and dishonest acts, and the defense clause in the policy provided:

With respect to such insurance as is afforded by this policy, the company shall: (a) defend any suit against the insured alleging such act or omission

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79. *Id.* at 176-77.

80. *Id.* at 179.

81. Two major costs of insurance are: (1) covered but exaggerated claims, and (2) intentional losses by insureds. M. GREENE & J. TRIESCHMAN, *RISK & INSURANCE* 30 (6th ed. 1984); *see also infra* note 83.

82. Keeton, *supra* note 29, at 968.

83. *See, e.g., Cochran v. MFA Mut. Ins. Co.*, 201 Neb. 631, 271 N.W.2d 331 (1978) (upholding a theft exclusion for property in an unattended motor vehicle in a homeowner's policy that required visible marks of forcible entry upon the exterior of the vehicle) In an early work on insurance law, the authors state:

Obviously the danger that the burglary, robbery or theft will be committed by an employee or even by the insured is great. In order to reduce this hazard and avoid paying this type of claim, the policies often require that the felonious entry into the premises or into the safe must be by actual force and violence and that visible marks must be left upon the exterior of the premises or safe. A provision of this nature is valid and in the absence of substantial compliance therewith, the insured cannot recover.

W. VANCE & B. ANDERSON, *VANCE ON INSURANCE* § 199, at 1015 (3d ed. 1951) (footnote omitted).

84. 267 N.W.2d 393 (Iowa 1978).

and seeking damages which are payable under the terms of this policy, even if any of the allegations of the suit are groundless, false or fraudulent. . . .<sup>85</sup>

The court refused to apply the doctrine of reasonable expectations because it found the language of the policy not to be misleading, impliedly found the language to be unambiguous, and found no conduct on the insurer's part which would have led the lawyer to believe he might be defended.<sup>86</sup> The court also refused to apply the faulty reasoning of *Gray v. Zurich Insurance Co.*<sup>87</sup> In addition, the court was undoubtedly influenced by the fact that the insured was a lawyer.<sup>88</sup>

The doctrine of reasonable expectations was misapplied by the California Supreme Court in *Smith v. Westland Life Insurance Co.*<sup>89</sup> In *Smith*, the decedent signed an application for life insurance and submitted the first month's premium to the agent. Because the decedent's occupation was hazardous, the insurer was not willing to insure the decedent with a policy that included accidental death benefits and a waiver of premium for disability as contained in the original application. Additionally, the insurer increased the original premium by \$4.57 per month.<sup>90</sup> The decedent orally refused the modified coverage and the additional premium charges. The evening before Smith's death, the insurer, through its agent, informed Smith that the company would not issue the policy and that the premium would be refunded.<sup>91</sup>

The court found coverage on three grounds. First, the court found

85. *Id.* at 394 (emphasis in original).

86. *Id.* at 396. Note that the court did not use the word "misconduct."

87. *Id.* See also 65 Cal. 2d 263, 419 P.2d 168, 54 Cal. Rptr. 104 (1966).

88. In the later case of *Farm Bureau Mut. Ins. Co. v. Sandbulte*, 302 N.W.2d 104 (Iowa 1981), the Iowa Supreme Court held that an insured driving a pickup from the insured farm was not entitled to coverage under a farm policy that excluded motor vehicles "while away from the insured premises or the ways immediately adjoining." *Id.* at 107. Applying an objective standard, the court found that no reasonable insured would have expected coverage. *Id.* at 114. *Sandbulte* seems to indicate that the doctrine is applicable only where:

- 1) an ordinary layperson would misunderstand coverage, or
- 2) either of the following occurs:
  - a) the exclusion is either
    - "(1) bizarre and oppressive, (2) eviscerates terms explicitly agreed to, or (3) eliminates the dominant purpose of the transaction," or
    - b) conduct attributable to the insurer creates a reasonable expectation of coverage.

*Id.* at 112-13.

89. 15 Cal. 3d 111, 539 P.2d 433, 123 Cal. Rptr. 649 (1975). The decision is criticized in Note, *A Reasonable Approach to the Doctrine of Reasonable Expectations As Applied to Insurance* 3 U. MICH. J.L. REF. 603, 614 (1980).

90. 15 Cal. 3d at 114-15, 539 P.2d at 435-36, 123 Cal. Rptr. at 651-52.

91. *Id.* at 115, 539 P.2d at 436, 123 Cal. Rptr. at 652.



that because the receipt did not explain how or when the temporary coverage would be terminated if the insurer rejected the application,<sup>92</sup> an ambiguity existed in the conditional receipt given to Smith by the agent. The court's finding of an ambiguity was unreasonable and probably represented no more than reliance on a covert judicial tool. The insurance contract was judicially implied and was not expressly set forth by the terms of the conditional receipt. Thus, the so-called ambiguity was not in the express terms of the receipt. The court was obviously annoyed that such conditional receipts had not been rewritten to recognize judicially implied temporary life insurance.<sup>93</sup> In addition, earlier California cases have indicated that mere notice of rejection is sufficient.<sup>94</sup> In *Smith*, the decedent had received actual notification that the insurer had rejected the insurance and that the premium would be refunded.<sup>95</sup>

A second basis relied upon by the *Smith* court in granting coverage was a finding of unconscionability.<sup>96</sup> Again, the court was in error. The court found the retention of the premium for six days after the notice of rejection to be unconscionable. The court reasoned that the insured may have expected coverage until the premium was refunded.<sup>97</sup> However, substantial evidence existed in the record to support the trial court's finding that Smith had been informed of the rejection<sup>98</sup> and that his premium was being refunded.<sup>99</sup> Thus, there was no reasonable basis for Smith to believe that he was still insured. The six-day retention of the premiums certainly does not rise to a level of oppressiveness that would justify a finding of substantive unconscionability.<sup>100</sup> Again, like the ambiguity argument, unconscionability was used in this decision as a covert judicial tool to avoid discussing the real reason for the decision.

Third, the court in *Smith* stated that the reasonable expectations of coverage by the insured, which were created by the application and the payment of the premium, would continue until the insured received the refund of the premium.<sup>101</sup> Nothing in the case indicates that Smith had any such expectations. In fact, the reasonable lay

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92. *Id.* at 120-21, 539 P.2d at 440-41, 123 Cal. Rptr. at 656-57.

93. *Id.* at 121-25, 539 P.2d at 440-43, 123 Cal. Rptr. at 656-59.

94. *Id.* at 127-28, 539 P.2d at 444-45, 123 Cal. Rptr. at 660-61 (Clark, J., dissenting).

95. *Id.* at 115, 539 P.2d at 436, 123 Cal. Rptr. at 652.

96. *Id.* at 124-25, 539 P.2d at 443, 123 Cal. Rptr. at 659.

97. *Id.*

98. *Id.* at 126, 539 P.2d at 444, 123 Cal. Rptr. at 660.

99. *Id.* at 115, 539 P.2d at 436, 123 Cal. Rptr. at 652.

100. See Note, *Termination of Temporary Insurance Coverage, Created by Application and Payment of Premium, Requires Both Actual Notice of Rejection to Applicant and Refund of Premium Paid*, 64 GEO. L.J. 1199 (1976). Cf. Abraham, *supra* note 57, at 1161-62, where the author illustrates that retroactive coverage may prove to be illusory.

101. 15 Cal. 3d at 126, 539 P.2d at 444, 123 Cal. Rptr. at 660.

person would have no such expectations because prior to *Smith*, the case law in California did not require such a refund for cancellation.<sup>102</sup>

The real reasons for the *Smith* decision appear to be twofold. First, the court desired to redistribute the wealth (paying the widow). Second, the court desired to judicially regulate the rejection practices of the life insurance industry.

In another case, *Karol v. New Hampshire Insurance Co.*,<sup>103</sup> the New Hampshire Supreme Court applied the doctrine of reasonable expectations, rather than possible reformation,<sup>104</sup> to ensure that the insured received the policy protection that he and the agent intended to procure. Karol was a lawyer turned professional film-maker. On several past film projects, Karol had procured insurance from the New Hampshire Insurance Company. In 1977, Karol asked his agent for an all-risk, broad form coverage. The agent specifically requested from New Hampshire a policy to cover film while in transit and while in laboratories.<sup>105</sup> An internal memorandum of the New Hampshire Insurance Company indicated that the transportation-type policy should be written. The policy actually issued excluded coverage while the film was being processed,<sup>106</sup> the very event which caused the claim.

The New Hampshire Supreme Court found there to be expectation of coverage because of the parties' prior dealings. Additionally, the exclusion relied upon was buried in the exclusion section of the policy following what the court described as an "Armageddon" clause which, among other things, excluded war, rebellion, and nuclear fission.<sup>107</sup>

The *Karol* court could have used a more direct approach by finding that the questioned exclusion in the issued policy was not what was requested or intended by the parties. The court could have also

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102. *Id.* at 127-29, 539 P.2d at 444-45, 123 Cal. Rptr. at 660-61 (Clark, J., dissenting). See also *Koorstad v. Washington Nat'l Ins. Co.*, 257 Cal. App. 2d 399, 64 Cal. Rptr. 882 (1967) (termination not effective until notice of rejection given to the prospective insured).

103. 120 N.H. 287, 414 A.2d 939 (1980).

104. Reformation of an insurance contract may be available as a result of mutual mistake, or unilateral mistake on the part of the insured when combined with the insurer's fraud or unconscionable conduct. A. WINDT, *INSURANCE CLAIMS AND DISPUTES* § 9.28 (1982).

105. 120 N.H. at 288-89, 414 A.2d at 940.

106. *Id.* at 289, 414 A.2d at 940-41.

107. *Id.* at 290, 414 A.2d at 941.

found that the exclusion effectively emasculated a dominant purpose of the transaction.

A 1982 California case, *Reserve Insurance Co. v. Pisciotto*,<sup>108</sup> illustrates the covert use that may be made of the doctrine of reasonable expectations. Pisciotto was in a speedboat accident in which his stepson was injured. Reserve, the liability insurer of the speedboat, filed a declaratory relief action claiming that it provided no coverage because of a family exclusion provision that excluded coverage for "bodily injury to the insured or to any member of the family of the insured residing in the same household as the insured."<sup>109</sup> The family exclusion was authorized by the California Insurance Code<sup>110</sup> and had recently been upheld by the California Supreme Court.<sup>111</sup> In order to find coverage, the court determined that the word "family" was ambiguous and then strictly construed the word against the insurer. A more reasonable approach would have been to interpret the language of the policy as it would be understood by the ordinary reasonable consumer of that type of insurance. An ordinary reasonable consumer of such insurance would believe that a stepson living in the home with the insured stepfather was a member of the stepfather's family. If the stepson were seeking coverage, the court would probably find him an insured if the definition of insured were the same as that used in the family exclusion by strictly construing any perceived ambiguity against the insurer. By eliminating the ambiguity rules and by construing the language pursuant to that of the ordinary reasonable insurance consumer of that type of insurance, the result would be one of consistency in interpreting the term "family."<sup>112</sup>

The real basis for the court's finding that the stepson was not excluded from coverage appears to be based on two principles. First,

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108. 30 Cal. 3d 800, 640 P.2d 764, 180 Cal. Rptr. 628 (1982).

109. *Id.* at 807, 640 P.2d at 767, 180 Cal. Rptr. at 631 (footnote omitted).

110. CAL. INS. CODE § 11580.1(c) (West Supp. 1985).

111. 29 Cal. 3d 383, 628 P.2d 1, 173 Cal. Rptr. 846 (1981). *Compare* State Farm Gen. Ins. Co. v. Emerson, 102 Wash. 2d 477, 687 P.2d 1139 (1984) (family exclusion in homeowner's policy not against public policy) with Mutual of Enumclaw Ins. Co. v. Wiscomb, 97 Wash. 2d 203, 643 P.2d 441 (1982) (family exclusion in automobile policy violates public policy). *See also* Transamerica Ins. Co. v. Royle, 656 P.2d 820 (Mont. 1983), where the court held that because Montana did not recognize parental immunity for torts to children, the family exclusion in a homeowners policy violated the reasonable expectations of the insured. The reasoning of the court is highly suspect because the issue of parental immunity was left unresolved and the policy specifically contained the family exclusion. It would appear that the objective reasonable expectations of the average purchaser of homeowner's insurance would have been the exact opposite of the court's finding. If the court had found that no parental immunity existed, then the issue of reasonable expectations would have been more properly presented.

112. *Cf.* State Farm Gen. Ins. Co. v. Emerson, 102 Wash. 2d 477, 687 P.2d 1139 (1984) (court upheld a family exclusion where the policy contained a more specific definition of insured).

the court apparently disliked the legislatively-approved family exclusion.<sup>113</sup> Second, the court desired to make the insurance proceeds available to the injured stepson (wealth-redistribution).

A classic case for the application of the doctrine of reasonable expectations was *Dobosz v. State Farm Fire and Casualty Co.*<sup>114</sup> The insured purchased a homeowner's policy entitled "'All-Risk' Special Policy." The insured then suffered water damage when water leaked into his basement. State Farm denied coverage because the policy specifically excluded such water damage.<sup>115</sup>

The policy was sold to Dobosz by a State Farm agent who described the "All-Risk" policy as the "Cadillac of the line." The agent gave Dobosz a brochure and told him that the brochure would explain what the policy covered. Dobosz relied upon the brochure and purchased the "All-Risk" policy.<sup>116</sup>

The brochure indicated that the "All-Risk" policy added coverages not contained in the other homeowner policies available through State Farm. In addition, under the coverages enumerated as part of the "All-Risk" policy, a picture with the caption "Water Damage" appeared. The picture portrayed an open window with rain falling through it, forming a puddle of water.<sup>117</sup> The picture apparently did not misrepresent the specific policy coverage. The brochure, in small print at the bottom, contained a disclaimer providing that the brochure only generally described the coverages and that coverages were subject to the specific policy's exclusions.<sup>118</sup>

The Illinois court found coverage on three theories. First, the court held that the brochure became part of the insurance contract and thus created an ambiguity.<sup>119</sup> Second, the court found coverage by estoppel.<sup>120</sup> Third, the court, though appearing to confuse estop-

113. 30 Cal. 3d at 807, 640 P.2d at 767, 180 Cal. Rptr. at 631.

114. 120 Ill. App. 3d 674, 458 N.E.2d 611 (1983).

115. *Id.* at 676, 458 N.E.2d at 612. This exclusion was delineated in the policy itself, but it was not delineated in the brochure sent to Dobosz.

116. *Id.* at 677, 458 N.E.2d at 612-13.

117. *Id.* at 677, 458 N.E.2d at 613.

118. "This brochure contains only a general description of coverages and is not a statement of contract. All coverages are subject to the exclusions and conditions in the policy itself." *Id.*

119. "[T]he clear implication of State Farm's advertising brochure differs from the exclusionary provisions of the policy issued to plaintiff." *Id.* at 679-80, 458 N.E.2d at 614-15.

120. "An insurer may be estopped to rely on an exclusionary clause in the insurance policy where descriptive brochures or solicitation materials distributed by the insurer misrepresent coverage." *Id.* at 680, 459 N.E.2d at 615.

pel with reasonable expectations, found that the reasonable expectations of the insured favored coverage.<sup>121</sup>

Rather than straining the law of contracts and misapplying the estoppel theory, a better approach for the court would have been a decision finding that under all of the circumstances, a reasonable consumer of this type of policy would have expectations of coverage. These circumstances included the agent's refusal to explain the coverages, the agent's assertion that the brochure would explain the policy, the depiction of water damage in the brochure, the inadequate small print disclaimer containing the exclusions, the agent's referral to the policy as an "All-Risk' Special Policy," and the fact that the technical meaning of an "all-risk" policy is not the same interpretation as that of a layperson.<sup>122</sup>

#### V. A JUDICIAL TOOL TO CREATE COVERAGE?

The doctrine of reasonable expectations clearly has not been applied in a one-sided manner in order to find coverage. The New Jersey Supreme Court applied the doctrine to deny excess coverage to a vehicle not listed under a family automobile policy.<sup>123</sup> The unlisted vehicle was regularly used by the named insured for personal business although title had been transferred to the named insured's business entity.<sup>124</sup>

Other cases have used the doctrine to avoid the stacking of underinsured coverages,<sup>125</sup> and uninsured motorist coverages,<sup>126</sup> to deny a claim that an agent's statement that the insured had full coverage meant there were no limitations on coverage,<sup>127</sup> and, in a state which allows stacking of uninsured motorist benefits, to avoid a totally unrealistic extension of the stacking precedents.<sup>128</sup>

On the other hand, some courts have applied the reasonable expect-

121. *Id.*

122. See Bragg, *Concurrent Causation and the Art of Policy Drafting: New Perils for Property Insurers*, 20 FORUM 385, 392 (1985).

123. DiOrio v. New Jersey Mfrs. Ins. Co., 79 N.J. 257, 398 A.2d 1274 (1979).

124. *Id.* at 265, 398 A.2d at 1278.

125. See Votedian v. General Accident Fire & Life Assurance Co., 330 Pa. Super. 13, 478 A.2d 1324 (1984). Cf. Hallowell v. State Farm Mut. Auto. Ins. Co., 443 A.2d 925 (Del. Super. Ct. 1982) (court refused to stack uninsured and underinsured coverages).

126. See Inter-Insurance Exchange v. State Farm Ins. Co., 113 Ill. App. 3d 157, 446 N.E.2d 1224 (1983). Compare Deyarmond v. Community Serv. Ins. Co., 132 Mich. App. 191, 347 N.W.2d 201 (1984) and Konopelski v. State Farm Mut. Auto. Ins. Co., 187 N.J. Super. 478, 455 A.2d 516 (1982) (both cases disallowed stacking of liability limits). See also Evenchik v. State Farm Ins. Co., 139 Ariz. 453, 679 P.2d 99 (Ct. App. 1984); Hallowell v. State Farm Mut. Auto. Ins. Co., 443 A.2d 925 (Del. Super. Ct. 1982).

127. See State Farm Gen. Ins. Co. v. Emerson, 102 Wash. 2d 477, 687 P.2d 1139 (1984).

128. Lambert v. Liberty Mut. Ins. Co., 331 So. 2d 260 (Ala. 1976) (attempt to stack coverage on 1969 vehicles in a fleet policy).

tations doctrine in a more questionable manner, raising the issue of whether the doctrine was being applied in a principled manner or being employed as a covert method to hide the true reasoning behind the decision. Examples are application of the doctrine to avoid the clear legal malpractice of the insured's lawyer,<sup>129</sup> applying the doctrine to avoid the apparent negligence of an agent in failing to insure an electrician for completed operations,<sup>130</sup> applying the doctrine to allow the innocent spouse to recover under a fire insurance policy when her husband was guilty of arson,<sup>131</sup> and applying the doctrine to insurance policies that are probably not true adhesion contracts.<sup>132</sup> In addition, there continue to be cases that strain hard-to-create ambiguities in order to find coverage.<sup>133</sup>

## VI. THE DEVELOPMENT OF JUDICIAL STANDARDS

In fleshing out the doctrine of reasonable expectations, the cases seem to be moving toward rules<sup>134</sup> which may be summarized as follows:

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129. See *Zuckerman v. Transamerica Ins. Co.*, 133 Ariz. 139, 650 P.2d 441 (1982); *Galinko v. Aetna Casualty & Sur. Co.*, 432 So. 2d 179 (Fla. Dist. Ct. App. 1983).

130. *Atwood v. Hartford Accident & Indem. Co.*, 116 N.H. 636, 365 A.2d 744 (1976).

131. *Richards v. Hanover Ins. Co.*, 250 Ga. 613, 299 S.E.2d 561 (1983).

132. See, e.g., *Endo Laboratories, Inc. v. Hartford Ins. Group*, 747 F.2d 1264 (9th Cir. 1984); *Jackson Township Mun. Util. Auth. v. Hartford Accident & Indem. Co.*, 186 N.J. Super. 156, 451 A.2d 990 (1982).

133. See, e.g., *National Union Fire Ins. Co. v. Reno's Executive Air, Inc.*, 682 P.2d 1380 (Nev. 1980); *Commercial Union Ins. Co. v. Chubb Group*, 194 N.J. Super. 69, 476 A.2d 290 (1984).

134. See A. WINDT, *supra* note 104, where the author postulates that the formulation of the reasonable expectations rule should be as follows:

1. The policy is in the nature of an adhesion contract.
2. The enforcement of the provision would defeat the reasonable expectations of the great majority of policyholders to whose claims the provision would be relevant.
3. The provision was not explained to the insured when he or she purchased the policy.
4. The provision is either unclear and inconspicuous, needlessly misleading and obscure, or unfair, in that either eviscerates any nonstandard terms explicitly agreed to or eliminates the dominant purpose of the transaction.

*Id.* § 6.03, at 235-37 (footnotes omitted).

See also Note, *A Common Law Alternative to the Doctrine of Reasonable Expectations in the Construction of Insurance Contracts*, 57 N.Y.U. L. REV. 1175, where the author proposes that the insurer be required to prove that the insurance provision was specifically explained to the insured. The author relied heavily on *Hionis v. Northern Mut. Ins. Co.*, 230 Pa. Super. 511, 327 A.2d 363 (1974), which held that the insurer must prove that the insured was not only aware of the exclusion, but also that the insured understood the exclusion. *Hionis* was subsequently overruled in *Standard Venetian Blind Co. v. American Empire Ins. Co.*, 503 Pa. 300, 469 A.2d 563 (1983). Cf. *Collister*

- 1) The doctrine should only apply to contracts of insurance that are true contracts of adhesion;<sup>135</sup>
- 2) In cases of ambiguity in the policy language, the policy will be interpreted in light of the objective reasonable expectations of the average insured;<sup>136</sup>
- 3) Regardless of any ambiguity in the language of the insurance policy, the objective reasonable expectations of the average insured will be applied where the insured did not receive full and adequate notice of the provision in question, and (a) the policy provision in question is unusual and unexpected,<sup>137</sup> or (b) the policy provision effectively emasculates the apparent coverage;<sup>138</sup>
- 4) Where, prior to contracting for the insurance, some activity on the part of the insurer, or activity which can be reasonably at-

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v. Nationwide Life Ins. Co., 479 Pa. 579, 388 A.2d 1346 (1978), *cert. denied*, 439 U.S. 1089 (1979).

135. *See, e.g.*, *Garcia v. Truck Ins. Exch.*, 36 Cal. 3d 426, 682 P.2d 1100, 204 Cal. Rptr. 435 (1984) (insurance contract negotiated by California Hospital Association not adhesive); *Robin v. Blue Cross Hosp. Serv., Inc.*, 637 S.W.2d 695 (Mo. 1982) (en banc) (employee group health policy not adhesive since employer negotiated terms); *cf.* *Royal Indem. Co. v. Westinghouse Elec. Corp.*, 385 F. Supp. 520 (S.D.N.Y. 1974).

136. *See, e.g.*, *Davenport Peters Co. v. Royal Globe Ins. Co.*, 490 F. Supp. 286 (D. Mass. 1980); *Western Exterminating Co. v. Hartford Accident & Indem. Co.*, 479 A.2d 872 (D.C. 1984); *Farm Bureau Ins. Co. v. Sandbulte*, 302 N.W.2d 104 (Iowa 1981); *Rodman v. State Farm Mut. Auto. Ins. Co.*, 208 N.W.2d 903 (Iowa 1973); *Baybutt Constr. Corp. v. Commercial Union Ins. Co.*, 455 A.2d 914 (Me. 1983); *Nationwide Mut. Ins. Co. v. Perlman*, 187 N.J. Super. 499, 455 A.2d 527 (1983). A number of cases apply a subjective standard erroneously in interpreting the policy language. Some of the cases applying a subjective standard also involve conduct attributable to the insurer. *See, e.g.*, *C & J Fertilizer, Inc. v. Allied Mut. Ins. Co.*, 227 N.W.2d 169 (Iowa 1975); *cf.* *Herzog v. National Am. Ins. Co.*, 2 Cal. 3d 192, 465 P.2d 841, 84 Cal. Rptr. 705 (1970).

137. *See, e.g.*, *Allstate Ins. Co. v. Reeves*, 66 Cal. App. 3d 464, 136 Cal. Rptr. 159 (1977); *Gross v. Lloyds of London Ins. Co.*, 121 Wis. 2d 78, 358 N.W.2d 266 (1984) (renewal policy allowed insurer to terminate duty to defend by tender of policy limits; court refused enforcement of this major change without specific notice to insured).

138. *See, e.g.*, *Huffman v. Aetna Life & Casualty Co.*, 337 Pa. Super. 274, 486 A.2d 1330 (1985). A group hospitalization policy provided coverage only if a hospital extended care facility was a "hospital." The policy required a "hospital" to provide facilities for diagnosis and major surgery, and excluded nursing homes, convalescent homes and similar facilities from the definition of "hospital." The court held for the insured because, in part, a reasonable insured would expect coverage while in a hospital department, even though the department itself might not meet the policy's definition of "hospital." *Id.* at 1337, 486 A.2d at 1335. *See also* *Entron, Inc. v. Affiliated FM Ins. Co.*, 749 F.2d 127 (2d Cir. 1984); *Kates v. St. Paul Fire & Marine Ins. Co.*, 509 F. Supp. 477 (D. Mass. 1981); *Farm Bureau Mut. Ins. Co. v. Sandbulte*, 302 N.W.2d 104 (Iowa 1979); *Cody v. Connecticut Gen. Life Ins. Co.*, 387 Mass. 142, 439 N.E.2d 234 (1982) (court can limit enforcement of ambiguous insurance contracts where (1) company's marketing techniques make contract misleading, and (2) contract as a whole is without substantial economic value); *Estrin Constr. Co., Inc. v. Aetna Casualty & Sur. Co.*, 612 S.W.2d 413 (Mo. Ct. App. 1981) (court upheld a care, custody, and control exclusion in a contractor's comprehensive liability policy as serving, rather than undermining, the dominant purpose of the policy — insuring against liability to third parties); *Kievit v. Loyal Protective Life Ins. Co.*, 34 N.J. 475, 170 A.2d 22 (1961).

tributed to the insurer, has created an objective impression of coverage as to a reasonable insured,<sup>139</sup> and

- 5) Where some activity reasonably attributable to the insurer prior to contracting for the insurance has caused this particular insured to reasonably believe that he has coverage, although such coverage is denied by the policy.<sup>140</sup>

#### *A. Applies Only To Adhesion Contracts*

Because the doctrine of reasonable expectations has its genesis in the desire of the courts to regulate adhesion contracts—contracts offered on a take-it-or-leave-it basis—the doctrine should have no application in interpreting policies of insurance that have been negotiated. As to these negotiated policies, the ordinary rules of contract law provide sufficient protection to both parties.<sup>141</sup>

Only a small percentage of insurance contracts are, in fact, negotiated or can be negotiated due to the insurer's economic power and the lack thereof on the part of most insureds. Although such insurance contracts may be reflected by standardized forms, insureds of sufficient economic power — generally large commercial, governmental, or special groups — may have access not only to in-house expertise, but also to attorneys and insurance consultants.<sup>142</sup>

#### *B. As An Interpretative Tool*

The majority of courts have restricted the application of the doctrine of reasonable expectations to only those cases where an ambiguity in the policy language exists.<sup>143</sup> This restriction is unfortunate

139. See, e.g., *Stewart-Smith Haidinger, Inc. v. Avi-Truck, Inc.*, 682 P.2d 1108 (Alaska 1984); *INA Life Ins. Co. v. Brundin*, 533 P.2d 236 (Alaska 1975); *Dobosz v. State Farm Fire & Casualty Co.*, 120 Ill. App. 3d 674, 458 N.E.2d 611 (1983); *Karol v. New Hampshire Ins. Co.*, 120 N.H. 287, 414 A.2d 939 (1980); *Bierer v. Nationwide Ins. Co.*, 314 Pa. Super. 397, 461 A.2d 216 (1983); cf. *Estrin Constr. Co., Inc. v. Aetna Casualty & Sur. Co.*, 612 S.W.2d 413 (Mo. Ct. App. 1981) (court indicated that the insured's knowledge is relevant in determining objective reasonable expectations).

140. See, e.g., *C & J Fertilizer, Inc. v. Allied Mut. Ins. Co.*, 227 N.W.2d 169 (Iowa 1975); *Trombly v. Blue Cross/Blue Shield*, 120 N.H. 764, 423 A.2d 980 (1980).

141. See *supra* note 135.

142. See *supra* note 135.

143. See, e.g., *Davenport Peters Co. v. Royal Globe Ins. Co.*, 490 F. Supp. 286 (D. Mass. 1980); cf. *Evenchik v. State Farm Ins. Co.*, 139 Ariz. 453, 679 P.2d 99 (1984); *Western Exterminating Co. v. Hartford Accident & Indem. Co.*, 479 A.2d 872 (D.C. 1984); *Sturla, Inc. v. Fireman's Fund Ins. Co.*, 67 Hawaii 203, 684 P.2d 960 (1984); *Twin City Hide v. Transamerica Ins. Co.*, 358 N.W.2d 90 (Minn. 1984) (where the insurance contract in question was found ambiguous); *Croteau v. John Hancock Life Ins. Co.*, 123



and seems to be based upon two notions: first, an over-reliance on the classical rules of freedom of contract,<sup>144</sup> and second, a probable fear of unprincipled application.<sup>145</sup> The answer to the first notion is simple — the insurance policy does not contain bargained-for terms. The second notion can only be overcome by requiring a principled approach with discrete rules of application.<sup>146</sup>

In jurisdictions which have adopted the interpretative doctrine, opinions either confuse or combine the reasonable expectations interpretation approach with other rules of construction, such as construing ambiguities strictly against the insurer. This indicates a failure of these courts to understand that by applying the interpretative rule of reasonable expectations, the other ambiguity construction rules become inapplicable.

It might be advisable for the courts to adopt the reasonable expectations doctrine as the primary rule of insurance contract interpretation and to discard the ambiguity rules altogether.<sup>147</sup> This would give clear notice to the insurance industry that an entire policy would be read based upon the objective reasonable expectations of the average consumer of that type of policy. Although many courts today probably interpret policies in this way, it appears unrealistic to expect the courts to abandon their past formulations of insurance policy construction in the near future.

By limiting the reasonable expectations doctrine as an interpretative tool only to be used in cases of perceived ambiguity in the policy language, courts must resort to the much criticized covert decisional methods. The reasonable expectations doctrine in its expanded form, applied in a principled manner, provides a more supportable decisional answer.

The doctrine of reasonable expectations, when used in the face of contrary policy language should not be used indiscriminately, which would lead to unprincipled uses for covert purposes. Rather, discriminate use of the doctrine can enhance the acceptability of the doctrine and the authority of the cases decided on that basis. The doctrine should not be used covertly for wealth-spreading purposes<sup>148</sup> or for mandating insurance coverage which is not provided in the marketplace.<sup>149</sup> These are areas of concern which are better left either to

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N.H. 317, 461 A.2d 111 (1983); *Storms v. United States Fidelity & Guar. Co.*, 118 N.H. 427, 388 A.2d 578 (1978).

144. See *Holmes*, *supra* note 2, at 384-95.

145. Cf. *Casey v. Highlands Ins. Co.*, 100 Idaho 505, 600 P.2d 1387 (1979); *Standard Venetian Blind Co. v. American Empire Ins. Co.*, 503 Pa. 300, 469 A.2d 563 (1983).

146. See *Abraham*, *supra* note 57, at 1197-98.

147. See *Collister v. Nationwide Life Ins. Co.*, 479 Pa. 579, 594, 388 A.2d 1346, 1353 (1978), *cert. denied*, 439 U.S. 1089 (1979).

148. Cf. *Abraham*, *supra* note 57, at 1193-95.

149. For examples of courts mandating coverage, see *Gray v. Zurich Ins. Co.*, 65

legislative action or to the private marketplace.

### C. *The Unusual Or Emasculating Provision*

The objective reasonable buyer of a particular type of insurance policy usually will be presumed to have had past dealings with insurance policies involving similar risks. Thus, the reasonable insured will come into the transaction with certain preconceived notions of insurance coverage. The insurer, as the marketer of the policy, should know, and therefore can be fairly charged with, this knowledge. Thus, when an insurer makes a major change in its policy which decreases coverage<sup>150</sup> or deviates from the provisions of the standard policies, the insurer should bear the burden of giving adequate notice of this deviation or change to the insured prior to the time the insurance is purchased.<sup>151</sup> Certain provisions in a policy, when applied to a particular insurance transaction, may result in seriously reducing the benefits in the policy, sometimes to the point that the protection provided is not economic from the standpoint of the insured. Such policy provisions cannot be adequately understood in the abstract. Due to the superior knowledge of the insurer, it seems fair that the insurer should bear the burden of either giving adequate notice to the insured or losing the benefits of the provision that the insurer drafted.<sup>152</sup>

A recent example of a policy provision that emasculated part of the coverage can be found in *Kates v. St. Paul Fire & Marine Insurance Co.*<sup>153</sup> The case involved a group policy purchased through the insured's workplace which provided for lifetime disability benefits. The policy also contained a clearly worded coordination-of-benefits clause for social security and workers' compensation benefits. When

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Cal. 2d 263, 419 P.2d 168, 54 Cal. Rptr. 104 (1966) (duty to defend case); *Gyler v. Mission Ins. Co.*, 10 Cal. 3d 216, 514 P.2d 1219, 110 Cal. Rptr. 139 (1973) (providing tail coverage in professional liability cases); *Government Employees Ins. Co. v. Brown*, 446 So. 2d 1002 (Miss. 1984) (stacking of uninsured motorist limits).

150. See *Allstate Ins. Co. v. Reeves*, 68 Cal. App. 3d 464, 136 Cal. Rptr. 159 (1977) (where amendment was added without request or explanation and contrary to previous coverage).

151. See *Gross v. Lloyds of London Ins. Co.*, 121 Wis. 2d 78, 358 N.W.2d 266 (1984).

152. Cf. *Abraham*, *supra* note 57, at 1169-75.

153. 509 F. Supp. 477 (D. Mass. 1981). See also *Cody v. Connecticut Gen. Life Ins. Co.*, 387 Mass. 142, 439 N.E.2d 234 (1982), which interprets *Kates* as indicating that marketing techniques can make an unambiguous insurance contract misleading. *Cody* upholds a coordination-of-benefits clause. *Cody* also indicates, contrary to *Kates*, that the court should determine whether the whole contract, rather than a particular provision, has substantial economic value to the insured. *Id.* at 150-51, 439 N.E.2d at 239-40.

this clause was applied to the insured, who received a disabling job-related injury, it reduced his disability benefits to zero after six months. In upholding the social security part of the coordination clause but denying enforceability of the workers' compensation part of the clause, Judge Keeton found no ambiguity in the literal terms of the document. However, he did find what he termed to be an "ambiguity in communication"<sup>154</sup> which caused the policy to become misleading. Due to the technical nature of the operation of such a clause, the true effect of the coordination-of-benefits clause as to workers' compensation benefits could not be understood by an insured unless the insured had sufficient information to know how such a clause would operate. Thus, the court found that the lifetime coverage for on-the-job injuries was of "no substantial value to the plaintiff or other employees of the participating companies similarly situated."<sup>155</sup>

The essence of *Kates* is that it would be unfair to enforce the coordination-of-benefits clause as to workers' compensation benefits in a claim arising from job-related injuries resulting in disability. Because the insurance was sold to the insured through his employment, it would be objectively reasonable for the insured to believe that the promised disability benefits would be available in the event of a job-related injury; such belief on the part of the insured would be a major consideration in the initial purchase of the policy. As to the coordination of social security benefits, such clauses are not unusual, and the clause would apply across the board to both job-related and non-job-related injuries; thus, the social security coordination provision was neutral. Neither the selling of the policy through the place of employment nor any other activity of the insured created any expectations of the insured different from the explicit terms of the social security coordination-of-benefits provision.

Clauses similar to the coordination-of-benefits clause in *Kates* are common, and generally will not emasculate the coverage. In fact, coordination-of-benefits provisions have distinctive value in the vast majority of cases.<sup>156</sup> Such clauses result in lower overall claim costs, as well as reduced premium costs. Additionally, such clauses reduce the possibility of an insured profiting from the insured incident, thereby discouraging claims of doubtful validity. These clauses also increase the insured's incentive to make a timely claim on those policies that are claims time-related, such as disability and hospitalization

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154. *Kates*, 509 F. Supp. at 485.

155. *Id.* at 492.

156. *See, e.g.*, *Blue Cross and Blue Shield of Alabama, Inc. v. Hendrix*, 385 So. 2d 63 (Ala. Civ. App. 1980) (coordination-of-benefits clause prevents double recovery, and insured could have no reasonable expectation of a double recovery); *Cody v. Connecticut Gen. Life Ins. Co.*, 387 Mass. 142, 439 N.E.2d 234 (1982).

policies. Although generally valid, clauses such as the workers' compensation coordination-of-benefits clause in *Kates* may result in little or no benefits to the insured. In particular insurance transactions, the marketing techniques or other insurer conduct may result in the unenforceability of an unambiguous provision because the activities of the insurer may have created objectively reasonable expectations of coverage in the insured — expectations which in all fairness should be honored.

Judicially mandating disclosure of the contents of insurance policies is a complex problem. Although it may appear to be the simple answer to a court faced with a single case, any such answer may be erroneous if studied in depth. The complications of such a solution include the increased administrative burden, the increased costs to policyholders, the extent to which the prospective insured can understand the information, and the ability of the marketing process to economically conform. Additionally, insurers may decide that the cost and marketing disadvantages of compliance outweigh the potential legal liability.<sup>157</sup>

#### *D. Insurer Conduct*

Cases decided on the basis of the reasonable expectations doctrine which involve conduct of the insurer, apart from the wording of the policy, often also involve discussions of the doctrine of equitable estoppel.<sup>158</sup> Cases limited to the wording of the policy involve discussions of unconscionability and reasonable expectations.<sup>159</sup> Those cases involving both insurer conduct and the wording of the policy may speak in terms of all three: reasonable expectations, unconscionability and equitable estoppel.<sup>160</sup> Attempting to distinguish between reasonable expectations, estoppel, and unconscionability can be difficult because the doctrine of reasonable expectations, with its equity origins, often overlaps with the other two.

Equitable estoppel normally requires a finding of misrepresentation, either active or passive.<sup>161</sup> The reasonable expectations doc-

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157. For a careful analysis of mandated disclosure, see Abraham, *supra* note 57, at 1169-75.

158. See, e.g., *Bouchard v. Travelers Indem. Co.*, 28 Conn. Supp. 122, 253 A.2d 497 (1969).

159. See, e.g., *Evans v. National Life Accident Ins. Co.*, 467 N.E.2d 1216 (Ind. Ct. App. 1984).

160. See, e.g., *C & J Fertilizer, Inc. v. Allied Mut. Ins. Co.*, 227 N.W.2d 169 (Iowa 1975).

161. See Abraham, *supra* note 57, at 1178-79.

trine, as applied by the courts, focuses more on the insured's view of the transaction rather than on the insurer's conduct. Many courts refuse to apply estoppel to expand coverage beyond the stated terms of the policy.<sup>162</sup> By applying the reasonable expectations doctrine, the limitations of the estoppel doctrine can be avoided without doing the estoppel doctrine injustice. Application of the reasonable expectations doctrine will produce a fair result.

In addition, because the expectations doctrine focuses on the insured's view, the doctrine transfers to the insurer the problem of lack of information about the specific terms of the policy. This is a fair transfer of such a burden because it is the insurer who is most responsible for lack of information and has the best ability to rectify the situation. Perhaps better information or notice cannot be provided economically or feasibly by the insurers. Even so, it is still fair to place the burden on the insurer, who can then pass on the economic costs to the whole pool of insureds as a method of risk-distribution.

Once beyond the question of the objective reasonable expectation of coverage, the question of the subjective expectation of a particular insured must be considered. The analysis of the latter is similar to that of equitable estoppel, with two exceptions. First, no actual finding of a misrepresentation, either active or passive, on the part of the insurer is required. Second, the insured need not prove reliance.

However, the differences here are not as great as they may seem. First, reliance and the reasonableness of the insured's expectations are very similar concepts, and the proofs may not significantly differ. Second, although the insurer's conduct may not rise to a level of misrepresentation as such, the insurer will be responsible for either some misinformation or lack of information which directly causes reasonable expectation of coverage by the insured.<sup>163</sup>

The doctrine of unconscionability, on the other hand, requires a finding of substantive oppressiveness in a particular provision. Most insurance provisions will not reach this level. As a result, the unconscionability doctrine has not had a major effect on the courts.<sup>164</sup> Because the unconscionability doctrine focuses on the fairness of the policy provision, the insurer can introduce evidence of the commercial reasonableness of the provision.<sup>165</sup> Such evidence might not

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162. See, e.g., *Twin City Hide v. Transamerica Ins. Co.*, 358 N.W.2d 90 (Minn. Ct. App. 1984).

163. See Abraham, *supra* note 57, at 1179-85.

164. See Gardner, *Reasonable Expectations: Evolution Completed or Revolution Begun*, 1978 INS. L.J. 573, 577 n.14 (1978). See also *Evans v. National Life Accident Ins. Co.*, 467 N.E.2d 1216 (Ind. Ct. App. 1984).

165. Cf. U.C.C. § 2-302(2) (1978), which provides: "When it is claimed or appears to the court that the contract or any clause thereof may be unconscionable the parties

enter into the consideration of whether the expectations of the insured were reasonable. In addition, unconscionability does not turn on the issue of the insured's expectations; thus, a provision could be declared unconscionable even though the provision was in accord with the insured's expectations.<sup>166</sup>

## VII. APPLYING THE RULES

In applying these judicial rules in a manner which gives some hope of predictability, the courts must be more principled in their approach and more careful in drafting opinions in this area. The courts need to be vigorous in their findings of reasonableness and need to carefully recite the factual basis upon which they rely in determining the standard of the reasonable expectations of the average insured. In using an *objective* standard, the courts should point out that the insured's own expectations are not controlling, but merely evidence on this issue. In fact, the insured's expectations<sup>167</sup> may often be suspect, especially if supportable only by state of mind evidence.

The courts should also abandon the term "average insured" and focus rather on *the reasonable expectations of the average consumer of the type of insurance in question*. As an example, lawyers should be held to a higher standard in purchasing a legal malpractice policy<sup>168</sup> than that of the average insured in some general market, such as the purchaser of an automobile policy.

Because of the large number of reported opinions in this area, precision in detailing the factual undergirdings of the reported decisions will result in a further refinement of the often cautiously stated rules and in the development of new rules. As the rules become further developed and as usable factual patterns appear in the opinions accompanying such rules, those courts that have limited the reasonable expectations doctrine to be used only as an interpretative tool will be more prone to adopt the doctrine in its expanded form. Such development and refinement of the doctrine will hopefully lead to less covert decision-making in the area of insurance law. The reported

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shall be afforded a reasonable opportunity to present evidence as to its commercial setting, purpose and effect to aid the court in making the determination."

166. Cf. *Smith v. Westland Life Ins. Co.*, 15 Cal. 3d 111, 539 P.2d 433, 123 Cal. Rptr. 649 (1975); RESTATEMENT (SECOND) OF CONTRACTS § 208 (1979); U.C.C. § 2-302(1) (1978).

167. FED. R. EVID. § 402. See also *Huffman*, *supra* note 144.

168. See, e.g., *Estrin Constr. Co., Inc. v. Aetna Casualty & Sur. Co.*, 612 S.W.2d 413, 425 (Mo. Ct. App. 1981) (analysis of general contractor's insurance knowledge).

opinions will then provide greater predictability for lawyers and provide trial judges with reported opinions more understandable and of greater precedential value.