Reasonable Expectations: Seeking A Principled Application

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I. INTRODUCTION

Insurance contracts, the written policies of insurance, are, in the vast majority of cases,1 clearly contracts of adhesion.2 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,3 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 insured 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.

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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 or have applied some other doctrine such as estoppel, waiver, public policy or unconscionability (where the decisions often turn on the status of the parties). Neither the Restatement (Second) nor the Uniform Commercial Code 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 nor does it appear beyond a slight reference.


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.


8. Professor Spiegel Leff, 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 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).


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, desire to judicially regulate some aspect of the insurance industry, perceived unfairness on the part of the insurer, or the desire to implement judicial theories of wealth-spreading or wealth-redistribution.

Though the problems caused by this covert means of judicial decision-making have been recognized for many years, judges, with all their human frailties, have continued to rely on such covert methods 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. 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-

13. See, e.g., id.
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.
urance 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.  

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. 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.

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.


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.24

The insurance contract does differ substantially from other adhe-
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, notwithstanding the fact that most insureds simply will not take the time and make the effort.

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, stretching to find ambiguities beyond a reasonable interpretation of the policy language and applying vague expressions of public policy.

As a result of the many problems caused by the perceived harshness of certain insurance policy provisions and the courts' desire to regulate, 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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27. See supra note 5.

28. See supra note 4.


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.*, 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. 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.

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. 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.

The seminal case in the evolution of the doctrine of reasonable expectations in insurance law is *Kievit v. Loyal Protective Life Insurance Co.* *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." The policy went on to provide the plaintiff with monthly payments "against loss resulting directly and independently of all other causes..."
from accidental bodily injuries. . . .”38 In addition the policy excluded “disability or other loss resulting from or contributed to by any disease or ailment.”39 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.40 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.41

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.42 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:

[The 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.43

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.,44 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)).
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."\(^{45}\)

The court's decision in \textit{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 \textit{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.\(^{46}\) Though the court in \textit{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),\(^{47}\) it is clear that the theory would have been applicable based on the misleading activity of the insurer.

The second case is \textit{Steven v. Fidelity and Casualty Co.}\(^{48}\) 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."\(^{49}\) 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.\(^{50}\) 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.\(^{51}\)

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-

\(^{45}\) 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.
\(^{49}\) 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.\(^52\)

The next major case in the development of the doctrine is the landmark duty-to-defend case of *Gray v. Zurich Insurance Co.*\(^53\) 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.”\(^54\) 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.\(^55\)

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.”\(^56\) 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.\(^57\) 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),\(^58\) the insurer would then have had to defend against the suit.\(^59\)

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.\(^60\) Keeton pointed out that a number of judicial doctrines employed to regulate the adhesion contract could better be grouped under a heading of

\(^{52}\) Id. at 877, 377 P.2d at 294, 27 Cal. Rptr. at 182.


\(^{54}\) 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.


\(^{58}\) 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." 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;
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;
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," 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.

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), was clearly not intended by Keeton. Keeton noted specifically that his formulation was not specific enough for courts in deciding particular cases. 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

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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.
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. . . 68

IV. THE MATURING OF THE DOCTRINE

The case of Herzog v. National American Insurance Co.,69 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.70 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.71 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.72 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.73 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

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 and in law reviews. 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., 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," 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. 74

74. There are literally hundreds of reported cases that discuss the doctrine.
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.\textsuperscript{79} 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.\textsuperscript{80} It should be noted that the court never found the provision to be ambiguous.

The court in \textit{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,\textsuperscript{81} 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"\textsuperscript{82} burglary coverage. In fact, such definitional language was not uncommon in like policies.\textsuperscript{83}

The \textit{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 \textit{Chipokas v. Travelers Indemnity Co.},\textsuperscript{84} 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

\textsuperscript{79} Id. at 176-77.
\textsuperscript{80} Id. at 179.
\textsuperscript{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.
\textsuperscript{82} Keeton, supra note 29, at 968.
\textsuperscript{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.


\textsuperscript{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. . . .

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. The court also refused to apply the faulty reasoning of Gray v. Zurich Insurance Co. In addition, the court was undoubtedly influenced by the fact that the insured was a lawyer.

The doctrine of reasonable expectations was misapplied by the California Supreme Court in Smith v. Westland Life Insurance Co. 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. 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.

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.
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, 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. In addition, earlier California cases have indicated that mere notice of rejection is sufficient. In Smith, the decedent had received actual notification that the insurer had rejected the insurance and that the premium would be refunded.

A second basis relied upon by the Smith court in granting coverage was a finding of unconscionability. 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. However, substantial evidence existed in the record to support the trial court’s finding that Smith had been informed of the rejection and that his premium was being refunded. 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. 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. Nothing in the case indicates that Smith had any such expectations. In fact, the reasonable lay

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.

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

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.,103 the
New Hampshire Supreme Court applied the doctrine of reasonable
expectations, rather than possible reformation,104 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.105 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,106 the very event which
causd 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 pol-
cy following what the court described as an "Armageddon" clause
which, among other things, excluded war, rebellion, and nuclear
fission.107

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

102. Id. at 127-29, 539 P.2d at 444-45, 123 Cal. Rptr. at 660-61 (Clark, J., dissenting).
See also Koorsd 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. Pisciotta, illustrates the covert use that may be made of the doctrine of reasonable expectations. Pisciotta 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." The family exclusion was authorized by the California Insurance Code and had recently been upheld by the California Supreme Court. 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."

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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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.
the court apparently disliked the legislatively-approved family exclusion. 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. 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.

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.

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. 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.

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. Second, the court found coverage by estoppel. Third, the court, though appearing to confuse estoppel.

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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.
peel with reasonable expectations, found that the reasonable expectations of the insured favored coverage.\textsuperscript{121}

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.\textsuperscript{122}

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.\textsuperscript{123} 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.\textsuperscript{124}

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

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

\textsuperscript{121} Id.
\textsuperscript{122} See Bragg, Concurrent Causation and the Art of Policy Drafting: New Perils for Property Insurers, 20 FORUM 385, 392 (1985).
\textsuperscript{124} Id. at 265, 398 A.2d at 1278.

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tions 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,\textsuperscript{129} applying the doctrine to avoid the apparent negligence of an agent in failing to insure an electrician for completed operations,\textsuperscript{130} applying the doctrine to allow the innocent spouse to recover under a fire insurance policy when her husband was guilty of arson,\textsuperscript{131} and applying the doctrine to insurance policies that are probably not true adhesion contracts.\textsuperscript{132}

In addition, there continue to be cases that strain hard-to-create ambiguities in order to find coverage.\textsuperscript{133}

VI. THE DEVELOPMENT OF JUDICIAL STANDARDS

In fleshing out the doctrine of reasonable expectations, the cases seem to be moving toward rules\textsuperscript{134} which may be summarized 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 obscene, or unfair, in that either eviscerates any nonstandard terms explicitly agreed to or eliminates the dominant purpose of the transaction.

\textit{Id.} § 6.03, at 235-37 (footnotes omitted).

See also Note, \textit{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 \textit{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. \textit{Hionis} was subsequently overruled in Standard Venetian Blind Co. \textit{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.135

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.136

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,137 or (b) the policy provision effectively emasculates the apparent coverage.138

4) Where, prior to contracting for the insurance, some activity on the part of the insurer, or activity which can be reasonably at-


tributed to the insurer, has created an objective impression of coverage as to a reasonable insured;\textsuperscript{139} 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.\textsuperscript{140}

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.\textsuperscript{141}

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.\textsuperscript{142}

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.\textsuperscript{143} This restriction is unfortunate


\textsuperscript{141} See supra note 135.

\textsuperscript{142} See supra note 135.

and seems to be based upon two notions: first, an over-reliance on the classical rules of freedom of contract, and second, a probable fear of unprincipled application. 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.

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. 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 or for mandating insurance coverage which is not provided in the marketplace. These are areas of concern which are better left either to


144. See Holmes, supra note 2, at 384-95.
146. See Abraham, supra note 57, at 1197-98.
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 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. 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.

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. 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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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).


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

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" 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."  

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. 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

155. Id. at 492.
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.157

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.158 Cases limited to the wording of the policy involve discussions of unconscionability and reasonable expectations.159 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.160 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.161 The reasonable expectations doc-

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157. For a careful analysis of mandated disclosure, see Abraham, *supra* note 57, at 1169-75.
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.\textsuperscript{162} 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.\textsuperscript{163}

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.\textsuperscript{164} Because the unconscionability doctrine focuses on the fairness of the policy provision, the insurer can introduce evidence of the commercial reasonableness of the provision.\textsuperscript{165} Such evidence might not

\textsuperscript{163} See Abraham, supra note 57, at 1179-85.
\textsuperscript{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.166

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 expectations167 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 policy168 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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167. FED. R. EVID. § 402. See also Huffman, supra note 144.

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