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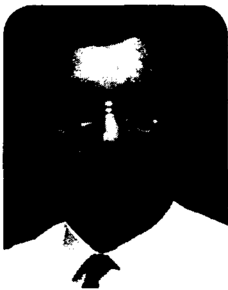
Towards a Unified Theory of Insurance Law

BY DAVID C. KNIERIEM



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In searching for a "Theory of Everything," one could argue that it is the quest that is more important than the result.[2] The quest in this article is to determine whether insurance law – for first party and third party claims – can have a unifying principle. This proposed unifying principle is not contract law or reasonable expectations – the two dominant but unsatisfying theories – but instead one based on equitable principles, of obligations owed between the insurer and its insured. This comes from the simple predicate that insurance is not a contract entered into between parties, but a product sold to consumers. This principle will be discussed in the context of Missouri insurance law for property-casualty insurance.

From a macro perspective, equity is, of course, only available when there is no adequate legal remedy. What will be seen is that as insurance law has devolved – and that word is chosen purposely – the legal remedies certainly available to the insured, and to a lesser extent the insurer, are not adequate. Instead, the law now encourages an *ad hoc* approach that distorts the risk calculation in evaluating whether to pay a claim, or challenging the denial of a claim.

The valid criticism of this approach is that it clings to a certain extent to the contractually-based nature of the present system. If there was one easy, correct paradigm, then the courts would have adopted it long ago. Within the context of the law and realistically available remedies, though, what is presented here is the best solution to the concerns raised by insurance law.

I. Reasons

Practically, there can be no agreement to an insurance contract, as the contract – the policy – is often not seen by the insured until after the contract is purchased and the policy terms begin. Even if the insured has seen the policy, the policy terms – definitions, exclusions, etc. – are never negotiated. The terms are standardized, certainly within a company, and often across the industry. Anti-trust laws do not apply to the insurance industry.[3] As a result, insurance companies formed Insurance Services Office, Inc. to create standardized forms for various types of insurance, both personal and commercial.[4]

Moreover, there can never even be a meaningful choice on the part of an insured. The insured can choose which coverage to purchase, and to a certain extent for what limits, but the policy itself – the definitions of the insured, the exclusions, the conditions – do not vary meaningfully from company to company. If the basic cornerstone of contract law is mutual assent,[5] this assent is present in insurance no more than any other product or service that is purchased. When a consumer buys a stereo, they choose the brand and the features, but that does not turn a stereo into a contract.

Why, then, is insurance considered a contract? Why is it that insurance

Theory

companies are evaluated in the context of their policy, and not by their actions in determining coverage?

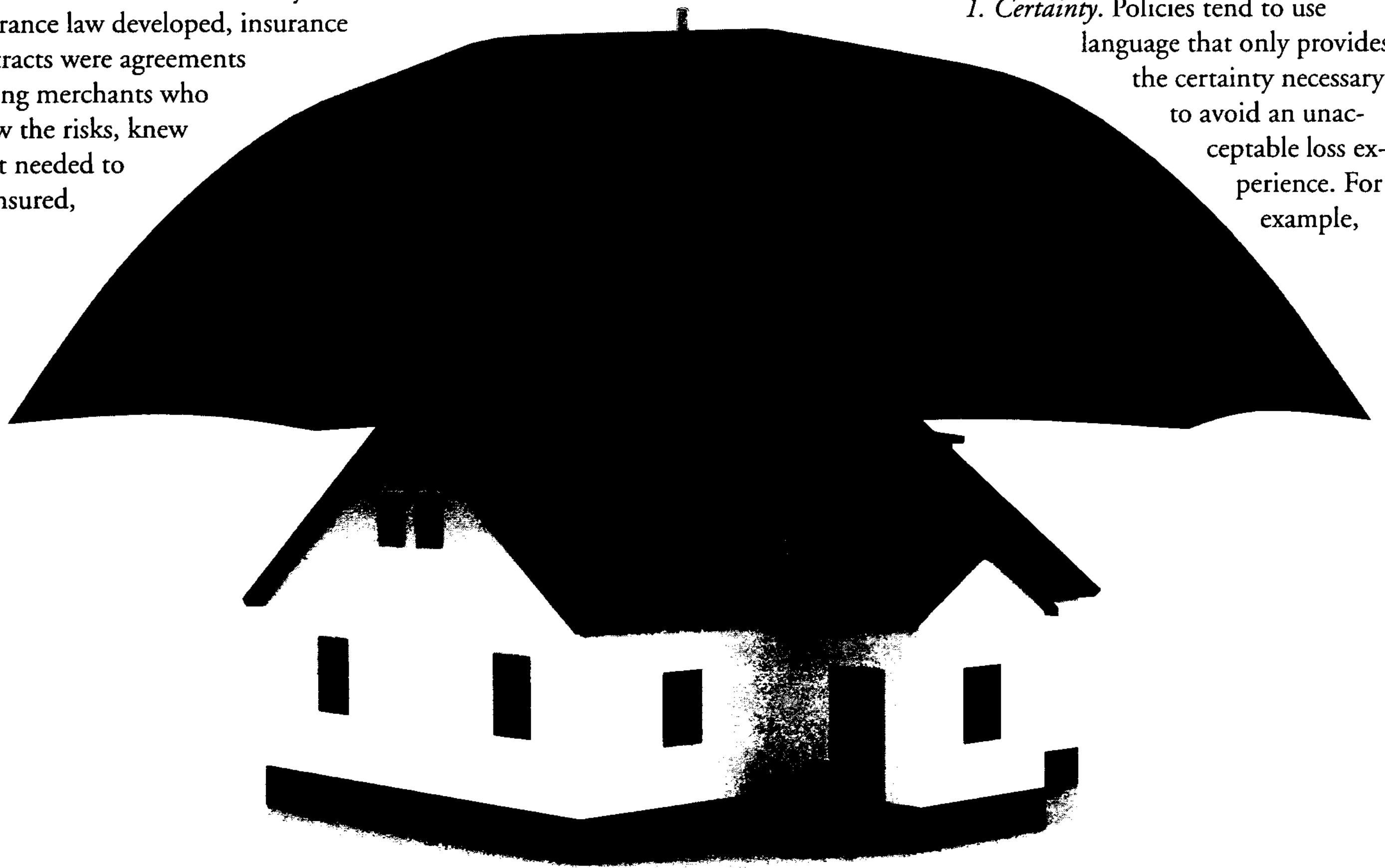
To understand insurance law, it is necessary to travel back in time a relatively short distance. At the turn of the 20th century, the concept of buying car or home insurance as consumers now do would be unthinkable.[6] Insurance law instead developed out of ship owners insuring their cargo and boats. As a result, "[u]ntil recent time, marine insurance remained the pre-eminently important branch and classification of insurance law."[7] It is not surprising, then, that as insurance law developed, it was the same as contract law. Inevitably, when insurance law developed, insurance contracts were agreements among merchants who knew the risks, knew what needed to be insured, and for how much. These policies were the result of negotiation and fairly simple: If the ship sinks, the insurer pays.[8]

This is why to equate what consumers purchase now to a contract is to deny reality. Consumers purchase an often-standardized product, not a contract. To call what is purchased a contract can quickly be reduced to the ridiculous. For example, if one were to invoke strict constructionist principles for standardized policies that are purchased, and allow those standardized policies to control the courts in guiding their interpretation, one commentator has gone so far as to suggest that this constitutes private lawmaking power that is unconstitutional in lacking procedural safeguards.[9]

Though that probably overstates the case, it is appropriate to question whether the courts, for any other product that is offered on a take-it-or-leave-it basis, would cede control of a liability determination to the maker of the product. Does Ford get to decide if a car is safe by the contract of sale it has with its customers? Though this relationship is, in a sense, "contractual," to define this relationship that way is, intuitively, problematic.

Professor Michelle Boardman recently wrote what will one day likely be the classic work on insurance company boilerplate.[10] As she noted, while insurance policies have the surface appearance of contracts, that is not the way the insurance industry views them. As opposed to a normal contract, where negotiation of terms would take place between insurer and insured, the insurance industry views the two parties to the insurance contract as the insurer and the courts. The reason for this has to do with how the insurance industry works, and the three interrelated forces driving insurance policy formation:

1. Certainty. Policies tend to use language that only provides the certainty necessary to avoid an unacceptable loss experience. For example,



if a court were to find the terrorism exclusions ambiguous and unenforceable, insurers would be forced to alter the policy, as the risk would be potentially too great. In Missouri, splitting off underinsured motorist coverage from uninsured motorist coverage had to take place, because allowing the coverages to stack relative to the premium charged for underinsured motorist coverage was unacceptable as well.

Assuming those unacceptable risks are not at issue, what insurers are looking for in the language is not clarity, but consistency of interpretation. And, to be even more precise, insurers seek interpretations they can rely on, even if inconsistent across courts. It is the classic "devil you know" situation – if language has a meaning as set forth by their partner, the courts, whether it is the original intent or not, insurers see no reason to risk drafting new language that may be interpreted in a new, unexpected way.

As a result, the policyholder plays no role in this process. In fact, the only concern for the insurer here is not clarity, but predictability.

2. Shared loss data. As long as the insurer can assign actuarial risk to however the policy is interpreted, it can assign a premium to that risk. As a result, insurers do not even care if the interpretation is uniform; if one-third of jurisdictions assign coverage to a phrase as X, and two-thirds assign coverage to that same phrase as X + Y, the insurer can still charge an appropriate premium, with sufficient loss data, for the risk presented. Again, the policyholder plays no role here; only the interpretation by the courts is relevant to this concern.

3. Lack of risk tolerance. Insurance executives have little incentive to change language, as whatever change they make can potentially be worse than whatever language they inherited. Again, as long as the language has been assigned a meaning, and that meaning can be assigned a risk, premiums can still be charged.

The upshot of this is that insurers have no interest in drafting language that is clear to policyholders. Their only interest is in drafting language that can present them with a basis to judge risk and assign premium, as interpreted by the courts.

This is complicated by the inevitable limitations in drafting these policies. Without the shared negotiation to come to an understanding of the terms, the insurer has to deal with the inherent limitations of the English language without any rhetorical devices to clarify the meaning. It is no wonder, then, that policies so often are ambiguous or opaque. That does not mean the task is impossible – far from it. But it is difficult, with no incentive, as outlined above, to take on that task.

If, then, the relationship between insured and insurer is no more "contractual" than between a buyer and a seller, what is the relationship? As insurance law has developed, there are two overriding problems – certainty and allocation of responsibility – that must be resolved in developing a unifying theory.

In order to have an efficient judicial system, an attorney has to be able to counsel a client as to the likely outcome of a particular fact-pattern. Certainly, there will always be the outliers that require adjudication, but if every problem has to be litigated, the system will be overwhelmed. As noted above, this certainly is true for insurers; it is even more important, though, for insureds. Because of the inherent unequal nature of the relationship, it is the insured who suffers most from the delay in adjusting a loss. If a house is destroyed, the insured still has a mortgage to pay and needs a place to live; waiting two or three years to determine if they will get paid by their insurance is just not an acceptable result. An insured can not afford to wait for the courts to resolve every potential dispute in an insurance policy.

There also has to be a method to fairly assign responsibility, taking into account the non-reciprocal nature of the insurance relationship, while at the same time recognizing that risk is the product that the insurance company is selling. In other words, just because the relationship is unequal, that does not mean the insurance company is strictly liable for all losses. In addition, any system has to take into account the fact that an insurance company has to have some control over the product it sells.

II. What Has Not Worked

Interestingly, as noted above, drafting an insurance policy is basically an exercise in reacting to court decisions. If so, it seems that insurance law is on a recycling treadmill of action and reaction, as the contours of what insurance companies intend to cover has not changed significantly for some 40 years. The classic example of this is the description of drafting anti-concurrent causation language in response to decisions originating out of California that attempted to expand the efficient proximate cause doctrine.[11] Defining anti-concurrent causation language is not important for purposes of this article.[12] What is more interesting is the description by a State Farm Fire and Casualty Company attorney of what the insurance industry went through in attempting to react to the various decisions that expanded coverage.[13] The point is that the insurance industry was fully aware of what it wanted to cover in its policies; it was fine-tuning language to say what the industry meant it to say in reaction to these court decisions. From the insurance industry's perspective, a court decision that alters coverage merely provokes a cat and mouse game with insurance policy drafters.

A. Reasonable Expectations

The concept of reasonable expecta-

tions, first enunciated in insurance law by Professor Robert Keeton in 1970,[14] is seductive in its simplicity and intuitive fairness. Its source is CORBIN ON CONTRACTS, which begins with the header that **"The Main Purpose of Contract Law Is the Realization of Reasonable Expectations Induced by Promises."**[15] Though stated with authority, it instead is a salvo in the clash of legal theories of contract law represented by WILLISTON ON CONTRACTS[16] – advocating the freedom of contract, plain meaning, and judicial non-intervention – and CORBIN, which advocated a more holistic approach.[17] The reasonable expectations doctrine asks what the parties (really, for all practical purposes, the policyholder) reasonably should have expected when the insured bought the policy. In Missouri, though, it occasionally makes an appearance in its pure form.[18] There is no question that courts have generally required an ambiguity in the insurance policy to consider these reasonable expectations,[19] thus making it meaningless, as all ambiguities are resolved in favor of the insured anyway.

This is not necessarily a bad thing, as the potent criticism of the doctrine of reasonable expectations is the *ad hoc* nature of its approach. Though courts often claim that the reasonable expectations doctrine is to prevent arbitrary interpretation of insurance policies,[20] it is the doctrine itself that is often applied arbitrarily – or, at least, as a rationale for supporting whatever result the court wishes to achieve.[21] As an analytic tool, it is of little help. Determining what is reasonable lies too often in the eyes of the beholder to make it a reliable solution in establishing certainty. Moreover, it permits a court to decide cases based on policies, insureds and fact patterns instead of providing some certainty in how the policies are interpreted. Though ostensibly an objective test, by permitting a court to evaluate the expectations within a specific context, it can become *de facto* a subjective test.

B. Breach of Contract

Alternatively, to deal with patently unfair situations, courts have declared provisions in a policy "ambiguous," leading to the same unsatisfactory rulings as the reasonable expectations doctrine. This is the approach taken in Missouri.

The problem is that the ambiguity doctrine has become as random as the reasonable expectations doctrine. For example, in *National Union Fire Insurance Co. v. Maune,*[22] the court evaluated the following household exclusion: "We do not provide Liability Coverage for any 'insured' for 'bodily injury' to you or any 'family member' to the extent that the limits of liability for this coverage exceed the limits of liability required by the Missouri Financial Responsibility Law."[23] In analyzing this clause, the court agreed that there is no such thing as the Missouri Financial Responsibility Law, and that a layperson could not understand this provision without the assistance of an attorney. However, that did not make the provision "ambiguous," merely "incomprehensible."[24] Interestingly, at oral argument, the opinion's author noted that an insured rarely reads the policy anyway until there is a loss.

That, of course, is the problem. After the loss, an insured has to go to a lawyer to have the product explained. If true, the point the court makes in *Maune* – that ambiguities have to produce alternative meanings, because otherwise there is no reliance by the insured – is patently contradictory. The reality is that there can be no reliance if the insured never reads the policy in the first place. As a result, the position of the court – that an incomprehensible policy is acceptable, but one with alternative meanings is unacceptable – is inherently problematic. Unfortunately, under the ambiguity doctrine as it has developed, the *Maune* court is not necessarily incorrect.

Another problem is that, in the first party context, identifying the claim as a simple breach of contract exacerbates the non-reciprocal nature of the insurer-insured relationship by the damages that are awarded. By refusing to pay a claim, the consequences for an insured are potentially catastrophic – the loss of a home, for example. The consequences of a lawsuit do not place a similar burden on the insurance company, though, as the remedy is simply to pay the claim. The only penalty to the insurance company when it does not pay a claim is the 10 percent imposed by the "vexatious refusal" statutes plus an award of attorney's fees – and that is only if the insurance company was unreasonable.[25] In other words, if the insurance company can advance any tenable reason for denying the claim, it can delay paying a claim with no consequences – or cause the insured to forego the claim in frustration.

What if there is a material misrepresentation by either the insured or the insurer in handling the claim? Again, the consequences are non-reciprocal. For the insured, it could be the loss of a home and, under a theory currently advanced by insurance companies pursuing declaratory judgments, an award of attorney's fees in favor of the insurer. For any family, that is a catastrophic result. Conversely, if the insurance company commits a material misrepresentation, the consequence – noted above under the vexatious statutes – is simply the cost of doing business. This unequal consequence inevitably has to skew the interaction of the parties, from motivation to claims handling to settlement posture.

III. What Can Work

Equitable principles already adopted in Missouri provide a ready analytic framework for resolving insurance disputes. Because of the nature of the relationship, third party and first party claims need to be approached differently. Third party claims should be

resolved using fiduciary principles, while first party claims can be analyzed using estoppel and unconscionability.

A. Third Party Claims

The full boundaries of the fiduciary relationship are complex. Originally, a trustee would "not be responsible for any loss of the trust fund, where he has acted in good faith, and in the exercise of a fair discretion, and in the same manner, as he has been accustomed to do, in regard to his own property."[26] Throughout the years, and more importantly for our purposes in Missouri, those responsibilities were refined:

> It contemplates good faith in all transactions rather than mere naked legal obligation. It comprehends integrity, loyalty, fidelity and trustworthiness more than it relates to credit or ability. This relationship need not be based upon some technical relation created or defined in law but exists where a special confidence has been reposed in one who in equity and good conscience is bound to act not only in good faith but also with utmost fidelity to the interests of those reposing such special confidence. Of necessity it must comprehend the safekeeping and separate holding of all monies received which the fiduciary is in law and good conscience bound to pay over to those for whom he is acting.[27]

For example, one issue frequently facing an insurer is whether to pay a demand for policy limits by a claimant. The choice is stark: An insurance company does not have an obligation as a fiduciary to accept all demands within the policy limits. Fiduciary law merely requires that the insurer act in good faith if it elects *not* to pay such a demand. As will be discussed below, that is the obligation now put on insurance companies acting in that fiduciary capacity.

In fact, Missouri courts, consistent with the correct view of fiduciaries, are quite clear as to the obligation put on an insurer:

> [A]n insurer has a duty to consider the insured's interest, and if this interest conflicts with its own, good faith obligates the insurer to sacrifice its interest in favor of the insured's. Hence, "bad faith on the part of the insurer would be the intentional disregard of the financial interest of the insured in the hope of escaping the responsibility imposed upon it by its policy." "'[An] insurer must act honestly to effectually indemnify and save the insured harmless as it has contracted to do – to the extent, if necessary, that it must make whatever payment and settlement an honest judgment and discretion dictate, within the limits of the policy[.]"[28]

As will be discussed below, simply equating an insurance policy to a contract and stating that "[c]ontracting parties are generally not fiduciaries to each other"[29] is insufficient. As the New York Court of Appeals said more than 80 years ago, "What do they know of the law of the insurance contract who only the law of contract know?"[30]

The insurance company's fiduciary responsibility was not an obligation that originated with Missouri courts; it was well-established in American jurisprudence prior to any decision by a Missouri court. This obligation of acting in good faith was an idea that had circulated around courts throughout the country in the early part of the 20th century.[31] As a result, when the Supreme Court of Missouri in *Zumwalt v. Utilities Insurance Co.*[32] stated the insurance company was "bound, under its contract of indemnity, and in good faith, to *sacrifice its interests in favor of those of the respondent*,"[33] the Court simply placed Missouri in line with a number of courts that had rejected the duty imposed on the insurance company as one of avoiding negligence, and instead imposed the different burden of acting in good faith. *Zumwalt* was what would now be considered a bad faith/failure to settle case. The suit against the insurer was brought both as a negligence claim and a bad faith claim. The Court held the insurance company must pay the verdict in excess of the policy limits because of its bad faith, but rejected the negligence claim.

What the *Zumwalt* Court did *not* do was place the insurance company's interest as equal with the insureds. As a result, when the court in *Craig v. Iowa Kemper Mutual Insurance Co.*[34] explicitly recognized a fiduciary relationship between insurer and insured in a third party claim, this was an analysis that had been well-accepted by other courts.[35] Though one could argue that this was *dicta* – *Craig* was a dispute about an uninsured motorist, first party claim – the court had an in-depth discussion as to why third party claims invoke the fiduciary duty and first party claims do not. The motivation behind the court imposing such an obligation is not to "'deter insurers from elevating their own interests above their insured's' interests,"[36] but instead a two-fold standard: to determine whether the settlement was reasonable without regard to policy limits; and whether the insured was potentially liable for an excess judgment.[37]

This is the substantive fallacy in the "co-equal" argument. The "co-equal" argument suggests both the insurer and insured have interests entitled to equal consideration, also known as a reciprocal relationship. However, the insurance company does *not* have exposure to an excess judgment. The two parties are never equal, because the insurance com-

pany has limited liability and the insured, potentially, does not. As a result, the interest of an insurance company on a case in excess of the policy limits is always fixed, while the insured, who has no control over whether that fixed amount is paid, does not. This is particularly dangerous in the situation where there is a high likelihood of recovery in excess of policy limits against a flush insured. The lack of interest by either side – the claimant and the insurance company – to seriously negotiate within the policy limits has prompted one court to hold that good faith requires the insurer to open negotiations.[38]

All fiduciary relationships are created by some form of agreement, whether it be an attorney fee contract, a trust, or the implied contract between principal and agent. It is likely true that insurers do not want to enter into a fiduciary relationship, but by assuming control of the property of their insured, the law has created that obligation, just as it does for attorneys, trustees and agents. The insurance agreement, by allowing the insurance company to control the destiny of the insured, imposes additional legal obligations on the insurance company.

This fiduciary relationship is demonstrated by Missouri courts' discussion of what are known as the two *Grewell* cases,[39] *Grewell I* and *Grewell II.*

Before discussing these two cases, it is important to understand what brought them about. The plaintiff was involved in a car accident, and discovered that the other driver had the same insurer, State Farm Mutual Automobile Insurance Co. As insurance companies are obligated to do, State Farm assigned separate adjusters for each party. Initially, Ms. Grewell's adjuster assigned her fault in the accident as 20 percent; however, after the other State Farm adjuster said Ms. Grewell was 50 percent at fault, her own adjuster changed Ms. Grewell's fault to 50 percent as well. Ms. Grewell was curious as to why.

Interestingly, she never found out. In *Grewell I*, the Supreme Court of Missouri told State Farm to turn over the claims file. *Grewell I* did not yet involve a claim that required the Court to confront whether the parties had a fiduciary relationship. Instead, the Court cast about for the proper analogy to decide a narrow issue: Pursuant to a declaratory judgment petition asking for the claims file, did the insurance company have an obligation to turn the file over? As the Court had previously decided that issue for a client's file from an attorney – and not, for example, by a trustee – the Court felt it appropriate to create an analogy between attorney and insurer. Though the Court sounded a cautionary note that the insurer-insured relationship was not identical to the attorney-client relationship, the court did not reject the fiduciary analysis. Instead, just as an attorney has more obligations and responsibilities than a trustee, an insurer is not an attorney. The courts have distinguished the fiduciary relationship owed by attorneys and insurers in other contexts.[40]

"It is appropriate to question whether the courts, for any other product that is offered on a take-it-or-leave-it basis, would cede control of a liability determination to the maker of the product."

In *Grewell II*, State Farm had *still* refused to turn over half the file. At that point, the Grewells added a claim for breach of fiduciary duty for failing to turn over the file. Therefore, facing an amended petition specifically confronting the fiduciary issue, *Grewell II* repeated that the relationship was fiduciary. *Grewell II* did not break new ground by finding a fiduciary relationship between insurer and insured; it simply followed a long line of cases that had found such a relationship.[41]

There are, of course, many purposes for these semantic gymnastics. One motivation of the insurance industry in insisting this relationship is merely contractual is to ensure that no lawsuit could allege punitive damages against the insurer. In fact, an argument could be made that the insurer would not be liable above the contractual limits unless the insured actually paid money out of pocket. This is juxtaposed with the recent affirmance of a $10 million punitive damages award in *Johnson v. Allstate Insurance Co.*,[42] which certainly explains the insurance industry's concern regarding the nature of its relationship with its insureds.

Johnson is an interesting case. It was a bad faith/failure to settle case; the insured had minimum limits, and Allstate did not respond to the demand for the policy limits or investigate the claim until long after the demand expired. Significantly, there was no disagreement as to whether such a fiduciary relationship exists. In fact, it is that relationship – and the subsequent personal (as opposed to contractual) basis for the claim – that caused the concurrence to question the assignability of such a claim to the injured party, as was done in *Johnson* and is commonly done in these type of claims.

A recent case that directly confronted the fiduciary relationship is *Truck Insurance Exchange v. Prairie Framing, L.L.C.*[43] The facts of the case would swallow this article; in brief, the insurance company refused to defend its insured. The circumstances surrounding this failure were so bad that the trial court granted summary judgment to

the insured on its claim for bad faith against the insurance company.

Though the appellate court reluctantly reversed that summary judgment – bad faith, the court held, is always an issue for the jury – its in-depth analysis of the duties of the insurance company is more relevant for our purposes. The insurance company attempted to revive the negligence/bad faith debate as to the insurance company's duties, which was roundly rejected by the court. In discussing the duty owed by the insurance company, the court again emphasized the *Zumwalt* Court's statement that the insurance company "must 'sacrifice its interests in favor of those of the [insured].'"[44]

B. First Party Claims

While a fiduciary relationship describes what occurs between an insured and insurer on a third party claim, the language used to describe a fiduciary is unsatisfying in the first party situation. Missouri courts have been unduly harsh in describing that relationship – the parties involved are nothing more than "adversarial."[45] To simplify the relationship that way misunderstands the nature of insurance and, more importantly, the legal nature of the interconnection.

The relationship between an insured and an insurer is a non-reciprocal, contractually-based relationship – precisely the same relationship that presages, for example, a medical malpractice claim.[46] If true, does the first party claim also present a relationship analogous to fiduciary, or doctor-patient, or whatever, beyond the arms-length breach of contract? As a practical matter, it does not change the extra-contractual remedies available between the parties. The courts have made it clear that the vexatious refusal statutes circumscribe the type of suit that can be brought on a first party claim. The legislature has preempted any other type of claim based on the insurance policy.[47] But what this relationship can establish is the contour of the product/service that the insurance companies provide, and, more importantly, the ability to pursue a claim based on that relationship.

Presently, according to Missouri law, an insured has a duty to read an insurance policy.[48] There are two problems with this. First, it is often impossible, as insurance policies are usually not even provided to an insured until weeks after the term of the policy begins. Second, it is a duty that is rarely fulfilled. Consumers simply do not read their policies.[49] An easy explanation is that consumers are forced to buy the two most common types of insurance – automobile, by statute; and homeowner's, by the lender – so any thought process in the purchase simply has no independent instigation. To impose this duty to read, then, is not only futile, but inequitable. A customer must buy a policy, must read it, deal with potentially incomprehensible language accepted by the courts – and then what? Hire a lawyer to explain what can not be negotiated anyway?

This is compounded by Missouri courts' refusal to provide what is known as "coverage by estoppel." In *Blew v. Conner*,[50] the Supreme Court of Missouri noted that "[w]aiver or estoppel can not be used to create a cause of action[,] but only to preserve pre-existing rights."[51] The Court later expanded on the distinction between waiver and estoppel in *Brown v. State Farm Mutual Automobile Insurance Co.*,[52] stating that estoppel only applies when an insured relies to their detriment on a statement by an insurer alleging a specific defense – almost certainly an exclusion – *after* the loss has taken place. However, Missouri has never wavered in refusing to allow estoppel to create coverage that did not already exist in the policy.

Why? Estoppel is an equitable remedy that should be used if no adequate remedy at law exists. In *Clevinger v. Oliver Insurance Agency, Inc.*,[53] the Supreme Court of Missouri refused to allow an estoppel claim because a negligence claim existed as well. There, an insurance broker had assured the Clevingers a claim would be covered, and it was not. The Clevingers sued the agent both in "negligence and promissory estoppel."[54] The Court said the negligence claim was adequate. More importantly, though it involved a broker who could not issue a policy, the Court stated the negligence cause of action was a "mistaken representation that the policy they did receive would provide coverage."[55] If so, why could not such a claim be brought against an insurance company?

However, as noted above, that fight was more than 60 years ago. An insured can not sue their insurer on a negligence claim. So, if there can not be a negligence claim against an insurance company, all that is left as a legal remedy is a breach of contract claim. But, as noted above, if there is a duty to read the policy, then there can be no claim based on any representations, as the duty to read precludes anything a company or agent may have said. It would seem, then, that if a legal remedy is not allowed, equitable remedies such as promissory estoppel would provide the perfect remedy for disputes between insurers and insureds. Promissory estoppel *can* create contract terms if those terms have as a basis some agreement – whatever form that may take, whether contained in the policy or not – between the company and the policyholder. To say estoppel can not create a contract term – or in this case coverage under the policy – belies the whole point of estoppel. For example, in *Bauer Development, L.L.C. v. BOK Financial Corp.*,[56] the court found promissory estoppel was appropriate to change a notice address in a deed of trust. This

has nothing to do with an affirmative defense, but the terms of the deed of trust. Moreover, it fulfills the whole point of promissory estoppel. Why are insurance policies treated any differently?

A tool that should be just as available to courts to interpret problematic insurance contracts is the doctrine of unconscionability. The RESTATEMENT (SECOND) OF CONTRACTS does provide that this doctrine gives a court the power to alter contracts:

> If a contract or term thereof is unconscionable at the time the contract is made a court may refuse to enforce the contract, or may enforce the remainder of the contract without the unconscionable term, or may so limit the application of any unconscionable term as to avoid any unconscionable result.[57]

What advantage does this provide over the other two doctrines? First, it eliminates the fiction of reasonable expectations with more than 60 years of analysis[58] to define this unconscionability while eliminating any need to also find an ambiguity in the policy. It also allows the court to determine whether the product provided is fair or not and, if not, declare that it is unfair and provide certainty in policy provisions. But, more importantly, it stops the continuous cat and mouse game of finding ambiguities in the policy. It recognizes the policy as a product, allows the court to alter unfair provisions, and declare what would be allowed in providing this product to consumers. The easy way to think of the unconscionability analysis is to consider whether the written product is reasonably safe for consumers from a financial and risk-sharing perspective. If not, it is unconscionable.

For example, in *Linderer v. Royal Globe Insurance Co.*,[59] the issue was whether uninsured motorist coverage should stack in fleet policies.[60] The potential liability to an insurance company, if the fleet policies did stack, would outstrip any reasonable assets an insurance company could hope to maintain. Unable to come up with a reason as to why the policies would not stack, the court declared that such a result would be unconscionable (which, of course, it was), and therefore refused to stack the policies. If so, with an insured also potentially on the hook for a loss just as catastrophic, why can the same result not protect insureds as well?

This approach would not be unique. In *Steven v. The Fidelity & Casualty Co. of New York*,[61] the court found an exclusion in a trip insurance policy unconscionable.[62] The court noted that the exclusion – requiring travel on a scheduled flight even if the insured's flight was cancelled – would not be expected, was not disclosed to the insured until after they bought the policy, and the policy required them to mail the policy to the beneficiary before the flight, so the policy was not available for review.[63] In *C & J Fertilizer, Inc. v. Allied Mutual Insurance Co.*,[64] the provision at issue was the definition of "burglary." The policy required visible marks of forced entry on the exterior of the building, while here only interior doors had visible marks of forced entry. The court, in voiding this definition based on unconscionability, specifically noted that the policy was not supplied to the insured until after it was purchased.

It is important, though, that this unconscionability analysis must be sufficiently meaningful to protect insureds (and, as noted above, insurers) from products that truly are unfair. To simply sweep aside concerns about improper policies with the "freedom of contract" mantra ignores the reason for invoking the unconscionability doctrine.

How the unconscionability doctrine could be used in analyzing insurance policies is demonstrated by comparing *Davis v. M.L.G. Corp.*[65] with *Public Employees Mutual Insurance Co. v. The Hertz Corp.*[66] Both decisions involved exclusions in car rental contracts for insurance coverage while the driver was intoxicated. In *Davis*, the court held that the provision was unconscionable in that it was unexpected, was in small print, and no attention was brought to it by the rental agreement. Conversely, in *Public Employees Mutual*, the court found the provision not unconscionable because the rental agreement highlighted the exclusion, thus making an effort to alert the reader to its existence. This comparison emphasizes the *Davis'* court enunciation of the factors relevant in an unconscionability analysis:

1. The parties have "unequal bargaining strength";[67]
2. "[L]ack of opportunity to read" the document before agreeing to it;[68]
3. "[U]se of fine print";[69]
4. Whether notice was given, or the provision was specifically agreed to;
5. Lack of evidence as to whether "the provision was commercially reasonable"[70] or anticipated;
6. Whether the provision is substantively unfair.

The first two factors are almost always true for insurance products, while the third and fourth occur rarely, if ever. As a result, an analysis of an insurance provision would inevitably involve whether the provision was commercially reasonable or unfair, and consequently whether the insured should reasonably have anticipated the provision. Due to the almost certainty that the first two factors are true, the presumption in favor of the insured would be preserved in evaluating the reasonableness of a provision. Alternatively, the insurance industry could

provide more in-depth notification of policy provisions in order to satisfy a court that an insured was aware of any specific provision that is problematic.

IV. Conclusion

Insurance law, as it developed through the years, is a good way to judge marine insurance contracts entered into two centuries ago. It does not acknowledge, though, how insurance products are marketed or sold today. Well-established equitable principles, already present in Missouri law, provide a more rational and consistent basis for resolving disputes between insurers and their insureds. Fiduciary principles for third party claims, and promissory estoppel and unconscionability for first party claims, track more accurately general theories of law that developed throughout the last century. These principles also reflect the reality that insurance is not a contract entered into by any meeting of the minds, but instead a product bought and sold like any other product in the marketplace.

Endnotes

1 David Knieriem is the principal of the Law Offices of David C. Knieriem, with a practice that emphasizes first party insurance litigation.

2 *See generally* John Barrow, New Theories of Everything (2008).

3 *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982).

4 *See* http://en.wikipedia.org/wiki/Insurance_Services_Office.

5 *Viacom Outdoor, Inc. v. Taouil*, 254 S.W.3d 234, 238 (Mo. App. E.D. 2008).

6 Admittedly, the first automobile policy was sold in 1898; however, it was a marine policy. The first company actually formed to write automobile insurance was created in 1907. Fire insurance has been around since long before the Revolutionary War, but "package" homeowner's policies such as those that exist now did not come about until after World War II.

7 1 Eric Mills Holmes & Mark S. Rhodes, Holmes's Appleman on Insurance, 2d, § 1.2, p.5 (1996).

8 Even the 1943 standard fire insurance policy – used in some places until 1980 – was only three pages long.

9 W. David Slawson, *Standard Form Contracts and Democratic Control of Lawmaking Power*, 84 Harv. L. Rev. 529 (1971).

10 Michelle Boardman, *Contra Proferentem: The Allure of Ambiguous Boilerplate*, 104 Mich. L. Rev. 1105 (2006).

11 *State Farm Mut. Auto. Ins. Co. v. Partridge*, 514 P.2d 123 (1973).

12 For the curious, it is discussed in *Toumayan v. State Farm Gen. Ins. Co.*, 970 S.W.2d 822 (Mo. App. E.D. 1998).

13 Michael E. Bragg, *Concurrent Causation and the Art of Policy Drafting: New Perils for Property Insurers*, 20 Forum 385 (1985).

14 Robert E. Keeton, *Insurance Law Rights at Variance With Policy Provisions*, 83 Harv. L. Rev. 961 (1970).

15 Joseph M. Perillo, Corbin on Contracts § 1.1 (Revised ed. West 1993).

16 Richard A. Lord, Williston on Contracts (4th ed. 1990).

17 *See generally* Eric Mills Holmes, *Education for Competent Lawyering – Case Method in a Functional Context*, 76 Colum. L. Rev. 535 (1976).

18 *Estrin Constr. Co. v. Aetna Cas. & Sur. Co.*, 612 S.W.2d 413 (Mo. App. W.D. 1981).

19 *Rodriguez v. Gen. Accident Ins. Co. of Am.*, 808 S.W.2d 379 (Mo. banc 1991).

20 *See, e.g., Atwater Creamery Co. v. Western Nat'l Mut. Ins. Co.*, 366 N.W.2d 271, 278 (Minn. 1985).

21 Jeffrey E. Thomas, *An Interdisciplinary Critique of the Reasonable Expectations Doctrine*, 5 Conn. Ins. L.J. 295, 325-27 (1998).

22 277 S.W.3d 754 (Mo. App. E.D. 2009).

23 *Id.* at 756.

24 *Id.* at 758.

25 Sections 375.296 and 375.420, RSMo. 2000.

26 James P. Holcombe, An Introduction to Equity Jurisprudence 246 (1846), *available at* http://books.google.com.

27 *In re Buder*, 217 S.W.2d 563, 571 (Mo. banc 1949).

28 *Johnson v. Allstate Ins. Co.*, 262 S.W.3d 655, 662 (Mo. App. W.D. 2008) (citations omitted).

29 Douglas R. Richmond & Patrick J. Kenny, *Why Liability Insurers Are Not Fiduciaries To Their Insureds and Why Missouri Courts Should Stop Saying They Are*, 65 J. Mo. Bar 135, 138 (2009).

30 *Satz v. Mass. Bonding & Ins. Co.*, 153 N.E. 844, 846 (N.Y. 1926) (J. Pound).

31 *See, e.g.*, the extended discussion in *Noshey v. Am. Auto Ins. Co.*, 68 F.2d 808 (6th Cir. 1934).

32 228 S.W.2d 750 (Mo. 1950).

33 *Id.* at 756.

34 565 S.W.2d 716 (Mo. App. W.D. 1978).

35 *See, e.g., Tyler v. Grange Ins. Ass'n*, 473 P.2d 193 (Wash. Ct. App. 1970); *Baxter v. Royal Indem. Co.*, 285 So.2d 652 (Fla. Dist. Ct. App. 1973); *Rova Farms Resort, Inc. v. Investors Ins. Co.*, 323 A.2d 495 (N.J. 1974).

36 Douglas R. Richmond & Patrick J. Kenny, *Why Liability Insurers Are Not Fiduciaries To Their Insureds and Why Missouri Courts Should Stop Saying They Are*, 65 J. Mo. Bar 135, 138.

37 22 Eric Mills Holmes, Holmes' Appleman on Insurance 2d, § 137.2(C)(2) (2003).

38 *Fulton v. Woodford*, 545 P.2d 979 (Ariz. Ct. App. 1976). However, Missouri courts have rejected such an obligation. *Bonner v. Auto. Club Inter-Ins. Exch.*, 899 S.W.2d 925 (Mo. App. E.D. 1995).

39 *Grewell v. State Farm Mut. Auto. Ins. Co.*, 102 S.W.3d 33 (Mo. banc 2003), *decision after remand*, 162 S.W.3d 503 (Mo. App. W.D. 2005).

40 *Freeman v. Basso*, 128 S.W.3d 138 (Mo. App. S.D. 2004).

41 *See the discussion in Overcast v. Billings Mut. Ins. Co.*, 11 S.W.3d 62, 67-8 (Mo. banc 2000); and, for example, *Shobe v. Kelly*, 279 S.W.3d 203 (Mo. App. W.D. 2009); *Freeman v. Leader Nat'l Ins. Co.*, 58 S.W.3d 590 (Mo. App. E.D. 2001); *Duncan v. Andrew County Mut. Ins. Co.*, 665 S.W.2d 13 (Mo. App. W.D. 1983); *State ex rel. J.E. Dunn Constr. Co. v. Sprinkle*, 650 S.W.2d 707 (Mo. App. W.D. 1983); *Varnal v. Weathers*, 619 S.W.2d 825 (Mo. App. W.D. 1981).

42 262 S.W.3d 655 (Mo. App. W.D. 2008)

43 162 S.W.3d 64 (Mo. App. W.D. 2005).

44 162 S.W.3d at 95.

45 *See, e.g., Kearbey v. Wichita Southeast Kan. Transit*, 240 S.W.3d 175, 189 (Mo. App. W.D. 2007).

46 Christopher J. Robinette, *Can There Be a Unified Theory of Torts? A Pluralist Suggestion From History and Doctrine*, 43 Brandeis L.J. 369, 401-10 (2005).

47 But not, of course, on those claims outside the insurance context. *Overcast v. Billings Mut. Ins. Co.*, 11 S.W.3d 62 (Mo. banc 2000).

48 *See, e.g., Girard v. State Farm Mut. Auto. Ins. Co.*, 737 S.W.2d 254, 256 (Mo. App. W.D. 1987).

49 Jeffrey E. Thomas, *An Interdisciplinary Critique of the Reasonable Expectations Doctrine*, 5 Conn. Ins. L.J. 295, 305 (1998).

50 328 S.W.2d 626 (Mo. banc 1959).

51 *Id.* at 631.

52 776 S.W.2d 384, 389 (Mo. banc 1989).

53 237 S.W.3d 588 (Mo. banc 2007).

54 *Id.* at 589.

55 237 S.W.3d at 591.

56 290 S.W.3d 96 (Mo. App. W.D. 2009).

57 Restatement (Second) of Contracts § 208 (1981); *available at* http://www.lexinter.net/LOTWVers4/restatement_(second)_of_contracts.htm.

58 The doctrine of unconscionability was brought to the fore with the publication of the Uniform Commercial Code, specifically U.C.C. § 2-302.

59 597 S.W.2d 656 (Mo. App. E.D. 1980).

60 *Id.* at 657.

61 58 Cal. 2d 862 (Cal. 1962).

62 *Id.* at 878.

63 *Id.*

64 227 N.W.2d 169 (Iowa 1975).

65 712 P.2d 985 (Colo. 1986).

66 800 P.2d 831 (Wash. Ct. App. 1990).

67 712 P.2d at 991.

68 *Id.*

69 *Id.*

70 *Id.*

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