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CONTRACT AND CLAIM IN INSURANCE LAW

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ABSTRACT

This article offers a new perspective on insurance law by examining and combining two basic features of insurance and insurance law: the nature of the insurance contract and the fact that most insurance law issues concern a disputed claim. Insurance law scholars are fond of reconceptualizing their subject. Insurance policies and insurance law have been likened to a means of public utility regulation, a product warranty, a social institution, or, perhaps mostly simply, a thing. This article represents another conceptualization of the subject, and one that may be less foreign to the subject and closer to the reality of the formation and performance of insurance relationships.

Every insurance policy is a contract between the policyholder and the insurer. Fundamentally, however, almost every insurance law problem, dispute, or doctrine is really about paying or not paying claims. These two features—contract and claim—are at the heart of most insurance law disputes. The significance of insurance as contract is generally recognized, but the centrality of claims, less so. The article examines each of them separately and then combines them. Doing so provides a perspective on a large number of insurance law issues, and that perspective should change the courts' approach to a number of issues and doctrines. The focus is on personal lines, particularly first-party insurance, but the analysis also has implications in other settings.

The article first presents the contract and claim analysis. It then applies the analysis to several common issues in insurance law. The illustrations come from three different points in the life of an insurance policy. The first concerns a formation issue: when an insurer may use misstatements by a policyholder in the application process to avoid coverage. The second, and most general, addresses interpretation issues that concern the insurer's performance of the insurance contract. The third concerns issues of policyholder and insurer performance after a claim is filed—the false swearing rule and the law of insurance bad faith. All three reinforce the

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insight that every doctrinal issue involves a conception of the insurance contract and arises because of a disputed claim. The discussion demonstrates that courts sometimes use similar analysis, describes those tendencies, suggests why they are incomplete, and uses the contract and claim analysis to make them explicit and more comprehensive. Other courts take quite different approaches; contrasting those approaches with the contract and claim analysis demonstrates what they get wrong. The result is both a demonstration of the usefulness of the article’s analysis and a beginning catalog of how it can reshape insurance law doctrine.

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This article offers a new perspective on insurance law by examining and combining two basic features of insurance and insurance law: the nature of the insurance contract and the fact that most insurance law issues concern a disputed claim.

Every insurance policy is a contract between the policyholder and the insurer. As such, many of the disputes between policyholders and insurers come to court framed as contract disputes. Many disputes are about rules and principles of interpretation. How is the policy term of “an occurrence” applied? When should policy language be read in accordance with the reasonable expectations of a policyholder and how are those expectations created? Other doctrines fill gaps in policy language or limit pure application of policy language. When does estoppel or waiver permit

an insurer's actions to trump policy language? Is anti-concurrent causation language void as against public policy because of a conflict with the doctrine of efficient proximate cause?

Fundamentally, however, almost every insurance law problem, dispute, or doctrine is really about paying or not paying claims. The rules of insurance policy interpretation determine whether facts giving rise to a claim are within policy language. Estoppel and waiver are asserted by a policyholder to prevent an insurer from denying a claim otherwise excluded from the terms of the policy. The doctrine of reasonable expectations, void as against public policy, and more rules and principles of insurance law become relevant and are given effect only because a policyholder disputes an insurer's denial of its obligation to pay a claim.

These two features—contract and claim—are entailed in most insurance law disputes. The significance of insurance as contract is generally recognized, but the centrality of claims, less so. The article examines each of them separately and then combines them. Doing so provides a perspective on a large number of insurance law issues, and that perspective should change the courts' approach to a number of issues and doctrines. The focus is on personal lines, particularly first-party insurance, but the analysis also has implications in other settings.

I. THE CONTRACT AND CLAIM ANALYSIS

A. CONTRACT

The non-controversial starting point is that an insurance policy is a contract. The policy is created by a voluntary market transaction between the insurer and the policyholder, but like every other contract, it is made enforceable and regulated by law. Law regulates insurance policies through statutes, administrative regulations, and judicial decisions. It does so with two aims.¹

The first aim is to improve the contracting process itself. This aim is concerned with improving the conditions of the many individual transactions through which insurance is bought and sold, thereby improving the insurance market as a whole. It defines the rules of contract formation, attempts to cure

¹ This structure is roughly parallel to Abraham's "two fundamental questions" of insurance law: the enforcement of policy language (to which I would add enforcement of a contractual obligation not clearly specified in the policy) and "'public law' values." Kenneth S. Abraham, *Four Conceptions of Insurance*, 161 U. PA. L. REV. 653, 656 (2013).

deficiencies in the process of assent, and addresses impediments to full and fair contracting such as moral hazard and adverse selection that potentially undermine the market for insurance.

The second aim is to advance public policies that are less immediately tied to the contracting process. There are a broad range of such policies including, for example, preventing discrimination in the underwriting process² and providing compensation for tort victims through liability insurance.³

This simple framing poses several complex questions. First, if an insurance policy is a contract, and what kind of contract is it, and what are the implications of that question for insurance law? Second, how should insurance contracts be regulated? This article mostly puts aside the second form of regulation, in service of external public policies, but that still leaves a lot of ground in which law can structure and intervene in insurance relationships.

The most obvious and universally recognized feature of the insurance policy as a contract is that it is a standard form contract, or a contract of adhesion.⁴ The features that define the policy as this type of contract are:

1. The contract is embodied in the written policy documents.
2. The policy is drafted by the insurer.
3. The policyholder is unlikely or unable to read or understand the terms, a fact known to the insurer.
4. The insurer enters into many such policies.
5. The policyholder enters into few such transactions.
6. Except for a few terms such as policy limits, deductible, and a small number of endorsements, the contract is take-it-or-leave-

² *E.g.*, NAT'L ASS'N OF INS. COMM'RS, MODEL UNFAIR TRADE PRACTICES ACT §4.G (2004), <http://www.naic.org/store/free/MDL-880.pdf>.

³ *See* *Odolecki v. Hartford Accident & Indem. Co.*, 264 A.2d 38, 42 (N.J. 1970).

⁴ The discussion focuses on personal lines and other insurance sold to less commercially sophisticated and empowered insureds largely on a take-it-or-leave-it basis. The practice of contracting for commercial lines covers a wide span, from transactions that largely track the model of adhesion contract described in the text to individually negotiated manuscript policies. The contract and claim analysis is most relevant in cases that resemble that model but it also informs other situations.

it.⁵

7. The policyholder's principal obligation is to pay the premium.
8. The insurer's obligations are conditional on loss and are more extensive than the policyholder's if there is a loss.

Features 1 through 6 are common to all form contracts and features 7 and 8 are distinctive to insurance contracts but certainly not limited to them.

That an insurance policy is a standard form contract does not suggest that it is unenforceable or that its terms should be disregarded. One of the central questions of modern contract law is how to regard such contracts.⁶ But because an insurance policy is a form contract, it is problematic to treat the policy as if it embodied the agreement of a detailed bargain between equal and informed parties, and the law needs to inquire more deeply into the nature of the insurance relation beyond the four corners of the policy.

With that as a noncontroversial starting point, think about the insurance policy as a contract which, like every other contract, has two key moments: formation and performance. At each of these moments, consider separately the position of the insurer and the policyholder.

1. Formation

An insurance policy is a product of an insurer's actuarial classification of risks and calculation of their probability and extent; a drafting process to express those risks in the language of the policy; and the underwriting of a particular policyholder under the classified, expressed risks based on information provided by the policyholder and information available to the insurer from its own and external sources. At the point of formation, therefore, for the insurer the policy represents an effort to embody the substantial terms of the relationship between it and the policyholder. That is, in the language of relational contract theory,⁷ the insurance relationship for

⁵ Todd D. Rakoff, *Contracts of Adhesion: An Essay in Reconstruction*, 96 HARV. L. REV. 1173, 1177 (1983).

⁶ See generally NANCY S. KIM, WRAP CONTRACTS: FOUNDATIONS AND RAMIFICATIONS (2013); MARGARET J. RADIN, BOILERPRINT: THE FINE PRINT, VANISHING RIGHTS, AND THE RULE OF LAW (2013); Friedrich Kessler, *Contracts of Adhesion—Some Thoughts About Freedom of Contract*, 43 COLUM. L. REV. 629 (1943); Rakoff, *supra* note 5.

⁷ Ian R. Macneil, *Restatement Second of Contracts and Presentation*, 60 VA. L. REV. 589, 610 (1974).

the insurer is substantially presentiated in the policy, with the terms of future performance delineated at the moment of formation.

Of course, the written policy, as complex and detailed as it may be, necessarily is incomplete. It does not include every conceivable element of the parties' relationship, and what it does state may be vague, ambiguous, or otherwise uncertain of application. Therefore, the express policy terms are supplemented and explained by industry understandings, regulatory requirements, and judicial interpretations, all of which are within the insurer's knowledge and expertise and none of which are within the policyholder's knowledge or expertise. If there is a loss, the insurer expects to pay what is owed, with "what is owed" defined by the terms of the policy as understood by surrounding industry, regulatory, and legal norms.

Even with the insurer's knowledge and expertise, of course, uncertainty will remain about application of the policy to particular circumstances. But the insurer's uncertainty is reduced because of an essential feature of the policy: it is one among many such policies. For the insurer, the policy has value precisely because it is part of a large pool of policies that insure similar but non-correlated risks. At the point of formation, the insurer anticipates the possibility of loss. The possibility of loss for an individual policy is trivial; what matters is the individual loss as part of a portfolio of risk.

Like all form contracts, an insurance policy serves "to stabilize [the insurer's] external market relationships . . . and to serve the needs of a hierarchical and internally segmented structure."⁸ Externally, standardization by contract reduces the transaction costs of contracting and aids the insurer in calculating and controlling risks. The particular form of external control that is most valuable for the insurer is the limiting and defining of underwriting risk, often in terms favorable to the insurer. In this way, it allows profitable risk spreading. Internally, standard terms are elements of organizational coordination and control, again reducing costs by making operations more predictable. One of the important features of an insurer's bureaucracy is the use of policy terms, among other systems, to limit the discretion of sales and claims personnel and to structure their interactions with policyholders.

At the point of formation, the policyholder is in a different situation. The insurance policy involves minimal planning by the policyholder, typically focusing on price, policy limits, deductible, a vague sense of the insurer's reputation, convenience, and perhaps a few items of coverage.

⁸ Rakoff, *supra* note 5, at 1220.

Indeed, often the policyholder is unable to agree to (or even have access to) the terms of the policy; personal lines insurers almost never provide a copy of the policy prior to purchase.⁹ An intermediary, an agent or broker, can provide the policyholder better understanding of the content of the policy at the time of formation, but it is rare that the content will be provided in great detail, certainly in personal lines and often even in commercial lines.¹⁰ The policyholder engages at most in what Karl Llewellyn called “blanket assent”:

What has in fact been assented to, specifically, are the few dickered terms, and the broad type of the transaction, and but one thing more. That one thing more is a blanket assent (not a specific assent) to any not unreasonable or indecent terms the seller may have on his form, which do not alter or eviscerate the reasonable meaning of the dickered terms.”¹¹

The policyholder, rather than agreeing to the detailed terms, invests in a relationship of security,¹² a relationship that is formally created by the policy but that is socially constructed and promoted by insurers as a group.¹³ The reasonable policyholder understands that relationship does not guarantee coverage for every conceivable loss. For example, certain risks that are highly correlated to many policyholders or those that pose excessive problems of moral hazard, may be excluded, for example. With those exceptions, however, the policyholder has a legitimate expectation of broad

⁹ See Jay M. Feinman, *The Regulation of Insurance Claim Practices*, 5 U.C. IRVINE. L. REV. 1319, 1321-23 (2015).

¹⁰ Daniel Schwarcz & Peter Siegelman, *Insurance Agents in the Twenty-First Century: The Problem of Biased Advice*, Daniel Schwarcz & Peter Siegelman EDS, RESEARCH HANDBOOK ON THE ECONOMICS OF INSURANCE LAW 36 (2015) (arguing that insurance agents can and often do fail to effectively serve consumers’ interests).

¹¹ KARL N. LLEWELLYN, THE COMMON LAW TRADITION: DECIDING APPEALS 370 (1960). See Rakoff, *supra*, at 1206.

¹² “The final and perhaps most significant characteristic of insurance contracts, differentiating them from ordinary, negotiated commercial contracts, is the increasing tendency of the public to look upon the insurance policy not as a contract but as a special form of chattel. The typical applicant buys ‘protection’ much as he buys groceries.” 7 WILLISTON ON CONTRACTS 34 (Walter H.E. Jaeger eds., 1957).

¹³ The ubiquity of insurance company advertising and the familiarity of insurance company slogans — “Nationwide is on your side,” sung to its well-known jingle — illustrate.

coverage.¹⁴

For the policyholder the insurance policy has value prior to loss because it provides this expectation of security. If a loss occurs, it is likely to be unique and potentially catastrophic; the policyholder, unlike the insurer, does not maintain a portfolio of risk for substantial losses in any meaningful sense. The policyholder's expectation is that if there is a loss the relationship of reasonable security will be realized. That expectation involves both vague ideas about the extent of coverage and perhaps a few specific terms and a general belief that there will be a reasonable process of adjusting the loss.

At the moment of formation, therefore, the insurer and the policyholder have different understandings of the policy and the insurance relation, so the policy serves different functions for each of them. That suggests a starting point for further analysis: it is an error to assume that the policy presentiates the terms of the parties' agreement, so it is an error to invest total weight or even too much weight on the express terms as precisely defining their rights and duties. Terms are a viable starting point but problematic as an ending point.

2. Performance

Now consider the essential moment of performance in an insurance contract—when a loss potentially within coverage occurs and the policyholder files a claim. As in any contract, there are risks of dispute over the performance due and of eventual nonperformance.

Two potential sources of failure to perform in other contracts are absent in insurance contracts: unavoidable breach, where a party is unable to perform, and efficient breach, where a party chooses to breach and compensate its contracting partner to take advantage of a better opportunity. Instead, a failure to perform may arise from a coverage dispute that arises because of disagreement about some mix of the interpretation of policy language, the facts of the claim, and controlling law. Or a dispute may be about one of the parties' performance obligations at the point of claim, such as an insurer's obligations in processing a claim or a policyholder's duty of cooperation. These disputes reflect features of the formation process such as the policy's incompleteness, leading to disputes over the performance owed, and the asymmetries of agreement due to the policy's status as a form contract, reflected in the parties' different expectations about the policy at

¹⁴ Mark Geistfeld, *Interpreting the Rules of Insurance Contract Interpretation*, 68 RUTGERS U. L. REV. 371, 386-91 (2015).

the time of formation. Often this will be caused by a relational expectation of coverage by the policyholder that the insurer believes is inconsistent with the express terms of the written policy.

The sources of these disputes vary. Some reflect good faith disputes about the interpretation of policy terms, the facts giving rise to the claim, or uncertain or undecided issues of applicable law. Others may arise from a careless failure to adhere to policy requirements or even deliberate advantage-seeking behavior. At least the last two sources can be seen as agency problems; each party has a degree of discretion in its performance which raises the risk that it will not respect its contractual commitment and instead will act in its own interest.¹⁵ Agency problems create the potential for opportunistic behavior. Opportunism can be defined narrowly—Williamson’s famous “self-interest seeking with guile”¹⁶—or broadly, to include “any contractual conduct by one party contrary to the other party’s reasonable expectations.”¹⁷

As with formation, consider separately the position of the insurer and the policyholder as to their risks and their means of controlling those risks.

For the insurer, the insurance policy represents one element of a portfolio of potential losses that are the basis of its business. The risk for the insurer at the point of claim is that its planning will be upset either by an unanticipated gap in the policy as applied to a claim or by an action of the policyholder. A gap arises because of the incompleteness of the policy in addressing all possible states of affairs, a discrepancy between the policyholder’s understanding of the coverage and the terms of the policy as interpreted by the insurer, or action of the policyholder that impacts the insurer’s risk allocation. The policyholder’s action may occur at the time of formation, by misrepresenting a material fact upon which the insurer underwrites the policy. The action may occur subsequent to formation but before the loss, by engaging in risky behavior inconsistent with its obligations under the policy that causes or contributes to the loss. Or the

¹⁵ See *The Regulation of Insurance Claim Practices*, *supra* note 9, at 1323-25.

¹⁶ Oliver E. Williamson, *Opportunism and Its Critics*, 14 *MANAGERIAL & DECISION ECON.* 97, 97 (1993).

¹⁷ George M. Cohen, *The Negligence-Opportunism Tradeoff in Contract Law*, 20 *HOFSTRA L. REV.* 941, 957 (1992). See also, *The Regulation of Insurance Claim Practices*, *supra* note 9, at 1325-26. For a survey of “the opportunism tradition,” see Cohen, *supra*, at 953- 61.

action may occur after the loss, such as negligently or intentionally misrepresenting information about the cause or severity of loss.

The insurer can attempt to control these risks at the time of formation, prior to the loss, or after the loss. It can address the gap by clarifying and extending the language of the policy and prospectively considering the interpretation and gap-filling functions of the law as supplements to the written policy.¹⁸ To avoid discrepancies between the policyholder's and the insurer's understanding, the insurer can be clearer and more forthcoming in the marketing of the policy. To control the policyholder's behavior and therefore to reduce the problem of policyholder agency, the insurer can engage in extensive information-gathering and underwriting practices. Policy terms, limits, and deductibles aim to reduce the insured's moral hazard and provide the basis for defenses to coverage. After a loss, it can engage in extensive investigation, information gathering, and information sharing to ascertain facts. Most importantly, it can deny a claim in whole or part; doing so, or even expressly or implicitly threatening to do so, increases a policyholder's cost of pursuing the claim and therefore increases the cost of nonperformance and diminishes the value of the claim.

For the policyholder, one risk is that its inchoate expectation of coverage and security will be disappointed by the insurer's assertion of contrary policy terms at the point of claim. Another risk occurs because the insurer's duties with respect to processing the claim are poorly defined in the policy; the policyholder therefore is at risk that the insurer will fail to conform to the policyholder's expectations.

The policyholder has very limited means to control those risks. It can attempt to become better informed about the terms of the policy at the time of formation, but that usually does not happen in part because the burden of doing so is disproportionate to the anticipated return. Because the policy is an adhesion contract, the policyholder cannot include terms that reduce the ambiguity or the insurer's agency. If a loss is significant, the policyholder is dependent on the success of the claim. Unlike other contracts, it cannot procure a substitute and sue for the added expense because insurance is unavailable for a loss that already has occurred. The last resort is litigation, which is expensive, protracted, and often not fully compensatory.

In short, both parties are subject to agency problems that extend to opportunism. The problems cannot be eliminated, but the consequences of them for the policyholder are much more severe and the insurer has a much

¹⁸ Macneil, *supra* note 7, at 606.

greater opportunity to control the risk posed by the policyholder than vice versa.

B. CLAIM

The discussion so far has focused on the insurance policy as contract. It described the policy as a form contract and considered the parties' situation in regard to the contract at the point of formation and the point of performance. Now consider the second point from a different perspective: the dynamics of the claim process. The insurance claim process exhibits common features that distinguish insurance contracts as a group from other types of contract. These features concern the advantages each party possesses in the claim process and the means the other party has in responding to those advantages.

The insurer initially is at a disadvantage relative to the policyholder in the claim process because the policyholder controls most of the information relevant to the claim. The insurer depends on the policyholder to provide the information completely and accurately in order for it to evaluate coverage and the extent of the loss. Typically, the insurer responds to this disadvantage by not relying exclusively on information provided by the policyholder. It may send an adjuster to assess the loss, and it has formal mechanisms to obtain information, such as requiring a Proof of Loss or Examination Under Oath, and informal mechanisms to enforce the policyholder's duty of cooperation, such as the leverage created by sequential performance.

In a number of other respects, the dynamics of the claim process put the policyholder at a disadvantage relative to the insurer.

First, the gap in knowledge about the terms of the policy between the insurer and the policyholder at the time of formation is mirrored at the time of claim. The policy description of the terms of coverage and the insurer's obligations are both technical and incomplete, so the policyholder is unable to fully understand what it is owed. In many cases, the policyholder's expectations about the relation vest the insurer with expertise, so the insurer's determination is effectively final even if it is objectively questionable. Therefore, even if a claim is incorrectly denied or the insurer otherwise fails to meet its obligations, the policyholder is either unlikely to perceive the failure or unable to do anything about it.¹⁹

¹⁹ This is an example of the flatness of the grievance pyramid. See William L.F. Felstiner, Richard L. Abel & Austin Sarat, *The Emergence and*

Second, the insurance relation combines sequential performance with the lack of substitute performances.²⁰ The insured renders its principal performance first—paying the premium. In the event of a loss, the insured cannot withhold its performance to provide an incentive for the company to fully perform its own obligation in the claim process. Moreover, unlike in many contracts, the policyholder cannot procure an adequate substitute performance, sue for any added cost, and, at least in concept, be made whole by the provision of damages; no insurer will sell insurance to compensate for a loss that has already occurred.²¹

Third, the insurer's duties in the claim process are not fully specified in the policy or elsewhere even in cases in which the policy terms clearly provide coverage. A typical HO-3 homeowners policy, for example, only requires the company to pay claims within sixty days of agreement or adjudication and to participate in appraisal; otherwise, it delineates no duties concerning processing of a claim.²² Even when a statute appears to narrowly specify a duty, the specification is usually qualified by a vague term such as "good faith."²³ Indeed, it would be hard to specify the insurer's duties because they necessarily rest on vague concepts such as promptness and

Transformation of Disputes: Naming, Blaming, Claiming, 15 L. & SOC. REV. 631 (1980).

²⁰ Jay M. Feinman, *The Insurance Relationship as Relational Contract and the "Fairly Debatable" Rule for First-Party Bad Faith*, 46 SAN DIEGO L. REV. 553, 558-59 (2009).

²¹ "[A] breach in the employment context does not place the employee in the same economic dilemma that an insured faces when an insurer in bad faith refuses to pay a claim or to accept a settlement offer within policy limits. When an insurer takes such actions, the insured cannot turn to the marketplace to find another insurance company willing to pay for the loss already incurred." *Foley v. Interactive Data Corp.*, 765 P.2d 373, 396 (Cal. 1988).

²² INS. SERVS. OFFICE, INC., HOMEOWNERS 3—SPECIAL FORM, 1, 15 (1999), http://www.iii.org/sites/default/files/docs/pdf/HO3_sample.pdf. The homeowner, by contrast, is subject to eight specified duties, including prompt notice, cooperation in investigation, and submission of proof of loss. *Id.* at 13.

²³ In Tennessee, for example, an insurer is subject to a statutory penalty if it fails to pay a claim within sixty days of a demand by the policyholder, but only if "the refusal to pay the loss was not in good faith." TENN. CODE ANN. §56-7-105.

reasonableness.²⁴

Fourth, even if the insurer's obligations are relatively clear, legal enforcement of the insurer's duties is difficult and often impossible to obtain. For small claims, hiring a lawyer or a public adjuster likely is not worth the expense or within the policyholder's means. For all claims, the insured's remedy is limited to the recovery of the benefits due under the policy and perhaps interest at the statutory rate. That remedy does not give the insured the promised benefits until the litigation is concluded, perhaps years later, during which time the insured is likely to have suffered financial and emotional hardship and therefore to have lost the security for which it contracted.²⁵

Fifth, all of the problems described above are exacerbated by the likelihood of the policyholder's emotional and financial vulnerability following the loss. The purpose of the insurance is to provide funds to repair, rebuild, or otherwise compensate, which would otherwise be unavailable at the time of loss. In a large number of cases, the policyholder's need for settlement of the claim provides its own incentive.

The dynamics of the claim process presents agency problems; each party has a degree of discretion in its performance which raises the risk that it will not respect its contractual commitment and instead will act in its own interest. Agency problems create the potential for opportunistic behavior. Policyholder opportunism includes misrepresentation at the time of application or the time of loss, the most egregious version of which is fraud. Insurer opportunism may take the form of profiting from pre-loss behavior; examples would include establishing the basis for a misrepresentation defense or drafting unexpectedly limiting policy language. Or it may occur after the loss, by delaying or denying payment of a valid claim in whole or part. The opportunism may be intentional and systematic, or it may be merely negligent.

For the policyholder, insurance presents a classic case of potential opportunism. One party has fully performed and has substantial sunk costs,

²⁴ As expressed in the Model Unfair Claims Settlement Practices Act, for example, a company must "adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies." MODEL UNFAIR CLAIMS SETTLEMENT PRACTICES ACT §4.C (NAT'L ASS'N OF INS. COMM'RS 1997).

²⁵ "Although the insured is not without remedies if he disagrees with the insurer, the very invocation of those remedies detracts significantly from the protection or security which was the object of the transaction." *Rawlings v. Apodaca v. Apodaca*, 726 P.2d 565, 570 (Ariz. 1986).

the policyholder has paid its premium and invested in a relation of security, and the other party's performance comes later and is not well-defined. The insurer has to pay if there is a loss covered by the policy and has to observe "reasonable" claim practices in doing so. The benefit to the insurer from opportunistic behavior, of course is that it increases its profits by reducing its claim costs and increasing the assets available to it to invest.

Because of the dynamics of the claim process described above, there are fewer effective checks on insurer opportunism than on policyholder opportunism. Litigation by the policyholder is unlikely in many cases and impossible in others. Because the insurer is managing a portfolio of such cases, paying damages, even extracontractual damages, in a portion of the cases does not outweigh the benefits of opportunism in a larger number of other cases. Because empirical data on claim practices is not publicly available,²⁶ an individual insurer's reputation is established by advertising and other intangible means, and consumer choice is more focused on price than quality, the market does not effectively deter opportunistic behavior. Nor do regulators effectively monitor market conduct.²⁷

Today the extent to which insurers act opportunistically is controversial. Insurers and industry representatives acknowledge that occasional mistakes are made but deny that there is systematic abuse. Industry critics argue that companies have increasingly viewed the claims process as a profit center.²⁸ For present purposes, it is only necessary to observe that opportunism can be broadly defined²⁹ and the potential for opportunism is inherent.

²⁶ The NAIC Market Conduct Surveillance Model Law § 7 and the National Conference of Insurance Legislators' Market Conduct Annual Statement Model Act § 8 provide that claims data reported to or collected by insurance commissioners are privileged and confidential. For adoptions, *see e.g.*, Ariz. Ann. Rev. Stat. § 20-158; Haw. Rev. Stat. Ann. § 431:2D-107; Ohio Rev. Code Ann. § 3916; R.I. Gen. Laws Ann. § 27-71-8; Ann. Rev. Code of Wash. § 48.37.080.

²⁷ *See* Feinman, *supra* note 9, at 1326-40.

²⁸ *See generally* JAY M. FEINMAN, DELAY, DENY, DEFEND: WHY INSURANCE COMPANIES DON'T PAY CLAIMS AND WHAT YOU CAN DO ABOUT IT (2010).

²⁹ *See* Cohen, *supra* note 17, at 957.

C. CONTRACT AND CLAIM COMBINED

Now consider together the insurance policy as a form contract and the dynamics of the claim process. The insurance policy is a standard form contract, or an adhesion contract. The policy takes on different functions at the point of formation for the policyholder and the insurer. At the point of performance, each is subject to different risks and possesses different means of controlling those risks. Seen differently, the point of performance involves claim dynamics that both increase the risks, which may be seen as agency bleeding into opportunism, and provide means of responding to the risks. In the claim process, the risks and responses put the policyholder at a systematic disadvantage relative to the insurer.

This analysis suggests that courts should further the regulatory role of law in improving the contracting process, not in the sense of improving formation *ex ante* but in the sense of realizing the parties' legitimate expectations.³⁰ The analysis contributes to that goal in several ways.

The contract and claim analysis clarifies the nature of the insurance policy as a contract. There is a tendency to regard the policy as the core of the relationship and everything else as peripheral to its construction. Therefore, the terms are the starting point and given great weight. Everything else—expectations created outside the written policy, public policies, measures against opportunism—necessarily carry less weight and have to struggle against the written terms. The two parts of the contract and claim analysis work against that construction. The contract is not constituted only by the written policy, and the differing conceptions of the contract by the policyholder and the insurer at the point of formation also needs to be considered.

Moreover, the problems of claim dynamics are also relevant to the resolution of disputes, even disputes about what are traditionally seen as formation or interpretation issues. The risks of agency and opportunism are broadly relevant, as is the relative advantage of the insurer in the claim process. This provides a perspective through which insurance law issues should be seen. In considering insurance law issues across a range of doctrines, courts should be sensitive to the nature of the contract relation as described here and the importance of claim process dynamics. This is

³⁰ “Legitimate” expectations, of course, are not just those of individual parties but reflect conceptions of reasonableness for policyholders and insurers as a whole. As Corbin proclaimed, “The Main Purpose of Contract Law Is the Realization of Reasonable Expectations Induced by Promises.” ARTHUR LINTON CORBIN, CORBIN ON CONTRACTS §1 (1952).

something like the use of general principles or policy arguments to shape doctrine. Particular issues are approached through an established doctrinal framework—categories, rules, sub-rules, and exceptions, for example—but the application of the elements of the framework is shaped by purposes and policies. The contract and claim analysis serves as a lens through which the problems would be seen or a weighty element in the balancing process in which courts engage to shape and apply doctrine.

This does not suggest that insurers should lose every case. Surely there are cases in which policy language should be interpreted to deny coverage,³¹ cases in which the insurer has observed fair claim practices, cases in which the policyholder has acted opportunistically, and more. This is obvious but it is worth stating to suggest the complexity of the analysis.

Nor should the contract and claim analysis be used on a case-by-case basis. Courts are ill equipped to consider in a particular case what the full context and expectations of the parties' contract were and whether an insurer has engaged in opportunistic behavior. Nor would it be worth the judicial resources to do so, because the more individualized the inquiry, the less impact it has on the pool of potential cases. And a case-by-case approach would undermine the general relevance of the resolution of particular disputes; certainty and predictability are important.

Finally, it could be possible to use the analysis to shape some insurance law doctrines but not others. For example, the next Part argues that the analysis supports the reasonableness standard for violation of claim practices ("bad faith") that is used by a minority of jurisdictions rather than the majority rule of "fairly debatable." It might be the case that the article's analysis is strongest on that issue but less persuasive on some other issue—for example, the rules about policyholder misrepresentation at the time of application that also are discussed later. In fact, the analysis in the article has sway across the entire field of insurance law.

II. APPLICATIONS OF THE CONTRACT AND CLAIM ANALYSIS

To illustrate and amplify the contract and claim analysis, this Part discusses several common issues in insurance law. The discussion demonstrates that courts sometimes use similar analysis, describes those tendencies, suggests why they are incomplete, and uses the contract and claim analysis to make them explicit and more comprehensive. Other courts take quite different approaches; contrasting those approaches with the

³¹ See *infra* text accompanying notes 62–66.

contract and claim analysis demonstrates what they get wrong. The result is both a demonstration of the usefulness of this Article's analysis and a beginning catalog of how it can reshape insurance law doctrine.

The illustrations come from three different points in the life of an insurance policy. The first concerns a formation issue: when an insurer may use misstatements by a policyholder in the application process to avoid coverage. The second, and most general, addresses interpretation issues that concern the insurer's performance of the insurance contract. The third concerns issues of policyholder and insurer performance at the end-point of the relation, after a claim is filed—the false swearing rule and the regulation of the insurer's claim practices. All three reinforce the notion that every doctrinal issue involves a conception of the insurance contract and arises because of a disputed claim.

A. AT FORMATION: REPRESENTATIONS AND WARRANTIES

One area in which there is a developed body of law that illustrates the conflict between traditional concepts and the contract and claim approach is what Jerry and Richmond define as a “fundamental question: the extent to which courts [and legislatures] will allow insurers to utilize inaccuracies in information provided by the insured to deny coverage.”³²

Lord Mansfield established the early contours of this area by distinguishing between a representation and a warranty:

There is a material distinction between a warranty and a representation. A representation may be equitably and substantially answered but a warranty must be strictly complied with.... A warranty in a policy of insurance is a condition or a contingency, and unless that be performed, there is no contract.³³

This formulation and its subsequent elaboration set a framework for problems about inadequate or incorrect information provided by a policyholder. A warranty is “a statement or promise by the insured, set forth or incorporated in the policy, which if untrue or unfulfilled provides the insured with a defense to coverage.”³⁴ A representation, in turn, is a statement that only provides a defense to coverage if it is false, material to

³² ROBERT H. JERRY & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW 717 (5th ed. 2012).

³³ De Hahn v. Hartley (1786) 99 Eng. Rep. 1130, 1131; 1 T.R. 343, 345-346.

³⁴ JERRY & RICHMOND, *supra* note 32, at 718.

the risk, relied on by the insurer, and in some jurisdictions made with intent to deceive.³⁵

The logic of this framework is traditionally contractual and reflects the insurer's conception of policy formation. The insurance policy is a contract, and the law's primary purpose is to enforce the legitimate expectations of the parties created by the contract. Where the parties have chosen to establish a statement or promise as a warranty, the disappointment of their planning by a breach provides a legitimate basis for nonperformance by the insurer. In the ordinary case, however, legitimate expectations distinguish between the essential and the peripheral. Therefore, the law does not convey the power to avoid a contract for every failure to conform to the information but only for the essential; that is the basis for the general contract doctrine that a contract can be avoided only for a misrepresentation that is false, material, relied upon, and intentionally made. But where the parties choose to do so, they can import a higher standard by making a statement a warranty, essentially designating it as material per se and removing the requirements of reliance and intent.

In addition to reflecting the insurer's approach to formation, the representations and warranties rules address the insurer's concern with policyholder agency at the point of formation. A potential policyholder has better information about its risk profile than the insurer. Where the information would demonstrate an increased risk, it is in the policyholder's interest to conceal or misrepresent the information in order to obtain coverage that might not otherwise be available or to obtain coverage at a lower premium. This is, of course, the problem of adverse selection. The insurer has some mechanisms to obtain or verify this information, but the mechanisms are limited, and the insurer must rely to a large extent on the policyholder's statement. Assuming that most potential policyholders give accurate information, it is not economical to invest the resources necessary to check on the policyholder at the point of formation; indeed, in some cases it will not be possible at all. At the point of claim, however, it often becomes economically justifiable and there may or may not be indicators of misrepresentation. In case of a loss and a subsequent claim, the insurer may assert that the policyholder failed to provide accurate information from which the insurer could perform appropriate underwriting as a basis for denying the claim. This cures the information asymmetry and allows the

³⁵ *Id.* at 721-22.

insurer to refuse the risk.³⁶

But the warranty-representation distinction and its functions have turned out neither to be a strict rule nor easy to enforce. Instead, the rule is rife with exceptions which the Jerry and Richmond treatise helpfully categorizes.

First, to constitute a warranty the promise or statement must be included in the policy either expressly or by express incorporation by reference, and the inclusion must show that the parties intended the inclusion to operate as a true warranty. Courts strictly apply the requirements, so any ambiguity or technical failure will lead to the creation of a representation, with its less severe consequences,³⁷ or as a means of identifying insured property but neither warranty nor representation.³⁸

Second, statements by the policyholder can be either affirmative, referring to a fact at the time the statement is made, or promissory, constituting a promise that state of facts will continue into the future. Courts will interpret statements as promissory to avoid the effect of a warranty.³⁹

Third, even when finding a warranty, courts often will interpret it narrowly. A well-known example is *Vlastos v. Sumitomo Marine & Fire Ins. Co. (Europe) Ltd.*⁴⁰ An endorsement expressly incorporated into the policy stated, “[w]arranted that the 3rd floor is occupied as a Janitor’s residence.” The court held that this provision was indeed a warranty but because it did not unambiguously state that the janitor’s occupancy was the exclusive use of the 3rd floor, the warranty was not breached by the partial occupancy of a massage parlor. In reaching its conclusion, the court relied on *contra proferentem*, extrinsic evidence to establish an ambiguity, “the context of the remainder of the policy, and of the alleged purposes of the warranty,” all factors removed from the strict warranty-representation distinction.

Fourth, “a court might interpret the warranty as only extending to a particular risk or a severable part of the policy [so that] the breach of

³⁶ “Strict enforcement protects insurers by limiting indemnity to cases where the insured has answered all application questions honestly; strict enforcement deters applicants from making false representations; integrity in insurance contracts is promoted, and fraud and perjury are deterred; and a strict rule is simple to enforce.” *Id.* at 720.

³⁷ *Id.* at 718-19, 725.

³⁸ *Id.* at 725.

³⁹ *Id.* at 724.

⁴⁰ *Vlastos v. Sumitomo Marine and Fire Ins. (Eur.) Co.*, 707 F.2d 775 (3d Cir. 1983).

warranty under one kind of risk will not avoid the policy with respect to other parts of the coverage.”⁴¹

Fifth, even if there is a breach of warranty, it may be construed as a “temporary breach” the cure of which before a loss revives coverage.⁴²

Sixth, the traditional doctrine has been undercut by statutes in most states; these statutes vary. One common limitation allows a warranty to operate to avoid coverage only where the breach of warranty is material.⁴³ Others require that the misrepresentation was made with actual intent to deceive,⁴⁴ or that the failure to conform to the warranty contributed to the loss,⁴⁵ or some combination of these.⁴⁶

Seventh, and perhaps most dramatically, are incontestability provisions.⁴⁷ Life insurance policies and many disability policies, usually under statutory mandate, are incontestable after two years, so that an insurer may not assert defenses such as breach of warranty to defeat payment of the policy proceeds.⁴⁸

Some of the exceptions can fit within the conception of the insurance policy as a contract, particularly a contract that is not presentiated in the policy but instead constructed by broader relations. For example, requiring that the warranty be included in the policy expressly or by express incorporation by reference represents a traditional view of contract. But narrowing interpretations such as in *Vlastos* rest on a broader conception of contract. Many courts today may be less prone to apply formal distinctions

⁴¹ JERRY & RICHMOND, *supra* note 32, at 726.

⁴² *Id.* at 726-27.

⁴³ *E.g.*, N.Y. INS. LAW § 3105 (McKinney 2001).

⁴⁴ MASS. GEN. LAWS ch. 175, § 186 (2008).

⁴⁵ IOWA CODE § 515.101 (2009).

⁴⁶ *E.g.*, FLA. STAT. § 627.409 (2014); UTAH CODE § 31A-21-105(2) (2003).

⁴⁷ *See* Eric K. Fosaaen, Note, *AIDS and the Incontestability Clause*, 66 N.D. L. REV. 267, 267-77 (1990).

⁴⁸ Incontestability clauses were originally included in policies to combat public mistrust of the insurance industry, a mistrust that often was justified. *See, E.g.*, Baumgart v. Modern Woodmen of Am., 55 N.W. 713, 714 (Wis. 1893). But insurers faced a collective action problem; an insurer that included a clause incurred higher costs but did not reap all the benefits of improved reputation of the industry as a whole. That phenomenon, along with exposés of industry abuses, led to the widespread adoption of statutes requiring incontestability clauses. *See* Fosaaen, *supra* note 47, at 269-270.

and doctrines to defeat the policyholder's expectations altogether.⁴⁹

The development of so many exceptions to and restrictions of the doctrine demonstrate unease with its application by courts and legislatures. That unease is best captured in the contract and claim analysis.

In part, the exceptions reflect unease with the exclusive focus on the insurer's conception of the policy at formation. The policyholder's conception focuses not on the policy as representing the agreement but on the written policy and the application process that gives rise to it as the formal elements of a broader, less formal relation. In that relation, loss of coverage for a statement that is ambiguous, for example, is inconsistent with the perception of security.

More importantly, the exceptions demonstrate a concern with insurer agency at the point of performance and the claim dynamics that limit the policyholder's ability to control that agency. This concern focuses on the claim process and the possibility of an insurer using the doctrine opportunistically. An insurer may assert breach of warranty to avoid coverage even if the information misrepresented had no effect on its underwriting. More generally, an insurer may under-invest in underwriting at the point of formation, await high-value claims or claims that are in any way suspect, and then perform an investigation that reveals a policyholder misrepresentation. At its extreme, this is the particularly egregious form of opportunism known as "post-claim underwriting."⁵⁰ When a claim is presented, a company can seize on errors by the insured in the application to deny coverage. And some insurers have systematically exploited the doctrines by designing an application process that would make misrepresentations a virtual certainty.⁵¹ The exceptions to the warranty-representation rule respond to the range of these types of behavior.

Jerry and Richmond are themselves skeptical of many of the mitigating doctrines, favoring bright-line rules to control adverse selection and moral hazard. But their analysis demonstrates that the prevailing view favors a focus on claims, with the presence of agency and the potential for opportunism:

[I]t must be assumed that those who make public policy believe that

⁴⁹ JERRY & RICHMOND, *supra* note 32, at 720.

⁵⁰ See Thomas C. Cady & Georgia Lee Gates, *Post Claim Underwriting*, 102 W. VA. L. REV. 809 (2000).

⁵¹ See *Conn. Mut. Life Ins. Co. V. Union Trust Co.*, 112 U.S. 250 (1884); *Baumgart*, 55 N.W. 713; Cady & Gates, *supra* note 50.

the instances of insurer use of warranties to gain advantage over unsophisticated insureds greatly outweigh the circumstances in which insurers use warranties to reduce costs for the benefit of all policyholders.⁵²

B. DURING PERFORMANCE: INTERPRETATION AND REASONABLE EXPECTATIONS

More challenging is the application of the contract and claim analysis to perhaps the largest set of issues in insurance law, the interpretation of the terms of an insurance policy and the associated doctrine of reasonable expectations. This is not the place for a comprehensive theory of interpretation and reasonable expectations.⁵³ The issues are complex, the case law is voluminous, and the commentary is rich. The contract and claim analysis does provide insight into both particular interpretation doctrines and general approaches to interpretation and the role of reasonable expectations.

A series of related controversies pervades the law of insurance contract interpretation. Those controversies include:

- A preference for a plain meaning approach to interpretation versus a preference for a contextual or functional approach.
- Determining whether a policy is ambiguous solely by using the terms of the policy and a general dictionary versus resorting to extrinsic evidence.
- The choice between a narrow version of the reasonable expectations doctrine in which reasonable expectations function at most as an interpretive tool versus a broad version in which reasonable expectation can trump unambiguous policy language.

The controversies reflect two contrasting visions of interpretation and of contract law more generally. At the level of interpretation, the textualist vision presumes that the parties have embodied their agreement in the express words of the policy, so courts should, to the extent possible, only resort to those words as generally understood to determine the scope of their obligation. The opposed vision suggests that parties express their agreements through words and conduct in commercial and social contexts, so words,

⁵² JERRY & RICHMOND, *supra* note 32, at 733.

⁵³ “The rules that courts apply to interpret insurance policies are surprisingly difficult to define.” Geistfeld, *supra* note 14, at 371.

conduct, and context are all potentially relevant to supplement the express words of the policy. This dispute reflects more fundamental oppositions in constructing the role of contract law, described at various levels and in various ways, such as between a formalist and a functionalist approach, or between an individualist and collectivist approach.⁵⁴

The insurer and policyholder approaches to formation in the contract and claim analysis resonate with these more fundamental conflicts. The insurer places great emphasis on the express terms of the policy as embodying the substantial terms of its obligation to the policyholder. The insurer generally has a preference for formality—the plain meaning rule—in interpreting the policy. Plain meaning presumes that insurers will draft terms clearly as the basis of their underwriting and by and large those terms will conform to the reasonable expectations of policyholders. The terms of the policy define the risk it has assumed across many such policies and help to stabilize its internal and external relations.⁵⁵ If the express terms are uncertain as applied, often they can be made more certain by prior regulatory or judicial interpretations and industry understandings, all of which are within the insurer’s knowledge and expertise. Formality, supplemented if necessary, provides more certainty and reduces litigation costs. Both of those elements support the risk allocation system embodied in the policy as one among many. Therefore, the insurer’s model favors plain meaning and a focus on express terms rather than extrinsic evidence and fears a broad resort to reasonable expectations as upsetting planning and increasing costs.

For the policyholder, by contrast, the policy provision involves little explicit planning and agreement and instead reflects agreement on a few key terms and blanket assent to not-unreasonable other terms and, more generally, to a relationship of security. Therefore, interpreting the policy terms strictly—terms that the policyholder has neither bargained for, explicitly agreed to, or even read—may disappoint the policyholder’s expectations. Instead, the process of interpretation should depart from the express terms in favor of extrinsic evidence⁵⁶ and reasonable expectations to

⁵⁴ See JEFFREY W. STEMPEL & ERIK S. KNUTSEN, STEMPEL AND KNUTSEN ON INSURANCE COVERAGE at 4-7 to 4-11; JERRY & RICHMOND, *supra* note 32, at 129-31; E. ALLAN FARNSWORTH, CONTRACTS 419-23 (4th ed. 2004); Jay M. Feinman, *Critical Approaches to Contract Law*, 30 UCLA L. REV. 829, 838-47 (1983).

⁵⁵ See *supra* text accompanying note 8.

⁵⁶ Extrinsic evidence may include:

more closely honor the true agreement; doing so benefits the individual policyholder, other policyholders who actually suffer a loss, and, in an indirect way, all policyholders whose expectation of security is strengthened.

The contract and claim analysis does more than define the contrasting positions of insurer and policyholder at the point of formation. It also requires a focus on the moment of performance and the dynamics of the claim process at that moment, and therefore demonstrates that interpretation cannot properly be accomplished solely by focusing on the policy as a product of contract formation. The analysis suggests that at the point of performance, both insurer and policyholder are subject to the risk of agency by the other, the claim dynamics affect the risks and the means of controlling them, and the policyholder is at a systematic disadvantage in the process.⁵⁷ This is relevant to interpretation questions in three ways.

First, at the point of claim, the insurer is subject to agency by the policyholder, who controls much of the information relevant to the claim. Some terms of the policy may exacerbate or reduce this risk, and interpretation of such terms should be sensitive to the need to promote the flow of information from the policyholder that is contractually required and consistent with the underwriting purposes of the term.

Second, when an insurer drafts a policy term, it looks forward to the point of claim. The insurer can use its power to draft and its knowledge of the tools courts will use in interpreting policies and the way particular provisions have been interpreted to define terms in a way that may be inconsistent with the policyholder's expectations of a relation of security and coverage. Where the insurer adopts a standard form such as an ISO policy,

pre-contractual negotiations, the parties' course of performance under the policy at issue, the course of dealing between the parties with regard to other policies, the drafting history of insurance policies, documents filed with state administrative agencies regarding an insurance policy or term, other versions of the relevant term available on the market, other forms of insurance available on the market, and expert testimony regarding topics such as the custom and practice in the insurance industry and the history, purpose, and function of policy terms and forms of insurance coverage.

RESTATEMENT OF THE LAW LIAB. INS. § 3, cmt. f (AM. LAW INST., Tentative Draft No. 1, 2016).

⁵⁷ See *supra* text accompanying notes 19-29.

its knowledge of the tools courts use and their past interpretations of the policy is more important. The agency problem is even more extreme where the insurer drafts and employs unique terms that are narrower than the standard terms and therefore even more to the disadvantage of the policyholder and even more inconsistent with its reasonable expectations.⁵⁸ This is true in individual cases and is part of the broader phenomenon of hollowing out coverage and fragmenting risk.

Third, at the point of claim it can exploit the results of its drafting and its advantages in the claim process to take advantage of either clarity or ambiguity in policy terms. Insurers do have an incentive to draft clearly so they can underwrite on that basis. Because of the different positions of insurer and policyholder at the time of formation, some portion of that clarity will be clear drafting that reduces coverage in a way that is inconsistent with widely held expectations of policyholders. In many cases, that drafting will constitute the single plain meaning which courts will enforce.

This is hardly new. In a well-known article, Clarence Morris describes the phenomenon:

American draftsmen-lawyers, sometimes in the hire of fly-by-night companies, proliferated fine print in the nineteenth century fire and life insurance policies. Companies, spurred by competition, debased their product (as the Germans did their linen). Restrictions on coverage, not noticed or not understood by policyholders at the time of issue, became painfully clear after uncovered losses which policyholders would have paid to cover.⁵⁹

Although an insurer has an incentive to draft clearly, it either cannot do so or chooses not to do so in every case. Nevertheless, an insurer may not suffer much or any cost from drafting an ambiguous term. Because of the dynamics of the claim process, a policyholder might defer to its perception of an insurer's expertise and accept the insurer's interpretation of an

⁵⁸ Compare ISO, HO 53 – Homeowners 3 – Special Form, Section I – Conditions, C. Loss Settlement (HO 00 03 05 01, 2000), with Farmers Insurance Group, Farmers Smart Plan Home Policy, NEV. DIV. OF INS., 1, 29-30 (last visited Oct. 8, 2018), http://doi.nv.gov/uploadedFiles/doinvgov/_publicdocuments/Consumers/Home/Farmers/56-5640_6-15.pdf (regarding payment for matching of damaged property).

⁵⁹ Clarence Morris, *Waiver and Estoppel in Insurance Policy Litigation*, 105 U. PA. L. REV. 925, 926 (1957) (footnote omitted) (Morris also sums up a solution: “The insurance market might have soured had not the law stepped in and afforded consumer protection greater than companies intend to sell.”).

ambiguous term as correct, a policyholder might disagree with the interpretation but not have the means to dispute it, or, particularly in a low-stakes case, a policyholder might conclude that it is not worthwhile to do so. If the policyholder pursues a dispute, the insurer's interpretation will prevail in some cases. Where it does not, and the term is interpreted against the insurer, in most cases the result will be a small effect on its underwriting which can be accounted for going forward.⁶⁰

The contract and claim analysis accordingly suggests some insights about the process of interpretation. As a starting point, in interpreting policy language, both of the conflicting models of contract in general and interpretation in particular, and their doctrinal implications, have contributions to make, neither is entirely correct, and each taken to an extreme or considered in isolation produces undesirable results. A pure view of plain meaning is wrong because it ignores the policyholder's conception of formation and the dynamics of the claim process; a too-expansive concept of reasonable expectations similarly ignores legitimate concerns of the insurer at the point of formation.

That suggests that any approach to interpretation needs to be attentive to multiple factors:

- The insurer's conception of the contract embodied in the policy at the point of formation, which favors adherence to the ordinary meaning of the text.
- The policyholder's conception of the contract at the point of formation, which is focused on a relation of reasonable security not fully embodied in the express terms.
- The problem of policyholder agency through the control of information at the point of claim.
- The problem of insurer agency at the point of claim, which tends toward opportunism
- The dynamics of the claim process, in which the policyholder is at a systematic disadvantage.

In interpreting a policy term, a court needs to take account of these factors. Interpretation is never carried out in the abstract; the court evaluates and balances the factors in the context of the particular dispute.⁶¹ The result

⁶⁰ See Michelle E. Boardman, *Contra Proferentem: The Allure of Ambiguous Boilerplate*, 104 MICH. L. REV. 1105, 1124 (2006).

⁶¹ On balancing as the defining characteristic of modern law, see Feinman, *supra* note 53, at 838.

of that process may be more or less clear, but it is necessary to effectuate the interests involved.

Consider two examples of how this analysis can be applied, using casebook staples, one of which presents a relatively clear result under the contract and claim analysis and one that requires more complex balancing.

Prudence Life Insurance Co. v. Wooley required the interpretation of the key term under a general disability policy.⁶² Derwood Wooley was a chicken farmer who previously had worked as a carpenter, truck driver and construction equipment operator. Wooley purchased a form of “general disability” policy⁶³ that contained this definition of total disability: “Complete loss of business time due to the inability of the insured to engage in his regular occupation or in any gainful occupation for which he is reasonably fitted by education, training or experience.” Wooley suffered a heart attack and the insurer paid benefits for two years and then ceased doing so, asserting that he no longer was totally disabled within the meaning of the policy.⁶⁴ At trial the issue was whether Wooley’s proof that he could no longer be a chicken farmer was sufficient, or whether the jury also should be charged that the policy required that he be unable to perform any other occupation “for which he is reasonably fitted by education, training or experience.”⁶⁵ The court adopted the majority rule that a general disability term requires not only that an insured be unable to perform his own occupation but that he also be unable to perform another occupation for which he is suited.⁶⁶

The contract and claim analysis would reach the same result. Both insurer and insured contract in a market in which there is a clear distinction between a general disability policy and an occupational disability policy. The former has what the *Wooley* court referred to as “a ‘double-barrel provision,’ which requires that disability be shown as inability to follow his regular occupation, or any other occupation for which insured is reasonably fitted by education, training or experience.” The latter only has the requirement that the insured be unable to perform his own occupation. In the market for disability insurance, both types are available, the choice between them is readily apparent to the reasonable insured, and the distinction is represented

⁶² *Prudence Life Ins. Co. v. Wooley*, 182 So. 2d 393 (Miss. 1966).

⁶³ See *JERRY & RICHMOND*, *supra* note 32, at 464.

⁶⁴ *Prudence Life Ins. Co.*, 182 So. 2d at 395, citing 29A AM. JUR. INS. § 1518 at 622-3-4 (1960).

⁶⁵ *Id.*

⁶⁶ *Id.* at 396.

by a difference in price to the policyholder and in underwriting to the insurer. At the point of claim any informational advantage possessed by the policyholder can be overcome by medical examination, testing, and investigation by the insurer. There is a potential for opportunism by the insurer, by denying a claim and forcing a disabled insured to litigation to receive benefits. In fact, that potential often has been realized in disability insurance cases.⁶⁷ But the potential is in concept not dramatically greater in disability cases than in many other types. On balance, the contract and claim analysis supports the insurer's interpretation of the policy and the result in *Wooley*.

A second example is the burglary provision in mercantile policies, of which the casebook classics are *C & J Fertilizer, Inc. v. Allied Mutual Insurance Co.*⁶⁸ and *Atwater Creamery Co. v. Western National Mutual Insurance Co.*⁶⁹ The definition of burglary in the policy is the felonious abstraction of insured property from within the premises by a person making felonious entry therein by actual force and violence, of which force and violence there are visible marks made by tools, explosives, electricity or chemicals upon, or physical damage to, the exterior of the premises at the place of such entry.⁷⁰

In the cases, the loss of property through an obvious burglary occurs but there are no such visible marks on the exterior. The conflict in the cases is whether to use a plain meaning approach that bars coverage or to resort to a reasonable expectations approach that might find coverage.

The courts note that for the insurer at the point of formation, there are two reasons for the visible marks requirement: to exclude coverage for "inside jobs" and to encourage policyholders to secure their premises.⁷¹ Both reasons are related to the insurer's risk allocation, designed to cover "real" burglaries and to reduce their incidence. But for the insurer, the clause also looks forward to the point of claim. Some losses caused by an inside job may be fraudulent, and the clause excludes coverage for those. In other cases it will be unclear whether the loss was due to burglary or an inside job, and the effect of the clause's proof requirement is to use an objective standard to

⁶⁷ See Jay M. Feinman, *The Law of Insurance Claim Practices: Beyond Bad Faith*, 47 TORT TRIAL & INS. PRAC. L.J. 693, 716 (2012).

⁶⁸ *C & J Fertilizer, Inc. v. Allied Mut. Ins. Co.*, 227 N.W.2d 169 (Iowa 1975).

⁶⁹ *Atwater Creamery Co. v. Western Nat. Mut. Ins. Co.*, 366 N.W.2d 271 (Minn. 1985).

⁷⁰ *Id.* at 275.

⁷¹ *Id.* at 276.

foreclose a more extended and uncertain inquiry into the nature of the loss and to conveniently exclude coverage in those cases.

From the policyholder's perspective, however, at formation the reasonable understanding of the provision is to pay for a burglary as comports with the general understanding of the term, as not an inside job. At the point of claim, a requirement of objective proof disappoints that expectation. Moreover, the policyholder is at risk of insurer agency because the requirement does more than place the burden on the policyholder to establish the cause of loss; it prevents the policyholder from proving that the cause was an actual burglary. It also gives the insurer discretion in applying the clause favorably to some policyholders and unfavorably to other, and it provides a disincentive to policyholders to pursue claims, particularly in cases involving relatively small claims.

The general disability cases present a relatively clear application of the contract and claim analysis, but the burglary cases are more complex and the resolution is less clear. Because the contract and claim analysis is more complex than, say, plain meaning purports to be, that may sometimes be the result. In individual cases particular facts may be decisive. In *C & J Fertilizer*, for example, the policyholder testified to his understanding of the policy at the time of purchase, that understanding was that burglary but not an inside job was covered, the understanding comported with general usage of the term, and the proof requirement was in a definition rather than an exclusion.⁷²

C. AT THE POINT OF CLAIM: FALSE SWEARING AND BAD FAITH

Whatever the substantive issues underlying a claim dispute, either party may assert that the other has violated some standard during the claim process itself. The insurer may assert that the policyholder has violated its obligations by making a false statement in presenting its claim, an issue covered by the false swearing rule. Or the policyholder may assert that the insurer has improperly handled the claim; these issues are resolved under the law of insurance claim practices, what is commonly known as "bad faith" or, in a growing term, the law of extracontractual liability.

1. False Swearing

Most insurance policies explicitly include a term declaring that fraud

⁷² *C & J Fertilizer*, 227 N.W.2d at 171-72.

or other false statements by the policyholder in filing a claim permit the insurer to void the policy.⁷³ Many of those terms require that the false statement concern a material fact or be made with an intent to deceive the insurer.⁷⁴ The misrepresentation provision in the most widely used homeowners insurance policy lists three circumstances in the alternative, any of which would result in a loss of coverage, if the policyholder has:

- Intentionally concealed or misrepresented any material fact or circumstance;
- Engaged in fraudulent conduct; or
- Made false statements.⁷⁵

The doctrine that applies to these provisions is the “false swearing” rule. As a general rule “false swearing” by an insured in a proof of loss or other element of the claim process enables the insurer to avoid paying a claim, even if the false swearing concerned only a portion of the loss.⁷⁶ Courts vary on the stringency of their application of the false swearing rule.⁷⁷ A broad, insurer-favorable version of the false swearing rule has generous standards for materiality and intent, no reliance requirements, and has the effect of avoiding the insurer’s obligations under the policy altogether. Narrower versions of the rule require that the insurer have relied on the misrepresentation⁷⁸ or that false swearing enables an insurer to avoid coverage only as to the portion of the claim that was misrepresented.⁷⁹

The justification for the broad rule rests on a particular conception of the insurance policy as a contract and on a focus on opportunism by the policyholder. The essential rationale for a broad view conceives of the insurance relation as created and substantially embodied in the insurance policy. Part of the insured’s contractual obligation with the insurer is to

⁷³ 13 STEVEN PLITT ET AL., COUCH ON INSURANCE § 197:1 (3d ed. 2018).

⁷⁴ *Id.* § 197:33.

⁷⁵ INS. SERVS. OFFICE, HOMEOWNERS-3 SPECIAL FORM (2010).

⁷⁶ STEMPEL & KNUTSEN, *supra* note 53, § 9.08[C], at 9-221; JERRY & RICHMOND, *supra* note 32, § 83; Versloot Dredging BV and another v. HDI Gerling Industrie Versicherung AG and others [2016] UKSC 45, ¶ 1 (Eng.).

⁷⁷ 5af-157f APPLEMAN ON INSURANCE LAW & PRACTICE ARCHIVE § 3587 (2nd ed. 2011).

⁷⁸ *Id.* at § 197:4, at 1.

⁷⁹ STEMPEL & KNUTSEN, *supra* note 53, § 908[C], at 9-22, 222.

refrain from misrepresentation in the claim process.⁸⁰ This element of the analysis is an instance of a principle of insurance law reflected in the insurer's perception of formation, that the relation between insurer and insured is created and substantially defined by their agreement.⁸¹

The reason such a provision is included in the policy is not only general to contracts; it is specific to insurance because of the risk of opportunistic behavior by the policyholder at the point of claim. A policyholder has an incentive to misrepresent or conceal information from its insurer during the claim process in order to maximize its recovery.⁸² Insurers, being aware of this possibility, must invest resources to monitor insureds' behavior and to ferret out their fraud. The false swearing doctrine deters wrongful behavior by policyholders and reduces the need for inefficient monitoring behavior by insurers. In that way, it benefits the pool of policyholders that otherwise would be subject to increased costs of fraudulent payments and inefficient monitoring.⁸³

The contract and claim analysis challenges the broad approach to false swearing as partial. The broad approach recognizes the insurer's conception of the contract at the point of formation but fails to recognize the policyholder's conception. A policy term on misrepresentation should be read in light of a reasonable understanding of the insurance relation as shaped both by policy language and more general norms and expectations of coverage and process. The policyholder's expectation of coverage would be disappointed by a broad false swearing rule. Fraudulent behavior by

⁸⁰ The obligation is clear and specific where the insurance policy contains a provision relating to misrepresentation after a loss. Even if the provision is less specific, it reasonably is interpreted to apply to post-loss conduct as well as to misrepresentations in the course of applying for the insurance.

⁸¹ See Abraham, *supra* note 1, at 658.

⁸² As the New Jersey Supreme Court stated the concern, "Such misrepresentations strike at the heart of the insurer's ability to acquire the information necessary to determine its obligations and to protect itself from false claims." Longobardi v. Chubb Ins. Co. of New Jersey, 582 A.2d 1257, 1261 (N.J. 1990). See also James Davey & Katie Richards, *Deterrence, Human Rights and Illegality: The Forfeiture Rule in Insurance Contract Law*, 2015 LLOYD'S MAR. & COM. L.Q. 314, 318 (2015).

⁸³ Tom Baker, *Constructing the Insurance Relationship: Sales Stories, Claims Stories, and Insurance Contract Damages*, 72 TEX. L. REV. 1395, 1411 (1994).

policyholders runs a spectrum from the callously deceitful, as the functional equivalent of stealing, to the improper but less ill-spirited, to make up for an inadequacy of record-keeping or a careless decision to under-insure. That behavior may cause an insurer to fail to properly investigate a cause of loss or incur significant additional expense in investigating a claim, or it may have no effect at all. Where the behavior is toward the less deceitful end of the spectrum and it does not affect the insurer's behavior, the loss of the entire value of the policy to the policyholder is too extreme a sanction.

A focus on the dynamics of the claim process also gives a different picture of the risks of opportunism. The risk of policyholder opportunism may be exaggerated, there are other mechanisms in place to deal with it, and there is a related risk of insurer opportunism.

Policyholder fraud is a familiar theme in discussions about insurance, both within the industry and in outreach to the public at large.⁸⁴ The empirical claim is that fraud is widespread.⁸⁵ The response that this claim justifies is a multi-front war on fraud. Sophisticated predictive analytics trigger identification of potentially fraudulent claims. Insurance companies contain Special Investigation Units to which claims of fraud are referred for more aggressive investigation. Insurance regulators and prosecutors in most states have established distinct units to seek civil and criminal penalties for fraud, and legislation often requires insurers to report suspected cases of fraud to them.⁸⁶ All states now make insurance fraud a crime, with two-thirds of the states treating it as a felony.⁸⁷ So to the extent that there is a problem, the false swearing doctrine is only one among many potential solutions, reducing its importance.

The false swearing doctrine aims to respond to opportunism by the insured. One might consider the problem of opportunism by the insurer to be entirely separate so that it is irrelevant to the false swearing doctrine and should be addressed through entirely separate doctrines and remedies. But in fact, the two problems are linked. One potential form of insurer opportunism is the assertion of fraud by the policyholder as a reason for not paying a

⁸⁴ FEINMAN, *supra* note 28, at ch. 10.

⁸⁵ According to the Coalition Against Insurance Fraud, "Insurance fraud is one of America's largest crimes—at least \$80 billion is stolen each year." Fraud: Why Worry?, COALITION AGAINST INS. FRAUD, <http://www.insurancefraud.org/fraud-why-worry.htm> (last visited Jan. 6, 2019).

⁸⁶ *E.g.*, N.Y. INS. LAW § 405 (N.Y. 2018).

⁸⁷ Statutes, COALITION AGAINST INS. FRAUD, <http://www.insurancefraud.org/statutes.htm>.

claim. An insurer could use allegations of fraud as part of a broader scheme to deny payment of valid claims. Or it could make use of the non-reliance false swearing rule in a parallel way to post-claim underwriting. If an insurer discovers a misrepresentation during the course of its investigation of a claim, it can use the misrepresentation as a basis for denying the claim even if the misrepresentation played no part in its investigation, just as an insurer in past times could use a misrepresentation on the application even if the misrepresentation played no role in its underwriting decision.⁸⁸ The doctrine that enforces and evaluates that reason becomes a tool for opportunism, and the severe consequences of a finding of false swearing raises the stakes considerably. Therefore, with respect to false swearing in the claim process, agency and opportunism are present on both sides and the better rule of false swearing would recognize that.

Under the contract and claim analysis, resolving the challenge of both types of opportunism once again requires balancing, here weighing the relative risk and severity of each type. How likely are insureds to control relevant information and at what expense could insurers discover it? If an insurer asserts fraud, how likely is an insured to contest its determination? How likely are insurers to opportunistically deny claims? How often does that behavior take the form of improper assertions that the insured's claim is fraudulent?

Empirical data on that question are hard to come by and subject to interpretation.⁸⁹ An analogous instance of balancing insurer, policyholder, and pool interests in cases of misrepresentation involves misrepresentation or concealment at the front end of the insurance relationship, in the application process, as discussed above. Information provided by the insured in the process of applying for an insurance policy should play a significant part in the underwriting decision of the insurer—whether to issue the policy, with what terms of coverage, and at what rate. In the classic example of “post-claim underwriting,” however, life insurance companies failed to do proper investigation before issuing the policy; after a claim was filed, they would refuse to pay death benefits, asserting that the insured had misrepresented his physical condition or medical history when applying for

⁸⁸ See text at notes 32-36 *supra*.

⁸⁹ The most authoritative quantitative study of insurance fraud concluded, for example, that the ratio of fraud alleged and reported by insurance companies to actual, provable fraud, was about 25 to 1. Richard A. Derrig, *Insurance Fraud*, 69 J. RISK & INS. 271 (2002).

the policy, which rendered the policy void.⁹⁰ These practices caused disproportionate forfeiture because the insured's beneficiaries lost the benefit of the policy because of a minor error, perhaps knowing or perhaps unintentional, that may or may not have affected the insurer's underwriting decision. Even worse, companies sometimes required voluminous but vague disclosures on the application for insurance to set up the misrepresentation argument,⁹¹ a clear instance of insurer opportunism. Over time, legislatures and courts recognized this problem and responded in various ways, such as through doctrines of incontestability, waiver, estoppel, and materiality of misrepresentation.⁹² Those doctrines attempt to balance the interests of insurer, insured, and pool in checking agency and opportunism on both sides of the insurance relation.

This suggests the advantage of a false swearing rule that at least has a serious requirement of materiality and includes an element of reliance. If an insurer has not been affected at all by a policyholder's misrepresentation, the entire loss of the relation of security by the policyholder, undermining the policyholder's conception of the contract, is too severe a consequence. Reliance does not need to be immense, but it does need to be tangible. If an insurer loses the opportunity adequately to investigate the cause of a fire⁹³ or incurs significant additional investigative expenses, that constitutes sufficient detrimental reliance;⁹⁴ processing the claim independently of the alleged misrepresentations does not.⁹⁵

The contract and claim analysis not only provides a perspective on a variety of substantive doctrinal issues; it also can be used to reframe elements of the litigation process through which those doctrines are realized. The process of proof in the application of the false swearing doctrine provides an example. Some jurisdictions require that the elements of false swearing be proven by clear and convincing evidence; others use only a

⁹⁰ See Cady & Gates, *supra* note 50, at 813-14.

⁹¹ *E.g.*, Connecticut Mut. Life Ins. Co. v. Union Trust Co., 112 U.S. 250 (1884); Baumgart v. Modern Woodmen of Am., 55 N.W. 713 (Wis. 1893).

⁹² See Cady & Gates, *supra* note 50.

⁹³ Allstate Ins. Co. v. Breeden, 410 Fed. Appx. 6, 8 (9th Cir. 2010).

⁹⁴ Leander Land & Livestock, Inc. v. Am. Econ. Ins. Co., 2013 WL 5940027, at *6 (D. Or. Nov. 1, 2013).

⁹⁵ Leavenworth v. State Farm Fire & Cas. Co., 297 Fed. Appx. 602 (D. Or. Oct. 22, 2008).

preponderance of the evidence standard.⁹⁶ The former is the standard ordinarily applied in cases involving the tort of fraud, the latter in cases in which fraud is the basis for avoidance of a contract. The difference follows from the idea that allegations of fraud are more serious than allegations of ordinary breach of contract, and “more evidence should be required to establish grave charges than to establish trifling or indifferent ones.”⁹⁷

Combining this framework with the contract and claim analysis suggests that false swearing should require proof by clear and convincing evidence. Indeed, false swearing in the insurance context is potentially a more serious matter than some other types of fraud. The insurance contract properly understood is about security and the consequences for the insured in losing the security of the insurance policy are often severe or even catastrophic. Especially where insurer reliance on the misrepresentation is not required, the trier of fact needs to be more certain that the other elements are met before attaching such drastic consequences, and more of the risk of error in fact-finding should be borne by the insurer. And the threat of insurer opportunism in using allegation of fraud as a strategy to avoid paying claims—exploiting false claims of false swearing, as it were—suggests that courts ought to be cautious in enabling an insurer to use a claim of false swearing to entirely void its obligation under the policy and should assign the risk of error in fact-finding to the insurer.

2. Bad Faith

In first-party bad faith cases, most jurisdictions require something more than a negligent failure to investigate or pay a claim to constitute a violation of claim practices standards, adopting instead the fairly debatable standard.⁹⁸ That standard requires the absence of a reasonable basis for denying the claim—that it was not “fairly debatable”—and intent or recklessness as to the absence of a reasonable basis.⁹⁹ The rationale for this

⁹⁶ 13 STEVEN PLITT ET AL., *COUCH ON INSURANCE* § 197:6 (3d ed. 2018).

⁹⁷ *Ziegler v. Hustisford Farmers Mut. Ins. Co.*, 298 N.W. 610, 612 (Wis. 1941) (quoting *JONES COMMENTARIES ON EVIDENCE* § 563, at 1036 (2d ed. 1926)).

⁹⁸ *Feinman*, *supra* note 67, at 702.

⁹⁹ Perhaps the most widely cited formulation of the standard comes from the Wisconsin Supreme Court’s decision:

rule is based in part on the potential *in terrorem* effect of bad faith litigation upon the insurer. ““An insurer should have the right to litigate a claim when it feels there is a question of law or fact which needs to be decided before it in good faith is required to pay the claimant.””¹⁰⁰ Some courts also use a procedural elaboration on the fairly debatable test. To establish bad faith, the policyholder is required to prove that it would have been entitled to summary judgment on the underlying coverage claim.¹⁰¹

The fairly debatable rule embodies strongly the insurer’s perspective of the contract, that the policy plans in detail the risks covered and excluded. Underlying the fairly debatable rule is a conception that at the time of performance, the policy represents an element of the insurer’s portfolio of risk, with its pricing and place determined by the policy terms. As insurers often say, an insurer is obligated to pay what is owed, no less but no more.¹⁰² Indeed, the insurer should be required to pay no more than what is owed; otherwise, it would upset the contractual risk allocation and burden the pool of policyholders.

Of course, the policy language and facts of the loss do not always lead to a clear conclusion about the insurer’s obligation. Language of coverage and exclusion may be unclear as applied to the facts of the loss. And in every case the policy includes only general terms about the insurer’s

To show a claim for bad faith, a plaintiff must show the absence of a reasonable basis for denying benefits of the policy and the defendant’s knowledge or reckless disregard of the lack of a reasonable basis for denying the claim. It is apparent, then, that the tort of bad faith is an intentional one. “Bad faith” by definition cannot be unintentional.

....

Under these tests of the tort of bad faith, an insurance company, however, may challenge claims which are fairly debatable and will be found liable only where it has intentionally denied (or failed to process or pay) a claim without a reasonable basis.

Anderson v. Cont’l Ins. Co., 271 N.W.2d 368, 376-77 (Wis. 1978).

¹⁰⁰ *Polizzi Meats, Inc. v. Aetna Life & Cas. Co.*, 931 F. Supp. 328, 334-35 (D.N.J. 1996) (citation omitted) (quoting *Anderson v. Cont’l Ins. Co.*, 271 N.W.2d 368, 377 (Wis. 1978)).

¹⁰¹ *Pickett v. Lloyd’s*, 621 A.2d 445, 454 (N.J. 1993).

¹⁰² *E.g., Libby v. Farmers Ins. Exch.*, 2008 WL 2421976 *44 (Cal. App. Div. Super. Ct. 2008).

obligations in the claim process. In those cases, the fairly debatable rule empowers the insurer to dispute coverage, as long as it does so for the purpose of fulfilling its expectations that were created by the policy; that is, without intent to dispute the claim for improper purposes or reckless disregard of the reasonableness of its position.

In this respect the fairly debatable rule captures one conception of the contract. But in doing so, it ignores the form-contract nature of the policy and the policyholder's less determinate and more relational expectation about coverage. It also ignores the policyholder's expectation that, at the point of claim, the insurer will act reasonably. More important, it also ignores the dynamics of the claim process. The rule completely discounts the insurer's agency and the risk of opportunism except at the extreme. Instead, it embodies a conception that only the most egregious intentional acts by the insurer violate the contract; that the vulnerability of the policyholder, the information imbalance, and the economics of litigation do not present bars to finding and pursuing such egregious acts; and that the courts are able to distinguish the intentionally wrongfully from more ordinary behavior.

A smaller number of jurisdictions apply a reasonableness rule of liability.¹⁰³ The duty of the insurer to act in good faith in handling an insured's claim is violated when an insurer "fails to deal fairly and in good faith with its insured by refusing, without proper cause, to compensate its insured for a loss covered by the policy"¹⁰⁴ or "when the insurer unreasonably and in bad faith withholds payment of the claim of its insured."¹⁰⁵

The rule that requires an insurer to act reasonably recognizes that the policy imperfectly embodies the insurance relation. Instead, the policy creates a relation that includes its written terms as well as less determinate expectations of the policyholder and industry and legal norms. The rule also recognizes the dynamics of the claim process, in which there is a risk of insurer opportunism that the policyholder cannot check in the terms of the contract, because it is an adhesion contract, or at the point of claim, because of the dynamics. All of those require that the insurer act reasonably in the claim process.

Reasonableness is not strict liability, however. The reasonableness rule does not ignore the legitimate interests of the insurer as representative of the pool; it only requires adherence to widely understood norms. Where

¹⁰³ The landmark case on this subject was *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032 (Cal. 1973).

¹⁰⁴ *Id.* at 1037.

¹⁰⁵ *Id.* at 1038.

the fairly debatable rule focuses on the risk to the pool if the insurer is deterred from litigating open questions of law or fact, the contract and claim approach demonstrates that the reasonableness rule benefits the pool by providing an appropriate level of incentive with a nontrivial risk of litigation to enforce the standard, a position that increases the probability that the insurer will respect the interests of policyholders in future claims.

CONCLUSION

Insurance law scholars are fond of reconceptualizing their subject. Insurance policies and insurance law have been likened to a means of public utility regulation, a product warranty, a social institution, or, perhaps mostly simply, a thing.¹⁰⁶ This article represents another conceptualization of the subject, and one that may be less foreign to the subject and closer to the reality of the formation and performance of insurance relationships. Insurer and policyholder approach the insurance relation from different perspectives at the moment of creation and the point of claim. Insurance law should recognize those differences and pay particular attention to the dynamics of the claim process in the resolution of insurance law disputes.

¹⁰⁶ Abraham, *supra* note 1; Daniel Schwarcz, *A Product Liability Theory for the Judicial Regulation of Insurance Policies*, 48 WM. & MARY L. REV. 1389 (2007); Jeffrey W. Stempel, *The Insurance Policy as Social Instrument and Social Institution*, 51 WM. & MARY L. REV. 1489 (2010); Jeffrey W. Stempel, *The Insurance Policy as Thing*, 44 TORT TRIAL & INS. PRAC. L.J. 813 (2009).