"INCOMPLETE" INSURANCE COVERAGE

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This Article examines the ways in which insurance coverage is incomplete, and the reasons why coverage is incomplete. It argues that, because all insurance policies and all insurance coverage is incomplete, the notions of a "gap" in coverage and "incomplete" coverage typically are unhelpful. A better understanding of the reasons for incomplete coverage would enrich the interpretation of insurance policies and produce more informed resolution of coverage disputes. The Article seeks to provide that understanding.

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INTRODUCTION

The world poses a nearly infinite variety of risks. Any form of insurance selects a small slice of the universe of all risks to cover. In this sense, all insurance policies provide incomplete coverage. By this I mean substantive, as distinguished from temporal or monetary incompleteness, both of which also characterize all insurance policies.[1] To be meaningful, the notion of incomplete coverage would therefore have to presuppose some substantive baseline against which the coverage provided by an insurance policy could be compared. In addition, for the notion of incomplete coverage to influence insurance rights and liabilities, it would have to be defined in a precise and operational manner. But that is not how I will use the notion here, because I am not proposing a test for liability. Rather, I am using the notion of incompleteness to explore the reasons why insurance policies cover some risks and do not cover others. The notion of incomplete coverage is simply a vehicle for identifying coverage that might plausibly be included in an insurance policy, but is not included.

Exploring the idea of incomplete insurance coverage may be useful for a number of purposes. Among other things, a better understanding of the reasons that insurance coverage may be considered incomplete may help courts facing insurance coverage disputes to understand seemingly opaque or arbitrary limitations on coverage.[2] This understanding may also help counsel for insureds and insurers to develop arguments for their positions about the meaning and application of contested policy provisions, and it may help policyholders and insurers to assess the reasonableness of claim denials. Finally, a better understanding of what it means for coverage to be incomplete may help regulators determine which policies and policy provisions to approve or disapprove.

There is a sense in which this Article develops a theory of incomplete insurance coverage. There are a sufficient number of reasons for incomplete coverage, however, that referring to "a theory" risks the misleading implication that there is a single reason for incomplete coverage, when that is not the case. Rather, there is a series of different explanations for incomplete coverage. They fall into three general categories. Part I addresses the *path-dependence* of coverage. Much of what is covered under particular policies but not covered by others is not a function of logic, but of

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[1] That is, all policies cover only a finite slice of time, and a finite sum of monetary loss.

[2] For discussion of the normative presumptions underlying the courts' reading of the "whole" insurance policy, see Kenneth S. Abraham*, Plain Meaning, Extrinsic Evidence, and Ambiguity: Myth and Reality in Insurance Policy Interpretation*, 25 CONN. INS. L.J. 329, 341-45 (2019).

the history of insurance. For reasons that I will explore, some kinds of coverage have come to be bundled together over time, while others have been fragmented. Once insurance develops in this manner, it tends to stay that way.

Part II examines the second general reason for incomplete coverage, certain aspects of the *dynamics and economics* of insurance. Insurance functions best under a particular set of conditions and is subject to a number of threats to its effective operation. These include, but are not limited to, the familiar phenomena of adverse selection and moral hazard. Insurance coverage is often incomplete in order to combat these threats, or because certain kinds of risks are difficult to insure. This Part examines those reasons.

Part III concerns *verbal incompleteness*. It explores the ways in which insurance policy language may omit coverage that is in fact, or arguably, provided by the policy. Even aside from ambiguity, which has garnered more than enough attention elsewhere,[3] coverage may be unambiguously incomplete by failing to mention a risk, providing underinclusive coverage, or being vague at the borderline. The reasons insurance policies do not say things is sometimes as important as the reasons they do. Often verbal incompleteness serves a legitimate purpose, but sometimes it does not. This Part explores the ways, and the reasons, that insurance policies leave some things unsaid.

Parts I through III are descriptive and analytical. Taken together, they comprise what amounts to a theory of incomplete coverage. In contrast, Part IV is more nearly normative. This Part considers the implications of the analysis. It suggests that the notions of a "gap" in coverage and "incomplete" coverage tend not to be helpful. In addition, while recognizing that resolving insurance disputes as a matter of law necessarily limits the factual material that courts may take into account in this setting, this Part argues that the tools currently used to interpret insurance policies are impoverished. The binary distinction between policy language with a plain meaning and ambiguous policy language is inadequate to the task of assessing the meaning of arguably incomplete insurance policies. This Part argues, among other things, that more extensive consideration of the reasons for incomplete coverage would enrich the interpretation of insurance policies and produce more informed resolution of coverage disputes.

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[3] *See, e.g.*, *id.*; Michelle E. Boardman, Contra Proferentem: *The Allure of Ambiguous Boilerplate*, 104 MICH. L. REV. 1105 (2006); Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. 531 (1997); Oliver Wendell Holmes, *The Theory of Legal Interpretation*, 12 HARV. L. REV. 417 (1899).

I. THE PATH DEPENDENCE OF COVERAGE

Without demand for it, insurance does not come into being, although demand can be created by external forces, including insurers themselves. For example, after the Great Fire of London in 1666, fire insurance developed as property owners came to appreciate the risk they faced.[4] In mid-nineteenth century America, breadwinners came to appreciate their families' economic dependence and to regard the purchase of life insurance as an act of morality rather than tampering with fate – partly through the persistence and ingenuity of insurance salesmen[5] –and life insurance spread. In the late nineteenth century, a group of textile manufacturers in Massachusetts became concerned about the risk of incurring tort liability for injury to their employees, and formed a company to sell the first form of liability insurance – "Employers Liability" insurance – ever offered in the United States.[6] After automobiles were invented, auto liability was first provided under the "team" (of horses) insurance policies that already existed, but very quickly, auto liability insurance came into being.[7] To simplify just a bit, in each of these instances, demand for insurance against a particular, discrete risk preceded supply, and the capital necessary for the existence of insurance – the availability of which is clearly a prerequisite – was supplied in order to meet that demand.

A. BUNDLING COVERAGE

Once a form of insurance is in place, insurers of course try to fuel demand by marketing it. An important marketing technique is "bundling": expanding the set of risks covered by a form of policy that originally covered only a single, discrete risk.[8] The newly-covered risks typically are associated enough with the original risk to make the expansion attractive and seamless. Thus, after it was introduced, fire insurance on real property added coverage of personal property, as well as coverage of perils other than fire, such as

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[4] STEPHEN PORTER, THE GREAT FIRE OF LONDON 34, 70-72 (1996); Kenneth S. Abraham, *Jefferson's Fire Insurance Policy and Monticello's Reconstruction of Slavery*, 19 GREEN BAG 2D 11 (2015).

[5] *See generally* VIVIANA A. ROTMAN ZELIZER, MORALS AND MARKETS: THE DEVELOPMENT OF LIFE INSURANCE IN THE UNITED STATES (2017).

[6] KENNETH S. ABRAHAM, THE LIABILITY CENTURY: INSURANCE AND TORT LAW FROM THE PROGRESSIVE ERA TO 9/11 28-32 (2008).

[7] *Id.* at 71.

[8] *See generally* Symposium, *Fragmented Risk: An Introduction*, 11 RUTGERS J. OF L. & PUB. POL'Y 1 (2013).

wind and theft.[9] Eventually it became "all-risk" coverage.[10] Similarly, Employers Liability insurance expanded to cover "public liability" – the risk of liability to individuals who are not employees.[11] Over time, auto liability insurance also expanded, adding (among other things) omnibus and drive-other-cars liability coverage, first-party property damage insurance on insured vehicles, a small slice of first-party medical coverage, and uninsured motorists coverage.[12]

Sometimes bundling occurs not merely for marketing purposes, but as a response to an imperfection in the market. Even after fire insurance evolved into all-risk property insurance covering personal residences, it was first-party insurance only. Third-party personal liability insurance (non-auto, non-professional, non-business liability insurance) still had to be purchased separately. Individuals had little exposure to these forms of liability, as well as little awareness of their exposure. Demand for personal liability insurance was therefore weak, especially since the administrative costs associated with selling free-standing policies insuring against minimal liability risk inflated premiums. The solution was to add a personal liability insurance component to first-party all-risk property insurance.[13] For a brief time in some places this was optional, but eventually the two forms of coverage were tied together automatically, and the liability insurance component added only minimally to the total premium.

Expanding from initial, single-risk coverage to the bundling of coverage of similar, related risks has thus been the repeated pattern. Each form of insurance followed this particular pattern of development, though each did so in a different manner because of the particular exigencies that were operating when it came into being.

B. FRAGMENTATION

If we think of bundling as the result of centripetal force, then fragmentation is the opposite. It is the result of centrifugal force. Some risks that might seem to belong in a particular form of policy are instead covered by another form of policy. As I use the term here, fragmentation refers to the omission of coverage from one form of policy but its inclusion in another form of insurance policy. Fragmentation does not mean that something is

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[9] KENNETH S. ABRAHAM & DANIEL SCHWARCZ, INSURANCE LAW & REGULATION 184 (6th ed. 2015).

[10] *See id.*

[11] *See* ABRAHAM, *supra* note 6, at 32-35.

[12] *Id.* at 77-80.

[13] *Id*. at 174-78.

missing from the overall fabric of available insurance coverage; quite the contrary.

Like bundled coverage, what ends up being covered in one type of policy and not in another has been to some extent path-dependent, rather than a consequence of some natural way in which we divide up and categorize the world of risk and insurance against it. For example, insurance of all property risks, including the risk of physical damage to cars, could have been bundled into a single property insurance policy. Home and auto property insurance would then have been covered by a single insurance policy. But once auto *liability* insurance emerged, it was more efficient in a number of different ways for auto insurance to include a component of first-party property insurance, rather than to bundle this with residential or commercial property insurance.

Similarly, health insurance might have been bundled with life insurance. There might have been significant underwriting efficiencies to bundling insurance against the related risks of sickness, injury, and death. But because health insurance first appeared in a significant way as group insurance provided as a fringe benefit of employment, it was not bundled with life insurance, which had already been sold individually for over a century at that point.

Despite the fact that there is a certain path-dependence and therefore contingency about what different types of policies cover, some omissions from coverage under certain kinds of policies would be surprising, based on the kind of policy involved. No one would expect a health insurance policy to exclude coverage of the cost of medical treatment of feet, leaving such coverage for a hypothetical "podiatry" treatment policy. No one would expect an auto liability policy to exclude coverage of liability of an insured driver for negligently failing to get of his vehicle to signal oncoming traffic after the vehicle had broken down, and instead leaving the liability insurance component of homeowners and renters policies to provide that coverage. These hypothetically non-covered liabilities fall too close to the core of health and auto liability insurance for these limitations on coverage to be routine. The core concept of health and auto insurance is an appropriate baseline for determining whether coverage is fragmented and results in what everyone would agree is a "gap" in these examples.

On the other hand, there are also instances in which coverage seemingly close to the core of a particular form of insurance is not provided and can only be obtained by another policy or the purchase of coverage as an add-on. The exclusion of coverage of loss caused by flood under Homeowners policies is the paradigm example. There are historical reasons for this fragmentation.[14] And since 1986, also for reasons of history,

[14] *See* ABRAHAM & SCHWARCZ, *supra* note 9, at 253.

standard-form CGL insurance policies have contained an absolute pollution exclusion. The limited coverage of liability for pollution that is potentially available must be obtained separately, either under a freestanding pollution liability insurance policy or through the purchase of a pollution "buyback" endorsement to the standard-form policy.[15]

My point here is that the very notion of fragmentation sometimes has a pejorative connotation, because it inaccurately presupposes that the divide between bundling and fragmentation is both logical and determinate. In fact, however, the degree and kind of bundling and fragmentation that actually occur often is historically contingent and path-dependent. It turns out that the only dependable way to ascertain why coverage that might be expected under one type of policy is actually excluded or limited but covered by another kind insurance policy, is to consider the reasons that a particular exclusion or limitation on coverage exists.

II. THE DYNAMICS AND ECONOMICS OF INSURANCE

In contrast to path-dependence, which helps to explain why a particular risk is covered under one type of policy rather than another, often coverage of a particular risk is not covered under any type of policy. Although no theory can account for every exclusion from or limitation on coverage in every type of insurance policy, there are a handful of explanations for the existence of most such provisions, all of which involve the dynamics and economics of the insurance function.

A. COMBATTING ADVERSE SELECTION

Adverse selection is the disproportionate tendency of those who believe they are at higher-than-average risk of suffering a loss to seek insurance of that loss.[16] Insurers try to combat this phenomenon by obtaining information – often on an application for insurance – about the risk levels posed by applicants for coverage.[17] Applicants are then charged premiums proportionate to the risks they pose and adverse selection is at least partly neutralized. Sometimes, however, gathering the information about certain risks that is necessary to set accurate premiums is either infeasible or too costly. In such instances, exclusions and limitations addressing those risks are employed in order to combat adverse selection.

There are any number of such provisions in a variety of different types of policies. For example, claims-made liability insurance policies often

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[15] *Id.* at 526.
[16] *Id.* at 6-7.
[17] *Id.* at 7.

contain broad exclusions applicable to claims that are "related" to the facts or circumstances associated with a claim made against the insured during an earlier policy period.[18] Similarly, many life insurance policies contain a delivery-in-good-health clause that precludes the policy from taking effect if the applicant's health status has changed in the period between the time of application and the time of issue.[19]

Provisions such as these circumvent the difficulty that insurers would otherwise face in obtaining information about risks known to the applicant but not the insurer. In theory an application can ask for information about facts or circumstances related to prior claims. But the ability of an insurer later to prove that a misrepresentation occurred is limited. Similarly, the moment of adverse selection in life insurance occurs at the time of application. But applicants may have suspicions, or even knowledge, about their health status that an insurer will never be able to prove the applicant had. For example, an applicant who has a numb foot and suspects he has a brain tumor might apply for insurance, pass a required physical examination, and then, only after a policy was issued, consult a physician and be diagnosed. A delivery-in-good-health clause sidesteps the difficulty of proving that the insured adversely selected in this situation.

Other exclusions combatting adverse selection are put in place not because of the difficulty of obtaining accurate information about the risk posed by the applicant, but because of the administrative cost that would be associated with setting accurate premiums for the excluded coverage. For example, Homeowners policies exclude coverage of loss caused by earth movement – mainly earthquakes.[20] Only a small percentage of policyholders poses a significant risk of suffering loss caused by earthquake. The costs of determining which small percentage of applicants pose such a risk and calibrating premiums to this risk, however, probably would not be worth the benefit of doing so. Consequently, if earthquake loss were covered without calibrating premiums, high risk applicants would be more likely to seek coverage. The simplest way to combat adverse selection of this sort is to exclude coverage of loss caused by earthquake on a blanket basis.[21]

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[18] *Id.* at 567.

[19] *Id.* at 30.

[20] *Id.* at 241-42.

[21] Another way exclusions that are in place under such circumstances are sometimes understood is to say that they are designed to avoid cross-subsidization, or that the exclusions reflect market "segmentation." *See, e.g.*, TOM BAKER & KYLE D. LOGUE, INSURANCE LAW & POLICY 417 (3d ed. 2013). Therefore, for example, if a party wants earthquake insurance, it must be separately purchased and priced. The problem with these explanations is that they do not identify the reason for avoiding cross-

B. MORAL HAZARD

Moral hazard is the tendency of a party, other things being equal, to exercise less care to avoid causing a loss that is insured than that party would exercise of the loss were not insured.[22] Unlike adverse selection, moral hazard results not only in fragmentation of coverage, but also, in some instances, in the complete unavailability of coverage.

The most salient example of the latter is the exclusion of coverage, in all policies, for loss that the insured intended or expected to occur.[23] Similarly, many policies exclude coverage of liability for loss resulting from criminal violations and fraud.[24] The moral hazard that would result if these forms of loss were insured is too great to be insurable.

Other common exclusions serve the same purpose, though less obviously. CGL insurance policies, for example, exclude coverage of liability for damage to the insured's own product or work.[25] Otherwise, the cost of replacing products damaged by the policyholder's own defective manufacture or design would not be shouldered by the policyholder, but by its insurer. The moral hazard that would be generated if a product maker were insured against liability arising out of poor quality control would be significant. The maker would have a significantly reduced incentive to maintain quality.

Similarly, Homeowners policies cover loss of trees caused by certain specified perils such as fire, lightning, and explosion, but these perils do not include wind or snow.[26] It seems likely that the absence of such coverage can be attributed to the moral hazard that it would otherwise generate, since poor tree maintenance – including inadequate pruning – will aggravate the risk that wind and snow will damage trees.

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subsidization, or for segmenting the insurance market. In each instance, the adverse selection that would result if cross-subsidization were facilitated, or if the market was not segmented, is the root cause of these effects. Cross-subsidization is not avoided for its own sake, but because it increases the risk of adverse selection. Market segmentation does not occur because of anything intrinsically desirable about separately covering the risk of earthquake loss, but because the administrative cost of bundling this coverage with other risks would increase adverse selection.

[22] ABRAHAM & SCHWARCZ, *supra* note 9, at 7.

[23] *Id.* at 440.

[24] *Id.* at 541.

[25] *Id.* at 443.

[26] *Id.* at 191.

Finally, burglary policies may exclude coverage unless the premises in question show visible evidence of forcible entry.[27] The limitation of coverage is a means of encouraging insureds to make reasonable efforts to secure the premises. Burglaries can occur without leaving visible evidence of forcible entry, but they are much less likely to occur without leaving such evidence if the premises have been properly secured against easy entry by a burglar. The evidence requirement combats this moral hazard.

Still other exclusions and limitations are designed to combat "ex post" moral hazard.[28] Homeowners policies exclude coverage of loss resulting from the neglect of the insured to use reasonable means to preserve property at and after the time of loss.[29] Uninsured motorist insurance covers hit-and-run losses when the responsible driver cannot be identified, but does not cover losses that occur without an actual "hit," in order to deal with the "phantom headlight" problem.[30] And cargo insurance policies cover the risk of livestock mortality but exclude coverage of animals that can walk away after an accident, in order (among other things) to encourage insureds to nurse the animals back to full health.[31]

C. CORRELATED LOSS

Insurance depends on the law of averages in order to operate successfully. For this to occur, the risks that are insured must be independent of each other, or uncorrelated. Otherwise losses will not be distributed randomly; a single event or cause will result in a large number of losses.[32] Either the insurer will profit enormously because there are no insured losses, or it will be stressed or rendered insolvent because of a large number of correlated losses. For example, flood losses, and especially flooding caused by hurricane-related storm-surge, are highly correlated. Homeowners policies therefore have long excluded coverage of loss caused by flood.[33] Similarly, Homeowners policies exclude coverage of loss caused by power

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[27] *Id.* at 54-63.

[28] This is the tendency of the insured to consume insurance after a loss occurs. Health insurance is the prime example. *See id.* at 352. Among other devices, deductibles, co-pays, and coinsurance address this problem.

[29] *Id.* at 198.

[30] *Id*. at 706.

[31] *See* Roseth v. St. Paul Prop. & Liab. Ins. Co., 374 N.W.2d 105 (S.D. 1985).

[32] *See* ABRAHAM & SCHWARCZ, *supra* note 9, at 4.

[33] *See generally* Jennifer Wriggins, *Flood Money: The Challenge of U.S. Flood Insurance Reform in a Warming World*, 119 PA. ST. L. REV. 361 (2014).

failure occurring off the insured premises.[34] And a "war" exclusion is included in both Homeowners and CGL insurance policies.[35] These all tend to be correlated losses.

D. UNCERTAINTY

Insurance functions best when it has reliable data about risk – the possibility of loss. When there is a chance of loss, but it is difficult or impossible to quantify the magnitude of that chance, insurance does not function well, because insurers do not know what to charge for coverage.[36] About a century ago, the economist Frank Knight captured this difference by coining the distinction between risk and uncertainty. Risk refers to a quantifiable probability of an event occurring, whereas uncertainty obtains when that probability cannot be quantified.[37]

Insurers have a decided tendency not to cover losses whose occurrence is characterized by uncertainty.[38] Business Interruption and Contingent Business Interruption policies, for example, typically require that loss of revenue or profits be the result of property damage rather than other forces, even though the property damage they require is not to the property of the insured, and sometimes not even to the property of a customer or supplier.[39] The property damage requirement is, among other things, a method of conditioning coverage on the quantifiable risk that property damage of some sort will occur and cause economic loss, rather than on unspecifiable and therefore uncertain causes of economic loss. Similarly, the war exclusions that I discussed above in connection with correlated loss also have been adopted because the chance of war occurring is uncertain and therefore difficult to quantify.

Perhaps the paradigm example of an exclusion involving uncertainty is the absolute pollution exclusion that was incorporated into standard-form CGL insurance policies in 1986.[40] There are a number of independent explanations for that exclusion, as I have already indicated, but uncertainty

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[34] ABRAHAM & SCHWARCZ, *supra* note 9, at 198.

[35] *Id.* at 198, 442.

[36] *See* KENNETH S. ABRAHAM, DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY 65 (1986).

[37] The seminal distinction comes from FRANK H. KNIGHT, RISK, UNCERTAINTY, AND PROFIT 197-263 (1921).

[38] I am indebted to Tom Baker for pointing out that a number of typical exclusions are related to the uncertainty difficulty.

[39] ABRAHAM & SCHWARCZ, *supra* note 9, at 228.

[40] For discussion of the points made in this paragraph and the two paragraphs that follow it see ABRAHAM, *supra* note 6, at 155-65.

– of two different sorts – also figures centrally in its history. Prior to 1986, the standard-form CGL insurance policy contained what was referred to as a "qualified" pollution exclusion. That provision excluded coverage of liability for harm caused by pollution, but included an exception to the exclusion if the discharge, dispersal, release, or escape was "sudden and accidental." The risk that an explosion or other abrupt event would cause pollution was apparently sufficiently quantifiable for that sort of event to be insurable. However, within a decade, a number of courts held (for reasons that have been explained in detail) that the word "sudden" did not necessarily have a temporal component, and therefore that gradual, unexpected pollution might fall within the exception to the exclusion.[41] Other courts held that the word "sudden" means "abrupt." This created considerable "juridical" uncertainty. There was no easy way to quantify the possibility that courts would hold that the word "sudden" could mean gradual.

In addition, the split created substantive uncertainty. There was apparently no sufficiently reliable way to quantify the possibility that a policyholder would be held liable for injury or damage caused by gradual, unexpected pollution, or the magnitude of that liability if it were imposed. Because there had been very little pollution liability until the enactment of the federal Superfund Act (CERCLA) in 1980, there was uncertainty about the scope of potential liability under that environmental cleanup regime.

The result, after considerable debate and controversy within the Insurance Services Office, the policy-drafting arm of the insurance industry, was the absolute pollution exclusion. Both juridical and substantive uncertainty had rendered it too difficult, at that point, to insure against pollution liability. For a considerable period of time, pollution liability insurance simply was unavailable. Slowly, insurance against liability arising out of abrupt events (defined by reference to a number of days rather than by an adjective such as "sudden") became selectively available again.[42] And some insurance against liability for gradual pollution – a specialty insurance product – also became selectively available, as actuarial experience made that possible.

E. AVOIDING DUPLICATION

The last major reason for exclusions is to avoiding insuring the same risk concurrently under two different policies – to implement a particular fragmentation and avoid what might be called "double bundling" that would needlessly increase the costs of both selling coverage and processing claims. Consequently, certain risks that might otherwise be covered under one type

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[41] *See id.* at 160-61.

[42] *See* ABRAHAM & SCHWARCZ, *supra* note 9, at 526.

of policy are excluded, because they are routinely covered under another type of policy.[43]

For example, Homeowners policies exclude coverage of damage to, and liability arising out of, the ownership or operation of motor vehicles.[44] These risks are covered by auto insurance. Directors & Officers liability insurance policies exclude coverage of liability for bodily injury and property damage.[45] These risks are covered by CGL policies. CGL policies exclude coverage of auto liability, which is, obviously, covered by auto insurance.[46]

III. VERBAL INCOMPLETENESS

In contrast to the absence of coverage – either an omission or a "gap," as I have been calling it – are situations in which there is at least arguably coverage, but language missing from the policy leaves coverage incompletely specified. There are three main ways in which insurance policies leave things unsaid.

A. THREE FORMS OF INCOMPLETENESS

Insurance policies leaves things unsaid in three different ways. First, some relevant, or potentially relevant, subjects of coverage are simply not addressed. These are pure omissions. Second, some subjects are addressed, but addressed incompletely. Third, some subjects are addressed, but vaguely or imprecisely, because they involve matters of degree.

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[43] This has sometimes also been called "market segmentation." *See* BAKER & LOGUE, *supra* note 21, at 417.

[44] *See* ABRAHAM & SCHWARCZ, *supra* note 9, at 189, 202.

[45] *Id*. at 541.

[46] It is worth noting, however, that not all duplication can be avoided through the use of exclusions. Some potential duplication occurs because an insured has access to concurrent coverage provided by two or more policies of the same type. An individual may be driving someone else's car, in which case both the driver's and the owner's auto insurance would cover him against liability. Or an individual may have health insurance provided by his own employer, as well as separate health insurance provided to him by his spouse's employer as a family member of the spouse. In instances such as these, separate provisions in each policy, labeled "other insurance" or "coordination of coverage" will specify which policy has primary and which policy has only secondary coverage responsibility.

1. Omissions

True omissions from insurance policies – instances in which there is no policy language bearing on an issue posed by a particular claim, but there is nonetheless a legitimate question whether there is coverage – are rare. When there is coverage, or it is arguable that there is coverage, there is almost always some language that has a bearing on the issue. But sometimes the relation between policy language and a particular claim is so attenuated that it amounts to an omission rather than merely incomplete expression. For example, business interruption coverage sometimes refers to the amount of time that "would be required" to "rebuild, repair, or replace" damaged, insured property.[47] If the damaged property is a drug store in one of the World Trade Center towers, then this provision is silent about what standard to use: a) the amount of time that would be required to build something that never existed – a freestanding drug store building, or b) the amount of time that would be required to rebuild the entire World Trade Center tower in which the drug store was located.[48]

Similarly, many insurance policies contain express subrogation provisions. Those provisions grant insurers the insured's right of recovery against third parties to the extent of the insurer's payment to the insured on account of a loss for which the insured has such a right of recovery. But those provisions say nothing about what happens when the insured exercises its own right of recovery against a third party, including what happens when the insured settles a claim against the third party for less than the full amount of the loss.[49] Neither of these cases involves a gap – the problem is not whether there could be coverage at all, but rather an omission of what the terms of coverage are. The policy omits mentioning what is necessary to make that determination.

2. Incompleteness

Many insurance policy provisions incompletely address the subject to which they pertain. For example, Homeowners policies contain exclusions applying to "intentional" property loss,[50] and CGL insurance policies insure

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[47] *See, e.g.*, Duane Reade, Inc. v. St. Paul Fire & Marine Ins. Co., 279 F. Supp. 2d 235, 237 (S.D.N.Y. 2003).

[48] *See id.* at 239 (holding that the former is the relevant time period).

[49] *See, e.g.*, ABRAHAM & SCHWARCZ, *supra* note 9, at 208; Associated Hosp. Serv. of Phila. v. Pustilnik, 396 A.2d 1332, 1338 (Pa. Super. Ct. 1979) (addressing the insurer's rights when the insured settles a suit against a third party).

[50] *See* ABRAHAM & SCHWARCZ, *supra* note 9, at 198.

against liability for bodily injury or property damage that is "expected or intended."[51] Neither provision specifies whether coverage is excluded when the insured expects, or intends, one type of bodily injury or property damage and a different type occurs, or whether coverage is excluded when property damage is expected or intended and bodily injury occurs instead.[52] Similarly, auto liability insurance policies cover liability for bodily injury or property damage caused by an "auto accident," without defining that term.[53] Beyond collisions, which would undoubtedly be considered "auto accidents," the term does not indicate what fortuitous occurrences involving an automobile are included. Each of these provisions is an example of incomplete specification.

Sometimes there is only a fine line, however, between a provision that is incomplete, and a provision that is complete but requires application to a particular set of facts. Although few policy provisions are self-applying in all situations, most policy provisions are not incomplete. Rather, even "complete" provisions often still require active interpretation when they are applied to the particular facts of a claim. For example, in *Port Authority of New York and New Jersey v. Affiliated FM Ins. Co.*[54] the question was whether the mere presence of asbestos containing materials in the policyholder's buildings constituted "physical loss or damage" under its property insurance policies. There is admittedly a sense in which that phrase is incomplete; the policy could have further defined it. But it seems more accurate to say that the phrase required application to a particular set of facts.

On the other hand, suppose that an auto liability insurance policy covers liability for injury "arising out of the use" of an auto, and the insured is sued for injury caused by throwing a firecracker out the window of a parked car.[55] There is admittedly a sense in which a coverage determination would merely constitute application of the term "use" to this set of facts. But it seems more accurate to say that the term use, standing alone, is incomplete in this context. But both situations are close.

3. Vagueness

The term "vagueness" is sometimes used interchangeably or along with "ambiguity." As I use the term here, a term is vague if its boundaries are indistinct or indeterminate, even if its core meaning is unambiguous. For

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[51] *Id.* at 440.

[52] Interestingly, Homeowners policies do so specify. *Id.* at 204.

[53] *Id.* at 639.

[54] 311 F.3d 226, 236 (3d Cir. 2002).

[55] *See* Farm Bureau Mut. Ins. Co., Inc. v. Evans, 637 P.2d 491, 493 (Kan. Ct. App. 1981).

example, many claims-made policies contain exclusions applicable to claims that are "related" to a claim that was made against the insured during an earlier policy period.[56] Obviously, claims that are identical or nearly identical are "related." Such claims fall within the core meaning of the term. But the term "related" is vague at the borderline. It does not specify the degree of similarity that two claims must share in order to be "related."

Occurrence-based CGL insurance policies also contain certain vague provisions. For example, the very definition of an occurrence is "an accident, including continuous or repeated exposure to substantially the same general harmful conditions."[57] The phrase "substantially the same general harmful conditions" is vague in two respects. The terms "substantially" and "general" are both indistinct at their boundaries.

Similarly, the standard-form CGL policy covers liability incurred because of bodily injury or property damage that occurs "during the policy period," and further provides that such bodily injury or property damage "includes any continuation, change or resumption of *that* 'bodily injury' or 'property damage' after the end of the policy period."[58] This is sometimes referred to as the "Montrose" clause, after the case that seems to have generated insurers' decision to incorporate the clause in CGL insurance policies.[59] The entire phrase "bodily injury or property damage" is vague. It does not indicate what constitutes "that" (i.e., prior – bodily injury or property) and what constitutes new, and therefore not "that" bodily injury or property damage. Clearly, if a fire starts burning, appears to have been extinguished, and then starts to burn in exactly the same place, the reignited fire is a resumption of "that" property damage. But beyond this core meaning of "that" property damage, the point at which subsequent harm ceases to be part of prior harm and is now new harm is indistinct. For example, suppose the fire spreads to another piece of property after it reignites.

The point is not that such issues cannot be resolved. On the contrary, the courts have long been in the business of resolving such issues by means of interpretation that makes reference, among other things, to the purposes that underlie provisions such as "that bodily injury or property damage." The point is that the provisions they are interpreting in such situations are vague,

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[56] Some policies go on to define a related claim as one arising from the same or related facts, circumstances, or wrongful act, which of course is not entirely helpful, in that the definition employs the defined term. ABRAHAM & SCHWARCZ, *supra* note 9, at 553.

[57] *Id.* at 453.

[58] *Id.* at 439 (italics added).

[59] *See* Craig F. Stanovich, *The Montrose Endorsement—15 Years Later*, IRMI (Sept. 2014), https://www.irmi.com/articles/expert-commentary/the-montrose-endorsement-15-years-later.

and that this very vagueness is what requires a process of interpretation of this sort, because something has been left unsaid in the insurance policy.

B. REASONS FOR VERBAL INCOMPLETENESS

There are roughly half a dozen reasons why insurance policies leave things unsaid. Some are linked predominately to omissions, incompleteness, or vagueness, whereas others apply to more than one of these forms of imperfect expression. They run along a spectrum from inevitable, or at least often benign or desirable reasons, to avoidable and undesirable reasons. I will discuss them in this order.

1. Avoiding Excessive Complexity

Insurance policies are necessarily complex documents. In order to specify what is and what is not insured, it is often necessary to articulate the terms of coverage in considerable detail. But there is a practical limit to the amount of specification that is desirable or even tolerable. Although greater specification often adds clarity, adding words also risks detracting from clarity. In any event, even when greater specification unquestionably would enhance clarity, it may have disadvantages. As Judge Posner put the point:

> Drafters cannot anticipate all possible interactions of fact and text, and if they could, to attempt to cope with them in advance would leave behind a contract more like a federal procurement manual than like a traditional insurance policy. Insureds would not be made better off in the process. The resulting contract would not only be incomprehensible but also more expensive.[60]

An insurance world in which an ordinary lawyer with a general civil practice would require several hours to understand a standard consumer or auto insurance policy in order to advise her client probably is not worth the enhanced clarity that much more explicit language in insurance policies would provide. This does not mean, of course, that every omission, incompleteness, or vagueness reflects an optimal level of specificity. Some provisions could be improved with little to no risk of facing the disadvantages that sometimes accompany greater specificity.

For example, I am not at all sure that including more detail in the Montrose clause that was quoted earlier would be worth the greater

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[60] Harnischfeger Corp. v. Harbor Ins. Co., 927 F.2d 974, 976 (7th Cir. 1991).

complexity that would accompany doing so. Without a great deal more language, revision through elaboration still would be unlikely to resolve many of the issues that would continue to arise in interpreting the clause. For example, one of the scenarios to which the clause applies is leakage of hazardous waste. Suppose that in policy year one, waste leaks from a site and contaminates groundwater (underground water) lying fifty feet beyond the boundary of the site where it was deposited. That is "property damage." Suppose further, however, that in policy year two, the waste that was already in the groundwater migrates further, and contaminates previously-uncontaminated groundwater lying between 50 and 500 feet beyond the boundary of the site. Redrafting the clause to make it clear whether it applies to this scenario would require considerable additional language. But such redrafting would not address other possible scenarios – for example, suppose that additional pollutants further contaminated the already-contaminated groundwater during year two. Still more language could be required to address this type of scenario. In the end, without complex elaboration, the different permutations that could arise cannot be addressed so as to be effectively self-applying.

Similarly, the liability insurance provided by the standard Homeowners policy contains an exclusion pertaining to "sexual molestation, corporal punishment or physical or mental abuse."[61] The term "abuse" is undoubtedly imprecise, but more precise language would be difficult to fashion without providing a series of non-exclusive illustrations, which would themselves be subject to interpretation. The game does not seem worth the candle in this situation.

On the other hand, it is not difficult to find policy provisions that leave things unsaid unnecessarily, because a few extra words could substantially increase their clarity. For example, for several decades, insurers have sometimes argued that they have a right to recoup the costs of defense from insureds they have defended when it is subsequently decided that there was no duty to defend.[62] Insurers could easily remedy this purported omission by providing for such a right with language to the effect of: "[i]f we defend you and it is later determined that we had no duty to do so, we have the right to be reimbursed by you for our costs of defense." Such a provision would not introduce excessive complexity.

Another provision that could benefit substantially from short and simple elaboration is the "expected or intended" harm exclusion in CGL insurance policies. As I noted earlier, that provision is incomplete in that it does not indicate whether liability for harm that is different from what the insured expected is excluded. Suppose the insured expects property damage

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[61] ABRAHAM & SCHWARCZ, *supra* note 9, at 204.

[62] *Id.* at 600-01.

but bodily injury occurs. Suppose the insured expects minor injury to one person and a dozen people are seriously injured. These omissions could be addressed, for example, by providing that the exclusion applies "even if the injury or damage that occurs is different in kind or magnitude from what was expected or intended."[63]

2. Accommodating Matters of Degree

Matters of degree are difficult to capture with bright-line, hard-edged language. That is as true of insurance policy provisions as it is of common law definitions of concepts such as negligence or reliance. Policy provisions that hinge on matters of degree are therefore likely to have an unavoidable measure of vagueness at the margin. The term "related," as described earlier in connection with "related claims" exclusions in claims-made policies, involves a matter of degree. The same is true of an exclusion of coverage in a property insurance policy when the insured property is "vacant" for a specified period.[64] Even definitions of coverage terms can fall prey to this problem. For example, by definition, an insured must be "disabled" under most Disability Insurance policies. One policy provided that the insured was disabled if he was "not able to engage in any gainful occupation" in which he "might reasonably be expected to engage because of education, training or experience."[65] The term "able" in this context poses a question of degree that the second quoted clause qualifies, but could never fully eliminate.

In contrast to omissions and incompleteness, the most effective remedy for the vagueness associated with policy provisions that involve matters of degree usually is not greater specification of the concept. The concepts of relatedness, vacancy, and ability to work will remain vague, though perhaps a bit less vague, even after greater specification, because they will remain matters of degree. Rather, a solution to the problem posed by concepts involving matters of degree is sometimes to shift to a less vague, though more rigid, proxy.

A classic example is the exception to the pollution exclusion for "sudden and accidental" discharges of pollutants that was contained in standard-form CGL insurance policies between 1973 and 1986. The term "sudden" is a question of degree, and posed a series of other interpretive

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[63] For a provision in the standard-form homeowners policy that says essentially that see *id.* at 204.

[64] *See, e.g.*, Langill v. Vermont Mut. Ins. Co., 268 F.3d 46, 47 (1st Cir. 2001).

[65] *See* Mossa v. Provident Life and Cas. Ins. Co., 36 F. Supp. 2d 524, 526 (E.D.N.Y. 1999).

problems. An "absolute" pollution exclusion was substituted, but a pollution "buyback" was sometimes offered, permitting coverage if the discharge of pollutants was discovered by the insured within a specified number of days after it commenced, and reported to the insurer within a certain number of days after that.[66] The vague concept of suddenness was replaced with a specified number of days, which is a concrete, though more rigid, concept.

3. Acquiescing in an Established Judicial Gloss

The final justifiable reason for not saying something in an insurance policy is that insurers sometimes find the courts' prior interpretation of omissions, incompleteness, or vagueness to be acceptable, even if the interpretations were not what the insurer originally intended. As long as the courts tend to produce similar or identical interpretations, and outcomes of claims are therefore predictable, insurers can calculate the appropriate additional premium to charge for coverage that the courts have held is broader than insurers intended.

The courts' interpretations of the duty to defend, contained in almost all standard-form liability insurance policies, is an example. That provision is brief in the extreme; it is a classic example of an incomplete provision. Consequently, many issues about the scope of the duty, that the provision does not address, have arisen over the years. Yet the standard-form provision has never been modified. Insurers have simply acquiesced in the scope of the duty that the courts have defined and have charged premiums accordingly.[67] This has been even more dramatically the case for liability insurers' duty to settle, which is not embodied in policy language at all. Liability insurance policies have always purported to give insurers discretion as to whether to settle claims against their insureds.[68] Yet the courts have fashioned a duty to accept reasonable settlement offers, and insurers have never modified their policies to specify that they have no such duty or to define the duty's scope. They have simply acquiesced in the duty as the courts have defined it.[69]

Obviously, not all insurers' decisions not to modify policy language constitute acquiescence in the gloss that the courts have placed on this language. There may be other reasons, specific to the particular situation, that prompt insurers to leave something unsaid, even if they object to the interpretations the courts have adopted. For example, a standard-form policy provision that has been interpreted differently in two different states would

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[66] *See* ABRAHAM & SCHWARCZ, *supra* note 9, at 526.

[67] *Id.* at 577.

[68] *Id.* at 609.

[69] *See* RESTATEMENT OF THE LAW LIAB. INS. § 24 (AM. LAW INST. 2019).

require a modification in one of the states to conform its meaning to that which already prevails in the other state. This would render the wording of the two provisions different, and therefore non-standard. Other things being equal, that is undesirable. In addition, changes in policy language typically require state regulatory approval or acquiescence before they can take effect.[70] Proposing a modification therefore risks drawing attention to the change and resulting regulatory rejection.

4. Deliberate Overbreadth

In contrast to the preceding reasons for verbally incomplete coverage, the following reasons usually are not justifiable. One example is an unnecessarily overbroad limitation on coverage. An overbroad limitation on coverage gives the insurer discretion to deny some claims based on the language of the limitation, but to pay some claims that the language also purports to preclude. Such a provision leaves the actual scope of the limitation on coverage unstated. Perhaps the classic example of this approach is the definition of "pollutants" in CGL insurance policies. These are defined as "any solid, liquid, gaseous or thermal irritant or contaminant."[71]

This language is broad enough that it could easily be applied to harm caused by substances that in most settings are not pollutants in any plausible sense, such as catsup or salt, which could irritate a person's eye or contaminate a batch of flour. The breadth of the policy language leaves unstated which substances the insurer will actually classify as pollutants and which it will not when a claim for coverage is actually made.

Overbreadth of this sort has two disadvantages. First, overbreadth undermines predictability of outcome. Insureds have less ability to determine whether a claim is likely to be paid, and both insureds and insurers have less ability predict the outcome of disputed claims in litigation. Second, overbreadth accords insurers discretion to pay or not to pay claims that is potentially subject to abuse. Insurers may treat identical claims differently for reasons that have nothing to do with the nature or merits of the claim itself. Like claims, then, are not treated alike. Although there is obviously no equal protection right accorded to policyholders, there is an implicit contractual norm that the same coverage rights apply to all claimants.[72] Selective payment of identical claims pursuant to overbroad limitations on coverage would violate this norm.

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[70] ABRAHAM & SCHWARCZ, *supra* note 9, at 142.

[71] *Id.* at 453.

[72] *See* Kenneth S. Abraham, *Four Conceptions of Insurance,* 161 U. PA. L. REV. 653, 691-93 (2013).

5. Coverage Information Asymmetry

Most insurers know more about what their policies cover than most insureds. Insurers not only know more about the language of their policies, but also more about how the courts have interpreted them. Sometimes an insured, or an insured's lawyer, interprets a policy not to provide coverage when it does provide it. This may be the result of misreading complicated language, interpreting ambiguous policy language against coverage, or not recognizing that the courts have held that a particular provision actually provides coverage. In this latter situation the policy leaves unsaid, or partially unsaid, the fact that the claim is covered. Modifying the policy to clarify that there is coverage in the relevant situations would result in more claims, without any obvious corresponding benefit. Consequently, the fact that there is coverage is left unsaid.

IV. IMPLICATIONS

The principal message of my analysis is that there are many reasons why insurance coverage is always incomplete in the sense that I have used this term here. In order to avoid making simplistic assumptions about the completeness or incompleteness of insurance coverage, courts, regulators, and commentators would benefit from a more sophisticated understanding of what it means to consider whether coverage is "incomplete." This means appreciating that the notion of a "gap" in coverage, standing alone, is usually unhelpful; recognizing that the notion of incompleteness is not meaningful without a particular baseline for comparison; and adopting an approach to interpretation that goes beyond the simple distinction between plain and ambiguous policy language.

A. "GAPS" IN COVERAGE

Insurance law scholars[73] and the courts[74] sometimes refer to a "gap" in the coverage provided by an insurance policy or by a particular form of

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[73] *See, e.g.*, Jay M. Feinman, *Fragmented Risk: An Introduction*, 11 RUTGERS J. L. & PUB. POL'Y 11, 6 (2013); Erik S. Knutsen*, Confusion about Causation in Insurance: Solutions for Catastrophic Losses,* 61 ALA. L. REV. 957, 986 (2010); Alexia Brunet Marks, *Under Attack: Terrorism Risk Insurance Regulation*, 89 N.C. L. REV. 387, 390-91 (2011); Jeffrey W. Stempel, *Rediscovering the Sawyer Solution: Bundling Risk for Protection and Profit,* 11 RUTGERS J. L. & PUB. POL'Y 171, 200 (2013).

[74] *See, e.g.,* Farm Family Cas. Ins. Co. v. Henderson, 116 N.Y.S.3d 771, 774 (N.Y. App. Div. 2020) (referring to "policies that leave gaps in

insurance in general. The very idea of a gap, however, at least implicitly presupposes some reference-class or baseline of comparison that does not contain a gap. When we speak of a gap between two mountains, for example, we are envisioning a continuous range of mountains with the same elevation and comparing it to a configuration of mountains that is not continuous. Without envisioning a continuous elevation, the notion of a "gap" would not have meaning. There would simply be mountains in some places and not in others.

Many references to, and arguments regarding, gaps in coverage, however, employ no express or obvious baseline. Some use the term "gap" simply to refer to something that is not covered. Others seem to presuppose some form of broader coverage, even if only as an ideal. Both uses of "gap" rhetorically trade on the pejorative connotation of the term, whether intentionally or subconsciously.[75] In contrast to the neutral notion of coverage that is not provided by an insurance policy, a "gap" in coverage implies that coverage which should be provided is omitted. The use of the term suggests that if there is a "gap" in coverage, that coverage is missing rather than just not provided.

For example, the insuring agreement of CGL insurance policies cover liability payable "as damages because of bodily injury or property damage . . ."[76] By virtue of this provision, liability for physical damage is covered, and liability for non-physical loss is not. To the extent that the absence of coverage of liability for non-physical loss is a "gap," it is a "gap" in the CGL policy's affirmative grant of coverage. But there are innumerable other risks that the policy does not affirmatively cover because of the kind of policy it is and is not. To think of all coverage that is not affirmatively provided as reflecting a "gap" would be fallacious.

Similarly, like all policies, the CGL policy goes on to reduce the coverage provided by the insuring agreement through the incorporation of exclusions, conditions, and other limitations on coverage. The coverage provided by the policy – the coverage carved *into* the policy out of the

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coverage"); Finch v. Steve Cardell Agency, 25 N.Y.S.3d 441, 443 (N.Y. App. Div. 2016) (referring to agent's failure to inform insured of an exclusion that create a "gap" in coverage); Dahms v. Nodak Mut. Ins. Co., 920 N.W.2d 293, 295 (N.D. 2018) (referring to brokers failure to procure policy that did not create "gaps in coverage"); First Mercury Ins. Co. v. Russell, 806 S.E.2d 429, 434 (W. Va. 2017) (referring to a "gap" in coverage lying in between two source of protection).

[75] As I noted at the outset, I am concerned here with substantive gaps, not temporal or monetary gaps. I have no quarrel with use of the term to apply to the latter two notions.

[76] ABRAHAM & SCHWARCZ, *supra* note 9, at 439.

universe of risks that it could insure, less the coverage that is then limited or excluded – is simply the combination of the insuring agreement and the other provisions in the policy. What is carved in is the coverage provided by the insuring agreement, net of the coverage removed by the exclusions, conditions, and other limitations.

In short, all insurance policies identify and insure a limited set of risks out of the universe of risks that an individual or entity faces. All insurance policies cover some risks but not others. This is the case regardless of whether this is done through limitations in the affirmative grant of coverage, exclusions and conditions that restrict the scope of that grant, or both. In order to determine whether, and in what sense, a policy contains a "gap" in coverage, it is necessary to have a baseline against which to measure or assess the coverage that the policy provides.

B. BASELINES

We have just seen that the notion of a "gap" in coverage, or coverage that is "incomplete," is likely not meaningful because there are always gaps and coverage is always incomplete. For the notion of a "gap" to be meaningful, the baseline being employed must be identified. There are a number of possible baselines, but each fails in different ways.

First, the scope of past coverage is likely to be an unsuitable baseline. Coverage often evolves in two directions: by expansion and contraction. Some risks that previously were not insured are added to coverage, but some risks that previously were insured are omitted or excluded. For example, Homeowners policies now cover losses resulting from credit card theft[77] whereas in the past they did not.[78] These policies now contain an extensive limitation on coverage of loss involving the collapse of insured property.[79] In the past they contained no such limitation.[80]

There are countless examples of evolving expansion and contraction of other types of policies as well. Changes in coverage, including new restrictions, are common. In this context, a restriction cannot automatically be considered a gap in coverage in the pejorative sense, simply by virtue of the fact that it is a restriction.

Second, even focusing exclusively on restrictions of coverage, the reason coverage that was once provided is now omitted or excluded is potentially relevant to the question of whether a restriction constitutes a gap.

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[77] *Id.* at 191.

[78] See the standard-form Homeowners policy set out in KENNETH S. ABRAHAM, INSURANCE LAW & REGULATION 184-95 (1st ed. 1990).

[79] *See* ABRAHAM & SCHWARCZ, *supra* note 9, at 194.

[80] *See* ABRAHAM, *supra* note 78.

The liability insurance portion of Homeowners policies now excludes coverage of liability for "sexual molestation," apparently regardless of whether any bodily injury associated with such molestation was "expected or intended."[81] Most people, I think, would not consider this new restriction a gap in coverage, but instead would view it as an appropriate limitation on what is insured.

Third, an alternative possible baseline is the coverage provided by contemporary standard-form policies. This approach has the great advantage of circumventing the principal deficiencies associated with using past policies as a baseline. The fact that a policy provides narrower coverage than a contemporary standard-form policy suggests that, however the expansion and contraction of coverage has evolved, the particular policy in question has evolved in a less expansive way than would have been feasible, and that any special restriction it embodies is probably not consonant with what would be viewed as a necessary or appropriate restriction on coverage. In an important study, for example, Daniel Schwarcz demonstrated that many Homeowners insurance policies have gaps in coverage, as compared to the standard-form Insurance Services Office (ISO) policy.[82] The idea of a gap, in that sense, is meaningful and useful. However, even if this is potentially an appropriate baseline, it does not follow that any variance between standard-form coverage and the coverage provided by the policy in question actually reflects a gap. There may still be good reason for an omission of coverage.

In addition, the deficiency of employing standard-form policies as a baseline is that this approach is necessarily incomplete. Although the coverage provided by a standard-form policy might be a suitable criterion by which to assess the coverage provided by a non-standard policy, that criterion cannot serve as a baseline for assessing whether the standard-form policy contains gaps of its own, and most policies are standard forms. That would be a completely circular test. To assess whether a standard-form policy contains a gap in coverage, a baseline external to the policy is required.

Finally, a very different baseline for determining whether a policy contains a gap in coverage could be the optimal set of coverages that a policy of that type would contain. Unfortunately, however, although this baseline is superior in principle to the other possible baselines, it is impractical in the extreme for a number of reasons.

The main reason is that the scope of coverage that is optimal for one policyholder is not necessarily optimal for others. A prototypical policyholder's preferences would have to be the model for this approach, and

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[81] ABRAHAM & SCHWARCZ, *supra* note 9, at 204.

[82] *See generally* Daniel Schwarcz, *Reevaluating Standardized Insurance Policies,* 78 U. CHI. L. REV. 1263 (2011).

it is far from clear what the characteristics of a prototypical policyholder are. Even setting this consideration aside, the prototypical policyholder's preferences are not necessarily congruent with the coverage that a prototypical insurer would be willing to provide. Various considerations influence that decision, and the premiums a prototypical insurer would charge will obviously depend on what the terms of coverage are. Consequently, the optimality standard would have to presuppose that each prototypical party had knowledge of the other party's preferences, as well as the constraints – administrative, financial, etc. – under which the other party was operating.

In any event, whoever were to decide whether a policy contained a gap based on that baseline would have to have that same knowledge. Academic analysts, courts, and even insurance commissioners fall far short of having such knowledge. Decades ago, during the high-water mark of common law judicial activism, there was experimentation with a modest version of the optimality baseline. Some courts held that the reasonable expectations of the insured as to coverage should be honored, despite unambiguous, fine-print policy language precluding coverage.[83] As many as a dozen or so jurisdictions purported to adopt this doctrine (perhaps provisionally adopted is a better description). A number have since backed away from the doctrine, and there is reason to wonder whether it is completely a thing of the past.[84]

Regardless of whether the doctrine still exists in a few states, I think that its failure to thrive can be attributed in part to the same kinds of practical difficulties that would be involved in identifying the optimal scope of coverage for a particular type of insurance policy. The courts asked to apply the doctrine often had no way of knowing the expectations of the typical policyholder. There does not appear to have been factual testimony about policyholder expectations generally, or about what would make an expectation reasonable, in any of the reasonable expectations cases.

Rather, whether a policyholder would reasonably expect the coverage in question seems to have been treated as a mixed question of fact and law, but ultimately a question to be decided as a matter of law by the court rather than by a jury. In some very simple cases, a court could see itself – or think that it could see itself – as the prototypical policyholder, and decide without evidence whether that policyholder would have expected the coverage at issue. But in any complex case, a sensible court would have to be agnostic. Exactly what coverage limitations a policyholder would reasonably expect, or not expect, would be difficult to know. The upshot was

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[83] *See generally* Symposium, *The Insurance Law Doctrine of Reasonable Expectations after Three Decades*, 5 CONN. INS. L.J. 1 (1998).

[84] *See* ABRAHAM & SCHWARCZ, *supra* note 9, at 59.

that, although it seems likely that some coverage limitations violate the prototypical policyholder's reasonable expectations, the game of identifying which limitations those were was not worth the candle. Moreover, as the era of judicial common law activism came to an end, it became an increasingly improper role for courts to play.

Insurance commissioners, in contrast to courts, are theoretically better equipped to independently investigate and make factual determinations regarding what risks prototypical policyholders would expect to be covered, and what exigencies and constraints might limit insurers' capacity to provide coverage that meets all these expectations. Realistically, however, regulatory resources are limited. Full-blown investigations will be rare. Instead, insurance commissioners are likely to use past policies and existing standard-form policies as baselines. The issue will be what changes a policy incorporates, and what justification can be given for the change. Only when there is an uninsured risk whose salience has recently increased will something resembling scrutiny from the ground up occur.

In short, for both courts and regulators, the optimal scope of coverage may seem to be an ideal baseline in principle, but it is not likely to be workable or employed often. Some metric other than the kinds of baselines we have considered must be used to determine whether a policy contains a gap in coverage, but it is not clear what that metric would be. The analysis thus far yields the conclusion that, without a baseline, the notions of a gap in coverage and incomplete coverage are not meaningful. And there is no generally suitable baseline available.

C. INTERPRETATION

The last implication of my analysis is that the stark distinction between plain meaning and ambiguity is often too simplistic to deal adequately with what might be considered incomplete coverage. The notions of plain meaning and ambiguity are often capable of dealing adequately with the interpretation of express policy language. But they are more likely to be unsophisticated tools for addressing the meaning and significance of what insurance policies do not say. There are too many potentially good reasons that a policy does not provide coverage, or leaves something unsaid, for either plain meaning or ambiguity to always control the characterization of the wide range of alternatives.

The principal device that the courts now use to deal with this phenomenon is to not mention it and then to develop a legal doctrine that addresses the problem. The courts' tendency to develop doctrines when insurance policies leave things unsaid, rather than invoking the blunt distinction between plain meaning and ambiguity, is an implicit recognition

of the inadequacy of the distinction in many contexts.[85] The problem with this approach, however, is that it does not recognize the reason for the problem and therefore does not lead naturally to the source of its solution. The courts, in effect, simply leave themselves with the need to devise a doctrinal solution.

But the source of the problem should inform the solution. As I have indicated, some "incomplete" coverage is the product of inevitable fragmentation. Some things are left unsaid in order to avoid unnecessary complexity or because vagueness at the borderline of a concept cannot be avoided. When this is the case, an attempt to fashion a doctrine or doctrinal interpretation without any artificial favoring of coverage is likely to be sensible. On the other hand, in cases of easily avoidable incompleteness, overbreadth, or apparent information asymmetry, a soft presumption in favor of coverage is more justified. Candid identification of the particular source of the problem, rather than non-interpretive silence followed by doctrinal elaboration, is a prerequisite to this approach.

I recognize that courts and the public usually have a strong interest in adjudicating insurance contract disputes as a matter of law. An approach that depends to some extent on resolution of questions of fact, and therefore often leads to the denial of summary judgment followed by discovery, is undesirable. But the need to identify the reasons insurance policies leave things unsaid should not often preclude summary judgment. These reasons are not adjudicative facts requiring fact-finding when they are disputed. They are "legislative," or policy-related facts that do not depend on the introduction of evidence.

Considering matters regarding what different kinds of standard-form insurance policies cover, for example, does not violate the rules precluding the admission of extrinsic evidence. Rather they relate to the kinds of (public) policy issues that courts are permitted to consider without the need for formal admission into evidence or fact-finding. Information about what different forms of standard-form policies are available and cover is available in treatises, casebooks, law review articles, and monographs that can be cited in briefs without being introduced into evidence or violating prohibitions on consideration of extrinsic evidence in the absence of ambiguity.[86]

As for omissions, incompleteness, and vagueness, the justification, or lack thereof, for policy provisions that leave something unsaid is one subject that the courts are capable of addressing without the aid of extrinsic evidence such as expert testimony. Judges are lawyers who can assess the quality of a policy's drafting, and the ease and simplicity with which a provision could have been more clear, with the input and arguments of

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[85] For discussion, see ABRAHAM & SCHWARCZ, *supra* note 9, at 359-61.

[86] *Id.* at 352-54.

counsel. This usually can be done on summary judgment without the need for fact or expert discovery.

In short, we need courts to have a more sophisticated understanding of the reasons that insurance policies sometimes leave things unsaid, as well as more candor from the courts about the bases for decisions that involve matters that policies have left unsaid. Insurance policy language often does not fit comfortably in the binary world in which language either has a plain meaning or is ambiguous. Pretending that it does will not produce progress or insight on this front.

CONCLUSION

All insurance policies, and consequently all insurance coverage, are incomplete. The notion of a gap in coverage is, therefore, unhelpful at best, and likely to be misleading. For reasons of historical path-dependence, coverage may be bundled or fragmented. For reasons associated with the dynamics and economics of the insurance function, coverage of certain risks will be excluded from, or limited by, insurance policies that might at first glance seem appropriate to cover these risks. And for both good reasons and bad, insurance policies leave some aspects of coverage unsaid. We would all do well to recognize these phenomena, and to bring a more sophisticated appreciation of the ways in which insurance coverage is incomplete and the reasons it is incomplete, to the task of understanding, interpreting, and applying insurance policies.