UNREASONABLE EXPECTATIONS? THE CONSTRUCTION OF GROUP INSURANCE POLICY PROVISIONS: HOWARD v. BLUE CROSS BLUE SHIELD OF NEBRASKA

INTRODUCTION

Because of the escalating cost of medical services and thus insurance premiums, employers sponsoring group insurance plans have been forced to decide between paying much more than the amount budgeted for employee health care or cancelling employee coverage altogether.¹ This increase in premiums and decrease in coverage has produced considerable litigation over claims of vested rights to continuing coverage under cancelled or terminated group insurance policies.² In an effort to reach an equitable solution to the problem, the courts have borrowed from existing principles of insurance policy construction, such as the doctrines of ambiguity and reasonable expectations.³

The Nebraska Supreme Court addressed this issue in Howard v. Blue Cross Blue Shield of Nebraska.⁴ Lloyd and Joy Howard were covered under a group health insurance policy provided by Lloyd Howard's employer, the City of Kimball, Nebraska.⁵ In 1984, Joy Howard gave birth to the Howard's daughter, Kathryn, who had a congenital birth defect.⁶ Less than a year after Kathryn's birth, Blue Cross Blue Shield of Nebraska ("Blue Cross") increased the policy premium by 31.9%.⁷ The City of Kimball responded to this premium increase by terminating its contract with Blue Cross in an effort to reduce costs.⁸

In Howard, the Nebraska Supreme Court looked only to the policy language, ignoring the question of whether the Howard's expectations of post-termination coverage were reasonable.⁹ This Note first re-

² See id.
⁶ Id. at 151, 494 N.W.2d at 101.
⁷ Id. at 152, 494 N.W.2d at 101.
⁸ Id.
⁹ Id. at 150-61, 494 N.W.2d at 99-106.
views the facts and holding of the *Howard* decision.10 This Note then examines cases in which the Nebraska Supreme Court and other courts have applied the ambiguity doctrine in construing insurance policy language.11 This Note then discusses decisions that have applied the reasonable expectations doctrine to the disputed insurance policy language.12 This Note then examines cases in which courts have fashioned a two-part analysis comprised of both the ambiguity and reasonable expectations doctrines in order to construe insurance policy language.13 Finally, this Note compares *Howard* with decisions of other courts faced with analogous factual settings.14 This Note then concludes with the suggestion that the Nebraska Supreme Court's failure to apply the reasonable expectations doctrine in *Howard* is inconsistent with established Nebraska law and the decisions of other jurisdictions.15

FACTS AND HOLDING

From May of 1979 to June of 1985, Lloyd and Joy Howard were covered under a group health insurance policy.16 The policy was negotiated between Blue Cross Blue Shield of Nebraska (“Blue Cross”) and the City of Kimball, Nebraska (“Kimball”), Lloyd Howard’s employer.17 The Blue Cross policy provided the group members with major medical benefits up to a lifetime maximum of one million dollars.18

In May of 1984, Joy Howard gave birth to a daughter, Kathryn.19 Kathryn Howard was born with spina bifida, a congenital birth defect,
which required intensive medical care and treatment. From May of 1984 until June of 1985, Blue Cross paid over $60,000 for medical and hospital treatment associated with Kathryn's condition.

In March of 1985, Blue Cross advised Kimball that its premium for the upcoming year would be increased by 31.9%. Kimball began accepting bids from competing insurance companies, hoping to replace the Blue Cross policy with a less expensive policy. Kimball terminated the policy with Blue Cross and replaced it with a policy from New York Life Insurance Company.

The termination clause of the Blue Cross policy provided in part: The Company may cancel this Contract at any time by written notice to the Applicant ... stating when, not less than 5 days later, the cancellation shall be effective. After this Contract has been in effect one year, the Applicant [City of Kimball] may cancel this Contract at any time by written notice to the Company, effective upon receipt or on such later date as may be stated in the notice. Thereupon, the Company will return the unearned portion of any dues paid, computed pro rata. Cancellation shall not affect any claim for services provided before the effective date of cancellation. If this Contract is cancelled or terminates or if Applicant executes a contract with another health care carrier or becomes self-insured, no conversion privileges shall apply.

Because the policy issued by New York Life provided lifetime maximum benefits of only $100,000, the Howards found themselves underinsured.

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(3) Pregnancy or any complications therefrom, unless normal childbirth would have occurred after 270 days of continuous maternity coverage.
  e. Congenital anomalies and birth abnormalities, which are defined as conditions existing at or from birth and which are a significant deviation from the common form or norm, including, but not limited to, ear deformities, harelip, birthmarks, webbed fingers or toes, or other conditions which may be reasonably determined by the Company to be congenital anomalies or birth abnormalities.

Blue Cross Blue Shield, Custom Flex Group Major Medical Master Contract 9742 4-83 at 11-12.

21. Id. The $60,000 paid by Blue Cross during that policy year accounted for 38% of the total claims paid by Blue Cross for Kimball employees covered under the group policy. Id. at 152, 494 N.W.2d at 101.
23. Id. The Howards expressed their concerns about the impending loss of coverage under the Blue Cross group plan directly to the mayor of Kimball, Nebraska and the Kimball City Council. Id.
25. Id. at 156, 494 N.W.2d at 103 (emphasis supplied by the court).
26. Id. at 165, 494 N.W.2d at 108 (White, J., dissenting). The difference between the lifetime maximums offered by the two policies amounted to a reduction of 90%. Id.
In September of 1989, the Howards filed a declaratory judgment action against Blue Cross. In their petition, the Howards alleged, among other things, that Blue Cross failed to continue coverage after the termination of the policy. The District Court for Scotts Bluff County, Nebraska, granted Blue Cross' motion for summary judgment, and in so doing, denied the Howards' claim for continued coverage. The district court granted the motion for summary judgment after noting that the policy was terminated by Kimball, not Blue Cross.

On appeal, the Nebraska Supreme Court affirmed the decision of the district court. The issue before the court was whether the language of the Blue Cross group policy was ambiguous on the issues of: (1) whether it was a contract of indemnity for services rendered during the life of the policy or a sickness and accident policy extending coverage for medical expenses or charges which result from sickness and accident; (2) its definition of services, covered services, and covered condition and the language of the termination provisions; (3) the specific extension of coverage for the care and treatment of birth defects and the insuring language which states that [Blue Cross] agreed to pay for 'services' as described in the policy; and (4) whether the policy extended lifetime coverage of $1,000,000 for medical catastrophes and permitted cancellation, termination, or modification after the catastrophe had occurred.

The court began its analysis by noting that an insurance policy provision is ambiguous "only if reasonably intelligent persons considering it in the light of the entire policy could honestly differ as to its meaning." The court stated that ambiguities in an insurance policy are to be construed against the insurer. The court acknowledged that if the Blue Cross policy was construed as a "medical expenses" policy, then the policy would be held to cover only those medical expenses incurred while the policy was in force. On the other hand, if the policy was construed as a "sickness and accident" policy, then the policy would be held to insure against the occurrence of sickness or injury arising during the life of the policy.

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28. Id. Both the Howards and Blue Cross moved for summary judgment. Id. at 152, 494 N.W.2d at 101.
30. Id. at 159, 494 N.W.2d at 105 (quoting the findings of the district court).
31. Howard, 242 Neb. at 161, 494 N.W.2d at 106.
32. Id. at 153, 494 N.W.2d at 102.
33. Id. at 154, 494 N.W.2d at 102.
34. Id. at 157, 494 N.W.2d at 104.
35. Id. at 154, 494 N.W.2d at 102.
36. Id.
In deciding whether the policy was a medical expenses policy or a sickness and accident policy, the court focused its analysis on the specific language of the insurance policy. The exclusions and limitations clause of the Blue Cross policy provided that "[n]o payments shall be made under this Contract, except as expressly stated herein, for . . . [s]ervices provided . . . [to] [a]ny Covered Person before their effective date of coverage, or after their termination." The Howards argued that the policy language was ambiguous and therefore should be construed in favor of their claim. In response, Blue Cross maintained that the policy language was unambiguous and therefore should be construed according to the plain and ordinary meaning of the terms. The court held that the disputed policy language was ambiguous neither as to the risk insured against nor as to the definition of the word "services" as used in the policy.

In denying the Howards' claim, the court reasoned that the policy was unambiguous. The court refused to "create an ambiguity where none exists or to father a contract obligation where none is stated or reasonably implied." The Howards claimed that the termination provision of the policy was ambiguous because the language failed to clearly state that all payments for services under the policy would cease on the date of termination. Instead, the policy provided that payment for "covered services" would terminate upon cancellation. The court reasoned that such an interpretation would be contrary to the fundamental nature of the insurance industry:

Insurance companies clearly base their premium rate on a calculation of their risk. To leave themselves open to risk after termination of [the] policy is not factored into the premium rates; to require them to do so would certainly create an undue burden, not only upon the insurance industry, but ultimately upon all policyholders, the very ones who pay the premiums, be it directly or indirectly.

37. Id.
38. Id. at 155, 494 N.W.2d at 103.
41. Howard, 242 Neb. at 156, 494 N.W.2d at 103.
42. Id. at 156, 494 N.W.2d at 105.
45. Howard, 242 Neb. at 157, 494 N.W.2d at 104.
46. Id. at 158, 494 N.W.2d at 105.
Because the court found no ambiguity in the policy, the court held in favor of Blue Cross.

The Blue Cross policy provided that new dependents could not be added until 270 days after the effective date of the policy. The Howards argued that the policy provision governing the addition of new dependents created reasonable expectations of coverage not only for maternity expenses, but also for medical expenses up to the one million dollar lifetime maximum in the event that the child was born with serious birth defects. However, the Supreme Court did not address this argument in its opinion.

Judge C. Thomas White, joined by Judge Thomas Shanahan, dissented. Although the dissent agreed with the majority that the Blue Cross policy was a medical expenses policy, the dissent argued that the policy language was utterly misleading with respect to when these services would be covered by Blue Cross.

The dissent distinguished between “cancellation” and “termination” of an insurance policy. The dissent pointed out that cancellation occurs when the insurer takes affirmative steps to end coverage prior to expiration under the policy terms. In contrast, termination of a policy occurs when coverage ends in accordance with the terms of the policy. The dissent observed that while the words “cancellation” and “termination” appeared throughout the contract, the section describing exclusions made no reference to the effect that cancellation would have on payments for services. Thus, the dissent reasoned that services would be excluded from coverage only upon termination of the policy, and any cancellation by Blue Cross would give rise to continuing liability for services rendered and expenses incurred after the effective date of such cancellation. According to the dissent, the essential issue in the case then became whether Blue Cross’ 31.9% increase in the annual premium effected a “constructive cancellation” of the policy. The dissent concluded that summary judgment was

47. Id. at 161, 494 N.W.2d at 106.
48. Id. at 164, 494 N.W.2d at 107-08 (White, J., dissenting).
50. Howard, 242 Neb. at 150-161, 494 N.W.2d at 99-106.
51. Id. at 161-66, 494 N.W.2d at 106-09 (White, J., dissenting).
52. Id. at 161, 494 N.W.2d at 106 (White, J., dissenting).
53. Id. at 161-62, 494 N.W.2d at 106-07 (White, J., dissenting).
54. Id. at 162, 494 N.W.2d at 106 (White, J., dissenting).
55. Id.
56. Id. at 161, 494 N.W.2d at 106 (White, J., dissenting).
57. Id. at 161-62, 494 N.W.2d at 106 (White, J., dissenting).
58. Id. at 162, 494 N.W.2d at 107 (White, J., dissenting).
improper because Blue Cross failed to distinguish between the terms “termination” and “cancellation.”

The dissent also questioned the propriety of the 31.9% premium increase in light of the promised one million dollar lifetime maximum provision contained in the policy. It reasoned that such a policy provision creates an expectation on the part of the insureds that if they suffer a catastrophic illness, then they would be covered by the policy. While acknowledging that an insurer, such as Blue Cross, may raise its premium, the dissent argued that an insurer should not be permitted to “grossly inflate” the premium charged when the language of the policy itself creates expectations on the part of the insured that coverage will be extended or continued after cancellation.

The dissent argued that Blue Cross should not have been at liberty to constructively cancel the policy by exorbitantly increasing the premium. The dissent noted that the Howards relied on the Blue Cross policy to their detriment by planning the pregnancy in accordance with the policy waiting period. Therefore, the dissent determined that a genuine issue of material fact existed which precluded summary judgment.

BACKGROUND

Insureds’ arguments for vested rights under group insurance policies are increasing in number at a time when the insurance industry is reassessing the profitability of group health insurance due to the escalating cost of medical services. As the cost of medical services has risen over the last decade, insurance companies have experienced eroding profit margins in the group insurance field.

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59. Id.
60. Id. at 162-63, 494 N.W.2d at 107 (White, J., dissenting).
61. Id. at 163, 494 N.W.2d at 107 (White, J., dissenting).
62. Id. The dissent referred to a recent decision of the Missouri Supreme Court, wherein that court reasoned that such a policy provision:

[...]

Lutsky v. Blue Cross Hosp. Serv., Inc., 695 S.W.2d 870, 874-75 (Mo. 1985) (en banc).
63. Howard, 242 Neb. at 163-64, 494 N.W.2d at 107-08 (White, J., dissenting).
64. Id.
65. Id. at 164, 494 N.W.2d at 108 (White, J., dissenting).
67. Id. at 622.
panies have responded by increasing the premiums charged to group sponsors or by reducing coverage under group plans.68

The primary contractual relationship in group insurance contracts is between the group sponsor and the insurance company.69 Ordinarily, the insurance company issues the policy to the group sponsor, who becomes the policyholder.70 As the policyholder, the group sponsor has an obligation to respect the rights of the persons covered under the plan.71 Under this arrangement, the group sponsor acts as neither the insurer nor the insured, and the obligation to respect the rights of the insureds does not rise to the level of a fiduciary duty to those insureds or their beneficiaries.72

In cases where insured persons claim vested rights to continuing coverage under group insurance policies, courts first must determine the particular risk against which the policy insures.73 The threshold issue courts must consider is whether the disputed policy language insures against medical expenses incurred while the policy is in force (“medical expenses policy”), or against the event giving rise to such expenses (“accident and sickness policy”).74 To resolve this question, courts analyze the specific language of the policies.75

THE AMBIGUITY DOCTRINE

The ambiguity doctrine has been defined as “a rule of construction which holds that any ambiguity found in insurance contracts must be

68. Id. Group insurance policy sponsors are ordinarily the insureds’ employers and are responsible for most if not all of the premium payments due under the group arrangement. Id. Compare Danzig v. Dikman, 434 N.Y.S.2d 217, 218 (N.Y. App. Div. 1980)(noting that counsel argued that the insurer increased premiums due to the rising costs of medical care), aff’d, 440 N.Y.S.2d 925 (N.Y. 1981) with Sonneman v. Blue Cross and Blue Shield of Minnesota, 403 N.W.2d 701, 703 (Minn. Ct. App. 1987)(noting that in order to continue the group plan and contain costs, the cost of coverage for out-patient mental health benefits would be reduced).


70. RONALD A. ANDERSON, 19 COUCH ON INSURANCE § 82:1, at 706-07 (2d ed. 1983) [hereinafter COUCH].

71. COUCH, supra note 70, § 82:1, at 707.

72. Id.


74. Auto-Owners, 349 N.W.2d at 244.

75. See id.
GROUP INSURANCE

construed strictly against the insurer. The ambiguity doctrine has been recognized and applied in Nebraska insurance disputes. The ambiguity doctrine is well established in the great majority of states. In practice, the ambiguity doctrine is applicable when disputed policy language "can be fairly interpreted in more than one way."

In Malerbi v. Central Reserve Life of North America Insurance Company, the Nebraska Supreme Court applied the ambiguity doctrine. In Malerbi, Larry Malerbi, his wife Linda, and son Bryan were covered under a group major medical policy. The policy provided indemnity for loss through sickness or accident. At the age of five, Bryan Malerbi underwent numerous hospitalizations for the treatment of a fever of undiagnosed origin. Bryan's condition was eventually diagnosed as epilepsy, which was subsequently treated with anticonvulsant drugs.

In 1982, Bryan was hospitalized at the Nebraska Psychiatric Institute ("NPI") after distinct changes in his personality were observed. Tests performed on Bryan during his hospitalization revealed that Bryan's condition was the result of a dysfunction in the temporal lobe of his brain. Bryan's doctor concluded that this organic dysfunction was the cause of both Bryan's epilepsy, and emotional and behavioral difficulties.

The Central Reserve Life of North America Insurance Company ("Central Reserve") policy provided coverage for mental disorders arising from organic origins but limited liability for mental disorders of

78. John Alan Appleman & Jean Appleman, 13 Appleman Insurance Law and Practice § 7401, at 179 (Revised 1976) [hereinafter Appleman].
79. Malerbi, 225 Neb. at 550-51, 407 N.W.2d at 162.
82. Id. at 544-45, 407 N.W.2d at 159-60.
83. Id. at 545, 407 N.W.2d at 159.
84. Id., 407 N.W.2d at 160.
85. Id. at 545-46, 407 N.W.2d at 160.
86. Id. at 545, 407 N.W.2d at 159-60.
87. Id. at 546, 407 N.W.2d at 160.
88. Id. An organic dysfunction is physiological in origin as opposed to a purely psychological dysfunction. Id., 407 N.W.2d at 159. The policy provided coverage for "any illness," which included a mental dysfunction caused by a physiological disorder. Id.
nonorganic origins. The policy provided coverage for "expenses . . . actually incurred for necessary medical care and treatment for a non-occupational sickness or injury." The policy defined the word "sickness" as "physical sickness, disease, illness, bodily infirmity, mental illness or functional nervous disorder." NPI billed the Malerbis $41,865.00 for Bryan's hospitalization and treatment.

Central Reserve paid $3,459.80 toward the total, but denied liability for the remainder based on Central Reserve's view that Bryan's illness was a mental condition of a nonorganic origin. With regard to limitations on coverage, the Central Reserve policy provided that "[c]overed [e]xpenses will not include and no benefits will be payable for expenses incurred . . . in connection with treatment or care of nervous, mental or alcoholic conditions."

The Malerbis filed suit against Central Reserve in January of 1984. The District Court for Douglas County, Nebraska, held in favor of the Malerbis, reasoning that Bryan's expenses were covered under the terms of the Central Reserve policy.

On appeal, Central Reserve argued that the district court erred in finding that Bryan's treatment and care were not for a "mental condition" as identified in the limitations clause. The Nebraska Supreme Court began its analysis by noting that the resolution of disputes over ambiguity in insurance policies "turns not on what the insurer intended the language to mean, but what a reasonable person in the position of the insured would have understood it to mean at the time the contract was made."

The court stated that the policy failed to define the terms "mental illness" and "mental condition." The court further noted that this omission created ambiguity as to the extent of Central Reserve's liability. The court then applied the ambiguity doctrine and construed the policy in favor of the Malerbis. The court held that the

89. Malerbis, 225 Neb. at 545, 407 N.W.2d at 159. A nonorganic mental disorder has a purely psychological etiology and would be subject to the policy limitation for psychological treatment. Id.
90. Malerbis, 225 Neb. at 548, 407 N.W.2d at 161.
91. Id. at 549, 407 N.W.2d at 162.
92. Id. at 547, 407 N.W.2d at 160.
93. Id. at 547, 407 N.W.2d at 160-61.
94. Id. at 548, 407 N.W.2d at 161.
95. Id. at 547, 407 N.W.2d at 161.
96. Id. at 548, 407 N.W.2d at 161.
97. Id. at 549, 407 N.W.2d at 162.
98. Id. at 551, 407 N.W.2d at 163 (citing Denis v. Woodmen Accident & Life Co., 214 Neb. 495, 334 N.W.2d 463 (1983)).
99. Id. at 552, 407 N.W.2d at 163.
100. Id.
101. Id., 407 N.W.2d at 163-64.
Malerbis reasonably could have believed that Bryan’s treatment would be covered under the Central Reserve policy based on the professional opinions of their doctors. The court noted that as the party that drafted the policy, Central Reserve had a duty to precisely define any terms which were intended to limit liability.

In Lutsky v. Blue Cross Hospital Service, Inc., the Missouri Supreme Court considered the ambiguity doctrine in the context of a group health insurance policy. In Lutsky, Dennis and Judith Lutsky obtained membership in the Missouri Farm Bureau Federation (“Farm Bureau”), which provided a group health care plan written by Blue Cross Hospital Service (“BCHS”). The plan contained a lifetime maximum of one million dollars for hospital and medical services for each insured. While the policy was in force the Lutskys’ son, Loren, developed a psychiatric disorder that required hospitalization. Over a year after Loren’s hospitalization, BCHS replaced the existing plan with what the company designated the “comprehensive plan.” The comprehensive plan retained the one million dollar lifetime maximum, but reduced coverage for mental illness to an annual maximum of $5,000 with a lifetime maximum of $25,000.

The Lutskys sued BCHS to enforce coverage under the policy. The Circuit Court for the City of St. Louis decided in favor of the Lutskys, holding that their right to continued coverage had vested. The Missouri Court of Appeals reversed the circuit court order because the contract between Farm Bureau and BCHS permitted modifications of the policy terms. On appeal, the Missouri Supreme Court applied the ambiguity doctrine and concluded that the construction of the policy argued by BCHS would render the one million dollar lifetime maximum valueless. Therefore, the court decided the case

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102. Id. at 552, 407 N.W.2d at 163.
103. Id.
104. 695 S.W.2d 870 (Mo. 1985) (en banc).
105. Lutsky v. Blue Cross Hosp. Serv., Inc., 695 S.W.2d 870, 874-75 (Mo. 1985) (en banc).
106. Id. at 871.
107. Id. The $1,000,000 lifetime maximum provision was not contained in the policy itself, but was instead included in brochures and other materials issued from Blue Cross Hospital Service in reference to the contract. Id. at 873.
108. Lutsky, 695 S.W.2d at 871.
109. Id.
110. Id.
111. Id.
112. Id. at 870-71. In addition to payments for future expenses, the trial court ordered Blue Cross Hospital Service to pay over $84,000 of Loren’s expenses. Id. at 871.
113. Lutsky, 695 S.W.2d at 871.
114. Id. at 875. The court stated that “[i]f a contract promises something at one point and takes it away at another, there is an ambiguity.” Id. The court characterized
in favor of the Lutskys' claim. The decisions of the Missouri Supreme Court in Lutsky and the Nebraska Supreme Court in Malerbi illustrate the success of insureds' claims for continued coverage in disputes over mental health insurance benefits.

The majority of jurisdictions that have faced the ambiguity issue in the context of disputes over termination or cancellation of group insurance policies follow the reasoning of the Illinois Court of Appeals in Bartulis v. Metropolitan Life Insurance Company. August Bartulis was covered under a group insurance policy arranged between his employer and Metropolitan Life Insurance Company ("Metropolitan Life") which insured against hospitalization and medical expenses. Bartulis was injured in a car accident on May 4, 1959. The trustees administering the group policy notified the policyholders that the insurance would be terminated effective July 31, 1959. Bartulis entered the hospital for treatment on September 11, 1959.

Although the circuit court noted that Bartulis had incurred his expenses after termination of the policy, it held that his right to coverage had vested because he had been injured before the policy was terminated. The Illinois Appellate Court reversed the circuit court decision on the issue of liability for expenses incurred after termination of the policy. Bartulis argued that "justice and public policy" demanded that the insurer remain liable for the expenses despite clear and unambiguous policy language to the contrary. Metropolitan Life maintained that the policy was a medical expenses policy and therefore covered Bartulis' medical expenses incurred during the life of the policy. The court found in favor of Metropolitan Life and held

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this type of ambiguity as patent, resolvable within the four corners of the document itself without reference to extrinsic materials. Id. 115. Lutsky, 695 S.W.2d at 877. 116. See, e.g., Di Pascal v. New York Life Ins. Co., 749 F.2d 255, 260 (5th Cir. 1985)(applying Louisiana law to construe the policy language and allowing coverage for the insured's mental illness); Fields v. Blue Shield of California, 209 Cal. Rptr. 781, 789 (Cal. Ct. App. 1985) (applying the ambiguity doctrine to policy provision in granting coverage for a mental disorder); Velez v. Sentry Ins. Co., 446 So. 2d 408, 411 (La. Ct. App. 1984) (requiring insurer to give adequate notice to the insured before modifying mental health benefits coverage). See Levy, 26 Tort & Ins. L.J. at 628-36. 117. 218 N.E.2d 225 (Ill. Ct. App. 1966). See Levy, 26 Tort & Ins. L.J. at 622. 118. Bartulis v. Metropolitan Life Ins. Co., 218 N.E.2d 225, 225 (Ill. App. Ct. 1966). 119. Id. at 225. 120. Id. The policyholders had the option of converting from group coverage to individual coverage so long as any conversion was effected within 31 days of cancellation. Id. at 225. Bartulis did not exercise this conversion privilege. Id. 121. Bartulis, 218 N.E.2d at 225. 122. Id. at 226. The policy unambiguously covered only medical expenses and hospitalization costs incurred during the life of the policy. Id. 123. Bartulis, 218 N.E.2d at 227. 124. Id. at 226. 125. Id. at 225.
that unambiguous policy language must be given its plain and ordinary meaning.\(^\text{126}\)

**THE REASONABLE EXPECTATIONS DOCTRINE**

Other courts have analyzed insurance policy language under the reasonable expectations doctrine.\(^\text{127}\) The reasonable expectations doctrine ensures that the "objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations."\(^\text{128}\)

Courts have applied the reasonable expectations doctrine to prevent an insurer from invoking closely written qualifications and exceptions against claims made by insured persons when such invocations are inconsistent with the policyholders' reasonable expectations.\(^\text{129}\) The reasonable expectations doctrine occasionally is applied by courts even in the absence of ambiguity.\(^\text{130}\) The Nebraska Supreme Court has previously recognized the applicability of the reasonable expectations doctrine in insurance disputes.\(^\text{131}\)

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\(^{126}\) *Id.* at 226. The court stated: "[w]e recognize the rule that insurance contracts are construed in favor of the insured, but construction does not degenerate into a perversion of plain language to create an ambiguity where none exists or to fathen a contract obligation where none is stated or reasonably implied." *Id.* (citations omitted). *See* Hamilton v. Travelers Ins. Co., 587 F.Supp. 521, 523 (E.D. Mo. 1984), *aff'd*, 752 F.2d 1350 (8th Cir. 1985) (holding that in the absence of ambiguity, only expenses incurred before termination of the policy will be covered); Jefferson v. State Farm Ins., 551 A.2d 283, 287 (Pa. Super. Ct. 1988) (holding that where there is no ambiguity as to whether the risk insured against is medical expenses or occurrence of sickness or injury, the policy will be enforced as written without creating ambiguity to reach an alleged construction); Robin v. Blue Cross Hosp. Serv., Inc., 637 S.W.2d 695, 698 (Mo. 1982) (en banc) (holding that where the policy language is unambiguous, the plain meaning rule is applied); Guardian Life Ins. Co. of Am. v. Zerance, 479 A.2d 949, 953 (Pa. 1984) (holding that where the policy language is unambiguous, a court will construe the language as written).


\(^{128}\) *Keeton*, 83 Harv. L. Rev. at 967. Keeton suggests that the reasonable expectations doctrine is properly viewed as a corollary of the ambiguity doctrine when applied to the interpretation of insurance contracts. *Id.*

\(^{129}\) *Keeton*, 83 Harv. L. Rev. at 967.


\(^{131}\) *See*, e.g., Central Waste Sys., Inc. v. Granite State Ins. Co., 231 Neb. 640, 642, 437 N.W.2d 496, 498 (1989) (stating that an insurance policy should be construed ac-
MFA Life Insurance Company, MFA sales manager Loren John-
son visited Dennis Hemenway’s home to discuss the possible sale of
health insurance coverage. After deciding to purchase coverage,
Hemenway filled out the application with Johnson’s assistance. On
the application, Hemenway referred to his past medical treatment for
hernia conditions.

Hemenway then paid the premium for the first two months of cov-
erage and was given a conditional receipt. The receipt stated that
coverage was conditional upon payment of the premium, and MFA’s
satisfaction of Hemenway’s insurability. MFA issued the policy on
March 25, 1978. On March 29, 1978, several weeks after the appli-
cation had been submitted, Hemenway underwent triple-bypass sur-
gery. Hemenway submitted the claims to MFA, who denied
liability on the grounds that coverage was not effective on March 25,
1978, because the application as submitted to MFA did not properly
refer to Hemenway’s hernia condition.

Hemenway sued for a declaratory judgment on the question of
MFA’s liability. The District Court for Antelope County, Nebraska,
held in favor of Hemenway. On appeal, the Nebraska Supreme
Court began its analysis by noting that the liability of an insurer in
such cases depends upon the specific language of the receipt. Although the court found that Hemenway had not satisfied the condi-
tions precedent in the receipt, the court applied the reasonable expec-
tations doctrine and held that Hemenway was “under the impression
cording to the insured’s reasonable expectations and that the policy be accorded a rea-
sonable construction to effectuate its purpose); Hemenway v. MFA Life Ins. Co., 211
Neb. 193, 199, 318 N.W.2d 70, 74 (1982) (stating that an insurance contract should be
construed according to the reasonable expectations of the insured, and liberally con-
strued in favor of the insured in the presence of doubt); Dairyland Ins. Co. v. Esterling,
205 Neb. 750, 752-53, 290 N.W.2d 209, 211 (1980) (same); Bracy v. American Family
Mut. Ins. Co., 189 Neb. 631, 633, 204 N.W.2d 174, 175 (1973) (noting that an insured’s
objectively reasonable expectations pertaining to policy terms ordinarily will be upheld).
See Henderson, 51 Ohio St. L.J. at 827-34.

133. Id. at 196, 318 N.W.2d at 73. 134. Id. at 195, 318 N.W.2d at 72.
135. Id., 318 N.W.2d at 73.
136. Id. at 196, 318 N.W.2d at 73. 137. Id. at 196, 318 N.W.2d at 73. 138. Hemenway, 211 Neb. at 196, 318 N.W.2d at 73.
139. Id. at 197, 318 N.W.2d at 73. 140. Id.
141. Id. at 194, 318 N.W.2d at 72.
142. Id.
143. Id. at 197-98, 318 N.W.2d at 73-74.
that some advantage" had accrued to him because he had paid the premium in advance.\footnote{144}{Id. at 198, 318 N.W.2d at 74.}

In \textit{Modern Sounds \& Systems, Inc. v. Federated Mutual Insurance Company},\footnote{145}{200 Neb. 46, 262 N.W.2d 183 (1978).} the Nebraska Supreme Court applied the reasonable expectations doctrine to an automobile insurance policy.\footnote{146}{Modern Sounds \& Sys., Inc. v. Federated Mut. Ins., 200 Neb. 46, 49, 262 N.W.2d 183, 186 (1978).} In 1974, Roy John Reid, president of Modern Sounds \& Systems, purchased a new automobile in Scottsbluff, Nebraska.\footnote{147}{Id. at 47, 262 N.W.2d at 185.} Reid decided to sell the vehicle approximately one year later.\footnote{148}{Id.} Reid arranged with Arthur Jay to sell the automobile in Denver, Colorado, while Reid held possession of the title certificate in Nebraska.\footnote{149}{Id.}

Approximately one month later, F. Jerrold McMillon offered to purchase the automobile on terms acceptable to Reid.\footnote{150}{Id.} Reid signed over the certificate of title, and mailed it to Jay, who delivered the title and the automobile to McMillon.\footnote{151}{Id.} Upon delivery, McMillon provided Jay with a business check for the purchase price.\footnote{152}{Id.} McMillon delivered the automobile and the title to a used car dealer, who delivered the vehicle to a second used car dealer where the automobile was sold to a retail customer.\footnote{153}{Id.} During the period in which the automobile passed from dealer to dealer, McMillon's check was returned to Reid due to insufficient funds, and all subsequent attempts by Reid to obtain payment were unsuccessful.\footnote{154}{Id.}

Reid filed a claim with Federated Mutual Insurance Company ("Federated Mutual") on January 2, 1976, in order to obtain payment for the loss of the automobile due to theft.\footnote{155}{Id.} Federated Mutual denied liability under the theft clause of the policy, and Reid filed suit.\footnote{156}{Id.} The District Court for Scotts Bluff County held in favor of Federated Mutual because the Federated Mutual policy did not cover Reid's loss due to specific exclusions in the policy.\footnote{157}{Id.} The Federated Mutual policy provided that coverage was not available "under the [c]omprehensive and [t]heft coverage, to loss or damage due to conver-
sion, embezzlement or secretion by any person in possession of a covered automobile under a bailment lease, conditional sale, purchase agreement, mortgage or other encumbrance. 158

On appeal, Reid argued that the word “theft” should be construed broadly so as to include any wrongful or unlawful appropriation. 159 Federated Mutual argued that the court should limit the construction of the word “theft” to its common-law definition, which would equate “theft” with larceny. 160 The court began its analysis by stating that the policy should be construed according to the reasonable expectations of the insured as those expectations existed at the time the parties made the contract. 161 The court further noted that the insurance policy should be reasonably construed to give effect to its purpose, and the policy would be construed liberally in favor of the individual insured in cases of doubt. 162

The court opined that under its reading of the policy the term “theft” was much broader in meaning than common-law larceny. 163 The court observed that the term “theft” need not be synonymous with larceny, but could include swindling, pilferage, conversion, embezzlement, and other unlawful appropriations. 164 The court reasoned that Federated Mutual was likely aware of the broader range of definitions because the policy specifically excluded from coverage numerous forms of appropriation. 165 Therefore, the exclusion of the various types of appropriation demonstrated to the court that Federated Mutual used the term “theft” in the broader sense. 166 Because Federated Mutual failed to define the term “theft” in the policy, the court held that the term would be construed broadly. 167 The court reversed the decision of the district court and remanded the action for a new trial. 168

In Brown v. Blue Cross & Blue Shield of Mississippi, 169 the Mississippi Supreme Court applied the reasonable expectations doctrine and held that an insurance company was estopped from cancelling coverage under a group insurance policy after the insured became

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158. Id.
159. Id. at 49, 262 N.W.2d at 185.
160. Id., 262 N.W.2d at 186.
161. Id., 262 N.W.2d at 186.
162. Id.
163. Id.
164. Id. at 49-50, 262 N.W.2d at 186.
165. Id. at 50, 262 N.W.2d at 186.
166. Id.
167. Id. at 52, 262 N.W.2d at 187.
168. Id. at 53, 262 N.W.2d at 187. The court directed that in order to obtain coverage for theft of the automobile, Reid was required to prove by a preponderance of the evidence that McMillon acted with criminal intent. Id. at 52-53, 262 N.W.2d at 187.
169. 427 So. 2d 193 (Miss. 1983) (en banc).
pregnant.170 Relying on their group health insurance policy, Jerry and Linda Brown planned the conception of their child in accordance with the waiting period required for maternity coverage.171 On February 1, 1976, Jerry Brown's employer terminated the group policy with Blue Cross & Blue Shield of Mississippi ("BCBSM") and replaced it with a group insurance policy that did not offer maternity benefits.172 Linda Brown gave birth on July 13, 1976, and incurred significant medical expenses.173 BCBSM denied liability on the grounds that the termination of the policy ended its coverage obligations.174

The Browns sued BCBSM seeking a judgment that would entitle them to coverage for the maternity expenses.175 The Circuit Court for Marion County, Mississippi, sustained BCBSM's motion to dismiss, and the Browns appealed.176 On appeal, the Mississippi Supreme Court applied the reasonable expectations doctrine.177 The court held that the Browns had "irrevocably committed themselves to incur expenses" that they reasonably expected would be paid at least in part by insurance.178 In addition, the court stated that Linda Brown's pregnancy made it virtually impossible for the family to obtain maternity coverage from another provider.179 Therefore, even though the policy was terminated in accordance with its terms, the court held that BCBSM could not defeat the Brown's reasonable expectations of coverage.180

In Providence Hospital v. Morrell,181 the Michigan Supreme Court applied the reasonable expectation doctrine to a group insurance policy.182 In Morrell, the court held that an insured's right to coverage for expenses resulting from pregnancy vested when the insured became pregnant while the policy was in force.183 In May of

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171. Brown, 427 So. 2d at 141. The Blue Cross policy required a 270 day waiting period before the policy would cover maternity expenses. Id.
172. Brown, 427 So. 2d at 140. Brown's employer did not notify the Browns of the termination. Id.
173. Brown, 427 So. 2d at 140.
174. Id.
175. Id. at 139-40.
176. Id. at 140.
177. Id. at 141 n.2.
178. Id. at 140. The court justified its reasoning by noting that the Browns would not have been interested in the insurance policy if they understood that the insurer possessed the unilateral power to terminate their coverage. Id.
179. Brown, 427 So. 2d at 141.
180. Id.
183. Morrell, 427 N.W.2d at 534.
1982, United Fidelity Insurance Company ("United Fidelity") cancelled the group policy that covered Norah Morrell.\textsuperscript{184} At the time of the cancellation, Norah Morrell was pregnant.\textsuperscript{185} In September of 1982, she gave birth to her child at Providence Hospital.\textsuperscript{186} The Morrells submitted their claim for maternity expenses to United Fidelity.\textsuperscript{187} However, United Fidelity refused payment because the policy had been terminated.\textsuperscript{188} Providence Hospital sued the Morrells, who joined United Fidelity as a third-party defendant.\textsuperscript{189}

The Thirty-Fifth District Court granted summary judgment in favor of the Morrells, holding that the maternity expenses were covered.\textsuperscript{190} On appeal, the Michigan Court of Appeals held that the policy language was clear and unambiguous, but applied a "public policy exception" to the plain meaning rule: \textsuperscript{191} Although the termination provisions of the policy at issue, as well as the provision that only those expenses incurred during the life of the policy are covered, have a clear meaning and definition in the policy, we do not believe that the public policy of this state will permit the enforcement of such a termination or cancellation clause where the effect is to render a now uninsurable person without insurance coverage for those conditions which exist at the time of termination. . . . An insurance company cannot assume a risk when a person is apparently healthy and, thereafter, disavow the risk when the person has developed an illness or other coverable condition.\textsuperscript{192}

In so holding, the court of appeals stated that the same result would be proper in all cases where an insurance contract was terminated or cancelled after the covered condition arose.\textsuperscript{193} On appeal, the Michigan Supreme Court sustained the Morrells' claim under the reasonable expectations doctrine but limited the result to cases involving maternity coverage.\textsuperscript{194} The court reasoned that pregnancy, unlike other contingencies commonly insured against, results from a "deliberate decision of the insured."\textsuperscript{195}

\textsuperscript{184} Id. at 532.  
\textsuperscript{185} Id.  
\textsuperscript{186} Id.  
\textsuperscript{187} Id. The Morrells owed Providence Hospital $2,329.05 at the time the action was brought. \textit{Id.}  
\textsuperscript{188} \textit{Morrell}, 427 N.W.2d at 532.  
\textsuperscript{189} Id.  
\textsuperscript{190} Id.  
\textsuperscript{191} Id. at 534.  
\textsuperscript{192} Id. at 534 (quoting Providence Hosp. v. Morrell, 408 N.W.2d 521, 524 (Mich. Ct. App. 1987)).  
\textsuperscript{193} \textit{Morrell}, 427 N.W.2d at 534.  
\textsuperscript{194} Id.  
\textsuperscript{195} Id.
cally noted that the decision of the court of appeals went too far toward exposing insurers to "the potential for enormous expansion of liability . . . for payment of very expensive long-term care benefits."\textsuperscript{196} The court envisioned that its more conservative application of the reasonable expectations doctrine would lead to more predictable results.\textsuperscript{197} The court reasoned that the extension of coverage for a pregnancy would operate for only a limited amount of time, as opposed to the potential for unlimited liability resulting from a liberal application of the rule to conditions requiring long-term care.\textsuperscript{198} Other courts have employed similar reasoning in finding in favor of the claims of insureds in cases involving maternity coverage.\textsuperscript{199}

**APPLICATION OF THE AMBIGUITY AND REASONABLE EXPECTATIONS DOCTRINES AS A TWO-PART ANALYSIS**

In *Myers v. Kitsap Physicians Service*,\textsuperscript{200} the Washington Supreme Court applied both the ambiguity and the reasonable expectations doctrines to a group health plan.\textsuperscript{201} John Myers was an employee insured under a group health service contract provided by Kitsap Physicians Service ("Kitsap").\textsuperscript{202} In 1960, Myers was admitted to a clinic specializing in the treatment of kidney ailments.\textsuperscript{203} Myers received regular hemodialysis treatments over the next year and submitted the claims for the treatments to Kitsap.\textsuperscript{204} Kitsap denied liability for the hemodialysis treatments on the grounds that the group policy did not explicitly refer to such treat-

\textsuperscript{196} Id. The court reasoned that limiting its application of the reasonable expectations doctrine to disputes over maternity coverage would expose insurers to predictable amounts of coverage for only a finite time. Id.

\textsuperscript{197} Id.

\textsuperscript{198} Compare Morrell, 427 N.W.2d at 534 (limiting its holding under the reasonable expectations doctrine to disputes over maternity coverage) with Morrell, 408 N.W.2d at 524 (applying the reasonable expectations doctrine broadly so as to cover all cases where the insured's claim arose prior to termination of the policy).


\textsuperscript{200} 474 P.2d 109 (Wash. 1970) (en banc).

\textsuperscript{201} Myers v. Kitsap Physicians Serv., 474 P.2d 109 (Wash. 1970) (en banc).

\textsuperscript{202} Id. at 109.

\textsuperscript{203} Id.

\textsuperscript{204} Id. at 109-10.
ment. The arbitrator assigned to decide the question found in favor of Myers. Soon after, Kitsap advised Myers' employer that it planned to modify the health care contract so as to exclude the treatment of chronic kidney disorders. Kitsap thereafter refused to honor Myers' claims for hemodialysis treatments.

Both the Superior Court of Kitsap County, Washington, and the Washington Court of Appeals agreed that the policy was a medical expenses policy. Both courts held that because Kitsap had reserved the right to modify coverage at the beginning of each policy year, Kitsap was not liable for expenses incurred after such modification.

On appeal, the Washington Supreme Court employed the following two rules: (1) insurance policy ambiguities must be construed in favor of the insured; and (2) insurance policy language must be interpreted as it would be understood "by the average man purchasing insurance."

The court noted that the Kitsap policy contained language that could reasonably lead the insured to believe that coverage would continue throughout the life of the contract once medical treatment was needed. Therefore, the Washington Supreme Court determined that the combination of policy ambiguity and Myers' reasonable expectations of coverage rendered the Kitsap policy an accident and sickness policy.

In Dale Electronics, Inc. v. Federal Insurance Company, the Nebraska Supreme Court also applied both rules of construc-

205. Id. at 110.
206. Id.
207. Id.
208. Id. The health service contract provided Kitsap with the contractual right to modify coverage under the policy. Id.
209. Id.
210. Id.
211. Id.
212. Id. The Washington Supreme Court stated:

We find it difficult to believe that the "average man purchasing insurance" would, or could, contemplate from a reading of this contract that [Kitsap Physicians Service's] obligation terminates when the clock strikes midnight and the contract year ends, even though the insured may still be hospitalized or in need of further medical treatment for an illness incurred during the contract year.

Id. at 111. Accord Danzig v. Dikman, 434 N.Y.S.2d 217 (N.Y. App. Div. 1980), aff'd, 440 N.Y.S.2d 925 (N.Y. 1981). In Danzig, the New York Supreme Court, Appellate Division, expanded upon the reasoning of the Washington Supreme Court by stating that:

"[t]he existence of a lifetime maximum (whether limited or unlimited) discloses an awareness on the part of the insurer and all interested parties that an illness or condition might well continue indefinitely beyond any one contract term and, indeed, persist for the lifetime of an individual subscriber or his or her beneficiary."

Id. at 220-21.

213. Id.
214. Id. at 111.
tion.\textsuperscript{215} In \textit{Dale Electronics}, an airplane, owned by Dale Electronics and flown by a single pilot, crashed while attempting to land.\textsuperscript{216} The plane was insured through Federal Insurance Company ("Federal") in the amount of $250,000.\textsuperscript{217}

The Federal policy coverage was subject to the condition that the plane be piloted by a "two-man crew consisting of a captain and a co-pilot."\textsuperscript{218} However, an exception to the condition provided coverage when the aircraft was flown for the purpose of maintenance or ferry flights during "daylight Visual Flight Rules conditions."\textsuperscript{219}

Federal denied liability for the loss, arguing that the plane was not on a maintenance or ferry flight at the time of the crash.\textsuperscript{220} The District Court for Platte County held in favor of Dale Electronics, and Federal appealed.\textsuperscript{221}

On appeal, the Nebraska Supreme Court affirmed on two grounds.\textsuperscript{222} First, the court stated that the failure of the policy to define the term "ferry flight" created an ambiguity which must be construed against Federal.\textsuperscript{223} Second, the court further stated that the insured reasonably expected that the flight was a covered ferry flight.\textsuperscript{224}

\section*{ANALYSIS}

\subsection*{APPLICATION OF THE AMBIGUITY DOCTRINE}

In June of 1985, Lloyd, Joy, and Kathryn Howard effectively lost $900,000 worth of group health insurance benefits.\textsuperscript{225} The issue in \textit{Howard v. Blue Cross Blue Shield of Nebraska}\textsuperscript{226} presented a dispute over whether the Blue Cross policy was a "medical expenses" policy or a "sickness and accident" policy.\textsuperscript{227} In order to resolve the issue, the Nebraska Supreme Court focused its analysis on the language of the Blue Cross policy.\textsuperscript{228} However, the court failed to properly analyze...
the policy language in two respects. 229 First, the court failed to recognize that the policy was ambiguous to the extent that essential terms remained undefined. 230 Second, the court failed to consider the Howards' reasonable expectations. 231

The Nebraska Supreme Court first could have utilized the ambiguity doctrine to find that the policy terms were not clear as to the extent of coverage after termination. 232 The Howards argued that ambiguity existed in the policy regarding the use of the words "services" and "covered services." 233 The policy generally provided that Blue Cross would pay for "services" during the policy term. 234 The policy also referred to "covered services," which specifically included medical care and treatment. 235 Although the words "services" and "covered services" were used throughout the policy, the policy failed to define the word "services" as used independently of "covered services." 236

The Nebraska Supreme Court previously has found ambiguity in undefined policy provisions similar to those in the Blue Cross policy. 237 Such a failure to define key terms in a group major medical policy triggered an application of the ambiguity doctrine in Malerbi v. Central Reserve Life of North America Insurance Company. 238 However, in Howard the court dismissed the possibility that the failure to define the disputed terms created ambiguity. 239 By stating that although the terms were not independently defined, the court found that the context in which the word "services" was used "was an elaboration of the policy's coverage." 240 Thus, by defining the term "services" within its context, the court avoided the application of the ambiguity doctrine. 241 Therefore, by reading the terms in context rather than according to their literal meaning, the court's reading of the policy ignores the reasoning in Malerbi. 242

Similarly, the majority failed to acknowledge the dissent's argument that the contract failed to distinguish between a "cancellation"
and a "termination." As the terms "cancellation" and "termination" are used, only a termination of the policy would end Blue Cross' liability. The court determined that the Blue Cross policy terminated according to its own terms when the City of Kimball entered into its new contract with New York Life. However, the court disregarded the dissent's compelling argument that the 31.9% premium increase constituted a "constructive cancellation." Therefore, the policy was ambiguous as to whether such a cancellation of the policy would end liability. This ambiguity along with the question of whether the 31.9% premium increase constituted a constructive cancellation of the policy presented a genuine issue of material fact which would have precluded summary judgment.

**APPLICATION OF THE REASONABLE EXPECTATIONS DOCTRINE**

The court also erred by refusing to apply the reasonable expectations doctrine. In doing so, the court ignored the Howards' argument that the existence of the one million dollar lifetime benefits maximum created a reasonable belief that a catastrophic illness or injury would be covered for the lifetime of the insured.

Other courts considering the issue of continuing coverage after termination or modification of group insurance policies have shown a greater willingness to decide in favor of insured persons. Courts have decided the issue in favor of the insured in cases involving either mental illness or pregnancy. In *Providence Hospital v. Morrell*, the Michigan Supreme Court carved out a specific "public policy exception," phrased in the context of reasonable expectations, for cases centered around the termination or cancellation of a group policy after conception of a child by an insured. Likewise, in *Brown v. Blue Cross & Blue Shield of Mississippi, Inc.*, the Mississippi Supreme Court held that an insured's right to maternity coverage could not be affected by termination or cancellation of the policy once the insured

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243. Howard, 242 Neb. at 162, 494 N.W.2d at 106 (White, J., dissenting).
244. Id.
245. Id. at 160, 494 N.W.2d at 105 (White, J., dissenting).
246. *See supra* notes 53-59 and accompanying text.
247. *See supra* notes 53-59 and accompanying text.
249. *See supra* notes 127-99 and accompanying text.
250. Howard, 242 Neb. at 162, 494 N.W.2d at 107 (White, J., dissenting).
251. *See supra* notes 104-17, 166-99 and accompanying text.
252. *See supra* notes 104-17, 166-99 and accompanying text.
255. 427 So. 2d 139 (Miss. 1983).
becomes pregnant. The courts that favor continuing coverage in pregnancy cases particularly appear to reach their decisions using the reasonable expectations doctrine.

In *Lutsky v. Blue Cross Hospital Service, Inc.*, the Missouri Supreme Court demonstrated a similar willingness to protect the benefits of insureds suffering from mental illness. The court in *Lutsky* accepted the insureds' contentions by refusing to allow an insurer to cancel or modify coverage even when cancellation or modification privileges were specifically contained in the contract.

The *Brown* and *Morrell* decisions indicate a willingness on the part of the courts to apply the reasonable expectations doctrine in cases involving pregnancies because the insureds have relied on their policies to their detriment. It therefore is consistent to extend this application of the reasonable expectations doctrine to *Howard* because Lloyd and Joy Howard expected that not only would Blue Cross cover Joy Howard's maternity expenses, but also that Blue Cross would be there in the event that "something could be wrong with their child." The Howards' reliance upon the policy is demonstrated by their compliance with the waiting period. Furthermore, the Howards did not seek supplemental coverage, indicating that they believed that their coverage would not be taken away. Because the Howards believed they were adequately insured the only issue remaining was the reasonableness of the Howards' expectations.

**The Ambiguity and Reasonable Expectations Doctrines as a Two-Part Analysis**

After concluding that the Blue Cross policy was unambiguous, the Nebraska Supreme Court ended its inquiry. The decision of the Washington Supreme Court in *Myers v. Kitsap Physicians Service* represents the better view in cases such as *Howard*. In *Kitsap*, the Washington Supreme Court applied the ambiguity and reasonable expectations doctrines as a two-part analysis for deciding whether an
insured's coverage under a group health plan should be extended after
the plan was modified.269 The Nebraska Supreme Court employed a
similar two-part analysis in Dale Electronics, Inc. v. Federal Insurance
Company.270 Under the first part of the analysis, courts are able to
utilize the ambiguity doctrine to ascertain the objective legal signifi-
cance of disputed insurance policy language.271 Under the second
part of the analysis, the application of the reasonable expectations
doctrine allows courts to analyze the subjective expectations of the
insured.272

The Nebraska Supreme Court did not offer a reason for its failure
to apply the reasonable expectations doctrine in Howard.273 Although
the court was willing to apply the reasonable expectations doctrine in
disputes over coverage under individual insurance policies such as in
Dale Electronics, Hemenway v. MFA Life Insurance Company,274 and
Modern Sounds & Systems v. Federated Insurance Company,275 the
court in Howard did not suggest why the reasonable expectations doc-
trine would not be applicable in a dispute over group insurance cov-
erage.276 Instead, upon finding that no ambiguity existed in the policy,
the court ended its analysis.277 Other courts however apply the rea-
sonable expectations doctrine even though the disputed policy con-
tains no ambiguity.278 In fact, in Modern Sounds the Nebraska
Supreme Court itself analyzed an automobile insurance policy in the
same way.279 Nevertheless, the Nebraska Supreme Court did not ex-
plain why this same reasoning would not apply in Howard.280

As demonstrated in both Kitsap and Dale Electronics, a two-part
analysis comprised of both rules of construction provides courts with a
framework for a more comprehensive analysis than does an applica-
tion of either the ambiguity doctrine or the reasonable expectations
doctrine alone.281 Therefore, the Nebraska Supreme Court would

270. 205 Neb. 115, 286 N.W.2d 437 (1979). See supra notes 214-24 and accompan-
ying text.
271. See supra notes 169-99 and accompanying text.
272. See supra notes 127-99 and accompanying text.
274. 211 Neb. 193, 318 N.W.2d 70 (1982).
277. See supra notes 33-50 and accompanying text.
278. See supra notes 130-99 and accompanying text.
279. See supra notes 145-68 and accompanying text.
280. Howard, 242 Neb. at 150-61, 494 N.W.2d at 99-106.
281. Compare notes 200-24 and accompanying text (demonstrating the application
of the ambiguity and reasonable expectations doctrines as a two-part analysis) with
notes 76-199 and accompanying text (illustrating the applicability of the ambiguity and
reasonable expectations doctrines when used independently).
have performed a more complete analysis if it had applied both doctrines in construing the policy language in Howard.\textsuperscript{282}

CONCLUSION

The great volatility of the issue in \textit{Howard v. Blue Cross Blue Shield of Nebraska}\textsuperscript{283} foreshadows a continuing groundswell of claims by insureds to continuing coverage. Moreover, the singular importance of insurance coverage to individuals and their families will grow, not decline, in the coming years. The present body of case law on the issue of continued coverage after termination of group insurance policies reveals an unsettled area of insurance law where the application of only the ambiguity doctrine or of only the reasonable expectations doctrine does not bring about satisfactory results. Better results are obtained when courts apply the two-part analysis comprised of both doctrines of insurance policy construction.

Using the ambiguity and reasonable expectations doctrines as a two-part analysis, courts can test both the objective policy language and the subjective expectations of the insured.\textsuperscript{284} By applying the ambiguity doctrine, the Nebraska Supreme Court in \textit{Howard} concluded that the Blue Cross policy was unambiguous.\textsuperscript{285} Despite this conclusion, the court could have applied the reasonable expectations doctrine and found in favor of the Howards. Even if the court had not held in favor of the Howards, the court still would have conducted a more complete analysis and provided a guide for future courts facing disputes over group insurance coverage.

\textit{Michael J. Leahy—'95}

\textsuperscript{282} Compare notes 33-50 and accompanying text (reviewing the Nebraska Supreme Court's application of the ambiguity doctrine in \textit{Howard} without consideration of the reasonable expectations doctrine) with notes 200-24 and accompanying text (demonstrating the feasibility of an application of a two-part analysis comprised of both the ambiguity and reasonable expectations doctrines in insurance disputes).

\textsuperscript{283} 242 Neb. 150, 494 N.W.2d 99 (1993).

\textsuperscript{284} See supra notes 266-81 and accompanying text.

\textsuperscript{285} See supra notes 33-50 and accompanying text.