WHY PROCESS CONSUMER COMPLAINTS? A CASE STUDY OF THE OFFICE OF THE COMMISSIONER OF INSURANCE OF WISCONSIN*

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I. INTRODUCTION

Much of the current concern about consumer protection stems

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* This paper describes the complaint processing of the Wisconsin Insurance Office, and seeks to identify and understand the functions of that processing and the various roles the Office played. In carrying out its tasks, the Office was faced with serious legal and political limits on its freedom of action; indeed, there is no clear statutory authority for the office to engage in most of the activities described here. It is important to emphasize, therefore, that the paper does not seek to measure the quality of the Office's performance. Our explorations give us no reason to believe that the Office failed to do an adequate job of the tasks it undertook, given the available resources; even less did they give us reason to doubt the bona fides of the Office personnel. The authors hope that the article may contribute to better understanding by the Office personnel and others of the place of complaint processing in the scheme of insurance regulation, and may ultimately lead to better performance of the tasks. Those seeking to find a muckraking account, casting aspersions and assessing blame, will have to look elsewhere.

Financial support for this study came from a variety of sources. The Institute for Research on Poverty of the University of Wisconsin has been the principal supporter, from funds made available by the Office of Economic Opportunity, pursuant to the Economic Opportunity Act of 1964. The University of Michigan Law School, when the second author taught there, gave aid for the historical inquiry. More recently the University of Wisconsin Law School provided some support. The American Bar Foundation has helped in the later stages of the project. Valuable research assistance has been received from Ms. Barbara Heaney, LL.B., 1954, University of Utah; S.J.D. 1955, University of Wisconsin, who did the historical study for Spencer Kimball; Mr. Vincent Paulauskis, J.D., 1971, University of Wisconsin; Mr. H.H. Bell III, J.D., 1973, University of Wisconsin; Mr. Scott Herrick, J.D., 1973, University of Wisconsin; and Ms. Merrily Burch, third year student at the University of Wisconsin. Many persons at the Office of the Commissioner of Insurance and from the insurance industry have been generous with their time and given us valuable assistance; we must mention especially Commissioner Stanley C. DuRose, Mr. Eugene Haskins and Mr. J. Nash Williams. Professors Hans Zeisel of the University of Chicago Law School and the American Bar Foundation and Richard Abel of U.C.L.A. Law School, and Dr. Werner Pfenningstorf of the American Bar Foundation, made many helpful comments on earlier drafts. Yakov Avichai of the American Bar Foundation gave helpful advice on the use of statistics. Of course sole responsibility for the conclusions drawn, views expressed, and errors made is ours.

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from the failure of the courts to provide cost-effective means to resolve small disputed claims, and even to resolve large claims if the claimant is poor.[1] One often recommended solution is the establishment of new dispute-settling institutions that can provide better access by resolving disputes less formally, more quickly, and at lower cost.[2] Some commentators have argued that such institutions are especially necessary for the poor because of the greater degree of alienation of low-income consumers from the legal system.[3] The processing of complaints about conduct in a private transaction, a species of legal behavior now engaged in by many public and some private agencies,[4] is potentially an institution of this type. Whatever it may cost the taxpayer or other consumers, agency review of such a dispute costs the individual consumer almost nothing in money, time, or convenience. Typically, the con-

1. *See generally* Jones & Boyer, *Improving the Quality of Justice in the Marketplace: The Need for Better Consumer Remedies*, 40 GEO. WASH. L. REV. 357 (1972); Pound, *The Administration of Justice in the Modern City*, 26 HARV. L. REV. 302 (1913); Rice, *Remedies, Enforcement Procedures and the Quality of Consumer Transaction Problems*, 48 B.U.L. REV. 559 (1968).

2. *See, e.g.*, Eovaldi & Gestrin, *Justice For Consumers: The Mechanisms of Redress*, 66 NW. U.L. REV. 281 (1971); Jones & Boyer, *supra* note 2. Small claims courts were once thought to be the solution but have not proved sufficient. They were established in part to provide consumers with such institutions for the resolution of disputes, but there is now widespread agreement that they have not generally fulfilled this need and have often become forums for cheap debt collection by creditors. *See e.g.*, Note, *The Persecution and Intimidation of the Low-Income Litigant as Performed by the Small Claims Court in California*, 21 STAN. L. REV. 1657 (1969). Some observers still have confidence that with appropriate reforms small claims courts could fulfill much of the need for informal dispute settlement institutions. *See* NATIONAL INSTITUTE FOR CONSUMER JUSTICE, REDRESS OF CONSUMER GRIEVANCES 13-25 (National Consumer Law Center, Boston, 1973). For the most comprehensive report on the operation of small claims courts, see STAFF STUDIES PREPARED FOR THE NATIONAL INSTITUTE FOR CONSUMER JUSTICE ON SMALL CLAIMS COURTS (National Consumer Law Center, Boston).

3. *See e.g.* Eovaldi & Gestrin, *supra* note 2.

4. These agencies are essentially of two types. Like the Office of the Wisconsin Commissioner of Insurance, many regulate industries and process complaints only when they pertain to those industries. *See e.g.*, Orton, Cook & Berlin, *State Regulatory Licensing Agencies: Can They Be Used for the Redress of Consumer Grievances?*, in STAFF STUDIES PREPARED FOR THE NATIONAL INSTITUTE OF CONSUMER JUSTICE ON STATE AND FEDERAL REGULATORY AGENCIES 286 (National Consumer Law Center, Boston). More recently in many states, attorneys general have begun dealing with complaints against merchants of almost any type, though they often refer them to specialized administrative agencies. *See, e.g.*, NATIONAL ASS'N OF ATTORNEYS GENERAL, STUDY OF THE OFFICE OF ATTORNEY GENERAL § 6.6 (1971); Sebert, *Consumer Protection in the States and Local Communities*, in STAFF STUDIES PREPARED FOR THE NATIONAL INSTITUTE OF CONSUMER JUSTICE ON STATE AND FEDERAL REGULATORY AGENCIES 1 (National Consumer Law Center, Boston); Steele, *Fraud, Dispute and the Consumer—Responding to Consumer Complaints* (unpublished manuscript on file with the American Bar Foundation, Chicago).

sumer needs only to send the agency a letter describing the dispute. Despite a usual lack of explicit authority to make binding decisions, the agency's prestige and sometimes its statutory authority over other aspects of a business are potentially sufficient to induce acceptance of recommended resolutions of disputes.

This is a study of the nature and handling of complaints[5] received by one such agency—the Office of the Commissioner of Insurance in Wisconsin.[6] Because the study covers a fifty-year period (1919-1969), during all of which the Office processed complaints, we will be able to offer some tentative generalizations about agency complaint processing and its likely efficacy for resolving consumer disputes.[7]

We begin with a brief description of the functions and administrative structure of the Office of the Commissioner of Insurance, and then a fuller description of complaint volume and the basic method of processing complaints. We will then describe complaint processing functionally, discussing first the theoretically possible functions of the process and then analyzing our data in terms of this theory. The final section suggests how far insurance complaint processing illuminates the problem of complaint processing by administrative agencies and similar institutions.

II. FUNCTIONS AND ORGANIZATION OF THE OFFICE

A. General

The law of insurance regulation has grown by slow accretion, with the legislature repeatedly dealing with immediate problems

5. The complaints studied were not about the Commissioner or his Office but about the conduct of a participant in an insurance transaction. Most were consumer complaints. For example, they might be about an insurance company's failure to pay a premium refund or a claim at all, in full or on time, or about marketing and underwriting practices such as an agent's misrepresentation of policy terms or a company's failure to issue, or its termination of, a policy. A very few were not consumer complaints but came from insurance agents or companies, often alleging unfair practice by a competitor.

6. The contemporary statutory term for what was formerly called The Insurance Department.

7. There have been a few other empirical studies of this nature. The most recent are in the Staff Studies for the National Institute for Consumer Justice, notes 2 & 4 *supra*. Orton, Cook & Berlin, note 4 *supra*, is especially important, reporting on complaint processing by three California regulatory agencies. For a general discussion of complaint processing by state insurance departments, see Statement of Herbert S. Denenberg, *Hearings on S. 2246 Before the Consumer Subcommittee of the Senate Committee on Commerce*, 91st Cong., 2nd Sess., ser. 91-48, pt. 2 at 324 (1970); Stone, *A Trend in Complaints Processed by State Insurance Departments*, 34 J. RISK & INS. 231 (1967). For a detailed study of complaint processing by the California Department of Insurance see Serber, *Resolution or Rhetoric: A*

but rarely addressing general objectives.[8] Nevertheless, most of the Commissioner's duties can be roughly if incompletely subsumed under two basic objectives: guaranteeing the solidity (essentially financial soundness) of insurers, and insuring fairness in transactions between companies and agents on one side and policyholders and third-party claimants on the other. Fairness comprehends at least (1) a principle of nondiscrimination requiring claimants to be treated alike if they cannot be distingushed by any relevant characteristic, and (2) such traditional consumer protection concerns as prevention of deception and exploitation of consumer ignorance and weakness.[9]

The solidity objective is reflected in the Commissioner's primary duties, most of which existed throughout the period covered by this study:[10] the licensing of foreign and domestic companies to sell insurance in the state[11] which is used to require a newly formed company to have adequate initial capitalization[12] and, after formation, to maintain specified reserves and surplus to protect future claimants and to guard against premature distribution of assets to equity holders;[13] the regulation of investments;[14] and the prohibition of inadequate rates.[15] Other duties are singularly concerned with fairness. The Office may disapprove a rate if it is excessive and thus exploitative.[16] There is authority to regulate the substantive content of many insurance policies and

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Study of Complaint Management in the California Department of Insurance (unpublished, undated manuscript, Center for the Study of Law and Society, University of California, Berkeley).

8. *See generally* S. KIMBALL, INSURANCE AND PUBLIC POLICY (1960); Kimball, *The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law*, 45 MINN. L. REV. 471 (1961). *But see* WIS. STAT. § 13.84 (1971), directing a unified and comprehensive revision of the insurance laws.

The revision has been proceeding since 1966 and is not yet complete. Statutes from chapter 600 to 650 are the product of the revision. Those from chapter 200 to chapter 212 are prerevision statutes not yet replaced. Unless otherwise indicated, citations are to the existing statutes except where they differ in relevant respects from the statutes in force during the period being discussed.

9. Kimball, *supra* note 8, at 478-500. "Fairness" is used here in a broader sense than in the article cited. These words are not terms of art.

10. S. KIMBALL, *supra* note 8, at 129-74.

11. WIS. STAT. §§ 611.20, 618.12, 201.045 (1971). There was a period when nonlife domestic companies did not need licenses, although they were subject to substantive restrictions. Northwestern Nat. Ins. Co. v. Freedy, 201 Wis. 51, 227 N.W. 952 (1929). The effect was to deprive the Office of license non-renewal or revocation as sanctions. Since 1961, all companies must be licensed. Ch. 562, § 13 [1961] Wis. Laws 627; WIS. STAT. § 201.045 (1971).

12. WIS. STAT. §§ 611.19, 618.23-618.25 (1971).

13. WIS. STAT. §§ 623.11-623.12 (1971).

14. WIS. STAT. ch. 620 (1971).

15. WIS. STAT. § 625.11(1), (3) (1971).

16. WIS. STAT. § 625.11(1), (2) (1971).

to forbid their use if they contain misleading or exploitative provisions, perhaps buried in fine print.[17] The Commissioner also licenses agents and may terminate a license for, *inter alia*, selling activity that misleads or abuses consumers, such as misrepresenting policy provisions.[18] Still other statutory duties reflect both fairness and solidity objectives. Thus, rates may be disapproved when discriminatory; that is, when the existence of rate classifications or the extent of the differential between them is not validated by data on loss experience.[19] Rebating of a portion of premiums to favored customers is also prohibited as discriminatory.[20] The fairness objective of these duties is obvious but sometimes they can also be justified on solidity grounds, since the lowering of the rates may threaten solidity.

Throughout the period under study, and consistent with the practices of his counterparts elsewhere, the Wisconsin Commissioner has given marked priority to the solidity objective. The Examining Division, by far the most heavily staffed division, is solidity oriented.[21] It acquires information mainly from auditing detailed annual financial reports and by periodically examining domestic and foreign companies doing business in Wisconsin.[22] Examinations are mainly to ascertain the company's financial position and to verify the accuracy of annual reports, but they may have such secondary objectives as a "review of the fairness of [the company's] treatment of policyholders and claims . . . ."[23] If the Examining Division concludes that a company's solidity is in question, ordinarily the Commissioner will informally recommend corrective measures, though he may apply formal sanctions ranging from a forfeiture to revocation of license (for a foreign company) or even a petition to a court to rehabilitate or liquidate a company.[24]

17. Provisions governing policy forms are scattered through the statutes, varying greatly by line of insurance. For accident and health policies, see, *e.g.*, WIS. STAT. §§ 204.31, 204.32, 204.321, 204.322 (1971). Section 204.31(3)(g)(3), for example, authorizes the Commissioner to disapprove an accident and health policy form on a variety of "fairness" grounds.

18. WIS. STAT. §§ 206.41(10), 209.04(9), 601.64(5) (1971).

19. WIS. STAT. § 625.11(1), (4) (1971).

20. WIS. STAT. § 207.04(1)(h) (1971).

21. For a general description of the activities of the Examining Division in 1969, see 101 WISCONSIN INSURANCE REPORT 70-73 (1970) [hereinafter cited as INS. REP.].

22. WIS. STAT. § 601.43(1)(a) (1971).

23. 101 INS. REP. 70 (1970). Recently the Office purports to have placed a greater emphasis on consumer protection objectives in examinations. *See* 104 INS. REP. 81-83 (1973).

24. WIS. STAT. §§ 601.64, 618.37, 645.31, 645.41 (1971). *See generally* Pfennigstorf, *The Enforcement of Insurance Laws*, 1969 WIS. L. REV. 1026. The Commissioner had no general authority to impose money penalties until 1947, although prior to 1947 various statutes granted such authority in specific circumstances. WIS. STAT. ANN. § 200.14 (Revisor's Note) (1957). Even then, until a statutory revision in 1969, the Commissioner could impose a forfeiture only with the consent of the company concerned. *Id.*; WIS. STAT. § 601.64 (1971).

The Rates Division, the next largest, enforces both the statutes regulating rates,[25] which have a mixture of solidity and fairness objectives, and those regulating policy forms, which are primarily concerned with fairness.[26]

B. *The Complaint Handling Function*

No statutes have ever explicitly directed the Commissioner to receive or process complaints or direct how they should be processed, but over the years the Governor and Legislature have clearly come to expect the office to engage in such activity. Indeed, through the budget and other processes of control they have encouraged it.[27] A few statutes deal with some of the subjects frequently complained about but they are often vague.[28] Bascially, guidance about the purposes of complaint processing must be inferred from the general objectives of insurance regulation; the purposes thus inferred are necessarily supplemented by the Commissioner's own views concerning consumer protection and perhaps his perceptions of the desires of the public officials to whom he is responsive.

In the early years of the period under study, the entire Office had too few complaints and too few personnel for specialized or standardized procedure on complaints. The Commissioner sometimes processed complaints personally, but as workload grew and there was greater specialization of function, they were usually re-

25. Historically much of the publicly expressed criticism of the Office's operations has focused on failure to disapprove allegedly excessive rates—an aspect of the "fairness" objective. S. KIMBALL, *supra* note 8, at 93-112. The Rates Division is not solely concerned with excessive rates and unfair policy provisions, however. Its concern that competitive pressures not lead to rates too low to permit actuarially sound operation has been manifested chiefly by encouragement of rate service organizations to collect claim data and recommend rates to all or many companies selling insurance of a particular type. The Rates Division licenses and regulates such organizations. WIS. STAT. §§ 625.31 & 625.32 (1971). At an earlier time, when a company submitted a rate substantially below a rate recommended by such an organization, the rate might be reviewed to determine whether it was inadequate. *See, e.g.*, S. KIMBALL & W. CONKLIN, THE MONTANA INSURANCE COMMISSIONER 30-33 (U. Mich. L. School, Ann Arbor 1960). The trend is strongly away from such concern, especially in Wisconsin.

26. *See, e.g.*, WIS. AD. CODE, Ch. Ins. 3.13, 3.14, 3.15 (1974).

27. The consumer movement has significantly affected the Office's self-image and the image others have of it. Despite the absence of authorizing legislation for complaint processing, recently some legislators even questioned the reappointment of a Commissioner of Insurance largely on the ground that he did not process consumer complaints well enough. *See* The Capital Times (Madison), March 27, 1974, at 1, col. 6. *Cf.* 104 INS. REP. 98-99 (1973) for earlier Office concern with the same matter, based on WIS. STAT. § 601.46(3)(f) (1971), an innovative statute requiring the Office to report annually complaints made about it.

28. *See, e.g.*, WIS. STAT. ch. 207 (1971) (Model State Unfair [Insurance] Practices Act, enacted in 1947); it codified what the Office already understood to be the law. *See also* Kimball & Jackson, *The Regulation of Insurance Marketing*, 61 COLUM. L. REV. 141 (1961).

ferred to a rates and forms analyst in the pertinent line of insurance. Under this system the Office was limited largely to information supplied by complainants and companies. It was not until 1960 when a separate Complaints Section with one full time investigator was finally established[29] that the Office gained capacity to conduct a field investigation as a part of ordinary complaint processing procedure. A second investigator was hired in 1961 and a third in 1962.[30] In 1969, there were three investigators in Madison and one in Milwaukee, and the work of the Section was supervised by an administrative assistant who divided his time about equally between Complaints and Agents Licensing Sections.[31] Most complaints were processed in Madison; even those received initially in Milwaukee were often sent to Madison.

III. COMPLAINT PROCESSING IN WISCONSIN

A. Sources of Information

The research for this study was done at different times and with different objectives. Integrating the information has therefore presented difficulties and necessitates a brief description of our data sources and their limitations.

Most of our information about complaint processing came from (1) complaint files; (2) a small survey of complainants; and (3) interviews with the Commissioner, complaint processing personnel in the Office, and insurers' claims officials. For the years up to 1959 our information came mainly from notes and memoranda from unpublished research done over a decade ago on all the complaint files of each of twelve different years: 1919 through 1923, 1931, 1936, 1941, 1946, 1951, 1956 and 1959.[32] We have not examined any complaint files for the 1960-68 period but have relied mostly on the complaint statistics which the Office began compiling in 1960 and on textual comments in the annual reports of the Office.

We have the greatest amount of information about the processing of complaints in 1969. We interviewed Office and company personnel, studied the Office's complaint statistics, and conducted a limited survey of complainants.[33] The bulk of our information, however, came from a detailed study of about 300 complaint files concerning automobile and accident and health insurance. This sample

29. 91 INS. REP. 23 (1961). The Complaints Section is now located in the Services Division. 104 INS. REP. 6 (1973).

30. 93 INS. REP. 38 (1962).

31. 101 INS. REP. 6 (1970). The Administrative Assistant in charge of the Agents Education and Licensing Section was also in charge of the Complaints Section.

32. 1919 was the earliest and 1959 the latest year for which the correspondence files were then available; most were missing for the late 1920's. The remainder of the years were chosen at 5 year intervals as a rough sampling technique.

33. See notes 74-75 *infra* and accompanying text.

was selected in a structured, nonrandom manner, and consequently we cannot usually make quantitative statements about complaint processing.[34] However, our complaint file survey has provided reliable qualitative information.[35]

B. *Volume and Subject Matter of Complaints*

A table of the volume of complaints received for which a correspondence file was created, broken down by line of insurance over

34. The sample was designed to test a hypothesis that in processing complaints against companies with high complaint to premiums ratios the Office would be more stringent than in processing complaints against those with low ratios. *See* notes 139-41 *infra* and accompanying text. Because 80% of all complaints now concern automobile and accident and health insurance, we limited our sample to those lines. As a result, our sample did not include any property or life complaints, which constitute over 15% of total complaints, and an even higher percentage of complaints about agents. The structuring of the sample makes it impossible to establish levels of confidence in quantitative findings; moreover, the extreme infrequency of some phenomena in which we are interested often required us to study files, not included in the complaint file sample, to which we were referred by complaint investigators. Because important information was sometimes missing from complaint files, we will sometimes be unable to provide statistical information even about the 297 complaints in our 1969 sample.

To construct the sample we used the Office's annual compilation of complaints received per $100,000 of premiums written for every company against which more than 20 complaints were received. In each of the automobile and health lines we selected three companies that were complained about with a greater than average frequency in relation to premium volume, and three that had a lower than average complaint frequency. Enough complaints against each company were selected for study to insure a reasonable number from each company, with the actual complaints studied for each company selected randomly. The total sample consisted of 115 complaints against accident and health companies and 182 against automobile companies. The number of complaints received and studied for each company is shown in the following table:

COMPANIES AND COMPLAINT FILE SURVEY

Company	Total Complaints	Complaints per $100,000 Premiums	Complaints Studied
	HEALTH		
A	54	9.08	18
B	95	8.15	21
C	38	4.91	19
D	50	.37	17
E	27	.23	14
F	131	.36	26
	AUTO		
L	65	2.59	30
M	53	1.30	27
N	84	1.18	27
O	167	.75	41
P	62	.58	31
Q	54	.51	26

35. Beginning in 1970, the statistics in the Insurance Reports are of closed files, not of complaints received. The latter figures are: 1970, 6213; 1971, 6391; 1972, 6765; 1973, 6374. We do not have the complaints received totals broken down by line of business.

the fifty-year period of the study is below. It needs to be immediately emphasized that our complaint volume data is not comparable throughout the period studied. Since 1960 our information about volume has come from complaint statistics compiled by the Office. Before then, when the Office did not compile such statistics, we have had to rely on a researcher's counting of complaint files. We assume this difference in our sources largely accounts for what our information would otherwise indicate was an inordinate growth in complaint volume around 1960.[36]

TABLE 1

COMPLAINT VOLUME

Year	Accident & Health		Auto-mobile		Life		Property		Other		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1919-23 (total)	82	30	34	12	87	32	62	23	9	3	274	100
1921 (average of 1919-23)	16	29	7	13	17	31	12	22	3	5	55	100
1931	33	39	35	16	45	21	37	17	15	7	215	100
1936	32	22	34	23	41	28	37	25	2	1	146	99
1941	50	31	50	31	24	15	30	18	8	5	162	100
1946	44	26	76	45	18	11	23	14	7	4	168	100
1951	133	47	109	38	8	4	28	10	6	2	284	101
1956[37]	249	56	170	38	13	3	10	2	3	1	445	100
1961	1179	51	820	36	73	3	129	6	100	4	2301	100
1962	1677	47	1363	38	160	4	213	6	188	5	3601	100
1963	1540	44	1312	37	181	5	222	6	252	7	3507	99
1964	1727	43	1319	33	182	5	365	9	434	11	4027	101
1965	1579	39	1501	37	217	5	325	8	413	10	4035	99
1966	1850	44	1513	36	214	5	385	9	249	6	4211	100
1967	1766	42	1615	39	203	5	371	9	223	5	4178	100
1968	1852	41	1697	38	329	7	393	9	241	5	4512	100
1969	1983	40	1979	39	397	8	417	8	237	5	5013	100
1970[38]	2148	40	2037	38	387[39]	—	551	10	273[40]	—	5396*	100

36. There are several reasons for this assumption. Many complaint files in the pre-1960 period were missing. Moreover, when the Office formalized the administration of complaints processing in 1960, it probably dealt more consistently with complaints by correspondence than by telephone or some other manner that would leave no record. Finally, in counting complaints it is necessary to discriminate between complaints and mere inquiries. We assume that the researcher who conducted the pre-1960 study and the Office made this discrimination differently. The public reporting of number of cases handled is invariably a powerful incentive to be inclusive in counting, as the agency seeks to impress its public with its workload and efficiency.

37. So many complaint files for 1959 were missing that no reliable data on complaint volume can be reported, although the available files were studied for qualitative information.

38. See note 35 *supra*.

39. 103 INS. REP. 85 (1970) shows the following tabular information on adjacent lines:

Line of Insurance	1971	1970
Nonauto Liability	185	387
Life and annuities	372	128

The 1970 life and annuities figures depart too greatly from the pattern for that line to be a random variation. The fact that nonauto liability var-

1971	2561	42	2165	35	372	6	599	10	435	7	(6213) 6132* (6391)	100
1972	3251	49	2092	31	499	7	599	9	250	4	6690* (6765)	100
1973	2863	49	1668	29	485	8	528	9	282	5	5826* (6374)	100

* Numbers in parentheses for 1970-73 are complaints received, not files closed. All numbers prior to 1970 are complaints received. The statistics were reported differently beginning in 1970.

In absolute numbers, the increase in volume of complaints seems very great. But the rate of increase has in fact been rather steady. Chart 1 plots complaints on a logarithmic scale against time, to exhibit more clearly the rate of increase in complaint volume. The graph suggests two periods of steady increase broken by a discontinuity when statistics began to be gathered. Assuming discontinuity for the reasons given above, we further assume constant rates of increase for the periods from 1921 to 1956 and from 1962 to 1969 and then from total complaint volume data calculate least squares equations for the two lines of best fit.[41] On the basis of the two computed equations, the average annual increase was five percent in the first period and four percent in the second.

ies from its normal pattern in similar magnitude but opposite direction leads us to believe there was a reversal of the figures, and the table in the text is constructed on that assumption. There is simply no reason to expect such a sudden, one year drop in life complaints and decrease in the nonauto liability complaints of the same magnitude. On the other hand, careful inquiry with Office personnel and search of the records has not revealed any evidence that the figures were reversed.

The 1971 rise in the "other" category is mainly accounted for by a rise of 95 complaints—from 115 to 210—in the true "other" category, with which nonauto liability is lumped for this table. Since we have made no attempt to do anything with that category, we have made no effort to account for the increase, though it may be too large to be random.

40. See note 39 *supra.*

41. This treatment is simplistic but suffices for the limited purpose for which we use it. There are not enough points on the graph from 1970 to 1973 to postulate any clearcut new pattern and we have neither attempted to treat them separately nor include them by extending the 1962-69 period.

CHART 1

COMPLAINT VOLUME

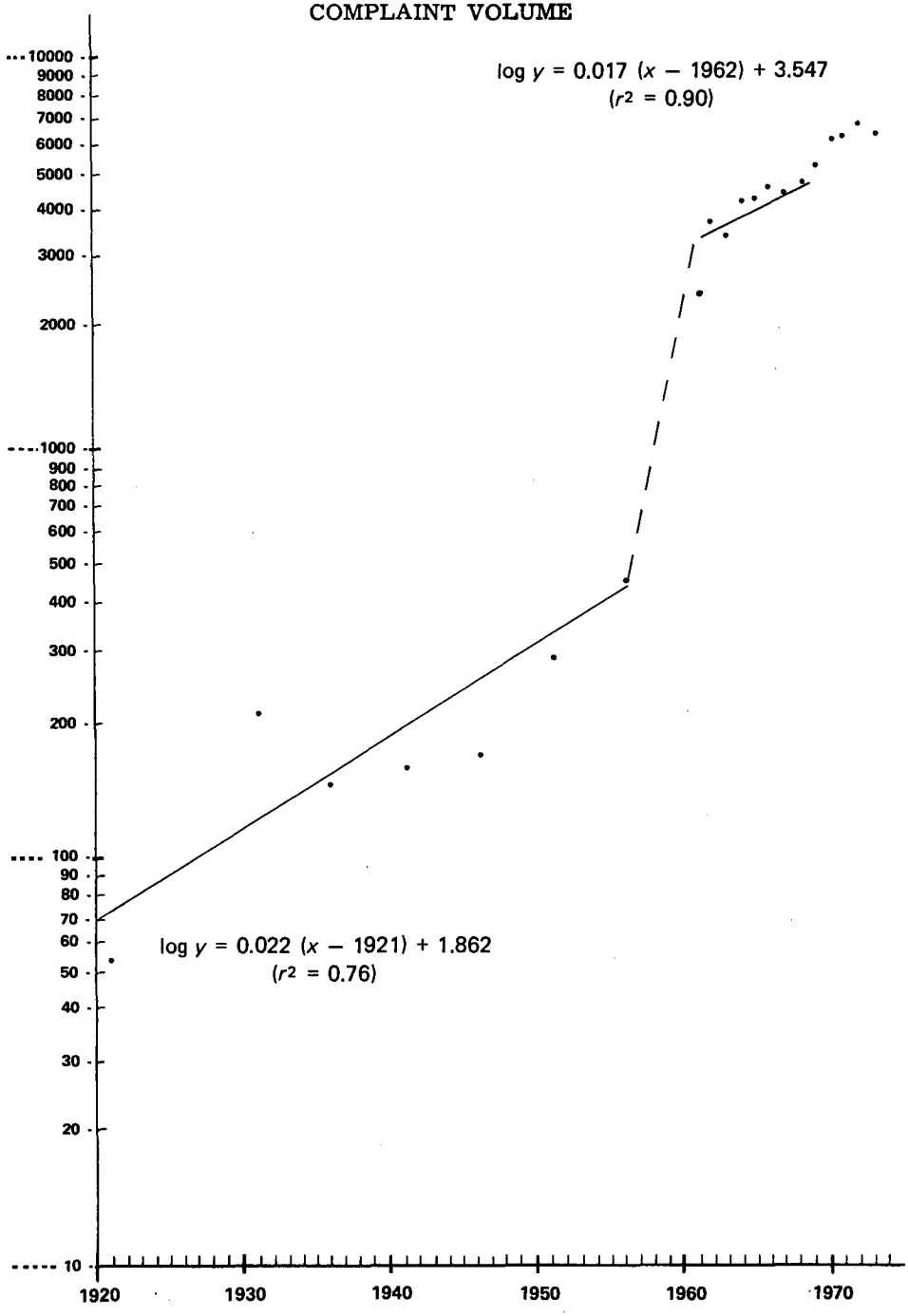

CHART 1

COMPLAINT VOLUME

While complaint volume has grown steadily, it does not necessarily indicate an increased proclivity of consumers to complain. Exposure to complaints is directly related to amount of business done in any given line of insurance. Focusing on the period since 1961, for which our complaint data is substantially comparable, premium volume has increased by almost 9 percent (uncorrected for inflation) or about 5½ percent (corrected for inflation) per year on the average, from 1961 to 1972. The total number of complaints closely paralleled the increase in premium volume, as Table 2 shows.

TABLE 2

RELATIONSHIP OF COMPLAINTS TO PREMIUM VOLUME

Year	Number of Complaints	Premium in $ Millions	Complaints Per $ Millions	Premium in $ Millions (corrected)[42]	Complaints per $ Millions (corrected)
1961	2301	756	3.0	844	2.7
1962	3601	816	4.4	901	4.0
1963	3507	878	4.0	958	3.7
1964	4027	925	4.4	995	4.0
1965	4035	1009	4.0	1068	3.8
1966	4211	1096	3.8	1128	3.7
1967	4178	1178	3.6	1178	3.6
1968	4512	1281	3.5	1230	3.7
1969	5013	1423	3.5	1296	3.9
1970	6213	1578	3.9	1357	4.6
1971	6391	1776	3.6	1463	4.4
1972	6765	1938	3.5		
1973	6374	2102	3.0		

The data reported heretofore concerns only complaints for which the Office has established a correspondence file. The Office has always disposed of some complaints without opening a file, but it has never maintained accurate statistics about such complaints. Since 1970, it has provided information about the number of complaints *and inquiries* handled without opening a file. These statistics indicate that at least in recent years the volume and rate of increase of such matters has been substantial, greatly exceeding that of the number of complaints for which a file was created.

42. Premiums are corrected to 1967=100 using table no. 557 in STATISTICAL ABSTRACT OF THE UNITED STATES 340 (U.S. Bureau of the Census, 1972). The correction is for inflation. Other choices of an index might be preferred, but the choice is less important than that a reasonable adjustment of premium volume be made. All such indices would be related, of course.

TABLE 3

MATTERS SUMMARILY DISPOSED OF[43]

Complaints & Inquiries—No File	Telephone			Personal Contact		
	Average No. Per Mo.	% Increase over Previous Years	% of 1970	Average No. Per Mo.	% Increase Over Previous Year	% of 1970
1970*	525	—	—	84	—	—
1971	789	50	150	136	62	162
1972†	1173	49	223	159	14.5	189

*1970 averages based on records for 8 months only.
†1973 figures were only estimates and are omitted.

There is reason to believe the volume of complaints so disposed of was considerably less in the years before records were kept. The Office has indicated that since 1970 there has been an increased emphasis on disposing of complaints without creating a file.[44] If true, it would explain why the rate of increase in complaint files declined from over 20 percent between 1969 and 1970 to a mere 3 percent between 1970 and 1971 and 6 percent between 1971 and 1972, with a 6 percent decrease between 1972 and 1973. This reduction in the rate of increase is otherwise inexplicable, since we would anticipate a rapid increase in recent years, pursuant to greatly increased consumer consciousness. Except as indicated, however, we can provide little information about complaints for which no file was established.

In addition to overall complaint volume, we are interested in the distribution of complaints among lines of insurance. A perusal of Table 1 indicates that except for the earliest years of this study, the vast majority of complaints have concerned automobile and accident and health insurance.[45] Table 4, compiled for the period in which we have substantially comparable complaint data, indicates that relative to premium volume these lines have accounted for much more than a proportionate share of complaints.[46] Average complaint volume for all lines is shown by Table 2 to be in the vicinity of 4 per million dollars of premiums.

43. 103 INS. REP. 84 (1972); 104 INS. REP. 100 (1973); 105 INS. REP. 102 (1974).

44. 103 INS. REP. 84 (1972). The 1973 correspondence file statistics confirm this notion for 1973. *See* Table 1 *supra*.

45. The domination of automobile and health complaints is typical throughout the country. Stone, *supra* note 7, at 231-33.

46. The following table, based just on 1969 complaints, makes essentially the same point. The table is extrapolated from data reported at 101 INS. REP. 20, 78 (1970).

TABLE 4

COMPLAINTS PER MILLION DOLLARS OF PREMIUMS[47]

Year	Auto	Accident & Health	Property[48]	Life
1961	6.7	6.3	1.6	.24
1962	10.5	7.8	2.6	.50
1963	9.6	6.5	2.6	.53
1964	8.9	6.6	3.9	.53
1965	8.8	5.4	3.3	.60
1966	7.7	6.0	3.6	.55
1967	7.6	5.2	3.3	.49
1968	7.5	4.9	3.2	.74
1969	8.1	4.5	3.1	.83
1970	7.2	4.2	3.6	.78[49]
1971	6.8	4.3	3.4	.68
1972	6.2	5.0	3.0	.84
1973	4.6	4.1	2.4	.75

Table 4 makes clear that there is a different complaint frequency for each line of insurance. Inquiry into the reasons for this variation can provide insights into the factors that tend to produce complaints. A starting point for this analysis is the Office's classification of the subject matter of complaints. The Office statistics for 1969, which are representative for the surrounding years, are as follows:

PREMIUMS WRITTEN AND COMPLAINTS BY LINE OF INSURANCE (1969)

Line of Insurance	Percent of Total Complaints	Percent of Total Premiums Written
Accident and Health	40	31
Automobile	39	17
Property	8	9
Life and Annuities	8	34
Other	5	9
Total	100	100

It should be noted that from a mere 3 percent of complaints in 1956 and 1961, life insurance made a comeback to a more respectable share of the larger number of complaints in 1968 to 1973, despite a steady decline in share of premium volume from 43 percent in 1956 to 31 percent in 1972. The secular trend in life insurance complaints would repay further study, but is not discussed in this article.

47. No correction has been made for inflation. For comparison among branches of the insurance business, that did not seem necessary.

48. There is some difficulty in being sure that both property complaints and claims were distinguished from other complaints and claims along the same dividing lines as are premiums. For present purposes, the figures are accurate enough. They come from the several annual reports. The classifications are for convenience only; for many purposes it would be important to call part of automobile insurance "property insurance"; the liability part could then be lumped with other kinds of liability insurance, which are treated as "other" in Table 1 and do not appear at all in Table 4.

49. *See* note 39 *supra*. If the uncorrected figures for 1970 are used, life complaints dropped to 26 per $1,000,000 of premiums—an unbelievable variation.

TABLE 5

REASON FOR COMPLAINTS[50]
1969

Reason	Complaints Percent of Total (Total = 5013)
Claims Administration	62
Termination of Coverage	10
Unfair Business Methods[51]	10
Premium Refund Denied or Delay	8
Misrepresentation[52]	3
Failure to Issue Policy	2
Other	5
	100

Table 5 shows that the majority of complaints concern claims administration. Table 4 compares complaints with premiums written, yet the number of claims filed would be a more accurate measure of a company's exposure to claims complaints. We do not have data on number of claims filed, but relative to premium volume more claims would be filed under automobile and health policies than under property and life policies, because the average amounts of benefits would be smaller and more claims would be unpaid because of exclusions from coverage. Increased exposure because of more numerous claims thus partly accounts for the concentration of complaints against automobile and health companies.[53]

Other factors probably also contributed to this concentration and therefore help explain the reasons for complaints. One is that claims for small amounts characteristic of automobile and accident and health insurance are more likely than larger claims to lead to complaints to the Office, since more authoritative dispute settling forums are less practicably available as the amounts in dispute de-

50. The table is derived from information in 101 INS. REP. 79 (1970). The 1969 data is reasonably typical for recent years. For example, the Office's statistics for the 1972 year indicate that about 58% of the complaints were claims related. Another 21% were classified "unfair business methods." Some of the latter were also claims related. 104 INS. REP. 101 (1973). *See* note 51 *infra*.

51. "Unfair business methods" is a miscellaneous category that includes many marketing complaints, such as false advertising, and some claims administration complaints. Thus, the actual percentage of claims administration complaints was higher than the 62% indicated in Table 5.

52. The Office's statistics probably significantly understate the number of complaints involving misrepresentation as one ground. *See* note 166 *infra* and accompanying text.

53. Claims related complaints were at least as large a portion of accident and health and automobile complaints as of other lines. We determined the Office's classification of complaints against all the automobile companies and five of the six accident and health companies included in the complaint file survey. Sixty-eight percent of the complaints against the automobile companies and 62% for the accident and health companies were claims related. The percentage varied among the companies, from 43% against one health company to 80% against two automobile companies.

crease. Support for this proposition comes from a breakdown of 1969 automobile complaints, indicating that approximately 95 percent of claims administration complaints pertained to physical damage[54] rather than personal injury. It seems unlikely that physical damage claims dominated personal injury claims to the same degree.[55] Unlike physical damage claims, personal injury claims often involve amounts sufficiently large for the claimant to retain an attorney and seek resolution in the courts.[56]

Another factor probably contributing to complaint distribution is that claims under automobile and health policies frequently turn on factual questions not easily resolved. There is reason to believe that such claims are more likely than others to cause complaints.[57]

54. 101 INS. REP. 78 (1970). By "physical damage" complaints we mean complaints about all claims for damage to property, whether submitted by the insured or a third party. In the Office's complaint statistics, the former are termed "auto physical damage," while third party claims are termed "property damage." For our special purpose, we use the terms in a way inconsistent with general usage.

55. This statement is based on general knowledge, not statistics. We did obtain actual claims data from one of the largest automobile insurers in Wisconsin. We cannot demonstrate that the company's claims experience was typical for the state though we have reason to expect it to be. Whatever the degree of confidence one can have, the data were consistent with the guess. For 1969, 9% of the claims received by the company concerned personal injury, the rest physical damage. On this evidence—*i.e.*, about twice as large a ratio of personal injury claims to physical damage claims as of personal injury complaints to physical damage complaints—the notion expressed in the text is plausible, and though not conclusively established, we believe it correct.

56. *See* H. ROSS, SETTLED OUT OF COURT (1970). A similar conclusion was reached in a recent study of complaints made to a large insurance company (rather than to a regulatory agency). Ross, *Insurance Claims Complaints: A Private Appeals Procedure*, 9 LAW & SOC'Y REV. No. 1 (forthcoming). Ross also suggested, as an alternative explanation for the predominance of property damage complaints, that companies handle bodily injury claims with greater care and skill, and hence there are fewer dissatisfied claimants.

57. In addition to the evidence provided subsequently in the text, a statistical breakdown of accident and health complaints provides support for this proposition. The Office separately reports complaints against Blue Cross and Blue Shield. Only about 25% of all accident and health complaints in 1969 were against them. 101 INS. REP. 78 (1970). Yet, they received some 39% of the accident and health premiums in Wisconsin. *Id.* at 20, 26. One factor that tends to distinguish the "Blues" from other accident and health companies is their high proportion of group policies. *Id.* The complaint investigators at the Office share the view that group policies produce fewer complaints than individual policies. *See also* Stone, *supra* note 7, at 232. A major difference between individual and group policies is that the former characteristically exclude coverage for preexisting medical conditions while group policies do not, at least not so often nor so completely. In our 1969 complaint file survey preexisting condition clauses were a frequent ground for complaints, but only for individual policies. Altogether 75 complaints were sampled from the four out of six sampled companies that wrote individual policies, with 19 (about 25 percent) concerning application of preexisting conditions clauses. Almost none of the complaints against the companies writing mostly group policies concerned pre-

For example, a breakdown of automobile complaints pertaining to physical damage claims indicates that claims under third party liability coverage accounted for nearly four times as many complaints as claims under first party coverages (basically collision and comprehensive).[58] It is unlikely that third party claims exceed first party claims in the same ratio.[59] Although there are several reasons why third party claimants are more likely to file complaints,[60] one is that such claims frequently raise issues of negligence, or in Wisconsin degree of negligence, whereas first party claims tend to raise only questions of damages. Degree of negligence is a factual dispute often not easily determined. In our 1969 complaint file survey more than 40 percent of automobile complaints objecting to the substance of a claims settlement offer raised a degree of negligence issue.

Still another factor contributing to high complaint volume is detailed restrictions on coverage. Accident and health policies are characterized by such restrictions. For example, only a percentage of costs may be covered, or a particular treatment may be covered if administered in a hospital but not if administered in a physician's office. Our complaint file survey showed that insureds have often either misunderstood these limitations or considered them unrea-

existing condition clauses.

Other factors undoubtedly also contributed to the higher complaint frequency for individual policies. Most important, the policyholder under a group policy may have more bargaining leverage than under an individual policy. If a significant number of certificate holders under a group policy become dissatisfied with the company's claims administration, the group through its representatives may decide to place its business elsewhere, with an inconvenient or even more serious loss of premiums for the first insurer. Secondly, an insurer selling an individual policy must carefully evaluate an applicant to guard against adverse risk selection, and frequently an application is denied. Many complaints concerned either such a denial or a failure to return the premium promptly after denial. Moreover, individual policies often have riders excluding coverage of particular risks, which easily give rise to factual or policy interpretation disputes. For example, one complaint involved a policy with a rider excluding coverage for cancer. The insured had an operation to repair a broken rib; during the operation the surgeon discovered cancer in three ribs and treated it. The issue was whether the rider excluded coverage.

58. 101 INS. REP. 78 (1970).

59. Data obtained from one of the largest automobile insurers in Wisconsin showed that in 1969 that company received only twice as many third party as first party physical damage claims. This evidence is not conclusive but it is suggestive. *See* note 55 *supra*.

60. Companies tend to be more generous with their own insureds than with third party claimants. Again, another study has shown that many insurance claimants, when unable to settle with the claims adjuster, complain directly to a higher official of the company. These complaints are almost invariably filed by first party claimants and are frequently resolved in the complainant's favor. *See* Ross, *Insurance Claims Complaints: A Private Appeals Procedure*, 9 LAW & SOC'Y REV. (forthcoming). Because of this effective alternate complaint route, first party claimants have less need to resort to the Office.

sonable, and then complained when the limitations were applied to deny or limit coverage.[61]

The relatively low volume of complaints for property and life insurance is consistent with our proposition that the factors just identified contribute to complaint volume. Life insurance is characterized by relatively large claims, few of which turn on difficult factual issues. In 1969 the mean death benefit under life insurance was $2658 in Wisconsin.[62] Neither automobile nor accident and health claims could possibly approach that. Additionally, the incontestable clause eliminates most potential controversies, both factual and legal. Claims under property policies, on the other hand, are on the average for smaller amounts than life claims and sometimes raise difficult factual questions about loss measurement. The estimated mean fire loss in the United States in 1969 was $805.[63] The mean *insured* claim would have to be over three times as great to equal the mean Wisconsin life insurance claim. One might expect therefore, a higher complaint volume for this line of insurance and, indeed, as Table 4 illustrates, relative to premium volume there were substantially more complaints on property than on life insurance. Property claims, however, rarely raise serious coverage issues and the policies contain relatively few limitations or exclusions from coverage that are not well understood by most insureds. Thus, there are good reasons why property insurance produces fewer complaints in relation to premium volume than automobile and accident and health insurance.

There are, of course, other factors contributing to the distribution of complaints. One is simply the divergent practices of companies. Staff personnel have sometimes explained these divergencies in moralistic tones: "It may be that the public relations, education, and goodwill procedures of the life insurance business could be adapted to some of the other lines of insurance, particularly to Accident and Health."[64] There is no hard evidence about the merit of such explanations. In the 1919-23 period, however, there were a large number of complaints about strict application of notice and proof of loss conditions. In later years, there were few such complaints, suggesting that most companies had abandoned strict enforcement of these conditions, as they had been urged to do by the Office.[65]

61. *See also* G. Stone, An Analysis of the Complaint Handling Procedures of State Insurance Departments 101-02, 1966 (unpublished thesis, U. Pa.).

62. INSTITUTE OF LIFE INSURANCE, 1970 LIFE INSURANCE FACT BOOK, 45.

63. INSURANCE INFORMATION INSTITUTE, 1971 INSURANCE FACTS, 31, 33. That included nonbuilding fires, which were about 60% of the total. They would be less likely to be insured, raising somewhat the mean *insured* loss, but it is inconceivable that the mean would equal the life insurance figures.

64. 93 INS. REP. 39 (1962). Education of the public about the meaning of policies was also urged as a solution. *Id. See also* 94 INS. REP. 48 (1963); 96 INS. REP. 89 (1965).

65. *See generally* S. KIMBALL, *supra* note 8, at 213-19.

Divergent practices can also often be accounted for by economic difficulties facing particular companies or lines of insurance.[66] Thus, a substantial number of complaints made to the Wisconsin Office during the 1960's concerned termination of automobile policies,[67] yet prior to the 1960's our studies revealed almost no such complaints. During the 1960's many automobile insurance companies experienced unfavorable loss ratios.[68] One response was to improve the quality of underwriting by refusing to provide further coverage to high risk insureds. This resulted in the increase in termination complaints. Other examples of economic conditions affecting complaint volume come from our historical study. In 1936 a disproportionate number of complaints concerned the failure of a company or agent to refund the proper portion of a prepaid premium after a voluntary policy termination. The depression probably contributed both to the number of policy terminations and to the unwillingness or inability of agents and companies to refund premiums.[69] In 1959, a much higher than usual percentage of accident and health complaints alleged agent misconduct, possibly reflecting unusual competitive conditions.

Although we made no effort to identify all the factors affecting the volume and distribution of complaints, a few other examples, also coming from our historical study, are as follows. New statutes may have had short term effects. In 1946, there were a number of complaints about problems and ambiguities in the application of a new automobile financial responsibility law,[70] but these complaints had largely disappeared by 1951. Changes in administrative rules have also had impact. The annual insurance report twice attributed a sharp increase in complaints in life insurance in large part to a new replacement rule.[71]

C. *Who Complains*

The Office collected almost no information about complainants except to identify them by their roles in the insurance transaction.

66. It has been forcefully argued that a company encountering financial difficulties is likely to take a stricter position on claims, with an increase in complaints. For example, it is reported that during the depression some companies regularly denied claims for less than $100 on the theory that the claimant would not litigate because of the small amount involved, resulting in a substantial increase in complaint volume. Stone, *supra* note 7, at 233-35.

67. Unpublished complaint statistics maintained by the Office show that in 1969 a total of 339 complaints—about one-sixth of all automobile complaints received and a majority of nonclaims complaints—pertained to termination of coverage.

68. As an illustration of increasing loss ratios for automobile insurers in the 1960's, *compare* 93 INS. REP. 6 (1962), *with* 88 INS. REP. 74 (1957).

69. Such findings have been made for other states. Stone, *supra* note 7, at 234. *See also* note 66 *supra*.

70. Ch. 375, [1945] Wis. Laws 595. *See* S. KIMBALL, *supra* note 8, at 25-26.

71. 94 INS. REP. 49 (1963); 100 INS. REP. 76 (1969).

Only 2 percent of the total complaints in 1969 were made by agents and companies; another 4 percent were classified as "other," a category consisting mostly of inquiries and complaints by good samaritans objecting to an insurance practice that did not involve them personally. The balance were filed by insureds (70 percent) or third party claimants (23 percent).[72] The Office has no statistical information on geographic or demographic distribution of complainants.[73] To obtain more information about complainants, we conducted a mail survey of 298 selected complainants, none of them agents or companies. The survey was conducted in the autumn of 1971; the sample was drawn from complaints on which action was completed between January 1, 1971 and September 22, 1971.[74] The questionnaire was short and refrained from asking about some matters about which we would have liked to know, such as personal income.[75]

Two findings about complainants come from the survey. First we wondered whether residents in certain areas of the state—for example, urban areas—were more likely to complain.[76] Residents of the 16 largest cities were represented in the sample proportionate to their share of the state's population. As we anticipated, Madison residents were overrepresented, but surprisingly Milwaukee residents were underrepresented. The following abbreviated table shows the figures.

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72. 101 INS. REP. 79 (1970).

73. Investigators do record the complainant's county of residence on the complaint summary form completed for each complaint, but the data is not aggregated. The investigators think complainants are geographically distributed roughly proportionate to population and that low income persons are not underrepresented. A primary purpose of locating one investigator in Milwaukee was to facilitate complaints from low income residents of that urban area.

74. The Office filed complaints by the company against which they were made, arranged alphabetically by name of company. Within each company file, there was no system for organizing complaints, except that a new file was started each year.

We chose in late September 1971 every 13th complaint in the 1971 complaint file, beginning with the 13th complaint in the file of the first company alphabetically, and continuing through about 85% of the complaints and the files of all companies beginning with S. Missing complaints were not counted; if action had not been completed on a complaint that otherwise would have been included, the next complaint was selected instead.

75. The brevity of the questionnaire may partially account for a response rate of 71%, high for a mail survey.

76. In a much larger sample of complainants to the Pennsylvania Insurance Department, a disproportionately high number resided in towns of less than 10,000 population. M. Boynton, An Assessment of Consumer Complaint Handling: The Pennsylvania Insurance Department 42, August, 1973 (unpublished thesis in Cornell University Library). The same study found complainants more likely than the Pennsylvania population to have a high status occupation and a high level of educational achievement, but the distribution of income in the complainant sample closely paralleled that of the state population. *Id.*, at 45-47. We do not have comparable data for our Wisconsin complainant sample.

TABLE 6

COMPLAINANTS IN RELATION TO POPULATION

	Complainants Sampled	Population (1000's)
Milwaukee	29(10%)	717 (16%)
Madison	22(7%)	172(4%)
16 largest cities	108(36%)	1693(38%)
Total	298(100%)	4418(100%)

The overrepresentation of Madison is statistically significant at the level of $P<0.001$.[77] We anticipated such a finding because of the high average educational level of Madison residents relative to the state as a whole, the accessibility of the Office to Madison residents, the local newspapers' comprehensive coverage of Madison events (including activities of state government), and the fact that a much larger percentage of the population are employed by, or have friends or relatives who are employed by, the state government (including the Office itself) or by insurance companies than in any other major city in the state. As discussed in the following paragraphs, our survey found factors such as the latter two influential in stimulating complaints.

The underrepresentation of Milwaukee is also significant at the 0.001 level but is more difficult to explain. It is less likely that our data reflects the lower proclivity of Milwaukians to complain than a difference in the manner in which the Office processed complaints. Our complainant sample was drawn from complaints for which a correspondence file was established. One of the complaint investigators was located in Milwaukee, but if a correspondence file was opened for any complaint he received, the complaint was sent to the Madison office and the file would be in the population from which our sample was drawn. If the Milwaukee investigator was able to settle the complaint summarily, however, he did not refer the matter to the Madison office. Consequently it seems reasonable to suppose, although there is no validating data available, that a disproportionately high percentage of complaints received by the Milwaukee investigator were disposed of summarily. This would at least partly explain the underrepresentation of Milwaukee residents in our complainant sample.

The second major finding in our complainant survey is that more than two-thirds of the respondents indicated awareness that the Office investigated consumer complaints when they "first decided" that they might have a valid complaint against an insurance company.[78] Common sense does not permit us to believe that nearly

77. That is, assuming our complainant sample was truly random, the probability that by pure chance Madison would be overrepresented in our sample to at least the extent it was is less than one in a thousand.

78. This question was worded ambiguously and may have biased the responses towards overestimating those aware of the Office's complaint activities before the dispute. The question was:

such a high proportion of the total population was aware of the Office's complaint activities,[79] perhaps even of the Office's existence, and it would follow that the office's services in investigating complaints were differentially available to "aware" consumers. To the extent that systematic nonrandom factors accounted for prior awareness, the Office's complaint investigation services were not equally available to different classes of the population. To help ascertain whether such nonrandom factors exist, we asked respondents how they first became aware that the Office would investigate complaints. Table 7 shows the distribution.

TABLE 7

SOURCES OF INFORMATION ABOUT COMPLAINT PROCESSING[80]

Source	Number	Percent
"Word of mouth"—friend or relative	55	26
General or past knowledge	31	14
Insurance agent who sold policy	21	10
Media or other generally available sources	17	8
Other agents	13	6
Lawyer	10	5
Elected official	5	2
Other	39	17
No answer or don't know	23	11
Total	214	99

The single most important source of awareness was word of mouth, commonly from a friend or relative.[81] Most persons can hardly have a close friend or relative who knows of the Office's complaint activities; the Office's complaint investigation services were much more available to that part of the population who did.

Many people are unaware that an agency of state government might help them in making a claim under an insurance policy. When you *first decided* that you might have a valid complaint about an insurance policy, did you know that the Commissioner of Insurance would investigate complaints such as the one you ultimately made?

The question does not clearly exclude the possibility that the respondent learned of the Office's activities while trying to settle the dispute. We doubt that this ambiguity distorted the responses very much.

79. That there is generally little awareness of the Office's complaint activities is indicated by the fact that in other states publicity about the insurance department's willingness to investigate complaints has usually resulted in a marked increase in complaints. Stone, *supra* note 7, at 235-36.

80. The "other" classification in this table is unduly high, but the responses to the open-ended questions did not lend themselves to useful further categorization. Further, many responses placed in the category "general or past knowledge" would, on further probing, probably have broken down into "media" and "word of mouth."

81. Some respondents said the friend or relative worked in the insurance industry; others that they worked in insurance and had learned of the Office's complaint processing in that way. In an unpublished paper prepared several years ago, John Frank, J.D. 1971, University of Wisconsin, reported a similar result for complainants to the Public Service Commission of Wisconsin. Frank surveyed 100 complainants to the Commission, finding that a disproportionately high percentage were aware of the Commission's com-

Ten percent of the respondents said the insurance agent who sold them the policy in dispute suggested they contact the Office; another 6 percent learned of the Office's complaint activities from another agent. Some complaint investigators at the Office and some company claims managers whom we interviewed suggested that agents often prompt consumers to file complaints. But the proportion of complainants who first learned of the Office's complaint investigation service from agents was far less than the 40 percent who, before complaining, discussed the dispute with the agents who sold the policies. Thus, consumers patronizing agents who referred clients to the Office had greater access to complaint investigation services.[82] Finally, a small group of respondents learned of the Office's complaint activities from a lawyer or elected official with whom they discussed the dispute. This source of information, too, likely was not equally available to consumers.

We have no way, of course, of describing in demographic variables that portion of the population that had greater access to information about the Office, but the preceding analysis of our complainant survey results suggests some such variables may exist. In any event, awareness of, and therefore access to, the Office is not equally possessed by all elements of the population.

D. The Processing Pattern

In this section we provide a basic description of complaint processing in 1969. The processing pattern in earlier years was similar, though less formalized the farther back one goes. An overview of this process is provided by chart 2.

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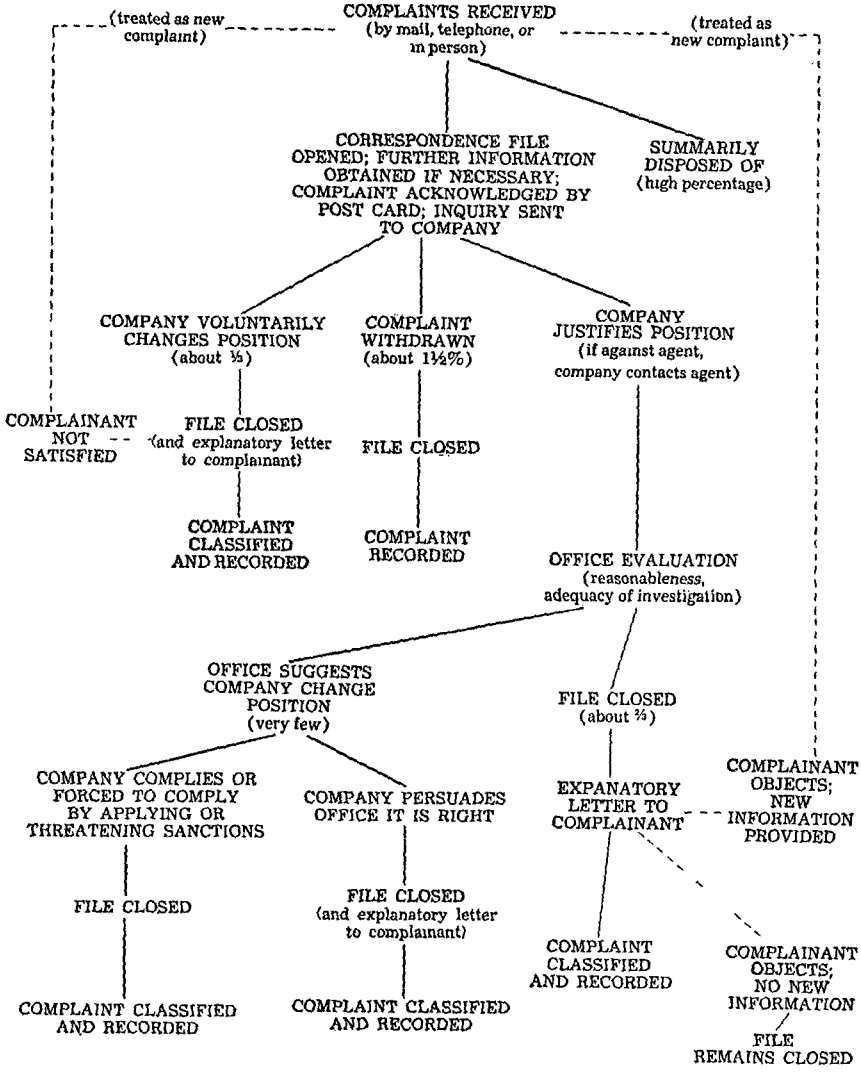
plaint processing activities before becoming involved in the dispute that yielded the complaint and that a high percentage of them first became aware of those services because they, or a close friend or relative, worked for a company regulated by the Commission.

In a study of complainants to the Pennsylvania Insurance Department, a substantial majority indicated they learned of the complaint processing service through the media. M. Boynton, *supra* note 76, at 53. In recent years Pennsylvania has had a highly publicized insurance commissioner, Herbert Denenberg, and this fact may account for the substantial differences in the manner Wisconsin and Pennsylvania complainants acquired information about complaint processing.

82. Some agents who did not refer clients to the Office may have suggested that they write a high official in the company, which may also have been effective. *See* Ross, *supra* note 56.

CHART 2

COMPLAINT PROCESSING IN 1969



The office recorded 5013 complaints for which a correspondence file was opened and statistics recorded.[83] An indeterminate but perhaps large number of complaints and inquiries were disposed

83. 101 INS. REP. 78 (1970) This figure is only an approximation. Some matters for which a correspondence file was opened and a statistic created were only inquiries—for example, an insured might inquire whether a rate increase was legal.

of summarily without creating such a file.[84] Summary action seemed not to be taken when there was fear such an action would make the complainant angry at the Office.[85] As a result, most complaints disposed of summarily were received by telephone or in person, permitting the investigator to judge the complainant's probable reaction to summary disposition.

If the complaint was not dismissed summarily, a correspondence file was started. If the initial contact was by telephone or in person, the complainant was given a standard form to complete, and if a mailed complaint failed to report important particulars, a standard complaint form was also sent. When essential information had been obtained in writing, a postcard was sent acknowledging receipt of the complaint and stating that the Office would be in further contact after its investigation. If the complaint was against a company, as over 94 percent were,[86] a letter then went to the company summarizing or enclosing the complaint and asking for the company's response. The letter might call attention to a possibly valid aspect of the complaint. The Office had a firm policy requiring reply, a policy that was apparently understood and accepted by the companies. The correspondence files were periodically reviewed to ensure timely response, which was expected within about a month. If a reply had not then been received, a reminder was sent. In our survey of 297 complaint files the Office never had to send more than one or two reminders before receiving a company response, but the Office has shown that it is prepared to impose forfeitures for failure to respond to an inquiry.[87]

Sometime after receipt of the company's reply, an investigator examined the file. Complaints were not allocated by subject matter, company or line of insurance; each investigator was expected

84. Records about such complaints and inquiries were kept beginning only in 1970. *See* notes 43-44 *supra* and accompanying text. The Office has claimed there were a "large number" of such matters before records were kept. 102 INS. REP. 80 (1971).

85. Occasionally when receiving a complaint by telephone or in person the Office simply telephoned the company and settled it immediately. Usually, however, a correspondence file was established whenever a company was contacted about a complaint.

86. 101 INS. REP. 79 (1970). Two percent of the complaints were directed at agents; another 4 percent were classified "other," which included both inquiries and complaints by good samaritans objecting to company practices not directly affecting them.

87. *See, e.g.*, 102 INS. REP. 103 (1971). The 1970 insurance report did not contain a report of all formal sanctions imposed in 1969. Nearly all forfeitures for failure to answer an Office inquiry are imposed on agents. It is not clear whether this means that the Office is reluctant to impose sanctions on companies or that companies always answer. In 1969, a statute directed agents and companies to reply to Office inquiries and authorized a forfeiture of not more than $100 for failure to do so. See WIS. STAT. § 201.49 (1967). This statute was repealed by Ch. 337, § 38, [1969] Wis. Laws 1059, and was replaced by more systematic and far reaching provisions. WIS. STAT. §§ 601.41, 601.64 (1971).

to be a "jack-of-all-trades," and work was assigned as it was needed or could be handled.

The key judgment in the complaint process came when an investigator examined the company's reply. No formal instructions guided his judgment. No marked inconsistency was apparent among investigators, however, perhaps because their desks were close together and most had prior insurance experience, were familiar with trade practices, and probably tended to have similar views about proper company conduct.[88]

After processing and evaluating company replies, the Office closed 4985 complaint files in 1969 and classified the dispositions as follows:

TABLE 8

DISPOSITION OF 1969 COMPLAINTS

	Number	Percent
Upheld:		
Adjusted	735	15
Other	7	0
Not Upheld:		
No basis for Complaint	2646	53
Complaint Withdrawn	73	1
Complaint Adjusted	897	18
Question of Fact	541	11
Question of Law	70	1
No Jurisdiction	16	0
Total	4985	99

Nearly all of the 15 percent of complaints that were upheld were sub-categorized "complaint adjusted." This meant, with rare exceptions, that the company had voluntarily changed its position, in a direction favorable to complainant, in response to the Office's initial inquiry. Of the "not upheld" complaints, a large number (18 percent of total complaints), were also subcategorized "complaint adjusted," meaning nearly always that although the company voluntarily altered its position in response to the Office's initial inquiry, the investigator believed the company was not at fault in failing to take that position earlier. For example, the company may have indicated that the change resulted from new information or was made to preserve the complainant's goodwill. A few—one to two percent of the total—were classified "complaint withdrawn," perhaps also reflecting voluntary adjustments not reported to the Office.

These statistics indicate that in approximately a third of the complaints, the company's initial reply was that it had voluntarily taken action to meet the complaint. Often, a gravaman of the com-

88. In 1969, two of the three Madison investigators and the administrative assistant were previously claims adjustors or agents.

plaint in these instances was a delay in ruling on a claim or in answering a request or inquiry. The company's initial reply was commonly that it had communicated with the complainant, thereby satisfying the complaint as originally formulated. In other cases, the company had originally communicated a position to the complainant but upon receiving the complaint changed position favorably to the complainant.

The nearly uniform response of the investigators to a company change of position was to send a copy of the reply to the complainant, assume the complaint was satisfied, and close the file. Companies sometimes volunteered an explanation for their changes of position but they were never asked for one. Often the complainant was invited to contact the Office again if still dissatisfied, but expressions of continued dissatisfaction were infrequent. When they were received, the Office usually treated them as new complaints.

In the remaining two-thirds of the complaints, the company's reply offered justification for its original position, frequently suggesting that the complainant misunderstood the company's reasons. For example, the company's reply often merely referred to a policy provision the complainant had not mentioned or had misinterpreted. If a factual issue underlay the dispute, the company sometimes forwarded substantiating evidence. Thus, if the dispute concerned application of a pre-existing condition clause in a health policy, the company might provide the Office with a copy of the complainant's medical history, or if the dispute arose from an automobile accident, the company might summarize its investigation.

The investigator almost always concluded solely on the basis of the complaint and the initial reply that the complaint was without merit or that factual or legal issues underlay the dispute the Office could not or should not resolve. A letter to the complainant so indicated and, often, either enclosed the company's reply or attempted an explanation of the policy provision or legal rule supporting the company's position. Where the dispute rested on a factual or legal issue the Office would not resolve, the letter usually explained the company's position without trying to defend it, and justified refusal to proceed further by saying the Office was a regulatory not a judicial agency. The complainant was often advised to see an attorney or sue in small claims court if he wished to pursue the matter further. Occasionally a complainant responded to this letter, most often merely expressing dissatisfaction with the Office's handling of the complaint;[89] if new information was provided or a fact was contested that the company alleged,

89. Expressed dissatisfaction seemed to be more frequent when the Office's letter explained that the complaint was without merit because a policy provision excluded coverage. The complainant would accuse the Office of unresponsiveness, stating that he or she knew what the policy provided but wanted to know if the provision was legal.

the Office might renew its investigation, usually by asking the company to respond to the new information.

After evaluating a company's reply, an investigator in a very few cases might decide that the company should be asked for further justification, which could entail additional investigation, or, less frequently, that the complaint was meritorious and that the company should take or consider corrective action. The instances are too few to be sure about company responses, but companies seemed to respond as suggested even though explicit threats of formal sanctions were rare. Implicit threats were undoubtedly more frequent.[90]

Some complaints pertained to activities of agents, not companies.[91] They were processed similarly; the Office's initial inquiry went to the company represented by the agent, and the company was expected to get a response from the agent. If it was determined that the agent should take corrective action, the Office expected the company to secure compliance. Occasionally a field investigation of an agent's activities took place,[92] but it nearly always focused on suspected wrongful practices, not individual complaints.

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90. Only two explicit threats of formal sanction appeared in the complaint file survey of 297 complaints. The Office threatened to seek a cease and desist order unless alleged false advertising were stopped, and it threatened to suspend or revoke an agent's license if he did not return a premium allegedly owing after a voluntary policy cancellation. In both instances, the Office's demand was satisfied. Both involved situations in which the Office commonly policed company conduct carefully. *See* notes 120, 162-64 *infra* and accompanying text.

The complaint file survey revealed one instance of successful resistance to an Office direction to settle a complaint, but on the basis of plausible assertion of facts inconsistent with the complaint. The Office backed down, sent complainant a letter explaining the company's position, and closed the file.

The most extreme implicit threat, unique in our survey, was in a letter from the Commissioner suggesting a company settle a claim more favorably to complainant. The Commissioner noted that the Office had received more complaints against that company in relation to premium volume than against any other in that line of insurance. The Commissioner asked the company to settle the particular complaint and to "review your claim handling procedures and inform me of any changes which you will make in order to improve your record in this state." The Commissioner seemed to be using a particular complaint as a vehicle for pressing a company because of its poor standing in the complaint statistics. *See* notes 134-38 *infra* and accompanying text.

91. The Office classified only 2% of complaints as against agents. *See* note 86 *supra*. However, we believe many complaints of agent misrepresentation were classified as claims complaints against companies. *See* note 166 *infra* and accompanying text.

92. Complaints of agent misconduct were the only ones on which field investigations were undertaken separately from examinations. One investigator spent about 50% of his time on such investigations. *See* notes 171-72 *infra* and accompanying text.

After an individual complaint file was closed, information about the complaint was recorded on a "complaint summary" form. The information went into a computer and was aggregated to provide the Office's complaint statistics, such as those we have frequently reported above. In addition to recording such information as the name of the company, line of insurance, and subject matter of the complaint, the investigator categorized the disposition as either "complaint upheld" or "complaint not upheld," with subcategories under each, as indicated in Table 8 above.

A potential use of statistics was to help identify possible unlawful practices, as opposed to single incidents, by ascertaining the frequency with which particular company practices were the subjects of complaints. Independent investigation could then have led to regulatory action. In fact, however, except for investigations of agents' activities, we observed no such use of complaint statistics. The only formal use of them was for the Office to identify annually the companies with the largest number of total and upheld complaints in relation to premium volume. Some of these companies were asked to take steps to reduce their complaint frequency.[93] Because the emphasis was on complaint frequency, it is possible company responses could range from altering practices productive of complaints to merely dissuading dissatisfied insureds and claimants from expressing their dissatisfaction to the Office. Our evidence is thin but there is some suggesting a wide range of responses.

In summary, the most salient features of the complaint process in 1969 were that: (1) although many complaints were disposed of summarily, even some clearly unmeritorious complaints were likely not to be so dismissed unless the Office personnel believed the complainant would accept such a disposition amicably; (2) a significant percentage of complainants received at least some satisfaction when the companies voluntarily changed position in response to the Office's initial inquiry; (3) unless a company changed its position at that time, complainants almost never received the requested satisfaction; and (4) although the Office maintained statistics on complaints, except with regard to agents' activities, only limited effort was made through use of statistics to identify and correct wrongful practices.

E. *Available Sanctions*

Though the Office rarely imposed formal sanctions as a result of an individual complaint, discussion of its authority to do so will help illuminate the legal environment of complaint processing. The ultimate available sanction was revocation or suspension of the license required to do business in the state. In 1969 the statutes

93. *See* note 90 *supra* & notes 134-35 *infra* and accompanying text.

authorized such action for any violations of "insurance law."[94] By giving the most liberal reading to this statutory language it can be argued—not very persuasively—that license revocation would be a possible solution for almost any misconduct that might have been the basis of a well-grounded complaint, including failure to honor a clearly proper claim.[95] In practice, it was quite unlikely that serious consideration would be given to revocation of any company license for that reason alone. Revocation of an agent's license for misconduct which was the subject of a complaint was more likely, but even then not without some evidence of a *pattern* of misconduct. One license suspension occurred in such circumstances in 1969.

The more significant, because less severe, sanctions were cease and desist orders and imposition of forfeitures. Authority to impose the former extended to any act or practice that was "unfair" or "deceptive";[96] authority to impose a forfeiture did not exist at all until 1947 and thereafter until 1970 it depended on consent of the person "charged with a violation of the insurance laws" and was limited to five hundred dollars per violation.[97] Presumably it was anticipated that the availability of more severe

94. The statutory provisions for license revocation were scattered throughout the statutes, and in earlier years the scope of this authority was even less clear. *See, e.g.*, WIS. STAT. ANN. § 200.14(1), 201.34, 201.41(2), 201.53(10) (1957); note 188 *infra*. These provisions were repealed in 1969. The Commissioner's authority to revoke the license of a domestic insurer was replaced by other remedies. *See* WIS. STAT. ch. 645 (1971). Agents' licenses can now be revoked for "persistently or substantially violating the insurance law. . . ." WIS. STAT. § 601.64(5) (1971) or on a variety of grounds specified in WIS. STAT. §§ 206.41(10) and 209.04(9) (1971). Licenses of foreign companies can be revoked for a wide range of reasons, WIS. STAT. § 618.37 (1971) (incorporating ch. 645 by reference; see especially §§ 645.31 & 645.41).

95. Since "insurance law" was not defined, arguably failure to pay a proper claim, in violation of the law of contract, would violate "insurance law." *Cf.* Duel v. State Farm Mut. Auto. Ins. Co., 240 Wis. 161, 1 N.W.2d 887 (1941). We have found two cases in which revocation of company license was attempted by Commissioners in other states for failure to honor claims. In both cases the Commissioner's action was reversed. Metropolitan Life Ins. Co. v. McNall, 81 F. 888 (1897); State *ex rel.* United States Fidelity & Guaranty Co. v. Harty, 276 Mo. 583, 208 S.W. 835 (1919).

96. WIS. STAT. ANN. § 200.14(1) (Revisor's Note) (1957); WIS. STAT. § 207.09 (1971). *See also* Wis. Stat. § 207.04 (1971). Since 1969 ,the Commissioner has had the authority to "issue such prohibitory, mandatory and other orders as are necessary to secure compliance with the law." WIS. STAT. § 601.41(4)(a) (1971). It is arguable, therefore, that he now has the authority to order payment of a particular claim, although the argument would seem to be a tenuous one; to our knowledge he has yet to do so, and such case law as exists elsewhere would cast doubt on the authority. *See* note 95 *supra*.

97. WIS. STAT. ANN. § 200.14(1) (Revisor's Note) (1957). The Office now has authority to impose forfeitures without first obtaining the offender's consent. WIS. STAT. § 601.64 (1971), enacted by Ch. 337, [1969] Wis. Laws 1052.

sanctions would induce the appropriate person to give consent, as indeed sometimes happened. As with the provision for license suspension or revocation, it was doubtful that the forfeiture provisions could be applied to such law violations as failure to honor a proper claim, rather than only to violations of the insurance code.

F. *Workload*

A wide variety of constraints limited the Office's options in structuring complaints processing, not the least of which were the limitations on legal authority that have been discussed. Because it is so important to an understanding of the Office's operations, we mention specially here one nonlegal constraint on complaint processing—paucity of resources. In 1969, approximately four and one-half investigators attempted to process over 5,000 correspondence files in addition to disposing of an unrecorded number of complaints and inquiries informally. The average workload for each investigator was over 1,000 correspondence files annually. It is now greater. By comparison, in 1958, the New York City office of New York's Superintendent of Insurance had 19 investigators to process 6,800 complaints—an average workload per investigator about one-third that in Wisconsin—yet those investigators were then considered seriously overworked.[98] Similarly, one commentator, who conducted a national survey of complaint processing, estimated that an appropriate workload for a complaint investigator is 500 complaints annually,[99] less than half of Wisconsin's average workload. Whether additional investment in the process would be justified depends on the benefits that would be obtained in relation to the costs. We return to this question in our conclusions.

IV. FUNCTIONS OF COMPLAINTS PROCESSING

Our main purpose is to inquire what functions complaint processing can fulfill and has fulfilled. We begin this section with a brief statement of the principal functions complaint processing can theoretically fulfill. We then analyze complaint processing in 1969 to determine to what extent each function was fulfilled. The primary focus of this discussion is the handling of claims administration complaints. Following this initial analysis, we analyze the 1969 handling of the other two principal types of complaints—automobile policy termination and agent misconduct complaints. We will then test the generality of our 1969 findings by comparing them to our historical data.

Because we do not have complete information about the behavior of the participants in complaint processing, our conclusions must frequently be based on inferences from behavior we have

98. Kimball & Jackson, *infra* note 156, at 169 n.104.
99. G. Stone, *supra* note 61, at 22-23.

observed. From time to time, we will describe the types of possible behavior we believe would imply fulfillment of, or an intent to fulfill, particular functions and then indicate to what extent we observed that behavior.

It should be noted here that although we will frequently indicate that particular behavior implies an intent by the Office to fulfill a particular function, we use "intent" here only in the sense that any person is said to intend the logical consequences of his actions. We do not suggest that there were necessarily considered decisions whether to structure complaint processing to fulfill any indicated function. Indeed, there are many indications that, at least until recently, complaint processing has usually been considered incidental and relatively unimportant, certainly not important enough for thorough planning.[100]

A. The Basic Functions

In the introduction, we suggested that provision of a viable institution for the resolution of small value disputes is one function complaint processing might serve. A second is aid in implementing such regulatory objectives as avoidance of exploitation. In fulfilling this function, the Office would view complaints less as disputes to be settled than as sources of information about regulatory problems or, on occasion, as themselves incidents for regulatory responses. A third possible function is the promotion of the good will of at least three different groups. The general public might see the Office as a more useful agency if it appears to help consumers in their complaints against insurance companies and agents; such a reputation might aid the agency in its dealings with the Governor and the Legislature. Second, the Office might help the insurance companies by legitimizing claim denial or other company action through affirming its correctness after making or appearing to make an investigation.[101] Finally, an agent who has been unsuccessful in helping a client secure payment of a claim by a company can appear helpful by suggesting a complaint to the Office. Perhaps the client will even get the claim reconsidered and paid. If not, the complaint processing can legitimize the agent's own efforts by showing that not even the Office could obtain payment.

Although we will refer to this function as a "good will" func-

100. The complaint investigators told us several times that they thought other Office personnel considered them relatively unimportant.

In recent years the Office has given considerably more thought to complaints processing. *See* note 27 *supra*. In the past year, in part because of dissatisfaction with the work of complaints investigators, the Commissioner requested and received authorization to hire an attorney to supervise the work of the Complaints Section. 105 INS. REP. 64-65 (1974).

101. Such legitimizing may even save the companies some litigation costs, though the claims are usually too small for litigation.

tion throughout this article, we do not intend the term to be pejorative. Agencies can be expected, of course, to enhance their public image and no doubt there are benefits in legitimizing such important social institutions as insurance. Moreover, much of what we denominate a good will function could be characterized as an educational one—namely explaining to consumers in an understandable and credible manner the reasons for company and agent actions and why they are legally permissible.

There may be other possible functions for complaint processing, but these are the obvious ones. They are not mutually exclusive—complaint processing could fulfill all three simultaneously —nor are they totally independent. Thus, the resolution of large numbers of disputes in fulfillment of a dispute resolution function could also enhance good will. It could also inform a participant of the wrongfulness of conduct he previously thought permissible, and reduce the profitability of objectionable practices, thus deterring them and serving a regulatory function. Alternatively reducing objectionable practices by direct regulation can fulfill a dispute settlement function in a preventive manner.

While a pattern of behavior may be consistent with more than one function, and while the functions are not altogether separable, it is possible to identify patterns of behavior that tend to imply fulfillment, or intent to fulfill, only one or perhaps two of the identified functions. Because of possible overlap, final conclusions about the functions of complaint processing will be based on the totality of available evidence.

B. 1969 Complaint Processing: Complaints Relating to Claims

1. INDICATORS OF A GOOD WILL FUNCTION

If the main concern of the Office were to enhance good will, it would deploy the available resources to give as many complainants as possible the feeling that the Office has tried to help, structuring complaint processing to minimize the resources committed to each complaint consistent with maintaining the appearance of good faith. Every complaint would be processed to a limited extent, however obviously lacking it was in merit, unless it was clear that the complainant would be satisfied with summary disposition. But it is only the complainant's feelings that would warrant the Office's attention; the merits of the complaint would only be considered if necessary to create the appearance of helping. Another indicator of a good will function would be special attention to complaints coming from or referred by a legislator, since the most tangible good will benefit to the Office is probably a good image with the Governor and Legislature.

Particularly suggestive that the Office did have a commitment to a good will function was its seeming reluctance to dispose of a com-

plaint without contacting the company unless the complainant appeared likely to accept summary disposition amicably. Most complaints disposed of summarily were received and dealt with by telephone (9469 in 1971) or in person (1634 in 1971),[102] permitting the investigator to judge the complainants' probable reactions to summary disposition. As a result, the Office processed many complaints, particularly when received by mail, where only a good will function was likely to be served; where the company was not likely voluntarily to modify its position, and where the Office would take no further action because, for example, a question of fact or law underlay the dispute that the Office had no authority to resolve.[103] It is difficult to measure the resources the Office could have saved by disposing of such complaints summarily, since we know neither how much time was spent in processing them nor how many of them could have been eliminated by summary disposition. But *some* resources could have been saved and devoted to other purposes,[104] and processing of such complaints is thus an indicator of an intent to fulfill good will functions.

Office personnel informed us that complaints referred by a legislator received expedited consideration, that the company was informed of the legislator's interest, and that a company was then more likely to reach an amicable settlement. They also said that a good predictor of a field investigation of an agent's activities was a legislator's request for one. No statistical verification is possible from our data, but we have no reason to doubt the accuracy of these statements. Such special concern for legislator interest is typical of administrative agencies, and not necessarily undesirable, but it is also an indication that the Office sought through complaint processing to enhance its standing with the Legislature.

Although it seems clear that good will goals were sought through complaint processing, subsequent discussion will make clear they were not the only goals, and we say nothing now about the relative importance of good will objectives. But we can inquire whether the good will objectives were actually achieved. Despite scanty evidence, two pieces of information suggest some success. First, a number of company officials interviewed believed complaint processing had advantages for them by legitimizing

102. 103 INS. REP. 84 (1972).

103. For example, a complaint might object to a company's failure to accept full responsibility, on behalf of its insured, for damages arising out of an intersection accident. Since there is an almost conclusive presumption of mutual responsibility for intersection accidents, with each party being somewhat negligent, it is a virtual certainty that the company has discounted the claim under Wisconsin's comparative negligence law, and that the Office will consider the question as one of fact that it has no authority to resolve.

104. Since 1970 the Office has attempted to dispose of more complaints summarily.

company action, a belief dramatically illustrated by one complaint in which a company recommended that a claimant send the Office a complaint against itself. Agents also apparently gained, or believed they gained, from complaint processing, since a number suggested that clients contact the Office after a claim denial.

Second, in the complainant survey, respondents were asked directly whether they (1) were satisfied with the way the Office handled the complaint; (2) believed the company paid more attention to the matter after the Office was contacted; and (3) would complain to the Office again on an appropriate occasion. Approximately 60 percent answered the first two questions affirmatively and 70 percent the third. But many of those responding negatively expressed intense feelings: comments were fairly common that the Office was an apologist for the companies. Consequently, it is not clear whether the Office gained more good will by complaint processing than it lost.

2. INDICATORS OF A DISPUTE SETTLING FUNCTION

Some disputes are settled through complaint processing. Indeed, factors that tend to get a dispute complained about—that it involves a small dollar value and turns on a factual issue about which reasonable people might differ—indicate that the Office is in a good position to fulfill a dispute settling function in situations in which other forums are not likely to be practically available. The important questions, therefore, are with what frequency disputes are settled, what types of disputes are settled or are capable of settlement, and whether settlement would often have occurred without Office intervention. After examining these questions, we will explore the various roles the Office can and does play in dispute settlement.

a. Commitment to and extent of dispute settlement

There is a fundamental ambiguity in the term "dispute settlement." A dispute might be considered "settled" only if the substantive outcome is consonant with the "correct" or "legal" resolution. Or "settlement" might be defined as any outcome which all parties to the dispute accept amicably, or perceive as fair.[105] Our discussion will encompass both types of settlement.

A number of behavior patterns would indicate the extent to

105. One possible definition of "dispute settlement"—any outcome both parties will accept without resorting to violence—leaves little for the Office to do in fulfilling a dispute settlement function, for the court system nearly always provides a sufficient forum to prevent violence.

For more detailed expositions of these differing concepts of dispute settlement, see Abel, *A Comparative Theory of Dispute Institutions in Society*, 8 LAW & SOC'Y REV. 217, 221-39 (1974); Fuller, *Mediation—Its Forms and Functions*, 44 S. CALIF. L. REV. 305 (1971).

which complaint processing fulfilled or was intended to fulfill a dispute settling function. For example, if the manner of processing aims at settlement of as many disputes as the Office's resources allow, it would be some indication that the Office intends dispute settling to be a major function of complaint processing. We have seen that frequently a company voluntarily changes position after the Office refers a complaint to it. If such changes usually satisfy the complainant—*i.e.*, "settle" the dispute—the settlement uses little of the Office's resources. Consequently, the practice of routinely forwarding all plausible complaints to companies is consistent with a commitment to a dispute settlement function. But sending complaints indiscriminately would not be, for it wastes resources better used to follow up some disputed complaints.

It is more difficult to determine how an Office committed to fulfillment of a dispute settlement function should behave when a company does not voluntarily change position. Available resources would not permit investigation of every such complaint. Since disputes on factual or legal issues about which reasonable men can differ are burdensome to investigate, complaints raising such issues should receive low investigative priority. Examples are disputes concerning whether a medical condition was "preexisting," and the degree of comparative negligence in an automobile accident. The Office could "settle" such complaints expeditiously by imposing a substantial burden of proof requirement on the complainant, but since most consumer complainants are unrepresented by counsel, and since the proof problem is difficult, that would be close to performing no dispute resolution function at all. On the other hand, higher investigative priority should be given if a single investigation would resolve many complaints, as where many complaints raise the same question of policy interpretation. The dispute settlement function suggests little else, however, about investigative priority in relation to subject matter.

An Office deeply committed to dispute settlement would be likely, in determining investigative priority, to weigh heavily the amount in dispute and the demographic characteristics of the complainant. If we assume that the lower the amount, the less practicably available are other forums, priority given to low value disputes indicates some commitment to dispute settlement. A similar inference could be drawn from refusal to investigate when litigation has started or seems likely. Priority concern for complaints from low income persons may also indicate a commitment to a dispute settling function, since such persons are usually less able to utilize other forums effectively, except when eligible for free legal service. If the Office actively solicited complaints of small dollar amount or from low income persons, that would even more clearly indicate commitment to a dispute settling function.

One concrete example of this was the placement in 1969 of one

complaint investigator in Milwaukee with an office near the principal low income residential area. A stated reason for the location was to facilitate complaints by low income persons and a limited direct effort to solicit complaints was attempted. Little concrete information is available as to the success this investigator had in attracting such complaints.

As suggested above, a good indication of the Office's commitment to dispute settlement was the practice of routinely forwarding a large percentage of complaints to companies for a response, since in one-third of the cases there resulted, at low cost to the Office, a voluntary change of company position favorable, and presumably usually acceptable, to the complainant. Two aspects of complaint processing probably enhanced the effectiveness of this practice in settling disputes. Most important was a company practice of having a supervisory employee respond to the inquiry.[106] The Office encouraged this practice by sending its inquiry to the company's home office. This usually produced an independent review of the company's original position by someone not previously involved, resulting in detection of some bureaucratic errors. Moreover, as shown by a recent study,[107] supervisory officials often apply substantive standards more favorable to claimants than do regular claims adjusters. They are more likely to prefer a satisfied customer to saving money by denying a small claim. They have broader discretion, and they are not subject to comparison with other claims adjusters or to budget-like controls over amounts of loss payments.

The second aspect of routine complaint processing enhancing its effectiveness in inducing voluntary changes in position was that the Office evaluated the company responses. Perhaps out of respect for the standards investigators apply in their evaluation, and perhaps out of pride, companies tried to provide a rational explanation for their handling of a case. It is widely believed that attempting rational explanations can reveal unintended and otherwise undiscovered mistakes, as is indicated by the importance administrative law attaches to written findings.[108]

Although there were voluntary changes of position in about a third of the complaints, that number exaggerates the extent to which a dispute settlement function was actually fulfilled. The estimate is based on the Office's classification of approximately one

106. *See* Ross, *supra* note 56.

107. H. Ross, *supra* note 56, at 52.

108. *See generally* 2 K. DAVIS, ADMINISTRATIVE LAW TREATISE § 16.05 (1958). Of course, as large bureaucracies, insurance companies have procedures for policing claims adjusters' decisions simply as a way of evaluating job performance. *See* J. ROSENBLUM, AUTOMOBILE LIABILITY CASES: INSURANCE COMPANY PHILOSOPHIES AND PRACTICES 64-69 (1968). It is unlikely, however, that they are ordinarily reviewed as carefully as when a complaint is filed with the Office.

third of the complaints as "adjusted"—some upheld and some not upheld. But complaints of different subject matters were classified adjusted at differential rates. Although the Office maintained no such statistics, table 9 shows the adjustment rates for complaints in our file survey concerning: (1) the merits of a claims settlement offer; (2) delay in settling a claim; (3) failure or delay in paying a premium refund; (4) automobile termination; and (5) other.

TABLE 9

ADJUSTMENT RATES FOR COMPLAINTS

Subject Matter of Complaint	Total No. of Complaints	No. Adjusted	Percent Adjusted
Claims Merits	147	34	23%
Claims Delay	40	21	53%
Premium Refund (mostly delay)[109]	31	25	81%
Auto Termination[110]	41	9	22%
Other	38	6	16%
Total	297	95	32%

Delay complaints were much more likely than other complaints to be adjusted, reflecting the frequency with which the Office classified delay complaints as adjusted if the company replied by saying it had since settled the matter, or sometimes if it merely indicated that it was now in communication with the complainant. Yet, in many cases the company action might have occurred as quickly without action by the Office—the Office's impact simply cannot be established.[111]

A change in company position still occurred with reasonable frequency in complaints about the substance of a company's response to a claim. These adjustments almost invariably pertained to factual issues, especially the amount of damages. A company was less likely to change its position if it had denied liability.[112] The adjust-

109. Our complaint file survey suggested that most of the premium refund complaints pertained to delay. The Office's statistics show that 18% of all 1969 complaints concerned delay in claims settlement, with another 8% about premium refund denial or delay. 101 INS. REP. 79 (1970). Thus, approaching 25% of the total complaints were delay complaints, a figure generally consistent with Ross's findings about complaints sent directly to a high official of a company. Ross, *supra* note 56.

110. A number of the "adjustments" of termination complaints consisted solely of providing the complainant reasons for the termination. In only four of the complaints was there clearly a reinstatement of a policy. In one instance the file was ambiguous as to whether the policy was reinstated, but the complaint was classified as adjusted.

111. If a company reply showed that the company had taken the requested action before receiving the Office's inquiry, the complaint was usually classified "no basis" rather than "adjusted." If company action was taken after receipt of the Office's inquiry, the complaint was almost uniformly classified "adjusted," although it could not be determined whether or how much the Office hastened the requested action.

112. Of the 18 automobile claims complaints in our complaint file survey

ment figures for contested factual issues probably overrepresents the frequency with which complaint processing contributed to dispute settlement. Not all company changes in position necessarily satisfied the complainant, through complainants usually stopped pursuing the matter;[113] only in the latter sense did the Office's classification consistently reflect actual dispute settlement. Second, it is not clear that most adjusted complaints would have remained unadjusted without the Office intervention. Although all complainants had made some effort to settle their disputes privately before contacting the Office, it was usually not possible to determine whether private negotiations might have continued in the absence of a complaint.[114] Moreover, many aggrieved persons, especially insureds rather than third party claimants, complain directly to a high official of the company rather than to the Office.[115] One company studied by Ross processed these complaints much as it processed complaints referred by a regulatory agency, resulting in a significant number of changes in company position. There is no reason to think the studied company unique. Consequently, if the Office were not available, more complainants might write directly to a high official of the company and obtain relief similar to what the Office can obtain. It is doubtful, however, that the Office could perform an equally efficient dispute settlement function more cheaply simply by advising complainants to write directly to the heads of companies. To assume so would require an assumption that the company's actions were not affected by the knowledge that a regulator was watching. This is especially the case for third party claimants, where the company has less need for concern about customer good will.

When a company responded to the Office's initial inquiry by justifying its original position, a complaint investigator evaluated the adequacy of the justification. Our complaint file survey uncovered

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that were classified adjusted, 11 concerned amount of damages and five degree of negligence. Ross drew the same basic conclusion from his study of complaints sent directly to companies. Ross, *supra* note 56. He found an adjustment in 75 percent of complaints involving amount of damage. In our file survey we had 28 damage complaints, only 11 of which (40 percent) were classified adjusted.

113. The Office often invited further communication if the complainant was not satisfied by the company's change in position.

114. Thus, a company sometimes explained its change in position on the ground that the complaint contained information new to it. Complaint processing did not often bypass the private negotiation process completely, however. In our survey of complainants, respondents were asked what efforts they made to settle the dispute privately. Nearly all indicated some direct contact with the company. More than 20% had contacted a claims supervisor. About 25% had consulted a lawyer before contacting the Office. The lawyers undoubtedly advised most of these latter complainants that a court action was not economically feasible because of the small amount at stake. For them a complaint to the Office probably seemed a last opportunity to redress an injustice.

115. Ross, *supra* note 56.

few instances in which the Office asked a company to take further action, making it difficult to generalize from the files alone about what induced the Office so to act. We found no evidence that investigators paid more attention to a complaint from a low income complainant or one for whom alternative forums seemed more inaccessible than usual. On the other hand, the investigators did consistently refuse to take further action when they learned a complainant was represented by an attorney or that the matter was in litigation—a practice consistent with a view that the Office should not expend its dispute settling resources when other forums are practicably available.

The complaint investigators said in interviews that in reviewing company justifications they applied substantive standards, which if true would indicate the Office fulfilled at least a limited dispute settlement function. For claims denials, they designated two basic standards. One was "reasonableness" in the interpretation of policy terms and assessment of conflicting evidence on factual issues. Reasonableness appeared to be based more on perceptions of generally accepted trade practices than on technical legal rights, although there is naturally considerable congruence between the two.[116] The second standard was adequacy of investigation of the claim, again apparently based on trade practices.

We cannot determine whether these standards were applied consistently. That companies tried to respond to the Office's initial inquiries with rational explanation and often with a description of the claims investigation may suggest a belief on their part that the Office would apply these standards in evaluating justifications. More important, there were cases in which the Office did challenge a justification as inconsistent with those standards. An example was a challenge for improper investigation of a company settlement offer for automobile damage based solely on an adjuster's inspection without obtaining estimates.[117] Another concerned a company that denied recovery under automobile comprehensive coverage for a stolen stereo tape player because it was not original equipment, despite absence of policy language to support that limi-

116. Most investigators had prior experience in the insurance industry. *See* note 88 *supra*.

117. This case illustrates the interaction of the standards of reasonableness and adequacy of investigation. Not only was the investigation inadequate, but arguably it would have been unreasonable to base a claim settlement on any other evidence than a garage's estimate. On the other hand, there were issues on claims for damage to an automobile for which an adjuster's inspection was considered an adequate investigation and a reasonable basis for a settlement offer. In total loss cases, when recovery was to be based on reasonable value rather than cost of repair, the claimant often claimed the vehicle was in especially good condition and that average market value of an automobile of that model was not an appropriate measure of recovery. An adjuster's inspection of the automobile would normally have been considered an adequate investigation and a reasonable basis for a settlement offer.

tation on coverage. The Office labeled the position "arbitrary"—*i.e.*, not "reasonable"—and demanded payment. The company complied.

Doubt about the consistency of application of these standards stems from the fact that very few challenges were made to company justifications. Most of the instances of which we know were called specially to our attention by complaint investigators, and were not revealed by our survey of over five percent of the 1969 automobile and health complaint files. Arguably the low incidence of challenges reflects widespread company acceptance of the Office's standards, with accidental mistakes being discovered and corrected in response to the Office's initial inquiry. But the complaint file survey revealed some instances, perhaps significant in view of the few challenges found, in which a challenge seemingly might have been made based on one of the Office's stated standards but was not made.[118]

Even if the standards were consistently applied, they were not standards that would permit the Office to declare in each case which party was "right," or more likely to win a lawsuit. As Table 8 shows, the Office classified 12 percent of the complaints as raising a question of fact or law it could not resolve. The Office may have decided the company adequately investigated the issue and reasonably assessed the conflicting evidence, but that the correct resolution was still in doubt. In these instances, the Office informed the complainant that a bona fide dispute existed and that it could do nothing further. Moreover, our complaint sample indictates that the Office's statistics seriously underrepresent the number of complaints that raised contested factual issues. Many complaints challenging a company position on a factual issue, such as degree of negligence, were classified "no basis," although it seemed to us there was sufficient evidence in complainant's favor at least to constitute a jury issue.[119] Perhaps the Office found

118. A common complaint raising issues of reasonableness and adequacy of investigation concerned a third-party claim arising from an automobile accident for which the company denied liability based on its insured's version of events. In a few instances the Office considered such action unreasonable, or based on inadequate investigation if a police report or the account of a disinterested witness had not been considered. In other instances, however, the Office did not challenge the company's position. We could not discern neutral principles that explained this diversity. One investigator said the judgment in this situation was "reasonably subjective"; the company's position should "ring true," he said. Interestingly, other commentators have indicated that in this situation insurance companies usually base a liability determination on an insured's account only if police reports and reports of disinterested witnesses are unavailable. *See, e.g.*, Ross, *supra* note 56. While such considerations clearly weighed heavily in the Office's evaluations, it did not follow a fixed rule to that effect.

119. Over one-third of the automobile complainants in our complaint file survey raised objections to a company's position on degree of negligence or on damages.

the company's evidence, as related in its justification, more credible. Complaints that raised questions on the interpretation of the policy were also sometimes left unresolved by the Office.

There are several styles the Office might assay in processing complaints in which both parties to the dispute were companies or agents. Our file survey uncovered few such complaints and a consistent pattern is difficult to establish. In some cases, notably in disputes about the payment of premiums and commissions between agents and companies, the Office seemed disinterested, perhaps believing the parties could resolve the dispute without help or perhaps regarding the matter as outside its regulatory power. But the Office took great interest in every false advertising complaint we found. The Office actively investigated them, and in each instance successfully requested cessation or alteration of the challenged advertising. Most of these infrequent complaints[120] were made by trade associations or by competing companies and agents, and thus can be viewed as disputes between companies and/or agents. Since false advertising complaints raise the possibility that consumers are being misled, they also present an occasion for fulfillment of a regulatory function.[121]

b. Role in dispute settlement

There are several styles the Office might assay in processing complaints. The Office might resemble a judge or arbitrator—attempting to ascertain the "correct" or "legal" resolution, with consideration limited to facts brought to its attention by the parties. It might resemble a mediator—attempting to induce the parties to agree but essentially unconcerned about the content of the agreement. Or it might serve as advocate for one of the parties. Private negotiation would then remain the basic technique for resolution, with the Office lending its bargaining expertise to one of the parties. Choice of the party to be aided is a part of the role definition. The Office may see itself as a consumer protection agency, or as a super-manager of dispute settlement for the industry, or as a servant of the party most in need of help (often but not always the complainant).

The differences among these approaches are not sharp, and it may be more meaningful to perceive them as points on a continuum. An Office taking a mediating approach could neverthe-

120. The Office presently maintains no separate statistics for false advertising complaints. In our complaint file survey, there were only three false advertising complaints. All concerned advertising placed by agents and all were upheld.

121. Complaints about "twisting," a type of agent misconduct to be discussed later, also attracted the special concern of the Office. Twisting complaints often concerned a dispute that in reality was between agents or between an agent and a company. *See* notes 167-69 *infra* and accompanying text.

less be biased towards the "legal" resolution of the dispute and attempt to move the parties in that direction. Even if the Office were to adopt an adjudicative style of intervention, it would have to rely on persuasion to secure acceptance of its decision, since a license could not practicably be revoked for a single failure to accept a proposed resolution, nor could the Office preclude a complainant's subsequent decision to bring a lawsuit. Moreover, in any mediation there is a tendency for the mediator to aid the party with least adequate information and bargaining skill. Thus the distinction between an adjudicative, a mediator's and an advocate's role may be blurred.[122] It is nonetheless useful to search for any indications there may be, if for no other reason than to provide better understanding of how complaint processing works.[123]

When disputes were settled by voluntary changes in position, the Office generally sought no additional information about either the propriety or legality of the company's new position or the reason for the change.[124] This singular concern for amicable settlement suggests that the best characterization of the Office's role in its routine complaint processing was as a mediator. If routine complaint processing produced an adjustment, it would necessarily be in favor of the complainant, but the Office cannot be regarded as a consumer advocate unless it does more than process the complaint.

A limited adjudicative label best characterizes the Office's dispute settling role once it received a company justification. The Office then perceived itself as evaluating and determining adequacy of company justifications.[125] It did not then seek to be a

122. *See generally* Abel, *supra* note 105.

123. Such an inquiry may give insights into the public policies that might be implemented through complaint processing. If the Office performs an advocate's role and settles disputes effectively, complaint processing has the potential to redress an inequality of bargaining power. If the Office adopts an adjudicative or mediation role, and is able to induce the parties to accept its "decisions," at a minimum complaint processing can provide persons who feel strongly they have been wronged in a small value dispute with a disinterested forum in which they can be heard. For a discussion of the role of the complaints division of a state attorney general office, see Steele, *supra* note 4.

124. The Office did classify the complaint as "upheld-adjusted" or "not upheld-adjusted," but this judgment was made on the basis of information supplied by the company, and thus was no reliable guide to the merits. This lack of serious concern about the propriety of the company change included the case where a company labeled its change a "policy adjustment"—that is, extending a benefit not required by the policy. Such a change was inconsistent with the Office's basic nondiscrimination standard. *See* notes 9, 19-20 *supra* and accompanying text.

125. In some earlier insurance reports, the textual summary makes it clear that the Office thinks of itself as a dispute settling agency, and seems to vacillate in its self-conception between an adjudicator's and mediator's role. *See, e.g.*, 96 INS. REP. 88 (1965); 97 INS. REP. 75 (1966).

mediator, though many disputes, especially close factual ones, presumably could have been resolved in that manner. This is not to say as we will discuss in our conclusions, that the Office would have been well advised to expend the resources necessary to mediate effectively. In a few cases, the Office challenged a company justification on a ground not raised by the complainant,[126] thus performing an advocate's role. However, an advocate's role seemed to be uncommon and perhaps adventitious.

3. INDICATORS OF A REGULATORY FUNCTION

From a regulatory point of view, if the Office is to use its resources efficiently, it should be concerned first with the identification and correction of objectionable *practices*—patterns of conduct inconsistent with such basic insurance regulation objectives as preservation of solidity and fairness. Settlement of a particular dispute might be a by-product, but stopping the practice for the future would be the principal goal. Consequently, processing complaints to maximize the number of voluntary changes in position by companies in individual cases, so important to fulfillment of a dispute settling function, would do little to fulfill a regulatory function, for a company would be less likely to change considered *practices* in this manner; or, alternatively, it might deliberately change position whenever challenged to avoid attempts to deal with its *practices*, which would continue unchanged.

There are essentially two ways in which complaints could facilitate identification of objectionable practices. Sometimes a single complaint may by its nature suggest a practice probably affecting many consumers, such as false advertising, or an unduly restrictive interpretation of a policy provision in a situation likely to arise frequently. Some complaints, even though not suggestive of a practice, identify conduct that has traditionally been regarded as a serious threat to the integrity of the insurance institution, and as such appropriately calls for a regulatory response. Rebating of premiums to favored customers would be an example to the extent that it exists. Giving investigative priority to such complaints would indicate an intent to fulfill a regulatory function.[127]

126. In one case, for example, the company had applied a $100 deductible clause to a collision claim arising out of a two car accident. When the Office discovered that both parties to the accident were insured by the same company, it directed the company's attention to a policy term providing that the deductible clause would be waived in such a situation. The company then paid the entire claim.

127. We earlier suggested that investigative priority for a policy interpretation issue about which there are many complaints would indicate a dispute settlement function. The behavior described here is different, in that there is no need that more than one victim feel aggrieved. The distinction is that fulfillment of the regulatory function involves concern for wrongs committed even without a dispute whereas fulfillment of the dispute settle-

A large number of complaints about a particular company also suggests a possible regulatory problem, and invites investigation. Thus maintenance and effective use of comprehensive statistics about complaints would be a good indication of an intent to identify possible objectionable practices. An even stronger indication of intent to fulfill a regulatory function would be maintenance and use of detailed statistics about complaints pertaining to areas of special regulatory interest, especially areas such as agent misconduct for which the Office has few alternative sources of information.[128]

A regulatory function would also be indicated by extensive communication between the Complaints Section and other divisions, which may have complementary information about regulatory problems and may be in a better position to make a regulatory response. A large number of complaints about settlement offers of a company can indicate "shaving" of claims because of financial difficulties.[129] A regulation oriented Office would be likely to identify such cases and refer them to the Examining Division, which could conduct an examination to determine solidity.

Although the purpose of regulation is largely preventive, not punitive, the frequent imposition of formal sanctions would be further indication of a regulatory orientation; sanctions have less place in a dispute settlement scheme where resolution is the objective. Except for failure to respond to an Office inquiry, however, both in 1969 and historically, sanctions have almost never been imposed on companies as a result of complaint processing.

The clearest indication of an intent to fulfill a regulatory function through complaint processing was the investigators' attempts, when evaluating company responses to complaints, to assess the adequacy of claims investigation. Since companies generally establish and enforce detailed claims investigation procedures for adjusters,[130] a single instance of inadequate investigation raised the

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ment function is consistent with indifference to wrongs unless there is a dispute referred to the Office by complaint.

128. If the Office relies heavily on complaint statistics for regulatory purposes, it ought to determine how representative of actual conduct are the complaints it receives. Complaints would be a less reliable indicator of the existence of objectionable practices in, say, claims administration, if particular types of misconduct are unlikely to be the subject of complaints or if particular subgroups in the population are unlikely to complain. A regulation-oriented Office could make a special effort to obtain information in another manner about such problems or attempt especially to solicit complaints about underrepresented misconduct and from underrepresented groups. We have already indicated, however, that the Office made no substantial effort to solicit complaints, or even to ascertain the demographic characteristics of its complainants. *See* note 73 *supra* and accompanying text.

129. Stone, *supra* note 7, at 234-35; G. Stone, *supra* note 61, at 72.

130. *See* H. Ross, *supra* note 56, at 87-135; Ross, *supra* note 56; J. ROSENBLUM, *supra* note 108, at 11-30.

possibility of an objectionable practice. Furthermore, when the Office challenged a claim investigation as inadequate, it insisted not only that the company rectify its handling of the particular claim but also that it desist from the practice in the future.[131] No Office procedure existed to insure compliance, though it is not clear a cost effective one could have been devised. A similar subsequent complaint likely would have received close scrutiny, but the low volume of complaints made a subsequent complaint unlikely.

There are many examples of how the Office failed to use complaint processing to fulfill regulatory functions. When a company voluntarily changed position, the Office invariably closed its file, seemingly never inquiring whether the change covered up an objectionable practice. The lack of frequent Office challenges to company justifications also raises doubts that the Office was consistently concerned to identify and stop objectionable practices.[132] Most important, the Office did not take a position on a number of policy interpretation or other "legal" questions of potentially broad significance.[133]

The best example of the Office's limited fulfillment of a regulatory function is the way it used statistics about complaints. The utility of the Office's complaint data was severely compromised by the generality and vagueness of many classifications on the "complaint summary" form on which information was recorded. Claims administration complaints were generally classified as "claim denied unjustly," "settlement offer inadequate," "delay in

131. A corresponding demand was made in the case of the stolen stereo tape player. *See* text following note 117 *supra*.

132. See note 118 *supra* and accompanying text.

133. In 1969, the Office classified 70 complaints as "not upheld: question of law." An undetermined number of other complaints about debatable policy interpretations were classified as "no basis," presumably because the Office concluded the company's position was reasonable.

Perhaps the best example in our complaint file survey concerned a claim under an accident and health policy covering professional "services rendered by a licensed physician and surgeon of the participant's choice for illness or pregnancy." Claimant, while hospitalized, had an oral cyst removed from her mouth by an oral surgeon who was a D.D.S. but not an M.D. The company justified its denial of the claim both on the ground that the condition was preexisting and that the services were not rendered by a physician. After much correspondence, including a letter from the oral surgeon arguing that an M.D. would not have been qualified to perform the particular surgical procedure, the Office classified the complaint as "no basis." The Office wrote complainant that it could not resolve the policy interpretation issue as it involved a "question of law." From a dispute settling point of view, the Office's action may have been proper: there was very little in the file contravening the company's position that the condition was preexisting, raising a factual issue the Office almost never tried to resolve. The policy interpretation issue, however, was likely to affect a substantial number of claimants—and thus had regulatory dimensions—yet the Office chose not to take a position.

settlement," or "unfair business methods," the latter a miscellaneous category in which many allegations of inadequate investigation were placed. Such general classifications made it essentially impossible for the Office to use aggregated statistics to determine whether a single company was receiving an undue number of complaints about any particular practice, and no such use was attempted. Very specific subject matter classifications, such as allegations of "inadequate investigation of damage to automobile," and "unjust application of pre-existing condition clause," would have yielded more useful data.

One reason the Office did not attempt more sophisticated data collection, as suggested, may be the inadequacy of the data processing service the Office receives from other state agencies. It is not within the competence of either of the authors to evaluate the extent of this problem, but accounts we have heard of the administrative difficulties faced by the Office in changing any of its data processing practices shock these two academics accustomed to the sophisticated, convenient and cheap data processing service available in a major university.

More sophisticated classifications alone would not have been enough to achieve regulatory objectives. Data was aggregated only yearly, rendering quick response impossible. Moreover, though overall complaint volume was substantial, the Office rarely received as many as a hundred complaints annually against a single company. As a result, a statistically significant increase in complaints of a particular type against a company was unlikely. An increase might still have led the Office to direct some attention to a particular company, even if the numbers were not statistically significant. Complaint statistics would have been even more useful if complaints were more numerous, however. Whether solicitation of complaints would have yielded a sufficient increase is not known.

The Office did make limited use of statistics for regulatory purposes. Once annual statistics became available, automobile and health insurance companies against which at least twenty complaints had been filed were ranked on the basis of total number of complaints received and total number upheld per unit of premium volume.[134] The Commissioner then communicated with

134. Since complaint frequency was computed only if there were at least twenty complaints, companies with a small Wisconsin business were effectively immune to this procedure for identifying regulatory problems, even if they had a high complaint to premium volume ratio.

If it were sufficiently reliable, reliance solely on the complaints-upheld statistic would have been the more useful for regulatory purposes. Almost all complaints classified as "upheld" involved a voluntary change of company position after an initial Office inquiry, as did also those classified "not upheld: complaint adjusted." The latter were supposed to indicate that the company change was caused by a decision to preserve good will or by

some or all of those companies and asked them to reduce their complaint frequency.[135]

He rarely recommended changes in particular practices, although sometimes he suggested a company reevaluate its procedures in some area, for example the speed with which it responded to claims. Since about 1961 the Office has often put the shoe on the other foot, by asking companies contacted about their complaint record to propose specific programs to reduce complaint frequency. So far as could be determined, however, in 1969 and prior years the complaint investigators never communicated a company's complaint record to the Examination Division for use in deciding whether to make an examination.[136] Moreover, the Commissioner's emphasis on reduction of complaint frequency may have mitigated the regulatory effect of his contacts with companies.[137] For ex-

receipt of new information, and not wrongdoing in the first instance. Companies did not always state the reasons for their change in position, however, nor did the Office inquire. As a result, often classification as upheld or not upheld was, in the investigators' word, "subjective"; complaints in the files which appeared similar in all important respects were sometimes classified "upheld" and sometimes "not upheld." Moreover, in many cases in which a company voluntarily changed position, the complaint would probably have been dismissed as raising a question of fact or law if the company had resisted. Consequently, attaching too much importance to "complaint upheld" statistics would have penalized companies for voluntarily relinquishing positions the Office would not (and perhaps could not) have insisted they abandon.

There were also difficulties in using the total complaints statistics for regulatory purposes. Aside from the fact that for irrelevant reasons frivolous complaints might be filed against companies at differential rates, a company's complaint volume was heavily dependent on the type of policies it sold or on other unobjectionable practices. For example, automobile companies may improve their books of business by refusing to renew insureds considered poor risks. This is not illegal and sometimes may be encouraged on solidity grounds, but it produces many complaints. A similar observation could be made about the frequent complaints about application of a preexisting condition clause, which mostly pertained to individual but not group health policies. For such reasons, the Office relied for regulatory purposes on both total complaints and complaints upheld, and supplemented those statistics with subjective judgments.

135. Usually the contact was by letter but occasionally informal meetings —called hearings by the Office—were arranged between Office and company personnel. We are not aware of any explicit threats of sanctions if complaint frequency was not reduced, but such threats may have been implicit. *See* note 90 *supra.*

136. Despite this lack of communication, a sample of claims files are regularly inspected during examinations, at least to verify the company's loss reserve practices. Occasionally examination reports commented on a company's fairness in handling claims. *See* notes 187 & 192 *infra* and accompanying text. Since 1969 there has apparently been some coordination between the Complaints Section and Examining Division. *See* text accompanying note 218 *infra.*

137. The companies' complaint frequency varied from year to year, of course, and a company with a high complaint per premiums written ratio in one year would often have a lower ratio in the next year. Chance would explain some of the variation, however.

ample, companies may have taken such complaint reducing steps as instructing agents not to refer unsuccessful claimants to the Office,[138] itself an objectionable practice but one which could reduce complaint frequency.

In sum, the Office made limited use of complaint statistics. Still, it is, of course, quite possible that the Office accomplished through subjective impressions much the same regulatory functions that statistics could have facilitated more scientifically. For instance, some investigators said they were more likely to be strict in processing individual complaints if a company's past performance was inadequate.[139] If true, this would regulate by providing an incentive to the companies to avoid a bad reputation with investigators. We tested this hypothesis by structuring our complaint file survey to include, for both the automobile and health insurance fields, complaints against three companies with a relatively good ranking and against three with a relatively bad ranking in the 1969 complaint statistics.[140] Reputation with investigators is a priori likely to be highly correlated with ranking in the complaint statistics, yet we could detect no significant difference in the way different companies' justifications were evaluated.[141] The infrequency with which company justifications were challenged lends further credence to the conclusion that investigators' impressions of companies were not given regulatory effect in the course of processing complaints. Information derived from statistics, or derived from the constant exposure of the complaint investigators to the practices of the companies, might also be communicated to the Commissioner in frequently held staff meetings and used by him as a basis for various informal actions—for example, contacting a company and suggesting changes in a practice. Since such action would occur outside of formal complaint processing, it did not appear in our study of complaint files, but we are

138. An employee of one company which, in a more recent year than 1969, had been asked by the Office to reduce its complaint frequency, said that such action was one of the principal strategies of the company.

139. But some of the same investigators said that each complaint was evaluated on its own merits. There was no clear consensus, therefore, whether stricter standards were applied in evaluating complaints against companies with poor reputations.

140. *See* note 34 *supra*. The Office calculated complaints to premium volume ratio only for companies against which there had been 20 or more complaints. In the automobile and health fields, however, any company doing a sizeable amount of Wisconsin business is almost certain to have at least 20 complaints. Consequently, companies with reasonably good complaint records, even though exceeding 20 annually, could be included in our file survey.

141. The exceptions, see note 90 *supra*, appeared to be isolated instances rather than part of a consistent pattern. Occasionally, when closing a complaint file after receiving a company's justification of its position, the Office would write the complainant that the company had a good reputation for dealing fairly with its insureds or third party claimants.

informed by the Commissioner that it occurred with some frequency.

C. *1969 Complaint Processing: Automobile Policy Termination and Agent Misconduct Complaints*

Automobile insurance termination complaints and agent misconduct complaints were the most important types the Office received that did not relate directly to claims and they presented the Office with some of its most attractive occasions for significant regulatory responses. The former also raised an issue that became unusually politicized for a technical insurance matter,[142] and the latter presented some kinds of disputes that the Office was consistently able to settle. Both, therefore, merit special discussion.

1. AUTOMOBILE POLICY TERMINATION COMPLAINTS

The 1969 legal setting for termination complaints was a statute prohibiting cancellation or nonrenewal of automobile insurance "solely because of the age, residence, race, color, creed, national origin, ancestry or occupation of anyone who is an insured."[143] The statute was enacted in response to political concern about the frequency of terminations in the 1960's,[144] made in an effort to improve unfavorable loss ratios by better underwriting.[145] To the insured, policy termination had significant economic consequences. Automobile insurance was a virtual necessity and once terminated, a standard rate policy became difficult if not impossible to get. A terminated insured usually had to purchase a substitute policy at a considerable increase in premium. Moreover, he would ordinarily be unable to get high limits of coverage except at prohibitive rates. Since many insureds believed their terminations were unjustified—particularly when not based on traffic violations or accidents—terminations quickly became a political issue.

The statute established a motive test, and most complaints therefore raised difficult fact issues. It was unclear whether violation of the statute could be redressed by a private remedy, but litigation was rarely practicable in any event, since the measure of damages was likely to be the difference in cost between the terminated and the new insurance, a few hundred dollars at most.[146] Given

142. The question became an issue in the 1966 gubernatorial campaign.

143. WIS. STAT. § 631.36(9) (1971), replacing an identical prior provision, WIS. STAT. § 204.341(4) (1967).

144. *See* C. REVIE, AUTOMOBILE INSURANCE CANCELLATIONS AND NONRENEWALS IN WISCONSIN 16-17 (September 1967) in Wisconsin Project Reports, vol. III No. 4 (Univ. of Wis. Bureau of Bus. Research & Service); Ghiardi & Wienke, *Recent Developments in the Cancellation, Renewal and Rescission of Automobile Insurance Policies*, 51 MARQ. L. REV. 219, 220 (1968).

145. *See* note 68 *supra* and accompanying text.

146. No private remedy is explicitly provided. WIS. STAT. § 631.36

the frequency of termination, a large number of complaints could be expected, therefore, and they were received—about one-sixth of all automobile complaints in 1969.[147]

On termination complaints the Office fulfilled even less extensive dispute settling and regulatory functions than on complaints about claims. They were processed in the same formal manner—an inquiry was sent to the company requesting the reason for the termination. But in only 10 percent of the complaints in the complaint file survey did the company voluntarily reinstate the policy, compared to 23 percent of voluntary position changes on claims complaints.[148] Furthermore, in evaluating company justifications of terminations the Office did not seem to apply the reasonableness and adequacy of investigation standards they purported to apply to claims justification. The statute did not limit grounds for termination; it only required companies to provide the insured the reasons for the termination on request,[149] and the Office insisted on compliance with that requirement. But the companies gave some reasons so vague as to have potential applicability to a large part of the population. Moreover, termination was frequently based on "allegations" of behavior deemed to render the insured unacceptable, and the Office apparently had little interest in the extent of the investigation that was made to determine the accuracy of the allegations.[150] In one instance the Office accepted without question a company statement that a policy was terminated because the insured was reputed to have a bad temper. Alleged sexual promiscuity or excessive drinking were relatively common justifications. These reasons were invariably unchallenged by the Office since examination of the statute makes it clear that in themselves they were not unlawful reasons for termination, whether sensible or not.[151]

Given the political setting of termination complaints, it is at

(1971). If one exists, possibly an improper termination would be considered ineffective. *Cf.* Fields v. Parsons, 234 N.E.2d 744 (Mass. 1968). Most insureds, however, would be unwilling to await the outcome of litigation to determine if they have insurance protection. Hence, the practicable remedy to obtain would usually be the cost difference between the insured's new and terminated policies; but it would be too expensive to pursue.

147. *See* note 67 *supra.*

148. See Table 9 and note 110 *supra.*

149. WIS. STAT. § 631.36(6) (1971). This section became effective on August 22, 1969, replacing and slightly changing WIS. STAT. § 204.341(5), (8) (1967). The current statute requires, specifically, that upon the insured's request, the company furnish "with reasonable precision the facts" on which the termination decision was based.

150. If a complainant learned of the reasons for termination and challenged their accuracy, the Office sent this information to the company, but the thrust of the inquiry seemed to be concern that termination may not have been in the company's best interests rather than concern about inadequate investigatory practices. This is a subjective judgment on our part based on a reading of the complaint files.

151. *See* text accompanying note 143 *supra.*

first glance surprising that the Office was so passive, despite the limited statutory grounds for concern. The vague reasons and limited investigation raised a question whether the stated reason was the real reason, and if so, whether the real reason may have been prohibited. It is hard to credit termination of a policy merely for "bad temper." Perhaps the Office should have placed a greater burden on a company to show the statute was not violated by asking what a bad temper meant and why it was disabling in some instances and not in others.

A clearer and more serious potential regulatory issue raised by termination complaints was also ignored in complaints processing. After termination, some companies offered the insured another policy through a high risk subsidiary. The insured often felt compelled to accept the offer for fear it was impossible to obtain standard rate insurance elsewhere. This made it possible for a company to terminate an insured primarily to raise the premium rate, which would be a serious violation of the spirit of the basic fairness objective, for by terminating the policy the company weakened the insured's bargaining position and was in a position to exploit the weakness through a high risk subsidiary. The point is not a simple one, of course, for the cancellation *could* be for quite bona fide underwriting reasons and the offer to insure in the high risk company a real service. Everything turned on motive, which is difficult to ascertain. A clear regulatory posture should have led the Office to make efforts to determine whether the stated reasons were the real ones whenever a terminated insured was offered a higher cost policy though the difficulties are obvious. If complaints suggested that a company was offering high cost policies with some regularity, a special investigation into the company's motives may have been appropriate. If the practice proved to be widespread, a rule if within the Commissioner's authority, or legislation prohibiting a terminating company from offering the insured a higher cost policy through an affiliated company might be indicated. There is no evidence whether the Office even considered any of these possibilities or the general problem behind them. In one such instance, the Office simply explained to the complainant: "In an effort to be of service to you, the company proposed to continue coverage in one of their affiliated companies." The statement may have been true but the fact situation suggests a possible regulatory problem, at least if often repeated.

There are explanations for the Office's avoidance of the issues raised by termination complaints. First, in practice, underwriting decisions are mostly educated guesses. While refusal to insure because of bad temper would be rare, an underwriter's hunch that bad temper coupled with something else indicated a bad risk might commonly lead to rejection of the risk. Given such uncertainty in underwriting standards, the vague reasons and limited investigations do not necessarily suggest statutory violations.

Second, the Office may have believed that policing of termination decisions was not needed because a company's self-interest is generally in carrying a risk with an adequate rate.[152] This may partly explain why companies so rarely changed position voluntarily on a termination complaint. They may investigate more carefully and make fewer bureaucratic mistakes before terminating than before denying a claim, because self-interest is directly engaged.[153] This supposition was supported by a study of automobile policy terminations undertaken by the Office in 1966 in conjunction with the University of Wisconsin Graduate School of Business. Although the study did not negate the existence of arbitrary and objectionable policy terminations, it concluded that the incidence of such practices was low.[154]

Finally, policy termination shows an inherent conflict between solidity and fairness. Too liberal underwriting practices result in high loss ratios. Then a company may seek to improve underwriting by terminating high risk insureds, often with Office encouragement. Rigorous policing of terminations would hinder a company's efforts to improve financial solidity.[155] The Office may resolve the conflict, and may have done so in 1969, by giving priority to solidity. The decision is not clearly wrong.

2. AGENT MISCONDUCT COMPLAINTS

Agent misconduct complaints[156] alleged many different improper practices. If the complaint originated from an insured, it usually alleged one of four types of misconduct: misrepresenting policy terms (the most frequent complaint); knowingly misstating in the application form information about an insured's past (usually

152. There are exceptions. A company writing in excess of capacity may wish to retrench or be required to retrench, even at the cost of losing good business. Then there is the possibility of exploiting the insured's bargaining weakness after termination.

153. Other possible explanations exist for the low incidence of voluntary position changes in termination cases. First, the statute requires a company to provide the insured with the reasons for termination which may permit the latter to direct the company's attention to a bureaucratic mistake before filing a complaint. Secondly, because the Office did not rigorously evaluate company justifications, the companies had little reason to fear a challenge. Finally, a complainant often secured alternative insurance before complaining. Voluntary reinstatement would not be very meaningful and the complaint was little more than an outlet for complainant's anger. Of course there was a legitimate issue about reimbursement for the difference in cost, but the Office never dealt with the issue. Compare this with note 146 *supra*.

154. C. REVIE, *supra* note 144. That study estimated that over a two year period only 3% of insureds had their policies cancelled or nonrenewed.

155. One investigator said this was precisely the conflict he felt in processing the many termination complaints filed against one company because the Office had previously expressed concern about its solidity.

156. For a general discussion of the regulation of agent misconduct by state insurance departments see Kimball & Jackson, *The Regulation of Insurance Marketing*, 61 COLUM. L. REV. 141 (1961).

medical history or automobile driving record);[157] and misappropriating premiums by either failing to send the application and the premium to the company, as a result of which the company considered itself not an insurer of the risk, or failing to return a portion of a premium after termination. In processing the complaint the Office often discovered that financial arrangements between the company and the agent required the latter to return the disputed portion of the premium.[158]

A few agent misconduct complaints originated from competing agents or companies. Some alleged false or misleading advertising by agents; these complaints were investigated thoroughly by the Office.[159] Others alleged misrepresentation or "twisting"—a special variant of misrepresentation in which the agent's motive is to induce an insured to switch policies, accomplished by falsely downgrading the value of an existing policy and/or exaggerating the value of the one the agent is selling.[160] There were also a few complaints that an agent was soliciting without a license or for lines for which he was not licensed.[161]

Formally, the Office processed agent misconduct complaints much as it processed others. The initial inquiry was sent to the agent's company, which was expected to investigate and procure any necessary statements from the agent. Except for formal processing, however, there were sharp distinctions in the way different types of agent misconduct complaints were handled.

If a complaint concerned premium misappropriation, the company usually made a thorough investigation in response to the initial inquiry and, if it determined the agent was at fault, took corrective action. In particular, if the company decided the agent had failed to forward the premium and application to the company, the company usually either treated the complainant as insured and paid the claim or at least returned the premium.[162] Most often pre-

157. Two and a half percent of 1969 complaints were classified as concerning misrepresentation, but this figure seriously understates the incidence of misrepresentation complaints. *See* note 166 *infra* and accompanying text. Misrecording of information was probably frequent but only when it resulted in a claim denial was it the basis of a complaint. We have no hard data on complaint frequency.

158. Eight percent of 1969 complaints were classified denial or delay of a premium refund, making such complaints one of the most common types of nonclaims complaints. 101 INS. REP. 79 (1970). There were very few complaints that an agent had not submitted an application to a company, but we do know it happened occasionally.

159. *See* note 125 *supra* and accompanying text.

160. See Kimball & Jackson, *supra* note 156, at 154-55 for a general discussion of twisting.

161. Interviews with complaint investigators and our complaint file survey suggested that in 1969 premium rebating was not an important problem.

162. If the agent represented more than one company, the company with which the agent told complainant the policy would be placed was considered the insurer. If the agent did not represent that company, the most

mium refund complaints involved delay in returning the premium. Many companies arranged for the agent to return the premium after cancellation by the policyholder in order to give the agent one last opportunity to persuade the policyholder to continue coverage.[163] If it could not induce the agent to take appropriate corrective action, the company returned the premium itself.[164] In both situations when the company returned the premium, it expected reimbursement from the agent, using a threat to terminate the agency as leverage.

When a premium refund complaint pertained to the amount of the refund rather than its timing, the company frequently justified its original determination. The complaint investigators reviewed such justifications carefully. The governing principles were relatively clear and the investigators usually agreed with the company. Where they disagreed, they often reacted strongly, as they also did if they felt a company or agent was not acting vigorously enough to correct a refund delay problem. Indeed, the only explicit threat of license revocation in our complaint file survey occurred when a company was not diligent in inducing an agent to return a portion of a premium for a cancelled policy. The Office wrote: "If you feel it is necessary . . . we would gladly commence the necessary procedure to suspend or revoke [the agent's] license for withholding of premiums. We await your comments." Two days later the company said it would itself return the amount involved.

In sharp contrast to the premium misappropriation situation, complaints about knowing misstatement of facts on an application form rarely led to corrective action by the Office. Technically the application is the policyholder's document; in practice it is often filled in by the agent from oral information supplied by the applicant; therein lies the difficulty, for oral statements are sometimes allegedly erroneously recorded on the form by the agent. The company usually relied on the applicant's duty to read the application and replied to the standard Office inquiry that the complainant who had signed the application form had attested to the accuracy of its statements. The Office seemed always to have accepted this response, permitting the company to cancel a policy or deny a claim on the basis of application misstatements.[165]

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the Office could attempt was to obtain a premium refund from the offending agent.

163. The unearned portion of the agent's commission, which he had already received, was normally part of the amount to be returned.

164. The frequency with which premium refund complaints were settled by such voluntary company action is indicated in Table 9.

165. This type of complaint arose after the company had discovered the misstatement and either cancelled the policy or denied a claim on the basis of it. This action was the gravamen of most such complaints.

Most such complaints were on accident and health policies, where an applicant was typically required to complete a medical history. WIS. STAT. § 204.31(2)(a)8 (1971) permits a policyholder to cancel a health policy,

Misrepresentation complaints also rarely led to corrective action by the Office. A policyholder's allegation of misrepresentation of policy terms was typically coupled with a complaint of claim denial.[166] The company's response to the standard Office inquiry often ignored the misrepresentation allegation altogether, sometimes simply citing a policy provision as justification for the denial; the Office generally accepts the response without further inquiry. Agents' statements about alleged misrepresentation inevitably said there was failure of communication and no intent to convey the impression held by complainant. The Office almost never took further action.

An exception to this pattern occurred when the allegation, often made by a rival agent, concerned twisting. Although complaints were uncommon, twisting was considered a serious regulatory problem, especially in life and health insurance, because the insured frequently lost important benefits by switching policies, such as the advantage of a waiver of preexisting conditions or an incontestability clause.[167] In addition, in life insurance, he had to pay the acquisition costs all over again. Companies too seemed to consider the allegations more serious than other misrepresentation allegations. The complaint was uniformly investigated to the extent of obtaining a statement from the challenged agent, invariably exculpatory. If the complaint was made by a rival agent, the company or the agent often obtained a statement from the policyholder,

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with full return of premium, within ten days after he receives it. The Office, after formal inquiry of the company, often took the position that the ten day "free look" provided the insured sufficient protection against both misrepresentation of policy terms and the type of agent misconduct being discussed, the latter because the application was attached to the policy, which was conditioned on the accuracy of the statements in the application.

Before responding to the Office, a company often first obtained a statement from the agent, or stated that it would do so. The agent's statement was invariably exculpatory. One investigator said that since 1969 the Office has adopted a somewhat more rigorous stance, always insisting that the company obtain a statement from the agent. Occasionally the agent has left the company and cannot be contacted. Sometimes the Office has then said that since the complainant's allegations are uncontroverted, they must be accepted as true, and the company should take appropriate corrective action, such as paying the claim. We do not know whether companies comply. For discussion of legal theories holding a company responsible where the agent has knowingly misstated facts on an application, see Note, *Insurance: False Answers In an Application*, 57 KY. L.J. 714 (1969).

166. Sometimes the complaint only mentioned claim denial, and only when the complaint was processed was the existence of an alleged misrepresentation revealed.

167. *See* Kimball & Jackson, *supra* note 156, at 185-98. Twisting has overtones of unfair competition, and this aspect may have contributed to the Office's concern about such complaints.

Our complaint file survey had very few twisting allegations, but it did not include complaints against life insurance companies, where twisting is most to be expected. The investigators indicated, however, that there were not many twisting complaints against life companies, either.

even without an Office request for it. If the insured indicated dissatisfaction with the new policy, the company sometimes permitted cancellation with full refund. If there was no voluntary company action, however, the Office generally did not pursue the matter.

By 1969 the Office had devised a special procedure for dealing with twisting in life insurance, where it has been considered especially serious. An administrative rule required an agent soliciting a policy with which the applicant intended to replace an existing policy to complete a special form detailing the advantages and disadvantages of the proposed course of action, and to provide copies to both the applicant and the company whose policy would be replaced.[168] If a complaint and ensuing investigation revealed that an agent had not timely completed this form, the Office generally undertook disciplinary action, often a small forfeiture.[169]

The Office maintained statistics about agent misconduct allegations in a separate file.[170] This file was used to help determine when to conduct a field investigation.[171] One investigator spent approximately half his time on such investigations, nearly all of it on agents' activities.[172] Field investigations were primarily directed at discovering persistent wrongful practices, although particular complaints might be resolved as a consequence. The na-

168. The current version of this rule is WIS. AD. CODE, Ch. Ins. 2.07 (1974). For the history of the rule, see WIS. AD. CODE, Ch. Ins. 2.065 (1974).

169. *See, e.g.*, In the Matter of the Forfeiture of Gerald Kamke, 104 INS. REP. 127 (1973).

170. Instead of aggregating data in the usual manner by computer, a separate card file was maintained by hand. Not all agent misconduct allegations were recorded in this file; the judgment whether to record an allegation seemed to be based on the seriousness of the alleged misconduct and on the agent's general reputation with the investigators. The resulting file consisted of a separate card for each agent with respect to whom an allegation of misconduct had been recorded, with each card referring to one or more recorded complaints.

171. The number of allegations of misconduct and their apparent seriousness, as revealed by the file, were not the only determinants of a field investigation but the other factors are not clear. Apparently the decision was a "subjective" one. If a legislator requested a field investigation, it was almost always undertaken. *See* text following note 104 *supra*.

The agent allegation file was also used as an aid in agent licensing. The Office maintained a separate card file for each agent licensed within the past five years. If an agent's license had been terminated, or sometimes if he was considered a problem, his card would be "flagged." When a flagged agent applied for a new license, the agent allegation file would usually be checked and the information it contained weighed in the Office's decision. If the new license was not actually denied, the company the agent expected to represent would probably be informed of his past record and on that basis the company might decide not to take on the agent. *See* Kimball & Jackson, *supra* note 156, at 171 n.109.

172. In 1969 most such investigations were actually conducted in the field, but in more recent years the agent has more often come to the Office, with appropriate records, for a conference.

ture of the field investigation varied according to the nature of the alleged improprieties. Financial improprieties, such as premium misappropriation, called for examining the agents' financial records. Allegations of misrepresentation (including twisting) were more difficult. The field investigators' usual strategy was to interview several of the agent's clients to see if they reported similar misrepresentations; if a pattern was discovered, the agent's denial was discredited.

Almost all sanctions imposed in 1969 as a result of complaint processing were for agent misconduct verified in field investigations. The sanctions were almost invariably imposed informally. Most commonly, the agent was warned by the Office and, of course, he then promised upright conduct in the future. Occasionally formal sanctions were applied; with the consent of the offending agent, a small forfeiture or brief license suspension was sometimes imposed.[173] If the Office believed that more severe action was needed, usually it contacted the companies represented by the agent; companies then usually terminated the agency relationship.[174] The Office almost never revoked a license directly. Agency termination through the companies had the advantage to the Office that it dispensed with the necessity for a formal hearing. There is no reason to believe that the informality of most sanctions that were utilized made them less effective than formal sanctions in deterring improper agent conduct, and they may have been more effective because they put the Office to a lesser burden of proof. Serious due process questions were raised, however.[175]

D. A Historical Analysis

1. PROCESSING CLAIMS COMPLAINTS: INDICATORS OF A GOODWILL FUNCTION

Little information is available about the extent to which, histor-

173. In 1969, sixteen forfeitures were imposed, mostly for unlicensed solicitation; there was one twenty-day license suspension. 101 INS. REP. 79 (1970). The Office had power to impose forfeitures only with the consent of the affected agent. *See* note 97 *supra* and accompanying text. By getting the consent of the affected agent to a license suspension, the Office could avoid the necessity of a formal hearing.

174. Each agent must obtain a certificate of registration and pass an examination demonstrating minimum competence in the lines of insurance to be sold. Before actually soliciting business, however, he must obtain a license issued by the Office through a company which must vouch for the agent's character. WIS. STAT. §§ 206.41, 209.04 (1971). *See* 104 INS. REP. 101-03 (1973). Since licenses are issued through companies, termination of an agency by a company terminates the license for that company. The Office would then make arrangements not to relicense the agent. *See* note 171 *supra*. Some agents, of course, have many licenses from different companies. Unless the Office pressed all the companies to terminate the agency relationship, which would be the normal practice, the agent might not be severely sanctioned.

175. *See* Kimball & Jackson, *supra* note 156, at 171-78.

ically, complaint processing performed or was intended to perform a good will function. Present Office personnel have the impression that throughout the period studied the Office processed most complaints received, which we regard as a key indication of an intent to fulfill a good will function. There were a number of instances in which the Office appeared to give special attention to a complaint in which a legislator or other politically influential person expressed interest, but since the files may not reveal every such expression of interest, we cannot conclude the Office uniformly gave such complaints special attention.

2. PROCESSING CLAIMS COMPLAINTS: INDICATORS OF A DISPUTE SETTLING FUNCTION

Complaint processing has always yielded some voluntary changes in position by companies, but our historical data do not permit reliable estimates of the frequency of such changes.[176] We can discern some changes over time in the Office's dispute settlement activities when a company or agent justified its original position.

In the period 1919 to 1923, there was a combative atmosphere surrounding complaint processing, giving the impression that the Office was more a consumer advocate than a disinterested adjudicator or mediator. Office challenges of company justifications, often made by the Commissioner himself, were quite common. The challenges usually concerned a legal position, such as a policy interpretation, of the company; they were often based on "good practice" or notions of fairness, even when existing statutes and court decisions seemed to support the company.[177] During this period companies also frequently resisted Office challenges of justifications. In some

176. The examination of the pre-1960 correspondence files had goals somewhat different from our present ones, and provided no basis for estimating the frequency with which such changes occurred. Nor do the Office's published statistics since 1961 show the frequency of such changes with precision; but they do indicate that throughout the 1960's the incidence of voluntary changes was substantial.

For most years since 1961 we have been able to obtain statistics, some published and some from the Office's files, about the percentage of complaints upheld. This percentage has varied from less than 11% in 1966 to over 22% in 1961. *See* 93 INS. REP. 39 (1962). In 1969 almost all upheld complaints represented voluntary changes in position and an approximately equal number of voluntary changes in position were classified "not upheld-adjusted." *See* notes 111-15 *supra* and accompanying text. It seems unlikely that the 1969 classification practices were adhered to for the whole of the 1960's for it would indicate a much greater fluctuation in the incidence of voluntary changes in position than is plausible.

177. Many of these situations involved strict application by companies of conditions requiring prompt notice and proof of loss. The Office usually took the position that claims should not be denied on this basis if the consumer had a "good" reason for not filing timely and the company had not been prejudiced. For a discussion of the applicable law, see S. KIMBALL, *supra* note 8 at 213-15.

instances they contested the Office's right to process complaints at all, asserting a legal right to resist payment of any claim until there was a court judgment. More commonly, they resisted by offering further justification for their particular legal position. The Office's response was mixed. Often it would acquiesce and advise the complainant that litigation was the only recourse. Sometimes the Office threatened license revocation or other sanctions or even threatened to recommend corrective legislation. Such threats were sometimes but not always effective in inducing a change of position.[178]

After this earliest period the Office's practices in challenging company justifications quickly became more like those prevailing in 1969. Complaint processing became less combative or antagonistic. Companies were almost never expressly threatened with license revocation or other formal sanction unless they failed to respond to Office inquiries. Companies usually acquiesced when there was a challenge to their justifications; but with the exception of complaints against one company, to be specially discussed later, such challenges were rare. When they occurred, the issue was apt to have regulatory connotations, such as a policy interpretation issue. As in 1969, the Office consistently dismissed a complaint if it discovered that the complainant was represented by an attorney or had initiated litigation. This is an indicator of a dispute settling posture rather than a regulatory one.

Despite this overall similarity to 1969, among the years studied there were differences in the Office's willingness to challenge company justifications. In 1946 and 1956, for example, the Office seemed more prone to challenge justifications of claims denials. Moreover, throughout the pre-1960 period, there were challenges to company justifications that are best described as idiosyncratic. A complaint and company justification would raise no issues having regulatory implications, yet the Office would make extensive efforts to persuade or induce the company to change its position, sometimes even on a factual issue. A possible explanation is that in a less bureaucratized department the person handling the complaint simply took a special interest in the matter and decided to ensure that "justice" was done.[179]

During most of the pre-1969 period, disputes in which both

178. In one instance, the Commissioner carred out his threat to revoke a company license. The company brought mandamus to have the license reinstated but before the matter came to trial the claims were settled and the action dropped.

179. These idiosyncratic interventions appeared to be specially common in the late 1950's. Apparently one employee who processed complaints often became irate with companies and even made veiled threats of license revocation or other sanctions. Eventually, the Office became unhappy with his activities and in 1961 he left the Office, to their mutual satisfaction.

parties were companies or agents were handled as in 1969. False advertising complaints consistently drew the Office's special attention, and it consistently, and usually successfully, sought to stop objectionable advertising. There was considerable variance among different years of the study, however, in how the Office handled complaints by companies that particular agents were not promptly remitting premiums. During the 1919 to 1923 and the post-war periods, as in 1969, the Office seldom took actions on such complaints, apparently believing the companies were capable of resolving such problems themselves. In 1931, 1936 and 1941, on the other hand, the Office processed such complaints and, where appropriate, pressed agents to make the appropriate payments. In essence, the Office functioned as a collection agent for the companies. Perhaps this activity reflected a regulatory concern for company solidity during depression and post-depression years.

3. PROCESSING CLAIMS COMPLAINTS: INDICATORS OF A REGULATORY FUNCTION

a. In general

The Office most often challenged a company justification when the complaint raised regulatory issues. Policy interpretation was the most common situation in which a challenge was made. Some complaints revealing conduct considered especially inimical to the integrity of the insurance institution—such as complaints about twisting or premium rebating (usually the sharing of the agent's commission with the insured)—also attracted the Office's special concern. The Office did not intervene in all such disputes, however, and we have been unable to discern clear principles underlying its decisions whether to intervene. Moreover, we saw no indication that through processing complaints the Office enforced standards as to the adequacy of a claims investigation. As in 1969, when the Office did obtain a company's agreement to adjust a complaint and change a practice, it made little evident effort to determine whether the company complied. And with the small number of complaints in the pre-1960 period, the Office had even less reason than in 1969 to suppose that another complaint would be filed if the company did not comply.

Since the Office did not maintain complaint statistics prior to 1960, obviously it could not use them to discover patterns of complaints indicating practices potentially susceptible to a regulatory response. The volume of complaints was rather small to be suggestive of patterns anyway. However, the persons handling complaints undoubtedly had subjective impressions about the existence of such patterns. The total dependence of our historical study on correspondence files precludes discovery of many of the ways in which the Office may have acted on such impressions in a regulatory manner. For example, the occurrence and results of an infor-

mal conference between the Commissioner and a company are unlikely to appear in the correspondence files. Nevertheless, the files for the 1919 to 1923 period contain some evidence of regulatory action based on impressions about patterns of complaints.[180] Letters challenging justifications frequently referred to prior difficulties with the same company and suggested a review or reform of some aspect of the company's operations. In the later pre-war years the correspondence files revealed similar reactions, but with reduced frequency. In the post-war years, with one major exception discussed below, the files did not reveal Office reactions of this nature; as in 1969, each complaint seemed to be processed as if it were completely independent of other complaints.[181]

Since it has maintained annual complaint statistics, the Office has consistently taken regulatory action against companies with the highest number of complaints and/or upheld complaints in relation to premium volume. In the early 1960's the Office automatically threatened license revocation to the worst ranking companies unless their complaint frequency declined, although no revocations in fact occurred.[182] Later, however, the practices of companies with the worst complaint rankings were evaluated subjectively before any contact was made and there were almost no threats of license revocation. Throughout the 1960's, a principal concern of the Office seemed to be reduction of complaint frequency, with the companies given considerable leeway in determining how best to accomplish that end.

b. Company X: a case study

One exceptional post-war situation demonstrates clearly that complaint processing can fulfill a regulatory function and therefore deserves careful consideration.[183] A company, called here

180. In 1923 the Commissioner asserted the power to require a considerable degree of standardization in accident and health policy forms. One of the justifications he advanced was a large number of complaints about claims denials based on technical restrictions in such policies. The Wisconsin Supreme Court held that the Commissioner had acted beyond his statutory powers. State *ex rel.* Time Ins. Co. v. Smith, 184 Wis. 455, 200 N.W. 65 (1924).

181. A possible exception occurred in the late 1950's. The Commissioner at that time sought additional funds to combat misrepresentation and other agent misconduct, which was quite prevalent at least in 1959. *See* note 195 *infra* and accompanying text. He also reportedly sought to stop the practice of some automobile insurers of offering less than adequate settlements in low value property damage claims where litigation was not feasible. Both efforts were unsuccessful. S. KIMBALL, *supra* note 8, at 205. These activities by the Commissioner were not reflected in the correspondence files, however.

182. *See* 93 INS. REP. 40 (1962).

183. We studied all complaints and other matters pertaining to the company involved in the correspondence files between 1939 and 1958. Information about the volume of complaints against this company after 1960 was

Company X, sold individual accident and health insurance policies with many technical exclusions. The first sign of serious problems with the company arose in the years around 1945 and mostly concerned a significant but still modest number of complaints about alleged misrepresentations by the company's agents.[184] The Office took no particular note of the complaints until 1948, however, when 38 complaints were received, concerning not only misrepresentation but also application of a preexisting condition exclusion. While processing particular complaints in that year, the Office sent several letters asking the company to reconsider its general practices.[185] Apparently they had little effect, for the 1949 complaint volume was 116, approximately one-third of the total complaints received by the Office. The Office significantly escalated the acerbity of its communications with the company, sending scathing letters characterizing Company X's practices as much worse than those of comparable companies. An informal conference was arranged between Office personnel and high officials of the company. Some modest reactions by the company were induced,[186] but when complaint volume, and particularly preexisting condition complaints, increased even further in 1950, the Office threatened license revocation if the company's practices were not changed. In 1951 complaint volume had declined and there were no complaints about misrepresentation. A periodic examination of the company's finances occurred in this year and, in what was

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obtained from unpublished complaint statistics maintained by the Office.

184. At the same time the Milwaukee Better Business Bureau informed the Office that it was receiving a considerable number of complaints about misrepresentations by the company's agents. The correspondence files contained the following number of complaints against this company for the 1939-58 period:

1939 — 7	1949 — 116
1940 — 22	1950 — 156
1941 — 9	1951 — 101
1942 — 6	1952 — 82
1943 — 0*	1953 — 89
1944 — 2*	1954 — 163
1945 — 14	1955 — 100
1946 — 16	1956 — 92
1947 — 23	1957 — 95
1948 — 38	1958 — 68

* Some files appeared to be missing for these years.

185. The company offered to refund the premium of many insureds who complained about misrepresentation. Such voluntary action in effect settled the dispute and the Office took no further interest in the complaint.

186. In particular, some agents against whom there had been many misrepresentation complaints were dismissed, and policy forms were revised to make the preexisting condition exclusion more prominent. This latter action was not likely, of course, to be effective in warning consumers about the limitations on the company's coverage. *See generally* Whitford, *The Functions of Disclosure Regulation in Consumer Transactions*, 1973 WIS. L. REV. 400.

then a significant deviation from usual practice, the examiners commented extensively on the company's claims practices. They observed that a disproportionate percentage of claims were being rejected on preexisting condition grounds and recommended that the company "look into their underwriting practices."[187]

Sometime between 1949 and 1951, the Office refused to renew Company X's license. Because of a legal peculiarity, throughout this period the company was able to continue selling policies in Wisconsin,[188] but lack of a license did foreclose expansion into Minnesota as the company planned in 1951.[189] This latter effect concerned the company greatly and it repeatedly pleaded with the Office to renew its license. Contrary to its prior practice, in dealing with complaints the company also generally acceded to any Office challenge of a justification. And the Office clearly reviewed each company justification with great care, frequently challenging the company's position in situations where ordinarily it would not have done so.[190] Complaint volume further declined in 1952 and the company replaced some key personnel. This apparently satisfied the Office, for the license was finally renewed late in the year. Through 1953 the Office continued to examine complaints thoroughly and the company generally capitulated on a claim denial if the Office suggested it, but relatively little concern was expressed by the Office about general practices. In 1954, however, complaint volume increased to the highest level ever, and the company reverted to its pre-1951 practice of rejecting many Office suggestions that particular claims be honored. In 1955 the license was again not renewed for a few months, and shortly thereafter the company again replaced some key personnel.[191] Apparently, Company X made substantial changes in its practices as well. Although complaint volume remained high in 1956 and 1957, the

187. Wisconsin Insurance Department, Examination Reports, Casualty Companies—1951, 1952, 1953, 56, 69 (on file at University Avenue Records Center, 4638 University Ave., Madison, Wisconsin 53705).

188. The license nonrenewal came during the period in which domestic fire and casualty companies did not need a license in Wisconsin. *See* note 11 *supra*. Throughout this period the Office continued to issue licenses despite the lack of statutory authority, but the company's lack of a license did not legally foreclose it from doing business in Wisconsin.

189. It is a common for a state in which a foreign company seeks a license to require evidence that the company is authorized to do the same business in its domiciliary state. Frequently the domiciliary state will issue a "certificate of compliance" for this purpose. *See* WIS. STAT. § 618.11(11) (1971).

190. For example, the company paid a small claim but immediately attached a rider excluding future coverage of the condition that produced the claim. Although this action was presumably legal, the Office labeled it as harsh and the company withdrew the rider.

191. Another periodic examination of the company's finances was made during this year but the examination report does not comment on the company's claims and underwriting practices. Wisconsin Insurance Department, 1955 Examination Reports, Casualty, Fire, Life and Town Mutual Companies, 105.

Office did not scrutinize company justifications nearly so closely. Starting with 1958, complaint volume declined steadily. In both the 1958 and 1961 examinations of the company's finances, considerable attention was given to claims and underwriting practices. Although criticisms were made, improvements in past practices were also noted.[192] By 1968 fewer than 20 complaints against the company were received, and they were handled routinely.

This history of the handling of complaints against one company demonstrates the capacity of complaint processing to fulfill important regulatory functions. The Office became aware of serious regulatory problems through complaints and it dealt with them, ultimately quite successfully, mostly through complaint processing. Of course, it would have been better if these problems had been solved more quickly and decisively.

4. AUTOMOBILE TERMINATION AND AGENT MISCONDUCT COMPLAINTS

Although in earlier years companies must have occasionally terminated policies because the insured was considered a bad risk, there were almost no complaints about the legitimacy of terminations prior to 1960. Occasionally there were complaints about failure to return an appropriate portion of the premium after a company terminated a policy, however, and these were processed like other premium refund complaints.

Throughout the period under study agent misconduct complaints generally pertained to the same practices as in 1969. Unlike 1969 there were occasional complaints of premium rebating, which were considered quite serious by the Office; in one case license revocation was threatened and litigation ensued.[193] Premium refund complaints consistently attracted the Office's attention, and as in 1969 a clear resolution of the controversy was usually arranged. Because the Office did not have a field investigator until 1960, misrepresentation and twisting complaints were always handled by writing the agent's company and expecting it to investigate. The extent to which the Office pressed the company to make a thorough investigation varied widely, although twisting allegations were regularly considered more serious than allegations of other types of misrepresentation.[194]

192. These examination reports are on file at the Office of the Commissioner of Insurance. Extensive comments on claims and underwriting practices in examination reports were still unusual during this era, so it is probable the Office still treated the company specially. In the 1958 examination report, it was noted that the company's loss ratio was below a "benchmark" figure set by the National Association of Insurance Commissioners for similar companies. By 1961, the loss ratio was closer to the norm.

193. Northwestern Nat'l Ins. Co. v. Mortenson, 230 Wis. 377, 284 N.W. 13 (1939).

194. Except for 1959, there were too few misrepresentation complaints to

In 1959 there were a large number of misrepresentation complaints, especially about twisting in accident and health insurance. To a lesser extent, the same situation prevailed with life insurance complaints. The complaint files do not indicate the Office viewed this concentration as an indication of a potential regulatory problem. Although each complaint was processed, the Office's only significant concern, usually expressed only if twisting was alleged, was that insureds who desired to do so be permitted to cancel and obtain a premium refund. If the company complied, as it typically did, the Office made no further effort to determine whether the allegations were true or whether the agent should be disciplined.

This lack of a regulatory response was probably attributable in part to the increasing complaint volume at a time when the Office still had not hired any personnel to work exclusively on complaints; it must have been difficult to complete even the most rudimentary processing of each complaint.[195] In the early 1960's a rule was adopted which dealt with an important cause of the twisting problem in the life area.[196] After a separate Complaints Section was organized in 1960, the Office began devoting considerable attention to agent misconduct problems. As the following table indicates, the Office imposed many more formal sanctions against agents during this period than in 1969.

TABLE 10

ACTION AGAINST AGENTS[197]

	1961	1962	1963	1964	1965
Will not relicense[198]	17	30	33	36	36
License Revoked	4	12	9	8	9
Fine or forfeiture	3	3	3	8	7
License suspended	—	3	1	—	3
License or certificate denied	—	—	1	—	2
Cease and desist	—	—	—	2	—
Total	24	48	47	54	57

permit reliable identification of particular years as ones in which the Office expressed special concern. The variations can be explained plausibly by assuming the Office reacted idiosyncratically to such complaints, or that there were so few that reactions to them depended on their particular facts.

195. In 1958 and 1959, the Commissioner unsuccessfully sought additional funds to permit more investigations of misrepresentation complaints. S. KIMBALL, *supra* note 8, at 373-374 n.81.

196. WIS. AD. CODE, Ch. Ins. 2.08 (1974). This rule prohibits, *inter alia*, coupon life policies, which tend to mislead purchasers as to the cost of insurance and the return they receive on their investment. Many of the 1959 life complaints concerned twisting to coupon policies.

197. 97 INS. REP. 78 (1966); 96 INS. REP. 89 (1965); 95 INS. REP. 60 (1964); 94 INS. REP. 50 (1963); 93 INS. REP. 39 (1962).

198. In most instances "will not relicense" refers to situations in which a company had terminated the agent's license, perhaps at the Office's urging,

Premium misappropriation was considered an especially severe problem. The 1962 insurance report called for legislation to prohibit commingling of funds, conduct described as "ranging from unintentional clerical errors and carelessness to larceny."[199] Of the 230 actions reported in Table 10, 129 were classified as misappropriation of premiums.[200] It will be recalled that in 1969 we found a disinclination in the Office to concern itself with a commingling problem if only a company's and an agent's interest were involved,[201] but during the early 1960's more interest was expressed in such matters.

Except for the period just discussed, so far as we know the Office rarely revoked an agent's license directly. Instead, if it believed an agent should be disciplined to that extent, it pressed the companies to dismiss the agent.[202] In 1947 the Office acquired authority to impose forfeitures with the consent of the agent concerned,[203] and at least since 1960 a few forfeitures have been imposed for agent misconduct.[204]

V. SUMMARY

The results of our 1969 and historical studies may be summarized by looking at two questions: the extent to which the Office has manifested "intent"[205] to fulfill particular functions, and the extent to which it has actually fulfilled them.

A. Functional Intent

The Office's behavior was consistent with an intent to use complaint processing to fulfill all three of the major potential functions of that process. This is not to say, however, that even within its limited resources the Office maximized its fulfillment of each function. Even in 1969, it seems likely that inexpensive changes in complaint processing could have increased efficiency, particularly in fulfilling a regulatory function.

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and the Office had "flagged" the agent's file. *See* note 174 *supra* and accompanying text; note 171 *supra*.

199. 93 INS. REP. 55 (1963).

200. 97 INS. REP. 78 (1966).

201. Text preceding and accompanying notes 120-21, 162-64 *supra*.

202. The prevalence of this informal system for disciplining agents is indicated by the Office's reaction to Company X. Despite the frequency of misrepresentation complaints in the late 1940's, most of them concerning just a few agents, the Office initiated no license revocation proceedings. A few years later, after extensive prodding by the Office, the company finally dismissed some of the offending agents.

203. WIS. STAT. ANN. § 200.14 (1957) (Revisor's Note). This statute has been repealed and replaced by WIS. STAT. § 601.64 (1971).

204. Since 1960 the Office's annual reports have usually noted the formal disciplinary action against agents. *See, e.g.*, 94 INS. REP. 50 (1963). The correspondence files do not note the imposition of any such sanctions.

205. See note 100 *supra* and accompanying text.

Much about complaint processing suggested a commitment to good will objectives. Most significant was the processing of many apparently frivolous complaints, which is consistent only with a commitment to a good will function. On the other hand, the Office did not generally solicit complaints or publicize its complaint processing activities, though such steps presumably would have produced good will benefits.

The Office's activities in 1969 were more consistent with an intent to accomplish disputes settlement. Especially important was the routine processing of complaints to secure for complainants the benefits of voluntary company changes in position, an activity also consistent with an intent to fulfill good will objectives. The location of an investigator near the inner city in Milwaukee, meant to attract complaints from an important part of Wisconsin's low income population, also suggests a commitment to a dispute settlement function, since low income persons are usually assumed to have less access to alternative forums for settling disputes.[206] That has apparently been the Office's only effort to solicit complaints, however. Our complainant survey suggested that because prior awareness is associated with likelihood to complain, the Office's complaint processing services are not equally available to all elements in the population.[207] By more solicitation of complaints, therefore, the Office could have made its complaint processing services more widely available, thereby enabling it to fulfill a more substantial disputes settlement function.[208]

If a company justified its original position in response to the Office's initial inquiry, the Office rarely did anything further to induce a company change of position. It is difficult to know how much more the Office could have done in this situation to improve its dispute settlement activities without large increases in resources. We have indicated doubt that the Office applied its reasonableness and adequacy of investigation standards consistently, something it could have done without much additional effort. In the small percentage of complaints raising policy interpretation issues, the Office probably could have effectively settled disputes by suggesting an interpretation more frequently, as it sometimes did historically. Yet valid considerations, to be discussed shortly, militated against this latter action, and there is probably not much the Office could have done in the large number of complaints raising contested factual issues not resolvable on the basis of documentary evidence.

206. *See* Levine & Preston, *Community Resource Orientation Among Low Income Groups*, 1970 WIS. L. REV. 80.

207. *See* notes 78-79 *supra* and accompanying text.

208. If solicitations had increased complaint volume without an increase in the number of investigators, it might have necessitated an even more perfunctory routine processing of complaints. Possibly, therefore, solicitation would have caused a net loss in actual fulfillment of a dispute settlement function.

The Office's failure to design complaint processing to maximize its effect was most apparent with respect to the regulatory function. Most obviously, a more sophisticated use of statistics would have permitted easier identification of practices to which a regulatory response would have been appropriate. The obstacles to that course of action will be discussed in the conclusion. It is also significant that the Office ceased all further processing of a complaint once a company voluntarily changed its position and satisfied the complainant. As a result, it was feasible for a company to engage in a wrongful practice and yet, unless complaints were very numerous, to escape sanctions by changing position whenever a victim complained. We cannot know that any company deliberately acted in that way, but given its procedures the Office could not have detected such activity. Finally, field investigatory resources were directed exclusively at agent problems and no instance appeared in which any other division of the Office was asked to investigate other complaints. Thus, whatever the Office's commitment to a regulatory function on agent misconduct complaints, there was a lesser commitment to use complaint processing to regulate other potential problems such as claims administration or automobile policy termination practices.

B. Actual Fulfillment of Functional Roles

The Office's experience in the 1919 to 1923 period, and later with Company X, demonstrates that complaint processing has at times fulfilled both dispute settlement and regulatory objectives. At other times, however, these functions were fulfilled only partially at best. Except during the period 1919 to 1923, companies and agents seem uniformly to have accepted the legitimacy of the Office's complaint processing activities, even though there has never been a statute authorizing them. There are two possible explanations for the industry resistance to the Office during the early twenties: complaint processing may have been relatively new,[209] and the Office appears to have had an unusually strong commitment to dispute settling and regulatory functions. Perhaps acceptance of the legitimacy of complaint processing came only after the Office demonstrated that the activity would not interfere unduly with the companies' decision making prerogatives.

For 1969 the complainant survey and the incidence of voluntary changes in company position indicate some fulfillment of the good will and disputes settlement functions. Almost all disputes settlement occurred because the companies voluntarily changed position. When the companies adhered to their positions, the Office seemed

209. There has been regulation of insurance in Wisconsin since 1850. S. KIMBALL, *supra* note 8, at 174, *et seq.* But we have no evidence about complaint processing until 1919. The earlier records, if there were any, are no longer extant.

best able to settle disputes in which the legal standards were clear and the relevant evidence consisted solely of written documents. Thus, the Office had good success in resolving premium misappropriation complaints in which the standards—including the principle that a company is responsible for its agent's malfeasance—are widely accepted and the relevant facts are often clearly indicated by such readily available documents as cancelled checks. These characteristics are also common to the situations in which the Office was able to settle claims disputes after company justification of its position—where the company had not taken a reasonable position on a policy interpretation issue or had not made an adequate investigation.[210] When an issue required evaluation of conflicting testimonial evidence, such as the degree of comparative negligence, the Office secured a voluntary change in company position with reasonable frequency, but absent this company action it could almost never resolve a dispute.

This last observation was generally validated by the historical study. In the pre-1960 period the issues on which the Office was able to achieve settlement without a voluntary change in the company's position were typically legal, such as questions of policy interpretation.[211] The period 1919 to 1923, when the Office more frequently made extensive efforts to settle disputes, was an exception. One possible explanation for that deviation is the views and personality of the Commissioner at that time. He played a greater personal role in the processing of complaints during this period than at any subsequent time. It is significant, however, that complaint volume was very low during this period, enabling Office personnel to devote considerable attention to particular complaints.

Throughout the rest of the pre-1960 period there were occasional claims complaints, including some raising factual issues, in which the Office challenged the company's justification for no evident reason. Although probably due to idiosyncratic behavior on the part of individual claims processors, the relatively greater frequency of such challenges prior to 1960 is noteworthy. Before 1960 there was no special section in the Office for handling complaints, and complaints were processed by persons with other duties. Centralized control over complaint processing was difficult, and considerable variation in standards was to be expected.[212] In 1969, by contrast,

210. The adequacy of a claims investigation can usually be determined simply from the company's claims file, which will indicate the inquiries that have been undertaken.

211. This is true even for the company against which so many complaints were filed. Although the Office often successfully encouraged that company to settle factual disputes, the Office's strongest reactions were consistently reserved for challenges to the company's interpretations of its policy.

212. The same institutional considerations may explain the Office's inconsistency in handling misrepresentation and twisting complaints and its greater willingness in some years than in others to challenge company justifications. *See* notes 179 & 194 *supra* and accompanying texts.

when the Complaints Section had existed for almost a decade, complaint investigators had developed standards—reasonableness and adequacy of investigation—that were used to support most challenges to company justifications of claims decisions.[213]

Complaint processing had limited regulatory effect in 1969. Although a few wrongful claims practices were detected and presumably changed through processing individual complaints, only limited use was made of statistics. Field investigations and imposition of sanctions were concentrated almost exclusively on agent misconduct, as has been true historically. In regulating agent misconduct, the Office has appeared to have regulatory impact on premium misappropriation problems; but, it has often seemed unable to cope effectively with misrepresentation, and even at times with twisting.[214]

A difficulty in reaching definite conclusions about the extent to which complaint processing has performed disputes settlement and regulatory functions is the impossibility of measuring the general deterrent effect of the mere existence of the process. Complaint processing made it more likely that the Office would find out about objectionable practices, a likelihood enhanced by a practice, at least in 1969, of providing a copy or summary of a company justification to the complainant who could then challenge any incorrect information it contained. We cannot even guess how far complaint processing reduced the incidence of objectionable practices, and therefore of disputes, but it is widely believed that company officials are concerned about the consequences of a bad reputation with the Office. This was said to be partly responsible for having relatively senior officials respond to initial Office inquiries about complaints, which probably contributed to the high number of voluntary changes in company position.[215] On the other hand, it would probably be economically irrational for a company to permit the existence of complaint processing to affect its deliberate practices, for there is no evidence that a company's relationship with the Office with regard to other regulatory activities, such as examinations or approval of rate filings, was affected by complaint outcomes. So long as the companies answered Office inquiries, the chance of punitive sanctions was negligible.

C. Complaint Processing Since 1969

This assessment of complaint processing is not necessarily accurate

213. It does not follow that the Office always challenged company justifications if the standards were not met. *See* notes 117-18 *supra* and accompanying text.

214. This was especially true in 1959. *See* text following note 194 *supra*.

215. *See* notes 106-07 *supra* and accompanying text. Company officials who were interviewed denied that their practices would have been different if there had been no complaint processing. Since the statements are self-serving, they are not necessarily significant.

today. Though we have made no systematic effort to keep abreast of complaint processing activities since 1969, we are aware of several recent changes of potentially major significance. We have noted that the Office now places emphasis on summary disposition of a large number of complaints. This may indicate a deemphasis of a good will function, or it may reflect mainly the problems of increasing complaint volume and scarce resources. Moreover, in recent years the Office has issued a number of regulations pertaining to claims administration and other issues dealt with in complaint processing. Probably the most significant rule, promulgated in October 1971, pertains to claims settlement practices.[216] The rule subjects a company to sanctions including fines and possible license revocation for engaging in proscribed conduct[217] relating to delay in processing claims, thoroughness of investigation, and failure to honor claims because it is unlikely the claimant will litigate.[218] Consultation with the Complaints Section preceded promulgation and many of the rule's provisions, such as those pertaining to the extent of claims investigations, reflect concerns voiced by the investigators in 1969. Moreover, the Examining Division is now expected to inspect a sample of claim files during an examination to determine whether the company is in compliance with the rule. Before making the investigation, the examiners check informally with the complaint investigators to determine areas of claims administration that should be specially investigated. Although much about this rule suggests that the Office is now performing a significant regulatory function with regard to claims administration, the real test is application in practice, and on that subject there is little information as yet. By the end of 1972 not a single formal sanction had been imposed for violation of the rule,[219] although there may have been informal action.

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216. WIS. AD. CODE, Ch. Ins. 6.11 (1974). *See also* WIS. AD. CODE, Ch. Ins. 3.28 (1974) (limiting uses of a preexisting condition clause).

217. The proscribed conduct must, with one exception, be a defined practice and not merely an individual instance. The exception is for "[K]nowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages involved." WIS. AD. CODE, Ch. Ins. 6.11(3)(b)1 (1974). Penalties are provided at WIS. AD. CODE, Ch. Ins. 6.11(5) (1974).

218. WIS. AD. CODE, Ch. Ins. 6.11(3)(a) (1974). Also prohibited are:

> Failure to make provision for adequate claims handling personnel, systems and procedures to effectively service claims in this state incurred under insurance coverage issued or delivered in this state.
>
> Failure to adopt reasonable standards for investigation of claims arising under its insurance policies.

Id. at 6.11(3)(b)2 & 3.

219. By statute all formal sanctions imposed by the Office must be listed in its annual reports. WIS. STAT. § 601.46(3)(d) (1971). No sanctions for violation of this rule have yet been reported. *See, e.g.*, 104 INS. REP. 127-31 (1973); 103 INS. REP. 111-14 (1972). As in 1969, in subsequent years almost all sanctions imposed as a result of complaint processing were for agent misconduct.

D. Constraints on the Uses of Complaint Processing

In addition to the Office's commitment to our three complaint processing functions, other values and constraints affected complaint processing and should be mentioned briefly. The most important constraint was the heavy workload borne by complaint investigators.[220] This cannot be a complete explanation for failure to fulfill complaint processing functions more completely, since the state could have made more resources available for complaint processing. Even without that, steps suggested earlier might have been taken to fulfill better the disputes settlement and regulatory functions. We cannot say how easy they would be to adopt.

A second constraint on complaint processing was highlighted by the study of automobile termination complaints. There is often a conflict between the main goals of insurance regulation—preserving company solidity and promoting fairness. Thus, one reason the Office may have taken a casual attitude towards the large number of automobile termination complaints was fear that to do otherwise would have made it difficult for a company to correct past poor underwriting practices. If the Office gives primacy to solidity as a goal, complaint processing cannot be used to achieve complete fairness.

The Office's (or the Commissioner's) view of legal limitations on its activity could have affected complaint processing, particularly in fulfillment of a dispute settling function. The Office's statutory authority to compel a company or agent to accept a suggested resolution of a particular complaint was, and remains, questionable at best.[221] Putting pressure on a company to make a concession could be considered an abuse of administrative powers. On that view, the most the Office could properly undertake in processing a complaint, unless a regulatory problem appeared, was to give the company complained against an opportunity to change its position voluntarily.

Finally, the Commissioner could also consider himself constrained in performance of a regulatory as well as a disputes settlement function by political considerations. The Commissioner is always sensitive to the political balance of power; if he pursues his activities too vigorously, a variety of undesirable consequences are possible. In addition, the recruitment patterns of key Office personnel, and the jobs available to them upon leaving the Office, may make them sensitive to company or agent interests. Some even suggest, unkindly, that the Office is a "captive" of the industry.[222]

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220. *See* text accompanying note 98 *supra*.

221. *See* notes 27-28 & 94-97 *supra* and accompanying text.

222. A recent study of complaint processing in the California Department of Insurance argued that such a phenomenon played an important role in that state. Serber, *supra* note 7.

There is no direct evidence that the Wisconsin Office ever felt excessively constrained by these legal or political considerations in routine complaint processing. In any case, we think it is a gross oversimplification to talk about the Office being a "captive" of the industry. Although it seems highly likely, and perhaps even proper, that the industry has influenced the Commissioner to some degree, in recent years the Office has taken a number of positions strenuously opposed by the industry. Moreover, the Office has threatened formal or informal sanctions in situations in which its statutory authority to do so was unclear, and the companies have not objected that the Office was abusing its powers. Because threats were few, however, and because most involved regulatory issues, it is possible the Office has felt constrained by concern about its legal authority in pursuing a disputes settlement function. The common practice of telling complainants that the Office could not act on a complaint raising a question of fact or law because the Office was a regulatory and not a judicial body is consistent with this assumption.

VI. CONCLUSIONS

Much has been written in recent years about the need for new institutions to settle low-value consumer disputes. The need is said to be most acute for the poor, who as a practical matter have least access to the courts. A commonly suggested solution is the establishment of informal institutions, much like the Complaints Section of the Office, which would settle disputes through some combination of mediation and adjudication.[223] This study has attempted to define the functional roles which such an institution can potentially fulfill and to assess the actual fulfillment of these functions in one institution. While the study does not demonstrate the inutility of such institutions, it does suggest serious limitations on their capacity to resolve disputes. Informal complaint handling by administrative agencies is no panacea.

The Wisconsin Office of the Commissioner of Insurance has been in a good position to fulfill the type of dispute settlement function commonly attributed to informal complaint processing. Complaints have mostly concerned low-value disputes for which other forums are not usually practicably available; there has been some tendency for them to concern disputes over factual issues about which reasonable men might disagree, which are less likely than many others to be resolved amicably by private negotiation. The Wisconsin Office has had considerable success in settling these disputes by routine complaint processing, giving companies an opportunity voluntarily to change previously adopted positions. The processing has

223. *See, e.g.*, Eovaldi & Gestrin, *supra* note 2; Jones & Boyer, *supra* note 1.

led to internal company review and frequently to an amended decision.

All complaint processing institutions could probably resolve some disputes in this manner, but the incidence of such dispute settlement is not likely always to be as high as for the Wisconsin Office. Insurance companies, as large bureaucratic organizations, tend to guide their internal decisionmaking by rules that seek to treat similar cases similarly. They cannot afford the luxury of making individualized determinations about norms.[224] Consequently, routine complaint processing in the manner of the Wisconsin Office should induce voluntary change whenever the company bureaucracy has not correctly applied its own rules. Significantly, other reported situations in which routine complaint processing has induced merchants to make numerous voluntary changes in position have also involved large bureaucratic companies.[225]

An informal complaint processing institution handling mostly complaints concerning the purchase of goods and services by low income consumers would be less likely to secure voluntary changes in position through low cost, routine complaint processing. Studies have shown that merchants operating in low income urban neighborhoods charge higher prices than their suburban counterparts, in large part because they make individualized decisions about how to deal with each customer.[226] In such circumstances a consumer complaint is more likely to involve a considered decision, and routine complaint processing is less likely to cause correction of a bureaucratic mistake.

Even without a voluntary change in position, the Wisconsin Office's experience demonstrates the capacity of informal complaint processing institutions to resolve disputes when accepted standards can be applied to easily determined facts. But the Wisconsin Office had substantial leverage because its general regulatory authority over agents and companies fostered their desire to maintain a favorable image with the Office. There is some indication that institutions without such leverage could not be as successful. For example, Company X was obviously less concerned about its image than most companies and it failed to apply accepted industry standards even to those claims that were the subject of specific complaints, until the Office finally made credible its threats to impose sanctions.

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224. For a discussion of the detailed rules insurance companies have developed for evaluating automobile claims, see L. Ross, *supra* note 56; Ross, *supra* note 56.

225. *See* Jones & Boyer, *supra* note 1, at 369-72; Whitford, *Law and the Consumer Transaction: A Case Study of the Automobile Warranty*, 1968 WIS. L. REV. 1006, 1023-24.

226. *See, e.g.*, FEDERAL TRADE COMMISSION, ECONOMIC REPORT ON INSTALLMENT CREDIT AND RETAIL SALES PRACTICE IN THE DISTRICT OF COLUMBIA (1968).

A key question is whether the Office's inability to deal effectively with close factual and legal issues is peculiar to an insurance regulatory agency or is likely to be a feature of all informal complaint handling institutions. No single case study can conclusively resolve the question, but we can offer some useful insights.

Turning first to the settlement of factual disputes, it is noteworthy that although many of these issues appeared eminently susceptible to mediation,[227] in 1969 the Office made no attempt to mediate beyond routinely requesting statements of the company position. Since mediation contemplates voluntary changes by the parties, it is hard to question statutory authority to mediate. One important explanation for this failure to attempt mediation is workload. The occasion to mediate arose only after some private negotiations had taken place between the consumer and the company, and after the Office, through routine complaint processing, had afforded the company one more opportunity to reassess its position. In such circumstances the Office probably could not have been an effective mediator without first acquainting itself thoroughly with the facts so it could identify for the parties the weaknesses in their positions.[228] Even if the Office was capable of discovering weaknesses in the companies' cases, something not yet proved, it is clear that the Complaints Section did not have the resources to make the effort systematically.

Given a workload that prevents effective mediation, probably the only technique available to induce a significant number of settlements of disputed factual issues was to threaten sanctions if large numbers of such disputes with a company were not settled to the satisfaction of the consumers. To some extent the Office did this by sending letters to the companies with the highest ratios of complaints to premiums, asking that steps be taken to reduce complaint volume. Without considerable and expensive effort to determine the merits,[229] more pressure than that would violate the spirit and perhaps the letter of due process requirements. In addition, the Office could properly doubt its statutory authority to do more.

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227. For example, on such issues as amount of damages or degree of comparative negligence, one would ordinarily expect the parties to be amenable to a compromise settlement. Further, this study has shown that companies are reasonably prone to change their positions voluntarily and compromise such issues. *See generally* Ross, *supra* note 56. This observation is not necessarily true for all close factual issues the Office faced, however. For example, where the legitimacy of an automobile policy termination was at issue there was rarely much room for compromise. The statutory requirement that rates be filed and approved by the Office and applied nondiscriminatorily, foreclosed such possible compromise positions as a slight increase in the complainant's premium.

228. *See* Fuller, *supra* note 105.

229. For a discussion of the inadequacy of the Office's classification of complaints as upheld and not upheld, see note 134 *supra*.

The Office's reluctance to intervene in close legal issues, such as policy interpretation questions, is also explicable by workload, but the explanation is more indirect. Because the Office had or could have acquired considerable expertise on such issues, the Office could have taken stands on them without extensive investigation. Indeed, under the guise of the "reasonableness" standard, the Office did sometimes take a position on a legal issue. But because the Office's authority to force compliance with its views is doubtful, attempts to impose them formally—for example, through cease and desist orders—would surely have led to litigation. Although the Office might have been able to use informal sanctions to secure compliance with its position—for example, by publicizing the company's lack of cooperation or harassing the company in its other dealings with the Office—such action might be limited by political considerations, and in any case would be viewed as beyond its power. As a result, the Office probably needed to rely heavily on persuasion to obtain compliance with its position on close legal questions. Since the company's position was a considered one—it had justified it in response to the Office's initial inquiry—such persuasion, even if possible, would have been time consuming, meaning the Office could attempt it only occasionally.

The conclusion that the Office's workload prevented it from generally being an effective settler of close legal and factual disputes is supported by our historical data. The situations in which the Office made extensive efforts to settle such disputes were the 1919 to 1923 period, when complaint volume was very low, and in dealing with Company X which was clearly viewed as presenting a special problem. Moreover, in other years in the pre-1960 period, when complaint volume was still modest, the Office, apparently for idiosyncratic reasons, actively tried to settle factual or legal disputes much more commonly than it did in 1969.[230]

230. An article on the settlement of disputes by third parties by Richard Abel offers theoretical support for the conclusion that workload has foreclosed the Office from being a more effective dispute settler. Abel, *supra* note 94. Borrowing heavily from Weber, Abel hypothesizes that as a dispute settling institution becomes more specialized and bureaucratized—in his terms more differentiated from the parties to the dispute—it becomes more concerned with the institution's own efficiency and tends to decide disputes by formal rules that yield clear dispositions, without the need to evaluate a great deal of objective evidence. For example, highly "differentiated" institutions, Abel predicts, are more likely to decide disputes on the basis of rules allocating burden of proof. *Id.* at 278-80. In Abel's terms, when, because of increasing complaint volume, the Office established a separate Complaints Section in 1960, the complaint processing personnel became more differentiated. They began specializing in complaint processing, with no other duties assigned to them. Consequently, Abel's theory predicts, the Office would adopt complaint processing principles leading to easy disposition of the potentially time consuming complaints raising difficult factual issues. In essence the Office did just that by dismissing such complaints as outside its jurisdiction, after initial processing, more consistently than in the pre-1960 period.

The reasons complaint volume has effectively prevented the Office from mediating or otherwise settling disputes raising close factual issues suggest that other complaint processing institutions will face similar constraints if they have a comparable workload.[231] This limitation on dispute settlement capacity is, of course, highly significant; insurance is not unique in having many low value consumer disputes turn on close factual issues. Near the top of almost all lists of consumer complaints are disputes about warranties and repairs of automobiles and appliances, which commonly turn on such close factual questions as whether a warranted good or a repair was "defective," and disputes over alleged oral misrepresentations by salesmen.[232] One solution to this problem is a higher level of staffing, but this raises the question whether the costs would exceed the benefits. Though the benefits of dispute settlement, which include the intangible gain of providing a disinterested forum to a consumer who believes he has been victimized, are difficult to measure, they are finite.[233] And if the only effective available techniques for settlement are mediation for close factual disputes and persuasion for legal disputes,[234] the monetary cost of settling such disputes is likely to be high indeed.

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231. Some other studies of consumer complaint processing by administrative agencies basically support this conclusion. A study of complaint processing by the California Department of Insurance indicated that agency probably settled disputes, including some factual disputes, with greater frequency than did the Wisconsin Office, but the level of staffing was also higher. Serber, *supra* note 7. A study of consumer complaint processing by some other California administrative agencies, all of them with a much lower workload per investigator than the Wisconsin Office, revealed greater success in dealing with factual issues. Some agencies actually sent experts into the field to evaluate specific complaints. Orton, Cook & Berlin, *supra* note 4.

232. *See* National Association of Attorneys General Committee on the Office of Attorney General and Consumer Protection Committee, *State Programs for Consumer Protection*, in STAFF STUDIES PREPARED FOR THE NATIONAL INSTITUTE OF CONSUMER JUSTICE ON STATE AND FEDERAL REGULATORY AGENCIES, 161, 201-07 (National Consumer Law Center, Boston, 1972). Another common complaint pertains to the failure of a mail order seller to deliver merchandise for which the price had already been paid. This type of dispute could usually be resolved on the basis of documentary evidence and we would expect agencies receiving such complaints to be reasonably successful in settling them.

233. We have made no effort to determine whether the benefits of complaint processing by the Wisconsin Office exceed its costs, but in view of the limited resources committed by the Office, it probably does. It achieves settlement in a quarter to a third of the cases at minimal cost. On the other hand, by responding to squeaky wheels, companies adjust many complaints that the investigators judge nonmeritorious. This indirectly penalizes policyholders who do not complain, since the costs of such adjustments are passed on to them.

234. The Office's difficulties in settling close legal issues may not be generalizeable. Other institutions may be given authority to threaten and to impose sanctions to induce compliance. If not, however, they would need to persuade the parties to accept their position on close legal issues.

Costs could be lowered if other settlement techniques were available. Thus, a complaint processing institution might be given authority to issue binding decisions on factual or legal issues. But adjudicative authority would not ease settlement of the factual disputes, for the institution would then need to acquaint itself with the conflicting evidence. Authority to decide legal issues would remove the need to persuade, but it might make necessary the incorporation of due process protections, including court review, so that the net gain in effect would be negligible.[235]

A more promising approach may be development of nontraditional techniques for resolving factual disputes. It has been suggested, for example, that automobile warranty claims could be adjudicated by authorizing an independent automobile diagnostic organization with adequate technical equipment to enter binding decisions.[236] The Milwaukee Better Business Bureau has a similar program for arbitrating complaints against dry cleaners about damage to garments.[237] Decisions are made by a panel of six or seven persons, generally consisting of two owners of dry cleaning establishments, two representatives of the retail clothing industry and three or four public representatives with expertise in clothing and textiles. After examining the damaged garments, the panel determines whether the damage was caused by negligence in the cleaning process, a defect in the material, or improper use of the garment by the consumer. Damages are determined according to a table prepared by the National Institute for Dry Cleaning indicating how much to depreciate the retail value of a garment for use. According to an official interviewed, the Milwaukee program successfully settles almost all disputes referred to it at low cost.[238] As many as 20 complaints are resolved at a single meeting.

The suggestion for resolving automobile warranty disputes and the Milwaukee Better Business Bureau program have in common

235. *See* Jones & Boyer, *supra* note 1, at 386-402.

236. Whitford, *supra* note 225, at 1077-81.

237. Our information about the details of this program comes from interviews conducted in 1971; there may have been some changes since then. Damage to garments occurring in the dry cleaning process is frequently caused by a defect in the material rather than by negligence in the cleaning process. Because many dry cleaners rely heavily on repeat business, they are in need of a credible way to convince customers, in appropriate cases, that the damage was not caused by improper cleaning, and the Better Business Bureau's dry cleaning arbitration program was designed to meet this need.

238. Decisions of the panel were binding by prior agreement on participating dry cleaners but not on consumers. If the panel determined that the damage was caused by a defect in the garment, the consumer usually returned it to the retailer involved for a refund. Although clothing retailers did not agree in advance to be bound by the decisions of the panel, they uniformly honored requests for refunds, obtaining reimbursement in turn from the manufacturer. For a brief description of a similar program in another community, see Jones & Boyer, *supra* note 1, at 376 n.45.

the abandonment of an adversary process and the substitution of an expert adjudicator who essentially acts in an inquisitorial manner. It may not be possible for similar schemes to deal with all kinds of consumer complaints raising close factual issues. But the schemes highlight the need to develop unconventional complaint processing techniques if such complaints are to be resolved in significant volume at low cost.[239]

So far our discussion has focused on the implications of this study for the fulfillment of a dispute settlement function through complaint processing. Although not all complaint processing programs have the statutory authority to fulfill regulatory functions, many do. Since resources are always scarce, these programs will need to decide what relative emphasis to give to fulfillment of different potential functions. There is much to be said for placing primary emphasis on a regulatory function.[240] The Wisconsin Office could

239. There have been a number of suggestions in recent years for extensive programs of local arbitration of consumer disputes. Eovaldi & Gestrin, *supra* note 2; Jones & Boyer, *supra* note 1; Rothschild & Davis, *How to Protect Consumers Through Local Regulation and Arbitration*, 1 LOYOLA CONSUMER PROTECTION J. 26 (1972). Although these commentators have not ignored the need for special techniques for resolving close factual issues, their principal emphasis has been on a need for an informal and geographically proximate institution that allows the consumer to participate personally—typically as an advocate—in the dispute settling process. This need arises, it is argued, in part because consumers feel alienated from contemporary dispute settling institutions, such as small claims courts, and consequently fail to use them.

Nothing in this study casts any light on the need for a dispute settling institution in which consumers participate more directly than by filing a complaint. The continuous growth in complaints sent to the Wisconsin Office suggests that many consumers are not reluctant to take this simple step even though the Office provides a less than totally effective dispute settling service. However, we have no way of determining how many aggrieved consumers fail to complain despite awareness of the Office's complaint processing activities. Moreover, developing institutions in which consumers participate more fully can potentially serve purposes other than simply increasing their practical availability. *See, e.g.*, Cahn & Cahn, *Power to the People or the Profession?—The Public Interest in Public Interest Law*, 79 YALE L.J. 1005 (1970); Wexler, *Practicing Law for Poor People*, 79 YALE L.J. 1049 (1970).

240. It is almost commonplace today for commentators on the consumer complaint processing activities of state attorneys general to argue for more emphasis on regulatory objectives and less on dispute settling. Regulatory activities, the argument runs, provide protection for more consumers at lower cost than do dispute settling activities. *See, e.g.*, Sebert, *Consumer Protection in State and Local Communities*, in STAFF STUDIES PREPARED FOR THE NATIONAL INSTITUTE OF CONSUMER JUSTICE ON STATE AND FEDERAL REGULATORY AGENCIES (National Consumer Law Center, Boston); Note, *Consumer Protection by the State Attorneys General: A Time for Renewal*, 49 NOTRE DAME LAWYER 410 (1973). Serber, *supra* note 7, argued for similar priorities in the complaint processing activities of the California Department of Insurance. Although much in this position is appealing, it needs to be remembered that an eschewing of dispute settling objectives may leave many consumers, who believe intensely they have been victimized, without

have substantially enhanced its fulfillment of a regulatory function by maintaining more sophisticated complaint statistics and concentrating investigatory resources on the regulatory problems revealed by those statistics.[241] Such a program would almost certainly involve less additional cost than any scheme for settling close factual and legal issues in significant volume. Moreover, if successful, it would fulfill a dispute settlement function of a different type, that of preventing potential disputes. On the other hand, to be successful a regulatory strategy may require a substantial increase in the number of complaints, so that sophisticated statistical indices of complaints against particular companies or merchants would have sufficient numbers to be meaningful. For the Wisconsin Office, without additional resources, a substantial increase in the number of complaints would mean even more perfunctory routine complaint processing, with likely negative effects on the ability of the Office to induce voluntary changes in position, and almost certainly a reduction in the fulfillment of a good will function. It is easy to say that this last function is not important, but if a reduction in its fulfillment should cause a reduction in appropriations, or other adverse legislative reactions, the consequences could be severe and unfortunate.

Although it is not our principal focus, we should comment briefly on what our inquiry shows about the regulation of insurance. Previous studies by one of the authors have shown that with the exception of the regulation of claims administration, and to a lesser extent of marketing, the Wisconsin legislature has been a more significant innovator of norms pertaining to the regulation of insurance than the courts, and that the Commissioner's Office is at least potentially a more important norm enforcer than the courts.[242] This study has added the demonstration that through complaint processing the Office has a substantial capacity both to create and to enforce norms in parts of the claims administration and marketing areas, a capacity that is potentially very significant since it pertains mostly to matters that are not and cannot effectively be brought before courts because of their small monetary value. The suggestions made about ways in which the Office could have better fulfilled a regulatory function indicate that it did not fully exploit this capacity. Nevertheless, particularly in recent years, the Office

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a practicably available, disinterested forum. Moreover, many would argue that the case has yet to be made that through regulatory activity administrative agencies can effectively protect the consumer. *Cf.* P. SHRAG, COUNSEL FOR THE DECEIVED (1972); E. COX, R. FELLMETH, J. SCHULZ, THE CONSUMER AND THE FEDERAL TRADE COMMISSION (1969).

241. To insure that available investigatory resources are not dissipated on routine complaint processing, perhaps one or two investigators could be placed in a separate administrative unit and assigned only investigations prompted by complaint statistics.

242. S. KIMBALL, *supra* note 8; Kimball, *The Role of the Court in the Development of Insurance Law*, 1957 WIS. L. REV. 520.

has exploited this capacity in interesting ways. Thus, in 1969 while evaluating company justifications of claims denials, and later by regulation,[243] the Office established standards for company claims investigations. Although the legislature and the courts have established fairly detailed standards to determine when a company may require notice and proof of loss, they have said almost nothing about other procedures a company must follow in evaluating claims.[244] Consequently, the Office, drawing on accepted industry practices, has acted as a principal legal norm innovator in this area. The analogy to Lord Mansfield's development of commercial law in the 18th century is both interesting and instructive.

The potential for norm innovation in the regulation of claims administration and marketing is also illustrated by the way in which the Office handled misrepresentation complaints. Although the Office made little effort to investigate such complaints, when it did establish that a violation or a pattern of violations existed, it often expected a company to terminate the agent. In contrast, there has been an increasing tendency of appellate court decisions to hold an insurance company liable for the representations of its agents.[245] Although it may necessitate an extension of these decisions, it would be consistent with their general thrust for the Office to consider a policy to read as it was represented by the agent and to evaluate claims on that basis. A court, however, could never require a company to terminate an agent, and consequently the different approach of the Office may only show that the Office, as an administrative agency, has more sanctions available to it and can choose from among a greater variety of strategies in deciding how to deter misrepresentation and other misconduct.

243. *See* notes 215-18 *supra* and accompanying text.

244. *See* Kimball, *supra* note 242, at 548-59.

245. *See* Jeske v. General Accident Fire & Life Assurance Corp., 1 Wis. 2d 70, 83 N.W.2d 167 (1957); S. KIMBALL, *supra* note 7, at 223-29; Note, *The Role of the Agent in Marketing*, 1957 WIS. L. REV. 655.