# INSURANCE CLAIMS COMPLAINTS: A PRIVATE APPEALS PROCEDURE

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## INTRODUCTION

Two of the major insights of the sociology of law are that legal rights in contemporary society are most often determined by bureaucratic actors and that the results differ systematically from those predictable on the basis of formal law alone (Mayhew, 1966; Ross, 1970; Skolnick, 1966; Whitford, 1968). The decision-maker who determines in practice the extent of legal rights and duties is most often a low-level employee of a bureaucracy—a patrolman, a tax auditor, a building inspector, or an insurance adjuster. He is usually untutored in academic law and possesses discretion because of his isolation from supervision, rather than by design. The decisions in theory may be removed from the bureaucracy and tried in a court of law. Critical attention, however, has recently focused on the fact that most claims based on legal rights are too small to warrant the cost and inconvenience of a formal trial. There has been less attention paid to the fact that bureaucracies typically offer internal means of appealing the decisions of low-level employees. These appeals procedures permit review and modification of initial decisions by higher-level employees,[1] and furnish the claimant with a less expensive and more convenient alternative to the removal of his claim to the courts. Where the claim is small the internal procedure is usually the only avenue of appeal from an adverse decision that is realistically available to the claimant. In these cases, the internal procedure is in fact the ultimate means by which legal rights and duties are determined. This paper reports a study of the functioning and outcomes of one such procedure, the handling of complaints about claims by a typical insurance company, hereafter called Acme.

Acme is a large, traditional general insurance company. Its practices and procedures seem typical of the major American companies. This impression is bolstered by statistics on com-

1. From the viewpoint of the bureaucracy, the appeals process furnishes a means of controlling the behavior of front-line officials to assure that their decisions accord with policies decided at higher levels of the bureaucracy. Cf. Whitford (1968:1016).

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plaints to the New York State Insurance Department (1973) which show Acme to have a ratio of 4.9 complaints per million dollars of premiums written in the state. This is considerably lower than the median of 8.3 for all companies, but very close to the figures for the large, well-known companies like Firemen's Fund, Aetna, Continental National American, and Hartford.

In 1972 and the first two months of 1973, the Head Office of Acme handled 304 formal complaints concerning claims in the areas of automobile insurance, general liability, and fire and theft insurance.[2] The files maintained on these complaints were studied to determine the bases of the complaints and the company's response to them. About one-third of the files were found to be complaints of delay. The balance were appeals from decisions to deny a claim or to pay less than the claimant demanded. Closer analysis of the latter—appellate complaints—revealed problems related to the applicability of insurance coverage, the existence of liability, and the extent of damages. The appeals process was often successful in obtaining adjustments of decisions when damages problems were involved. It was less often successful with liability problems, and least successful in cases involving coverage. The files falling in each of these categories were analyzed to ascertain the reasons for the differential outcomes observed, and these outcomes were compared with those that might have been achieved in courts of law.

## I. THE COMPLAINTS PROCEDURE

The files analyzed here concerned complaints handled from the Head Office of Acme. They generally originated either in letters to company officials or in correspondence first directed to the insurance commissioners of the various states. Most of the 112 complaints presented directly to the company were made in letters to its president at his Head Office address. The company encourages its policyholders to express any dissatisfaction with its service. A form is included with the claim payment, signed by the president, inviting the payee to inform him "personally" if payment was not made "promptly and satisfactorily." This form is not sent to third-party liability claimants,[3] but their

2. Complaints about claims, as contrasted with those concerning coverage, cancellations, and other matters, have recently constituted between one-fourth and one-half of all complaints received by Acme.
3. Third-party claimants are principally those whose claims are based on the negligence of the policyholder, e.g., people injured in an automobile accident purported to be the policyholder's fault. In contrast, for example, to fire insurance claimants, these people are not customers of the company to which their claims are presented for payment.

complaints to the company are handled in much the same manner as those of policyholders.

Most complaints in the files—189 of the total 304—originated in letters to insurance commissioners. People complaining about their own insurance tended to write to the company; those complaining about other people's companies (liability claimants) overwhelmingly addressed their complaints to the commissioners. The law of most states gives the commissioners little formal power to deal with individual complaints, but the commissioners are perceived by the public as a source of help.[4] They in fact provide limited mediation services by forwarding the complaints they receive to the companies in question, requesting information, commenting upon the handling reported to them, and explaining the companies' positions to the complainants. A very few complaints—only three in the sample studied—originated with newspaper action lines, consumer groups, and other outside parties.

When the complaint is received at the company's Head Office, whether directly from the claimant or through the insurance commissioners, it is routed to an official in the claims department. He immediately acknowledges the letter, sets up a file, and forwards the complaint to the field office which handled the claim to which the complaint refers. The manager of the field office is given general responsibility for the complaint. The actual investigation, however, is likely to be made by a claims supervisor, one bureaucratic level removed from the field adjuster whose handling of the case is being questioned. At a minimum, a complaint will produce a review of the original file by the supervisor and field office manager and an explanatory telephone call and letter to the complainant or his representative. In some cases, additional investigation will be undertaken. The advice of Head Office management may be sought or offered. The field office manager usually makes a final determination of whether any change in the company's stance is warranted. He notifies the Head Office of his decision and writes a letter explaining his position to the complainant or the insurance commissioner, depending on the circumstances. Files in which a response has been made are held open for a month or two, and are closed if no further word is received.

4. The typical state law regulating insurance does not permit insurance commissioners to demand that companies settle claims. However, the statutes are generally broad enough to justify investigation of complaints, e.g., in order to learn of possible financial unsoundness (Stone, 1966:39).

## II. APPELLATE COMPLAINTS

Complaints alleging insufficient payment or improper denial of claims constituted 66 percent of all complaints analyzed. These will be termed "appellate complaints" because they represent appeals to higher levels of the bureaucracy from adverse decisions by lower-level personnel, in this case insurance adjusters. Since all insurance claims are claims of legal rights—contractual rights in the case of first-party claims and rights to recover in tort in the case of third-party liability claims—the parallel with judicial appeals is more than metaphoric. Settlement of a claim by agreement with an insurance adjuster specifies the monetary value of the claim and, by means of a release signed by the claimant, generally concludes the dispute as a matter of law. If the claimant and adjuster do not come to an agreement, the claimant may take his case to formal adjudication (though claims based on contract may have to be appealed through arbitration rather than litigation). The complaint mechanism permits appeal of the legal right through informal channels. The major incentive to use these channels is cost. In the usual complaint, the entire expense of reconsideration is borne by the company, whereas resort to official channels usually requires expensive legal assistance and involves a variety of administrative costs for both parties. Moreover, an unsuccessful complainant does not compromise any formal rights unless the complaint procedure diverts his attention from a statute of limitations that bars the filing of suit after a certain time.

The low cost of complaining as compared with litigating makes it particularly attractive when the amount at stake is insufficient to warrant the time and expense involved in formalizing the claim. For claims where the exposure of the company is very limited, as in the typical automobile property damage situation, complaint may be the only practical method of appealing an adverse decision. Even where small claims courts and artibration are available, their use involves significantly more cost and effort for the claimant than does the complaint procedure. On the other hand, where much is at stake, the cost advantage of the complaint process loses its importance. For this reason, apparently, automobile bodily injury claims are rarely found among complaints. There were only 13 automobile bodily injury claims in the 304 files studied here, and several of these appear to have been presented by sophisticated claimants as negotiating tactics to bolster their property damage claims. In routine bodily injury liability claims, legal representation and ac-

cess to the formal process can be obtained without out-of-pocket cost, and the right to compensation for pain and suffering makes even a trivial injury a source of considerable potential payment. These factors override the cost advantage of the complaint procedure, and it seems in consequence not to be used.[5] (An alternative explanation exists, however: bodily injury claims may be more skillfully and more generously handled in the first place.)

Examination of the appellate complaints in Acme files reveals three major categories of underlying problems. These concern the applicability of insurance coverage, the existence of liability and the extent of damages. They will be discussed in turn in the following sections. Table 1 summarizes the Acme data on numbers of cases and outcomes of complaints.

TABLE I. Major Types and Dispositions of Appellate Complaints

| Complaint type | Number of complaints | Percentage of total appellate complaints | Percentage of category obtaining additional compensation following complaint |
|---|---|---|---|
| Coverage | 19 | 9% | 5% |
| Liability | 105 | 52% | 18% |
| Damages | 77 | 38% | 76% |

*Coverage problems.* In a small group of complaints—6 percent of the total and 9 percent of appellate complaints—the claimant expects insurance coverage but the company finds that no coverage exists because no policy is in force for the insured, or because the policy called upon does not insure against the hazard in question, or because exclusions narrow the coverage. The responses to several complaints merely stated that no coverage was in force for the insured. In some cases, a third-party claimant had mistakenly identified Acme when coverage was provided by another carrier; there were a handful of cases where Acme was confused with Apex, a similarly-named carrier. In other cases, while coverage had been applied for or had been issued at one time, it was no longer in force because of denial, termination, expiration, or suspension.

5. Some evidence for the generality of this finding is reported by Stone (1966:109). Of all complaints to the Wisconsin insurance commissioner, about 8 percent involve bodily injury liability policies, a figure proportional to the amount of premium volume for this type of insurance. In contrast, property damage liability policies are the basis of 21 percent of complaints, six times the premium volume in that category.

More interesting problems were raised when the claimant expected coverage from a policy in force but the coverage provided was held not to apply in the particular situation. Liability policies, for instance, were called upon in vain to provide defense against criminal charges (assault) and to pay damages resulting from deliberate acts (a child throwing an eraser). Some auto liability claims were denied on the grounds that the operator of the car was driving without the permission of the insured. One such case involved toddlers who had climbed into a car and let off the brake, allowing the car to roll downhill into a parked vehicle. With no-fault coverages like fire and theft, claimants complained when items stolen from a car were deemed not covered by general theft policies, and when medical bills attributable to an accident were incurred after the one-year limit specified in the policy. Some complaints indicated that the claimants did not understand the routine deductible provisions written into their own policies.

These problems suggest that a segment of the public expects insurance to give total coverage for a broadly and vaguely defined class of events. Theft insurance is expected to compensate for any theft. "Complete" auto protection is expected to pay for all damage done to or caused by an automobile. In contrast, the company sees its policy as a bundle of specific promises tied into a package, given a general name but not intended to handle all related situations. For instance, those hazards which are actuarially incalculable or which depend strongly on the volition of the insured are not insurable, even though they may be logically related to similar coverages which are provided. Certain hazards may also be excluded from one bundle and the insuring public expected to purchase coverage against them separately.

The company writes its own expectations into the policy; neither claims adjusters nor the administrators of the complaint procedure find frequent reason to change coverage decisions. Of the 19 complaints judged to rest primarily on coverage problems, only 1 received any substantive amelioration.

*Liability problems.* The most important segment of appellate complaints concerns claims denied on grounds of no liability. The files contained 105 such complaints, representing 34.5 percent of all complaints and 52 percent of appellate complaints. In general, it can be said that many complainants show an ignorance of and lack of sympathy for the principles of legal liability and insurance policies based on those principles. These principles are significantly stretched in the adjustment of bodily injury claims,

where settlement reflects allowance for the nuisance and danger of possible litigation (Ross, 1970). Property damage claims, however, are adjusted closer to the rules, which require proof of the insured's negligence and of the causal relationship between the allegedly negligent behavior and the damage.

A major subcategory of liability problems can be styled "evidence questions." In these cases, the claimant alleges facts which, if true, would justify payment, but his allegations are disputed by the insured. A typical instance is the crash at an interlight was red for the other. Adjusters will find liability in such section controlled by a traffic light where each party claims the a situation if a disinterested witness, such as a police officer or an uninvolved bystander, confirms the story of the claimant. Often, however, there are no witnesses and the claim involves credible but conflicting stories. Company policy in this situation is to accept the word of the insured. This not only avoids payment of the claim, but it also avoids the insured's anger and the possible loss of his patronage. Typical situations in the files are:

> A and B sideswipe while going in the same direction. A, on the left, claims B was passing on the right. B, on the right, claims A was cutting into his lane.
>
> B's front collides with A's rear while stopped at a red traffic light. A claims B rear-ended him, and B claims that A backed up or rolled backward.
>
> Intersection collision, right front to left front. Each party claims he had the green light.

Evidence questions are not resolved in favor of the claimant in the absence of corroboration, but the supervisor handling a complaint will offer to hear new evidence. If the claim has received even routine attention before, this is unlikely to produce any different results, but it may quiet the claimant by appearing to leave the matter open. The following material, taken from a letter explaining the company's position to an Insurance Commissioner, illustrates the handling of evidence questions:

> This case involves conflicting stories. Our client's driver, Mr. Jones, states he was stopped in a line of traffic when he was rear-ended by the Smith's vehicle. Mr. Smith contends he was backed into by the Jones vehicle.
>
> There are no known witnesses to this accident and the investigating officer gave both Mr. Jones and Mr. Smith a ticket. In traffic court Mr. Jones pleaded not guilty and the charges against him were dismissed. We do not know the disposition of the charges against Mr. Smith.
>
> As was explained to Mr. Smith, in view of the conflicting stories and the lack of any witnesses or overwhelming evidence favoring his position, we had no alternative but to deny his claim.
>
> We further advised Mr. Smith that if [he] were able to locate any witness or produce new evidence, we would be willing to reconsider our position on this matter. Mr. Smith's response was

> to write to the Better Business Bureau and now to the Department of Insurance.
>
> We repeat our previous offer, if Mr. Smith can produce a witness or new evidence, we will reconsider our position. In the absence of a witness or new evidence, we must respectfully stand on our denial of Mr. Smith's claims.

Another subcategory of liability problems appears when payment is denied because of legal defenses such as contributory negligence or lack of proximate cause. In automobile property damage claims, the classic case seems to be the parking lot accident when both cars are in motion. Traffic laws, such as those giving priority to the car on the right or the first car in an intersection, do not apply automatically on the issue of driver negligence when an accident occurs on private property. Liability will usually be admitted when the claimant car was properly parked, or when the insured is believed to have backed from a parking stall into a claimant proceeding in a traffic lane. Otherwise, liability is usually denied. In general public liability situations the classic case is the slip and fall where maintenance of the property is not an issue. Again, few complaints in which there are legal defenses are likely to obtain payment. The outcome is more likely to be a lecture on the relevant law, through which the claimant is made to see that the law, not the insurance company, prevents him from recovering his damages. The following passage from a letter to a claimant is typical:

> The coverage we have for Mr. Street is liability coverage. In order to increase liability there must be some negligence on the part of our insured. No negligence is involved in a truck or trailer tire kicking up a rock or stone from the road. This is a road hazard to which all of us are exposed. Under these circumstances I must again, respectfully, decline to make any payment in connection with your loss.

The prominence of liability problems in the complaint files of this major insurance company suggests that there may be an important disjunction between popular expectations and legal requirements concerning responsibility for injuring the property of others. This disjunction can be expressed in two rules that may have popular support but lack legal status: "If I didn't do it, it's his fault," and "If he's in charge, it's his fault."

The first rule, "If I didn't do it, it's his fault," could be entitled *Res Ipsa Loquitur* Extended.[6] Some examples will illustrate its meaning. Consider the unfortunate victim of a driver

6. The doctrine of *res ipsa loquitur* (literally, "the thing speaks for itself") arose to save a faultless plaintiff from the rigors of Nineteenth Century tort law. It shifts the burden of proof to the defendant when there is no direct evidence or testimony on the cause of the accident. The "classic case" involved a plaintiff who, while walking next to a mill, was hit by a barrel of flour falling from an open window.

who died at the wheel and whose car veered into and damaged a legally parked car. There was no question in this claimant's mind that the deceased's insurance company would pay his loss—until he tried unsuccessfully to collect. A similar situation occurred when an insured's automatic transmission malfunctioned, causing her to go through a stop sign and into the path of the claimant. Again, a claimant properly stopped at a traffic signal suffered considerable damage when struck from behind by Acme's insured. Acme refused to pay when it was established that a third car, unfortunately without insurance, hit Acme's stopped car, forcing it into the claimant. A non-automobile example is that of a tenant whose belongings were totally destroyed by a fire originating in a neighboring building and spreading to his own well-kept home. In all these cases the claimants appeared to have suffered a loss without any fault on their part. In all cases the parties causing the damage had purchased insurance to cover damage to third parties. But in all cases, the insurance failed to respond because it was limited to damage entailing legal liability. It is easy to sympathize with these complaints.

The second rule, "If he's in charge, it's his fault," could be entitled *Respondeat Superior* Extended.[7] There are numerous examples in the files, including the routine slip-and-fall cases. Often there exists some legally responsible party, but he is not the insured owner of the premises and may not be identifiable. A classic case is the hit-and-run dent in the parking lot of a theater or supermarket. The claim against the owner of the premises and subsequent complaint are denied with acknowledgment that the claimant has reason to be upset, but it is the unidentified driver who bears the only responsibility. Similar in principle are claims of thefts from motel rooms where the proprietors are legally liable only for articles checked at the office. Sometimes the response to the complaint identifies the legally responsible party, suggesting that the claimant take his claim to him. For instance, the owner of a car damaged by an ice cream rack blown across the insured's parking lot was directed to the dairy responsible for the rack. Perhaps the most aggravating loss in the files awaited the woman who went on a cruise and delivered her car with the employee of an insured waterfront garage for storage.

7. *Respondeat superior* (literally, "Let the master answer") is a maxim expressing that the master (or principal) is liable in certain cases for the wrongful acts of his servants (or agents) if they fail to use reasonable care in the exercise of their duties.

A collision on the way to the garage was judged not to be the responsibility of the insured; the car was then run into a wall by the independent tow truck taking it to a repair shop. Several bodily injury claims also fit this category: e.g., the woman who was floored by another customer's cart in the insured supermarket and the child who came home from school with an eye injury resulting from a classroom missile. Again, popular belief is not without merit—the victims can claim sympathy, though not the benefits of liability insurance.

A preliminary verification of the pervasiveness of these popular expectations was attempted using abstracts of complaints and subsequent letters of denial for nine cases in the Acme files. The nine complaints were selected to present possible applications of the rules proposed here. Two test groups, consisting of 32 university undergraduates and of 36 members of an insurance agents' group, were asked to indicate whether or not they thought the company's response was justified. In several (but not all) instances, majorities of both students and agents criticized the company's responses to the complaints. The extreme response concerned the dying driver whose car damaged a legally parked car. Three-quarters of the students and 60 percent of the agents thought the company was both legally and morally wrong in denying the claim, and approximately 90 percent of both groups believed the company to be wrong at least in a moral sense in its denial. In none of the examples presented was there complete approval of the company's response, either by the students or the agents. This sounding, though haphazard in sampling of questionnaire items and respondents, suggests great promise for additional research.

*Damages problems.* Complaints were considered "damages problems" when the insurance company admitted its responsibility to pay for damage, but did not agree with the dollar amount of the claim. The files contained 77 such cases, constituting 25.3 percent of all complaints and 38 percent of appellate complaints. The response to damage problems differs between cases in which the issue is one of repairing a damaged item and those in which the issue is replacing an item damaged beyond repair. These issues will be discussed in turn.

When the damaged property can be repaired, standard procedure is to ask the claimant to obtain two cost estimates. If the lower appears reasonable in the light of what is known about the accident, the company offers to pay that amount, less any

applicable deductible amount. If not, the company makes its own appraisal (either through its adjuster or an independent appraisal firm) and offers to pay this amount, less the deductible. Although good faith differences of opinion can be expected in this situation, the company's figure will be backed by an offer to supply a list of repairers who will accept it, or the company will attempt to obtain agreement from the repairer of the claimant's choice to do the work for the specified amount. The complaint files show that a principal source of contention in the routine situation involving automobiles concerns replacement of damaged parts by used rather than new parts. In automobiles older than one year, the company insists on used parts when these are available, unless the claimant chooses to pay the difference in price for new parts. The same problem occurs with respect to damage to homes and other property where the company demands that the claimant absorb depreciation or pay for betterment when the damaged item has depreciated prior to the insured event. Complaints here involve allegations by claimants that the particular item has depreciated less than normally for something of its age. The company's response to these complaints often seems accommodating, especially when the sums involved are small and the claimant is a policyholder.

A difficult problem is raised when the item is a new one which has been extensively damaged but is repairable. The most vivid case in the files involved an eight-day-old Mercedes Benz which suffered damage estimated to cost more than $2,600 to repair. From the claimant's viewpoint, the accident destroyed the object's quality of newness. It will "never be the same," according to complaints like the following:

> As you well know after having a new car and it has been in this type of a collision it is never to be repaired to be as it was prior and it was a one owner car so since my Insurance is for full coverage and prepaid til February 73, I am within my rights to state I will not accept this car to be repaired and given back to me to be satisfied. My car was a new car prior to this accident. It's never been in one. So it can never be as it was.

The claimant demands that the company replace the damaged car with a new one. The company rule is that the car will be repaired unless the cost of repairs exceeds the actual cash value of the car, less salvage value. There were four files that seemed to involve this situation, all of them apparently involving cars less than two years old. In only one was the company's position changed as a result of the complaint. However, a management representative stated that when the claimant is a policyholder and the damage is great, the company attempts to bend the rule to accommodate him.

Another problem that occasionally arises in claims for repair concerns additional damage discovered after the claimant has agreed to accept the company's offer on his claim. The files give the impression that the company is usually willing to reopen a claim when the new damage is discovered during the repair or shortly thereafter and seems reasonably related to the other damage.

Different problems occur when the insured item is damaged beyond repair. In both first-party and third-party claims, the insurance provides for the payment of the "actual cash value" of the destroyed item. This can be a source of considerable difference of opinion. Appraisal takes into consideration the market value of the item as expressed in published guides and in the prices of similar items for sale locally, but these are acknowledged to be valid only in general. The claimant argues that his property had been better maintained, was in better condition, had less than average mileage, etc., and sometimes he wins the point. With homes and personal property, other than automobiles, depreciation and betterment are also sources of contention. Liability claimants, especially, make the reasonable argument that, while their property may have depreciated, they ought not to be forced to replace it when someone negligently destroys it.

A specific situation in this subcategory concerns damage to older cars. The market value of cars older than about five years is generally so low that relatively minor accidents can produce repair bills in excess of their value. If a claim is presented, the company will declare the car a total loss and offer a figure considered to be market value. This figure often is unsatisfactory to the claimant, and the company's refusal to pay significantly more produces complaints. The complaints allege that the car furnished reliable transportation and that no replacement can be bought with the amount offered by the company. The problem is illustrated in the following excerpt:

> The car is a 1962 Studebaker wagon and will require a left back quarter. Though we have owned the car for ten years, it has less than 50,000 miles, passes inspection at all times with no problems, has excellent tires (both regular and snow) and everything about it works perfectly. I drive it because it is what I can afford . . . I am asking for $300 because I do not feel I will be able to get another car comparable for twice that much, and I do not feel I should be obliged to drive a beaten-up car through no fault of my own.

There were four such complaints in the files, all very vivid. In three cases the company raised its offer as a result of the complaint. In general, however, the problem of a disparity between market value and utility remains unsolved.

Another type of complaint that falls in the category of damages problems concerns the alleged inadequacy of allowances for a replacement automobile during repairs. People who lose the use of their cars for extended time periods in our suburbanized society frequently incur considerable rental bills in order to remain mobile. Many automobile collision policies, however, contain no provision for repayment of these bills, presenting a mini-coverage problem. Claims based on the negligence of another party will be allowed rental expenses if they are demanded, if the car is used for business or is in other ways essential, and if the charges are reasonable and relate directly to the time the car is being repaired. Car rental payments demanded on the basis of an endorsement to collision coverage are also subject to some conditions, but do not prove as troublesome as those demanded on a liability basis. In the latter, the company typically takes deductions from the bill presented for mileage charges and gasoline expenses on the grounds that these expenses would have been incurred even without the accident. Furthermore, no allowance is made for days beyond a "reasonable" period for repair of the car. If the repairer is slow—if the body shop is unable to begin work promptly, if parts are delayed in arriving, if additional work is needed because the claimant judges the work to be unsatisfactory, etc.—the additional rental costs are not reimbursed. These deductions are generally unexpected by the claimants. In all seven of the cases in the files, the company offered more as a result of the complaints, but it seldom paid the full amounts demanded.

Turning briefly to automobile liability claims involving bodily injury, the problems often relate to demands for considerable sums in the absence of proof of medical treatment likely to warrant the demand. In routine bodily injury liability claims, the payment for pain and suffering is tacitly understood to depend on justification by medical bills bearing a particular relationship to the amount claimed (Ross, 1970). The claims complained of in the files studied lacked bills sufficient to support them on the basis of the locally prevailing formulas.

Complaints based on problems of damages are relatively most likely to receive some positive action in the form of additional payment by the company. As seen in Table 1, of all such complaints in the files, 76 percent received some additional payment compared to 18 percent in files based on liability problems and 6 percent in files based on coverage problems. This relative liberality is caused by the fact that in many cases the claimants are satisfied with relatively small additional payments. There

are no issues of principle involved comparable to those present in the other categories.

However, problems of damages remain a constant source of trouble in adjustment and the handling of complaints. The most serious trouble seems to be created when the loss involves matters over and above market value. The loss of "newness" in one's car or of the utility of reliable transportation or of the affection of a beloved pet are not viewed as compensable (barring special stipulations) in the law or in insurance. Unlike good-faith differences in opinion over market value, they are not susceptible to resolution by arbitration, nor is it likely that most claimants would be satisfied with the amounts that a court would award.

## III. COMPLAINTS OF DELAY

About a third of claims complaints in the Acme files were primarily concerned with delay, demanding a decision rather than protesting one already given. The files suggested a variety of origins for these complaints. Sometimes they seemed to arise merely from routine investigations. In other cases they occurred when, for one reason or another, the investigations became extensive. In still other cases delay seemed to indicate errors and breakdowns in communication, or reflected an attempt to deny the claim which was misunderstood by the claimant. These conditions will be discussed in turn, but, because of the small numbers of cases and the sketchy contents of many files, no attempt will be made to analyze them quantitatively.

*Routine investigations.* No data are available to me concerning the average time required to handle a routine property damage claim, but the necessary steps in a typical claim are obviously time-consuming. In any claim the damage must be appraised, and although the company requires the appraisal to be performed in no more than 48 hours from the time the claim is reported, even this minimal time may seem intolerable to someone dependent on his automobile for his livelihood. Moreover, additional time is needed for an offer to be considered and delivered, for the mailing of the proof of loss, and for preparation and delivery of the payment draft. If the claim is based on liability, some minimal investigation of the facts of the accident is required. Many complaints of delay appear to have been written within a few days of the insured event, and to have crossed in the mails with the payment draft forwarded by the company.

*Extraordinary investigations.* Certain claims require more extensive investigation than do routine ones. In these cases additional claimants run out of patience and complain. A classic example is the complex accident involving several drivers and several insurance companies, in which agreements on relative shares of liability and payment are worked out among the companies before payments are made. Even in a relatively simple accident, recovery of a collision insured's deductible through subrogation may take months. This situation accounts for several of the complaints of delay in the file. Costly liability claims involving unclear factual situations necessitate unusually extensive investigations. In uninsured motorist claims, there may be difficulty in ascertaining that the adverse party was in fact uninsured. These problems are exacerbated when some of the parties prove elusive or uncooperative. The company's usual response to the complainant is to explain the reasons for this type of delay and to promise diligent pursuit of the investigation. It is likely that the claimant benefits from his complaint in these situations, since the adjuster realizes that the speed of his handling has become a concern of someone in higher management.

*Breakdown in communication.* Complaining is most effective in situations where delay is a manifestation of communications problems. In several automobile cases the insured had not reported the accident to the company and no investigation was made until the complaint was entered. In a few cases, the claim had simply gone off the calendar through error. Drafts and other documents on occasion were lost in the mail, or failed to be recorded. Addresses and telephone numbers sometimes proved to be erroneous. Once these matters were drawn to attention, the claims received priority handling.

*Intended denials.* In some cases what the claimant viewed as delay turned out to be a denial from the company's viewpoint. Perhaps the claimant viewed the adjuster's "cooling out" advice that the file would be "kept open" as assurance that it would be paid. Perhaps it was wishful thinking in the face of clear language to the contrary. It is company policy that a denial should be explicit, and these complaints were handled by sending firm letters of denial.

Delay is a matter of perception. One who alleges delay believes that the business could and should have been terminated

sooner than it was. No reasonable claimant demands instant payment, but to some people it appears that even routine cases handled expeditiously from the company's viewpoint involve delay. It is possible that Acme's traditional form of claims handling is becoming more susceptible to this complaint as drive-in claims services are introduced by the mass-market insurance companies. In the latter, a driveable car can be appraised and paid for in a matter of minutes provided that questions of coverage or liability do not intrude. The problem is exemplified by one insured who stated that she had settled with and been paid for her liability claim with the insurer for the other driver before her own company's adjuster arrived to look at her damage.

## CONCLUSION

The internal appeals procedure in insurance companies and other bureaucracies determining legal rights is of greatest significance for those claims which, because of their size, can be heard nowhere else. Most of the complaints analyzed in this study in fact involved relatively small losses, usually between one hundred and two hundred dollars, and both complainants and company officials recognized that the complaints procedure was likely to be ultimately determinative of the value of the claims asserted. One may speculate on the differences between the results obtained in the complaints procedure and those which, on the basis of our understanding of the courts, we might expect to find if the cases had been determined by a judge or jury.

When the underlying problem concerned coverage issues, the complainants were nearly all unsuccessful in their appeals. The legal issues here tend to be very clear-cut. Rules, rather than facts, are at issue and it is unlikely that the claimants would have been very successful in any other forum.

When the underlying problem concerned liability, it is likely that the bureaucracy was more "legal" than the courts might have been. Some of these problems concerned factual issues, as when contradictory stories were told by the parties to an accident. The company deliberately preferred its own insureds. Furthermore, some of the rules by which liability was denied appear to have been unattractive, at least in the specific cases of their application, and juries are known to disregard unlovable rules of law (Kalven and Zeisel, 1966). One may reasonably speculate, then, that claims involving liability questions would be treated more generously in the courtroom than in the private appeals process.

When the underlying problem was damages, however, the complainant most often won his point, at least in part, in the private forum. The proportion of complainants receiving some additional compensation is remarkable because the company in most cases could have denied reconsideration with little fear that its decision would be reversed by an outside agency. Typically, the amount claimed was only slightly greater than a sum already offered, virtually guaranteeing that the claimant would have little incentive to take the case to court in the event of denial.

In complaints centering on these damages problems, the company has admitted its obligation to pay something on the claim, and the question remains how much to pay. The willingness of supervisors to override the decisions of their subordinates in these cases may reflect a greater consciousness on the part of the higher officials of the long-range self-interest of the insurance company in dealing with its insureds and with potential insureds. The company's concern is to offer enough to secure a happy customer, even though this sum be greater than that needed to secure a grudging settlement, or even though it be greater than that which a jury might award in the case. It is possible, then, that in these cases, the outcomes of the private appeals process are more liberal than those that could have been obtained in court.

These findings and interpretations have an import beyond the case of insurance claims. Complaint is recognized as an important means of obtaining the redress of grievances and the granting of claimed rights in the area of public law (Gellhorn, 1966). It is also perhaps the most important mode of appeal from adverse decisions in the area of private law, though this fact is less well recognized and very little researched. To the extent that legal claims by private citizens against bureaucratic entities involve sums that are small in comparison to the cost of litigation, the complaint procedure stands as the ultimate determinant of the citizens' rights.

Although small claims courts and legal aid and insurance are diminishing the costs of litigation, it is unlikely that increasing the access of citizens to the courts and decreasing the costs of this access will greatly affect the frequency and usefulness of the complaint procedure. The volume of complaints is very likely too high to be significantly affected by manifold increases in the use of the formal process. More importantly, the complaints procedure can succeed in types of cases where the formal procedure would fail to supply redress. If the complainant can

invoke bureaucratic policies favoring good will towards clients, the desire for favorable publicity, and the dislike of unfavorable publicity, he may find satisfaction in situations in which the litigant would be rebuffed.

If we are to understand the real nature of legal rights—the results which people get when they put forth their claims—we must look to all the forums that are used, and determine the patterns of outcomes in each. This observation applies whether we are ivory-tower academicians speculating on law and justice or practical lawyers concerned with maximizing the recovery of our clients. It is in informal negotiations, complaints to the heads of bureaucratic organizations, letters to Better Business Bureaus and calls to newspaper Action Lines, that most legal claims of the ordinary citizen are ultimately determined. Certainly, the rules of formal law cast long shadows on the informal process. But, if our understanding and our practice of law are to be satisfactory, we should distinguish shadow from substance and broaden our concern and research beyond the courts.

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