The British Approach to Consumer Financial Disputes:  
A Model for Reform in Insurance Law and Beyond

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Abstract:

Much of insurance law and regulation is concerned with compensating consumers who have been wrongly denied coverage. But policyholders nonetheless have relatively few realistic options for challenging an insurer’s adverse coverage determination. Litigation is often too slow and costly for those who have recently suffered significant financial loss. Meanwhile, the alternative dispute resolution options that do exist – such as the mediation services that insurance regulators offer or the existing variants of insurance arbitration – are generally either ineffective or unavailable for most disputes. This Article proposes a new way forward by looking to the United Kingdom’s innovative Financial Ombudsman Service, which operates in parallel to the British regulatory agency and is devoted solely to resolving consumer financial disputes. It argues that the comparative success of the Financial Ombudsman Service is attributable primarily to the ways in which it blends elements of the individual, uncoordinated insurance ADR schemes that are used in America. As such, the Article concludes that American lawmakers can significantly improve insurance compensation by strategically rethinking the institutional architecture of insurance dispute resolution. It also suggests that the British Financial Ombudsman Service may offer a model for improving consumer dispute resolution in realms beyond insurance.

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Introduction

The Arbitration Fairness Act has proven to be one of the most controversial bills before Congress in the past year, provoking significant academic interest and intense lobbying from multiple constituencies. The proposed legislation would limit the use of pre-dispute, mandatory arbitration provisions in consumer contracts, ending what many view to be the firms’ unfair use of bargaining power to compel arbitration that favors repeat players and limits consumers’ rights. Whatever the ultimate fate of the Arbitration Fairness Act, however, American consumers will still face the problems that arbitration was intended to remedy: litigation is a costly and inaccessible option for a wide range of consumer grievances.

As such, this Article moves beyond the debate about the desirability of consumer arbitration, taking seriously the advice of one leading scholar that “the public needs fewer categorical pronouncements and more contextual evaluation” of alternative dispute resolution (ADR) mechanisms. Instead, it assesses how lawmakers can effectively design and implement ADR schemes that actually deliver what proponents of consumer arbitration have long promised: an accessible, fast and reasonably fair option for redressing consumer grievances. To do so, the Article focuses on the resolution of consumer disputes in the realm of insurance.

Insurance presents a compelling case study for designing effective consumer ADR. First, a rising chorus of scholars, lawmakers, and interest groups now support varying types of insurance regulatory reform. Whatever their merits, these recent proposals present a natural opportunity to revisit insurance ADR, which is a currently a central function of most

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3 See, e.g., Laura Nader, No Access to Law 3-49 (1980).
5 The Treasury Department recently proposed a federal insurance regulator in its Blueprint for financial reform and a significant Bill has been introduced in Congress to create an optional federal charter. For a good, basic description of these developments, see http://www.iii.org/media/hottopics/insurance/opt.
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state insurance regulators. Second, dispute resolution is a uniquely important element of insurance law, as insurers’ liabilities are contingent on events – such as fires, thefts, health problems, and lawsuits – which cannot be determined solely by reference to the underlying contract or related financial documents. These events are often difficult to specify fully ex ante or to verify accurately ex post, leading to frequent insurance claims disputes. Because aggrieved policyholders need compensation quickly while insurers have a natural incentive and capacity to delay litigation, the efficient resolution of such disputes is a core concern of insurance law.

Finally, and most importantly, a significant number of ADR reforms have been implemented in the consumer insurance context. Numerous mediation schemes to help resolve consumer disputes have evolved within state insurance regulators’ offices. Similarly, states have experimented with a number of rules and procedures for regulating private insurance arbitration. Such experimentation is unique to insurance, as the Federal Arbitration Act – which normally stymies arbitration-specific laws – is “inversely preempted” by state laws governing insurance. Taken together, these ADR reforms constitute extensive data on consumer insurance arbitration generated by our “laboratories of democracy.” These data are waiting to be analyzed.

Nor are the available “data” limited to American experiments. Foreign jurisdictions have also developed ADR schemes in the realm of insurance. The most notable example is Britain’s Financial Ombudsman Scheme (FOS), which is virtually unheard of in American legal circles, but which has served as a model for reform in countries such as South Africa, Ireland, Germany, India, Japan, Switzerland, Malaysia, Poland, Finland, France, Australia and New Zealand.

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6 See Part II, supra.
12 See Rashmi Abichandi, Policyholder’s Interest Protection: Review of the Insurance Ombudsman Scheme, 5 ICFAI J. OF INS. L. 45-57 (2007) (India); Explanatory Materials on the Establishment of the Japan Financial ADR/Ombudsman Study Group (on file with author) (Japan); Yokoi-Arai, Mamiko, A Comparative Analysis of the Financial Ombudsman Systems in the UK and Japan, 5 J. OF INT’L BANK REG. 333 (2004) (Japan); http://www.financialombudsman.ie/about-us/ (Ireland); Geraint Howells, Litigation in the Consumer Interest, 9 ILSA J INT’L & COMP L 1, 10-11 (2002) (“In… Australia, Canada, New Zealand, and the UK, the private ombudsman has proved to be a popular consumer remedy with business, government, and broadly with consumer interests.”). Many other European countries also have ombudsman services that resemble the FOS. For a website that details the financial
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was founded as a joint venture among insurers, but is now an independent government entity whose sole function is to resolve consumers’ disputes with financial service providers generally, including insurers. Consumers lodge complaints with the FOS against their financial service providers free of charge and without representation. If the FOS believes the complaint has merit, it attempts to mediate a resolution of the dispute and can ultimately compel the company to award up to £100,000 (roughly $200,000) in compensation to the consumer.

Analysis of this comparative data presents a puzzle. Like state insurance departments in America, the FOS is a government body that processes consumers’ complaints about insurers and attempts to mediate settlements. Similarly, as with the limited existing forms of insurance arbitration, the FOS evaluates cases using a paper-based, inquisitorial method after which it can require insurers to pay consumer claims. Despite these similar constitutive elements, the British FOS has enjoyed far more success than its American counterparts. It achieves higher rates of voluntary settlement, covers a broader array of disputes, and enjoys remarkable support among British consumers, consumer groups, industry, and academics.

This Article contends that the FOS’s comparative success is primarily attributable to the way in which it blends and coordinates reforms that have been used independently in America. For instance, the FOS coordinates mediation, arbitration and even negotiation under a unified scheme in a way that allows more expensive ADR stages (like arbitration) to facilitate compromise at earlier, cheaper stages (like mediation). Similarly, the FOS’s public identity allows it to manage decision-maker bias while its independence from the regulator counteracts regulatory capture and other problems stemming from the dual identity of regulator-mediators. This explanation of the FOS’s success motivates the Article’s normative claim that America’s consumer insurance ADR can be radically improved with an alternative institutional architecture based on the FOS. Moreover, it presents the real possibility that the British “private ombudsman” model offers a promising, “post-arbitration,” way forward for the resolution of consumer financial disputes generally.

ombudsman schemes of all European countries, see http://ec.europa.eu/internal_market/finnet/members_en.htm.
17 See infra Part III.
This Article proceeds in five Parts. Part I explores the need to modernize our approach to resolving consumer insurance disputes. Part II critically examines individual states’ attempts to promote such ADR, arguing that these efforts have had limited benefits for consumers. Part III compares American ADR efforts in insurance to the FOS. It claims that the FOS has many of the same elements as American consumer insurance ADR, yet is wildly more successful. Part IV – the intellectual heart of the Article – offers several explanations for this seeming contradiction, each of which focuses on the way that the FOS blends and coordinates the individual ADR reforms in consumer insurance. Finally, Part V analyzes some potential strategies for implementing an FOS-type scheme in America and speculates about the extent to which the FOS might serve as a model for consumer ADR reform in domains beyond insurance.

Part I: Litigation and Insurance Coverage Disputes

All forms of consumer insurance raise a common dilemma. Consumers purchase insurance to protect themselves against significant financial risks. When those risks arise, consumers are often desperately in need of money and ill-equipped to battle with their insurer. Insurers, however, face an inevitable temptation to deny claims aggressively in order to inflate their bottom line. Although the long run reputational consequences of this strategy can be dire, the “long run” is often long indeed: consumers are poorly equipped to detect aggressive claims handling given the inherent malleability of insurance contract language, the impediments to full information in consumer insurance markets, and the strategic disadvantages that policyholders face in battling coverage decisions.

One of the primary ways that insurance law addresses this problem is by expanding the remedies that are available to successful plaintiffs in insurance coverage cases. Unlike ordinary breach of contract cases, aggrieved policyholders can receive attorneys’ fees, emotional distress damages, and even punitive damages.18 Despite this expansive set of potential remedies, insurance litigation actually provides a relatively poor source of compensation for most aggrieved policyholders. The problem is not that the remedies available through litigation are insufficient – indeed, some might argue that they are excessive.19 Rather, the problem is that the process of litigation is a poor mechanism for making any types of remedies

19 In particular, the availability of emotional distress damages in this context is controversial. Compare id. at 1423 (arguing that as “compensation should be the province of the ordinary insurance action, and that compensation should be as complete as the courts can make it,” and consequently include attorneys’ fees and emotional distress damages); with George Priest, The Current Insurance Crisis, 96 YALE L. J. 1521, 1546-47 (1987) (suggesting that emotional distress insurance is generally undesirable for most consumers).
available to aggrieved policyholders.\textsuperscript{20} Whereas litigation is slow, costly, and unpredictable, litigants in insurance coverage cases need compensation quickly, have few resources (financial and emotional) to devote to litigation, and are generally risk averse.

This Part elaborates on these points. Section A first describes the risk of opportunistic breach by insurers. Section B then critically examines the ability of litigation to compensate wronged policyholders. Taken together, this Part sets the stage for the remainder of the Article by motivating the need to construct ADR mechanisms that compensate policyholders more effectively than litigation.

### A. The Risk of Wrongful Coverage Denials

Scholars, policymakers and judges have long recognized that consumer insurance arrangements raise significant concerns about improper claims-handling.\textsuperscript{21} Unlike many contracts, insurance policies are sequential and contingent: whereas the policyholder performs routinely by paying premiums, the insurer performs by paying a claim if, and only if, a loss occurs.\textsuperscript{22} Vulnerable parties in sequential and contingent contracts can usually protect themselves by clearly specifying the conditions upon which an obligors’ performance is due.\textsuperscript{23} But such protection is difficult, if not impossible, in the insurance context. Because insurance policies concern an entire universe of potential risks, they necessarily incorporate abstract language that leaves insurers with significant contractual discretion.\textsuperscript{24} These structural features of insurance contracts create an inevitable temptation for insurers to adopt overly aggressive claims-handling practices: every dollar that an insurer avoids paying in claims adds to the bottom line.

In most cases, of course, insurers resist the temptation to aggressively limit claims payments for business reasons. Insurers’ capacity to sell insurance is premised on purchasers’ willingness to believe that, should they suffer a covered loss, their insurer will make good on its promise.\textsuperscript{25} But such market forces are not always sufficient to stem insurers’ temptation to short-change policyholders, as insurers’ reputations often do not accurately track the true quality of their claims-handling.

\textsuperscript{20} See Sykes \textit{supra} note 9, at 422 (arguing that improving the process for compensating aggrieved policyholders may mitigate the capacity of insurers to exploit litigation delay in order to extract favorable settlements).

\textsuperscript{21} Abraham, \textit{supra} note 8, at 179 (noting that the insurance dynamic “create[s] special opportunities for inefficient breach”).

\textsuperscript{22} See Works, \textit{supra} note 8, at 578-88; Baker, \textit{supra} note 8, at 94-96.


\textsuperscript{24} Abraham, \textit{supra} note 8, at 174 (“Insurance policies are often not specific to make the rights and obligations of the parties during the claims process crystal clear.”); Kenneth S. Abraham, \textit{A Theory of Insurance Policy Interpretation}, 95 Mich. L. Rev. 531, 547-50 (1996) (similar).

\textsuperscript{25} For a general discussion of the role of reputation in disciplining sellers’ contracting behavior, see Klein & Leffler, \textit{The Role of Market Forces in Assuring Contractual Performance}, 89 J. Pol. Econ. 615 (1981).
practices. Consumers’ impressions of insurers are formed primarily by advertising and word-of-mouth rather than by concrete information about insurers’ relative reliability. Given the complexity of insurance, it is no surprise that insurance advertising focuses on abstract, unverifiable promises. Less intuitively, word-of-mouth also has a limited capacity to transmit information in consumer insurance markets. Unlike virtually any other product, consumers typically never experience the most important element of their policies – the protection they provide against low-probability, high-cost losses. Moreover, even when consumers do have a negative experience with their insurers in such situations, they are often ill-equipped to judge whether their insurer acted properly. Consequently, even long time policyholders often have little capacity to judge or accurately inform others about the quality of their insurance.

These problems are exacerbated by the fact that consumers typically purchase insurance as part of a larger event or transaction, such as taking a job or buying a home or automobile. Empirical research has consistently found that individuals make market decisions using heuristics that balance “the desire to achieve accuracy with the desire to minimize effort.” For this reason, “as decisions become more complex, decision makers will tend to adopt simpler choice strategies to cope with that complexity.” Consumers who bundle insurance decisions with other highly significant choices are consequently likely to rely on disproportionately simple choice strategies when making insurance decisions. This is particularly true given the inherent complexity of the insurance decision-making process. While these “choice strategies” will clearly encompass factors such as price and the types of coverage available, this research suggests that it will frequently

26 See [Schwarcz, supra note 9, at 1413-15. But cf. Sykes, supra note 9, at 418 (“[A]ny insurer who frequently refused to pay covered claims would likely soon develop a reputation for behaving in this fashion and lose customers.”}).
27 See [Schwarcz, supra note 9, at 1413-15. One significant reason that people rely on such information is that “[i]nformation about the reliability of different insurers is hard to come by [and] the quality of insurance coverage is almost impossible to assess without an expert.” ABRAHAM, supra note 8, at 176. Although the internet has improved matters in recent years, information about the relative quality of insurers’ claims handling is still remarkably unavailable. One recent proposal to the National Association of Insurance Commissioners (NAIC) would empower regulators to collect and publicly disclose important data elements about the relative quality of insurers’ claims handling during a policy period. See Proposal for Centralized Data Collection, National Association of Insurance Commissioners (Market Regulation Committee Proposal). Unfortunately, insurers’ have bitterly resisted the proposal under the guise of confidentiality and trade secrets.
28 Baker, supra note 18, at 1403-07.
29 See Schwarcz, supra note 9, at 1413-15.
30 See Baker, supra note 18, at 1407-1413.
32 See id. at 1226
33 Consumers’ decision-making processes about insurance are a complicated mix of intuitive, emotional and rational responses that are susceptible to manipulation. See generally KUNRUTH AND PAULY, INSURANCE DECISION-MAKING AND MARKET BEHAVIOR (2005); Cutler & Zeckhauser, Extending the Theory to Meet the Practice in Insurance (working paper) (2004); PAUL SLOVIC, THE PERCEPTION OF RISK 76-77 (2000).
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not include such intangible criteria as the quality of different insurers’ claims handling practices. In this environment, market forces may actually encourage insurers to offer claims-handling that is more aggressive than consumers would purchase were they fully informed and rational.34

Much of insurance law is designed to respond to these market problems by deterring improper claims handling practices. First, all states have adopted some version of the Model Unfair Claims Settlement Practices Act (UCSPA), which authorizes state regulators to take action in cases of flagrant or repeated unfair claims practices.35 Second, many states also rely on ex post, private regulation of claims handling through litigation. Under the doctrine of bad faith, policyholders are entitled to emotional distress damages and potentially even punitive damages if an insurer negligently, knowingly, or recklessly denies a claim without a reasonable basis.36

Although these measures help to mitigate the risk that insurers will adopt inefficiently restrictive claims handling practices, they hardly solve the underlying problem. In practice, most states’ UCSPAs have little impact on insurers’ claims handling because the Act employs vague standards37 and most insurance regulators do not devote significant resources to its enforcement.38 Even when state regulators do attempt to enforce their state’s UCSPA, the sheer volume of claims that insurers process makes regulating that activity exceptionally difficult.39


35 See NAIC MODEL UNFAIR CLAIMS SETTLEMENT PRACTICES ACT (hereinafter MODEL UCSPA); See generally ETTLINGER AT AL, STATE INSURANCE REGULATION 103 (1995 1st ed.).


37 This is not necessarily a fault with the model act, as the proper handling of a claim depends on innumerable factors. Additionally, the UCSPA does admittedly have some clear procedural requirements that states can, and do, monitor through complaint handling. See ETTLINGER, supra note 35, at 90-97; JEFFREY STEMPBEL, STEMPBEL ON INSURANCE CONTRACTS § 2.04.

38 ETTLINGER, supra note 35 (“Many claims people consider private regulation to be the primary method to assure that claims activities are monitored and that consumers are treated in good faith.”); Moradi-Shalal v. Firemans Fund Insurance Co., 758 P.2d 58, 77 (1988) (Mock, J, dissenting), reproduced in BAKER, supra note 8, at 583 (observing that, since the California UCPA was enacted in 1959, there is not “a single case reported in which the Insurance Commissioner has taken disciplinary action against a carrier for "unfair and deceptive acts or practices in the business of insurance" involving a claimant”). Given the limited resources of most insurance departments, this balance is sensible. Unlike claims-handling, many insurance regulatory issues – such as insurers’ solvency, pricing schemes, and forms –cannot be remedied ex post. Faced with a choice, regulators ought to devote their scarce resources to these problems. See Steven Shavell, Liability for Harm Versus Regulation of Safety, 13 J Legal Stud 357, 364 (1984).

39 Insurance regulators do target their market conduct exams to companies or practices that data suggest are particularly problematic. See NAIC, Framework for Market Analysis, available at http://www.naic.org/documents/committees_d_mapwg_market_analysis_framework_final.pdf.
The doctrine of bad faith similarly faces significant limitations in its capacity to mitigate the risk of improper claims handling. Most fundamentally, the doctrine is often unavailable to aggrieved policyholders. Even when it is available, the doctrine’s deterrent force is undermined by the malleability of insurers’ coverage obligations, which blurs the distinction between merely incorrect coverage denials and true bad faith. Additionally, bad faith causes of action will not protect consumers with legitimate grievances who cannot credibly threaten to litigate the dispute. As a result of the underwriting process, insurers are uniquely positioned to discriminate between such policyholders and those who are more litigious. Insurers may thereby be able to shortchange non-litigious policyholders without facing an effective deterrent threat from the doctrine of bad faith.

B. Coverage Litigation and Compensation

One major function of insurance coverage litigation is to provide a publicly-funded route through which insurance policyholders who have been denied coverage can seek payment of their claims. Like tort law, insurance coverage law can therefore be conceptualized as a form of

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40 Some states have not adopted the remedy, and it is preempted by ERISA in all states when the underlying insurance is part of an employee benefit plan. See Roger C. Henderson, The Tort of Bad Faith in First Party Insurance Transactions After Two Decades, 37 ARIZ. L REV 1153 (1995) (cataloguing which states have bad faith remedies and which do not); John Langbein, Trust Law as Regulatory law: The Unum/Provident Scandal and Judicial Review of benefit Denials under ERISA, 101 NW. U. L. REV. 1315 (2007) (arguing that ERISA’s exclusive remedial scheme, which generally limits remedies to the recovery of benefits contributed to the unfair claims practices of the disability insurer unum provident). Without the prospect of owing more in litigation than they would have owed had they paid the claim originally, insurers will not be deterred from denying claims in bad faith. See Mark Gergen, A Cautionary Tale, 72 TEX. L. REV. 1235 (1994); William S. Dodge, The Case for Punitive Damages in Contracts, 28 DUKE L. REV. 629 (1999).

41 See Sykes, supra note 9, at 429-31.

42 See Schwarcz, supra note 9, at 1407-09.

43 See R. Ted Cruz & Jeffrey J. Hinck, Not My Brother’s Keeper: The Inability of the Informed Minority to Correct for Imperfect Information, 47 HAST. L. REV. 635, 675 (1998) (describing how firms that can discriminate between informed and uninformed consumers will not be constrained by the former in their dealings with the later). Alternatively, insurers may be able to safely adopt a “deny first, pay later” claims strategy wherein they preliminarily deny uncertain claims, but then reverse course to the extent that a policyholder “reveals” herself to be likely to litigate. Informed policyholders may be sufficiently risk averse and have a sufficiently high discount rate that they will predominantly accept late settlement offers instead of litigating.

44 Some law and economics scholars have argued that compensation-oriented goals ought not to affect normative legal analysis in tort law because privately-provided insurance is cheaper than public-provided insurance. See, e.g., STEVEN SHAVELL, FOUNDATIONS OF ECONOMIC ANALYSIS OF LAW 267-69 (2004); W. Kip Viscusi, Reforming Products Liability 170-72 (1991). Whatever the merits of this argument, it is inapplicable to insurance coverage disputes because no insurer could feasibly provide insurance to cover the risk that another insurer would inappropriately deny coverage. Although one could arguably purchase such coverage from one’s own insurer, this argument raises the same problem that creates the underlying risk in the first place: insurance consumers have informational and cognitive limitations that impede their capacity to assess insurers’ promises to pay claims, and certain market forces exacerbate these limitations. See Part I.A., supra.
publicly-mandated and facilitated insurance.\textsuperscript{45} This insurance protects policyholders against the risk, described above, that one’s insurer will be overly aggressive in denying coverage relative to consumers’ preferences in ideal market conditions.\textsuperscript{46}

Ironically, though, insurance coverage litigation typically proves to be a poor insurance mechanism. It is inaccessible, slow, and unpredictable. This point is hardly novel – scholars have long made the same observation about tort law’s insurance function.\textsuperscript{47} But because many of the criticisms of tort insurance focus on the incompatibility of the litigation process with efficient insurance, they are directly applicable to insurance coverage litigation.\textsuperscript{48} For instance, litigation is inherently slow, whereas accident victims need compensation quickly and may not have the emotional stamina necessary for litigation.\textsuperscript{49} Similarly, the costs of litigation typically make it accessible only to accident victims who can find an attorney willing to take the case on a contingency fee basis.\textsuperscript{50} Finally, the litigation process

\textsuperscript{45} See, e.g., Patricia M. Danzon, Tort Reform and the Role of Government in Private Insurance Markets, 13 J. LEG. STUD. 517, 517 (1984) ("The tort system may be viewed as a system of compulsory insurance, with terms of coverage determined largely by the private choices that generate court decisions."). Professor Kenneth Abraham has made a similar, though slightly distinct point. He also suggests that certain doctrines of insurance law – in particular the doctrine of bad faith – often provides the “seemingly paradoxical” protection of “insurance against the risk of not being insured.” His argument, however, is that insurance law sometimes provides insurance against the non-pecuniary consequences of a claims denial. Abraham, supra note 8, at 205. The point here is broader: insurance law provides insurance against the pecuniary (as well as, on occasion, non-pecuniary) risks of being denied coverage.

\textsuperscript{46} This insurance function resembles the insurance that state insolvency guarantee funds provide to policyholders against the risk that their insurers will be financially unable to pay their claims when they become due. See generally Emmett Vaughan & Theres Vaughan, Fundamentals of Risk and Insurance 104-05 (9th ed.2003) (describing guarantee funds as publicly-provided insurance).


\textsuperscript{48} Of course, some of the problems with “tort insurance” are specific to tort law and have no analog in the insurance coverage context. For instance, some scholars argue that tort law’s inquiry into fault is inefficient because insurance should be available even to negligent parties. See O’Connell, supra note 47, at 749. Whatever the merits of this argument in the tort context, it does not translate into the insurance coverage context, where the underlying risk is the wrongful denial of a claim.

\textsuperscript{49} See Sugarman, supra note 47, at 593-94 (explaining that tort plaintiffs often settle cases for less than their full value due to, among other things, “delay” and “urgent financial need”); O’Connell, supra note 47, at 827 (concluding that “the delay and expense of ascertaining fault” often leads accident victims to choose not to litigate claims). Victims of economic loss – whether they are suing their injurer or their insurer – tend to have much higher discount rates than other litigants because they have immediate financial needs to pay medical bills, fix cars, rebuild houses, and supplement lost income.

\textsuperscript{50} See Jeffrey O’Connell, Statutory Authorization of Nonpayment of Noneconomic Damages as Leverage for Prompt Payment of Economic Damages in Personal Injury Cases, 71 Tenn. L. Rev. 191, 192 (2003) (explaining that, because of the costs and prolonged nature of tort liability litigation, most plaintiff’s lawyers paid on a contingency fee basis “probably will not take a case unless they are confident it is likely to lead to at least some substantial payment.”). Similarly, accident victims are generally unable to hire legal counsel at an hourly rate because they do not have reserves of funds that can be directed towards legal fees.
produces highly variable and unpredictable damages, whereas accident victims are typically risk-averse.\textsuperscript{51}

In fact, litigation may be a particularly unattractive option for accident victims who are seeking compensation from their own insurer. First, litigants in insurance coverage cases typically receive limited insurance payments prior to litigation.\textsuperscript{52} By contrast, tort victims often receive first-party insurance payments (payments made by their own insurer) independently of any litigation. They are therefore comparatively well equipped to manage delays in litigation awards. Second, because insurance coverage suits are not usually initiated until after the claims process has stalled, there is often a significant delay between an insured’s need for cash and the initiation of coverage litigation. In tort cases, no such barrier exists between the time of injury and the initiation of litigation. Third, plaintiffs in insurance coverage cases are more likely to be risk-averse than tort victims: all such litigants purchased insurance before their loss, whereas only some tort victims were sufficiently risk averse to purchase first party insurance.\textsuperscript{53} Finally, the class action mechanism, which helps to fund litigation challenging individually small financial disputes, holds limited promise in the insurance coverage context, as common issues do not often predominate in such cases.\textsuperscript{54}

Because litigation is so undesirable for aggrieved policyholders, insurers generally hold an upper hand in settlement negotiations. For this reason, insurance coverage litigants are particularly likely to settle with

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\textsuperscript{51} See Sugarman, supra note 47, at 594 (“Tort compensates in an arbitrary, perhaps whimsical, way, . . . [L]awyers talents, plaintiffs’ demeanor, defendants’ grit, and the idiosyncrasies of jury composition combine to hand similar victims altogether dissimilar results.”); O’Connell, supra note 47, at 751 (discussing a 1970 study showing that “[a]bout half of those seriously injured in traffic accidents get nothing at all from tort liability claims.”). Whether accident victims are truly risk-averse may depend on whether they view litigation awards to be gains, or to be ways of mitigating losses. According to prospect theory, people tend to be risk averse when they frame payoffs as gains, but risk seeking when they frame them as losses. See generally Daniel Kahneman & Amos Tversky, Prospect Theory: An Analysis of Decision under Risk, 46 ECONOMETRICA 263 (1979). But under the more classical expected utility model, accident victims should be quite risk averse because the initial dollars they receive will be disproportionately valuable. See David Rosenberg, Decoupling Deterrence and Compensation Functions in Mass Tort Class Actions for Future Loss, 88 VA. L. REV. 1871, 1884 (2002).

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\textsuperscript{52} Interestingly, a new insurance product eases this problem for businesses, providing up to $250,000 to pay attorneys’ fees for another insurers’ denial of coverage. See Susanne Sclafane, New Insurance Product Covers Legal Costs if Buyers Decide to Challenge Claim Denial, NAT’L UNDERWRITER (7/7/08).

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\textsuperscript{53} At least two objections can be made to this point. First, many purchase insurance because it is required by state law or by their lender. But the bare bones insurance that is required in these contexts is less likely to result in coverage litigation because less is at stake for policyholders in such cases. Second, some who do not purchase insurance simply cannot afford it. This, however, likely reflects less risk-aversion in many cases: these individuals will tend to value insurance less because they have fewer assets to lose (health insurance may be an exception).

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\textsuperscript{54} Most insurance-related class actions concern non-claims issues, such as the calculation of premiums or the selling of policies. See Jonathon Klick and Eric Helland, The Tradeoffs between Regulation and Litigation: Evidence from Insurance Class Actions, J. TORT L., Vol. 1 : Iss. 3, Article 2. (2007) (collecting instances of insurance class actions in recent years). There are exceptions, like the non-OEM parts class action. See id.
their insurer for less than the value of their claim. Consequently, insurers may artificially delay the litigation process (or implicitly threaten to do so) to fully exploit this strategic advantage. Doing so may enhance their profits for totally unrelated reasons: investing the “float” on insurance premiums is one of the primary ways in which insurers make a profit. Although most states attempt to counteract this benefit by permitting plaintiffs to recover prejudgment interest, this offset may not be reflected in settlements if the plaintiff cannot credibly threaten to see the case to trial. Similarly, the problem could not easily be remedied by allowing claimants to sell their insurance coverage claims to third-party firms, as information problems such as adverse selection and moral hazard would plague any such market. Taken together, these factors may explain why it is in insurance coverage cases where one tends to find the most vivid “references to insureds who lose their homes because a claim is denied, who are unable to secure needed medical care, [or] even to a disabled fellow whose wheelchair was repossessed.”

Part II. Alternative Approaches in the U.S. for Resolving Consumer Insurance Coverage Disputes

Over the last century, state lawmakers have developed a patchwork of approaches to improving policyholders’ capacity to challenge insurers’ claims decisions. Perhaps the most frequently overlooked example is the distinctive brand of conciliation/mediation that state regulators use to help resolve disputes between consumers and insurers. States have also experimented with different types of arbitration schemes in consumer insurance, where federal law favoring arbitration is “inversely preempted” by state insurance law under the McCarran Ferguson Act. This Part critically describes these two ADR approaches.

A. State Sponsored Mediation of Insurance Coverage Disputes

1. An Overview

55 See Sykes, supra note 9, at 415.
57 See Sykes, supra note 9, at 409, 413.
58 See id. at 421-22 (suggesting that assignment of claims could improve insurance markets). The adverse selection problem stems from the fact that insurers may have much better information than third-party firms about various coverage-related factors, such as the precautions they took and the statements they made to insurers. The moral hazard problem stems from the fact that once a claimant settled, he or she would have little monetary incentive to participate in future litigation.
59 Id. at 414-15.
60 Modern commentators seem to have implicitly dismissed the importance of regulator-sponsored conciliation, as this process has received little attention in modern-day insurance law scholarship. See William Whitford & Spencer Kimball, Why Process Consumer Complaints? A Case Study of the Office of the Commissioner of Insurance of Wisconsin, 1974 Wis. L. REV. 639; David Serber, Resolution or Rhetoric: Managing Complaints in the California Department of Insurance, in NADER, supra, note 3.
Every state insurance department provides a mechanism by which aggrieved policyholders can lodge complaints about their insurers. In 2007, the consumer services departments of states insurance regulators “investigated” and “resolved to [their] satisfaction” over 222,000 consumer complaints. This figure represents a small fraction of the overall consumer contacts with state insurance departments, which are generally treated as “inquiries” rather than “complaints.” Of the roughly 222,000 consumer complaints, approximately 126,000 were deemed to be “confirmed” by standards developed by the National Association of Insurance Commissioners (NAIC). Consumers complain about a variety of coverage types – with Health/Accident, Auto, and Homeowners consistently leading the list. Complaints usually concern insurers’ claim-handling practices.

Insurance regulators process consumers’ complaints for a variety of purposes, including identifying potential regulatory infractions and publicly disclosing complaint data to help inform consumers. But perhaps the most significant goal of regulators in receiving complaints is to help consumers resolve their insurance disputes. To do so, regulators often

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62 The National Association of Insurance Commissioners (“NAIC”) provides links to each state website’s description of how to file a complaint about an insurer. See http://www.naic.org/cis/fileComplaintMap.do. Virtually all states allow consumers to complain electronically, over the phone, or through ordinary mail. See id.


64 In 2006, for instance, 2006, regulators received approximately 400,000 complaints and about 2.5 Million consumer inquiries. NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, STATE INSURANCE REGULATORS’ RESOURCE MANUAL 11 (2006) (hereinafter RESOURCE MANUAL). The figure in the text may also underestimate the number of complaints, as state reporting to the NAIC database is voluntary and only includes closed, confirmed complaints and states undoubtedly differ about when a consumer complaint is “closed.” See NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, CLOSED CONFIRMED CONSUMER COMPLAINT STUDY 21 (3/25/08) (hereinafter COMPLAINT STUDY). Moreover, some jurisdictions do not even process some consumer complaints. See NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, SURVEY OF CONSUMER SERVICES (hereinafter CONSUMER SERVICES SURVEY).

65 COMPLAINT STUDY, supra note 64 (defining “closed” claims and “confirmed” claims).

66 Id.

67 Id. In 2007, 58% of closed, confirmed consumer complaints involving claims handling, as opposed to “underwriting” or “policyholder service.” Of these complaints, 20% concerned delayed claims, 18% concerned denied claims, 14% concerned unsatisfactory settlement offers, and 6% concerned some “other” claim handling problem. Id.

68 The Unfair Claims Settlement Practices Act erects procedural requirements that insurers must follow in processing a claim, and which regulators can monitor through complaints. See TAN 37-39.

69 Different states disclose this information to varying degrees and using varying formats. See generally REPORT OF THE NAIC COMPLAINTS HANDLING AND REPORTING STANDARDS SUB-GROUP.

70 See NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, WHITE PAPER ON COMPLAINT HANDLING 4 (2000) (hereinafter WHITE PAPER) (“State insurance departments should provide an avenue for resolution of all consumer complaints.”). See also CONSUMER SERVICES SURVEY, supra note 64, at 23 (reporting that half of departments view primary purpose of consumer services division to be “assist[ing] consumers in a time of crisis” rather than “investigating violations of law”).

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attempt to mediate settlements of consumers’ disputes with their insurers. In that capacity, regulators generally have no authority to require insurers to settle a claim. In fact, only a small handful of states even require by statute that insurance departments provide this ADR service to complaining consumers.

Most states adhere to a similar protocol for attempting to resolve consumer complaints. When a consumer first complains, a regulator determines whether (i) the call is a complaint or merely an “inquiry,” and whether (ii) the department has jurisdiction over the complaint. Many departments recommend that consumers first complain to their insurer, though few seem to insist on that as a condition of lodging a complaint. Insurers are required to maintain their own “complaint handling procedures” under each state’s Unfair Claims Practices Act. Outside of the health care context, most states do not specify the details of this requirement. Those that do require only that insurers compile basic data about internal complaints, such as the type of complaint, the underlying line of insurance, and the company’s disposition after receipt. Moreover, most

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71 See White Paper, supra note 70, at 8 (“Even if there is no apparent violation of any statute or regulation, it should be the complaint analyst’s goal to assist the consumer in resolving the situation.”); id. at 16 (consumer assistance can be provided by “the complaint analyst… assuming the role of a mediator”); Consumer Services Survey, supra note 64 (reporting that in survey of which training programs would be of value to individual departments’ consumer services staff, the most common answer, selected by 31 of 40 responding jurisdictions, was training for “conflict resolution skills”).

72 Ertlenger, supra note 35, at 103 (“Although many insurance departments have consumer sections available to answer consumers’ questions and review claims complaints, the insurance departments are usually not expected to make decisions to resolve the complaints.”).

73 See, e.g., Cal. Ins. Code 12921.1(f)(6) & 4(a); (a)(5)(B) (describing a scheme for “complaint mediation [and] investigation,” which does not “give the commissioner power to adjudicate claims” but suggests that Department employees ought to facilitate “insurer compromise, or other remed[ies] for the complainant”); Burns Ind. Code Ann. 27-4-1-5.6 (authorizing commissioner to evaluate consumer complaints and to mediate settlements in appropriate cases); N.J. § 17:29B-18(b)(2) (“the Commissioner of Banking and Insurance . . . shall investigate an insurer” upon receiving a consumer complaint, and may “order the insurer to make restitution to the aggrieved person”).

74 Interestingly, the current process for resolving complaints is not terribly different than that described by Whitman and Kimball almost thirty years ago. Compare Whitman & Kimball, supra note 60, at 661-67.

75 Although definitions of a “complaint” differ by state, complaints generally include “any communication that expresses dissatisfaction with a specific insurance company or agent.” See NACOMI COMPLAINT HANDLING AND REPORTING STANDARDS SUBGROUP.

76 Jurisdiction may be limited if the complaint does not concern an insurance product, is governed by another state’s laws, or is preempted by federal law. See Ettlenger, supra note 35.

77 See, e.g., California Department of Insurance, http://www.insurance.ca.gov/contact-us/0200-file-complaint/index.cfm (“Before you file a complaint with the California Department of Insurance, you should first contact the insurance company, agent or broker in an effort to resolve the issue(s).”); Virginia Department of Insurance, http://www.scc.virginia.gov/division/boi/webpages/boifilecomplaint.htm (“The BOI encourages consumers to try and resolve any problem with their company, plan or agent before contacting the Consumer Services Section.”).

78 See Model UCPA, supra note 35.

79 The internal complaint rules that govern in the health insurance context are discussed infra.

80 See National Association of Insurance Commissioners, Model Regulation for Complaints Records to be Maintained § 884-1.
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states define a complaint to include only written expressions of a grievance.81

When these initial screens are met, a regulator will typically investigate complaints that seem potentially legitimate.82 In some states, the regulator who initially interacts with the consumer investigates the complaint, whereas in others the complaint is assigned to a designated complaint handler.83 The investigation begins with the complaint investigator forwarding the consumer’s complaint to the insurer and asking for a response.84 An insurer’s response may (but need not) be informed by any earlier response it gave directly to the consumer. Because complaint handlers have a limited capacity to investigate or assess cases – they typically handle between 400 and 600 complaints a year85 – they rely heavily on the insurer’s response to the complaint. When the complaint appears to raise a broad regulatory issue, it is typically referred to a separate market conduct division of the department. This happens very rarely: in 2007, complaint handlers referred only .4% of complaints to their market conduct divisions.86

Throughout this investigation process, complaint investigators engage in a process resembling “evaluative mediation”87 or conciliation, wherein the regulator presses the insurer, directly or indirectly, to resolve complaints that appear to have merit.88 States vary in how – and whether – they attempt to accomplish this.89 Often the complaint investigator simply “discusses” the merits of the complaint with a representative of the

81 See Model UCPA, supra note 35.
82 See White Paper, supra note 70, at 6. 35 out of 40 states report that their consumer services staff spends at least 60% of its time on investigating complaints. Consumer Services Survey, supra note 64, at 9. Complaints that seem to be clearly illegitimate are often coded as inquiries rather than complaints.
83 Consumer Services Survey, supra note 64, at 32.
84 Id. at 29-31; White Paper, supra note 70, at 7.
85 Consumer Services Survey, supra note 64, at 15.
86 Complaint Study, supra note 64.
88 Similarly, Whitford and Kimball found that “the best characterization of the [Wisconsin Insurance] Office’s role in routine complaint processing was as a mediator,” though, in other cases, “a limited adjudicative label best characterizes the Office’s dispute settling role.” Whitford & Kimball, supra note 60, at 681.
89 White Paper, supra note 70, at 28 (“it is clear [that] differences exist between states regarding, among other things, the extent of services provided and the procedures relating to the investigation and resolution of consumer complaints.”).
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insurer. In Pennsylvania, for instance, complaint investigators facing disputes about policy language may ask the insurer whether there have been earlier instances in which the regulator interpreted the relevant clause differently. Where there is tension between an adjuster and a policyholder, the department will often propose that a different adjuster be assigned to review the case afresh. States may also attempt to encourage mediated settlements in other ways. For instance, Minnesota generally does not include complaints that are resolved within three days in an insurer’s complaint ratio. In general, though, states are careful not to do anything in the mediation process that could be construed as a “regulatory decision,” which might be appealable.

2. Evaluating the Success of Mediation

Although state-sponsored insurance mediation is a valuable resource for consumers, it suffers from three inter-related limitations: it is frequently unsuccessful at convincing insurers to compromise, insurance departments often have inadequate resources meaningfully to review claims, and review may tend to be biased in favor of insurers.

The first of these limitations is the most significant. Regulatory complaint handlers are often unable to mediate resolutions of complaints in which the state insurance department “upheld the consumer’s complaint position,” under NAIC standards. In fact, according to states’ complaint data, regulators do not convince insurers to alter their original position in the majority of “confirmed” complaints. Importantly, this data is merely

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90 CONSUMER SERVICES SURVEY, supra note 64, at 31. Ideally, complainants receive periodic updates from the complaint handler as the investigation proceeds. See WHITE PAPER, supra note 70, at 7.
91 See interview with Ron Gallagher, Deputy Commissioner, Officer of Consumer and Producer Services, Pennsylvania Department of Insurance (3/30/08).
92 See id.
93 See interview with Robert Commodore, Director of Market Assurance, Minnesota Department of Commerce (12/12/07).
94 See Gallagher interview, supra note 91.
95 See COMPLAINT STUDY, supra note 64. Under NAIC standards, consumer complaints are “confirmed” if the regulator codes the complaint with a “disposition code” that is not on the following list: (1) Unable to assist; (2) Cancellation Upheld; (3) Nonrenewal Upheld; (4) No Action Requested/Required; (5) Handling Was Satisfactory; (6) Referred to Proper Agency/Section; (7) Company In Compliance; (8) Company Position Upheld; (9) No Jurisdiction; or (10) Insufficient Information.” Id. A new proposal would require regulators to directly determine whether the complaint was confirmed, rather than making an inference about the complaint based on the above scheme. See Proposed Definition of Confirmed Complaint (on file with author).
96 In 2007, there were 67,558 instances in which departments reported that they “advised complainant,” the complainant “entered into arbitration/mediation” or “filed suit or retained an attorney,” “information was furnished or expanded,” the complaint involved a legal or factual issue, or they were otherwise “unable to assist.” See COMPLAINT STUDY, supra note 64. These figures do not even include complaints where regulators report only that they were “unable to assist,” as such complaints are not deemed to be “confirmed.” By contrast, there were 62,391 instances in which departments reported a “compromised settlement,” “additional payment,” “coverage extended,” “claim reopened,” “claim settled,” “delay resolved,” “cancellation notice withdrawn,” “nonrenewal notice withdrawn,” “nonforfeiture problem resolved,” “deductible refunded,” “endorsement processed,” “policy issued/restore,” “refund,” “premium problem
suggestive, as regulators have widely acknowledged that the underlying data elements are over-lapping, confusing, and ambiguous. Nonetheless, the data strongly suggests that regulators are often quite limited in their capacity to convince insurers to compromise on seemingly legitimate consumer complaints. Interestingly, state-sponsored mediation programs that departments arrange for after a natural disaster enjoy much better rates of claim resolution than ordinary regulatory-mediation.

A second – and likely related – limitation of regulator-mediation is that the consumer affairs divisions of many state insurance departments are significantly resource-constrained, resulting in vast differences among the states regarding “the extent of services provided” in attempting to resolve consumer complaints. In 15 of 40 states that responded to an NAIC survey, complaint handlers have caseloads of 600 or more, and in 7 of those states complaint handlers have caseloads of over 1000 complaints a year. Resource constraints obviously limit the extent to which a complaint handler can carefully scrutinize a consumer’s complaint or an insurer’s response. In some cases, they also lead to consumer complaints simply being ignored. Indeed, 45% of states responding to the NAIC survey reported that they do not process all consumer complaints. One 1998 investigation found that, due to resource constraints, the Indiana Department of Insurance “rarely does anything in response” to consumer complaints. As the insurance commissioner at the time explained, “without

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97 Currently the Market Analysis and Priorities Working Group of the NAIC is working to develop better codes for the entire complaint data collection effort. See http://www.naic.org/committees_d.htm

98 These programs are typically conducted by external organizations with which the department has a standing agreement. Elizabeth Baker Murrill, Mass Disaster Mediation: Innovative ADR, or a Lion’s Den?, 7 PEPP. DISP. RESOL. L. J. 401, 404-05. Some insurance departments have also experimented with external mediation in non-catastrophe disputes. See http://www.oid.state.ok.us/www2.oid.state.ok.us/Programs/EAGLE.asp (describing the Oklahoma Department of Insurance’s EAGLE program, which assists consumers whose complaints the department could not resolve because of a disputed question of fact).

99 The first such program in Florida handled around 2,400 disputes and achieved a settlement rate of 92%, leading the Florida department to label the program “a resounding success.” Murrill, supra note 98, at 404. Since then, several other states have adopted similar catastrophe-based insurance mediation programs, which also appear to resolve a high percentage of claims. Id. at 404-05. As Murrill noted, this success is partially offset by the prospect that such mediations may present significant risks for uninformed consumers. See id.

100 ETLINGER, supra note 35, at 103 (“Insurance departments . . . are not equipped to deal with the volumes of consumers’ claims complaints that are generated daily.”).

101 WHITE PAPER, supra note 70, at 28.

102 CONSUMER SERVICES SURVEY, supra note 64, at 15. By contrast, 14 of those states reported that complaint handlers enjoyed caseloads of fewer than 400 cases a year. Id.
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One common way that departments adjust their complaint handling role due to resource constraints is by artificially, and confusingly, limiting the types of complaints that they handle. For instance, many departments claim that they will not attempt to resolve complaints involving “legal or factual issues.” In 2007, complaint handlers turned away approximately 15-20% of consumer complaints on that basis. Many other consumers presumably did not seek assistance from their regulator precisely because they already knew of this limitation. Some departments justify this limited role on grounds of a lack of authority, as opposed to resources constraints. The view of these departments is that such questions of fact or law fall outside of the insurance department’s “regulatory” authority. But it is hard to understand what this means, as almost all complaints that implicate regulatory issues can also be described as involving either a legal or factual dispute. Moreover, no laws prevent regulators from mediating disputes of any type, and most insurance departments report that they do indeed attempt to resolve all complaints, including those that could be characterized as factual or legal in nature.

Finally, regulator-mediation of consumer complaints may tend to be biased in favor of insurers. To some extent, this possibility is correlated with the prospect of regulatory capture, which many have argued is a significant problem in the insurance industry. But there are particular reasons why regulatory complaint handlers may tend to favor insurer interests in attempting to resolve consumer complaints. As noted above,

104 See Scott Paltrow, A Matter of Policy: How a state Becomes Popular with Insurers – But not Consumers, WALL ST. J. 1/14/98, A1. Even when complaints were attended to, the consumer consultants on the staff “did little more than forward complaints to the companies.” Id.
105 See Complaint Study, supra note 64.
106 Many insurance department websites explicitly warn consumers that the department cannot do anything to help resolve legal or factual issues. See, e.g., Virginia Department of Insurance, http://www.scc.virginia.gov/division/boi/webpages/boifilecomplaint.htm (“We cannot resolve a dispute that is a question of fact.”); Maine Depart of Insurance, http://www.maine.gov/pfr/insurance/complaint.htm#a (similar).
107 See Whitford & Kimball, supra note 60, at 665 (describing letter that department sent to consumers when a dispute rested on a factual or legal issue, justifying refusal to proceed further by observing that “the office was a regulatory not a judicial agency”).
109 White Paper, supra note 70, at 15.
110 See Baker, supra note 8, at 47 (noting that while “there is no systematic, scholarly study of the effectiveness of state regulation of insurance forms,” most assume that such regulation is inadequate); Susan Randall, Insurance Regulation in the United States: Regulatory Federalism and National Association of Insurance Commissioners, 26 FLA. ST. U. L. REV. 625, 640-41 (1999) (arguing that “the problem of capture as it exists in other regulatory contexts is minimal when compared to the problem in the insurance industry” for various reasons, including that “[t]he industry directly funds the National association of Insurance Commissioners); Robert Keeton, Insurance Law Rights at Variance with Policy Provisions, 83 HARV. L. REV. 961, 967 (1970) (“Regulation is relatively weak in most instances, and even the provisions prescribed or approved by legislative or administrative action ordinarily are in essence adoptions, outright or slightly modified, of proposals made by insurers’ draftsmen.”).
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virtually any insurance complaint can be framed as either a legal or factual conflict, allowing complaint handlers to disregard certain complaints in a way that may reflect conscious or unconscious biases. One study of the California Department of Insurance in 1980 noted just such a trend, reporting that complaint handlers would disregard complaints based on “the personality of the complainant and the estimated straightforwardness of the complaint.”\(^{111}\) It also reported that this authority was used to “deselect complaints” lodged by “people who can be fooled or who will not or cannot challenge the staff.”\(^{112}\) A more recent Article raised concerns about the fairness of disaster insurance mediation, suggesting that the disparity in sophistication between insurers and consumers results in the process significantly favoring insurers.\(^{113}\)

B. Arbitration of Coverage Disputes

1. An Overview

Pre-dispute, mandatory arbitration provisions are seemingly ubiquitous, regularly appearing in agreements governing cell phone plans, credit cards, rental cars and countless other consumer transactions.\(^{114}\) This proliferation of arbitration requirements is largely attributable to the Federal Arbitration Act (FAA), which prevents states from significantly interfering with arbitration agreements.\(^{115}\) But unlike all other fields of consumer law, the FAA poses no obstacle to states regulating or prohibiting insurance-specific arbitration laws: under the McCarran Ferguson Act, state laws that regulate insurance trump federal statutes of general applicability, such as the FAA.\(^{116}\) This unique legal backdrop has allowed states to regulate insurance policy terms governing arbitration.\(^{117}\)

States have used this capacity to experiment with insurance arbitration schemes in a few key areas.\(^{118}\) The most long-standing example is the “appraisal” clause found in virtually all auto and homeowners

\(^{111}\) Serber, supra note 60, at 329-331.
\(^{112}\) Id. at 331.
\(^{113}\) See Murrill, supra note 98, at 403.
\(^{115}\) See EDWARD BRUNET ET AL., ARBITRATION LAW IN AMERICA: A CRITICAL ASSESSMENT 157-159 (2006) (describing various state efforts to protect consumers from mandatory arbitration, and noting that most of them “have been rendered substantially irrelevant by [a] series of Supreme Court Decisions”).
\(^{116}\) See 15 USC 1012 (b).
\(^{117}\) See Randall, supra note 61.
\(^{118}\) This Article adopts a broad definition of “arbitration” that encompasses all instances in which an independent third party is endowed with the power to bind one, or both, disputants to a particular outcome.
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policies. These clauses originally appeared in state-mandated fire insurance policies, and continue to be mandatory in most states. Under the appraisal clause, two independent experts, each of whom is selected by one of the parties, resolve disputes about the extent of loss to insured property. Parties generally bear the costs of hiring their appraiser. Appraisal is not available to resolve disputes about the existence of coverage. In general, the appraisal process is highly informal, and involves the selected appraisers independently investigating the loss and reaching a joint conclusion. In many states, appraisal can be waived by one, or both, parties, who can opt for litigation rather than appraisal at the time the dispute arises.

States have more recently experimented with insurance arbitration when it comes to certain limited health insurance disputes. Most states require health insurers to offer policyholders “external review” of any coverage denial that is predicated on the insurer’s determination that a treatment is not “medically necessary.” Such external review is performed by independent doctors, who are part of external review organizations (EROs). States typically certify EROs and nominally monitor their decisions for quality and objectivity. Additionally, states generally

119 See generally 2-30 Matthew Bender & Co., Insuring Real Property § 30.01. In the auto insurance context, appraisal clauses may accrue to the benefit of auto shops, not consumers, if they involve disputes about the charge that the repair shop sends the insurer. But appraisal can also benefit consumers in total loss situations or other cases in which they are directly paid by insurers for their losses.
120 See id; see, e.g., NC G.S. 58-176 (fire insurance policy with appraisal provision); Cal Ins. Code, § 2071 (same). Standard fire insurance policies set a floor for property fire insurance coverage in most states. See BAKER, supra note 8, at 350. Some states explicitly require by statute consumer property insurers to offer appraisal to resolve all disputes over the actual cash value of damage to property. See, e.g., Alaska stat 21.89.035 (mandating appraisal clauses in all auto and property coverage policies). Where there is no statutory mandate, it is still highly unlikely that a state regulator would approve a consumer property insurance form that did not contain an appraisal clause.
121 Although each party chooses its own appraiser, they must be “competent and independent,” and are frequently licensed by state regulators. See Insuring Real Property, supra note 119.
122 Id.
123 Id. Although the basic structure of the appraisal process is uniform, some of the details differ by state. Generally appraisers choose an umpire to resolve disagreements between them.
124 See id.
125 Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002), distinguishes external review from arbitration in assessing whether ERISA preempts external review because it is an “alternative remedy” under ERISA. Regardless, external review clearly fits the broad definition of arbitration used in this article. See note 118, infra.
126 Under ERISA, self-funded employer plans are not subject to these laws. See Rush, at fn 6.
127 In 2006, over forty states required health insurers See generally Nan D. Hunter, Managed Process, Due Care, 6 YALE J. HEALTH POL’Y, L. & ETHICS 93, 128-40 (2005). Recently, even more states have adopted similar laws. See NAIC, UNIFORM HEALTH CARRIER EXTERNAL REVIEW MODEL ACT (2007). A few states have also extended the breadth of external review to include other types of coverage determinations, including determinations that a treatment was experimental. Hunter, supra, at 129.
128 See Leatrice Berman Sandler, Independent Medical Review: Expanding Legal Remedies to Achieve Managed Care Accountability, 13 ANNALS HEALTH L. 233, 239 (2004); Hunter, supra note 128, at 156. Such monitoring can be performed by state agencies, designated panels, or private accreditation organizations. See id.
specify the procedures of external review, such as what evidence can be considered and when hearings can be held.\textsuperscript{130} The external review process is paper-based, involving the ERO doctors reviewing the medical evaluations of the insurer, and any independent doctors, and assessing whether the insurer has followed proper procedures.\textsuperscript{131}

Before invoking external review, states typically require that complainants first exhaust their insurer’s internal review procedures.\textsuperscript{132} Unlike the internal review procedures in other lines of insurance,\textsuperscript{133} most states have relatively well-developed internal grievance processes for health insurers.\textsuperscript{134} The documents, information, and correspondence that is generated during this process is usually, but not always, part of any record that is before an external review panel.\textsuperscript{135} In most states, consumers are charged little or no fee for external review\textsuperscript{136} and they generally do not hire lawyers.\textsuperscript{137} Policyholders in most states do not need to invoke external review as a prerequisite to suing their insurer.\textsuperscript{138}

Outside of appraisal and external review, states have generally used their authority to prohibit or otherwise restrict arbitration. Approximately twenty jurisdictions prohibit pre-dispute, mandatory arbitration provisions in insurance policies.\textsuperscript{139} Other states limit certain types of arbitration clauses, requiring particular procedural safeguards or notice requirements for arbitration agreements in health insurance, life insurance or other policies.\textsuperscript{140} Significantly, a newly developed Interstate Insurance Compact – which establishes and enforces uniform product standards for 33 states in

\textsuperscript{130}See Hunter, supra note 128, at 132-36. “External Review laws [therefore] use process itself as a structure of accountability.” Id. at 143.

\textsuperscript{131}Id.

\textsuperscript{132}EXTERNAL REVIEW MODEL ACT, supra note 128 at § 7.

\textsuperscript{133}See TAN 79-80.

\textsuperscript{134}The NAIC’s model act governing health care grievances requires insurers to include a significant amount of information in internal grievance handling decisions sent to insureds, including: the titles and credentials of the people reviewing the grievance, a statement of the reviewers’ understanding of the grievance, the reviewers’ decision and rationale in sufficient detail for the insured to respond further to the insurer’s position, and references to all evidence and documentation used as the basis for the decision. NAIC HEALTH CARRIER GRIEVANCE PROCEDURE MODEL ACT § 6(G)(1-5). At least one state has adopted this aspect of the NAIC model act verbatim. See NEB. REV. STAT. § 44-7308 (2007). Many other state statutes require insurers to explain grievance decisions to insureds, but they are often not as specific as the NAIC model. See, e.g., FLA. STAT. § 641.511(f) (2004) (requiring only that insurers establish procedures to “notify the [insured] of a final decision in writing.”).

\textsuperscript{135}E.g., FLA. STAT. § 408.7056 (2008). But see MINN. STAT. § 62Q.73 (2007) (requiring insurers to provide to external review entity only “any information [the insurer] wish[es] to be considered.”). The NAIC’s model act for external review requires insurers to provide to the external review organization “the documents and any information considered in making the adverse determination or final adverse determination.” EXTERNAL REVIEW MODEL ACT, supra note 128 at § 8(E)(1).

\textsuperscript{136}EXTERNAL REVIEW MODEL ACT, supra note 128 at 75-1, § 12.

\textsuperscript{137}Hunter, supra note 128, at 134; Berman Sandler, supra note 119, at 261-62.

\textsuperscript{138}See Hunter, supra note 128, at 137-38.

\textsuperscript{139}See Randall, supra note 61, at 270-71 (citing eight jurisdictions that explicitly prohibit arbitration clauses in insurance policies and eleven that have the effect of doing so by explicitly excluding insurance from their state versions of the FAA).

\textsuperscript{140}See id. at 272-73.
life insurance, annuities, disability insurance, and long term care insurance — bans all pre-dispute, binding arbitration provisions. Although many states and territories do not explicitly prohibit arbitration provisions in consumer insurance policies, insurers in those states usually do not include general arbitration provisions in their policies, outside of health insurance and uninsured/underinsured automobile coverage.

To be sure, several enterprising states have affirmatively experimented with consumer insurance arbitration schemes. For instance, four of the dozen “no fault” auto insurance states require auto insurers to participate in an arbitration scheme wherein all disputes concerning “no fault” benefits are subject to arbitration. Second, at least one state, Delaware, requires that insurers make arbitration available to consumers in

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142 See Interstate Insurance Product Regulation Commission, Rulemaking Record http://www.insurancecompact.org/compact_rlmkng_record.htm (including in every Policy Standard a provision that “[o]nly arbitration clauses that permit voluntary post-dispute binding arbitration are allowed in policy forms.”).
143 To be sure, some insurers do use arbitration provisions in their policies and some assert that this trend is on the rise. See id. (“arbitration provisions are appearing with increasing frequency in all types of insurance policies.”); Public Citizen, Arbitration Clauses in Insurance Contracts: The Urgent Need for Reform. Whatever the trend, general arbitration clauses are certainly not the norm in most basic consumer insurance policies, including homeowners, renters, and auto. See Insurance Services Organization Standard Forms; Matthew Bender, Underinsured Motorist Insurance: The Claims Process § 22.3 (“In the absence of mandates, the insurance industry has not introduced arbitration clauses in other types of coverage” aside from uninsured/underinsured motorist coverage). see also Kenneth Abraham & J. W. Montgomery III, The Lawlessness of Arbitration, 9 CONN. INS. L. J. 355, 358 (2003) (“Few standard-form primary commercial liability and property insurance policies issued by American insurers contain arbitration clauses.”). It is difficult to explain insurers’ apparent ambivalence to arbitration in states that do not limit the use of these clauses. While insurers may fear triggering enhanced regulatory or judicial scrutiny, they may also be responding to consumer demand or wary of schemes that make policyholders more likely to challenge coverage decisions.
144 Empirical evidence suggests that arbitration clauses are more common in health insurance policies, particularly those involving HMOs. See Rolph, Moller & Rolph, Arbitration Agreements in Health Care: Myths and Reality, 60 LAW & CONT. PROHS. 153, 172-73 (1997) (finding that most HMOs require arbitration of contract disputes with enrollees, while PPOs do not).
145 For uninsured/underinsured coverage, policy provisions usually require the arbitration of disputes involving (i) whether the policyholder could recover in damages from the uninsured/underinsured driver, and (ii) how much he could recover. Alan I Widiss, The Enforceability of Arbitration Terms in Uninsured Motorist Coverage and Other Form Contracts, 66 IOWA L. REV. 241 (1981). Insurers popularized this innovation in order to avoid conflicts of interest that are distinctive to uninsured/undersured coverage. See id. (exploring how insurers may simultaneously have an incentive to show that (i) their policyholder, rather than the underinsured/uninsured driver, was at fault in the accident, and (ii) the underinsured/uninsured driver, rather than the policyholder, was at fault in the accident, and how arbitration solves this conflict by requiring arbitration of disputes concerning the first issue). Some states regulate the arbitral procedures and selection of arbitrators for uninsured/underinsured arbitration. See, e.g., Rules for Arbitration of Supplementary Uninsured/Underinsured Motorist Insurance Disputes and Uninsured Motorist Insurance Disputes in the State of New York, available at http://www.adr.org/sp.asp?id=22086.
disputes arising out of auto, homeowners, and health insurance.\textsuperscript{147} In both instances, states employ the same basic consumer protections that exist in the external review and appraisal contexts. First, in two of the four “no fault” arbitration states, the consumer can opt for litigation rather than arbitration after the dispute arises.\textsuperscript{148} The same consumer choice at the time of dispute is built into the Delaware scheme.\textsuperscript{149} Second, in both cases, the state specifies the arbitral procedures and chooses a panel of acceptable arbitrators.\textsuperscript{150}

2. Evaluating the Success of Insurance Arbitration

Evaluating the success of consumer insurance arbitration requires a baseline view of the desirability of such arbitration. This is hardly a simple proposition. Numerous academics have debated the desirability of arbitration for consumers, and Congress is currently considering legislation that would curtail the use of pre-dispute, mandatory arbitration provisions.\textsuperscript{151} Proponents of arbitration often claim that it has the virtues of increased speed and decreased cost, expert decision-makers, and confidentiality.\textsuperscript{152} Critics counter that it tends to favor repeat players, suppress public information, produce sub-optimal levels of precedent, have little impact in practice on costs or speed, and undermine class action lawsuits or punitive damages.\textsuperscript{153}

\textsuperscript{147} See 18 Del. C. § 331, Chapter 23; 21 Del. C. §§ 2118 & 2118B.
\textsuperscript{149} See Interview with Julia Moore, Arbitration Secretary for the Delaware Department of Insurance (4/22/08).
\textsuperscript{150} Three of the four no-fault states (New York, Minnesota and New Jersey) have special procedures, administered through the American Arbitration Association or the National Arbitration Forum, which must be followed in no-fault arbitrations. 1-15 No-Fault & Uninsured Motorist Auto Insurance § 15.30. In each case, the parties must select arbitrators from a panel of approved arbitrators. See id. Similarly, the process of arbitration in Delaware is mandated by regulation. See Reg. 901. Arbitrators are volunteer attorneys who are paid a nominal amount and whose win/loss records and awards are monitored by the department. See Moore Interview, supra note 149.
\textsuperscript{151} Arbitration Fairness Act of 2007, S. 1782,100th Cong. (2007). For an excellent review of the basic terrain of the consumer arbitration debate, see BRUNET ET AL., supra note 115, at 127-85.
\textsuperscript{152} See, e.g., Stephen Ware, Paying the Price of Process, 2001 J. DISP. RESOL. 89 (arguing that the efficiency of arbitration can ultimately benefit consumers); Samuel Estreicher, Saturns for Rickshaws: The Stakes in the Debate of Predispute Employment Arbitration Agreements, 16 OHIO ST. J. ON DISP. RES. 559 (2001) (similar).
The desirability of arbitration is no clearer in the specific context of insurance law. On one hand, there are legitimate reasons to think that concerns about arbitration may be enhanced when it comes to consumer insurance disputes. Consumer insurance arbitration may be unusually susceptible to biased decision-making given the intensity of the “repeat player” problem in insurance and the malleability of insurance law. Moreover, the secrecy of most forms of consumer arbitration may be particularly unfavorable to long-run consumer interests because of the importance of reputation to the functioning of consumer insurance markets. However, arbitration may also offer distinctive potential benefits for insurance consumers. As described in Part I, the slow pace of litigation and its potential cost are particularly problematic for aggrieved insurance consumers. To the extent that arbitration allows policyholders to easily, cheaply, and quickly challenge their insurer’s adverse coverage decision, it helps to offset these concerns. For related reasons, it may encourage settlement by lending credibility to plaintiffs’ threats to challenge a coverage decision.

Weighing these competing costs and benefits of consumer insurance arbitration is ultimately a subjective enterprise. But the unique flexibility that states enjoy to regulate insurance arbitration shifts the relevant inquiry in this domain away from the desirability of arbitration as it currently exists in the consumer world. Instead, the relevant question is how effectively states have leveraged their regulatory authority to facilitate schemes that harness the strengths of arbitration while limiting its weaknesses.

Judged by this metric, consumer insurance arbitration in America is, at most, only modestly successful. Most states have done little to promote insurance arbitration outside of the highly-specific areas of property valuation and medical necessity disputes. For the vast majority of insurance coverage disputes, states have either largely ignored arbitration or have merely sought to ban mandatory arbitration terms. Regardless of which of these approaches is preferable, both fail to harness the potential benefits of arbitration while limiting its costs.

Where states have experimented with arbitration, they have designed schemes that are closely tied to the underlying dispute’s subject
matter and that therefore cannot be extended to other types of insurance disputes. First, both appraisal and external review attempt to limit the “repeat player” problem of arbitration by using experts to resolve factual disputes. Although experts often have divergent views that can implicate repeat player problems, experts are generally less susceptible to biased decision-making than ordinary arbitrators because of their professional training and the “objectivity” of the underlying subject matter. States also have an easier time licensing and approving expert decision-makers than ordinary arbitrators. Although ordinary arbitrators are not state-approved, they typically are licensed, or otherwise regulated, in each of the consumer insurance arbitration schemes described above. Relatedly, the insignificance of precedent – which ordinarily exacerbates insurers’ repeat player advantage – may be less problematic in such expertise-driven arbitrations, as precedent is generally irrelevant to the resolution of such disputes. Consequently, while the subject matter underlying appraisal and external review may result in decreased consumer risks, the basic design of these arbitration schemes cannot easily be extended to other coverage disputes.

Second, appraisal and external review both offer the prospect of genuinely faster and more accessible dispute resolution than litigation for reasons that are similarly tied to the underlying subject matter of the disputes. Both forms of ADR can be distinguished from “ordinary” arbitration because they are relatively informal, are paper-based, and

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160 See, e.g., Hunter, supra, at 156 (criticizing the ERO system because it “lacks sufficient mechanisms either to correct for possible bias or to enhance quality by reviews of the most difficult, and indeterminate, medical judgments”). Cf. Murrill, supra note 98, at 403 (criticizing disaster mediation in which regulators hired and monitored private ADR firms as is biased in favor of insurers).


162 Most professions, including the medical profession and real estate appraisal profession, have clearly developed licensing standards.

163 See subsection 1, supra (describing licensing and monitoring of EROs, appraisers, arbitrators in no-fault states, and Delaware arbitrators). For a convincing argument that all arbitrators should be licensed and approved, see Jeffrey Stempel, Keeping Arbitrations from Becoming Kangaroo Courts, 8 NEV. L. REV. 251 (2007).

164 Abraham & Montgomery, supra note 143, at 365 (“Because arbitrations are essentially confidential and set no precedents . . . each arbitration is an island unto itself, not governed by any prior arbitration outcomes . . .”). This may work to the benefit of insurers, who are better able than non repeat players to learn the patterns of specific arbitrators.

165 See id. This may be particularly true when it comes to factual disputes requiring expertise, as expert-arbitrators employ decision-making criteria that are the output of their professions, rather than of precedent.

166 The potential benefits of a speedy and inexpensive forum may also be particularly significant in these contexts. In the health care context, coverage denials based on medical necessity determinations require fast decision-making because they typically prevents patients from getting the treatment they seek. Similarly, valuation disputes tend to be too small in monetary value to allow policyholders to find representation on a contingency fee basis.
incorporate elements of an inquisitorial, rather than adversarial, style.\textsuperscript{167} These design features are key reasons that appraisal and external review prove more accessible and efficient than litigation. Policyholders generally need not hire lawyers and the process proceeds much more quickly than ordinary arbitration.\textsuperscript{168} By contrast, there is some empirical evidence that the elaborate procedures of ordinary arbitration, along with its adversarial style, often render it no faster or more accessible than litigation.\textsuperscript{169} Unfortunately, the feasibility of informality and inquisitorial inquiry once again stems directly from the unique subject matter underlying external review and appraisal: in factual disputes involving experts, the risk of biased decision-making is muted and decision makers are generally equipped to guide their own inquiries without the benefit of adversarial presentations. Consequently, there is much less of a need to rely on an adversarial method or elaborate procedural protections to ensure the fairness of the process.\textsuperscript{170}

In sum, states have done little to harness the benefits and limit the costs of consumer arbitration in the domain of insurance, even though they have unique authority to do so. Where states have actively promoted consumer insurance arbitration, they have done so only where the risk of a “repeat player” problem is inherently low and the prospect of increased accessibility is high. These efforts are consequently of limited use for crafting reform of consumer insurance arbitration more broadly.

Part III. The Private Ombudsman Model for Resolving Insurance Disputes

Given the states’ poor track records for facilitating consumer insurance ADR, this Part looks beyond our own borders for guidance. Of the many potential models, the British scheme for resolving financial disputes, which is known as the Financial Ombudsman Service (FOS),\textsuperscript{171} is

\textsuperscript{167} See subsection 1, supra (describing informal and inquisitorial elements of external review and appraisal).
\textsuperscript{168} See TAN Notes 124 & 137.
\textsuperscript{169} See Brunet et al., supra note 115, at 18 (noting little empirical evidence that arbitration guarantees a more efficient process than trial and suggesting that trials can be as efficient as arbitration according to some new evidence’’); Bert Kritzer & Jill K. Anderson, The Arbitration Alternative (1983) (finding that arbitration may, on average, take just as long as litigating due to the fact there exists less settlement in the arbitration context); Ware, supra note 152.
\textsuperscript{170} By contrast, the primary justifications for the elaborate processes that accompany “ordinary” arbitration are that they are needed to protect consumer interests and ensure the neutrality of the process. See, e.g., Estreicher, supra note 153; Margaret M. Harding, The Limits of Due Process Protocols, 19 Ohio St. J. Disp. Res. 369 (2004).
\textsuperscript{171} Although few sources in American legal literature have discussed the FOS, a number of academic sources from the UK and from international journals describe the FOS. See generally Sharon Gilad, Accountability or Expectations Management? The Role of the Ombudsman in Financial Regulation, 30 Law & Policy 227 (2008); James & Morris, supra note 14; James, supra note 13; Yokoi-Arai, Mamiko, A Comparative Analysis of the Financial Ombudsman Systems in the UK and Japan, 5 J of Int’l Banking Reg. 333 (2004); Philip Rawling & Chris Willett, Ombudsman Schemes in the United Kingdom’s Financial Sector: The Insurance
the most natural source of guidance. Indeed, “the United States and United Kingdom are often portrayed as fellow travelers in the world of financial regulation,” given “their shared traditions of laissez-faire capitalism, common-law jurisprudence, self-regulatory organizations, and disclosure-based securities regulation.”172 In the insurance realm, in particular, Britain has recently served as a regulatory model for would-be reformers of regulation.173 Moreover, the UK’s insurance market is one of the few in the world that even approaches the US in size and complexity.174

The FOS traces its history to the early 1970s, when the British consumer insurance industry was widely believed to be in a state of disrepair.175 In response, three British insurance companies voluntarily formed an independent “Insurance Ombudsman Bureau” (IOB) that had many of the same basic features as the current FOS. The IOB investigated consumers’ complaints and, when appropriate, ordered insurers to pay up to £100,000 to the consumer.176 Consumers who were not pleased with the IOB’s decision were free to sue in court.177 The IOB expanded quickly, with virtually all insurers joining it within a few years.178 In the next two decades, seven other British industries developed their own “private ombudsman” schemes based on the insurance industry model.179 By 2000, the British Parliament formally joined the IOB with its peer ombudsman organizations to form the FOS.180 Today, the FOS employs approximately 1000 people and works with a budget of approximately £50 million (approximately $100 million).181 Its jurisdiction extends to virtually all consumer financial services, including insurance, banking, and

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174 Whereas the US insurance market is the largest in the world, accounting for 31% of world-wide premium income, the UK is the third largest in the world (behind Japan), accounting for 11% of world-wide premium income. See Association of British Insurers, UK Insurance – Key Facts, available at http://www.abi.org.uk/BookShop/ResearchReports/UK%20Insurance%20-%20Key%20Facts%202007.pdf

175 See id.; Rawling & Willett, supra note 171, at yy.

176 See id.; Rawling & Willett, supra note 171, at yy; Rawling & Willett, supra note 171, at yy.


178 James & Morris, supra note 14, at 167.

179 Id.

180 FINANCIAL OMBUDSMAN SERVICE, ANNUAL REVIEW 49 (2007-08), available at http://www.financial-ombudsman.org.uk/publications/annual-reviews.htm (hereinafter “ANNUAL REVIEW '08”), Case fees, discussed infra, supply the FOS with about 66% of its funding, with the remaining 34% coming from a general tax on the industry. See id. at 50.
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In recent years, between 17-22% of its total caseload has involved complaints about insurance.182

This Part compares the FOS with its American counterparts. Section A describes the FOS in detail, comparing it to consumer insurance ADR in the US. Section B then argues that many of the FOS’s constitutive elements mirror consumer insurance ADR in the U.S. It concludes with a puzzle that is the subject of Part IV: how can it be that the FOS is so much more successful than its American counterparts when many of its basic features seem to resemble the American system?

A. The FOS’s Process of Dispute Resolution

The FOS can be understood to utilize four stages of dispute resolution: (i) internal complaint procedures, (ii) a front-line call office, (iii) an adjudicator’s assessment and mediation, and (iv) an ombudsman’s decision. This Section describes these four stages, emphasizing how each one resembles an element of American consumer insurance ADR.

1. Stage One: Internal Complaints

Before consumers can complain to the FOS, they must first lodge a grievance with their insurer and provide it with eight weeks to address the complaint.184 This echoes, and formalizes, the recommendations of many state insurance regulators that consumers first contact their insurer before lodging a complaint.185 Similarly, as in most American states, British insurers must maintain their own internal complaint handling procedures.186 But British firms are required not simply to keep track of basic data about internal complaints, but also to investigate those complaints and to respond to them in writing within eight weeks.187 All such responses must inform policyholders of their right to refer the case to the FOS and must also contain a separate pamphlet, written by the FOS, about the FOS process.188 Internal complaint handling therefore more closely resembles the analogous American rules governing health insurance than the more general American

182 Id.
183 Id. at 18.
184 Rawling & Willett, supra note 171, at 311.
185 TAN 77.
188 See Rules on Dispute Resolution 1.2.3, in SOURCEBOOK, supra note 187. These rules are intended to ensure “effective and transparent procedures for the reasonable and prompt handling of complaints.” Id. 1.1; see Samuel, supra note 186, at 676.
internal review rules for insurers. Additionally, whereas most American states define a complaint only to include written expressions of grievances, the British definition encompasses oral expressions of dissatisfaction.

2. Stage Two: The Front-Line Call Center

All complaints to the FOS are initially routed to a call center, which is roughly analogous to the branch of state regulatory offices that answers incoming consumer calls. As with state regulators, the services of the FOS are available to consumers free of charge. FOS call center employees perform many of the same duties as state regulators, ensuring that the consumer has lodged an internal complaint, that the complaint is within the FOS’s jurisdiction, and that the grievance is timely. FOS call center employees also mirror state regulators in that they determine whether the call is merely an inquiry and, if so, they advise the consumer or provide information.

There are at least two differences between the FOS call center and American regulators’ processes for initially processing consumer complaints. First, call center employees contact the consumer’s insurer and ask it to forward its response to the consumer from Stage One, the internal complaint handling process. Second, once a call center employee designates a consumer complaint as an official “case,” the firm is required to pay a £400 ($800) fee, regardless of the case’s subsequent trajectory. Call center employees often attempt to resolve relatively straightforward complaints with a firm quickly, before the matter is designated a case and the firm is charged.

3. Stage Three: Adjudicator Mediation

Once the call-center elevates a complaint to an official “case,” it is routed to an “adjudicator.” Adjudicators are quite similar to the “complaint investigators” in state regulators’ offices: they are drawn from a wide variety of backgrounds, including from inside the industry, from law, from public interest organizations, and from dispute resolution...
backgrounds. Adjudicators’ investigations are “inquisitorial” in the sense that they are not limited by the specific claims that complainants articulate. As with regulatory complaint investigators, adjudicators have no legal authority to issue binding decisions on individual disputes. Adjudicators nonetheless attempt to mediate settlements between consumers and insurers that are consistent with their view of the case.

Despite the many similarities in the roles of FOS adjudicators and state complaint investigators, there are several important distinctions as well. First, unlike state regulators, adjudicators’ evaluation of the case focuses heavily on the insurer’s internal complaint file. Recall that the insurer prepares this file before the consumer ever complains to the FOS. By contrast, in most states, insurers’ internal complaint files do not contain any analysis of the complaint and complaint investigators rely principally on the insurer’s prepared response to the regulator.

Second, unlike complaint investigators in the U.S., FOS adjudicators focus solely on resolving consumer complaints and have no regulatory authority. The FOS is formally independent from the British insurance regulator, the Financial Services Authority (FSA). As the FOS

199 See Interview with Melissa Colet, Ombudsman, Financial Ombudsman Bureau (January 8 & 9, 2008).
200 See id.
202 See ANNUAL REVIEW ‘08, supra note 181, at 43.
203 See id. The FOS terms this process “guided conciliation.” See FINANCIAL OMBUDSMAN SERVICE, ANNUAL REVIEW (2002-03), Chief Ombudsman’s Report, available at http://www.financial-ombudsman.org.uk/publications/annual-reviews.htm. The adjudicator will often first contact the party against whom it is inclined to decide to explain his or her initial take on the case and determine that party’s willingness to accept it. See James & Morris, supra note 14, at 179-80. In cases of resistance, the adjudicator may take more formal measures to mediate a resolution, often writing an adjudicator’s report that lays out his or her views of the proper resolution and is sent to both parties. See id.
204 See SAMUEL, supra note 186; Walter Merricks, Chief Ombudsman, Financial Ombudsman Service, Is the Ombudsman Fair and Reasonable?, Speech at the Financial Services Authority as part of the Canary Wharf Lecture Series, (October 28, 2004) (hereinafter “Merricks Speech”) (explaining that the FOS “resolves disputes by examining written materials submitted to us” and the “firm should send us the fruits of its own investigations, with its files and the reason it rejected the complaint.”).
205 See TAN 85-86.
206 See James & Morris, supra note 14, at 173-74. The FSA regulates all financial services in the UK, including insurance. While the FOS is primarily retrospective in its orientation, focusing on resolving individual disputes that have already occurred, the FSA is primarily prospective in its outlook, focusing on prospective issues, such as market stability, conduct, and structure. See Memorandum of Understanding between the Financial Ombudsman Service and the Financial Services Authority, available at http://www.fsa.gov.uk/pubs/mou/fsafos.pdf (hereinafter “Memorandum of Understanding”). Financial Ombudsman Service, Annual Review, supra, 42-45. However, the FSA does retain some control over the FOS. For instance, it approves its budget and nominates some of its Board members. See James & Morris, supra note 14, at 173-74.
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has put it: “we make decisions in one-off cases... we do not carry out regulatory functions.” Of course, these dividing lines are far from crisp, and the FSA and FOS must consequently coordinate with one another and share information and resources. For instance, the FOS provides the FSA with its data, which the FSA uses to help guide its market conduct analysis. It also recently committed to making firm-specific outcome data publicly available, as do American insurance regulators. Similarly, when adjudicators encounter potential regulatory issues, they can formally refer them to the FSA for investigation. Not only does the FOS assist the FSA in its regulatory function, but the FSA also assists the FOS in dealing with cases that have “wider implications” for the industry.

Finally, unlike American regulators, who have no formal criteria for determining how complaints that do not raise regulatory issues ought to be resolved, adjudicators evaluate complaints in written letters that are based on a “fair and reasonable” standard. Although, the standard is broad and flexible – requiring adjudicators to determine, based on consumer expectations and industry practice, a fair and reasonable resolution of the complaint – it is often quite specific in practice. In fact, specific sub-

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208 See generally Gilad, Exchange Without Capture, supra note 178 (exploring the practical difficulties that the FOS encounters in attempting to confine its role dispute resolution rather than regulation).

209 See Memorandum of Understanding, supra note 206.


211 See Memorandum of Understanding, supra note 206.

212 The details of this exchange are described in a dedicated website, www.wider-implications.info, that the FOS and FSA jointly maintain. Under the Wider Implications Process, any interested party, including the FOS, the firm, or the FSA can argue that a particular case at the FOS, or issue that the FOS deals with, involves wider implications. Id. The relevant criteria for assessing whether to invoke this process includes whether it affects a large number of consumers or businesses, the financial integrity of a business, interpretation of FSA rules or a common practice by businesses. Id. When a case is deemed to involve wider implications, the FOS has discretion to develop a consistent approach to relevant cases while the FSA addresses the issue. Id.

213 See James & Morris, supra note 14, at 184-88.

214 See, e.g., Adjudicator Nigel Pope’s letter to Teresa Fritz, (12/8/06) (describing specific procedure for handling Mortgage Endowment complaints, and noting where it is available online). As Rawlings and Willet describe, this basic principle has been employed to form more specific precedents. For instance, insurers are liable for misstatements by their agent and are responsible for asking for material information. See Rawlings & Willet, supra note 171, at 312-14. Much like certain versions of the reasonable expectations doctrine, the standard thus serves as a broad goal upon which more specific, and rule-like standards are constructed. See Schwarcz, supra note 9, at 1427-30; Kenneth S. Abraham, The Expectations Principle as a Regulative Ideal, 5 Conn. Ins. L.J. 59, 61-62 (1998). Indeed, Rawlings and Willet describe the fair and reasonable standard as a way of ensuring that the outcome should match the “responsibility which the consumer – with no knowledge of insurance law – might reasonably anticipate the insurer would bear.” See supra, at 313.
rules of the standard are available to adjudicators through an extensive set of online materials, including a knowledge toolkit which provides detailed information on the various topics of complaints with links to ombudsman decisions (described later). While these rules are not “binding” on adjudicators, adjudicators in practice rely on these materials in seeking to mediate appropriate resolutions of disputes.

Adjudicator evaluations of a case generally describe the background facts, reference relevant rules or procedures, and justify their view of the case based on factors such as policy language, industry standards, and the consumer’s reasonable expectations. All factual disputes are resolved based on “the balance of the probabilities” in light of the available evidence. Importantly, adjudicators do not merely attempt to convince parties to accept their written evaluation of a case: their efforts to mediate settlements are much more fluid, and often involve phone conversations, initial letters setting out their preliminary view of a case, and efforts to convince either party to accept various different concessions.

4. Stage Four: Ombudsman Review

If either party is unwilling to settle a case voluntarily at the adjudicator stage, then the case proceeds to ombudsman review. Ombudsman review strongly resembles appraisal and external review, the prominent forms of state-facilitated arbitration in the U.S. Most notably, ombudsmen are legally empowered to bind insurers to pay consumers up to £100,000. As in both external review and most versions of appraisal, consumers can opt out of the ADR process after a dispute arises and sue their insurer. Finally, like external review and appraisal (as well as the

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215 See interview with Simon Coe, Service Manager of the Assessment Unit, Financial Ombudsman Service (1/9/08).
216 See Rawlings & Willet, supra note 171, at 313; Gilad, Accountability or Expectations Management?, supra note 171, at 241-42.
217 See, e.g., Adjudicator Decision in Graham’s Complaint about Abbey National (4/2/07); Anonymous Adjudicator Decision (3/2/07); Anonymous Adjudicator Decision (8/16/07) (on file with author).
219 See generally Gilad, Acceptability or Expectations Management?, supra note 171; Interview with Ray Neighbor, Service Review Manager, Financial Ombudsman Service; 2008 ANNUAL REVIEW, supra note 181, at 42.
220 See Part II.B., supra.
221 See James & Morris, supra note 14, at 189. Insurers enjoy a limited right of appeal to the courts when an ombudsman rules against them. See id. at 175. In certain cases, the FOS has the power to terminate a case that it decides is more appropriately dealt with in the courts. Rules on Dispute Resolution 3.3.1.(10), in SOURCEBOOK, supra note 187. There are numerous reasons that the FOS can dismiss a complaint without consideration of the merits, including belief that (1) a claim of fraud (which is hard to adjudicate on paper), (2) a novel legal issue, (3) matter involves reasonable application of commercial judgment, (4) no material loss. See id.
222 See Rules on Dispute Resolution 3.8.2,(2)-(4), in SOURCEBOOK, supra note 187.
earlier adjudicator stage), the ombudsman’s evaluation of the case is essentially inquisitorial rather than adversarial.223

As with the other FOS stages, however, the ombudsman review stage is distinctive from American versions of consumer insurance arbitration in several important respects.224 First, ombudsmen’s authority is asymmetric: ombudsmen are only empowered to bind insurers, but not consumers.225 In other words, consumers are free to sue their insurers for coverage regardless of the outcome of FOS review, whereas insurers are bound to adhere to an ombudsman decision. However, adverse ombudsman decisions are admissible in court against a consumer.226

Second, ombudsmen are public, high-ranking officials, whereas American arbitrators are private contractors.227 In that sense, ombudsmen are closer to administrative law judges than to arbitrators, even though they resolve disputes between private parties, rather than between individuals and the government. Unlike either administrative law judges or arbitrators, ombudsmen not only decide cases, but they also help to administer the FOS. In the latter capacity, they help train and monitor adjudicators, develop strategic plans for the FOS, and create policy for the organization.228

Third, ombudsmen base their decisions in individual cases predominantly on the paper materials that FOS adjudicators and call center employees compiled at earlier stages of the process. This record includes all papers relating to the case, such as the adjudicator’s analysis, the internal complaint, and any documents generated during the mediation process.229 Consequently, unlike any version of American arbitration, ombudsmen have full access to earlier efforts to mediate a solution to the parties’ dispute.230 By contrast, a fundamental tenet of mediation in most American contexts is that it is secretive, especially with respect to subsequent decision-makers.231

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223 See Ombudsman News, supra note 201.
224 Like Adjudicators, Ombudsmen do not perform a regulatory role and only refer matters to the FSA as a secondary portion of their job. See Memorandum of Understanding, supra note 206. This, however, is not a distinction between the Ombudsman review stage and arbitration, which is also non-regulatory in orientation.
225 See Ombudsman News, supra note 201.
226 Merricks Speech, supra note 204 (“[C]ourts are off-putting enough to most consumers – even if they do not have a reasoned rejection from the ombudsman of their complaint – that the judge would certainly see.”). See, e.g., Tonkin v. U.K. Ins., Ltd. [2006] EWHC (TCC) 1120, [134]-[145], [2006] 2 All E.R. (Comm.) 550 (summarizing and adopting as a “sensible” conclusion an adjudicator’s decision, after the insured chose not to accept the adjudicator’s decision at the FOS and sued in court).
227 See James & Morris, supra note 14, at 174-75.
229 See Colet Interview, supra note 199.
230 See id.
231 See Reuben, supra note 156, at 1280.
Finally, like adjudicators, ombudsmen employ a “fair and reasonable” standard in evaluating cases and writing their decisions. This standard is defined by statute, and requires ombudsmen to take into account “the relevant law, regulations, regulators’ rules and guidance, relevant codes of practice and, where appropriate, what he considers to have been good industry practice at the relevant time.” Although this standard does not require ombudsmen to adhere to the law, there are only a limited number of domains in which ombudsmen affirmatively depart from legal principles. When doing so, ombudsmen must correctly explain the law and their rationale for departing from it. Ombudsmen decisions resolve factual disputes based on “the balance of the probabilities” and are subject to narrow judicial review to determine whether they contain legal or procedural errors or are “perverse and irrational.” In a limited number of cases – including insurers’ allegations of consumer fraud and cases that raise difficult and novel legal questions – ombudsman may decline to consider the merits of a dispute because it is best suited for judicial resolution.

In practice, ombudsman decisions resemble adjudicators’ “views” and “evaluations” of the case. In part, this is because, as described earlier, adjudicators use ombudsman decisions when they are attempting to resolve cases. However, ombudsmen decisions do tend to be more legalistic than the materials produced by adjudicators, as most ombudsmen

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232 The Financial Services and Markets Act, § 228(2) (2000) provides that “in considering what is fair and reasonable… the ombudsman.

233 See Rawlings and Willett, supra note 171, at 312-14; Law Commission Report, supra note 239, at 70. The most notable examples where the FOS affirmatively departs from the law involves non-disclosure and misrepresentation. See id. at 65-66 (describing ways in which FOS departs from law). These departures are longstanding and reflect a near-consensus among British legal experts that certain substantive areas of insurance law are unreasonably harsh when applied in the consumer sphere. See id. at 71.

234 See R in re Heather Moor & Edgecomb, Ltd. v. Fin. Ombudsman Serv., Ltd. [2008] EWCA (Civ) 642, [49], [2008] All E.R. (D) 126 (“[an ombudsman] is free to depart from the relevant law, but if he does so he should say so in his decision and explain why.”).

235 See, e.g., Ombudsman Decision in Graham’s Complaint about Abbey National (4/2/07).

236 See R in re Green Denman & Co. v. Fin. Ombudsman Serv., Ltd. [2003] EWHC (Admin) 388, [60], [2003] All E.R. (D) 399 (“The [reviewing] court cannot quash a decision of an [ombudsman] . . . merely because it considers that a finding of fact by the [ombudsman] was incorrect, or because . . . the Court would have made a different assessment of the respective merits . . . .”); R in re IFG Fin. Serv., Ltd. v. Fin. Ombudsman Serv., Ltd. [2005] EWHC (Admin) 1153, [13], [2006] 1 B.C.L.C. 534 (“if [an ombudsman’s] decision as to what is fair and reasonable in all the circumstances of the case is perverse or irrational, that opinion, and any determination made pursuant to it, is liable to be set aside on conventional judicial review grounds.”) (emphasis added).

237 See Rules on Dispute Resolution 3.3, in SOURCEBOOK, supra note 187.

238 See, e.g., Ombudsman Decision in Graham’s Complaint about Abbey National (4/2/07); Anonymous Ombudsman Decision (3/2/07); Anonymous Ombudsman Decision (8/16/07) (on file with author).

have some legal training. 240 Ombudsman decisions are sent to both parties, and abbreviated, anonymous versions are published in a regular publication called “Ombudsman News.” 241

B. Comparing the US and British Approaches

1. The Similar Elements of Consumer Insurance ADR in Britain and America

Although there are significant distinctions between the British and American ADR schemes, their basic components are quite similar. In both systems, there are four potential types of publicly-facilitated ADR: internal negotiation, initial call center, mediation, and some version of arbitration. These stages are diagrammed below. In the UK, these stages are unified within a single umbrella organization, whereas they are more dispersed within the U.S. Indeed, the arbitration stage of “Appraisal/External Review” is unrelated to the first three stages and only available for a small subset of issues. These distinctions resurface later, but for now, the basic point is that each of the FOS’s constituent elements has a direct analog in most U.S. state systems.

<table>
<thead>
<tr>
<th>ADR Structure (Figure A)</th>
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<tr>
<td><strong>FOS</strong></td>
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<tr>
<td>Internal complaints prerequisite to FOS review</td>
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<tr>
<td>Call center receives complaint</td>
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<tr>
<td>Adjudicators attempt to mediate resolution of case</td>
</tr>
<tr>
<td>Review by ombudsmen, who are public employees</td>
</tr>
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Not only are the basic elements of the FOS and American schemes similar, but so too are a number of other features of the ADR process, which are summarized graphically in Figure B. First, both the FOS and many American schemes allow consumers to choose between the available ADR options and litigation after a dispute arises. In America, such ex post consumer opt-out is common in both external review and appraisal as well as other consumer insurance arbitration schemes, such as those involving no-fault and Delaware’s arbitration program. 242 It is also a centerpiece of the Interstate Insurance Compact, as well as proposed federal legislation on

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240 See James, supra note 13, at 209 (describing “the dominance of the legal profession amongst those appointed to the post of ombudsman”).

241 See James, supra note 13, at 209. See, e.g., http://www.financial-ombudsman.org.uk/publications/ombudsman.htm (website with latest ombudsman news, which describes various cases that the FOS resolved). Prior to 1991, the IOB annual reports articulated general principles to serve as guidance to the insurance community. See Gilad, Exchange Without Capture, supra note 178, at 6-8. This created some tensions, as it appeared to move the IOB closer to a regulator than a body for resolving consumer disputes. In response, the IOB moved to simply publishing anonymous summaries of cases. See id.

242 See Part II.B, supra.
consumer arbitration provisions. This structure serves as a consumer safeguard, ensuring that consumers will not be made worse off by the ADR process than they are without it.

Second, in each ADR mechanism, the process is inquisitorial and relatively informal. Recall that, like the FOS, both regulator-facilitated mediation and the two forms of state-facilitated insurance arbitration are fundamentally inquisitorial, with the neutral third party scrutinizing the merits of the dispute in ways that are not confined to the arguments that each party raised. As above, this structure is a crucial feature in making ADR truly accessible to uninformed consumers, who generally will have little sense of how to frame or substantiate their complaint.

Finally, both the FOS and most American consumer insurance ADR mechanisms are free, or quite inexpensive, for consumers and are predominantly funded by insurers. In many ways, the $800 case fee that British insurers pay to the FOS is comparable to the costs that insurers face when a consumer invokes external review: in both cases, the insurer directly funds the ADR process regardless of the ultimate outcome of the dispute. As above, this significantly increases the accessibility of insurance ADR, especially given that aggrieved insurance consumers will tend to be resource-constrained.

<table>
<thead>
<tr>
<th>Other ADR Features (Figure B)</th>
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<tr>
<td><strong>FOS</strong></td>
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<tr>
<td>Consumer opt-out</td>
</tr>
<tr>
<td>Service is free</td>
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<tr>
<td>Inquisitorial, paper based process</td>
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</table>

243 See Note 151.
244 Many American academics have endorsed this proposal. See BRUNET ET AL., supra note 115, at 182-83. Unlike consumers, insurers can not opt-out after a dispute arises in any of these schemes. This makes sense: not only would such an opt-out undermine any authority of the ADR mechanism, but insurers are less in need of such protection, as ADR generally poses less risk for repeat players. Some have argued against post-dispute consumer opt-out, observing that consumers who have strong cases will choose not to pursue arbitration. See Estreicher, supra note 152, at 567-68. This may be less of a problem in the insurance context, given the significant discount rate of policyholders and their risk aversion. See Part I.B., supra. Moreover, this result would be no worse than the status quo.
245 See Part II, supra.
247 Regulatory complaint handling is free for consumers in all states, and the same is generally true of External Review. However, consumers must generally pay the costs of their own appointed appraiser in appraisal. See TAN 123, 136.
248 See Part I.B, supra.
While there are also some striking distinctions between the FOS and American consumer insurance ADR, even these are less significant than they initially appear. Most notably, the asymmetric authority of the FOS – which allows policyholders to litigate a case even if an ombudsman rules against them249 – is perhaps the most “radical” element of the FOS process for Americans. This consumer protection device is designed to ensure consumers that they will not lose anything by seeking FOS review. But, in practice, this protection is largely illusory in the UK, as consumers virtually never invoke their “litigation option.”250 There are a variety of reasons for this fact. First, punitive damages are much less common in Britain than in America and have historically been unavailable in breach of contract cases.251 Consequently, it is much more difficult to find British attorneys who will take cases on a contingency fee basis. Second, Britain’s loser pays fee shifting rule enhances the riskiness of litigation for consumers, who will need to pay for their opponent’s fees if they lose.252 Third, the British courts have historically been quite anti-consumer in insurance contexts.253 Finally, and most significantly, consumers’ supposed right to litigate even if an ombudsman rules against them is significantly undermined by the fact that the ombudsman’s adverse decision is generally admissible in court against the consumer.254

2. The Different Results of Consumer Insurance ADR in Britain and America

The individual pieces of the FOS process therefore resemble our own internal complaint, mediation, and arbitration procedures for consumer insurance disputes. This sub-section shows that, despite these similarities, the FOS has enjoyed far greater success than the American ADR schemes. In fact, the FOS performs remarkably well along each of the dimensions in which American ADR schemes falter.

First, the FOS has had dramatically more success than American regulators in quickly mediating voluntary resolutions to insurance disputes. Recall that American regulators successfully convince insurers to voluntarily compromise in less than half of all confirmed consumer complaints.255 By contrast, the FOS convinces parties to voluntarily settle their insurance disputes, without seeking ombudsman review,

249 See TAN 225.
250 Merricks Speech, supra note 204 (“[F]ew commentators suggest that consumers should be bound by the ombudsman – perhaps for the reason that very few of the consumers whose cases we reject then exercise their right to take their dispute to court”). But cf. Ombudsman News, supra note 201 (stating that a fundamental principle of the FOS is that “consumers should not lose their legal rights by complaining to the ombudsman”).
253 See Law Commission Report, supra note 239, at 65-66; Rawlings and Willett, supra note 171, at 314 (describing “the unfair nature of insurance contract law”).
254 See TAN 226.
255 See TAN 95-99.
approximately 94% of the time. Of course, these percentages are not directly comparable. First, the FOS settlement figure reflects the voluntary resolution of all complaints, which favor consumers in 1/3 to 1/2 all insurance cases, depending on the relevant line of insurance. By contrast, the state figure reflects only insurers’ willingness to voluntary compromise in the face of “confirmed complaints” where the regulator has “upheld the consumer position.” It may be easier, or harder, for the FOS to convince losing consumers to voluntarily settle than it is for regulators to convince insurers to compromise. Second, the methodology for generating these two figures differs. Nonetheless, the gap in settlement rates is at least a rough reflection of the relative effectiveness of the two different mediation programs.

Second, the FOS better maintains neutrality than American ADR schemes, even though its jurisdiction is not limited to cases in which this neutrality is easiest to ensure. The best evidence of this neutrality is the support that the FOS enjoys from competing constituencies. Insurers, voluntarily created the FOS’s predecessor almost three decades ago, and their enthusiasm for it has not waned in the interim: A 2007 survey, conducted by the British Insurance Association, reported that 88% of British insurers are “satisfied with [their] overall relationship with the FOS,” 87% believe the roles of the FOS and FSA are “reasonably clear,” 94% support the use of the “fair and reasonable” standard, and 75% believe that the role of the FOS should not change dramatically.

Perhaps even more importantly this enthusiasm for the FOS is shared by consumers and consumer groups. Among consumers who complain to the FOS, 70% believe that the FOS “handle[s] complaints efficiently and professionally, and only 12% disagree. This positive

256 See Presentation of Simon Coe, Service Manager of the Assessment Unit at the Financial Ombudsman Service, January 10, 2008, pages 9, 14, 15 (on file with the author). 40% of insurance cases are assigned to an “assessment team” that resolves insurance cases voluntarily 96.2% of the time, whereas 60% of insurance cases are assigned to an “investigation team” that resolves insurance cases voluntarily 92.6% of the time. The resulting 94.01% settlement rate in insurance is almost identical to the larger voluntary settlement rate at the FOS. See Financial Ombudsman Service, Annual Review (2006-07), at 1, available at http://www.financial-ombudsman.org.uk/publications/annual-reviews.htm (reporting 94% settlement rate); 2008 Annual Review, supra note 181, at 1 (reporting 95% settlement rate).

257 See 2008 Annual Review, supra note 181, at 44.

258 Compare Complaint Study, supra note 64, with 2008 Annual Review, supra note 181, at 1.

259 In particular, whereas the success rate for FOS mediation is based simply on whether either party seeks ombudsmen review, the success rate for state regulators is based on examination of the individual “disposition codes” that regulators assign to complaints. Compare Complaint Study, supra note 64, with Annual Review, supra note 181, at 1.

260 See TAN 175-176.


262 Favorable consumer ratings of the FOS should not necessarily be equated with evidence of a well-functioning dispute resolution process. As Sharon Gilad has argued, much of what the FOS does is to “manage” consumers’ expectations and communicate with them in a way that engenders the complainant’s trust and satisfies their emotional needs. See generally Gilad, Acceptability or Expectations
impression of the FOS was held not only by consumers who felt they had “won” their complaint (with 86% reported that they were satisfied with the FOS), but also by those who believed they “lost” their complaint (48% of whom were satisfied with the FOS). One of the primary consumer rights groups in Britain, Which?, similarly promotes the FOS, noting that it “provides an effective alternative to the court system which levels the playing field between firms and consumers.” Another major consumer group, the National Consumer Council, opines that “the FOS does a good job under difficult circumstances” and makes its “services accessible to consumers.”

Finally, two independent assessments of the FOS found that the FOS provides a generally impartial process for evaluating consumer complaints. The first, conducted by the Personal Finance Research Centre at the University of Bristol, concluded that the FOS provides a “robust,” “fair,” “reasonable,” “flexible,” and “efficient” process for resolving consumer complaints. A more recent independent report struck a more critical tone, noting that the FOS “can seem intimidating and unwelcoming to the less educated” and that it is sometimes perceived to “make[] it up as it goes along.” Nonetheless, the report repeatedly lauds the FOS’s “independence from industry, regulators and consumer bodies” and the “impartial nature of its internal processes.”

In contrast to the FOS, each of the American schemes reviewed in Section II raise significant questions about third-party neutrality, with the concerns being so significant in the arbitration context that states generally refuse to promote arbitration outside of narrow factual disputes. The FOS, by contrast, succeeds in maintaining its neutrality, even though its jurisdiction extends to all types of insurance complaints (and beyond). Unlike neutrality-promoting procedural safeguards in arbitration, the FOS’s neutrality does not unduly sacrifice speed or efficiency: the FOS resolves over half of all disputes within three months.

Favorable consumer perceptions of the FOS may be driven more by this focus on effective communication with consumers than by the underlying quality of the dispute resolution process.

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263 2007 ANNUAL REVIEW, supra note 256, at 61.
267 Hunt Report, supra note 209, at 3-4.
268 Id. at 15, 21, 24, 27.
269 See Part II, supra.
270 See TAN 182.
271 See Estreicher, supra note 152, at 159.
272 See 2008 ANNUAL REVIEW, supra note 181, at 47. These numbers exclude “mortgage endowment cases,” which involve interest-only mortgages that are coupled with an endowment.
Finally, the FOS accomplishes this with roughly the same amount of resources that American insurance regulators devote to dispute resolution. For instance, the number of FOS employees who work on insurance disputes is quite similar to the number of American regulators who deal with insurance disputes. There are about 119 adjudicators who work on insurance matters and about six insurance ombudsmen.\textsuperscript{273} Approximately 100 additional FOS employees, such as call center staff and support staff, can be allocated to the insurance function of the FOS, resulting in a total of about 230 FOS insurance employees.\textsuperscript{274} By contrast, there were 1,723 total employees in state consumer affairs divisions in 2006, 540 of which were complaint investigators and 213 of which were supervisory staff.\textsuperscript{275} Of course, precise comparison of these figures is impossible. First, the two countries are different sizes: the US has about three times the total insurance premium income as the UK\textsuperscript{276} and about five times the total population of the UK.\textsuperscript{277} Second, American consumer affairs divisions perform regulatory functions in addition to complaint mediation.\textsuperscript{278} A rough, but generous, estimate is that consumer affairs divisions spend half of their time on regulatory activities that are separate from complaint processing and resolution.\textsuperscript{279} These two considerations suggest that direct comparison requires multiplying the number of FOS employees by anywhere from six to ten, resulting in an adjusted figure of anywhere between (roughly) 1380 FOS employees and 2300 FOS employees who work on insurance. This compares well to the 1,723 regulatory complaint handlers in the US, especially as the US estimate does not include resources that are devoted to insurance arbitration, while the FOS figure does.

The caseloads of FOS and American complaint handlers are also roughly comparable to one another. Insurance adjudicator caseloads are approximately 160-200 cases a year.\textsuperscript{280} By contrast, American regulators reported that complaint investigators have caseloads of about 400-600 on policy to which payments are made. See Financial Services Authority, \textit{How Mortgage Endowments Work}, available at http://www.moneymadeclear.fsa.gov.uk/news/product/endowments/how_mortgage_endowments_work.html. Such endowments have not been used in U.S. markets.\textsuperscript{273} See Presentation of Simon Coe, Service Manager of the Assessment Unit at the Financial Ombudsman Service, 9, 14, 15 (January 10, 2008) (on file with the author).\textsuperscript{274} The FOS has about 1000 employees, and its insurance caseload is about 17-22\% of its total cases, see TAN 181-183, resulting in somewhere between 170 and 220 FOS employees that can be roughly allocated to the insurance function of the FOS.\textsuperscript{275} \textsc{resource manual}, supra note 64, at 11.\textsuperscript{276} Association of British Insurers, \textit{UK Insurance – Key Facts} (2006), available at http://www.abi.org.uk/BookShop/ResearchReports/UK%20Insurance%20-%20Key%20Facts%202007.pdf.\textsuperscript{277} See United States Census Bureau, International Database, available at http://www.census.gov/ ipc/www/idb/summaries.html.\textsuperscript{278} See Part II, supra.\textsuperscript{279} Half of responding insurance departments reported that the primary purpose of their Consumer Affairs Divisions is to “assist consumers in a time of crisis” rather than to “investigate violations of the law.” See note 70.\textsuperscript{280} See Coe Presentation, supra note 273, at 9, 14, 15.
average.\textsuperscript{281} This discrepancy, while significant, is less than it may initially appear. First, a higher percentage of consumer calls to American regulators, as opposed to the FOS, are mere “inquiries” as opposed to “complaints” and, for that reason, are relatively less time intensive.\textsuperscript{282} While adjudicator case figures do not reflect any inquiries (which are dealt with by the consumer call center), regulator caseload figures often do, as complaint investigators directly receive consumer calls in many states.\textsuperscript{283}

Part IV. Explaining the Comparative Success of the British Private Ombudsman Model

Part III raises a puzzle. Given that so many of the basic building blocks of the FOS resemble ADR schemes used in America, why is the FOS so much more successful than our own consumer insurance ADR? This Part proposes an answer to that puzzle that focuses on the comparative institutional architecture of the two ADR processes. The structure of the FOS, Part IV argues, blends elements of the uncoordinated insurance ADR schemes used in America, most notably regulator-facilitated mediation and arbitration. Other non-structural elements of the FOS facilitate the smooth operation of this conglomerate. As a result, even though the constituent elements of the FOS scheme only differ marginally from individual American ADR schemes, these pieces are combined within an institutional architecture that creates multiple synergies.

The FOS’s blending of ADR elements takes place along at least three dimensions. First, Section A argues that the FOS’s combination of the independent ADR processes – including insurer-policyholder negotiation, regulator-initiated mediation and state-regulated arbitration – into a single coordinated scheme facilitates an ADR process that is as broad and accessible as mediation, while remaining as effective and cost-efficient as state-regulated arbitration. It explores how the FOS’s ultimate authority to issue binding decisions has disproportionate “trickle down” effects that improve the efficacy of earlier, cheaper stages of the ADR process. Section B, in turn, contends that the public, but independent, status of the FOS blends private arbitration with the public facets of regulator-sponsored mediation. Once again, this unusual intermediate position helps the FOS to overcome the problems endemic to our ADR systems. The FOS’s public

\textsuperscript{281} See TAN 85.
\textsuperscript{282} American regulators receive almost 400,000 complaints and 2.5 million consumer inquiries a year, meaning that only 1 out of every 7.5 calls is a complaint rather than an inquiry. \textit{RESOURCE MANUAL}, supra note 64, at 11. The FOS handles about 94,000 to 163,000 insurance complaints and inquiries a year. Only about 16,000 to 27,000 insurance cases, or 1 in 6 consumer contacts, become formal “cases” that are reviewed by adjudicators. 2007 \textit{ANNUAL REVIEW}, supra note 256, at 1, 16; 2008 \textit{ANNUAL REVIEW}, supra note 181, at 1, 21. Although many calls do not become cases because they are inquiries, others do not become cases for other reasons: a consumer has not lodged an internal complaint, or the complaint can be resolved quickly. 2008 \textit{ANNUAL REVIEW}, supra note 181, at 13. But even if every call that did not become a complaint was an inquiry, this would still mean that 1 out of every 6 calls was a complaint rather than an inquiry.
\textsuperscript{283} See TAN 83.
and unitary status allows it to manage effectively the problem of decision-maker bias while its independence from the regulator counteracts the problems stemming from the dual identity of regulator-mediators. Finally, Section C explores how the FOS’s unique “reasonable fairness” standard blends formal doctrinal precedent with informal industry norms and equitable principles in a way that makes possible the FOS’s efficient operation.

A. The FOS’s Tiered ADR Structure and America’s Uncoordinated Design

A fundamental principle of effective dispute resolution design is that most disputes should be resolved by aligning the interests of the competing parties.\(^{284}\) Only when this proves impossible should disputes be decided based on which party is “right.”\(^{285}\) Finally, only in the remainder of cases, where both an interests-based and rights-based approach proves impossible, should the relative power of the parties dictate who prevails.\(^{286}\) The explanation for this tiered approach is simple: “in general, reconciling interests is less costly than determining who is right, which in turn is less costly than determining who is more powerful.”\(^{287}\)

The FOS employs this tiered approach for resolving consumer insurance disputes by combining the elements of the American ADR system – including negotiation, mediation and arbitration – into a single coordinated scheme. Each successive stage of the FOS process presents a new opportunity for policyholder complaints to be resolved in a way that is one degree further along the “interests-rights-power” spectrum. For instance, strictly requiring that consumers lodge their complaints with insurers prior to initiating a complaint with the FOS\(^{288}\) helps to ensure that all complaints that are susceptible to voluntary settlements are resolved in that fashion. Similarly, funneling all cases through the adjudicator/mediation stage before the ombudsman/arbitration stage\(^{289}\) helps ensure that only the cases where the parties’ interests are least aligned – where a party is unwilling to forego even a small probability of winning the case, despite the associated costs – end up reaching the ombudsman stage.\(^{290}\) Finally, a tiny minority of cases – those presenting novel legal issues or factual issues beyond the capacity of the FOS to assess – are left

\(^{285}\) Id.
\(^{286}\) Id.
\(^{287}\) Id.
\(^{288}\) See TAN 184-190.
\(^{289}\) See TAN 198-216.
\(^{290}\) This happens most often with cases that raise systemic issues. See Sharon Gilad, Juggling Conflicting Demands: The Case of the UK Financial Ombudsman Service, J. PUB. ADMIN. RESEARCH & THEORY 7 (2008) (“High ratios of firms’ appeals for an ombudsman’s review were typically associated with the FOS’s handling of new influxes of complaints of a systemic nature.”).
unresolved by the rights-based ombudsman approach, subject to the power struggle of litigation.\textsuperscript{291}

This ADR structure is an important, if unremarkable, feature of the FOS. What is remarkable, however, is the way that the FOS implements this tiered approach to ADR resolution. The FOS process is structured so that the authority that exists later in the process, during the right-based ombudsman/arbitration stage, exerts significant pressure on the earlier stages. Consequently, many disputes that would not ordinarily be resolved through a relatively cheap, interests-based, form of ADR, such as negotiation or mediation, are indeed resolved in the FOS’s version of that process, based simply on the prospect of later stages. The result of this trickle-down effect of ombudsman authority is that, at each of the FOS’s stages, a significant majority of disputes – between 80 and 95% – are resolved.\textsuperscript{292} The authority that exists at the end of the FOS structure is thus a central ingredient to the organization’s success because it enhances the effectiveness of each of the earlier stages. The FOS’s creative use of this authority allows it to transcend the trade-off between accessibility and affordability, on the one hand, and effectiveness, on the other, which seems embedded in American ADR approaches to consumer insurance.

This Section teases these ideas out with respect to each stage of the FOS process. It shows how the coordination of the individual ADR approaches significantly enhances the effectiveness of the relatively cheap stages, and contrasts that effectiveness with the largely uncoordinated, though similar, ADR stages in America. Because the FOS’s coordination operates by allowing later, more expensive ADR stages to influence earlier, faster and cheaper stages, the analysis below proceeds in reverse, with the later links in the FOS chain coming first.

1. \textit{The FOS’s Use of Med-Arb: the Success of Adjudication as a function of the Ombudsman Stage}

The FOS combines the interests-oriented approach of regulator-mediators and the authority-based approach of arbitrators in a way that allows it to be roughly as cost efficient and accessible as the former while remaining as effective as the latter. As Part III makes clear, FOS adjudicators are roughly comparable to regulatory complaint investigators and have similar (though perhaps slightly lighter) caseloads.\textsuperscript{293} Yet they convince parties voluntarily to resolve their insurance disputes about 95% of the time, compared to the roughly 50% success rate of American regulators.\textsuperscript{294}

\textsuperscript{291} See TAN 237.
\textsuperscript{292} See infra.
\textsuperscript{293} See TAN 198-203, 280-283.
\textsuperscript{294} See TAN 255-259.
This effectiveness in mediating settlements at the adjudicator stage is vital to the FOS’s success. Not only is mediation likely to result in the mutual satisfaction of the parties, but it involves comparatively low transaction costs. For the FOS, this means that the vast majority of cases that are handled by adjudicators never reach ombudsmen and are resolved relatively quickly – usually within three months. Given that ombudsmen must be significantly more experienced than adjudicators (after all, they have significant legal authority), and that speedy payments are a key concern for policyholders, this fact is a key ingredient to the entire FOS scheme.

The primary reason why FOS adjudicators enjoy such a higher settlement rate than their American counterparts is that their mediation efforts are linked to the subsequent ombudsman stage, the FOS’s version of arbitration. This link exists on several independent levels. First, adjudicators’ decision-making strongly resembles ombudsman decision-making, as adjudicators are trained by ombudsmen, seek advice from ombudsmen on individual cases, learn from ombudsmen over time, and use ombudsman decisions to help mediate their own cases. Because ombudsmen have the dual roles of deciding individual cases and training and advising adjudicators, they also help to shape an institutional culture that impacts the decision-making heuristics and instincts of individual adjudicators. The link has real results: as the FOS explains, “our adjudicator will have seen many very similar cases before – and will have a very good idea of how the ombudsman would be likely to view your case.”

This link in the decision-making processes of adjudicator/mediators and ombudsmen/arbitrators significantly enhances the effectiveness of mediation. Insurers and consumers are generally willing to accept adjudicators’ decisions precisely because appealing to the ombudsman will not typically change the outcome, but will result in increased delay, costs and stress to both parties. Insurers, of course, learn this fact from experience. And adjudicators communicate this link in decision-making processes to consumers as well: they inform consumers that adjudicator’s decisions are highly predictive of ombudsmen’s decisions and explain the rationale for the decision based on FOS source materials.
A second link between adjudicator/mediators and ombudsmen/arbitrators is that both are part of a structure that has the authority to bind insurers. Even if ombudsmen frequently overturned adjudicators’ decisions, the mere fact that adjudicators are part of an organization that can definitively resolve consumer complaints (at least those under £100,000) affords them significantly more credibility than their American counterparts, regulator-mediators. This is particularly true with respect to consumers. A large body of work in psychology shows that when individuals perceive a dispute resolution process to be procedurally fair, they are more likely to accept the results and, correspondingly, less likely to appeal those decisions. Disputants are more likely to view ADR processes as procedurally fair when they have a chance to participate personally in the process and communicate with the decision-maker. Because adjudicators are part of an organization with the authority to resolve consumer disputes, complainants often feel that they have this “voice” in the ADR process once a complaint goes through the adjudicator stage.

The third, and final, link between the adjudication and ombudsman stages of the FOS process is that ombudsmen have access to all papers relating to a case, including materials generated during the earlier mediation process. Insurers must often explain in writing why they are seeking such review, which further aides this process. Especially for insurers, who are repeat players, ombudsmen can use this information to assess whether parties are seeking ombudsman review because they have legitimate disagreements with adjudicators, or whether they are simply doing so as a matter of course. In the latter situation, the ombudsman can refer the firm to the Financial Services Authority (FSA) for regulatory violations. Perhaps more importantly, such firms will inevitably develop a reputation within the FOS that may well affect how future cases are handled.

provide any further evidence or arguments, an ombudsman’s decision is unlikely to differ from what I have said above.”).

303 See Neighbour interview, supra note 219.
305 Lind & Tyler, supra note 304, at 100-05.
306 See generally Gilad, Acceptability or Expectations Management?, supra note 171, at 232-35 (detailing the various strategies of the FOS in attempting to satisfy the emotional needs of complainants, and thus convince them not to appeal to an ombudsman). One way that FOS adjudicators seek to give complainants voice, and thus avoid an appeal to an ombudsman, is by “quoting an approximation of the complaint’s statements on the complaint form.” Id. at 235.
307 See Colet Interview, supra note 199.
308 See id.
309 See id. at 13-14 (noting that the FOS followed through on such threats).
Ultimately, then, the ombudsman/arbitration stage of the FOS significantly influences the earlier adjudicator/mediation process even though, as is usually the case, neither party ever invokes it. In this way, FOS adjudicators are cloaked with quasi-authority because of the links between their mediation/evaluation and the authority of ombudsman to render decisions that are binding on insurers. Adjudicators’ quasi-authority not only enhances settlement, but it also improves consumer confidence in the insurance industry by giving consumers a relatively accessible and independent option for determining whether their insurer has treated them fairly. To be sure, this quasi-authority has its costs. Most notably, it allows adjudicators to discourage consumers from seeking ombudsman review even when the adjudicator is wrong about the underlying merits of the case. This may create its own repeat-player advantage for insurers, who are comparatively well-equipped to assess the relative quality of an individual adjudicator’s decision.

This quasi-authority of FOS adjudicators is a striking contrast with regulator-initiated mediation in America, where the mediation process is generally completely untethered from any rights-based adjudication that can bind either party. Unlike FOS officials, American regulatory mediators must generally rely entirely on aligning the parties’ interests in order to convince them to resolve a case voluntarily. But most significant insurance coverage disputes are zero-sum games: the consumer’s primary interest is in the payment of the claim, while the insurer’s primary interest is in not paying the claim. Moreover, the insurer will often have very little interest in preserving the relationship, as the insured’s loss (as well as her willingness to complain) provides prima facie evidence that he or she is a “bad” risk. As the literature on ADR has long recognized, aligning the interests of such competing parties is generally quite difficult.

Admittedly, regulator-mediators may be able to align the interests of insurers and policyholders in ways that FOS adjudicators cannot by leveraging their regulatory authority to induce settlement. For instance, a

311 See Stempel, supra note 87, at 214 (arguing that mediation which is evaluative, and thus helps inform the parties of their background legal rights, is an important facet of mediation because it assures that mediated results do not depart too drastically from what the parties’ legal entitlements).

312 Ultimately, though, this problem is limited given how infrequently ombudsmen actually overturn adjudicators’ decisions.

313 See Part II.A, supra.

314 See URY ET. AL., supra note 284, at 16 (“In some disputes, the interests are so opposed that agreement is not possible.”); JOHN THIBAUT & LAURENS WALKER, PROCEDURAL JUSTICE: A PSYCHOLOGICAL ANALYSIS 8-15 (1975) (explaining that mediation is often impossible when the parties have “non-correspondent outcomes,” meaning that for one party to win, the other must lose).

315 Of course, there are other cases in which regulators can, and do, align the interests of consumers and insurers. This is particularly likely in small value cases or cases in which the reputational consequences to the insurer of denying coverage are significant. As Part I suggests, ordinarily the reputational impact of a claims denial will often be less for an insurer than the value of denying the claims. See TAN 26-30. But this is not always true. For instance, cases that attract significant media coverage may invert the ordinary calculus. This may well be why the success rate of insurance mediation in mass disasters is so high. See TAN 98-99.
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regulator-mediator might suggest that an insurers’ refusal to compromise may lead to heightened regulatory scrutiny in the future. Ultimately, though, the use of regulatory leverage to align interests is more likely to harm the bargaining dynamic than to help it because so few consumer complaints actually implicate regulatory issues. In 2007, complaint handlers referred only .4% of confirmed consumer complaints to their market conduct divisions, and in 2006 the percentage was even smaller. Complaint handlers’ implicit or explicit threats of such regulatory action are therefore unlikely to prove credible. In fact, they may be counterproductive: insurers facing threats of regulatory action may be less willing to compromise in response to a consumer complaint, fearing that such compromise may be used against them in a subsequent regulatory action.

2. The Call Center and the Case Fee

A second way that the FOS leverages the later, more involved ADR stages to facilitate early and efficient resolution of disputes is through the case fee that its call center levies. As described above, once a complaint is elevated to an adjudicator, the consumer’s insurer is charged a case fee of about $800. This structure not only provides the FOS with funding, but it allows call center employees to convince insurers to settle cases before the case fee is levied against them. It is therefore partly responsible for the significant percentage of calls that are “weeded out” at this stage of the FOS process: in most years, only one out of every six calls to the call center results in full-blown cases that reach an adjudicator. This narrowing of calls that turn into cases not only promotes early-stage resolution of disputes, but it avoids the direct involvement of both ombudsmen and adjudicators. Moreover, it contributes to the comparatively low caseload of adjudicators.

As with the adjudicator stage, early dispute resolution by the call center uses the later, more expensive stages of the tiered FOS process to facilitate early resolution of cases. Because the FOS conducts both early- and late-stage tiers of the ADR process, the call center mediators can leverage the expense that exists later on in ways that would otherwise be impossible – they can control the imposition of associated fees. Although regulator-mediators may ordinarily focus insurers on the potential costs of litigation, those costs are always hypothetical for the insurer because a failed

316 Such threats of future regulator action are described in Whitford and Kimball, supra note 60, at 665.
317 COMPLAINT STUDY, supra note 64.
318 See Gilad, Juggling Conflicting Demands, supra note 290, at 2 (“Firms resisted informal conciliation of complaints when concerned that their agreement to redress an individual complaint might be interpreted by the regulator or the media as entailing compensation awards to a large number of other customers in similar circumstances.”).
319 See TAN 196.
320 Id. at 1; 2007 ANNUAL REVIEW, supra note 256, at 1. There are a number of other reasons that calls are not elevated, including that no internal complaint was filed, the call was clearly not meritorious, or was merely an inquiry. 2008 ANNUAL REVIEW, supra note 181, at 13.
321 See TAN 280-283.
mediation may not necessarily result in litigation. By contrast, because FOS call center employees impose the $800 fee, they can guarantee reluctant insurers that failure to compromise will result in subsequent ADR costs. Like adjudicators, and unlike American regulator-mediators, FOS call center employees thus enjoy a quasi-authority in attempting to convince insurers to settle cases early.

In fact, the distinctions between the FOS and American schemes run even deeper. American insurers do indeed pay for the dispute resolution services of regulators, but they do so indirectly, through premium taxes. Because the amount of taxes that insurers owe is not influenced by how often their particular consumers complain to regulators, insurers have no incentive to use the common resource of regulator-facilitated mediation judiciously by resolving cases quickly. The FOS avoids this tragedy of the commons by forcing insurers to internalize the dispute resolution costs of FOS-provided mediation, in addition to the potential costs of litigation or arbitration. This provides British insurers with an incentive to avoid consumer complaints in the first place, and to settle those complaints quickly before the imposition of a case fee.

3. The Internal Complaint Process and Subsequent FOS Review

Finally, the various links between firms’ internal process of reviewing consumer complaints and subsequent FOS review once again uses the FOS’s tiered and interconnected design to promote cheap and effective dispute resolution. Recall that all consumer complaints must be lodged with the underlying firm before a consumer can initiate the FOS process. Firms are statutorily required to investigate and respond to internal complaints, and these responses form the basis of the FOS’s subsequent evaluation of the case. Informal estimates suggest that consumers who lodge internal complaints seek FOS assistance only about 2-10% of the time. This internal complaint resolution obviously reduces the number of complaints that reach the FOS, and may be one of the reasons why FOS adjudicators enjoy lighter caseloads than their American counterparts.

322 See generally Susan S. Silbey & Sally E. Merry, Mediator Settlement Strategies, 8 L. & POL’Y 7 (1986).
323 This pseudo-authority may be similar to the authority that Minnesota regulator-mediators possess by virtue of their capacity to link quick complaint resolution with public disclosure. See TAN 93.
324 Randall, supra note 110, 643 (explaining funding of state insurance departments).
325 See TAN 187.
326 This is true of review for both adjudicators and ombudsmen. See TAN 204-205, 228-231.
327 See Gilad, Juggling Conflicting Demands, supra note 290, at 5, fn 2 (noting that no formal statistic is available, but reporting her own estimate based on interviews with FOS employees); Merricks Speech, supra note 204 (“In most classes of business, one might hope that firms would resolve all but a tiny minority of complaints – leaving perhaps between 2% and 5% to be referred to the ombudsman.”). A comparative figure for American regulators is difficult to estimate, as internal complaints may not be recorded, aggrieved insurance consumers often pursue legal recourse without consulting regulators, and there are only sporadic requirements that insurers inform consumers about their right to complain.
328 See TAN 280-283.
Once again, the effectiveness of internal complaint handling in the UK is significantly enhanced by the FOS’s tiered ADR process. Because firms’ internal complaint files form the basis of subsequent FOS review of complainants’ cases, firms have a natural incentive to take this process seriously.329 First, a deficient internal complaint file will prejudice a firm’s case if it ends up at the FOS. Second, it may cause the FOS to refer the matter to the FSA for regulatory action and tarnish the firm’s larger reputation within the FOS.330 The FOS can promote effective regulation of the internal complaint handling process precisely because adjudicators and ombudsmen review these files in the ordinary course of resolving disputes.

Encouraging insurers more carefully to investigate and process consumer complaints has the potential to improve insurers’ resolution of consumer disputes. Insurers may incorrectly deny a claim and subsequently reject consumer complaints because they rely on a claims-handling bureaucracy whose members may be encouraged (directly or indirectly) to keep payments low and profit high.331 Even insurers who instill in their employees a culture of upholding claims in cases of doubt must nonetheless “proceed by routinizing and simplifying [the] inherently complex and difficult procedures” of claims handling.332 The UK’s experience suggests that forcing insurers to disentangle the jobs of claims handlers and complaint handlers could help to limit the prospect that an intransigent insurance claims bureaucracy would stand in the way of resolving legitimate consumer complaints.333

Of course, as described above, state regulators do make nominal efforts to link the internal complaint process and the regulatory complaint process: regulators often request that consumers first contact their insurer with complaints, and insurers are subject to some minimal regulation of their internal complaint handling process.334 But outside of the realm of health insurance, these links are too weak to create any real incentive for insurers to take internal complaint handling seriously because, unlike with the FOS, the results of that complaint handling are not generally incorporated into subsequent dispute resolution stages.335 Nor could they

329 See Interview with Adam Samuel, Complaint Handling Consultant (1/7/08).
330 See Samuel, supra note 186, at 676-77 (discussing fines for inappropriate complaint handling, but suggesting that the regulator has not be sufficiently aggressive on this front, as one firm was “notorious” for its complaint handling “for many years in Ombudsman circles which had repeatedly asked regulators to take action”).
331 See Baker, supra note 8, at 54-55, 106 (quoting Hayseeds Inv. V. State Farm Fire & Cas., 352 S.E.2d 73, 78-79 (W. Va. 1986)) (noting that “the vast majority of insurance cases are resolved by the insurance law of the insurance adjustor” and exploring the competitive pressures that may be placed on such adjustors).
332 H. Laurence Ross, Settled Out of Court 135 (1980).
333 See James, supra note 13, at 205-07 (Although the benefits of internal review are “not clear cut” because some firms have poor internal complaint mechanisms, in general “the development of internal procedures has been one of the additional benefits flowing from the ombudsman scheme” as “many complainants will have their complaint satisfactorily resolved internally”).
334 See Tan 77-81.
335 See generally Part II.A.
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be: insurers are free to ignore oral complaints, they need not provide written responses to any complaints, and they are permitted to respond to consumer complaints after the complaint has been lodged with the regulator.\footnote{See id.}

B. The Role of the Regulator and Private Parties in Dispute-Resolution

The second structural way in which the British scheme successfully melds the two ADR approaches used in America is by relying on a non-regulatory, but public organization to handle disputes. Unlike regulator-initiated mediation, which is conducted by regulatory employees, FOS complaint handlers are largely independent of the FSA, the British insurance regulator. At the same time, the FOS does not utilize private complaint handlers as in American insurance arbitration. Instead, the FOS is a unitary, public entity. The FOS’s organizational structure therefore straddles the two options that currently exist for the ADR of consumer insurance disputes in America. This intermediate position allows the FOS to take advantage of American ADR’s benefits while avoiding many of the associated pitfalls.

1. The FOS’s Independence from the Regulator

The FOS’s independence from the FSA has a number of important advantages that contribute to its success.\footnote{See TAN 206.} Most importantly, this separation enhances the FOS’s independence in evaluating consumer complaints. The primary tasks of regulators are to monitor insurers’ solvency, help insurers avoid systemic risk, and examine insurers’ market conduct for regulatory violations.\footnote{See generally ETTLINGER, supra note 35.} Each of these tasks requires affirmative engagement with the industry, meaning that regulators’ independence from the industry is often impossible, and perhaps even undesirable.\footnote{See Richard B. Stewart, The Reformation of Administrative Law, 88 Harv. L. Rev. 1669, 1684-87 (1975) (suggesting that capture often results from innocuous repeat interactions between regulators and the subjects of that regulation). Given the necessity of dialogue between industry and regulators and the simultaneous risk that that can lead to capture, some have argued that regulators who handle solvency and systemic risk concerns should be separated from those who deal with consumer protection issues. See Adam J. Levitin, Hydraulic Regulation: Regulating Markets Upstream, working paper (August 2008) (“The safety-and-soundness mission is incompatible with consumer protection because practices that might be profitable and thus increase banks’ safety-and-soundness might also be abusive and unfair to consumers.”); Elizabeth Warren & Oren Bar-Gill, Making Credit Safer, 157 U. Penn. L. Rev. (forthcoming); Heidi Mandanis Schooner, Consuming Debt: Structuring the Federal Response to Abuses in Consumer Credit, 18 Loyola Consumer L. Rev. 43, 48 (2005).}

By contrast, housing complaint handlers in their own organizational setting allows for the development of a culture of independence. First, it facilitates the ability of lead officials to promote such a culture internally,
because of the organization’s unity of purpose.\textsuperscript{340} The internal development of this message would be difficult in a regulatory context, given that the central goal of regulators is to preserve stability and consumer confidence in the underlying industry.\textsuperscript{341} Second, a complaint organization’s lack of regulatory authority allows its employees to clearly articulate their role to consumers, insurers and other stakeholders. Indeed, FOS communications to consumers repeatedly explain that the purpose of the FOS is simply to resolve disputes fairly, and not to punish wrongdoers.\textsuperscript{342} Over time, this message tends to become a self-fulfilling prophecy, with the organization embracing the culture of independence that it espouses to outsiders.\textsuperscript{343}

This culture of independence makes complaint handling organizations such as the FOS unlikely to fall prey to some of the problems that plague American regulator-mediators. For instance, faced with resource constraints, the FOS seeks to streamline its dispute resolution process rather than to set it aside completely (as do some regulators).\textsuperscript{344} This might entail standardizing the resolution of certain types of complaints or encouraging firms’ cooperation by assuring confidentiality and that cooperation will not be used to support regulatory action.\textsuperscript{345} Similarly, because the message of independence and fairness defines the FOS, it goes to great length to avoid “deselection” of cases based on non-neutral principles that may occur in American regulator-mediation.\textsuperscript{346}

The FOS’s independence from the regulator also facilitates the industry’s willingness to cooperate by decreasing insurers’ fear that settling individual cases will trigger enhanced regulatory scrutiny. Although the FOS reports patterns of complaints or complaints raising systemic issues to the regulator,\textsuperscript{347} it is “not in the business of shopping [firms] to the regulator for minor things,” and will tend to refer only “matter[s] that instinctively call[] for . . . regulatory intervention.”\textsuperscript{348} The resulting separation of the FOS and FSA reportedly facilitates insurers’ willingness

\begin{thebibliography}{99}
\item \textsuperscript{340} Merricks Interview, supra note 246 (opining that the FOS is able to instill in its employees an ethos of resolving cases fairly and independently because that is its central mission).
\item \textsuperscript{341} See James & Morris, supra note 14, at 174 (“[T]oo intimate a relationship with the regulator can raise questions about the genuine independence of the ombudsman.”); James, supra note 13, at 220-21 (describing how “the ombudsman’s independence may be compromised by, for example, subtle and unacknowledged pressure from . . . those within the industry concerned” and suggesting that this may happen when ombudsman are selected by “a regulatory body closely linked with the industry”); Fritz Interview, supra note 264 (suggesting that the FOS can maintain its neutrality because, unlike the FSA, it does not affirmatively scrutinize market actors and is merely responsive to consumer contacts).
\item \textsuperscript{342} See sources cited in 235.
\item \textsuperscript{343} See Gilad, Exchange Without Capture, supra note 178, at 2 (arguing that the FOS’s frequent emphasis on the individualized and case-specific nature of its work, which was designed to avoid being perceived as a regulator, created a self-reinforcing trend).
\item \textsuperscript{344} See TAN 100-109.
\item \textsuperscript{345} See Gilad, Juggling Conflicting Demands, supra note 290, at 19.
\item \textsuperscript{346} Compare TAN 110-113, with Gilad, Juggling Conflicting Demands, supra note 290, at 19 (explaining that the FOS was motivated to avoid inconsistency in its decision making, especially as firms would often track FOS decisions in order to detect potential inconsistencies).
\item \textsuperscript{347} See TAN 211.
\item \textsuperscript{348} Gilad, Juggling Conflicting Demands, supra note 290, at 13 (quoting FOS executive).
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to compromise, by mitigating insurers’ perception that any concession or error could be used against them in subsequent regulatory actions. By contrast, it is possible that insurers in America are hesitant to settle individual cases through regulatory-facilitated mediation because they fear that admitting a mistake will make them “look bad” to their regulator.

To be sure, there are a number of potentially significant drawbacks to disaggregating complaint-handling and regulation. Perhaps the most significant such cost is that regulators and complaint handlers may develop conflicting views, leading to uncertainty in the industry. Indeed, empirical research suggests that the FOS and FSA do not always coordinate well and that the FOS is often subject to industry criticisms that it is acting as a regulator rather than an adjudicator. While a number of formal channels exist to address these issues, these channels are imperfect. Ultimately, though, the conflicts that stem from disentangling the jobs of complaint handlers and regulators can be managed because the roles of regulators and complaint handlers are fundamentally different. Regulators attempt to avoid abstract problems in the future while complaint handlers attempt to resolve specific problems in the past. Indeed, the fact that insurance regulators handle consumer complaints is attributable largely to historical accident as opposed to thoughtful institutional design.

2. The FOS as a Public Entity

Despite its formal separation from the regulator, the British scheme does not utilize individual, private complaint handlers as in American arbitration. The FOS is a unitary public entity and, as with regulators, it is operated entirely by public employees. This structure helps avoid a number of well-known pitfalls from privatizing ADR of consumer disputes.

First, as discussed earlier, arbitrators may tend to favor repeat players such as insurance companies because they depend on them for business and develop relationships with them over time. A unified public

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349 See Interview with Harriet Quiney, Partner, Fishburns Solicitors, (1/10/08) (opining that big firms would worry more about resolving cases if the FOS were a branch of the regulator, as they would be cautious about revealing facts that might prejudice them, even if they did not implicate regulatory issues); Interview with Linda Smith, Policy Team Manager, Association of Independent Financial Advisors, (1/11/08) (suggesting that the FOS’s independence from the regulator limits insurers’ perception that any concession or error could be used against them in subsequent regulatory actions).

350 See TAN 318.

351 See Gilad, Exchange Without Capture, supra note 178, at 11 (describing “firms’ allegations that the ombudsman was inappropriately assuming the role of the regulator.”)

352 See TAN 207-212.

353 See Whitford & Kimball, supra note 60, at 661-67.

354 The idea of publicly provided ADR was first promoted by Frank Sander. See THE POUND CONFERENCE: PERSPECTIVES ON JUSTICE IN THE FUTURE (A. Levin & R. Wheeler eds. 1979); Judith Resnik, Failing Faith, Adjudicatory Procedure in Decline, 53 U. CHI. L. REV. 494, 516 (1986). Sander’s call for a “multi-door courthouse” largely envisioned the judiciary providing this ADR role, however. See id. By contrast, the FOS is independent from the British judiciary.

355 See TAN 155.
body such as the FOS can monitor the independence of its employees to prevent this repeat player advantage. Indeed, the FOS goes to great lengths to assure the independence of individual adjudicators and ombudsman: case files are randomly checked each month by a quality assurance team; ombudsman directly review adjudicator case files in the course of their own review; and adjudicator’s decision patterns are tracked to identify statistical anomalies. Where consumers believe that an adjudicator or ombudsman is biased, they can lodge a complaint with an “independent assessor,” who considers the propriety of the employee’s behavior (but not the merits of the underlying complaint), and, where appropriate, orders the FOS to pay redress. Moreover, because the individual adjudicators and ombudsmen who deal with a case are not chosen by either party and no competing private entities provide this service, there is no opportunity for repeat players to select sympathetic decision-makers. This system of internal checks on employees’ behavior is far superior, and easier to implement, than the regulation of independent, autonomous, private arbitrators.

The FOS’s public status also allows it to identify and address complaints that raise broad regulatory issues. One of the major criticisms of insurance arbitration in the U.S is that it prevents relevant information from entering the public domain and being acted on appropriately by regulators. A unitary public entity such as the FOS cannot only identify regulatory issues much better than independent arbitrators, but it can coordinate with the regulator to handle these situations cooperatively. Of course, the transmission of this information may be imperfect, as individual adjudicators may have an incentive to refrain from referring firms to the regulator in order to increase insurers’ willingness to compromise in individual cases. For this reason, FOS employees may be less willing to refer firms to the FSA than American regulator-mediators are to refer an insurer to their market-conduct division. But this difference is unlikely to be significant, and appears to strike an effective balance of facilitating regulation and promoting compromise.

Finally, a unitary, a public complaint-handling entity provides greater transparency than a system of private adjudicators. Private decision-makers will inevitably use different and potentially conflicting approaches for resolving cases, which can indirectly exacerbate the repeat player advantage. By contrast, a unitary, public entity can more easily

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356 See Neighbour interview, supra note 219; Gilad, Accountability or Expectations Management?, supra note 171, at 244 (“Managers conducted an intensive random quality assurance review of adjudicators’ decisions...”).
357 2008 ANNUAL REVIEW, supra note 181, at 74-78.
358 See TAN 160 (noting limitations of monitoring and regulating private decision makers for neutrality). Cf. Stempel, supra note 163, at 251-56 (advocating for regulation and licensing of arbitrators).
359 See TAN 155.
360 See Memorandum of Understanding, supra note 206; TAN 206.
361 See Gilad, Juggling Conflicting Demands, supra note 290, at 12-13 (finding mixed evidence of such negotiations).
362 See TAN 164.
assure consistency through internal monitoring, communication among
decision-makers, and dissemination of decision-making criteria, as
described below.363

C. The Reasonable Fairness Standard

A final way that the FOS scheme blends elements of ADR
approaches used in America is through its decision-making criteria of
“reasonable fairness.” In certain ways, the reasonable fairness standard
resembles ordinary law: its content is developed in publicly-available
ombudsmen decisions that develop over time and are subject to limited
judicial review.364 In other ways, though, the “reasonable fairness”
standard more closely resembles broad equitable principles that tend to
inform mediation and arbitration: it is flexible, focuses on fairness, and
does not constitute binding precedent for future cases.365 This combination
once again harnesses many of the benefits of these two alternative decision-
making criteria in a way that facilitates the FOS’s operation.

The legalistic characteristics of the fair and reasonable standard
help mitigate some of the most vexing problems of consumer ADR in
America. First, the publication of ombudsmen decisions explaining and
applying the fair and reasonable standard366 enhances the consistency of
FOS decision-making in the same way as legal precedent: by providing a
baseline against which future cases should be compared. This helps to
offset both the “deselection” that can occur in regulator-mediation and the
alleged “lawlessness” of insurance arbitration.367 It also limits the repeat
player advantage of insurers, who tend to benefit from inconsistency, which
allows more room for them to “game the system.”368 Publication of
ombudsmen decisions also provides guidance to the industry about its
practices.369 Finally, it ensures that the content of the fair and reasonable
standard is subject to public scrutiny and accountability.370

Second, the legalistic structure and content of ombudsmen decisions
applying the fair and reasonable standard also helps to harness many of the
benefits of judicial precedent. Ombudsman decisions must demonstrate
awareness of the law and use analogical reasoning to apply or distinguish

363 Gilad, Juggling Conflicting Demands, supra note 290, at 11-12 (describing each of these
efforts at coordinated decision-making and the way in which multiple FOS stakeholders monitor
adherence to such consistent decision-making).
365 See id.
366 See TAN 241.
367 See TAN 110-113, 155.
368 See TAN 155.
369 A recent survey of British Insurers found that “one half [of respondents] think anticipation of
FOS rulings impacts upon business decisions.” Survey of Members’ Experiences, supra note
261; James, supra note 13, at 216 (“Decisions made in individual cases may provide an informal
body of case law which can affect the way in which those within an industry formulate policy and
design procedures”).
370 See Ombudsman News Website, supra note 241.
previous ombudsman decisions. As with judicial precedent, this process facilitates consistency over time and across cases, but can nonetheless evolve over time to address novel situations. It also produces decisions that reflect the collective views of multiple experts, which are generally much wiser than any individual expert’s analysis. Finally, it constrains the authority of ombudsmen by forcing them to articulate their decisions in written form based on pre-defined rules.

At the same time, the non-legalistic elements of the reasonable fairness standard provide the FOS with important benefits that would be undercut by the use of a strictly legalistic standard. Most significantly, it allows FOS adjudicators, who are generally not legally trained, reliably to employ this standard in resolving disputes. It does so by providing a vehicle through which ombudsmen essentially “translate” legal principles into a relatively simple set of rules that can be implemented by non-lawyers. In that sense, it is similar to the rules of thumb that insurance adjustors use to settle cases. The non-precedential nature of the standard also facilitates its use by adjudicators who are not legally trained: because prior ombudsman decisions are not binding precedent, adjudicators’ letters do not need to rigorously compare cases to previous decisions in a way that a strictly legal process would demand.

Part V. From Theory to Reality: Towards a Private Insurance Ombudsman for the US

The FOS’s success suggests several straight-forward reforms that could easily be accommodated within America’s existing consumer insurance ADR structures. For instance, state insurance departments could be authorized to collect case fees. Arbitrators’ decisions could be

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371 See Financial Services and Markets Act, § 228(2) (2000); JAMES, supra note 13, at 216.
375 See Merricks interview, supra note 246 (explaining that adjudicators do not need to be lawyers apply the fair and reasonable standard accurately).
376 See Gilad, Accountability or Expectations Management?, supra note 171, at 241-42 (“Interviewees maintained that complaints were usually straightforward from a professional stance, involving simple and recurrent issues.”)
377 See ROSS, supra note 332 (describing how vague standards such as negligence are translated into concrete rules of thumb in insurance companies in order to manage the volume of claims that claims handlers must deal with).
378 See TAN 319-324. State legislation could easily permit insurance departments to collect individual case fees from insurers for resolving their customers’ complaints. Armed with this authority, insurance departments that have a two-stage mediation process – wherein initial calls are answered by one employee, and subsequent mediation efforts are taken up by a second employee, see TAN 83 – could make payment of the case fee contingent on the insurer’s refusal to settle at the first mediation stage. In fact, such a scheme would simply be one variation on Minnesota’s procedure of excluding from insurers’ complaint ratio disputes that insurers quickly resolve. See TAN 93.
published and publicly disseminated. And insurers’ internal complaint handling rules could be strengthened.

To be sure, each of these incremental reforms would probably help to improve consumer insurance ADR in America. But simply cherry-picking individual elements of the FOS scheme that can easily be mimicked within our own institutional framework misses the larger lesson that the FOS presents for reform. No single policy or practice accounts for a significant percentage of the FOS’s success. Rather, it is the FOS’s institutional architecture that explains the stark discrepancies in outcomes between the US and UK systems for resolving consumer insurance disputes. This architecture coordinates the different stages of ADR and leverages the FOS’s ultimate authority in order to promote settlement at each of the earlier stages. It also ensures the FOS’s neutrality, while promoting dialogue and communication with regulators, industry and consumers.

Indeed, many of the non-structural reforms noted above contribute to the FOS’s success precisely because they support and compliment the organization’s institutional structure. For instance, the rules governing insurers’ internal complaint handling promote early settlement in the UK because of the way they fit within the larger FOS framework. Because the FOS regularly reviews internal complaint files in the course of resolving disputes, and its employees are part of a unified organization with authority to resolve disputes against the insurer, most firms take the rules governing internal complaint handling seriously. Similarly, the publication of ombudsman decisions certainly helps to promote a coherent, and consistent, standard of review. But part of this success is attributable to the fact that ombudsman are part of a single organization that actively monitors itself for consistency and fairness, and that promotes a larger institutional culture that reflects these values.

Although the FOS may offer few “quick-fix” policy reforms, the big-picture structural lessons that it does offer are less daunting than they may initially appear. Because so many of the constitutive elements of the FOS resemble ADR approaches that are already used in American insurance contexts, implementing an American scheme based on the FOS

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379 Lawmakers could follow the FOS and require that insurance arbitrators publish their decisions and make those decisions available to regulators. As noted earlier, arbitrators in other fields, such as labor and employment, already publish their decisions as a matter of course. See TAN 156. In fact, California already requires arbitrators in medical service agreements to issue a written decision that must be provided to the insurance department and made publicly available upon request. See CAL. HEALTH & SAFETY CODE § 1373.21 (2005).

380 State regulators could easily improve the rules governing insurers’ internal complaint handling. See TAN 78-81. They could expand the definition of a complaint and require insurers to provide written explanations to such complaints within a specified time period. These responses could then automatically form the basis of any subsequent mediation by the regulator. See TAN 184-190.

381 See supra, Part IV.A.

382 See supra, Parts IV.B-C.

383 See TAN 325-336.

384 See TAN 303-310.
would merely involve rearranging existing ADR pieces rather than funding and developing those pieces out of whole cloth. For instance, an interested jurisdiction could begin simply by removing the consumer affairs division from its insurance regulator and hiring several attorneys or insurance experts who might otherwise be arbitrators. Some of the legal infrastructure for this new entity could be borrowed from the rules that already govern external review and appraisal. These might include regulations governing internal review of complaints, when parties must submit documents for review, and when (and if) they can request a hearing. Of course, these sources might provide limited guidance in a few areas, and here policymakers could easily turn to the provisions of the Financial Services Markets Act that created the FOS in 2000.

American jurisdictions could adopt these basic elements of the FOS scheme without embracing its most politically untenable elements. For instance, an American scheme could employ an ombudsman/arbitration stage that was binding on both consumers and insurers. As discussed earlier, such an approach might well be necessary given the differences in the background insurance law regimes of the UK and US. For instance, the potential of punitive damages in the US could cause successful applicants to an American ombudsman to try their luck in litigation, leading to duplicative resources being devoted to the dispute resolution process.

The legal obstacles to such reform would likely be minimal. The U.S. Constitution does not mandate any particular procedure for resolving disputes. So long as each party is afforded meaningful notice and opportunity to be heard, “a state may choose the remedy best adapted, in the legislative judgment, to protect the interests concerned.” For this reason, even a scheme that replicated the FOS’s asymmetric authority to bind insurers, but not policyholders, would likely survive challenge. Similarly, an FOS-like scheme would pose few state constitutional problems. Although the jury trial rights of state constitutions have proven to be a major obstacle to tort reform, they would not interfere with an FOS scheme. Consumers would face no deprivation of their jury trial right so long as they could opt for litigation after the dispute arose, as is the case

385 See TAN 250-254.
386 This would be an extreme form of the problem with consumer opt out identified by Estreicher and others. See note 244.
388 The asymmetry would not pose any obvious Due Process concerns, as both insurers and consumers retain a meaningful right to be heard. See George Rutherglen, Better Late than Never: Notice and Opt Out at the Settlement Stage of Class Actions, 71 N.Y.U. L. REV. 258 (1996) (no Due Process challenge was ever levied against the old “one-way intervention” class action procedure, wherein class members could “benefit from a favorable judgment but escape the preclusive effect of an unfavorable judgment”).
with the FOS. Insurers would similarly have no viable jury trial claim. Because they are "affected with a public interest," insurers are routinely subject to regulation that might otherwise impair constitutional rights. Just as insurers do not suffer an unconstitutional taking when their rates are regulated, they would not be deprived of their jury trial right by regulation of their claims dispute resolution process.

A much more significant obstacle to reform based on the FOS model is political. As Howell Jackson has demonstrated, some of the political differences between America and the UK help to explain why the UK was so much more successful than America in radically modernizing financial regulation in the late 1990s. One might similarly argue that the political distinctions between the UK and America—particularly the power of lobbying interests such as the insurance industry—makes an FOS-like scheme politically infeasible. Although the political obstacles to such a scheme may well be significant, there is nonetheless reason to believe that such a scheme could well prove politically viable.

First, and most importantly, because the states regulate insurance, only a single state must be convinced to embrace an FOS-like scheme. Once a state implemented such a scheme, others could observe the results and adopt it if it proved successful. Moreover, an FOS-like scheme could also be offered at the federal level, where many lawmakers and policy experts are already attempting to build an insurance regulator from the ground up. In a climate wherein a new insurance regulator is being designed from scratch, the idea of supplementing the regulator with an FOS-like scheme could prove politically viable because it would have no impact on entrenched agencies or procedures.

Second, the British experience suggests that the insurance industry—the most significant potential opponent of an FOS-like scheme—could be convinced to endorse an FOS scheme. Indeed, British insurers overwhelmingly support the scheme as a valuable mechanism for enhancing

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390 A fundamental element of the right to a jury trial is that it can be waived. A post-dispute opt-out may not even be necessary to accomplish waiver. Some courts have held that consumers can waive their jury trial rights voluntarily simply by signing an insurance policy, rejecting "contract of adhesion" arguments. See, e.g., Meyer v. State Farm Fire & Casualty Co., 582 A.2d 275 (1990). As argued above, though, consumer opt-out is essential for consumer protection reasons. See TAN 242-244.


392 See German, 233 U.S. at 389.

393 See Jackson, supra note 172, at 41-42 ("[T]he highly decentralized structure of traditional financial regulation in the United States creates numerous constituencies inclined to resist any efforts to make major changes in regulatory structures.").

394 See TAN 5.

395 Compare Jackson, supra note 172, at 41-42 ("[s]uggests that entrenched agency powers were a significant impediment to more substantial financial reform in the late 1990s, whereas the British avoided this infighting in the design of the FSA by providing "guaranteed continuity of employment for all regulatory personnel over the course of the consolidation process").
consumer confidence in the industry. “The industry perceives that the FOS plays a key role in providing consumers with a complaints resolution service that is free to the consumer, easy to understand and non-legalistic in its approach. This helps underpin consumer confidence in financial services and avoids lengthy courts processes that would add to our costs.” Part of the reason is that FOS helps to “manage the public’s unrealistic and irrational expectations” of coverage by “communicating adverse decisions to complainants in a sensitive and persuasive manner” that emphasizes its “independence from firms.”

Finally, the evolution of the FOS in the UK demonstrates that legislative mandate is not the only way in which such a scheme could develop. Rather, it was the insurance industry in the UK that forged the private ombudsman scheme. Accounts of insurers’ motivations for doing so differ. But at least one contributing factor seems to have been the prospect of legislative action if the industry did not itself act. American lawmakers could similarly design inducements, both positive and negative, to encourage insurers to cooperatively design their own FOS-type scheme. Alternatively, because a private scheme would have some drawbacks, lawmakers could also experiment with trying to induce insurers to voluntarily comply with a public FOS scheme. In either case, lawmakers might, for instance, consider allowing insurers to avoid bad faith claims as an inducement to action. States without bad faith schemes could do the opposite, threatening to adopt such a scheme in the absence of an FOS-like approach. In the end, the potential that more effective ADR could both mitigate litigation costs and buttress consumer confidence makes the prospect of such reform more realistic than it might initially appear.

Ultimately, it is true that the FOS is a product of a unique British history and culture. For that reason, its success may not be easily replicated in America. For instance, it may be that its origins as a voluntary scheme among insurers imbued it with a credibility that is entirely path dependent and that cannot be replicated here. Alternatively, one might argue that U.K. citizens and businesses are simply more amenable to government intervention in their daily lives, as evidenced by their government-run health care system. But the sheer scope of the FOS’s success – both across all consumer financial services in the UK and across geographic regions ranging from Japan, India, and much of Europe – minimizes these

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396 See TAN 259-261.
397 See Survey of Members’ Experience, supra note 261.
398 See Gilad, Acceptability or Expectations Management?, supra note 171, at 30. Complaint handlers accomplish this not only by focusing on their independence, but also making written communications clear, grammatically correct, informal and friendly, and reflect an understanding of the basis for the complaint. See id.
399 See generally Tyldesley, supra note 15 (reviewing history of initial insurance ombudsman bureau).
400 See id.
401 Another option is that lawmakers could require insurers who reject the recommendations of complaint handlers, to (i) fund a set amount of attorneys’ fees upfront in such cases, and/or (ii) provide subsistence payments to policyholders during the course of any such litigation.
objections. At the very least, it provides a sufficient case for state experimentation with an American insurance ombudsman modeled on the FOS.

If such a scheme were successful, the implications would be significant for consumer financial law more generally. As in the UK, the private ombudsman model could grow beyond insurance, representing a new way for resolving virtually all consumer financial disputes. Indeed, as in insurance, the basic infrastructure for a private ombudsman scheme already exists in the banking and securities realms. The Office of the Comptroller of the Currency has a Customer Assistance Group that largely mirrors state insurance regulators in terms of the complaint mediation services it provides.402 The Securities & Exchange Commission similarly provides limited consumer complaint services to investors via its Office of Investor Education and Advocacy.403 Many of the lessons that the FOS offers for insurance are therefore likely to be applicable to a wide range of consumer financial disputes.