Consumer Complaint Investigation

Consumer Complaint Investigation Section

The Consumer Complaint Section investigates property, casualty, life, and health complaints made by policyholders, claimants, beneficiaries, and providers of health care services. In FY 2000 and 2001, the Section handled approximately 25,000 complaints each year. The Section is divided into three divisions. The Appeals & Grievance Division investigates whether a particular healthcare service is medically necessary. The Life & Health Division resolves complaints involving claims payment and determinations as to whether a particular service is covered under the terms of the insured's contract. The Property & Casualty Division investigates automobile, homeowner and other complaints regarding property and casualty insurance policies. In addition to taking action on individual complaints, business practices discovered during the complaint process may lead to market conduct examinations.

In May, 2001, the Complaint Section began sending surveys to all consumers along with closing letters where the Administration had jurisdiction over the complaint. The survey includes questions to determine how the consumer learned of the Administration and whether they were satisfied with the complaint process.

From May, 2001 through June 30, 2001 2,302 surveys were mailed. The Administration has received 480 responses. Consumers indicated they learned about the Administration in a variety of ways but most frequently either through their health care provider, their insurance agent or insurance carrier.

The majority of the consumers were either satisfied or very satisfied with the process. This holds true even for those consumers who did not have the case decided in their favor. Also, overwhelmingly consumers have indicated that they would use the process again.

Appeals and Grievance Division

The Appeals and Grievance Law passed by the General Assembly in 1998 established a procedure for consumers to appeal decisions made by health maintenance organizations (HMO's), insurers and nonprofit health service plans (also referred to as "Carriers" or "health plans") that a covered health service is not "medically necessary." The law took effect January 1, 1999, and was codified at §15-10A et seq. of the Insurance Article. One key component of the legislation is a consumer's right to internal and external review where care is denied on the grounds that it is not "medically necessary."

In most cases, a consumer must exhaust the internal grievance procedure of the relevant health insurer before the Administration can conduct an independent review of the denial. The Appeals & Grievance Law created specific standards and time frames to which health insurers must adhere in operating their internal grievance processes. In addition, the Appeals & Grievance Law provided the Insurance Administration with the necessary tools, such as the ability to enter into contracts with independent review organizations (IROs), to enable it to independently review denials by health insurers that are based on an alleged lack of medical necessity.

A comprehensive report is prepared in accordance with §15-10A-06 of the Insurance Article for each calendar year. This report provides a detailed analysis of the complaints handled by the Administration as well as the data reported by the carriers concerning the cases.

In FY2000, the Appeals & Grievance Division received 1582 complaints. In FY 2001 the Appeals and Grievance Division received 1380 complaints

The statutory authority for the Commissioner to enforce the Appeals & Grievance law is found in § 15-10A et al, §15-10B et al, §4-113, and §27-303. These provisions allow the Commissioner to require the payment of medically necessary services. In addition, the Commissioner may fine Carriers for 1) failure to authorize medically necessary treatment; 2) sending an adverse or grievance decision letter which did not comply with the law; 3) failure to timely authorize medically necessary services; and 4) failure to have the appropriate physician conduct the utilization review.

During FY 2000, the Administration issued 66 Orders and entered 5 Consent Orders based on the complaints which it received. During FY 2001, the Administration issued 43 Orders and entered 23 Consent Orders based on the complaints which it received.

A detailed explanation of all Orders is included in the *Insurance*

Regulator found on the MIA website, *www.mdinsurance.state.md.us* The Orders issued have required coverage of various services including residential treatment for minors; durable medical equipment; coverage of inpatient hospital days; coverage of emergency room visits; bilateral breast reduction; finding that treatment was not experimental; coverage of various prescriptions, coverage of dental procedures.

Appeal and Grievance Statistics
Totals for Complaints Filed
July 1, 1999 - June 30, 2000

COMPLAINTS FILED **1582**

NO JURISDICTION		**506**
Referred to DOL (*ERISA)*	**234**	
Referred to OPM *(FEHBP)*	**82**	
Referred to Medicaid	**73**	
Referred to Medicare	**75**	
Referred to Insurance Department in Another State	**31**	
Referred to Other*	**11**	

*Includes complaints referred to Workers Compensation Commission and Other State agencies

COMPLAINT WITHDRAWN	**41**
INSUFFICIENT INFORMATION	**88**
NO ADVERSE DECISION/OTHER	**372**
ADVERSE DECISION	**560**

-Referred to HEAU to Exhaust Internal Remedy	**281**
-MIA Conducted Investigation:	**279**
-Carrier Reversed Itself During Investigation	**149**
-Carrier Upheld by MIA	**65**
-Carrier Reversed by MIA	**54**
-Carrier Modified by MIA	**11**

Appeal and Grievance Statistics
Totals for Complaints Filed
July 1, 2000 - June 30, 2001

COMPLAINTS FILED **1380**

NO JURISDICTION		**460**
Referred to DOL (*ERISA)*	**228**	
Referred to OPM *(FEHBP)*	**58**	
Referred to Medicaid	**33**	
Referred to Medicare	**56**	
Referred to Insurance Department in Another State	**57**	
Referred to Other*	**28**	

*Includes complaints referred to Workers Compensation Commission and Other State agencies

COMPLAINT WITHDRAWN	**16**
INSUFFICIENT INFORMATION	**84**
NO ADVERSE DECISION/OTHER	**342**
ADVERSE DECISION	**478**

-Referred to HEAU to Exhaust Internal Remedy	**260**
-MIA Conducted Investigation:	**218**
-Carrier Reversed Itself During Investigation	**79**
-Carrier Upheld by MIA	**82**
-Carrier Reversed by MIA	**44**
-Carrier Modified by MIA	**13**

Life & Health Division

The Life & Health Division investigates complaints regarding premium problems, claims handling, coordination of benefits, and agent misrepresentations against health maintenance organizations, long-term care, dental care, and commercial life and health insurance companies.

During FY 2000, the Division received 10,185 complaints from citizens and providers of medical care. The majority of the complaints received during FY 2000 involved delay or denial of payment of claims. The Administration does not have jurisdiction to investigate self-funded employee benefit plans, Medicaid, Medicare, and Federal Employee Health Benefit plans as such. When complaints are received involving these issues, the complaint is referred to the proper agency. Through the successful conclusion of the complaints over which the Administration has jurisdiction, $ 1,900,087 was recovered for Maryland citizens in the form of claims payment or restitution. Also, 54 hearings were requested during FY 2000. Eighteen (18) Orders were issued against companies during FY 2000. The majority of these Orders were for violation of the prompt pay law (§ 15-1005 of the Insurance Article.) Two Consent Orders were issued during that time.

The Division concluded three special projects during fiscal year 2000. Full reports were written on each project. They include the following:

1. **Retro denials:** This project involved the investigation of approximately 700 claims where various providers had asserted that Mid-Atlantic Medical Services Inc. (MAMSI) violated §15-1008 of the Insurance Article by retroactively denying reimbursement of claims. Of the 700 claims submitted, 233 were adjudicated by the Administration. The remaining claims were excluded due to jurisdictional issues, failure of the providers to submit documentation or a determination that the claim did not involve any retroactive denial activity. A total of 22 violations of the Insurance Code were found. An Administrative penalty of $17,500 was imposed.

2. **MHA complaint:** The Maryland Hospital Association (MHA) alleged that BlueCross BlueShield of Maryland (BlueCross BlueShield) and Mid-Atlantic Medical Services (MAMSI) were denying payment for medically necessary services. In support of its contention, MHA submitted 106 individual patient specific complaints to the Administration for review. Of the 106 complaints submitted, 57 were adjudicated. The others were excluded due to jurisdictional issues, duplicate files, and recession by the complainant. The Administration

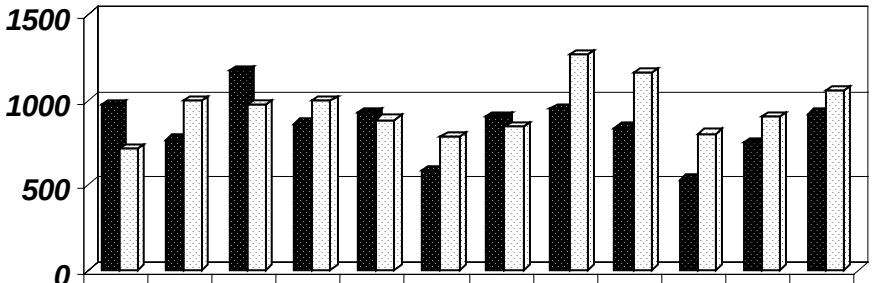
found that in 21 cases violations of the insurance laws had occurred. These findings resulted in the issuance of 20 Orders and administrative penalties totaling $20,000. Both carriers were required to pay for all medically necessary services.

3. **Emergency Room Doctors** This complaint involved the review of 833 claims filed by members of the American College of Emergency Physicians (ACEP). The complaint involved 23 carriers. The basis of the review was to determine whether carriers had inappropriately denied payment for Emergency Room services. Although the Administration found that the actions of the carriers did not constitute a violation of the prudent layperson statute in the Health-General Article, the Administration found that while the patient's condition may in fact have been an emergency, the diagnosis code used on the claim form was not sufficient to prove an emergent condition. Many claims were paid once additional documentation was provided. Based on this report, the Administration recommended clarification of the law to make clear what information should be submitted to receive payment. The Administration also began a series of target market conduct exams to monitor the carriers payment of the claims.

During Fiscal Year 2001, the Division received 7,756 complaints from citizens and providers of medical care. The majority of the complaints received during FY 2001 involved delay or denial of payment of claims. Through the successful conclusion of the complaints over which the Administration has jurisdiction, $2,181,167 was recovered for Maryland citizens in the form of claims payment or restitution. Also, 161 hearings were requested during FY 2001. Three Orders were issued against companies during FY 2001. Three Consent Orders were issued during that time.

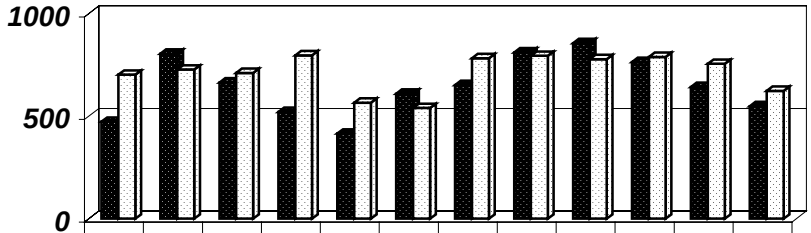
A detailed explanation of orders can be found in *The Regulator* on the MIA website, w*ww.mdinsurance.state.md.us.*

Life & Health
July 1999-June 2000



	Jul	Au	Se	Oct	No	De	Jan	Feb	Ma	Apr	Ma	Jun
Received	972	767	117	863	924	587	902	950	840	530	750	923
Closed	713	998	976	100	887	783	841	127	116	803	900	105

Life & Health
July 2000 - June 2001



	Jul	Au	Se	Oc	No	De	Ja	Fe	Ma	Ap	Ma	Ju
Received	473	804	664	520	415	609	651	810	856	764	642	548
Closed	702	727	711	796	566	540	782	794	778	789	755	623

Property & Casualty Division

Complainants request assistance from the Property & Casualty Division when their property and casualty policies are canceled or non-renewed, when their premiums are increased, or when their coverage is modified by the insurers in some manner. Most complainants request assistance during the claim settlement process, frequently inquiring whether there is coverage for the claim, or if the insurer has paid or denied the claim in an appropriate manner. The services provided by the Property & Casualty Division often result in the continuation of coverage, the return of premiums to insureds, or the settlement of claims.

In FY 2000, the Unit received 4,181 written and walk-in complaints that involved issues other than personal automobile liability cancellations, non-renewals, reductions in coverage and increases in premiums. As a result of processing the justified complaints, a total of $ 654,304 was recovered for Maryland residents from insurance companies, agents, and brokers.

Section 27-605 of the Insurance Article gives the citizens of the State of Maryland the right to protest the cancellation or non-renewal of an automobile insurance policy; a reduction in coverage under an automobile insurance policy; or an increase in a premium due to a surcharge under an automobile policy. In FY 2000, the Property & Casualty Division received 8,066 protests in accordance with §27-605 of the Insurance Article.

In those instances where an investigation results in the need for a hearing, the Division prepares the case for the hearing. In FY 2000, the Division prepared 484 cases for hearings; 302 hearing requests were as a result of personal automobile policy termination, while 182 hearing requests involved complaints other than personal automobile terminations.

In certain instances, the investigations indicate that further administrative action is warranted. In FY 2000, the Property & Casualty Division issued 32 Orders which required administrative penalties to be paid, claims to be settled and policies to be reinstated.

In FY 2001, the Unit received 4,196 written and walk-in complaints that involved issues other than personal automobile liability cancellations, non-renewals, reductions in coverage and increases in premiums. As a result of processing the justified complaints, a total of $ 1,271,962 was recovered for Maryland residents from insurance companies, agents, and brokers.

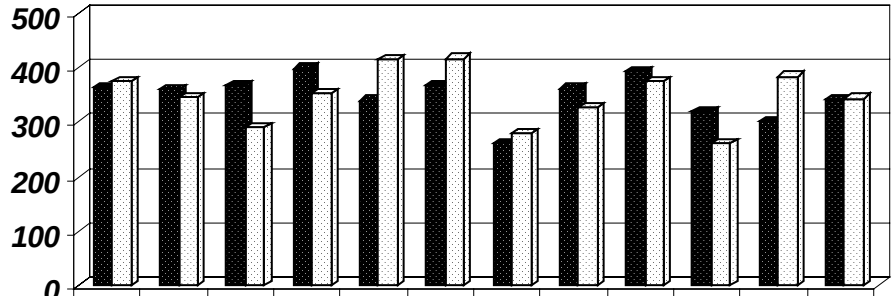
Section 27-605 of the Insurance Article gives the citizens of the State of Maryland the right to protest the cancellation or non-renewal of an automobile insurance policy; a reduction in coverage under an automobile insurance policy; or an increase in a premium due to a surcharge under an automobile policy. In FY 2001, the

Property & Casualty Division received 8,560 protests in accordance with §27-605 of the Insurance Article.

In those instances where an investigation results in the need for a hearing, the Division prepares the case for the hearing. In FY 2001, the Division prepared 551 cases for hearings; 347 hearing requests were as a result of personal automobile policy termination, while 204 hearing requests involved complaints other than personal automobile terminations.

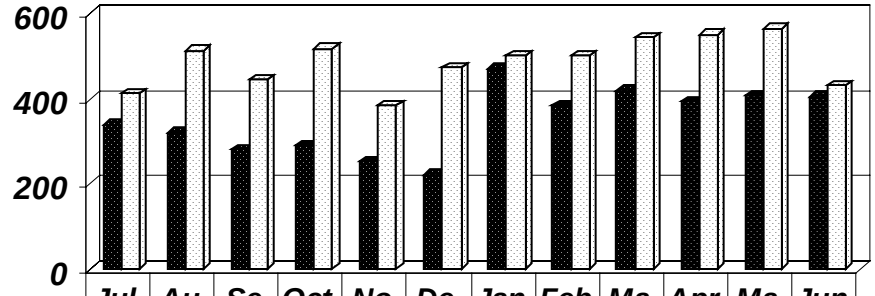
In certain instances, the investigations indicate that further administrative action is warranted. In FY 2001, the Property & Casualty Division issued 43 Orders which required administrative penalties to be paid, claims to be settled and policies to be reinstated.

Property & Casualty
July 1999 - June 2000



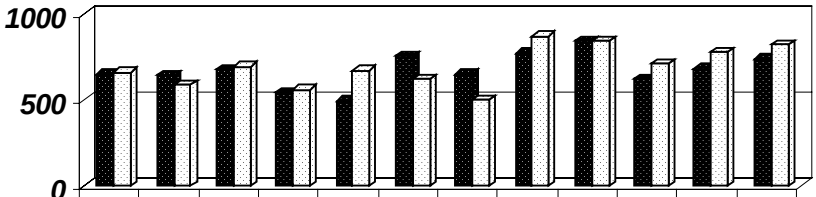
	Jul	Au	Sep	Oct	No	Dec	Jan	Feb	Mar	Apr	Ma	Jun
Received	365	360	367	399	341	368	262	363	393	319	302	342
Closed	375	345	291	353	416	418	280	327	375	261	384	344

Property & Casualty
July 2000 - June 2001



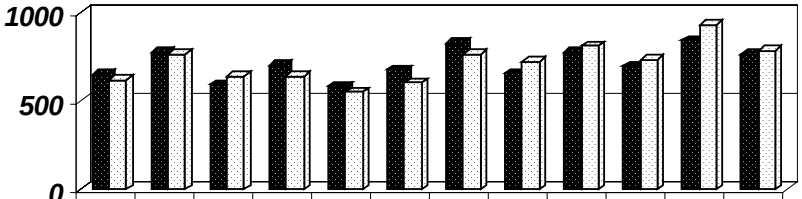
	Jul	Au	Se	Oct	No	De	Jan	Feb	Ma	Apr	Ma	Jun
Received	341	321	282	290	253	222	473	384	420	394	410	406
Closed	412	514	447	520	384	476	504	504	547	553	567	432

Property & Casualty 27-605
July 1999-June 2000



	Jul	Au	Se	Oct	No	De	Jan	Fe	Ma	Ap	Ma	Ju
Received	650	642	675	546	493	757	649	772	840	623	682	737
Closed	661	592	693	560	671	622	500	872	840	713	774	825

Property & Casualty 27-605
July 2000-June 2001



	Jul	Au	Se	Oct	No	De	Jan	Feb	Ma	Apr	Ma	Jun
Received	651	775	596	702	581	680	829	659	777	701	842	767
Closed	619	765	641	641	553	604	767	723	815	736	933	786