Consumer Complaints
White Paper

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NAIC
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Consumer Complaint White Paper

Introduction

The Consumer Complaint White Paper Working Group was appointed by the Market Conduct and Consumer Affairs (EX3) Subcommittee at the 1998 NAIC Spring National Meeting and given the following charge: Prepare a white paper regarding the handling of consumer complaints by insurance departments, including recommendations for features of an effective complaint handling process.

One of the primary missions of state insurance departments is to serve and protect the insurance consumer. A valuable service that state insurance departments provide to fulfill that mission is the handling of consumer complaints. The Consumer Services Division of a department serves as the frontline for consumer contact. The Consumer Services Division is often the initial and sometimes the only contact that a consumer has with a department of insurance. For this reason the methods and procedures used in complaint handling are important and deserve attention. In drafting this paper the working group surveyed the state insurance departments to determine complaint handling procedures and identify “best practices” for handling complaints. A variety of procedures were identified in the May 13, 1998 survey and are referenced throughout the paper. Examples of state specific procedures have been included when possible.

This paper provides an overview of the concepts, principles and procedures currently in use for resolution of consumer complaints. The procedures in place reflect the budgetary and legal constraints within each state. The paper is intended as a resource guide for regulators. By identifying “best practices” for complaint resolution the paper provides state insurance departments with options for effective complaint handling. It is not the intent of the paper to prescribe a single methodology or procedure, but to identify processes that have proven effective and to promote dialogue within the state insurance departments for improving service to the consumer.

Definition of a Complaint

Statutory Definition and Department Practices

For the purposes of this white paper a complaint is defined as any communication—written or oral—that expresses dissatisfaction with a specific insurance company or agent or other regulated entity. The survey of the state insurance departments asked “How do your state statutes, regulations or departmental practices define complaint?” Sixteen states indicated that their statute does not define the term complaint. Most state insurance departments define complaint as a written correspondence primarily expressing a grievance. This definition is derived from a statutory basis in some states and from departmental practices in other states. This is also the definition found in the NAIC’s Market Conduct Examiners Handbook and used by market conduct examiners in defining and tracking complaints during a company examination. Survey responses indicate that 22 states use this or a similar definition. However, an almost equal number of states, 19, indicated that by statute or internal procedure they define complaint as a written or oral expression of a grievance. A broad definition that includes both written and oral grievances is the best practice.

Distinguish Between Complaints and Inquiries

Whether written or oral, the distinction between complaints and inquiries centers on the expression of a grievance. Departments distinguish between complaints and inquiries and track both types of...
communication. A consumer expressing dissatisfaction regarding a state’s mandatory auto insurance laws is expressing a grievance that the department should record and track. However, such a grievance is not a complaint against a specific insurance entity and would not be included in complaint ratios. Likewise, a consumer inquiring about rates or coverage for a specific line of business should be classified as an inquiry rather than a consumer complaint. Departments serve as a resource for information and handle far more inquiries than complaints. For example, in 1998 Arkansas logged 23,695 telephone inquiries and 2,734 complaints. The Maryland Department of Insurance averages over 100,000 telephone inquiries per year and 20,000 written or oral complaints. North Carolina’s biennium report indicates 100,000 telephone inquiries and 10,000 written consumer complaints. In 1998, Missouri logged 70,488 inquiries and 5,272 complaints. The “expression of a grievance” is what distinguishes inquiries from complaints and is a key component of the definition of complaint.

Is a Statutory Violation Required?

The majority of states recognize and accept any consumer grievance as a complaint. In response to the state survey only 6 states indicated their statutes require that a complaint allege a statutory violation. It is the recommendation of the working group that the state insurance departments recognize that consumer complaints do not necessarily relate to statutory violations. For example, a consumer complaint may involve quality of service issues that are not addressed in a statute. Resolution of a consumer’s grievance is no less important simply because no statutory violation is alleged. State insurance departments should provide an avenue for resolution of all consumer complaints. Even in instances when the department lacks jurisdiction to address a consumer complaint, the department should provide information and brochures outlining the consumer rights and resources. Staffing and budgetary restrictions will affect the level of service a department can provide.

The following best practices may be of assistance to state insurance departments evaluating or enhancing their current complaint handling procedures.

- A complaint is defined as any communication—written or oral—that expresses dissatisfaction with a specific insurance company or agent or regulated entity.

- A statutory violation is not required for communication to be classified as a consumer complaint.

Receipt of Complaints

Written, Electronic, Verbal

Complaints should be accepted through any mode of communication and states are focusing on new methods to facilitate consumer access to the departments. Virtually all departments now have Web sites or home pages on the Internet. Thirty-five (35) of the 48 department Web sites provide a consumer complaint form on-line that can be downloaded, printed and mailed to the department. Seventeen of those departments will accept the completed form online or by email. Appendix A provides sample consumer complaint forms from state Web sites. Acceptance of a consumer complaint by email is consistent with the best practices for handling complaints.

Historically, the mail and telephone have been the most frequent means of complaint submission. In recent years, submission of complaints by fax became common. In response to the survey, all states indicated they accept complaints by mail and fax and 33 states indicated they routinely receive complaints by telephone. States are encouraged to provide consumers with access to toll-free numbers
for the departments and, where available, for insurers. The transcription of verbal complaints, either received by telephone or in person, is also encouraged. To assure that issues and facts are properly captured states should provide the transcribed complaint to the consumer for review and approval. At a minimum, a notation should indicate that the information was reported to the insurance department and transcribed by department staff.

State survey responses indicated that insurance departments currently receive complaints in several ways:

All states accept complaints by mail on a regular basis.

All states accept complaints by fax, although 12 states indicated that they “seldom” receive complaints in this manner.

Fourteen states regularly receive complaints by email, 29 states “seldom” receive complaints in this manner and six states never receive complaints by email.

Thirty-three states regularly receive complaints by telephone, 11 states seldom do and five states never do.

Signature Requirement

Consumer complaints should be accepted in any medium. However, since complaints will be accepted in a variety of mediums, not all complaints will include a signature. The lack of signature should not preclude the initial investigation of the complaint. In instances where it is determined that a signature is required, such as for a Release of Medical Records, a follow-up request for a signature can be initiated by the department.

As states expand their use of the Internet, procedures and regulations for the “electronic authentication” of complaints will be developed. An electronic signature is generally defined as a computer-generated electronic identifier intended to have the force and effect of a signature. Electronic authentication serves the same purpose as a “wet” signature. Technology for authenticating electronic signatures exists and state statutes are developing. In 1997 there were 18 state statutes addressing the regulation and acceptance of electronic signatures. As of this writing 28 states have statutes on the books. Most statutes provide that an electronic signature shall have the full force and effect of a manual signature in so far as it is unique to the signor, is verifiable and cannot reasonably be altered. State statutes are developing that will better address this issue.

In 1999 Congress drafted the Electronic Signatures in Global and National Commerce Act which allows private parties to reach agreements and engage in contracts using electronic signatures. The House passed its version of the legislation on November 9, 1999 and it is anticipated that differences between the House and Senate versions will be addressed in a conference committee. The legislation would establish the legal framework for authenticating signatures in electronic commerce and specifically includes the business of insurance. State laws that deny the legal effect of e-signatures would generally be preempted. Under the proposed legislation states would have four years to avoid preemption by enacting a model law called the Uniform Electronic Transactions Act (UETA) developed by the National Conference of Commissioners on Uniform State Laws. In December 1999, the NAIC approved a resolution encouraging state adoption of UETA to ensure that electronic commerce is treated in a fair and non-discriminatory manner. For purposes of consumer complaints, this means that consumers
should be able to utilize electronic commerce to file and communicate about complaints in the same manner as they currently use other modes of communication. States should review and update internal procedures to meet this goal.

Record Receipt of Complaint/Determine Jurisdiction

The first step upon receipt of a complaint should be to assess whether the insurance department has proper jurisdiction to resolve the complaint. If the department does not have proper jurisdiction, the complaint should be immediately referred to the proper regulatory agency. For example, in some states, HMO complaints or health care issues must be referred to the appropriate health care regulatory agency. The referral letter to the other agency should request that the state insurance department be informed of the outcome of the investigation. A copy of the letter to the proper regulatory agency should be sent to the complainant. The state should track the quantity and type of referrals made to other agencies and the outcome of each. In instances involving joint or overlapping jurisdiction such as health care issues, the state is encouraged to enter into a Memorandum of Understanding such as the one entered into by the Maryland Department of Insurance and the Department of Health to handle consumer complaints regarding health care. There are instances in which departments assist in resolution of complaints that are outside of their statutory jurisdiction. Additional information regarding the handling of claims outside the departments’ jurisdiction is located in the section titled Jurisdictional Issues.

If the department determines that it will handle the complaint, the complaint should be assigned a complaint number, recorded in the state’s complaint database and assigned to a specific complaint analyst for resolution. It is important that the initial record of the complaint be accurately recorded into the state’s complaint database to assure that the closed complaint data can be successfully transferred to the NAIC Complaints Database System (CDS). Additional information regarding the CDS is located in the section titled Collection and Disclosure of Complaint Data.

An initial screening to evaluate and prioritize all complaints may provide efficiency. Complaints should be given priority and handled out of sequence when they touch upon one of the following issues: 1) imminent harm to the public, 2) critical or emergency situations, 3) time-sensitive issues such as cancellations or terminations of coverage or 4) general urgency of the complaint. Otherwise, complaints are generally processed in the order of receipt to ensure that all complainants are treated fairly.

Acknowledge Receipt of the Complaint to the Consumer and Respondent

Once the complaint is properly recorded in the department’s complaint system, the department should acknowledge the receipt of the complaint. In some cases the complaint can be resolved with a telephone call and written correspondence may not be required. In the remaining cases, virtually all states send a written acknowledgment of the complaint. Some states acknowledge the receipt of the complaint by sending a formal Notice of Complaint letter to the regulated entity or respondent specifying that a complaint has been filed against them. The state will then send a copy of the notice letter to the consumer. Some states also include an insert in the letter to the consumer that describes the process that will be followed to address the complaint. Other states use two separate letters; one as a notice to the respondent and a separate acknowledgment letter to the consumer.

Some state statutes prescribe a maximum time for the insurance department to acknowledge consumer complaints. In Ohio the statute requires that the department acknowledge complaints within 5 days and in California there is a 10-day statutory deadline for acknowledging complaints. However, many states strive to respond in a faster manner. For example, California with a 10-day statutory deadline strives to
acknowledge consumer complaints within two business days. Most states’ internal procedures require that an acknowledgment from the department be issued between 48 hours and 7 working days. Some states, such as Pennsylvania, strive for a 24-hour acknowledgment time.

The New York department uses an automated system to log in complaints, assign each to a complaint analyst and issue automated response letters. As states become more automated the acknowledgment time shortens and the process becomes more efficient and responsive to the consumer.

State insurance departments should acknowledge the receipt of the complaint within two business days by sending either an acknowledgment card or letter to the complainant and an investigative or inquiry letter to the respondent. The acknowledgment should identify the complaint file number, the complaint analyst’s name, telephone number and, if available, email address. It should also contain basic information regarding how the department will process the complaint.

In addition to the initial acknowledgment, it is important for complainants to receive periodic updates regarding the processing of their complaints. To accomplish this, some states copy the consumer on all communication to the respondent. Other states have a system that generates an initial acknowledgment card when the processing of the complaint begins and only send a final letter to the consumer explaining the resolution of the complaint. The Kentucky department states in the initial acknowledgement letter that if the complaint is not resolved within thirty days a follow-up letter explaining the status of the investigation will be issued. The California department will issue a follow-up letter every 25 days until the complaint is resolved. The recommended guideline is for departments to establish procedures that assure the complainant is kept apprised of the status of the complaint handling process.

Substantive Analysis

An issue related to the acknowledgement of a complaint is what, if any, substantive analysis should occur prior to the initial acknowledgement of a complaint. In response to the survey, the majority (38) of state insurance departments indicated that an initial screening and substantive review of a complaint is performed to identify the issues, determine what, if any, statutory violations may be involved and to request pertinent documentation from the respondent. Some states follow this procedure in order to facilitate a substantive response from the respondent and in the hope of resolving the complaint following the initial contact of the respondent.

By contrast, other states take the position that a substantive review prior to contacting the respondent is unnecessary and may actually slow the processing of the complaint. In response to the survey, eight states indicated that they perform only an initial screening before the complaint is forwarded for response. While an initial substantive review may slightly delay the initial release of the complaint, the benefit of such a review is that it shortens the resolution process.

Review Company’s/Agent’s Response for Timeliness

The next step in the complaint handling process is to ensure timely response by the respondent. The statutorily imposed timelines for reply by the respondent vary from five days in Washington, D.C. to 20 days in Colorado, Indiana, Oklahoma and Wisconsin. Other states impose response deadlines of 7, 10, 14, 15 or 21 days. Statutes and internal procedures vary in their determination of the trigger point or the date from which a response time is calculated. In some states the response time is calculated from the date the notice or inquiry letter is mailed by the department of insurance to the respondent. In other states the response time is calculated from the date the respondent receives the inquiry letter. In addition,
states vary in whether they count business days or calendar days. Absent any statutory timelines, the department should request a substantive response from the respondent within ten business days of receipt of the department of insurance letter. The respondent should provide a substantive analysis rather than a standardized form letter acknowledging receipt of the complaint.

**Review Process**

Although the timetables for reply by the respondent vary, the department review process is fairly consistent. The response is reviewed by the department to determine if 1) it is timely, 2) it is complete and responsive to all issues raised, 3) it includes adequate documentation to support the respondent’s position, 4) the respondent’s actions are appropriate from a business practice standpoint, 5) the respondent’s actions comply with all applicable statutes, rules and policy or contract provisions and 6) appropriate remedies for the consumer are identified.

The entity’s response should be reviewed for its consistency with the provisions of the contract and for its applicability with the insurance laws and regulations of the state. The complaint analyst should look for support of the position taken and evaluate the response for potential business practices or activity in violation of statutes or regulations. The review of the complaint should include an analysis of the overall complaint in order to prepare and suggest options for resolution. 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. In some cases, the complaint analyst must clearly detail why the complaint can not be resolved. The explanation should conclude with other remedies and options the consumer may pursue. Examples may include a legal venue, arbitration, appeals or other remedy outlined in the contractual language of the policy.

**Final Communication**

Once a complaint investigation is completed a department will send out a final communication to the complainant explaining the department’s final disposition and the legal options available to appeal the final disposition. Some states make a distinction in their final determination as to whether the complaint was justified or non-justified. For example, in California if the complaint is determined to be justified the final communication will be issued to the consumer and to the respondent. Otherwise, the final communication would be issued only to the complainant. In some states, once an investigation is complete an initial closing letter will be released to the complainant with an option for the consumer to present additional information for consideration prior to the final closing of the file. If there are no additional facts for consideration the file is closed and a final communication letter is issued to the complainant.

The following best practices may be of assistance to state insurance departments evaluating or enhancing their current complaint handling procedures.

- Consumer complaints should be accepted through any mode of communication. When necessary, a signature may be obtained as part of a follow up request to the consumer for documentation. Given the rapid growth of electronic commerce, consumers should be able to file and communicate about complaints in the same manner as they currently use other modes of communication.

- Consumers should be provided with access to toll free telephone numbers for state insurance departments and, where available, for the respondent.
• States should adopt procedures and accept electronic signatures as technology advances and becomes more readily available.

• States should maintain procedures to initially screen, evaluate and prioritize all complaints as they are received.

• All complainants should receive an initial acknowledgment within 2 business days. Complainants should be provided with the complaint file number, complaint analyst name, telephone number and, if available, email address. It should also contain information regarding the department’s complaint handling process, including procedures for submitting additional information.

• Insurance departments should establish procedures to assure that the complainant is kept apprised of the complaint handling process.

• Insurance departments should establish procedures to ensure that a timely response is received from the respondent.

• Insurance departments should perform some preliminary substantive analysis of the issues prior to contacting the respondent in order to perfect a better response from the entity.

• The entity’s response should, at a minimum, be reviewed for its consistency with the provisions of the contract and for its applicability with the insurance laws and regulations of the state.

• Insurance departments should communicate the final disposition of the complaint in a format consistent with the administrative appeal procedures in the state.

Customer Service Enhancements/Accessibility

Methods of Communication

The goal of all state insurance departments should be to use procedures that increase consumer access to departments and decrease delays in the complaint handling process. States have a variety of ways to communicate with consumers and industry representatives. Most states communicate with complainants through correspondence or through telephone communications. One specific procedure to enhance accessibility is to develop flexible working hours to ensure complaint analysts are available outside the normal working hours of 8:00 a.m. to 5:00 p.m. In Kentucky, the consumer hotline is answered from 7:30 a.m. to 5:30 p.m. In Georgia, the consumer hotline is answered from 7 a.m. to 7 p.m. daily. California has implemented 8 a.m. to 6 p.m. service. States are also encouraged to contact consumers by email or telephone as an immediate means of communication.

While technology has enhanced communication with the public, there is still a benefit to providing opportunities for face to face contact. When the volume of consumer traffic warrants it, specific locations within the department’s office space should be set aside for visits with consumers. These areas should be well marked and easily accessible. As resources allow, states should provide bilingual assistance and accommodations for speech/hearing impaired telephone callers and walk-ins. States must also be cognizant of both state and federal requirements for public access and are encouraged to make reasonable accommodations for the disabled.
Remote Complaint Offices

When resources are available, states are encouraged to provide consumers access through field offices or satellite service sites in different regions of the state. Such satellite sites can serve a dual purpose of complaint handling and consumer education or outreach office. The state of Florida has eleven field offices which provide outreach and education programs. Following an emergency such as withdrawal of a major carrier or a natural disaster such as a storm or earthquake, states should establish temporary storefront locations to provide consumer assistance and to accept complaints. The Department of Insurance staff should be a part of the emergency disaster response team and should coordinate activities with statewide officials to assure consumers have adequate information and assistance.

Consumer Education and Outreach

While some larger states have satellite offices or regional field operations, resources may constrain such efforts in other states. However, all states should be encouraged to provide consumer outreach programs. Opportunities exist for developing consumer outreach and education programs in libraries, county court houses or the chamber of commerce. Consumer outreach and education programs are an important element in addressing consumer issues and may help prevent complaints. Some of the services that an outreach program may provide include:

- Consumer Brochures regarding consumer rights, types of insurance coverage, premium cost comparisons, how to file a claim, complaint ratios and anti-fraud literature. Appropriate brochures can be included with the response letters to the consumer.
- Outreach in the form of a Commissioners Bulletin or a department seminar for companies and agents regarding trends in consumer complaints or the marketplace.
- Outreach programs for small business owners regarding insurance coverage options.
- Outreach programs for the elderly regarding health care insurance.
- Outreach programs for young drivers regarding shopping for insurance and the importance of maintaining a good driving record.

The opportunities to provide assistance to the public are numerous and should be fully utilized by each department. In Florida the outreach program visits condominiums and recreation facilities for the elderly. The Kentucky Department of Insurance recently established a consumer educator position within the newly established Division of Consumer Protection and Education. The consumer educator is responsible for all aspects of the department’s Speaker Bureau including soliciting organizations for speaking opportunities, scheduling speakers, locating and/or creating the necessary educational materials, assisting with research, staffing displays and presentations. The Kentucky Department of Insurance conducts consumer forums throughout the state and has organized a daylong “insurance college.” The activities of the consumer educator can be coordinated with those of the consumer complaint area to provide statewide access.

The following best practice may be of assistance to state insurance departments evaluating or enhancing their current complaint handling procedures.

- Insurance departments should pursue programs that increase the accessibility of complaint analysts and consumer education services to all consumers.
Communication with Other Divisions of the Department

The flow of information between the Consumer Services Division to other divisions of the insurance department is critical to ensure efficient and effective regulation. Within each department, division supervisors should determine what information from other divisions is necessary to efficiently perform the work of that section. For instance, the Rates and Forms Division should be made aware when a complaint regarding an unlawful exclusion is submitted. Similarly, the Market Conduct Division and the Financial Services Division would want to be made aware of complaint trends reflecting a business practice of late payment of claims.

It is important to realize that each division needs certain information but may not need all information available from the Consumer Services Division. In order to avoid either the sharing of no information between divisions or the sharing of too much information, each division should identify the specific information from the Consumer Services Division which is required and also identify the format or medium which is best for communication of that information. For instance, the Financial Services Section may be interested primarily in written reports showing the complaint trends related to delays in claim payments. In contrast, the Market Conduct Section may be interested not only in evidence of trends but may also find that other facts discovered by the complaint analysts indicating any other systemic problems may be of value. Because some of this information may be anecdotal or may require dialogue between the complaint analysts and market conduct examiners, regular meetings of key staff may be desired. Likewise, each the Consumer Services Section should identify all useful information that can reasonably be produced and communicated by other sections to the Consumer Services Section.

The Consumer Affairs Section may identify the other divisions, sections or work groups that rely on complaint information to include management, actuarial, market conduct, financial services, rates and forms, policy groups, and the public information officer. Current identified practices reflect that states recognize the importance of communicating information between different divisions but often do not have established procedures in place to ensure such communication is carried out in a timely, efficient manner. Some states may leave it to the discretion of the complaint analyst while other states may have specifically scheduled meetings among divisions to share information. While the appropriate method of communication may depend upon the size of the department, all departments should establish some mechanism to ensure open lines of communication between the Consumer Services Division and other divisions of the department.

In addition to division meetings, agencies may want to consider establishing a task group to meet regularly for specific purposes. For example, in Colorado, complaint analysts meet weekly for peer review of complex cases. Policy Issues groups, consisting of key staff from each of the sections within the Consumer Affairs Section, meet biweekly to discuss issues related to coordination, planning and consistency and to make recommendations to the Commissioner. Finally, market conduct planning meetings for section managers are held prior to market conduct examinations to advise the examiners of concerns related to the company to be examined.

The following best practice may be of assistance to state insurance departments evaluating or enhancing their current complaint handling procedures.

- State insurance departments should establish a method of communicating information between divisions. A cross-section of staff from areas such as market conduct, complaints, rates & forms and compliance should meet regularly to exchange information and discuss issues.
Collection and Disclosure of Complaint Information

Establish Database to Identify Trends

It is critically important for departments to establish a database to track key elements of the complaint process. The analysis of complaint data can identify potential company or industry trends or concerns including non-complying general business practices or acts that may adversely affect consumers. For instance a large influx of complaints relating to premiums may indicate a lack of affordable coverage in a specific geographic area or a rate increase by carriers within a specific area. The trends identified from analysis of the database can be used to trigger a referral to the market conduct or enforcement area. The database might track the number of complaints against a particular company/agent for the improper cancellation or denial of coverage. When the number of such complaints reaches a certain level, other divisions of the department should be automatically notified. In addition, the database can provide a management tool for identifying staffing requirements or training needs.

When establishing an internal complaint tracking system, it is imperative that states adopt the uniform data standards used for the NAIC Complaints Database System (CDS). The CDS was established to facilitate uniform data standardization, complaint analysis and the sharing of complaint data by multiple states. The CDS provides a central repository for complaint information in a standardized format that is electronically retrievable. The information in CDS is available only to regulators. However, release of the data to the public is currently under consideration. A variety of standard reports are currently available to regulators. The computerized data collection system provides states with a resource for in-depth analysis of complaint information. Data can be analyzed by geographical area, by line of business, by company or any other standardized data element. The CDS provides the states with a technological tool to enhance their ability to regulate the industry and assist the consumer.

The CDS provides a uniform complaint recording form with data fields that identify and categorize the complainant, the entity against whom the complaint is filed, the type of coverage, the reason for the complaint and the final disposition of the complaint. See Appendix B for a sample of the standard submission form. Some states have developed sub-codes that allow for collection of additional data. States with internal complaint tracking systems that comply with the CDS standards are able to submit closed complaint information to the NAIC. Some states submit to CDS only closed complaints that the department determines are justified. The majority of states not using CDS compliant systems are recording complaints on some type of spreadsheet application or computer program designed within the department. The working group acknowledges that budget constraints within each department impact implementation of computer hardware and software for complaint tracking systems. However, to facilitate uniform reporting and analysis states are urged to become CDS compliant as soon as budgetary constraints allow.

Participation in CDS will enable a state to obtain access to a broader database. The following standard reports are available from the CDS. In addition, states are able to run ad hoc queries against the database utilizing their own spreadsheet software packages.

Complaints Database System (CDS) Index Report
The CDS Entity Index report compares a company’s market share to its complaint share, resulting in an “index.” For example, an index of 1.0 indicates that the company had a percentage of complaints equal to its percentage of premium written for the coverage type and state(s) selected. This report is available for those companies that file annual financial statements with the NAIC. This report can be run in a summary format for a group of companies or for a specific entity. In using the index report, regulators

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should be aware that complaint ratios may be developed in various ways. Complaint ratios may be determined by comparing complaints to other denominators including the number of policies in force or the number of units insured. Comparing ratios within a line of coverage may be very beneficial to determine the relativity of consumer satisfaction. The user of such information, however, should be careful when establishing relativities or making comparisons between various lines of coverage, such as lines where the premium per policy may vary substantially.

**CDS Summary Closed Complaint Counts by State**
The CDS Summary Closed Complaint Counts by State report displays a list of all the NAIC member states/territories and the number of complaints received from each state/territory, based on a variety of criteria. This report can only be viewed on an all state basis and not on an individual state basis.

**CDS Summary Closed Complaint Counts by Code**
The CDS Summary Closed Complaint Counts by Code report displays a list of all the complaints and the number of complaints based on a variety of criteria.

**CDS Summary Closed Complaint Trend Report**
The CDS Summary Closed Complaint Trend Report displays the number of complaints and the percent of change on both a monthly basis and an annual basis for a pre-determined date range. A three-year period is shown on a month by month basis, beginning with the previous calendar month. A six-year period is shown on the year by year breakdown.

**CDS Closed Complaint Filing Status**
The CDS Filing Status report lists by state/territory the number of closed complaints entered into CDS, the earliest recorded closed date and the most recent recorded closed date. This report is useful in determining which states/territories are actively participating in submission of complaint records to CDS.

The CDS also assists the states in compliance with the Omnibus Budget Reconciliation Act of 1990 (OBRA) requirements for complaint reporting on Medicare Supplement policies. The OBRA requires states to report to the Health Care Financing Administration (HCFA) information on all complaints received or investigated during the prior calendar year involving Medicare Supplement coverage. The NAIC submits quarterly reports to HCFA on behalf of all states that submit data to the CDS. States that do not send complaint records to the NAIC are required to comply with the OBRA requirements on their own.

Once the Department has determined that a problematic complaint trend is occurring, the complaint data may be helpful in resolving issues for consumers in a number of different ways. Department staff may want to meet with the company to review adverse trends and require that the company establish a compliance plan, which may include self-audits and refunds to consumers. Colorado has established an optional semi-annual meeting between carriers and key department staff to review complaint data trends. As indicated above, the information should be considered in the selection of companies for examination and in the determination of the scope of an examination. Additionally, the Department may temporarily assign all complaints against that company to a single analyst or team of analysts. Assignment to a specific analyst or team leads to increased scrutiny allowing the analyst to gain a better understanding of what might be occurring within the company.
General Guidelines for Disclosure of Information

The disclosure of information in an individual complaint file is governed by state Freedom of Information or Open Records laws. Some state laws require disclosure of information within closed individual files. Where state laws require disclosure of closed individual complaint file information it is a best practice for states to develop specific protocols consistent with state law for release of this information. Providing clear guidelines to staff regarding the state Freedom of Information law and the department’s protocols is essential. When developing protocols and releasing information, states must take steps to preserve the confidentiality of medical and personal information under state and federal law. Furthermore, if individual complaint information is publicly released once a complaint is closed, the department should undertake strong notification efforts to ensure the consumer understands his/her complaint information will become public information once the complaint file is closed. One suggested practice is to obtain a signature from the complainant whereby he/she affirmatively signs a statement indicating that he/she understands his/her complaint file will become a public document once the complaint is closed. Another option is the inclusion of a Notice of Public Access statement on standardized complaint forms and other information released by the department.

Since complaint information is of interest to the general public, states insurance departments receive requests for complaint files from the media, attorneys and other outside sources. As such requests are made, the department should be guided by the respective Freedom of Information or Open Records statute. The department may aid in the process by forwarding the request to the consumer without encouraging or discouraging participation.

Affirmative Dissemination of Complaint Information

The disclosure of aggregate complaint data varies by state, but most states publish aggregate data in some format. In response to the state survey, 26 states indicated that they publish complaint information in either an annual report, consumer brochure or on the department’s Web site. While not all states affirmatively disseminate aggregate complaint information, many states now publish complaint index ratios. Whether information is provided in aggregate form or broken down into complaint index ratios, it is important to define the complaint tracking terminology and identify the type of data released. The terminology used by states to define complaints varies. Some states track justified versus non-justified complaints. The California department categorizes complaints as justified, question of fact or other. The Kentucky department includes a category for extra-contractual complaints. The Maine department tracks substantiated complaints. To avoid misinterpretation, all data released must be defined.

The complaint ratio is designed to compare a company’s percentage of complaints to their percentage of the market share. The complaint index is a ratio of the company’s number of complaints per thousand dollars of premium written, divided by the total number of complaints per thousand dollars of premium written for all companies for a line of business. The ratio is then multiplied by 100 to make it a percentage. For example, if a company has a complaint index of 10, its complaint ratio is only 10 percent of the average of all companies. A company with a complaint index of 100 has a complaint-to-premium ratio equal to the average of all companies. A company with a complaint index of 235 has a complaint-to-premium ratio of 135 percent greater than the average of all companies. The complaint ratio itself is not as meaningful to the consumer as how the company compares with others. The index ratio format facilitates comparison between companies and takes into consideration the size or premium volume of a company.
Because complaint ratios can have an impact on a department’s decision to conduct a market conduct examination of a company and the general public’s perception of the company, it is very important that complaint ratio indices be based on reliable data and that all categories and terms be adequately defined. Internal quality control measures to assure data integrity should be implemented. Routine audits or studies should be conducted to determine that proper codes are in place and being used. States should also review the codes to determine if new or amended codes are necessary to address evolving market issues. However, states must be cognizant of the fact that any change in internal code structures will impact reporting to the NAIC CDS and that all code changes should be coordinated through the NAIC.

The complaint index should be adequately footnoted to clearly specify how the complaint index was calculated. While it would be more beneficial and accurate to have complaint index ratios based upon the number of policies in force instead of premium volume, most complaint index ratios are based upon premium volume because the number of policies in force is not readily available. Thus, when appropriate, a complaint index ratio should have a footnote that the complaint index ratio is based upon premium volume and not the number of policies in force. In addition, the complaint index ratio, where appropriate, may also need a footnote that explains how a “complaint” is defined and should contain well-documented definitions and explanations of calculation methodology.

The following best practices may be of assistance to state insurance departments evaluating or enhancing their current complaint handling procedures.

- Insurance departments should develop specific protocols consistent with state Information and Open Records laws to make information in closed individual complaint files public.

- Aggregate complaint information should be provided in complaint index ratio format and should include well-documented definitions and explanations of calculation methodology.

- State insurance departments should establish a database to identify complaint trends. The database should be consistent with the NAIC Complaints Database Systems.

- Insurance departments should submit closed complaint data to the NAIC Complaint Database Systems to facilitate data analysis and the sharing of information between states.

Questions of Fact

Many consumer complaints express concerns based primarily on questions of fact rather than allegations of statutory violations. Examples of factual issues may involve determination of fault in liability claims, agent or company misrepresentations, and necessity of medical care. Complaints regarding questions of fact are, in some cases, not within the jurisdiction of the department to handle as a violation. However, many departments attempt to resolve these complaints. Where the factual issues can not be resolved, consumers should be informed of their options. It is essential that each department provide adequate training for consumer services staff as to what complaint issues are within the jurisdiction of the department and those that are not. In many cases involving questions of fact, the consumer services staff member should refer the consumer to the appropriate remedy to address the concern. This may be the court system, arbitration, appraisal, independent medical examination, or other appropriate mediator.

In some cases, the complaint involves issues that are both questions of fact and potential violations. In such cases, the consumer services staff should fully investigate the complaint to determine if any violation occurred and should identify the factual questions that should be referred to an appropriate
tryer of fact. For instance, on a third party automobile claim, the complainant may allege that the company needlessly delayed investigation of a claim and then denied the claim asserting that there was no negligence on the part of its insured. In this case, the complaint analyst would investigate the complaint to determine if the claim was handled in a timely manner and that all available information was considered in its determination, according to Unfair Claims Practices Act requirements. The complaint analyst would not attempt to assess negligence, but would appropriately refer the consumer to the court of appropriate jurisdiction.

One of the options developed in Oklahoma for handling unresolved factual issues is the EAGLE Program. In the summer of 1999 the Oklahoma Department of Insurance initiated an alternate dispute resolution program named EAGLE. EAGLE stands for “ending arguments gently, legally and economically.” The voluntary program is designed to provide consumers and insurers a forum for dispute resolution through the mediation process. The objective is to resolve complaints before they escalate to the courthouse. If after review by the Consumer Assistance Division, a complaint remains unresolved due to a question of fact, the parties are asked if they wish to voluntarily participate in non-binding mediation. The EAGLE program is not used if there is a statutory violation or breach of policy provision. If all parties are interested in mediation, the claim is referred from the Consumer Assistance Division to the Legal Division for coordination of the mediation process. The department uses trained volunteer mediators certified by the Oklahoma Supreme Court. The department believes that the EAGLE program will be especially useful in resolving disputes related to natural disasters such as tornadoes. The department has been successful in mediating claims for which the insured was unable to obtain payment for wind damage repairs due to disagreement between a contractor and the insurer regarding the repair. A three party mediation involving the insured, insurer and general contractor resolved the dispute.

While some states take the position that the legal system is the correct place for resolution of all liability issues, other states review issues of comparative negligence, make an assessment of how well the claim was investigated and resolved and then communicate that assessment to the complainant and company.

When dealing with factual issues and comparative negligence, complaint analysts must recognize the distinction between offering consumer assistance and intervening with regulatory authority. Many times a complaint analyst may be able to offer the consumer some assistance by explaining the concept of comparative negligence and how factual issues are resolved through the legal system. Beyond this, a complaint analyst may assume the role of a mediator or refer a case for independent mediation and thus help the parties arrive at an amicable solution. These steps may always be taken despite the fact the complaint analyst does not have the regulatory authority to decide certain factual issues, such as comparative negligence.

States are subject to a statutory framework. In addressing complaints that involve questions of fact or comparative negligence, the department may not be able to resolve the issues presented. However, states should track complaints involving questions of fact, issues of comparative negligence or disputes regarding liability in the same manner in which all other complaints are tracked. Disposition codes exist in the NAIC CDS for arbitration/mediation and question of fact and legal issues. Again, it is important that complaints be properly coded so that trends or reoccurring patterns that may indicate violation of the states unfair claims settlement practices act or unfair trade practices act can be identified and addressed.

The following best practices may be of assistance to state insurance departments evaluating or enhancing their current complaint handling procedures.
- Consumer services staff should be trained to identify and make appropriate referrals for complaints that involve questions of fact that may be outside of the jurisdiction of the department.

- All complaints should be tracked and properly coded in the NAIC CDS.

**Standard of Review**

Some complaints involve a possible violation of a state’s Unfair Trade Practice Act or Unfair Claim Settlement Practice Act. For instance, a complaint may involve an unfair trade practice of misrepresentation and false advertising or unfair discrimination. Similarly, a complaint may involve an unfair claim settlement practice of misrepresentation of a policy provision or a refusal to pay a claim when liability is reasonably clear. Because the filing of a complaint by one or more consumers may indicate a widespread problem, complaint analyst should be aware of the activities that constitute an unfair trade practice or unfair claim settlement practice and the standard of review used to determine if an insurer or agent is in violation of their state’s Unfair Trade Practice Act or Unfair Claim Settlement Practice Act. Some states specify that an unfair trade practice and unfair claim practice, as defined in the respective state statutes, must be 1) committed flagrantly and in conscious disregard or 2) committed with such frequency to indicate a general business practice. Other states specify that an insurer must act in an arbitrary and capricious manner before its actions are a violation of the Unfair Trade Practice Act or Unfair Claim Practice Act. Regardless of the standard applied, once an unacceptable general business practice is recognized, the complaint analyst should advise the market conduct section so that they can determine if a market conduct exam should be conducted.

The following best practice may be of assistance to state insurance departments evaluating or enhancing their current complaint handling procedures.

- Complaint analysts should be aware of the activities that constitute an unfair claim settlement practice or unfair trade practice and the standard of review used to determine if an insurer or agent is in violation.

**Quality Control Measures**

All states should have quality control measures in place to monitor both the individual complaint analyst and the department performance and to ensure that complaints are being handled properly. Supervisory review and telephone monitoring are two of the methods used to assure quality service at the staff level. Consumer satisfaction surveys and benchmarking are two of the quality assurance techniques used to measure department performance. Colorado relies on several measures to monitor quality control. Members of management audit closed cases and the results are evaluated when determining the employee’s effectiveness. Consumer satisfaction cards are mailed as files are closed. Regular Peer Review meetings provide support for analysts handling difficult cases as well as assuring that consistent procedures are followed. In addition, the Property group and the Health group meet routinely to discuss issues and make recommendations to executive management regarding emerging trends or policy issues.

*Supervisory Review*

All departments should have some type of supervisory review procedures with specific standards of review. A supervisory review should, at a minimum, include a review of complaints to determine the timeliness of the resolution, clarity of communication, accuracy and quality of response to consumer
questions, friendliness to consumers and overall consumer satisfaction. A monthly review form should be developed. Included as Appendix C are sample Supervisory Review and Audit Forms from the states of Colorado, California, Florida and Kentucky. The review forms help to assure that issues are identified and addressed appropriately. Most of these forms track response times while also monitoring complaint coding to assure that proper referrals are made to the enforcement division and to assist in the identification of complaint trends. In addition to standard reviews, a supervisor should also review all non-routine complaints and complaints falling under the purview of a newly law.

Telephone Monitoring

Random monitoring of complaint analysts telephone conversations is another method of assuring quality control at the staff level. In addition to random telephone monitoring states may also choose to conduct “blind telephone call” investigations. For example, one state had investigators call the Consumer Services Section and represent themselves as consumers in order to identify areas where improvements and job training were needed. All telephone monitoring procedures should be consistent with state laws regarding wire-tapping.

Consumer Satisfaction Survey

A Consumer Satisfaction Survey is essential to providing feedback on overall performance of the Consumer Services Section and the department as a whole. States should implement a consumer satisfaction survey that can be randomly sent to complainants after their complaint file is closed. For example, the Wisconsin Department of Insurance uses a survey and the results are published on their Web site. A compilation of the survey results through 1998 is listed below.
Complainant Survey  
1-1-98 Thru 12-31-98

Survey Cards Sent  1,803  
Survey Cards Returned  961  
Response Rate  53%  

Results

1. How did you hear about the Office of the Commissioner of Insurance?

<table>
<thead>
<tr>
<th>Source</th>
<th>Yes</th>
<th>No</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Word of Mouth</td>
<td>287</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance Agent</td>
<td>143</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance Company</td>
<td>81</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Book</td>
<td>42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lawyer</td>
<td>69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Care Provider</td>
<td>93</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>260</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Answer</td>
<td>199</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Did we respond to your complaint promptly?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>859</td>
<td>87</td>
<td>15</td>
</tr>
<tr>
<td>90.8%</td>
<td>9.2%</td>
<td></td>
</tr>
</tbody>
</table>

3. Do you feel your complaint was handled fairly by our office?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>629</td>
<td>278</td>
<td>54</td>
</tr>
<tr>
<td>69.3%</td>
<td>30.7%</td>
<td></td>
</tr>
</tbody>
</table>

4. Do you feel you were given an adequate explanation on your complaint?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>631</td>
<td>265</td>
<td>65</td>
</tr>
<tr>
<td>70.4%</td>
<td>29.6%</td>
<td></td>
</tr>
</tbody>
</table>

5. If you called our office, do you feel we treated you courteously?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>584</td>
<td>27</td>
<td>26</td>
</tr>
<tr>
<td>95.6%</td>
<td>4.4%</td>
<td></td>
</tr>
</tbody>
</table>

6. If you have another insurance problem, would you contact our office again?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>763</td>
<td>97</td>
<td>24</td>
</tr>
<tr>
<td>88.7%</td>
<td>11.3%</td>
<td></td>
</tr>
</tbody>
</table>

The survey allows the department to determine where the consumer learned about the department, whether the consumer feels they were treated courteously and if the consumer felt the response time was prompt. Each of these is a key element in determining consumer satisfaction and, in turn, department performance levels.

Alternatively, a state may want to mail self-addressed postcards to all or a random selection of complainants with closed complaint files to determine if the consumer is satisfied with how the department handled their complaint. In Colorado, consumer satisfaction cards are mailed as each file is closed. The returned cards are reviewed by a lead analyst and/or supervisor to determine if any action is required. The consumer satisfaction cards provide feedback that assists the department in the evaluation of the effectiveness of the individual analyst and the Consumer Affairs Section processes. A sample Consumer Satisfaction Survey Card is shown below.
COLORADO DIVISION OF INSURANCE
INSURANCE CONSUMER ASSISTANCE REGULATORY ENFORCEMENT (ICARE)

Dear Consumer: Recently you contacted the Colorado Division of Insurance concerning an insurance matter. We hope your case was handled professionally. We value your comments and suggestions to enable us to serve you better. Would you mind taking a minute to complete this card and return it to us?

William J. Kirven III
Commissioner of Insurance

Please circle one answer for each question
1. How would you rate the analyst’s knowledge:
   Excellent   Satisfactory   Unsatisfactory
2. How would you rate the analyst’s professionalism:
   Excellent   Satisfactory   Unsatisfactory
3. How adequately were your concerns responded to:
   Excellent   Satisfactory   Unsatisfactory

SUGGESTIONS
COMMENTS:

A state that conducts such a survey should be cognizant of the fact that people may tend to respond in a positive manner if the complaint is resolved in his/her favor and respond in a negative manner if the complaint is not resolved in his/her favor. States are able to determine resource needs by identifying how consumers learned of the availability of consumer assistance and information, the means of communication used, the reason for contact, and the consumer’s age and county of residence.

Division Performance/Workload

In terms of division performance reviews, most states track and monitor activity such as the number of telephone calls, service and informational requests, Internet site hits, the average resolution time for consumer service requests and the amount of monies recovered during the year. However, states should go beyond monitoring activity and develop performance measurements. Once the activity level is determined states should draft specific outcome measures. For example, an outcome may measure prompt response times. The activity data can be utilized to establish a baseline and performance benchmarks can then be established. Such a standard performance measurement benefits the department at several levels. It allows the department to determine the quality of service provided, it assists the Consumer Services Section in determining the areas where training or enhancement of services may be needed, and it focuses the individual complaint analysts on the impact their performance has on individual lives.

The Kansas Insurance Department uses Outcome and Output Measures developed to provide empirical data regarding the divisions performance. The Measures are listed below.

Outcome Measures:
➢ business days to generate letters to companies asking for a response to a complaint
➢ business days to generate letter to consumer upon receipt of a complaint
➢ business days to generate letter with “good news” for consumer

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customer survey satisfaction rating generated from mailing to randomly selected complainants
number of complaints against companies in the years following a market conduct exam compared to previous years

Output Measures:
average number of phone calls received per month/year on toll-free line
amount of money recovered on a differential basis
number of complaint and inquiry files closed per year
number of speeches given each year, number of people in attendance

States should also set some type of benchmark in terms of the average number of complaints handled by complaint analysts each month and the median time it takes to resolve a complaint. Desk audits can be performed to establish a baseline against which to measure future performance. Since this benchmark may be impacted by the department's budgetary measures each state should independently determine the number of complaints each complaint analyst should handle and how quickly complaints should be processed. Appendix D illustrates the form used by Kentucky for tracking WorkLoad Status.

States also measure workload performance by the amount of money recovered on behalf of consumers. With regards to the amount of monies recovered during the year, some states track the amount of monies recovered by recording the entire amount recovered by the complainant. Other states record the amount of money recovered subsequent to the involvement of the division (a differential basis). The recommended practice is for states to track the amount of monies recovered on a differential basis.

The following best practices may be of assistance to state insurance departments evaluating or enhancing their current complaint handling procedures.

- Insurance departments should implement quality control measures to assure that complaints are handled properly.
- Insurance departments should establish a benchmark to measure division performance and determine workload factors.

Training of Complaint Analysts

Complaint analysts may be trained in a variety of ways, from initial orientation and on the job training to continuing education courses. Some complaint analysts may also specialize by line of insurance. Departments should establish a training and career path that recognizes employee development and improvement. The Kentucky Department of Insurance now requires that all employees receive at least 12 hours of continuing education per year. One training path that may be followed is the training and educational program developed by the Insurance Regulatory Examiners Society (IRES) as detailed in Appendix E. Pursuit of professional designations such as the AIE (Accredited Insurance Examiner), CIE (Certified Insurance Examiner), FLMI (Fellow, Life Management Institute), CPCU (Chartered Property Casualty Underwriter) or certification as a trained mediator should be encouraged. Other pertinent training may include classes on negotiation skills, communication and/or writing skills, and investigation and claims settlement courses.

All complaint analysts should have some minimal level of cross training relating to job duties such as telephone answering or coding of complaints. In addition each complaint analyst should have a basic understanding of all lines of insurance. This is particularly important in catastrophic situations where an
inordinately high number of complaints could be received in a very short time period. States may also develop in-house training and continuing education programs that include opportunities for staff to teach each other in their respective areas of expertise. In addition, a mentoring program may be implemented if the department is large enough to make such a program meaningful and useful. Finally, all complaint analysts should receive a minimal level of customer service training.

The following best practice may be of assistance to state insurance departments evaluating or enhancing their current complaint handling procedures.

- Insurance departments develop a training and career path for complaint analysts that recognizes development and improvement and provides a minimal level of cross training.

**Enforcement Issues**

In the vast majority of complaints handled by insurance departments, the focus of the complaint-handling process is on resolving complaints as expeditiously as possible rather than proving legal violations. In the 1998 survey, two-thirds of the responding states reported that less than 3 percent of complaints result in enforcement actions, and only three states reported that more than 10 percent of complaints result in enforcement actions. Rather than serving as the basis for individual enforcement actions, complaint analysis and aggregate consumer complaint statistics are increasingly used by states to identify problem companies for purposes of market conduct exams and other oversight.

In this regard, in many states the complaint-handling process is closer to an informal dispute resolution process than an investigation that meets the formal legal requirements that are a prerequisite to enforcement actions under many state administrative procedure acts. This “alternative dispute resolution” approach is appropriate since it does not always make sense to add the time and cost of a formal administrative procedure to all cases, when most are resolved informally.

There also are other advantages to a less legalistic approach to complaint resolution. In Oregon, for instance, complaint analysts are trained to advocate for the consumer in cases where the company’s practices are outside industry norms or otherwise not fair to the consumer even if there is no clear legal violation. Encouraging companies “to do the right thing” can be easier when such advocacy is clearly distinguished from enforcement and the company is not worried about its corrective action being used as the basis for an enforcement action.

There are, however, cases in which consumer complaints do involve legal violations that merit enforcement actions. In those cases, the challenge is to establish procedures that accomplish two purposes: identifying cases where enforcement should be considered, and coordinating the complaint resolution and enforcement processes as much as possible to minimize duplication and delay. Some states have separate investigations units for which individual complaints may be referred if enforcement actions are contemplated. Some states refer such cases directly to attorneys in the department.

Complaint analysts should be trained to recognize cases that merit an enforcement review and to make appropriate referrals of such cases. In Wisconsin, complaint analysts, who also function as rates and forms analysts and market conduct examiners, are encouraged to refer potential enforcement cases to the legal section, and there are procedures that facilitate a close working relationship between analysts and attorneys in gathering information and doing whatever else is necessary to resolve the complaint and the enforcement case jointly. In Maryland, complaint analysts perform the investigative function for the majority of individual complaints that result in enforcement actions.
In some recurring types of cases, the referral process can be standardized to the point where the complaint analyst can do all or virtually all of the work necessary for enforcement. An example would be failure of a company to respond within a legally mandated timeframe. Such cases are often very straightforward, and some states have trained their complaint analysts to collect the information necessary to secure a company stipulation to the violation, or to prove the violation at hearing if the company will not stipulate. In Maryland, for instance, the Consumer Services Division formulates orders in failure to respond cases, submits those orders to the Attorney General’s office for review, and then directly issues orders upon approval.

Maryland complaint analysts also are trained to handle certain kinds of claims-handling violations with a “strong letter” indicating that the company should pay the claim. Such letters are precursors to formal enforcement actions if the claim is not paid. Such procedures can strengthen the analyst’s hand in helping consumers, and also streamline enforcement actions. However, the procedures should be carefully worked out with the legal section or whatever section or agency is responsible for administrative hearings, since companies typically will have the right to disagree with the analyst and request an administrative hearing before being required to take a specific action.

Another reason for coordination is that certain violations may merit enforcement actions regardless of whether the company corrects the problem in a particular case. Examples might be willful violations of an unambiguous law or recurrent violations of the same law. In Oregon, for instance, companies have been fined for single violations of the state law limiting the use of driving history to three years despite having taken corrective action when the violations were brought to the companies’ attention. Similarly, two HMOs were fined for failing to conduct reasonable investigations prior to denying emergency room claims despite the companies’ argument that they routinely reversed initial denials on appeal. Maryland also issues fines in individual cases.

These latter cases highlight an additional consideration about enforcement. Namely, that state unfair trade practice laws typically focus on general business practices rather than individual violations. This means that the real issue with certain complaints is whether the company action was an isolated violation or whether it reflects a general business practice. To handle cases that raise concerns about the potential for a general business practice violation, complaint analysts should be trained to make appropriate inquiries as to the scope of the company’s problem activity, and to refer cases to the market conduct section where those concerns merit a more in-depth review.

The following best practices may be of assistance to state insurance departments evaluating or enhancing their current complaint handling procedures:

- Complaint analysts should be trained to identify complaints where an enforcement action may be appropriate in addition to resolving the complaint.

- Complaint analysts should understand the differences between complaint resolution and enforcement actions. Where both processes are relevant to a particular case, they should be coordinated to minimize duplication and delay.

- Complaint analysts should be trained to recognize when individual complaints may reflect general business practices, and to make appropriate inquiries and/or refer such cases to the market conduct section.
Jurisdictional Issues

There are a number of areas for which the state insurance department has no jurisdiction, but receives and must respond to complaints. Some of these areas are discussed below. States may chose to assist these consumers with educational materials, or through intervention, when time and resources are available. In general, the department should refer the complainant to the proper agency and track the referral and the outcome. But care should be taken that the non-jurisdictional cases are not handled to the exclusion or detriment of those cases for which the department has jurisdiction and full responsibility.

States should also develop an inter-agency task force that meets on a routine basis to address issues that cross agency lines. For instance, the state of Pennsylvania recently established a joint program between the Department of Health and the Department of Insurance. The Commonwealth of Kentucky has established the Medicare Partners Network, which is a joint partnership between private, federal and state agencies. The goal of the Network is to educate the consumers of Kentucky and conduct a series of forums covering such topics as the quality assurance aspect of Medicare, Medicare+Choice program, Medicaid, aging services, direct pay for Social Security, changes in Medicare supplemental insurance and long term care insurance.

Medicare and Medicaid Complaints

State insurance department survey responses regarding both the Medicare and Medicaid programs are substantially similar. The majority of the states indicated that since the Medicare program exists under the authority of the federal government and since the Medicaid program administration occurs under another state agency, a state insurance regulator would be unable to resolve complaints against the Medicare and Medicaid programs. States are encouraged to enter into cooperative agreements with the appropriate regulatory agency. Appendix G provides an example of a Memorandum of Understanding (MOU) between the Maryland Insurance Administration and the Department of Health. HCFA and the NAIC have developed a document entitled Guidelines to be used between HCFA and the state insurance departments for the Medicare+Choice Program. The guidelines are intended to provide guidance to states in determining their regulatory role and interaction with HCFA. HCFA allows states to perform the initial investigation on consumer complaints to determine if the complaint falls outside of the specific preemption area, and is therefore subject to state jurisdiction. If the complaint triggered questions regarding Medicare supplement insurance whose purpose is to provide coverage not provided by Medicare, then the state insurance department has authority over both the product itself and the insurance company selling such product. Nevertheless, a complaint against the Medicare or Medicaid program places the state in a position of not being able to provide a resolution for the complainant. The established practice is a referral to HCFA or the Social Security Administration at the federal government level or to state Medicaid agency. An additional referral to a senior citizens counseling or outreach program may also be appropriate. Another resource available to all states is the State Health Insurance and Assistance Program (SHIP) funded primarily by grants from HCFA, which provides counseling services to Medicare beneficiaries through trained volunteer counselors. In some states, it appears an insurance company may have contracted with the federal or state government to administer the Medicare program or Medicaid program. As such, some intervention by the state insurance department may be available in those instances where the insurance entity is providing administrative services to the Medicare or Medicaid program.
COBRA Complaints

When surveyed, the majority of the states responded that they provide the complainant with general information about the COBRA requirements and then make a referral to the federal Department of Labor in order to pursue the complaint to a resolution. However, if the complaint involves a regulated insurance entity, then the state insurance department would contact the regulated insurance entity in order to seek a resolution to the complaint.

ERISA Complaints

The majority of the states advise the complainant that federal law pre-empts the ability of the state insurance department to fully resolve a complaint against a self-funded ERISA plan. While state insurance departments may not have the authority to take administrative action against self-funded plans or impose state health insurance mandates, the department should always be willing to assist all complainants who have problems with their health insurance or health plan. By adopting this policy, the department will often be able to facilitate the communication process among the employer, third party administrator (TPA) and employee. By staying involved in the process, the department can also play an important role in educating the consumer.

Some states will determine if the transaction involves an entity regulated by the department of insurance and then seek a response from that entity. In general, the complainant is referred to federal Department of Labor. Another state indicated that it forwards all ERISA complaints to that state’s United States senators and congressional members and provides the complainant with addresses of the federal representatives. In spite of the fact that many insurance entities provide administrative services to self-funded ERISA plans, the federal preemption of state authority may not permit the state insurance department to demand resolution. The state insurance department should be a source of information providing a referral to the Department of Labor.

Because complaint analysts in some states must trace their activities to a funding source and there is no funding allocated for issues outside the jurisdiction of the department, it is a significant problem for some departments to offer any type of consumer assistance for ERISA complaints. If this is an ongoing issue, the department should inform their U.S. Congressional Representatives about the ERISA complaints.

Complaints Filed by Health Care Providers

Given the increasing volume of provider complaints many insurance departments receive as providers react to the administrative burdens and complexity of issues in the health care market, regulators struggle with what to do with these complaints given the volume of consumer complaints requiring attention. The general preference of the states is to have the insured file the complaint rather than the health care provider. Regulators are appropriately concerned with not being used as collection agencies, and should always insist that providers comprehensively document a complaint if they expect regulatory assistance. However, regulators should bear in mind that providers are an integral part of the health care delivery system. As states adopt health insurance consumer protection standards, educating providers on medical service authorization timelines, appeal rights, prudent layperson emergency services standards, and the like, is a key element of any strategy to promote compliance and improved health plan performance. Regulators cannot conduct provider outreach to educate providers on statutory and regulatory standards yet decline to respond to provider complaints. Provider complaints may also serve as an indicator of problems warranting regulatory concern. If late payments to health care providers
occur with substantial frequency, such practice may indicate solvency concerns or lack of responsible service, which may reveal how the regulated entity is treating insureds.

Providers are consumers in the health system and are protected by statute. At a minimum, complaint analysts should watch for provider abuses. Complaint analysts must be able to recognize the distinction between complaints involving a provider that is trying to obtain payment and complaints involving denied payments due to denial of coverage. A copy of the Colorado Department of Insurance letter to providers is included in Appendix F - sample letters.

Complaints Filed by Attorneys

Each agency should establish a consistent policy for determining how complaints filed by attorneys or consumers represented by attorneys will be handled. Such a policy should consider what potential outcomes may be achieved for the consumer by opening a complaint and the authority of the Department to become involved. For instance, in many states, it may be considered inappropriate for the complaint analyst to become involved in an issue involving questions of fact, amounts of liability, or other issues more appropriately resolved through the courts or arbitration. The Department may determine that it is appropriate to open a complaint and investigate the company’s actions where there is a concern that the company has not complied with insurance statutes or rules.

The agency may also determine that certain types of attorney generated or attorney represented complaints are not appropriately handled by the Department. Examples of such a case may be where the attorney is using the complaint process to gather information that is more appropriately found through the process of discovery or where it appears that the attorney may be involving the agency for the purpose of intimidation or harassment of the defendant. In each case, the attorney and consumer, if possible, should be advised in writing of the specific reason that the Department does not have authority to become involved in a complaint, or, conversely, if a complaint is opened, both the attorney and consumer should be advised in writing of the extent of the involvement that they can anticipate from the Department.

As with any complaint, the analyst should be careful when handling attorney generated or attorney represented complaints that he or she is not giving legal opinions, but instead is providing established policy positions of the Department.

Other Complaints Triggering Problems as to Jurisdiction

Other types of complaints which create jurisdictional issues for some, but not all, state insurance departments include: 1) federal government programs; 2) quality of medical care; 3) out-of-state contracts; 4) workers’ compensation; 5) warranties; 6) CHIP and 7) insurance marketed through banking institutions.

As a result of changes in both the banking and insurance industries, national banks have become increasingly involved in the distribution of insurance products. The increasing involvement of national banks in insurance sales activity and the applicability of state laws to these activities creates a common interest between the state insurance regulator and the Office of the Comptroller of Currency (OCC). In an effort to strengthen the relationship between these two jurisdictions several state insurance departments and the OCC have entered into an Agreement in Principle that addresses communication and cooperation between the entities. Under the agreement, consumer complaint information will be shared between the OCC and the state insurance departments. When a consumer has a complaint about
an insurance product sold by a national bank, the OCC will forward the complaint to the appropriate state insurance department. State insurance departments signing the Agreement in Principle agree to forward any complaints received about a national bank to the OCC. The agreements are a formal recognition of the functional regulation of the OCC and state insurance departments. As of February 2000, a total of 25 states have signed agreements with the OCC. All state insurance departments should be encouraged to consider signing the Agreement in Principle.

Situations also arise between two state insurance departments as to which state has jurisdiction. Examples include a citizen that purchases a policy in one state but relocates to reside in another state, and liability claims, such as automobile accidents, which occur out-of-state.

Assimilation of Data

The majority of the states do not obtain complete information from complainants if the complaint involves an entity or issue for which the state insurance department may have no jurisdiction. Other states have a coding system to identify the type of complaint and capture even those complaints for which there may be no jurisdiction to effectuate a resolution. However, the coding may place non-jurisdictional complaints in the same category as those complaints that the department has authority to resolve. For example, the coding of complaints involving ERISA may be mixed in category with traditional health insurance. States must remain cognizant of the coding issues and their impact on complaint ratios and statistics. The NAIC CDS includes disposition codes for referral to proper agency, ERISA complaints and complaints for which the insurance department has no jurisdiction. States should ensure that internal data coding is consistent with that of the NAIC CDS.

All states recognize limitations on their authority to fully resolve consumer complaints outside of state jurisdiction.

The following best practices and procedures may assist states in responding to the consumers with complaints involving jurisdictional issues.

- Determine Jurisdiction. If a regulated insurance entity is involved in the transaction generating the complaint the insurance department should call upon the insurance entity to provide a remedy where appropriate. If the complaint involves no insurance entity, then the state insurance department should be a source of information by providing a referral to the appropriate governmental agency that has the authority to correct the problem.

- Appropriate Referral. If after providing the relevant information, the consumer desires to continue with his complaint, then the state insurance department should know the appropriate governmental agency, contact person and telephone number to refer the consumer. Also private entities, especially groups assisting the elderly, may be a source to assist in advocating for the consumer.

- Maintain Data. During the intake process, the state insurance department should record as much information as practical from the consumer regarding the complaint. This information should be reported to the NAIC CDS for future study regarding trends and suspect practices, some of which may involve insurance regulated entities. Such data may be important to determine the need for legislation, or to focus public policy debates.

- Coordination. Since many types of complaints fall outside of insurance regulation, there has to be some understanding among the different states, among other state agencies and with federal

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governmental agencies as to how consumer complaints are to be resolved. States should participate in inter-agency task forces, establish routine contact with other agencies and, when appropriate enter into Memorandum of Understanding with other entities to facilitate resolution of consumer concerns.

- States should consider signing the Agreement in Principle allowing for the sharing of consumer complaint information between the OCC and state insurance departments.

- Adequate Training. The staff of the state insurance department must be trained to recognize whether jurisdiction exists and, if not, who is the appropriate party to handle the complaint. Providing the correct information to the consumer should occur at all times.

**Conclusion**

Upon review of the survey responses it is clear differences exist between the states regarding, among other things, the extent of services provided and the procedures relating to the investigation and resolution of consumer complaints. Some of these differences are the result of a conscious effort to meet the unique needs of consumers in a given state, while others are the consequence of the prioritization that must occur whenever resources are limited. It has not been the drafters intent to point out deficiencies that may exists with any state’s program. Rather, it was our goal to identify those “best practices” that, if appropriately adopted for use by the individual states, will result in better consumer service and protection on a national basis.

An advantage of regulation by the states is that each jurisdiction may establish laws and implement those laws in ways that suit the expectations of the citizens of each jurisdiction. To a great extent, it appears that many regulatory agencies are achieving that objective in assisting consumers with insurance complaints. The survey results indicate that much effort has been extended toward performing complete and accurate investigations of complaints, proper analysis of case related facts and appropriate resolution and disposition of consumer complaints. A primary effort of this white paper has been to identify areas where the preponderance of states have migrated to certain practices that appear to be efficient, effective and common between many states. Additionally, this paper has attempted to identify certain practices implemented by a few states that appear to be outstanding and should be recognized as a model, or at least as a beginning point for other states seeking to improve their regulatory processes.

Just as regulators anticipate that regulated companies will continually look at internal processes to search for areas of improvement, this paper should serve as an opportunity for regulators in all jurisdictions to critically review procedures and processes involving consumer complaints to determine if the needs of its consumers are satisfied. This paper should also serve as a reminder of just how valuable the information gathered from the complaint process is for other divisions as they carry out their responsibilities to the public and in the development of public policy. Additionally, regulators must remember that the complaint resolution function is generally the most visible of all department functions and how well the needs of consumers are met will in large part shape the public’s perception of the department as a whole.
Appendix A Sample Claim Forms from State Web Sites

Electronic Consumer Complaint Form

You may complete the form on screen and send it to us by pressing the Send button below.

**Important Notice**: Under Illinois Insurance laws, disclosure of this information is voluntary. However, failure to supply complete information may result in this complaint not being processed.

Your Name: 
Address: 

City, State and Zip: 

Home Phone: 

Work Phone: 

e-mail: 

Name of Person Insured: 

Complaint is Against: 

Address of Company or Agent: 

Type of Insurance: 

Policy Number: 

Claim Number: 

Please state your complaint. You may be asked to send supporting documents by mail or fax.

Questions? Contact dale_emerson@ins.state.il.us
Appendix A

Commonwealth of Pennsylvania
Complaint Form

As an insurance consumer of the Commonwealth of Pennsylvania, you may submit a complaint electronically. You also can download the complaint form and mail or fax it to the Bureau of Consumer Services. Addresses and fax numbers for the regional offices are listed at the bottom of this page."
It is our goal to assist you in resolving your complaint as quickly as possible. Therefore, the more information and supporting documentation you provide with your complaint, the better we will be able to assist you in a timely manner. If your complaint requires submission of supporting documentation, we urge you to submit your package of correspondence and the complaint form by mail or fax.
You will receive an acknowledgment within a few days of our receipt of your complaint advising you of the name and telephone number of the investigator assigned to assist you and the file number of your case.

Name: ___________________________
Address: _________________________
City: _____________________________ State: ___________ Zip: _____________

Phone number where you can be reached during the day: _________________________
E-Mail Address: ____________________
Insured's Name: (if different from above) __________________________

Type of Insurance: (Please select one)
☐ Auto
☐ Homeowner
☐ Commercial

☐ Individual Life
☐ Group Life
☐ Annuity

☐ Individual Health
☐ Group Health
☐ HMO

Type of Problem: (Please select one)
If your problem involves an insurance company, give the full name of the company:

If your problem involves an agent or broker, give his/her full name, address and phone number:

Policy Number:

In what State was this policy sold?

Date & location of loss:

Claim #:

Have you previously reported this problem to our office or any other agency?  Yes  No
If yes, to whom?

File Number:

Are you represented by an attorney?  Yes  No
If yes, please give name, address and telephone #.

Note: If you have proceeded with litigation against the company and/or agent we will not be able to assist you until the litigation has been completed and the court has found misconduct on the part of these parties. Briefly describe your problem and state how you feel it should be resolved. If you have copies of your policy or other supporting documentation that will assist us in understanding or evaluating the issues, please print this form and mail it along with the documentation to one of the regional offices listed below.
HARRISBURG REGIONAL OFFICE
Room 1321 Strawberry Square
Harristown State Office Bldg. #1
Harrisburg, PA 17120
Phone: (717) 787-2317
Fax: (717) 787-8585

PHILADELPHIA REGIONAL OFFICE
Room 1701 State Office Bldg.
1400 Spring Garden Street
Philadelphia, PA 19130
Phone: (215) 560-2630
Fax: (215) 560-2648

PITTSBURGH REGIONAL OFFICE
Room 304 State Office Bldg.
300 Liberty Avenue
Pittsburgh, PA 15222
Phone: (412) 565-5020
Fax: (412) 565-7648

ERIE REGIONAL OFFICE
Room 808 Renaissance Center
10th & State Streets - PO Box 6142
Erie, PA 16512
Phone: (814)-871-4466
Fax: (814) 871-4888

Last modified on Wednesday, June 02, 1999
Appendix A

Florida Department of Insurance
Do You Need Our Help?

Need help regarding your insurance policy?
Fill out the Consumer Assistance Request form below, or download this form using Adobe Acrobat for later use and/or printing. Please be sure to include your mailing address.
You may also call the Insurance Consumer Helpline at 1-800-342-2762 between the hours of 8 a.m. and 4:45 p.m. EST Monday through Friday.
Fields marked with * are mandatory.

*First Name: [ ] *Last Name: [ ]
*Street
Address: [ ]
*City: [ ] *State: [ ] *Zip: [ ]
*County: [ ]
Home Telephone: [ ] Work Telephone: [ ]
E-mail address: [ ]
Your Age Group: [ ] Under 25 [ ] 25-49 [ ] 50-64 [ ] 65 and up

Type of Insurance:
[ ] Accident & Health [ ] Medicare Supplement [ ] Life & Annuities
[ ] Personal P&C [ ] Commercial P&O [ ] Warranties [ ] Motor Vehicle
[ ] Residential P&C [ ] Health Maintenance Org Miscellaneous
Name of Insurance Company: 
Name of Insured: (as shown on policy) 
Policy Number: 
Claim Number: 
Agent First Name: Agent Last Name: 
Adjuster First Name: Adjuster Last Name: 
Date of Loss: (please use 8 digits (mm/dd/yyyy), i.e. "12/28/1998") 

* Briefly explain your complaint in the order of events (Please limit your response to 480 characters - about 8 lines).
Appendix B

**NAIC STANDARD COMPLAINT DATA**

*FIELDS WHICH ARE SHAPED ON THIS FORM MUST BE USED FOR REPORTING MEDICARE SUPPLEMENT COMPLAINT INFORMATION THROUGH THE CDS.*

<table>
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<tr>
<th>State:</th>
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<th>Date Closed:</th>
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**Complaint Against**

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<table>
<thead>
<tr>
<th>Address:</th>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
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**Complainant/Insured Information**

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<tr>
<th>Complainant Zip Code:</th>
<th>Insured Age Group: 1 2 3 4</th>
<th>Age Group Codes: 1 = &lt; 25; 2 = 25 to 49; 3 = 50 to 64; 4 = 65 +</th>
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<table>
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<tr>
<th>Complainant Type Code:</th>
<th>Medicare Supplement Policy Type Code:</th>
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**Type of Coverage**

*Select only one (1) item from the first level of coverage listed; up to three (3) may be selected from the second level.*

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<th>AUTO</th>
<th>LIFE &amp; ANNUITY</th>
<th>FIRE, ALLIED LINES &amp; CMP</th>
<th>ACCIDENT &amp; HEALTH</th>
<th>LIABILITY</th>
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<tr>
<td>0105</td>
<td>0405 Individual Life</td>
<td>0205 Fire, Allied Lines</td>
<td>050505 Individual</td>
<td>0605 General</td>
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<td>0107</td>
<td>0410 Group Life</td>
<td>0207 Crop/Hail</td>
<td>0510 Group</td>
<td>0610 Products</td>
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<tr>
<td>0110 Commercial</td>
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<td>0210 Commercial Multi-Peril</td>
<td>0515 Credit</td>
<td>0615 Professional E &amp; O</td>
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<td>0115 Motorcycle</td>
<td>0417 Group Annuities</td>
<td>0215 Credit Property</td>
<td>0517 Other</td>
<td>0617 Umbrella</td>
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<td>0120 Motorhome/Recreational Vehicle</td>
<td>0420 Credit Life</td>
<td>0217 Dwelling Fire</td>
<td>0520 Accident Only</td>
<td>0618 Directors &amp; Officers</td>
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<tr>
<td>0123 Motorsport</td>
<td>0425 Accelerated Benefits</td>
<td>0218 Builder's Risk</td>
<td>0525 Disability Income</td>
<td>0620 Other</td>
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<tr>
<td>0124 Rental</td>
<td>0430 Other</td>
<td>0220 Other</td>
<td>0530 Health Only</td>
<td>0625 Employment Policy</td>
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<td>0125 Other</td>
<td>0435 Accidental Death &amp; Dismemberment</td>
<td>0225 Liability</td>
<td>0535 Medicare Supplement</td>
<td>0630 Excess Loss</td>
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<td>0635 Medical Malpractice</td>
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<td>0540 Long-Term Care</td>
<td>0640 Pollution</td>
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<td>0235 Fire - Real Property</td>
<td>0541 Home Health Care</td>
<td>0695 Other</td>
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<td>0240 Personal Property</td>
<td>0543 Mental Health</td>
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<td>0554 Pre-existing Condition</td>
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<td>0555 Cancer/Deaf Disease</td>
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<td>0556 Self-funded/ERISA</td>
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<td>_1005 Unsatisfactory Settlement/Offer</td>
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<td><em>0710 Fidelity &amp; Surety</em></td>
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<td>_1023 Utilization Review</td>
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**Reason for Complaint**
Select up to three (3) items per category.

**Disposition**
Select up to three (3) items.

| 1205 Policy Issued/Restored                        | 1240 Referred to Proper Agency | 1275 Apparent Unlicensed Activity |
| 1207 Advised Complainant                           | 1243 Appointed                 | 1277 Deductible Refunded          |
| 1208 Compromised Settlement/Resolution             | 1244 Licensed                 | 1278 Forfeiture                   |
| 1210 Additional Payment                            | 1245 Advertising Withdrawn/Amded | 1280 Referred for Disciplinary Action |
| 1215 Refund                                        | 1250 Underwriting Practice Resolved | 1285 Question of Fact            |
| 1217 Entered into Arbitration/Mediation            | 1253 Information Furnished/Expanded | 1287 Rating Problem Resolved      |
| 1220 Coverage Extended                             | 1255 Delay Resolved            | 1290 Contract Provision/Legal Issue |
|                                                    | 1257 Fine                     | 1293 Company in Compliance        |
|                                                    | 1260 Cancellation Notice Withdrawn | 1295 Company Position Upheld     |
|                                                    | 1228 Nonrenewal Upheld        | 1297 Endorsement Processed        |
|                                                    | 1265 Nonrenewal Notice Rescinded |                                  |
|                                                    | 1267 Nonforfeiture Problem Resolved |                                  |
|                                                    | 1270 Premium Problem Resolved  |                                  |
|                                                    | 1273 ERISA Complaint          |                                  |
|                                                    | 1275 Apparent Unlicensed Activity |                                  |
|                                                    | 1277 Deductible Refunded       |                                  |
|                                                    | 1278 Forfeiture                |                                  |
|                                                    | 1280 Referred for Disciplinary Action |                              |
|                                                    | 1285 Question of Fact          |                                  |
|                                                    | 1287 Rating Problem Resolved   |                                  |
|                                                    | 1290 Contract Provision/Legal Issue |                           |
|                                                    | 1293 Company in Compliance     |                                  |
|                                                    | 1295 Company Position Upheld   |                                  |
|                                                    | 1297 Endorsement Processed     |                                  |
|                                                    | 1300 No Jurisdiction           |                                  |
|                                                    | 1303 Recovery                  |                                  |
|                                                    | 1305 Insufficient Information  |                                  |
|                                                    | 1310 Other                     |                                  |
### Entity Type Codes

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<td>Adjuster/Appraiser</td>
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<tr>
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<td>Alien Insurer or Reinsurer</td>
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<tr>
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<td>Bail Bond Agency</td>
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<td>Bogus</td>
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<td>CAI</td>
<td>Captive Insurer</td>
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<tr>
<td>HCP</td>
<td>Health Care Provider</td>
<td></td>
</tr>
<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
<td></td>
</tr>
<tr>
<td>INC</td>
<td>Insurance Consultant</td>
<td></td>
</tr>
</tbody>
</table>

### Entity Function Codes

<table>
<thead>
<tr>
<th>Categories</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Underwriting Association</td>
<td>JUA</td>
</tr>
<tr>
<td>Key Employee</td>
<td>KEE</td>
</tr>
<tr>
<td>MEWA or Multiple Employer Trust</td>
<td>MET</td>
</tr>
<tr>
<td>Managing General Agent</td>
<td>MGA</td>
</tr>
<tr>
<td>Officer</td>
<td>OFF</td>
</tr>
<tr>
<td>Other</td>
<td>OTH</td>
</tr>
<tr>
<td>Public Adjuster</td>
<td>PAJ</td>
</tr>
<tr>
<td>Premium Finance Company</td>
<td>PPC</td>
</tr>
<tr>
<td>Preferred Provider Organization</td>
<td>PPO</td>
</tr>
<tr>
<td>President</td>
<td>PRE</td>
</tr>
<tr>
<td>Principal or Owner</td>
<td>PRI</td>
</tr>
<tr>
<td>Producer (agent, broker, solicitor, etc.)</td>
<td>PRO</td>
</tr>
</tbody>
</table>

### Function Codes: Relation to Entity Type

- **IND**
- **FRM**
- **EITHER**
  - ADJ
  - BGA
  - BOG
  - CAI
  - CEE
  - HMO
  - JUA
  - KEE
  - MET
  - MGA
  - OFF
  - OTH
  - PAJ
  - PPC
  - PPO
  - PRE
  - PRI
  - PRO
  - UDI

- **AMER**
- **ASSN**
- **ASSOC**
- **ASSR**
- **CO**

- **Corporation**
- **Incorporated**
- **Insurance**
- **International**
- **Limited**

### Standard Abbreviations

- **AMER**
- **ASSN**
- **ASSOC**
- **ASSR**
- **CO**
- **CORP**
- **INC**
- **INS**
- **INTL**
- **LTD**
- **NATL**
- **MGT**
- **MUT**
- **PSHIP**
- **REINS**

### 2-Letter State Abbreviations

- **AL**
- **AK**
- **AS**
- **AZ**
- **AR**
- **CA**
- **CN**
- **CO**
- **CT**
- **DE**
- **DC**
- **FL**
- **MA**
- **MI**
- **MN**
- **MS**
- **MO**
- **MT**
- **NE**
- **NV**
- **NH**
- **NJ**
- **NM**
- **NY**
- **NC**
- **ND**
- **OH**
- **OK**
- **OR**
- **PA**
- **PR**
- **RI**
- **SC**
- **SD**
- **TN**
- **TX**
- **UT**
- **VT**
- **VA**
- **WA**
- **WV**
- **WI**
- **WY**

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Appendix C

Florida Dept. Of Insurance
Audit Procedures and Forms

No.: I3900.15
Effective Date: 08-21-92
Revision Date: 3-23-99

I. TITLE
Audits of Office and Insurance Consumer Files

II. STATEMENT OF POLICY
It is the policy of the Division of Insurance Consumer Services that office operations and insurance consumer files shall be audited to ensure quality service is being provided to the Division’s customers and proper training and tools are being provided to staff.

III. PURPOSE OR OBJECTIVE
To provide all staff of the Division of Insurance Consumer Services with uniform procedures for auditing offices and insurance consumer files.

IV. DEFINITIONS

Monthly Audit of Insurance Consumer Files: Monthly review of insurance consumer files to ensure they are handled in accordance with established policies and procedures.

Periodic Audit of the Office: A Periodic review, conducted no less than annually, of office activities to ensure that they are being handled in accordance with established policies and procedures. These activities include, but are not limited to, overall workload, consumer file and inquiry handling, file referrals, outreach programs, disaster handling, staff training, and the overall office environment.

Office: refers to the individual offices of the Bureau of Consumer Outreach and Education and to the Units of the Bureau of Consumer Assistance.

Office Supervisor: refers to the manager charged with operating the office.

V. PROCEDURES

Assigned auditor(s):

The Monthly Audit is the responsibility of the office supervisor.
The Periodic Audit is the responsibility of the Bureau Chief and/or his/her designee.

Responsibilities of Auditor:

1. To conduct the audit in accordance with audit definition as defined by established policies & procedures.

2. To document the audit and its findings.

3. To report deficiencies to the staff member responsible for the activity.

4. To work with the responsible staff member to devise an action plan for correcting areas not in compliance with established policies and procedures.
# MONTHLY FILE AUDIT FORM

**FLORIDA DEPARTMENT OF INSURANCE**  
**DIVISION OF INSURANCE CONSUMER SERVICES**  
**MONTHLY FILE AUDIT FORM**

<table>
<thead>
<tr>
<th>DATE:</th>
<th>FILE NAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SPECIALIST:</th>
<th>FILE #:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date Received</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date Opened/Date Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opened w/in 5 work days?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Closed w/in 5 work days?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diary procedure followed?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Correspondence:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consumer's questions answered in layman's terms?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grammatically correct and directed to Proper parties?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technically correct?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did we provide an appropriate level of Customer service? Was it quality service?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did the issue involve a referable violation? Was file referred?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Was the explanation clear &amp; accurate?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Was all activity accurately and properly recorded in the file log?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is the file coding correct?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Comments/Suggestions/Trends:

Administrator __________________________  Date ____________

Insurance Specialist _____________________  Date ____________

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PERIODIC OFFICE AUDIT FORM

A. OFFICE WORKLOAD

TOTAL NUMBER OF FILES OPENED:
TOTAL NUMBER OF FILES CLOSED:
AVERAGE NUMBER OF DAYS TO close A FILE: 30  __ 60  ____ 90 ______
TOTAL FILES OPEN ON AUDIT DATE:
TOTAL NUMBER OF WALK-INS:

B. CONSUMER OUTREACH PROGRAMS

TOTAL NUMBER OF COPS DONE:
FIELD TRIPS: ___ SPEECHES: ___ FAIRS: ___
OTHER:
NEW PROGRAMS & IDEAS:

C. EMPLOYEE TRAINING

IN-HOUSE STAFF:
IN-HOUSE INVITEE:
CROSS TRAINING:
OUTSIDE SOURCE:
"INSURANCE INSIGHTS" DEVELOPED:
NEW EMPLOYEE OFFICE ORIENTATION:

D. STAFFING

VACANCIES:
PENDING APPOINTMENTS:
MEETINGS:
STAFF MATTERS:

E. CATASTROPHE PROCEDURES

MANUAL UPDATED SEASONALLY:
STAFF MEETINGS:
TEAM MEMBERS HAVE OUTSIDE MANUAL:

F. REFERRAL PROCEDURES

NUMBER OF FILES TO A&A:
NUMBER OF FILES TO M/C P&C:
NUMBER OF FILES TO M/C L&H:
NUMBER OF FILES TO FRAUD:
NUMBER OF FILES TO REHAB. & LIQUIDATION:
NUMBER OF FILES TO MISC.:
PROPER PROCEDURES FOLLOWED:

COMMENTS/TRENDS:
G. TOPICS OF CONCERN

TRENDS:

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OFFICE PARTICIPATION:

H. LEGISLATIVE SUGGESTIONS

STATUTES:
RULES:
CURRENT RULE MANUAL:
LOG:

I. GOALS

OFFICE:
BUREAU:
DIVISION:

J. OVERALL OFFICE ENVIRONMENT

LIBRARY:
LOBBY:
INDIVIDUAL OFFICES:
FILE ROOM:
CONSUMER FRIENDLY:

K. COMMENTS/TRENDS/SUGGESTIONS

DATE OF AUDIT: ____________________

REVIEWER'S SIGNATURE: ____________________ DATE: __________
Appendix C
Colorado Division of Insurance
CASE INVESTIGATION AUDIT SHEET

Analyst: ____________________ Division File Number/Name: ____________________

FACTOR:  TIMELINESS          RATING WEIGHT 15

MAINTAINED TIME STANDARD FOR SENDING INITIAL LETTER (5) __________
MAINTAINED TIME STANDARD FOR SENDING STIPULATION LETTER (5) __________
MAINTAINED TIME STANDARD FOR SENDING CLOSING LETTER (5) __________

PERFORMANCE RATING __________

FACTOR:  COMPLETE INVESTIGATION       RATING WEIGHT 60

INVESTIGATED ALL POSSIBLE INSURANCE VIOLATIONS & CONSUMER CONCERNS (25) __________
APPROPRIATE DOCUMENTATION OBTAINED DURING INVESTIGATION (15) __________
APPROPRIATE FOLLOW-UP ACTION PURSUED (10) __________
F.R.E.D. INPUT COMPLETE (10) __________

PERFORMANCE RATING __________

FACTOR:  CORRESPONDENCE          RATING WEIGHT 20

APPROPRIATE ISSUES ADDRESSED IN CORRESPONDENCE (8) __________
CORRECT GRAMMAR, USAGE & SPELLING (2) __________
APPROPRIATE DOCUMENTATION REQUESTED (6) __________
APPROPRIATE LEGAL CITATIONS (3) __________
RESPONSE TIME SPECIFIED (1) __________

PERFORMANCE RATING __________

FACTOR:  CLOSURE                RATING WEIGHT 5

CONFIDENTIALITY PROCEDURES FOLLOWED (2) __________
APPROPRIATE CODING UTILIZED (3) __________

PERFORMANCE RATING __________

TOTAL RATING __________

COMMENTS: ____________________

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Appendix C

DATE: ___________  FILE #: ___________  INVESTIGATOR: ___________

Date Received: ___________
Date Assigned: ___________
Date Opened: ___________
Opened within 3 work days? ______Yes____No
Acknowledgement letter within 3 work days? ______Yes____No

No

Investigative/Inquiry letter within 3 work days? ______Yes____No

Date Final Response Received: ___________
Closed within 5 work days? ______Yes____No  Final communication letter sent? ______Yes____No

CORRESPONDENCE
Timely follow-up to correspondences? ______Yes____No
Consumer’s questions answered in layman’s terms? ______Yes____No
Grammatically correct and directed to proper parties? ______Yes____No
Chronologically placed in file? ______Yes____No

ENFORCEMENT ISSUES
Investigative/Inquiry letter clear in relevant information needed? ______Yes____No
- copy of complaint letter sent to company/agent? ______Yes____No
Violation of statutes or regulations identified? ______Yes____No
Actions recommended? ______Yes____No

Jurisdictional authority? ______Yes____No
If No, was complaint referred to proper authority within 2 work days? ______Yes____No
Did the issue involve a referable violation? ______Yes____No
If Yes, was filed referred? ______Yes____No If Yes, to who? _____________________________

Was all activity accurately and properly recorded in the file log? ______Yes____No
Is the file coding correct? ______Yes____No

Comments/Suggestions/Trends: ____________________________

_________________________  ___________________________
SUPERVISOR  INVESTIGATOR

_________________________  ___________________________
DATE  DATE

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Appendix C  
California Quality Control Form

OFFICER NAME
DATE RECEIVED BY BUREAU:
FILE CLOSED:

FILE NUMBER:
NUMBER OF WORKDAYS FILE WAS OPEN:
DATE

<table>
<thead>
<tr>
<th>REVIEW CATEGORIES</th>
<th>FILE CORRECT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DID DEPARTMENT COMPLY WITH CIC 12921.4?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>DID OFFICER COMPLY WITH CIC 12921.4?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WAS CORRECT CODING USED?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WERE ALL BUREAU FILE HANDLING PROCEDURES FOLLOWED?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;WAS RESOLUTION THOROUGH,&quot; &quot;LOGICAL, APPROPRIATE, AND &quot; ALL NECESSARY ACTION TAKEN?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WAS RESOLUTION IN &quot;COMPLIANCE WITH CIC, RELATED&quot; &quot;REGS AND LAWS, INCLUDING&quot; JUSTIFIABILITY?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WAS CORRESPONDENCE &quot;CLEAR, CONCISE, USING PROPER&quot; &quot;GRAMMAR, &amp; FREE OF SPELLING&quot; &amp; PUNCTUATION ERRORS?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

REVIEWERS COMMENTS:

OFFICER'S PLAN OF ACTION:

OFFICER'S SIGNATURE: 

DATE

SENIOR'S SIGNATURE:

DATE
## Appendix D Workload Forms

Kentucky Department of Insurance  
Consumer Protection & Education Division  
Investigator Work Load Status 9/99

<table>
<thead>
<tr>
<th>INVESTIGATOR:</th>
<th>DATE:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>FOR PERIOD: FROM</th>
<th>TO</th>
</tr>
</thead>
</table>

# Of Available Work Days for Above Period: 

# Of Days Worked During Above Period: 

### I. Total number of files opened YTD:

<table>
<thead>
<tr>
<th>Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. health</td>
<td></td>
</tr>
<tr>
<td>b. life</td>
<td></td>
</tr>
<tr>
<td>c. auto</td>
<td></td>
</tr>
<tr>
<td>d. property</td>
<td></td>
</tr>
<tr>
<td>e. other</td>
<td></td>
</tr>
</tbody>
</table>

List Types:

### II. Total number of files closed YTD:

### III. Number of open files this date:

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30 days:</td>
<td></td>
</tr>
<tr>
<td>&gt;30 days &lt;60 days:</td>
<td></td>
</tr>
<tr>
<td>&gt;60 days &lt;90 days:</td>
<td></td>
</tr>
<tr>
<td>&gt;90 days:</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX E
IRES Education Requirements

Curriculum Requirements for AIE/CIE

State insurance departments, as well as the National Association of Insurance Commissioners, formally recognize the two professional designations developed and awarded by the Insurance Regulatory Examiners Society -- AIE and CIE. This program demonstrates the Society's belief that insurance regulators, like other professionals, must continually commit themselves to education and training in order to remain abreast of the complex issues with which they deal every day.

Before seeking accreditation, a regulator must have completed at least two years of full time regulatory work. Reminder: The new three year regulatory work requirement for CIE applicants will be effective August 1, 2002. All CIE accreditation applicants after that date must show that they have worked in insurance regulation for at least three years.

Recognition as an AIE (Accredited Insurance Examiner) involves a course of study in either of the two primary fields of insurance regulation -- property & casualty or life & health -- and the insurance field itself. Preliminary certification requires completion of at least eight professional development courses.

The designation of CIE (Certified Insurance Examiner) is presented to an insurance regulatory professional who has attained the AIE in one field and then cross-trains in the other field by taking four additional courses.

Life and Health Educational Path

These courses may be taken in any order. Passage of eight of the following courses is necessary to obtain an AIE. [American College course equivalents, shown in brackets, may be used as a substitute.]

1. FLMI 280 - Principles of Life and Health Insurance. Introduction to life and health insurance products. [HS 323]

2. FLMI 290 - Life and Health Insurance Company Operations. Examination of company functions and activities. [HS323,324,325]

3. FLMI 310 - Legal Aspects of Life and Health Insurance. Review of laws that affect products and operations. [HS 324]

4. FLMI 320 - Marketing Life and Health Insurance. Functions and understanding of basic marketing principles.


6. FLMI 340 - Information Management in Insurance Companies. Management systems and statistical tools used in decision making.


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8. ICA C3 - The Claims Environment. Claim practices, philosophy, decisions and considerations.

The following courses will be added as of September 1, 2000:

9. ICA C1 – Medical and Dental Aspects of Claims
10. AIRC 410 – Regulatory Compliance – Companies, Producers and Operations
11. AIRC 411 – Regulatory Compliance – Insurance and Annuity Products

To obtain a CIE designation, you must take and pass the following four additional courses:

1. INS 21 - Principles of Insurance. Basic insurance contracts, analysis, marketing, underwriting, etc.
2. CPCU 5 - Insurance Company Operations. Examination of company functions and activities.
3. CPCU 6 - The Legal Environment of Insurance. General business law and its application to insurance.
4. ARP 101 - Business Research Methods. Statistical analysis, evaluation and reporting techniques. [In lieu of ARP 101, applicant may substitute a course from the property-casualty path]

Note: ARP 101 will no longer be required after September 1, 2000. The following courses have been added instead:

5. IR 201 – Insurance Regulation
6. AIC 34, 35, or 36 – Claims [may only count 1 course]

Property and Casualty Path

These courses may be taken in any order. Passage of any eight of the following ten courses is necessary to obtain your AIE.

1. INS 22- Personal Insurance. Personal loss exposures and various kinds of insurance available to protect individuals and families from financial consequences of personal losses.
2. INS 23 - Commercial Insurance. Review of commercial lines policy forms.
4. CPCU 4 - Commercial Liability Risk Management & Insurance. Survey of commercial liability loss exposure and the insurance coverage and the noninsurance techniques used to manage those exposures.
5. CPCU 5 - Insurance Company Operations. Examination of company functions and activities.
6. CPCU 6 - The Legal Environment of Insurance. General business law and application to insurance.
7. CPCU 7 - Management. Principles and problems and an introduction to insurance management information systems.

8. CPCU 8 - Accounting and Finance. Basic accounting/finance and an introduction to insurance accounting.

9. CPCU 9 - Economics. General economic concepts at the micro and macro levels, with particular emphasis on applications to insurance operations.


The following courses will be deleted as of September 1, 2000:

* AIC 33 – Claims Handling
* CPCU 8 - Accounting
* ARP 101 – Business Research Methods

The following courses will be added as of September 1, 2000:

11. IR 201 – Insurance Regulation
12. AIAF 111 – Insurance Accounting
13. AIC 34, 35, or 36 – Claims [may only count one course]

To obtain a CIE designation, you must take and pass the following four additional courses. [American College course equivalents, shown in brackets, may be used as substitute.]

1. FLMI 280 - Principles of Life and Health Insurance. Introduction to life and health insurance products. [HS 323]

2. FLMI 290 - Life and Health Insurance Company Operations. Examination of company functions and activities. [HS 323,324,325]

3. FLMI 320 - Marketing Life and Health Insurance. Functions and understanding of basic marketing principles.

4. FLMI 340 - Information Management in Insurance Companies. Management systems and statistical tools used in decision making.

The following courses will be added September 1, 2000:

5. AIRC 410 – Regulatory Compliance – Companies, Producers and Operations
6. AIRC 420 – Regulatory Compliance – Insurance and Annuity Products

I. Continuing Education

IRES members who have earned either the AIE or CIE designation must also take part in ongoing continuing education, thus assuring the continuing integrity of the designations.
Appendix F  Sample Letters

Colorado Division of Insurance
Health Care Provider Letter

Dear Provider:

Thank you for your letter regarding delay or nonpayment of your claim, or other issues relating to payment for services rendered. The Division of Insurance does not have broad jurisdiction to assist you in your dispute with a carrier, so allow me to take time to explain your rights and obligations under Colorado law.

First, as a general rule, the Division does not have jurisdiction to arbitrate, mediate, or settle disputes between a carrier and its providers regarding contractual arrangements, such as the level and method of payment. The Division will not take a position in contract negotiation issues.

Having said that, the Division can get involved, and is concerned with, the procedures by which a carrier resolves payment or other provider disputes. Regulation 4-2-7 requires the prompt investigation and payment of policyholder claims. Interest must be paid to the insured on indemnity claims that are not paid within 60 days. However, no provision for payment of interest is made for late claims submitted directly by providers under managed care contracts. Late fees may be a negotiated provision in your contract. Further, if you are a provider with a managed care plan, Colorado law requires a provision in your managed care contract that you will not bill the patient directly in the event you are unable to collect charges from a carrier.

A recent law requires a carrier to have and utilize dispute resolution mechanisms for payment or claims disputes as well as other contractual issues. If you have not attempted to utilize such internal dispute resolution mechanisms, this process is intended to provide a reasonable and expedient means to resolve issues. The outcome of that “appeal” may be denial of your claim, or other result, unsatisfactory to you. In the majority of cases, the next step is to seek legal enforcement of what you believe are your contract rights. The Division will not play a role in such arbitration, mediation or litigation.

Please note that there may be other resources available to assist you in this dispute resolution.

One such program is “Project Hassle Factor”, a recent initiative by the Colorado Medical Society to assist member physicians and other providers with carrier disputes. The Division does not sponsor, aid, or otherwise endorse this or any other initiative, but we note it as a resource. You may contact the Colorado Medical Society at (303) 779-5455.

It may turn out that the carrier does not have a dispute resolution mechanism, or refuses to use reasonable conduct in such resolution processes. If you believe that an insurer has failed to implement, or comply with, internal carrier dispute resolution procedures, required by Section 10-16-705(13), C.R.S., or is engaged in a pattern of slow or no payment, please inform the Division, in writing, describing the procedures used by your office to contact and request resolution of your dispute in accordance with the required dispute resolution process.

If you have any questions, please feel free to contact me at (303) 894-7499.

Sincerely,
Appendix F

Colorado Division of Insurance
(No-fault Auto Letter to be used for providers and attorneys)

Date

Name

Division File No.:  
Division File Name:

Dear PROVIDER/ATTY:

I am in receipt of your complaint letter of …..

Review of this matter indicates that your complaint concerns the disposition of a PIP claim against (INSURANCE CO. NAME), on behalf of your client(patient) (NAME). You request that the Division of Insurance review...(I.E. DIRECT THE DIVISION OF INSURANCE TO INSTRUCT THE INSURER TO PAY THE OUTSTANDING BILLS)

Insurance law does not allow the Division of Insurance to determine if treatment is reasonable, necessary or related to the accident. However, if your firm disagrees with (INSURANCE COMPANY’S) handling of your client's(patient’s) PIP claim, the following prescribed options are available by insurance law:

1) If treatment was conducted within the PPO network, you may file for a reconsideration with the insurer. If the reconsideration does not change the outcome, you may appeal. If the appeal does not change the outcome, the insured may request an IME at his/her own expense through the State IME Administrator.

2) If treatment was conducted totally outside the PPO network, the insured may, at his/her own expense, request an IME to address his/her injuries through the State IME Administrator.

3) If treatment was not provided under a PPO/PIP program, the insured may request an IME, at his/her own expense, through the State IME Administrator.

4) Request that the Insurer voluntarily engage in Arbitration for PIP disputes pursuant to Regulation 5-2-7.

5) Have your concerns addressed by an appropriate court of competent jurisdiction.

The Division of Insurance is not a trier of fact nor is it able to settle disputes over the treatment recommendations of medical doctors. Once you have addressed the options available to you as provided for under Section 10-4-708 C.R.S., regarding prompt payment of direct benefits, and a dispute still exists, you may re-file your complaint with our office. At that time, the Division of Insurance will begin a complete investigation of this matter on behalf of your client(patient).
Additionally, you should note that Section 10-4-115 C.R.S. allows an insurer to use a Utilization Review Service to determine if your charges were reasonable, necessary and related to the motor vehicle accident. Section 10-4-706(g)(h) C.R.S. states: "In the event the finding, opinions, and conclusion of the PIP review panel member are contrary to the statement of causation, diagnosis, prognosis, plan of treatment, opinions, or recommendations of the treating practitioner whose actions have been reviewed, any party dissatisfied with such findings, opinions, and conclusions may seek and pay for a second PIP examination under the procedures set forth in paragraphs (c) and (d) of this sub-section (6). In any arbitration or judicial proceeding commenced by the insurer, insured or the injured person entitled to benefits, the findings, opinions, and conclusions of the PIP examination shall be presumed to be correct, but such presumption may be rebutted by a preponderance of the evidence."

Thank you for your bringing this matter to our attention.

Sincerely,
Appendix F

Maine Bureau of Insurance
Sample Provider Letter

Dear PROVIDER,
This letter serves to acknowledge your complaint, received here on [DATE]. My apologies for the delay in responding. The Bureau has been grappling with formulating a policy for handling provider complaints, which have been increasing in number, as have the complaints we receive from consumers. Our resources are limited and we regularly struggle with whether we should limit our focus to the consumers it is our agency mission to protect. Because our loss of a complaint analyst coincided with our complaint volume problem, I volunteered to review September and October provider complaints to get a feel for the nature of the issues being raised as a first step to developing a policy for responding to provider complaints.

I have reviewed the complaints received during that period, and the Bureau has concluded that we will handle provider complaints subject to the following general principles:

- The Bureau recognizes the critical role providers play in Maine’s health care delivery system. Your experience and frustration help us better understand and regulate our licensees.
- The Bureau believes provider education on the consumer protection standards in Maine law and regulation is an important element to ensuring health carrier compliance with those standards.
- Because the Bureau’s resources are limited, contracted providers are encouraged to familiarize themselves with the terms of the contracts they have entered into with health carriers, including the arbitration clauses in place to resolve conflicts.
- The Bureau expects providers to attempt to resolve their problems with health carriers before seeking our assistance.
- If providers seek the Bureau’s assistance with a particular problem, we expect the problem to be documented. Explanatory narratives should accompany documentation (such as coded billing records and claims), that is not self-explanatory.
- The Bureau does not expect to be viewed as a provider collection agency for billing problems, but will monitor the nature and magnitude of payment problems brought to our attention.
- The Bureau will explore with provider associations whether or not they are interested in developing provider complaint resolution projects such as those in existence in other states.
- Providers pursuing a complaint on behalf of a patient should be sure to have the patient’s authorization for the Bureau to review any medical records we may need to access in order to investigate the complaint. Bureau consumer complaint forms include a consumer authorization signature line. The complaint form also includes a provider authorization box indicating the patient has authorized the provider’s release of patient medical records.

Moving forward, provider complaints will be logged into the system and assigned to a complaint analyst. This will ensure timely acknowledgement of complaints received, something that did not occur with your complaint. Again, please accept my apologies the delay. Your complaint has now been referred to a complaint analyst for review and response and you should be hearing from them in the near future.

If you have any questions, please don’t hesitate to call.

Sincerely,

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February 28, 2000

RE: Complainant:
MIA File No:
Policy No:

Dear:

Insurance Company

We received a complaint/inquiry from the above named complainant and are enclosing a copy of their correspondence. Please specifically address all concerns raised in the complaint and describe any steps you may have taken or will be taking to resolve the problem. Also, please answer the following questions, and provide the specific documents we are requesting, as well as any other relevant documents:

1. A copy of the policy.
2. A copy of the cancellation notice.
3. What is the policy effective date?
4. What are the applicable underwriting standards and/or rating rules?
5. What is the cancellation date?
6. What is the reason for the cancellation of the policy?
7. Why wasn’t policy canceled on 9/30/99 per insured’s request?
8. Has cancellation been revised to reflect coverage with XYZ Insurance Company?

We are requesting your reply within fifteen (15) working days from the date of this letter. If compliance is not possible, please acknowledge and provide estimated response date. Failure to provide a complete and/or timely response may result in administrative action.

Sincerely

Insurance Investigator
(410) 468-2359

Enclosure cc:

525 ST PAUL PLACE - BALTIMORE, MARYLAND 21202-2272 - DIRECT DIAL (410) 468--
(410)468-2000 * Outside Baltimore Metro Area. Toll Free 1-800-492-6116 * FAJL- (410) 468-2020 TTY Users via the Maryland Relay Service at 1-800-735-2258
DATE

RE: Complainant: MIA
    File No: Policy No:
    Claim No:

Dear

We received a complaint/inquiry from the above named complainant and are enclosing a copy of their correspondence. Please specifically address all concerns raised in the complaint and describe any steps you may have taken or will be taking to resolve the problem. Also, please answer the following questions, and provide the specific documents we are requesting, as well as any other relevant docum3nts:

<INSERT QUESTIONS HERE>

We are requesting your reply within fifteen (15) working days from the date of this letter. If compliance is not possible, please acknowledge and provide estimated response date. Failure to provide a complete and/or timely response may result in administrative action.

Sincerely,

Insurance Investigator
(410)468-

cc:

525 ST. PAUL PLACE - BALTIMORE, MARYLAND 21202-2272 - DIRECT DLAL (410) 468-
(410)468-2000 - Outside Baltimore Metro Area, Toll Free 1-800-492-6116 - FAK (410) 468-2020 TTY Users via the Maryland Relay Service at 1-800-735-2258
February 1, 2000

RE: Complainant
    File Number

Dear

The Maryland Insurance Administration has received a complaint regarding the actions of your company. (A copy of the complaint is attached herein.)

The Administration will conduct a thorough investigation of this matter. Please respond to all of the allegations made in the complaint. In addition, please provide the following information:

1) The allegations of being granted an out-of-network referral to obtain all services.

    Please contact 410 additional Information. If the referral was given, it would appear these charges, up to the UCR, should be considered.

2) It is also alleged that the insured was unable to travel back to Maryland to receive care from a participating provider. If you disagree that she was incapable of traveling then provide us with your response.

3) Please advise whether this is a self-funded plan.

Your response is required within 10 working days of receipt of this letter.

Sincerely

Enclosure
cc:
File

525 ST. PAUL PLACE - BALTIMORE, MARYLAND 21202-2272 * DIRECT DIAL (410) 468-2861
468-2000 * Outside Baltimore Metro Area, Toll Free 1-800-492-6116 * FAX: (410) 468-2020
TTY Users via the Maryland Relay Service at 1-800-735-2258

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Appendix G

Memorandum of Understanding
Maryland Insurance Administration and
Department of Health and Mental Hygiene
MEMORANDUM OF UNDERSTANDING

Department of Health and Mental Hygiene
Maryland Insurance Administration

HMO Quality of Care Complaint Investigation Procedures

Whereas, the Department of Health and Mental Hygiene (DHMH) and the Maryland Insurance Administration (MIA), ("Parties") share statutory and regulatory authority and responsibility for oversight of Health Maintenance Organizations (HMO);

Whereas, in order to prevent duplication and overlap of efforts, several areas of this shared authority concerning complaint investigations, collaboration on regulations and communications regarding the regulatory process must be understood between the parties:

Whereas, DHMH has statutory authority to investigate complaints concerning quality of care in HMOs; and

Whereas, DHMH and MIA agree to cooperate toward a common goal of high quality HMO care for Maryland's citizens:

It is hereby AGREED between the parties as follows:

A. Complaint Investigation:

1. The MIA is the single point of entry for all complaints and is the primary agency for tracking, reporting, aggregating and closing complaints. DHMH is responsible for investigating all complaints concerning quality of care. Health Gen. §19705.2. Attachment "I" includes a listing of some of the areas within the jurisdiction of DHMH and MIA. Attachment"I" also includes a listing of areas which both the MIA and DHMH have joint jurisdiction. This is not intended to be an exhaustive list but instead are examples.

2. The MIA has developed an intake process for tracking all complaints. All HMO complaints will be logged and tracked through the MIA Complaint Tracking System.

3. The MIA will forward to DHMH weekly (or bi-weekly if volume requires) copies of all medically related HMO complaints. The complaint will provide a MIA with a tracking number as well as the name of the investigator who is handling the complaint on behalf of the MIA.

   a. DHMH will review each complaint and determine whether it involves a quality of care issues in accordance with the criteria set forth in COMAR 10.07.11.11 B.

   b. Within ten (10) days of receipt of the complaint, DHMH will provide the MIA with written notification whether or not it is a quality of care complaint and whether DHMH is conducting an investigation.
4. If DHMH receives a complaint about an HMO from a source other than the MIA, DHMH will forward a copy of the complaint to the MIA for entry into the Complaint Tracking System. Upon receipt of this complaint, MIA will assign a tracking number and notify DHMH of such number.

5. DHMH will conduct the complaint investigation in a timely manner (usually within 30 days), and notify the complainant in writing of the results of the investigation.

6. Prior to rendering a final decision, DHMH will notify the MIA of the results of its investigations.

7. DHMH will provide a monthly report to the MIA which describes any outstanding issues and delays for each unresolved complaint.

B. Imposition of Sanctions Resulting from Quality of Care Complaints

1. DHMH will determine whether an HMO has failed to meet the requirements of the law or regulations governing quality of care issues. Health Gen. §§19-705; 19-705.1; 19-705.2(b)(2) and (3); 19-705.8.

2. If the Secretary of DHMH (Secretary) determines that an HMO has failed to meet the requirements of the law or regulations governing quality of care issues, the Secretary may issue an Order under Health General, §19-731. Health General §19705.8(f).

3. A copy of the Order and final decision resulting from a hearing will be provided immediately by DHMH to the MIA. Health General §19-731.

This MOU may be amended at any time by mutual agreement of the parties and shall remain in full force and effect until terminated by either party by giving 30 days prior notice of termination.
Date

Approved as to form and legal sufficiency

John F. Lessner
Assistant Attorney General

Date

Approved as to form and legal sufficiency

Christina G. Beusch
Principal Counsel

Date

Dr. Georges C. Benjamin
Secretary, Department of Health and Mental Hygiene

Steven B. Larsen, Commissioner
Maryland Insurance Administration
ATTACHMENT “1”

MIA JURISDICTION

2. Provision of HMO materials (including policy, benefit booklet, etc.) to subscriber.
3. Appeals and Grievance issues (denials based on medical necessity).
4. Complaints involving utilization review standards of carriers and PRAs.
5. Contractual and coverage issues.

DHMH JURISDICTION

1. Failure to follow-up on diagnostic procedures.
2. Failure to provide treatment for presenting complaint/symptom consistent with standard of care.
3. Failure to appropriately document medical records.
4. Confidentiality and privacy issues related to care.
5. General dissatisfaction with care.
6. Qualifications of staff.
7. Misdiagnosis.
8. Environmental issues related to infection control and hazardous medical waste.
9. Failure to respond in emergency situation.
10. Failure to provide quality assurance procedures.

MIAIDHMH JOINT JURISDICTION

1. Failure to notify patient of change in provider.
2. Out-of-network access to medically necessary care.
3. Access in certain geographical sites (network adequacy).
4. Referral Issue.