PERFORMANCE AUDIT

DEPARTMENT OF INSURANCE
DIVISION OF CONSUMER AFFAIRS
COMPLAINT PROCESSING

From The Office Of State Auditor
Claire McCaskill

Procedures to investigate and resolve consumer complaints could be improved.

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YELLOW SHEET

Office of
Missouri State Auditor
Claire McCaskill

June 2002

<u>State agency adequately handles most citizen complaints on insurance companies; some improvements are needed in timeliness and completing case files</u>

The Department of Insurance sufficiently resolved most of the approximately 500 complaints received each month from citizens concerning insurance companies and agencies. This audit focused on ways to improve the effectiveness of the consumer complaint process.

Untimely actions caused unnecessary delays

Of the 126 consumer complaints reviewed by auditors, 80 percent of the files were closed in an average of 33 days, which is under the department goal of 60 days. However, auditors found 20 percent of the cases took 180 days to close, with only 2 of these cases having reasonable reasons for remaining open. Untimely actions by specialists and follow up on inadequate responses from companies caused some delays. Specialists said periodically excessive workloads contributed to these delays. (See page 3)

Better response needed from insurance companies

Department officials closed 13 percent of the complaints reviewed before receiving adequate responses from insurance companies. For five of these cases, department officials could have assessed penalties for the insufficient responses. Some department staff told auditors it was not their place to question or audit a company’s response. (See page 4)

Department's penalty is not effective

Department officials said they did not always assess penalties because the hearing process was not cost effective and the $100 penalty did not have enough impact on the companies. Because raising the fine would require legislative change, department staff are considering alternatives, such as issuing subpoenas to companies, to ensure adequate responses are obtained. (See page 5)

Supervisors do not review files before closure

Supervisors do not review complaint files before they are closed, which could catch instances of closing a file before receiving an adequate response from an insurance company. Instead, the specialist who handles the case can deem it closed. In some cases, the work load is too high to expect review of all cases, but there are also no written guidelines to assure these complaints are resolved equitably. (See page 4)

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DEPARTMENT OF INSURANCE
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Missouri State Auditor

Honorable Bob Holden, Governor
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The Department of Insurance, Division of Consumer Affairs, receives about 5,000 telephone calls and about 500 new complaints per month from citizens concerning insurance companies or agents. Division personnel help citizens resolve disputes regarding insurance policies and claims without requiring legal action. The objective for this report was to determine if the division resolves consumer complaints in a timely and satisfactory manner using all enforcement methods available.

We found the division generally resolves consumer complaints in a timely manner or with sufficient information from insurance companies. While division staff tracked information requested from insurance companies, they did not always require adequate responses. Lack of a policies and procedures manual detailing staff requirements on complaints and no supervisory review of files upon closing led to inequitable case resolutions. We make several recommendations to improve these operations and to help ensure complainants are treated equitably.

The audit was conducted in accordance with applicable standards contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and included such tests of the procedures and records as were considered appropriate under the circumstances.

Claire McCaskill
State Auditor

March 18, 2002 (fieldwork completion date)

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RESULTS AND RECOMMENDATIONS

Consumer Complaint Procedures Need Improvement

Consumer Services section specialists must balance between closing cases within 60 days and resolving consumers' complaints equitably. In 20 percent of the cases we reviewed, unnecessary delays in resolving complaints occurred because specialists did not always process complaints timely or obtain adequate responses from insurance companies. Further, specialists closed 13 percent of the cases without obtaining adequate responses from insurance companies. When enforcement may have been warranted, specialists chose not to issue subpoenas or assess a penalty. Division procedures do not require supervisors to review complaint files before they are closed, and there are no written formal policies and procedures for staff working consumer complaints. Thus, there is little assurance consumer services complaints are resolved equitably or accurate information is entered into the database from these files.

Background

Citizens can contact the Department of Insurance, Division of Consumer Affairs when they have inquiries concerning, or believe they were treated unfairly by, employees and agents of insurance companies, health services corporations and health maintenance organizations. Complaints are reviewed, processed and investigated to ensure consumers have been treated fairly under state insurance laws. The division is divided into two sections - Consumer Services and Investigations. The Consumer Services section handles inquiries and complaints from the public regarding actions of insurers and other licensed companies. The Investigations section reviews complaints involving agents, brokers and agencies that can result in legal action such as the loss of a license. (*See Appendix II, page 10, for the division's caseload during 2000 and 2001.)*

When a complaint is received, it is reviewed, set up as a file and entered into a computerized database. A specialist or investigator reviews the file and mails the insurance company or agent a copy of the complaint requesting a response in 20 days. At the same time, an acknowledgement letter is also sent to the complainant. When the company's response is received, it is reviewed for violations of the insurance laws and additional information is requested, if needed. If the original response is not adequate or timely, the department can either assess a voluntary forfeiture (penalty) or issue a subpoena. Once all of the necessary information is collected and reviewed, the file is closed and a closing letter is sent to the complainant. The division's goal is to close 95 percent of all complaint files within 60 days.

In September 2001, the Consumer Services section established performance expectations for the specialists, which outline specific timeframes and goals for processing consumer complaints. To accomplish these goals, necessary documentation is to be requested from the company within two business days of receipt of the assigned complaint. Additional documentation is to be requested within 10 business days of receiving a response and files should be closed within 10 days of receiving a final response. The division also tracks recoveries, which are the amounts of monetary relief provided to consumers who were previously denied claims or denied premium refunds.

Untimely actions caused unnecessary delays in the complaint process

For the 126 Consumer Services section complaints reviewed, we found that the time between receiving the complaint and the file being closed averaged 62 days. The length of time to close files varied depending on how soon insurance companies responded, and what actions, if any, the specialists took to obtain an adequate response. Eighty percent of the complaint files were closed in an average of 33 days; however, for the remaining 20 percent (25 cases), it took an average of 180 days to close the complaint file. While the degree of difficulty can cause cases to be open greater than 60 days, only two of the 25 cases had reasonable explanations for exceeding 60 days, such as waiting for the insurance adjuster to meet with the complainant.

For the 23 cases without a reasonable explanation for delays, 12 were at least partially caused by specialists following up on inadequate responses from companies. Specialists for the remaining 11 cases did not take timely or adequate actions to process them, such as waiting 9 business days to open a complaint file, 31 business days to follow up on an inadequate response, and 39 business days to close a file after the final response was received. In one case, there was no documentation in the file after December 1998, but the specialists did not close the file until March 2000. The file did not contain a closing letter documenting the actions taken.

None of the 11 complaint files documented the reasons for the untimely actions. Several consumer services specialists indicated they did not process the complaint files timely due to the excessive, and at times unmanageable, volume of telephone calls and complaint files. For example, one specialist had 192 files open at one time. This specialist indicated she could not keep up with the volume of work assigned to her.

Department officials have not established workload parameters. The overall workload, as of October 31, 2001, averaged 115 cases per specialist ranging from 57 to 192 cases. The Deputy Director told us supervisors try to distribute the workload evenly but some cases may be more difficult and take longer to resolve causing the number of open cases among specialists to vary. He also indicated consumer phone calls and complaints have increased mainly due to an April 2001 hailstorm in the St. Louis area. While the hailstorm contributed to the complaint volume, files we reviewed from prior to the hailstorm included some of the untimely actions noted above. In addition, the division has experienced turnover in consumer services specialists.

Supervisor reviewed Investigations section files

The time from receiving the complaint to final closure averaged 276 days for the 20 Investigations complaint files reviewed. Because the Investigations section complaints are complex, they generally take longer than 60 days to resolve. The supervisor initially prioritizes and assigns cases. If a file is expected to be open longer than 60 days, the investigator prepares a preliminary case assessment, which summarizes the complaint, the agent's response, potential law violations, planned actions for the file and estimated closing date. The preliminary case assessment is to be approved by the section supervisor. Preliminary case assessments were generally prepared as required and the supervisor and investigators responsible for these cases told us they communicated regarding case priority and status.

Adequate responses were not always obtained from insurance companies

We found Consumer Services section specialists closed 13 percent (16 of 126 cases) of the complaint files without an adequate response from the insurance companies. The specialists did not follow up on information requested, verify employer self-funded medical plans or verify payments were made. These cases were closed in an average of 37 days. In five of the cases, specialists could have assessed penalties for inadequate responses. However, supervisors did not review the files to determine if specialists obtained the requested or necessary information from the insurance companies.

To resolve a consumer's complaint against an insurance company, the specialist working the complaint is to determine what information is needed and should request it from the company. The specialist allows the company 20 days to provide an adequate response, the timeframe required by state law.[1] Once the company responds, the specialist reviews the information and determines if it satisfactorily resolves the consumer's complaint. A company can respond after the 20-day timeframe with reasonable justification for the delay. State law defines an adequate response as written communication with reasonably specific answers to each question. The training manual states that unless the company has resolved the complaint in favor of the complainant, the specialist should not accept, as an adequate response, a letter from the company summarizing the handling of the situation with no supporting documentation.

In one case we reviewed, a specialist did not follow up with an insurance company after company officials failed to submit all requested documents, including the insurance policy. In another case, the consumer services specialist closed the file and informed the complainant the case should be resolved when the insurance adjuster returned from his or her travel. However, the specialist did not obtain a written response documenting the final decision from the insurance company before closing the file. Although the specialist told us the issue had been resolved, the file should not have been closed until all the complaint issues were resolved.

When questioned why they did not obtain adequate responses from the insurance companies, the specialists on these cases stated they believed they had sufficient information to resolve the complaints. However, one specialist told us she did not believe it was within her responsibility to audit the response. Another specialist told us it is not her place to question a company's response. Two supervisors added that the consumers must have been satisfied since follow-up complaints were not filed.

Supervisors do not review files

Supervisors do not review consumer services complaint files before they are closed and do not have useful management reports to monitor these cases. Files are closed when deemed appropriate by the specialist who handled them. While the Jefferson City complaint file volume may be too high to review each file before it is closed, there is no written guidance to assure consumer services complaint files are resolved equitably. The Kansas City supervisor reviews the closing letters to consumers, but not the case file, before files are closed. The supervisors in Jefferson City and St. Louis do not review letters or files. The St. Louis

[1] 20 CSR 100-4.100 Required Response to Divisional Inquiries.

supervisor said that reviewing each file is not necessary because the specialists are experienced and would have consulted the manager if they had questions.

The supervisors monitor complaint files that have been open in excess of 60 days. The Jefferson City supervisor, who handles a higher volume of files, told us she conducts monthly reviews of files. However, the monthly reviews were not documented, and the supervisors generally do not review files open less than 60 days.

Division staff did not assess any penalties or issue any subpoenas in the cases where the specialists did not obtain adequate responses. Between January 2000 and September 2001, the section issued 297 penalties and issued 2 subpoenas while assisting 9,887 complainants. However, if the company refused to pay the $100 penalty, the department either waived the penalty or held an administrative hearing. The department Deputy Director indicated the division did not always assess the penalty because the hearing process was not cost effective, and the $100 does not have enough impact on the companies. To increase the penalty to a more effective amount, division management would have to seek legislative authority. In lieu of legislative changes, division officials are considering alternative procedures within their authority, such as issuing subpoenas or threatening to issue subpoenas, to ensure adequate responses are received within 20 days. According to the Deputy Director, the division needs to change the behavior of the insurance companies to ensure adequate responses are always received. He believes more adequate and timely responses can be achieved through other enforcement tools.

Formal policies and procedures for the Consumer Services section have not been established

The Consumer Services section does not have written policies and procedures for processing complaints. In 2000, division officials prepared a training manual for the Consumer Services section staff that outlines general procedures for handling inquiries, setting up complaint files, handling phone calls, initiating penalties and using the department's independent review organization. It also includes relevant state regulations and statutes as well as useful information for various types of insurance, such as health, life, automobile, homeowners, and workers' compensation. This training manual, which some specialists did not know existed, is not a specific policies and procedures manual. Division officials recognize the need for a written policies and procedures manual and plan to implement one by June 2002. The Director told us the development of the written policies and procedures manual was delayed because the workload was extremely heavy due to the April 2001 hailstorm in the St. Louis area.

The Investigations section has a formal policies and procedures manual that is available to each investigator. In addition, the National Association of Insurance Commissioners (NAIC) prepared a report[2] to share best practices among insurance departments regarding the handling of consumer complaints.

[2] National Association of Insurance Commissioners' Consumer Complaint White Paper dated March 13, 2000.

Computer information is not always accurate

We found inaccurate computer data for 18 of the 126 (14 percent) consumer services complaint files. The errors included the complaint received date, the insurance company involved, closing date, disposition code and recovery amount. The Investigations section supervisor codes the complaint files upon receipt and reviews the files once closed. No errors were found for the Investigations section files. However, the Consumer Services section does not verify the data entered into the system.

This data is maintained to track key complaint information, comply with national insurance standards and trend complaints. It is also used by other department divisions, such as the Division of Market Conduct, to identify complaint trends and select insurance companies for review. The complaint information is also compiled and analyzed by the NAIC to share among the states.

Division officials did not consistently record recovery amounts or ensure case files adequately supported the amounts. Some amounts included recoveries obtained by complainants before the division was involved and amounts recovered by the division. On the other hand, some amounts were based solely on the recoveries obtained by the division. The Division Director stated recoveries should only include the amounts recovered after the division's involvement.

Conclusions

The division did not always enforce timely or adequate responses from insurance companies to resolve consumer complaints. Two factors affected this condition and limit the department's ability to resolve consumer complaints equitably. First, the division has not established formal policies and procedures for the Consumer Services section staff to follow. These procedures would help ensure (1) actions taken by specialists to resolve consumer complaints are timely, (2) adequate responses to division inquiries are received, (3) supervisors and specialists prioritize their workload to facilitate management involvement in these cases, (4) actions taken to resolve complaints are documented, and (5) computer data, including recoveries, is accurate. The division could use the Investigations section's manual or the NAIC's report to help develop a formal policies and procedures manual.

The second factor is a lack of supervisor involvement in resolving consumer complaints. Supervisors do not obtain management reports which could assist them in monitoring complaint processing or distribution among specialists. In addition, the supervisors generally do not review consumer complaint files before they are closed to ensure reasonably specific information is received from insurance companies and considered by specialists. We noted five cases in which penalties could have been issued but were not and specialists closed files before obtaining reasonably specific responses from insurance companies. Division officials do not believe the $100 penalty (voluntary forfeiture) effectively changes the behavior of unresponsive companies.

Recommendations

We recommend the Director, Department of Insurance:

1.1 Establish written policies and procedures for the Consumer Services section, including the use of enforcement tools to obtain reasonably specific responses.

1.2 Establish procedures for a supervisory review of complaint files before they are closed.

1.3 Evaluate the effectiveness of the monthly management reports.

Department of Insurance Responses

1.1 A draft procedure manual with written policies and procedures has been developed for the Consumer Services section. This manual includes a procedure for the use of subpoenas and fines as an enforcement tool in order to obtain specific responses. The manual will be ready for use and the Consumer Services section will have a staff meeting to go over all information in the procedure manual before June 30, 2002.

1.2 As of March 1, 2002, the Supervisor of the Investigations section is reviewing all files before they are closed. The review includes approval of the Closing Memorandum for the files and the final closing letter before it is sent to the complainant.

As specified in the procedure manual, the Department will do a random review by the Supervisor of the files before closing. This review will include review of a sampling of files handled and closed by all Consumer Services Specialists.

Because of the volume of files handled in the Consumer Services section, it is unrealistic to expect a review of all files before closing. There were 5,672 files handled in the Consumer Services section in 2001 compared to 450 in the Investigations section.

1.3 The Supervisors of the Consumer Services section and the Investigations section are working with the Information Technology (IT) section to identify reports from the database to monitor the flow of work of each office, section and individual working in these sections. They are meeting with IT on a regular basis and will have this completed by mid summer depending on the availability of IT to work on their reprogramming needs.

The department made the following general comments about specific sections of the report

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"…only two of the 25 cases had reasonable explanations for exceeding 60 days…."

We have developed and implemented use of a complaint activity log that will assist in accurate documentation of the file activities.

"Department officials have not established workload parameters."

The volume of work coming into this section is not directly controlled by the Department since complaints and inquires are submitted by the general public. We deal with the volume of work that the general public sends in. With a finite number of employees, the work has to be distributed among the employees available. Due to budget constraints, we are not in a position to consider the addition of staff, but are looking at ways to stabilize employee turnover and improve employee productivity.

Page 4

"We found Consumer Services section specialists closed 13 percent (16 of 126 cases) of the complaint files without an adequate response from the insurance companies."

The newly implemented procedure of random review by the supervisor of Consumer Services Specialists should reduce this percentage.

Page 6

"We found inaccurate computer data for 18 of the 126 (14 percent) consumer services complaint files."

We implemented a procedure for reviewing the file for accuracy before closing the file.

"Division officials did not consistently record recovery amounts or ensure case files adequately supported the amounts."

The complaint activity log will assist in adequate file documentation and we implemented a standard procedure for computing the recovery amounts.

APPENDIX I

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

The objective for this report was to determine if the Division of Consumer Affairs resolves consumer complaints in a timely and satisfactory manner using all enforcement methods available.

Scope and Methodology

To determine the extent to which the division resolved consumer complaints in a timely and satisfactory manner, we selected 132 of the 9,487 complaint files closed between January 1, 2000 and September 30, 2001 for a detailed review. Complaints are filed by consumers regarding coverage and costs on all types of insurance including life, homeowners, automobile, workers' compensation, and medical. The files were judgmentally selected to ensure that each office location and specialist or investigator was included. We also selected 14 workers' compensation complaint files that were closed between January 1, 1997 and December 31, 1999. In total, we reviewed 126 Consumer Services section complaint files and 20 Investigations section complaint files. We interviewed the Division Director, the Investigations section supervisor, branch managers, five Investigations section investigators and 11 Consumer Services section specialists from the Jefferson City, St. Louis, and Kansas City offices regarding these complaints and related matters. In addition, we reviewed monthly management reports.

To determine the division workload, we obtained data from the department regarding the volume of telephone calls received and consumer complaints received and closed, as well as the average number of days complaint files were open for 2000 and 2001.

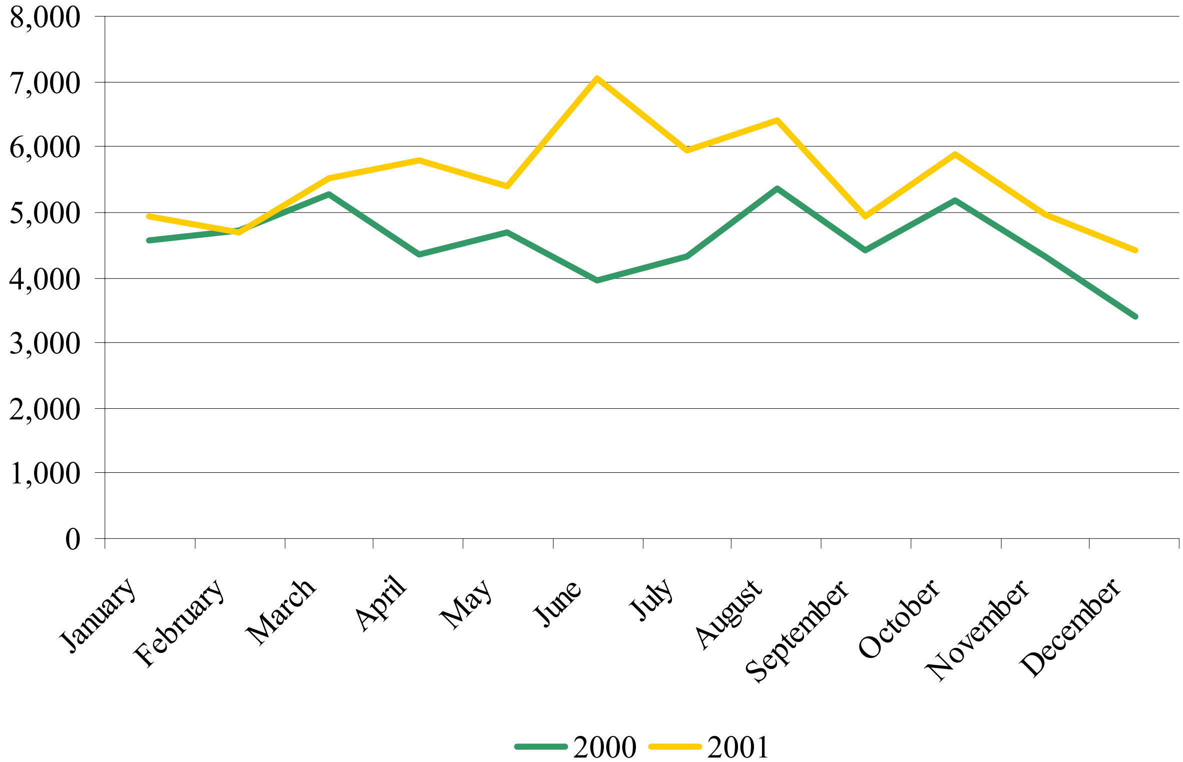
To determine what policies or practices govern insurance consumer complaint processing, we reviewed state laws and regulations, the division’s policies, and the National Association of Insurance Commissioners’ Consumer Complaint White Paper dated March 13, 2000.

We conducted our fieldwork between October 2001 and March 2002.

VOLUME OF TELEPHONE CALLS AND COMPLAINTS

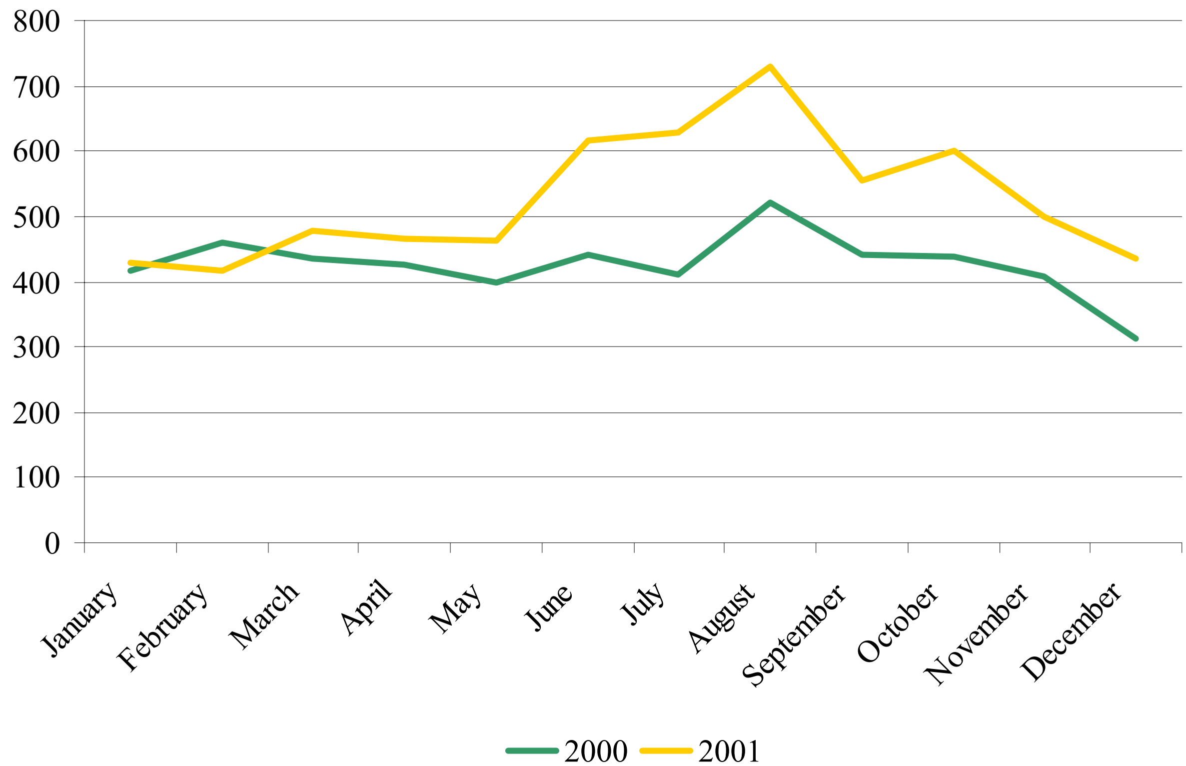
This appendix shows the volume of telephone calls and complaints the Division of Consumer Affairs received between January 2000 and December 2001.

Figure II.1: Volume of Telephone Calls Received



Source: Department of Insurance data

Figure II.2: Volume of Complaints Received



Source: Department of Insurance data