OFFICE OF THE INSURANCE COMMISSIONER
MARYLAND INSURANCE ADMINISTRATION

MARYLAND INSURANCE ADMINISTRATION *EX REL.* U.W.[1],	*	
Complainant	*	
v.	*	**Case No. MIA 2022-07-015**
UNITED OF OMAHA LIFE INSURANCE COMPANY,	*	
Licensee.	*	

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MEMORANDUM AND FINAL ORDER

Pursuant to §§ 2-204 and 2-214 of the Insurance Article of the Annotated Code of Maryland,[2] the Undersigned concludes that United of Omaha Life Insurance Company ("Licensee") did not commit an unfair claim settlement practice in violation of § 27-303 or refuse or delay payment of amounts due without just cause in violation of § 4-113 in its handling of U.W.'s ("Complainant") Long-term Disability ("LTD") claim.

STATEMENT OF THE CASE

This matter arose from an administrative complaint ("Complaint") filed by Complainant with the Maryland Insurance Administration ("MIA") on May 3, 2022. (MIA Exhibit ("Ex.") 1) Complainant alleged that Licensee improperly denied her LTD claim due to a pre-existing condition (*Id.*) After investigating the Complaint, the MIA's Life and Health Unit determined that Licensee had not violated the Maryland Insurance Article and notified the Parties of its

[1] The MIA uses initials to identify a Complainant and to protect the privacy of the Parties.
[2] Unless otherwise noted, all statutory citations are to the Insurance Article of the Annotated Code of Maryland.

findings by letter dated June 3, 2022. (MIA Ex. 9) The letter included a notice of hearing rights for the Parties. (*Id.*) Complainant disagreed with this determination and filed a timely request for a hearing, which was granted. (MIA Ex. 10 and 12)

ISSUE

The issue presented in this case is whether Licensee violated the Insurance Article in its handling and denial of Complainant's LTD claim.

SUMMARY OF THE EVIDENCE

A. Testimony

A virtual hearing was held on November 30, 2022. Complainant was *pro se* and provided sworn testimony on her own behalf. Licensee was represented by Jeaneen J. Johnson, Esq. of Semmes, Bowen & Semmes. Mona Bombassi (Appeals Manager in Insurance Services) testified on behalf of the Licensee.

B. Exhibits

MIA Exhibits[3] (In Record)

1. On May 3, 2022, the MIA received a letter of complaint from the Complainant.
2. On May 3, 2022, the MIA received additional information from the Complainant.
3. On May 4, 2022, the MIA sent an acknowledgement letter to the Complainant informing her of the investigation process.
4. On May 4, 2022, the MIA sent a letter to the Licensee requesting a response to the Complaint.
5. On May 12, 2022, the MIA received a response from the Licensee
6. On May 12, 2022, the MIA received correspondence from the Complainant.

7. On May 17, 2022, the MIA sent a letter to the Licensee requesting additional information.

8. On May 26, 2022, the MIA received a response from the Licensee

9. On June 3, 2022, the MIA sent a closing letter to the Complainant

10. On July 7, 2022, the MIA received an email requesting a hearing from the Complainant.

11. On July 8, 2022, the MIA sent a letter to the Licensee, advising of the Complainant's request for an administrative hearing.

12. On July 8, 2022, the Administration sent a letter to the Complainant advising the approval of the hearing request.

FINDINGS OF FACT

These findings of fact are based upon a complete and thorough review of the entire record in this case, including the hearing transcript and all exhibits and documentation provided by the Parties. The credibility of the witnesses has been assessed based upon the substance of their testimony, their demeanor, and other relevant factors. To the extent that there are any facts in dispute, the following facts are found to be true by a preponderance of the evidence. Citations to particular parts of the record are for ease of reference and are not intended to exclude, and do not exclude, reliance on the entire record.

1. At all relevant times, Licensee held, and currently holds, a Certificate of Authority from the State of Maryland to act as a LTD insurer.

2. On October 11, 2021, Complainant became employed with MPF Federal, Inc. ("MPF") as a telehealth registered nurse.

[3] At the start of the hearing, the Parties stipulated to the admission of all of the MIA exhibits.

3. Complainant participated in training with her employer where she was provided frequent breaks (Transcript ("Tr.") at 12) She was able to walk around and change positions. (*Id*.)

4. After the training, Complainant had to sit for two to three hours. (*Id*.) Her breaks and lunches were scheduled, but they could change due to call volume. (*Id*. at 12-13)

5. Through the Licensee, MPF offers group short-term disability (STD) and group LTD coverage to its employees. (*Id*. at 26-29)

6. Complainant's STD and LTD coverage became effective on November 1, 2021. (MIA Ex. 5) The STD policy does not have a pre-existing condition exclusion. (Tr. at 27)

7. On November 9, 2021, Complainant stopped working due to bi-lateral low back pain with right side sciatica. (*Id*.)

8. Licensee approved 12 weeks of STD benefits - the maximum STD benefit. (MIA Ex. 5)

9. After the STD period ended, Complainant remained out of work; therefore, a LTD investigation was initiated by Licensee. (*Id*.)

10. The LTD policy includes a Pre-Existing Condition Exclusion provision, which states:

> A *Pre-existing Condition* means any Injury or Sickness for which You received medical treatment, advice or consultation, care or services, including diagnostic measures, or had drugs or medicines prescribed or taken in the 3 months prior to the day You became insured under the Policy. A pre-existing condition does not include a condition revealed on an application for insurance unless excluded by a signed waiver.
>
> We will not provide benefits for any Disability caused by, attributable to, or resulting from a Pre-existing Condition which begins in the first 12 months after You are continuously insured under the policy.

11. (MIA Ex. 6)Since Complainant's LTD claim was submitted within twelve months of the effective date of the policy, Licensee reviewed Complainant's medical records to see if her sickness or injury was a pre-existing condition as defined by the Policy. (MIA Ex. 9) The 3-month look back period was August 1, 2021, through October 31, 2021. (*Id.*)

12. Medical records prepared by Dr. Emma Ocampo indicated Complainant was treated for low back pain with right-side sciatica symptoms on August 2, 2021. (MIA Ex. 6) Additionally, Complainant's prescription records show that Complainant filled a prescription for a lidocaine patch on October 18, 2021. (*Id.*)

13. Complainant testified her August 2, 2021, visit with Dr. Ocampo was for a physical, and the doctor conducted a full system review at that time. (Tr. at 21) The Progress Note prepared by Dr. Ocampo at 10:15 a.m. states, in part, "Patient is here for her annual physical .(sic)" (MIA Ex. 6) Additionally, Complainant stated the lidocaine patch had helped her manage her chronic back pain since 2020. (Tr. at 16)

14. At the August 2021 visit, Complainant and her doctor discussed some alternate pain treatments for her back pain (including pain management and narcotic medication), but Complainant declined. (Tr. at 21 and MIA Ex. 6)

15. On March 24, 2022, Licensee notified Complainant that her LTD benefits claim was denied. (MIA Ex. 6) Licensee's denial letter advised "you were treated for, received advice or consultation, care or services, including diagnostic measures for the condition(s) for a condition [sic] that caused, attributed to, or resulted in the condition for which you are now claiming disability during the pre-existing periods of August 01, 2021 through October 31, 2021. As a result, Long-Term Disability benefits will not be provided." (*Id.*)

16. On April 3, 2022, Complainant appealed Licensee's decision. (*Id.*) On April 25, 2022, Licensee completed its internal appeal review. As a result, Complainant's claim was reviewed by a physician consultant. (*Id.*) On April 26, 2022, Licensee upheld its decision to deny Complainant's LTD claim. (*Id.*)

13. The appeal response provided Complainant until May9, 2022, to submit any outstanding medical documentation from the period of August 1, 2021, to November 1, 2021. (*Id.*) Licensee did not receive any additional documentation from Complainant. (Tr. at 24)

14. Complainant filed a complaint with the MIA on May 3, 2023, asking Licensee to pay her LTD claim. (MIA Ex. 4)

15. In a determination letter dated June 3, 2022, the MIA's Life and Health Unit stated Licensee did not violate Maryland insurance law and that it could not order Licensee to pay Complainant's LTD claim based on the provisions of her policy. (MIA Ex. 10)

16. On June 7, 2022,[4] Complainant, not satisfied with the MIA's determination, requested a hearing. (*Id.*)

17. The hearing was granted in this matter by letter dated July 8, 2022. (MIA Ex. 11)

DISCUSSION

A. Positions of the Parties.

Complainant contends that Licensee improperly handled and denied her LTD claim due to an assertion that she had a pre-existing condition, which is excluded under the Policy. Complainant contends that she saw Dr. Ocampo on August 2, 2021, for an annual physical. At that time, a "systems review" was performed. Complainant and her doctor discussed some

[4] The record shows Complainant sent an email requesting a hearing on July 5, 2022, at 4:05 p.m. to the email address of ECTSNoReply.mia@maryland.gov. (MIA Ex. 10) She then sent another email to the MIA investigator on July 7, 2022, stating that her earlier email went to the wrong address. (*Id.*)

additional treatment options for Complainant's back pain (narcotics or pain management), but Complainant declined. She then renewed her lidocaine patch prescription in October 2021, as she had been using it since 2020.

Licensee argues that it properly handled Complainant's LTD claim. Specifically, Licensee argues that Complainant received twelve full weeks of STD. At the end of the STD period, Licensee began an investigation into the possibility of LTD. The medical records showed Complainant had seen her doctor during the look back period and discussed some alterative treatment for her back condition. Additionally, during the look back period, Complainant refilled her lidocaine patch prescription. As a result, Licensee denied Complainant's LTD claim based on the Pre-Existing Condition Exclusion.

B. Statutory Framework

The Notice of Hearing in this case states that specific attention at the hearing shall be directed to § 27-303 of the Insurance Article.

Section 27-303 states in pertinent part:

> It is an unfair claim settlement practice and a violation of this subtitle for an insurer, nonprofit health service plan, or health maintenance organization to:
>
> (1) misrepresent pertinent facts or policy provisions that relate to the claim or coverage at issue;
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> (2) refuse to pay a claim for an arbitrary or capricious reason based on all available information;
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> * * *
>
> (6) fail to provide promptly on request a reasonable explanation of the basis for a denial of a claim [.]

(LexisNexis 2022.)

In *Berkshire Life Insurance Co. v. Maryland Insurance Administration,* the Court of Special Appeals adopted the Insurance Commissioner's interpretation of the "arbitrary and

capricious" standard as articulated in an earlier case. *See* 142 Md. App. 628 (2002). As the Court explained:

> The Commissioner has previously construed [Section] 27-303(2) as requiring a licensee insurer to show that it refused to pay the claim at issue based on: (1) an otherwise lawful principle or standard which the insurer applies across the board to all claimants; and (2) reasonable consideration of "all available information."

Id. at 671. (*internal citations omitted*). Complainant bears the burden of proof. The Court explained a Complainant's burden of proof as follows:

> [A] claimant must prove that the insurer acted based on "arbitrary and capricious reasons." The word "arbitrary" means a denial subject to individual judgment or discretion, … and made without adequate determination of principle. …. The word "capricious" is used to describe a refusal to pay a claim based on an unpredictable whim. …. Thus, under Ins. Art. § 27-303, an insurer may properly deny a claim if the insurer has an otherwise lawful principle or standard which it applies across the board to all claimants and pursuant to which the insurer has acted reasonably or rationally based on "all available information."

Id. at 671-72 (citations omitted). Additionally, § 4-113 may affect the disposition of this matter. Section 4-113(b)(5) states, in pertinent part:

> (b) The Commissioner may deny a certificate of authority to an applicant or, subject to the hearing provisions of Title 2 of this article, refuse to renew, suspend, or revoke a certificate of authority if the applicant or holder of the certificate of authority:
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> * * *
>
> (5) refuses or delays payment of amounts due claimants without just cause[.]

(LexisNexis 2022.)

Therefore, the Complainant has the burden of persuasion to demonstrate by a preponderance of the evidence that Licensee violated the Insurance Article in its denial of her disability claim. *See* Md. Code Ann., State Gov't § 10-217 (LexisNexis 2022); *Berkshire,* 142 Md. App at 672. To satisfy her burden of persuasion in this case by a preponderance of the

evidence, Complainant must, "prove that something is more likely so than not so" when all of the evidence is considered. *Coleman v. Anne Arundel County Police Dep't*, 369 Md. 108, 125 n. 16 (2002) (*quoting* Maryland Pattern Jury Instructions) (*internal citations omitted*). Under this standard, if the supporting and opposing evidence is evenly balanced on an issue, the finding on that issue must be against the party who bears the burden of proof. *(Id.*)

C. Licensee did not violate §§ 4-113 or 27-303(b)(5) in its handling and denial of Complainant's LTD claim.

After investigating the Complaint concerning Licensee's handling and denial of Complainant's LTD claim, the MIA determined that Licensee did not violate the Insurance Article. For the reasons set forth below, I affirm.

The evidence demonstrates that Licensee had a reasonable basis for its denial of Complainant's claim. Complainant became employed with MPF as a telehealth registered nurse on October 11, 2021. (Tr. at 8) She applied for and obtained STD and LTD coverage, which became effective November 1, 2021. (*Id*. at 26-29) Less than a month after she began working at MPF, on November 9, 2021, Complainant began STD and remained on it for the maximum amount of time allowed under the Policy - twelve weeks. (Tr. at 13). Thereafter, Licensee began to investigate Complainant's eligibility for LTD. (*Id*. at 29) The LTD policy's Pre-Existing Condition Exclusion states:

> A Pre-existing Condition means any Injury or Sickness for which You received medical treatment, advice or consultation, care or services, including diagnostic measures, or had drugs or medicines prescribed or taken in the 3 months prior to the day You became insured under the Policy. A pre-existing condition does not include a condition revealed on an application for insurance unless excluded by a signed waiver.
>
> We will not provide benefits for any Disability caused by, attributable to, or resulting from a Pre-existing Condition which begins in the first 12 months after You are continuously insured under the policy.

(MIA Ex. 6)

As Complainant's LTD policy had been in effect for less than a year, she was subject a three month look back period under the terms of the policy. The look back period ran from August 1, 2021, through October 31, 2021. (MIA Ex. 5)

The medical records revealed Complainant had seen her doctor during the look back period and discussed some alterative treatment for her back pain that Complainant declined to pursue. (Tr. at 20-21) Additionally, she refilled her lidocaine patch prescription on October 18, 2021. (Tr. at 21 and MIA Ex. 6)

The evidence shows that Complainant's back pain meets the Policy definition of "Pre-existing Condition," because Complainant had an injury or sickness for which she received medical treatment, advice or consultation, and had medicine prescribed and which she took in the three months prior to the day she became insured under the LTD policy. (MIA Ex. 6) The Pre-Existing Condition Exclusion expressly states "We will not provide benefits for any Disability caused by, attributable to, or resulting from a Pre-existing Condition which begins in the first 12 months after You are continuously insured under the policy." I find this evidence sufficient, by a preponderance of the evidence, that Complainant received medical treatment, advice or consultation, care or services or had drugs or medicines prescribed or took medicine for the same injury or sickness in the three months prior to the day she became insured under the LTD Policy. Accordingly, Licensee did not refuse to pay a claim for an arbitrary or capricious reason based on all available information in violation of § 27-303(2) and did not refuse or delay payment of amounts due without just cause in violation of § 4-113(b)(5).

I also find that Licensee did not misrepresent pertinent facts or policy provisions that relate to the claim in violation of § 27-303(1) and did not fail to provide promptly on request a reasonable explanation of the basis for a denial of a claim violation of § 27-303(6). After completing its investigation, on March 24, 2022, Licensee notified Complainant that her LTD benefits claim was denied. (MIA Ex. 6) Licensee's denial letter outlined the language of the Pre-existing Condition Exclusion and advised "you were treated for, received advice or consultation, care or services, including diagnostic measures for the condition(s) for a condition that caused, attributed to, or resulted in the condition for which you are now claiming disability during the pre-existing periods of August 01, 2021 through October 31, 2021. As a result, Long-Term Disability benefits will not be provided." (*Id.*) Accordingly, Licensee did not violate §§ 27-303(1) and (6) in its investigation and denial of Complainant's LTD claim.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact and Discussion, it is found as a matter of law that Licensee has not committed an unfair claim settlement practice in violation of § 27-303 or delayed or denied payment of amounts due without just cause in violation of § 4-113, or otherwise violated the Insurance Article.

FINAL ORDER

IT IS HEREBY ORDERED that the determination issued by the Maryland Insurance Administration is AFFIRMED; and it is further

ORDERED that the records and publications of the Maryland Insurance Administration reflect this decision.

It is so **ORDERED** this _17_ day of March, 2023.

KATHLEEN A. BIRRANE
Insurance Commissioner

Tammy R. J Longan
TAMMY R. J. LONGAN
Acting Deputy Commissioner