OFFICE OF THE INSURANCE COMMISSIONER
MARYLAND INSURANCE ADMINISTRATION

MARYLAND INSURANCE ADMINISTRATION *EX. REL.* G.B.H.[1],	*	
Complainant	*	
v.	*	**Case No. MIA 2022-10-011**
UNUM LIFE INSURANCE COMPANY OF AMERICA,	*	
Licensee.	*	

* * * * * * * * * * * * *

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 Unum Life Insurance Company of America ("Licensee") did not violate the Insurance Article in its handling of G.B.H.'s ("Complainant") Long Term Care ("LTC") insurance claim.

STATEMENT OF THE CASE

This matter arose from an administrative complaint ("Complaint") filed by Complainant with the Maryland Insurance Administration (the "MIA") on August 5, 2022. (MIA Exhibit ("Ex.") 1.) Complainant brought her Complaint regarding Licensee's denial of benefits under her LTC Policy. (*Id.*) Specifically, Complainant argued that she is entitled to receiving the benefits because she is suffering from multiple health issues that have led to needing assistance in daily activities. (*Id.*) After investigating the Complaint, the MIA determined that Licensee had not

[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.

violated the Insurance Article and notified the Parties of its findings by letter dated September 29, 2022 ("Determination"). (MIA Ex. 7.) The Determination 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 Exs. 8, 9, and 10.)

ISSUE

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

SUMMARY OF THE EVIDENCE

A. Testimony

A hearing was held using remote video technology on March 21, 2023.

Complainant represented herself and provided sworn testimony on her own behalf.

Licensee was represented by Cynthia L. Maskol, Esquire, with Wilson, Elser, Moskowitz, Edelman & Dicker LLP, who provided remarks on Licensee's behalf.

B. Exhibits

MIA Exhibits[3] *(In Record)*

1. Initial Complaint from Complainant to MIA, dated August 5, 2022
2. Letter from MIA to Licensee regarding Complaint, dated August 8, 2022
3. Second letter from MIA to Licensee regarding Complaint, dated August 8, 2022
4. Response from Licensee to MIA and supporting documents, dated August 30, 2022
5. Letter from MIA requesting additional information, dated August 31, 2022
6. Supporting documents from Licensee to MIA, dated September 19, 2022
7. Determination letter from MIA to Parties, dated September 29, 2022
8. Request for a hearing from Complainant, dated October 20, 2022
9. Letter granting hearing request from MIA to Licensee, dated October 21, 2022
10. Letter granting hearing request from MIA to Complainant, dated October 21, 2022

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 life and disability insurer.

2. At the time of the claim, Complainant held a LTC insurance policy under policy number LAC726895 ("Policy") issued by the Licensee. (MIA Ex. 4.) This Policy provided coverage for Complainant's long term care if she can prove disability as defined under the Policy. (*Id.*) This Policy was in effect starting January 31, 2002. (*Id.*) The Policy provided as follows regarding the monthly benefit provision:

> **Monthly Benefit**
> You are eligible for a Monthly Benefit after:
> (a) You become Disabled;
> (b) You are receiving services in a Nursing Facility or Assisted Living Facility; and
> (c) You have satisfied Your Elimination Period.
> A monthly benefit will become payable once all of these requirements are met.
> ***
> The Policy provided as follows regarding the definition of "disability" and "disabled":
> **"Disability and Disabled"** means:
> (a) You are cognitively impaired; or
> (b) You cannot perform 2 or more Activities of Daily Living (ADLs) without standby assistance.
> ***

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

The Policy provided as follows regarding the definition of Activities of Daily Living:

> **Activities of Daily Living (ADLs) are:**
> (a) **Bathing:** the ability to wash yourself either in the tub or shower or by sponge bath, with or without equipment or adaptive devices.
> (b) **Dressing:** the ability to put on and take off all garments, and medically necessary braces or artificial limbs usually worn, and to fasten or unfasten them.
> (c) **Toileting:** the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene, and to care for clothing.
> (d) **Transferring:** the ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
> (e) **Continence:** the ability to voluntarily control bowel and bladder function, or, in the event of incontinence, the ability to maintain a reasonable level of hygiene.
> (f) **Eating:** the ability to get nourishment into the body by any means once it has been prepared and made available to you.
> ***

(*Id.*)

3. On April 4, 2022, Complainant initiated a claim with Licensee for LTC benefits under the Policy by submitting a LTC claim form. (*Id.*) In response, Licensee requested that Complainant submit the necessary documentation, including Complainant's Power of Attorney and a signed authorization form. (*Id.*)

4. On April 13, 2022 and April 14, 2022, Complainant contacted Licensee requesting an update on the claim. (*Id.*) Both times Licensee told her that it was still waiting for the requested documents. (*Id.*)

5. On April 15, 2022, Licensee received Complainant's signed authorization form. (MIA Ex. 4.)

6. On April 22, 2022, Licensee held a claim review with Complainant via a telephone call. During this call, Licensee discussed Complainant's care, treatments, medical care providers, medications, and regular activities. (*Id.*) Licensee also went over the Policy requirements, Activities of Daily Living ("ADLs"), and a claim status update. (*Id.*)

7. Also on April 22, 2022, Licensee sent Complainant a letter that summarized the earlier phone call and requested Complainant submit necessary records. (*Id.*)

8. On April 23, 2022, Licensee sent a letter to Complainant's primary care physician, Dr. Mindi Cohen ("Dr. Cohen"), with a request for Complainant's records. (*Id.*)

9. On April 24, 2022, Licensee sent a letter to Pain Arthritis Relief Center ("Pain Arthritis") regarding Complainant's outpatient therapy and to Dr. Nadia Yusuf ("Dr. Yusuf") at the Neurology Center ("Neurology") with a request for Complainant's records. (*Id.*)

10. On April 25, 2022, Licensee followed up with a second letter to Pain Arthritis and requested the start and end dates of care, as well as the services provided and treatment schedule. (*Id.*)

11. On April 26, 2022, Pain Arthritis sent Licensee therapy records from January 5, 2022 through April 21, 2022. (*Id.*) These records indicated that Complainant was receiving physical therapy and chiropractic treatments one to two days a week. (*Id.*)

12. Also on April 26, 2022, Licensee received an email from Dr. Cohen stating Complainant's records could not be located. (*Id.*)

13. On April 27, 2022, Licensee held a phone call with Complainant and Complainant's caregiver to discuss what type of care was being provided. (*Id.*) The caregiver noted that she was helping Complainant with dressing, washing, cleaning, and Complainant's mobility three to four days a week. (MIA Ex. 4; Transcript "Tr." at 18.)

14. On April 28, 2022, Licensee sent another letter to Dr. Cohen and requested Complainant's records. (MIA Ex. 4.)

15. On April 29, 2022, Dr. Yusuf at Neurology sent Licensee Complainant's records from October 19, 2021 through March 9, 2022. (*Id.*)

16. On May 2, 2022, Complainant called Licensee for a claim update. Licensee told Complainant that it was reviewing the records that had been submitted but was still waiting for additional records from Dr. Cohen and Dr. Keith Myers ("Dr. Myers") at Advanced Wellness Systems, LLC ("Advanced"). (*Id.*)

17. On May 4, 2022, Licensee sent a letter to Pain Arthritis with a request for missing therapy records. (*Id.*)

18. In response, on May 6, 2022, Pain Arthritis sent Licensee the therapy records for April 19, 2022 through April 27, 2022. (*Id.*)

19. On May 9, 2022, Complainant called Licensee and requested an update on the claim status. (MIA Ex. 4.) Licensee advised Complainant that it was reviewing the records it had but was still awaiting the submission of some additional records. (*Id.*)

20. On May 11, 2022, Complainant called Licensee with frustration about how long the claim was taking and accused Licensee of intentionally stalling the claim from being resolved. (MIA Ex. 4.) Licensee explained to Complainant that it was reviewing what records it had but was still waiting for the requested medical records. (*Id.*)

21. On May 16, 2022, Licensee called Complainant to give an update and advised her that it was still waiting for records from Dr. Cohen and Dr. Myers at Advanced. (*Id.*)

22. Also, on May 16, 2022, Licensee sent a letter to Dr. Myers with a request for Complainant's records. (*Id.*)

23. On May 17, 2022, Licensee sent a letter to Adventist Healthcare, where Complainant had her pacemaker implant procedure, and to Candid Home Healthcare Services ("Candid Home") with a request for records that showed the dates of service. (*Id.*)

24. On May 18, 2022, Licensee received a medical record for May 9, 2022 from Dr. Cohen. (MIA Ex. 4.) Also on this date, Pain Arthritis submitted a medical record for March 31, 2021. (*Id.*)

25. On May 19, 2022, Licensee received records from Dr. Myers for January 5, 2022 through January 20, 2022. (*Id.*)

26. On May 20, 2022, Licensee received records from Dr. Cohen for January 14, 2021 through May 9, 2022. (*Id.*)

27. Also on May 20, 2022, Licensee sent a letter to Advanced and requested the dates of service as well as the type of services provided. (*Id.*)

28. On May 23, 2022, Licensee provided Complainant an update on the claim status via a telephone call. (MIA Ex. 4.) Also on this date, Licensee sent another letter to Adventist Healthcare requesting records for dates of service. (*Id.*)

29. On May 25, 2022, Complainant contacted Licensee for a claim status update and Licensee advised her that it was still reviewing the documentation. (*Id.*)

30. On May 26, 2022, Candid Home provided the records that indicated care for Complainant was from May 10, 2022 through May 22, 2022. (*Id.*)

31. On June 2, 2022, Licensee sent letter to Advanced with a request for records of dates of service and type of services provided. (*Id.*)

32. On June 7, 2022, Candid Home submitted the dates of service to Licensee. (MIA Ex. 4.) Also on this date, Licensee sent another letter to Adventist Healthcare requesting the records for dates of service. (*Id.*)

33. On June 8, 2022, Licensee sent a letter to Dr. Cohen requesting her opinion on the accumulated medical records and their significance to Complainant's long term care needs. (MIA Ex. 4; Tr. at 19.)

34. On June 9, 2022, Complainant called Licensee for a claim status update and Licensee advised her that it was still reviewing the claim records. (MIA Ex. 4.)

35. On June 10, 2022, Licensee received records from Advanced that included the start date of Complainant's therapy care. (*Id.*)

36. On June 14, 2022, Candid Home submitted the missing dates of service to Licensee. (*Id.*)

37. On June 17, 2022, Licensee sent Complainant a claim status update letter. (*Id.*)

38. On June 22, 2022, per Complainant's request, Licensee called her and gave a claim status update. (*Id.*)

39. On June 27, 2022, Licensee received a LTC External Review Response of Complainant. (*Id.*) The report determined that specific evidence of inability to perform ADLs, like bathing, dressing and toileting, were not present at the initiation of Complainant's claim and that therapy goals pertaining to these ADLs were not present. (*Id.*)

40. On June 29, 2022, Licensee sent Complainant a claim denial letter. (*Id.*)

41. Licensee also called Complainant and advised her the basis for its decision was because there was not enough support for loss of at least two ADLs. (MIA Ex. 4; Tr. at 26-27.)

42. On August 5, 2022, Complainant submitted her initial Complaint to the MIA. (MIA Ex. 1; Tr. at 4.)

43. On August 9, 2022, Licensee reviewed additional medical records that were received on August 5, 2022. (MIA Ex. 4.) Licensee noted that this new information could lead to

a different outcome if Complainant initiated another claim but that it did not affect the outcome of its denial of Complainant's claim. (MIA Ex. 4; Tr. at 27.)

44. On September 29, 2022, the MIA concluded its investigation into Complainant's Complaint and determined that Licensee had not violated the Insurance Article in its handling of Complainant's claim. (MIA Ex. 7; Tr. at 5.)

45. On October 20, 2022, Complainant was not satisfied with the MIA's determination and requested the instant hearing. (MIA Ex. 8.) The hearing was granted in this matter by letter dated October 21, 2022. (MIA Exs. 9, 10; Tr. at 5.)

DISCUSSION

A. Positions of the Parties.

Complainant argues that she is entitled to payment from Licensee to cover LTC expenses. Specifically, Complainant contends that she has proven that her health conditions and the presence of at least two ADLs warrant the use of LTC benefits under the Policy. Lastly, Complainant avers that Licensee improperly denied her claim and improperly found that she did not qualify for LTC benefits.

Licensee argues that it properly handled Complainant's claim after performing a full investigation. Licensee contends that, after completing its investigation, it determined that, at the time she initiated the claim, Complainant did not meet the disability and ADLs requirements in her Policy to receive the LTC benefits. Lastly, Licensee avers that Complainant has failed to meet her burden to show that the claim was improperly handled in this case.

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;
> (2) refuse to pay a claim for an arbitrary or capricious reason based on all available information;
>
> * * *
>
> (6) fail to provide promptly on request a reasonable explanation of the basis for a denial of a claim [.]
>
> * * *

(Westlaw 2023.)

In *Berkshire Life Insurance Co. v. Maryland Insurance Administration,* the Appellate Court of Maryland (then known as 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).

Therefore, "[t]he claimant must… prove by a preponderance of the evidence that the insurer acted arbitrarily and capriciously." *Id.* at 672. In other words, the burden of proof rests with Complainant to demonstrate by a preponderance of the evidence that Licensee acted without adequate factual support, in a "`nonrational' and `[w]illful and unreasoning… [manner] without consideration and regard for facts and circumstances presented' . . .." *Hurl v. Board of Educ. of Howard Co.*, 107 Md.App. 286, 306 [667 A.2d 970] (1995) (quoting Black's Law Dictionary, 6th Ed.). *See also Comm'r of Labor & Indus. v. Bethlehem Steel Corp.,* 344 Md. 17, 34 (1996); Md. Code Ann., State Gov't § 10-217 (Westlaw 2023); and *Berkshire, supra,* 142 Md. App at 672. To prove something by a "preponderance of the evidence" means "to 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 §27-303 in its handling of Complainant's LTC insurance claim.

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

Complainant reported this claim to Licensee on April 4, 2022. That same day, Licensee immediately started investigating the claim and requested Complainant submit the necessary

documentation. Throughout the months of April, May and June 2022, Licensee did the following:

- Held multiple claim reviews with Complainant via telephone calls, discussing Complainant's care, treatments, medical care providers, medications, and regular activities as well as the Policy requirements, ADLs, and claim status updates.

- Sent letters to Complainant's medical care providers requesting copies of Complainant's medical records, including but not limited to Complainant's primary care physician, Dr. Cohen; Pain Arthritis; Dr. Yusuf at Neurology; Dr. Myers at Advanced; Adventist Healthcare, where Complainant had her pacemaker implant procedure; and Candid Home, which provided Complainant with residential nursing and home aid services.

- Held a conference call with Complainant and Complainant's caregiver to discuss what type of care was being provided, which included helping Complainant with dressing, washing, cleaning, and Complainant's mobility three to four days a week.

- Reviewed medical records and sent multiple requests in follow-up letters to obtain additional records as needed.

- Sent a letter to Dr. Cohen requesting her opinion on the accumulated medical records and their significance to Complainant's long term care needs.

- Called Complainant as well as sent Complainant a claim denial letter in order to advise her of its decision and explain its decision, which was based on there not being enough support for loss of at least two ADLs.

- Reviewed additional medical records that were received on August 5, 2022, which was after Licensee denied Complainant's claim. Licensee noted that this new information could lead to a different outcome if Complainant initiated another claim but that it did not affect the outcome of its denial of Complainant's claim.

In this instance, my determination in this matter is based on whether the Licensee had a reasonable basis for its refusal to pay Complainant's claim. Here, Complainant initiated a claim with Licensee so that Licensee could investigate whether Complainant qualified for LTC benefits under her Policy. Licensee initially began its investigation on April 4, 2022 by requesting that

Complainant submit all necessary documentation, including Complainant's Power of Attorney and a signed authorization form. On April 23, 2022 and April 24, 2022, Licensee further investigated the claim by sending letters to Complainant's medical care providers, Dr. Cohen, Pain Arthritis and Dr. Yusuf, that requested a copy of Complainant's medical records. Furthermore, on April 27, 2022, Licensee held a conference call with Complainant and Complainant's caregiver to discuss what type of care was being provided, which included helping Complainant with dressing, washing, cleaning, and Complainant's mobility three to four days a week. Licensee continued its investigation on May 16, 2022 and May 17, 2022, by sending letters to Dr. Myers, Adventist Healthcare, and Candid Home with a request for Complainant's medical records. Similarly, on May 20, 2022, Licensee sent a letter to Advanced and requested the dates of service as well as the type of services provided. Additionally, on June 8, 2022, Licensee sent a letter to Dr. Cohen requesting her opinion on the accumulated medical records and their significance to Complainant's long term care needs.

After reviewing all of the provided medical records, on June 29, 2022, Licensee sent Complainant a denial letter and called to explain its decision. During that conversation, Licensee advised Complainant that the basis for its decision was because there was not enough support for loss of at least two ADLs, and thus she could not be considered disabled under the Policy in order to receive LTC benefits. In response, Complainant was dissatisfied with the claim decision and submitted additional medical documentation on August 5, 2022. On August 9, 2022, Licensee reviewed the new documents and determined that this new information could lead to a different outcome if Complainant initiated another claim but that it did not affect the outcome of its denial of Complainant's claim because the ADLs were not present at the time the Complainant initiated the claim. Therefore, I find that Licensee had a reasonable basis for its

denial of Complainant's claim and did not act in an arbitrary or capricious manner, and therefore did not violate § 27-303(2).

I also find that Licensee did not fail to promptly provide on request a reasonable explanation of the basis for handling of the claim in violation of § 27-303(6) of the Insurance Article. The record before me demonstrates that Licensee communicated with Complainant multiple times over the course of the claim. Part of this communication included an explanation of the reason why Licensee denied Complainant's claim at the conclusion of its investigation. Here, Licensee expressed it denied Complainant's claim on June 29, 2022. Specifically, Licensee told Complainant the basis for its decision was because the medical records her medical providers submitted were not enough support for loss of at least two ADLs. Licensee further explained that without having evidence of loss of at least two ADLs, Complainant would not qualify for LTC benefits under the Policy. Additionally, after Complainant submitted additional medical documentation, on August 9, 2022, Licensee reviewed the new records and Licensee noted that this new information could lead to a different outcome if Complainant initiated another claim but that it did not affect the outcome of its denial of Complainant's claim because evidence of loss of two ADLs were not present at the time the claim was initiated. Therefore, I find that Licensee did not violate § 27-303(6).

Lastly, I find that Licensee did not misrepresent pertinent facts or policy provisions that relate to the claim in violation of § 27-303(1). The language of the Policy in this case reads:

> **Monthly Benefit**
> You are eligible for a Monthly Benefit after:
> (a) You become Disabled;
> (b) You are receiving services in a Nursing Facility or Assisted Living Facility; and
> (c) You have satisfied Your Elimination Period.
> A monthly benefit will become payable once all of these requirements are met.
> ***

> **"Disability and Disabled"** means:
> (a) You are cognitively impaired; or
> (b) You cannot perform 2 or more Activities of Daily Living (ADLs) without standby assistance.
> ***
>
> **Activities of Daily Living (ADLs) are:**
> (a) **Bathing:** the ability to wash yourself either in the tub or shower or by sponge bath, with or without equipment or adaptive devices.
> (b) **Dressing:** the ability to put on and take off all garments, and medically necessary braces or artificial limbs usually worn, and to fasten or unfasten them.
> (c) **Toileting:** the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene, and to care for clothing.
> (d) **Transferring:** the ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
> (e) **Continence:** the ability to voluntarily control bowel and bladder function, or, in the event of incontinence, the ability to maintain a reasonable level of hygiene.
> (f) **Eating:** the ability to get nourishment into the body by any means once it has been prepared and made available to you.
> ****

Here, the Policy specifically states that Licensee will not compensate Complainant for LTC benefits unless she is considered disabled by being cognitively impaired or, more importantly in this case, Complainant cannot perform at least two ADLs without assistance. In this case, through the Licensee's investigation, it determined that the evidence from the provided medical records did not demonstrate the loss of two ADLs at the time the claim was initiated, and Complainant could not be considered disabled to warrant the award of LTC benefits. Thus, Licensee acted according to the Policy and properly denied Complainant's claim. Therefore, I find that there was no misrepresentation of the Policy provisions related to the claim, and Licensee did not violate § 27-303(1).

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact and Discussion, it is found as a matter of law that Licensee did not improperly handle Complainant's LTC insurance claim in violation of §27-303, or otherwise violate 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 May 8, 2023.

KATHLEEN A. BIRRANE
Insurance Commissioner

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