

DEFINITION OF A JUSTIFIED COMPLAINT

A complaint is justified if:

- there is an apparent violation of a policy provision, contract provision, rule or statute, or
- there is a valid concern that a prudent layperson would regard as a practice or service that is below customary business or medical practice.

Some examples include:

- the complainant has a reason to be dissatisfied with how the claim was handled; the amount paid was less than it should have been;
- the claim was denied when it should have been paid;
- the claim was not handled timely;
- the complainant was given poor customer service, for instance, the consumer's repeated phone calls to the company or agent are not returned, or the company or agent did not do what they told the consumer they would do;
- the company's position was not adequately explained;
- the premium was not calculated in accordance with TDI rules;
- the policy was not canceled according to policy or contract provisions, rules or statutes.

A complaint is unjustified if there is no apparent violation of a policy provision, contract provision, rule or statute, or there is no valid concern that a prudent layperson would regard as a practice or service that is below customary business or medical practice.

RELATED DEFINITIONS OF COMPLAINTS

"Number of complaints resolved" measure: The number of written communications primarily expressing a grievance which has been resolved. (This definition of complaint comes from TIC Art. 21.21-2 Sec. 2 (b)(6).) All complaints are tracked on the mainframe Complaint Inquiry System (CIS). The complaint is resolved when staff have closed the complaint on CIS. To close a complaint on CIS, staff must exhaust actions deemed appropriate to resolve the complaint and have sent the complainant a letter explaining the final disposition of the complaint. Anonymous complaints will have a memo to file instead of a letter to the complainant. The source of the data is the quarterly and annual CIS "Summary Work Measures Report" (CISMESUM.REP and CISMEDET.REP) and is the sum of complaint records coded in CIS as either "F 11" (justified complaint) or "F 20" (unjustified complaint) that at the time of closing are not linked to a legal or fraud case. Complaints that are referred to other entities having primary responsibility for the subject are not included in this measure. Cumulative.

"Number of inquiries answered" measure: An "inquiry" is a request for insurance information from an external customer received during business hours. Customers include individual insurance consumers, business consumers, regulated entities, state agencies, and legislators.

"Complaint" in TIC Article 21.21-2 Sec. 2 (b)(6): "For the purposes of this subsection, "complaint" means any written communication primarily expressing a grievance;"

Complaints Inquiry System (complaint tracking system) glossary: "An expression of dissatisfaction by a party external to the TDI which is justified, verified as accurate, and documented as valid and which, directly or implicitly, requests that the TDI act to obtain relief or redress for the party or another whose interests the party represents."

"Complaint" in the HMO Act, TIC Article 20A.02 (f): "Complaint" means any dissatisfaction expressed by a complainant orally or in writing to the health maintenance organization with any aspect of the health maintenance organization's operation, including but not limited to dissatisfaction with plan administration; appeal of an adverse determination; the denial, reduction, or termination of a service; the way a service is provided; or disenrollment decisions expressed by a complainant. A complaint is not a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the enrollee."