Market Conduct Examination

Allstate New Jersey Insurance Company

Bridgewater, New Jersey

STATE OF NEW JERSEY

DEPARTMENT OF BANKING AND INSURANCE

Office of Consumer Protection Services

Market Conduct Examination Section

Date Report Adopted: June 3, 2008

REPORT

of the

MARKET CONDUCT EXAMINATION

of

Allstate of New Jersey Insurance Company

located in

Bridgewater, NEW JERSEY

as of

October 12, 2006

BY EXAMINERS

of the

STATE OF NEW JERSEY

DEPARTMENT OF BANKING AND INSURANCE

OFFICE OF CONSUMER PROTECTION SERVICES

MARKET CONDUCT EXAMINATION SECTION

DATE REPORT ADOPTED:

June 3, 2008

TABLE OF CONTENTS

Page

I. INTRODUCTION 1
A. SCOPE OF EXAMINATION 1
B. ERROR RATIOS 1
C. COMPANY PROFILE 2
II. PIP CLAIMS REVIEW 3
A. INTRODUCTION 3
B. ERROR RATIO CHART 3
C. EXAMINERS' FINDINGS 3
III. POLICY TERMINATIONS 9
A. INTRODUCTION 9
B. ERROR RATIO CHART 9
C. EXAMINERS' FINDINGS 9
IV. RECOMMENDATIONS 12
A. GENERAL INSTRUCTIONS 12
B. CLAIMS REVIEW 12
C. TERMINATIONS 13
APPENDIX A – CLAIM ERRORS 14
APPENDIX B – TERMINATION ERRORS 17
V. VERIFICATION PAGE 18A

I. INTRODUCTION

This is a report of the Market Conduct activities of Allstate New Jersey Insurance Company (hereinafter referred to as Allstate or the Company). In this report, examiners of the New Jersey Department of Banking and Insurance (NJDOBI) present their findings, conclusions and recommendations as a result of their examination.

A. SCOPE OF EXAMINATION

The scope of the examination included private passenger automobile insurance sold by the Company in New Jersey. The examiners evaluated Allstate's compliance with the regulations and statutes pertaining to automobile policy nonrenewals and Personal Injury Protection (PIP) claims. The review period for the examination was April 1, 2005 to March 31, 2006. The examiners conducted their fieldwork at the company's offices in Woodbridge, New Jersey and Wall, New Jersey between June 26, 2006 and September 1, 2006. On various dates following the fieldwork, the examiners completed additional review work and report writing. The Market Conduct Examiners were Examiner-in-Charge Marleen J. Sheridan, Thomas H. Goehrig, Ralph J. Boeckman and Richard Segin.

The examiners randomly selected files and records from computer listings and documents provided by the Company. The random selection process is in accordance with the National Association of Insurance Commissioner's (NAIC) Market Conduct Handbook. In addition, the examiners used the NAIC Handbook, Chapter VIII – Conducting the Property and Casualty Examination as a guide to examine the Company and write this report.

B. ERROR RATIOS

Error ratios are the percentage of files reviewed which an insurer handles in error. A file is counted as an error when it is mishandled or the insured is treated unfairly, even if no statute or regulation is applicable. If a file contains multiple errors, the examiners will count the file only once in calculating error ratios. However, any file that contains more than one error will be cited more than once in the report. In the event that the insurer corrects an error as a result of a consumer complaint or due to the examiners' findings, the error will be included in the error ratio. If the insurer corrects an error independent of a complaint or NJDOBI intervention, the error is not included in the error ratios.

There are errors cited in this report that define practices as specific acts that an insurer commits so frequently that it constitutes an improper general business practice. Whenever the examiners find that the errors cited constitute an improper general business practice, they have stated this in the report.

The examiners sometimes find improper general business practices or errors of an insurer that may be technical in nature or which did not have an impact on a consumer. Even though such errors or practices would not be in compliance with law, the examiners do not count each of these files as an error in determining error ratios. Whenever such business practices or errors do have

an impact on the consumer, each of the files in error will be counted in the error ratio. The examiners indicate in the report whenever they did not count particular files in the error ratio.

The examiners submitted written inquiries to Company representatives on the errors cited in this report. These inquiries provided Allstate the opportunity to respond to the examiners' findings and to provide exceptions to the statutory and/or regulatory errors or mishandling of files reported. In response to these inquiries, Allstate agreed with some of the errors cited in this report. On those errors with which the Company disagreed, the examiners evaluated the individual merits of each response and gave due consideration to all comments. In some instances, the examiners did not cite the files due to the Company's explanatory responses. In others, the errors remained as cited in the examiners' inquiries. For the most part, this is a report by exception.

C. Company Profile

Allstate New Jersey Insurance Company (ANJ) is an Illinois domiciled insurer licensed to write property and casualty business in the states of New Jersey and Illinois. On October 7, 1997, Allstate New Jersey Holdings, Inc. (now NJ Holdings, LLC), a wholly-owned subsidiary of Allstate Insurance Company (AIC), purchased all of the issued and outstanding common stock of ANJ. AIC is 100% owned by The Allstate Corporation. As a result, The Allstate Corporation indirectly owns 100% of ANJ's 42,000 outstanding shares. In 1997, ANJ received its certificate of authority to transact insurance business from the Illinois Department of Insurance. Later that same year, ANJ was licensed in New Jersey. ANJ is licensed to offer automobile and homeowners insurance. In 1999, AIC along with ANJ and Allstate Floridian Insurance Company (AFIC) completed the acquisition of the personal lines auto and homeowners insurance business of CNA, which was renamed Encompass Insurance. ANJ reinsures Encompass policies written only in New Jersey. Allstate New Jersey Insurance Company has a contract with Auto Injury Solutions to provide medical claims management services.

II. PIP CLAIMS REVIEW

A. INTRODUCTION

This review covers Personal Injury Protection (PIP) claims submitted under private passenger automobile insurance. Any New Jersey PIP claim closed from April 1, 2005 through March 31, 2006 was subject to review. In reviewing each claim, the examiners checked for compliance with all applicable statutes and regulations that govern timeliness requirements in settling PIP claims. The examiners conducted specific reviews placing particular emphasis on **N.J.A.C. 11:2-17** (Unfair claim and settlement practices), **N.J.S.A. 39:6A-5** (Payment of Personal Injury Protection Benefits), **N.J.A.C. 11: 3-4** (PIP Benefits/ Medical Protocols), **N.J.A.C. 11: 3-5** (PIP Dispute Resolution) as well as **N.J.A.C. 11:3-37.10(a)5** (Explanation of Benefits). These requirements relate to the standards in Section G, of Chapter VIII - Property and Casualty Insurance Examinations of the NAIC Market Conduct Examination Handbook.

B. ERROR RATIO CHART

The examiners calculated the error ratios by applying the procedure outlined in the introduction of this report. Error ratios are itemized separately based on the review samples as indicated in the following chart. The PIP review consisted of one randomly selected billing from each file.

Random Claim Sample	Files Reviewed	Files in Error	Error Ratio
Paid PIP	104	13	13%
Denied PIP	105	45	43%
Total	209	58	28%

C. Examiners' Findings

1. Excess Co-payments by Insured Due to Computer Malfunction – 2 Files in Error (3,649 Exceptions) – Improper General Business Practice

According to **N.J.A.C. 11:3-4.4(a)**, an insured that elects a standard $250 deductible will pay a 20 percent co-payment on medical expense benefits payable between $250 and $5,000. Allstate experienced a computer system malfunction for all bills processed from November 10, 2005 to December 12, 2005. The system malfunction caused the Company to underpay claims

and indicated that the insured owed more than the standard deductible and the 20 percent co-payment. In some claims the system indicated that the insured's co-payment was 100 percent of the covered amount.

On randomly selected claim **4124874936**, the insured paid more than $3,000 in co-payments on multiple bills. In response to an inquiry, Allstate stated this error occurred due to the above-referenced computer programming error. When asked if the Company adjusted this claim to offset the excessive $3,000 co-payment, Allstate responded that "[Since] the company paid the provider for covered services rendered under an assignment of benefits … any co-pay and deductible reimbursement would be between the eligible injured party and the provider." In response to further examiner inquiries regarding the propriety of this practice, the examiners noted that Allstate amended its claim processing system to reflect a zero-dollar co-pay.

In order to determine the extent of this error and to verify proper adjustment of the $3,000 error on claim **4124874936** referenced above, the examiners submitted to Allstate inquiry number 88 dated August 14, 2006. After several additional communications with the Company, Allstate provided a master list of claim numbers on January 2, 2008 that included supplemental payment amount and date of supplemental payment. Based on this report, the examiners confirmed that Allstate did in fact issue supplemental payments on claim **4124874936**; however, Allstate did not conclude the remediation process on this claim until September 21, 2007, or over 13-months after the examiners first made Allstate aware of this particular error.

Based on the January 2, 2008 report referenced above, Allstate underpaid 2,055 claims in the amount of $276,342 during the period November 10, 2005 to December 12, 2005. Remediation of these errors occurred during the 21-mionth period beginning November 2005 and ending September 2007.

2. Failure to Pay Claim When Benefits are Due - 10 Files in Error

According to **N.J.A.C. 11:2-17.8(i)**, no insurer shall deny a claim when it is reasonably clear that either full or partial benefits are payable. Contrary to this regulation, the examiners found that Allstate improperly denied ten PIP claim billings. On seven, Allstate's PIP vendor, Auto Injury Solutions, actually approved the physician's treatment through the pre-certification process. As such, approval occurred prior to the denial. On one of the remaining three files (1425607536), Allstate erroneously denied benefits under the premise that it was secondary to a primary health carrier. However, Allstate's own systems records indicated that it was in fact the primary carrier. On claim number 4124837511, Allstate erroneously denied benefits after a 90-day eligibility investigation confirmed that the claim was in fact valid. Since the Company denied these bills in error, Allstate further failed to comply with **N.J.A.C. 11:2-17.8(i)** and **N.J.S.A. 39:6A-5g.** The Company agreed with the examiners' findings. On the last file (basic policy claim number 4124767411), Allstate denied payment for trauma treatment involving an open reduction procedure for a serious ankle fracture because the actual cost of this procedure exceeded the $15,000 basic policy PIP limit. The examiners noted to the company by inquiry that **N.J.S.A. 39:6A-3.1(a)** permits benefits up to $250,000 "…for medically necessary treatment of permanent or significant injuries rendered at a trauma center." In response, the company agreed with this error and ultimately paid an additional benefit of $25,325.71.

SEE APPENDIX A-1 FOR A LIST OF FILES IN ERROR

3. Failure to Pay PIP Claims Timely – 10 Files in Error

N.J.S.A. 39:6A-5g and **N.J.A.C. 11:2-17.7(b)** state that the maximum period for all personal injury protection (PIP) claims shall be 60 calendar days after the insurer is furnished written notice of the fact of a covered loss; provided however that an insurer may secure a 45-day extension. When an insurer requests such an extension, the maximum settlement period may not exceed 105 days.

The examiners reviewed 105 paid PIP claims and found that Allstate failed to settle six claims within the maximum 60-calendar day time frame without issuing the 45-day extension for additional time to investigate. On these six claims, Allstate disagreed that it should be held accountable to the maximum payment periods because it paid interest incident to the late payment. Although the Company did comply with **N.J.S.A. 39:6A-5h** by paying interest on these claims, it still did not comply with **N.J.S.A. 39:6A-5g** and **N.J.A.C. 11:2-17.7(b)** which require insurers to pay claims timely and to issue a 45-day notice of delay stating the reasons why additional time is necessary to settle the claim. The examiners note that the interest requirement is in reality a penalty for failing to pay a claim timely. On four additional claims, the Company issued the 45-day delay letter, but failed to pay these claims within 105 days, also contrary to **N.J.S.A. 39:6A-5g** and **N.J.A.C. 11:2-17.7(b)**. In response to the examiners' inquiries, the Company agreed that it did not pay these four claims timely.

SEE APPENDIX A-2 FOR A LIST OF FILES IN ERROR

4. Failure to Pay Interest on Overdue PIP Payments – 4 Files in Error

N.J.S.A. 39:6A-5h requires the payment of interest on all overdue benefits. Contrary to this requirement, Allstate New Jersey failed to pay interest on four PIP bills out of 10 cited for delays. In response to inquiries, the Company agreed with this error and issued interest payments for each file cited.

SEE APPENDIX A-3 FOR A LIST OF FILES IN ERROR

5. Failure to Provide Specific or Correct Explanation for Denial on Explanation of Benefits Form – 35 Files in Error (Improper General Business Practice)

N.J.A.C. 11:3-37.10(a)5 requires all explanation of benefits (EOB) forms to provide a concise explanation as to why any claim-related expense is considered ineligible. The examiners determined that Allstate did not provide a specific, concise statement on 32 EOB's, and further failed to provide the correct reason for denial on three additional claim EOB's.

On the 32 non-specific EOB's, the Company stated "Denied based on physician advisory review." This reason is not specific; the insured does not know why the physician advisor denied

the claim, and is therefore unable to effectively contest the denial. These errors are outlined in Appendix A4.a.

On the remaining three EOB's, Allstate's stated reason for denial was inconsistent with the actual reason identified in the file. These discrepancies are outlined in Appendix A4.b. The Company agreed with two of the three files in error. However, on claim number 4123776933, the Company stated that, "… in addition to the EOB, the Company also sends the Explanation of Review (EOR) which indicates the correct reason." However, in other inquiry responses, the Company stated that Concentra generates the EOR and sends it to Allstate's centralized processing center where the information from the EOR results in an EOB. The Company does not send an EOR to the insured. Allstate issues the EOB and a standard form cover letter to the insured.

SEE APPENDIX A-4 FOR A LIST OF FILES IN ERROR

6. Failure to Deny PIP Claims Timely - 5 Files in Error

N.J.S.A. 39:6A-5g provides that a claim "shall be overdue if not paid within 60 days after the insurer is furnished written notice of the fact of a covered loss … provided, however, that any payment shall not be deemed overdue where, within 60 days of receipt of notice of claim, the insurer notifies the claimant … in writing of the denial of the claim or the need for additional time, not to exceed 45 days, to investigate the claim …" In addition, **N.J.A.C. 11:2-17.7(b)** states that the maximum payment period for all personal injury protection (PIP) claims shall be 60 calendar days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same; provided, however that an insurer may secure a 45-day extension in accordance with N.J.S.A. 39:6A-5." Of the 105 denied PIP claims reviewed, the examiners found three files in which the Company did not issue a 45-day delay letter and denied the claim beyond the maximum 60-day settlement period. Additionally, the examiners noted the Company issued delay letters on two PIP bills but denied the bills beyond the 105-day settlement period. In response to the draft report, Allstate disagreed with this error, stating that **N.J.S.A. 39:6A-5g** does not provide a timeframe in which a claim must be settled. Allstate also cited case law for unlimited settlement time frames, but failed to associate the specific facts in the cited files with the specific settlement facts that were present in the referenced case law.

SEE APPENDIX A-5 FOR A LIST OF FILES IN ERROR

7. Failure to Respond Timely to Pre-Certification Request – 2 Files in Error

N.J.A.C. 11:3-4.7(c)4 requires insurers to respond within three business days to pre-certification requests by insureds or providers. Contrary to the regulation, Allstate failed to respond timely to two pre-certification requests. On denied claim number **4124424807** the Company received a pre-certification request on March 14, 2005 but did not respond until April 21, 2005, 28 business days later. For denied claim number **4124604473** the provider submitted a pre-certification request to which the Company did not respond. The Company agreed with the examiners' findings. The examiners also cited these files pursuant to **N.J.A.C. 11:3-4.7(g)**, which states that an insurer shall not retrospectively deny payment for treatment, diagnostic testing or

durable medical equipment on the basis of medical necessity where a decision point review or precertification request for that treatment or testing was properly submitted to the insurer, unless the request involved fraud or misrepresentation as defined in **N.J.A.C. 11:16-6.2**. In each case, fraud or misrepresentation was not present, and the providers met their obligation to submit pre-certification requests.

8. Failure to Pay Full Amount of Interest Owed – 1 File in Error

N.J.S.A. 39:6A-5(h) requires the payment of interest on all overdue benefits. Contrary to the statute, the company failed to pay the full amount of interest on one PIP bill for claim number **1425129770**. In response to an inquiry, the company agreed with the examiners' findings and paid the additional interest owed.

9. Failure to Provide PIP Application Claim Forms Within 10 Working Days of Notice- 2 Files in Error

N.J.A.C. 11:2-17.6(c) requires every insurer, upon receiving notification of a claim, to promptly provide first party claimants with necessary claim forms within 10 working days of the notice. Contrary to the maximum 10 working day period specified in **N.J.A.C. 11:2-17.6(c),** Allstate New Jersey failed to provide the necessary claim forms within the required time frame for one denied and one paid PIP claim file.

SEE APPENDIX A-6 FOR A LIST OF FILES IN ERROR

10. Miscellaneous Findings

A. Personal Injury Protection Dispute Resolution Files

Pursuant to **N.J.S.A. 39:6A-5.1** and **N.J.A.C. 11:3-5,** the Commissioner has established a Dispute Resolution Organization for the resolution of disputes concerning the payment of medical expenses and other benefits provided under Personal Injury Protection coverage. The examiners reviewed 30 PIP claim files that were involved in the dispute resolution process and found that the Dispute Resolution Professional (DRP) found in favor of the provider, based on the following administrative file handling errors: denial of benefits even though treatment was precertified; and failure of the Company to respond to a request for treatment pre-certification within three days with subsequent denial of such treatment. The DRP also disagreed with the manner in which Allstate handled the following: denial of bills due to lack of documentation when in fact documentation was attached to the file; erroneously down coding medical bills; and denial of benefits due to lack of medical necessity where the file clearly documented that treatment was medically necessary.

B. Citing an Incorrect New Jersey Administrative Code on EOB

Allstate's Explanation of Benefits includes a statement, "This claim has been repriced according to the PIP medical fee schedule set forth in **N.J.A.C. 11:3-29.6**." However, **N.J.A.C.**

11:3-29.6 was repealed in 2001 and placed in reserved status. In response to an inquiry, the Company agreed to remove the incorrect citation.

III. POLICY TERMINATIONS

A. INTRODUCTION

During the review period of April 1, 2005 through March 31, 2006, Allstate New Jersey Insurance Company nonrenewed 2,364 automobile insurance policies. The examiners checked for compliance with applicable statutes and regulations relating to terminations. These included **N.J.A.C. 11:3-8** (nonrenewal of automobile policies), **N.J.A.C. 11:3-34** (eligible persons), **N.J.S.A. 17:29C-7.1** and **N.J.S.A. 17: 29C-9** through **11** (automobile insurance terminations), all of which relate to NAIC standards of Chapter VIII - Conducting Property and Casualty Insurance Examinations of the Market Conduct Examination Handbook. The examiners reviewed samples of randomly selected nonrenewed policies.

B. ERROR RATIO CHART

The examiners calculated the error ratios by applying the procedure outlined in the introduction of this report. Error ratios are itemized separately based on the review samples as indicated in the following chart.

Nonrenewals	File Review	Files in Error	Error Ratio
2% Nonrenewals	47	1	2%
Underwriting Rules and Eligibility	68	65	96%
Totals	115	66	57%

C. EXAMINERS' FINDINGS

1. Failure to Retain Certified True Copy of Cancellation Notice – 115 Errors (Improper General Business Practice)

N.J.S.A. 17:29C-10b states no cancellation notice or intention not to renew shall be effective unless the insurer retains a duplicate copy of the mailed termination notice which is certified to be a true copy. Contrary to this requirement, Allstate was unable to provide the examiners with the certified true copy of the termination notice for 115 nonrenewal notices.

In response to an inquiry, the Company disagreed and stated, "We have the ability to produce duplicate copies of the nonrenewal notice. Additionally, we maintain a date-stamped record of mailings, which establishes proof of mailing by a specific date. We believe that our current

practices satisfy **N.J.S.A. 17:29C-10**." The examiners acknowledge that Allstate has the ability to produce copies of the notices but the Company could not certify the notices to be true copies of the nonrenewal notices that it actually mailed. The examiners cited this error as an improper general business practice since the examiners found this error on all 115 nonrenewal notices reviewed. The examiners did not include this error in the error ratio chart.

SEE APPENDIX B-1 FOR A LIST OF FILES IN ERROR

2. Failure to Include Designated Provision in the Nonrenewal Notice – 64 Errors (Improper General Business Practice)

N.J.A.C. 11:3-8.3(e)1 states that a notice of nonrenewal shall not be valid unless it contains the designated provision under which action is being taken. Allstate relied on its underwriting guidelines as a means to justify its decision to terminate 64 policies. Contrary to **N.J.A.C. 11:3-8.3(e)1,** and as an improper general business practice, the Company failed to reference **N.J.A.C. 11:3-8.4(a),** which specifies that insurers may issue a notice of nonrenewal to any person who is not an eligible person as defined by **N.J.A.C. 11:3-34.4**. The Company's notice referenced **N.J.A.C. 11:3-34.4**, which is not a designated provision of the non-renewal regulation.

The Company disagreed with the examiners' findings stating that the referenced nonrenewal notices include the information required by **N.J.A.C. 11:3-8.3(e)1** such as eligibility points and events and sources which resulted in their assessment. However, when the Company nonrenews a policy due to an ineligible person, the designated provision under which action is being taken is **N.J.A.C. 11:3-8.4(a)** and should be included on the nonrenewal notice.

SEE APPENDIX B-2 FOR A LIST OF FILES IN ERROR

3. Incorrect Facts Listed on the Nonrenewal Notice – 5 Errors

N.J.A.C. 11:3-8.3(e) states that a notice of nonrenewal shall set forth the reason(s) for such nonrenewal. **N.J.A.C.11:3-8.3(e)1** states that a nonrenewal notice shall not be valid unless it contains the facts relied upon by the insurer in determining to nonrenew the insured. The notice shall include the dates and other facts necessary for identification of the incidents. On five policies the Company listed incorrect information on the nonrenewal notice, contrary to the regulations cited above.

On policy **909386974** the nonrenewal notice stated the insured was no longer an eligible person as defined by **N.J.A.C. 11:3-34** due to a driver's license suspension. However, the name of the person that appears on the notice as an ineligible person is not the insured and is not listed as a driver on the insured's policy. The Company agreed with the examiners' findings.

The Company noted an at fault accident with nine points instead of the required five points on the nonrenewal notice for policy **909133430**. The examiners noted the driver is ineligible since he has a total accumulation of 13 eligibility points. However, the nonrenewal notice incorrectly indicates that one accident accounted for nine points.

On policy **909144362**, the Company listed territory number five on the 2% nonrenewal notice instead of correct territory number three. The Company agreed with the examiners' findings.

Allstate failed to include an at-fault accident on the nonrenewal notice for policy **909238532**. The notice correctly listed a four point conviction for speeding but did not include the at-fault accident to correctly show all of the facts the Company relied upon in determining that the insured was not an eligible person as defined by **N.J.A.C. 11:3-34**. The Company agreed with the examiners' findings.

The Company nonrenewed policy **909419692** because a driver on the policy had two at-fault accidents (January 6, 2004 and July 18, 2005). The Company could not provide documentation that the January 6, 2004 event was a chargeable, at-fault accident. In response to an inquiry, Allstate stated, "It is the Company's position that the insured has the burden of proof for an accident listed on an MVR to support that the accident is not an at-fault accident." However, **N.J.A.C. 11:3-34.5(b)1** states an insurer shall not underwrite a policy based on an accident until total payment by an insurer equals or exceeds $1,000. Allstate provided a copy of the driver's Motor Vehicle abstract which indicated, "1/6/04- involved in an accident." This merely states that the driver was involved in an accident; it does not indicate that the accident is chargeable nor does it indicate the amount paid. The examiners noted that the driver is ineligible due to a chargeable, at-fault accident on August 17, 2005 that the Company should have included on the notice.

4. Failure to State Information Sources on Termination Notices – 1 Error

According to **N.J.A.C. 11:3-8.3(e)1i**, when a notice of nonrenewal is based on automobile insurance eligibility points, the notice shall identify the number of eligibility points and the events and sources which resulted in their assessment. Contrary to the regulation stated above, the examiners found the nonrenewal notice for policy **909148258** did not identify the source from where the Company obtained the information referenced on the notice. The Company agreed with the examiners findings.

IV. RECOMMENDATIONS

Allstate New Jersey should inform all responsible personnel and third party entities who handle the files and records cited as errors in this report of the examiners' recommendations and remedial measures that follow in the report sections indicated. The examiners also recommend that Allstate New Jersey establish procedures to monitor compliance with these measures.

Throughout this report, the examiners cite and/or discuss all errors found. If the report cites a single error, the examiners often include a "reminder" recommendation because if a single error is found, more errors may have occurred.

The examiners acknowledge that during the examination Allstate New Jersey had agreed and had already complied with, either in whole or in part, some of the recommendations. For the purpose of obtaining proof of compliance and for the Company to provide its personnel with a document they can use for future reference, the examiners have listed all recommendations below.

A. GENERAL INSTRUCTIONS

All items requested for the Commissioner and copies of all written instructions, procedures, recommended forms, etc., should be sent to the Commissioner, c/o Clifton J. Day, Manager of the Market Conduct Examinations and Anti-fraud Compliance Unit, Mary Roebling Building, 20 West State Street, PO Box 329, Trenton, N.J. 08625, within thirty (30) days of the date of the adopted report.

B. CLAIMS REVIEW

1. The Company should review all 3,649 bills that were affected by the computer malfunction and provide a list which includes each claim number and the amount of underpayment for each claim. The Company is to provide documentation that a refund was issued for each claim.

2. Allstate New Jersey should issue written instructions to all appropriate claims personnel stating that:
a.) Pursuant to **N.J.A.C. 11:2-17.8(i),** no insurer shall deny payment of a claim when it is reasonably clear that full or partial benefits are payable.
b.) PIP claims must be settled within 60 days unless an extension of 45 days is requested in writing pursuant to **N.J.S.A. 39:6A-5g** and **N.J.A.C. 11:2-17.7(b).**
c.) Pursuant to **N.J.S.A. 39:6A-5h** and **N.J.A.C. 11: 2-17.7(b)**, the Company must pay interest on PIP claims settled beyond the required time frames.
d.) **N.J.A.C. 11:3-37.10(a)5** requires all Explanation of Benefit (EOB) forms to provide a concise explanation as to why any item of expense is considered ineligible.
e.) **N.J.A.C. 11:3-4.7(c)4** requires an insurer to respond within three business days to pre-certification requests by insureds or providers.

f). **<u>N.J.A.C.</u> 11:3-4.7(g)** prohibits retrospective medical necessity claim denials where the provider or insured properly seeks precertification for treatment. Allstate should reopen claim numbers **4124424807** and **4124604473** as cited in section II.C.7 above in order to pay these claims with applicable interest.
g.) The company must correctly calculate the interest on overdue PIP benefits pursuant to **<u>N.J.S.A</u>. 39:6A-5(h).**
h.) **<u>N.J.A.C.</u> 11:2-17.6(c)** requires insurers to provide first party claimants with all forms necessary to make a claim within 10 working days of notice of claim; including PIP applications.

3. Allstate should review the ten claims listed in Appendix A-1 of this report. The Company should provide documentation that indicates the principal amount paid, interest amount paid, date of payment and date of notice used to measure total payment period for each claim.

4. Allstate should remove all reference to the incorrect citation **<u>N.J.A.C.</u> 11:3-29.6** found in its Explanation of Benefit (EOB) forms.

5. On basic policy claim number **4124767411**, Allstate should advise the outcome of its additional claims review, including the date and amount of additional benefits paid.

C. Terminations

6. Allstate should issue written instructions to appropriate personnel stating that:
a.) To comply with **<u>N.J.S.A.</u> 17:29C-10b**, no notice of cancellation or notice not to renew shall be effective unless the insurer has retained a duplicate copy of the mailed notice, which is certified at the time of mailing to be a true copy. The Company must provide documentation reflecting the implementation of this process.
b.) Notices of nonrenewal should include the correct provision under which action is being taken as required by **<u>N.J.A.C.</u> 11:3-8.3(e)1.**
c.) **<u>N.J.A.C.</u> 11:3-8.3(e)** requires that a notice of nonrenewal set forth the reason(s) for such nonrenewal. **<u>N.J.A.C.</u>11:3-8.3(e)1** requires a nonrenewal notice to contain the facts relied upon by the insurer to nonrenew a policy. The notice shall include the dates and other facts necessary for identification of the incidents caused the nonrenewal.
d.)When a notice of nonrenewal is based on eligibility points, the notice must identify the events and sources which resulted in their assessment pursuant to **<u>N.J.A.C.</u> 11:3-8.3(e)1i** .

7. Allstate should issue written reminders to all appropriate personnel stating that the determination of accident chargeability ultimately rests with company underwriters and not the applicant or insured. This reminder should include specify that a loss must have resulted in payment of $1,000 or more in order to qualify as an adverse, chargeable underwriting event.

Appendix A – Claim Errors

1. **Failure to Pay Claim When Benefits are Due - 10 Files in Error**

Claim Number	Service Pre-certified	Co.'s Response to Examiners' Inquiry
1874701335	Yes	Co. paid $2.73 interest
4124532970	Yes	Co. paid $339.51plus $6.28 interest
1425607536	No	Co. paid bill plus interest
1425428776	Yes	Co. paid $1,575.30 plus $23.91 interest
4124837511	No	Co. paid interest
4124916745	Yes	Co. paid $2,151.44 plus $20.20 interest
4124869530	Yes	Co. paid $34.04 plus $.42 interest
1874540154	Yes	Co. paid bill plus interest
1424933230	Yes	Co. paid bill plus interest
4124767411	No	Reviewing claim for additional payments

2. **Failure to Pay PIP Claims Timely – 10 Files in Error**

Claim Number	Date Bill Received	Date Bill Paid	Days Greater Than 60	Days Greater Than 105
4124691751	07/13/05	10/28/05	N/A*	2
4124719883	04/21/06	10/03/05	105**	N/A
1874863465	12/09/05	03/13/06	34**	N/A
1874592494	07/28/05	12/02/05	N/A*	22
1874649526	03/09/05	10/03/05	N/A*	103
4124595225	04/29/05	08/31/05	64**	N/A
1425294822	04/22/05	08/01/05	41**	N/A
4124373426	12/22/04	06/27/05	N/A*	82
4123864714	12/03/04	05/25/05	113**	N/A
4124631492	03/28/05	07/26/05	60**	N/A

* Allstate issued a 45-day delay letter within the first 60 days from notice of claim, but failed to settle the claim within the maximum 105 day period specified in N.J.S.A. 39:6A-5(g). Days delayed are those beyond 105 days from notice of loss.

**Allstate did not issue 45 day delay letter when settlement exceeded 60 days from notice of loss. Days delayed are those beyond 60 days from notice of loss.

3. Failure to Pay Interest on Overdue PIP Benefits – 4 Files in Error

Claim Number	Claim Number	Claim Number	Claim Number
1425294822	4124373426	4123864714	4124631492

4.a Failure to Provide Specific Explanation for Denial on Explanation of Benefits – 32 Files in Error

Claim Number	Denial Reason on Notice
4124604473	Denied based on Physician advisory review
4124789407	Denied based on Physician advisory review
1874701335	Denied based on Physician advisory review
1425009014	Denied based on Physician advisory review
4124535677	Denied based on Physician advisory review
4124471279	Denied based on Physician advisory review
1425301197	Denied based on Physician advisory review
1874540154	Denied based on Physician advisory review
1425235148	Denied based on Physician advisory review
4124621691	Denied based on Physician advisory review
1425388541	Denied based on Physician advisory review
1874168089	Denied based on Physician advisory review
4124535999	Denied based on Physician advisory review
1874748856	Denied based on Physician advisory review
1425638838	Denied based on Physician advisory review
1425004734	Denied based on Physician advisory review
4124605769	Denied based on Physician advisory review
1425461231	Denied based on Physician advisory review
4124775497	Denied based on Physician advisory review
4124801293	Denied based on Physician advisory review
1425327515	Denied based on Physician advisory review
1424570909	Denied based on Physician advisory review
1425457964	Denied based on Physician advisory review
4124563737	Denied based on Physician advisory review
4124773229	Denied based on Physician advisory review
1874642620	Denied based on Physician advisory review
1874717620	Denied based on Physician advisory review
1874721804	Denied based on Physician advisory review
1874861055	Denied based on Physician advisory review
4124280332	Denied based on Physician advisory review

4124869530	Denied based on Physician advisory review
1425391073	Denied based on Physician advisory review

4.b Failure to Provide Correct Explanation for Denial on Explanation of Benefits – 3 Files in Error

Claim Number	Denial Reason on Notice	Correct Denial Reason
4124544109	Have the Policy Limits Been Exhausted?	Policy Limits Exhausted
1425391073	Physician Advisor Review	Denied for Duplicate Services
4124776933	Code Description not found	Submitted for an independent medical exam and payment was denied

5. Failure to Deny PIP Claims Timely - 5 Files in Error

Claim Number	45 Day Delay Notice Sent	Date Bill Received	Date Bill Denied	Days Beyond Required Time Frames
4124563737	No	04/21/05	09/02/05	74 Days beyond 60
1874642620	No	07/07/05	09/08/05	4 Days beyond 60
4124604473	No	10/27/05	08/23/05	100 Days beyond 60
4124571938	Yes	05/03/05	08/23/05	7 Days beyond 105
1874785510	Yes	07/14/05	11/01/05	5 Days beyond 105

6. Failure to Provide Necessary PIP Claim Forms Within 10 Working Days of Notice – 2 Files in Error

Claim Number	Date of Notice	Date Claim Forms Sent	Working Days Beyond 10
4124767411	6/03/05	7/13/05	17
1425585286	8/16/05	10/12/05	30

Appendix B – Termination Errors

1. Failure to Retain Certified True Copy of Cancellation Notice – 115 Errors (Improper General Business Practice)

Policy Number	Policy Number	Policy Number	Policy Number
909344097	009976802	909198575	909160534
909344159	909416646	909409048	139068262
909163267	909401817	909437349	909208737
909300034	109858740	839053607	009827654
839008579	909256200	909020325	909293584
909027343	009875695	009869384	909111315
909386974	909410086	009777168	909151248
909392085	809586818	009996576	009784578
009888383	809564591	909422716	109313894
809513396	909265910	809411622	909286624
109375022	809603908	009680513	009871936
139036792	909091645	909173061	909302340
809272309	909133430	909182427	909331089
809531125	909136941	909249884	909348596
909025095	909144377	909266591	909398012
909083413	909164561	909267119	909419692
909441269	009702952	009971401	009989900
009998063	139812127	809008421	809098115
809131036	809307399	809321659	809330579
809394863	809469219	809494434	809549448
809551340	809562132	809662924	809680124
839152195	839159789	909003146	909007332
909008630	909040908	909060461	909074155
909091064	909096176	909122207	909131275
909137247	909143643	909144249	909144362
909363281	909145648	909148258	909176435
909200539	909220200	909228446	909238532
909240218	909266763	909279267	909393303
909383410	909333850	909345808	

2. Failure to Include Designated Provision in the Nonrenewal Notice – 64 Errors (Improper General Business Practice

Policy Number	Policy Number	Policy Number	Policy Number
909344097	009976802	909198575	909160534
909344159	909416646	909441269	139068262
909163267	909401817	909419692	909208737
909300034	109858740	839053607	009827654
839008579	909256200	909020325	909293584
909027343	009875695	009869384	909111315
909386974	909410086	009777168	909151248
909392085	909238532	009996576	009784578
009888383	809564591	909422716	109313894
809513396	909265910	809411622	909286624
109375022	809603908	009680513	009871936
139036792	909091645	909173061	909302340
809272309	909133430	909182427	909331089
809531125	909136941	909249884	909348596
909025095	909144377	909266591	909398012
909083413	909164561	909267119	009998063

V. VERIFICATION PAGE

I, Marleen J. Sheridan, am the Examiner-in-Charge of the Market Conduct Examination of Allstate New Jersey Insurance Company conducted by examiners of the New Jersey Department of Banking and Insurance. This verification is based on my personal knowledge as acquired in my official capacity.

The findings, conclusions and recommendations contained in the foregoing report represent, to the best of my knowledge, a full and true statement of the Market Conduct examination of Allstate New Jersey Insurance Company as of October 12, 2006.

I certify that the foregoing statements are true. I am aware that if any of the foregoing statements made by me is willfully false, I am subject to punishment.

____

Date:

____

Marleen J. Sheridan

Examiner-In-Charge

New Jersey Department

of Banking and Insurance