CHAPTER 25

OFFICE OF THE INSURANCE CLAIMS OMBUDSMAN

Authority

N.J.S.A. 17:1-8.1, 17:1-15e and 17:29E-1 et seq.

Source and Effective Date

R.2007 d.156, effective April 13, 2007.
See: 38 N.J.R. 4166(a), 39 N.J.R. 1737(b).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 25, Office of the Insurance Claims Ombudsman, expires on October 10, 2014. See: 46 N.J.R. 837(a).

Chapter Historical Note

Chapter 25, Office of the Insurance Claims Ombudsman, was adopted as R.2001 d.376, effective October 15, 2001. See: 33 N.J.R. 982(a), 33 N.J.R. 3680(a).

Chapter 25, Office of the Insurance Claims Ombudsman, was readopted as R.2007 d.156, effective April 13, 2007. See: Source and Effective Date. See, also, section annotations.

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 25, Office of the Insurance Claims Ombudsman, was scheduled to expire on April 13, 2014. See: 43 N.J.R. 1203(a).

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SUBCHAPTER 1. GENERAL POWERS AND DUTIES

11:25-1.1 Purpose and scope

(a) The purpose of this subchapter is to establish procedures for the Insurance Claims Ombudsman to exercise his or her statutory authority to:

1. Investigate consumer complaints involving policies of insurance, including the payment of claims;

2. Monitor the implementation of N.J.S.A. 17:23A-1 et seq. (policyholder's personal information disclosure practices of regulated insurers);

3. Monitor the implementation of N.J.S.A. 17:29B-1 et seq. and 17B:30-1 et seq. (consumer complaints regarding unfair methods of competition; unfair, deceptive and discriminatory acts or practices by insurers);

4. Monitor the implementation of N.J.S.A. 17:35C-1 et seq. (Medicare supplement health insurance policies; regulation of contract provisions and required disclosure to consumers);

5. Investigate alleged violations of N.J.S.A. 17:35C-11 (use of false, misleading, or fraudulent statements and advertising to sell Medicare supplement insurance to consumers);

6. Respond to consumer inquiries, including, but not limited to, those regarding policy terms and availability of coverage;

7. Ensure that accurate and understandable buyers' guides and rate comparisons are published and disseminated to consumers where required by law, except those with respect to health insurance coverages provided pursuant to N.J.S.A. 17B:27A-2 et seq. and 17B:27A-17 et seq.;

8. Review the conduct of arbitrators appointed in accordance with the terms of a policy of insurance to arbitrate disputes, except those arbitration proceedings arising out of policies issued pursuant to N.J.S.A. 39:6A-1 et seq. or already subject to the provisions of N.J.A.C. 11:22-1;

9. Investigate such other improper patterns or practices as are deemed necessary and appropriate to the Office of Insurance Claims Ombudsman; and

10. Review disputes that are appealed by consumers after an internal appeals procedure (N.J.A.C. 11:25-2) is conducted by life, property and casualty insurers.

(b) This subchapter shall apply to all claims filed under a policy of insurance issued in accordance with N.J.S.A. 17:17-1, 39:6A-1 et seq., or any policy of life or health insurance issued in accordance with Title 17 or Title 17B of the New Jersey Statutes, except any dispute which may be or has been filed or adjudicated pursuant to N.J.S.A. 39:6A-5.1 and 39:6A-5.2 (PIP Alternate Dispute Resolution) shall not be subject to the Ombudsman's review.

11:25-1.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Claim" means any claim filed under a policy of insurance issued pursuant to N.J.S.A. 17:17-1 et seq., 39:6A-1 et seq., or any policy of life or health insurance issued pursuant to Title 17 or Title 17B of the New Jersey Statutes.

"Commissioner" means the Commissioner of the Department of Banking and Insurance.

"Disputed insurance claim" means any offer of settlement made by any insurer which is, in whole or in part, rejected or refused by the claimant or a claim denial.

"Insurance" means any contract of direct insurance written pursuant to N.J.S.A. 17:17-1 et seq., 39:6A-1 et seq., or any policy of life or health insurance issued pursuant to Title 17 or Title 17B of the New Jersey Statutes.

"Ombudsman" or "Insurance Claims Ombudsman" means the Office of Insurance Claims Ombudsman within the New Jersey Department of Banking and Insurance established in accordance with N.J.S.A. 17:29E-1.

Amended by R.2007 d.156, effective May 7, 2007.
See: 38 N.J.R. 4166(a), 39 N.J.R. 1737(b).
In definitions "Claim" and "Insurance", inserted "17:17-1 et seq.," and in definition "Disputed insurance claim", inserted "or a claim denial".

11:25-1.3 General provisions; disputed claims

(a) Upon the request of a consumer, the Ombudsman may conduct a review of any disputed insurance claim settlement where there is reasonable cause to believe that an insurer has failed or refused to settle a claim in accordance with the provisions of the policy or has engaged in any practice that may constitute a violation of N.J.S.A. 17:23A-1 et seq., 17:29B-1 et seq., 17:35C-1 et seq., 17B:30-1 et seq., or 17:35C-11; or

(b) Consumers seeking review in accordance with (a) above shall file a complaint with the Ombudsman in any form, which indicates that the complainant is seeking review of a disputed claim. All complaints shall be sent to:

The Office of Insurance Claims Ombudsman
20 West State Street
PO Box 472
Trenton, NJ 08625-0472
Telephone: (800) 446-7467
Telefax: (609) 292-2431
E-mail: ombudsman@dobi.state.nj.us

1. All complaints received by the Ombudsman shall be entered into the data tracking system of the Office of Consumer Protection Services. The Ombudsman shall retain complaints for further action, or refer them to the Office of Consumer Protection Services for disposition. The Office of Consumer Protection Services may likewise refer matters to the Ombudsman.

2. If the Ombudsman needs further information on any complaint, the office shall notify the complainant of the additional information needed before any further action may be taken.

3. A copy of the filed complaint shall be sent promptly to the respondent together with a transmittal letter that advises the respondent that an answer to the complaint must be filed no more than 15 business days after the date of receipt of the transmittal letter.

4. The respondent may raise a general denial to the complainant's allegations and may also raise such other legal, contractual or equitable defenses, which explain or justify the actions of the respondent.

5. Thereafter, the complainant shall be advised of the respondent's contentions and given an opportunity to rebut within 15 business days of receipt of the notice.

6. When deemed appropriate, the Ombudsman may extend all time limits mentioned in this subsection.

(c) At the discretion of the Ombudsman, an investigation and hearing may be conducted in person and under oath.

1. In the conduct of an investigation, the Ombudsman may, in his or her sole discretion:

i. Investigate whether the insurer's actions, determinations and proceedings with respect to the claim were in accordance with the law and the policy;

ii. Make any necessary and appropriate inquiries of the insurer or any other interested person to obtain such information as the Ombudsman deems necessary to the investigation;

iii. Hold a hearing on the disputed claim;

iv. Inspect any books and records that relate to the claim; and

v. Issue subpoenas to compel the attendance of any person at a specific time and place, as well as require the production of any documents, books, records, papers, objects and other evidence deemed necessary and relevant to the claim under investigation.

2. The Ombudsman may elect not to investigate a complaint if it is determined that:

i. The complaint is trivial, frivolous, vexatious or not made in good faith;

ii. The complaint has been too long delayed to justify further investigation;

iii. The resources available, considering the established priorities, are insufficient for an adequate investigation;

iv. The matter complained of is not within the investigatory authority of the Ombudsman; or

v. The subject is already under investigation by the Department or the Office of Insurance Fraud Prosecutor.

Amended by R.2007 d.156, effective May 7, 2007.
See: 38 N.J.R. 4166(a), 39 N.J.R. 1737(b).
In the address within the introductory paragraph of (b), substituted "472" for "329" and "0472" for "0329"; in (b)1, substituted "Office of Consumer Protection Services" for "Office of Enforcement and Consumer Protection" three times; in (b)3, inserted "business"; and in (b)5, substituted "15 business" for "seven".

11:25-1.4 Consultants and experts

When deemed necessary to any inquiry undertaken pursuant to this subchapter, the Ombudsman may, in accordance with N.J.S.A. 17:29E-3b, engage the services of consultants and other professionals to assist in the investigation or understanding of any relevant issue, pursuant to all applicable laws regarding same.

11:25-1.5 Trade and marketing practices; investigations, hearings and complaints

(a) The Ombudsman may, upon his or her initiative, or upon the filing of a complaint by any interested party, conduct an investigation and/or hearing into an insurer's trade practices, including claims settlement practices, and marketing practices which may deviate from N.J.S.A. 17:29B-1 et seq., N.J.S.A. 17B:30-1 et seq., and/or N.J.A.C. 11:2-17.

(b) When making investigations or conducting hearings, the Ombudsman may consider any and all information deemed necessary and proper to resolve the issues raised by the investigation or hearing.

(c) The Ombudsman may inspect and copy books, papers, objects, documents, records and other evidence considered material or relevant to the matter under investigation, and may issue a subpoena to compel any person to attend and testify as well as to produce documents, books, papers, objects, records and other evidence at such place and time as is selected by the Ombudsman.

(d) At the conclusion of the investigation, inquiry or hearing, the Ombudsman may, in his or her discretion or at the request of the Commissioner, issue a report as to any findings and conclusions reached regarding the trade practice, marketing practice, policy or provision being investigated. The Ombudsman may determine if any policy provision, endorsement or form is unfairly discriminatory, confusing, misleading or contrary to public policy together with a specific recommendation as to the modification or discontinuance of the policy, form or provision. The report may also include a recommendation to the Commissioner regarding any further investigation of an insurer's practices together with a recommendation regarding the imposition of penalties or other sanctions.

11:25-1.6 Registry of closed complaints and confidentiality of information

(a) The Ombudsman shall maintain a central registry of all closed complaint investigations that shall contain information on the nature of the investigation, findings and disposition. The Ombudsman shall report to the Commissioner any evidence that an insurer may be engaged in a pattern of conduct which violates N.J.S.A. 17:29B-1 et seq., 17:23A-1 et seq., 17:29B-1 et seq., 17B:30-1 et seq., 17:35C-1 et seq., or 17:35C-11. The contents of this central registry shall be confidential and shall not be subject to public inspection or copying pursuant to the "Right to Know Law," N.J.S.A. 47:1A-1 et seq.

(b) Any correspondence or written communication from any complainant and any written material submitted by an insurer to the Ombudsman shall remain confidential and shall not be considered a public record pursuant to the "Right to Know Law," N.J.S.A. 47:1A-1 et seq., and shall not be subject to release unless such disclosure is necessary to enable the Ombudsman to perform his or her duties and to support any opinions or recommendations, or as may be necessary to enable the Commissioner to perform any function authorized by law, including any action to stop unfair claims settlement practices. Any statement or communication made by the Ombudsman or which is provided in good faith to the Ombudsman shall be deemed to be privileged and confidential in accordance with N.J.S.A. 17:29E-12(c). Confidentiality shall attach only after the Ombudsman has exercised his or her jurisdiction to investigate a complaint. Complaints sent to the Ombudsman that he or she does not elect to investigate pursuant to N.J.A.C. 11:25-1.4(c)2 shall be returned to the complainant or referred to the Office of Consumer Protection Services for further action. Only those complaints retained by the Ombudsman shall be subject to the confidentiality provision of this chapter.

Amended by R.2007 d.156, effective May 7, 2007.
See: 38 N.J.R. 4166(a), 39 N.J.R. 1737(b).
Section was "Registry of closed claims and confidentiality of information". In (a), substituted "complaint" for "claims"; in (b), substituted "Office of Consumer Protection Services" for "Division of Enforcement and Consumer Protection" and "complaints" for "claims".

11:25-1.7 Publication of information

(a) Every buyer's guide given to insureds in accordance with Title 11 of the New Jersey Administrative Code shall contain a notice describing the existence and function of the Office of Insurance Claims Ombudsman together with the mailing address, toll-free telephone number and e-mail address listed below.

(b) As a part of any claim, claim denial, payment, compromise or any other disposition, all insurers shall provide notice and explanation of the insurer's internal appeal process that is established in accordance with N.J.A.C. 11:25-2.

(c) As a part of any final action taken by an insurer's internal appeals panel, except those covered by N.J.S.A. 39:6A-5.1 and 5.2 and N.J.A.C. 11:22-1, notice shall be provided to all parties that the Office of Insurance Claims Ombudsman may be contacted at the address in (d) below if further review is sought.

(d) Any document described in (a), (b) and (c) above shall list the following information for contacting the Ombudsman:

Office of Insurance Claims Ombudsman
Department of Banking and Insurance
PO Box 472
Trenton, NJ 08625-0472
Telephone: (800) 446-7467
Telefax: (609) 292-2431
E-mail: ombudsman@dobi.state.nj.us

Amended by R.2007 d.156, effective May 7, 2007.
See: 38 N.J.R. 4166(a), 39 N.J.R. 1737(b).
In (b), substituted "claim" for "consumer"; and in (c), substituted "except" for "excepted".

SUBCHAPTER 2. INTERNAL APPEALS PROCEDURE

11:25-2.1 Purpose and scope

(a) The purpose of this subchapter is to implement the provisions of N.J.S.A. 17:29E-9, that requires life, property and casualty insurers to establish an internal appeals procedure for consumers seeking review of disputed claims.

(b) This subchapter shall apply to all disputed consumer claims with the exception of those to which the provisions of N.J.S.A. 39:6A-5.1 and 5.2 apply (that is, disputes arising out of personal injury protection coverage claims) or the process established in N.J.A.C. 11:22-1.

11:25-2.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Claimant" means a first-party claimant, a third-party claimant, or a designated representative.

"Claims settlement" means all activities of an insurer relating directly or indirectly to the determination of the extent of liabilities due or potentially due under the coverage afforded by the policy, and which can or does result in a claim payment or acceptance, compromise or rejection.

"Insurer" means any entity authorized or admitted to transact the business of a property/casualty and life insurance in accordance with Titles 17 and 17B of the New Jersey Statutes.

"Internal appeals" means any notification, in written form which is received either by mail, electronic mail, facsimile or by delivery to the insurer that advises the insurer that the final offered claim settlement remains unacceptable to the claimant.

11:25-2.3 Complaint and internal appeals system—general requirements

(a) Every insurer shall establish and maintain an internal appeals system to provide for the presentation and review of complaints brought by a consumer. All internal appeals procedures shall, at a minimum, include the following components:

1. A system to record and document the status of all internal appeals including whether the appeal is pending or resolved, the type of coverage, type of claim, the specific disposition of the appeal, and the amount of additional benefits paid on resolved internal appeals. The data shall be maintained for a period of three years from the date the internal appeal is closed and shall be made available to the Department upon request;

2. The availability of an insurer's member service representative to assist insureds, when requested, with information pertaining to the insurer's internal appeals system;

3. Establishment of a specified response time which shall be no more than 10 business days from receipt of the appeal for disposition of an internal appeal;

4. A communication sent to the claimant when the appeal is filed which describes in non-technical terms how internal appeals are processed and resolved;

5. Procedures for follow-up action including methods to inform the complainant of the decision of the internal appeals panel within three working days of its decision; and

6. A mechanism for notifying claimants in writing that they may contact the Insurance Claims Ombudsman if there continues to be dissatisfaction with the decision reached by the insurer's internal appeals panel.

Amended by R.2007 d.156, effective May 7, 2007.
See: 38 N.J.R. 4166(a), 39 N.J.R. 1737(b).
Deleted (a)1; recodified former (a)2 through (a)7 as new (a)1 through (a)6; and in (a)1, substituted "three" for "five" and "closed" for "filed".
Amended by R.2011 d.166, effective June 6, 2011.
See: 42 N.J.R. 1981(a), 43 N.J.R. 1350(a).
Rewrote (a)1.

11:25-2.4 Composition of internal appeals panel

The internal appeals review shall be conducted by a panel of at least three of the insurer's employees who possess experience and expertise in claims procedures but are not assigned to day-to-day claims payment and adjustment.

11:25-2.5 Notice to insureds and maintenance of data

(a) All insurers shall provide policyholders and claimants with a written explanation of the insurer's internal appeals system which is consistent with this subchapter, including any pertinent telephone numbers, fax numbers, e-mail ad-

dresses (if used) and business addresses to which the internal appeals shall be submitted.

(b) The insurer shall maintain continuously updated records regarding all internal appeals processed in accordance with this subchapter and shall make the data available, upon request, to the Department or to the Office of the Insurance Claims Ombudsman. The data shall include, but not be limited to:

1. A copy of the internal appeal filed by the insured;

2. A copy of the decision being appealed;

3. A list of the documents, records and other pertinent information relied upon by an internal appeals panel in deciding the appeal; and

4. A copy of the notice sent to the claimant advising the claimant of the decision and the right to subsequent appeals in accordance with N.J.A.C. 11:25-2.3.

Amended by R.2007 d.156, effective May 7, 2007.
See: 38 N.J.R. 4166(a), 39 N.J.R. 1737(b).
Rewrote (a).

11:25-2.6 (Reserved)

Repealed by R.2011 d.166, effective June 6, 2011.
See: 42 N.J.R. 1981(a), 43 N.J.R. 1350(a).
Section was "Reporting".

11:25-2.7 Penalties

Failure to comply with the provisions of this subchapter and N.J.A.C. 11:25-1.7 shall subject the insurer to penalties as provided by N.J.S.A. 17:29E-14.

Amended by R.2007 d.156, effective May 7, 2007.
See: 38 N.J.R. 4166(a), 39 N.J.R. 1737(b).
Inserted "and N.J.A.C. 11:25-1.7".

APPENDIX

(Reserved)

Repealed by R.2011 d.166, effective June 6, 2011.
See: 42 N.J.R. 1981(a), 43 N.J.R. 1350(a).
Appendix was "Internal PCL Claims Appeals Report Form".