

STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

INSURANCE DIVISION

REPORT OF MARKET CONDUCT EXAMINATION

OF

**ALLSTATE INSURANCE COMPANY  
NORTHBROOK, ILLINOIS**

**NAIC COMPANY CODE 19232**

AS OF

DECEMBER 31, 1998

## TABLE OF CONTENTS

<b>SCOPE OF EXAMINATION.....</b>	<b>4</b>
<b>COMPANY DESCRIPTION .....</b>	<b>5</b>
<b>MANAGEMENT AND CONTROL .....</b>	<b>5</b>
<b>COMPLAINT HANDLING PRACTICES.....</b>	<b>6</b>
<i>Findings .....</i>	<i>7</i>
<b>UNDERWRITING AND RATING.....</b>	<b>11</b>
<i>Findings .....</i>	<i>15</i>
<i>Additional Findings and Procedures .....</i>	<i>24</i>
<i>Compliance with ORS 746.650.....</i>	<i>24</i>
<b>CLAIMS .....</b>	<b>27</b>
<i>Findings .....</i>	<i>28</i>
<i>Additional Findings and Procedures .....</i>	<i>51</i>
<i>PIP Review .....</i>	<i>51</i>
<i>Comparative Negligence.....</i>	<i>52</i>
<i>Customer Service Money.....</i>	<i>53</i>
<i>Other Claim Issues.....</i>	<i>56</i>
<b>COMPLIANCE WITH PRIOR EXAMINATION RECOMMENDATIONS.....</b>	<b>57</b>
<b>CONCLUSIONS.....</b>	<b>57</b>
<b>MANAGEMENT AFFIRMATION .....</b>	<b>59</b>
<b>ACKNOWLEDGMENT .....</b>	<b>60</b>
<b>AFFIDAVIT .....</b>	<b>61</b>
<b>APPENDIX A.....</b>	<b>62</b>
<i>Complaints .....</i>	<i>62</i>
<i>Underwriting and Rating.....</i>	<i>62</i>
<i>Claims .....</i>	<i>63</i>

January 4, 2000

Honorable Mary C. Neidig, Director  
Department of Consumer and Business Services  
State of Oregon  
350 Winter Street NE, Room 440  
Salem, Oregon 97301

Dear Director:

In accordance with your instructions and pursuant to ORS 731.300, we have examined the business affairs of

**ALLSTATE INSURANCE COMPANY**

**2775 Sanders, Suite A4  
Northbrook, IL 60062-6127**

**NAIC Company Code 19232**

hereinafter referred to as the "Company." The following report of examination is respectfully submitted.

## **SCOPE OF EXAMINATION**

The market conduct examination of the Company was conducted as of December 31, 1998, covering the period of January 1, 1998 through December 31, 1998, and included a review of material transactions or events which occurred subsequent to the examination cut-off date and were noted during the examination.

A target examination was performed focusing on personal lines automobile insurance. The examination of the Company was conducted pursuant to ORS 731.300 and in accordance with procedures and guidelines established by the Oregon Insurance Division's Market Conduct Program. The program generally follows the Market Conduct Examination Handbook as adopted by the National Association of Insurance Commissioners (NAIC) to the extent that it is consistent with Oregon law. The purpose was to determine the Company's ability to fulfill and manner of fulfillment of its obligations, the nature of its operations, whether it has given proper treatment to policyholders, and its compliance with the Oregon Insurance Code and Administrative Rules.

In order to determine the practices and procedures of the Company's operations, one or more of the following procedures was performed in each phase:

1. A sample of files was selected from listings provided by the Company. The examiner then reviewed each file.
2. The procedure manuals and/or memorandum were evaluated.
3. The Company responded to a series of questions regarding the phase being examined.

The examination was comprised of the following three phases:

Complaint Handling Practices  
Underwriting  
Claims Handling Practices

## **COMPANY DESCRIPTION**

The Company was incorporated on February 9, 1931, under the laws of Illinois and commenced business on April 17, 1931. Allstate Insurance Company is wholly owned by Allstate Corporation, which is now a publicly traded holding company.

Allstate Insurance Company is the lead company of the Allstate Insurance Group. The Company is licensed in all states and the District of Columbia as well as Puerto Rico and provinces of Canada.

In Oregon, the Company is licensed to write the following lines of business:

Property and Casualty (including workers' compensation)  
Marine and Transportation  
Surety  
Health

## **MANAGEMENT AND CONTROL**

The members of the Board of Directors serving as of December 31, 1998 were:

<b><u>Name</u></b>	<b><u>Principal Affiliation</u></b>	<b><u>Director Since</u></b>
Jerry D. Choate Barrington, IL	Director	February 25, 1985
Richard I. Cohen Libertyville, IL	Director	October 28, 1987
Joan M. Crockett Lake Barrington, IL	Director	December 20, 1994
Edward J. Dixon Japan	Director	December 17, 1993
Robert W. Gary Lake Forest, IL	Director	December 17, 1993
Steven L. Groot North Barrington, IL	Director	December 20, 1994
Edward M. Liddy Lake Forest, IL	Director	August 11, 1994
Louis G. Lower, II Winnetka, IL	Director	November 20, 1986
Michael J. McCabe North Barrington, IL	Director	June 29, 1995

<b><u>Name</u></b>	<b><u>Principal Affiliation</u></b>	<b><u>Director Since</u></b>
Ronald D. McNeil North Barrington, IL	Director	December 20, 1994
Robert W. Pike Lake Forest, IL	Director	January 1, 1987
Francis W. Pollard North Barrington, IL	Director	December 20, 1994
Casey J. Sylla Barrington, IL	Director	September 27, 1995
Thomas J. Wilson, II Chicago, IL	Director	June 29, 1995
Rita P. Wilson Barrington, IL	Director	May 31, 1996
Edward William Young Barrington, IL	Director	December 17, 1993

Operating management of the Company as of December 31, 1998, was under the direction of the following principal officers:

<b><u>Name</u></b>	<b><u>Office</u></b>
Jerry Dale Choate	Chairman of the Board and Chief Executive Officer
Edward Michael Liddy	President and Chief Operating Officer
Robert William Pike	Senior Vice-President, Secretary, and General Counsel
James Philip Zils	Senior Vice-President and Treasurer
Thomas J. Wilson, II	Senior Vice-President and Chief Financial Officer
Casey Joseph Sylla	Senior Vice-President and Chief Investment Officer
Francis W. Pollard	Senior Vice President and Chief Information Officer

### **COMPLAINT HANDLING PRACTICES**

The Company uses the following definition of a complaint: “Any written or oral communication received by Allstate indicating any or all degrees of dissatisfaction.”

Complaints are classified by type based upon the general nature of concern:

Claim	Sales
Pricing	Underwriting
Operations	

Complaints may be received at various corporate locations, such as home offices in New York or Chicago, or regional offices, the operations center, or the payment center. They are recorded by “sequence number” using the corporate-wide “action line,” a computerized method of tracking complaint activity. This system maintains a continuous record for state insurance departments, measures complaint activity by region, and assists in identifying training opportunities. Telephone complaints that can be resolved at the time of the initial call are not entered in the system, although the Company considers them no less important than written complaints. Company policy and procedure requires documentation to affirm that the Company attempted to contact customers by telephone within 24 hours after complaints are received. Complaints are to be resolved by phone or by letter by the close of business on the seventh calendar day.

When they are received at the regional office, complaints are directed to the customer care department, where they are logged into the system and redirected to the department considered most appropriate for handling based upon the general nature of the concern expressed. Primary handling is conducted at this level and when written responses are required, they are drafted and returned through the customer care department for review and approval. Insurance department complaints receive responses under the regional vice president’s signature.

### **Findings**

The standards used may be found in Appendix A immediately following the report. The Company passed the following standards without comment:

<b><u>Standard</u></b>	<b><u>Regulatory Authority</u></b>
<u>Complaint Handling Standard #1</u> – All complaints are recorded on the Company complaint register.	ORS 731.302(1)
<u>Complaint Handling Standard #2</u> – The Company has adequate complaint handling procedures in place and communicates such procedures to policyholders.	ORS 731.302(1)
<u>Complaint Handling Standard #3</u> – The Company furnished a response within 21 days of an inquiry from the Insurance Commissioner.	ORS 731.296 and OAR 836-080-0225(2)
<u>Complaint Handling Standard #4</u> – The Company responds to Insurance Commissioner complaints adequately and conclusively.	OAR 836-080-0225(2)

The Company’s complaint register for Insurance Division inquiries received during the examination period was used to develop the population reviewed for Standards 3 and 4. From a total of 209 inquiries received from the Oregon Insurance Division, a random sample of 50 (24%) items was selected for review. Summaries of the reasons for the inquiries and their dispositions are shown below:

<b><u>Reason</u></b>	<b><u>Number</u></b>	<b><u>Percentage</u></b>
Claims - delay in settlement	15	30%
Claims - denial of claim	4	8
Claims - settlement too low	9	18
Claims - failure to respond	8	16
Claims - unsatisfactory repair	2	4
Claims - inadequate explanation	2	4
Claims - unsatisfactory offer	1	2
Claims - delay in repairs	1	2
Claims - miscellaneous handling	1	2
Claims - rudeness	1	2
Underwriting - refusal to renew	2	4

Underwriting - company underwriting practice	2	4
Pricing - renewal increase	<u>2</u>	<u>4</u>
Total	<u>50</u>	<u>100%</u>

<b><u>Disposition</u></b>	<b><u>Number</u></b>	<b><u>Percentage</u></b>
Corrective action taken	2	4%
Satisfactory explanation given	47	94
No action required	<u>1</u>	<u>2</u>
Total	<u>50</u>	<u>100%</u>

<b><u>Days to Respond</u></b>	<b><u>Number</u></b>	<b><u>Percentage</u></b>
0-21	50	100%
22-45	0	0
Over 45	<u>0</u>	<u>0</u>
Total	<u>50</u>	<u>100%</u>

The following exceptions to the standards were noted:

The Company's complaint register for noninsurance division inquiries received during the examination period was used to develop the population reviewed for Standards 5 and 6. From a total of 413 inquiries, a random sample of 50 (12%) items was selected for review.

Summaries of the reasons for the inquiries and their dispositions are shown below:

<b><u>Reason</u></b>	<b><u>Number</u></b>	<b><u>Percentage</u></b>
Operations - collections letter received	12	24%
Sales - agent failed service request	9	18
Pricing - renewal increase	6	12
Operations - endorsement incomplete	4	8
Claims - delay in settlement	3	6
Claims - rudeness	2	4
Claims - miscellaneous handling	2	4
Operations - dissatisfied with service	2	4
Sales - request to change agent	2	4
Operations - cancellation notice	1	2
Operations - billing confusion	1	2
Operations - no bill received	1	2
Claims - inadequate explanation	1	2
Claims - surcharge problem	1	2
Sales - inadequate explanation	1	2

Sales - discourteous treatment	1	2
Underwriting - company underwriting practice	<u>1</u>	<u>2</u>
Total	<u>50</u>	<u>100%</u>

<b><u>Disposition</u></b>	<b><u>Number</u></b>	<b><u>Percentage</u></b>
Corrective action taken	23	46%
Satisfactory explanation given	27	54
No action taken - position upheld	<u>0</u>	<u>0</u>
Total	<u>50</u>	<u>100%</u>

Complaint Handling Standard #5 – The Company furnished a response within 30 days of an inquiry from an insured. Reference: OAR 836-080-0225(3).

### Findings

Passed with comment. 98% compliance. One (2%) review unit failed this standard because the Company did not retain, or could not locate, copies of documents relating to the complaint. This complaint was handled by the Company's Great Lakes Innovation Center. During a period of time in 1998, the Great Lakes Innovation Center decreased its record retention time for outgoing correspondence. The Company did take corrective action during this market conduct examination to ensure Company records of complaints and their responses are maintained for a minimum period of seven years.

A recommendation does not appear to be warranted due to the low ratio of non-compliance. Additionally, the Company took corrective action to rectify this situation during this market conduct examination.

<b><u>Days to Respond</u></b>	<b><u>Number</u></b>	<b><u>Percentage</u></b>
0-30	49	98%
31-45	0	0
Over 45	0	0
Unknown	<u>1</u>	<u>2</u>

Total 30 100%

Complaint Handling Standard #6 – The Company response to an inquiry from an insured is adequate and answers the questions being raised. Reference: OAR 836-080-0225(3).

### Findings

Passed with comment. 98% compliance. One (2%) review unit failed this standard because the Company did not retain, or could not locate, copies of documents relating to the complaint. This complaint was handled by the Company's Great Lakes Innovation Center. During a period of time in 1998, the Great Lakes Innovation Center decreased its record retention time for outgoing correspondence. The Company did take corrective action during this market conduct examination to ensure Company records of complaints and their responses are maintained for a minimum period of seven years.

A recommendation does not appear to be warranted due to the low ratio of noncompliance. Additionally, the Company took corrective action to rectify this situation during this market conduct examination.

### **UNDERWRITING AND RATING**

The Company uses captive and independent agents to market its products in Oregon. Quotations are prepared by the agency force in their field offices.

Agents can prepare a quote from information provided by the applicant using the Company's ALSTAR system. The agent may also use PQB (prequalifying business) to assist in developing the customer information to prepare a quote.

PQB is a process that allows agents to accurately develop a risk profile by providing them with necessary information at the point of sale. When the PQB program is run, that system automatically orders the MVR (motor vehicle report) on requested operators, LIS (loss information system) information, DADS (additional drivers in the household) information and financial stability information. The agent receives a PQB report that contains all of this information. The agent may run PQB in order to develop the information to provide an accurate quote without submitting an application. The PQB report helps the agent determine whether the applicant is eligible for coverage in the preferred market and to calculate the correct premium.

Financial stability information is developed from credit reports. The Company orders credit reports on all applicants. Instead of using credit scores, all applicants are categorized into one of three categories: clean, acceptable, or unacceptable. The Company developed the formula used to determine which category is appropriate for the applicant. Financial stability is one of several factors the Company uses in underwriting. Credit information is not used to determine premium.

An additional underwriting tool is IRMS (integrated risk management system). IRMS performs an assessment of the risk based on the information gathered by the agent. It provides an indication of the underwriting acceptability of the risk. IRMS may be run before or after coverage is bound. Agents may request information through PQB first and then through IRMS, or they may run these programs simultaneously.

If the risk is acceptable to the Company, the agent may make a formal electronic submission of the application. The Company calls this process “slotting.” The policy then may be automatically issued without manual underwriting intervention or may be referred to underwriting for verification of proper classification.

In some instances, IRMS returns a “no decision” response. If so, the agent reviews the case for missing, incorrect, or inconclusive information and, if necessary, updates the information. The agent then may rerun IRMS to reevaluate, or the information may be manually reviewed by an underwriter. At this point, the IRMS decision does not mean that coverage has been bound.

When IRMS indicates that the application would not meet the Company’s underwriting criteria, the agent gives the applicant an opportunity to withdraw the request for coverage. If coverage was not bound and the applicant has chosen to withdraw the application, no action is required by the agent.

If coverage was bound and the application was not yet slotted, the customer still has the option to withdraw the application. The Company’s definition of this process is “rescinding.”

If the agent determines that there is duplicate coverage, the application will be “rescinded,” with no coverage provided. Any payment received from the customer will be refunded in full, and the agent provides the customer with a letter confirming the customer’s decision to withdraw the application.

If there was no duplicate coverage and the customer indicates that they still wish to withdraw the application, the Company will issue coverage on a temporary basis in order to allow the customer time to obtain replacement coverage. A letter is sent to the customer confirming the customer's request and indicating the date and time coverage will cease. Any unearned premium is refunded to the customer.

If IRMS has indicated that the application does not meet the Company's underwriting criteria and the customer does not wish to withdraw their bound application, the application is slotted and referred to an underwriter for review. If the underwriter rejects the application, a letter is mailed to the applicant indicating the date and time the coverage will cease and specifying the reason(s) for the adverse underwriting action.

A customer who does not meet the underwriting criteria for Allstate Insurance Company may have the option to submit an application to Allstate Indemnity Company for coverage in the nonpreferred market.

Prior to the renewal date, the IRMS renewal program is run to determine which policies are acceptable to renew and which cases should be referred to underwriting for renewal evaluation. IRMS screens each policy against established risk profiles and in some cases may order MVR reports to assist in the evaluation. Those which result in either a nonrenew or reengineer determination are reviewed by underwriting and are also presented to the agent. The agent has an opportunity to review each case prior to the renewal date and may agree with the decision or provide additional information to underwriting for consideration.

## **Findings**

The underwriting review consists of eighteen standards. A list of all standards appears in Appendix A immediately following this report. Standards number 6 and 16 were waived, as they did not pertain to personal lines automobile insurance, which was the target of this examination.

The Company provided population runs of business issued, nonrenewed, canceled, new business issued with premium surcharge, and new business issued with mismatched bodily injury and uninsured motorist limits from which random samples were drawn. The chart below illustrates the size of the original population as well as the size of the sample selected for review.

<b><u>Population Reviewed</u></b>	<b><u>Total Population</u></b>	<b><u>Random Sample</u></b>	<b><u>Percentage to Total</u></b>	<b><u>Used to Review Standards</u></b>
New business issued	9,846	100	1.02%	#1, #2, #7, #8, #9, #10, #11, #12, #13
Policies nonrenewed	950	50	5.26%	#15
Policies canceled	1,186	50	4.22%	#14, #15
Policies issued with named exclusion endorsements	2	2	100.00%	#5
New business issued with premium surcharge	1,209	50	4.14%	#3
New business issued with record of no prior insurance and in compliance with financial responsibility laws	9	9	100.00%	#3
New business issued with mismatched BI and UM limits	301	50	16.61%	#4

The following standard was deemed to pass without comment:

**Standard**

**Regulatory Authority**

Underwriting Standard #10 – All forms and endorsements forming a part of the contract are listed on the declaration page and are with the department of insurance.

ORS 742.003

The following exceptions were noted:

Underwriting Standard #1 - The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the company rating plan. Reference: ORS 737.205.

**Findings**

Failed. 94% compliance. Six files (6%) failed this standard for the following reasons:

**Reason**

**Number of Policies**

Incorrect vehicle symbol assigned	3
Examiner unable to confirm correct symbol code assigned due to insufficient documentation regarding method used	1
Company unable to provide documentation	1
Premium discount granted for completion of defensive driving course, insured did not take this course	<u>1</u>
Total	<u>6</u>

**I recommend the Company charge rates for policy coverage in accordance with its filed rating plan pursuant to the provisions of ORS 737.205.**

Underwriting Standard #2 - Disclosures to insureds concerning rates and coverage are accurate and timely. Reference: ORS 737.205 and ORS 742.566.

### Findings

Passed with comment. 99% compliance. One file (1%) failed this standard because the Company was unable to provide documentation for the examiner's review.

A failure rate of 1% does not appear to represent a pattern; therefore, no recommendation is warranted.

Underwriting Standard #3 - An insured or applicant may not be assigned to a higher risk category than the person would normally be assigned because the person allowed a motor vehicle liability policy to lapse or had driving privileges suspended due to a nondriving offense. Reference: ORS 742.449.

### Findings

Passed with comment. 97% compliance. Two populations were evaluated; policies issued with surcharges and policies issued with no prior insurance. No discrepancies were noted in the sample of policies issued with surcharges; however, two of the policies issued with no prior insurance (3%) were rated incorrectly which resulted in a higher amount than should have been charged.

A failure rate of 3% does not appear to indicate a pattern; therefore, no recommendation is warranted.

Underwriting Standard #4 – Written rejection for higher limits of uninsured and underinsured motorist coverage limits must be obtained. Reference: ORS 742.502(2)(a) and OAR 836-054-0000.

### Findings

Failed. 92% compliance. Four files (8%) failed this standard.

<b><u>Reason</u></b>	<b><u># of Failures</u></b>
Form for incorrect company was used	1
Company was unable to provide a copy of the signed waiver	1
Rates on waiver form are incorrect	1
Signed waiver is incomplete and rates on waiver form are incorrect	<u>1</u>
Total	<u>4</u>

**I recommend the Company obtain written rejection for higher limits of uninsured and underinsured motorist coverage in accordance with the provisions of ORS 742.502(2)(a) and OAR 836-054-0000.**

Underwriting Standard #5 – Named exclusions are signed by all named insureds and comply with all rules and regulations. Reference: ORS 742.450(5).

Findings

Passed with comment. The Company issued just two policies with named exclusions during the examination period.

In one case, two family members in one household were excluded from coverage. The signed exclusion form was correct; however, the Company’s computer record was not. This was corrected during this market conduct examination.

A recommendation does not appear to be warranted.

Underwriting Standard #7 – The Company underwriting practices are not unfairly discriminatory. The Company adheres to applicable statutes, rules and regulations and Company guidelines in the selection of risks. Reference: ORS 746.015, ORS 746.018 and OAR 836-081-0030.

## Findings

Passed with comment. 98% compliance. Two files (2%) failed this standard.

The Company was unable to provide the examiner with documentation regarding one of the policies.

The other policy was issued with a defensive driving discount. Company guidelines require submission of a certificate of course completion in order to qualify for this discount. The applicant did not provide the required certificate of completion but was allowed the discount. The Company subsequently discovered the applicant failed to complete the course.

A failure rate of 2% does not appear to indicate a pattern; therefore, no recommendation is warranted.

Underwriting Standard #8 – Employment driving record may not be used to determine if the file is issued, renewed or in the calculation of rates. Reference: ORS 746.260 and ORS 746.265(1).

## Findings

Passed with comment. 99% compliance. The Company was unable to provide the examiner with documentation regarding one of the policies (1%).

A failure rate of 1% does not appear to represent a pattern; therefore, no recommendation is warranted.

Underwriting Standard #9 – For the purpose of determining whether or not to issue or renew a policy and the calculation of rates, an insurer may not use a driving

record older than three years immediately preceding the issuance or renewal.  
Reference: ORS 746.265(2).

### Findings

Passed with comment. 99% compliance. One file (1%) failed this standard because the Company was unable to provide the examiner with documentation for review.

Agents do not make an independent selection to choose whether a three-year or five-year record is obtained. ALSTAR interfaces with an outside vendor with which the Company has contracted to obtain MVRs. The ALSTAR system requires the agent to input the class of business being written. For example, line 11 is commercial and line 10 is private passenger auto insurance. The ALSTAR system has been programmed to retrieve the correct three-year MVR record.

A failure rate of 1% does not appear to represent a pattern; therefore, no recommendation is warranted.

Underwriting Standard #11 – Underwriting, rating and classification are based on adequate information developed at or near inception of the coverage rather than near expiration, or following a claim. Reference: ORS 731.302(1).

### Findings

Passed with comment. 99% compliance. One file (1%) failed this standard because the Company was unable to provide the examiner with documentation for review.

A failure rate of 1% does not appear to represent a pattern; therefore, no recommendation is warranted.

Underwriting Standard #12 – File documentation adequately supports decisions made. Reference: ORS 733.170.

Findings

Failed. 94% compliance. Six files (6%) failed this standard. The reasons for these failures are described in Underwriting Standard #1 above.

**I recommend the Company's documentation adequately support all decisions made by the underwriters and underwriting decisions made by agents in accordance with ORS 733.170.**

Underwriting Standard #13 – The Company does not engage in collusive or anticompetitive underwriting practices. Reference: ORS 731.302(1).

Findings

Passed with comment. 99% compliance. One file (1%) failed this standard because the Company was unable to provide the examiner with documentation for review.

A failure rate of 1% does not appear to represent a pattern; therefore, no recommendation is warranted.

Underwriting Standard #14 – Rejections and declinations are not unfairly discriminatory. Reference: ORS 746.015, ORS 746.018 and OAR 836-081-0030.

Findings

Failed. 88% compliance. The Company was unable to provide documentation regarding six (12%) of the 50 canceled policies selected for review.

The Company experienced problems with termination letter record retention as a result of a conversion to a new computer system. The Company indicated these problems were recognized in June of 1998. During this examination, the Company demonstrated to the examiners that the problem was corrected as of March 30, 1999.

It appears a recommendation is not warranted since the Company has identified and corrected the problem that caused these policies to fail this standard.

Underwriting Standard #15 – Cancellation/nonrenewal notices comply with policy provisions and state laws and company guidelines. Cancellation must be made within the first 60 days of the policy except for the exemption. Nonrenewal and changes in policy must be sent at least 30 days in advance of the renewal date. Reference: ORS 742.566 through ORS 742.572 and ORS 746.650.

Findings

Failed. 94% compliance. Two populations were reviewed: canceled policies and nonrenewed policies.

No exceptions were noted in the nonrenewed sample of 50 records. However, the Company was unable to provide documentation regarding six (6% of total sample) of the 50 canceled policies selected.

<b><u>Population Reviewed</u></b>	<b><u># Files</u></b>	<b><u># Passed Standard</u></b>	<b><u># Failed Standard</u></b>
Canceled policies	50	44	6
Nonrenewed policies	<u>50</u>	<u>50</u>	<u>0</u>
Total	<u>100</u>	<u>94</u>	<u>6</u>

The Company experienced problems with termination letter record retention as a result of a conversion to a new computer system. The Company indicated these

problems were recognized in June of 1998. During this examination, the Company demonstrated to the examiners that the problem was corrected as of March 30, 1999.

It appears a recommendation is not warranted since the Company identified and corrected the problem that caused these policies to fail this standard.

Underwriting Standard #17 – The insurer reports the name, address, and VIN number of each vehicle covered by a motor vehicle liability policy whether the policy was bought, canceled or not renewed within 30 days of cancellation or nonrenewal and within 15 days of issuance to the Department of Transportation. Reference: ORS 742.580.

#### Findings

Passed with comment. The Company transmits the required information to the Department of Transportation electronically and has not developed a system program to print the reports. The transmissions are sent from the Company's home office in Northbrook, Illinois each Friday.

From the information provided, it appears the procedures the Company has established are in compliance with this standard.

Underwriting Standard #18 – Rescissions are not made for nonmaterial misrepresentations in accordance with the Company's established procedures. Reference: ORS 746.240.

#### Findings

Passed with comment. The Company indicated it does not have a post-issue rescind process. Once the Company has accepted the policy, the Company follows the cancellation provisions outlined in the policy.

### **Additional Findings and Procedures**

#### **Compliance with ORS 746.650**

ORS 746.650 states that in the event of an adverse underwriting decision, the insurer or agent responsible for the decision shall either provide the applicant, policyholder or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing or advise the person that upon written request the person may receive the specific reason or reasons in writing and provide the applicant, policyholder or individual proposed for coverage with a summary of the rights established under subsection (2) of this section and ORS 746.640 and 746.645.

The definition of “adverse underwriting decision” is contained in ORS 746.600 which states:

746.600 Definitions for ORS 746.600 to 746.690 and 750.055. As used in ORS 746.600 to 746.690 and 750.055:

- (1) “Adverse underwriting decision” means, except as provided in subsection (2) of this section, any of the following actions with respect to insurance transactions involving insurance coverage which is individually underwritten:
  - (a) A declination of insurance coverage.
  - (b) A termination of insurance coverage.
  - (c) Failure of an agent to apply for insurance coverage with a specific insurer which the agent represents and which is requested by an applicant.
  - (d) In the case of life or health insurance coverage, an offer to insure at higher than standard rates.

(e) In the case of other kinds of insurance:

(A) Placement by an insurer or agent of a risk with a residual market mechanism, an unauthorized insurer or an insurer which specializes in substandard risks.

(B) The charging of a higher rate on the basis of information which differs from that which the applicant or policyholder furnished.

(2) “Adverse underwriting decision” does not include the following actions, but the insurer or agent responsible for the occurrence of the action shall nevertheless provide the applicant or policyholder with the specific reason or reasons for the occurrence:

(a) The termination of an individual policy form on a class or statewide basis.

(b) A declination of insurance coverage solely because the coverage is not available on a class or statewide basis.

(c) The rescission of a policy.”

This same statute defines “declination of insurance coverage”. It states:

(9) “Declination of insurance coverage” means a denial, in whole or in part, by an insurer or agent of requested insurance coverage.

It appears that when applications are initially run through the Company’s IRMS system and a reject decision is returned, this is an adverse underwriting decision and notice should be provided to the individual proposed for coverage in accordance with ORS 746.650.

When IRMS indicates that the application would not meet the Company’s underwriting criteria, the agent gives the applicant an opportunity to withdraw the request for coverage. If coverage was not bound and the applicant has chosen to withdraw the application, no action is required by the agent.

If coverage was bound and the application was not yet slotted, the customer still has the option to have the application withdrawn. The Company refers to this process as “rescinding.”

Even though the Company provides the applicant with the opportunity to cancel the application so that a rejection of coverage does not appear on their record, it appears an adverse underwriting decision was reached.

The form letters mailed to persons whose coverage had been bound only explain that the application was voided at the applicant’s request. These letters do not explain the specific reason for the adverse underwriting decision that prompted the consumer’s “withdrawal” of the application.

From the information reviewed, it appears the Company is not in compliance with ORS 746.650. The individual’s request to withdraw the application was initiated by a response received from the Company’s IRMS system and the specific reason for the adverse underwriting decision is not provided to the applicant.

**I recommend the Company provide the applicant, policyholder or individual proposed for coverage with the specific reason or reasons for an adverse underwriting decision in writing or advise the person that upon written request the person may receive the specific reason or reasons in writing in accordance with ORS 746.650.**

The Company has agreed to supply the applicant, policyholder or individual proposed for coverage, a letter indicating that upon written request, the person may receive the reason or reasons for the adverse underwriting decision in writing.

## **CLAIMS**

Claims are reported to either the agent, the market claims office or the claims service center.

If the claim has been reported to the agent, the agent takes the loss facts, enters the data into a centralized computer system and forwards this “promise line” claim to the national claims service center. The agent will also answer questions the customer may have.

If the claim is reported to the market claim office (MCO), the customer is transferred on-line to the national claims service center. The MCO stays on the line until they are certain the customer is connected with the loss report taker. Upon collection of all relevant loss facts from the customer, depending on the level of urgency of the claim, a commitment is made to the customer for a return call from the appropriate MCO.

Both the agent and the national claims service center, when gathering the loss facts from the customer establish the formal claim record in the Company’s computer system and a claim number is assigned.

Either a claims adjuster or claims processor, depending on the nature of the claim, makes contact directly with the claimant, obtains the necessary documents and explains all applicable coverages and the claim process.

Reserves are established automatically for certain coverages, and by the claims adjuster for casualty coverage. Individual reserve amounts are revised upwards or downwards as needed to reflect the current value of the claim.

Once the investigation is complete, the claims adjuster pays the claim and the reserve is released.

Certain denial letters involving coverage issues are reviewed by the market claim manager (MCM) before mailing. If the gross value of the claim authority exceeds local authority, prior home office approval is obtained.

Claims involving unusual or complicated situations or large exposure may be submitted to the home office for recommendation on handling the case.

The Company maintains a claims manual outlining in detail its claim procedures.

### **Findings**

The Company provided lists of claims paid, claims closed without payment, subrogated claims, and total loss claims paid during the examination period. Random samples were selected from these lists for review.

The Company was unable to produce a list of denied claims excluding those which were simply closed without payment. An alternative method was used to select the denied claims for review. The examiner produced a random sample of 400 claims closed without payment. Each record was checked to determine whether benefits had actually been denied. From this sample, only 31 true denials were identified. A second random sample of 400 records was generated in order to select the remaining 19 records to complete the sample of 50 claims. When reviewing the hard copy files

along with the Company's electronic records, the examiner learned that not all of the 50 items identified as true denials were denied claims. Although all 50 files were reviewed, only 26 of the 50 files evaluated represented actual coverage denials.

<b><u>Type of Claim</u></b>	<b><u>Total Population</u></b>	<b><u>Random Sample</u></b>	<b><u>Percentage to Total</u></b>
Claims paid	24,459	100	.40%
Total loss claims paid	1,218	50	4.10%
Subrogated claims	3,452	50	1.44%
Denied claims	Unknown	50	Unknown

The total loss claims were reviewed for compliance with Standards 5 and 17 only.

The subrogated claims were reviewed for compliance with Standard 19 only.

The items were tested for compliance with the following standards based on Oregon Revised Statutes or Oregon Administrative Rules.

The following standards were deemed to pass without comment:

<b><u>Standard</u></b>	<b><u>Regulatory Authority</u></b>
Claims Standard #10 – The Company did not attempt to settle a claim on the basis of an altered application without notice to or consent of the applicant.	ORS 746.230(1)(i)
Claims Standard #18 – Automobile claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.	OAR 836-080-0240(2), (3), (5), (6), (7), and (8) and ORS 746.230(1)(i)

The following exceptions were noted:

Claims Standard #1 – The initial contact by the Company with the claimant is within 30 days. Reference: OAR 836-080-0225.

### Findings

Passed with comment. 98% compliance to applicable files. Three files (2%) failed this standard.

The Company was notified of a claimant's loss and opened reserves for that loss on May 19, 1998. The Company made one attempt to contact this third party claimant by telephone at 8:30 a.m. on Wednesday, May 20, 1998. The claimant did not answer the telephone and apparently did not have an answering machine or voice mail, so the Company could not leave a message. The file was closed without payment on June 25, 1998, due to no claimant contact. The Company indicates correspondence was mailed to this claimant on July 1, 1998; however, no copy of that correspondence was retained in the Company's records either in hard copy or electronic form. July 7, 1998, the claimant contacted the Company in response to the July 1, 1998, correspondence and the claim was paid July 15, 1998.

The Company made one attempt to reach a third party claimant by telephone, but the line was busy. Although the insured informed the Company that no damage was sustained to the third party claimant's vehicle, the Company did not contact the claimant to confirm this fact or to obtain that person's version of the loss facts. The Company acknowledged additional contact should have occurred with the third party claimant.

The Company received a subrogation notice from a third party carrier on July 1, 1998, and did not respond to this demand for payment until September 1, 1998.

<b><u>Population Reviewed</u></b>	<b><u># Units</u></b>	<b><u># Not Applicable (N/A)</u></b>	<b><u># Passed Standard</u></b>	<b><u># Failed Standard</u></b>
Claims paid	100	0	98	2
Claims denied	<u>50</u>	<u>24</u>	<u>25</u>	<u>1</u>
Subtotal	150	24	123	3
Less N/A files	<u>24</u>			
Total	<u>126</u>	<u>24</u>	<u>123</u>	<u>3</u>

<b><u>Days to Acknowledge</u></b>	<b><u>Number</u></b>	<b><u>Percentage to Total</u></b>
0-30	123	97.6%
31-45	0	0
Over 45	2	1.6
Unknown	<u>1</u>	<u>.8</u>
Total	<u>126</u>	<u>100.0%</u>

A failure rate of 2% does not represent a pattern. Therefore, no recommendation is warranted.

Claims Standard #2 - Investigations are conducted within 45 days. Reference: OAR 836-080-0230.

### Findings

Passed with comment. 98% compliance to applicable files. Two files (2%) failed this standard.

One claim was reported to the Company in May of 1998, but the Company did not complete its investigation until September 29, 1998. The estimate for the third party

claimant's property damage was prepared May 20, 1998, and the check was not written until September 30, 1998. The Company cannot explain the reason for this delay.

The Company received a subrogation notice from a third party carrier July 1, 1998, and did not respond to that demand for payment until September 1, 1998.

<b><u>Population Reviewed</u></b>	<b><u># Units</u></b>	<b><u># Not Applicable (N/A)</u></b>	<b><u># Passed Standard</u></b>	<b><u># Failed Standard</u></b>
Claims paid	100	0	99	1
Claims denied	<u>50</u>	<u>24</u>	<u>25</u>	<u>1</u>
Subtotal	150	24	124	2
Less N/A files	<u>24</u>			
Total	<u>126</u>	<u>24</u>	<u>124</u>	<u>2</u>

A failure rate of 2% does not represent a pattern. Therefore, no recommendation is warranted.

Claims Standard #3 – Claims are resolved in 30 days unless a delay letter (45 days) has been sent. Reference: OAR 836-080-0235(1) and (4).

### Findings

Failed. 86% compliance to applicable files. Ten files (14%) failed this standard.

The Company received a final billing from one of its priority repair option (PRO) facilities that included an amount exceeding the original estimate. The file handler improperly identified this billing as a duplicate of the original estimate that had

already been paid. The supplemental amount billed was not paid within 30 days and no delay letter was mailed.

The Company explained that another property damage claim was not paid in a timely manner due to an oversight. The PRO shop estimate was received January 30, 1998, but payment was not made until the insured called the Company to check on the status of the claim on March 16, 1998.

A supplemental payment to a shop was authorized on December 18, 1998, and the check was not issued until the shop called to check on the status February 5, 1999. The Company indicated this was due to an adjuster error in not following up on a dispatch message received by another claim employee.

A medical bill was received by the Company January 6, 1998, and was not paid until May 27, 1998, 141 days later. The Company explained that this claim had been reassigned to another adjuster and acknowledged it failed to meet this standard with this claim.

The other five paid claims that failed this standard are PIP (Personal Injury Protection) claims described below:

<u>Unit #</u>	<u>Date Bill Received</u>	<u>Date Bill Paid</u>	<u>Comments</u>
---------------	---------------------------	-----------------------	-----------------

7	6/4/98	7/24/98	Company completed investigation and determined bill was payable on June 4, 1998, check not mailed until 50 days later - no delay notice mailed
61	6/19/98	7/31/98	Completed PIP application (claim form) was received June 22, 1998, bill wasn't paid until July 31, 1998, 39 days after completed proofs of loss were received – no delay notice mailed
67	12/16/97	2/9/98	Company did not require a PIP application from the claimant in order to process this claim. Payment wasn't made until 55 days after receipt of bill – no delay notice mailed
80	3/19/98	6/30/98	Company informed examiner that it did write to medical provider for information in order to process the claim and did pay the bill when it was resubmitted. The Company is unable to provide documentation indicating when the request for information was sent or that a copy of the request was sent to the claimant – no delay notice mailed
81	9/15/97	10/22/97	The Company denied this bill without investigation on September 30, 1997, and requested chart notes with the EOB (explanation of benefits) denying benefits. The Company cannot provide documentation to confirm the claimant received a copy of the correspondence between the Company and the medical provider – no delay notice mailed.

One claim was received by the Company March 6, 1998, and denied April 21, 1999, more than one year after the proof of loss was received. The Company's records do not include documentation to explain the reason for this delay.

<b><u>Population Reviewed</u></b>	<b><u># Units</u></b>	<b><u># Not Applicable (N/A)</u></b>	<b><u># Passed Standard</u></b>	<b><u># Failed Standard</u></b>
Claims paid	100	33	58	9
Claims denied	<u>50</u>	<u>45</u>	<u>4</u>	<u>1</u>
Subtotal	150	78	62	10
Less N/A files	<u>78</u>			
Total	<u>72</u>	<u>78</u>	<u>62</u>	<u>10</u>

Note: This standard applies to first party claims only. The N/A files represent third party claims and denied claims selected for review which were not true denials.

Although they respectfully disagree, the Company indicated it is taking steps to modify its processes to ensure that delay notices are sent to PIP (Personal Injury Protection) claimants within the time frames outlined in OAR 836-080-0235 whenever the Company requires additional time to complete its investigation and make a payment decision.

**I recommend the Company send delay letters in accordance with the provisions of OAR 836-080-0235(4) for all claims which are not resolved in 30 days.**

**I recommend the Company resolve within 30 days first party claims for which more time to determine whether the claim should be accepted or denied is not required in accordance with the provisions of OAR 836-080-0235(1).**

Subsequent to the examination, the Company informed the examination team that they have revised their process to comply. The examiner did not perform a re-test.

Claims Standard #4 – The Company responds to claim correspondence in 30 days.

Reference: OAR 836-080-0225 All Subparts.

#### Findings

Failed. 88% compliance to applicable files. Four files (12%) failed this standard.

The Company received a subrogation demand from a claimant's carrier December 17, 1998, and did not respond to this correspondence until March of 1999. The Company

explained that the delay was caused by a turnover in personnel and subsequent difficulties in the indexing and routing of the paperwork to the file because the subrogation demand was addressed to the adjuster originally assigned to the file.

The Company received a supplemental bill for property damage repair in December of 1998 and did not pay the claim until the body shop called to check on the status of the supplemental claim in February of 1999. The Company reported that this was due to an adjuster's error.

An insured submitted a written request for the Company to collect rental car expense from the claimant's carrier as part of the subrogation demand. The Company did not respond to this request, did not collect this amount on the insured's behalf and did not inform her they would not do this.

The Company received a notice of subrogation rights from the claimant's carrier November 11, 1998. The Company denied the claim, but did not communicate with the claimant's carrier regarding this decision until July of 1999.

An attorney wrote to the Company asking for the denial of benefits to be reconsidered. That claim file does not indicate the Company responded to the attorney's request.

<b><u>Population Reviewed</u></b>	<b><u># Units</u></b>	<b><u># Not Applicable (N/A)</u></b>	<b><u># Passed Standard</u></b>	<b><u># Failed Standard</u></b>
Claims paid	100	71	26	3
Claims denied	<u>50</u>	<u>46</u>	<u>3</u>	<u>1</u>
Subtotal	150	117	29	4
Less N/A files	<u>117</u>			
Total	<u>33</u>	<u>117</u>	<u>29</u>	<u>4</u>

Note: The N/A files are those without claim correspondence and denied files selected for review that were not true denials.

**I recommend the Company respond to claim correspondence within 30 days in accordance with the provisions of OAR 836-080-0225.**

Subsequent to the examination, the Company indicated that it has heightened awareness of this standard through training and will monitor compliance through internal reviews.

Claims Standard #5 - Claim files are adequately documented. Reference: OAR 836-080-0215 and ORS 733.170.

#### Findings

Passed with comment. 96% compliance. Seven files (4%) failed this standard.

The Company canceled a check written on November 19, 1998, and issued another on December 4, 1998. The Company's file documentation does not explain the reason for this action.

The Company paid a supplemental property damage claim more than 30 days from the date the bill was generated. Because the Company did not date stamp or otherwise record the date the supplemental bill was received, the examiner used one business day after the bill was generated by the body shop to measure the length of time the Company needed to pay the claim.

In another case, the Company sent correspondence identified as "speed memos" to both the insured and claimant. The Company did not retain copies of this

correspondence in its file. The Company's response to the examiner indicates these letters were both sent the same day and that the speed memo to the insured was not sent as he called in later the same day. The Company's documentation does not adequately explain what action was taken on this file.

The Company paid a supplemental property damage claim but does not have a copy of the bill supporting the claim payment.

Another speed memo was mailed to a claimant and a copy of that correspondence was not retained in the claim file.

The Company indicated it did write to a medical provider for additional information required for processing a PIP claim. A copy of that correspondence was not retained in the claim file and the Company does not have the capability of reproducing the documentation electronically. The Company's computer system was modified in 1999 and now allows for electronic reproduction of form letters mailed that do specify the date they were actually generated and the all recipients of that correspondence.

A total loss claim was settled with a 75% - 25% comparative negligence decision. The Company's file documentation indicates the settlement amount took into consideration the 75% payoff and the salvage bid. The Company later determined the claimant to be only 10% negligent. When the examiner asked if the claimant had received an additional 15% payment for the actual cash value, the Company stated an error was made when the claim was originally paid and the 25% deduction was not taken. The file documentation does not support the Company's response.

<b><u>Population Reviewed</u></b>	<b><u># Units</u></b>	<b><u># Not Applicable (N/A)</u></b>	<b><u># Passed Standard</u></b>	<b><u># Failed Standard</u></b>
Claims paid	100	0	94	6
Claims denied	50	24	26	0
Total loss claims	<u>50</u>	<u>0</u>	<u>49</u>	<u>1</u>
Subtotal	200	24	169	7
Less N/A files	<u>24</u>			
Total	<u>176</u>	<u>24</u>	<u>169</u>	<u>7</u>

A failure rate of 4% does not appear to represent a pattern. Therefore, no recommendation is warranted.

Claims Standard #6 - Claims are not denied without first conducting a reasonable investigation. Reference: ORS 746.230(1)(c) and (d).

### Findings

Failed. 92% compliance. Two files (8%) failed this standard.

When the Company notified a claimant that her claim was being denied, the Company told the claimant that a scene investigation had been done. A subsequent subrogation demand received by the Company was suspended while waiting for a scene investigation to be completed. There is no documentation in the file to indicate such an investigation was conducted either prior to the claim denial or as part of the subrogation process. The Company indicated the file will be reopened to complete a scene investigation and pursue subrogation or pay the claimant's damages.

The Company denied a PIP claim submitted and requested chart notes for review on the same EOB that denied benefits. It appears the claim should have been pended rather than denied while the Company obtained the additional documentation necessary to make a claim determination. The Company changed the EOB text that prints out when additional documentation is required from a provider. The statement that now prints is “In compliance with ORS 742.528, reimbursement is suspended pending submission of the following:” (the missing information or documentation is identified in this space).

<b><u>Population Reviewed</u></b>	<b><u># Units</u></b>	<b><u># Not Applicable (N/A)</u></b>	<b><u># Passed Standard</u></b>	<b><u># Failed Standard</u></b>
Claims denied	50	24	24	2
Less N/A files	<u>24</u>			
Total	<u>26</u>	<u>24</u>	<u>24</u>	<u>2</u>

The Company has corrected the situation with the PIP claims in that it now pends the claims when writing for additional documentation from a provider instead of denying at the same time this information is requested. A recommendation does not appear to be warranted. When the PIP claim failure is removed, the result is 96% compliance.

As explained above, the examiner worked with a reduced population size due to difficulties encountered while attempting to develop a population of claims that were truly denied.

<b><u>Reason For Denial</u></b>	<b><u>Number</u></b>	<b><u>% to Total</u></b>
Insured not negligent	21	42%
Not a true denial	24	48
Applied to deductible	1	2
Not medically necessary	1	2
No coverage for loss	1	2

Proof of loss not received	<u>2</u>	<u>4</u>
Total	<u>50</u>	<u>100%</u>

Claims Standard #7 – The Company promptly and in good faith equitably settles claims in which liability has become reasonably clear. Reference: ORS 746.230(1)(f), (L), and (h).

Findings

Passed with comment. 96% compliance. Four paid claim files (4%) failed this standard.

One claim was received from the claimant’s carrier December 17, 1998 and not paid until March 8, 1999. The file documentation indicates the Company requested additional information from the claimant carrier that it already had on file. The Company indicated problems were encountered with this case because the original adjuster left the Company and the file was transferred to someone else.

Supplemental work done by a body shop was authorized for payment December 18, 1998, and the claim was not paid until February 5, 1999. The Company indicated this was due to an error made by the adjuster.

The Company determined a claimant was 10% liable for an accident. It appears this judgement was made when the adjuster believed the claimant was driving the wrong way down a parking lot aisle. The file notes regarding statements made by the insured do not support this decision. Following the Company’s review of the examiner’s inquiry regarding this case, the Company changed the at fault coding to 100% for the insured and 0% for the claimant who was clearly established in the lane of traffic when the insured backed into the claimant’s car.

The other claim was reported to the Company by the insured who indicated the claimant did sustain property damage. The Company established reserves for this loss but did not contact the claimant and closed the file without payment even though it was aware the insured was 100% negligent and the claimant incurred property damage.

<b><u>Population Reviewed</u></b>	<b><u># Units</u></b>	<b><u># Passed Standard</u></b>	<b><u># Failed Standard</u></b>
Claims paid	100	96	4

A failure rate of 4% does not appear to indicate a pattern. Therefore, no recommendation is warranted.

Claims Standard #8 – The Company did not misrepresent the facts or policy provisions while settling a claim. Reference: ORS 746.230(1)(a).

Findings

Passed with comment. 97% compliance to applicable files. Two paid claim files (3%) failed this standard.

These files did not contain supporting documentation to indicate the applicable coverages were explained to the insureds.

<b><u>Population Reviewed</u></b>	<b><u># Units</u></b>	<b><u># Not Applicable (N/A)</u></b>	<b><u># Passed Standard</u></b>	<b><u># Failed Standard</u></b>
Claims paid	100	33	65	2
Claims denied	<u>50</u>	<u>45</u>	<u>5</u>	<u>0</u>
Subtotal	150			
Less N/A files	<u>78</u>			
Total	<u>72</u>	<u>78</u>	<u>70</u>	<u>2</u>

A failure rate of 3% does not appear to represent a pattern. Therefore, no recommendation is warranted.

Claims Standard #9 – Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy. Reference: ORS 746.230(1)(g).

Findings

Passed. 4,777 bodily injury claims were opened during the examination period. Of these, 20 (0.42%) were litigated claims. From the information provided, it appears the Company is in compliance with this standard. In addition to the global review, the following files were reviewed:

<b><u>Population Reviewed</u></b>	<b><u># Units</u></b>	<b><u># Not Applicable (N/A)</u></b>	<b><u># Passed Standard</u></b>
Claims paid	100	0	100
Claims denied	<u>50</u>	<u>24</u>	<u>26</u>
Subtotal	150		
Less N/A files	<u>24</u>		
Total	<u>126</u>	<u>24</u>	<u>126</u>

Claims Standard #11 – The Company did not delay investigation or payment of claims by requiring a claimant to submit a preliminary claims report and then requiring subsequent submission of loss forms when both require essentially the same information. Reference: ORS 746.230(1)(k).

Findings

Passed with comment. 99% compliance. One file (1%) failed this standard.

The Company received a PIP subrogation demand from the claimant's carrier which appears to contain all information the Company would require in order to make payment. The Company requested additional documentation from the claimant's carrier which the Company already had in its possession. The Company explained that this error was caused by a turnover in personnel and subsequent difficulties in the indexing and routing of the paperwork to the file because the subrogation demand was addressed to the adjuster originally assigned to the file.

<b>Population Reviewed</b>	<b># Units</b>	<b># Not Applicable (N/A)</b>	<b># Passed Standard</b>	<b># Failed Standard</b>
Claims paid	100		99	1
Claims denied	<u>50</u>	<u>24</u>	<u>26</u>	<u>0</u>
Subtotal	150	24	125	1
Less N/A files	<u>24</u>			
Total	<u>126</u>	<u>24</u>	<u>125</u>	<u>1</u>

A failure rate of 1% does not represent a pattern. Therefore, no recommendation is warranted.

Claims Standard #12 – The Company uses the reservation of rights and excess of loss letters in accordance with the Company's established procedures. Reference: ORS 746.240.

Findings

Passed. 100% compliance to applicable files. Because of the low number of applicable files found in the sample, the examiner reviewed the Company's established procedures for use of reservation of rights and excess of loss letters. These procedures do appear to be in compliance with this standard.

<b><u>Population Reviewed</u></b>	<b><u># Units</u></b>	<b><u># Not Applicable (N/A)</u></b>	<b><u># Passed Standard</u></b>	<b><u># Failed Standard</u></b>
Claims paid	100	99	1	0

Note: The N/A files are those which did not require either a reservation of rights or excess of loss letter according to the Company's established procedures.

Claims Standard #13 – Claim files are reserved in accordance with the Company's established procedures. Reference: ORS 746.240.

Findings

Passed with comment. 98% compliance. Two files failed this standard.

The property damage component of one claim was not established. Instead, the Company coded the entire case as a collision coverage claim. Reserves should have been established for the property damage claim paid.

Uninsured motorist reserves were not set for another claim for which benefits were paid under that coverage. The Company indicated this was due to an oversight.

<b><u>Population Reviewed</u></b>	<b><u># Units</u></b>	<b><u># Passed Standard</u></b>	<b><u># Failed Standard</u></b>
Claims paid	100	98	2

A failure rate of 2% does not represent a pattern. Therefore, no recommendation is warranted.

Claims Standard #14 – Denied and closed-without-payment claims are handled in accordance with policy provisions and state law. Reference: ORS 746.230(1)(m), and OAR 836-080-0235(1).

Findings

Passed with comment. 96% compliance. One file (4%) failed this standard.

This claim was received in March of 1998 and not processed until one year later. The Company cannot explain why the claim wasn't handled in a timely manner.

<b><u>Population Reviewed</u></b>	<b><u># Units</u></b>	<b><u># Not Applicable (N/A)</u></b>	<b><u># Passed Standard</u></b>	<b><u># Failed Standard</u></b>
Claims denied	50	24	25	1

A failure rate of 4% does not appear to represent a pattern. Therefore, no recommendation is warranted.

Claims Standard #15 – Canceled benefit checks and drafts reflect appropriate claim handling practices. Reference: ORS 746.240.

Findings

Passed.

The examiner visited the mailroom of an MCO where thirty-three claim payments were selected for review. The examiner compared the date of the check to the mail date. All of the checks contained the same date as the mail date.

Claims Standard #16 – Personal injury protection claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations. Reference: ORS 742.520 through ORS 742.544.

Findings

Failed. 90% compliance to applicable files. Two files (10%) failed this standard.

One claim was received in March of 1998 and not processed until one year later. The Company cannot explain why the claim wasn't handled in a timely manner.

The other claim was received March 18, 1998, and not paid until June 30, 1998, 103 days later. The Company stated that action was taken on this claim in March of 1998 but cannot support its statement with acceptable documentation.

<b><u>Population Reviewed</u></b>	<b><u># Units</u></b>	<b><u># Not Applicable (N/A)</u></b>	<b><u># Passed Standard</u></b>	<b><u># Failed Standard</u></b>
Claims paid	100	79	19	2

Note: The N/A files are those reviewed which were not personal injury protection claims.

The provisions of ORS 742.528 require the Company to provide written notice of the denial to the insured stating the reason for the denial and informing the insured of the method for contesting the denial. A copy of the denial is to be sent to the provider as well. During the examination period, it appears the Company did not maintain documentation in its hard copy file or electronically to prove that copies of

EOBs sent to providers containing denial language were actually mailed to the insured.

Effective March 15, 1999, the Company implemented enhancements to its computer system so that the EOB forms include the name and address of each person to whom a copy of the EOB was mailed. The Company now has the capacity to recreate from its computer system exact replicas of the EOBs that were mailed. With the enhanced system, EOB copies are not required to be kept in the file because the Company can retrieve all EOBs as originally generated.

**I recommend the Company properly handle personal injury protection claims in accordance with ORS 742.520 through ORS 742.544.**

Claims Standard #17 – Total loss settlements are handled in accordance with policy provisions and applicable statutes, rules and regulations. Reference: OAR 836-080-0240(1).

#### Findings

Failed. 84% compliance. Eight files (16%) failed this standard.

Three claims failed because the amounts initially offered to settle the claims did not represent the loss vehicles as equipped.

Two claimants received additional compensation during the examination period because the total loss vehicles' equipment was not correctly considered at the time the ACV was established. The Company paid a total of \$655.00.

The Company also paid an additional \$155.00 to a claimant during the examination period because the condition of the vehicle was not properly represented and the equipment was not correctly considered at the time the ACV was determined.

Two claims were overpaid because the vehicles' condition was not properly represented when the ACV was established. A deduction of \$50.00 was to have been made on one case due to rust and this was not done. The other car actually had over 100,000 miles on it and the ACV was established using 44,938 miles, which resulted in an inappropriate adjustment to the value. It appears that claim was overpaid by at least \$1,450.00.

<b><u>Population Reviewed</u></b>	<b><u># Units</u></b>	<b><u># Passed Standard</u></b>	<b><u># Failed Standard</u></b>
Total loss claims	50	42	8

<b><u>Disposition</u></b>	<b><u>Number</u></b>	<b><u>% to Total</u></b>
First offer accepted	26	52%
Negotiated ACV with claimant	24	48
Appraisal process used	<u>0</u>	<u>0</u>
Total	<u>50</u>	<u>100%</u>

The Company does not require photographs of total loss vehicles and does use an outside vendor for assistance in establishing the actual cash value (ACV) of a loss vehicle.

**I recommend the Company process total loss settlements in accordance with policy provisions and applicable rules and regulations pursuant to OAR 836-080-0240(1).**

Subsequent to the examination, the Company indicated it is providing ongoing training to adjusters to ensure compliance with internal processes .

Claims Standard #19 – Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner. Reference: OAR 836-080-240(4).

Findings

Failed. 70% compliance to applicable files. Three files (30%) failed this standard.

The Company collected partial subrogation from the claimant carrier on one case and failed to return the \$100.00 deductible to the insured. This amount was paid to the insured during this examination.

The Company’s standard procedure is to include the insured’s deductible amount in the subrogation demand. The Company neglected to include this amount in one claim for which subrogation payment was collected from the claimant’s carrier. The Company indicated this was due to an oversight and paid the \$100.00 deductible to the insured during this examination.

The Company received an arbitration award that included the insured’s \$300.00 deductible but failed to return this amount to the insured. The Company indicated this was due to an oversight and the insured was paid this amount during this examination.

<b><u>Population Reviewed</u></b>	<b><u># Units</u></b>	<b><u># Not Applicable (N/A)</u></b>	<b><u># Passed Standard</u></b>	<b><u># Failed Standard</u></b>
Subrogated claims	50	40	7	3
Less N/A files	<u>40</u>			
Total	<u>10</u>	<u>40</u>	<u>7</u>	<u>3</u>

Note: The N/A files are those subrogated claim files reviewed which did not include recovery of the claimant's deductible.

In addition to the subrogated claims reviewed, the examiner noted in the claims paid population three other cases for which the deductible was not returned when the subrogation demand was paid by the claimant carrier. The Company forwarded a total of \$500.00 due these insureds during this examination.

**I recommend the Company reimburse deductibles to insureds upon subrogation recovery in a timely and accurate manner in accordance with OAR 836-080-0240(4).**

Subsequent to the examination, the Company indicated it is conducting training to address the concerns of the Insurance Division.

### **Additional Findings and Procedures**

#### **PIP Review**

From the claims paid random sample, the examiner selected all claims that were identified as PIP cases. The examiner compared PIP claims billed amounts to the paid amounts. Twenty claims were chosen for this PIP review. The examiner evaluated all paid medical bills for each claim, including all patients listed under the claim. The twenty claim files contained one hundred forty separate medical bills. One hundred fourteen of these were paid at 100% of the billed amount. The other twenty-six were paid at less than the billed amount for the following reasons:

**Reason**

**Number**

Amount billed exceeded the reasonable and customary amount	12
Duplicate charge	3
Coding errors or concerns	5
Not medically necessary	3
Amount billed was a finance charge	1
Durable medical equipment charge	1
Service not provided by qualified provider	<u>1</u>
Total	<u>26</u>

Nineteen percent of the bills reviewed were paid at less than the billed amount. Of these, 14 (10%) were for miscellaneous reasons listed above and 12 (9%) were above the reasonable and customary amount. The 9% billed above the reasonable and customary charge were submitted by four providers from Lebanon, OR, Gresham, OR, Portland, OR and Boise, ID. The bills reviewed were received from 63 medical providers and eight were for prescriptions.

**Comparative Negligence**

The Company indicated that before any insured's claim is assigned 100% negligence, the case is reviewed by a manager for verification that the determination is correct. Of the 100 paid claims reviewed, only five (5%) were assigned comparative negligence. The chart below shows the market claim office (MCO) involved and the percentage assigned for each case. The first number represents the amount of negligence on behalf of the Company's insured and the second is the other party's assigned percentage of responsibility for the accident.

<b><u>Percentage</u></b>	<b><u>MCO</u></b>
75-25	Portland
50-50	Portland
90-10	Eugene
75-25	Eugene
80-20	Clackamas

Upon review of an inquiry submitted by the examiner regarding the claim assigned 90%-10% comparative negligence, the Company corrected the at fault to coding to reflect the Company's insured as 100% negligent.

Subsequent to the examination, the Company has informed the examiners that it has modified its processes from a required review of all 100% negligence calls to review of 100% negligence calls at the manager's discretion.

### **Customer Service Money**

The Company has a customer service authorization procedure that provides for limited amounts to be paid for the resolution of customer grievances which may arise in situations where the handling of the claim was technically correct, but failed to meet the Company's standards of fairness and customer service. The Company's procedures indicate the MCM has a maximum authority of \$500 per case without prior approval from the territorial claim manager (TCM). This authority may be extended to qualified managers, claim representatives and agents within the service area at the discretion of the MCM.

These customer service dollars are not be used to pay customers whose dissatisfaction is without merit, or used to supplement an already reasonable and fair course of action or offer of settlement.

Each MCO is required to maintain a register of customer service payments made. The Company's procedures establish the format to be used and specify that the register pages should be retained for a minimum of three years.

The examiner requested copies of the registers for the Oregon MCOs for payments made during the examination period. The Company found that not all of the MCOs

retained registers or lists of payments made, but did furnish separate copies of the customer service authorization procedure pages with details regarding payments made. The Company's examination coordinator informed the examiner that not all claims with customer service money may have been included on the registers or other documentation provided. None of the cases reviewed in the total loss random sample which included customer service money were listed on the registers or other documentation provided.

A brief review of the customer service authorization register documentation for the examination period revealed customer service dollars paid for the reasons shown below. Please note that these amounts reflect combined totals for Allstate Insurance Company and Allstate Indemnity Company.

<b><u>Reason</u></b>	<b><u># Claims</u></b>	<b><u>Amount Paid</u></b>
Delay	42	\$8,630.28
Call not returned	1	250.00
Agent's negligence	1	200.00
Customer service/rapport	8	1,933.50
Long time customer	10	2,373.50
Rental car issues	6	1,684.70
Poor service from PRO shop	4	550.00
Unhappy with total loss offer	2	620.00
Management error	1	200.00
Confusion regarding coverage	7	958.91
Failed to subrogate	2	500.00
Other misunderstanding	1	140.00
Loss item not covered	2	400.00
Other repair considerations	3	392.31
To retain customer	1	40.00
Loss of use	<u>1</u>	<u>282.81</u>
Total	<u>92</u>	<u>\$19,156.01</u>

It appears the Company's claim documentation does not adequately describe the reason for the use of customer service money. Some of the reasons stated such as "to retain customer" or "long time customer" may not have qualified for additional payment under the customer service authorization procedures.

It also appears the MCM has complete authority over this program for the MCO. The Company does not generate management reports regarding this issue and it appears no other mechanism to oversee appropriate use of the customer service money is in place.

Eight (16%) of the total loss claims paid included customer service money. The amounts paid and reasons are shown in the chart below.

<b><u>Unit #</u></b>	<b><u>MCO</u></b>	<b><u>Amount Paid</u></b>	<b><u>Reason Shown in Company's Documentation</u></b>
13	Eugene	\$ 225.00	C/S money for delay and an Allstate cust since '72
21	Eugene	475.00	Paid 475.00 cust ser money because of delays, insured since '66
30	Eugene	150.00	Gave 150 in cust serv, delay in getting ver 2 to insd and to settle and keep cust completely sat
20	Eugene	250.00	This is a 38 yr customer and they feel the vehicle work 2k-This being the case I extended \$150 c/s and settled the claim, making them completely satisfied EXAMINER'S NOTE: THE COMPANY ACTUALLY ADDED \$250.00 IN CUSTOMER SERVICE MONEY
29	Eugene	500.00	Reached agreed with clmt, ACV 750.00 + 500.00 mgr disc = 1250.00 with clmt keeping salvage, ADP retail graph had only one for 2090.00
6	Eugene	300.00	I added 300 c/s for delays

17	Eugene	250.00	I did add 250 for the delay
23	Eugene	<u>200.00</u>	+200.00 cs delay
	Total	<u>\$2350.00</u>	

Six of the claimants received additional money due to delays. The other two appear to have been paid customer service money because the Company and the claimant could not agree on the ACV of the loss vehicle. This action is contrary to the Company's instructions regarding use of these funds. The customer service dollars are not be used to supplement an already reasonable and fair course of action or offer of settlement.

**Other Claim Issues**

One paid claim reviewed was improperly investigated by the file handler. This prevented the Company from pursuing subrogation because the Company failed to recognize the subrogation potential and had not completed the investigation.

The Company sent \$50.00 to an insured during the exam because this paid claim was calculated with the incorrect deductible. The Company charged the \$250.00 deductible instead of the correct \$200.00 deductible for this uninsured motorist claim. The Company was successful in its subrogation efforts against the uninsured motorist responsible for this accident. It did not, however, promptly return the deductible to the insured. The Company did refund the entire \$200.00 deductible to the insured during this examination.

In reviewing the subrogated claims, the examiner discovered a case where the insured collected for his total loss under his uninsured motorist coverage and also received payment from the other carrier. The Company learned the identity of the other insurance company after the claim had already been paid. At that time, the

Company's employee took no action on this claim. The Company is currently attempting to collect this overpayment from the insured.

The Company paid \$50.00 to a claimant during the examination for a total loss case reviewed. The Company incorrectly charged a \$250.00 deductible when the correct deductible for this uninsured motorist claim was \$200.00.

The Company paid \$500.00 to a claimant during the examination because the deductible should have been waived. When both parties involved in an accident are insured with the Company, the Company's standard procedure is to waive the deductibles.

### **COMPLIANCE WITH PRIOR EXAMINATION RECOMMENDATIONS**

This was the first market conduct examination for this Company. Therefore, there were no prior recommendations.

### **CONCLUSIONS**

	<b>Recommendation</b>	<b>Page</b>
1	I recommend the Company charge rates for policy coverage in accordance with its filed rating plan pursuant to the provisions of ORS 737.205.	16
2	I recommend the Company obtain written rejection for higher limits of uninsured and underinsured motorist coverage in accordance with the provisions of ORS 742.502(2)(a) and OAR 836-054-0000.	17
3	I recommend the Company's documentation adequately support all decisions made by the underwriters and underwriting decisions made by agents in accordance with ORS 733.170.	20

4	I recommend the Company provide the applicant, policyholder or individual proposed for coverage with the specific reason or reasons for an adverse underwriting decision in writing or advise the person that upon written request the person may receive the specific reason or reasons in writing in accordance with ORS 746.650.	26
5	I recommend the Company send delay letters in accordance with the provisions of OAR 836-080-0235(4) for all claims which are not resolved in 30 days.	34
6	I recommend the Company resolve within 30 days first party claims for which more time to determine whether the claim should be accepted or denied is not required in accordance with the provisions of OAR 836-080-0235(1).	34
7	I recommend the Company respond to claim correspondence within 30 days in accordance with the provisions of OAR 836-080-0225.	36
8	I recommend the Company properly handle personal injury protection claims in accordance with ORS 742.520 through ORS 742.544.	46
9	I recommend the Company process total loss settlements in accordance with policy provisions and applicable rules and regulations pursuant to OAR 836-080-0240(1).	48
10	I recommend the Company reimburse deductibles to insureds upon subrogation recovery in a timely and accurate manner in accordance with OAR 836-080-0240(4).	49

**MANAGEMENT AFFIRMATION**

## **ACKNOWLEDGMENT**

The cooperation and assistance rendered by the officers and employees of the Company during this examination is hereby acknowledged and appreciated.

A special thanks is extended to the examination coordinators for their courtesy, assistance, and promptness in providing, correlating, or coordinating all requested documents and statistics necessary to ensure a smooth transition during the overall examination process. The responsibilities that were undertaken during this examination were in addition to the scope of their regular assigned duties.

In addition to the undersigned, market conduct examiner Thomas G. Moeller, AIE, RHU, CLU, participated in this examination.

Respectfully submitted,

---

Jann Goodpaster, CIE, CPCU  
Chief Market Conduct Examiner  
Market Conduct Section  
Department of Consumer and Business Services  
Insurance Division  
State of Oregon

---

Gayle L. Woods, AIE  
Market Conduct Examiner  
Market Conduct Section  
Department of Consumer and Business Services  
Insurance Division  
State of Oregon



## **APPENDIX A**

### **STANDARDS ALLSTATE INSURANCE COMPANY MARKET CONDUCT EXAMINATION**

#### **Complaints**

1	All complaints are recorded on the Company complaint register.	ORS 732.302(1)
2	The Company has adequate complaint handling procedures in place and communicates such procedures to policyholders.	ORS 732.302(1)
3	The Company furnished a response within 21 days of an inquiry from the Insurance Commissioner.	ORS 731.296, OAR 836-080-0225(2)
4	The Company responds to Insurance Commissioner complaints adequately and conclusively.	OAR 836-080-0225(2)
5	The Company furnished a response within 30 days of an inquiry from an insured.	OAR 836-080-0225(3)
6	The Company response to an inquiry from an insured is adequate and answers the questions being raised.	OAR 836-080-0225(3)

#### **Underwriting and Rating**

1	The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the company rating plan.	ORS 737.205
2	Disclosures to insureds concerning rates and coverage are accurate and timely.	ORS 737.205 and ORS 742.566
3	An insured or applicant may not be assigned to a higher risk category than the person would normally be assigned because the person allowed a motor vehicle liability policy to lapse or had driving privileges suspended due to a nondriving offense.	ORS 742.449
4	Written rejection for higher limits of uninsured and underinsured motorist coverage limits must be obtained.	ORS 742.502(2)(a) and OAR 836-054-0000
5	Name exclusions are signed by all named insureds and comply with all rules and regulations.	ORS 742.450(5)
6	Individual Risk Package Modifiers (IRPM) are used in accordance with the instructions from the Oregon Insurance Division.	Bulletin 82-4
7	The company underwriting practices are not unfairly discriminatory. The company adheres to applicable statutes, rules and regulations and company guidelines in the selection of risk.	ORS 746.015, ORS 746.018, and OAR 836-081-0030
8	Employment driving record may not be used to determine if the file is issued renewed or in calculation of rates.	ORS 746.260 and ORS 746.265(1)

9	For the purpose of determining whether or not to issue or renew a policy and the calculation of rates an insurer may not use a driving record older than three years immediately preceding the issuance or renewal.	ORS 746.265(2)
10	All forms and endorsements forming a part of the contract are listed on the declarations page and should be filed with the department of insurance.	ORS 742.003
11	Underwriting, rating and classifications are based on adequate information developed at or near the inception of the coverage rather than near expiration, or following a claim.	ORS 746.240
12	File documentation adequately supports decisions made.	ORS 733.170
13	The company does not engage in collusive or anticompetitive underwriting practices.	ORS 746.240
14	Rejections and declinations are not unfairly discriminatory.	ORS 746.015, ORS 746.018 and OAR 836-081-0030
15	Cancellation/nonrenewal notices comply with policy provisions and state laws and company guidelines. Cancellation must be made within the first 60 days of the policy except for the exemption. Nonrenewal and changes in policy must be sent at least 30 days in advance of the renewal date.	ORS 742.566 through ORS 742.572 and ORS 746.650
16	Cancellation/nonrenewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract.	ORS 742.224
17	The insurer reports the name, address, and VIN number of each vehicle covered by a motor vehicle liability policy whether the policy was bought, canceled, or not renewed within 30 days of cancellation or nonrenewal and within 15 days of issuance to the Department of Transportation.	ORS 742.580
18	Rescissions are not made for nonmaterial misrepresentations in accordance with the Company's established procedures.	ORS 746.240

### **Claims**

1	The initial contact by the Company with the claimant is within 30 days.	OAR 836-080-0225
2	Investigations are conducted within 45 days.	OAR 836-080-0230
3	Claims are resolved in 30 days unless a delay letter (45 days) has been sent.	OAR 836-080-0235(1) and (4)
4	The Company responds to claim correspondence in 30 days.	OAR 836-080-0225 All Subparts
5	Claim files are adequately documented.	OAR 836-080-0215, ORS 733.170

6	Claims are not denied without first conducting a reasonable investigation.	ORS 746.230(1)(c) and (d)
7	The Company promptly and in good faith equitably settles claims in which liability has become reasonably clear.	ORS 746.230(1)(f), (L) and (h)
8	The Company did not misrepresent the facts or policy provisions while settling a claim.	ORS 746.230(1)(a)
9	Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.	ORS 746.230(1)(g)
10	The Company did not attempt to settle a claim on the basis of an altered application without notice to or consent of the applicant.	ORS 746.230(1)(i)
11	The Company did not delay investigation or payment of claims by requiring a claimant to submit a preliminary claims report and then requiring subsequent submission of loss forms when both require essentially the same information.	ORS 746.230(1)(k)
12	The Company uses the reservation of rights and excess of loss letters in accordance with the Company's established procedures.	ORS 746.240
13	Claim files are reserved in accordance with the Company's established procedures.	ORS 746.240
14	Denied and closed-without-payment claims are handled in accordance with policy provisions and state law.	OAR 836-080-0235(1), ORS 746.230(1)(m) and OAR 836-080-0235(1)
15	Canceled benefit checks and drafts reflect appropriate claim handling practices.	ORS 746.240
16	Personal injury protection claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.	ORS 742.520 through ORS 742.544
17	Total loss settlements are handled in accordance with policy provisions and applicable statutes, rules and regulations.	OAR 836-080-0240(1)
18	Automobile claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.	OAR 836-080-0240(2), (3), (5), (6) (7) and (8) and ORS 746.230(1)(i)
19	Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner.	OAR 836-080-0240(4)