STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

MARKET CONDUCT EXAMINATION

NUMBER 2013C-0061

May 20, 2014

TARGETED MARKET CONDUCT EXAMINATION REPORT

OF

ALLSTATE INSURANCE COMPANY

NORTHBROOK, ILLINOIS

NAIC COMPANY CODE 19232

For the Period January 1, 2012 through December 31, 2012

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I. EXECUTIVE SUMMARY

Allstate Insurance Company (the Company) is an authorized Michigan domiciled company. This examination was conducted by DIFS in conformance with the National Association of Insurance Commissioners (NAIC) *Market Regulation Handbook* (2012) (*Handbook*) and the Michigan Insurance Code, MCL 500.100 et seq. (the Code). The purpose of the exam is to evaluate the compliance of the Company with applicable Michigan statutes, NAIC Guidelines and DIFS regulations. The scope of market conduct examination has been limited to the Company's activities related to the handling of Personal Injury Protection (PIP) Complaints. The examination covers the period January 1, 2012 through December 31, 2012.

This summary of this targeted market conduct examination of the Company is intended to provide an overview of the examination results. The body of the report provides details of the scope of the examination, findings, DIFS recommendations, and Company responses.

DIFS considers a substantive issue one in which a "finding" or violation of Code was found to have occurred, or one in which corrective action on the part of the Company is deemed advisable.

Findings:
There are no findings.

Recommendations:
There are no recommendations.

Company Response:
The Company stated that it has no questions or concerns.

II. OBJECTIVES, SCOPE AND METHODOLOGY

This report is based on a targeted market conduct examination of Allstate Insurance Company. The examination was conducted at the DIFS office located at 611 West Ottawa Street, Lansing, MI. The contact for this exam was Celeste Vanduch, Senior State Filings Analyst. DIFS conducted this examination in accordance with statutory authority of MCL 500.222 et seq. All Michigan laws, regulations and bulletins cited in this report may be viewed on the DIFS website at www.michigan.gov/difs.

The purpose of the exam is to evaluate the compliance of the Company with applicable Michigan statutes, NAIC Guidelines and DIFS regulations.

The examination covers the period January 1, 2012 to December 31, 2012. This examination was conducted under the supervision of Sherry J. Bass-Pohl, Manager of the Market Conduct Company Examination Unit.

This examination includes reviews of, but not limited to, the area of Personal Injury Protection (PIP) Complaints. The examination covers the period January 1, 2012 through December 31, 2012.

The examination was called due to changes in the MCAS complaint index.

The examiner sampled Company records in the area of PIP complaints. The analysis and examination of this area was conducted and measured according to the Standards and practices in the NAIC *Handbook*, the applicable statutes in the Code, and the Company's internal guidelines and procedures.

Three types of review may be utilized for the above standards. Certain standards may be examined with a single review, and others may be examined using one or more types of review. The NAIC *Handbook* calls for a random sample of 100 files when the examination population is greater than 5,000. This statistical sample is applied as follows:

A. Generic Review: A standard test is applied using analysis of all files written by agents at the specific branch office for the time frame of the examination. The Company provides the general file information as a response to examiner questions.

B. Sample Review: A "sample" review indicates that a standard is tested through direct review of a random sample of files using sampling methodology described in the NAIC *Handbook*, Chapter 14. The samples include all files within a specific subgroup. The sampling techniques used are based on a 95 percent (95%) confidence level, meaning there is 95 percent (95%) confidence that the error percentages shown in the various standards so tested are representative of the entire set of records from which it was drawn. An error rate in excess of the tolerance level in these sections of the report is indicative of a general business practice of engaging in that type of conduct. Note that the statistical error tolerance is not indicative of the actual tolerance of DIFS for deliberate or systematic error.

C. Census Review: Marketing and Sales, as well as Complaint files, are not subject to the sampling procedure, as the number of relevant files does not warrant taking a sample. Therefore, every relevant marketing piece and complaint file for the examination period is reviewed by the examination team for compliance with applicable statutes, regulations and internal company guidelines.

This examination report is a report by test. The report contains a summary of pertinent information about the lines of business examined. This includes each NAIC *Handbook* source and Standard, Code citation, any examination findings detailing the non-compliant or problematic activities that were discovered during the course of the exam, the Company response proposing methods for correcting the deficiencies, and recommendation for any further action by DIFS.

III. COMPANY OPERATIONS AND PROFILE

Allstate Insurance Company began operations in 1931, as an Illinois domiciled company. It is a stock company. Allstate was founded as part of Sears, Roebuck & Co., and became a publicly traded company in 1993. At the time, the initial public offering of Allstate was the largest in U.S. history. On June 30, 1995, it became a totally independent company after Sears divested its remaining shares to Sears stockholders. It is currently licensed to market its products in 50 states. The Company markets and sells its products through captive agents. Approximately 600 producers are appointed in Michigan. The Company's top lines of business are auto and home insurance. Its size category is XV ($2 billion or greater), and the Company is rated A+ (Superior) by the A.M. Best Company. Its outlook is stable. The Company plans to expand its Drivewise program and continue its Esurance and Encompass distribution channels.

IV. EXAMINATION FINDINGS AND RECOMMENDATIONS

COMPLAINT HANDLING

Standard 1*:* All complaints are recorded in the required format on the regulated entity's complaint register. NAIC *Handbook,* Chapter 16.

Standard 2: The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders. NAIC *Handbook*, Chapter 16.

Standard 3: The Company takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations, and contract language. NAIC *Handbook,* Chapter 16.

Standard 4: The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations. NAIC *Handbook,* Chapter 16.

MCL 500.2213:

> (1) Except as otherwise provided in subsection (4), each insurer and health maintenance organization shall establish an internal formal grievance procedure for approval by the commissioner for persons covered under a policy, certificate, or contract issued under chapter 34, 35, or 36 that provides for all of the following:
>
> (a) A designated person responsible for administering the grievance system.
>
> (b) A designated person or telephone number for receiving grievances.

(c) A method that ensures full investigation of a grievance.

(d) Timely notification in plain English to the insured or enrollee as to the progress of an investigation of a grievance.

(e) The right of an insured or enrollee to appear before a designated person or committee to present a grievance.

(f) Notification in plain English to the insured or enrollee of the results of the insurer's or health maintenance organization's investigation of the grievance and of the right to have the grievance reviewed by the commissioner or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(g) A method for providing summary data on the number and types of complaints and grievances filed under this section. The insurer or health maintenance organization shall annually file the summary data for the prior calendar year with the commissioner on forms provided by the commissioner.

(h) Periodic management and governing body review of the data to assure that appropriate actions have been taken.

(i) That copies of all complaints and responses are available at the principal office of the insurer or health maintenance organization for inspection by the commissioner for 2 years following the year the grievance was filed.

(j) That when an adverse determination is made, a written statement in plain English containing the reasons for the adverse determination is provided to the insured or enrollee along with written notifications as required under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(k) That a final determination will be made in writing by the insurer or health maintenance organization not later than 35 calendar days after a formal grievance is submitted in writing by the insured or enrollee. The timing for the 35-calendar-day period may be tolled, however, for any period of time the insured or enrollee is permitted to take under the grievance procedure and for a period of time that shall not exceed 10 business days if the insurer or health maintenance organization has not received requested information from a health care facility or health professional.(l) That a determination will be made by the insurer or health maintenance organization not later than 72 hours after receipt of an expedited grievance. Within 10 days after receipt of a determination, the insured or enrollee may request a determination of the matter by the commissioner or his or her designee or by an independent review organization under the patient's right to independent review act, 2000

PA 251, MCL 550.1901 to 550.1929. If the determination by the insurer or health maintenance organization is made orally, the insurer or health maintenance organization shall provide a written confirmation of the determination to the insured or enrollee not later than 2 business days after the oral determination. An expedited grievance under this subdivision applies if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance under subdivision (k) would seriously jeopardize the life or health of the insured or enrollee or would jeopardize the insured's or enrollee's ability to regain maximum function.

(m) That the insured or enrollee has the right to a determination of the matter by the commissioner or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(2) An insured or enrollee may authorize in writing any person, including, but not limited to, a physician, to act on his or her behalf at any stage in a grievance proceeding under this section.

(3) This section does not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health care services.

(4) This section does not apply to a policy, certificate, care, coverage, or insurance listed in section 5(2) of the patient's right to independent review act, 2000 PA 251, MCL 550.1905, as not being subject to the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(5) As used in this section:

(a) "Adverse determination" means a determination that an admission, availability of care, continued stay, or other health care service has been reviewed and denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

(b) "Grievance" means a complaint on behalf of an insured or enrollee submitted by an insured or enrollee concerning any of the following:

(i) The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review.
(ii) Benefits or claims payment, handling, or reimbursement for health care services.
(iii) Matters pertaining to the contractual relationship between an insured or enrollee and the insurer or health maintenance organization.

MCL 500.2026:

> (2) The failure of a person to maintain a complete record of all the complaints of its insureds which it has received since the date of the last examination is an unfair method of competition and unfair or deceptive act or practice in the business of insurance. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition thereof, and the time it took to process each complaint. For purposes of this subsection, "complaint" means a written communication primarily expressing an allegation of acts which would constitute violation of this chapter. If a complaint relating to an insurer is received by an agent of the insurer, the agent shall promptly forward the complaint to the insurer unless the agent resolves the complaint to the satisfaction of the insured within a reasonable time. An insurer shall not be deemed to have engaged in an unfair method of competition or an unfair or deceptive act or practice in the business of insurance in violation of this chapter because of the failure of an agent who is not also an employee to forward a written complaint as required by this subsection.

<u>Complaints – Personal Auto PIP</u>

The examiners requested the population of Michigan Complaints – Personal Auto PIP.

File Data	Population Size	Maximum Number of Failures Permitted in Sample	Stage 1 Sample Size	Date Sample Pulled	Errors Found
Litigated Personal Auto PIP Claims	6	0	6	12/20/2013	0

Findings:
The company is in compliance with all Michigan statutes.

Recommendations:
There are no recommendations.

Company Response:
The Company stated that it has no questions or concerns.

V. ACKNOWLEDGEMENT

This examination report of Allstate Property and Casualty Insurance Company is respectfully submitted to the Director of the Department of Insurance and Financial Services, State of Michigan.

The courteous cooperation and assistance of the officers and employees of the Company extended to the examiners during the course of the examination is hereby acknowledged.

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David A. Haddad, CPCU, MCM
Examiner-in-Charge
Department of Insurance and Financial Services
Market Conduct Section