



**COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT**

MARKET CONDUCT
EXAMINATION REPORT

OF

**STATE FARM MUTUAL AUTOMOBILE
INSURANCE COMPANY**
BLOOMINGTON, IL

As of: November 19, 2024
Issued: January 16, 2025

**BUREAU OF MARKET ACTIONS
PROPERTY & CASUALTY DIVISION**



PENNSYLVANIA INSURANCE DEPARTMENT
EXAMINATION VERIFICATION

I, Richard J. Barr, Market Conduct Examiner from
(Name of Examiner) (Title of Examiner)

the Pennsylvania Insurance Department certify that I was the Examiner-In-Charge of the Report of
(Name of Vendor/Department)

Examination of State Farm Mutual Automobile Insurance Co made as of 11/18/2024.
(Name of Examined Company) (Date)

The last date of examination file review was 06/27/2024 and the written Report
(Date)

of Examination was reviewed and accepted by the Paul Towsen
(Chief of Market Conduct Examiner)

On 11/19/24.
(Date)

I have reviewed the completed written Report of Examination and certify that the facts and figures recited therein are true and accurate, according to the records, documents and other evidence obtained during the course of the examination.

Richard J. Barr
(Examiner-in Charge)

Pennsylvania Insurance Department
(Name of Vendor/Department)

1321 Strawberry Square, Harrisburg, PA 17120
(Address of Vendor/Department)

Richard J. Barr Digitally signed by Richard J. Barr
(Examiner in Charge Signature) Date: 2024.11.18 14:00:42 -05'00'

11/18/2024
(Date)

IN ORDER TO SATISFY SECTION 40 P.S. § 323.5(b), THAT PROVIDES FOR NO LONGER THAN SIXTY (60) DAYS FROM THE COMPLETION OF THE EXAMINATION, THE EXAMINER IN CHARGE SHALL FILE WITH THE DEPARTMENT A VERIFIED WRITTEN REPORT OF EXAMINATION UNDER OATH.

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY

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BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this __3rd__ day of _July___, 2023, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate David J. Buono, Jr., Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.



Michael Humphreys
Insurance Commissioner

1. Respondent hereby admits and acknowledges that it has received proper notice of its rights to a formal administrative hearing pursuant to the Administrative Agency Law, 2 Pa.C.S. §101, et seq., or other applicable law.

2. Respondent hereby waives all rights to a formal administrative hearing in this matter and agrees that this Consent Order shall have the full force and effect of an order duly entered in accordance with the adjudicatory procedures set forth in the Administrative Agency Law, supra, or other applicable law.

FINDINGS OF FACT

3. The Insurance Department finds true and correct each of the following Findings of Fact:

- (a) Respondent is State Farm Mutual Automobile Insurance Company, and maintains its address at One State Farm Plaza, Bloomington, IL 61710.
- (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the experience period from July 1, 2022 through June 30, 2023.
- (c) On November 19, 2024, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on December 19, 2024.

(e) The Market Conduct Examination of Respondent revealed violations of the following:

(i) All findings and conclusions in the Examination Report, which is attached hereto, are hereby incorporated into this Consent Order

CONCLUSIONS OF LAW

4. In accord with the above Findings of Fact and applicable provisions of law, the Insurance Department makes the following Conclusions of Law:

(a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.

(b) Violations of 40 P.S. §991.2006 and 991.2008(b) (relating to motor vehicles) of 40 P.S. are punishable by the following, under Section 991.2013: Any individual or insurer who violates any of the provisions of this article may be sentenced to pay a fine not to exceed five thousand dollars (\$5,000).

- (c) Violations of Section 4 of the Casualty and Surety Rate Regulatory Act, No. 246 (40 P.S. §1184(a)&(h)) are punishable under Section 16 of the Act:
 - (i) imposition of a civil penalty not to exceed \$50 for each violation or not more than \$500 for each such willful violation.
 - (ii) suspension of the license of any insurer which fails to comply with an Order of the Commissioner within the time limited by such Order, or any extension thereof which the Commissioner may grant.

- (d) Respondent's violations of 31 Pa. Code §§146.3, 146.5(b), 146.5(d), 146.6, and 146.7(a)(1) are punishable under Sections 1 through 5 and Section 9 of the Unfair Insurance Practices Act (40 P.S. §§1171.1 – 1171.5 and 1171.9):
 - (i) cease and desist from engaging in the prohibited activity.
 - (ii) suspension or revocation of the license(s) of Respondent.

- (e) In addition to any penalties imposed by the Commissioner for Respondent's violations of 40 P.S. §§1171.1 – 1171.5, the Commissioner may, under (40 P.S. §§1171.10, 1171.11) file an action in which the Commonwealth Court may impose the following civil penalties:
 - (i) for each method of competition, act, or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00).
 - (ii) for each method of competition, act, or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars (\$1,000.00).

ORDER

5. In accord with the above Findings of Fact and Conclusions of Law, the Insurance Department orders and Respondent consents to the following:

- (a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.
- (b) Respondent shall pay Fifty-Five Thousand Dollars (\$55,000.00) in settlement of all violations contained in the Report.
- (c) Payment of this matter shall be made at <https://www.bpp.ob.pa.gov/Customer>.
Instructions on how to do this are provided in the attached cover letter to this order.
Payment must be made no later than thirty (30) days after the date of this Order.
- (d) To determine Respondent's compliance with the full and timely implementation of all recommendations in the Examination Report, the Department may inquire with the Respondent about its implementation of the Recommendations no earlier than twelve (12) months from the date of this Order.
- (e) Respondent shall share the Examination Report and this Order with each of its directors and submit affidavits executed by each of its directors, stating under oath that they have received a copy of the Examination Report and this Order. Such affidavits shall be submitted within thirty (30) days of the date of this Order.

(f) Respondent shall comply with all recommendations contained in the attached Report.

6. In the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, based upon the Findings of Fact and Conclusions of Law contained herein may pursue any and all legal remedies available, including but not limited to the following: The Insurance Department may enforce the provisions of this Order in the Commonwealth Court of Pennsylvania or in any other court of law or equity having jurisdiction; or the Department may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

7. Alternatively, in the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, the Department may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

8. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

11. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law contained herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized delegee.

BY: STATE FARM MUTUAL AUTOMOBILE
INSURANCE COMPANY
Respondent
Andy Rader

Andy Rader, VP of Operations- P&C Underwriting

Greg Jones

Gregory Jones, Operations VP- P&C Claims

David J. Buono

DAVID J. BUONO
Deputy Insurance Commissioner
Commonwealth of Pennsylvania

I. INTRODUCTION

The Market Conduct Examination of State Farm Mutual Automobile Insurance Company, hereinafter referred to as “Company”, was conducted at the Pennsylvania Insurance Department beginning August 15, 2023. There was no onsite portion of the exam.

Pennsylvania Market Conduct Examination Reports generally note only those items to which the Department, after review, takes exception. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review those areas of concern in order to determine the potential impact upon Company operations or future compliance. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Report may result in imposition of penalties.

In certain areas of review listed in this Report, the examiners will refer to “error ratio.” This error ratio is calculated by dividing the number of policies with violations by the total number of policies reviewed. For example, if 100 policies are reviewed and it is determined that there are 20 violations on 10 policies, the error ratio would be 10%.

Throughout the course of the examination, Company officials were provided with status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company personnel to discuss the various types of violations identified during the examination and review written summaries provided on the violations found.

The courtesy and cooperation extended by the officers and employees of the Company during the course of the examination is hereby acknowledged.

The following examiners participated in this examination and in preparation of this Report.

Paul Towsen, MCM
Market Conduct Division Chief
Pennsylvania Insurance Department

Richard Barr, MCM
Market Conduct Examiner II, EIC
Pennsylvania Insurance Department

Vern Schmidt, MCM
Market Conduct Examiner II, EIC
Pennsylvania Insurance Department

Ellis Savage, MCM
Market Conduct Examiner I
Pennsylvania Insurance Department

Joe Bieniek, AIE, AMCM, CPCU, CRM
Market Conduct Examiner
INS Regulatory Insurance Services, Inc.

Trisha Crissman, MCM
Market Conduct Examiner
INS Regulatory Insurance Services, Inc.

JoAnn Baldo, CIE, MCM, CPA, HCP
Market Conduct Examiner
INS Regulatory Insurance Services, Inc.

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted on State Farm Mutual Automobile Insurance Company, at the Pennsylvania Insurance Department, located in Harrisburg, Pennsylvania. The examination was conducted pursuant to Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act of 1921 and covered the experience period of July 1, 2022, through June 30, 2023, unless otherwise noted. The purpose of the examination was to determine the Company's compliance with Pennsylvania insurance laws and regulations.

The examination focused on Company operations in the following areas:

1. Private Passenger Automobile
 - Underwriting – Appropriate and timely notices of nonrenewal, midterm cancellations, 60-day cancellations, declinations, and rescissions.
 - Rating – Proper use of all classification and rating plans and procedures.
2. Claims
3. Complaints
4. Underwriting Practices & Procedures
5. Forms
6. Data Integrity

III. COMPANY HISTORY

State Farm Mutual Automobile Insurance Company (hereinafter referred to as "SFMAIC") was incorporated on March 29, 1922, under the Uniform Mutual Law of Illinois. The Company commenced business on June 7, 1922. SFMAIC, the lead company in the State Farm Group ("The Group"), is the nation's largest automobile insurer. The Group offers multiple lines of property, casualty and life and health insurance throughout the United States through an exclusive agency force. The affiliated entities are listed on Schedule Y from the Annual Statement. Corporate offices are located in Bloomington, Illinois. SFMAIC is licensed in all 50 states and the District of Columbia.

LICENSING

State Farm Mutual Automobile Insurance Company's last Certificate of Authority to write business in the Commonwealth was last issued on April 1, 2024. The Company is licensed in all 50 states and the District of Columbia. The Company's 2022 annual statement reflects Direct Written Premium for all lines of business in the Commonwealth of Pennsylvania as \$1,776,761,100. Premium volume related to the areas of this review were: Private Passenger Automobile Direct Written Premium was reported as Private Passenger Auto No-Fault (Personal Injury Protection) \$0; Other Private Passenger Auto Liability \$830,380,863; and Private Passenger Auto Physical Damage \$888,252,532.

IV. UNDERWRITING

A. Private Passenger Automobile

1. Nonrenewals

A nonrenewal is considered to be any policy that was not renewed, for a specific reason, at the normal twelve-month policy anniversary date.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited, and Section 2006 (40 P.S. §991.2006), which establishes the requirements which must be met regarding the form and conditions of the cancellation notice.

From the universe of 5,244 private passenger automobile policies which were nonrenewed during the experience period, 100 files were selected for review. All 100 files requested were received and reviewed. The one violation noted was based on one file, resulting in an error ratio of 1%.

The following finding and concern were noted.

1 Violation 40 P.S. §991.2006

A cancellation or refusal to renew by an insurer of a policy of automobile insurance shall not be effective unless the insurer delivers or mails to the insured at the address shown in the policy a written notice of the cancellation or refusal to review. The Company failed to have proof in the file to indicate the insured requested cancellation for the file noted.

2. Midterm Cancellations

A midterm cancellation is any policy that terminates at any time other than the normal twelve-month policy anniversary date.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited, and Section 2006 (40 P.S. §991.2006), which establishes the requirements which must be met regarding the form and conditions of the cancellation notice.

From the universe of 104,210 private passenger automobile policies which were cancelled during the experience period, 99 files were selected for review. All 99 files requested were received and reviewed. There were no violations noted.

3. 60-Day Cancellations

A 60-day cancellation is considered to be any policy, which was cancelled within the first 60 days of the inception date of the policy.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited. These files were also reviewed for compliance with Act 68, Section 2002(b)(3) (40 P.S. §991.2002(b)(3)), which requires an insurer who cancels a policy of automobile insurance in the first 60 days, to supply the insured with a written statement of the reason for cancellation.

From the universe of 9,457 automobile policies that were cancelled within the first 60 days of new business, 100 files were selected for review. All 100 files requested were received and reviewed. There were no violations noted.

4. Declinations

A declination is any application that is received by the Company and was declined to be written.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited.

From the universe of 6,112 declinations for private passenger automobile insurance, 144 files were selected for review. All 144 files requested were received and reviewed. The 16 violations noted was based on 16 files, resulting in an error ratio of 11%.

The following finding was noted.

16 Violations 40 P.S. §991.2008(b)

Any applicant for a policy who is refused such policy by an insurer shall be given a written notice of refusal to write by the insurer. Such notice shall state the specific reason or reasons of the insurer for refusal to write a policy for the applicant. Within 30 days of the receipt of such reasons, the applicant may request in writing to the Insurance Commissioner that he review the action of the insurer in refusing to write a policy for the applicant. The Company failed to provide a written notice of refusal to write for the file noted. The Company failed to provide a specific reason for the declination on 14 of the files noted and sent a notice of cancellation which did not advise the insureds of their right to request in writing a review by the Commissioner on 2 of the files noted.

CONCERN: Declination letters sent to the applicants are not accurately reflecting the reasons for declinations. The Company should require that letters provided to the applicants are clear as to the reason(s) why they are being declined. The Company is responsible for the agents' actions when declining an applicant.

5. Rescissions

A rescission is any policy which was void ab initio by the Company.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited. The review also determines compliance with the rescission requirements established by the Supreme Court of Pennsylvania in *Erie Insurance Exchange v. Lake*.

The universe of 13 private passenger automobile policies that were identified by the Company as rescissions during the experience period was selected for review. All 13 files requested were received and reviewed. There were no violations noted.

V. RATING

A. Private Passenger Automobile

1. New Business

New business, for the purpose of this examination, is defined as policies written for the first time by the Company during the experience period.

The primary purpose of the review was to measure compliance with The Casualty and Surety Rate Regulatory Act, Section 4(a) and (h) (40 P.S. §1184(a), (h)), which requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time. Files were also reviewed to determine compliance with all provisions of the Motor Vehicle Financial Responsibility Law (75 Pa. C.S. §§1701 – 1799.7) and Act 68, Section 2005(c) (40 P.S. §991.2005(c)), which requires insurers to provide to insureds a detailed statement of the components of a premium and shall specifically show the amount of surcharge or other additional amount that is charged as result of a claim having been made under a policy of insurance, or as a result of any other factors.

The Company uses an automated system to process and issue personal automobile policies. By reviewing base premiums, territory assignments, rating symbols, classifications and surcharge disclosures, the examiners were able to determine compliance with the Company's filed and approved rating plans.

Private Passenger Automobile Rating – New Business without Surcharges

From the universe of 138,737 private passenger automobile policies identified as new business without surcharges by the Company, 100 files were selected for review. All 100 files requested were received and reviewed. The 14 violations noted were based on 10 files, resulting in an error ratio of 10%.

The following findings were noted:

10 Violations 75 Pa. C.S. §1705(a)(4)

Requires every insurer, prior to the issuance of a private passenger motor vehicle liability insurance policy to provide each applicant an opportunity to elect a tort option. A policy may not be issued unless the applicant has been provided an opportunity to elect a tort option. The Company failed to provide a signed and dated limited tort option selection form for the ten files noted.

2 Violations 75 Pa. C.S. §1734

Request for lower (or higher) limits of coverage. A named insured may request in writing the issuance of coverages under section 1731 (relating to availability, scope and amount of coverage) in amounts equal to or less than the limits of liability for bodily injury. The Company failed to provide written request for UM/UIM limits not equal to BI Liability coverage for the two files noted.

2 Violations 75 Pa. C.S. §1738(d)(1) &(2)(e)

Stacking of uninsured and underinsured benefits and option to waive. (d) Forms- (1) The named insured shall be informed that he may exercise the waiver of the stacked limits of uninsured motorist coverage by signing the written rejection form. (2) The named

insured shall be informed that he may exercise the waiver of the stacked limits of underinsured motorist coverage by signing the written rejection form. (e) Signature and date. – The forms described in subsection (d) must be signed by the first named insured and dated to be valid. Any rejection form that does not comply with this section is void. The Company failed to provide the signed rejection form of stacked limits for uninsured and underinsured motorists coverage for the two files noted.

Private Passenger Automobile Rating – New Business with Surcharges

From the universe of 8,340 private passenger automobile policies identified as new business with surcharges by the Company, 100 files were selected for review. All 100 files requested were received and reviewed. The 14 violations noted was based on 8 files, resulting in an error ratio of 8%.

The following finding was noted:

1 Violation 40 P.S. §323.3(a)

Requires every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person has complied with the laws of the Commonwealth. The Company failed to maintain a complete underwriting file for the violation noted.

7 Violations 75 Pa. C.S. §1705(a)(4)

Requires every insurer, prior to the issuance of a private passenger motor vehicle liability insurance policy to provide each applicant an opportunity to elect a tort option. A policy may not be issued unless the applicant has been provided an opportunity to elect a tort option. The Company failed to provide a signed and dated limited tort option selection form for the seven files noted.

1 Violations 75 Pa. C.S. §1734

Request for lower (or higher) limits of coverage. A named insured may request in writing the issuance of coverages under section 1731 (relating to availability, scope and amount of coverage) in amounts equal to or less than the limits of liability for bodily injury. The Company failed to provide written request for UM/UIM limits not equal to BI Liability coverage for the file noted.

5 Violations 75 Pa. C.S. §1738(d)(1) & (2) & (e)

Stacking of uninsured and underinsured benefits and option to waive. (d) Forms – (1) The named insured shall be informed that he may exercise the waiver of the stacked limits of uninsured motorist coverage by signing the written rejection form. (2) The named insured shall be informed that he may exercise the waiver of the stacked limits of underinsured motorist coverage by signing the written rejection form. (e) Signature and date. – The forms described in subsection (d) must be signed by the first named insured and dated to be valid. Any rejection form that does not comply with this section is void. The Company failed to provide the signed

rejection form of stacked limits for uninsured and underinsured motorists coverage for the five files noted.

CONCERN: The tort form was signed and dated for full tort, but policy was issued with limited tort.

2. Renewals

A renewal is considered to be any policy, which was previously written by the Company and renewed on the normal twelve-month anniversary date.

The purpose of the review was to measure compliance with The Casualty and Surety Rate Regulatory Act, Section 4(a) and (h) (40 P.S. §1184(a), (h)), which requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time. Files were also reviewed to determine compliance with Act 68 of 1998, Section 2005(c) (40 P.S. §991.2005(c)), which requires insurers to provide to insureds a detailed statement of the components of a premium and shall specifically show the amount of surcharge or other additional amount that is charged as a result of a claim having been made under a policy of insurance, or as a result of any other factors.

The Company processes and issues personal automobile policies using an automated system. By reviewing base premiums, territory assignments, rating symbols, classifications and surcharge disclosures, the examiners were able to determine compliance with the Company's filed and approved rating plans.

Private Passenger Automobile – Renewals without Surcharges

From the universe of 504,848 private passenger automobile policies identified as renewals without surcharges, 100 files were selected for review. All 100 files requested were received and reviewed. There were no violations noted.

Private Passenger Automobile – Renewals with Surcharges

From the universe of 14,409 private passenger automobile policies identified as renewals with surcharges, 100 files were selected for review. All 100 files requested were received and reviewed. The 3 violations noted were based on 3 files, resulting in an error ratio of 3%.

The following findings were noted:

1 Violation 40 P.S. §323.3 (a)

Requires every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such a manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person and ascertain whether the company or person has complied with the laws of this Commonwealth. The Company failed to maintain a complete underwriting file for the file noted.

1 Violation 40 P.S. §1184(a)&(h)

Rate filings. (a) Every insurer shall file with the commissioner every manual of classifications, rules and rates, every rating plan and every modification of any of the foregoing which it proposes to use

in this Commonwealth. The filing of the aforementioned shall be made whether or not the coverage is provided on an individual or group basis and whether or not the group policy is issued in this Commonwealth or another state. Every such filing shall state the proposed effective date thereof and shall indicate the character and extent of the coverage contemplated. When a filing is not accompanied by the information upon which the insurer supports such filing, and the commissioner does not have sufficient information to determine whether such filing meets the requirements of the act, he may require such insurer to furnish the information upon which it supports such filing. Any filing may be supported by (1) the experience or judgment of the insurer or rating organization making the filing, (2) the experience of other insurers or rating organizations, or (3) any other factors which the insurer or rating organization deems relevant. A filing and any supporting information shall be open to public inspection after the filing becomes effective. (h) Beginning ninety (90) days after the effective date of this Act, no insurer shall make or issue a contract or policy except in accordance with filings or rates which are in effect for said insurer as provided in this Act or in accordance with subsections (f) or (g) of this section. The Company failed to assign the correct territory code for the file noted.

1 Violation 75 Pa. C.S. §1799.3(a)

No insurer shall cancel or refuse to renew a policy or apply any surcharge, rate penalty or driver record point assignment where, during the preceding three-year period, the aggregate cost to be less than \$1,700 (effective 7/1/17) in excess of any self-insured retention or deductible applicable to the named insured. The Company failed

to address that the accident did not meet the surcharge threshold requirement for the file noted.

VI. CLAIMS

The Company was requested to provide copies of all established written claim handling procedures utilized during the experience period. Written claim handling procedures were received and reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature.

The Claims review consisted of the following areas of review:

- A. Automobile Property Damage Claims
- B. Automobile Comprehensive Claims
- C. Automobile Collision Claims
- D. Automobile Total Loss Claims
- E. Automobile First Party Medical Claims
- F. Automobile First Party Medical Claims Referred to a PRO

The primary purpose of the review was to determine compliance with 31 Pa. Code, Chapter 146, Unfair Claims Settlement Practices. The files were also reviewed to determine compliance with Act 205, Section 4 (40 P.S. §1171.4) and Section 5(a)(10)(vi) of the Unfair Insurance Practices Act (40 P.S. §1171.5(a)(10)(vi)).

A. Automobile Property Damage Claims

From the universe of 76,802 private passenger automobile property damage claims reported during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The 12 violations noted were based on 8 files, resulting in an error ratio of 8%.

The following findings were made:

4 Violations 31 Pa. Code §62.3

An appraisal shall meet all applicable standards per statute. The Company failed to provide an appraisal that meets all applicable standards per statute for the four claim files noted.

5 Violations 63 P.S. § 861(b)

The appraiser shall furnish a legible copy of the appraisal to the repair shop selected by the consumer to make the repairs and also furnish a copy to the owner of the vehicle. The appraisal shall contain the name of the insurance company ordering it, if any, the insurance file number, the number of the appraiser's license and the proper identification number of the vehicle being inspected. The appraisals were missing the appraiser's license number for the five claim files noted.

3 Violations 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide timely status letters for the three claim files noted.

CONCERN: The Company closes the claim without support and or justification of why the claim is being closed without payment.

CONCERN: Status Letters are automatically generated and sent to the insured/claimant that do not specifically describe the delay reason. The letter lists eight possible delay reasons.

B. Automobile Collision Claims

From the universe of 101,475 private passenger automobile collision claims reported during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The 16 violations noted were based on 10 files, resulting in an error ratio of 10%.

The following findings were noted:

1 Violations 18 Pa. C.S. §4117(k)(1)

Insurance Fraud. (k) Insurance forms and verification of services. (1) All applications for insurance and all claim forms shall contain or have attached thereto the following notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. The Company failed to provide an appraisal with the required fraud statement for claim file noted.

5 Violations 31 Pa. Code §62.3

An appraisal shall meet all applicable standards per statute. The Company failed to provide an appraisal that meets all

applicable standards per statute for the five claim files noted.

5 Violations 63 P.S. §861(b)

The appraiser shall furnish a legible copy of the appraisal to the repair shop selected by the consumer to make the repairs and also furnish a copy to the owner of the vehicle. The appraisal shall contain the name of the insurance company ordering it, if any, the insurance file number, the number of the appraiser's license and the proper identification number of the vehicle being inspected. The appraisals were missing the appraiser's license number for the five claim files noted.

1 Violations 31 Pa. Code §146.3

File and record documentation. The claim files of the insurer shall be subject to examination by the Commissioner or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed. The Company failed to maintain a complete claim file for claim file noted.

4 Violations 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide timely status letters

for the four claim files noted.

The following concerns were noted:

CONCERN: The Carrier issues automatic closing letters when claims are still open causing confusion to the insureds.

CONCERN: The Carrier included Ohio statutes in the closing letter for a claim, which was for a collision that occurred in Pennsylvania. Applying Ohio statutes is inappropriate handling of this claim and reference to such statutes in the closing letter is misleading to the insured.

CONCERN: Status Letters are automatically generated, and the letter sent to the insured does not specifically describe the delay reason for the Company deciding to pay or not to pay. The letter lists eight possible delay reasons.

C. Automobile Comprehensive Claims

From the universe of 47,027 private passenger automobile comprehensive claims reported during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The 13 violations noted were based on 7 files, resulting in an error ratio of 7%.

The following findings were noted:

6 Violations 31 Pa. Code §62.3

An appraisal shall meet all applicable standards per statute.

The Company failed to provide an appraisal that meets all applicable standards for the six claim files noted.

6 Violations 63 P.S. §861(b)

The appraiser shall furnish a legible copy of the appraisal to the repair shop selected by the consumer to make the repairs and also furnish a copy to the owner of the vehicle. The appraisal shall contain the name of the insurance company ordering it, if any, the insurance file number, the number of the appraiser's license and the proper identification number of the vehicle being inspected. The appraisals were missing the appraiser's license number for the six claim files noted.

1 Violation 31 Pa. Code §146.6

Standards for prompt investigation of claims. Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless such investigation cannot reasonably be completed within such time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

The Company did not provide timely status letters for the claim file noted.

The following concern was noted:

CONCERN: In two of the files reviewed, the Company prepared original appraisals without including known damage at the time of the appraisal.

D. Automobile Total Loss Claims

From the universe of 32,069 private passenger automobile total loss claims reported during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The 17 violations noted were based on 12 files, resulting in an error ratio of 12%.

The following findings were made:

6 Violations 31 Pa. Code §62.3

An appraisal shall meet all applicable standards per statute. The Company failed to provide an appraisal that meets all applicable standards for the six claim files noted.

6 Violations 63 P.S. § 861(b)

Professions and Occupations. (b) The appraiser shall furnish a legible copy of his appraisal to the repair shop selected by the consumer to make the repairs and also furnish a copy to the owner of the vehicle. This appraisal shall contain the name of the insurance company ordering it, if any, the insurance file number, the number of the appraiser's license and the proper identification number of the vehicle being inspected. The Company failed to provide an appraisal that contained the appraiser's license number for the six claim files noted.

1 Violation 31 Pa. Code §62.3(e)(4)

Applicable standards for appraisal. (e) The appraised value of the loss shall be the replacement value of the motor vehicle if the cost of repairing a motor vehicle exceeds its appraised value less salvage

value, or the motor vehicle cannot be repaired to its predamaged condition. (4) Applicable sales tax on the replacement cost of a motor vehicle shall be included as part of the replacement value. The Company failed to apply proper sales tax on the total loss appraisal for the claim file noted.

1 Violation 31 Pa. Code §62.3(e)(7)

Applicable standards for appraisal. (e) The appraised value of the loss shall be the replacement value of the motor vehicle if the cost of repairing a motor vehicle exceeds its appraised value less salvage value, or the motor vehicle cannot be repaired to its predamaged condition. (7) The appraiser is responsible for ensuring that a copy of the total loss evaluation report be sent within 5 working days to the consumer by the appraiser after the appraisal is completed. If a settlement offer is extended before the consumer receives the total loss evaluation report, the consumer shall be advised of the total loss evaluation report's contents and of the consumer's right to be sent a copy within 5 days after its completion. The Company failed to send the evaluation to the insured within five working days for the claim file noted.

3 Violations 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the

three claim files noted.

The following concern was noted:

CONCERN: Status Letters are automatically generated and sent to the insured/claimant that do not specifically describe the delay reason. The letter lists eight possible delay reasons.

E. Automobile First Party Medical Claims

From the universe of 30,501 private passenger automobile first party medical claims reported during the experience period, 100 claim files were selected for review. All 100 files requested were received and reviewed. The twenty violations noted were based on twenty files, resulting in an error ratio of 20%.

The following findings were noted:

3 Violations 31 Pa. Code §69.52(b)

Peer review procedures. An insurer shall make a referral to a PRO within 90 days of the insurer's receipt of sufficient documentation supporting the bill. An insurer shall pay bills for care that are not referred to a PRO within 30 days after the insurer receives sufficient documentation supporting the bill. If an insurer makes its referral after the 30th day and on or before the 90th day, the provider's bill for care shall be paid. The Company failed to pay or deny medical bills within 30 days for the three claim files noted.

16 Violations 31 Pa. Code §146.5(d)

Requires an insurer, upon receiving notification of a claim,

shall provide within ten working days necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with policy conditions and reasonable requirements of the insurer. The Company did not provide the necessary claim forms to the claimant within ten working days for the sixteen claim files noted.

1 Violation 75 Pa. C.S. §1716

Payment of Benefits. Benefits are overdue if not paid within 30 days after the insurer receives reasonable proof of the amount of the benefits. If reasonable proof is not supplied as to all benefits, the portion supported by reasonable proof is overdue if not paid within 30 days after the proof is received by the insurer. Overdue benefits shall bear interest at the rate of 12% per annum from the date the benefits become due. In the event the insurer is found to have acted in an unreasonable manner in refusing to pay the benefits when due, the insurer shall pay, in addition to the benefits owed and the interest thereon, a reasonable attorney fee based upon actual time expended. The Company failed pay interest on first party medical bills, when the bills are not paid within 30 days. The Company shall provide the correct interest amounts for each medical bill. In addition, the Company shall provide the department with documentation of all interest payments for the claim file noted.

The following concern was noted:

CONCERN: Status Letters are automatically generated and sent to the insured/claimant that do not specifically describe the delay reason. The letter lists eight possible delay reasons.

F. Automobile First Party Medical Claims Referred to PRO

The universe of 11 automobile first party medical claims that were referred to a peer review organization by the Company was selected for review. All 11 files were received and reviewed. The Company was also asked to provide a copy of all peer review contracts in place during the experience period. The twenty violations noted were based on ten files, resulting in an error ratio of 91%.

The following findings were noted:

3 Violations 31 Pa. Code §69.52(a)

A provider's bill shall be referred to a PRO only when circumstances or conditions relating to medical and rehabilitative services provided cause a prudent person, familiar with PRO procedures, standards and practices, to believe it necessary that a PRO determine the reasonableness and necessity of care, the appropriateness of the setting where the care is rendered, and the appropriateness of the delivery of the care. An insurer shall notify a provider, in writing, when referring bills for PRO review at the time of the referral. The Company failed to provide a written notification to the provider when referring a bill for PRO review for the three claim files noted.

3 Violations 31 Pa. Code §69.52(b)

An insurer shall make a referral to a PRO within 90 days of the insurer's receipt of sufficient documentation supporting the bill. An insurer shall pay bills for care that are not referred to a PRO within 30 days after the insurer receives sufficient documentation supporting the bill. If an insurer makes its referral after the 30th day and on or before the 90th day, the provider's bill for care shall be

paid. The Company failed to pay or deny medical bills within 30 days for the three claim files noted.

10 Violations 31 Pa. Code §69.52(e)

Requires an insurer to pay bills that are not referred to a Peer Review Organization within 30 days after the insurer receives sufficient documentation supporting the bill. The Company failed to pay medical bills within 30 days for the claim noted. The Company failed to provide PRO report to provider and insured within 10 days of receipt for the ten claim files noted.

4 Violations 31 Pa. Code §146.7(a)(1)

Standards for prompt, fair and equitable settlements applicable to insurers. (a) Acceptance or denial of a claim shall comply with the following: (1) Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to send a denial letter to the insured for the four claim files noted.

The following concern was noted:

CONCERN: The Carrier issued a letter to the provider and insured regarding the Peer Review Report, and it had confusing language included. It stated that based on the PRO report and the Carrier’s review “payment will be forthcoming”; but

then it included a paragraph that said, “absent a change in condition, a decision of not medically necessary by the PRO is basis for an insurer to deny payment for similar services.” This contradictory language could confuse the insured and lead them to question if services are treated as medically necessary or not.

VII. CONSUMER COMPLAINTS

The Company was requested to identify all consumer complaints received during the experience period and provide copies of their consumer complaint logs for the preceding four years. The Company identified 1,590 consumer complaints received during the experience period and provided all consumer complaint logs requested. From the 1,590 complaint files, 75 were selected for review. All 75 complaint files were reviewed.

The purpose of the review was to determine compliance with the Unfair Insurance Practices Act, (40 P.S. §§1171.1 – 1171.5). Section 5(a)(11) of the Act (40 P.S. §1171.5(a)(11)), requires a company to maintain a complete record of all complaints received during the preceding four years. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. The individual complaint files were reviewed for the relevancy to applicable statutes and to verify compliance with 31 Pa. Code §146.5(b)(c).

The following findings were noted:

4 Violations 31 Pa. Code §146.5(b)

Every insurer, upon receipt of any inquiry from the Department respecting a claim shall, within 15 working days of receipt of such inquiry, furnish the Department with an adequate response to the inquiry. The Company failed to provide the Department with an adequate response to their inquiry within 15 working days for the four files noted.

The following synopsis reflects the nature of the 75 complaints that were received.

35	Cancellation/Nonrenewal	47%
17	Claims Related	23%
12	Premium/Setup/Bind	16%
6	Billing and Payment	8%
3	Customer Service	4%
2	Miscellaneous	2%
<hr/>		<hr/>
75		100%

VIII. UNDERWRITING PRACTICES AND PROCEDURES

As part of the examination, the Company was requested to supply manuals, underwriting guides, bulletins, directives, or other forms of underwriting procedure communications for each line of business being reviewed. Underwriting guides and supplements were furnished for Private Passenger Automobile. The purpose of this review was to identify any inconsistencies which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. No violations were noted.

IX. FORMS

Throughout the course of the examination, all underwriting files were reviewed to identify the policy forms used in order to verify compliance with the Insurance Company Law, Section 354 (40 P.S. §477b), Approval of Policies, Contracts, etc., Prohibiting the Use Thereof Unless Approved. During the experience period of the examination, Section 354 provided that it shall be unlawful for any insurance company to issue, sell, or dispose of any policy contract or certificate covering fire, marine, title and all forms of casualty insurance or use applications, riders, or endorsements in connection therewith, until the forms have been submitted to and formally approved by the Insurance Commissioner. All underwriting and claim files were also reviewed to verify compliance with 75 Pa. C.S. §1822, which requires all insurers to provide an insurance fraud notice on all applications for insurance, all claims forms and all renewals of coverage and 18 Pa. C.S. §4117(k)(1), which requires all insurers to provide an insurance fraud notice on all applications for insurance and all claim forms.

The following finding was noted:

1 Violation 75 Pa. C.S. §1799.3(f)

If requested by the applicant, an agent for an insurer shall submit an application for automobile insurance to the insurer or provide the applicant written notice of the reasons for refusal to write on a form supplied by the insurer and approved by the Commissioner. An applicant receiving a notice of reasons under this subsection may obtain review by the commissioner pursuant to the Automobile Insurance Policy Act. If either the applicant or insurer is aggrieved by the Commissioner's review, the commissioner may, in his discretion and for cause shown, hold a hearing pursuant to the

Automobile Insurance Policy Act. No insurer shall take any action, overt or otherwise, against any agent or broker for complying with this subsection. The Company failed to provide the right of review on the refusal to write letter.

X. DATA INTEGRITY

As part of the examination, the Company was sent a preliminary examination packet in accordance with NAIC uniformity standards and provided specific information relative to the exam. The purpose of the packet was to provide certain basic examination information, identify preliminary requirements and to provide specific requirements for requested data call information. Once the Company provided all requested information and data contained within the data call, the Department reviewed and validated the data to ensure its accuracy and completeness to determine compliance with Insurance Department Act of 1921, Section 904(b) (40 P.S. §323.3(a)). Several data integrity issues were found during the exam.

The data integrity issue of each area of review is identified below.

Collision Claims

Situation: As the examiners reviewed the Collision files of the Claims section of the exam, it was noted that not all the 100 files selected for review were Collision files.

Finding: Of the 100 Collision files reviewed, 2 files were identified as Total Loss Claims.

Auto Underwriting 60-Day Cancellations

Situation: As the examiners reviewed the 60-Day Cancellation files of the Auto Underwriting section of the exam, it was noted that not all the 100 files selected for review were 60-Day Cancellation files.

Finding: Of the 100 60-Day Cancellation files reviewed, 3 files were identified as Midterm Cancellations, and 3 files were identified as Nonrenewals.

The following finding was noted:

General Violation 40 P.S. §323.3(a)

Requires every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of that company or person and ascertain whether the company or person has complied with the laws of this Commonwealth. The violation was the result of a failure to exercise sufficient due diligence to ensure compliance with the Insurance Department Act of 1921.

XI. RECOMMENDATIONS

The recommendations made below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other statutory or regulatory violations, noted in the Report.

1. The Company must review 18 Pa. C.S.§4117(k)(1) to ensure that violations regarding the requirement of a fraud warning on all claim forms, as noted in the Report, do not occur in the future.

2. The Company must review 31 Pa. Code §62.3 with its claim staff to ensure appraisal requirements are met so violations, as noted in the Report, do not occur in the future.

3. The Company must review 31 Pa. Code §62.3(e)(4) with its claim staff to ensure a copy of the total loss evaluation is provided to the insured within 5 working days so the violation, as noted in the Report, does not occur in the future.

4. The Company must review 31 Pa. Code §62.3(e)(7) with its claim staff to ensure a copy of the total loss evaluation is provided to the insured within 5 working days so the violation, as noted in the Report, does not occur in the future.

5. The Company must review 31 Pa. Code §69.52(a) with its claim staff to ensure that a written notification is sent to the provider when referring a bill for PRO review.

6. The Company must review 31 Pa. Code §69.52(b) with its claim staff to ensure that first party medical bills are paid within 30 days.
7. The Company must review 31 Pa. Code §69.52(e) with its claim staff to ensure that the insured is provided a copy of a PRO evaluation in a timely manner.
8. The Company must review 31 Pa Code §146.3 with its claim staff to ensure the claims department maintains complete claim files.
9. The Company must review 31 Pa. Code §146.5(b) to ensure that all Department inquiries are responded to within 15 working days of receipt of such inquiry, so that the violations noted in the Report do not occur in the future.
10. The Company must review 31 Pa Code §146.5(d) with its claim staff to ensure that the claims department promptly provides the required claim forms for first party medical claims within 10 days of receiving the claim notification, so that violations noted in the Report do not occur in the future.
11. The Company must review 31 Pa Code §146.6 with its claim staff to ensure that the claims department promptly provides the required 30/45-day status letter to claimants, so that violations noted in the Report do not occur in the future.
12. The Company must review 31 Pa Code §146.7(a)(1) with its claim staff to ensure the claims department promptly sends denial letters to insureds within the required 15 working days of receiving proofs of loss.
13. The Company must reinforce its internal data controls to ensure that all records and documents are maintained in accordance with 40 P.S. §323.3(a), so that violations noted in the Report do not occur in the future.

14. The Company must review and revise internal control procedures to ensure compliance with nonrenewal and cancellation notice requirements of 40 P.S. §991.2006 and §991.2008(b), so that the violations noted in the Report do not occur in the future.
15. The Company must review 40 P.S. §1184(a)&(h) and take appropriate measures to ensure the correct territory code is utilized to avoid an incorrect rate from being charged in the future.
16. The Company must review 63 P.S. §861(b) with its claim staff to ensure violations for missing appraiser name and appraiser license information on auto appraisal copies as noted in the Report, do not occur in the future.
17. The Company must revise its underwriting procedures to ensure that each applicant for private passenger automobile liability insurance is provided an opportunity to elect a tort option and that signed tort option selection forms are obtained and retained with the underwriting file. This is to ensure that violations noted under 75 Pa. C.S. §1705(a)(4) do not occur in the future.
18. The Company must review 75 Pa. C.S. §1716 with its claim staff to ensure insureds are paid interest on first party medical bills, when the bills are not paid within 30 days to ensure the violation as noted in the Report, does not occur in the future.
19. The Company must review 75 Pa. C.S. §1734 with its underwriting staff to ensure insureds are provided written requests for lower UM/UIM limits.
20. The Company must revise underwriting procedures to ensure that the insured is aware that he may exercise the waiver of stacked limits for uninsured and

underinsured motorist coverage by signing written rejection forms. This is to ensure that violations, as noted in the Report under 75 Pa. C.S. §1738(d)(1) and (2)(e) do not occur in the future.

21. The Company must review 75 Pa. C.S. 1799.3(a) to ensure that insureds accidents meet the surcharge threshold requirements as noted in the Report, to avoid the incorrect rates from being charged in the future.

22. The Company must review 75 Pa. C.S. 1799.3(f) to ensure that refusal to write letters include the required right of review on all refusal to write letters issued to Pennsylvania insureds, so that violation as noted in the Report, does not occur in the future.

XII. COMPANY RESPONSE



PENNSYLVANIA INSURANCE DEPARTMENT
EXAMINATION VERIFICATION

I, Richard J. Barr, Market Conduct Examiner from
(Name of Examiner) (Title of Examiner)

the Pennsylvania Insurance Department certify that I was the Examiner-In-Charge of the Report of
(Name of Vendor/Department)

Examination of State Farm Mutual Automobile Insurance Co made as of 11/18/2024.
(Name of Examined Company) (Date)

The last date of examination file review was 06/27/2024 and the written Report
(Date)

of Examination was reviewed and accepted by the Paul Townsen
(Chief of Market Conduct Examiner)

On 11/19/24.
(Date)

I have reviewed the completed written Report of Examination and certify that the facts and figures recited therein are true and accurate, according to the records, documents and other evidence obtained during the course of the examination.

Richard J. Barr
(Examiner-in Charge)

Pennsylvania Insurance Department
(Name of Vendor/Department)

1321 Strawberry Square, Harrisburg, PA 17120
(Address of Vendor/Department)

Richard J. Barr Digitally signed by Richard J. Barr
Date: 2024.11.18 14:00:42 -05'00'
(Examiner in Charge Signature)

11/18/2024
(Date)

IN ORDER TO SATISFY SECTION 40 P.S. § 323.5(b), THAT PROVIDES FOR NO LONGER THAN SIXTY (60) DAYS FROM THE COMPLETION OF THE EXAMINATION, THE EXAMINER IN CHARGE SHALL FILE WITH THE DEPARTMENT A VERIFIED WRITTEN REPORT OF EXAMINATION UNDER OATH.

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY
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I. INTRODUCTION

The Market Conduct Examination of State Farm Mutual Automobile Insurance Company, hereinafter referred to as “Company”, was conducted at the Pennsylvania Insurance Department beginning August 15, 2023. There was no onsite portion of the exam.

Pennsylvania Market Conduct Examination Reports generally note only those items to which the Department, after review, takes exception. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review those areas of concern in order to determine the potential impact upon Company operations or future compliance. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Report may result in imposition of penalties.

In certain areas of review listed in this Report, the examiners will refer to “error ratio.” This error ratio is calculated by dividing the number of policies with violations by the total number of policies reviewed. For example, if 100 policies are reviewed and it is determined that there are 20 violations on 10 policies, the error ratio would be 10%.

Throughout the course of the examination, Company officials were provided with status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company personnel to discuss the various types of violations identified during the examination and review written summaries provided on the violations found.

The courtesy and cooperation extended by the officers and employees of the Company during the course of the examination is hereby acknowledged.

The following examiners participated in this examination and in preparation of this Report.

Paul Towsen, MCM
Market Conduct Division Chief
Pennsylvania Insurance Department

Richard Barr, MCM
Market Conduct Examiner II, EIC
Pennsylvania Insurance Department

Vern Schmidt, MCM
Market Conduct Examiner II, EIC
Pennsylvania Insurance Department

Ellis Savage, MCM
Market Conduct Examiner I
Pennsylvania Insurance Department

Joe Bieniek, AIE, AMCM, CPCU, CRM
Market Conduct Examiner
INS Regulatory Insurance Services, Inc.

Trisha Crissman, MCM
Market Conduct Examiner
INS Regulatory Insurance Services, Inc.

JoAnn Baldo, CIE, MCM, CPA, HCP
Market Conduct Examiner
INS Regulatory Insurance Services, Inc.

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted on State Farm Mutual Automobile Insurance Company, at the Pennsylvania Insurance Department, located in Harrisburg, Pennsylvania.

The examination was conducted pursuant to Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act of 1921 and covered the experience period of July 1, 2022, through June 30, 2023, unless otherwise noted. The purpose of the examination was to determine the Company's compliance with Pennsylvania insurance laws and regulations.

The examination focused on Company operations in the following areas:

1. Private Passenger Automobile
 - Underwriting – Appropriate and timely notices of nonrenewal, midterm cancellations, 60-day cancellations, declinations, and rescissions.
 - Rating – Proper use of all classification and rating plans and procedures.
2. Claims
3. Complaints
4. Underwriting Practices & Procedures
5. Forms
6. Data Integrity

III. COMPANY HISTORY

State Farm Mutual Automobile Insurance Company (hereinafter referred to as "SFMAIC") was incorporated on March 29, 1922, under the Uniform Mutual Law of Illinois. The Company commenced business on June 7, 1922. SFMAIC, the lead company in the State Farm Group ("The Group"), is the nation's largest automobile insurer. The Group offers multiple lines of property, casualty and life and health insurance throughout the United States through an exclusive agency force. The affiliated entities are listed on Schedule Y from the Annual Statement. Corporate offices are located in Bloomington, Illinois. SFMAIC is licensed in all 50 states and the District of Columbia.

LICENSING

State Farm Mutual Automobile Insurance Company's last Certificate of Authority to write business in the Commonwealth was last issued on April 1, 2024. The Company is licensed in all 50 states and the District of Columbia. The Company's 2022 annual statement reflects Direct Written Premium for all lines of business in the Commonwealth of Pennsylvania as \$1,776,761,100. Premium volume related to the areas of this review were: Private Passenger Automobile Direct Written Premium was reported as Private Passenger Auto No-Fault (Personal Injury Protection) \$0; Other Private Passenger Auto Liability \$830,380,863; and Private Passenger Auto Physical Damage \$888,252,532.

IV. UNDERWRITING

A. Private Passenger Automobile

1. Nonrenewals

A nonrenewal is considered to be any policy that was not renewed, for a specific reason, at the normal twelve-month policy anniversary date.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited, and Section 2006 (40 P.S. §991.2006), which establishes the requirements which must be met regarding the form and conditions of the cancellation notice.

From the universe of 5,244 private passenger automobile policies which were nonrenewed during the experience period, 100 files were selected for review. All 100 files requested were received and reviewed. The one violation noted was based on one file, resulting in an error ratio of 1%.

The following finding and concern were noted.

1 Violation 40 P.S. §991.2006

A cancellation or refusal to renew by an insurer of a policy of automobile insurance shall not be effective unless the insurer delivers or mails to the insured at the address shown in the policy a written notice of the cancellation or refusal to review. The Company failed to have proof in the file to indicate the insured requested cancellation for the file noted.

COMPANY RESPONSE:

AGREE. This was an individual underwriter mistake. The

Emergency Roadside Assistance coverage was to be cancelled; however, the policy was cancelled. State Farm has followed up with the insured and he already has coverage with another carrier and did not want to return as a State Farm customer.

2. Midterm Cancellations

A midterm cancellation is any policy that terminates at any time other than the normal twelve-month policy anniversary date.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited, and Section 2006 (40 P.S. §991.2006), which establishes the requirements which must be met regarding the form and conditions of the cancellation notice.

From the universe of 104,210 private passenger automobile policies which were cancelled during the experience period, 99 files were selected for review. All 99 files requested were received and reviewed. There were no violations noted.

3. 60-Day Cancellations

A 60-day cancellation is considered to be any policy, which was cancelled within the first 60 days of the inception date of the policy.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited. These files were also reviewed for compliance with Act 68, Section 2002(b)(3) (40 P.S. §991.2002(b)(3)), which requires an insurer who cancels a policy of automobile insurance in the first 60 days, to supply the insured with a written statement of the reason for cancellation.

From the universe of 9,457 automobile policies that were cancelled within the first 60 days of new business, 100 files were selected for review. All 100 files requested were received and reviewed. There were no violations noted.

4. Declinations

A declination is any application that is received by the Company and was declined to be written.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited.

From the universe of 6,112 declinations for private passenger automobile insurance, 144 files were selected for review. All 144 files requested were received and reviewed. The 16 violations noted was based on 16 files, resulting in an error ratio of 11%.

The following finding was noted.

16 Violations 40 P.S. §991.2008(b)

Any applicant for a policy who is refused such policy by an insurer shall be given a written notice of refusal to write by the insurer. Such notice shall state the specific reason or reasons of the insurer for refusal to write a policy for the applicant. Within 30 days of the receipt of such reasons, the applicant may request in writing to the Insurance Commissioner that he review the action of the insurer in refusing to write a policy for the applicant. The Company failed to provide a written notice of refusal to write for the file noted. The Company failed to

provide a specific reason for the declination on 14 of the files noted and sent a notice of cancellation which did not advise the insureds of their right to request in writing a review by the Commissioner on 2 of the files noted.

COMPANY RESPONSE:

AGREE: Our standard business practice is to include information regarding the customer's right to request the Pennsylvania Insurance Commissioner to review the action and retain it with the Notice of Refusal to Write. This practice is demonstrated by the other 142 documents in this production set. However, some of the files reviewed contained instances of individual file mistakes and do not represent a systemic issue.

CONCERN: Declination letters sent to the applicants are not accurately reflecting the reasons for declinations. The Company should require that letters provided to the applicants are clear as to the reason(s) why they are being declined. The Company is responsible for the agents' actions when declining an applicant.

COMPANY RESPONSE:

AGREE: Our standard business practice is to include information regarding the customer's right to request the Pennsylvania Insurance Commissioner to review the action and retain it with the Notice of Refusal to Write. This practice is demonstrated by the other 142 documents in this production set. However, some of the files reviewed contained instances of individual file mistakes and do not represent a systemic issue.

5. Rescissions

A rescission is any policy which was void ab initio by the Company.

The primary purpose of the review was to determine compliance with Act 68, Section 2003 (40 P.S. §991.2003), which establishes conditions under which action by the insurer is prohibited. The review also determines

compliance with the rescission requirements established by the Supreme Court of Pennsylvania in *Erie Insurance Exchange v. Lake*.

The universe of 13 private passenger automobile policies that were identified by the Company as rescissions during the experience period was selected for review. All 13 files requested were received and reviewed. There were no violations noted.

V. RATING

A. Private Passenger Automobile

1. New Business

New business, for the purpose of this examination, is defined as policies written for the first time by the Company during the experience period.

The primary purpose of the review was to measure compliance with The Casualty and Surety Rate Regulatory Act, Section 4(a) and (h) (40 P.S. §1184(a), (h)), which requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time. Files were also reviewed to determine compliance with all provisions of the Motor Vehicle Financial Responsibility Law (75 Pa. C.S. §§1701 – 1799.7) and Act 68, Section 2005(c) (40 P.S. §991.2005(c)), which requires insurers to provide to insureds a detailed statement of the components of a premium and shall specifically show the amount of surcharge or other additional amount that is charged as result of a claim having been made under a policy of insurance, or as a result of any other factors.

The Company uses an automated system to process and issue personal automobile policies. By reviewing base premiums, territory assignments, rating symbols, classifications and surcharge disclosures, the examiners were able to determine compliance with the Company's filed and approved rating plans.

Private Passenger Automobile Rating – New Business without Surcharges

From the universe of 138,737 private passenger automobile policies identified as new business without surcharges by the Company, 100 files were selected for review. All 100 files requested were received and reviewed. The 14 violations noted were based on 10 files, resulting in an error ratio of 10%.

The following findings were noted:

10 Violations 75 Pa. C.S. §1705(a)(4)

Requires every insurer, prior to the issuance of a private passenger motor vehicle liability insurance policy to provide each applicant an opportunity to elect a tort option. A policy may not be issued unless the applicant has been provided an opportunity to elect a tort option. The Company failed to provide a signed and dated limited tort option selection form for the ten files noted.

COMPANY RESPONSE:

AGREE: However, there is no violation of the law in any of these files. In the event of a covered loss, State Farm would treat the customer as if full tort had been selected. It's important to note that the customer had the opportunity to make a tort election and did not do so.

2 Violations 75 Pa. C.S. §1734

Request for lower (or higher) limits of coverage. A named insured may request in writing the issuance of coverages under section 1731

(relating to availability, scope and amount of coverage) in amounts equal to or less than the limits of liability for bodily injury. The Company failed to provide written request for UM/UIM limits not equal to BI Liability coverage for the two files noted.

COMPANY RESPONSE:

AGREE: It's important to note that named insureds in both files were offered the opportunity to purchase or reject UM/UIM coverage as required in the statute. Because the customers did not return the signed forms, in the event of a covered loss, State Farm would treat the customer as if UM/UIM limits equal to BI limits has been selected. Therefore, we do not believe there is a violation of the law. State Farm has instructed the agent to reach out and confirm the customer's selection and obtain any corresponding forms.

2 Violations 75 Pa. C.S. §1738(d)(1) &(2)(e)

Stacking of uninsured and underinsured benefits and option to waive. (d) Forms- (1) The named insured shall be informed that he may exercise the waiver of the stacked limits of uninsured motorist coverage by signing the written rejection form. (2) The named insured shall be informed that he may exercise the waiver of the stacked limits of underinsured motorist coverage by signing the written rejection form. (e) Signature and date. – The forms described in subsection (d) must be signed by the first named insured and dated to be valid. Any rejection form that does not comply with this section is void. The Company failed to provide the signed rejection form of stacked limits for uninsured and underinsured motorists coverage for the two files noted.

COMPANY RESPONSE:

AGREE: It's important to note that named insureds in both files were offered the opportunity to purchase or reject UM/UIM coverage as required in the statute. Because the customers did not return the signed forms, in the event of a covered loss, State Farm

would treat the customer as if UM/UIM limits equal to BI limits has been selected. Therefore, we do not believe there is a violation of the law. State Farm has instructed the agent to reach out and confirm the customer's selection and obtain any corresponding forms.

Private Passenger Automobile Rating – New Business with Surcharges

From the universe of 8,340 private passenger automobile policies identified as new business with surcharges by the Company, 100 files were selected for review. All 100 files requested were received and reviewed. The 14 violations noted was based on 8 files, resulting in an error ratio of 8%.

The following finding was noted:

1 Violation 40 P.S. §323.3(a)

Requires every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person has complied with the laws of the Commonwealth. The Company failed to maintain a complete underwriting file for the violation noted.

COMPANY RESPONSE:

DISAGREE: The insured moved to Louisiana, applied for insurance in Louisiana, and subsequently cancelled their Pennsylvania policy. The customer's application in Louisiana and the Policy Master Record are the documentation of the request to cancel and have been added to the policy file.

7 Violations 75 Pa. C.S. §1705(a)(4)

Requires every insurer, prior to the issuance of a private passenger motor vehicle liability insurance policy to provide each applicant an opportunity to elect a tort option. A policy may not be issued unless the applicant has been provided an opportunity to elect a tort option. The Company failed to provide a signed and dated limited tort option selection form for the seven files noted.

COMPANY RESPONSE:

AGREE: It's important to note that named insureds in all files were offered the opportunity to purchase or reject UM/UIM coverage as required in the statute. Because the customers did not return the signed forms, in the event of a covered loss, State Farm would treat the customer as if UM/UIM limits equal to BI limits has been selected. Therefore, we do not believe there is a violation of the law. State Farm has instructed the agents to reach out and confirm the customer's selection and obtain any corresponding forms.

1 Violations 75 Pa. C.S. §1734

Request for lower (or higher) limits of coverage. A named insured may request in writing the issuance of coverages under section 1731 (relating to availability, scope and amount of coverage) in amounts equal to or less than the limits of liability for bodily injury. The Company failed to provide written request for UM/UIM limits not equal to BI Liability coverage for the file noted.

COMPANY RESPONSE:

AGREE: It's important to note the named insured was offered the opportunity to purchase or reject UM/UIM coverage as required in the statute. Because the customer did not return the signed forms, in the event of a covered loss, State Farm would treat the customer as if UM/UIM limits were equal to BI limits. State Farm instructed the agent to reach out and confirm the customer's selection and obtain any corresponding forms. The

customer has since signed the forms as of 2/22/24.

5 Violations 75 Pa. C.S. §1738(d)(1) & (2) & (e)

Stacking of uninsured and underinsured benefits and option to waive.

(d) Forms – (1) The named insured shall be informed that he may exercise the waiver of the stacked limits of uninsured motorist coverage by signing the written rejection form. (2) The named insured shall be informed that he may exercise the waiver of the stacked limits of underinsured motorist coverage by signing the written rejection form. (e) Signature and date. – The forms described in subsection (d) must be signed by the first named insured and dated to be valid. Any rejection form that does not comply with this section is void. The Company failed to provide the signed rejection form of stacked limits for uninsured and underinsured motorists coverage for the five files noted.

COMPANY RESPONSE:

AGREE: It's important to note the named insureds were informed that they may exercise the waiver of the stacked limits of uninsured motorist coverage by signing the written rejection form. The named insureds were informed that they may exercise the waiver of the stacked limits of underinsured motorist coverage by signing the written rejection form. The forms were not necessary in these files for various reasons:

- **Two policies were cancelled due to nonpayment of premium during the underwriting review period, before the customers returned the signed forms. Because the policy was no longer in force, it was not necessary to follow up to obtain forms from the customer.**
- **One policy for a vehicle was combined with an existing policy at the request of the customer during the underwriting review period. Because the original policy was no longer in force, it was not necessary to follow up to obtain forms from the customer for the terminated policy.**
- **The policy was initially cancelled during the underwriting**

review period and forms were no longer necessary to obtain.

- **The customer did not return the signed forms.**

Since forms were no longer required, a violation of the law would not occur. In the event of a covered loss, State Farm would treat the customer as if stacked limits had been selected.

CONCERN: The tort form was signed and dated for full tort, but policy was issued with limited tort.

COMPANY RESPONSE:

AGREE: Please see above. Since forms were no longer required, we do not believe a violation of the law occurred. In the event of a covered loss, State Farm would treat the customer as if stacked limits had been selected.

2. Renewals

A renewal is considered to be any policy, which was previously written by the Company and renewed on the normal twelve-month anniversary date.

The purpose of the review was to measure compliance with The Casualty and Surety Rate Regulatory Act, Section 4(a) and (h) (40 P.S. §1184(a), (h)), which requires every insurer to file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan and every modification of any rating plan, which it proposes to use in the Commonwealth. Also, no insurer shall make or issue a contract or policy except in accordance with filings or rates, which are in effect at the time. Files were also reviewed to determine compliance with Act 68 of 1998, Section 2005(c) (40 P.S. §991.2005(c)), which requires insurers to provide to insureds a detailed statement of the components of a premium and shall specifically show the amount of surcharge or other additional amount that is charged as a result of a claim having been made under a policy of insurance, or as a result of any other factors.

The Company processes and issues personal automobile policies using an automated system. By reviewing base premiums, territory assignments, rating symbols, classifications and surcharge disclosures, the examiners were able to determine compliance with the Company's filed and approved rating plans.

Private Passenger Automobile – Renewals without Surcharges

From the universe of 504,848 private passenger automobile policies identified as renewals without surcharges, 100 files were selected for review. All 100 files requested were received and reviewed. There were no violations noted.

Private Passenger Automobile – Renewals with Surcharges

From the universe of 14,409 private passenger automobile policies identified as renewals with surcharges, 100 files were selected for review. All 100 files requested were received and reviewed. The 3 violations noted were based on 3 files, resulting in an error ratio of 3%.

The following findings were noted:

1 Violation 40 P.S. §323.3 (a)) State Farm believes this citation is incorrect and should be replaced with 40 P.S. §323.4 (b)

Requires every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such a manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of the company or person and ascertain whether the company or person has complied with the laws of this Commonwealth. The Company failed to maintain a complete underwriting file for the file noted.

COMPANY RESPONSE:

AGREE: This was an individual underwriting mistake.

1 Violation 40 P.S. §1184(a)&(h)

Rate filings. (a) Every insurer shall file with the commissioner every manual of classifications, rules and rates, every rating plan and every modification of any of the foregoing which it proposes to use in this Commonwealth. The filing of the aforementioned shall be made whether or not the coverage is provided on an individual or group basis and whether or not the group policy is issued in this Commonwealth or another state. Every such filing shall state the proposed effective date thereof and shall indicate the character and extent of the coverage contemplated. When a filing is not accompanied by the information upon which the insurer supports such filing, and the commissioner does not have sufficient information to determine whether such filing meets the requirements of the act, he may require such insurer to furnish the information upon which it supports such filing. Any filing may be supported by (1) the experience or judgment of the insurer or rating organization making the filing, (2) the experience of other insurers or rating organizations, or (3) any other factors which the insurer or rating organization deems relevant. A filing and any supporting information shall be open to public inspection after the filing becomes effective. (h) Beginning ninety (90) days after the effective date of this Act, no insurer shall make or issue a contract or policy except in accordance with filings or rates which are in effect for said insurer as provided in this Act or in accordance with subsections (f) or (g) of this section. The Company failed to assign the correct territory code for the file noted.

COMPANY RESPONSE:

AGREE: This file was rated incorrectly based on the rate manual. This was an individual underwriter mistake. The policy has been corrected.

1 Violation 75 Pa. C.S. §1799.3(a)

No insurer shall cancel or refuse to renew a policy or apply any surcharge, rate penalty or driver record point assignment where, during the preceding three-year period, the aggregate cost to be less than \$1,700 (effective 7/1/17) in excess of any self-insured retention or deductible applicable to the named insured. The Company failed to address that the accident did not meet the surcharge threshold requirement for the file noted.

COMPANY RESPONSE:

AGREE: The loss was surcharged under the insured's prior Virginia policy. The surcharge should have been removed in Pennsylvania. This policy has been reviewed and a refund is in the process of being provided.

VI. CLAIMS

The Company was requested to provide copies of all established written claim handling procedures utilized during the experience period. Written claim handling procedures were received and reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature.

The Claims review consisted of the following areas of review:

- A. Automobile Property Damage Claims
- B. Automobile Comprehensive Claims
- C. Automobile Collision Claims

D. Automobile Total Loss Claims

E. Automobile First Party Medical Claims

F. Automobile First Party Medical Claims Referred to a PRO

The primary purpose of the review was to determine compliance with 31 Pa. Code, Chapter 146, Unfair Claims Settlement Practices. The files were also reviewed to determine compliance with Act 205, Section 4 (40 P.S. §1171.4) and Section 5(a)(10)(vi) of the Unfair Insurance Practices Act (40 P.S. §1171.5(a)(10)(vi)).

A. Automobile Property Damage Claims

From the universe of 76,802 private passenger automobile property damage claims reported during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The 12 violations noted were based on 8 files, resulting in an error ratio of 8%.

The following findings were made:

4 Violations 31 Pa. Code §62.3

An appraisal shall meet all applicable standards per statute.

The Company failed to provide an appraisal that meets all applicable standards per statute for the four claim files noted.

COMPANY RESPONSE:

AGREE: Upon looking into these violations, State Farm discovered that our Select Service repair facilities were not correctly utilizing the profile built for them that requires the appraiser license number be included on the estimate. The Company practice is to comply with all statutory requirements; accordingly, State Farm will communicate with all repairers participating in the Select Service program to follow the requirements of the Pennsylvania Insurance Code [31 Pa. Code §62.3 and 63 P.S. § 861(b)] and address the issues identified in the examiners findings.

5 Violations 63 P.S. § 861(b)

The appraiser shall furnish a legible copy of the appraisal to the repair shop selected by the consumer to make the repairs and also furnish a copy to the owner of the vehicle. The appraisal shall contain the name of the insurance company ordering it, if any, the insurance file number, the number of the appraiser's license and the proper identification number of the vehicle being inspected. The appraisals were missing the appraiser's license number for the five claim files noted.

COMPANY RESPONSE:

AGREE: Upon looking into these violations, State Farm discovered that our Select Service repair facilities were not correctly utilizing the profile built for them that requires the appraiser license number be included on the estimate. The Company practice is to comply with all statutory requirements; accordingly, State Farm will communicate with all repairers participating in the Select Service

program to follow the requirements of the Pennsylvania Insurance Code [31 Pa. Code §62.3 and 63 P.S. § 861(b)] and address the issues identified in the examiners findings.

3 Violations 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide timely status letters for the three claim files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will work to improve and/or implement where necessary an automated solution to comply with 31 PA Code §146.6.

CONCERN: The Company closes the claim without support and or justification of why the claim is being closed without payment.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will work to improve and/or implement where necessary an automated solution to comply with 31 PA Code §146.6.

CONCERN: Status Letters are automatically generated and sent to the insured/claimant that do not specifically describe the delay reason. The letter lists eight possible delay reasons.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will work to improve and/or implement where necessary an automated solution to comply with 31 PA Code §146.6.

B. Automobile Collision Claims

From the universe of 101,475 private passenger automobile collision claims reported during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The 16 violations noted were based on 10 files, resulting in an error ratio of 10%.

The following findings were noted:

1 Violations 18 Pa. C.S. §4117(k)(1)

Insurance Fraud. (k) Insurance forms and verification of services. (1) All applications for insurance and all claim forms shall contain or have attached thereto the following notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. The Company failed to provide an appraisal with the required fraud statement for claim file noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will communicate with all claim handlers with Pennsylvania responsibilities the requirements of Pennsylvania Insurance Code [18 Pa. C.S. 4117(k)] to address the issues identified in the examiners findings.

5 Violations 31 Pa. Code §62.3

An appraisal shall meet all applicable standards per statute. The Company failed to provide an appraisal that meets all applicable standards per statute for the five claim files noted.

COMPANY RESPONSE:

AGREE: Upon looking into these violations, State Farm discovered that our Select Service repair facilities were not correctly utilizing the profile built for them that requires the appraiser license number be included on the estimate. The Company practice is to comply with all statutory requirements; accordingly, State Farm will communicate with all repairers participating in the Select Service program to follow the requirements of the Pennsylvania Insurance Code [31 Pa. Code §62.3 and 63 P.S. § 861(b)] and address the issues identified in the examiners findings.

5 Violations 63 P.S. §861(b)

The appraiser shall furnish a legible copy of the appraisal to the repair shop selected by the consumer to make the repairs and also furnish a copy to the owner of the vehicle. The appraisal shall contain the name of the insurance company ordering it, if any, the insurance file number, the number of the appraiser's license and the proper identification number of the vehicle being inspected. The appraisals were missing the appraiser's license number for the five claim files noted.

COMPANY RESPONSE:

AGREE: Upon looking into these violations, State Farm discovered that our Select Service repair facilities were not correctly utilizing the profile built for them that requires the appraiser license number be included on the estimate. The Company practice is to comply with all statutory requirements; accordingly, State Farm will communicate with all repairers participating in the Select Service program to follow the requirements of the Pennsylvania Insurance Code [31 Pa. Code §62.3 and 63 P.S. § 861(b)] and address the issues identified in the examiners findings.

1 Violations 31 Pa. Code §146.3

File and record documentation. The claim files of the insurer shall be subject to examination by the Commissioner or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed. The Company failed to maintain a complete claim file for claim file noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will review 31 Pa Code §146.3 with its claim staff to ensure all documentation is properly contained within the claim file.

4 Violations 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide timely status letters for the four claim files noted.

COMPANY RESPONSE:

AGREE. The Company practice is to comply with all statutory requirements; accordingly, State Farm will move to improve and/or implement where necessary an automated solution to comply with 31 PA Code §146.6.

The following concerns were noted:

CONCERN: The Carrier issues automatic closing letters when claims are still open causing confusion to the insureds.

COMPANY RESPONSE:

AGREE. The Company practice is to comply with all statutory requirements; accordingly, State Farm will move to improve and/or implement where necessary an automated solution to comply with 31 PA Code §146.6.

CONCERN: The Carrier included Ohio statutes in the closing letter for a claim, which was for a collision that occurred in Pennsylvania. Applying Ohio statutes is inappropriate handling of this claim and reference to such statutes in the closing letter is misleading to the insured.

COMPANY RESPONSE:

AGREE. The Company practice is to comply with all statutory requirements; accordingly, State Farm will move to improve and/or implement where necessary an automated solution to comply with 31 PA Code §146.6.

CONCERN: Status Letters are automatically generated, and the letter sent to the insured does not specifically describe the delay reason for the Company deciding to pay or not to pay. The letter lists eight possible delay reasons.

COMPANY RESPONSE:

AGREE. The Company practice is to comply with all statutory requirements; accordingly, State Farm will move to improve and/or implement where necessary an automated solution to comply with 31 PA Code §146.6.

C. Automobile Comprehensive Claims

From the universe of 47,027 private passenger automobile comprehensive claims reported during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The 13 violations noted were based on 7 files, resulting in an error ratio of 7%.

The following findings were noted:

6 Violations 31 Pa. Code §62.3

An appraisal shall meet all applicable standards per statute.

The Company failed to provide an appraisal that meets all applicable standards for the six claim files noted.

COMPANY RESPONSE:

AGREE: Upon looking into these violations, State Farm discovered that our Select Service repair facilities were not correctly utilizing the profile built for them that requires the appraiser license number be included on the estimate. The Company practice is to comply with all statutory requirements; accordingly, State Farm will communicate with all repairers participating in the Select Service program to follow the requirements of the Pennsylvania Insurance Code [31 Pa. Code §62.3 and 63 P.S. § 861(b)] and address the issues identified in the examiners findings.

6 Violations 63 P.S. §861(b)

The appraiser shall furnish a legible copy of the appraisal to the repair shop selected by the consumer to make the repairs

and also furnish a copy to the owner of the vehicle. The appraisal shall contain the name of the insurance company ordering it, if any, the insurance file number, the number of the appraiser's license and the proper identification number of the vehicle being inspected. The appraisals were missing the appraiser's license number for the six claim files noted.

COMPANY RESPONSE:

AGREE: Upon looking into these violations, State Farm discovered that our Select Service repair facilities were not correctly utilizing the profile built for them that requires the appraiser license number be included on the estimate. The Company practice is to comply with all statutory requirements; accordingly, State Farm will communicate with all repairers participating in the Select Service program to follow the requirements of the Pennsylvania Insurance Code [31 Pa. Code §62.3 and 63 P.S. § 861(b)] and address the issues identified in the examiners findings.

1 Violation 31 Pa. Code §146.6

Standards for prompt investigation of claims. Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless such investigation cannot reasonably be completed within such time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

The Company did not provide timely status letters for the claim file noted.

COMPANY RESPONSE:

AGREE. The Company practice is to comply with all statutory requirements; accordingly, State Farm will move to implement an automated solution to comply with 31 PA Code §146.6.

The following concern was noted:

CONCERN: In two of the files reviewed, the Company prepared original appraisals without including known damage at the time of the appraisal.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will move to implement an automated solution to comply with 31 PA Code §146.6.

D. Automobile Total Loss Claims

From the universe of 32,069 private passenger automobile total loss claims reported during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The 17 violations noted were based on 12 files, resulting in an error ratio of 12%.

The following findings were made:

6 Violations 31 Pa. Code §62.3

An appraisal shall meet all applicable standards per statute.

The Company failed to provide an appraisal that meets all applicable standards for the six claim files noted.

COMPANY RESPONSE:

AGREE: Upon looking into these violations, State Farm discovered that our Select Service repair facilities were not correctly utilizing the profile built for them that requires the appraiser license number be included on the estimate. The Company practice is to comply with all statutory requirements; accordingly, State Farm will communicate with all repairers participating in the Select Service program to follow the requirements of the Pennsylvania

**Insurance Code [31 Pa. Code §62.3 and 63 P.S. § 861(b)]
and address the issues identified in the examiners findings.**

6 Violations 63 P.S. § 861(b)

Professions and Occupations. (b) The appraiser shall furnish a legible copy of his appraisal to the repair shop selected by the consumer to make the repairs and also furnish a copy to the owner of the vehicle. This appraisal shall contain the name of the insurance company ordering it, if any, the insurance file number, the number of the appraiser's license and the proper identification number of the vehicle being inspected. The Company failed to provide an appraisal that contained the appraiser's license number for the six claim files noted.

COMPANY RESPONSE:

AGREE: Upon looking into these violations, State Farm discovered that our Select Service repair facilities were not correctly utilizing the profile built for them that requires the appraiser license number be included on the estimate. The Company practice is to comply with all statutory requirements; accordingly, State Farm will communicate with all repairers participating in the Select Service program to follow the requirements of the Pennsylvania Insurance Code [31 Pa. Code §62.3 and 63 P.S. § 861(b)] and address the issues identified in the examiners findings.

1 Violation 31 Pa. Code §62.3(e)(4)

Applicable standards for appraisal. (e) The appraised value of the loss shall be the replacement value of the motor vehicle if the cost of repairing a motor vehicle exceeds its appraised value less salvage value, or the motor vehicle cannot be repaired to its predamaged condition. (4) Applicable sales tax on the replacement cost of a motor vehicle shall be included as part of the replacement value. The Company failed to apply proper sales tax on the total loss appraisal

for the claim file noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, the Company will review 31 Pa. Code §62.3(e)(4) with its claim staff and monitor timeliness of work product.

1 Violation 31 Pa. Code §62.3(e)(7)

Applicable standards for appraisal. (e) The appraised value of the loss shall be the replacement value of the motor vehicle if the cost of repairing a motor vehicle exceeds its appraised value less salvage value, or the motor vehicle cannot be repaired to its predamaged condition. (7) The appraiser is responsible for ensuring that a copy of the total loss evaluation report be sent within 5 working days to the consumer by the appraiser after the appraisal is completed. If a settlement offer is extended before the consumer receives the total loss evaluation report, the consumer shall be advised of the total loss evaluation report's contents and of the consumer's right to be sent a copy within 5 days after its completion. The Company failed to send the evaluation to the insured within five working days for the claim file noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, the Company will review 31 Pa. Code §62.3(e)(7) with its claim staff and monitor timeliness of work product.

3 Violations 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide

the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the three claim files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will move to improve and/or implement where necessary an automated solution to comply with 31 PA Code §146.6.

The following concern was noted:

CONCERN: Status Letters are automatically generated and sent to the insured/claimant that do not specifically describe the delay reason. The letter lists eight possible delay reasons.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, State Farm will move to improve and/or implement where necessary an automated solution to comply with 31 PA Code §146.6.

E. Automobile First Party Medical Claims

From the universe of 30,501 private passenger automobile first party medical claims reported during the experience period, 100 claim files were selected for review. All 100 files requested were received and reviewed. The twenty violations noted were based on twenty files, resulting in an error ratio of 20%.

The following findings were noted:

3 Violations 31 Pa. Code §69.52(b)

Peer review procedures. An insurer shall make a referral to a PRO

within 90 days of the insurer's receipt of sufficient documentation supporting the bill. An insurer shall pay bills for care that are not referred to a PRO within 30 days after the insurer receives sufficient documentation supporting the bill. If an insurer makes its referral after the 30th day and on or before the 90th day, the provider's bill for care shall be paid. The Company failed to pay or deny medical bills within 30 days for the three claim files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, the Company will review 31 Pa. Code §69.52(b) with its claim staff and monitor timeliness of work product.

16 Violations 31 Pa. Code §146.5(d)

Requires an insurer, upon receiving notification of a claim, shall provide within ten working days necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with policy conditions and reasonable requirements of the insurer. The Company did not provide the necessary claim forms to the claimant within ten working days for the sixteen claim files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, the Company will review 31 Pa Code §146.5(d) with its claim staff to ensure that the claims department promptly provides the required claim forms for first party medical claims within 10 days of receiving the claim notification, so that violations noted in the Report do not occur in the future.

We will work with POST and Jurisdictional Resources to include the Application for Benefits and Authorization to Release Information form in the automated letter FC00015248 on all Tier 1 and Tier 2 claims.

Execution will monitor for any failed automated letters and reissue.

The agreed action items for implementation are outlined below:

- 1. Providing necessary claim forms, instructions and reasonable assistance within 10 days of receiving notice of claim.**
- c. Execution will monitor for any failed automated letters to reissue.**
 - a. In review of the Peer review procedures (PRO), the Section Manager confirmed there is a clear understanding of the Peer review requirements in 31 Pa. Code §69.52(a, b and e). Her review indicates most of the noted violations were primarily influenced by a failure to maintain timeliness of work. This is being addressed immediately.**
 - b. As such, the additional steps will be taken:**
 - i. Section Manager will review the PRO violations with Team Managers in an upcoming staff meeting and reiterate expectations**
 - ii. Team Managers will complete an upskilling/review session with all Claim Specialists to verify understanding of the expectations.**
 - iii. Team Managers will monitor the timeliness of Claim Specialists submission of PRO requests by setting calendars for follow-up on status.**
 - iv. Team Managers will also monitor the timeliness of any denials based on PRO reports by providing specific direction to the Claim Specialists and setting a Team Manager calendar to monitor for accurate and timely handling.**
 - v. Section Manager will discuss findings/results of the Team Manager monitoring on a quarterly basis.**
- 3. We will also review the referenced statutes with all Pennsylvania T1 and T2 handlers at minimum annually.**

1 Violation 75 Pa. C.S. §1716

Payment of Benefits. Benefits are overdue if not paid within 30 days after the insurer receives reasonable proof of the amount of the benefits. If reasonable proof is not supplied as to all benefits, the portion supported by reasonable proof is overdue if not paid within 30 days after the proof is received by the insurer. Overdue benefits shall bear interest at the rate of 12% per annum from the date the benefits become due. In the event the insurer is found to have acted in an unreasonable manner in refusing to pay the benefits when due,

the insurer shall pay, in addition to the benefits owed and the interest thereon, a reasonable attorney fee based upon actual time expended. The Company failed pay interest on first party medical bills, when the bills are not paid within 30 days. The Company shall provide the correct interest amounts for each medical bill. In addition, the Company shall provide the department with documentation of all interest payments for the claim file noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, the Company will review 75 Pa. C.S. §1716 with its claim staff to ensure insureds are paid interest on first party medical bills, when the bills are not paid within 30 days to ensure the violation as noted in the Report, does not occur in the future. Claims will also monitor timeliness of work product. The Company delivered the correct interest amounts for each medical bill noted and the Company provided the department with documentation of all interest payments on October 30, 2024.

The following concern was noted:

CONCERN: Status Letters are automatically generated and sent to the insured/claimant that do not specifically describe the delay reason. The letter lists eight possible delay reasons.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, the Company will review 75 Pa. C.S. §1716 with its claim staff to ensure insureds are paid interest on first party medical bills, when the bills are not paid within 30 days to ensure the violation as noted in the Report, does not occur in the future. Claims will also monitor timeliness of work product. The Company delivered the correct interest amounts for each medical bill noted and the Company provided the department with documentation of all interest payments on October 30, 2024.

F. Automobile First Party Medical Claims Referred to PRO

The universe of 11 automobile first party medical claims that were referred to a peer review organization by the Company was selected for review. All 11 files were received and reviewed. The Company was also asked to provide a copy of all peer review contracts in place during the experience period. The twenty violations noted were based on ten files, resulting in an error ratio of 91%.

The following findings were noted:

3 Violations 31 Pa. Code §69.52(a)

A provider's bill shall be referred to a PRO only when circumstances or conditions relating to medical and rehabilitative services provided cause a prudent person, familiar with PRO procedures, standards and practices, to believe it necessary that a PRO determine the reasonableness and necessity of care, the appropriateness of the setting where the care is rendered, and the appropriateness of the delivery of the care. An insurer shall notify a provider, in writing, when referring bills for PRO review at the time of the referral. The Company failed to provide a written notification to the provider when referring a bill for PRO review for the three claim files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, in addition to examiner recommendation, State Farm will implement the following action plan:

a. In review of the Peer review procedures (PRO), Section Managers have confirmed there is a clear understanding of the Peer review requirements in 31 Pa. Code §69.52(a, b and e) and the noted violations were primarily influenced by a failure to maintain timeliness of work. This is being addressed immediately.

b. As such, the additional steps will be taken:

- i. Section Manager will review the PRO violations with Team Managers in an upcoming staff meeting and reiterate expectations**
- ii. Team Managers will complete an upskilling/review session with all Claim Specialists to verify understanding of the expectations.**
- iii. Team Managers will monitor the timeliness of Claim Specialists submission of PRO requests by setting calendars for follow-up on status.**
- iv. Team Managers will also monitor the timeliness of any denials based on PRO reports by providing specific direction to the Claim Specialists and setting a Team Manager calendar to monitor for accurate and timely handling.**
- v. Section Manager will discuss findings/results of the Team Manager monitoring on a quarterly basis.**

3 Violations 31 Pa. Code §69.52(b)

An insurer shall make a referral to a PRO within 90 days of the insurer's receipt of sufficient documentation supporting the bill. An insurer shall pay bills for care that are not referred to a PRO within 30 days after the insurer receives sufficient documentation supporting the bill. If an insurer makes its referral after the 30th day and on or before the 90th day, the provider's bill for care shall be paid. The Company failed to pay or deny medical bills within 30 days for the three claim files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, in addition to examiner recommendation, State Farm will implement the following action plan:

a. In review of the Peer review procedures (PRO), Section Managers have confirmed there is a clear understanding of the Peer review requirements in 31 Pa. Code §69.52(a, b and e) and the noted violations were primarily influenced by a failure to maintain timeliness of work. This is being addressed immediately.

b. As such, the additional steps will be taken:

- i. Section Manager will review the PRO violations with Team**

Managers in an upcoming staff meeting and reiterate expectations

ii. Team Managers will complete an upskilling/review session with all Claim Specialists to verify understanding of the expectations.

iii. Team Managers will monitor the timeliness of Claim Specialists submission of PRO requests by setting calendars for follow-up on status.

iv. Team Managers will also monitor the timeliness of any denials based on PRO reports by providing specific direction to the Claim Specialists and setting a Team Manager calendar to monitor for accurate and timely handling.

v. Section Manager will discuss findings/results of the Team Manager monitoring on a quarterly basis.

10 Violations 31 Pa. Code §69.52(e)

Requires an insurer to pay bills that are not referred to a Peer Review Organization within 30 days after the insurer receives sufficient documentation supporting the bill. The Company failed to pay medical bills within 30 days for the claim noted. The Company failed to provide PRO report to provider and insured within 10 days of receipt for the ten claim files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, in addition to examiner recommendation, State Farm will implement the following action plan:

a. In review of the Peer review procedures (PRO), Section Managers have confirmed there is a clear understanding of the Peer review requirements in 31 Pa. Code §69.52(a, b and e) and the noted violations were primarily influenced by a failure to maintain timeliness of work. This is being addressed immediately.

b. As such, the additional steps will be taken:

i. Section Manager will review the PRO violations with Team Managers in an upcoming staff meeting and reiterate expectations

ii. Team Managers will complete an upskilling/review session with all Claim Specialists to verify understanding of the expectations.

- iii. **Team Managers will monitor the timeliness of Claim Specialists submission of PRO requests by setting calendars for follow-up on status.**
- iv. **Team Managers will also monitor the timeliness of any denials based on PRO reports by providing specific direction to the Claim Specialists and setting a Team Manager calendar to monitor for accurate and timely handling.**
- v. **Section Manager will discuss findings/results of the Team Manager monitoring on a quarterly basis.**

4 Violations 31 Pa. Code §146.7(a)(1)

Standards for prompt, fair and equitable settlements applicable to insurers. (a) Acceptance or denial of a claim shall comply with the following: (1) Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to send a denial letter to the insured for the four claim files noted.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, the Company will review 31 Pa Code §146.7(a)(1) with its claim staff to ensure the claims department promptly sends denial letters to insureds within the required 15 working days of receiving proofs of loss and monitor timeliness of work product.

The following concern was noted:

CONCERN: The Carrier issued a letter to the provider and insured regarding the Peer Review Report, and it had confusing language included. It stated that based

on the PRO report and the Carrier’s review “payment will be forthcoming”; but then it included a paragraph that said, “absent a change in condition, a decision of not medically necessary by the PRO is basis for an insurer to deny payment for similar services.” This contradictory language could confuse the insured and lead them to question if services are treated as medically necessary or not.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, the Company will review 31 Pa Code §146.7(a)(1) and compare the content of this letter to improve readability and customer comprehension.

VII. CONSUMER COMPLAINTS

The Company was requested to identify all consumer complaints received during the experience period and provide copies of their consumer complaint logs for the preceding four years. The Company identified 1,590 consumer complaints received during the experience period and provided all consumer complaint logs requested. From the 1,590 complaint files, 75 were selected for review. All 75 complaint files were reviewed.

The purpose of the review was to determine compliance with the Unfair Insurance Practices Act, (40 P.S. §§1171.1 – 1171.5). Section 5(a)(11) of the Act (40 P.S. §1171.5(a)(11)), requires a company to maintain a complete record of all complaints received during the preceding four years. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. The individual complaint files were reviewed for the relevancy to applicable statutes and to verify compliance with 31 Pa. Code §146.5(b)(c).

The following findings were noted:

4 Violations 31 Pa. Code §146.5(b)

Every insurer, upon receipt of any inquiry from the Department respecting a claim shall, within 15 working days of receipt of such inquiry, furnish the Department with an adequate response to the inquiry. The Company failed to provide the Department with an adequate response to their inquiry within 15 working days for the four files noted.

The following synopsis reflects the nature of the 75 complaints that were received.

COMPANY RESPONSE:

AGREE: The Company practice is to comply with all statutory requirements; accordingly, the Company will review 31 Pa Code §146.5(b) with its complaint staff to ensure the complaints department promptly sends responses within the required 15 working days.

35	Cancellation/Nonrenewal	47%
17	Claims Related	23%
12	Premium/Setup/Bind	16%
6	Billing and Payment	8%
3	Customer Service	4%
2	Miscellaneous	2%
<hr/>		<hr/>
75		100%

VIII. UNDERWRITING PRACTICES AND PROCEDURES

As part of the examination, the Company was requested to supply manuals, underwriting guides, bulletins, directives, or other forms of underwriting procedure communications for each line of business being reviewed. Underwriting guides and supplements were furnished for Private Passenger Automobile. The purpose of this review was to identify any inconsistencies which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. No violations were noted.

IX. FORMS

Throughout the course of the examination, all underwriting files were reviewed to identify the policy forms used in order to verify compliance with the Insurance Company Law, Section 354 (40 P.S. §477b), Approval of Policies, Contracts, etc., Prohibiting the Use Thereof Unless Approved. During the experience period of the examination, Section 354 provided that it shall be unlawful for any insurance company to issue, sell, or dispose of any policy contract or certificate covering fire, marine, title and all forms of casualty insurance or use applications, riders, or endorsements in connection therewith, until the forms have been submitted to and formally approved by the Insurance Commissioner. All underwriting and claim files were also reviewed to verify compliance with 75 Pa. C.S. §1822, which requires all insurers to provide an insurance fraud notice on all applications for insurance, all claims forms and all renewals of coverage and 18 Pa. C.S. §4117(k)(1), which requires all insurers to provide an insurance fraud notice on all applications for insurance and all claim forms.

The following finding was noted:

1 Violation 75 Pa. C.S. §1799.3(f)

If requested by the applicant, an agent for an insurer shall submit an application for automobile insurance to the insurer or provide the applicant written notice of the reasons for refusal to write on a form supplied by the insurer and approved by the Commissioner. An applicant receiving a notice of reasons under this subsection may obtain review by the commissioner pursuant to the Automobile Insurance Policy Act. If either the applicant or insurer is aggrieved by the Commissioner's review, the commissioner may, in his discretion and for cause shown, hold a hearing pursuant to the

Automobile Insurance Policy Act. No insurer shall take any action, overt or otherwise, against any agent or broker for complying with this subsection. The Company failed to provide the right of review on the refusal to write letter.

COMPANY RESPONSE:

AGREE: After conducting a diligent search, we have not been able to locate the third page of the Notice of Refusal to Write for these insureds. Our standard business practice is to include information regarding the customer's right to request the Pennsylvania Insurance Commissioner to review the action and retain it with the Notice of Refusal to Write. This practice is demonstrated by the other 142 documents we produced. Instances of individual file mistakes and do not represent a systemic issue.

X. DATA INTEGRITY

As part of the examination, the Company was sent a preliminary examination packet in accordance with NAIC uniformity standards and provided specific information relative to the exam. The purpose of the packet was to provide certain basic examination information, identify preliminary requirements and to provide specific requirements for requested data call information. Once the Company provided all requested information and data contained within the data call, the Department reviewed and validated the data to ensure its accuracy and completeness to determine compliance with Insurance Department Act of 1921, Section 904(b) (40 P.S. §323.3(a)). Several data integrity issues were found during the exam.

The data integrity issue of each area of review is identified below.

Collision Claims

Situation: As the examiners reviewed the Collision files of the Claims section of the exam, it was noted that not all the 100 files selected for review were Collision files.

Finding: Of the 100 Collision files reviewed, 2 files were identified as Total Loss Claims.

Auto Underwriting 60-Day Cancellations

Situation: As the examiners reviewed the 60-Day Cancellation files of the Auto Underwriting section of the exam, it was noted that not all the 100 files selected for review were 60-Day Cancellation files.

Finding: Of the 100 60-Day Cancellation files reviewed, 3 files were identified as Midterm Cancellations, and 3 files were identified as Nonrenewals.

The following finding was noted:

General Violation 40 P.S. §323.3(a)

Requires every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify the financial condition of that company or person and ascertain whether the company or person has complied with the laws of this Commonwealth. The violation was the result of a failure to exercise sufficient due diligence to ensure compliance with the Insurance Department Act of 1921.

COMPANY RESPONSE:

DISAGREE. The company disagrees with the examiner's assertion. These claims appropriately came in as Collision claims and the vehicles were later determined to be a Total Loss. While the handlers in each of the identified claims did not check the "confirmed Total Loss" box, the files were handled as a Total Loss, and a Total Loss payment was issued with a Total Loss reason code which would have been reported to the National Motor Vehicle Title Information System (NMVTIS) if applicable.

XI. RECOMMENDATIONS

The recommendations made below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other statutory or regulatory violations, noted in the Report.

1. The Company must review 18 Pa. C.S. §4117(k)(1) to ensure that violations regarding the requirement of a fraud warning on all claim forms, as noted in the Report, do not occur in the future.
2. The Company must review 31 Pa. Code §62.3 with its claim staff to ensure appraisal requirements are met so violations, as noted in the Report, do not occur in the future.
3. The Company must review 31 Pa. Code §62.3(e)(4) with its claim staff to ensure a copy of the total loss evaluation is provided to the insured within 5 working days so the violation, as noted in the Report, does not occur in the future.
4. The Company must review 31 Pa. Code §62.3(e)(7) with its claim staff to ensure a copy of the total loss evaluation is provided to the insured within 5 working days so the violation, as noted in the Report, does not occur in the future.
5. The Company must review 31 Pa. Code §69.52(a) with its claim staff to ensure that a written notification is sent to the provider when referring a bill for PRO review.

6. The Company must review 31 Pa. Code §69.52(b) with its claim staff to ensure that first party medical bills are paid within 30 days.
7. The Company must review 31 Pa. Code §69.52(e) with its claim staff to ensure that the insured is provided a copy of a PRO evaluation in a timely manner.
8. The Company must review 31 Pa Code §146.3 with its claim staff to ensure the claims department maintains complete claim files.
9. The Company must review 31 Pa. Code §146.5(b) to ensure that all Department inquiries are responded to within 15 working days of receipt of such inquiry, so that the violations noted in the Report do not occur in the future.
10. The Company must review 31 Pa Code §146.5(d) with its claim staff to ensure that the claims department promptly provides the required claim forms for first party medical claims within 10 days of receiving the claim notification, so that violations noted in the Report do not occur in the future.
11. The Company must review 31 Pa Code §146.6 with its claim staff to ensure that the claims department promptly provides the required 30/45-day status letter to claimants, so that violations noted in the Report do not occur in the future.
12. The Company must review 31 Pa Code §146.7(a)(1) with its claim staff to ensure the claims department promptly sends denial letters to insureds within the required 15 working days of receiving proofs of loss.
13. The Company must reinforce its internal data controls to ensure that all records and documents are maintained in accordance with 40 P.S. §323.3(a), so that violations noted in the Report do not occur in the future.

14. The Company must review and revise internal control procedures to ensure compliance with nonrenewal and cancellation notice requirements of 40 P.S. §991.2006 and §991.2008(b), so that the violations noted in the Report do not occur in the future.
15. The Company must review 40 P.S. §1184(a)&(h) and take appropriate measures to ensure the correct territory code is utilized to avoid an incorrect rate from being charged in the future.
16. The Company must review 63 P.S. §861(b) with its claim staff to ensure violations for missing appraiser name and appraiser license information on auto appraisal copies as noted in the Report, do not occur in the future.
17. The Company must revise its underwriting procedures to ensure that each applicant for private passenger automobile liability insurance is provided an opportunity to elect a tort option and that signed tort option selection forms are obtained and retained with the underwriting file. This is to ensure that violations noted under 75 Pa. C.S. §1705(a)(4) do not occur in the future.
18. The Company must review 75 Pa. C.S. §1716 with its claim staff to ensure insureds are paid interest on first party medical bills, when the bills are not paid within 30 days to ensure the violation as noted in the Report, does not occur in the future.
19. The Company must review 75 Pa. C.S. §1734 with its underwriting staff to ensure insureds are provided written requests for lower UM/UIM limits.
20. The Company must revise underwriting procedures to ensure that the insured is aware that he may exercise the waiver of stacked limits for uninsured and

underinsured motorist coverage by signing written rejection forms. This is to ensure that violations, as noted in the Report under 75 Pa. C.S. §1738(d)(1) and (2)(e) do not occur in the future.

21. The Company must review 75 Pa. C.S. 1799.3(a) to ensure that insureds accidents meet the surcharge threshold requirements as noted in the Report, to avoid the incorrect rates from being charged in the future.

22. The Company must review 75 Pa. C.S. 1799.3(f) to ensure that refusal to write letters include the required right of review on all refusal to write letters issued to Pennsylvania insureds, so that violation as noted in the Report, does not occur in the future.

XII. COMPANY RESPONSE

State Farm's individual responses to each concern or criticism is outlined above. We encourage the Insurance Department to remove those violations or concerns that are below the NAIC benchmark error rate and do not demonstrate a pattern or practice of the company before publishing the final report.