COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

MARKET CONDUCT
EXAMINATION REPORT

OF

LM GENERAL
INSURANCE COMPANY
HOFFMAN ESTATES, IL

As of: September 19, 2023
Issued: November 13, 2023

BUREAU OF MARKET ACTIONS
PROPERTY & CASUALTY DIVISION

pennsylvania
INSURANCE DEPARTMENT

PENNSYLVANIA INSURANCE DEPARTMENT
EXAMINATION VERIFICATION

I, Joshua Gotwalt (Name of Examiner), Market Conduct Examiner II (Title of Examiner) from Pennsylvania Insurance Department (Name of Vendor/Department) certify that I was the Examiner-In-Charge of the Report of Examination of Liberty Mutual General Insurance Company (Name of Examined Company) made as of 09/18/2023 (Date).

The last date of examination file review was 07/11/2023 (Date) and the written Report of Examination was reviewed and accepted by the Chief Paul Towsen (Chief of Market Conduct Examiner) on 09/18/2023 (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.

Joshua Gotwalt
(Examiner-in Charge)

Pennsylvania Insurance Department
(Name of Vendor/Department)

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

Joshua Gotwalt
(Examiner in Charge Signature)

09/18/2023
(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.

Liberty Mutual General Insurance Company

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BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

O R D E R

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

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
LM GENERAL INSURANCE	:	
COMPANY	:	40 P.S. §323.3(a)
2815 Forbs Avenue, Suite 200	:	
Hoffman Estates, IL 60192	:	31 Pa. Code §§62.3, 62.3(e)(7), 69.52(a),
	:	69.52(b), 69.52(e), 146.5(d), 146.6, and
	:	146.7(a)(1)
	:	
	:	75 Pa. C.S. §§1791.1(a) and 1799.3(d)
	:	
	:	
	:	
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	:	
Respondent.	:	Docket No. MC23-09-013

CONSENT ORDER

AND NOW, this 13th day of November, 2023, this Order is hereby issued by the Insurance Department of the Commonwealth of Pennsylvania pursuant to the statutes cited above and in disposition of the matter captioned above.

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 LM General Insurance Company, and maintains its address at 2815 Forbs Avenue, Suite 200, Hoffman Estates, IL 60192.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the experience period from January 1, 2022 through December 31, 2022.

(c) On September 19, 2023, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on October 19, 2023.

(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) Respondent's violations of 31 Pa. Code §§146.5(d), 146.6, and 146.7(a)(1) are punishable under Sections1 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.

(c) 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 Fifteen Thousand Dollars ($15,000.00) 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: LM GENERAL INSURANCE COMPANY
Respondent

James Closson
President / Vice President

Kristin Kelley
Secretary / Treasurer

David J. Buono
DAVID J. BUONO
Deputy Insurance Commissioner
Commonwealth of Pennsylvania

I. INTRODUCTION

The Market Conduct Examination of LM General Insurance Company, hereinafter referred to as "Company", was conducted at the Pennsylvania Insurance Department beginning January 13, 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

Joshua Gotwalt, MCM
Market Conduct Examiner II, EIC
Pennsylvania Insurance Department

Richard Barr, MCM
Market Conduct Examiner I
Pennsylvania Insurance Department

Robert Reichart, MCM, CIE, ARM
Examiner
Exam Resources

Greg Hawkins, MCM
Examiner
Exam Resources

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted on LM General 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 January 1, 2022, through December 31, 2022, 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:

Private Passenger Automobile

1. Underwriting - Appropriate and timely notices of nonrenewal, midterm cancellations, 60-day cancellations, declinations, and rescissions.

2. Rating - Proper use of all classification and rating plans and procedures.

3. Claims

4. Complaints

5. Underwriting Practices and Procedures

6. Forms

7. Data Integrity

8. MCAS

III. COMPANY HISTORY

Liberty Mutual Insurance helps people preserve and protect what they earn, build, own and cherish. Keeping this promise means we are there when our policyholders throughout the world need us most. In business since 1912, and headquartered in Boston, Mass., today Liberty Mutual is a diversified insurer with operations in 28 countries and economies around the world. The company is the fifth largest property and casualty insurer in the U.S. based on 2018 gross written premium as reported by the National Association of Insurance Commissioners. Liberty Mutual is ranked 75th on the Fortune 100 list of largest corporations in the U.S. based on 2018 revenue. As of December 31, 2018, the company had $126 billion in consolidated assets, $105.2 billion in consolidated liabilities, and $41.6 billion in annual consolidated revenue. Liberty employs more than 50,000 people in approximately 30 counties throughout the world, and we offer a wide range of insurance products and services, including personal automobile, homeowners, accident & health, commercial automobile, general liability, property, surety, workers compensation, group disability, group life, specialty lines, reinsurance, individual life, and annuity products. The business of Liberty Mutual is headquartered in Boston, Massachusetts.

LICENSING

LM General Insurance Company's last Certificate of Authority to write business in the Commonwealth was issued on April 1, 2023. LM General Insurance Company is licensed to transact private passenger automobile insurance business in all 50 states except Hawaii and New Jersey. The Company's 2021 annual statement reflects Direct Written Premium for all lines of business in the Commonwealth of Pennsylvania as $266,298,203. 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) $17,687,652; Other Private Passenger Auto Liability $124,780,283; and Private Passenger Auto Physical Damage $123,830,268.

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 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 1,801 private passenger automobile policies which were nonrenewed during the experience period, 75 files were selected for review. All 75 files requested were received and reviewed. No violations were noted.

2. Mid-term Cancellations

A mid-term 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 37,462 private passenger automobile policies which were cancelled during the experience period, 100 files were selected for review. All 100 files requested were received and reviewed. No violations were noted.

3. 60-Day Cancellations

A 60-day cancellation is 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(c)(3) (40 P.S. §991.2002(c)(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.

The Company did not report any private passenger automobile 60-day cancellations for the experience period.

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.

The Company did not report any private passenger automobile declinations for the experience period.

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 Company did not report any private passenger automobile rescissions for the experience period.

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 a 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

The Company did not report any private passenger automobile new business policies without surcharges for the experience period. Business stopped at the end of 2021. The Company only writes motorcycle policies currently.

Private Passenger Automobile Rating – New Business With Surcharges

The Company did not report any private passenger automobile new business policies with surcharges for the experience period. Business stopped at the end of 2021. The Company only writes motorcycle policies currently.

2. Renewals

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

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 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 Rating – Renewals Without Surcharges

From the universe of 89,824 private passenger automobile policies identified as renewals without surcharges, 100 files were selected for review. All 100 files requested were received and reviewed. The 89,824 violations noted were based on 89,824 files, resulting in an error ratio of 100%.

The following findings were noted:

89,824 Violations 75 Pa. C.S. §1791.1(a)

> Requires that at the time of application for original coverage and every renewal thereafter, an insurer must provide to an insured an itemized invoice listing the minimum motor vehicle insurance coverage levels mandated by the Commonwealth and the premium charge for the insured to purchase the minimum mandated coverages. The invoice must contain the following notice in print of no less than ten-point type: "The laws of the Commonwealth of Pennsylvania, as enacted by the General Assembly, only require you to purchase liability and first-party medical benefit coverages. Any additional coverage or coverages in excess of the limits required by law are provided only at your request as enhancements to basic coverages." The insurer shall provide the itemized invoice to the insured in conjunction with the

declaration of coverage limits and premiums for the insured's existing coverages. The Company failed to provide the itemized invoice to the insured at the time of application for the 89,824 files noted.

Private Passenger Automobile Rating – Renewals With Surcharges

From the universe of 3,003 private passenger automobile policies identified as renewals with surcharges, 50 files were selected for review. All 50 files requested were received and reviewed. The 6,006 violations noted were based on 3,003 files, resulting in an error ratio of 100%.

The following findings were noted:

3,003 Violations 75 Pa. C.S. §1791.1(a)

Requires that at the time of application for original coverage and every renewal thereafter, an insurer must provide to an insured an itemized invoice listing the minimum motor vehicle insurance coverage levels mandated by the Commonwealth and the premium charge for the insured to purchase the minimum mandated coverages. The invoice must contain the following notice in print of no less than ten-point type: "The laws of the Commonwealth of Pennsylvania, as enacted by the General Assembly, only require you to purchase liability and first-party medical benefit coverages. Any additional coverage or coverages in excess of the limits required by law are provided only at your request as enhancements to basic coverages." The insurer shall provide the itemized invoice to the insured in conjunction with the declaration of coverage limits and premiums for the insured's existing coverages. The Company failed to provide the

itemized invoice to the insured at the time of application for the 3,003 files noted.

3,003 Violations 75 Pa. C.S. §1799.3(d)

Requires notice to the insured that if an insurer makes a determination to impose a surcharge, rate penalty or driver record point assignment, the insurer shall inform the named insured of the determination and shall specify the manner in which the surcharge, rate penalty or driver record point assignment was made and clearly identify the amount of the surcharge or rate penalty on the premium notice for as long as the surcharge or rate penalty is in effect. The Company failed to provide the amount of surcharges / rate penalties at the time of renewal for the 3,003 files 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 9,486 private passenger automobile property damage claims reported during the experience period, 75 files were selected for review. All 75 files selected were received and reviewed. The four violations noted were based on four files, resulting in an error ratio of 5%.

The following findings were 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.

1 Violation 31 Pa. Code §146.7(a)(1)

Acceptance or denial of a claim shall comply with the following: 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. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the insured/claimant in writing and the claim file of the insurer contain a copy of the denial. The Company failed to issue a denial letter to the insured/claimant within 15 working days for the claim file noted.

CONCERN: In four files reviewed, the Company did not issue the policyholder/claimant a written notice indicating it was closing the file without payment. The Company should, in all cases of claims closed without payment, issue a written notice to the policyholder/claimant indicating the file is being closed with no payment.

B. Automobile Comprehensive Claims

From the universe of 3,484 private passenger automobile comprehensive claims reported during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. The three violations noted were based on three files, resulting in an error ratio of 6%.

The following findings were noted:

1 Violation 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 claim file noted.

2 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 two claim files noted.

CONCERN: In three files reviewed, the Company did not issue the policyholder/claimant a written notice indicating it was closing the file without payment. The Company should, in all cases of claims closed without payment, issue a written notice to the policyholder/claimant indicating the file is being closed with no payment.

C. Automobile Collision Claims

From the universe of 12,150 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 15 violations noted were based on 13 files, resulting in an error ratio of 13%.

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 per statute for the six claim files noted.

5 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 five claim files noted.

4 Violations 31 Pa. Code §146.7(a)(1)

Acceptance or denial of a claim shall comply with the following: 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. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion

unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the insured/claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to issue a denial letter to the insured/claimant within 15 working days for the four claim files noted.

CONCERN: In two files reviewed, the Company did not issue the policyholder/claimant a written notice indicating it was closing the file without payment. The Company should, in all cases of claims closed without payment, issue a written notice to the policyholder/claimant indicating the file is being closed with no payment.

CONCERN: In one file reviewed, the Company did not issue the policyholder a written notice indicating the damages were below their deductible. The Company should, in all cases issue a written notice to the policyholder indicating the damages were below their deductible.

D. Automobile Total Loss Claims

From the universe of 3,044 private passenger automobile total loss claims reported during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. The eight violations noted were based on eight files, resulting in an error ratio of 16%.

The following findings were noted:

2 Violations 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 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 provide the total loss evaluation within 5 days to the insured/claimant for the two claim files 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 did not provide timely status letters for the four claim files noted.

2 Violations 31 Pa. Code §146.7(a)(1)

Acceptance or denial of a claim shall comply with the following: 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. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition or exclusion is

included in the denial. The denial shall be given to the insured/claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to issue a denial letter to the insured/claimant within 15 working days for the two claim files noted.

E. Automobile First Party Medical Claims

From the universe of 3,610 private passenger automobile first party medical claims reported during the experience period, 50 claim files were selected for review. All 50 files requested were received and reviewed. Out of the 50 files reviewed, one file was identified as a collision claim. The two violations noted were based on two files, resulting in an error ratio of 4%.

The following findings were noted:

1 Violation 31 Pa Code §146.5(d)

Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a). The Company failed to send the necessary claim form (application for benefits) within 10 working days for the claim file noted.

1 Violation 31 Pa. Code §146.7(a)(1)

Acceptance or denial of a claim shall comply with the following: 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. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the insured/claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to issue a denial letter to the insured/claimant within 15 working days for the claim file noted.

F. Automobile First Party Medical Claims Referred to a PRO

The universe of 28 automobile first party medical claims that were referred to a peer review organization, by the Company, was selected for review. All 28 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 nine violations noted were based on eight files, resulting in an error ratio of 29%.

The following findings were noted:

7 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 caused 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 notify the provider in writing, when referring bills to a Peer Review Organization for the seven claim files noted.

1 Violation 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 medical bills within 30 days for the claim file noted.

1 Violation 31 Pa. Code §69.52(e)

A PRO shall provide a written analysis, including specific reasons for its decision, to insurers, which shall within 5 days of receipt, provide copies to providers and insureds. The Company failed to provide copies of the PRO report to providers and insureds within 5 days of receipt for the claim file noted.

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 227 consumer complaints received during the experience period and provided all consumer complaint logs requested. From the universe of 227 complaint files, 35 files were selected for review. All 35 files were received and 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 statues and to verify compliance with 31 Pa. Code §146.5(b)(c). No violations were noted.

The following synopsis reflects the nature of the 35 complaints that were received.

4	Accounting/Billing	11%
16	Claims	46%
8	Distribution (Sales/Service)	23%
7	Underwriting	20%
35		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. Memos and underwriting rule guides were furnished for Liberty Mutual Insurance Company. 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 There of 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 files were 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. No violations were noted.

The following concern was noted:

CONCERN: The Company should use 18 Pa. C.S. §4117(k)(1) with verbatim wording on all claim forms. The Company is using incorrect wording on the following forms: Private Passenger Automobile Appraisals, Renewal Declaration Packets, and Application for Benefits Letters.

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 Section 903(a) [40 P.S. §323.3(a)].

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

First Party Medical Claims

Situation: As the examiners reviewed the PPA claims files of the First Party Medical claims section of the exam, it was noted that not all 50 files were First Party Medical claims.

Finding: Of the 50 First Party Medical Claims files reviewed, one policy was identified as a Collison claim.

Based on the data integrity finding noted above, the following violation 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 and any or all computer or other recordings relating to its property, assets, business, and affairs in such manner and for 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 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. PPA MCAS REPORTING

In Pennsylvania, insurers are required annually to submit a Market Conduct Annual Statement (MCAS) to the National Association of Insurance Commissioners (NAIC). The review of MCAS data was conducted pursuant to the authority granted by Section 903 and 904 [40 P.S. §§323.3 and 323.4] of the Insurance Department Act and covered the Market Conduct Annual Statement (MCAS) reporting for 2021.

The examination team reviewed the Company's 2021 Private Passenger Automobile MCAS Submissions. All companies that submit an MCAS filing must attest to the completeness and accuracy of their submission. The attestation is required once per filing period and applies to all submissions for a specific company code. No submissions will be accepted until an attestation is completed for the company. Below are the private passenger automobile sections that were reviewed.

A.	Number of autos which have policies in-force at the end of the period.
B.	Number of Policies in-force at the end of the period.
C.	Number of new business policies written during the period.
D.	Number of Company-Initiated nonrenewals during the period.
E.	Dollar amount of direct written premium during the period.
F.	Number of cancellations for non-pay, non-sufficient funds or insured's request.
G.	Number of Company-Initiated cancellations that occur in the first 59 days after effective date, excluding rewrites to an affiliated Company.
H.	Number of Company-Initiated cancellations that occur 60 or more days after effective date, excluding rewrites to an affiliated Company.
I.	Number of Complaints received directly from the consumer.
J.	Number of Claims open at the beginning of the Period
K.	Number of Claims opened during the period.
L.	Number of Claims closed during the period, with payment.
M.	Number of Claims closed during the period, without payment.
N	Number of Claims remaining open at the end of the period.
O.	Number of Claims closed with payment within 0-60 days.
P	Number of Claims closed with payment >60 days.
Q.	Number of Suits open at beginning of the period.

R	Number of Suits opened during the period.
S.	Number of Suits closed during the period.
T.	Number of Suits open at end of period.

The review consisted of three phases, as noted below.

Phase 1

The Company was asked to provide the Private Passenger Automobile claims and policy data listings that support the 2021 MCAS filing. Each list contained the claim and policy numbers for each category. The 2021 data submitted was validated to ensure the information was accurate and consistent with the information provided to the NAIC. No violations were found.

Phase 2

The Company was asked to provide a record of all claims and policy data listings which supported the 2021 Private Passenger Automobile MCAS filings. From each universe list of 2021 data, a random sample of 5 claims or policy files was requested, received, and reviewed. The files were reviewed to ensure compliance with the Commonwealth of Pennsylvania's Statutes and Regulations. The following violation 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 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 provide accurate data for one underwriting category.

Phase 3

A review was performed on various policies and claims provided in the Market Conduct portion of the exam to ensure the 2021 Private Passenger Automobile MCAS data was inclusive of all the policies applicable to each line item. The files were reviewed to ensure compliance with the Commonwealth of Pennsylvania's Statutes and Regulations. No violations were noted.

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

2. 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 five working days so the violations, as noted in the Report, do not occur in the future.

3. 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.

4. 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 so that the violations, as noted in the Report, do not occur in the future.

5. 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.

6. The Company should review and revise internal control procedures to ensure compliance with the claims handling requirements of 31 Pa. Code, Chapter 146, Unfair Claims Settlement Practices so that the violations relating to providing

necessary claim forms (application for benefits), status letters, and acceptance / denials, as noted in the Report, do not occur in the future.

7. 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.

8. The Company must review 75 Pa. C.S. §1791.1(a) to ensure that violations regarding the requirement to provide an itemized invoice listing minimum coverages at the time of application and every renewal thereafter, as noted in the Report, do not occur in the future.

9. The Company must review 75 Pa. C.S. §1799.3(d) to ensure that violations regarding the requirement to provide the amounts of surcharge / rate penalty at the time of application and every renewal, thereafter, as noted in the Report, do not occur in the future.

XIII. COMPANY RESPONSE

Sebestyen Q. Martens
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October 19, 2023

Paul E. Towsen III
P&C/Life & Annuity Division Chief
Pennsylvania Insurance Department
1321 Strawberry Square
Harrisburg, PA 17120

Re: Examination Warrant Number: 23-M44-001

Dear Mr. Towsen,

Below please find the Company's response to the Report of Examination of LM General Insurance Company and the Department's recommendations.

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

   Company Response: We agree with this finding and are engaging our APD Appraisal team to review actions needed to ensure Appraiser ID is included on all estimates.

2. 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 five working days so the violations, as noted in the Report, do not occur in the future.

   Company Response: We agree with this finding and have begun analysis to determine why these claims did not automate within the current system rules. At the time of the exam, the company does have a process for identifying when a vehicle valuations is not sent via the automated process. Managers are expected to review any outliers and resolve the issue trigger that prevented the automation. The team will review these instances and determine what actions are needed to improve the automated process.

3. 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.

   Company Response: We agree with this finding and the team has begun its review to determine how to include notice to the provider at the same time notice is sent to the insured or insureds representative.

4. 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 so that the violations, as noted in the Report, do not occur in the future.

   Company Response: The company agrees with this finding.

5. 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.

   Company Response: The Company agrees with the one exception found during the exam.

6. The Company should review and revise internal control procedures to ensure compliance with the claims handling requirements of 31 Pa. Code, Chapter 146, Unfair Claims Settlement Practices so that the violations relating to providing necessary claim forms (application for benefits), status letters, and acceptance / denials, as noted in the Report, do not occur in the future.

   Company Response: The Company agrees with the one exception found during the exam.

7. 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.

   Company Response: The company agrees with this finding.

8. The Company must review 75 Pa. C.S. §1791.1(a) to ensure that violations regarding the requirement to provide an itemized invoice listing minimum coverages at the time of application and every renewal thereafter, as noted in the Report, do not occur in the future.

   Company Response: We agree with this finding. We have engaged our systems teams to begin the process of updating our processes to include this invoice as required.

9. The Company must review 75 Pa. C.S. §1799.3(d) to ensure that violations regarding the requirement to provide the amounts of surcharge / rate penalty at the time of application and every renewal, thereafter, as noted in the Report, do not occur in the future.

   Company Response: We agree with this finding. We have engaged our systems teams to begin the process of updating our surcharge documentation to include the specific dollar amount of surcharge.

If you have any additional questions, please let us know.

Sincerely,

Sebestyen Q. Martens