pennsylvania
INSURANCE DEPARTMENT

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

MARKET CONDUCT
EXAMINATION REPORT

OF

METROMILE
INSURANCE COMPANY
WILMINGTON, DE

As of: January 2, 2020
Issued: February 27, 2020

BUREAU OF MARKET ACTIONS
PROPERTY AND CASUALTY DIVISION

VERIFICATION

Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).

Nanette R Soliday
(Examiner Name), Examiner-in-Charge

Sworn to and Subscribed Before me

This Day of December, 2019

Jean A. Cuaz
Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Jean A. Cuaz, Notary Public
City of Harrisburg, Dauphin County
My Commission Expires Feb. 26, 2021
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

METROMILE INSURANCE COMPANY

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BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 28th day of March, 2018, 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 Christopher R. Monahan, 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.

Jessica K. Altman
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
METROMILE INSURANCE COMPANY	:	40 P.S. §323.4(b)
690 Folsom St., Suite 200	:	
San Francisco, CA 94107	:	40 P.S. §§991.2003(a)(13)(ii), 991.2003(a)(14), 991.2008(b)
	:	
	:	31 Pa. Code §§62.3, 62.3(e)(4), 62.3(e)(7), 69.52(a), 69.52(b), 69.52(e), 69.53(a), 146.3, 146.5(a), 146.5(d), 146.6, 146.7(a)(1)
	:	
	:	75 Pa. C.S. §1161(a)(b),1716, 1797(b)(1)
Respondent	:	Docket No. MC20-01-010
	:	

CONSENT ORDER

And now, this 27th day of February, 2020, 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 Metromile Insurance Company, and maintains its address at 690 Folsom St., Suite 200, San Francisco, CA 94107.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2018 to December 31, 2018.

(c) On January 2, 2020 the Insurance Department issued a Market Conduct Examination Report to Respondent ("Examination Report").

(d) Respondent provided to the Insurance Department a response to the Examination Report on January 31, 2020.

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

(i.) 40 P.S. §323.4(b), requires every company or person from whom information is sought, its officers, directors and agents must provide to the examiners timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined;

(ii.) 40 P.S. §991.2003(a)(13)(ii), states an insurer may not cancel or refuse to renew a policy of automobile insurance for an accident which occurred under the following circumstances: The applicant, owner or other resident operator is reimbursed by or on behalf of a person who is responsible for the accident or has judgement against such person;

(iii.) 40 P.S. §991.2003(a)(14), states an insurer may not cancel or refuse to renew a policy of automobile insurance for an accident which occurred under the following circumstances: Any claim under the comprehensive portion of the policy unless such loss was intentionally caused by the insured;

(iv.) 40 P.S. §991.2008(b), requires 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 Commissioner that he review the action of the insurer in refusing to write a policy for the applicant;

(v.) 31 Pa. Code §62.3, requires that an appraisal shall meet all applicable standards per statute;

(vi.) 31 Pa. Code §62.3(e)(4), requires that applicable sales tax on the replacement cost of a motor vehicle shall be included as part of the replacement value;

(vii.) 31 Pa. Code §62.3(e)(7), states 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;

(viii.) 31 Pa. Code §69.52(a), requires an insurer to refer a provider's bill to a Peer Review Organization only when circumstances or conditions

relating to medical and rehabilitative services provided cause a prudent person, familiar with Peer Review Organization procedures, standards and practices, to believe it necessary that a Peer Review Organization 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. The insurer shall notify a provider, in writing, when referring bills for Peer Review Organization review at the time of referral;

(ix.) 31 Pa. Code §69.52(b), requires an insurer to pay medical bills for care that are not referred to a Peer Review Organization within 30 days after the insurer receives sufficient documentation supporting the bill;

(x.) 31 Pa. Code §69.52(e), requires an insurer to provide copies of the Peer Review Organization's written analysis to the provider and the insured within 5 days of receipt;

(xi.) 31 Pa. Code §69.53(a), requires a Peer Review Organization to contract, in writing, jointly or separately with an insurer for the provision of peer review services as authorized by Act 1990-6 and this chapter;

(xii.) 31 Pa. Code §146.3, requires the claim files of the insurer shall be subject to examination by the Commissioner or by his/her appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed;

(xiii.) 31 Pa. Code §146.5(a), states every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice, unless payment is made within such period. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated;

(xiv.) 31 Pa. Code §146.5(d), states that 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;

(xv.) 31 Pa. Code §146.6, states that if an investigation cannot be completed within thirty (30) days, and every forty-five (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;

(xvi.) 31 Pa. Code §146.7(a)(1), requires 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;

(xvii.) 75 Pa. C.S. §1161(a)&(b), states an insurer who owns, possesses or transfers a vehicle located or registered in the Commonwealth which qualifies as a salvage vehicle shall make application to the Department for a certificate of salvage for that vehicle. An owner who transfers a vehicle to be destroyed or dismantled, salvaged or recycled shall assign the certificate of title to the person to whom the vehicle is transferred. Except as provided in section 1163, the transferee shall immediately present the assigned certificate of title to the department with an application for a certificate of salvage upon a form furnished and prescribed by the department;

(xviii.) 75 Pa. C.S. §1716, states that benefits are overdue if not paid within 30 days after the insurer receives reasonable proof of the amount of 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.

(xix.) 75 Pa. C.S. §1797(b)(1), requires that a peer review plan for challenges to reasonableness and necessity of treatment by the insurer shall contract jointly or separately with any peer review organization for the purpose of evaluating treatment, health care services, products or accommodations provided to any injured person.

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. §§991.2003(a)(13)(ii), 991.2003(a)(14), 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).

(e) Respondent's violations of 31 Pa. Code §§146.3, 146.5(a), 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.

(f) 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 Thirty-Five Thousand Dollars ($35,000.) in settlement of all violations contained in the Report.

(c) Payment of this matter shall be made to the Commonwealth of Pennsylvania. Payment should be directed to Paul E. Towsen III, Pennsylvania Insurance Department, Office of Market Regulation, RE: Bureau of Market Actions, 1209 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

(d) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.

(e) 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: METROMILE INSURANCE COMPANY
Respondent

President / Vice President

Secretary / Treasurer

CHRISTOPHER R. MONAHAN
Deputy Insurance Commissioner
Commonwealth of Pennsylvania

I. INTRODUCTION

The Market Conduct Examination of Metromile Insurance Company, hereinafter referred to as "Company", was conducted at the Pennsylvania Insurance Department beginning on August 19, 2019. 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

Nanette Soliday, MCM
Market Conduct Examiner
Pennsylvania Insurance Department

Joshua Gotwalt, MCM
Market Conduct Examiner
Pennsylvania Insurance Department

Benjamin Darnell, MCM
Market Conduct Examiner
Examination Resources, LLC

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted on Metromile 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, 2018, through December 31, 2018, 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.

2. Claims

3. Complaints

4. Underwriting Practices and Procedures

5. Forms

6. Data Integrity

III. COMPANY HISTORY

Metromile Insurance Company was acquired by Metromile, Inc., its ultimate controlling parent, in August of 2016. Previously it had been a subsidiary of AXA and was called Mosaic Insurance Company. All policies underwritten by Metromile Insurance Company are sold and serviced by Metromile Insurance Services, LLC – a general agency also fully owned by parent Metromile, Inc. The Company offers a pay-per-mile car insurance in Pennsylvania, along with seven other states. Metromile is currently licensed in all states and the District of Columbia except Tennessee. Metromile is currently transacting the following lines of business: Private Passenger Auto No-Fault, Other Private Passenger Auto Liability, and Private Passenger Auto Physical Damage.

LICENSING

Metromile Insurance Company's last Certificate of Authority to write business in the Commonwealth was last issued on April 1, 2019. The Company is licensed in all states and the District of Columbia except Tennessee. The Company's 2017 annual statement reflects Direct Written Premium for all lines of business in the Commonwealth of Pennsylvania as $3,691,532. 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) $416,251; Other Private Passenger Auto Liability $1,806,766; and Private Passenger Auto Physical Damage $1,468,515.

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.

The universe of 11 private passenger automobile policies which were nonrenewed during the experience period, was selected for review. All 11 files requested were received and reviewed. There were no violations.

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 1,248 private passenger automobile policies which were cancelled midterm, 100 files were selected for review. All 100 files requested were received and reviewed. There were no violations.

The following concerns were noted:

CONCERN: On some copies of the Notice of Cancellations, the required Right of Review address includes the phone number for the Philadelphia office. This needs to be removed from all cancellation notices. The following should be listed for the Right of Review on all Notice of Cancellations:

Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA 17120
Toll Free Consumer Line (877)881-6388
Fax: (717)787-8585

CONCERN: The Company is sending a Notice of Cancellation with no address and phone number to contact Assigned Risk. The Company should add the telephone number and address of Assigned Risk to the Notice of Cancellation so the insured can contact Assigned Risk if needed.

CONCERN: The label "Notice of Cancellation" should be on the front page of the document in boldface font.

CONCERN: The Company is stating on the mailed cancellation notices **"As of the generation of this communication, there is more than one reason that is causing your policy to be cancelled. Please review the information below to view all of these reasons."** However, in many cases,

there is only one reason listed on the notice. The Company should consider revising or removing the wording as this can be construed as misleading.

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(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.

From the universe of 196 automobile policies that were cancelled within the first 60 days of new business, 50 files were selected for review. All 50 files requested were received and reviewed. There were no violations.

The following concerns were noted.

CONCERN: On some copies of the Notice of Cancellations, the required Right of Review address includes the phone number for the Philadelphia office. This needs to be removed from all cancellation notices. The following should be listed for the Right of Review on all Notice of Cancellations:

Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA 17120
Toll Free Consumer Line (877)881-6388
Fax: (717)787-8585

CONCERN: The Company is sending a Notice of Cancellation with no address and phone number to contact Assigned Risk. The Company should add the telephone number and address of Assigned Risk to the Notice of Cancellation so the insured can contact Assigned Risk if needed.

CONCERN: The label "Notice of Cancellation" should be on the front page of the document in boldface font.

CONCERN: The Company is stating on the mailed cancellation notices **"As of the generation of this communication, there is more than one reason that is causing your policy to be cancelled. Please review the information below to view all of these reasons."** However, in many cases, there is only one reason listed on the notice. The Company should consider revising or removing the wording as this can be construed as misleading.

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 1,213 declinations for private passenger automobile insurance, 40 files were selected for review. All 40 files requested were received and reviewed. The 1,213 violations noted were based on the universe of 1,213 files, resulting in an error ratio of 100%.

The following findings were made:

1,213 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 1,213 files noted.

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 one private passenger automobile policy, which was

rescinded during the experience period, was received and reviewed. This was not a rescission, therefore there was no violation.

V. 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 350 private passenger automobile property damage claims reported during the experience period, 75 files were selected for review. Of the 75 files reviewed, one file was identified as being a First Party Medical claim. The 35 violations noted were based on 32 files, resulting in an error ratio of 43%.

The following findings were made:

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.

1 Violation 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 claim file noted.

25 Violations 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the 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 25 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. The Company failed to deny the claim in writing for the four claim files noted.

The following concerns were noted:

CONCERN: In some 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: The Company is providing a statement/code on the second page of the Explanation of Benefits (EOB) to the provider that the 'Benefits are Exhausted' under First Party Medical coverage for the insured. The Company should provide the 'Benefits are Exhausted' statement in bold print on the first page of the EOB so it is more visible to the provider.

B. Automobile Comprehensive Claims

From the universe of 168 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 29 violations noted was based on 25 files, resulting in an error ratio of 50%. 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 per statute for the six claim files noted.

1 Violation *31 Pa. Code §146.3*

The claim files of an insurer shall be subject to examination by the Commissioner or by 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 did not provide a complete claim file for the file noted.

2 Violations *31 Pa. Code §146.5(a)*

Every insurer, upon receiving notification of a claim, shall, within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company did not acknowledge the claim within 10 working days for the two claim files noted.

20 Violations *31 Pa. Code §146.6*

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the 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 20 claim files noted.

The following concern was noted:

CONCERN: In some 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 430 private passenger automobile collision claims reported during the experience period, 75 files were selected for review. All 75 files selected were received and reviewed. The 23 violations noted were based on 22 files, resulting in an error ratio of 29%.

The following findings were made:

13 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 13 claim files noted.

9 Violations *31 Pa. Code §146.6*

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the 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 nine 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. The Company failed to provide acceptance or denial of the claim within 15 working days for the claim file noted.

The following concern was noted:

CONCERN: In some 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.

D. Automobile Total Loss Claims

From the universe of 93 private passenger automobile total loss claims reported during the experience period, 40 files were selected for review. All 40 files were received and reviewed. The 34 violations noted were based on 25 files, resulting in an error ratio of 63%.

The following findings were made:

12 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 12 claim files noted.

1 Violation 31 Pa. Code §62.3(e)(4)

Requires that applicable sales tax on the replacement cost of a motor vehicle shall be included as part of the replacement value. The Company failed to include the sales tax on the replacement value of the vehicle for the claim file noted.

4 Violations 31 Pa. Code §62.3(e)(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 provide a

copy of the total loss evaluation to the insured within 5 working days for the four claim files noted.

16 Violations 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the 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 16 claim files noted.

1 Violation 75 Pa. C.S. §1161(a)(b)

A person, including an insurer or self who owns, possesses or transfer a vehicle located or registered in the Commonwealth which qualifies as a salvage vehicle shall make application to the department for a certificate of salvage for that vehicle.-An owner who transfers a vehicle to be destroyed or dismantled, salvaged or recycled shall assign the certificate of title to the person to whom the vehicle is transferred. Except as provided in section 1163, the transferee shall immediately present the assigned certificate of title to the department or an authorized agent of the department with an application for a certificate of salvage upon a form furnished and prescribed by the department. An insurer as defined in section 1702 to which title to a vehicle is assigned upon payment to the insured or claimant of the replacement value of a vehicle shall be regarded as a transferee under this subsection. The

Company failed to secure the Pennsylvania certificate of salvage when replacement value is paid for the claim file noted.

E. Automobile First Party Medical Claims

From the universe of 95 private passenger automobile first party medical claims reported during the experience period, 40 claim files were selected for review. All 40 files requested were received and reviewed. The 29 violations noted were based on 18 files, resulting in an error ratio of 45%.

The following findings were made:

7 Violations 31 Pa. Code §69.52(b)

Requires an insurer to pay bills for care 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 seven claim files noted.

13 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 13 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. The Company failed to provide acceptance or denial of the claim within 15 working days for the two claim files noted.

7 Violations 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 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 to pay interest on a medical bill that was not paid within 30 days on the seven claim files noted.

The following concern was noted:

CONCERN: The Company is providing a statement/code on the second page of the Explanation of Benefits (EOB) to the provider that the 'Benefits are Exhausted' under First Party Medical coverage for the insured. The Company should provide the 'Benefits are Exhausted' statement in bold print on the first page of the EOB so it is more visible to the provider.

F. Automobile First Party Medical Claims Referred to a PRO

The universe of one automobile first party medical claims that was referred to a peer review organization by the Company was reviewed. The Company was also asked to provide a copy of all peer review contracts in place during the experience period. The four violations noted were based on one file, resulting in an error ratio of 100%.

The following findings were made:

1 Violation *31 Pa. Code §69.52(a)*

Requires an insurer to refer a provider's bill 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. The insurer shall notify a provider, in writing, when referring bills for PRO review at the time of referral. The

Company failed to notify the provider, in writing, upon referring a bill to a PRO on the claim file noted.

1 Violation *31 Pa. Code §69.52(b)*

Requires an insurer to pay bills for care 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 the bill within 30 days on the claim file noted.

1 Violation *31 Pa. Code §69.52(e)*

States 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 the PRO report to the provider and the insured within 5 days of receipt on the claim file noted.

1 Violation *31 Pa. Code §69.53(a) and*
75 Pa. C.S. §1797(b)(1)

A Peer Review Organization shall contract, in writing, jointly or separately with an insurer for the provision of peer review services as authorized by Act 1990-6 and this chapter. Peer review plan for challenges to reasonableness and necessity of treatment. Peer review plan. Insurers shall contract jointly or separately with any peer review organization established for the purpose of evaluating treatment, health care services, products or accommodations provided to any injured person. Such evaluation shall be for the purpose of confirming that

such treatment, products, services or accommodations conform to the professional standards of performance and are medically necessary. An insurer's challenge must be made to a PRO within 90 days of the insurer's receipt of the provider's bill for treatment or services or may be made at any time for continuing treatment or services. The Company utilized a peer review organization without having a contract in place.

VI. 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 ten consumer complaints received during the experience period and provided all consumer complaint logs requested. All ten files requested 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). There were no violations.

The following synopsis reflects the nature of the 30 complaints that were received.

3	Cancellation /Nonrenewal	30%
3	Claims related	30%
3	Rates	30%
1	Rates	10%
10		100%

VII. 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.

The following findings were made:

1 Violation *40 P.S. §991.2003(a)(13)(ii)* – Discrimination Prohibited – An insurer may not cancel or refuse to write or renew a policy of automobile insurance for any of the following reasons: (13) Any accident that occurred under the following circumstances: the applicant, owner or other resident operator is reimbursed by or on behalf of a person who is responsible for the accident or has judgement against such person. The Company cannot discriminate using not-at-fault accidents.

1 Violation *40 P.S. §991.2003(a)(14)* – Discrimination Prohibited – An insurer may not cancel or refuse to write or renew a policy of automobile insurance for any of the following reasons: (14) Any claim under the comprehensive portion of the policy unless such loss was intentionally caused by the insured. The Company cannot discriminate using comprehensive claims.

VIII. 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. There were no violations.

IX. 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. §323.4(b)). One data integrity issue was found during the exam.

The data integrity issue is identified below.

Automobile Property Damage claims

Situation: As the examiners reviewed the automobile property damage files of the automobile claim section of the exam, it was noted that not all files selected for review were automobile property damage claims.

Finding: Of the 75 automobile property damage files reviewed, one file was identified as being an automobile first party medical claim.

General Violation 40 P.S. §323.4(b)

Requires every company or person from whom information is sought must provide to the examiners timely, convenient and free access to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the

company being examined. The violation was the result of a failure to exercise sufficient due diligence to ensure compliance with Insurance Department Act of 1921.

X. 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 31 Pa. Code §62.3 with its claim staff to ensure all appraisal requirements are met so the violations noted in the Report do not occur in the future.

2. The Company must review 31 Pa. Code §62.3(e)(4) with its claim staff to ensure that applicable sales tax on the replacement cost of a motor vehicle is included in the replacement value of the vehicle.

3. 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 violations noted in the Report do not occur in the future.

4. The Company must review 31 Pa. Code §69.52(a) with its claim staff to notify the provider, in writing, upon referring a bill to a PRO.

5. 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.

6. 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 within 5 days of receipt.

7. The Company must review 31 Pa. Code §69.53(a) and 75 Pa. C.S. §1797(b)(1) with its claim staff to ensure that a written contract is in place with an approved peer review organization established for the purpose of evaluating treatment, health care services, products or accommodations provided to any injured person. Such evaluation shall be for the purpose of confirming that such treatment, products, services or accommodations conform to the professional standards of performance and are medically necessary.

8. 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 acknowledgement, status letters and acceptance and denials, as noted in the Report do not occur in the future.

9. The Company must reinforce its internal data controls to ensure that all records and documents are maintained in accordance with 40 P.S. §323.4(b), so that violations noted in the Report do not occur in the future.

10. The Company must review and revise internal control procedures to ensure compliance with refusal to write notice requirements of 40 P.S. §991.2008, so that the violations noted in the Report do not occur in the future.

11. The Company must review 75 Pa. C.S. §1161(a)(b) to ensure that violations regarding providing the required certificate of salvage as noted in the Report, do not occur in the future.

12. The Company must review 75 Pa.C.S. §1716 with its claim staff to ensure

that proper interest is paid on first party medical bills when the bills are not paid within 30 days of receipt.

XI. COMPANY RESPONSE

Metromile Insurance Company
690 Folsom St, Suite 200
San Francisco, CA 94107

Date: January 31, 2020

Pennsylvania Insurance Department
Attn: Paul E. Towsen III, Property & Casualty Market Conduct Division Chief
1321 Strawberry Square
Harrisburg, PA 17120

VIA EMAIL ptowsen@pa.gov

RE: Response to Report of Market Conduct Examination
Metromile Insurance Company
Warrant Number 19-M43-015
Examination Period: January 1, 2018 through December 31, 2018

Dear Mr. Towsen

Thank you for your letter and Report of Examination (the "Report"). Metromile Insurance Company (the "Company") appreciates the opportunity to review the findings and recommendations contained in the Report. The Company acknowledges the Report findings and recommendations contained therein except with respect to VI. Consumer Complaints and V. Claims, as specified below.

VI. Consumer Complaints

The Report states that the synopsis reflects the nature of the 30 complaints that were received. However, there were only 10 complaints. The Company respectfully requests that the Department update the Report to reflect the correct number of complaints, 10, received during the review period.

V. Claims

With respect to **Section A. Automobile Property Damage Claims**, the Company appreciates the Department's time and feedback during follow-up discussions. However, we respectfully continue to disagree with the 4 violations of 31 Pa. Code §146.7(a)(1) as the Company maintains that subsection (a)(1) applies to first-party claimants only. The Company's position is based on the language contained in the statute. It is the Company's position that the reference to "claimant" in the third sentence of 31 Pa. Code §146.7(a)(1) should be read in conjunction with the first sentence that refers specifically to "first-party claimant" as it is a continuing thought.

Furthermore, we disagree with the Department's view that "claimant" in the final sentence of this subsection actually refers to the defined term "Claimant" in 31 Pa. code §146.2(b). The defined term Claimant includes first-party claimants and third-party claimants (among others) which indicates the legislature's understanding that first-party and third-party claimants are distinct, except when viewed as a collective with the intentional use of the defined term. The introductory sentence of 31 Pa. code §146.2(b) states; "[t]he following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise..." . As noted, in drafting section 146.7(a)(1) the drafters specifically did not use the defined term "Claimant" and instead intentionally used a sub part of the definition "first-party claimant." We believe that by the use of this specific language the legislators specifically intended to exclude third-party claimants from this section.

Notwithstanding the Company's position on the intent of 31 Pa. Code §146.7(a)(1), in early 2019 we revised our claims handling procedures to send written denials, when applicable, to third-party claimants in all states, including Pennsylvania. Therefore, the Company's current practice aligns with the Department's interpretation of 31 Pa. Code §146.7(a)(1).

The Company requests that the Department remove these violations and note them as concerns to be addressed by the Company going forward.

X. Recommendations

The Company will take appropriate corrective actions to ensure compliance going forward and submits the following responses in the order of each recommendation:

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

   Company Response: It is the Company's general business practice to comply with all Pennsylvania statutes and regulations. The Company has updated its claim handling procedures to ensure that all appraisals meet the applicable standards per 31 Pa. Code §62.3. Specifically, all appraisals written on behalf of the Company continue to be signed by the appraiser and will indicate clearly when electronically signed. Based on the Department's feedback, appraisals have also been revised to include the appraiser's license number underneath the appraiser's signature. In addition as of October 31, 2018, appraisals written on behalf of the Company include the following statement embedded within the appraisal; "OEM parts are available at OE/Vehicle dealership."

2. The Company must review 31 Pa. Code §62.3(e)(4) with its claim staff to ensure that applicable sales tax on the replacement cost of a motor vehicle is included in the replacement value of the vehicle.

   Company Response: It is the Company's general business practice to comply with all Pennsylvania statutes and regulations. The Company has practices and procedures in place to ensure that the applicable sales tax is included in the replacement value of a motor vehicle; sales tax is automatically built into every total loss settlement calculation. The instance noted was inconsistent with our established practices and the result of an inadvertent error by the claim handler. The Company has reimbursed the insured in this instance 6% of the valuation amount. To help prevent future occurrences of this error, the Company has counseled the individual claim handler in this isolated incident.

3. 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 violations noted in the Report do not occur in the future.

   Company Response: It is the Company's general business practice to comply with all Pennsylvania statutes and regulations. The Company has practices and procedures in place to ensure that a copy of the total loss evaluation is provided to the insured within 5 working days. The instances noted were inconsistent with our established practices and procedures. To help prevent future occurrences of this violation, the Company reminded all claim handlers of the requirement on October 28, 2019. This claim communication was shared with the Department in our response to the violation.

4. The Company must review 31 Pa. Code §69.52(a) with its claim staff to notify the provider, in writing, upon referring a bill to a PRO.

Company Response: It is the Company's general business practice to comply with all Pennsylvania statutes and regulations. The Company has practices and procedures in place to ensure that the provider is notified in writing when a bill is referred to a PRO. The one instance noted was inconsistent with our established practices and the result of the claim handler's inadvertent error. To help prevent future occurrences of this violation, the Company has reminded all medical claim associates of the requirement on October 28, 2019. This communication dated October 28, 2019 (Memorandum Pennsylvania PRO Procedures) has been submitted to the Department.

5. 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.

   Company Response: It is the Company's general business practice to comply with all Pennsylvania statutes and regulations. The Company has practices and procedures in place to ensure that first party medical bills are paid within 30 days. The instance noted was inconsistent with our established practices and the result of the claim handler's inadvertent error. To help prevent future occurrences of this violation, the Company has reminded all medical claim associates of the requirement in a memorandum dated October 28, 2019.

6. 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 within 5 days of receipt.

   Company Response: It is the Company's general business practice to comply with all Pennsylvania statutes and regulations. The Company has practices and procedures in place to ensure that the insured is provided a copy of a PRO evaluation. The instance noted was inconsistent with our established practices and the result of the claim handler's inadvertent error. To help prevent future occurrences of this violation, the Company has reminded all medical claim associates of the requirement in a memorandum dated October 28, 2019.

7. The Company must review 31 Pa. Code §69.53(a) and 75 Pa. C.S. §1797(b)(1) with its claim staff to ensure that a written contract is in place with an approved peer review organization established for the purpose of evaluating treatment, health care services, products or accommodations provided to any injured person. Such evaluation shall be for the purpose of confirming that such treatment, products, services or accommodations conform to the professional standards of performance and are medically necessary.

   Company Response: The Company acknowledges the Department's recommendation and has reviewed the requirements of 31 Pa. Code §69.53(a) and 75 Pa. C.S. §1797(b)(1) with the appropriate claim staff. The Company has taken steps to correct this issue by formalizing its agreement with the approved peer review organization into a written contract.

8. 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 acknowledgement, status letters and acceptance and denials, as noted in the Report do not occur in the future.

   Company Response: It is the Company's general business practice to comply with all Pennsylvania statutes and regulations. The Company has internal practices, procedures and controls in place to ensure that the requirements of 31 Pa. Code, Chapter 146 are met. The instances noted were inconsistent with our established practices and procedures. To help prevent future occurrences of this violation, the Company has

reminded all claim handlers of the requirements of 31 Pa. Code §146. Please see the previously submitted communications sent to the claim staff dated October 14, 2019 and October 29, 2019.

9. The Company must reinforce its internal data controls to ensure that all records and documents are maintained in accordance with 40 P.S. §323.4(b), so that violations noted in the Report do not occur in the future.

   Response: It is the Company's general business practice to comply with all Pennsylvania statutes and regulations. The Company maintains that this was an isolated instance of a file inadvertently set up with a liability property damage exposure based on a vague letter of representation from the insured's attorney. Therefore, pursuant to the Department's request to provide a listing of all liability property damage claim files, the claim was reported to the Department as such, based on the initial claim set up. The Company will continue to reinforce its internal data controls to ensure that all records and documents are maintained in accordance with 40 P.S. §323.4(b).

10. The Company must review and revise internal control procedures to ensure compliance with refusal to write notice requirements of 40 P.S. §991.2008, so that the violations noted in the Report do not occur in the future.

    Company Response: It is the Company's general business practice to comply with all Pennsylvania statutes and regulations. In the noted instances, declination notices were electronically presented to the declined applicants at the time of the refusal to write. To help prevent the violations noted in the Report from occurring in the future, the Company will review its forms and internal procedures to ensure the declination notice is filed and approved by the Department prior to use, and will implement measures to ensure that in the future, a declination notice is also sent to the email address on file for the declined applicant.

11. The Company must review 75 Pa. C.S. §1161(a)(b) to ensure that violations regarding providing the required certificate of salvage as noted in the Report, do not occur in the future.

    Company Response: It is the Company's general business practice to comply with all Pennsylvania statutes and regulations. The Company has reviewed 75 Pa. C.S. §1161(a)(b) and believes that the one instance found was an isolated incident and as a result of the claim handler's inadvertent error. The Company will continue to ensure that claim handlers follow the established practice of uploading the certificate of salvage title into the claim file when applicable.

12. The Company must review 75 Pa.C.S. §1716 with its claim staff to ensure that proper interest is paid on first party medical bills when the bills are not paid within 30 days of receipt.

    Company Response: It is the Company's general business practice to comply with all Pennsylvania statutes and regulations. The Company has practices and procedures in place to ensure that proper interest is paid on first party medical bills when applicable. The instances noted were isolated incidents that were inconsistent with our established practices. To help prevent future occurrences of this violation, the Company claims management has reviewed the requirement with staff and issued a memorandum on October 29, 2019 reminding all medical claim associates of the requirements of the Unfair Insurance Practices/Unfair Claims Settlement Practices.

The Company acknowledges the Department's concerns noted within the Report and has implemented measures to address the identified issues.

The Company appreciates the Department's time and feedback during the course of this exam. We look forward to working with the Department to resolve any outstanding issues. Please contact the undersigned if you have any further questions regarding this response.

Sincerely,

Belema D. Ogulu-Ejorh
Product/Regulatory Counsel