COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

MARKET CONDUCT
EXAMINATION REPORT

OF

PROGRESSIVE ADVANCED INSURANCE COMPANY
CLEVELAND, OH

As of: November 4, 2019
Issued: December 20, 2019

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 4th Day of November , 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

PROGRESSIVE ADVANCED 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:
PROGRESSIVE ADVANCED INSURANCE COMPANY 6300 Wilson Mills Road Mayfield Village, OH 44143	:	40 P.S. §323.4(b) 40 P.S. §§991.2006(2), 991.2008(b) 40 P.S. §1171.5(a)(11) 31 Pa. Code §§62.3, 62.3 (e)(7), 69.22(c), 69.52(b), 146.5(b), 146.5(c), 146.5(d), 146.6, and 146.7(a)(1) 75 Pa. C.S. §1716
	:	Docket No. MC19-12-001
Respondent	:	

CONSENT ORDER

And now, this 20th day of December, 2019, 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 Progressive Advanced Insurance Company, and maintains its address at 6300 Wilson Mills Road, Mayfield Village, OH 44143

(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 November 4, 2019 the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) Respondent provided to the Insurance Department a response to the Examination Report on December 4, 2019.

(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. §991.2006(2), prohibits a cancellation or refusal to renew from being effective unless the insurer delivers or mails a written notice of the cancellation or refusal to renew, which will include the date, not less than 60 days after the date of mailing or delivery, on which the cancellation or refusal to renew shall become effective. When the policy is being cancelled or not renewed for reasons set forth in Sections 2004(1) and (2), however, the effective date may be 15 days from the date of mailing or delivery;

(iii.) 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;

(iv.) 40 P.S. §1171.5(a)(11), requires a company to maintain a complete record of all the complaints it has received during the preceding four years;

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

(vi.) 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;

(vii.) 31 Pa. Code §69.22(c), requires the insurer, when an insured's first-party limits have been exhausted, to provide notice to the provider and the insured within 30 days of the receipt of the provider's bill;

(viii.) 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;

(ix.) 31 Pa. Code §146.5(b), states every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of such inquiry, furnish the Department with an adequate response to the inquiry;

(x) 31 Pa. Code §146.5(c), states an appropriate reply shall be made within 10 working days on other pertinent communications from a claimant which reasonably suggest that a response is expected;

(xi) 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;

(xii) 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;

(xiii) 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;

(xiv) 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.

CONCLUSIONS OF LAW

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

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

(b) Violations of 40 P.S. §§991.2006(2) and 991.2008(b) (relating to motor vehicles) of 40 P.S. are punishable by the following, under Section 991.2013: Any individual or insurer who violates any of the provisions of this article may be sentenced to pay a fine not to exceed five thousand dollars ($5,000).

(c) Respondent's violation of 40 P.S. §1171.5(a)(11) is punishable by the following, under Section 9 of the Unfair Insurance Practices Act (40 P.S. §1171.9):

(i) cease and desist from engaging in the prohibited activity;

(ii) suspension or revocation of the license(s) of Respondent.

(d) 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).

(e) Respondent's violations of 31 Pa. Code §§146.5(b), 146.5(c), 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-Eight Thousand Dollars ($38,000.00) 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 Crystal B. Welsh, 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.

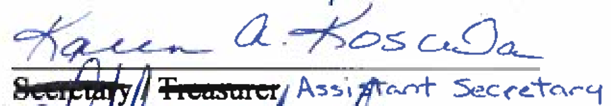
9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

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.

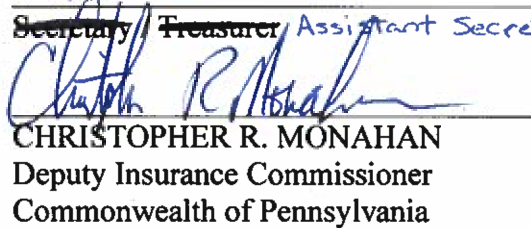
11. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law contained herein, and this Consent Order is not effective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

BY: PROGRESSIVE ADVANCED INSURANCE COMPANY
Respondent

~~President / Vice President~~ Assistant Vice President



~~Secretary / Treasurer~~ Assistant Secretary



CHRISTOPHER R. MONAHAN
Deputy Insurance Commissioner
Commonwealth of Pennsylvania

I. INTRODUCTION

The Market Conduct Examination was conducted at the claims office of Progressive Advanced Insurance Company, hereinafter referred to as "Company", located in Camp Hill, Pennsylvania from April 1, 2019, through April 5, 2019. Subsequent review and follow-up were conducted in the office of the Pennsylvania Insurance Department.

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

Vern Schmidt
Market Conduct Examiner
Pennsylvania Insurance Department

Nanette Soliday
Market Conduct Examiner
Pennsylvania Insurance Department

Joshua Gotwalt
Market Conduct Examiner
Pennsylvania Insurance Department

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted on Progressive Advanced Insurance Company, at the claims office located in Camp Hill, 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

Progressive Advanced Insurance Company ("PRADV") is a wholly-owned subsidiary of Progressive Direct Holdings, Inc., whose ultimate parent is The Progressive Corporation, an insurance holding company. PRADV was incorporated in the State of Tennessee in June of 1930 for the purpose of transacting insurance business, except life insurance, in various classes of insurance as set forth in the insurance laws. PRADV redomesticated to the state of Ohio effective December of 2001. The Company's name changed from Midland Risk Insurance Company to Progressive Home Insurance Company effective September 27, 1999. The Company's name changed from Progressive Home Insurance Company to Progressive Advanced Insurance Company effective May 19, 2006. PRADV is a property and casualty insurer and is part of The Progressive Insurance Group, which consists of 75 companies, of which 43 are insurance companies. PRADV is currently transacting the following lines of business: Inland Marine, Other Liability, Private Passenger Auto No-Fault, Other Private Passenger Auto Liability, and Private Passenger Auto Physical Damage.

LICENSING

Progressive Advanced 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 Connecticut, Massachusetts, Michigan, Minnesota, New Jersey and Wyoming. The Company's 2017 annual statement reflects Direct Written Premium for all lines of business in the Commonwealth of Pennsylvania as $375,785,324. 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) $29,956,076; Other Private Passenger Auto Liability $198,926,287; and Private Passenger Auto Physical Damage $145,246,847.

IV. 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. There were no violations.

V. UNDERWRITING

A. Private Passenger Automobile

1. 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 13,636 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. No violations were noted.

The following concern was noted.

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.

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 61,753 private passenger automobile policies which were cancelled midterm, 75 files were selected for review. All 75 files requested were received and reviewed. No violations were noted.

The following concern was noted:

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.

3. 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 327 private passenger automobile policies which were nonrenewed during the experience period, 50 files were selected for review. All 50 files requested were received and reviewed. The six violations noted were based on six files, resulting in an error ratio of 12%.

The following findings were made:

6 Violations 40 P.S. §991.2006(2)

Requires an insurer to deliver or mail to the named insured a cancellation notice and state the date, not less than sixty (60) days after the date of the mailing or delivery, on which cancellation shall become effective. When the policy is being cancelled for the nonpayment of premium, the effective date may be fifteen (15) days from the date of mailing or delivery. The Company issued a notice of cancellation following an insured request and failed to provide 60 days mailing notice prior to the cancellation effective date on the one file noted. The Company failed to provide 60 days mailing notice prior to the cancellation effective date on the other five files noted.

The following concern was noted:

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.

4. <u>Declinations</u>

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 906 declinations for private passenger automobile insurance, 35 files were selected for review. All 35 files requested were received and reviewed. The 35 violations noted were based on 35 files, resulting in an error ratio of 100%.

The following findings were made:

35 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 the request for review by the Commissioner notice on the declination notices issued for 33 of the files noted. The Company failed to provide a written notice of refusal to write by the insurer for the other two 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.

From the universe of 3,403 private passenger automobile policy, which were rescinded during the experience period, 45 files were received and reviewed. There were no violations 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 27,975 private passenger automobile property damage claims reported during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. The 60 violations noted were based on 49 files, resulting in an error ratio of 49%.

The following findings were made:

37 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 37 claim files noted.

22 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 22 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 claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to deny the claim in writing for the 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.

B. Automobile Comprehensive Claims

From the universe of 16,693 private passenger automobile comprehensive claims reported during the experience period, 50 files were selected for review. All 50 files selected were received and reviewed. Of the 50 files reviewed, one was identified as a collision claim. The 21 violations noted was based on 20 files, resulting in an error ratio of 40%.

The following findings were made:

17 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 17 claim files noted.

4 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 four 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 33,387 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 41 violations noted were based on 32 files, resulting in an error ratio of 43%.

The following findings were made:

28 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 28 claim files noted.

10 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 ten claim files noted.

3 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 claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to provide acceptance or denial of the claim within 15 working days for two of the claim files noted. The Company failed to deny the claim in writing for the other 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 11,215 private passenger automobile total loss claims reported during the experience period, 45 files were selected for review.

All 45 files were received and reviewed. The 45 violations noted were based on 37 files, resulting in an error ratio of 82%.

The following findings were made:

37 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 37 claim files noted.

1 Violation 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 claim file noted.

4 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 four claim files noted.

3 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 three claim files noted.

E. Automobile First Party Medical Claims

From the universe of 9,368 private passenger automobile first party medical claims reported during the experience period, 65 claim files were selected for review. All 65 files requested were received and reviewed. The 43 violations noted were based on 26 files, resulting in an error ratio of 40%.

The following findings were made:

8 Violations *31 Pa. Code §69.22(c)*

States if an insured's first-party limits have been exhausted, the insurer shall, within 30 days of the receipt of the provider's bill, provide notice to the provider and the insured that the first-party limits have been exhausted. The Company failed to provide notice to the provider and/or insured that the first-party benefits have been exhausted for the eight claim files noted.

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.

21 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 21 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 letter shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to deny the claim in writing for the claim file noted.

6 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 did not pay interest on the six claim files that were not paid within 30 days on the claim files noted.

The following concern was noted:

CONCERN: The Company should use the fraud warning under 18 Pa. C.S. §4117(k)(1), "Any person who knowingly, and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects suck person to criminal and civil penalties", on all claim forms.

F. Automobile First Party Medical Claims Referred to a PRO

The universe of 148 automobile first party medical claims that were referred to a peer review organization by the Company 35 files were

selected for review. All 35 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 one violation noted was based on one file, resulting in an error ratio of 3%.

The following findings were made:

1 Violation *31 Pa. Code §69.52(b)*

Requires an insurer to pay bills that are not referred to a Peer Review Organization within 30 days after the insurer receives sufficient documentation supporting the bill. The Company failed to pay medical bills within 30 days for the claim file noted.

VII. 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.

The following concern was noted.

CONCERN: The Company should use the fraud warning under 18 Pa. C.S. §4117(k)(1), "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.", on all claim forms. The Company was using the fraud warning under 75 Pa. C.S. §1822 on the Application for Benefits.

VIII. 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 200 consumer complaints received during the experience period and provided all consumer complaint logs requested. From the universe of 200 complaint files, 55 files were selected for review. All 55 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).

The following findings were made:

5 Violations *40 P.S. §1171.5(a)(11)*

Failure of any person to maintain a complete record of all the complaints which it has 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 Company failed to provide a complete complaint log for the four preceding years. The logs provided do not indicate the time it took to process each complaint and do not list the number of

total complaints. The Company failed to maintain a complete record of all complaints received by the Company from the Department during 2018.

1 Violation *31 Pa. Code §146.5(b)*

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

1 Violation *31 Pa. Code §146.5(c)*

An appropriate reply shall be made within 10 working days on other pertinent communications from a claimant which reasonably suggest that a response is expected. The Company failed to provide a response to the claimant within 10 working days for the claim file noted.

The following concerns were noted:

CONCERN: In one of the 55 complaint files reviewed, the Company received an inquiry or complaint from a consumer and did not respond to the consumer within 10 working days. The Company should respond to a consumer complaint or inquiry that is not related to claims within 10 working days.

CONCERN: In one of the 55 complaint files reviewed, the Company received an inquiry or complaint from the Department and did not respond to the Department within 15 working days. The Company should respond to a Department complaint or inquiry that is not claims related within 15 working days.

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

9	Claims Related	16%
7	Rates	13%
4	Body Shop	7%
13	Miscellaneous	24%
55		100%

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.

Auto Comprehensive Claims

Situation: As the examiners reviewed the comprehensive files of the automobile claims section of the exam, it was noted that not all of the 50 files selected for review were comprehensive files.

Finding: Of the 50 comprehensive claim files reviewed, one file was identified as a collision 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)(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.

3. The Company must review 31 Pa. Code §69.22(c) with its claim staff to ensure that a notice is sent to the provider that first-party benefits were exhausted.

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.

5. 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.

6. 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.

7. The Company must review and revise internal control procedures to ensure compliance with nonrenewal and cancellation notice requirements of 40 P.S. §§991.2006 and 991.2008, so that the violations noted in the Report do not occur in the future.

8. The Company must review 40 P.S. §1171.5(a)(11) to ensure that a complete complaint log is maintained.

9. 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

XI. COMPANY RESPONSE

PROGRESSIVE

December 4, 2019

Progressive Advanced Insurance Company ("Progressive") submits the following responses to the above report. Progressive thanks the Department for its time and cooperation throughout this examination.

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:

   Progressive has already taken steps to update our appraisal forms for compliance with 31 Pa Code §62.3.

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 5 working days so the violations noted in the Report do not occur in the future.*

   Company Response:

   Progressive will reinforce compliance with our claims staff through recommunication of the requirements for 31 Pa. Code §62.3(e)(7).

3. *The Company must review 31 Pa. Code §69.22(c) with its claim staff to ensure that a notice is sent to the provider that first-party benefits were exhausted.*

   Company Response:

   Progressive continues to respectfully disagree with these violations. The code does not prescribe that the notice to the provider take the form of a separate notice, nor does it specify the type of notice that's required to comply with the statute. Additionally, the code does not define what constitutes a "notice," thus, it is reasonable to rely on a common language definition of the term, such as Black's Law Dictionary.

   Black's Law Dictionary defines notice as: 1. Legal notification required by law or agreement, or imparted by operation of law as a result of some fact (such as the recording of an instrument); definite legal cognizance, actual or constructive, of an existing right or title <under the lease, the tenant must give the landlord written notice 30 days before vacating the premises>. • A person has notice of a fact or condition if that person (1) has actual knowledge of it; (2) has received information about it; (3) has reason to know about it; (4) knows about a related fact; or (5) is considered as having been able to ascertain it by checking an official filing or recording. 2. The condition of being so notified, whether or not actual awareness exists <all prospective buyers

were on notice of the judgment lien>. Cf. knowledge. 3. A written or printed announcement <the notice of sale was posted on the courthouse bulletin board>. (11th ed., 2019)

When considering this dictionary definition, the Company's Explanation of Benefits provides the provider with the necessary information that the benefits have been exhausted. The reader of the Explanation of Benefit can ascertain that the benefits have been exhausted by referencing the endnote code. Thus, the Company's Explanation of Benefits complies with the statutorily required notice to the provider.

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.*

Company Response:

Progressive will reinforce compliance with our claims staff through recommunication of the requirements for 31 Pa. Code §69.52(b).

5. *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:

Progressive has already taken steps to revise our internal procedures based on the Department's recommendations with regards to 31 Pa. Code §146.5(d).

6. *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.*

Company Response:

Progressive will review its internal data controls and make any adjustments as necessary.

7. *The Company must review and revise internal control procedures to ensure compliance with nonrenewal and cancellation notice requirements of 40 P.S. §§§991.2004, 991.2006 and 991.2008, so that the violations noted in the Report do not occur in the future.*

Company Response:

Progressive continues to respectfully disagree with two of the violations noted. In Erie Insurance Exchange v. Lake, the Court held:

"an insurer may rescind a policy of insurance as to the actual perpetrator of the fraud, where the fraud could not reasonably have been discovered within the 60 day period immediately

following issuance of the policy; limited to those instances where the undiscovered fraud was of such a nature that it is clear that an insurer would never have accepted the risk inherent in issuing the policy. To find otherwise would be to interpret Act 78 as intending an absurd result."

In the two instances noted in the report, the policies were procured with fraudulent credit cards and subsequent payments were made with insufficient funds. Progressive receives and downloads batch files of credit card chargebacks daily (Monday - Friday) from its credit card vendors and then processes them in the order in which they are received and due back to the vendor. Credit card users typically do not see a potential chargeback or unauthorized use until it appears on their monthly statement, which can be 30+ days after the chargeback or unauthorized use has occurred. The customer reports this information to their credit card company, who sends to Progressive. This process can take longer than 60 days to complete.

Here, Progressive respectfully asserts that it would not have accepted these policies had it known that the funds used to purchase them were fraudulent. Progressive was unable to discover this fraudulent activity until it received and processed the chargeback information, which occurred after the first 60 days of inception. Thus, Progressive maintains it has complied with Pennsylvania law. Policy timeline and details available upon request.

With regards to language on our declination notices, Progressive has already initiated a project to provide the request for Review by Commissioner on our declination notices.

8. *The Company must review 40 P.S. §1171.S(a)(l l) to ensure that a complete complaint log is maintained.*

Company Response:

Progressive will review our current complaint log and make any adjustments as necessary.

9. *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:

Progressive will reinforce compliance with our claims staff through recommunication of the requirements for 75 Pa.C.S. §1716.