COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

MARKET CONDUCT
EXAMINATION REPORT

OF

Liberty Mutual
General Insurance Company
BOSTON, MA

As of: July 6, 2018
Issued: September 5, 2018

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).

Paul E Tower III

(Examiner Name), Examiner-in-Charge

Sworn to and Subscribed Before me

This 20th Day of June, 2018

Glenda J Ebersole

Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Glenda J. Ebersole, Notary Public
City of Harrisburg, Dauphin County
My Commission Expires Feb. 13, 2019

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
LIBERTY MUTUAL GENERAL INSURANCE COMPANY Attn: Sebestyn Martens 175 Berkeley Street Boston, MA 02116	:	40 P.S. §323.4(b)
	:	
	:	18 Pa. Code §4117(k)(1)
	:	
	:	31 Pa. Code §§62.3, 62.3(e)(7), 69.22(c)
	:	69.43(d), 69.52(a), 69.52(b), 69.53(a)
	:	146.3, 146.5(a), 146.5(c), 146.5(d), 146.6
	:	146.7(a)(1) and 146.7(c)(1)
	:	
	:	75 Pa. C.S. §§1161(a)(b), 1716
	:	and 1797(b)(1)
	:	
	:	
Respondent.	:	Docket No. MC18-07-003

CONSENT ORDER

AND NOW, this 5th day of September, 2018, 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 Liberty Mutual General Insurance Company, and maintains its address at 175 Berkely Street, Boston, MA 02116.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the experience period from January 1, 2016 through December 31, 2016.

(c) On July 6, 2018, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on August 6, 2018.

(e) The Market Conduct Examination of Respondent revealed 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) 18 Pa. Code §4117(k)(1), states 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;

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

(iv) 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;

(v) 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;

(vi) 31 Pa. Code §69.43(d), requires an insurer to provide a complete explanation of the calculations made in computing its determination of the repriced bill;

(vii) 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;

(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 §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;

(x) 31 Pa. Code §146.3, requires the claim files of the insurer shall be subject to examination by the Commissioner or by his 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;

(xi) 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;

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

(xiii) 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;

(xiv) 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;

(xv) 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;

(xvi) 31 Pa. Code §146.7(c)(1), states the following provisions govern acceptance or denial of a claim where additional time is needed to make a determination: (1) If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected;

(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) Respondent's violations of 31 Pa. Code §§146.3, 146.5(a), 146.5(c), 146.5(d), 146.6, 146.7(a)(1) and 146.7(c)(1) are punishable under 40 P.S. §1771.9:

(1) An order to cease and desist.

(2) License suspension or revocation.

(c) In addition to any penalties imposed by the Commissioner for Respondent's violations of 31 Pa. Code §§146.3, 146.5(a), 146.5(c), 146.5(d), 146.6, 146.7(a)(1) and 146.7(c)(1) 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:

(1) An injunction.

(2) 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) for each violation but not to

exceed an aggregate penalty of fifty thousand dollars ($50,000) in any six month period.

(3) 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) for each violation but not to exceed an aggregate penalty of ten thousand dollars ($10,000) in any six month period.

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 Seventy Five Thousand Dollars ($75,000.00) 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 April Phelps, Insurance Department, Bureau of

Market Actions, 1227 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.

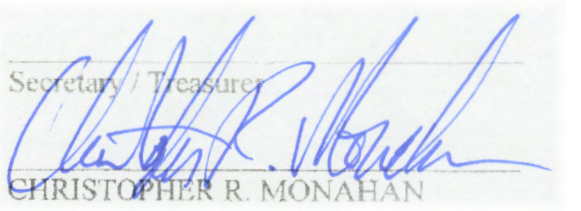
9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

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: LIBERTY MUTUAL GENERAL INSURANCE COMPANY
Respondent

Secretary / Treasurer



CHRISTOPHER R. MONAHAN
Deputy Insurance Commissioner
Commonwealth of Pennsylvania

BY: LIBERTY MUTUAL GENERAL INSURANCE COMPANY
Respondent

President / Vice President

LAURANCE YAHIA

Secretary / Treasurer

CHRISTOPHER R. MONAHAN
Deputy Insurance Commissioner
Commonwealth of Pennsylvania

I. INTRODUCTION

The Market Conduct Examination of Liberty Mutual General Insurance Company, hereinafter referred to as "Company", was conducted in the office of the Pennsylvania Insurance Department beginning on December 4, 2017. 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.

Kelly Krakowski, MCM
Market Conduct Division Chief
Pennsylvania Insurance Department

Paul Towsen
Market Conduct Examiner
Pennsylvania Insurance Department

Ryan Sellers
Market Conduct Examiner
Pennsylvania Insurance Department

Nanette Soliday
Market Conduct Examiner
Pennsylvania Insurance Department

Vern Schmidt
Market Conduct Examiner
Pennsylvania Insurance Department

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted in the office of the Pennsylvania Insurance Department. There was no onsite portion of the exam. 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, 2016, through December 31, 2016, 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. Claims
2. Forms
3. Complaints
4. Data Integrity
5. Private Passenger Automobile MCAS Reporting

III. COMPANY HISTORY

The business of Liberty Mutual is headquartered in Boston, Massachusetts. Liberty Mutual General Insurance Company's date of registration in the state of Pennsylvania is 7/24/81. Liberty Mutual General Insurance Company has the ability the write different types of business including Accident and Health, Auto Liability, Boiler & Machinery, Burglary-Theft, Credit, Fidelity and Surety, Inland Marine & Physical Damage, Ocean Marine, Other Liability and Workers' Compensation. Liberty Mutual General Insurance Company is a company under Liberty Mutual Insurance. Today Liberty Mutual is a diversified insurer with operations in 28 countries and economies around the world.

LICENSING

Liberty Mutual General Insurance Company's last Certificate of Authority to write business in the Commonwealth was last issued on April 1, 2018. The Company is licensed in the District of Columbia and all fifty states with the exception of New Jersey, Alaska, and Hawaii. The Company's 2016 annual statement reflects Direct Written Premium for all lines of business in the Commonwealth of Pennsylvania as $222,623,069. Premium volume related to Private Passenger Automobile Direct Written Premium was reported as Private Passenger Auto No-Fault (Personal Injury Protection) $23,142,065; Other Private Passenger Auto Liability $98,498,744; and Private Passenger Auto Physical Damage $100,982,260.

IV. 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 13,189 private passenger automobile property damage liability claims reported during the experience period, 175 files were selected for review. All 175 files selected were received and reviewed. Of the 175 files reviewed, two files were noted as total loss claims. The 89 violations noted were based on 82 files, resulting in an error ratio of 47%.

The following findings were made:

39 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 39 claims noted.

8 Violations 31 Pa. Code §146.5(a)

Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgement is made by means other than writing, an appropriate notation of the acknowledgement 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 failed to acknowledge the claim within 10 working days for the eight claims noted.

19 Violations 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the 19 claims noted.

23 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 deny the claim in writing for the 23 files noted.

The following concern was noted:

CONCERN: When the Company closes a claim file with no payment, it is not providing the policyholder/clamant with written notice indicating its action. The Company should provide policyholders/claimants with written notice when a claim file is being closed with no payment.

B. Automobile Comprehensive Claims

From the universe of 29,192 private passenger automobile comprehensive claims reported during the experience period, 180 files were selected for review. All 180 files selected were received and reviewed. Of the 180 files reviewed, 35 files were identified as collision claims. The 69 violations noted were based on 53 files, resulting in an error ratio of 29%.

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 claims noted.

13 Violations 31 Pa. Code §146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his 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. The Company failed to provide a complete file for the 13 claims noted.

6 Violations 31 Pa. Code §146.6

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

13 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 accept or deny the claim within 15 working days for 12 of the files noted and failed to issue a denial letter to the insured for one file noted.

The following concern was noted:

CONCERN: When the Company closes a claim file with no payment, it is not providing the policyholder/clamant with written notice indicating its action. The Company should provide policyholders/claimants with written notice when a claim file is being closed with no payment.

C. Automobile Collision Claims

From the universe of 14,394 private passenger automobile collision claims reported during the experience period, 175 files were selected for review. All 175 files selected were received and reviewed. The 86 violations noted were based on 77 files, resulting in an error ratio of 44%.

The following findings were made:

68 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 68 claims noted.

1 Violation 31 Pa. Code §146.5(a)

Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgement is made by means other than writing, an appropriate notation of the acknowledgement 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 failed to acknowledge the claim within 10 working days for the claim noted.

15 Violations 31 Pa. Code §146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the 15 claims noted.

2 Violations 31 Pa. Code §146.7(a)(1)

Acceptance or denial of a claim shall comply with the following: Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the

claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to accept or deny the claim within 15 working days for the two files noted.

The following concern was noted:

CONCERN: When the Company closes a claim file with no payment, it is not providing the policyholder/clamant with written notice indicating its action. The Company should provide policyholders/claimants with written notice when a claim file is being closed with no payment.

D. Automobile Total Loss Claims

From the universe of 3,401 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 79 violations noted were based on 64 files, resulting in an error ratio of 85%.

The following findings were made:

47 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 47 claims noted.

10 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 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 ten claims noted.

15 Violations *31 Pa. Code §146.6*

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless such investigation cannot be reasonably be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the 15 claims 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 accept or deny the claim within 15 working days for the three files noted.

1 Violation *31 Pa. Code §146.7(c)(1)*

States if an insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. The Company failed, within 15 working days, to provide notice to the first-party claimant that more time is needed for the claim noted.

3 Violations *75 Pa. C.S. §1161(a)(b)*

Requires a person, including an insurer or self-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 who 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. An insurer 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. The Company did not provide a copy of a Pennsylvania certificate of salvage for two claims noted. The Company also paid a claim for an owner retained vehicle prior to obtaining the Pennsylvania salvage certificate for one claim noted.

E. Automobile First Party Medical Claims

From the universe of 3,009 private passenger automobile first party medical claims reported during the experience period, 75 files were selected for review. All 75 files selected were received and reviewed. One file was identified as a first party medical claim referred to a PRO. The 76 violations noted were based on 61 files, resulting in an error ratio of 81%.

The following findings were made:

5 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 five claims noted.

6 Violations 31 Pa. Code §69.43(d)

Requires an insurer to provide a complete explanation of the calculations made in computing its determination of the repriced bill. The Company failed to provide a complete

explanation of how the repriced bill was calculated for the eight claims noted.

3 Violations *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 three claims noted.

1 Violation *31 Pa. Code §146.5(a)*

Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgement is made by means other than writing, an appropriate notation of the acknowledgement 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 failed to acknowledge the claim within 10 working days for the file noted.

54 Violations *31 Pa. Code §146.5(d)*

Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim

shall constitute compliance with subsection (a). The Company failed to send the necessary claim forms within 10 working days for the 54 files noted.

3 Violations 31 Pa. Code §146.6

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

2 Violations 75 Pa. C.S. §1716

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 the proper amount of interest for the two claims noted. The Company must provide proof that the outstanding

amount plus 12% interest per year was paid to the provider for the claims noted.

F. Automobile First Party Medical Claims Referred to a PRO

From the universe of 87 private passenger automobile first party medical claims referred to a PRO reported during the experience period, 15 files were selected for review. All 15 files were received and reviewed. The 22 violations noted were based on 14 files, resulting in an error ratio of 93%.

The following findings were made:

3 Violations 31 Pa. Code §69.52(a)

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

3 Violations 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 three claims noted.

2 Violations *31 Pa. Code §69.53(a)*

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 purposes 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 failed to have a written contract in place with two of its Peer Review Organizations.

10 Violations *31 Pa. Code §146.6*

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

delay and state when a decision on the claim may be expected. The Company did not provide timely status letters for the ten claims noted.

2 Violations *75 Pa. C.S. §1716*

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 the proper amount of interest for the two claims noted. The Company must provide proof that the outstanding amount plus 12% interest per year was paid to the provider for the claim noted.

2 Violations *75 Pa. Code §1791(b)(1)*

Insurers shall contract jointly or separately with any peer review organization established for the purposes 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 failed to refer to a PRO within 90 days of the insurer's receipt of the provider bill for treatment or services for the two claims noted.

V. FORMS

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

The following findings were made:

4 Violations 18 Pa. C.S. §4117(k)(1)

> All applications for insurance and all claim forms shall contain or have attached thereto the following notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. For three of the violations noted,

the Company failed to provide the required fraud warning on claims forms. For one of the violations noted, the company used a fraud warning that was not verbatim per statute on a claims form.

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 281 consumer complaints received during the experience period and provided all consumer complaint logs requested. From the universe of 281 complaint files, 75 files were selected for review. All 75 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:

20 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 20 claims noted.

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 noted.

2 Violations 31 Pa. Code §146.5(a)

Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgement is made by means other than writing, an appropriate notation of the acknowledgement 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 failed to acknowledge the claim within 10 working days for the two claims 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 noted.

11 Violations 31 Pa. Code §146.6

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

expected. The Company did not provide timely status letters for the 11 claims 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 issue a denial letter to the insured for the file noted.

1 Violation *75 Pa. C.S. §1161(a)(b)*

Requires a person, including an insurer or self-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 who 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. An insurer 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. The Company did not provide a copy of a Pennsylvania certificate of salvage for the claim noted.

The following concerns were noted:

CONCERN: The Company should maintain its Complaint data in a specific log format which will allow the Department to more readily ensure compliance with 40 P.S. §1171.1(a)(11).

CONCERN: In one of the 75 complaint files reviewed, the Company received an inquiry or a 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.

CONCERN: In one of the 75 complaint files reviewed, the Company received an inquiry or a complaint directly 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 claims related within 10 working days.

CONCERN: In one file 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.

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

9	Cancellation/Nonrenewal	12%
51	Claims Related	68%
7	Premium/Rating	9%
8	Miscellaneous	11%
75		100%

VII. 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)). Several data integrity issues were found during the exam.

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

Automobile Comprehensive Claims

Situation: As the examiners reviewed the comprehensive claim files of the automobile claims section of the exam, it was noted that not all of the 180 files selected for review were comprehensive claim files.

Finding: Of the 180 Comprehensive Claims reviewed, 35 files were identified as Collision Claims.

Property Damage Claims

Situation: As the examiners reviewed the property damage claim files of the automobile claims section of the exam, it was noted that not all of the 175 files selected for review were property damage claim files.

Finding: Of the 175 Property Damage Claims reviewed, two files were identified as Total Loss claims.

First Party Medical Claims

Situation: As the examiners reviewed the first party medical claim files of the automobile claims section of the exam, it was noted that not all of the 75 files selected for review were first party medical claim files.

Finding: Of the 75 First Party Medical Claims reviewed, one file was identified as a First Party Medical Claim Referred to PRO claim.

The following finding was made:

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.

VIII. PRIVATE PASSENGER AUTOMOBILE MCAS REPORTING

In Pennsylvania, insurers are required annually to submit a Market Conduct Annual Statement (MCAS) to the National Association of Insurance Commissioners (NAIC). The review of MCAS data was conducted pursuant to the authority granted by Section 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the Market Conduct Annual Statement (MCAS) reporting for 2015 and 2016.

The examination team reviewed the Company's 2015 and 2016 MCAS Submissions. All companies that submit an MCAS filing must attest to the completeness and accuracy of their submission. The attestation is required once per filing period and applies to all submissions for a specific company code. No submissions will be accepted until an attestation is completed for the company. Below are the private passenger automobile sections that were reviewed.

A.	Number of claims open at the beginning of the period.
B.	Number of claims open at the beginning of the period.
C.	Number of claims opened during the period.
D.	Number of claims closed during the period, with payment.
E.	Number of claims closed during the period, without payment.
F.	Number of claims remaining open at the end of the period.
G.	Number of claims closed with payment within 0-60 days.
H.	Number of claims closed with payment > 60 days.
I.	Number of suits open at the beginning of the period.
J.	Number of suits open during the period.
K.	Number of suits closed during the period.
L.	Number of suits open at the end of the period.

The review consisted of three phases, as noted below.

Phase 1

The Company was asked to provide the claims and policy data listings that support the 2015 and 2016 MCAS filing. Each list contained the claim and policy numbers for each category. The 2015 and 2016 data submitted was validated to ensure the information was accurate and consistent with the information provided to the NAIC.

The following findings were made:

8 Violations 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 eight violations resulted from the failure to exercise sufficient due diligence to ensure the requirement of providing data that was consistent with the information provided to the NAIC for eight claim categories.

Phase 2

The Company was asked to provide a record of all claims and policy data listings which supported the 2015 and 2016 MCAS filings. From each universe list of 2015 and 2016 data, a random sample of five claims was requested, received and reviewed. The files were reviewed to ensure compliance with the Commonwealth of Pennsylvania's Statutes and Regulations.

The following findings were made:

22 Violations 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 Company failed to provide accurate data for 22 files in nine claim categories.

Phase 3

A review was performed on various claims provided in the Market Conduct portion of the exam to ensure the MCAS data was inclusive of all the policies applicable to each line item. The files were reviewed to ensure compliance with the Commonwealth of Pennsylvania's Statutes and Regulations.

The following findings were made:

1 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 Company failed to provide accurate data for the claim category noted.

IX. 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 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.

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

3. 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.

4. The Company must review 31 Pa. Code §62.3(e)(7) with its claim staff to ensure that the consumer receives the total loss evaluation report within 5 working days after the appraisal is completed.

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

6. The Company must review 75 Pa. C.S. §116l (a)&(b) with its claim staff to ensure that Pennsylvania salvage certificates are obtained and retained with the claim file and also that claims are not paid on owner retained vehicles prior to obtaining the Pennsylvania salvage certificate.

7. The Company must review 31 Pa. Code §69.22(c) with its claim staff to ensure that the insured and provider are properly notified when first-party medical benefits have been exhausted.

8. 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.

9. The Company must review 31 Pa. Code §69.43(d) with its claim staff to ensure a complete explanation of how a repriced bill was calculated is sent to the provider.

10. The Company must review 31 Pa. Code §69.52(a) with its claim staff to ensure that a written notification is issued to providers when referring bills for a PRO review.

11. The Company must review 75 Pa. C.S. §1716 with its claim staff to ensure that a provider is paid the outstanding amount plus 12% interest when appropriate.

12. The Company must review 75 Pa. C.S. §1797(b)(1) and 31 Pa. Code §69.53(a) 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.

13. The Company must review 75 Pa. C.S. §1797(b)(1) with its claim staff to ensure that a bill is referred to a PRO within 90 days of receipt of providers bill for treatment of services.

14. The Company must review 31 Pa Code §146.3 with its claim staff to ensure the claims department maintains complete claim files.

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

X. COMPANY RESPONSE

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August 6, 2018

Kelly Krakowski
Chief, Property & Casualty Division
Office of Market Regulation
Pennsylvania Insurance Department
1321 Strawberry Square
Harrisburg, PA 17120

Re: Examination Warrant Number: 17-M36-012
LM General Insurance Company
LM Insurance Corporation

Dear Ms. Krakowski,

LM General Insurance Company, and LM Insurance Corporation (collectively the "Companies'") are in receipt of the Draft Reports ("Reports") dated July 6, 2018. Thank you for the opportunity to review the findings and recommendations contained therein. The Companies' acknowledge the Report findings and each of the Department's thirteen (13) recommendations. With respect to the recommendations noted the Companies' will take corrective action where appropriate to revise internal processes to ensure compliance going forward.

Finally, to the extent the Department requires more detail on any corrective action taken by the Companies' relative to the Report please feel free to contact the undersigned.

Thank you again for your time and consideration.

Sincerely,

Sebestyen Q. Martens