



**COMMONWEALTH OF PENNSYLVANIA  
INSURANCE DEPARTMENT**

**MARKET CONDUCT  
EXAMINATION REPORT**

**OF**

**SAFE AUTO INSURANCE COMPANY  
COLUMBUS, OH**

**As of: March 13, 2018**

**Issued: May 11, 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. Towser III*

(Examiner Name), Examiner-in-Charge

Sworn to and Subscribed Before me

This *12<sup>th</sup>* Day of *April*, 2018

*Reuben Morris Jackson*  
Notary Public

COMMONWEALTH OF PENNSYLVANIA

NOTARIAL SEAL

REUBEN MORRIS JACKSON

Notary Public

TREDYFFRIN TWP, CHESTER COUNTY

My Commission Expires Jul 20, 2020

BEFORE THE INSURANCE COMMISSIONER  
OF THE  
COMMONWEALTH OF PENNSYLVANIA

IN RE: : VIOLATIONS:  
: :  
SAFE AUTO INSURANCE COMPANY : 40 P.S. §323.4(b)  
Attn: Kelly Armstrong : :  
4 Easton Oval : 40 P.S. §§991.2002(c)(3)  
Columbus, OH 43219 : 991.2003(a)(13)(ii), 991.2004  
: 991.2006(2) and 991.2008(b)  
: :  
: 40 P.S. §§1171.5(a)(7)(iii)  
: and 1171.5(a)(11)  
: :  
: 18 Pa Code §4117(k)(1)  
: :  
: 31 Pa. Code §§62.3(a)(1), 62.3(b)(2)  
: 62.3(b)(3), 62.3(b)(4), 62.3(b)(5)  
: 62.3(b)(6), 62.3(b)(7), 62.3(b)(9)  
: 62.3(b)(10), 62.3(e)(7), 69.22(c), 69.52(a)  
: 69.52(b), 69.52(d), 69.52(e), 69.53(a)  
: 146.3, 46.5(a), 146.5(d), 146.6 and  
: 146.7(a)(1)  
: :  
: 75 Pa. C.S. §§1161(a)(b), 1716  
: 1797(b)(1) and 1797(b)(5)  
: :  
Respondent. : Docket No. MC18-03-012

CONSENT ORDER

AND NOW, this 11<sup>th</sup> day of May, 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 Safe Auto Insurance Company, and maintains its address at 4 Easton Oval, Columbus, OH 43219.

(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 March 13, 2018, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on April 12, 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) 40 P.S. §991.2002(c)(3), requires that an insurer supply the insured with a written statement of the reason for cancellation;
- (iii) 40 P.S. §991.2003(a)(13)(ii), requires states that an insurer may not cancel or refuse to renew a policy of automobile insurance for the following reason: An accident which occurred under the following circumstances: The applicant, owner or other resident operator is reimbursed by or on behalf of a person who is responsible for the accident or has judgment against such person.

- (iv) 40 P.S. §991.2004, requires that no insurer shall cancel a policy of automobile insurance except for (a) nonpayment of premium, (b) suspension or revocation of the named insured's driver license or motor vehicle registration or a (c) determination that the insured has concealed a material fact or has made a material allegation contrary to fact or has made a misrepresentation of material fact and that such concealment, allegation or misrepresentation was material to the acceptance of the risk by the insurer;
  
- (v) 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;
  
- (vi) 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;

- (vii) 40 P.S. §1171.5(a)(7)(iii), defines and prohibits unfair methods of competition as making or permitting any unfair discrimination between individuals of the same class and essentially the same hazard with regard to underwriting standards and practices or eligibility requirements by reason of race, religion, nationality or ethnic group, age, sex, family size, occupation, place of residence or marital status;
  
- (viii) 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;
  
- (ix) 18 Pa. C.S. §4117(k)(l), 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;
  
- (x) 31 Pa. Code §62.3(a)(1), states an appraisal shall be signed by the appraiser before submitting the information to an insurer, consumer, or other party involved. An electronic signature is acceptable to remain compliant with appraisal requirements;

- (xi) 31 Pa. Code §62.3(b)(2), states an appraisal statement shall contain all items necessary to return the vehicle to its condition prior to the damage in question, including, but not necessarily limited to labor involved; necessary painting or refinishing, and all sublet work to be done and a clear indication of the cost or dollar amount value of all specified items. In addition to the requirements listed, the appraisal shall also contain a written disclosure that states costs above the appraised amount may be the responsibility of the vehicle owner;
  
- (xii) 31 Pa. Code §62.3(b)(3), states an appraisal statement shall contain all items necessary to return the vehicle to its condition prior to the damage in question, including, but not necessarily limited to labor involved; necessary painting or refinishing, and all sublet work to be done and a clear indication of the cost or dollar amount value of all specified items. In addition to the requirements listed, an appraisal shall also contain a written disclosure informing the policyholder that there is no requirement to use any specified repair shop;
  
- (xiii) 31 Pa. Code §62.3(b)(4), states an appraisal statement shall contain all items necessary to return the vehicle to its condition prior to the damage in question, including, but not necessarily limited to labor involved; necessary painting or refinishing, and all sublet work to be done and a clear indication of the cost or dollar amount value of all specified items. In addition to the requirements listed, an appraisal shall also contain a written disclosure informing the

consumer of repair facilities that are able to repair the vehicle for the appraised amount;

(xiv) 31 Pa. Code §62.3(b)(5), states an appraisal statement shall contain all items necessary to return the vehicle to its condition prior to the damage in question, including, but not necessarily limited to labor involved; necessary painting or refinishing, and all sublet work to be done and a clear indication of the cost or dollar amount value of all specified items. In addition to the requirements listed, an appraisal shall also contain a written disclosure informing the consumer of repair facilities that are able to repair the vehicle for the appraised amount;

(xv) 31 Pa. Code §62.3(b)(6), requires an appraisal shall contain a written disclosure which includes the following: Incidental charges, known at the time of appraisal, including towing, protective care, custody, storage, depreciation, battery and tire replacement;

(xvi) 31 Pa. Code §62.3(b)(7), states an appraisal statement shall contain all items necessary to return the vehicle to its condition prior to the damage in question, including, but not necessarily limited to labor involved; necessary painting or refinishing, and all sublet work to be done and a clear indication of the cost or dollar amount value of all specified items. In addition to the requirements of the act, an appraisal shall contain a written disclosure of applicable sales tax;

- (xvii) 31 Pa. Code §62.3(b)(9), requires that an appraisal shall contain a written disclosure which includes the following: The location where the listed parts are available in a condition equivalent to, or better than, the condition of the replaced parts prior to the accident;
  
- (xviii) 31 Pa. Code §62.3(b)(10), requires that an appraisal shall contain a written disclosure which includes the following: If the appraisal includes aftermarket crash parts, a statement that the appraisal has been prepared based on the use of aftermarket crash parts, and that if the use of an aftermarket crash part voids the existing warranty on the part being replaced or any other part, the aftermarket crash part shall have a warranty equal to or better than the remainder of the existing warranty;
  
- (xix) 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;
  
- (xx) 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;

- (xxi) 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;
- (xxii) 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;
- (xxiii) 31 Pa. Code §69.52(d), states a PRO's initial determination shall be completed within 30 days after the receipt of requested information. When a provider fails to respond to the PRO's inquiry or provide requested information, a PRO may commence its review 30 days after the request for information is postmarked. If additional information critical for the outcome of the determination is submitted by a provider or requested by a PRO, the 30-day review period may be tolled up to 20 days for the information to be received and taken into consideration;

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

- (xxix) 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;
- (xxx) 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;
- (xxxii) 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;
- (xxxiii) 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;

(xxxiii) 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;

(xxxiv) 75 Pa. C.S. §1797(b)(5), requires that if a PRO determines that medical treatment or rehabilitative services or merchandise were medically necessary, the insurer must pay to the provider the outstanding amount plus interest at 12% per year on any amount withheld by the insurer pending PRO review.

## 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. §§991.2002(c)(3), 991.2003(a)(13)(ii), 991.2004, 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 violations of 40 P.S. §§1171.5(a)(7)(iii) and 1171.5(a)(11) are 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 §§146.3, 146.5(a), 146.5(d), 146.6 and 146.7(a)(1) are punishable under Sections 1 through 5 and Section 9 of the Unfair Insurance Practices Act (40 P.S. §§1171.1 – 1171.5 and 1171.9):

- (i) cease and desist from engaging in the prohibited activity;
- (ii) suspension or revocation of the license(s) of Respondent.

(f) In addition to any penalties imposed by the Commissioner for Respondent's violations of 40 P.S. §§1171.1 – 1171.5, the Commissioner may, under (40 P.S. §§1171.10, 1171.11) file an action in which the Commonwealth Court may impose the following civil penalties:

- (i) for each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00);
- (ii) for each method of competition, act or practice which the company did

not know nor reasonably should have known was in violation of the law,  
a penalty of not more than one thousand dollars (\$1,000.00).

ORDER

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

- (a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.
- (b) Respondent shall pay Ninety-Five Thousand Dollars (\$95,000.00) 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.

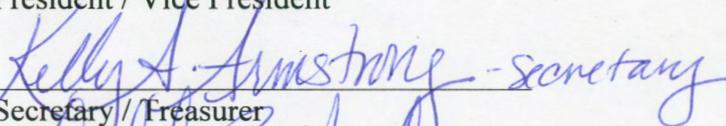
9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

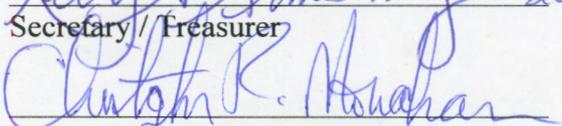
10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

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: SAFE AUTO INSURANCE COMPANY  
Respondent

  
\_\_\_\_\_  
President / Vice President

  
\_\_\_\_\_  
Secretary / Treasurer

  
\_\_\_\_\_  
CHRISTOPHER R. MONAHAN  
Deputy Insurance Commissioner  
Commonwealth of Pennsylvania

## **I. INTRODUCTION**

The market conduct examination was conducted at the home office of Safe Auto Insurance Company, hereinafter referred to as “Company,” located in Columbus, Ohio from August 22, 2017, through September 1, 2017. Subsequent review and follow-up was 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.

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

## **II. SCOPE OF EXAMINATION**

The Market Conduct Examination was conducted on Safe Auto Insurance Company, at its home office located in Columbus, Ohio. 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. Private Passenger Automobile
  - Underwriting – Appropriate and timely notices of nonrenewal, midterm cancellations, 60-day cancellations, rescissions and declinations.
2. Claims
3. Forms
4. Complaints
5. Data Integrity

### **III. COMPANY HISTORY**

Safe Auto Insurance Company is an Ohio corporation, founded in 1993 and maintains its principal place of business in Columbus, Ohio. The founders Ari Deshe and Jon Diamond, serve as co-Chairmen of the Board, with Ronald Davies serving as CEO. Safe Auto is owned by Safe Auto Insurance Group, Inc., an insurance holding company also based in Columbus, Ohio, and is primarily owned by the Deshe and Diamond families. Safe Auto is a single line company, with a niche market of minimum limits private passenger automobile liability coverage. The company writes primarily through employee agents on a direct basis, and maintains call centers at its corporate headquarters in Columbus, Ohio as well as in Woodsfield, Ohio and Somerset, Kentucky for handling policy sales and customer service requests. In addition to the liability, comprehensive, collision, uninsured and underinsured motorist coverages, the company offers rental reimbursement, towing and labor, excess medical expense and accidental death coverages.

### **LICENSING**

Safe Auto Insurance Company's Certificate of Authority to write business in the Commonwealth was issued on April 1, 2017. The Company is licensed in Arizona, California, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Nevada, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, and Virginia. The Company's 2016 annual statement reflects Direct Written Premium for all lines of business in the Commonwealth of Pennsylvania as \$43,704,518. Premium volume related to Private Passenger Automobile Direct Written Premium was reported as Private Passenger Auto No-Fault (Personal Injury Protection) \$5,472,513; Other Private Passenger Auto Liability \$25,951,294; and Private Passenger Auto Physical Damage \$12,280,711.

#### **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.

The following findings were made:

*2 Violations 40 P.S. §991.2003(a)(13)(ii)*

States that an insurer may not cancel or refuse to renew a policy of automobile insurance for the following reason: An accident which occurred under the following circumstances: The applicant, owner or other resident operator is reimbursed by or on behalf of a person who is responsible for the accident or has judgment against such person. The two violations noted were the result of the Company's guidelines indicating the use of not at fault accidents to determine driver eligibility.

*2 Violations 40 P.S. §1171.5(a)(7)(iii)*

States that "Unfair Methods of Competition" and "Unfair or Deceptive Act or Practices" prohibits unfairly discriminating by means of making or permitting any unfair discrimination between individuals of the same class and essentially the same hazard with regard to underwriting standards and practices or eligibility requirements by reason of race, religion, nationality or ethnic group,

age, sex, family size, occupation, place of residence or marital status. The two violations were the result of the Company's guidelines indicating the use of age to determine driver eligibility. It is noted that the February 2011 Safe Auto Insurance Company Inc., Report of Market Conduct Examination also found that the Company had the same violation.

## 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(b)(3) (40 P.S. §991.2002(b)(3)), which requires an insurer who cancels a policy of automobile insurance in the first 60 days, to supply the insured with a written statement of the reason for cancellation.

From the universe of 36,104 private passenger automobile policies that were cancelled within the first 60 days of new business, 150 files were selected for review. All 150 files requested were received and reviewed. Of the 150 files reviewed, one file was identified as a flat cancellations and three were duplicate files with the same cancellation information. The 39 violations noted were based on 39 files, resulting in an error ratio of 26%.

The following findings were made:

*36 Violations 40 P.S. §991.2002(c)(3)*

*Adjudications: Tampa v. State Farm (P91-06-01, 1992)*

*Gorba v. Allstate (P92-02-92, 1993)*

To any policy of automobile insurance which has been in effect less than sixty (60) days, unless it is a renewal policy, except that no insurer shall decline to continue in force such a policy of automobile insurance on the basis of the grounds set forth in Section 2003(a) and except that if an insurer cancels a policy of automobile insurance in the first 60 days, the insurer shall supply the insured with a written statement of the reason for cancellation. The Company failed to provide 15 days mailing notice prior to the cancellation effective date for the 36 files noted.

*3 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 did not provide a specific reason for the cancellation for the three files noted.

The following concern was noted:

**CONCERN:** The Company is including language on the NSF Memo that states “To avoid cancellation please do not delay in making a payment.” This language appears to give the impression that the policy has not yet cancelled while the policy has actually been cancelled, backdated to the

original date of cancellation on the previous notice. The Company should remove the wording “To avoid a cancellation” from the notice.

## **B. Private Passenger Automobile**

### 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 60,408 private passenger automobile policies which were cancelled during the experience period, 150 files were selected for review. All 150 files requested were received and reviewed. Of the 150 mid-term cancellation files reviewed, seven files were identified as being nonrenewals and three were duplicate files with the same cancellation dates. The 55 violations noted were based on 55 files, resulting in an error ratio of 37%.

The following findings were made:

#### *2 Violations 40 P.S. §991.2004*

An insurer may not cancel a policy except for one or more of the following specified reasons: (1) Nonpayment of premium. (2) The driver’s license or motor vehicle

registration of the named insured has been under suspension or revocation during the policy period; the applicability of this reason to one who either is a resident in the same household or who customarily operates an automobile insured under the policy shall be proper reason for the insurer thereafter excluding such individual from coverage under the policy, but not for cancelling the policy. (3) A determination that the insured has concealed a material fact, or has made a material allegation contrary to fact, or has made a misrepresentation of a material fact and that such concealment, allegation, or misrepresentation was material to the acceptance of the risk by the insurer. 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. The Company did not provide a valid reason for the cancellation for the two files noted.

*53 Violations 40 P.S. §991.2006(2)*

A cancellation or refusal to renew by an insurer of a policy of automobile insurance shall not be effective unless the insurer delivers or mails to the named insured at the address shown in the policy a written notice of cancellation or refusal to renew. The notice shall state the date, not less than sixty (60) days after the date of the mailing or delivery, on which cancellation or refusal to renew shall become effective. When the policy is being cancelled or not renewed for the reasons set forth in section 2004(1) and (2), however, the effective date may be fifteen (15) days from the date of mailing or delivery. The Company did not provide 15 days

mailing notice prior to the cancellation effective date for the 53 files noted.

The following concerns were noted:

**CONCERN:** The Company is including language on the NSF Memo that states “To avoid cancellation please do not delay in making a payment.” This language appears to give the impression that the policy has not yet cancelled while the policy has actually been cancelled, backdated to the original date of cancellation on the previous notice. The Company should remove the wording “To avoid a cancellation” from the notice.

**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 so the insured can contact Assigned Risk if needed.

### 3. Nonrenewal Cancellations

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

The universe of 12 nonrenewal files was selected for review. All 12 files were received and reviewed. Of the 12 files reviewed, one file was noted

as a mid-term cancellation. The one violation noted was based on one file, resulting in an error ratio of 8%

The following findings were made:

*1 Violation 40 P.S. §991.2004*

An insurer may not cancel a policy except for one or more of the following specified reasons: (1) Nonpayment of premium. (2) The driver's license or motor vehicle registration of the named insured has been under suspension or revocation during the policy period; the applicability of this reason to one who either is a resident in the same household or who customarily operates an automobile insured under the policy shall be proper reason for the insurer thereafter excluding such individual from coverage under the policy, but not for cancelling the policy. (3) A determination that the insured has concealed a material fact, or has made a material allegation contrary to fact, or has made a misrepresentation of a material fact and that such concealment, allegation, or misrepresentation was material to the acceptance of the risk by the insurer. 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. The Company did not provide a valid reason for the cancellation for the file noted.

The following concern was noted:

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

#### 4. Declinations

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

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

From the Universe of 119 declinations for private passenger automobile insurance, 25 files were selected for review. All 25 files requested were received and reviewed. There were no violations 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 98 private passenger automobile policies which were rescinded during the experience period, 25 files were selected for review. During the review it was noted that 11 of the files were insured initiated

cancellations and three of the files were 60 day cancellations. Due to the volume of insured initiated cancellations contained in the initial sample, an additional 10 files were selected for review. All 35 files requested were received and reviewed. The six violations noted were based on six files, resulting in an error ratio of 17%.

The following finding was made:

*6 Violations 40 P.S. §991.2004*

*Adjudications: Nationwide Insurance v. Ancona  
(PH94-07-005, 1997)*

An insurer may not cancel a policy except for one or more of the following specified reasons: (1) Nonpayment of premium. (2) The driver's license or motor vehicle registration of the named insured has been under suspension or revocation during the policy period; the applicability of this reason to one who either is a resident in the same household or who customarily operates an automobile insured under the policy shall be proper reason for the insurer thereafter excluding such individual from coverage under the policy, but not for cancelling the policy. (3) A determination that the insured has concealed a material fact, or has made a material allegation contrary to fact, or has made a misrepresentation of a material fact and that such concealment, allegation, or misrepresentation was material to the acceptance of the risk by the insurer. 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. The Company rescinded policies after 60 days from the policy inception date for the six files noted.

## VI. CLAIMS

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

The Claims review consisted of the following areas of review:

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

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

### **A. Automobile Property Damage Claims**

From the universe of 4,577 private passenger automobile property damage liability claims reported during the experience period, 100 files were selected for review. All 100 files selected were received and reviewed. Of the 100 files reviewed, one file was noted as a total loss claim. The 29 violations noted were based on 25 files, resulting in an error ratio of 25%.

The following findings were made:

*5 Violations 31 Pa. Code §62.3(a)(1)*

An appraisal shall be signed by the appraiser before the appraisal is submitted to the insurer, the consumer or another involved party. The appraiser may utilize an electronic signature. The Company failed to provide a signed appraisal for the five claims noted.

*14 Violations 31 Pa. Code §62.3(b)(9)*

An appraisal shall contain a written disclosure which includes the following: The location where the listed parts are available in a condition equivalent to, or better than, the condition of the replaced parts prior to the accident. The Company failed to provide an appraisal with a written disclosure informing the consumer of the location where the listed parts are available in a condition equivalent to, or better than, the condition of the replaced parts prior to the accident for the 14 claims 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.

*8 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 eight claims noted.

The following concern was noted:

**CONCERN:** When the Company closes a claim file with no payment, they are not providing the policyholder/claimant with written notice indicating their 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 473 private passenger automobile comprehensive claims reported during the experience period, 35 files were selected for review. All 35 files selected were received and reviewed. The 15 violations noted were based on 13 files, resulting in an error ratio of 37%.

The following findings were made:

*2 Violations 31 Pa. Code §62.3(a)(1)*

An appraisal shall be signed by the appraiser before the appraisal is submitted to the insurer, the consumer or another involved party. The appraiser may utilize an electronic signature. The Company failed to provide a signed appraisal for the two claims noted.

*12 Violations 31 Pa. Code §62.3(b)(9)*

An appraisal shall contain a written disclosure which includes the following: The location where the listed parts are available in a condition equivalent to, or better than, the condition of the replaced parts prior to the accident. The Company failed to provide an appraisal containing a written disclosure informing the consumer of the location where the listed parts are available in a condition equivalent to, or better than, the condition of the replaced parts prior to the accident for the 12 claims noted.

*1 Violation 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 claim noted.

The following concern was noted:

**CONCERN:** When the Company closes a claim file with no payment, they are not providing the policyholder/claimant with written notice indicating their 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 2,159 private passenger automobile collision claims reported during the experience period, 75 files were selected for review. All 75 files selected were received and reviewed. Of the 75 files reviewed, two files were identified as total loss claims and one file was identified as a property damage claim. The 40 violations noted were based on 26 files, resulting in an error ratio of 35%.

The following findings were made:

#### *4 Violations 31 Pa. Code §62.3(a)(1)*

An appraisal shall be signed by the appraiser before the appraisal is submitted to the insurer, the consumer or another involved party. The appraiser may utilize an electronic signature. The Company failed to provide a signed appraisal for the four claims noted.

*2 Violations 31 Pa. Code §62.3(b)(2)*

An appraisal shall contain a written disclosure which includes the following: A statement that costs above the appraised amount may be the responsibility of the vehicle owner. The Company failed to provide an appraisal containing a written disclosure informing the consumer that costs above the appraised amount may be the responsibility of the vehicle owner for the two claims noted.

*2 Violations 31 Pa. Code §62.3(b)(3)*

An appraisal shall contain a written disclosure which includes the following: A statement that there is no requirement to use any specified repair shop. The Company failed to provide an appraisal containing a written disclosure informing the consumer that there is no requirement to use any specified repair shop for the two claims noted.

*2 Violations 31 Pa. Code §62.3(b)(4)*

An appraisal shall contain a written disclosure which includes the following: A statement informing the consumer that information regarding repair facilities which will be able to repair the vehicle for the appraised amount is available from the insurer. The Company failed to provide an appraisal containing a statement informing the policyholder that information regarding repair facilities which will be able to repair the vehicle for the appraised amount from the insurer for the two claims noted.

*1 Violation 31 Pa. Code §62.3(b)(6)*

An appraisal shall contain a written disclosure which includes the following: Incidental charges, known at the time of appraisal, including towing, protective care, custody, storage, depreciation, battery and tire replacement. The Company failed to provide an appraisal containing a statement informing the policyholder of any incidental charges, known at the time of appraisal, including towing, protective care, custody, storage, depreciation, battery and tire replacement for the claim noted.

*1 Violation 31 Pa. Code §62.3(b)(7)*

An appraisal shall contain a written disclosure which includes the following: Applicable sales tax. The Company failed to provide an appraisal containing a written disclosure informing the consumer of the applicable sales tax for the claim noted.

*20 Violations 31 Pa. Code §62.3(b)(9)*

An appraisal shall contain a written disclosure which includes the following: The location where the listed parts are available in a condition equivalent to, or better than, the condition of the replaced parts prior to the accident. The Company failed to provide an appraisal containing a written disclosure informing the consumer of the location where the parts are available in a condition equivalent to, or better than, the condition of the replaced parts prior to the accident for the 20 claims noted.

*1 Violation 31 Pa. Code §62.3(b)(10)*

An appraisal shall contain a written disclosure which includes the following: If the appraisal includes aftermarket crash parts, a statement that the appraisal has been prepared based on the use of aftermarket crash parts, and that if the use of an aftermarket crash part voids the existing warranty on the part shall have a warranty equal to or better than the remainder of the existing warranty. The Company failed to provide an appraisal containing a statement informing the policyholder that if the appraisal has been prepared based on the use of aftermarket crash parts, and that if the use of an aftermarket crash part voids the existing warranty on the part being replaced or any other part, the aftermarket crash part shall have a warranty equal to or better than the remainder of the existing warranty for the claim 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 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 noted.

*2 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 claim file for the two 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.

*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 concern was noted:

**CONCERN:** When the Company closes a claim file with no payment, they are not providing the policyholder/claimant with written notice indicating their 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 847 private passenger automobile collision claims reported during the experience period, 25 files were selected for review. All 25 files selected were received and reviewed. The 34 violations noted were based on 20 files, resulting in an error ratio of 80%.

The following findings were made:

##### *2 Violations 31 Pa. Code §62.3(a)(1)*

An appraisal shall be signed by the appraiser before the appraisal is submitted to the insurer, the consumer or another involved party. The appraiser may utilize an electronic signature. The Company failed to provide a signed

appraisal for the two claims noted.

*1 Violation 31 Pa. Code §62.3(b)(2)*

An appraisal shall contain a written disclosure which includes the following: A statement that costs above the appraised amount may be the responsibility of the vehicle owner. The Company failed to provide an appraisal containing a written disclosure informing the consumer that costs above the appraised amount may be the responsibility of the vehicle owner for the claim noted.

*1 Violation 31 Pa. Code §62.3(b)(3)*

An appraisal shall contain a written disclosure which includes the following: A statement that there is no requirement to use any specified repair shop. The Company failed to provide an appraisal containing a written disclosure informing the consumer that there is no requirement to use any specified repair shop for the claim noted.

*1 Violation 31 Pa. Code §62.3(b)(4)*

An appraisal shall contain a written disclosure which includes the following: A statement informing the consumer that information regarding repair facilities which will be able to repair the vehicle for the appraised amount is available from the insurer. The Company failed to provide an appraisal containing a statement informing the policyholder that information regarding repair facilities which will be able to repair the vehicle for the appraised amount from the insurer for the claim noted.

*1 Violation 31 Pa. Code §62.3(b)(5)*

An appraisal shall contain a written disclosure which includes the following: A description of repairs, known at the time of appraisal, necessary to return the vehicle to its predamaged condition, including labor involved, cost of all parts, necessary painting or refinishing and all sublet work to be done. The Company failed to provide an appraisal containing a written disclosure that includes a description of the necessary repairs to return the vehicle to its pre-damaged condition for the claim noted.

*16 Violations 31 Pa. Code §62.3(b)(9)*

An appraisal shall contain a written disclosure which includes the following: The location where the listed parts are available in a condition equivalent to, or better than, the condition of the replaced parts prior to the accident. The Company failed to provide an appraisal containing a written disclosure informing the consumer of the location where the parts are available in a condition equivalent to, or better than, the condition of the replaced parts prior to the accident for the 16 claims noted.

*2 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 two claims noted.

*3 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 three claims noted.

*7 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 seven claims noted.

The following concern was noted:

**CONCERN:** When the Company closes a claim file with no payment, they are not providing the policyholder/claimant with written notice indicating their action. The Company should provide policyholders/claimants with written notice when a claim file is being closed with no payment.

#### **E. Automobile First Party Medical Claims**

From the universe of 2,649 private passenger automobile first party medical 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 file was identified as a first party medical claim referred to a PRO. The 72 violations noted were based on 43 files, resulting in an error ratio of 86%.

The following findings were made:

*1 Violation 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 claim noted. It is noted that the February 2011 Safe Auto Insurance Company Inc., Report of Market Conduct Examination also found that the Company violated Title 31, Chapter 62.22(c).

*12 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 12 claims noted. It is noted that the February 2011 Safe Auto Insurance Company, Inc. Report of Market Conduct Examination also found that the Company violated Title 31, Chapter 69.52(b).

*2 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 claim file for the two files 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.

*5 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 five claims noted. It is noted that the February 2011 Safe Auto Insurance Company, Inc. Report of Market Conduct Examination also found that the Company violated Title 31, Chapter 146.5(d).

*39 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 39 claims noted.

*12 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 12 claims noted. It is noted that the February 2011 Safe Auto Insurance Company, Inc. Report of Market Conduct Examination also found that the Company violated Title 75, Chapter 1716.

The following concern was noted:

**CONCERN:** When the Company closes a claim file with no payment, they are not providing the policyholder/claimant with written notice indicating their action. The Company should provide policyholders/claimants with written notice when a claim file is being closed with no payment.

#### **F. Automobile First Party Medical Claims Referred to a PRO**

The universe of three private passenger automobile first party medical claims referred to a PRO reported during the experience period was selected for review. All three files were received and reviewed. The 20 violations noted were based on three files, resulting in an error ratio of 100%.

The following findings were made:

*2 Violations 31 Pa. Code §69.52(a)*

Requires an insurer to refer a provider's bill to a PRO only when circumstances or conditions relating to medical and rehabilitative services provided cause a prudent person, familiar with PRO procedures, standards and practices, to believe it necessary that a PRO determine the reasonableness and necessity of care, the appropriateness of the delivery of the care. An insurer shall notify a provider, in writing, when referring bills for PRO review at the time of the referral. The Company failed to provide written notification to the provider when referring bills for PRO review for the two 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.

*3 Violations 31 Pa. Code §69.52(d)*

A PRO's initial determination shall be completed within 30 days after the receipt of requested information. When a provider fails to respond to the PRO's inquiry or provide requested information, a PRO may commence its review 30 days after the request for information is postmarked. If additional information critical for the outcome of the determination is submitted by a provider or requested by a PRO, the 30-day review period may be tolled up to 20 days

for the information to be received and taken into consideration. The Company failed to complete an initial determination within the allowable timeframe for the three claims noted.

*5 Violations 31 Pa. Code §69.52(e)*

A PRO shall provide a written analysis, including Specific reasons for its decision, to insurers, which Shall within 5 days of receipt, provide copies to Providers and insureds. The Company failed to provide written analysis notifying all parties of the process for requesting information on three of the claim files noted and failed to provide copies of written analysis to providers and insureds within 5 days of receipt on two of the 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.

*1 Violation 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. 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 claim file for the file noted.

*3 Violations 31 Pa. Code §146.6*

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

*1 Violation 75 Pa. C.S. §1797(b)(1)*

Insurers shall contract jointly or separately with any peer review organization established for the purpose of evaluating treatment, health care services, products or accommodations provided to any injured person. Such evaluation shall be for the purpose of confirming that such treatment, products, services or accommodations conform to the professional standards of performance and are medically necessary. An insurer's challenge must be made to a PRO within 90 days of the insurer's receipt of the provider's bill for treatment or services or may be made at any time for continuing treatment or services. The Company failed to refer to a PRO within 90 days of the insurer's receipt of the provider's bill for treatment or services for the claim noted.

*1 Violation 75 Pa. C.S. §1797(b)(5)*

If a PRO determines that medical treatment or rehabilitative services or merchandise were medically necessary, the insurer must pay to the provider the outstanding amount plus interest at 12% per year on any amount withheld by the insurer pending PRO review. The Company failed to pay the provider outstanding amount plus interest at 12% per year on any amount withheld by the insurer pending PRO review for the one claim noted. The Company must provide proof that the outstanding amount plus 12% interest per year was paid to the provider.

## 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 Title 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 Title 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:

### *2 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 the

two violations noted, the Company failed to provide the required fraud warning on claim forms.

The following concern was noted.

**CONCERN:** The Company should use 18 Pa. C.S. §4117(k)(1) with verbatim wording on all claim forms. The Company was using 75 Pa. C.S. §1822 on the following forms:

Theft Affidavit  
Authorization for Release of Information  
Application for Benefits  
Property Damage Release  
Release for Property Damage Only  
Release of All Claims  
Affidavit of No Insurance Coverage

### 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 56 consumer complaints received during the experience period and provided all consumer complaint logs requested. From the universe of 56 complaint files, 25 files were selected for review. All 25 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 statutes and to verify compliance with 31 Pa. Code §146.5(b)(c).

The following findings were made:

#### *4 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. For purposes of this paragraph, “complaint” means any written communication primarily expressing a grievance.

The complaint logs/registers for 2013, 2014, 2015, and 2016 do not indicate the total number of complaints, their classification by line of insurance, and the time it took to process each complaint.

*1 Violation 40 P.S. §991.2006(2)*

A cancellation or refusal to renew by an insurer of a policy of automobile insurance shall not be effective unless the insurer delivers or mails to the named insured at the address shown in the policy a written notice of cancellation or refusal to renew. The notice shall state the date, not less than sixty (60) days after the date of the mailing or delivery, on which cancellation or refusal to renew shall become effective. When the policy is being cancelled or not renewed for the reasons set forth in section 2004(1) and (2), however, the effective date may be fifteen (15) days from the date of mailing or delivery. The Company did not provide 15 days mailing notice prior to the cancellation effective date for the file 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 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 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.

*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.

The following concern was noted:

**CONCERN:** In one of the 25 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.

The following synopsis reflects the nature of the 25 complaints that were received.

12	Cancellation/Nonrenewal	48%
1	Rating	4%
12	Claims Related	48%
<hr/>		<hr/>
25		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)). Several data integrity issues were found during the exam.

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

### Automobile 60 Day Cancellations

Situation: As the examiners reviewed the 60 day cancellation files of the underwriting section of the exam, it was noted that not all of the 150 files selected for review were 60 day cancellation files.

Finding: Of the 150 60 day cancellation files reviewed, one file was identified as a flat cancellation and three files were duplicate files.

### Automobile Midterm Cancellations

Situation: As the examiners reviewed the midterm cancellation files of the underwriting section of the exam, it was noted that not all of the 150 files selected for review were midterm cancellation files.

Finding: Of the 150 midterm cancellation files reviewed, six files were identified as nonrenewal cancellations and three files were identified as duplicate files.

#### Automobile Rescissions

Situation: As the examiners reviewed the rescission files of the underwriting section of the exam, it was noted that not all of the 35 files selected for review were rescission files.

Finding: Of the 35 rescission files reviewed, 11 files were identified as insured request cancellations and three files were identified as 60 day cancellations.

#### Automobile Collision Claims

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

Finding: Of the 75 collision claim files reviewed, one file was noted to be a total loss claim.

#### Automobile First Party Medical Claims

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

Finding: Of the 50 First Party Medical Claims reviewed, one file was identified as a first party medical referred to a 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.

## **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 and revise internal control procedures to ensure compliance with nonrenewal and cancellation notices requirements of 40 P.S. §§991.2002, 991.2003, 991.2004, 991.2006, and 991.2008 so that the violations noted in the Report do not occur in the future.
2. The Company must remove the wording in their underwriting guidelines regarding age being used to determine acceptable drivers to ensure they are in accordance with 40 P.S. §1171.5(a)(7)(iii) and remove the wording that not at fault accidents are being used to determine acceptable drivers to ensure they are in accordance with §991.2003(a)(13)(ii).
3. 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.
4. 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.

5. Company must review 31 Pa. Code §§62.3(a)(1) and 62.3(b)(2)(3)(4)(5)(6)(7)(9)(10) with its claim staff to ensure all appraisal requirements are met so the violations noted in the Report do not occur in the future.
6. 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.
7. 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.
8. The Company must review 75 Pa. C.S. §1161 (a)&(b) with its claim staff to ensure that Pennsylvania salvage certificates are obtained and are retained with the claim file.
9. 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.
10. The Company must review 31 Pa. Code §69.52(a) with its claim staff to ensure that a provider is notified, in writing, when bills are referred for a PRO review at the time of the referral.
11. 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.

12. The Company must review 31 Pa. Code §69.52(d) with its claim staff to ensure an initial determination is completed within an allowable timeframe when needed.
13. The Company must review 31 Pa. Code §69.52(e) with its claim staff to ensure a written analysis is provided notifying all parties of the reconsideration process and that copies of the written analysis to providers and insureds is provided within 5 days of receipt.
14. 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.
15. 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.
16. The Company must review 75 Pa. C.S. §1797(b)(5) and 75 Pa. C.S. §1716 with its claim staff to ensure that a provider is paid the outstanding amount plus 12% interest when needed.

17. The Company must review 31 Pa Code §146.3 with its claim staff to ensure the claims department maintains complete claim files.
  
18. The Company must review 40 P.S. §1171.5(a)(11) to ensure that a complete complaint log is maintained .

**XI. COMPANY RESPONSE**



4 Easton Oval  
Columbus, OH 43219  
1-800-SAFEAUTO  
(1-800-723-3288)

April 11, 2018

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

Re: Response to the Report of Market Conduct Examination Warrant: 17-M36-007

Dear Ms. Krakowski:

On behalf of Safe Auto Insurance Company please allow this letter to serve as our response to the Report of the Market Conduct Examination Warrant Number 17-M36-007, which was received with your cover letter dated March 13, 2018. We have reviewed the Report and respectfully submit the following responses to address the recommendations identified by the Department in the Recommendation Section at the conclusion of the Report. With respect to the other violations identified in the Report, but not addressed in the recommendations or within these responses, Safe Auto Insurance Company wishes to note that corrective actions have been taken where necessary.

We have organized our response in relation to the recommendations set forth in the Report as follows:

**Recommendation #1:** The Company must review and revise internal control procedures to ensure compliance with nonrenewal and cancellation notices requirements of 40 P.S. §§991.2002, 991.2003, 991.2004, 991.2006, and 991.2008 so that the violations noted in the Report do not occur in the future.

**Company Response:** The Company accepts this recommendation with respect to the issues identified in the exam report other than those related to insured request cancellations. The Company will continue to monitor and, where appropriate, revise internal controls to further ensure compliance.

With respect to insured-requested cancellations, while recognizing the Department's interpretation of the statute, we believe the plain language of Act 68 expressly does not apply "if the named insured has demonstrated by some overt action to the insurer or its agent that he wishes the policy to be cancelled or that he does not wish the policy to be renewed." 40 P.S. § 991.2002(c). As such, the Company respectfully disagrees with these violations. Pennsylvania law requires that a proper notification of intent to cancel *by an insurer* of a policy of automobile insurance shall not be effective unless the insurer delivers or mails to the named insured a notice, on a form that meets the requirements of 40 P.S. §991.2006, either sixty (60) days or fifteen (15) days prior to cancellation. As noted by the Department in these critiques, the majority of the policies cited cancelled due to insured request, which, by definition, is not a cancellation by the insurer, and which the Department has determined on numerous occasions does not require the insurer to send a formal notice of cancellation. See Fletcher/Allstate Indemnity, P00-05-014

(2002). In these cases, the Company provided the insured with confirmation of their own requested cancellation, on or about the date upon which such insured requested the subject cancellation.

**Recommendation #2:** The Company must remove the wording in their underwriting guidelines regarding age being used to determine acceptable drivers to ensure they are in accordance with 40 P.S. §1171.5(a)(7)(iii) and remove the wording that not at fault accidents are being used to determine acceptable drivers to ensure they are in accordance with §991.2003(a)(13)(ii)

**Company Response:** The Company accepts this recommendation and agrees to remove any wording from our underwriting guidelines to ensure compliance with 40 P.S. §1171.5(a)(7)(iii) and §991.2003(a)(13)(ii) and to ensure alignment with our practices. The Company further notes that our system code is programmed correctly and these errors are simply paper documentation errors and did not result in any consumer harm. These documentation errors have since been corrected.

**Recommendation #3:** 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:** As indicated in 40 P.S. § 323.4(b), a company being examined is required to 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.” The Company has provided such access to the Department through the course of the examination. Throughout the examination the Company cooperated with the Department’s examination in good faith and shared all available information with the Department and endeavored to submit data as requested. In those in those few cases where errors were made or there was a misunderstanding of the request, the Company attempted to timely address questions surrounding the same. The Company will review our processes around the collection of data to ensure greater accuracy going forward.

**Recommendation #4:** 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.

**Company Response:** The Company accepts this recommendation and will continue to monitor and, where appropriate, revise internal controls to further ensure compliance.

**Recommendation #5:** Company must review 31 Pa. Code §62.3(a)(1) and 62.3(b)(2)(3)(4)(5)(6)(7)(9)(10) 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:** The Company has reviewed the regulation with its claim staff. The Company is in the process of revising its procedures with respect to the same.

**Recommendation #6:** 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.

**Company Response:** The Company accepts this recommendation and agrees to take measures to ensure compliance.

**Recommendation #7:** 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.

**Company Response:** The Company accepts this recommendation and agree to take measures to ensure that the fraud warning verbiage of 18 Pa. C.S.§4117(k)(1) and 75 Pa. C.S. § 1822 will be used verbatim on Company claims forms.

**Recommendation #8:** The Company must review 75 Pa. C.S. §1161 (a)&(b) with its claim staff to ensure that Pennsylvania salvage certificates are obtained and are retained with the claim file.

**Company Response:** The Company accepts this recommendation and agrees to take measures to ensure compliance.

**Recommendation #9:** 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.

**Company Response:** The Company accepts this recommendation and agrees to take measures to ensure compliance

**Recommendation #10:** The Company must review 31 Pa. Code §69.52(a) with its claim staff to ensure that a provider is notified, in writing, when bills are referred for a PRO review at the time of the referral.

**Company Response:** The Company accepts this recommendation and agrees to take measures to ensure compliance.

**Recommendation #11:** 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:** The Company accepts this recommendation and agrees to take measures to ensure compliance.

**Recommendation #12:** The Company must review 31 Pa. Code §69.52(d) with its claim staff to ensure an initial determination is completed within an allowable timeframe when needed.

**Company Response:** The Company accepts this recommendation and agrees to take measures to ensure compliance.

**Recommendation #13:** The Company must review 31 Pa. Code §69.52(e) with its claim staff to ensure a written analysis is provided notifying all parties of the reconsideration process and that copies of the written analysis to providers and insureds is provided within 5 days of receipt.

**Company Response:** The Company accepts this recommendation and is in the process of revising its procedures concerning the same.

**Recommendation #14:** 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.

**Company Response:** The Company accepts this recommendation and agrees to ensure compliance.

**Recommendation #15:** 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.

**Company Response:** The Company accepts this recommendation and agrees to take measures to ensure compliance.

**Recommendation #16:** The Company must review 75 Pa. C.S. §1797(b)(5) and 75 Pa. C.S. §1716 with its claim staff to ensure that a provider is paid the outstanding amount plus 12% interest when needed.

**Company Response:** The Company accepts this recommendation and agrees to review 75 Pa. C.S. §1797(b)(5) and 75 Pa. C.S. §1716 with its claim staff to ensure compliance.

**Recommendation #17:** The Company must review 31 Pa Code §146.3 with its claim staff to ensure the claims department maintains complete claim files.

**Company Response:** The Company accepts this recommendation and has taken measures to ensure that the claims department maintains complete claim files.

**Recommendation #18:** The Company must review 40 P.S. §171.5(a)(11) to ensure that a complete complaint log is maintained.

**Company Response:** This issue has been resolved. A complete complaint log is being maintained consistent with the statutory requirements.

Thank you for your consideration on this matter and for providing us with an opportunity to respond to the Report. We wish to offer our gratitude to the Department and each individual examiner for the courtesies granted to us throughout the course of this examination.

Sincerely,



Kelly A. Armstrong  
General Counsel  
Safe Auto Insurance Company  
4 Easton Oval  
Columbus, OH 43219