STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

MARKET CONDUCT EXAMINATION

NUMBER 2014C-0073

March 2, 2015

TARGETED MARKET CONDUCT EXAMINATION REPORT

OF

PROGRESSIVE MARATHON INSURANCE COMPANY

PLYMOUTH, MI

NAIC COMPANY CODE 37605

For the Period January 1, 2013 through December 31, 2013

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I. EXECUTIVE SUMMARY

Progressive Marathon Insurance Company (the Company) is an authorized domestic insurance company. This examination was conducted by DIFS in conformance with the National Association of Insurance Commissioners (NAIC) *Market Regulation Handbook* (2012) (*Handbook*) and the Michigan Insurance Code, MCL 500.100 et seq. (the Code). The purpose of the exam is to evaluate the compliance of the Company with applicable Michigan statutes, NAIC Guidelines and DIFS regulations. The scope of market conduct examination includes the Company's activities related to the handling of: (1) Bodily Injury (BI) Claims and BI/Personal Injury Protection (PIP) Litigated Claims and (2) PIP Complaint Handling. The examination covers the period January 1, 2013 through December 31, 2013.

This summary of this targeted market conduct examination of the Company is intended to provide an overview of the examination results. The body of the report provides details of the scope of the examination, findings, DIFS recommendations, and Company responses.

DIFS considers a "finding" one in which a substantive issue or violation of Code was found to have occurred, or one in which corrective action on the part of the Company is deemed advisable. In certain circumstances, an "Observation" is made in lieu of a Finding and Recommendation.

Findings:
There are no findings.

Recommendations:
There are no recommendations

Observation:
The Company's personal auto policy contract contains the following bodily injury exclusion: "Bodily injury to you or a relative. This exclusion applies only to damages in excess of the minimum limit mandated by the motor vehicle financial responsibility law of Michigan". The Company states, "Situations may arise where an injured family member may receive less compensation for non-economic damages as a result of the household coverage limitation."

The Company responded to DIFS inquiry: "There is no legal requirement to tell the costumer [sic] about this exclusion prior to purchase". However, in order to best serve its customers, DIFS advises the Company to consider making notification of this exclusion to current policyholders at renewal, and prospective insureds when delivering a quote.

Company Response:
Progressive understands the concern about consumer awareness. As noted, there's no legal requirement for notification but, in spite of that, Progressive will explore ways to incorporate a disclosure on its auto quoting platforms' help text in order to disclose the reduction-in-limits for Bodily Injury to the named insured or a relative. Progressive will also remind its current auto policyholders of this provision in an upcoming renewal notice. We've confirmed that some key

competitors have a similar provision in place and we regularly gather competitive intelligence to ensure that our contract terms remain competitive in the marketplace. We appreciate the dialog on this topic.

II. OBJECTIVES, SCOPE AND METHODOLOGY

This report is based on a targeted market conduct examination of Progressive Marathon Insurance Company. The examination was conducted at the DIFS office located at 611 West Ottawa Street, Lansing, MI 48909. The contact for this exam was Patricia Kraven, Associate Manager Market Conduct. DIFS conducted this examination in accordance with statutory authority of MCL 500.222 et seq. All Michigan laws, regulations and bulletins cited in this report may be viewed on the DIFS website at www.michigan.gov/difs.

The purpose of the exam is to evaluate the compliance of the Company with applicable Michigan statutes, NAIC Guidelines and DIFS regulations.

This examination was conducted under the supervision of Sherry J. Bass-Pohl, Manager of the Market Conduct Unit. The examination team consisted of David A. Haddad, CPCU, MCM, Examiner-in-Charge.

The examination was called due to an internal analysis of the Company's Market Conduct Annual Statement (MCAS) statistics. The analysis and examination were conducted and measured according to the Standards and practices in the NAIC *Handbook*, the applicable statutes in the Code, and the Company's internal guidelines and procedures.

Three types of review may have been utilized for the above standards. Certain standards were examined with a single review, and others were examined using one or more type of review. The NAIC *Handbook* calls for a random sample of 100 files when the examination population is greater than 5,000. This statistical sample applies to the Company as follows:

A. Generic Review: A standard test was applied using analysis of all files written by agents at the specific branch office for the time frame of the examination. The Company provided the general file information as a response to examiner questions.

B. Sample Review: A "sample" review indicates that a standard was tested through direct review of a random sample of files using sampling methodology described in the NAIC *Handbook*, Chapter 14. The samples included all files within a specific subgroup. The sampling techniques used are based on a 90 percent (90%) confidence level, meaning there is 90 percent (90%) confidence that the error percentages shown in the various standards so tested are representative of the entire set of records from which it was drawn. An error rate in excess of the tolerance level in these sections of the report is indicative of a general business practice of engaging in that type of conduct. Note that the statistical error tolerance is not indicative of the actual tolerance of DIFS for deliberate or systematic error.

C. Census Review: Marketing and Sales, as well as Complaint files, were not subject to the sampling procedure, as the number of relevant files did not warrant taking a sample. Therefore, every relevant marketing piece and complaint file for the examination period was reviewed by the examination team for compliance with applicable statutes, regulations and internal Company guidelines.

This examination report is a report by test. The report contains a summary of pertinent information about the lines of business examined. This includes each NAIC *Handbook* source and Standard, Code citation, any examination findings detailing the non-compliant or problematic activities that were discovered during the course of the exam, the Company response proposing methods for correcting the deficiencies, and recommendation for any further action by DIFS.

III. COMPANY OPERATIONS AND PROFILE

Progressive Marathon Insurance Company began operations in 1998 as a Michigan-domiciled company. It is a stock company. Progressive Insurance originally started in Cleveland, OH in 1937. The Company prides itself on the use of technology to improve service to policy holders. The Company was the first to offer the internet as a means of obtaining quotes. The Company markets and sells its products through in-house agents and over the internet. The Company's top lines of business are auto, motorcycles, boats, recreational vehicles and business vehicles. Its size category is XV ($2 Billion or greater), and the Company is rated A+ Superior by the A.M. Best Company. Its outlook is stable and the rating was affirmed December 20, 2013. The Company plans to earn a profit by offering consumers products and services they want.

IV. EXAMINATION FINDINGS AND RECOMMENDATIONS

A. CLAIMS

Standard 1: The initial contact by the regulated entity with the claimant is within the required time frame. NAIC *Handbook*, Chapter 16.

Standard 2: Timely investigations are conducted. NAIC *Handbook,* Chapter 16.

MCL 500.3151:

> (1) When the mental or physical condition of a person is material to a claim that has been or may be made for past or future personal protection insurance benefits, the person shall submit to mental or physical examination by physicians. A personal protection insurer may include reasonable provisions in a personal protection insurance policy for mental and physical examination of persons claiming personal protection insurance benefits.

Standard 3: Claims are resolved in a timely manner. NAIC *Handbook,* Chapter 16.

MCL 500.3142:

> (1) Personal protection insurance benefits are payable as loss accrues.
>
> (2) Personal protection insurance benefits are overdue if not paid within 30 days after an insurer receives reasonable proof of the fact and of the amount of loss sustained. If reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within 30 days after the proof is received by the insurer. Any part of the remainder of the claim that is later supported by reasonable proof is overdue if not paid within 30 days after the proof is received by the insurer. For the purpose of calculating the extent to which benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.
>
> (3) An overdue payment bears simple interest at the rate of 12% per annum.

MCL 500.3145:

> (1) An action for recovery of personal protection insurance benefits payable under this chapter for accidental bodily injury may not be commenced later than 1 year after the date of the accident causing the injury unless written notice of injury as provided herein has been given to the insurer within 1 year after the accident or unless the insurer has previously made a payment of personal protection insurance benefits for the injury. If the notice has been given or a payment has been made, the action may be commenced at any time within 1 year after the most recent allowable expense, work loss or survivor's loss has been incurred. However, the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced. The notice of injury required by this subsection may be given to the insurer or any of its authorized agents by a person claiming to be entitled to benefits therefor, or by someone in his behalf. The notice shall give the name and address of the claimant and indicate in ordinary language the name of the person injured and the time, place and nature of his injury.
>
> (2) An action for recovery of property protection insurance benefits shall not be commenced later than 1 year after the accident.

***Standard 4*:** The regulated entity responds to claims in a timely manner. NAIC *Handbook,* Chapter 16.

Standard 5: Claim files are adequately documented. NAIC *Handbook,* Chapter 16.

Standard 6: Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations. NAIC *Handbook*, Chapter 16.
MCL 500.3107:

> (1) Except as provided in subsection (2), personal protection insurance benefits are payable for the following:
>
> > (a) Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation. Allowable expenses within personal protection insurance coverage shall not include either of the following:
> >
> > > (i) Charges for a hospital room in excess of a reasonable and customary charge for semiprivate accommodations except if the injured person requires special or intensive care.
> > > (ii) Funeral and burial expenses in excess of the amount set forth in the policy which shall not be less than $1,750.00 or more than $5,000.00.
>
> > (b) Work loss consisting of loss of income from work an injured person would have performed during the first 3 years after the date of the accident if he or she had not been injured. Work loss does not include any loss after the date on which the injured person dies. Because the benefits received from personal protection insurance for loss of income are not taxable income, the benefits payable for such loss of income shall be reduced 15% unless the claimant presents to the insurer in support of his or her claim reasonable proof of a lower value of the income tax advantage in his or her case, in which case the lower value shall apply. For the period beginning October 1, 2012 through September 30, 2013, the benefits payable for work loss sustained in a single 30-day period and the income earned by an injured person for work during the same period together shall not exceed $5,189.00, which maximum shall apply pro rata to any lesser period of work loss. Beginning October 1, 2013, the maximum shall be adjusted annually to reflect changes in the cost of living under rules prescribed by the commissioner but any change in the maximum shall apply only to benefits arising out of accidents occurring subsequent to the date of change in the maximum.
>
> > (c) Expenses not exceeding $20.00 per day, reasonably incurred in obtaining ordinary and necessary services in lieu of those that, if he or she had not been injured, an injured person would have performed during the first 3 years after the date of the accident, not for income but for the benefit of himself or herself or of his or her dependent.

MCL.500.3135:

> (1) A person remains subject to tort liability for noneconomic loss caused by his or her ownership, maintenance, or use of a motor vehicle only if the injured person has suffered death, serious impairment of body function, or permanent serious disfigurement.
>
> * * *
>
> (5) As used in this section, "serious impairment of body function" means an objectively manifested impairment of an important body function that affects the person's general ability to lead his or her normal life.

MCL 500.3148:

> (1) An attorney is entitled to a reasonable fee for advising and representing a claimant in an action for personal or property protection insurance benefits which are overdue. The attorney's fee shall be a charge against the insurer in addition to the benefits recovered, if the court finds that the insurer unreasonably refused to pay the claim or unreasonably delayed in making proper payment.

Standard 7: Regulated entity claim forms are appropriate for the type of product. NAIC *Handbook,* Chapter 16.

Standard 9: Denied and closed without payment claims are handled in accordance with policy provisions and state law. NAIC *Handbook,* Chapter 16.

MCL 500.2026:

> (1) Unfair methods of competition and unfair or deceptive acts or practices in the business of insurance, other than isolated incidents, are a course of conduct indicating a persistent tendency to engage in that type of conduct and include:
>
> (a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue.
>
> (b) Failing to acknowledge promptly or to act reasonably and promptly upon communications with respect to claims arising under insurance policies.
>
> (c) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.
>
> (d) Refusing to pay claims without conducting a reasonable investigation based upon the available information.

> (e) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.
>
> * * *
>
> (h) Attempting to settle a claim for less than the amount to which a reasonable person would believe the claimant was entitled, by reference to written or printed advertising material accompanying or made part of an application.
>
> * * *
>
> (m) Failing to promptly settle claims where liability has become reasonably clear under 1 portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy.
>
> (n) Failing to promptly provide a reasonable explanation of the basis in the policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

1. Claims Paid – Personal Auto Bodily Injury

The examiners requested the population of Michigan Claims Closed With Payment – Personal Auto Bodily Injury.

File Data	Population Size	Maximum Number of Failures Permitted in Sample	Stage 1 Sample Size	Date Sample Pulled	Errors Found
Claims Closed With Payment -Personal Auto Bodily Injury.	172	2	50	10/3/2014	0

Observation:
The Company's personal auto policy contract contains the following bodily injury exclusion: "Bodily injury to you or a relative. This exclusion applies only to damages in excess of the minimum limit mandated by the motor vehicle financial responsibility law of Michigan". The Company states, "Situations may arise where an injured family member may receive less compensation for non-economic damages as a result of the household coverage limitation."

The Company responded to DIFS inquiry: "There is no legal requirement to tell the costumer [sic] about this exclusion prior to purchase". However, in order to best serve its customers, DIFS advises the Company to consider making notification of this exclusion to current policyholders at renewal, and prospective insureds when delivering a quote.

Company Response:
Progressive understands the concern about consumer awareness. As noted, there's no legal requirement for notification but, in spite of that, Progressive will explore ways to incorporate a disclosure on its auto quoting platforms' help text in order to disclose the reduction-in-limits for Bodily Injury to the named insured or a relative. Progressive will also remind its current auto policyholders of this provision in an upcoming renewal notice. We've confirmed that some key competitors have a similar provision in place and we regularly gather competitive intelligence to

ensure that our contract terms remain competitive in the marketplace. We appreciate the dialog on this topic.

2. Claims Closed Without Payment – Personal Auto Bodily Injury

The examiners requested the population of Michigan Claims Closed Without Payment – Personal Auto Bodily Injury.

File Data	Population Size	Maximum Number of Failures Permitted in Sample	Stage 1 Sample Size	Date Sample Pulled	Errors Found
Claims Closed Without Payment - Personal Auto Bodily Injury.	138	2	50	10/4/2014	0

Findings:
There are no findings.

Recommendations:
There are no recommendations.

Company Response:
No Company response was received.

3. Litigated Claims – Personal Auto Bodily Injury

The examiners requested the population of Michigan Litigated Claims - Personal Auto Bodily Injury.

File Data	Population Size	Maximum Number of Failures Permitted in Sample	Stage 1 Sample Size	Date Sample Pulled	Errors Found
Litigated Personal Auto Bodily Injury Claims	224	2	50	12/20/2013	0

Findings:
There are no findings.

Recommendations:
There are no recommendations.

Company Response:
No Company response was received.

4. Litigated Claims – Personal Auto PIP

The examiners requested the population of Michigan Litigated Claims – Personal Auto PIP.

File Data	Population Size	Maximum Number of Failures Permitted in Sample	Stage 1 Sample Size	Date Sample Pulled	Errors Found
Litigated Personal Auto PIP Claims	265	2	50	12/20/2013	0

Findings:
There are no findings.

Recommendations:
There are no recommendations.

Company Response:
No Company response was received.

B. COMPLAINT HANDLING

Standard 1*:* All complaints are recorded in the required format on the regulated entity's complaint register. NAIC *Handbook,* Chapter 16.

Standard 2: The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders. NAIC *Handbook,* Chapter 16.

Standard 3: The Company takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations, and contract language. NAIC *Handbook,* Chapter 16.

Standard 4: The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations. NAIC *Handbook,* Chapter 16.

MCL 500.2213:

> (1) Except as otherwise provided in subsection (4), each insurer and health maintenance organization shall establish an internal formal grievance procedure for approval by the commissioner for persons covered under a policy, certificate, or contract issued under chapter 34, 35, or 36 that provides for all of the following:
>
> (a) A designated person responsible for administering the grievance system.

(b) A designated person or telephone number for receiving grievances.

(c) A method that ensures full investigation of a grievance.

(d) Timely notification in plain English to the insured or enrollee as to the progress of an investigation of a grievance.

(e) The right of an insured or enrollee to appear before a designated person or committee to present a grievance.

(f) Notification in plain English to the insured or enrollee of the results of the insurer's or health maintenance organization's investigation of the grievance and of the right to have the grievance reviewed by the commissioner or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(g) A method for providing summary data on the number and types of complaints and grievances filed under this section. The insurer or health maintenance organization shall annually file the summary data for the prior calendar year with the commissioner on forms provided by the commissioner.

(h) Periodic management and governing body review of the data to assure that appropriate actions have been taken.

(i) That copies of all complaints and responses are available at the principal office of the insurer or health maintenance organization for inspection by the commissioner for 2 years following the year the grievance was filed.

(j) That when an adverse determination is made, a written statement in plain English containing the reasons for the adverse determination is provided to the insured or enrollee along with written notifications as required under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(k) That a final determination will be made in writing by the insurer or health maintenance organization not later than 35 calendar days after a formal grievance is submitted in writing by the insured or enrollee. The timing for the 35-calendar-day period may be tolled, however, for any period of time the insured or enrollee is permitted to take under the grievance procedure and for a period of time that shall not exceed 10 business days if the insurer or health maintenance organization has not received requested information from a health care facility or health professional.

(l) That a determination will be made by the insurer or health maintenance organization not later than 72 hours after receipt of an expedited grievance. Within 10 days after receipt of a determination, the insured or enrollee may request a determination of the matter by the commissioner or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929. If the determination by the insurer or health maintenance organization is made orally, the insurer or health maintenance organization shall provide a written confirmation of the determination to the insured or enrollee not later than 2 business days after the oral determination. An expedited grievance under this subdivision applies if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance under subdivision (k) would seriously jeopardize the life or health of the insured or enrollee or would jeopardize the insured's or enrollee's ability to regain maximum function.

(m) That the insured or enrollee has the right to a determination of the matter by the commissioner or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(2) An insured or enrollee may authorize in writing any person, including, but not limited to, a physician, to act on his or her behalf at any stage in a grievance proceeding under this section.

(3) This section does not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health care services.

(4) This section does not apply to a policy, certificate, care, coverage, or insurance listed in section 5(2) of the patient's right to independent review act, 2000 PA 251, MCL 550.1905, as not being subject to the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(5) As used in this section:

(a) "Adverse determination" means a determination that an admission, availability of care, continued stay, or other health care service has been reviewed and denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

(b) "Grievance" means a complaint on behalf of an insured or enrollee submitted by an insured or enrollee concerning any of the following:

> (i) The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review.
> (ii) Benefits or claims payment, handling, or reimbursement for health care services.
> (iii) Matters pertaining to the contractual relationship between an insured or enrollee and the insurer or health maintenance organization.

MCL 500.2026:

* * *

> (2) The failure of a person to maintain a complete record of all the complaints of its insureds which it has received since the date of the last examination is an unfair method of competition and unfair or deceptive act or practice in the business of insurance. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition thereof, and the time it took to process each complaint. For purposes of this subsection, "complaint" means a written communication primarily expressing an allegation of acts which would constitute violation of this chapter. If a complaint relating to an insurer is received by an agent of the insurer, the agent shall promptly forward the complaint to the insurer unless the agent resolves the complaint to the satisfaction of the insured within a reasonable time. An insurer shall not be deemed to have engaged in an unfair method of competition or an unfair or deceptive act or practice in the business of insurance in violation of this chapter because of the failure of an agent who is not also an employee to forward a written complaint as required by this subsection.

Complaints – Personal Auto PIP

The examiners requested the population of Michigan Complaints – Personal Auto PIP.

File Data	Population Size	Maximum Number of Failures Permitted in Sample	Stage 1 Sample Size	Date Sample Pulled	Errors Found
Personal Auto PIP Complaints	10	0	10	9/19/2014	0

Findings:
There are no findings.

Recommendations:
There are no recommendations.

Company Response:
No Company response was received.

V. ACKNOWLEDGEMENT

This examination report of Progressive Michigan Insurance Company is respectfully submitted to the Director of the Department of Insurance and Financial Services, State of Michigan.

The courteous cooperation and assistance of the officers and employees of the Company extended to the examiners during the course of the examination is hereby acknowledged.

In addition to the undersigned, Zachary Dillinger, MCM, Market Conduct Examiner participated in the examination.

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Examiner-in-Charge
Department of Insurance and Financial Services
Market Conduct Section