STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

MARKET CONDUCT EXAMINATION

NUMBER 2012C-0031

June 20, 2013

TARGETED MARKET CONDUCT EXAMINATION REPORT

OF

MEMBERSELECT INSURANCE COMPANY

DEARBORN, MICHIGAN

NAIC COMPANY CODE 21229

For the Period January 1, 2010 through December 31, 2011

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

Pursuant to Executive Order 2013-1, all authority, powers, duties, functions, and responsibilities of the commissioner of the Office of Financial and Insurance Regulation (Commissioner) have been transferred to the Director of the Department of Insurance and Financial Services (Director).

MemberSelect Insurance Company (Company) is an authorized Michigan domiciled company. This examination was conducted in conformance with the National Association of Insurance Commissioners (NAIC) *Market Regulation Handbook* (2011) (*Handbook)* and the Michigan Insurance Code, MCL 500.100 et seq. This was a targeted examination which reviewed the Company's homeowner claims and complaint handling. The examination covers the period January 1, 2010 to December 31, 2011.

This summary of the 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, Company responses, and the Michigan Department of Insurance and Financial Services (DIFS) recommendations.

DIFS considers a substantive issue one in which a "finding" or violation of Michigan Insurance Code was found to have occurred, or one in which corrective action on the part of the Company is deemed advisable. This examination has prompted several recommendations for MemberSelect Insurance Company. The more significant findings and recommendations are listed below. A complete list is in the Examination Findings section.

Findings:
The Company imposes an undue burden of proof on claimants submitting claims for damage to electronic equipment done by lightning. The claimant is made to obtain proof that the claim was caused by lightning, rather than a power surge.

Recommendations:
If the Company wishes to dispute the assertion made by the claimant with respect to lightning losses, it should take responsibility for doing so.

Company Response:
This issue arose out of an insured complaint regarding damage to home electronic items. The Company position is that the insured is responsible for providing proof of loss. In this circumstance, the Company would bear the cost for investigation as to the cause of loss. This position was not challenged by the Department in the course of the handling of the complaint.

II. PURPOSE, SCOPE AND METHODOLOGY

This report is based on a targeted Market Conduct Examination of MemberSelect Insurance Company (Company). The examination was conducted at the Company's home offices located at 1 Auto Club Drive, Dearborn, MI 48126. 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.

This examination was conducted under the supervision of Regan Johnson, Director of the Market Conduct Section, and Sherry J. Bass-Pohl, Manager of the Market Conduct Unit. The on-site examination team consisted of David A. Haddad, CPCU, MCM, Examiner-in-Charge, and Zachary Dillinger, Lynell Cauther, and Sherry Barrett, Market Conduct Examiners.

This examination includes review of, but not limited to, the areas of Claims Handling and Complaint Handling practices. The examination covers the period of January 1, 2010 through December 31, 2011. DIFS called this examination in accordance with MCL 500.222 (and other statutes as applicable) and the guidelines of the NAIC.

The examination was called due to changes in the complaint index and the absence of a prior Market Conduct Examination.

The examination team sampled company records in the areas of (1) Complaint Handling and (2) Claims Handling. The analysis and examination of these areas were conducted and measured according to the standards and practices in the NAIC *Handbook*, the applicable statutes in the Michigan Insurance Code, and the Company's internal guidelines and procedures. The examiners used the NAIC suggested error tolerance rate of seven percent (7%) for claims handling practices. 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.

Three types of review were 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 general information provided as a response to examiner questions.
B. Sample Review: Sample test review was applied by means of direct review of random sample files. This methodology is described in the NAIC *Handbook*. Statistical sampling is based on a ten percent (10%) error tolerance and a 95 percent (95%) confidence level.
C. Electronic Review: This standard was employed using a computer program applied to a sample of company records.

The examiners reviewed samples based on the sampling method in Chapter 14 of the NAIC *Handbook*.

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 standard, Michigan Insurance Code citation, and NAIC *Handbook* source, 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

MemberSelect Insurance Company began operations in 1964 as a Michigan domiciled company. It is currently authorized to market and write new insurance business in Michigan and several other Midwestern states. MemberSelect is part of the Auto Club Group. The Auto Club Group (Group) includes Auto Club Group Insurance Company, Auto Club Property/Casualty Insurance Company, MemberSelect Insurance Company and most recently, MEEMIC Insurance Company. Auto Club Group/MemberSelect is in the XIV Financial Size Category ($1.5 billion to $2 billion), and its latest financial rating is A (excellent). In 2011, the Group's outlook was changed to Negative. This was affirmed in February of 2012. The negative outlook is based on the deterioration in the Group's operating earnings in recent years, driven by unfavorable underwriting results. Auto Club Group/MemberSelect has a well-established position as a personal lines market leader in Michigan. The Company markets its property/casualty products through a network of captive and independent agents throughout the state of Michigan. A.M. Best reports that the Company has recently implemented numerous strategic initiatives to improve underwriting performance, which include private passenger auto and homeowners rate adjustments in states where they are indicated, increased pricing sophistication to improve profitability and competitive position, and decreases in staffing and overhead costs to reduce the underwriting expense ratio.

IV. EXAMINATION FINDINGS AND RECOMMENDATIONS

A. Claims Handling

1. Claims Paid

The examiners requested the population of Michigan homeowner claims paid and closed.

File Data	***Population Size***	***Maximum Number of Failures Permitted in Sample***	***Stage 1 Sample Size***	***Date Sample Pulled***	***Errors Found***
Claims Closed With Payment - Homeowners	*10,464*	*2*	*88*	*7/31/12*	*0*

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

MCL 500.2006(3):

> An insurer shall specify in writing the materials that constitute a satisfactory proof of loss not later than 30 days after receipt of a claim unless the claim is settled within the 30 days.…

Findings:
The population of Claims Closed With Payment was 10,464. There were 88 files sampled. In all of the 88 files sampled, initial contact was made within 30 days; in all of the 88 files sampled the materials that constitute a satisfactory proof of loss were specified in writing to the claimant within 30 days after the receipt of the claim. In the vast majority of the files reviewed, the initial contact was made within three days.

Recommendation:
No action is recommended. The Company exceeds any statutory requirement and NAIC guidelines in this area.

Company Response:
No Company response was made.

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

MCL 500.2006(3) and (4):

> (3) An insurer shall specify in writing the materials that constitute a satisfactory proof of loss not later than 30 days after receipt of a claim unless the claim is settled within the 30 days. If proof of loss is not supplied as to the entire claim, the amount supported by proof of loss shall be considered paid on a timely basis if paid within 60 days after receipt of proof of loss by the insurer. Any part of the remainder of the claim that is later supported by proof of loss shall be considered paid on a timely basis if paid within 60 days after receipt of the proof of loss by the insurer. If the proof of loss provided by the claimant contains facts that clearly indicate the need for additional medical information by the insurer in order to determine its liability under a policy of life insurance, the claim shall be considered paid on a timely basis if paid within 60 days after receipt of necessarymedical information by the insurer. Payment of a claim shall not be untimely during any period in which the insurer is unable to pay the claim when there is no recipient who is legally able to give a valid release for the payment, or where the insurer is unable to determine who is entitled to receive the payment, if the insurer has promptly notified the claimant of that inability and has offered in good faith to promptly pay the claim upon determination of who is entitled to receive the payment.

> (4) If benefits are not paid on a timely basis the benefits paid shall bear simple interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12 % per annum, if the claimant is the insured or an individual or entity directly entitled to benefits under the insured's contract of insurance. If the claimant is a third party tort claimant, then the benefits paid shall bear interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12 % per annum if the liability of the insurer for the claim is not reasonably in dispute, the insurer has refused payment in bad faith and the bad faith was determined by a court of law. The interest shall be paid in addition to and at the time of payment of the loss. If the loss exceeds the limits of insurance coverage available, interest shall be payable based upon the limits of insurance coverage rather than the amount of the loss. If payment is offered by the insurer but is rejected by the claimant, and the claimant does not subsequently recover an amount in excess of the amount offered, interest is not due. Interest paid pursuant to this section shall be offset by any award of interest that is payable by the insurer pursuant to the award.

Findings:
Of the 88 files sampled, seven files Closed With Payment showed payments later than 60 days. However, in each of the seven files, the policy holder failed to provide adequate proof of loss in a timely manner. In every instance, the Company did notify the policy holder of their duties after a loss. In no case was the Company liable to pay 12 percent interest for late payment.

Recommendation:
No action is recommended. The Company exceeds any statutory requirement and NAIC guidelines in this area.

Company Response:
No Company response was made.

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

Findings:
In none of the 88 files reviewed was a file found to be lacking in documentation.

Recommendation:
No action is recommended. The Company exceeds any statutory requirement and NAIC guidelines in this area.

Company Response:
No Company response was made.

2. Claims Closed without Payment

The examiners requested the population of Michigan claims paid and closed without payment.

File Data	*Population Size*	*Maximum Number of Failures Permitted in Sample*	*Stage 1 Sample Size*	*Date Sample Pulled*	*Errors Found*
Claims Closed Without Payment - Homeowners	*4,577*	*2*	*88*	*07/31/12*	*0*

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

MCL 500.2006(3) (see above)

Findings:
The population of Claims Closed Without Payment was 4,577. There were 88 files sampled. In all of the 88 files sampled, initial contact was made within 30 days; in all of the 88 files sampled, the materials that constitute a satisfactory proof of loss were specified in writing to the claimant within 30 days after the receipt of the claim. In the vast majority of the files reviewed, the initial contact was made within three days.

Recommendation:
No action is recommended. The Company exceeds any statutory requirement and NAIC guidelines in this area.

Company Response:
No Company response was made.

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

Findings:
The claims in these 88 files were Closed Without Payment. However, the claims must still be resolved in a timely manner. In all of the 88 files reviewed the claim was resolved in a timely manner. The Company's internal guidelines are much more stringent than any statutory guidelines.

Recommendation:
No action is recommended. The Company exceeds any statutory requirement and NAIC guidelines in this area.

Company Response:
No Company response was made.

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

Findings:
Of the 88 files reviewed, six were missing. The six missing files had the following claim numbers: 7141403, 4862430, 7370078, 6897373, 8131495, and 5577695. The basic content of these files was available, however, in the Company internal electronic claim records.

Of the 88 files reviewed, the denial letter was not found in five of the files. The claim numbers of these files are: 6972429, 7967230, 6504434, 5437150, and 5714952.

Recommendations:
The Company is in transition to paperless claims files. Consequently, missing paper files will soon be a moot point. Nevertheless, the Company may want to consider why the four files are missing and reconstruct the files until such time as the transition to a paperless environment is completed.

Denial letters should be in every denied claim file. The Company should verify that the letters were sent and place a copy of the letter in the file.

Company Response:
Files 8131495, and 5577695 were located within the sample provided and contain the appropriate communications. Scan copies of the contents of those files are attached. The Company has yet to actively transition to paperless claim files, but otherwise accepts these findings.

DIFS Response:
The Company is correct that files 8131495 and 5577695 were located within the sample and contain the appropriate communications.

***Standard 9*:** Denied and Closed Without Payment claims are handled in accordance with policy provisions and state law. NAIC *Handbook*, Chapter 16.

Findings:
The 88 files sampled were handled in accordance with policy provisions and state law.

Recommendation:
No action is recommended. The Company clearly exceeds any statutory requirement and NAIC guidelines in this area.
Company Response:
No Company response was made.

B. Complaint Handling Practices

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

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.

Findings:
The examiners requested and reviewed the Company complaint register for DIFS and in-house complaints. These complaints consisted of 93 complaints for the year 2010, and 104 for the year 2011, giving a total of 197 complaints for the examination period. After a census review of all 197 complaint files, examiners found all complaints were reflected on the complaint register, as required by MCL 500.2026(2). Further, examiners reviewed all DIFS complaints for the examination period and found that all were reflected on the complaint register.

Recommendation:
No further action is required at this time. The Company is in compliance with all statutes, rules, regulations and internal guidelines relevant to this area.

Company Response:
No Company response was made.

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

Findings:
The Company has a 14 page Complaint Handling Guide (Guide). The Overview of the Guide states that: "…[I]t costs a company five times as much money to get a new customer as it does to retain an existing one". Consequently, the goal of MemberSelect is to: "… consistently meet the highest levels of service". The Guide goes on to state: "In all cases, we will operate within federal and state laws and regulations as well as within the standards established by AAA National." The Company also recently formed the Customer Experience Business Unit (CEBU). Among other things, CEBU is focused on improving customer satisfaction.

Recommendation:
No further action is required at this time. The Company is in compliance with all statutes, rules, regulations and internal guidelines relevant to this area and should be commended for its conscientious efforts to retain customers through prompt and fair handling of complaints.

Company Response:
No Company response was made.

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, Complaint Handling.

Findings:
Three separate facets of this standard were examined: Does the response completely address the issue; does the file contain adequate documentation; and is the remedy appropriate. The following complaints raised questions in one or more of these areas.

HOM 010323430: It is unclear why the credit score changed to eight from nine, and then back again. The file is not adequately documented.

Company Response:
The change in insurance score was not on the home policy, but only the insured's auto policy. The return to the higher score was processed on the auto policy and noted in the auto policy remarks but the home file did not contain the updated remarks from the auto policy. The home policy that was subject to this review maintained an insurance score of nine.

DIFS Response:
The Company is correct that the change in insurance score was not on the home policy.

HOM 015831121: The insured legitimately submitted a lightning claim. Undue burden of proof was placed on the insured to verify cause of loss. The remedy was not appropriate.

Company Response:
The company position is that the insured is responsible for providing proof of loss. In this circumstance, the company would bear the cost for investigation as to the cause of loss. This position was not challenged by the Department in the course of the handling of the complaint.

HOM 031444303: The inspection indicated "cracked" basement window. The cancellation notice cited "broken or boarded window". The cancellation notice also stated that "after written notice from the Company, the insured failed to correct a physical condition which presents a clear risk of significant property or liability loss". There is no evidence that a written notice from the Company was sent. Nor does a "cracked" basement window constitute a clear risk of significant property loss. Cancellation was not warranted. The reinstatement was an appropriate remedy for the complaint. With respect to the "written notice from the company", the file does not contain adequate documentation.

Company Response:
The Company agrees that the notice is not in the file. The policy was reinstated with no lapse in coverage.

HOM 029499169: The agent deleted the rental property loss history from the rating of insured's homeowner policy. This rating "error" by the agent was "corrected" by the Company, but the "correction" was later reversed and the agent's rating "error" was allowed to stand. Of course, it is the practice of the Company to correct agent errors, in accordance with Essential Insurance, MCL 500.2101 et seq. The reason the correction was originally made in this case is due to the Company's interpretation of 500.2111(7)(f):

> (7) Classifications established pursuant to this section for home insurance other than inland marine insurance provided by policy floaters or endorsements shall be based only upon one or more of the following factors:
>
> * * *
>
> (f) Loss experience of the insured, based upon prior claims attributable to factors under the control of the insured that have been paid by an insurer.

The Company interprets the statute to mean that all property losses, even those incurred on a dwelling fire policy, apply to the Homeowner rating. The Company reversed its position in this instance for various reasons. However, if the Company's interpretation leads to this type of complaint, the Company may want to consider the statute to mean that only homeowner losses should be considered for the rating of Homeowner policies. We would have no issue with this interpretation. Rental property losses could be eschewed in Homeowner rating. The remedy is appropriate.

Company Response:
The company accepts the conclusion made in this case. The credit was issued to compensate for the agent's rating "error".

HOM 026510374: It is unclear how Coverage A was increased after the renewal went out. The file does not have adequate documentation.

Company Response:
The file does contain the policy remarks which state clearly that the company changed Coverage A from $175,000 to $280,000 on September 10, 2010 due to the results of the home inspection conducted by Sentinel Underwriting. The change was to be effective January 26, 2011.

DIFS Response:
It is agreed that the file contains remarks. However, Coverage A increases are typically made *prior* to processing the renewal, not after.

HOM 023853131: The claim was denied due to the engineering report, which is not in the file. The file does not have adequate documentation.

Company Response:
The engineering report is documented in the claim file; however, the Company agrees that the engineering report should be in the complaint file.

Recommendations:
Several complaint files lack adequate documentation. It is clear, however, that the Company makes a concerted effort to adequately document complaint files.

The lightning claim is problematic. In such cases, the Company needs to bear the burden of proof, or risk violating MCL 500.2026(f).

Underwriting guidelines are the right of the Company to establish. However, referring to a "cracked" window as "broken" seems to be taking a liberty with the facts presented in the inspection report. Nor was there any written notice from the Company sent, as stated in the cancellation notice. The Company needs to ensure that the underwriters adhere to the facts stated on inspection reports. Nor is it clear why an underwriter would want to cancel a policy for such a minor problem.

As mentioned earlier, the Company may want to reconsider its choice to apply dwelling fire loss history to homeowner rating.

Company Response:
The company will continue its efforts to adequately document complaint files and will continue to track and report complaint issues to management.

***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, Complaint Handling.

Findings:
The Company overwhelmingly responds to complaints in a timely manner. Of the 197 complaints reviewed, only four showed a response not initiated within a day or two. Those four files are: HOM 028725566; HOM 024491238; HOM 028180447; HOM 012029012.

Recommendations:
No further action is required at this time. The Company is in compliance with all statutes, rules, regulations and internal guidelines relevant to this area.

Company Response:
No Company response was made.

Additional Observations
There was one file (HOM028480497) which revealed internal, possibly systemic confusion on the proper time and circumstances in which a credit score is to be ordered. We trust the Company has addressed the issue with proper training/discussion.

Company Response:
The Company has addressed the issue in the context of the handling of this complaint file.

V. ACKNOWLEDGEMENT

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

The exceptional courtesy and cooperation of the officers and employees of the Auto Club Group, especially Mike Hailer and the staff of the Regulatory Compliance Department, during the course of the examination is hereby acknowledged.

In addition to the undersigned, Lynell Cauther, Zachary Dillinger, and Sherry Barrett, Market Conduct Examiners, participated in the examination.

_____

David A. Haddad, CPCU, MCM
Examiner-in-Charge
Department of Insurance and Financial Services
Market Conduct Section
June 20, 2013