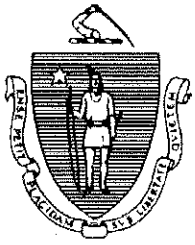

THE COMMONWEALTH OF MASSACHUSETTS

OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

DIVISION OF INSURANCE

Report on the Limited-Scope Market Conduct Examination of

Massachusetts Homeland Insurance Company
Tower National Insurance Company

Quincy and Boston, Massachusetts

For the Period January 1, 2012 through December 31, 2012

NAIC COMPANY CODES: 40320, 43702

EMPLOYER ID NUMBERS: 04-2739739, 04-2811570

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COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE
1000 Washington Street, Suite 810 • Boston, MA 02118-6200
(617) 521-7794 • Toll-free (877) 563-4467
http://www.mass.gov/doi

CHARLES D. BAKER
GOVERNOR

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LIUETENANT GOVERNOR

JAY ASH
SECRETARY OF HOUSING AND ECONOMIC DEVELOPMENT

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GARY D ANDERSON
ACTNG COMMISSIONER OF INSURANCE

January 15, 2015

Honorable Joseph G. Murphy
Commissioner of Insurance
Commonwealth of Massachusetts
Division of Insurance
1000 Washington Street, Suite 810
Boston, Massachusetts 02118-6200

Dear Commissioner Murphy:

Pursuant to your instructions and in accordance with Massachusetts General Laws, Chapter 175, § 4, a limited-scope examination has been made of the market conduct affairs of

MASSACHUSETTS HOMELAND INSURANCE COMPANY
TOWER NATIONAL INSURANCE COMPANY

at their administrative office located at:

120 Broadway, 30st Floor
New York, New York 10271

The following report thereon is respectfully submitted.

SCOPE OF EXAMINATION

The Massachusetts Division of Insurance (the "Division") conducted a limited-scope market conduct examination ("examination") of Massachusetts Homeland Insurance Company ("MHIC") and Tower National Insurance Company ("TNIC"), (collectively, the "Company") for the period January 1, 2012 to December 31, 2012, focusing on personal lines operations. The examination was called pursuant to authority in Massachusetts General Laws Chapter ("M.G.L. c.") 175, § 4. The examination also evaluated the Company's compliance with requirements from a previous Regulatory Settlement Agreement on motorcycle premiums between the Company and the Division. The examination was conducted under the direction, management and control of the market conduct examination staff of the Division. Representatives from the firm of Rudmose & Noller Advisors, LLC ("RNA") were engaged to complete the examination.

The Division originally called a comprehensive market conduct examination of TNIC and MHIC on January 14, 2013. During 2013, the Company, part of Tower Group International, Ltd. ("Tower Group"), experienced significant losses in its business operations, which resulted in a severe reduction in its surplus. The losses were primarily due to adverse development in prior years' loss reserves within its casualty-related lines of business including workers' compensation, commercial multi-peril, other liability, and commercial automobile liability lines. As a result, MHIC and TNIC consented to administrative supervision by the Division on November 26, 2013. Further, the Division revised the scope of the examination to limited-scope to focus on specific industry issues and claims.

On January 3, 2014, Tower Group entered into an Agreement and Plan of Merger ("Merger Agreement") with ACP Re Ltd. ("ACP Re"), a Bermuda-based reinsurance company. The controlling shareholder of ACP Re is a trust established by the founder of AmTrust Financial Services, Inc. ("AmTrust"), National General Holdings Corporation ("NGHC") and Maiden Holdings, Ltd. Also, as of January 3, 2014, MHIC and TNIC entered into cut-through reinsurance agreements, such that subsidiaries of AmTrust and NGHC reinsured at least 60% of the unearned premium reserve for new and renewal business produced by the Company, including unearned premium for all personal lines business.

Throughout 2014, the Tower Group's financial condition continued to deteriorate with A.M. Best downgrading of the Tower Group and its operating subsidiaries from a financial strength rating of "B (Fair)" to a financial strength rating of "C ++ (Marginal)" on May 9, 2014. In September 2014, the Merger Agreement was finalized and approved by Division and other insurance regulators, and the merger was completed and effective on September 15, 2014. As a result, NGHC acquired the renewal rights to the policies written in the Tower Group personal lines operations, including MHIC and TNIC personal lines policies. Also, AmTrust acquired the renewal rights to the policies written in the Tower Group commercial lines operations, including TNIC commercial lines policies. On December 4, 2014, A.M. Best upgraded the financial strength rating of MHIC and TNIC to "A- (Excellent)" with a stable outlook.

EXAMINATION APPROACH

A tailored examination approach was developed using the guidance and standards of the *2012 NAIC Market Regulation Handbooks,* ("the Handbook") the examination standards of the Division, the Commonwealth of Massachusetts' insurance laws, regulations and bulletins, and selected Federal laws and regulations. All procedures were performed under the supervision of the market conduct examination staff of the Division. The operational areas that were reviewed under this examination include selected standards within complaint handling, underwriting and rating, and claims. This examination report describes the procedures performed in these operational areas and the results of those procedures.

In addition to the processes and procedures guidance in the Handbook, the examination included an assessment of the Company's related internal controls. While the Handbook approach is designed to detect incidents of deficiency through transaction testing, the internal control assessment provides an understanding of the key controls that the Company's management uses to operate their business and to meet key business objectives, including complying with applicable laws and regulations related to market conduct activities.

The internal control assessment is comprised of three significant steps: (a) identifying controls; (b) determining whether the control has been reasonably designed to accomplish its intended purpose in mitigating the risk; and (c) verifying that the control is functioning as intended (i.e., review or testing of the controls). The effectiveness of the internal controls was considered when determining sample sizes for transaction testing. The form of this examination report is "Report by Test," as described in Chapter 15, Section A of the Handbook.

The Division considers a "finding" to be a violation of Massachusetts insurance laws, regulations or bulletins. An "observation" along with a recommendation is considered a departure from an industry best practice. The Division recommends that Company management evaluate any "finding" or "observation" for applicability to other jurisdictions. All unacceptable or non-compliant practices may not have been discovered or noted in this report. Failure to identify unacceptable or non-compliant business practices does not constitute acceptance of such practices. When applicable, corrective actions should be taken in all jurisdictions. The Company shall report to the Division any such corrective actions taken.

EXECUTIVE SUMMARY

This summary of the examination of the Company is intended to provide a high-level overview of the examination results highlighting where recommendations were made or required actions were noted. The body of the report provides details of the scope of the examination, the examination approach, internal controls for each standard, review and test procedures conducted, findings and observations, recommendations and required actions, and if applicable, subsequent Company actions. Company managerial and supervisory personnel from each operational area should review the examination report for results relating to their specific area.

The following is a summary of all findings and observations, along with related recommendations and required actions and, if applicable, subsequent Company actions noted in this examination report. All Massachusetts laws, regulations and bulletins cited in this report may be viewed on the Division's website at www.mass.gov/doi.

SECTION II-COMPLAINT HANDLING

STANDARD II-1

Findings: RNA determined that five Division regulatory complaints were not properly contained on the Company's complaint register in violation of M.G.L. c. 176D, § 3(10).

Observations: Based on testing, the Company's complaint registers included all statutorily-required database elements.

Required Actions: The Company shall develop new policies, procedures and controls for the maintenance of all complaints in accordance with statutory requirements, and provide training to staff on those procedures. The new procedures and controls shall be tested by internal audit or compliance to ensure that they are effectively implemented with the results of the independent testing completed and reported to the Audit Committee of the Board of Directors and the Division by September 30, 2015 or another agreed upon date.

Subsequent Company Actions: The Company states that it has developed new procedures and controls to address the required actions and provided training to staff on the new procedures and controls.

SECTION VI-UNDERWRITING AND RATING

STANDARD VI-1

Findings: RNA testing indicated that for five of the 50 Board of Appeal vacated surcharges, the surcharges were not properly and timely reversed in accordance with M.G.L. c. 175E, § 7A and Division Bulletin 2010-11. At the request of the Division, the Company reviewed Board of Appeal vacated at-fault accident determinations for the period 2003-2013 and determined that additional vacated surcharges were not properly reversed in accordance with M.G.L. c. 175E, § 7A and Division Bulletin 2010-11.

RNA's testing of private passenger automobile claims indicated that one claim was not reported to the Merit Rating Board ("MRB"), in accordance with 211 CMR 134.00. Further, for this claim, the at-fault operator was not provided a notice of the at-fault accident determination stating the operator's right to

appeal that determination in accordance with M.G.L. c. 175E, § 7A. At the request of the Division, the Company reviewed at-fault accident determinations for the period 2012-2014 and concluded that at least 1490 claims were not reported to the MRB in accordance with 211 CMR 134.00. Also, for these claims, at-fault operators were not provided a notice of at-fault accident determination stating their right to appeal those determinations in accordance with M.G.L. c. 175E, § 7A. As a result, the Company and the Division entered into a Regulatory Settlement Agreement on December 10, 2014 requiring corrective actions and restitution for these statutory violations. See Appendix B.

Observations: Based upon testing, except as noted above, the Company appears to calculate policy premiums, discounts, at-fault accident surcharges and vacated surcharges in compliance with its policies, procedures, and statutory requirements, and in compliance with rates filed with the Division.

Required Actions: The Company shall provide premium refunds and 6% annual interest to consumers for 2003-2013 vacated at-fault accident determinations not properly reversed. In addition, the Company shall adopt new controls and procedures to ensure that premium refunds for vacated surcharges by the Board of Appeal are timely and properly processed. The Company shall also provide training or guidance to staff about these new controls and procedures. Finally, the Company shall adopt a new procedure to complete an annual review and comparison of their vacated surcharge data with data directly obtained from the Board of Appeal. The review shall include testing to obtain reasonable assurance that the vacated surcharges were accurately and timely reversed with the proper premium credit applied.

The Company shall report all required claims to the MRB, and provide notices of the at-fault accident determinations to the operators, noting their right to appeal those determinations. In addition, the Company shall adopt new controls and procedures to ensure that at-fault accident claims are reported to the MRB, and at-fault accident determination appeal notices are provided to at-fault operators. The Company shall also provide training or guidance to staff about these new controls and procedures. The new controls and procedures shall be tested by internal audit or an independent quality assurance function to ensure that they are effectively implemented, with the results of the independent testing reported to the Company's Board of Directors or a committee thereof, and the Division by September 30, 2015 or another agreed upon date. If significant issues are identified in the audit, follow up audits shall continue to be performed with related reports issued, until no significant issues remain.

Subsequent Company Actions: The Company agrees with the required actions and is currently working to address the findings noted above. The Company has begun to report these claims to the MRB, reporting 274 claims with at-fault accident determinations and numerous comprehensive claims in January 2015.

SECTION VII-CLAIMS

STANDARD VII-3

Findings: One claim payment was not paid to a claimant for nine months after the claim payment was approved in violation of M.G.L. c. 176D, § 3(9)(f).

Observations: Based upon testing, except as noted above, it appears that the Company's processes for timely resolving claims are generally functioning in accordance with its policies, procedures, and statutory requirements.

Required Actions: The Company shall enhance procedures and controls over claims monitoring and provide related training to staff to ensure claims are timely and properly paid.

Subsequent Company Actions: The Company agrees with the required actions and is currently working to address the findings noted above.

STANDARD VII-5

Findings: None.

Observations: RNA noted that for each of the tested claims, the Company's claim files adequately documented claims handling, except for four bodily injury claimants where settlement offers were below the targeted settlement ranges and without adequate supporting documentation. One of these claimants was not represented by counsel.

Recommendations: The Company should adopt a policy requiring that all claim settlement offers must be fair and reasonable, and should be within the targeted settlement range with documentation supporting the settlement offers made. The Company should provide guidance and training to staff on the development of claim settlement offers and related documentation.

Subsequent Company Actions: The Company agrees with the required actions and is currently working to address the findings noted above.

STANDARD VII-6

Findings: Testing indicated that seven tested homeowners claims over $1,000 were not properly and timely reported to local building and health authorities to disclose a potentially dangerous condition in accordance with M.G.L. c. 139, § 3B. Also, testing identified one homeowners claim where the required Department of Revenue checks were not completed in violation of M.G.L. c. 175, § 24D, 24E and 24F.

Observations: RNA noted each of the tested claims was handled according to the Company's policies and procedures, except as noted above. Based upon testing, it appears that the Company's processes for handling claims are generally functioning in accordance with its policies, procedures and statutory requirements. Finally, upon evaluation of the claims-related complaints, the related claims appeared to be properly handled.

Required Actions: The Company shall adopt new policies and control procedures to address the requirements of M.G.L. c. 139, § 3B, and review its current policies and controls for compliance with required Department of Revenue checks. Further, the Company shall provide training or guidance to claims adjustors on proper and timely implementation of these related policies and procedures. Finally, the new M.G.L. c. 139, § 3B policies and control procedures shall be tested by internal audit or compliance to ensure that they are effectively implemented, with the results of the independent testing completed and reported to the Division by September 30, 2015, or another agreed upon date.

Subsequent Company Actions: The Company states that it has developed new procedures and controls to address the required actions and provided training to staff on the new procedures and controls. The Company has also conducted subsequent audits to ensure compliance.

STANDARD VII-14

Findings: RNA testing determined that one homeowners claim had an improper loss date and catastrophe code in violation of M.G.L. c. 174A, §15(a) and 211 CMR 15:00.

Observations: RNA noted that selected loss data appears to be accurate and complete for tested claims, except as noted above. Based upon testing, the Company generally appears to have processes for timely and accurately reporting of loss statistical data to rating bureaus in accordance with its policies and statutory requirements.

Required Actions: The Company shall adopt new controls and procedures and provide training to staff ensure that claim statistical elements are properly coded.

Subsequent Company Actions: The Company agrees with the required actions and is currently working to address the findings noted above.

COMPANY BACKGROUND

MHIC writes personal lines business in Massachusetts, Connecticut and Rhode Island, where all business is ceded to its NGHC affiliates. TNIC offers a broad range of commercial, specialty and personal property and casualty insurance products to businesses and individuals in 37 states. MHIC has a 100% quota share reinsurance agreement on in-force new and renewal business effective July 1, 2010 with TNIC. TNIC is party to an intercompany pooling agreement where the member companies' premiums and losses are ceded to Tower Insurance Company of New York with TNIC retaining 2% of the business of the pool. All MHIC and TNIC business is distributed through independent agents.

As of the date of the examination report, MHIC and TNIC have an A.M. Best financial strength rating of "A- (Excellent)" with a stable outlook. The following financial information is as of, or for the year ended December 31, 2012:

Massachusetts Homeland Insurance Company:

Admitted assets	$8.3 million
Statutory surplus	$8.3 million
Direct written premium	$124.9 million
Massachusetts business - direct written premium	$64.3 million

Tower National Insurance Company:

Admitted assets	$49.5 million
Statutory surplus	$11.8 million
Direct written premium	$188.8 million
Massachusetts business - direct written premium	$10.2 million

The key objectives of this examination were determined by the Division with emphasis on the following areas.

II. COMPLAINT HANDLING

Evaluation of the Standards in this business area is based on (a) an assessment of the Company's internal control environment, policies and procedures, (b) the Company's response to various information requests, and (c) a review of several types of files at the Company.

Standard II-1. All complaints are recorded in the required format on the regulated entity's complaint register.

Objective: This Standard addresses whether the Company formally tracks complaints or grievances as required by statute. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: The following controls were noted in review of all complaint Standards:

- The Company defines a complaint as any written correspondence expressing a grievance. Concerns expressed by phone received in operational areas are handled by those units.
- All complaints are sent to the Vice-President, Insurance Regulatory Counsel. The Corporate Paralegal logs the complaints into the Company's complaint register and forwards the complaints to the appropriate operational area for review and preparation of the complaint response. Coordinators in operational areas are responsible for preparing complaint responses. When the complaint response is complete and approved by a manager, the response is sent to the Division or complainant with a copy of the response sent to the Corporate Paralegal, who enters the remaining complaint data points in the complaint register.
- The Company's complaint register includes total number of complaints, the classification of each complaint by line of insurance, the nature of each complaint, the disposition of each complaint and the number of days to process each complaint.
- The Company does not use social media and therefore does not receive complaints through social media.
- The Company provides a telephone number and address in its written responses to complaints, inquiries and on its web-site.
- The Company reviews all complaint activity for identification of any recurring, systemic or potential problems.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed management and staff responsible for complaint handling, and examined evidence of the Company's related processes and controls. RNA reviewed the Company's complaint registers for 2012-2013 to evaluate the Company's compliance with statutory complaint requirements. RNA also reviewed the Company's complaint registers for 2012-2013 to determine whether they properly contained all Division complaints.

Transaction Testing Results:

Findings: RNA determined that five Division regulatory complaints were not properly contained on the Company's complaint register in violation of M.G.L. c. 176D, § 3(10).

Observations: Based on testing, the Company's complaint registers included all statutorily-required database elements.

Required Actions: The Company shall develop new policies, procedures and controls for the maintenance of all complaints in accordance with statutory requirements, and provide training to staff on those procedures. The new procedures and controls shall be tested by internal audit or compliance to ensure that they are effectively implemented with the results of the independent testing completed and reported to the Audit Committee of the Board of Directors and the Division by September 30, 2015 or another agreed upon date.

Subsequent Company Actions: The Company states that it has developed new procedures and controls to address the required actions and provided training to staff on the new procedures and controls.

Standard II-2. The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders.

Objective: This Standard addresses whether the Company has adequate complaint handling procedures, and communicates those procedures to policyholders and consumers. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: See Standard II-1.

Controls Reliance: See Standard II-1.

Transaction Testing Procedure: RNA interviewed management and staff responsible for complaint handling, and examined evidence of the Company's related processes and controls. RNA reviewed four regulatory and Company complaints from 2012-2013, to evaluate the Company's compliance with statutory complaint requirements. RNA reviewed the complaint handling for these complaints, including the adequacy of documentation supporting the facts and resolution of the complaints. In addition, RNA reviewed the Company's website and communications to consumers, to determine whether the Company provides contact information for consumer inquiries.

Transaction Testing Results:

Findings: None.

Observations: Based upon testing, RNA noted that the Company has adequate procedures in place to address complaints, and adequately communicates such procedures to consumers.

Recommendations: None.

Standard II-3. The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations, and contract language.

Objective: This Standard addresses whether the Company's response to the complaint fully addresses the issues raised, and whether policyholders or consumers with similar fact patterns are treated consistently and fairly. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: See Standard II-1.

Controls Reliance: See Standard II-1.

Transaction Testing Procedure: RNA interviewed management and staff responsible for complaint handling, and examined evidence of the Company's related processes and controls. RNA reviewed four regulatory and Company complaints from 2012-2013, to evaluate the Company's efforts to properly dispose of complaints.

Transaction Testing Results:

Findings: None.

Observations: RNA noted that the Company fully addressed the issues raised in the complaints tested. Documentation for the complaints appeared complete, including the original complaints and related correspondence.

Recommendations: None.

Standard II-4. The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations.

Objective: This Standard addresses the time required for the Company to process each complaint. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: See Standard II-1.

Controls Reliance: See Standard II-1.

Transaction Testing Procedure: RNA interviewed management and staff responsible for complaint handling, and examined evidence of the Company's related processes and controls. RNA reviewed four regulatory and Company complaints from 2012-2013, to evaluate the Company's complaint response times.

Transaction Testing Results:

Findings: None.

Observations: The Company addressed the tested regulatory complaints within 14 days, or with additional time as allowed by the Division. The Company also addressed the Company complaints within 14 days. The Company appears to respond to complaints in a timely manner in

accordance with its policies, procedures, and regulatory requirements.

Recommendations: None.

VI. UNDERWRITING AND RATING

Evaluation of the Standards in this business area is based on (a) an assessment of the Company's internal control environment, policies and procedures, (b) the Company's response to various information requests, and (c) a review of several types of files at the Company.

Standard VI-1. The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the regulated entity's rating plan.

Objective: This Standard addresses whether the Company is charging premiums using properly filed rates. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: The following controls were noted in review of this Standard and Standards VI-4 and VI-10:

- The Company has written underwriting and rating policies and procedures designed to reasonably assure consistency in classification and rating.
- To obtain private passenger automobile and motorcycle quotes, the independent agents may use either the Company's agent portal or a third party comparative rating service. Any policy issued electronically must be processed through the agent portal.
- Company policy prohibits unfair discrimination in the application of premium discounts and surcharges, and in the application of its general rating methodology, in accordance with statutory and regulatory requirements.
- Private passenger automobile and motorcycle rates are filed with the Division and approved prior to use. All approved rates are loaded in the Company's underwriting and policy administration systems and are tested prior to use.
- Workers' compensation rates are determined by the Workers' Compensation Rating and Inspection Bureau of Massachusetts ("WCRIB") and approved by the Division.
- The Company's policy is to adhere to Massachusetts regulatory standards of fault in determining at-fault accidents and to ensure that at-fault drivers are appropriately surcharged for such accidents. Surcharged drivers are to be notified of the right to appeal the surcharge. The Company does not report the at-fault indicator to consumer reporting agencies. The Company's identifies vacated surcharges and completes processing for those transactions.
- Private passenger automobile rates are based on Automobile Insurers Bureau of Massachusetts ("AIB") base rates with deviations using actuarial guidelines and principles.
- The Company is subject to periodic premium data audits by Commonwealth Automobile Reinsurers ("CAR") for compliance with statutes and CAR Rules of Operation.
- The Company is subject to review and audit of workers' compensation rates and methodologies by the WCRIB.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel with responsibility for the underwriting and rating processes. RNA reviewed the Company's most recent motorcycle rating internal audit and selected 20 motorcycle policies to test rates charged and valuations used for comprehensive and collision coverages. RNA also tested 50 vacated at-fault accident determinations by the Board of Appeal from the examination period for accurate and timely reversal of the vacated at-fault accident

determinations. In addition, RNA reviewed the Company's self-testing of 2013 vacated at-fault accident determinations to revaluate the Company's 2013 vacated surcharge procedures. During private passenger automobile claims testing, RNA assessed whether at-fault accidents were properly reported to the Merit Rating Board with surcharge appeal notices timely provided to operators in accordance with statutory and regulatory requirements.

Transaction Testing Results:

Findings: RNA testing indicated that for five of the 50 Board of Appeal vacated surcharges, the surcharges were not properly and timely reversed in accordance with M.G.L. c. 175E, § 7A and Division Bulletin 2010-11. At the request of the Division, the Company reviewed Board of Appeal vacated at-fault accident determinations for the period 2003-2013 and determined that additional vacated surcharges were not properly reversed in accordance with M.G.L. c. 175E, § 7A and Division Bulletin 2010-11.

RNA's testing of private passenger automobile claims indicated that one claim was not reported to the Merit Rating Board ("MRB"), in accordance with 211 CMR 134.00. Further, for this claim, the at-fault operator was not provided a notice of the at-fault accident determination stating the operator's right to appeal that determination in accordance with M.G.L. c. 175E, § 7A. At the request of the Division, the Company reviewed at-fault accident determinations for the period 2012-2014 and concluded that at least 1,490 claims were not reported to the MRB in accordance with 211 CMR 134.00. Also, for these claims, at-fault operators were not provided a notice of at-fault accident determination stating their right to appeal those determinations in accordance with M.G.L. c. 175E, § 7A. As a result, the Company and the Division entered into a Regulatory Settlement Agreement on December 10, 2014 requiring corrective actions and restitution for these statutory violations. See Appendix B.

Observations: Based upon testing, except as noted above, the Company appears to calculate policy premiums, discounts, at-fault accident surcharges and vacated surcharges in compliance with its policies, procedures, and statutory requirements, and in compliance with rates filed with the Division.

Required Actions: The Company shall provide premium refunds and 6% annual interest to consumers for 2003-2013 vacated at-fault accident determinations not properly reversed. In addition, the Company shall adopt new controls and procedures to ensure that premium refunds for vacated surcharges by the Board of Appeal are timely and properly processed. The Company shall also provide training or guidance to staff about these new controls and procedures. Finally, the Company shall adopt a new procedure to complete an annual review and comparison of their vacated surcharge data with data directly obtained from the Board of Appeal. The review shall include testing to obtain reasonable assurance that the vacated surcharges were accurately and timely reversed with the proper premium credit applied.

The Company shall report all required claims to the MRB, and provide notices of the at-fault accident determinations to the operators, noting their right to appeal those determinations. In addition, the Company shall adopt new controls and procedures to ensure that at-fault accident claims are reported to the MRB, and at-fault accident determination appeal notices are provided to at-fault operators. The Company shall also provide training or guidance to staff about these new controls and procedures. The new controls and procedures shall be tested by internal audit or an independent quality assurance function to ensure that they are effectively implemented, with the results of the independent testing reported to the Company's Board of Directors or a committee thereof, and the Division by September 30, 2015 or another agreed upon date. If significant issues are identified in the audit, follow up audits shall continue

to be performed with related reports issued, until no significant issues remain.

Subsequent Company Actions: The Company agrees with the required actions and is currently working to address the findings noted above. The Company has begun to report these claims to the MRB, reporting 274 claims with at-fault accident determinations and numerous comprehensive claims in January 2015.

Standard VI-2. All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-3. The regulated entity does not permit illegal rebating, commission cutting or inducements.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-4. The regulated entity underwriting practices are not unfairly discriminatory. The company adheres to applicable statutes, rules and regulations and regulated entity guidelines in the selection of risks.

Objective: This Standard addresses whether unfair discrimination is occurring in insurance underwriting, primarily related to rating. See Standard VI-1 for testing of premium rating. See Appendix A for applicable statutes, regulations and bulletins.

Standard VI-5. All forms including contracts, riders, endorsement forms and certificates are filed with the insurance department, if applicable.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-6. Policies, riders and endorsements are issued or renewed accurately, timely and completely.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-7. Rejections and declinations are not unfairly discriminatory.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-8. Cancellation/non-renewal, discontinuance and declination notices comply with policy provisions, state laws and regulated entity guidelines.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-9. Rescissions are not made for non-material misrepresentation.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-10. Credits, debits and deviations are consistently applied on a non-discriminatory basis.

Objective: This Standard addresses whether unfair discrimination is occurring in the application of premium discounts and surcharges. See Standard VI-1 for testing of premium rating. See Appendix A for applicable statutes, regulations and bulletins.

Standard VI-11. Schedule rating or individual risk premium modification plans, where permitted, are based on objective criteria with usage supported by appropriate documentation.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-12. Verification of use of the filed expense multipliers; the regulated entity should be using a combination of loss costs and expense multipliers filed with the insurance department.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-13. Verification of premium audit accuracy and the proper application of rating factors.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-14. Verification of experience modification factors.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-15. Verification of loss reporting.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-16. Verification of regulated entity data provided in response to the NCCI call on deductibles.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-17. Underwriting, rating and classification are based on adequate information developed at or near inception of the coverage rather than near expiration, or following a claim.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-18. Audits, when required, are conducted accurately and timely.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-19. All forms and endorsements, forming a part of the contract are listed on the declaration page and should be filed with the insurance department (if applicable).

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-20. The regulated entity verifies that the VIN number submitted with the application is valid and that the correct symbol is utilized.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-21. The regulated entity does not engage in collusive or anti-competitive underwriting practices.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-22. The regulated entity underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations in application of mass marketing plans.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-23. All group personal lines property and casualty policies and programs meet minimum requirements.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-24. Cancellation/non-renewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-25. All policies are correctly coded.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

Standard VI-26. Application or enrollment forms are properly, accurately and fully completed, including any required signatures, and file documentation supports underwriting decisions made.

No work performed. This Standard is not covered in the examination for the reasons described in the scope of examination section.

VII. CLAIMS

Evaluation of the Standards in this business area is based on (a) an assessment of the Company's internal control environment, policies and procedures (b) the Company's response to various information requests, and (c) a review of several types of files at the Company.

Standard VII-1. The initial contact by the regulated entity with the claimant is within the required time frame.

Objective: This Standard addresses the timeliness of the Company's initial contact with the claimant. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: The following controls were noted in review of this Standard through Standard VII-13:

- Written policies and procedures govern claims handling processes. Claims are generally reported by the claimant by phone, internet, or e-mail or by fax from an agent. The call center intake specialists request claims information, such as the claimant's name, policy number, loss date, and facts of the claim, and records the claim in the automated claims processing system, which includes a diary system and history notes.
- Automobile physical damage claims' adjustors are assigned automatically by the claims system based on pre-determined claim attributes. When claims have multiple exposures, the claim investigation is assigned to multiple adjusters based on the exposure attributes. The adjustors are to contact the claimants the same day or the next business day morning.
- Claims are investigated to determine existence of coverage, and an initial liability determination is made. Independent field adjustors are utilized as needed and provide on-site-inspections and /or investigations; however, the handling adjuster continues to be primarily responsible for the claim. Independent field adjustors are provided written documentation of the Company's procedures along with detailed instructions covering tasks to be performed and timeframes for completion.
- The Company has adopted a supervisory structure to ensure that settlement authorities and procedures are followed. Individual claim settlement authority limits are assigned commensurate with claims adjustors' experience. Claims adjustors are responsible for verifying coverage, coordinating claim investigations, establishing liability and determining damages.
- The Company, prior to integration with NGHC, used Colossus, a vendor-purchased claim evaluation software, as a guide in connection with assessing damages on third party bodily injury claims. The Company states that Colossus results were not solely used to set claim reserves, determine final claim evaluations or offer claim settlements.
- Company policy is to comply with claim settlement performance standards established by CAR and those set forth in statute. The Company is subject to audits from CAR for compliance with the standards, which specify time frames for assigning an appraiser, inspecting a vehicle, and paying a claim. The Company follows standard industry and CAR claim handling guidelines in its claim investigations including Massachusetts standards of fault. Information from police reports, witness statements, photographic evidence and consumer reporting agencies are used to evaluate the claim.
- The Company's policy is to adhere to Massachusetts regulatory standards of fault in determining at-fault accidents and to ensure that at-fault drivers are appropriately surcharged for such accidents. Surcharged drivers are to be notified of the right to appeal the surcharge. The Company does not report the at-fault indicator to consumer reporting agencies. The Company's identifies vacated surcharges and completes processing for those transactions.

- Company policy is to comply with CAR's Special Investigative Unit ("SIU") performance standards. Claim adjustors are provided training regarding SIU red flags and make referrals to SIU as needed. Automobile theft claims are to be reported through Insurance Services Office ("ISO") to the National Crime Insurance Bureau. The SIU is responsible for coordinating with the Massachusetts Insurance Fraud Bureau, in cases where fraud is believed to have occurred to assist with criminal investigation and prosecution.
- The Company has implemented Office of Foreign Asset Control compliance initiatives including searches of the Specially Designated Nationals ("SDN") database for any policyholders, claimants, or vendors that might be included in the SDN database.
- Massachusetts Department of Revenue checks are to be performed as required by statute and are documented in the claim files.
- The Company has adopted procedures to report homeowners dwelling claims exceeding $1,000 to municipal authorities prior to payment in accordance with statutory requirements.
- Reservation of rights and excess of loss letters are issued when potential coverage issues arise. Also, underwriting risk referrals are made to the underwriting department as necessary.
- No liability release is required from insureds, unless the claim involves other parties who were underinsured or not insured. Third party property damage claimants are generally not required to sign a liability release unless there is a settlement dispute or general damages awarded. Releases are routinely required from third party bodily injury claimants.
- Criteria for unit managers' periodic reviews of the adjustors' work have been established, and such reviews are documented in the claim system. The Company is to report all closed automobile bodily injury claims to the AIB Detail Claims Database, and is to report required claims to the Merit Rating Board as required in Massachusetts.
- The Claims Department produces metric reports for the daily, weekly and monthly claims reporting of key service and quality metrics.
- The Company has established a quality assurance program through monthly self-review of open and closed claim files by claims managers. The sampled claims cover all adjustors to assess adherence to Company policies, procedures and best practices. In addition, a corporate regulatory compliance team and a claims best practices team, which are independent of branch claims management, annually review branch claim operations. The quality assurance and corporate team review results are documented and scored in checklists. Results are reported for each adjustor for use by claims management as part of the employee training and performance evaluation processes.
- The Company is subject to periodic loss data audits by CAR for compliance with statutes and CAR Rules of Operation.
- The Company conducts post-claim payment telephone surveys of first party claims. The survey results using a net promoter score are summarized for management reporting. Any negative comments from respondents are addressed.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected private passenger automobile claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. Also, RNA selected homeowners claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. RNA verified the date each selected claim was recorded by the Company, and noted whether the initial contact with the claimant was timely acknowledged.

Transaction Testing Results:

Findings: None.

Observations: RNA noted each of the tested claims was processed according to the Company's policies and procedures, with timely initial contact from the Company. Based upon testing, it appears that the Company's processes for providing timely initial contact with claimants are functioning in accordance with its policies, procedures, and statutory requirements.

Recommendations: None.

Standard VII-2. Timely investigations are conducted.

Objective: The Standard addresses the timeliness and completeness of the Company's claim investigations. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: Refer to Standard VII-1.

Controls Reliance: Refer to Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected private passenger automobile claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. Also, RNA selected homeowners claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. RNA tested each selected claim noting whether the investigations were conducted in a timely manner and whether the investigations were complete.

Transaction Testing Results:

Findings: None.

Observations: RNA noted each of the tested claims was timely reported and investigated according to the Company's policies and procedures. Based upon testing, it appears that the Company's processes for timely investigating claims are functioning in accordance with its policies, procedures, and statutory requirements.

Recommendations: None.

Standard VII-3. Claims are resolved in a timely manner.

Objective: The Standard addresses the timeliness of the Company's claim settlements. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: Refer to Standard VII-1.

Controls Reliance: Refer to Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected private passenger automobile claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. Also, RNA selected homeowners claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. RNA tested each selected claim noting whether the claims were resolved in a timely manner.

Transaction Testing Results:

Findings: One claim payment was not paid to a claimant for nine months after the claim payment was approved in violation of M.G.L. c. 176D, § 3(9)(f).

Observations: Based upon testing, except as noted above, it appears that the Company's processes for timely resolving claims are generally functioning in accordance with its policies, procedures, and statutory requirements.

Required Actions: The Company shall enhance procedures and controls over claims monitoring and provide related training to staff to ensure claims are timely and properly paid.

Subsequent Company Actions: The Company agrees with the required actions and is currently working to address the findings noted above.

Standard VII-4. The regulated entity responds to claim correspondence in a timely manner.

Objective: The Standard addresses the timeliness of the Company's response to claim correspondence. See Standard VII-6 for testing of required claim correspondence. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: Refer to Standard VII-1.

Controls Reliance: Refer to Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected private passenger automobile claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. Also, RNA selected homeowners claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. RNA tested each selected claim noting whether the Company timely responded to claim correspondence.

Transaction Testing Results:

Findings: None.

Observations: RNA noted that for each of the tested claims, the Company timely responded to claim correspondence. Based upon testing, it appears that the Company's processes for timely

responding to claims correspondence are functioning in accordance with its policies, procedures and statutory requirements.

Recommendations: None.

Standard VII-5. Claim files are adequately documented.

Objective: The Standard addresses the adequacy of information maintained in the Company's claim files. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: Refer to Standard VII-1.

Controls Reliance: Refer to Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected private passenger automobile claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. Also, RNA selected homeowners claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. RNA reviewed the file for each selected claim, and noted whether its documentation was adequate.

Transaction Testing Results:

Findings: None.

Observations: RNA noted that for each of the tested claims, the Company's claim files adequately documented claims handling, except for four bodily injury claimants where settlement offers were below the targeted settlement ranges and without adequate supporting documentation. One of these claimants was not represented by counsel.

Recommendations: The Company should adopt a policy requiring that all claim settlement offers must be fair and reasonable, and should be within the targeted settlement range with documentation supporting the settlement offers made. The Company should provide guidance and training to staff on the development of claim settlement offers and related documentation.

Subsequent Company Actions: The Company agrees with the required actions and is currently working to address the findings noted above.

Standard VII-6. Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPPA), rules and regulations.

Objective: The Standard addresses whether the claim appears to have been paid for the appropriate amount to the appropriate claimant/payee. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: Refer to Standard VII-1.

Controls Reliance: Refer to Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected private passenger automobile claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. Also, RNA selected homeowners claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. RNA reviewed the file for each selected claim, and noted whether the claim was properly handled in accordance with policy provisions and statutory requirements. Finally, RNA reviewed the Company's complaint log for complaints that were claim-related and tested three claim-related complaints.

Transaction Testing Results:

Findings: Testing indicated that seven tested homeowners claims over $1,000 were not properly and timely reported to local building and health authorities to disclose a potentially dangerous condition in accordance with M.G.L. c. 139, § 3B. Also, testing identified one homeowners claim where the required Department of Revenue checks were not completed in violation of M.G.L. c. 175, §§ 24D, 24E and 24F.

Observations: RNA noted each of the tested claims was handled according to the Company's policies and procedures, except as noted above. Based upon testing, it appears that the Company's processes for handling claims are generally functioning in accordance with its policies, procedures and statutory requirements. Finally, upon evaluation of the claims-related complaints, the related claims appeared to be properly handled.

Required Actions: The Company shall adopt new policies and control procedures to address the requirements of M.G.L. c. 139, § 3B, and review its current policies and controls for compliance with required Department of Revenue checks. Further, the Company shall provide training or guidance to claims adjustors on proper and timely implementation of these related policies and procedures. Finally, the new M.G.L. c. 139, § 3B policies and control procedures shall be tested by internal audit or compliance to ensure that they are effectively implemented, with the results of the independent testing completed and reported to the Division by September 30, 2015, or another agreed upon date.

Subsequent Company Actions: The Company states that it has developed new procedures and controls to address the required actions and provided training to staff on the new procedures and controls. The Company has also conducted subsequent audits to ensure compliance.

Standard VII-7. Regulated entity claim forms are appropriate for the type of product.

Objective: The Standard addresses the Company's use of claim forms that are proper for the type of product. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: Refer to Standard VII-1.

Controls Reliance: Refer to Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected private passenger

automobile claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. Also, RNA selected homeowners claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. RNA reviewed the file for each selected claim, and verified that required claim forms were appropriately used.

Transaction Testing Results:

Findings: None.

Observations: RNA noted each of the tested claims appropriately used the required claim forms in accordance with the Company's policies and regulatory requirements.

Recommendations: None.

Standard VII-8. Claim files are reserved in accordance with the regulated entity's established procedures.

Objective: The Standard addresses the Company's process to establish and monitor claim reserves for reported losses. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: Refer to Standard VII-1.

Controls Reliance: Refer to Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected private passenger automobile claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. Also, RNA selected homeowners claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. RNA reviewed the file for each selected claim, and noted whether claim reserves were evaluated, established and adjusted in a reasonably timely manner.

Transaction Testing Results:

Findings: None.

Observations: RNA noted that reserves for each of the tested claims were evaluated, established and adjusted according to the Company's policies and procedures. Based upon testing, it appears that the Company's processes for evaluating, establishing and adjusting reserves are functioning in accordance with its policies and procedures.

Recommendations: None.

Standard VII-9. Denied and closed-without-payment claims are handled in accordance with policy provisions and state law.

Objective: The Standard addresses the adequacy of the Company's decision making and documentation of denied and closed-without-payment claims. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: Refer to Standard VII-1.

Controls Reliance: Refer to Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected denied or closed-without-payment claims including four private passenger automobile claims and four homeowners claims for testing. RNA evaluated whether the Company handled these claims timely and properly before closing or denying them.

Transaction Testing Results:

Findings: None.

Observations: RNA noted each of the tested claims was handled according to the Company's policies and procedures. Based upon testing, it appears that the Company's claim handling and denial practices are appropriate and are functioning in accordance with its policies, procedures, and statutory requirements.

Recommendations: None.

Standard VII-10. Cancelled benefit checks and drafts reflect appropriate claim handling practices.

Objective: The Standard addresses the Company's procedures for issuing claim checks as it relates to appropriate claim handling practices. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: Refer to Standard VII-1.

Controls Reliance: Refer to Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA reviewed procedures regarding the use of claim payment checks for the claimant to attest to full claim settlement by endorsing the claim check.

Transaction Testing Results:

Findings: None.

Observations: RNA noted that the Company does not use claim payment checks for the claimant to attest to full claim settlement by endorsing the claim check. Based upon review, it appears that the Company's processes for issuing claim payment checks are appropriate and functioning in accordance with its policies and procedures.

Recommendations: None.

Standard VII-11. Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.

Objective: The Standard addresses whether the Company's claim handling practices force claimants to (a) institute litigation for the claim payment, or (b) accept a settlement that is substantially less than due under the policy. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: Refer to Standard VII-1.

Controls Reliance: Refer to Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected private passenger automobile claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. Also, RNA selected homeowners claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. RNA reviewed the file for each selected claim, and noted whether claim practices appeared to compel claimants to institute litigation to recover amounts due under the policies by offering substantially less than would be due under the policies, and whether the Company attempted to settle claims for less than reasonable amounts due under the policies.

Transaction Testing Results:

Findings: None.

Observations: Based upon review of procedures and testing, the Company did not appear to compel claimants to institute litigation to recover amounts due under the policies by offering substantially less than would be due under the policies, and the generally Company did not attempt to settle claims for less than reasonable amounts due under the policies.

Recommendations: None.

Standard VII-12. Regulated entity uses the reservation of rights and excess of loss letters, when appropriate.

Objective: The Standard addresses the Company's use of reservation of rights letters, and its procedures for notifying an insured when it is apparent that the amount of loss will exceed policy limits. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: Refer to Standard VII-1.

Controls Reliance: Refer to Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected private passenger automobile claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. Also, RNA selected homeowners claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. RNA reviewed the file for each selected claim, and noted whether reservation of rights or excess of loss letters were warranted and issued as appropriate.

Transaction Testing Results:

Findings: None.

Observations: Based upon testing, RNA found four instances where reservation of rights or excess of loss letters were used. The use of these letters appeared appropriate. RNA noted no instances where reservation of rights or excess of loss letters should have been used, but were not. The Company's appears to have reasonable policies and procedures for the use of reservation of rights and excess of loss letters.

Recommendations: None.

Standard VII-13. Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner.

Objective: The Standard addresses whether the Company accurately and timely issues deductible reimbursements upon subrogation recovery. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: Refer to Standard VII-1.

Controls Reliance: Refer to Standard VII-1.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its claim handling processes, and obtained documentation supporting such processes. RNA selected private passenger automobile claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. Also, RNA selected homeowners claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. RNA reviewed each selected claim file, and noted whether deductible reimbursement to insureds upon subrogation recoveries were reasonably timely and accurate.

Transaction Testing Results:

Findings: None.

Observations: RNA noted that deductible reimbursement to insureds, upon subrogation recoveries, for five tested claims was timely, accurate and processed according to the Company's policies and procedures. Based upon testing, it appears that the Company's processes for making

deductible reimbursement to insureds upon subrogation recoveries are functioning in accordance with its policies and procedures.

Recommendations: None.

Standard VII-14. Loss statistical coding is complete and accurate.

Objective: The Standard addresses the Company's complete and accurate reporting of loss statistical data to appropriate rating bureaus. See Appendix A for applicable statutes, regulations and bulletins.

Controls Assessment: The following controls were noted in review of this Standard:

- Company policy is to report complete and accurate loss data timely to appropriate rating bureaus.
- The Company reports private passenger automobile loss data to CAR in a format required by CAR. The Company is subject to periodic loss data audits by CAR for compliance with statutes and CAR Rules of Operation.
- The Company also reports loss data to the AIB, which is a rating bureau that represents the Massachusetts insurance industry.
- The Company reports homeowners loss data to ISO in the required format.
- The Company has processes to correct loss data coding errors and to make subsequent changes, as needed.

Controls Reliance: Controls tested via documentation inspection, procedure observation and/or corroborating inquiry appear to be sufficiently reliable to be considered in determining the extent of transaction testing procedures.

Transaction Testing Procedure: RNA interviewed Company personnel to understand its loss statistical reporting processes, and obtained documentation supporting such processes. RNA selected private passenger automobile claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. Also, RNA selected homeowners claims including 12 paid claims, four denied or closed-without-payment claims, and nine open claims for testing. RNA reviewed each selected claim file and noted whether selected loss data was accurate and complete.

Transaction Testing Results:

Findings: RNA testing determined that one homeowners claim had an improper loss date and catastrophe code in violation of M.G.L. c. 174A, §15(a) and 211 CMR 15:00.

Observations: RNA noted that selected loss data appears to be accurate and complete for tested claims, except as noted above. Based upon testing, the Company generally appears to have processes for timely and accurately reporting of loss statistical data to rating bureaus in accordance with its policies and statutory requirements.

Required Actions: The Company shall adopt new controls and procedures and provide training to staff ensure that claim statistical elements are properly coded.

Subsequent Company Actions: The Company agrees with the required actions and is currently working to address the findings noted above.

SUMMARY

Based upon the procedures performed in this examination, RNA has reviewed and tested Complaint Handling, Underwriting and Rating, and Claims as set forth in the *2012 NAIC Market Regulation Handbooks,* the examination standards of the Division, and the Commonwealth of Massachusetts' insurance laws, regulations and bulletins. RNA has provided recommendations and required actions to address standards in these sections.

ACKNOWLEDGEMENT

This is to certify that the undersigned is duly qualified and that, in conjunction with RNA applied certain agreed-upon procedures to the corporate records of the Company in order for the Division to perform an examination of the Company.

The undersigned's participation in this examination as the Examiner-In-Charge encompassed responsibility for the coordination and direction of the examination performed, which was in accordance with, and substantially complied with, those standards established by the NAIC and the Handbook. This participation consisted of involvement in the planning (development, supervision and review of agreed-upon procedures), communication and status reporting throughout the examination, administration and preparation of the examination report.

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

Matthew C. Regan III
Director of Market Conduct &
Examiner-In-Charge
Commonwealth of Massachusetts
Division of Insurance
Boston, Massachusetts

APPENDIX B

IN THE MATTER OF

MASSACHUSETTS HOMELAND INSURANCE COMPANY

REGULATORY SETTLEMENT AGREEMENT ON REPORTING OF MOTOR VEHICLE AT-FAULT ACCIDENTS TO THE MERIT RATING BOARD AND TO AFFECTED OPERATORS

This Regulatory Settlement Agreement ("Agreement") is entered into as of this ___day of December 2014 by and between Massachusetts Homeland Insurance Company (the "Company") and the Commissioner of the Massachusetts Division of Insurance ("the Division").

A. Recitals

1. The Company maintains its home office in Quincy, Massachusetts and at all relevant times has been a licensed insurance company in Massachusetts. On or about January 14, 2013, pursuant to authority in Massachusetts General Laws ("M.G.L.") Chapter 175, Section 4, the Division called a comprehensive market conduct examination of the Company. The Division later changed the scope of the examination to limited-scope due to financial difficulties of the Company's affiliates and a pending acquisition of control of the Company and its affiliates. The limited-scope examination is ongoing. In accordance with 211 CMR 134, the Company is to report motor vehicle at-fault accident determinations, in which the Company has determined that fault is greater than 50% in accordance with 211 CMR 74.04, to the Merit Rating Board ("MRB") and to vehicle operators determined to be at-fault in motor vehicle accidents ("At-fault Operators"). Concurrent with the reporting of the insurer's at-fault determination for the At-fault Operator, the Company is required to provide notice of the At-fault Operator's right to appeal the at-fault determination to the Massachusetts Board of Appeals ("BOA")

or a court of competent jurisdiction in accordance with M.G.L. Chapter 175E, Section 7A. If the Company's at-fault accident determination is vacated by the Massachusetts BOA or a court of competent jurisdiction, the At-fault Operator's insurer is required to refund any additional premium collected as a result of the Company's at-fault determination, and the Company must report such vacated at-fault accident determinations to the same consumer reporting agencies to whom the original at-fault accident determinations were reported in accordance with M.G.L. Chapter 175E, Section 7A.

2. During the limited-scope examination, the Division determined that the Company failed to report at-fault accident determinations to affected At-fault Operators and to report at-fault accident determinations to the MRB between 2012 and 2014. Specifically, the Company failed to report numerous at-fault accident determinations to affected At-fault Operators and to provide the affected At-fault Operators with notices of their right to appeal those determinations in accordance with M.G.L. Chapter 175E, Section 7A. Further, the Company failed to report these at-fault accident determinations to the MRB in accordance with 211 CMR 134.

3. During the limited-scope examination, the Division engaged in discussions with Company management with respect to the matters in this Agreement. The Company agreed to the corrective actions set forth in Section B, which seeks to provide notice to affected At-fault Operators of the Company's at-fault accident determinations, so as to reinstate such operators' rights to appeal their at-fault accident determinations in accordance with M.G.L. Chapter 175E, Section 7A, and to report all claims to the MRB as required by 211 CMR 134. Further, the corrective action plan set

forth in Section B will require settlement of potential claims to other affected parties, including the current private passenger automobile insurer of an At-fault Operator. Finally, the corrective action plan seeks changes in the Company's related business practices and monitoring efforts.

4. The parties further agree that the subject of this Agreement is the Company's Massachusetts private passenger automobile line of business ("block of business"). This Agreement covers this block of business written by the Company, its affiliates or any successor in interest, upon the sale of either the Company or the block of business solely, (collectively, "the Stipulated Insurer").

B. Plan of Corrective Action

1. Notice to Affected At-fault Operators

An affected At-fault Operator is a motor vehicle operator, who was determined by the Company to be at-fault for a motor vehicle accident in accordance with 211 CMR 134, and not notified of the Company's at-fault determination and the operator's corresponding right to appeal the Company's at-fault determination in accordance with M.G.L. Chapter 175E, Section 7A. For each affected At-fault Operator, the Stipulated Insurer shall provide to each such operator the following information within 60 days of the execution of this Agreement, unless additional time is granted by the Division:

a. A notice describing the Company's failure to report timely to the operator that he or she was determined to be at-fault in a motor vehicle accident. A description of the potential impact of the error on the operator's current and future policy premium,

b. The surcharge notice required by 211 CMR 134 to be sent to the affected At-fault Operator, which includes the application and process to appeal the Company's at-fault determination. A statement that the operator must file an appeal within 30 days of the date on the notice, and that the Stipulated Insurer will reimburse the affected At-fault Operator for the $50 appeal fee if he or she elects to appeal the Company's at-fault determination,

c. The notice to the affected At-fault Operator will state that the claim was not reported to the MRB, and that the Stipulated Insurer will report the claim to the MRB within 15 days of the execution of this Agreement, unless additional time is granted by the Division.

d. In addition, if the affected At-fault Operator is not currently insured under a policy issued by the Company, the notice to the affected At-fault Operator will include a statement that the At-fault Operator's current private passenger automobile insurer may be notified by the MRB of this claim. Further, the Stipulated Insurer will coordinate with the current insurer through the Division to ensure that, if the failure to report claims timely led to improper premiums for prior policy terms, the Stipulated Insurer will compensate the insurer. The At-fault Operator is not responsible for any past premium inadequacy under these circumstances.

2. *Notice to all other affected operators regarding claims that were not reported to the MRB*

The Stipulated Insurer shall provide notice to all other affected operators not currently insured by the Stipulated Insurer, of all claims covered by this Agreement that were not reported to the MRB in accordance with 211 CMR 134. The Stipulated Insurer shall provide to each such operator the following information within 60 days of the execution of this Agreement, unless additional time is granted by the Division:

a. A notice describing the Company's failure to report claims timely to the MRB as required by 211 CMR 134, and a description of the potential impact of the error on the operator's current and future policy premium,

b. The notice will include a statement that the Stipulated Insurer either has recently reported the claim to the MRB, or will report the claim to the MRB and any other consumer reporting agencies within 60 days of the execution of this Agreement, unless additional time is granted by the Division.

c. The notice shall contain or be accompanied by a statement that identifies the accident dates on the claims that will be reported to the MRB and a statement that these reported claims will not result in at-fault accident surcharges to the operator.

3. *Notice to Commonwealth Automobile Reinsurers ("CAR")*

The Stipulated Insurer shall provide notice to CAR of all policies covered by the Agreement. The Stipulated Insurer shall also provide CAR with the accident dates, amounts paid on the claims by coverage type, and if applicable, the at-fault accident determination for such claims, and any other data reasonably requested by CAR for the purposes of assessing the impact to the residual market quota share.

4. *Changes in Business Practices and Monitoring Efforts*

The Stipulated Insurer , shall institute and report to the Division all new business practices and monitoring efforts to address the errors noted in this Agreement.

a. Within 60 days of the execution of the Agreement, unless additional time is granted by the Division, the Stipulated Insurer shall develop and adopt new business practices to ensure that it timely and properly rates it policies in accordance with its rating plan filed with the Division and provides operators determined to be at-fault for accidents involving motor vehicles insured by the Stipulated Insurer, with proper notice of the at-fault determination, and the at-fault operator's right to appeal the determination in accordance with M.G.L. Chapter 175E, Section 7A. Further, the Stipulated Insurer shall develop and adopt new business practices to ensure that claim data is properly and timely reported to the MRB in accordance with 211 CMR 134. Training to staff on these new business practices shall be provided to them.

b. The Stipulated Insurer's internal audit department or independent quality assurance function shall test the design and effectiveness of the new business practices noted in Section B, and issue a written report on their findings and any related recommendations to management, the Stipulated Insurer's Board of Directors or a committee thereof, and to the Division by June 30, 2015, unless additional time is granted by the Division. If significant business practice issues are identified in the report, follow up audits by the internal audit department or quality assurance function will continue to be performed, with related reports issued, until no significant business practice issues remain.

C. Other Provisions

1. The Division will monitor the Stipulated Insurer's compliance with this Agreement. The Division will conduct a re-examination of the Stipulated Insurer for issues addressed under this Agreement and any other issues identified in the Company's examination within twenty-four (24) months after the execution of this Agreement. The Stipulated Insurer shall be deemed in compliance with this Agreement unless the re-examination testing conducted within the aforementioned twenty-four (24) month period results in an error rate that exceeds three (3) percent. Such error rate shall be determined by use of a statistical credible sample, and that sample will be based on guidance contained in the current version of the *NAIC Market Regulation Handbook.*

2. The monitoring of the Stipulated Insurer for compliance with the terms of this Agreement constitutes an ongoing examination. In accordance with M.G.L. Chapter

175, Section 4, the Division shall afford confidential treatment to the workpapers, recorded information, or documents provided by the Stipulated Insurer as part of the ongoing examination.

3. All Division monitoring and examination costs, including interim reviews and testing, shall be borne by the Stipulated Insurer in accordance with M.G.L. Chapter 175, Section 4.

4. The Stipulated Insurer does not admit to any wrong doing or violation of law.

5. The Stipulated Insurer agrees that all amounts paid or expenses incurred in complying with the terms and conditions of this Agreement shall not be included or recoverable as expenses in any rate filing filed with the Division or any other insurance regulatory agency.

6. This Agreement may be executed in counterparts. A true and correct copy of the Agreement shall be enforceable the same as the original Agreement. The provisions of this Agreement may be amended, modified, or expanded solely in writing by joint consent of the Division and the Stipulated Insurer.

7. This Agreement shall be governed by and interpreted according to the laws of the Commonwealth of Massachusetts.

8. This Agreement represents the entire understanding between the parties hereto with respect to the subject matter hereof and supersedes any and all prior understandings, agreements, plans, and negotiations, whether written or oral, with respect to the subject matter hereof.

9, The Division releases and discharges the Stipulated Insurer with respect to all fines, claims, sanctions or redress that could have been pursued as a result of the Company's past conduct addressed by the Plan of Corrective Action other than as set forth in this Agreement. Notwithstanding the foregoing, the Division's authority to investigate any assertion of the Stipulated Insurer's noncompliance with law applicable to matters not within the scope of this Agreement, and to act thereon, shall not be limited in any way by this Agreement.

10. The Division retains the right to impose any regulatory penalty otherwise available by law, including fines, with respect to the Stipulated Insurer's willful violation of this Agreement or other violation of law.

11. Except as set forth herein, nothing in this Agreement shall be construed to waive or limit the right of the Division to seek such other remedies or to otherwise waive or limit the continuing regulation of the Stipulated Insurer in the normal course.

12. The parties hereto agree that time shall be of the essence with respect to the performance of this Agreement.

13. The parties also agree that every covenant, term and provision of this Agreement shall follow the block of business and shall be binding upon any future successors in interest to the Company or future owners of the block of business.

14. This Agreement shall be binding upon the personal representatives, successors and assignees of the parties.

D. Remedies

1. Within 15 days of the execution of this Agreement, the Stipulated Insurer shall pay a fine of $150,000 to the Division. Also, after completion of the re-examination conducted within twenty-four (24) months of the execution of this Agreement, as referenced in Section C.1, the Commissioner may require an additional fine of up to $150,000 in the event that the error rate exceeds the maximum tolerance level in Section C.1.

2. The Stipulated Insurer shall be entitled to review and comment on any re-examination results in accordance with the current version of the *NAIC Market Regulation Handbook*.

MASSACHUSETTS HOMELAND INSURANCE COMPANY

BY: 

December 9, 2014

MASSACHUSETTS DIVISION OF INSURANCE

BY: _____
Joseph G. Murphy, Commissioner

December ___, 2014

D. Remedies

1. Within 15 days of the execution of this Agreement, the Stipulated Insurer shall pay a fine of $150,000 to the Division. Also, after completion of the re-examination conducted within twenty-four (24) months of the execution of this Agreement, as referenced in Section C.1, the Commissioner may require an additional fine of up to $150,000 in the event that the error rate exceeds the maximum tolerance level in Section C.1.

2. The Stipulated Insurer shall be entitled to review and comment on any re-examination results in accordance with the current version of the *NAIC Market Regulation Handbook.*

MASSACHUSETTS HOMELAND INSURANCE COMPANY

BY: _____

December 10, 2014

MASSACHUSETTS DIVISION OF INSURANCE

BY: _____
Joseph G. Murphy, Commissioner

December 10, 2014