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DANIEL R. JUDSON
PRESIDENT

**NOTICE OF MEETING**

**AD HOC PERFORMANCE STANDARDS LABOR RATES AND TIMES SUBCOMMITTEE**

A meeting of the Ad Hoc Performance Standards Labor Rates and Times Subcommittee will be held at the offices of Commonwealth Automobile Reinsurers, 225 Franklin Street, Boston, on

**WEDNESDAY APRIL 9, 2014 AT 10:00 A.M.**

**MEMBERS OF THE SUBCOMMITTEE**

Mr. David Antocci – Chairman
MAPFRE U.S.A. Corporation

| | |
|---|---|
| Mr. Donald F. Baldini | Liberty Mutual Group |
| Mr. Francis N. Delage | The Hanover Insurance Company |
| Mr. Eric Doyle | Amica Mutual Insurance Company |
| Ms. Ann-Marie Kendall | Quincy Mutual Group |
| Mr. David E. Krupa | Safety Insurance Company |
| Ms. Marie-Armel Theodat | R. Theodat Insurance Agency, Inc. |

**AGENDA**

**AHLR**
**14.03 Performance Standards Review**

The Subcommittee should be prepared to consider changes to the Private Passenger and Commercial Performance Standards relating to Auto Body Payments – Labor Rates and Times. The proposed modifications to both the Private Passenger and Commercial Performance Standards previously forwarded to the Governing Committee for its February 2014 meeting are attached for informational purposes. (Docket #AHLR14.03, Exhibits #1 & 2)

**Other Business**

To transact any other business that may properly come before this Subcommittee.

**Executive Session**

The Ad Hoc Performance Standards Labor Rates and Times Subcommittee may convene in Executive Session in accordance with the provisions of G.L. c. 30A, § 21.

DANIEL R. JUDSON
President

Boston, Massachusetts
March 28, 2014

# *Performance Standards for the Handling and Payment of Private Passenger Claims by Assigned Risk Companies*

## Introduction

Massachusetts G.L.c.175, §113H requires Commonwealth Automobile Reinsurers (CAR) to establish Performance Standards designed to contain costs, ensure prompt customer service, monitor the payment of legitimate claims, and to resist inflated, fraudulent, and unwarranted claims. Periodic audits of members of the plan are required in order to determine whether there is a difference in claims handling between policies insured voluntarily and involuntary policies issued through the plan. The Performance Standards were last approved by the Commissioner of Insurance on May 13, 2011.

The introduction of competitive rating in the Massachusetts insurance market in April 2008 and the transition from a ceded pool environment to an assigned risk plan has necessitated modifications to the procedures for conducting the Claims and SIU Performance Standards reviews. These proposed changes are contained in the Measurements and Penalties section and Appendix J and K. The procedures used by CAR to conduct the reviews follow those outlined in the National Association of Insurance Commissioners' Market Conduct Examiners Handbook Chapter VIII G. Claims. Appendix N details the sections in the Performance Standards and Rule 32 that conform to the NAIC Standards.

Statistical Plan data is used to supplement the information obtained in the claims file review to evaluate Assigned Risk Companies' (ARCs) performance. ARCs are also required to report savings brought about by SIU activities for physical damage, bodily injury, and personal injury protection claims.

The Performance Standards require and are in addition to compliance with Massachusetts laws and regulations regarding automobile insurance and the CAR Rules of Operation. When revisions to existing laws or regulations or any new laws or regulations relating to claims handling are promulgated, they will become part of the Performance Standards.

Under competitive rating ARCs are offering additional coverages and services that may exceed specific approved Performance Standards. In the event that a difference exists between the Standard and a coverage offered by the ARC the policy coverage will supersede the Standard.

The following Appendices are attached to assist ARCs in implementing the Performance Standards:

**Appendix A – Special Investigative Unit Standards**

SIU Investigative Standards were developed by CAR to help ARCs resist payment of fraudulent claims, deter fraud, control costs, and ultimately help control insurance rates.

**Appendix B – Regulation 211 CMR 123.00**

**Direct Payment of Motor Vehicle Collision and Comprehensive Coverage Claims and Referral Repair Shop Programs**

**Appendix C – Industry Direct Payment Plan for the Settlement of Insured Auto Damage Repairs**

**Appendix D – Decision and Order on the Application for Approval of the Massachusetts Automobile Rating and Accident Prevention Bureau Direct Payment Plan**

**Appendix E – Regulation 212 CMR 2.00**
**The Appraisal and Repair of Damaged Motor Vehicles**

Regulation 212 CMR 2.00 promotes public welfare and safety by improving the quality and economy of the appraisal and repair of damaged motor vehicles. It is intended to be read in conjunction with 211 CMR 133.00, which follows in Appendix F.

**Appendix F – Regulation 211 CMR 133.00**
**Standards for the Repair of Damaged Motor Vehicles**

Regulation 211 CMR 133.00 promotes the public welfare and safety by establishing fair and uniform standards for the repair of damaged motor vehicles when an insurer pays for the cost of repairs. It is intended to be read in conjunction with 212 CMR 2.00 in Appendix E

**Appendix G – Regulation 211 CMR 94.00**
**Mandatory Pre-Insurance Inspection of Private Passenger Motor Vehicles**

**Appendix H - Salvage Title Law, Chapter 90D, Section 20 (a through e)**

**Appendix I - M.G.L. Chapter 175: Section 24D**
**Insurance Claim Payment Intercept Program and**
**Regulation 830 CMR 175.24D.1.1**
**Intercept of Insurance Payments to Satisfy Child Support Liens**

**Appendix J – CAR Compliance Audit Claim Review Process**

This section incorporates the selection of the sample, review procedures, and criteria to conduct these examinations.

**Appendix K – SIU File Review Process**

CAR's SIU conducts a triennial review of the ARC's Special Investigative Unit. The reviews evaluate the adequacy of staffing, quality of investigations, accuracy of reported savings, and compliance with the Standards and reporting requirements.

**Appendix L – Questionnaire**

The Questionnaire is sent to the ARC prior to the commencement of CAR's periodic review in order to provide background information on claims handling programs established by the ARC. Completion of the Questionnaire certifies that the ARC's claims handling practices comply at a minimum with the approved Performance Standards.

**Appendix M – Industry Best Practices**

The outline identifies where industry Best Practices are referenced in the Performance Standards.

**Appendix N – NAIC Standards**

Reference to NAIC Standards, CAR Rule 32, and the Performance Standards are included.

**Appendix O - DOI 2008-12 Clarification of Coordination of Benefits under MGL c 90, §34A and the Interrelationship by and among PIP, Health Insurance and Medical Payments**

# *Performance Standards for the Handling and Payment Of Claims by Assigned Risk Companies*

## I. Auto Physical Damage & Property Damage Liability Claims

### A. Auto Body Payments

#### 1. Service Times

a. Assigned Risk Companies (ARCs) must establish programs and procedures to ensure prompt settlements of warranted auto physical damage claims.

b. ARCs must establish procedures to permit prompt appraisal of damage and to make prompt claim payments of auto physical damage claims.

c. The Standard for assignment to an appraiser from the date the report is received or date of notice of recovery of theft is 2 business days.

d. The Standard for transmittal of the completed appraisal from the date of the appraisal assignment is 5 business days in accordance with 212 CMR 2.04(1)(e).

e. The Standard for payment of a first party auto physical damage claim under any Direct Payment Plan is 5 business days from completion of the appraisal on all repairable vehicles, subject to all other provisions of the Plan.

f. The Standard for payment of a first party auto physical damage claim that is not under any Direct Payment Plan is 7 business days following receipt of a Completed Work Claim Form.

#### 2. Direct Payment Plan

a. ARCs must have a Direct Payment Plan unless their average Massachusetts private passenger market share is less than 1 percent of the total Massachusetts private passenger market.

1) The Industry Plan can be adopted (Appendix C).

2) Modifications to the Industry Plan can be filed for approval by the Commissioner of Insurance.

3) An ARC can develop its own plan and submit it for approval by the Commissioner of Insurance.

b. Any Direct Payment Plan developed by an ARC must include a referral shop program.

#### 3. Parts Cost

a. ARCs must have programs and procedures to demonstrate their efforts to obtain discounts and pay less than full retail price for parts.

b. ARCs must consider the applicability of aftermarket, rebuilt, and like kind and quality (LKQ) parts on all appropriate appraisals.

c. ARCs must allow for, and insist on, the use of aftermarket, rebuilt, and LKQ parts in lieu of new or cost of repair, whenever appropriate.

4. Labor Rates and Times

a. ARCs must have a plan designed to control labor costs, ~~and~~ to seek the most competitive labor rates and times, and to determine whether labor, repair, and replacement times are reasonable and consistent with industry-recognized sources.

~~b. ARCs must have a plan to demonstrate their efforts to resist labor rate increases or to lower rates whenever possible.~~

~~c. ARCs must have a plan to determine whether labor, repair, and replacement times are reasonable and consistent with industry recognized sources.~~

5. Total Loss Payments

a. ARCs shall not declare any vehicle a total loss when a prudent appraisal evaluation would have shown that the vehicle could have been repaired at an overall cost less than the actual cash value minus the salvage value.

b. The actual cash value of any vehicle must be determined based on the following requirements of Regulation 211 CMR 133.05 Determination of Value (Appendix F).

1) Actual Cash Value: Whenever the appraised cost of repair plus the probable salvage value may be reasonably expected to exceed the actual cash value of the vehicle, the insurer shall determine the vehicle's actual cash value. This determination shall be based on a consideration of all the following factors:

a) the retail book value for a motor vehicle of like kind and quality, but for the damage incurred.

b) the price paid for the vehicle plus the value of prior improvements to the motor vehicle at the time of accident, less appropriate depreciation;

c) the decrease in value of the motor vehicle resulting from prior unrelated damage which is detected by the appraiser; and

d) the actual cost of purchase of an available motor vehicle of like kind and quality but for the damage sustained.

c. Existing pre-insurance inspection reports must be reviewed for options, mileage, prior condition, prior damages, and placed in the claim file on all total losses.

d. ARCs must be in compliance with the Salvage Title Law, Chapter 90D, section 20 (a through e).

6. Towing and Storage Costs

    a. ARCs must have a plan to demonstrate that their staffs have knowledge of and enforce all regulations applicable to towing and storage rates and conditions.

    b. ARCs must have a plan to ensure that non-regulated towing and storage charges are reasonable, or to resist and reduce said charges if they are unreasonable.

    c. ARCs must have a plan to control storage costs including the prompt disposition of salvage.

7. Appraisal of Damage and Reinspections

    a. ARCs must have basic guidelines for appraisers, which include the following areas:

        1) Compliance with Regulation 212 CMR 2.00 – The Appraisal and Repair of Damage Motor Vehicles

        2) Scoping and completing an appraisal

        3) Use of aftermarket, rebuilt, LKQ parts

        4) Open items and supplements

        5) Refinishing

        6) Depreciation and betterment

        7) Unrelated damage

        8) Structural damage

        9) ACV estimating

        10) Screening for fraudulent claims

    b. ARCs must have an ongoing training plan and program for continuing education of staff appraisers, including fraud awareness.

    c. ARCs must have a plan for periodic evaluation of the quality and accuracy of its independent appraisers.

    d. Reinspections must be completed on 75 percent of all repaired vehicles whose damage exceeded $4,000 including damages paid under a Direct Payment Plan.

    e. Reinspections must be completed on 25 percent of all repaired vehicles whose damage was less than $4,000 including damages paid under a Direct Payment Plan.

8. ARCs must establish procedures to comply with claims requirements included in the mandatory pre-insurance inspection program established by Regulation 211 CMR 94.00 (Appendix G).

B. Normal Claim Handling

1. Initial screening of reports of accidents and losses

   a. All new notices shall be screened by a person with sufficient experience and training to be able to identify warning signs requiring special inquiry or investigation or by an appropriate expert software system designed for fraud screening, and thereafter assigned by a person with sufficient experience and training.

   b. The initial screening shall determine whether accident circumstances, facts, and information reported are consistent and sufficient to establish the occurrence.

   c. The initial screening shall identify losses involving theft or arson, which always require detailed investigation.

   d. The fraud indicators of Commonwealth Automobile Reinsurers Special Investigative Unit (CAR SIU) Standards and Fraud Profile (Appendix A) shall be considered to determine possible warning signs of fraud.

   e. A determination shall be made of the type and extent of further investigation that may be necessary if the initial screening identifies discrepancies or inconsistencies.

2. Initial Investigation

   The initial investigation shall include:

   a. Reviewing policy information to verify coverage, resolve any issues including garaging or operators, and notifying Underwriting where appropriate.

   b. Timely contact with involved parties to secure sufficient documentation of facts involving accident circumstances, to verify occurrence, and to establish degree of fault and, in cases where no injuries reported, appropriate to the loss.

   c. Obtaining documentation of ownership and existence of said vehicle in appropriate cases, especially total losses.

   d. Documenting the damages or value of the vehicle.

   e. Reviewing and evaluating discrepancies and fraud indicators to determine the scope of further investigation.

   f. Timely setting of reasonable initial reserves and following the documented company policy.

3. Appraisal Program

a. Appraisers must recognize and report discrepancies which may indicate need for further investigation.

b. Appraisals shall be reviewed in conjunction with all other information developed to determine if there are any indicators of fraud.

4. Prompt Evaluation and Settlement

a. After initial investigation is complete, a decision must be made to promptly process for settlement or refer case for special investigation.

b. In the normal course of claim handling a file shall be referred for special investigation or expert analysis when discrepancies exist that are unresolved.

c. ARCs shall have a litigation management program designed to bring cases to the earliest conclusion at a reasonable value.

5. Prior to making any payment equal to or in excess of $500 to a third-party claimant, the ARC must comply with the requirements of the Insurance Claim Payment Intercept Program, M.G.L. Chapter 175, Section 24D. NOTE: Failure to comply with M.G.L. Chapter 175, Section 24D will subject the ARC to penalties proscribed by the Department of Revenue. These penalties will be in lieu of those penalties imposed for non compliance with the Performance Standards.

6. Subrogation/Recovery

a. The investigation shall determine other parties involved in the accident, the probable extent of liability on each party, and the carrier or party against whom subrogation will be directed, if applicable.

b. Upon subrogation recovery the deductible shall be reimbursed in a timely and accurate manner when and where appropriate.

C. Fraud Handling

1. Screening process for suspected fraudulent claims

a. When a discrepancy is of such weight as to raise substantial questions of fraud (example: all keys accounted for and the vehicle shows no ignition damage), the case shall be referred for special investigation.

b. Whenever several discrepancies exist and/or a pattern appears that matches prior suspicious cases, the case shall be referred for special investigation.

c. Unresolved discrepancies, such as VIN problems, prior total loss or salvaged vehicle, title inconsistencies, or other verifiable documents shall result in the case being referred for special investigation.

d. Whenever a combination of minor discrepancies occur which cannot be resolved, the case shall be referred for special investigation.

2. Appraisal Program

   a. When damage to the vehicle is identified as inconsistent with accident circumstances, the case shall be considered for special investigation.

   b. Clear photographs must accompany explanation of all damage inconsistencies.

3. Special Investigation

   a. Claims identified as suspicious or suspected fraudulent shall be referred for more detailed special investigation and consideration given to referring the claim to IFB, NICB and/or the appropriate law enforcement agency for prosecution.

   b. The CAR SIU Standards for investigation of suspicious claims (Appendix A) must be consulted and considered as part of the special investigation process.

   c. The savings recorded on physical damage claims shall be documented and reported to CAR on a quarterly basis.

4. Evaluation and Settlement

   After a special investigation is complete, a decision must be made to pay the claim or resist. The claim file must clearly document the basis for the decision and result.

D. Glass

1. ARCs must establish a program to effect prompt repair or replacement of damaged or broken glass covered under automobile physical damage coverage, at a fair and competitive cost.

2. ARCs must have a plan to screen all glass bills and obtain reasonable discounts on market price lists for all domestic and foreign windshields and all side and back glass.

3. ARCs must have a plan to pay labor costs which are reasonable and competitive for glass repair or replacement.

4. ARCs must consider a plan to waive any glass deductible if the insured elects to repair the glass damage in lieu of replacement.

5. ARCs must have a plan to address fraud, including inspection or reinspection of a representative sampling of all glass losses. In no event shall the selection be based on the age or sex of the policyholder, customary operators of vehicle, or the principal place of garaging of the vehicle.

E. Fraud Training

1. ARCs must have a plan that provides for ongoing training of fraud awareness and how to identify suspicious claims.

2. ARCs must have a plan for training of special investigation and handling of suspicious and suspected fraudulent claims.

3. ARCs must have a plan to provide training on claim reporting and fraud recognition to producers and their customer service representatives.

## II. Bodily Injury & Uninsured/Underinsured Motorist

A. Normal Claim Handling

1. Initial Screening of Reports of Accident and Losses

a. All new notices shall be screened by a person with sufficient experience and training to be able to identify warning signs requiring special inquiry or investigation or by an appropriate expert software system designed for fraud screening, and thereafter assigned by a person with sufficient experience and training.

b. The initial screening shall determine whether accident circumstances, facts, and information reported are consistent and sufficient to establish the occurrence.

c. The initial screening shall include checking policy information and accident history, and reporting to the Central Index Bureau (CIB) to evaluate for possible warning signs.

d. The fraud indicators of the CAR Fraud Profile shall also be considered for possible warning signs.

e. A determination shall be made of the type and extent of further investigation that may be necessary if the initial screening identifies discrepancies or inconsistencies.

2. Initial Investigation

The initial investigation shall include:

a. Reviewing policy information to verify coverage and resolve any coverage issues. Reservation of Right letters and Excess of Loss letters shall be used when and where appropriate.

b. Contacting involved parties and securing sufficient documentation of facts involving the accident circumstances to verify occurrence and to establish degree of fault.

c. Securing documentation to verify that all alleged injured parties were actually involved in the accident.

d. Reviewing and evaluating discrepancies and fraud indicators to determine scope of further investigation.

e. Timely setting of reasonable initial reserves and following the documented company policy.

3. Contacts

a. Injured persons or their legal representative making a claim shall be contacted within 2 business days of receipt of notice of injury for purposes of investigation and verification.

b. The named insured, if not an injured party, shall be contacted within 3 business days of receipt of notice of injury for purposes of investigation and verification.

c. The insured operator, if not one of the above, shall be contacted within 3 business days of receipt of notice of injury for purposes of investigation and verification.

4. Loss Management

a. Loss management, assessment, & verification tools shall be used when appropriate to identify the disability claimed, the medical treatment, and whether the treatment and medical expenses are reasonable, necessary, and related to the auto accident.

5. Follow-Up and Continuing Investigation

The continuing investigation shall include:

a. Verifying and evaluating the type and extent of injury substantiated by available reports and/or independent examinations.

b. Confirming and documenting that treatment and expenses are reasonable, necessary, and related to the accident.

c. Reviewing and evaluating discrepancies and fraud indicators to determine the scope of further investigation.

d. Employing proper diary systems and ensuring ARC reporting and authority levels are followed.

e. Timely and reasonable changes to the reserves that follow the documented company policy.

6. Settlement Negotiations or Denial

a. ARCs shall have a settlement evaluation plan to obtain reasonable negotiated settlements of warranted claims. Settlements shall be within the approved range or the reason clearly documented if exceeded.

b. Settlements shall be evaluated and pursued when the injury and expense end result can be established.

c. Mitigating factors that may reduce settlement value, such as comparative negligence or joint tortfeasor situations shall be evaluated.

d. Unwarranted or fraudulent claims shall be resisted and denied.

e. In the normal course of claim handling, a file shall be referred for special investigation or expert analysis when discrepancies exist that are unresolved.

f. Underinsured motorist claims shall document when no other party is identified as liable.

7. Cases in Suit

a. ARCs shall have a litigation management program designed to bring cases to the earliest conclusion at a reasonable value.

b. Reservation of Right letters and Excess of Loss letters shall be used when and where appropriate.

c. Suit referral shall be timely and assigned to appropriate counsel.

d. Evaluation, case strategy, and legal action plan shall be documented.

e. Legal bills shall be reviewed for accuracy and reasonableness.

f. ARCs shall have an Alternative Dispute Resolution Program.

8. Prior to making any payment equal to or in excess of $500 to a third-party claimant the ARC must comply with the requirements of the Insurance Claim Payment Intercept Program, M.G.L. Chapter 175, Section 24D. NOTE: Failure to comply with M.G.L. Chapter 175, Section 24D will subject the ARC to penalties proscribed by the Department of Revenue. These penalties will be in lieu of those penalties imposed for non compliance with the Performance Standards (Appendix I).

9. Recovery

a. The investigation shall determine other parties involved in the accident, the probable extent of liability on each party, and the carrier or party against whom subrogation will be directed, if applicable.

B. Fraud Handling

1. Screening Process for Suspected Fraudulent Claims

a. If in the course of the screening process or initial investigation discrepancies develop of a sufficiently serious nature or there are indications of potential fraud, such as:

Accident of unusual circumstances
Severity of accident
Unusual number of injured passengers
Prior index history
Recognition of a pattern related to prior cases of fraud
(See Appendix A for other indicators)

The case shall be referred for special investigation and consideration given to referring the claim to IFB, NICB, or appropriate law enforcement agency for prosecution.

2. Special Investigation

a. Claims identified as suspicious or suspected fraudulent shall be referred for more detailed special investigation and consideration given to referring the claim to IFB, NICB, or appropriate law enforcement agency for prosecution.

b. The CAR SIU Standards for investigation of suspicious claims must be consulted and considered as part of the special investigation process.

c. ARCs shall have a plan designed to deal with claims involving exaggerated damages or injuries, such as inflated doctors' bills or wage statements, and such plan shall provide a strategy for concluding those cases at a reasonable amount, as well as reporting the same to the Detail Claim Database (DCD) at AIB. Savings realized from this process shall be documented on the SIU Quarterly Log.

d. Legal expenses incurred shall be itemized, monitored, and related to the claim being paid.

3. Evaluation and Settlement

After a special investigation is complete, a decision must be made to pay the claim or resist. The file shall clearly document the basis for the decision and result.

C. Fraud Training

1. ARCs must have a plan that provides for ongoing training on fraud awareness and how to identify suspicious claims.

2. ARCs must have a plan for training on special investigation and handling of suspicious and suspected fraudulent claims.

3. ARCs must have a plan to provide training on claim reporting and fraud recognition to producers and their customer service representatives.

## III. **No-Fault Personal Injury Protection Benefits Handling**

A. Screening Reports and Initial Investigation

1. All new notices shall be screened by a person with sufficient experience and training to be able to identify warning signs requiring special inquiry or investigation or by an appropriate expert software system designed for fraud screening, and thereafter assigned by a person with sufficient experience and training.

2. Initial investigation shall confirm that coverage is appropriate:

   a. Date of loss within policy period and all policy coverage is in order.

   b. Injured persons are eligible for no-fault benefits.

   c. Private health insurance availability shall be verified and documented.

   d. Injuries arise from use of motor vehicle.

   e. Massachusetts's statute applies.

   f. No exclusions apply, such as drunk driving, stolen car, and workers compensation.

3. The setting of initial and subsequent reserves shall be timely, reasonable, and follow documented company policy.

B. Contacts

1. Injured persons or their legal representative making a claim shall be contacted within 2 business days of the ARC's receipt of notice of injury for purposes of investigation and verification.

2. The named insured, if not an injured party, shall be contacted within 3 business days of the ARC's receipt of notice of injury for purposes of investigation and verification.

3. The insured operator, if not identified in B.1 or B.2, should be contacted within 3 business days of the ARC's receipt of notice of injury for purposes of investigation and verification.

4. Necessary forms shall be mailed or, if preferred by the injured party, electronically sent to the address specified within 5 business days after notice of injury.

C. Medical Management

1. ARCs must establish a plan to maintain a continuing awareness of the disability claimed, the medical treatment, and whether the treatment and medical expenses are reasonable, necessary, and related to the auto accident.

2. Any plan shall include historically utilized techniques such as timely independent medical examinations, medical bill reviews including but not limited to a determination of usual and customary charges, use of preferred provider organizations, managed care programs, and/or expert medical systems, as well as innovative approaches.

D. Fraud Handling

1. Screening Process for Suspected Fraudulent Claims

   If in the course of the screening process or initial investigation discrepancies develop of a sufficiently serious nature or there are indications of potential fraud, such as:

   Accident of unusual circumstances
   Severity of accident
   Unusual number of injured passengers
   Prior index history
   Recognition of a pattern related to prior cases of fraud
   (See Appendix A for other indicators)

   the case shall be referred for special investigation and consideration given to referring the claim to IFB, NICB, or appropriate law enforcement agency for prosecution.

E. Subrogation

1. The initial contact and investigation shall determine other parties involved in the accident, the probable extent of liability on each party, and the carrier against which subrogation may be directed. If applicable, a preliminary notice of subrogation shall be sent to the other carrier.

2. In cases of injury serious enough to exceed the tort threshold, the no-fault carrier shall alert the tort carrier immediately.

F. Claim Payment

1. There shall be no payment until the reported loss has been verified and:

   a. The deductible applied if applicable.

   b. Benefits coordinated in conjunction with existing health carrier and wage continuation plans.

   c. Medical bills verified prior to payment and reviewed for reasonableness, medical necessity, and relationship to the accident.

   d. Wage rate/working hours verified with employer, using wage/salary verification forms.

   e. Lost wages confirmed by employer's statement as to time missed and by physician's statement verifying disability for that period of time.

   f. Investigations promptly conducted. Upon agreement to pay, checks shall be issued within 10 business days.

   g. A litigation management program designed to bring cases to the earliest conclusion at a reasonable value.

h. Legal expenses incurred are itemized, monitored, and related to the claim being paid.

2. In the normal course of claim handling, a file shall be referred for special investigation when discrepancies exist that are unresolved (see list of indicators in Appendix A).

3. Evaluation and Settlement

After a special investigation is complete, a decision must be made to pay the claim or resist. The file shall clearly document the basis for the decision and result.

## IV. **Voluntary/ Involuntary Claim Handling Differential**

A. MAIP claims must be processed with the same degree of diligence as voluntary claims.

B. Voluntary and MAIP claims shall be reviewed for compliance with policy provisions and applicable statutes, rules, and regulations for the Best Practices of Coverage, Investigation, Special Investigation, Medical Management, Litigation Management, and Evaluation & Settlement. Statistical testing shall be conducted on each Best Practice Voluntary and MAIP score to determine if there is any statistical difference in handling.

## V. **Expenses**

A. ARCs must establish a program with guidelines that control claim adjustment expenses.

B. ARCs must establish guidelines to control legal defense costs:

1. Evaluation, case strategy, and legal action plan shall be documented.

2. Legal bills shall be reviewed for accuracy and reasonableness.

3. ARCs shall have an Alternative Dispute Resolution Program.

C. ARCs must establish a program to review vendor bills for accuracy, and deduct for unauthorized services.

D. ARCs must report allocated expenses properly as defined in the Statistical Plan and Manual of Administrative Procedures. Extra contractual expenses and unallocated expenses shall not be reported as allocated expenses.

## Measurements & Penalties

Measurements

The key claim requirements of MGL, c. 175, § 113 H that will be measured by the Compliance Audit Plan are:

- That claims handling is consistent for voluntary and involuntary claims.
- That each ARC maintains a Special Investigative Unit which provides effective fraud control procedures.

Voluntary and MAIP claims will be reviewed for compliance with policy provisions and applicable statutes, rules, and regulations for the following Best Practices:

- Coverage
- Investigation
- Special Investigation
- Medical Management
- Litigation Management
- Evaluation and Settlement

The benchmark for compliance with these Best Practices is 93% in accordance with the NAIC error tolerance of 7% for standards involving claim resolution. The aggregate score for these best practices will be calculated. If the score is less than 93% the ARC will be required to address the reasons in their response and submit a remedial action plan.

Chi square testing will be conducted on each Best Practice Voluntary and MAIP score to determine if there is any statistical difference in handling. If the difference is statistically significant, the ARC will be required to address the reasons in their response and submit a remedial action plan when requested.

Non Compliance Penalties

In the case of non-compliance, the ARC will be required to submit a remedial action plan to CAR. The Governing Committee will determine if further action including penalties is warranted based on the recommendation of the Compliance Audit Committee.

# *Performance Standards for the Handling and Payment of Commercial Claims by Servicing Carriers*

## Introduction

G.L.c.175, §113H requires Commonwealth Automobile Reinsurers (CAR) to establish Performance Standards for Servicing Carriers designed to contain costs, ensure prompt customer service, monitor the payment of legitimate claims, and to resist inflated, fraudulent, and unwarranted claims. G.L.c.175, §113H further provides that the Performance Standards be reviewed two years after such Standards are approved.

The Performance Standards were last approved by the Commissioner of Insurance in her Decision of September 6, 2011 to apply to the Commercial Servicing Carrier Program.

The Performance Standards developed by CAR, require Servicing Carriers to establish and maintain plans and programs to comply with the Standards. In some situations, time frames have been established to ensure prompt customer service.

Measurements of performance and compliance with the Standards are conducted through examinations of claims enhanced by relevant Statistical Plan data and procedures established by CAR. The procedures used to conduct these examinations will follow those outlined in the NAIC Market Conduct Examiners Handbook Chapter VIII G. Claims. Further details are contained in Appendix J CAR Claim Department File Review Process Section 2. Commercial Policies, and the Manual of Administrative Procedures (MAP).

Statistical Plan data including the Average Cost per Claim and Allocated Expense Report is used to supplement the information obtained in the claims file review to evaluate carriers' performance. Servicing Carriers are also required to report savings brought about by SIU activities for physical damage, bodily injury, and personal injury protection claims.

The Performance Standards require and are in addition to compliance with Massachusetts laws and regulations regarding automobile insurance and the CAR Rules of Operation. When revisions to existing laws or regulations or any new laws or regulations relating to claims handling are promulgated, they will become part of the Performance Standards.

The following Appendices are included to assist Servicing Carriers in implementing the Performance Standards:

**Appendix A – Special Investigative Unit Standards: Section 2 Commercial**

SIU Investigative Standards were developed by CAR to help carriers resist payment of fraudulent claims, deter fraud, control costs, and ultimately help control insurance rates.

**Appendix B – Regulation 211 CMR 123.00**

**Direct Payment of Motor Vehicle Collision and Comprehensive Coverage Claims and Referral Repair Shop Programs**

**Appendix C – Industry Direct Payment Plan for the Settlement of Insured Auto Damage Repairs**

**Appendix D – Decision and Order on the Application for Approval of the Massachusetts Automobile Rating and Accident Prevention Bureau Direct Payment Plan**

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Regulation 212 CMR 2.00 promotes public welfare and safety by improving the quality and economy of the appraisal and repair of damaged motor vehicles. It is intended to be read in conjunction with 211 CMR 133.00, which follows in Appendix F.

**Appendix F – Regulation 211 CMR 133.00**
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Regulation 211 CMR 133.00 promotes the public welfare and safety by establishing fair and uniform standards for the repair of damaged motor vehicles when an insurer pays for the cost of repairs. It is intended to be read in conjunction with 212 CMR 2.00 in Appendix E.

**Appendix G – Regulation 211 CMR 94.00**
**Mandatory Pre-Insurance Inspection of Private Passenger Motor Vehicles**

**Appendix H – Salvage Title Law, Chapter 90D, Section 20 (a through e)**

**Appendix I - M.G.L. Chapter 175: Section 24D**
**Insurance Claim Payment Intercept Program and**
**Regulation 830 CMR 175.24D.1.1**
**Intercept of Insurance Payments to Satisfy Child Support Liens**

**Appendix J - CAR Claim Department File Review Process: Section 2. Commercial Policies**

This section incorporates the selection of the sample, review procedures, and criteria to conduct these examinations following the guidelines in the NAIC Market Conduct Examiners Handbook Chapter VIII G. Claims.

**Appendix K - SIU File Review Process: Section 2. Commercial**

CAR's SIU conducts a biennial review of the Servicing Carriers' Special Investigative Unit. The reviews evaluate the adequacy of staffing, quality of investigations, accuracy of reported savings, and compliance with the Standards and reporting requirements.

**Appendix L – Questionnaire: Section 2. Commercial**

The completion of a questionnaire by the Servicing Carriers provides background information on the claim handling programs and procedures established by the carrier to comply with the Standards. Activity indicated on the questionnaire is compared to the activity observed in the Claim Reviews. The Questionnaire will be sent to the Company prior to the commencement of CAR's periodic review.

**Appendix M – Industry Best Practices**

The outline identifies where the industry Best Practices are referenced in the Performance Standards.

**Appendix N – NAIC Standards: Section 2. Commercial**

Reference to NAIC Standards, CAR Rule 10, and the Performance Standards are included.

**Appendix O - DOI 2008-12 Clarification of Coordination of Benefits under MGL c 90, §34A and the Interrelationship by and among PIP, Health Insurance and Medical Payment.**

This bulletin clarifies the coordination of benefits between PIP, Health Insurance, and Medical Payments.

# *Performance Standards for the Handling and Payment Of Commercial Claims by Servicing Carriers*

## I. Auto Physical Damage & Property Damage Liability Claims

### A. Auto Body Payments

#### 1. Service Times

a. Servicing Carriers (hereafter referred to as "carriers") must establish programs and procedures to ensure prompt settlements of warranted auto physical damage claims.

b. Carriers must establish procedures to permit prompt inspection of damage at drive-in locations or in the field and to make prompt claim payments of auto physical damage claims.

c. The Standard for assignment to an appraiser from the date the report is received or date of notice of recovery of theft is 2 business days.

d. The Standard for transmittal of the completed appraisal from the date of the appraisal assignment is 5 business days in accordance with 212 CMR 2.04(1)(e) (Appendix E).

e. The Standard for payment of a first party auto physical damage claim under any Direct Payment Plan is 5 business days from completion of the appraisal on all repairable vehicles, subject to all other provisions of the Plan.

f. The Standard for payment of a first party auto physical damage claim that is not under any Direct Payment Plan is 7 business days following receipt of a Completed Work Claim Form.

#### 2. Direct Payment Plan

a. Carriers must have a Direct Payment Plan unless their average Massachusetts private passenger market share is less than 1 percent of the total Massachusetts commercial market.

1) The Industry Plan can be adopted (Appendix C).

2) Modification to the Industry Plan can be filed for approval by the Commissioner of Insurance.

3) A Carrier can develop its own plan and submit it for approval by the Commissioner of Insurance.

b. Any Direct Payment Plan developed by a carrier must include a referral shop program.

#### 3. Parts Cost

a. Carriers must have programs and procedures to demonstrate their efforts to obtain discounts and pay less than full retail price for parts.

b. Carriers must consider the applicability of aftermarket, rebuilt, and like kind and quality (LKQ) parts on all appropriate appraisals.

c. Carriers must allow for, and insist on, the use of aftermarket, rebuilt, and LKQ parts in lieu of new or cost of repair, whenever appropriate.

4. Labor Rates and Times

a. Carriers must have a plan designed to control labor costs, ~~and~~ to seek the most competitive labor rates and times, and to determine whether labor rates, repair, and replacement times are reasonable and consistent with industry-recognized resources.

~~b. Carriers must have a plan to demonstrate their efforts to resist labor rate increases or to lower rates whenever possible.~~

~~c. Carriers must have a plan to determine whether labor, repair, and replacement times are reasonable and consistent with industry-recognized sources.~~

5. Total Loss Payments

a. Carriers shall not declare any vehicle a total loss when a prudent appraisal evaluation would have shown that the vehicle could have been repaired at an overall cost less than the actual cash value minus the salvage value.

b. The actual cash value of any vehicle must be determined based on the requirements of Regulation 211 CMR 133.05 Determination of Value (Appendix G).

1) Actual Cash Value: Whenever the appraised cost of repair plus the probable salvage value may be reasonably expected to exceed the actual cash value of the vehicle, the insurer shall determine the vehicle's actual cash value. This determination shall be based on a consideration of all the following factors:

a) the retail book value for a motor vehicle of like kind and quality, but for the damage incurred.

b) the price paid for the vehicle plus the value of prior improvements to the motor vehicle at the time of accident, less appropriate depreciation;

c) the decrease in value of the motor vehicle resulting from prior unrelated damage which is detected by the appraiser; and

d) the actual cost of purchase of an available motor vehicle of like kind and quality but for the damage sustained.

c. Existing pre-insurance inspection reports must be reviewed for options, mileage, prior condition, prior damages, and placed in the claim file on all total losses.

d. Carriers must be in compliance with the Salvage Title Law, Chapter 90D, section 20 (a through e) (Appendix H).

6. Towing and Storage Costs

a. Carriers must have a plan to demonstrate that their staffs have knowledge of and enforce all regulations applicable to towing and storage rates and conditions.

b. Carriers must have a plan to ensure that non-regulated towing and storage charges are reasonable, or to resist and reduce said charges if they are unreasonable.

c. Carriers must have a plan to control storage costs including the prompt disposition of salvage.

7. Appraisal of Damage and Reinspections

a. Carriers must have basic guidelines for appraisers, which include the following areas:

1) Compliance with Regulation 212 CMR 2.00 – The Appraisal and Repair of Damage Motor Vehicles (Appendix E)

2) Scoping and completing an appraisal

3) Use of aftermarket, rebuilt, LKQ parts

4) Open items and supplements

5) Refinishing

6) Depreciation and betterment

7) Unrelated damage

8) Structural damage

9) ACV estimating

10) Screening for fraudulent claims

b. Carriers must have an ongoing training plan and program for continuing education of staff appraisers, including fraud awareness.

c. Carriers must have a plan for periodic evaluation of the quality and accuracy of its independent appraisers.

d. Reinspections must be completed on 75 percent of all repaired vehicles whose damage exceeded $4,000 including damages paid under a Direct Payment Plan.

e. Reinspections must be completed on 25 percent of all repaired vehicles whose damage was less than $4,000 including damages paid under a Direct Payment Plan.

8. Carriers must establish procedures to comply with claims requirements included in the mandatory preinsurance inspection program established by Regulation 211 CMR 94.00 (Appendix G).

B. Normal Claim Handling

1. Initial screening of reports of accidents and losses

a. All new notices shall be screened by a person with sufficient experience and training to be able to identify warning signs requiring special inquiry or investigation or by an appropriate expert software system designed for fraud screening, and thereafter assigned by a person with sufficient experience and training.

b. The initial screening shall determine whether accident circumstances, facts, and information reported are consistent and sufficient to establish the occurrence.

c. The initial screening shall identify losses involving theft or arson, which always require detailed investigation.

d. The fraud indicators of Commonwealth Automobile Reinsurers Special Investigative Unit (CAR SIU) Standards and Fraud Profile (Appendix A) should be considered to determine possible warning signs of fraud.

e. A determination shall be made of the type and extent of further investigation that may be necessary if the initial screening identifies discrepancies or inconsistencies.

2. Initial Investigation

The initial investigation shall include:

a. Reviewing policy information to verify coverage, resolve any issues including garaging or operators, and notifying Underwriting where appropriate.

b. Timely contact with involved parties to secure sufficient documentation of facts involving accident circumstances, to verify occurrence, and to establish degree of fault and, in cases where no injuries reported, appropriate to the loss.

c. Obtaining documentation of ownership and existence of said vehicle in appropriate cases, especially total losses.

d. Documenting the damages or value of the vehicle.

e. Reviewing and evaluating discrepancies and fraud indicators to determine the scope of further investigation.

f. Timely setting of reasonable initial reserves and following the documented company policy.

3. Appraisal Program

a. Appraisers must recognize and report discrepancies which may indicate need for further investigation.

b. Appraisals shall be reviewed in conjunction with all other information developed to determine if there are any indicators of fraud.

4. Prompt Evaluation and Settlement

a. After initial investigation is complete, a decision must be made to promptly process for settlement or refer case for special investigation.

b. In the normal course of claim handling a file shall be referred for special investigation or expert analysis when discrepancies exist that are unresolved.

c. Carriers shall have a litigation management program designed to bring cases to the earliest conclusion at a reasonable value.

5. Prior to making any payment equal to or in excess of $500 to a third-party claimant the carrier must comply with the requirements of the Insurance Claim Payment Intercept Program, M.G.L. Chapter 175, Section 24D. NOTE: Failure to comply with M.G.L. Chapter 175, Section 24D will subject Company to penalties proscribed by the Department of Revenue. These penalties will be in lieu of those penalties imposed for non compliance with the Performance Standards (see Appendix I).

6. Recovery

a. The investigation shall determine other parties involved in the accident, the probable extent of liability on each party, and the carrier or party against whom subrogation will be directed, if applicable.

b. Upon subrogation recovery the deductible shall be reimbursed in a timely and accurate manner when and where appropriate.

C. Fraud Handling

1. Screening process for suspected fraudulent claims

a. When a discrepancy is of such weight as to raise substantial questions of fraud (example: all keys accounted for and the vehicle shows no ignition damage), the case shall be referred for special investigation.

b. Whenever several discrepancies exist and/or a pattern appears that matches prior suspicious cases, the case shall be referred for special investigation.

c. Unresolved discrepancies, such as VIN problems, prior total loss or salvaged vehicle, title inconsistencies, or other verifiable documents shall result in the case being referred for special investigation.

d. Whenever a combination of minor discrepancies occur which cannot be resolved, the case shall be referred for special investigation.

2. Appraisal Program

a. When damage to the vehicle is identified as inconsistent with accident circumstances, the case shall be considered for special investigation.

b. Clear photographs must accompany explanation of all damage inconsistencies.

3. Special Investigation

a. Claims identified as suspicious or suspected fraudulent should be referred for more detailed special investigation and consideration given to referring the claim to IFB, NICB and/or the appropriate law enforcement agency for prosecution.

b. The CAR SIU Standards for investigation of suspicious claims (Appendix A) must be consulted and considered as part of the special investigation process.

c. The savings recorded on physical damage claims shall be documented and reported to CAR on a quarterly basis.

4. Evaluation and Settlement

After a special investigation is complete, a decision must be made to pay the claim or resist. The claim file must clearly document the basis for the decision and result.

D. Glass

1. Carriers must establish a program to effect prompt repair or replacement of damaged or broken glass covered under automobile physical damage coverage, at a fair and competitive cost.

2. Carriers must have a plan to screen all glass bills and obtain reasonable discounts on market price lists for all domestic and foreign windshields and all side and back glass.

3. Carriers must have a plan to pay labor costs which are reasonable and competitive for glass repair or replacement.

4. Carriers must consider a plan to waive any glass deductible if the insured elects to repair the glass damage in lieu of replacement.

5. Carriers must have a plan to address fraud, including inspection or reinspection of a representative sampling of all glass losses. In no event shall the selection be based

on the age or sex of the policyholder, customary operators of vehicle, or the principal place of garaging of the vehicle.

E. Fraud Training

1. Carriers must have a plan that provides for ongoing training on fraud awareness and how to identify suspicious claims.

2. Carriers must have a plan for training on special investigation and handling of suspicious and suspected fraudulent claims.

3. Carriers must have a plan to provide training on claim reporting and fraud recognition to producers and their customer service representatives.

## II. Bodily Injury & Uninsured/Underinsured Motorist

A. Normal Claim Handling

1. Initial Screening of Reports of Accident and Losses

a. All new notices shall be screened by a person with sufficient experience and training to be able to identify warning signs requiring special inquiry or investigation or by an appropriate expert software system designed for fraud screening, and thereafter assigned by a person with sufficient experience and training.

b. The initial screening shall determine whether the accident circumstances, facts, and information reported are consistent and sufficient to establish the occurrence.

c. The initial screening shall include checking policy information and accident history, and reporting to Central Index Bureau (CIB) to evaluate for possible warning signs.

d. The fraud indicators of the CAR Fraud Profile shall also be considered for possible warning signs.

e. A determination shall be made of the type and extent of further investigation that may be necessary if the initial screening identifies discrepancies or inconsistencies.

2. Initial Investigation

The initial investigation shall include:

a. Reviewing policy information to verify coverage and resolve any coverage issues. Reservation of Right letters and Excess of Loss letters shall be used when and where appropriate.

b. Contacting involved parties and securing sufficient documentation of facts involving the accident circumstances to verify occurrence and to establish degree of fault.

c. Securing documentation to verify that all alleged injured parties were actually involved in the accident.

d. Reviewing and evaluating discrepancies and fraud indicators to determine scope of further investigation.

e. Timely setting of reasonable initial reserves and following the documented company policy.

3. Contacts

a. Injured persons or their legal representative making a claim shall be contacted within 2 business days of receipt of notice of injury for purposes of investigation and verification.

b. The named insured, if not an injured party, shall be contacted within 3 business days of receipt of notice of injury for purposes of investigation and verification.

c. The insured operator, if not one of the above, shall be contacted within 3 business days of receipt of notice of injury for purposes of investigation and verification.

4. Loss Management

a. Loss management, assessment, and verification tools shall be used when appropriate to identify the disability claimed, the medical treatment, and whether the treatment and medical expenses are reasonable, necessary, and related to the auto accident.

5. Follow-Up and Continuing Investigation

The continuing investigation shall include:

a. Verifying and evaluating the type and extent of injury substantiated by available reports and/or independent examinations.

b. Confirming and documenting that treatment and expenses are reasonable, necessary, and related to the accident.

c. Reviewing and evaluating discrepancies and fraud indicators to determine the scope of further investigation.

d. Employing proper diary systems and ensuring ARC reporting and authority levels are followed.

e. Timely and reasonable changes to the reserves that follow the documented company policy.

6. Settlement Negotiations or Denial

a. Carriers shall have a settlement evaluation plan to obtain reasonable negotiated settlements of warranted claims. Settlements shall be within approved range or the reason clearly documented if exceeded.

b. Settlements shall be evaluated and pursued when the injury and expense end result can be established.

c. Mitigating factors that may reduce settlement value, such as comparative negligence or joint tortfeasor situations shall be evaluated.

d. Unwarranted or fraudulent claims shall be resisted and denied.

e. In the normal course of claim handling, a file shall be referred for special investigation or expert analysis when discrepancies exist that are unresolved.

f. Underinsured motorist claims shall document when no other party is identified as liable.

7. Cases in Suit

a. Carriers shall have a litigation management program designed to bring cases to the earliest conclusion at a reasonable value.

b. Reservation of Right letters and Excess of Loss letters shall be used when and where appropriate.

c. Suit referral shall be timely and assigned to appropriate counsel.

d. Evaluation, case strategy, and legal action plan shall be documented.

e. Legal bills shall be reviewed for accuracy and reasonableness.

f. Carriers shall have an Alternative Dispute Resolution Program.

8. Prior to making any payment equal to or in excess of $500 to a third-party claimant the carrier must comply with the requirements of the Insurance Claim Payment Intercept Program, M.G.L. Chapter 175, Section 24D. NOTE: Failure to comply with M.G.L. Chapter 175, Section 24D will subject the company to penalties proscribed by the Department of Revenue. These penalties will be in lieu of those penalties imposed for non compliance with the Performance Standards (Appendix I).

9. Recovery

a. The investigation shall determine other parties involved in the accident, the probable extent of liability on each party, and the carrier or party against whom subrogation will be directed, if applicable.

B. Fraud Handling

1. Screening Process for Suspected Fraudulent Claims

a. If in the course of the screening process or initial investigation discrepancies develop of a sufficiently serious nature or there are indications of potential fraud, such as:

Accident of unusual circumstances
Severity of accident
Unusual number of injured passengers
Prior index history
Recognition of a pattern related to prior cases of fraud
(See Appendix A for other indicators)

The case shall be referred for special investigation.

2. Special Investigation

a. Claims identified as suspicious or suspected fraudulent shall be referred for more detailed special investigation and consideration given to referring the claim to IFB, NICB, or appropriate law enforcement agency for prosecution.

b. The CAR SIU Standards for investigation of suspicious claims must be consulted and considered as part of the special investigation process.

c. Carriers shall have a plan designed to deal with claims involving exaggerated damages or injuries, such as inflated doctors' bills or wage statements, and such plan should provide a strategy for concluding those cases at a reasonable amount, as well as reporting the same to the Detail Claim Database (DCD) at AIB. Savings realized from this process should be documented on the SIU Quarterly Log.

d. Legal expenses incurred shall be itemized, monitored, and related to the claim being paid.

3. Evaluation and Settlement

After a special investigation is complete, a decision must be made to pay the claim or resist. The file shall clearly document the basis for the decision and result.

C. Fraud Training

1. Carriers must have a plan that provides for ongoing training on fraud awareness and how to identify suspicious claims.

2. Carriers must have a plan for training on special investigation and handling of suspicious and suspected fraudulent claims.

3. Carriers must have a plan to provide training on claim reporting and fraud recognition to producers and their customer service representatives.

## III. **No-Fault Personal Injury Protection Benefits Handling**

A. Screening Reports and Initial Investigation

1. All new notices shall be screened by a person with sufficient experience and training to be able to identify warning signs requiring special inquiry or investigation or by an appropriate expert software system designed for fraud screening, and thereafter assigned by a person with sufficient experience and training.

2. Initial investigation should confirm that coverage is appropriate:

   a. The date of loss is within policy period and all policy coverage is in order.

   b. Injured persons are eligible for no-fault benefits.

   c. Private health insurance availability shall be verified and documented.

   d. Injuries arise from use of motor vehicle.

   e. Massachusetts's statute applies.

   f. No exclusions apply, such as drunk driving, stolen car, and workers compensation.

3. The setting of initial and subsequent reserves shall be timely, reasonable, and follow documented company policy.

B. Contacts

1. Injured persons or their legal representative making a claim shall be contacted within 2 business days of the carrier's receipt of notice of injury for purposes of investigation and verification.

2. The named insured, if not an injured party, shall be contacted within 3 business days of the carrier's receipt of notice of injury for purposes of investigation and verification.

3. The insured operator, if not identified in B.1 or B.2, shall be contacted within 3 business days of the carrier's receipt of notice of injury for purposes of investigation and verification.

4. Necessary forms shall be mailed or, if preferred by the injured party, electronically sent to the address specified within 5 business days after notice of injury.

C. Medical Management

1. Carriers must establish a plan to maintain a continuing awareness of the disability claimed, the medical treatment, and whether the treatment and medical expenses are reasonable, necessary, and related to the auto accident.

2. The plan shall include historically utilized techniques such as timely independent medical examinations, medical bill reviews including but not limited to a determination of usual and customary charges, use of preferred provider

organizations, managed care programs, and/or expert medical systems, as well as innovative approaches.

D. Fraud Handling

1. Screening Process for Suspected Fraudulent Claims

If in the course of the screening process or initial investigation discrepancies develop of a sufficiently serious nature or there are indications of potential fraud, such as:

Accident of unusual circumstances
Severity of accident
Unusual number of injured passengers
Prior index history
Recognition of a pattern related to prior cases of fraud
(See Appendix A for other indicators)

the case shall be referred for special investigation and consideration given to referring the claim to IFB, NICB, and/or appropriate law enforcement agency for prosecution.

E. Subrogation

1. The initial contact and investigation shall determine other parties involved in the accident, the probable extent of liability on each party, and the carrier against which subrogation may be directed. If applicable, a preliminary notice of subrogation shall be sent to the other carrier.

2. In cases of injury serious enough to exceed the tort threshold, the no-fault carrier shall alert the tort carrier immediately.

F. Claim Payment

1. There shall be no payment until the reported loss has been verified and:

a. The deductible applied if applicable.

b. Benefits coordinated in conjunction with existing health carrier and wage continuation plans.

c. Medical bills verified prior to payment and reviewed for reasonableness, medical necessity, and relationship to the accident.

d. Wage rate/working hours verified with employer, using wage/salary verification forms.

e. Lost wages confirmed by employer’s statement as to time missed and by physician’s statement verifying disability for that period of time.

f. Investigations promptly conducted. Upon agreement to pay, checks shall be issued within 10 business days.

g. A litigation management program designed to bring cases to the earliest conclusion at a reasonable value.

h. Legal expenses incurred are itemized, monitored, and related to the claim being paid.

2. In the normal course of claim handling, a file shall be referred for special investigation when discrepancies exist that are unresolved (see list of indicators in Appendix A).

3. Evaluation and Settlement

After a special investigation is complete, a decision must be made to pay the claim or resist. The file shall clearly document the basis for the decision and result.

## IV. Voluntary/Ceded Claim Handling Differential

A. Ceded claims must be processed with the same degree of diligence as voluntary claims.

B. CAR will conduct biennial audits of claims using a random sample in order to evaluate and compare the individual carrier performance on the handling of ceded and voluntary claims. Statistical testing will be performed to determine if there is any statistically significant difference in the handling of voluntary and ceded claims by the Servicing Carrier.

C. The audit shall include voluntary retained policies in order to determine if there is a difference in claims handling between policies insured voluntarily and those ceded through CAR.

## V. Expenses

A. Carriers must establish a program with guidelines that control claim adjustment expenses.

B. Carriers must establish guidelines to control legal defense costs:

1. Evaluation, case strategy, and legal action plan shall be documented.

2. Legal bills shall be reviewed for accuracy and reasonableness.

3. Carriers shall have an Alternative Dispute Resolution Program.

C. Carriers must establish a program to review vendor bills for accuracy, and deduct for unauthorized services.

D. Carriers must report allocated expenses properly as defined in the Statistical Plan and Manual of Administrative Procedures. Extra contractual expenses and unallocated expenses shall not be reported as allocated expenses.

## Measurements & Penalties

Measurements

G.L.c.175 §113H requires that CAR propose rules to govern the application of penalties for, among other things, the failure to meet the Performance Standards for the Handling and Payment of Claims by Servicing Carriers.

The following Performance Standards, approved by the Commissioner of Insurance apply to the Commercial Servicing Carrier Program.

Measurements of performance and compliance with the Standards are conducted through examinations of claims enhanced by relevant Statistical Plan data and procedures established by CAR. The completion of a questionnaire by the Servicing Carriers prior to the biennial review provides background information on the claim handling programs established by the carrier to comply with the Standards. This will be supplemented at the time of the examination by a review of company internal documentation including but not limited to claim manuals, reserving and claim settlement procedures, and internal audits. In addition to Statistical Plan data, Servicing Carriers are required to report savings brought about by SIU activities for physical damage, bodily injury, and personal injury protection claims.

Servicing Carriers are evaluated on the effectiveness of their claim handling in meeting industry best practices as well as for their compliance with the Performance Standards and the NAIC Standards. Carriers are measured against the benchmarks listed and industry averages as well as their own prior performance. Both quantitative and qualitative aspects of the claims process are evaluated. The most readily quantifiable standards are the ones that involve specific time frames, averages, and counts. Other standards are qualitative such as reserving, medical management, evaluation, and settlement. The benchmark for compliance with the best practices and standards is 80%. The measurements for glass, reinspections, and ICPIP are set at MA statutory levels.

If it is determined that a Servicing Carrier is not in compliance on ceded files with the Performance Standards the CAR Claim Department will then determine the degree to which the non-compliance exists in the following areas addressed by the Standards. Specifically, the areas are:

I. Auto Physical Damage & Property Damage Liability Claims
II. Bodily Injury & Uninsured/Underinsured Motorist
III. No Fault Personal Injury Protection Benefits
V. Expenses

For Section IV. Voluntary/Ceded Claim Handling Differential, CAR will evaluate and compare the individual company performance on the handling of ceded and voluntary claims. Statistical testing will be performed to determine if there is any statistically significant difference in the handling of voluntary and ceded claims by the Servicing Carrier. If CAR determines that the company is in non-compliance with the Voluntary/Ceded Claims Handling Differential Standard a penalty will be assessed.

Minor non-compliance indicates that a carrier is not in compliance with the Standards in one or more areas but the quality of claim handling is unaffected and no overpayments result from this situation.

Major non-compliance indicates that a carrier has failed the Standards in one or more area. Claim handling is affected and overpayments may be occurring as a result. The carrier will be notified of the extent and areas in which non-compliance exists and will be warned that the subsequent review of the carrier must reflect compliance in all of the cited areas to avoid penalty.

If in the review subsequent to being warned of major non-compliance a carrier remains in non-compliance but has improved its claim handling practices significantly, a Type I penalty will be assessed for the area in which this non-compliance exists.

If in the review subsequent to being warned of major non-compliance a carrier fails to improve its claim handling practices, a Type II penalty will be assessed for the area in which this non-compliance exists.

One penalty will be assessed in each of the following sections of the Standards in which major non-compliance is found:

I. Auto Physical Damage & Property Damage Liability Claims
II. Bodily Injury & Uninsured/Underinsured Motorist
III. No Fault Personal Injury Protection Benefits
IV. Voluntary/Ceded Claim Handling Differential
V. Expenses

The amount of the penalty will be determined by the type of penalty using the following Schedule of Penalties.

In the event that non-compliance continues beyond two years, the penalties will increase for the third year according to the Schedule of Penalties. In the fourth year of non compliance the Carrier would be referred to the Governing Committee for possible termination.

Should a carrier achieve compliance after being penalized for non-compliance with the Standards, it must maintain compliance for two years before it is returned to pre-warning status.

Should a carrier disagree with the findings of the CAR Compliance Audit Department, it will notify the Vice President of Compliance Audit and a meeting will be held to discuss the findings. If agreement cannot be reached, the carrier may appeal the decision to the Governing Committee in accordance with Rule 20.

| Schedule of Penalties | | | |
|---|---|---|---|
| Type I Penalty by Year | | | |
| 1st Year | 2nd Year | 3rd Year | 4th Year |
| Warning | $6,000 | $30,000 | Governing Committee |
| Type II Penalty by Year | | | |
| 1st Year | 2nd Year | 3rd Year | 4th Year |
| Warning | $20,000 | $100,000 | Governing Committee |

The compliance status of the Commercial Servicing Carriers will be reported to the Compliance Audit Committee, Governing Committee, and the Division of Insurance.

The following benchmarks and measurements are utilized to compare the Servicing Carrier's performance to the Industry on commercial claims handling. Except where noted, the benchmarks for compliance is 80%.

| Best Practices | NAIC Standard | Measurement | Benchmark |
|---|---|---|---|
| Physical Damage/Property Damage | | | |
| Assignment/Contact | NAIC 1 | • Appropriate assignment & contact to establish loss fact | |
| Coverage | NAIC 3, 7 | • Coverage verified, garaging, operator issues resolved if applicable | |
| Appraisal | NAIC 6 | • Appraisal assignment within 2 business days.<br>• Transmittal of appraisal within 2 business days.<br>• Quality of appraisal - Aftermarket/LKQ, betterment, screening for fraud, photos, recognition of fraud, and cause & origin. | |
| Reserving | NAIC 10 | • Timely, reasonable, follow documented company policy. | |
| Screening and Investigation | NAIC 2, 3, 6 | • Screening for fraud, recognition of fraud indicators.<br>• Timely investigation.<br>• Liability apportioned correctly. | |
| Settlement | NAIC 3, 6 | • Depreciation and ACV calculations appropriate.<br>• Salvage disposal proper.<br>• On property damage, comparative negligence recognized.<br>• Payment within 5 days under Direct Payment Plan; 7 days CWCF. | |
| Subrogation | NAIC 8 | • Subrogation recognized and pursued.<br>• Reimbursement of deductible is timely and accurate when and where appropriate. | |
| Reinspections | NAIC 6, 9 | • Compliance with Regulation 211 CMR 2. | 75%>$4,000; 25%<$4,000 |
| Glass | NAIC 6 | • Program for repair of glass in place.<br>• Carrier tracks percent of repair. | 100% |
| Litigation Management | NAIC 13 | • Bring cases to the earliest conclusion at a reasonable value. | |
| No Fault Personal Injury Protection Claims | | | |
| Contact | NAIC 1, 9 | • Injured party - 2 days.<br>• Uninjured party - 3 days.<br>• PIP form mailing - 5 days. | |

| Best Practices | NAIC Standard | Measurement | Benchmark |
|---|---|---|---|
| Reserving | NAIC 10 | • Initial and subsequent reserves timely and appropriate; follow documented company policy | |
| Medical Management | NAIC 4, 5, 6, 11 | • Claims warranting IME referral vs. claims referred for IME.<br>• Appropriate utilization of IME results to cut off claim, reduce bills.<br>• Appropriate utilization of Medical Bill Review program. | |
| Loss Management/Special Investigation | NAIC 4, 11 | • Claims warranting special investigation vs. claims referred for special investigation. | |
| Subrogation | NAIC 8 | • Subrogation recognized and pursued.<br>• Reimbursement of deductible is timely and accurate when and where appropriate. | |
| Bodily Injury/Uninsured Motorist Claims | | | |
| Contact | NAIC 1 | • Injured party - 2 days.<br>• Uninjured party - 3 days. | |
| Reserves | NAIC 10 | • Initial and subsequent reserves timely and appropriate; follow documented company policy | |
| Loss Management/Special Investigation | NAIC 4, 11 | • Claims warranting special investigation vs. claims referred for special investigation. | |
| Litigation Management | NAIC 7, 13 | • Reservation of Rights and Excess letters used when and where appropriate. | |
| Settlement | NAIC 3, 5, 6 | • Evaluation range documented and appropriate.<br>• Settlement within range or documented why exceeded. | |
| Recovery | NAIC 3 | • Recovery potential recognized and pursued.<br>• Contribution from joint tortfeasor obtained. | |
| Voluntary/Ceded Claim Handling Differential | | | |
| Claim Handling | NAIC 6 | • A comparison of the compliance results for each of the resolution standards in the Ceded and Voluntary claims will be calculated.<br>• Statistical testing will be performed on the aggregate results of each of the three applicable sections: Physical Damage/Property Damage, PIP, and BI. | |

| Best Practices | NAIC Standard | Measurement | Benchmark |
|---|---|---|---|
| | | • If the difference is statistically significant, the carrier will be required to address the reasons in their response.<br>• Following the response, CAR will make a determination on whether the Voluntary/Ceded Standard was in compliance. | |
| Expenses | NAIC 14 | • Reported properly as defined in the Statistical Plan. | |