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NATALIE A. HUBLEY
PRESIDENT

NOTICE OF MEETING

CLAIMS SUBCOMMITTEE

A meeting of the Claims Subcommittee will be held virtually via Zoom video conferencing software on

WEDNESDAY, NOVEMBER 30, 2022, AT 10:00 A.M.

If you plan to attend this meeting and are not a member of this Committee, please RSVP by completing the Visitor Security Form located in the Contact Us/Visitor Information section of CAR's website. CAR will then forward to you, via email, meeting access information. Please do not share access information provided by CAR, but refer others wishing to attend the meeting to CAR's Visitor Security Form.

MEMBERS OF THE SUBCOMMITTEE

Mr. David Deluca – Chair
Vermont Mutual Insurance Company

Mr. Daniel Clough	Arbella Insurance Group
Ms. Ida Denard Jones	Denard Insurance Agency, Inc.
Mr. Nathan Joyner	Amica Mutual Insurance Company
Ms. Heidi Mussler	Quincy Mutual Group
Ms. Paul Narciso	Safety Insurance Company
Ms. Mary Singas	MAPFRE U.S.A. Corporation
Mr. Doug Sprous	Plymouth Rock Assurance Corporation

AGENDA

CLMS
22.01 Records of Previous Meeting

The Records of the Claims Subcommittee meeting of January 26, 2022 should be read and approved.

CLMS
22.03 CAR Conflict of Interest Policy

The Chair will read a statement relative to CAR's Conflict of Interest Policy.

CLMS
22.05 Claims Performance Standards

The Subcommittee will begin its biennial review of the Private Passenger and Commercial Claims Performance Standards pursuant to G.L. c. 175, 113H. The Subcommittee should be prepared to comment on suggested changes to the Standards and recommend additional modifications as necessary. Relevant documents, including the CAR staff draft revisions to the Private Passenger and Commercial Claims Performance Standards, are attached (Docket #CLMS22.05, Exhibit #1).

Other Business

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

Executive Session

The Claims Subcommittee Committee may convene in Executive Session in accordance with the provisions of G.L. c. 30A, § 21.

PETER BERTONI
Compliance Auditor II

Attachment

Boston, Massachusetts
November 17, 2022

Private Passenger and Commercial Claim Performance Standards – November 30, 2022
Memorandum of Changes

General Modifications

The Performance Standards for The Handling and Payment of Claims (the Standards), including its appendices, are reviewed every two years in accordance with Massachusetts G.L. c. 175 §113H. The 'redlined' formatting is used to identify only proposed modifications to the Standards.

Modifications to the Private Passenger Standards:

Standard II: Bodily Injury & Uninsured/Underinsured Motorist

- The Normal Claim Handling section that begins Standard II addresses requirements applicable to the initial screening of accident and loss reports. Part of the initial screening process includes the expectation to review policy information, accident history, and the Central Index Bureau (CIB) to determine if any possible red flags exist.
- The Central Index Bureau database was previously sold to a different vendor and no longer exists.
    - The Standards do not typically identify a specific vendor in any section. Therefore, staff recommends removing the CIB reference and replace without naming a specific database.

Standard III: No-Fault Personal Injury Protection (PIP) Benefits Handling

- Appendix N: Division of Insurance (DOI), Bulletin 2017–06 addresses proper coordination of PIP and MedPay claims with health plans. However, Standard III applicable to the handling of PIP claims does not reference Appendix N nor the DOI Bulletin.
    - Staff suggests including in the Evaluation and Settlement section of Standard III, a direct reference to Appendix N and the requirements that pertain to the coordination of benefits.

Appendix H: Chapter 175, Section 24D

- Appendix H: Chapter 175, Section 24D is included in the Standards to ensure that companies research pending claims to prevent payments to claimants that owe past due child support or are subject to a child support lien. This appendix outlines required steps prior to a company issuing payments.
- Chapter 175 was amended in 2003 by adding Section 24E after Section 24D. The adopted language placed additional responsibility on insurers to check with the Division of Medical Assistance and the Department of Transitional assistance for liens prior to issuing 3rd party settlement payments.
    - Staff suggests modifying Appendix H to also include §24E.
        - Chapter 175, Section 24E language is included in the draft redlined material for the Subcommittee's review.

Appendix J: CAR Special Investigative Unit (SIU) File Review Process – MAIP Policies

- Staff is proposing modifications to Appendix J to reflect recent changes to the ARC Procedures Manual and to CAR Rule 32 - Claim Practices, as well as to require ARC use of a template to report SIU referrals.
    - The ARC Procedures Manual was recently updated to adjust the frequency of the Hybrid Audit for all ARCs writing private passenger business from once every three years to once every five years. This change occurred to address the significant increase in the number of companies writing private passenger business since the onset of competitive rates and the MAIP, and the increased need to conduct focus audits of companies with statistical reporting issues and quota share audits of new entrants as required in the ARC Procedures Manual.
        - Staff recommends updating the reference in Appendix J relative to the frequency of the Hybrid Audits from triennial to once every five years.

- Rule 32 – Claim Practices applicable to private passenger business was corrected to now reference the ARC Procedures Manual. Section 32.C. was also reformatted for consistency with Rule 10.C. applicable to commercial business. Both Rule 10.C. and 32.C. pertain to SIU responsibilities.
  - Staff proposes to update Appendix J to reflect the formatting changes made to Rule 32.C.
- Reporting of SIU completed audits of voluntary and MAIP policies to verify garaging and policy facts.
  - The prior two biennial reviews of the Standards included changes to improve the quality and consistency of SIU industry data. Part of those approved changes resulted in the requirement for the industry to use templates, as prescribed by staff, to submit SIU claims and underwriting referral data into CAR's SIU System.
    - Staff proposes the required use of the template developed by staff to report the 32.C.2. SIU completed audits to CAR to continue industry SIU data improvements.

Appendix M: NAIC Standards:

- Appendix M details each of the NAIC Claims Standards included in the Market Regulation Handbook. These Standards have been amended from 14 to 11 standards.
  - Staff proposes modifications to Appendix M to reflect the current NAIC Standards, and to update applicable references for each NAIC Standard to the Performance Standards or Rules of Operation where necessary.

Modifications to the Commercial Standards:

Standard II: Bodily Injury & Uninsured/Underinsured Motorist

- The Normal Claim Handling section that begins Standard II addresses requirements applicable to the initial screening of accident and loss reports. Part of the initial screening process includes the expectation to review policy information, accident history, and the Central Index Bureau (CIB) to determine if any possible red flags exist.
- The Central Index Bureau database was previously sold to a different vendor and no longer exists.
  - The Standards do not typically identify a specific vendor in any section. Therefore, staff recommends removing the CIB reference and replacing it without naming a specific database.

Standard III: No-Fault Personal Injury Protection (PIP) Benefits Handling

- Appendix N: Division of Insurance (DOI), Bulletin 2017–06 addresses the proper coordination of PIP and MedPay claims with health plans. However, Standard III applicable to the handling of PIP claims does not reference Appendix N nor the DOI Bulletin.
  - Staff proposes including in the Evaluation and Settlement section of Standard III, a direct reference to Appendix N and the requirements that pertain to the coordination of benefits.

Appendix H: Chapter 175, Section 24D

- Appendix H: Chapter 175, Section 24D is included in the Standards to ensure that companies research pending claims to prevent payments to claimants that owe past due child support or are subject to a child support lien. This appendix outlines required steps prior to a company issuing payments.

- Chapter 175 was amended in 2003 by adding Section 24E after Section 24D. The adopted language placed additional responsibility on insurers to check with the Division of Medical Assistance and the Department of Transitional assistance for liens prior to issuing 3rd party settlement payments.
    - Staff recommends modifying Appendix H to include §E.
        - Chapter 175, Section 24E language is included in the draft redlined material for the Subcommittee's review.

Appendix J: CAR SIU File Review Process

- As noted in the proposed changes to the Private Passenger Standards, the recent modifications to Rule 32 created improved consistency to Rule 10, specifically with Section C that pertains to the SIU.
- The suggested changes to Appendix J for commercial business are similar to those proposed in the private passenger Standards.
    - Staff is proposing the clarification of references to Rule 10.C.1 and 10.C.2.
    - Reporting of SIU completed audits of voluntary and ceded policies to verify garaging and policy facts.
        - The prior two biennial reviews of the Standards included changes to improve the quality and consistency of SIU industry data. Part of those approved changes resulted in the requirement for the industry to use templates, as prescribed by staff, to submit SIU claims and underwriting SIU referral data into CAR's SIU System.
            - Staff proposes the required use the template developed for industry use in the completion of 10.C.2. SIU audits.

Appendix M: NAIC Standards:

- Appendix M details each of the NAIC Claims Standards included in the Market Regulation Handbook. These Standards have been amended from 14 to 11 standards.
    - Staff proposes modifications to Appendix M to reflect the current NAIC Standards, and to update applicable references for each NAIC Standard to the Performance Standards or Rules of Operation where necessary.

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 to 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)~~ industry claims database to evaluate for possible warning signs.

   d. The fraud indicators of CAR SIU Standards and Fraud Profile shall also be considered for possible warning signs. Refer to Appendix A.

   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 the 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

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 motor vehicle 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 a special investigation or expert analysis when discrepancies exist that are unresolved.

f. Underinsured motorist claims shall be documented 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. DOR Requirements

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, G.L. c.175, §24D. NOTE: Failure to comply with G.L. c.175, §24D will subject the ARC to penalties proscribed by the DOR. These penalties will be in lieu of those penalties imposed for noncompliance with the Performance Standards. Refer to Appendix H.

9. Subrogation/Recovery

   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

   If in the course of the screening process or initial investigation discrepancies develop of a sufficiently serious nature or 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), the case shall be referred for special investigation with consideration given to referring the claim to IFB, NICB, or appropriate law enforcement agency for prosecution. Refer to Appendix A for other indicators.

2. Special Investigation

   a. Claims identified as suspicious or suspected fraudulent shall be referred for more detailed special investigation with 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 adhered to 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 the 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 claim file must clearly document the basis for the decision and result.

C. 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 to provide training for 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.

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 a motor vehicle.

   e. Massachusetts statute applies.

   f. No exclusions apply, such as drunk driving, stolen car, or 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 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 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 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 expense are reasonable, necessary, and related to the motor vehicle accident.

2. Any plan shall include historically utilized techniques such as: (i) timely independent medical examinations; (ii) medical bill reviews, including but not limited to a determination of usual and customary charges, with or without the use of medical fee databases; (iii) use of preferred provider organizations, managed care programs, and/or expert medical systems; and (iv) other 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 indications of potential fraud exist (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), the case shall be referred for special investigation. Refer to Appendix A for other indicators.

2. Special Investigation

   a. Claims identified as suspicious or suspected fraudulent shall be referred for more detailed special investigation with 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 adhered to 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 the 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.

E. Subrogation/Recovery

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. No payment shall be made 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 are issued within 10 business days.

   g. A litigation management program is 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. Refer to Appendix A for a list of indicators.

3. Evaluation and Settlement

   a. All claim payments shall be made in accordance with Division of Insurance Bulletin 2017-06, attached as Appendix N.

   b. 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.

PART I ADMINISTRATION OF THE GOVERNMENT
TITLE XXII CORPORATIONS
CHAPTER 175 INSURANCE
Section 24D Lump sum insurance payments; exchange of claimant information between IV-D and insurance companies; withholding of past-due child support subject to lien

Section 24D. (a) Prior to making any nonrecurring payment equal to or in excess of $500 to a claimant under a contract of insurance, every company authorized to issue policies of insurance pursuant to this chapter shall exchange information with the IV–D agency, as set forth in chapter 119A, to ascertain whether such claimant owes past due child support to the commonwealth or to an individual to whom the IV–D agency is providing services, and is subject to a child support lien pursuant to section 6 of said chapter 119A. To determine whether a claimant owes past due child support, the company shall either provide the IV–D agency with information about the claimant or examine information made available by the IV–D agency and updated not more than once a month. If the company elects to provide the IV–D agency with information about a claimant, the company shall provide to the IV–D agency, not less than ten business days prior to making payment to such claimant, the claimant's name, address, date of birth and social security number as appearing in the company's files and such other information appearing in the company's files as the commissioner of revenue may require by regulation in consultation with the commissioner of insurance. The company shall use a method and format prescribed by the commissioner of revenue but if the company is unable to use a method and format prescribed by said commissioner of revenue, such company shall cooperate with the IV–D agency to identify another method or format, including submission of written materials. If the company elects to examine information made available by the IV–D agency and such claimant owes past due child support and is subject to a lien, the company shall notify the IV–D agency, not less than ten business days prior to making payment to such claimant, of the claimant's name, address, date of birth and social security number as appearing in the company's files and such other information appearing in the company's files as the commissioner of revenue may require by regulation in consultation with the commissioner of insurance, using a method and format prescribed by the commissioner of revenue. The company may remit to the IV–D agency the full amount of the lien or the full amount otherwise payable to the claimant at the time that it so notifies the IV–D agency at any time prior to making payment to the claimant, without regard to the ten business day period. If, at any time prior to payment, the IV–D agency notifies the company of its child support lien against a claimant by giving the company a notice of levy pursuant to said section 6 of said chapter 119A, the company shall withhold from the payment the amount of past due support as set forth in the notice of levy and shall provide such amount to the IV–D agency for disbursement to the obligee. The child support lien shall encumber the right of the claimant to payment under the policy and the company shall disburse to the claimant only that portion of the payment, if any, remaining after the child support lien has been satisfied. For the purpose of this section, the word ''claimant'' shall mean an individual who brings a claim against an insured under a liability insurance policy or the liability coverage portion of a multiperil policy or a beneficiary under a life insurance policy.

(b) This section shall not apply to that portion of a claim resulting in payments on behalf of the claimant issued to a third party where there is documentation showing that the third party has provided or agreed to provide the claimant with a benefit or service related to the claim including, but not limited to, the services of an attorney or a medical doctor, or to any portion of a claim based on damage to or a loss of real property. The commissioner of revenue, in consultation with the commissioner of insurance, shall promulgate regulations setting forth procedures for making payment to the IV–D agency when a third party has either provided or agreed to provide goods or services to the claimant,

and the insurance company cannot reasonably determine the remaining amount payable to the claimant.

(c) The provisions of the Employee Retirement Income Security Act limiting, for contracts of insurance, the amounts which may be assigned or attached in order to satisfy child support obligations shall apply to the provisions of this section.

(d) Pursuant to regulations issued by the commissioner of revenue in consultation with the commissioner of insurance, a company that knowingly fails to accurately exchange information regarding a claim to which this section applies shall be subject to a penalty assessed by the IV–D agency. A company that fails or refuses to surrender property subject to a child support lien to the IV–D agency shall be liable as provided in paragraph (7) of subsection (b) of section 6 of said chapter 119A. A company that makes a payment to the IV–D agency pursuant to this section and an insured individual on whose behalf the company makes a payment shall be immune from any obligation or liability to the claimant or other interested party arising from the payment, notwithstanding the provisions of this chapter or any other law.

(e) Information provided by the IV–D agency to a company under this section may only be used for the purpose of assisting the IV–D agency in collecting past due child support. Any individual or company who uses such information for any other purpose shall be liable in a civil action to the IV–D agency in the amount of $1,000 for each violation.

(f) An individual making a claim governed by this section shall provide his current address, date of birth and social security number to the insurance company, upon the request of the company. Such company may inform the claimant that such request is being made in accordance with this section for the purpose of assisting the IV–D agency in enforcing child support liens arising pursuant to section 6 of chapter 119A. Any such individual who refuses to provide the information required by this section shall not receive payment on the claim, and the company that declines payment on this basis shall be exempt from suit and immune from liability under this chapter or any other chapter or in any common law action in law or equity.

(g) In the event of a state of emergency declared by the governor or the president of the United States, the commissioner of insurance may temporarily suspend the application of this section to claims made due to the conditions resulting in such state of emergency.

PART I ADMINISTRATION OF THE GOVERNMENT
TITLE XXII CORPORATIONS
CHAPTER 175 INSURANCE
Section 24E Duty to assist recovery of public benefits; denial of claims; penalties; electronic access; wrongful use; emergencies

Section 24E. (a) Notwithstanding the provisions of any general or special law or rule or regulation to the contrary, prior to making any nonrecurring payment equal to or in excess of $500 to a claimant under a contract of insurance, every company authorized to issue policies of insurance pursuant to this chapter shall exchange information with the division of medical assistance and the department of transitional assistance for use by said agencies for the purpose of the recovery of public assistance benefits. The company shall either provide the division of medical assistance and the department of transitional assistance with information about the claimant or examine information made available by said agencies and updated not more than once a month. If the company elects to provide the division of medical assistance and the department of transitional assistance with information about a claimant, the company shall provide to said agencies, not less than ten business days prior to making payment to such claimant, the claimant's name, address, date of birth and social security number as appearing in the company's files and such other information appearing in the company's files as said agencies may require. The company shall use a method and format prescribed by the division of medical assistance and the department of transitional assistance but if the company is unable to use a method and format prescribed by said agencies, such company shall cooperate with said agencies to identify another method or format, including submission of written materials. If the company elects to examine information made available by the division of medical assistance and/or the department of transitional assistance concerning individuals who have received public assistance benefits and may be subject to a lien to secure repayment, the company shall notify the division of medical assistance and the department of transitional assistance, not less than ten business days prior to making payment to a claimant who has received public assistance benefits and may be subject to a lien to secure repayment, of the claimant's name, address, date of birth and social security number as appearing in the company's files and such other information appearing in the company's files as said agencies may require. A company shall not share information with the agencies if doing so would require the companies to violate the claimant's right to privacy under state or federal law.

For the purpose of this section, the word ''claimant'' shall mean an individual who brings a claim against an insured party under a liability insurance policy issued in the Commonwealth or under the liability coverage portion of a multiperil policy issued in the Commonwealth. For the purposes of this section, the term ''non-recurring payment'' does not include fines paid by companies to claimants pursuant to subsection (f).

(b) An individual making, a claim governed by this section shall provide his current address, date of birth and social security number to the insurance company, upon the request of the company. Such company may inform the claimant that such request is being made in accordance with this section for the purpose of assisting the division of medical assistance and the department of transitional assistance in the recovery of public assistance benefits. Any such individual who refuses to provide the information required by this section shall not receive payment on the claim, and the company that declines payment on this basis shall be exempt from suit and immune from liability under this chapter or any other chapter or in any common law action in law or equity.

(b.5) A company shall not be required under subsection (a) to exchange information with the division of medical assistance and the department of transitional assistance regarding payments to a third party where there is documentation showing that the third party has provided or agreed to provide the claimant with a benefit or service related to the claim including, but not limited to, the services of an attorney or a physician or payments for damage to or loss of real or personal property. Nothing herein shall subordinate the rights of the division of medical assistance under section 22 of chapter 118E and the department of transitional assistance under section 5G of chapter 18 to other third parties.

(c) Pursuant to regulations issued by the secretary of the executive office of health and human services in consultation with the commissioner of insurance, a company that knowingly fails to accurately exchange information regarding a claim to which this section applies shall be subject to a penalty assessed by the division of medical assistance and the department of transitional assistance. A company that fails or refuses to surrender property subject to a lien to the agency shall be liable in the same manner as provided in paragraph (7) of subsection (b) of section 6 of said chapter 119A. A company that makes a payment to the division of medical assistance or the department of transitional assistance pursuant to this section and an insured individual on whose behalf the company makes a payment shall be immune from any obligation or liability to the claimant or other interested party arising from the payment, notwithstanding the provisions of this chapter or any other law.

(d) The division of medical assistance, the department of transitional assistance and the Title IV–D agency shall use their best efforts to make mutually satisfactory arrangements so companies have a single point of entry for accessing and transmitting information electronically pursuant to this section and section 24D. The division of medical assistance and the department of transitional assistance shall provide the Title IV–D agency with access to information regarding individuals receiving assistance under their programs for that purpose and so that a company can be informed if the claimant or the claimant's heirs or legal representative may owe monies to the division or the department.

(e) Information provided by the division of medical assistance and the department of transitional assistance to a company under this section may only be used for the purpose of assisting the division or the department in collecting public assistance benefits. Any individual or company who uses such information for any other purpose shall be liable in a civil action to both the division or department and the claimant in the amount of $1,000 each, for each violation.

(f) In the event of a state of emergency declared by the governor or the president of the United States, the commissioner of insurance may temporarily suspend the application of this section to claims made due to the conditions resulting in such state of emergency.

A. ARCs are required by G.L. c.175, §113H and Rule 30 to maintain a SIU to investigate suspicious or questionable motor vehicle insurance claims for the purpose of eliminating fraud. The SIU must have at least one full time employee whose responsibility is principally directed towards the recognition and investigation of fraud. ARCs are required to report SIU activity - assignments, denials, compromises, and savings to CAR using the standardized SIU Quarterly Activity Log.

During the ~~triennial~~ Hybrid Audit, conducted once every five years, a sample of 25 voluntary and/or MAIP claims or underwriting ~~cases~~ referrals selected from the SIU log will be reviewed to determine the effectiveness of the ARC's fraud screening and quality of the SIU investigations. The cases will be evaluated on the quality of investigation, timeliness of investigation, resolution, statutory requirements, and accuracy of savings.

The evaluation of savings is based on the Saved Amount reported in the claims activity log. The Saved Amount reported for physical damage losses should be based upon the appraisal. Property Damage savings should also be based on the appraisal. If there is no appraisal available, the current reserve should be reported as the Saved Amount. PIP savings should be based on the total amount of medical bills less any cost containment results and should be reported as the Saved Amount. If there were no medical bills submitted, the current reserve should be reported as the Saved Amount. Bodily Injury savings and the reported Saved Amount should be based on the settlement evaluation referenced in Section A.6.a.-f. of Standard II: Bodily Injury & Uninsured/Underinsured Motorist.

B. Rule 32 requires that the ARC's SIU investigate suspicious claims on all policies whether issued through the MAIP or issued voluntarily. Also, Rule 32.C.1. requires that the SIU shall investigate suspicious circumstances surrounding underwriting, rating, and premium issues. Additionally, Rule 32.C.2. requires the ARC to conduct an audit of voluntary and MAIP policies to verify garaging and policy facts. The completed audit reports verifying garaging and policy facts conducted by the ARC's SIU shall be emailed to siulog@commauto.com at the end of each quarter and no later than the 15th of the following month using the template available on CAR's website. The SIU relevant components are included in the Hybrid Audit report and considered by the Compliance and Operations Committee upon completion.

Special Investigations may be performed by SIU personnel or other personnel trained to handle suspicious claims using activity checks, surveillance, accident reconstruction, statements or examinations under oath. Special investigations also include third party expert analysis of

documents associated with suspicious claims. Liability investigations are not considered to be special investigations.

The NAIC Standards for Claims as defined in the NAIC Market Conduct Examiners Handbook Chapter VIII are based on two model acts, the Unfair Claims Settlement Practices Act and the Unfair Property and Casualty Claims Settlement Practices Model Regulation.

- In Massachusetts unfair claim settlement practices are defined in G.L. c.176D, §3 Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance.
- CAR Rule 32 is modeled on this statute and contains the elements of unfair claim settlement practices defined in §3. 9.

The following identifies where the NAIC Standards are contained in Rule 32 and the Performance Standards:

A. NAIC Standard 1

1. Description

   The initial contact by the company with the claimant is within the required timeframe.

2. Performance Standards References

   a. Standard I.B.2.b.: Physical Damage Contact

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

   b. Standard II.A.3.a. - c.: Bodily Injury Contact

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

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

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

c. Standard III.B.1. - 4.: PIP Contact

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

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

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

Necessary forms should be mailed within 5 business days after notice of injury.

B. NAIC Standard 2

1. Description

Timely investigations are conducted.

2. CAR Rules of Operation

Rule 32

Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:

Comply with the standards for prompt investigation of claims.

3. Performance Standards References

a. Standard I.B.2.b.: Physical Damage Initial Screening and Investigation

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

b. Standard II.A.2.a. - d.: BI Initial Investigation

Review policy information to verify coverage and resolve any coverage issues.

Contact involved parties and secure sufficient documentation of facts involving accident circumstances to verify occurrence and to establish degree of fault.

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

Review and evaluate discrepancies and fraud indicators to determine scope of further investigation.

c. Standard III.A.1. – 2.: PIP Initial Screening and Investigation

Initial investigation should confirm that coverage is appropriate:

- Date of loss within policy period and all policy coverage is in order.
- Injured persons are eligible for no-fault benefits.
- Private health insurance availability should be verified and documented.
- Injuries arise from use of motor vehicle.
- Massachusetts statute applies.
- No exclusions apply, such as drunk driving, stolen car, and workers compensation.

C. NAIC Standard 3

1. Description

Claims are resolved in a timely manner.

2. CAR Rules of Operation

a. Rule 32

Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:

Effectuate prompt, fair and equitable settlements of claims in which liability is reasonably clear.

In the handling of residual market claims, ARCs shall not:

Fail to promptly settle claims, where liability is reasonably clear, under one portion of the policy coverage in order to influence settlements under other portions of the policy coverage.

3. Performance Standards References

   a. Standard I.B.4.a.: Physical Damage Prompt Evaluation and Settlement

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

   b. Standard II.A.6.b.: Bodily Injury Settlement Negotiations or Denial

      Evaluate and pursue warranted settlements when the injury and expense end result can be established

   c. Standard III.F.1.f.: PIP Claims Payment

      There should be no payment until the claimed loss has been verified and:

      - Investigations promptly conducted, and upon agreement to pay, checks should be issued within 10 business days.

D. NAIC Standard 4

   1. Description

      The Company responds to claim correspondence in a timely manner.

   2. CAR Rules of Operation

      Rule 32

      Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:

      Acknowledge and act promptly upon communications regarding claims.

E. NAIC Standard 5

   1. Description

      Claim files are adequately documented.

   2. Performance Standards References

a. Standard I.C.4.: Physical Damage Evaluation and Settlement

The file must clearly document the basis for the decision and result.

b. Standard II.A.6.a.: Bodily Injury Settlement Negotiations or Denial

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

c. Standard II.B.3.: Bodily Injury Fraud Handling Evaluation and Settlement

The file must clearly document the basis for the decision and result.

d. Standard III.F.3.: PIP Claim Payment

The file shall clearly document the basis for the decision and result.

F. NAIC Standard 6

1. Description

Claims are properly handled in accordance with policy provisions and applicable statues including HIPAA rules and regulations.

2. Performance Standards References

Introduction

The Performance Standards are developed to establish a benchmark for the handling of private passenger motor vehicle insurance claims. Also, these standards are designed to require compliance with Massachusetts laws and regulations regarding motor vehicle insurance and the CAR Rules of Operation. Any revisions to existing laws or regulations are incorporated into the Appendices as these are promulgated.

Several regulations and statutes are referenced in the Performance Standards and incorporated in the Appendices.

G. NAIC Standard 7

1. Description

~~Company uses the reservation of rights and excess of loss letters, when appropriate~~Company claim forms are appropriate for the type of product.

2. Performance Standards References

The use of required State forms is included in the Standards. ARC claim forms are reviewed as found in the claim reviews and commented upon in the Hybrid Audit Review if not appropriate.

~~a. Standard II. A.2.a.: Bodily Injury Initial Investigation~~

~~Reservation of Right letters and Excess of Loss letters should be used when and where appropriate.~~

~~b. Standard II.A.7.b.: Bodily Injury Cases in Suit~~

~~Reservation of Right letters and Excess of Loss letters should be used when and where appropriate.~~

H. NAIC Standard 8

1. Description

~~Deductible reimbursement to insured upon subrogation recovery is made in a timely and accurate manner~~Claim files are reserved in accordance with the company's established procedures.

2. CAR Rules of Operation

Rule 32

Claim practices for each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with Performance Standards and Best Practices:

Maintain claim reserving procedures for claims arising out of residual market business commensurate with their procedures for claims arising out of voluntary business.

3. Performance Standard References

a. Standard I.B.2.f.: Physical Damage Initial Investigation

The setting of initial reserves should be timely, reasonable, and follow documented ARC policy.

b. Standard II.A.2.e.: Bodily Injury Initial and Follow-up Investigation

The setting of initial reserves should be timely, reasonable, and follow documented ARC policy.

c. Standard II.A.5.e.: Bodily Injury Initial and Follow-Up Investigation

Changes to reserves should be timely, reasonable, and follow documented ARC policy.

d. Standard III.A.3.: PIP Initial Investigation

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

~~a. Standard I.B.6.b.: Physical Damage Claims Subrogation/Recovery~~

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

I. NAIC Standard 9

1. Description

a. ~~Company claim forms are appropriate for the type of product.~~ Denied and closed without payment claims are handled in accordance with policy provisions and state law.

~~b. The use of required State forms is included in the Standards. ARC claim forms are reviewed as found in the claim reviews and commented upon in the Hybrid Audit Review if not appropriate.~~

2. CAR Rules of Operation

Rule 32

Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:

Promptly provide a reasonable explanation for denial of a claim or for the offer of a compromise settlement.

3. Performance Standards References

a. Standard I.C.4.: Physical Damage Evaluation and Settlement

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

b. Standard II.B.3.: Bodily Injury Fraud Handling Evaluation and Settlement

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

c. Standard III.F.3.: Claims Payment

After 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.

Note that denials of claims are evaluated in SIU reviews.

J. NAIC Standard 10

1. Description

~~Claim files are reserved in accordance with the company's established procedures.~~ Canceled benefit checks and drafts reflect appropriate claim handling practices.

~~2. CAR Rules of Operation~~

~~Rule 32~~

~~Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:~~

~~Maintain claim reserving procedures for claims arising out of residual market business commensurate with their procedures for claims arising out of voluntary business.~~

~~3. Performance Standards References~~

~~a. Standard I.B.2.f.: Physical Damage Initial Investigation~~

~~The setting of initial reserves should be timely, reasonable, and follow documented ARC policy.~~

~~b. Standard II.A.2.e.: Bodily Injury Initial and Follow-Up Investigation~~

~~The setting of initial reserves should be timely, reasonable, and follow documented ARC policy.~~

~~c. Standard II.A.5.e.: Bodily Injury Initial and Follow-Up Investigation~~

~~Changes to reserves should be timely, reasonable, and follow documented ARC policy.~~

~~d. Standard III.A.3.: PIP Initial Investigation~~

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

K. NAIC Standard 11

1. Description

~~Denied and closed without payment claims are handled in accordance with policy provisions and state law~~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.

2. CAR Rules of Operation

Rule 32

Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:

Effectuate prompt, fair, and equitable settlements of claims in which liability is reasonably clear.

In the handling of residual market claims, ARCs shall not:

Fail to promptly settle claims, where liability is reasonably clear, under one portion of the policy coverage, in order to influence settlements under other portions of the policy coverage.

3. Performance Standards References

~~a. Standard I.C.4.: Physical Damage Evaluation and Settlement~~

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

~~b. Standard II.B.3.: Bodily Injury Fraud Handling Evaluation and Settlement~~

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

~~c. Standard III.F.3.: Claims Payment~~

~~After 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.~~

~~Note that denials of claims are evaluated in SIU reviews.~~

a. Standard I.B.4.c.: Physical Damage Prompt Evaluation and Settlement

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

b. Standard II.A.7.a.: Bodily Injury – Cases in Suit

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

c. Standard III.F.1.g.: PIP Claim Payment

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

~~K. NAIC Standard 12~~

~~Canceled benefit checks and drafts reflect appropriate claim handling practices.~~

~~Note that as part of the Reinsurance Audits CAR's Compliance Audit Department conducts a study on duplicate payments that encompasses stop payment and canceled checks.~~

~~L. NAIC Standard 13~~

~~1. Description~~

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

~~2. CAR Rules of Operation~~

~~Rule 32~~

~~Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:~~

~~Effectuate prompt, fair and equitable settlements of claims in which liability is reasonably clear.~~

~~In the handling of residual market claims, ARCs shall not:~~

~~Fail to promptly settle claims, where liability is reasonably clear, under one portion of the policy coverage in order to influence settlements under other portions of the policy coverage.~~

~~3. Performance Standards References~~

~~a. Standard I.B.4.c.: Physical Damage Prompt Evaluation and Settlement~~

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

~~b. Standard II.A.7.a.: Bodily Injury – Cases in Suit~~

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

~~c. Standard III.F.1.g.: PIP Claim Payment~~

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

~~M. NAIC Standard 14~~

~~1. Description~~

~~Loss statistical coding is complete and accurate.~~

~~2. Performance Standards References~~

~~Standard V.D.: Expenses~~

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

~~Note that loss statistical coding is audited as part of the Hybrid Audit.~~

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 to 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)~~ industry claims database to evaluate for possible warning signs.

   d. The fraud indicators of CAR SIU Standards and Fraud Profile shall also be considered for possible warning signs. Refer to Appendix A.

   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 the 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

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 motor vehicle 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 SC 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. SCs 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 a special investigation or expert analysis when discrepancies exist that are unresolved.

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

7. Cases in Suit

a. SCs 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. SCs shall have an Alternative Dispute Resolution Program.

8. DOR Requirements

Prior to making any payment equal to or in excess of $500 to a third-party claimant, the SC must comply with the requirements of the Insurance Claim Payment Intercept Program, G.L. c.175, §24D. NOTE: failure to comply with G.L. c.175, §24D will subject the SC to penalties proscribed by the DOR. These penalties will be in lieu of those penalties imposed for noncompliance with the Performance Standards. Refer to Appendix H.

9. Subrogation/Recovery

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

B. 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 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), the case shall be referred for special investigation with consideration given to referring the claim to IFB, NICB, or appropriate law enforcement agency for prosecution. Refer to Appendix A for other indicators.

2. Special Investigation

   a. Claims identified as suspicious or suspected fraudulent shall be referred for more detailed special investigation with 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 adhered to as part of the special investigation process.

   c. SCs 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 the Automobile Insurers Bureau (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 claim file must clearly document the basis for the decision and result.

C. Fraud Training

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

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

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

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 a motor vehicle.

   e. Massachusetts statute applies.

   f. No exclusions apply, such as drunk driving, stolen car, or 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 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 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 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. SCs 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 motor vehicle accident.

2. Any plan shall include historically utilized techniques such as: (i) timely independent medical examinations; (ii) medical bill reviews, including but not limited to a determination of usual and customary charges, with or without the use of medical fee databases: (iii) use of preferred provider organizations, managed care programs, and/or expert medical systems; and (iv) other 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 indications of potential fraud exist (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), the case shall be referred for special investigation. Refer to Appendix A for other indicators.

2. Special Investigation

a. Claims identified as suspicious or suspected fraudulent shall be referred for more detailed special investigation with 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 adhered to as part of the special investigation process.

c. SCs 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 the Automobile Insurers Bureau (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.

E. Subrogation/Recovery

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

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. No payment shall be made 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 are issued within 10 business days.

   g. A litigation management program is 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. Refer to Appendix A for a list of indicators.

3. Evaluation and Settlement

   a. All claim payments shall be made in accordance with Division of Insurance Bulletin 2017-06, attached as Appendix N.

   b. 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.

PART I ADMINISTRATION OF THE GOVERNMENT
TITLE XXII CORPORATIONS
CHAPTER 175 INSURANCE
Section 24D Lump sum insurance payments; exchange of claimant information between IV-D and insurance companies; withholding of past-due child support subject to lien

Section 24D. (a) Prior to making any nonrecurring payment equal to or in excess of $500 to a claimant under a contract of insurance, every company authorized to issue policies of insurance pursuant to this chapter shall exchange information with the IV–D agency, as set forth in chapter 119A, to ascertain whether such claimant owes past due child support to the commonwealth or to an individual to whom the IV–D agency is providing services, and is subject to a child support lien pursuant to section 6 of said chapter 119A. To determine whether a claimant owes past due child support, the company shall either provide the IV–D agency with information about the claimant or examine information made available by the IV–D agency and updated not more than once a month. If the company elects to provide the IV–D agency with information about a claimant, the company shall provide to the IV–D agency, not less than ten business days prior to making payment to such claimant, the claimant's name, address, date of birth and social security number as appearing in the company's files and such other information appearing in the company's files as the commissioner of revenue may require by regulation in consultation with the commissioner of insurance. The company shall use a method and format prescribed by the commissioner of revenue but if the company is unable to use a method and format prescribed by said commissioner of revenue, such company shall cooperate with the IV–D agency to identify another method or format, including submission of written materials. If the company elects to examine information made available by the IV–D agency and such claimant owes past due child support and is subject to a lien, the company shall notify the IV–D agency, not less than ten business days prior to making payment to such claimant, of the claimant's name, address, date of birth and social security number as appearing in the company's files and such other information appearing in the company's files as the commissioner of revenue may require by regulation in consultation with the commissioner of insurance, using a method and format prescribed by the commissioner of revenue. The company may remit to the IV–D agency the full amount of the lien or the full amount otherwise payable to the claimant at the time that it so notifies the IV–D agency at any time prior to making payment to the claimant, without regard to the ten business day period. If, at any time prior to payment, the IV–D agency notifies the company of its child support lien against a claimant by giving the company a notice of levy pursuant to said section 6 of said chapter 119A, the company shall withhold from the payment the amount of past due support as set forth in the notice of levy and shall provide such amount to the IV–D agency for disbursement to the obligee. The child support lien shall encumber the right of the claimant to payment under the policy and the company shall disburse to the claimant only that portion of the payment, if any, remaining after the child support lien has been satisfied. For the purpose of this section, the word ''claimant'' shall mean an individual who brings a claim against an insured under a liability insurance policy or the liability coverage portion of a multiperil policy or a beneficiary under a life insurance policy.

(b) This section shall not apply to that portion of a claim resulting in payments on behalf of the claimant issued to a third party where there is documentation showing that the third party has provided or agreed to provide the claimant with a benefit or service related to the claim including, but not limited to, the services of an attorney or a medical doctor, or to any portion of a claim based on damage to or a loss of real property. The commissioner of revenue, in consultation with the commissioner of insurance, shall promulgate regulations setting forth procedures for making payment to the IV–D agency when a third party has either provided or agreed to provide goods or services to the claimant,

and the insurance company cannot reasonably determine the remaining amount payable to the claimant.

(c) The provisions of the Employee Retirement Income Security Act limiting, for contracts of insurance, the amounts which may be assigned or attached in order to satisfy child support obligations shall apply to the provisions of this section.

(d) Pursuant to regulations issued by the commissioner of revenue in consultation with the commissioner of insurance, a company that knowingly fails to accurately exchange information regarding a claim to which this section applies shall be subject to a penalty assessed by the IV–D agency. A company that fails or refuses to surrender property subject to a child support lien to the IV–D agency shall be liable as provided in paragraph (7) of subsection (b) of section 6 of said chapter 119A. A company that makes a payment to the IV–D agency pursuant to this section and an insured individual on whose behalf the company makes a payment shall be immune from any obligation or liability to the claimant or other interested party arising from the payment, notwithstanding the provisions of this chapter or any other law.

(e) Information provided by the IV–D agency to a company under this section may only be used for the purpose of assisting the IV–D agency in collecting past due child support. Any individual or company who uses such information for any other purpose shall be liable in a civil action to the IV–D agency in the amount of $1,000 for each violation.

(f) An individual making a claim governed by this section shall provide his current address, date of birth and social security number to the insurance company, upon the request of the company. Such company may inform the claimant that such request is being made in accordance with this section for the purpose of assisting the IV–D agency in enforcing child support liens arising pursuant to section 6 of chapter 119A. Any such individual who refuses to provide the information required by this section shall not receive payment on the claim, and the company that declines payment on this basis shall be exempt from suit and immune from liability under this chapter or any other chapter or in any common law action in law or equity.

(g) In the event of a state of emergency declared by the governor or the president of the United States, the commissioner of insurance may temporarily suspend the application of this section to claims made due to the conditions resulting in such state of emergency.

PART I ADMINISTRATION OF THE GOVERNMENT
TITLE XXII CORPORATIONS
CHAPTER 175 INSURANCE
Section 24E Duty to assist recovery of public benefits; denial of claims; penalties; electronic access; wrongful use; emergencies

Section 24E. (a) Notwithstanding the provisions of any general or special law or rule or regulation to the contrary, prior to making any nonrecurring payment equal to or in excess of $500 to a claimant under a contract of insurance, every company authorized to issue policies of insurance pursuant to this chapter shall exchange information with the division of medical assistance and the department of transitional assistance for use by said agencies for the purpose of the recovery of public assistance benefits. The company shall either provide the division of medical assistance and the department of transitional assistance with information about the claimant or examine information made available by said agencies and updated not more than once a month. If the company elects to provide the division of medical assistance and the department of transitional assistance with information about a claimant, the company shall provide to said agencies, not less than ten business days prior to making payment to such claimant, the claimant's name, address, date of birth and social security number as appearing in the company's files and such other information appearing in the company's files as said agencies may require. The company shall use a method and format prescribed by the division of medical assistance and the department of transitional assistance but if the company is unable to use a method and format prescribed by said agencies, such company shall cooperate with said agencies to identify another method or format, including submission of written materials. If the company elects to examine information made available by the division of medical assistance and/or the department of transitional assistance concerning individuals who have received public assistance benefits and may be subject to a lien to secure repayment, the company shall notify the division of medical assistance and the department of transitional assistance, not less than ten business days prior to making payment to a claimant who has received public assistance benefits and may be subject to a lien to secure repayment, of the claimant's name, address, date of birth and social security number as appearing in the company's files and such other information appearing in the company's files as said agencies may require. A company shall not share information with the agencies if doing so would require the companies to violate the claimant's right to privacy under state or federal law.

For the purpose of this section, the word ''claimant'' shall mean an individual who brings a claim against an insured party under a liability insurance policy issued in the Commonwealth or under the liability coverage portion of a multiperil policy issued in the Commonwealth. For the purposes of this section, the term ''non-recurring payment'' does not include fines paid by companies to claimants pursuant to subsection (f).

(b) An individual making, a claim governed by this section shall provide his current address, date of birth and social security number to the insurance company, upon the request of the company. Such company may inform the claimant that such request is being made in accordance with this section for the purpose of assisting the division of medical assistance and the department of transitional assistance in the recovery of public assistance benefits. Any such individual who refuses to provide the information required by this section shall not receive payment on the claim, and the company that declines payment on this basis shall be exempt from suit and immune from liability under this chapter or any other chapter or in any common law action in law or equity.

(b.5) A company shall not be required under subsection (a) to exchange information with the division of medical assistance and the department of transitional assistance regarding payments to a third party where there is documentation showing that the third party has provided or agreed to provide the claimant with a benefit or service related to the claim including, but not limited to, the services of an attorney or a physician or payments for damage to or loss of real or personal property. Nothing herein shall subordinate the rights of the division of medical assistance under section 22 of chapter 118E and the department of transitional assistance under section 5G of chapter 18 to other third parties.

(c) Pursuant to regulations issued by the secretary of the executive office of health and human services in consultation with the commissioner of insurance, a company that knowingly fails to accurately exchange information regarding a claim to which this section applies shall be subject to a penalty assessed by the division of medical assistance and the department of transitional assistance. A company that fails or refuses to surrender property subject to a lien to the agency shall be liable in the same manner as provided in paragraph (7) of subsection (b) of section 6 of said chapter 119A. A company that makes a payment to the division of medical assistance or the department of transitional assistance pursuant to this section and an insured individual on whose behalf the company makes a payment shall be immune from any obligation or liability to the claimant or other interested party arising from the payment, notwithstanding the provisions of this chapter or any other law.

(d) The division of medical assistance, the department of transitional assistance and the Title IV–D agency shall use their best efforts to make mutually satisfactory arrangements so companies have a single point of entry for accessing and transmitting information electronically pursuant to this section and section 24D. The division of medical assistance and the department of transitional assistance shall provide the Title IV–D agency with access to information regarding individuals receiving assistance under their programs for that purpose and so that a company can be informed if the claimant or the claimant's heirs or legal representative may owe monies to the division or the department.

(e) Information provided by the division of medical assistance and the department of transitional assistance to a company under this section may only be used for the purpose of assisting the division or the department in collecting public assistance benefits. Any individual or company who uses such information for any other purpose shall be liable in a civil action to both the division or department and the claimant in the amount of $1,000 each, for each violation.

(f) In the event of a state of emergency declared by the governor or the president of the United States, the commissioner of insurance may temporarily suspend the application of this section to claims made due to the conditions resulting in such state of emergency.

A. The CAR SIU is charged with monitoring the efforts of the SCs to control fraud. A biennial evaluation of each SC's SIU is conducted to examine the overall SIU operation and quality of investigations.

File Selection and Review

B. A random sample of ~~approximately~~ 25 voluntary and ceded referrals from the SIU Quarterly Activity Log pertaining to claims or underwriting is selected. Files are reviewed to determine the ability of the staff to recognize potentially fraudulent claims and the quality of the SIU investigations. In addition, CAR reviews the accuracy of the savings reported to CAR. An examination of the effectiveness of the carriers' fraud screening and the SIU referral process has been incorporated into the biennial Claims Reviews. Cases will be evaluated on the quality of investigation, timeliness of investigation, resolution, statutory requirements, and accuracy of savings.

The evaluation of savings is based on the Saved Amount reported in the claims activity log. The Saved Amount reported for physical damage losses should be based upon the appraisal. Property Damage savings should also be based on the appraisal. If there is no appraisal available, the current reserve should be reported as the Saved Amount. PIP savings should be based on the total amount of medical bills less any cost containment results and should be reported as the Saved Amount. If there were no medical bills submitted, the current reserve should be reported as the Saved Amount. Bodily Injury savings and the reported Saved Amount should be based on the settlement evaluation referenced in Section A.6.a.-f. of Standard II: Bodily Injury & Uninsured/Underinsured Motorist.

C. Rule 10.C.1. requires that the SC's SIU investigate suspicious circumstances surrounding underwriting, rating and premium issues. Also that a claim shall not be investigated by the SIU solely on the basis that the claim arises from a ceded policy. Additionally, Rule 10.C.2. requires the SC to conduct an audit of a representative sample of policies to verify garaging and policy facts using the template available on CAR's website. The completed audit reports verifying garaging and policy facts conducted by the SC's SIU shall be emailed to siulog@commauto.com at the end of each quarter and no later than the 15th of the following month. The SIU relevant components are included in the Commercial Claims Performance Standards Report and SIU Evaluation. This report is considered by the Compliance and Operations Committee upon completion.

The NAIC Standards for Claims as defined in the NAIC Market Conduct Examiners Handbook Chapter VIII are based on two model acts, the Unfair Claims Settlement Practices Act and the Unfair Property and Casualty Claims Settlement Practices Model Regulation.

- In Massachusetts unfair claim settlement practices are defined in G.L. c.176D, §3 Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance.
- CAR Rule 32 is modeled on this statute and contains the elements of unfair claim settlement practices defined in §3. 9.

The following identifies where the NAIC Standards are contained in Rule 32 and the Performance Standards:

A. NAIC Standard 1

1. Description

   The initial contact by the company with the claimant is within the required timeframe.

2. Performance Standards References

   a. Standard I.B.2.b.: Physical Damage Contact

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

   b. Standard II.A.3.a. - c.: Bodily Injury Contact

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

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

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

c. Standard III.B.1. - 4.: PIP Contact

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

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

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

Necessary forms should be mailed within 5 business days after notice of injury.

B. NAIC Standard 2

1. Description

Timely investigations are conducted.

2. CAR Rules of Operation

Rule 32

Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:

Comply with the standards for prompt investigation of claims.

3. Performance Standards References

a. Standard I.B.2.b.: Physical Damage Initial Screening and Investigation

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

b. Standard II.A.2.a. - d.: BI Initial Investigation

Review policy information to verify coverage and resolve any coverage issues.

Contact involved parties and secure sufficient documentation of facts involving accident circumstances to verify occurrence and to establish degree of fault.

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

Review and evaluate discrepancies and fraud indicators to determine scope of further investigation.

c. Standard III.A.1. – 2.: PIP Initial Screening and Investigation

Initial investigation should confirm that coverage is appropriate:

- Date of loss within policy period and all policy coverage is in order.
- Injured persons are eligible for no-fault benefits.
- Private health insurance availability should be verified and documented.
- Injuries arise from use of motor vehicle.
- Massachusetts statute applies.
- No exclusions apply, such as drunk driving, stolen car, and workers compensation.

C. NAIC Standard 3

1. Description

Claims are resolved in a timely manner.

2. CAR Rules of Operation

a. Rule 32

Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:

Effectuate prompt, fair and equitable settlements of claims in which liability is reasonably clear.

In the handling of residual market claims, ARCs shall not:

Fail to promptly settle claims, where liability is reasonably clear, under one portion of the policy coverage in order to influence settlements under other portions of the policy coverage.

3. Performance Standards References

   a. Standard I.B.4.a.: Physical Damage Prompt Evaluation and Settlement

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

   b. Standard II.A.6.b.: Bodily Injury Settlement Negotiations or Denial

      Evaluate and pursue warranted settlements when the injury and expense end result can be established

   c. Standard III.F.1.f.: PIP Claims Payment

      There should be no payment until the claimed loss has been verified and:

      - Investigations promptly conducted, and upon agreement to pay, checks should be issued within 10 business days.

D. NAIC Standard 4

1. Description

   The Company responds to claim correspondence in a timely manner.

2. CAR Rules of Operation

   Rule 32

   Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:

   Acknowledge and act promptly upon communications regarding claims.

E. NAIC Standard 5

1. Description

   Claim files are adequately documented.

2. Performance Standards References

a. Standard I.C.4.: Physical Damage Evaluation and Settlement

The file must clearly document the basis for the decision and result.

b. Standard II.A.6.a.: Bodily Injury Settlement Negotiations or Denial

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

c. Standard II.B.3.: Bodily Injury Fraud Handling Evaluation and Settlement

The file must clearly document the basis for the decision and result.

d. Standard III.F.3.: PIP Claim Payment

The file shall clearly document the basis for the decision and result.

F. NAIC Standard 6

1. Description

Claims are properly handled in accordance with policy provisions and applicable statues including HIPAA rules and regulations.

2. Performance Standards References

Introduction

The Performance Standards are developed to establish a benchmark for the handling of private passenger motor vehicle insurance claims. Also, these standards are designed to require compliance with Massachusetts laws and regulations regarding motor vehicle insurance and the CAR Rules of Operation. Any revisions to existing laws or regulations are incorporated into the Appendices as these are promulgated.

Several regulations and statutes are referenced in the Performance Standards and incorporated in the Appendices.

G. NAIC Standard 7

1. Description

~~Company uses the reservation of rights and excess of loss letters, when appropriate~~Company claim forms are appropriate for the type of product.

2. Performance Standards References

The use of required State forms is included in the Standards. ARC claim forms are reviewed as found in the claim reviews and commented upon in the Hybrid Audit Review if not appropriate.

~~a. Standard II. A.2.a.: Bodily Injury Initial Investigation~~

~~Reservation of Right letters and Excess of Loss letters should be used when and where appropriate.~~

~~b. Standard II.A.7.b.: Bodily Injury Cases in Suit~~

~~Reservation of Right letters and Excess of Loss letters should be used when and where appropriate.~~

H. NAIC Standard 8

1. Description

~~Deductible reimbursement to insured upon subrogation recovery is made in a timely and accurate manner~~Claim files are reserved in accordance with the company's established procedures.

2. CAR Rules of Operation

Rule 32

Claim practices for each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with Performance Standards and Best Practices:

Maintain claim reserving procedures for claims arising out of residual market business commensurate with their procedures for claims arising out of voluntary business.

3. Performance Standard References

a. Standard I.B.2.f.: Physical Damage Initial Investigation

The setting of initial reserves should be timely, reasonable, and follow documented ARC policy.

b. Standard II.A.2.e.: Bodily Injury Initial and Follow-up Investigation

The setting of initial reserves should be timely, reasonable, and follow documented ARC policy.

c. Standard II.A.5.e.: Bodily Injury Initial and Follow-Up Investigation

Changes to reserves should be timely, reasonable, and follow documented ARC policy.

d. Standard III.A.3.: PIP Initial Investigation

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

~~a. Standard I.B.6.b.: Physical Damage Claims Subrogation/Recovery~~

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

I. NAIC Standard 9

1. Description

a. ~~Company claim forms are appropriate for the type of product.~~ Denied and closed without payment claims are handled in accordance with policy provisions and state law.

~~b. The use of required State forms is included in the Standards. ARC claim forms are reviewed as found in the claim reviews and commented upon in the Hybrid Audit Review if not appropriate.~~

2. CAR Rules of Operation

Rule 32

Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:

Promptly provide a reasonable explanation for denial of a claim or for the offer of a compromise settlement.

3. Performance Standards References

a. Standard I.C.4.: Physical Damage Evaluation and Settlement

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

b. Standard II.B.3.: Bodily Injury Fraud Handling Evaluation and Settlement

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

c. Standard III.F.3.: Claims Payment

After 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.

Note that denials of claims are evaluated in SIU reviews.

J. NAIC Standard 10

1. Description

~~Claim files are reserved in accordance with the company's established procedures.~~Canceled benefit checks and drafts reflect appropriate claim handling practices.

~~2. CAR Rules of Operation~~

~~Rule 32~~

~~Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:~~

~~Maintain claim reserving procedures for claims arising out of residual market business commensurate with their procedures for claims arising out of voluntary business.~~

~~3. Performance Standards References~~

~~a. Standard I.B.2.f.: Physical Damage Initial Investigation~~

~~The setting of initial reserves should be timely, reasonable, and follow documented ARC policy.~~

~~b. Standard II.A.2.e.: Bodily Injury Initial and Follow-Up Investigation~~

~~The setting of initial reserves should be timely, reasonable, and follow documented ARC policy.~~

~~c. Standard II.A.5.e.: Bodily Injury Initial and Follow-Up Investigation~~

~~Changes to reserves should be timely, reasonable, and follow documented ARC policy.~~

~~d. Standard III.A.3.: PIP Initial Investigation~~

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

K. NAIC Standard 11

1. Description

~~Denied and closed without payment claims are handled in accordance with policy provisions and state law~~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.

2. CAR Rules of Operation

Rule 32

Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:

Effectuate prompt, fair, and equitable settlements of claims in which liability is reasonably clear.

In the handling of residual market claims, ARCs shall not:

Fail to promptly settle claims, where liability is reasonably clear, under one portion of the policy coverage, in order to influence settlements under other portions of the policy coverage.

3. Performance Standards References

~~a. Standard I.C.4.: Physical Damage Evaluation and Settlement~~

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

~~b. Standard II.B.3.: Bodily Injury Fraud Handling Evaluation and Settlement~~

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

~~c. Standard III.F.3.: Claims Payment~~

~~After 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.~~

~~Note that denials of claims are evaluated in SIU reviews.~~

a. Standard I.B.4.c.: Physical Damage Prompt Evaluation and Settlement

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

b. Standard II.A.7.a.: Bodily Injury – Cases in Suit

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

c. Standard III.F.1.g.: PIP Claim Payment

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

~~K.~~ ~~NAIC Standard 12~~

~~Canceled benefit checks and drafts reflect appropriate claim handling practices.~~

~~Note that as part of the Reinsurance Audits CAR's Compliance Audit Department conducts a study on duplicate payments that encompasses stop payment and canceled checks.~~

~~L. NAIC Standard 13~~

~~1. Description~~

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

~~2. CAR Rules of Operation~~

~~Rule 32~~

~~Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:~~

~~Effectuate prompt, fair and equitable settlements of claims in which liability is reasonably clear.~~

~~In the handling of residual market claims, ARCs shall not:~~

~~Fail to promptly settle claims, where liability is reasonably clear, under one portion of the policy coverage in order to influence settlements under other portions of the policy coverage.~~

~~3. Performance Standards References~~

~~a. Standard I.B.4.c.: Physical Damage Prompt Evaluation and Settlement~~

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

~~b. Standard II.A.7.a.: Bodily Injury – Cases in Suit~~

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

~~c. Standard III.F.1.g.: PIP Claim Payment~~

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

~~M. NAIC Standard 14~~

~~1. Description~~

~~Loss statistical coding is complete and accurate.~~

~~2. Performance Standards References~~

~~Standard V.D.: Expenses~~

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

~~Note that loss statistical coding is audited as part of the Hybrid Audit.~~