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NATALIE A. HUBLEY
PRESIDENT

RECORDS OF MEETING

CLAIMS SUBCOMMITTEE – DECEMBER 20, 2018

Members Present

Mr. David DeLuca – Chair	Vermont Mutual Insurance Company
Ms. Elizabeth Kim	Arbella Insurance Company
Mr. Paul Narciso	Safety Insurance Company
Ms. Mary Singas [1]	MAPFRE U.S.A. Corporation
Ms. Amy Smith [2]	Amica Mutual Insurance Company
Ms. Marie-Armel Theodat	R. Theodat Insurance Agency, Inc
Mr. Aaron Wheaton [3]	Plymouth Rock Assurance Corporation

Substituted for:
[1]Mr. Steven Shiner
[2]Mr. Steven McNaney
[3]Mr. Robert Hallinan

Not in Attendance:	
Mr. Gregory Favreau	Electric Insurance Company

18.01 Records of Previous Meeting

The Subcommittee unanimously voted to approve the Records of the Claims Subcommittee meeting of October 25, 2018. The Records have been distributed and are on file.

18.04 Claims Performance Standards

The Governing Committee remanded the proposed modifications to the Private Passenger and Commercial Claims Performance Standards (the Standards) to the Claims Subcommittee (Subcommittee) at the November 14, 2018 meeting. Discussion by the Governing Committee focused on the Compliance and Operations Committee's (COPC) decision to remove the reference to the use of medical fee databases from Standard III pertaining to the handling of PIP claims. The Subcommittee was provided direction to review and enhance the record to address concerns raised by the COPC regarding the use of medical fee databases. Also, the Governing Committee requested that a final recommendation be prepared for the February 2019 Governing Committee meeting.

The Subcommittee Chair, Mr. David DeLuca, began the meeting by proposing that the Subcommittee individually consider and respond to each of the concerns discussed by COPC members that led to the elimination of the reference to database usage. He also advised that the Subcommittee should revisit any other specific questions asked by the Hearing Officer at the January 2016 Public Hearing to

further document explanations into the meeting records if not already considered in the COPC related discussion. At that time, CAR had proposed similar language be added into the Standards but was later rejected by the Division of Insurance (DOI) in the May 31, 2016 Order. In his opening remarks, Mr. DeLuca indicated he would specifically refer to the COPC records from the November 7, 2018 meeting and the discussion outline provided to the Subcommittee that noted each individual concern noted by the COPC. He emphasized the importance of providing clear explanations to support the recommendation as mutually beneficial to the consumer and the industry while improving the record in accordance with the Governing Committee directive.

The first discussion point focused on the COPC's overall perception that the main purpose of the change in language was to strengthen legal defense when a medical provider has filed a lawsuit due to fee reduction resulting from utilization of a medical fee database. The COPC had argued that CAR shouldn't set a precedent by adding a tool for the purpose of strengthening a legal position. Mr. DeLuca suggested that this view represented a narrow interpretation of the discussion and actual intent. He countered that the main purpose was to mitigate excessive costs due to overbilling by medical providers. Insurers have been able to reduce excessive medical charges through the use of these databases in the determination of usual and customary charges. This in turns allows insureds more access to treatment as the purchased PIP and Medical Payment coverages have not been exhausted. Mr. DeLuca supported the savings by referencing the greater than $8 million in fee reductions recorded in the industry survey.

The second COPC discussion point was that the Standards as currently written do not preclude the use of medical fee databases therefore making the specificity unnecessary. The COPC pointed to the second reference in the Medical Management section of Standard III that includes a list of acceptable techniques to maintain a continuing awareness of the disability claimed. While none of the techniques are specifically required, the broad wording of historically utilized techniques allows for the use of other 'innovative approaches'. The COPC considered this description to sufficiently permit the use of medical fee databases while allowing companies the flexibility to determine usage. After brief discussion, the Subcommittee acknowledged agreement that companies may currently use medical fee databases as part of a medical management program as concluded by the COPC and that the existing language did not preclude use. However, Ms. Elizabeth Kim stated the lack of the direct reference to medical fee databases as a tool available to claims handlers is detrimental to the credibility of an effective tool. She added that this also creates a lack of transparency towards claim payment expectations. Ms. Marie-Armel Theodat added that the industry survey also documented that medical fee databases are commonly used by the industry. The direct reference would encourage pricing consistency for both the industry and insureds through the use of a widely accepted tool. Ms. Mary Singas also noted the importance of enhancing the credibility of the technique by specifically including the reference. Mr. DeLuca summarized by stating that the Subcommittee agreed that adding the specific reference to medical fee databases adds emphasis while serving as a prime example of a successful innovative approach that strengthens claim mitigation. He also noted that in his opinion, an integral charge of the Subcommittee is to propose adjustments to the Standards that reflect current industry procedures including those specific to the determination of usual and customary. Not including the reference to the use of databases would be a significant omission to current claims practices.

The next discussion point by the COPC was that the record did not support inclusion of medical fee databases into the Standards as in the best interest of the motoring public and the residual market. Mr. DeLuca disagreed stating that inserting the use of databases into the language of Standard III would improve the quality of claim settlements thereby reducing the overall claim payout. The general principle is that significant overbilling by medical providers increases the amount of PIP and liability bodily injury claim payments. This in turn increases the ultimate payout by insurers which leads to rate increases thus impacting policyholders and motorists. If the language benefits the policyholders and motorists, then the inclusion of specific language would also benefit the residual market. He also again referenced that

inclusion would more accurately reflect current industry practices. The Subcommittee agreed that the pervasiveness of use is so significant that its absence is conspicuous.

The final discussion point by the COPC was that the 2016 DOI order based on the same recommendation concluded that the Standards provided sufficient tools for considering usual and customary charges for the purpose of negotiating PIP claims. The COPC questioned if anything had changed regarding the use of medical fee databases since the 2016 DOI Order and whether or not CAR had established a defensible position to the current recommendation. Mr. DeLuca stated that the responses to the discussion points already considered are all reasons for the reference to medical fee databases in Standard III. He also noted that specifically identifying the use of databases would serve as a visible record of a valid technique in the determination of reasonable and necessary considerations while improving the credibility and transparency of the commonly used tool.

Upon concluding the review of the COPC concerns, Mr. DeLuca directed the Subcommittee's attention to the questions asked by the DOI Hearing Officer at the January 2016 Public Hearing. He noted that significant overlap existed between the COPC concerns and the questions asked by the Hearing Officer.

The first several questions asked by the Hearing Officer were to determine the reason that CAR chose to insert the reference to and the specificity of medical fee databases into the existing language. Mr. DeLuca referenced the Subcommittee's prior discussion and that the dual main purpose was to mitigate medical costs while preserving PIP and Medical Payment benefits for policyholders. This would serve to benefit insureds by providing full access to the selected coverages while adhering to cost containment requirements already included in the Standards. The Subcommittee again noted that specific language would provide credibility to a medical management technique that also aids industry cost containment efforts.

The Subcommittee proactively directed staff to develop a survey at the July 25, 2018 meeting because the Hearing Officer questioned whether CAR had surveyed the industry regarding the use of medical fee databases during the 2016 process. In preparation for the possibility of a similar recommendation, a survey was developed that considered questions asked by the Hearing Officer in January 2016. Certain assumptions were necessary to develop a standardized survey including the elimination of any responses that were using data greater than six years prior to the survey. Also, based on Subcommittee's discussion, FAIR Health is the only provider of the underlying data used to determine pricing. Therefore, the Subcommittee concluded that all other vendors use data supplied by Fair Health. The initial survey results were provided to the Subcommittee and detailed in the October 25, 2018 meeting Records. Staff was subsequently directed to further segregate counts and dollars by private passenger and commercial business, and market share. Market shares were determined using internal CAR statistical data reports. Notable accumulated survey responses include:

- An indication that industry use of medical fee databases varies widely from not at all, to on a case specific basis, to on all medical bills for the consideration of usual and customary.
- Legal challenges were prevalent for those companies that choose to use the databases.
- Company provided responses indicated approximate savings of 5.5% and 6.0% for the private passenger and commercial markets, respectively.
- Survey responses included nine unique vendors with FAIR Health the most commonly used.

Other questions that were asked by the Hearing Officer and considered by the Subcommittee included whether the use of such databases would assist companies in meeting the statutory standards for determining when a claim is reasonable. The Subcommittee stated that adoption of the suggested language would assist in determining whether the cost of settling the claim is reasonable. This would benefit both consumers and the industry. Without specifically naming medical fee databases in the Standards, companies

would be limiting the number of useful tools at their disposal. The Subcommittee argued that this fact is well established in the record.

As the Subcommittee now considered the COPC and Hearing Officer's concerns fully addressed, the discussion focused on a suggested change to the recommended language submitted by Mr. DeLuca. The original recommendation approved by the Subcommittee was identical to 2016 that simply inserted 'medical fee databases' into subsection 2 of the Medical Management section of Standard III. This change simply added the use of databases as an additional option in the listing of acceptable techniques. Mr. DeLuca's suggestion was:

2. Any plan shall include historically utilized techniques such as timely independent medical examinations, medical bill reviews including but not limited to a determination of usual and customary charges*, with or without the use of medical fee databases*, use of preferred provider organizations, managed care programs, and/or expert medical systems, as well as innovative approaches.

Ms. Kim supported the modification stating that by including 'with or without' the use of databases, the language acknowledged that companies were able to independently determine usage as deemed appropriate by the individual carrier. Mr. Aaron Wheaton also supported the restructuring of the subsection because the placement now directly tied usage to usual and customary considerations. He also suggested that the subsection should be further modified to more clearly differentiate each of the different techniques available to the industry. The Subcommittee agreed with Mr. Wheaton's additional suggestion.

Overall the Subcommittee considered each concern as interrelated. Companies are required by the Standards to have a medical management program. These programs should consider concerns tied to cost containment such as reasonable, necessary and causally related as well as usual and customary. Cost containment efforts are a primary objective of the Standards and are mandated by insurance specific laws including CAR's enabling statute. Through maintaining awareness of claimant's injuries, ongoing medical treatment and the consideration of usual and customary, the industry is able to reduce costs that have a direct impact to rates. Adding a reference to the Standards that would recognize the use of medical fee databases as one of multiple acceptable techniques in a company's medical management plan would benefit the industry and the policyholder in each of these considerations. The industry survey indicates that companies have successfully reduced overbilling fees for services by medical providers through the use of medical databases. The reduction of overbilling not only extends PIP or Medical Payment coverage benefits selected and purchased by the insureds but also reduces insurance industry expenses.

Ms. Singas proposed a motion to adjust the suggested language to include 'with or without the use of medical fee databases' as suggested by Mr. DeLuca. The Subcommittee voted unanimously to recommend approval of the amendment to Standard III No-Fault Personal Injury Protection Benefits Handling of the Standards to the Compliance and Operations Committee.

PETER BERTONI
Compliance Auditor

Boston, Massachusetts
January 17, 2019

ATTACHMENT LISTING

Docket #CLMS18.02, Exhibit #4	Attendance Listing
Docket #CLMS18.04, Exhibit #4	Performance Standards Discussion Outline

CLAIMS SUBCOMMITTEE MEETING
SIGN-IN SHEET
THURSDAY, DECEMBER 20, 2018

Individual's Name PLEASE PRINT	Company / Agency
Peter Bertoni	CAR Staff
Elizabeth Kim	Arbella
Amy Smith	Amica
Mary Griggs	Mapfre
Marie-Anne Theodat	R Theodat Ins Agcy
Ben Hincks	TSHD - CAR Counsel
Wendy Brayne	CAR
Darcy DeLuca	Vermont Mutual
MACK AIKES	CAR
Paul Narcisi	Safety
Aaron Wheaton	Plymouth Rock
James Rosary	CAR
Robert Jones	CAR

Count	Section	Subsection	Change Recommendation	Claims Subcommittee Comments and Discussion Points
1	PP	Table of Contents	CAR Staff	Discussion Points: Change One: Page 2 of 2 - Update Appendix N to most recent June 2017 Coordination of Benefits DOI Bulletin.
2	PP	Standard III	Claims Subcommittee	Discussion Points: Change One: Page 2 of 3 - Under section C. Medical Management, subsections 1 and 2. ARC's and SC's are required to establish medical cost containment plans in the handling of No-Fault Personal Injury Protection claims. 1. *"ARC's 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 automobile accident*." 2. Medical Management section specifically states that said plan shall include *"…historically utilized techniques such as timely independent medical examinations, medical bill reviews including but not limited to a determination of usual and customary charges, use of preferred provider organizations, managed care programs, and/or expert medical systems, as well as innovative approaches."*
				Discussion Points (Continued): The Claims Subcommittee believes explicit language regarding the use of "medical fee data base" should be included in the Standards. • Some companies use medical fee databases as a tool to gauge usual and customary charges leading to cost appropriate payments to medical providers (based on current and comparative data). • Bill reductions include cost containment benefits in accordance with the Standards. • Medical providers have fought these cost containment efforts by filing lawsuits. Subcommittee members observed that these complaints typically include bad faith allegations. • Subcommittee members observed that defense of this litigation has been mostly unsuccessful and costly from an insurance industry perspective. • Subcommittee members stated that providers will continue to challenge bill adjustments regardless of the language in the Standards. However, inclusion may strengthen acceptance by the courts. • Excessive billing could potentially exhaust PIP benefits prematurely.
				Discussion Points (Continued): Original Recommendation The Claims Subcommittee recommends the language in C. Medical Management, subsection 2 should be modified to: "…historically utilized techniques such as timely independent medical examinations, medical bill reviews including but not limited to a determination of usual and customary charges, use of preferred provider organizations, managed care programs, *medical fee databases*, and/or expert medical systems, as well as innovative approaches."

Count	Section	Subsection	Change Recommendation	Claims Subcommittee Comments and Discussion Points
2 (Cont.)	PP (Cont.)	Standard III (Cont.)	Claims Subcommittee	Discussion Points (Continued): Alternative suggested language – Subcommittee Chair Dave Deluca "….historically utilized techniques such as timely independent medical examinations, medical bill reviews including but not limited to a determination of usual and customary charges*; with or without the use of medical fee databases;* use of preferred provider organizations, managed care programs, and/or expert medical systems, as well as innovative approaches."
				Discussion Points (Continued): On November 7, 2018, the Compliance and Operations Committee (COPC) voted 6-1 to remove the medical fee database language from the proposed Standards. COPC discussion focused on: • The main purpose of the language change shouldn't be to strengthen defense as an aid in future legal proceedings. • The Standards as written does not preclude the usage of medical fee databases and adding language specifically referencing medical fee databases is unnecessary. • The broad wording that includes "historically utilized techniques" as well as "innovative approaches" sufficiently permits usage and this becomes the carrier's decision. • Didn't fully answer questions posed by the Division as detailed in July 12, 2018 Memorandum. • The record didn't support inclusion of medical fee databases into the Standard as in the best interest of the motoring public and the residual market. • The Standards didn't currently preclude the use of medical fee databases and use was verified by the industry survey responses. • The 2016 DOI order based on the same recommendation concluded that the Standards provide sufficient tools for considering usual and customary charges for the purpose of negotiating PIP claims. On November 14, 2018, the Governing Committee (GC) without a vote subsequently remanded the Standards back to the Claims Subcommittee with the direction to enhance the record to address concerns raised by the COPC.
			Claims Subcommittee and CAR Staff	Discussion Points: Change Two: CAR Staff recommended adding language from Standard II Bodily Injury & Uninsured/Underinsured Motorist B. 2. Special Investigation to Standard III - No-Fault Personal Injury Protection Benefits Handling, D. Fraud Handling. • This recommendation was made to make both Standards consistent with Fraud Handling.

Count	Section	Subsection	Change Recommendation	Claims Subcommittee Comments and Discussion Points
2 (Cont.)	PP (Cont.)	Standard III (Cont.)	Claims Subcommittee	Discussion Points (continued): The Subcommittee determined that striking the reference in the Screening Process for Suspected Fraudulent Claims was appropriate because any referral to the IFB, NICB or law enforcement agency would occur during the investigations process of claims handling and during the screening process. • Applies to Private Passenger and Commercial Standards. • Section D. 1. Screening Process for Suspected Fraudulent Claims reads as follows - "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 ~~with consideration given to referring the claim to IFB, NICB, or appropriate law enforcement agency for prosecution~~. Refer to Appendix A for other indicators.
3	PP	Measurement & Penalties	CAR Staff	Discussion Points: Change One: Page 1 of 1 - Update to reflect current Committee.
4	PP	Appendix A	CAR Staff	Discussion Points: Change One: Page 2 of 8 - Update SIU language to current process for providing Quarterly SIU Activity Log.
5	PP	Appendix I	CAR Staff	Discussion Points: Change One: Page 2 of 3 - Update to reflect current Committee. Change Two: Page 2 of 3 - Update to reflect current Committee.
6	PP	Appendix J	CAR Staff	Discussion Points: Change One: Page 1 of 1 – Update to SIU language to current process for providing SIU components included in the Hybrid Audit Report.
7	PP	Appendix N	CAR Staff	Discussion Points: Change One: Update to June 2017 Coordination of Benefits DOI Bulletin.
8	CCPS	Table of Contents	CAR Staff	Discussion Points are same as PP:

Count	Section	Subsection	Change Recommendation	Claims Subcommittee Comments and Discussion Points
9	CCPS	Standard III	Claims Subcommittee	Discussion Points are same as PP
10	CCPS	Measurements and Penalties	CAR Staff	Discussion Points Change One: Page 3 of 6 - Update to reflect current Committee. Change Two: Page 6 of 6 – Update Expenses in Best Practice Standards section.
11	CCPS	Appendix A	CAR Staff	Discussion Points are same as PP
12	CCPS	Appendix I	CAR Staff	Discussion Points Change One: Page 2 of 4 – Rule 10 is adjusted to Rule 10.C. Change Two: Page 2 of 4 - Update to reflect current Committee.
13	CCPS	Appendix J	CAR Staff	Discussion Points Change One: Page 1 of 1 – Section C. Update SIU language, specifically Rule 10.C. to current process for the components of the Commercial Claims Standards Report and SIU Evaluation.
14	CCPS	Appendix K	CAR Staff	Discussion Points Change One: Page 2 of 4 – Insert question regarding SC verifying Principal Place of Business for commercial business to the claims questionnaire (same questionnaire for private passenger and commercial).
15	CCPS	Appendix N	CAR Staff	Discussion Points are same as PP