Approved Changes – September 6, 2011

September 2011

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

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

Introduction

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

The Performance Standards were last approved by the Commissioner of Insurance in her Decision of June 10, 2009 to apply to the Commercial Limited Servicing Carrier Program for policies effective January 1, 2006 and subsequent.

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

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

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

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

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

Appendix A – Special Investigative Unit Standards: Section 2 Commercial

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

Appendix B – Regulation 211 CMR 123.00

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

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

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

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

Regulation 212 CMR 2.00 was promulgated to promote public welfare and safety by improving the quality and economy of the appraisal and repair of damaged motor vehicles. This regulation was revised effective February 23, 1996 and is intended to be read in conjunction with 211 CMR 133.00, which follows in Appendix G.

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

Regulation 211 CMR 133.00 was promulgated on February 23, 1996 to promote the public welfare and safety by establishing fair and uniform standards for the repair of damaged motor vehicles when an insurer pays for the cost of repairs. It is intended to be read in conjunction with 212 CMR 2.00 in Appendix F.

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

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

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

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

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

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

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

Appendix L – Questionnaire: Section 2. Commercial

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

Appendix M – Industry Best Practices

An outline has been added to identify where the industry Best Practices are referenced in the Performance Standards.

Appendix N – NAIC Standards: Section 2. Commercial

The NAIC Standards are included showing their reference in CAR Rule 10 and the Performance Standards.

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

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

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

I. Auto Physical Damage & Property Damage Liability Claims

A. Auto Body Payments

1. Service Times

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

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

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

d. The Standard for transmittal of the completed appraisal from the date of the appraisal assignment is 5 business days in accordance with 212 CMR 2:04 Section 1e (see Appendix E).

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

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

2. Direct Payment Plan

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

1) The Automobile Insurers Bureau of Massachusetts (hereafter referred to as "AIB") Industry Plan can be adopted (see Appendix C).

2) A modification of the AIB Industry Plan can be filed for approval by the Commissioner.

3) Carriers can develop and submit for approval their own plan.

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

3. Parts Cost

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

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

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

4. Labor Rates and Times

a. Carriers must have a plan designed to control labor costs and to seek the most competitive labor rates and times.

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

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

5. Total Loss Payments

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

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

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

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

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

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

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

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

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

6. Towing and Storage Costs

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

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

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

7. Appraisal of Damage and Reinspections

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

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

2) Scoping and completing an appraisal

3) Use of aftermarket, rebuilt, LKQ parts

4) Open items and supplements

5) Refinishing

6) Depreciation and betterment

7) Unrelated damage

8) Structural damage

9) ACV estimating

10) Screening for fraudulent claims

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

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

d. Reinspections must be completed on 75 percent of all repaired vehicles whose damage exceeded $4,000, whether paid under a Direct Payment Plan or not.

e. Reinspections must be completed on 25 percent of all repaired vehicles whose damage was less than $4,000, whether paid under a Direct Payment Plan or not.

8. Carriers shall report any repair shop which engages in any of the following practices directly to the Division of Standards, Office of Consumer Affairs and Business Regulation.

a. Advertise for motor vehicle repair in the Commonwealth without including either the number of its certificate of registration issued by the director or the words “unregistered repair shop”, as part of the advertisement.

b. Fails to charge all or any part of the applicable deductible to be paid by the insured.

c. Gives any rebate, gift, prize, premium, bonus, fee, or any other monetary or tangible thing to the insured or any other person not in the employ of the repair shop as an inducement to have the repair made at the repair shop. A discount on parts, glass, labor rate or other item or customer service in connection with the repair of motor vehicles offered by a repair shop to an insurer shall not constitute a “payment, gift, or any other thing of value” for purposes of Regulation 211 CMR 123.06 (8) (a) (see Appendix B).

d. Charges or offers to charge a higher rate or discount for an insured repair than for an uninsured repair. Discounts for insured repairs may be offered through the Direct Payment Plan approved by the Commissioner.

e. Makes any false or fraudulent statement in connection with any repair or attempt to collect for a repair

f. Without lawful authority, prevents the owner of a motor vehicle from recovering the same.

9. Carriers must establish procedures to comply with the various claims requirements of the mandatory preinsurance inspection program established by Regulation 211 CMR 94.00 (see Appendix G attached).

B. Normal Claim Handling

1. Initial screening of reports of accidents and losses

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

b. Initial screening should determine that accident circumstances, facts, and information reported are consistent and sufficient to establish the occurrence.

c. Initial screening should identify losses involving theft or arson, which always require detailed investigation.

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

e. If the initial screening identifies discrepancies or inconsistencies, a determination of the type and extent must be made to evaluate extent and nature of further investigation necessary.

2. Initial Investigation

a. Review policy information to verify coverage and resolve any issues including garaging and operators, and notify Underwriting where appropriate.

b. Contact 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.

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

d. Secure documentation of the damages or value of the vehicle.

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

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

3. Appraisal Program

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

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

4. Prompt Evaluation and Settlement

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

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

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

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

6. Recovery

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

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

C. Fraud Handling

1. Screening process for suspected fraudulent claims

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

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

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

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

2. Appraisal Program

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

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

3. Special Investigation

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

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

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

4. Evaluation and Settlement

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

D. Glass

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

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

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

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

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

6. Carriers shall report any repair shop which engages in any of the following practices directly to the Division of Standards, Office of Consumer Affairs and Business Regulation:

   a. Advertise for motor vehicle repair in the Commonwealth without including either the number of its certificate of registration issued by the director or the words “unregistered repair shop”, as part of the advertisement.

   b. Fails to charge all or any part of the applicable deductible to be paid by the insured.

   c. Gives any rebate, gift, prize, premium, bonus, fee, or any other monetary or tangible thing to the insured or any other person not in the employ of the repair shop as an inducement to have the repair made at the repair shop. A discount on parts, glass, labor rate, or other item or customer service in connection with the repair of motor vehicles offered by a repair shop to an insurer shall not constitute a “payment, gift, or any other thing of value” for purposes of Regulation 211 CMR 123.06 (8)(a) (see Appendix B).

d. Charges or offers to charge higher rate or discount for an insured repair than for an uninsured repair. Discounts for insured repairs may be offered through the Direct Payment Plan approved by the Commissioner.

e. Makes any false or fraudulent statement in connection with any repair or attempt to collect for a repair.

f. Without lawful authority, prevents the owner of a motor vehicle from recovering the same.

E. Fraud Training

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

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

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

II. Bodily Injury & Uninsured/Underinsured Motorist

A. Normal Claim Handling

1. Initial Screening of Reports of Accident and Losses

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

b. Initial screening should determine that accident circumstances, facts, and information reported are consistent and sufficient to establish the occurrence.

c. Initial screening should include checking policy information and accident history, and reporting to Central Index Bureau (hereafter referred to as “CIB”) to evaluate for possible warning signs.

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

e. If the initial screening identifies discrepancies or inconsistencies, a determination of the type and extent of discrepancies or inconsistencies must be made to evaluate extent of further investigation necessary.

2. Initial Investigation

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

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

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

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

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

3. Contacts

    a. 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.

    b. 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.

    c. 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.

4. Loss Management

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

5. Follow-Up and Continuing Investigation

    a. Verify and evaluate type and extent of injury and substantiate by available reports and/or independent examinations.

    b. Confirm and document that treatment and expenses are reasonable, necessary, and related to the accident.

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

d. Proper diary systems should be employed and company reporting and authority levels followed.

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

6. Settlement Negotiations or Denial

a. Carriers 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.

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

c. Evaluate mitigating factors that may reduce settlement value, such as comparative negligence or joint tortfeasor situations.

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

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

f. Underinsured motorist claims should document that no other party may be identified as liable. Recovery efforts should be made.

7. Cases in Suit

a. Carriers should 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 should be used when and where appropriate.

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

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

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

f. Carriers should have an Alternative Dispute Resolution Program.

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

9. Recovery

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

B. Fraud Handling

1. Screening Process for Suspected Fraudulent Claims

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

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

        The case should be referred for special investigation.

2. Special Investigation

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

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

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

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

3. Evaluation and Settlement

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

C. Fraud Training

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

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

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

III. No-Fault Personal Injury Protection Benefits Handling

A. Screening Reports and Initial Investigation

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

2. Initial investigation should confirm that coverage is appropriate:

a. 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 should be verified and documented.

d. Injuries arise from use of motor vehicle.

e. Massachusetts's statute applies.

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

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

B. Contacts

1. 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.

2. 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.

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

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

C. Medical Management

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

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

D. Fraud Handling

1. Screening Process for Suspected Fraudulent Claims

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

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

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

E. Subrogation

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

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

F. Claim Payment

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

   a. Deductible applied.

   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, and upon agreement to pay, checks should be issued within 10 business days.

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

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

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

3. 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.

IV. Voluntary/Ceded Claim Handling Differential

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

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

C. The audit shall include policies not insured or reinsured by the Plan in order to determine if there is a difference in claims handling between policies insured voluntarily and those insured or reinsured by the Plan.

V. Expenses

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

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

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

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

3. Carriers should have an Alternative Dispute Resolution Program.

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

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

Measurements & Penalties

Measurements

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

The following Performance Standards, approved by the Commissioner of Insurance in her Decision of June 10, 2009, apply to the Commercial Servicing Carrier Program.

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

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

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

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

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

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

Major non-compliance indicates that a carrier is not in compliance with the Standards in one or more areas and claim handling is affected and overpayments may be occurring as a result. The carrier will be notified of the extent and areas in which non-compliance exists and will be warned that the subsequent review of the carrier must reflect compliance in all of the cited areas to avoid penalty.

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

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

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

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

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

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

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

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

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

Commercial Claims Performance Standards

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

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

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

Best Practices	NAIC Standard	Measurement	Benchmark
Medical Management	NAIC 4, 5, 6, 11	• Claims warranting IME referral vs. claims referred for IME. • Appropriate utilization of IME results to cut off claim, reduce bills. • Appropriate utilization of Medical Bill Review program.	
Loss Management/Special Investigation	NAIC 4, 11	• Claims warranting special investigation vs. claims referred for special investigation.	
Subrogation	NAIC 8	• Subrogation recognized and pursued. • Reimbursement of deductible is timely and accurate when and where appropriate.	
Bodily Injury/Uninsured Motorist Claims			
Contact	NAIC 1	• Injured party - 2 days. • Uninjured party - 3 days.	
Reserves	NAIC 10	• Initial and subsequent reserves timely and appropriate; follow documented company policy	
Loss Management/Special Investigation	NAIC 4, 11	• Claims warranting special investigation vs. claims referred for special investigation.	
Litigation Management	NAIC 7, 13	• Reservation of Rights and Excess letters used when and where appropriate.	
Settlement	NAIC 3, 5, 6	• Evaluation range documented and appropriate. • Settlement within range or documented why exceeded.	
Recovery	NAIC 3	• Recovery potential recognized and pursued. • Contribution from joint tortfeasor obtained.	
Voluntary/Ceded Claim Handling Differential			
Claim Handling	NAIC 6	• A comparison of the compliance results for each of the resolution standards in the Ceded and Voluntary claims will be calculated. • Statistical testing will be performed on the aggregate results of each of the three applicable sections: Physical Damage/Property Damage, PIP, and BI. • If the difference is statistically significant, the carrier will be required to address the reasons in their response. • Following the response, CAR will make a determination on whether the Voluntary/Ceded Standard was in compliance.	
Expenses	NAIC 14	• Reported properly as defined in the Statistical Plan.	