COMMONWEALTH AUTOMOBILE REINSURERS

COMMERCIAL CLAIMS PERFORMANCE STANDARDS

FOR THE HANDLING AND PAYMENT OF CLAIMS BY SERVICING CARRIERS

REVISED THROUGH MAY 31, 2016

101 ARCH STREET, SUITE 400
BOSTON, MA 02110

Performance Standards

Appendices

G.L.c.175, §113H requires that Commonwealth Automobile Reinsurers (CAR) establish Performance Standards for claim handling for Massachusetts Commercial motor vehicle insurance policies. These Performance Standards are designed to contain costs, ensure prompt customer service and timely payment of legitimate claims, and prevent the payment of inflated, fraudulent, and unwarranted claims. Periodic audits of Servicing Carriers (SC) are conducted to maintain consistency of claims handling for policies insured voluntarily and those ceded to CAR.

The Performance Standards documented in this manual are developed to establish a benchmark for the handling of commercial motor vehicle insurance claims. Also, these standards are designed to ensure compliance with Massachusetts laws and regulations regarding motor vehicle insurance and the CAR Rules of Operation.

The Appendices are an integral part of the Performance Standards. These document audit and SIU procedures designed to verify compliance with the Performance Standards and contain copies of statutes and regulations that are referenced in the Performance Standards. Revisions to existing laws or regulations are incorporated into the Appendices as these are promulgated.

A. Motor vehicle Body Payments

1. Service Times

   a. Servicing Carriers (SCs) must establish programs and procedures to ensure prompt settlements of warranted motor vehicle physical damage claims.

   b. SCs must establish procedures to permit prompt appraisal of damage at drive-in locations or in the field and to make prompt claim payments of motor vehicle physical damage claims.

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

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

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

   f. The Standard for payment of a first party motor vehicle 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. All SCs must have a Direct Payment Plan .

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

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

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

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

3. Parts Cost

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

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

    c. SCs 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

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

5. Total Loss Payments

    a. SCs shall not declare any motor vehicle a total loss when a prudent appraisal evaluation would have shown that the motor 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 motor vehicle must be determined based on the following requirements of Regulation 211 CMR 133.05 Determination of Value (Appendix E).

        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 motor vehicle, the insurer shall determine the motor vehicle's actual cash value. This determination shall be based on a consideration of all the following factors:

        1) The retail book value for an motor vehicle of like kind and quality, but for the damage incurred;

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

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

4) 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. SCs must be in compliance with the Salvage Title Law, G.L.c.90D, §20 (a through e) (Appendix G).

6. Towing and Storage Costs

a. SCs must have a plan to demonstrate that its staff has knowledge of and enforce all regulations applicable to towing and storage rates and conditions.

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

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

7. Appraisal of Damage and Reinspections

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

1) Compliance with Regulation 212 CMR 2.04 – The Appraisal and Repair of Damaged Vehicles (Appendix D).

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

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

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

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

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

B. Normal Claim Handling

1. Initial screening of reports of accidents and losses

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

d. The fraud indicators of CAR Special Investigations Unit (SIU) Standards and Fraud Profile shall be considered to determine possible warning signs of fraud (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, resolve any issues including garaging or operators, and notifying Underwriting where appropriate.

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

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

d. Documenting the damages or value of the motor vehicle.

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

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

3. Appraisal Program

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

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

4. Prompt Evaluation and Settlement

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

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

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

5. Department of Revenue (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 (Appendix H).

6. Subrogation/Recovery

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

C. Fraud Handling

1. Screening process for suspected fraudulent claims

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

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

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

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

2. Appraisal Program

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

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

3. Special Investigation

a. Claims identified as suspicious or suspected fraudulent shall be referred for more detailed special investigation and consideration given to referring the claim to Insurance Fraud Bureau (IFB), National Insurance Crime Bureau (NICB) and/or the 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 (Appendix A).

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

4. Evaluation and Settlement

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

D. Glass

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

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

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

5. SCs 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 motor vehicle, or the principal place of garaging of the motor vehicle.

E. 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 for training of 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 its customer service representatives.

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) 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 (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 document 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 (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 and consideration given to referring the claim to IFB, NICB, or appropriate law enforcement agency for prosecution (See Appendix A for other indicators).

2. Special Investigation

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

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

   c. 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 for training of 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 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

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 and consideration given to referring the claim to IFB, NICB, or appropriate law enforcement agency for prosecution (See Appendix A for other indicators).

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 shall be issued within 10 business days.

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

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

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

3. Evaluation and Settlement

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

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

B. CAR will conduct biennial audits of claims using a random sample in order to evaluate and compare the individual SC 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 SC.

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

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

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

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

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

   3. SCs shall have an Alternative Dispute Resolution Program.

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

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

A. 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 SCs.

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

1. 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 SCs prior to the biennial review provides background information on the claim handling programs established by the SC 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 the Statistical Plan data, SCs are required to report savings brought about by SIU activities for physical damage, bodily injury, and personal injury protection claims.

2. SCs 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. SCs 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 timeframes, 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, re-inspections, and ICPIP are set at MA statutory levels.

3. If it is determined that a SC 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:

Standard I – Motor Vehicle Physical Damage & Property Damage Liability Claims
Standard II – Bodily Injury & Uninsured/Underinsured Motorist
Standard III – No-Fault Personal Injury Protection Benefits
Standard V – Expenses

4. For Standard 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 SC. If CAR determines that the company is in non-compliance with the Voluntary/Ceded Claims Handling Differential Standard a penalty will be assessed.

B. Non Compliance Penalties

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

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

3. If in the review subsequent to being warned of major non-compliance a SC 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.

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

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

Standard I – Motor Vehicle Physical Damage & Property Damage Liability Claims
Standard II – Bodily Injury & Uninsured/Underinsured Motorist
Standard III – No-Fault Personal Injury Protection Benefits

Standard IV – Voluntary/Ceded Claim Handling Differential
Standard V – Expenses

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

7. 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 SC would be referred to the Governing Committee for possible termination.

8. Should a SC 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.

9. Should a SC disagree with the findings of the CAR Compliance Audit Department, it will notify the Governing Committee and a meeting will be held to discuss the findings. If agreement cannot be reached, the SC may appeal the decision to the Commissioner of Insurance 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

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

11. The following benchmarks and measurements are used to compare the SCs performance to the Industry on commercial claims handling. Except where noted, the benchmark compliance is 80%.

Best Practices	NAIC Standard	Measurement	Benchmark
Physical Damage/Property Damage			
Assignment/Contact	NAIC 1	• Appropriate assignment and contact to establish loss fact	
Coverage	NAIC 3, 7	• Coverage verified, garaging and 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 and 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/Recovery	NAIC 8	• Subrogation recognized and pursued • Reimbursement of deductible is timely and accurate when and where appropriate	

Best Practices	NAIC Standard	Measurement	Benchmark
Reinspections	NAIC 6, 9	• Compliance with Regulation 212 CMR 2.04	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	Contact
		• PIP form mailing - 5 days	
Reserving	NAIC 10	• Initial and subsequent reserves timely and appropriate; follow documented company policy	
Medical Management	NAIC 4, 5, 6, 11	• Claims warranting IME referral vs. claims referred for IME • 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/Recovery	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	

Best Practices	NAIC Standard	Measurement	Benchmark
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	
Subrogation/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 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	