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Performance Standards for the Payment and Handling of Private Passenger Motor Vehicle Insurance Claims
Docket No. C2011-01

Decision

Commonwealth Automobile Reinsurers ("CAR"), established pursuant to G.L. c. 175, §113H to administer the residual market for motor vehicle insurance, is required by statute to prepare performance standards for the handling and payment of motor vehicle insurance claims. It then submits those standards to the Commissioner of Insurance ("Commissioner") who, after a public hearing, may approve or modify them. On November 3, 2010 the CAR Governing Committee approved proposed changes to the Performance Standards for the Payment and Handling of Private Passenger Motor Vehicle Insurance Claims, last approved by the Commissioner on November 13, 2009. On February 11, 2011 the Commissioner issued a notice scheduling a hearing on March 8, 2011 to afford interested persons an opportunity to provide oral and written comments regarding the proposed standards. CAR, in response to the hearing notice, notified the Commissioner that Valerie Gedziun, its vice-president for compliance audit, would offer testimony in favor of the proposed standards at the hearing. No other person submitted a notice of intent to make a statement at the hearing. At the hearing, Ms. Gedziun submitted a statement supplementing the information that CAR previously provided on the reasons for revising the standards. Peter Abdelmaseh, executive director of the Alliance of Automotive Service Providers of Massachusetts, spoke on behalf of that organization.

The record shows that CAR's proposed changes to the private passenger motor vehicle claims handling performance standards were made in response to the full implementation of the Massachusetts Automobile Insurance Plan ("MAIP") and CAR's

adoption of a new Hybrid Audit Plan ("HAP"). Under HAP, claims review will focus on adherence to statutory requirements, particularly on verifying that companies consistently handle claims made under policies assigned through the MAIP and those made under voluntary policies, and that their Special Investigations Units provide effective fraud control. The revised standards retain the factors which are directly pertinent to claims handling that the Commissioner approved in 2009 but eliminate any that are no longer within the audit scope. The benchmark for compliance with best practices relating to claim resolution remains at 93 percent. The section in the current performance standards prescribing penalties for non-compliance has been substantially revised because those penalties were developed for use in a pooled residual market and are not applicable to the MAIP. If an audit indicates that an insurer has failed to meet its statutory obligations with respect to claims handling, and has not developed a satisfactory remedial action plan, the Governing Committee retains the authority to determine whether penalties are warranted. HAPs will be conducted on a three-year cycle, using consistent sample selections, and reports will be given concurrently to the insurer and the Commissioner.

At the close of the hearing CAR was requested to revise the proposed standards and to resubmit them to the Commissioner within 30 days. Because the revisions required Governing Committee approval, that date was later enlarged to April 22, 2011. On April 21, the CAR Governing Committee approved modifications to the proposed performance standards made in response to questions and comments made at the March 8 Hearing and transmitted them to the Commissioner.

CAR's Performance Standards for the Payment and Handling of Private Passenger Motor Vehicle Insurance Claims, as submitted to the Commissioner on April 21, 2011, are hereby approved.

Date: May 13, 2011

Jean F. Farrington
Presiding Officer

Affirmed:

Joseph G. Murphy
Commissioner of Insurance

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

Summary of Approved Changes
May 13, 2011

PERFORMANCE STANDARDS

Introduction

Massachusetts G.L.c.175, §113H requires Commonwealth Automobile Reinsurers (CAR) to establish Performance Standards designed to contain costs, ensure prompt customer service, payment of legitimate claims, and to resist inflated, fraudulent, and unwarranted claims. Periodic audits of members of the plan are required in order to determine whether there is a difference in claims handling between policies insured voluntarily and involuntary policies issued through the plan. The Performance Standards were last approved by the Commissioner of Insurance on November 13, 2009.

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

I. Auto Physical Damage & Property Damage Liability Claims

A. Auto Body Payments

8. a - f which pertains to the G.L. c. 100 § A8, the Motor Vehicle Repair Shop law, has been deleted in its entirety. Although ARCs should report infractions of the law by repair shops it is not part of the revised audit scope.

D. Glass

6. a - f which is the same language as above has been deleted in its entirety.

IV. Voluntary/ Involuntary Claim Handling Differential

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

B. Voluntary and MAIP claims will be reviewed for compliance with policy provisions and applicable statutes, rules, regulations, and Best Practices. Statistical testing will be conducted on each Best Practice Voluntary and MAIP score to determine if there is any statistical difference in handling.

Measurements

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

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

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

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

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

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

Non Compliance Penalties

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

APPENDICES

With the elimination of Appendix E - Regulation 211 CMR 93.00 that was repealed the subsequent appendices have been re-lettered.

Appendix A - Special Investigative Unit Standards

All references to Servicing Carriers have been changed to ARCs.

Appendix B: 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 Revised 2008

Appendix F: Regulation 211 CMR 133 - Standards for the Repair of Damaged Motor Vehicles

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..e)

Appendix I: M.G.L. Chapter 175: Section 24D_Insurance Claim Payment Intercept Program

Appendix J - CAR Compliance Audit Claim Review Process
Section 1. Private Passenger Policies

Effective April 2010 the Performance Standards Claims and SIU Reviews have been incorporated into the Hybrid Audit Plan approved by the Governing Committee in February 2010 and forwarded to the Division of Insurance. The Hybrid Audit Plan includes the Premium and Claims Statistical audits, Claims Performance Standards reviews, and SIU reviews.

The following procedures will replace the current Claims Review process contained in Appendix J and SIU procedures in Appendix K.

One of the four primary objectives of the audit is to verify adherence to statutory requirements. The review will evaluate the company's compliance with the key statutory requirements of MGL, c. 175, § 113 H:

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

Performance Standards

The Performance Standards approved by the Commissioner of Insurance on November 13, 2009 will remain in effect. Completion of the Questionnaire by the ARC will certify that its claims handling programs comply at a minimum with the Performance Standards.

Cycle and Sample

For all private passenger business, the current claim audits have transitioned to a three year cycle. In this new cycle, every actively reporting Member and ARC will be audited. The cycle will be continually evaluated as new Members enter the Massachusetts private passenger automobile insurance market. The ARC Questionnaire and internal documentation including, but not limited to, claim manuals, reserving and claim settlement procedures, and internal audits will be reviewed at the onset of the examination.

Under the Hybrid Audit Plan all of an individual Member or ARC compliance audits will be conducted concurrently using a consistent sample selection. The sample size will be 270 policies with at least one claim. Data for the Audit is verified at a 90% confidence level with a standard error rate of + 5% through stratified random sample audits for all functions.

Measurements & Penalties

Rather than measuring the individual Performance Standards on the benchmark of 90% for claim procedures Voluntary and MAIP claims will be reviewed for compliance with policy provisions and applicable statutes, rules, and regulations for the following Best Practices:

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

The benchmark for compliance with these Best Practices is 93% in accordance with the NAIC error tolerance of 7% for standards involving claim resolution.

Compliance will be measured as YES, NO, or NA. If NO, a COMMENT will be entered into the worksheet with an explanation. Chi square testing will be conducted on each Best Practice Voluntary and MAIP score to determine if there is any statistical difference in handling. If the aggregate score is less than 93% or the difference is statistically significant the Member or ARC will be required to address the reasons in their response and submit a remedial action plan. The Governing Committee will determine if a penalty should be assessed based on the recommendation of the Compliance Audit Committee.

Appendix K - CAR SIU File Review Process

ARCs are required by MGL, c. 175, § 113 H and Rule 30 to maintain a Special Investigative Unit to investigate suspicious or questionable motor vehicle insurance claims for the purpose of eliminating fraud. Rule 32 C. requires that special investigative units investigate claims on any policies that are issued through MAIP and on policies issued on a voluntary basis by ARCs. An SIU must have at least one full time employee whose responsibility is principally directed towards the recognition and investigation of fraud.

ARCs will continue to report SIU activity - assignments, denials, compromises, and savings to CAR on a quarterly basis along with their log identifying those cases. During the triennial audit a sample of cases selected from the SIU log will be reviewed to determine the effectiveness of the Carriers' fraud screening and quality of the SIU investigations.

Appendix L – Questionnaire

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

Appendix M - Industry Best Practices - Performance Standards

Appendix N - NAIC Standards - CAR Rule 32 & Performance Standards

All references to Servicing Carriers have been changed to ARCs.

All references to Rule 10 have been changed to Rule 32.

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

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

Introduction

Massachusetts G.L.c.175, §113H requires Commonwealth Automobile Reinsurers (CAR) to establish Performance Standards designed to contain costs, ensure prompt customer service, payment of legitimate claims, and to resist inflated, fraudulent, and unwarranted claims. Periodic audits of members of the plan are required in order to determine whether there is a difference in claims handling between policies insured voluntarily and involuntary policies issued through the plan. The Performance Standards were last approved by the Commissioner of Insurance on November 13, 2009.

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

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

The Performance Standards 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.

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

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

Appendix A – Special Investigative Unit Standards

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

Appendix B – Regulation 211 CMR 123.00
Direct Payment of Motor Vehicle Collision and Comprehensive Coverage Claims and Referral Repair Shop Programs

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

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

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

Regulation 212 CMR 2.00 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 in 2008 to include Section (i) Expedited Supplemental Appraisals. It is intended to be read in conjunction with 211 CMR 133.00, which follows in Appendix F.

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

Regulation 211 CMR 133.00 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 E.

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

This regulation was revised effective July 24, 2009 by Commissioner of Insurance Nonnie S. Burnes.

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

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

Appendix J - CAR Compliance Audit Claim Review Process

This section incorporates the selection of the sample, review procedures, and criteria to conduct these examinations. As of April 2010 the Claims and SIU reviews have been incorporated into the Audit Plan.

Appendix K - SIU File Review Process

CAR's SIU conducts a triennial review of the ARCs' 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 M – Questionnaire

The Questionnaire will be sent to the ARC prior to the commencement of CAR's periodic review in order to provide background information on claims handling programs established by the ARC.

Completion of the Questionnaire will certify that the ARC's claims handling practices comply at a minimum with the approved Performance Standards.

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

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 Payments

The Bulletin issued by Commissioner of Insurance Nonnie S. Burnes on September 16, 2008 clarifying the coordination of benefits between PIP, Health Insurance, and Medical Payments has been added to the Appendices.

Performance Standards for the Handling and Payment
Of Claims by ARCs

I. Auto Physical Damage & Property Damage Liability Claims

A. Auto Body Payments

1. Service Times

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

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

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

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

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

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

2. Direct Payment Plan

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

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

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

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

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

3. Parts Cost

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

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

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

4. Labor Rates and Times

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

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

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

5. Total Loss Payments

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

b. The actual cash value of any vehicle must be determined based on the following requirements of Regulation 211 CMR 133.05 Determination of Value (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. ARCs must be in compliance with the Salvage Title Law, Chapter 90D, section 20 (a..e).

6. Towing and Storage Costs

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

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

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

7. Appraisal of Damage and Reinspections

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

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

2) Scoping and completing an appraisal

3) Use of aftermarket, rebuilt, LKQ parts

4) Open items and supplements

5) Refinishing

6) Depreciation and betterment

7) Unrelated damage

8) Structural damage

9) ACV estimating

10) Screening for fraudulent claims

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

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

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. ARCs must establish procedures to comply with the various claims requirements of the mandatory pre-insurance 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, attached) 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 with involved parties to secure sufficient documentation of facts involving accident circumstances, to verify occurrence, and to establish degree of fault should be timely and, in cases where no injuries reported, appropriate to the loss.

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. ARCs 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 ARC must comply with the requirements of the Insurance Claim Payment Intercept Program, M.G.L. Chapter 175, Section 24D. NOTE: Failure to comply with M.G.L. Chapter 175, Section 24D will subject the ARC to penalties proscribed by the Department of Revenue. These penalties will be in lieu of those penalties imposed for non compliance with the Performance Standards.

6. <u>Subrogation</u>/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, attached) 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 special investigation is complete, a decision must be made to pay the claim or resist. The claim file must clearly document the basis for the decision and result.

D. Glass

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

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

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

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

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

E. Fraud Training

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

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

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

II. Bodily Injury & Uninsured/Underinsured Motorist

A. Normal Claim Handling

1. Initial Screening of Reports of Accident and Losses

a. All new notices 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, & 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 ARC reporting and authority levels followed.

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

6. Settlement Negotiations or Denial

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

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. ARCs 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. ARCs 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 ARC must comply with the requirements of the Insurance Claim Payment Intercept Program, M.G.L. Chapter 175, Section 24D. NOTE: Failure to comply with M.G.L. Chapter 175, Section 24D will subject the ARC to penalties proscribed by the Department of Revenue. These penalties will be in lieu of those penalties imposed for non compliance with the Performance Standards.

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

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

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

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, 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 or, if preferred by the consumer, electronically sent to the address they specify within 5 business days after notice of injury.

C. Medical Management

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

2. Any plan 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. ARCs 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 are 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/ Involuntary Claim Handling Differential

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

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

V. Expenses

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

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

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

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

3. ARCs should have an Alternative Dispute Resolution Program.

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

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

Measurements & Penalties

Measurements

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

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

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

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

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

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

Non Compliance Penalties

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

Appendix A
Section 1 - MAIP Policies

CAR Special Investigative Units Standards

The reduction of insurance fraud, by monitoring and coordinating the investigation of suspicious claims, is an important goal of Commonwealth Automobile Reinsurers. It seeks the achievement of three beneficial results:

1. Successful resistance to the payment of fraudulent claims,

2. The establishment of a deterrent to fraud, and

3. The reduction of losses, with the consequent improvement in insurance rates.

In order to achieve these results, ARCs must pursue the investigation of fraud by establishing a commitment to support and encourage the activities of their Special Investigative Units.

CAR Special Investigative Unit

The CAR Special Investigative Unit exists under the authority of Article III of the Plan of Operation. It is charged with monitoring the efforts of Servicing Carriers to control fraud. In addition, it will assist Members and ARCs on request. CAR will perform a triennial audit of the Special Investigative Unit of each ARC as part of the HAP audit to evaluate its effectiveness.

Assistance of the CAR Special Investigative Unit is intended to provide expert investigation beyond the capabilities of the average Servicing Carrier's investigator. The basic investigation of a suspicious claim is the responsibility of the ARC. CAR Special Investigative Unit will also assist with the coordination of an investigation involving several ARCs.

CAR Standards for Servicing Carrier Special Investigative Units

CAR evaluations of ARC's Special Investigative Units will be based on their performance in accordance with the following guidelines:

1. Each Servicing Carrier is required by Article IV of the Plan of Operation to maintain a Special Investigative Unit to investigate suspicious claims for the purpose of eliminating fraud. A Special Investigative Unit shall be staffed by experienced salaried employees who are adequately trained in the recognition and investigation of insurance fraud. An SIU must have at least one full time employee whose responsibility is principally directed towards the recognition and investigation of fraud. The work of a Special Investigative Unit may be supplemented by closely supervised independent adjusters or investigators.

2. Each ARC shall ensure that all automobile insurance claims, where there is a suspicion of fraud, are referred promptly to its Special Investigative Unit.

3. Each ARC SIU shall maintain a log of cases referred to it containing at least the following information:

Date of Referral
Date of Loss
Claim Number
Policyholder
Type of Claim
Amount of Claim
Amount Paid
Date Completed

Copies of active pages of the log shall either be mailed or submitted electronically at the end of each calendar quarter to:

Commonwealth Automobile Reinsurers
225 Franklin Street
Boston, MA 02110

ATTN: Special Investigative Unit

4. Regulation 211 CMR 75.00 establishes the National Insurance Crime Bureau as the central organization engaged in motor vehicle loss prevention as required by Section 113-0 of Chapter 175. It also requires certain actions by insurers with respect to theft claims. An insurer must, among other things:

A. report all thefts to National Insurance Crime Bureau,

B. obtain National Insurance Crime Bureau's acknowledgement before paying claims,

C. report disposition of salvage,

D. investigate and report evidence of fraud, and

E. defer payment in certain circumstances.

5. The National Insurance Crime Bureau (NICB) has been established as the central organization to whom insurance companies report cases of bodily injury fraud for possible further action with law enforcement agencies and criminal prosecuting authorities.

In all cases where careful further investigation has established the strong possibility of bodily injury fraud, the ARC should forward a complete photocopy of the claim file to NICB for further consideration and action.

If a ARC is not a member of NICB, the ARC may refer such case directly to the appropriate local law enforcement agency for consideration of criminal prosecution.

6. The attached AUTO FRAUD PROFILE identifies circumstances in which an auto theft or fire claim should be considered suspicious. Such claims warrant careful investigation into the possibility of fraud.

7. Both law and equity dictate that a prompt and thorough investigation precede any decision with respect to payment or denial of a claim. The provisions of Chapters 93A and 176D must be borne in mind at all times. Penalties incurred by members for violations of these laws are subject to reimbursement by CAR and may not be reported as loss or allocated expense.

8. The quality of investigation performed by an SIU is an important criterion of its effectiveness. It will be given careful consideration by CAR during an audit. It is not possible to outline every avenue of the investigation of a suspicious claim; it is limited to only by the experience and imagination of the investigator. There are, however, certain elements which are common to the investigation of suspicious fire or theft claims that should be covered in every such case referred to an SIU, or the file should reflect the reasons why they were not. They are the "guidelines" which follow:

CAR Standards for investigation of Collision and Comprehensive Losses

1. Interviews of Owner, Custodian, Companions, Witnesses, etc.

A recorded statement should be obtained from the owner of the vehicle, exploring in depth and in detail the areas described below. Statements of others with knowledge of some or all of the circumstances are also important.

The Individual Interviewed

Name, Address, Date of Birth, Occupation, Employer

The Vehicle

Year, make, model, identification number. When purchased, from whom, amount paid, vehicle traded in, amount allowed. If used, condition, odometer reading, improvements, if any, by insured. Amount borrowed, from whom, term of loan. Where kept when not in use. Who uses car, purpose. Service, inspection, repair. Problems.

Insurance

How long insured by this company. If short time, former carrier. Any other insurance. Recent changes of coverage. History of claims.

The Loss

Date, time, and place. Description of event. When and how the vehicle got to that location. Purpose of its presence there. Identity of witnesses. Was car locked. Who had keys. Activities between leaving car and discovery of loss. Time, place, and method of report to police. Identity of those responsible.

2. Police

The owner or custodian of a vehicle which is stolen or substantially damaged must report in writing to the police. An insurer may not pay a theft claim until it has confirmed the existence of such a report. Its file should contain a copy of the report or an explanation of its absence. Police reports of the recovery of a vehicle and any investigation should be obtained. Interviews of police officers are useful in selected cases. The possibility of investigation by other governmental agencies should be considered if the claim appears to be part of an organized pattern of activity.

3. Claim History

A record of the policyholder's prior losses should be obtained. The record, per se, is not evidence of impropriety, but an extensive record warrants a study of the claim files to identify patterns of activity or other information of interest. This is a fruitful source of leads.

4. Insurance

A study of the underwriting file should be undertaken. A recent application and/or changes of vehicle or coverage may suggest premeditation.

5. Mortgagee

Inquire via telephone about the timeliness of installment payments and the amount of the loan outstanding. A history of late payments and/or a delinquency of several months suggest financial difficulty which might motivate one to destroy his/her automobile.

6. Ownership and Value

Copies of the Bill of Sale, the Application for Title and/or Registration, and the Title should be obtained. These establish ownership, identify the prior owner, and establish the value at the time of purchase. Inconsistencies of purchase price suggest dishonesty. Seek verification by the seller of the price and condition at the time of sale. Be alert to prior use as a public or private livery vehicle.

7. Betterment

It is often claimed that the value of a vehicle has been enhanced by the addition of special equipment or by cosmetic improvements. Receipts for such things should be requested, and if received, verified.

8. Service and Repair

The interview with the policyholder and the examination of the vehicle should cover the service and repair history of the vehicle. The inspection sticker and stickers recording oil changes and lubrication will provide leads, as may the contents of the glove compartment. Investigate recent service and repair activity to identify problems which might provide a motive for destroying the automobile.

9. The Vehicle (When available)

A careful, thorough, and early examination of the vehicle is important.

A. Start with the plate bearing the vehicle identification number. Look for evidence of tampering, either of the plate itself or of the rivets that hold it in place. Record the complete number by placing a paper over it and rubbing it with a pencil. Report whether the number is consistent with the type and model of the vehicle and consistent with the policy.

B. Abundant clear photographs should be obtained of the engine, passenger, and trunk compartments and all areas of the exterior, including wheels and tires. The engine, the ignition lock, and the registration plate particularly are important. Don’t mark the face of a photograph; it may destroy its value as evidence.

C. Determine the odometer reading. Report whether it is consistent with the age and condition of the vehicle and with the mileage reported by the owner.

D. Examine the ignition lock. Report whether there is evidence of damage and whether it contained a key.

E. Report whether the glove or trunk compartments contain the usual articles. Take possession of bills related to service, repair, or improvements. A thief has no interest in the usual contents; their absence may suggest removal by the owner in anticipation of a loss.

F. Examine the inspection sticker. Report when and where it was inspected, whether it is current, or whether there is a rejection sticker.

G. Examine the registration plate. Report the date of expiration.

H. Record date on service or oil change stickers.

I. Try to distinguish old damage from new. The presence or absence of dirt and/or rust should be considered. Report evidence of recent changes of wheels or tires.

J. Consideration should be given to wear and tear, mechanical and electrical failures, and missing parts and equipment.

K. Determine the level and condition of crankcase and transmission oil, brake fluid, and radiator coolant.

L. In selected cases, a professional analysis of the ignition, the engine, or the transmission may be warranted.

Auto Fraud Profile

The following items should serve as indicators in determining whether an investigation, beyond normal claim handling, is justified in the processing of all automobile claims. None of these indicators is necessarily incriminating. Perfectly appropriate claims can often bear these characteristics. These items are presented only to provoke further thought on the part of the claim adjusters when one or more of the indicia are present. A common sense approach to potential fraud investigation is recommended; therefore, any factor that suggests that a fraudulent claim is being made is worth discussing with your SIU.

Collision & Comprehensive Fraud Indicators

Vehicle

- Late model vehicle with unusually high mileage
- Excessive mileage on leased vehicles
- Completely burned
- Previous total loss
- High value extras on inexpensive vehicle
- Missing parts surgically removed
- Allegedly numerous repairs prior to theft
- Registered other than in the state of residence.
- Extensive collision damage, especially if no collision coverage
- Gray market foreign car or American diesel.
- Inspection sticker expired, altered or otherwise defective
- NICB difficulty in matching the VIN to the vehicle
- Ignition or steering lock intact
- Purchase price exceptionally low

Loss

- Loss near inception of policy
- Fire late at night in remote area
- Loss prior to titling and registration
- Loss reported unusually late
- Loss near date of cancellation

Insured

- Occupation does not justify expensive vehicle
- Insured or friend locates the stolen vehicle
- Insured avoids use of mail
- No report to police
- Loan payments late
- Bad loss record
- Insured is suspiciously knowledgeable of insurance terminology and the claim process
- Insured is evasive as to identity of prior owner of vehicle
- Insured exceptionally anxious to settle
- Insured wants to retain total loss
- Insured uses PO Box, hotel, or motel as his or her policy address
- Insured recently purchased stated value
- Insured in obvious financial difficulty
- Insured has no phone and cannot be contacted at work.
- Insured is unemployed and without visible means of support

Coverage

- Coverage increased just prior to loss
- No lienholder on new model, or lienholder is an individual rather than a lending institution

Purchase

- Title a duplicate, or none available
- Previous owner cannot be located

Bodily Injury, Including No-Fault

The Accident

- No witness
- Police report fails to verify accident, or presence of claimants fails to verify any injury on the part of any claimant
- Other auto in the accident denies involvement
- Too many claimants for described accident
- Any allegation of intentional involvement
- Description of accident does not support injuries claimed
- Claimant or insured is difficult to find, claims to be self employed, or employed by another family member

The Vehicle

- No verification that described vehicle involved
- Damage seems too minor for injuries alleged
- Extent and location of damage do not match allegations

Injuries & Damages

- Injuries appear to be excessive in light of details of the accident or appear unrelated to the accident
- Treatment appears excessive for the type of injury, indicative of build-up to exceed tort threshold
- Injuries are limited to soft tissue, and recovery appears to be unusually prolonged
- Index history shows a history of claims
- The attorney and physician involved have appeared on a number of questionable cases
- Medical bills received are reproductions of originals or bear evidence of alterations
- Wage loss not verified or wage verification form not signed, bears questionable signature or is suspicious

211 CMR 123.00: DIRECT PAYMENT OF MOTOR VEHICLE COLLISION AND COMPREHENSIVE COVERAGE CLAIMS AND REFERRAL REPAIR SHOP PROGRAMS

Section

123.01: Authority

211 CMR 123.00 is issued under the authority of M.G.L. c. 90, M.G.L. c. 175, and M.G.L. c. 176D.

123.02: Purpose and Scope

The purpose of 211 CMR 123.00 is to establish a procedure for approval of direct payment and referral repair shop plans by motor vehicle insurers for collision, limited collision and comprehensive insurance claims, and to establish the minimum requirements for such plans.

123.03: Definitions

As used in 211 CMR 123.00, the following words will have the meanings indicated:

Claimant means any person making a claim for motor vehicle damage or loss for first party damages.

Collision coverage means that optional coverage defined in M.G.L. c. 90, § 34O(1) offered as part of a motor vehicle liability policy or bond.

Commissioner means the Commissioner of Insurance appointed under the provisions of M.G.L. c. 26, § 6, or his or her designee.

Comprehensive coverage means that optional coverage defined in M.G.L. c. 175, § 113O as fire and theft coverage or comprehensive coverage, so-called, offered as part of a motor vehicle liability policy or bond.

Insurer means any insurance company authorized to write motor vehicle insurance in the Commonwealth.

Limited collision coverage means that optional coverage defined in M.G.L. c. 90, § 34O(2) offered as part of a motor vehicle policy or bond.

Motor vehicle insurance means motor vehicle liability policies or bonds as defined in M.G.L. c. 90, §§ 34A, 34O, and in M.G.L. c. 175.

Plan means a detailed proposal or filing describing a formal direct payment and referral program based on a written plan.

123.03: continued

Rating organization means an insurance rating organization licensed under M.G.L. c. 175A.

Repair shop means a motor vehicle repair shop as defined in M.G.L. c. 100A, § 1, but not including glass specialty shops and shops which primarily sell tires or audio equipment.

123.04: Procedure for Approval of Plans

(1) Who May File: Any insurer may file a direct payment plan for approval by the Commissioner. Any licensed insurance rating organization may file a direct payment plan on behalf of its members ("industry plan"), provided that each insurer member of the rating organization which intends to implement such plan shall individually file notice of its intention to adopt the industry plan before actively implementing the plan. Any insurer may file for approval a plan which adopts some provisions of an industry plan without adopting the entire plan, but to the extent such individual plan deviates from the industry plan by omitting, adding or changing any particular provision, it shall require separate approval by the Commissioner. Any insurer filing a plan which deviates from an industry plan shall specify in detail the differences between the plans.

(2) Time for Filing: Any plan which is intended to be effective on January 1, 1989, shall be filed on or before December 15, 1988. Any plan which is intended to be effective after January 1, 1989 shall be filed at least 60 days prior to its effective date. Any notice of an insurer's intention to adopt an industry plan shall be filed at least 14 days prior to the insurer's implementation of the said plan, but in no event shall the insurer's implementation of the plan take place prior to the effective date of the industry plan, provided such plan has been approved.

(3) Method of Filing: An insurer or rating organization seeking approval of a plan shall file five copies of the proposed plan with the Commissioner. Any form intended to be used in connection with a proposed plan and which is to be delivered to consumers shall be included in the filing.

(4) Consideration of Proposed Plan: Upon receipt of a proposed plan, the Commissioner shall promptly schedule a hearing to determine whether the plan is consistent with M.G.L. c. 90, § 34O and M.G.L. c. 175, § 113O, as amended, with 211 CMR 123.000, and with other applicable laws and regulations, and whether the plan would carry out the purposes of M.G.L. c. 90, § 34O and M.G.L. c. 175, § 113O. No hearing shall be required in connection with an insurer's plan which the Commissioner determines does not substantially deviate from a previously approved plan. The Commissioner may schedule more than one plan to be considered at any given hearing. The Commissioner may require an insurer or any other party to the hearing to submit other or further information for purposes of considering the plan. The insurer or rating organization which filed the plan, and any other interested person, may file written materials in support of or in opposition to the plan.

(5) Timing of Hearing: With respect to any plan for which a hearing is required and which is filed to be effective on January 1, 1989, the Commissioner shall schedule the hearing thereon for such date as will allow a full and fair consideration of the plan, and as will allow the issuance of a decision approving or disapproving the plan prior to January 1, 1989. With respect to any other plan for which a hearing is required, the Commissioner shall schedule the hearing thereon to begin no less than 21 days after the plan is filed. The party filing the plan and other persons affected shall be notified of the date of the hearing at least ten days in advance.

(6) Approval or Disapproval of Plan: After a hearing, the Commissioner shall approve or disapprove the plan in writing and if the plan is disapproved or modified, shall state the reasons for the decision. Approval of a plan may be conditioned upon its modification, including a change in its effective date. The Commissioner may, prior to approving or disapproving a plan, request the party filing it to supplement or modify it.

123.04: continued

(7) Effective Date of Plan: The benefits of an approved plan shall be made available to all claimants submitting claims arising from accidents or other losses occurring on or after the effective date of the plan, unless and until the approval of the plan is revoked or the plan is otherwise terminated in accordance with 211 CMR 123.04(9), or unless and until the insurer implementing such plan ceases to do so in accordance with 211 CMR 123.04(10).

(8) Reconsideration: Within ten days after the disapproval of a plan, any affected person may request reconsideration. Such request may be allowed only if the person submitting such request presents new and previously unavailable information which the Commissioner determines should be considered in evaluating the plan.

(9) Revocation of Approval: At any time after approval of a plan, the Commissioner may, after due investigation, commence proceedings to revoke or suspend such approval if he or she determines the insurer is not complying with the terms of the plan or that the plan does not carry out the intent of 108 CMR 123.00. He or she shall commence such proceedings by issuing an order to show cause why the approval of such plan should not be revoked or suspended, which shall briefly set forth the asserted grounds for revocation or suspension. The party which filed the plan, any insurer which has filed a notice that it intends to adopt or has adopted an industry plan, and any interested person may appear at the hearing. The Commissioner may schedule the revocation of more than one plan to be considered at any given hearing. After such hearing, the Commissioner shall issue a written decision, stating reasons for any determination to revoke or suspend approval of the plan. Non-revocation may be conditioned upon modification of the plan or other means of compliance with 211 CMR 123.00. Unless the Commissioner for good cause orders otherwise, the institution of revocation proceedings shall not act to enjoin or suspend the operation of the plan as originally approved. The Commissioner may, instead of or in addition to revocation or suspension, impose fines or other appropriate sanctions under M.G.L. c. 175 and 176D for any violations of law or of 108 CMR 123.00.

(10) Voluntary Withdrawal of Plan: Any party which has filed or adopted a plan may voluntarily withdraw such plan, or voluntarily withdraw its notice of intention to implement an industry plan, prior to the Commissioner's final approval of the plan. After that date, no insurer intending to implement or actively implementing such plan shall cease implementing the plan without first notifying the Commissioner of its intent to do so at least 60 days in advance. The Commissioner may make any orders reasonably necessary to prevent such cessation from causing undue hardship to consumers or disruption to the automobile repair market, but in no event shall such cessation be delayed, without the consent of the insurer, for more than six months, unless the insurer fails to comply with orders of the Commissioner relating to the cessation.

123.05: Direct Payment Plans: Required Provisions

No plan shall be approved unless it contains each of the following provisions:

(1) Payment to the claimant: The insurer shall offer to pay every claimant for the loss of or damage to the insured motor vehicle under collision coverage, limited collision coverage or comprehensive coverage the full amount, less any applicable deductible, of the cost of repair of the damage as described in an appraisal made by a licensed automobile damage appraiser employed or designated by the insurer, subject to the terms and conditions of the applicable insurance policy. In the case of property damage liability claims, the insurer may make such offer to the person to whom such liability payments are owed.

Unless such direct payment is refused by the claimant, the insurer shall make such payment at the time of, or within five business days after, the preparation of said appraisal. In no event shall payment be made prior to provision of a copy of the appraisal to the claimant. Nothing in 108 CMR 123.05 be construed to affect the right of any insurer to delay payment for a period of time reasonably necessary to investigate any claim before authorizing repair work or making payment on such claim.

123.05: continued

If the claimant refuses such direct payment, the insurer shall comply with applicable laws and regulations relating to such payments without regard to the plan.

(2) Form of Payment: The payments described in 211 CMR 123.05(1) shall be in cash or a negotiable instrument payable to the claimant, and the lienholder, if applicable.

(3) Repair certification: Each claimant shall receive, with the appraisal and direct payment check, a repair certification form, the form for which shall be included as part of the filed plan. The repair certification form shall at a minimum contain the following:

(a) An explanation of the claimant's rights and obligations with respect thereto.

(b) Certification that the repair work has been completed.

(c) Identification of the repair shop or individual who performed the repair work.

(d) An agreement that the claimant will permit the insurer to reinspect the repaired vehicle within a reasonable period of time after the return of the repair certification form.

The claimant shall return the repair certification form to the insurer upon completion of the repairs. If the claimant elects not to repair the vehicle or if the repair certification form is not returned to the insurer, the actual cash value of the insured vehicle will be reduced by the amount of the claim payment plus any applicable deductible, unless and until such time as the insurer or any successor insurer receives a repair certification form.

(4) Resolution of Consumer Disputes: If the claimant disputes the accuracy of the appraisal or the amount of the payment based thereon, the insurer shall resolve such dispute as follows:

(a) The claimant, or the claimant's representative or repair shop at the direction of the claimant, must notify the insurer by telephone or in writing if the cost of repairs is expected to exceed the amount of the payment plus any applicable deductible and the claimant is seeking to have the insurer pay any part of the difference. Such notice must be prior to, or in the course of, the repair work.

(b) The insurer shall promptly evaluate the source of any differences between the insurer's appraisal and the cost of repairs and either authorize or deny a supplemental payment within three business days after the notification of such difference and inspection of the vehicle. During such three-day period, the insurer may inspect the vehicle, and if it so requests, the claimant or repair shop shall make the vehicle available for inspection by the insurer. The insurer shall not delay such inspection for more than three days without the consent of the claimant. If the insurer makes a timely request for inspection the insurer will either authorize or deny a supplemental payment within three business days after the inspection. The claimant may direct the insurer to make any supplemental payment to the repair shop, provided the repair shop is registered under M.G.L. c. 100A. Otherwise, any supplemental payment must be made directly to the claimant.

(c) If the claimant and the insurer are unable to reach agreement as to any dispute as to the amount of the payment by the insurer, either party may demand arbitration of the dispute. The demand for arbitration must be in writing and it must include an appraisal of the cost of the repair prepared by a licensed automobile damage appraiser and an itemized bill for the actual cost of the repair, if the repair has been completed. The arbitration will be conducted pursuant to General Provision Section 11 of the Massachusetts Standard Automobile Insurance Policy and the applicable provisions of M.G.L. c. 175, § 191A. Notwithstanding this provision, the claimant may, without prejudice, pursue any other remedy which may be available.

(d) If the repair is made at a registered repair shop which is an insurer referral shop as provided in 211 CMR 123.06, neither the repair shop nor the insurer shall require the claimant to pay more than the amount of the direct payment plus the amount of any applicable deductible to have the repair work completed, and any dispute as to the amount of the appraised damage shall be resolved between the referral repair shop and the insurer.

(5) Repair Shop Referral: The plan must provide for referral insurer referral repair shops as provided in 211 CMR 123.06.

(6) Disclosures to Consumers: The plan must provide for full and accurate disclosures to consumers as provided in 211 CMR 123.07.

123.06: Referral Repair Shop Programs

(1) Consumer's Choice of Shop: No direct payment plan approved under 211 CMR 123.000, and no insurer in implementing such plan, shall require a claimant to have repairs made at any specific repair shop.

(2) Number of Shops:

(a) Every plan must provide that every claimant will be given a single list containing the names and locations of all registered repair shops as defined in 211 CMR 123.03 that appear on the list of registered repair shops maintained by the Division of Standards pursuant to M.G.L. c. 100A, § 6. The insurer may indicate by clearly marking with an asterisk or other means of highlighting on the list of all registered repair shops at least five repair shops geographically convenient for the claimant which will perform the repairs on referred claims without undue delay. An insurer shall not provide a separate list containing only its referral shops. A repair shop may not be an insurer's referral shop unless that repair shop appears on the list of all registered repair shops maintained by the Division of Standards and complies with the provisions of M.G.L. c. 100A. The claimant may or may not choose to use an insurer's referral shop.

(b) The list of all registered repair shops maintained by the Division of Standards pursuant to M.G.L. c. 100A, § 6 shall be updated quarterly. The Automobile Insurers Bureau of Massachusetts or any successor thereto shall maintain a separate list containing the names and locations of all registered repair shops as defined in 211 CMR 123.03 that appear on the list maintained by the Division of Standards. For the purposes stated in 211 CMR 123.06(2)(a), every insurer with an approved Direct Payment Plan shall reproduce the listing of all registered repair shops maintained by the Automobile Insurers Bureau of Massachusetts or any successor thereto. The list given to the claimants by the insurers pursuant to 211 CMR 123.06(2)(a) shall not exceed 12 standard size (8½ by 11 inches) pages unless the Commissioner has given a written waiver of this requirement.

(c) Any individual insurer wishing to implement a plan which does not contain at least five repair referral shops geographically convenient for the claimant which will perform the repairs on referred claims may petition the Commissioner for a waiver of this requirement. The insurer seeking such a waiver shall set forth the specific facts regarding market share, geographic location, availability of repair shops, or other circumstances in support of its petition. No insurer may implement a plan which does not meet this requirement unless and until the Commissioner has granted a petition for waiver.

(3) Insurer's Choice of Shops:

(a) Insurer's referral shops shall include only shops:

1. which are registered repair shops; and
2. which have entered into an agreement satisfactory to the insurer, to complete repairs for claimants referred by the insurer without undue delay, for the amount of the direct payment to the insured plus any applicable deductible, plus any supplemental payment authorized by the insurer.

(b) In determining which registered repair shops will be referral shops, the insurer shall consider all of the following criteria, and only the following criteria: the quality and cost of repairs at a particular shop, the quality of the service given the customer, the responsiveness of the shop to the customer's needs, the ability of the shop to perform repairs without undue delay, the geographic convenience of the shop for the claimant, cooperation of the shop with the pre- and post-repair inspections and the shop's compliance with applicable laws and regulations.

Each individual insurer shall maintain written guidelines incorporating these criteria as applied by the insurer in implementing its plan; such guidelines shall be deemed to be a part of the individual insurer's plan. While individual insurers which have adopted an industry plan shall maintain such written guidelines, under no circumstances shall a rating organization which files an industry plan propose or maintain such guidelines. Individual insurers' guidelines shall be made available to the Commissioner upon his or her request and shall also be made available to any repair shop in the event the insurer denies that shop's request to be a referral shop or revokes the referral shop agreement of any referral shop.

123.06: continued

A repair shop shall be included as an insurer's referral shop if the shop agrees in writing to comply fully with the plan, unless the shop's request is denied or the shop's referral shop agreement is revoked pursuant to 211 CMR 123.06(4), and is determined by the insurer not to satisfy one or more of the criteria listed above. The form of agreement between the insurer and the insurer's referral shops may provide adequate assurances that the repair shop will continue to satisfy the insurer as to such criteria.

(4) Development and Changes of Referral Shops: An insurer may deny a repair shop's request to be a referral shop or revoke a referral shop's agreement, provided the insurer files a statement with the Commissioner specifying the nature of the shop's failure to comply with the plan or with the agreement or proposed agreement between the insurer and the repair shop. A repair shop which claims that it has been improperly denied as a referral shop or whose referral shop agreement has been revoked may demand arbitration. Such binding arbitration shall be conducted by a neutral arbitrator jointly agreed to by the insurer and the repair shop, or, in the absence of such agreement, within 21 days of submission of the request for arbitration to the insurer, by an arbitrator selected by the Commissioner. The parties to the arbitration shall bear the costs of the arbitration equally, but the losing party shall be liable to the prevailing party for its costs, unless the arbitrator orders otherwise. If the arbitrator finds that the losing party acted in bad faith, he or she may also award the prevailing party attorney's fees, if any. The arbitrator shall determine whether the repair shop was improperly denied, but shall make no finding or order as to any damages other than the award of costs and/or attorney's fees, if any. The decision of the arbitrator shall be final.

(5) Insurer's Guarantee: If a claimant has repairs performed at a repair shop included on the insurer's list, then the insurer shall guarantee the quality of the materials and workmanship used in making the repairs. No insurer may petition the Commissioner for a waiver of this requirement. This guarantee by the insurer shall be in addition to all other guarantees which may be made by the manufacturer and the repair shop. The agreement between the insurer and the repair shop may provide for indemnification of the insurer by the repair shop for any costs associated with such guarantee under such terms and conditions as the parties to the agreement shall specify.

(6) Reinspection Requirements: Every plan shall provide that the insurer shall have a licensed automobile damage appraiser reinspect vehicles following completion of repairs as follows:

(a) with respect to repairs as to which the appraisal indicates that the cost is expected to exceed $4,000, at least 75% of such vehicles shall be reinspected;

(b) with respect to repairs as to which the appraisal indicates that the cost is not expected to exceed $4,000, at least 25% of such vehicles shall be reinspected.

In no event shall the selection of vehicles for reinspection be based on the age or sex of the policyholder or of the customary operators of the vehicle, or on the principal place of garaging the vehicle, or on whether the repairs were performed at a repair shop that is not a referral repair shop.

(7) Conflicts of Interest:

(a) No employee or agent of an insurer with responsibility for entering into referral shop agreements as prescribed in 211 CMR 123.06(3) shall receive or ask for any payment, gift or any other thing of value from any repair shop seeking to be a referral shop or from any referral shop. No repair shop, or employee or owner thereof, shall give, pay or offer to give or pay, any thing of value to any employee or agent of an insurer with responsibility for creating, managing or maintaining a list of repair shops. No repair shop, or employee, owner or agent thereof, shall give or pay, or offer to give or pay, or offer to give or pay, any thing of value to any person in exchange for being included, or as an inducement for being included, as an insurer's referral shop. For purposes of 211 CMR 123.08(7)(a), the words "employee", "owner" and "agent" shall also include any spouse or child of an employee, owner or agent.

123.06: continued

(b) 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 211 CMR 123.06(7)(a).

123.07: Disclosures to Consumers

Every claimant under a plan shall be given full and adequate disclosure on a form approved by the Commissioner. The disclosure form shall be given to the claimant prior to, or at the same time as, any payment being made. The disclosure form shall be given with the appraisal and at such other times as the insurer may determine, and shall state, with the appraisal and at such other times as the insurer may determine, and shall state that:

(1) the claimant may elect to accept direct payment under the plan and receive a list of all registered repair shops pursuant to 211 CMR 123.06(2), or he or she may choose to pursue the claim without regard to the plan;

(2) if the claimant accepts direct payment, he or she may choose to have repairs made at any repair shop, whether or not the shop is an insurer's referral shop;

(3) if the claimant accepts direct payment, the claimant may choose a shop that is an insurer's referral shop in which case the insurer will guarantee the materials and workmanship of the repair, and the cost of the repair to the claimant will not exceed the amount of the insurer's direct payment to the claimant plus any applicable deductible.

(4) the procedure for resolving claimants' disputes under the plan; and

(5) such other information as will aid the claimant in exercising his or her rights under the plan.

123.08: Penalties

(1) A violation of any provision of 211 CMR 123.00 shall be considered to be an unfair or deceptive act or practice, in violation of M.G.L. c. 176D.

(2) A violation of any provision of 211 CMR 123.00 by any insurance agent, insurance broker, insurer or employee or representative of an insurer, or motor vehicle damage appraiser shall be grounds for suspension or revocation of the license of such person or persons.

(3) Nothing herein shall be deemed to preclude the claimant or policyholder, the Commissioner, the Attorney General or the Director of the Division of Standards from pursuing any other remedy or penalty provided by law including any remedy provided under M.G.L. c. 93A or M.G.L. c. 100A.

(123.09: Reserved)

123.10: Severability

If any section or portion of a section of 211 CMR 123.00 or the applicability thereof to any person, entity or circumstance is held invalid by any court, the remainder of 211 CMR 123.00 or the applicability of such provision to other persons, entities or circumstances shall not be affected thereby.

REGULATORY AUTHORITY

211 CMR 123.00: M.G.L. c. 90; M.G.L. c. 175; M.G.L. c. 176D

NON-TEXT PAGE

AUTOMOBILE INSURANCE RATE FILING

OF THE

MASSACHUSETTS AUTOMOBILE RATING AND ACCIDENT PREVENTION BUREAU

Docket 88-57

Industry Direct Payment Plan
(Line of Business)

December 15, 1988
(Date of Filing)

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

Objective: In order to provide, by January 1, 1989, for the implementation of a Direct Payment Plan for auto damage repairs insured under collision, limited collision and comprehensive coverages, excluding glass claims, in accordance with Sections 24 and 51 of c.273 of the Acts of 1988 and Regulation 211 CMR 123 (the "Regulation"), as issued on an emergency basis 12/8/88 and attached as Exhibit A, the Massachusetts Automobile Rating and Accident Prevention Bureau (MARB) files the following plan on behalf of its member companies under 211 CMR 123.04(1) to be effective for the settlement of all auto physical damage claims arising from accidents on or after January 1, 1989, provided, however, that each member company electing to implement the industry plan shall file a Notice of Election of the Industry Plan, attached as Exhibit B, at least 14 days prior to implementation as required by the Regulation. Any member insurer may deviate from the industry Direct Payment Plan upon approval by the Commissioner of the insurer's own individual plan filed in accordance with Sections 24 and 51 and the Regulation using the Notice of Election of a Modified Industry Plan form attached as Exhibit C or their own filing format.

The Industry Plan

1. Payment to the claimant:

The insurer shall offer to pay every claimant for the loss of or damage to the insured motor vehicle under collision coverage, limited collision coverage or comprehensive coverage, excluding glass claims, the full amount, less any applicable deductible, of the cost of repair[1] of the damage as described in an appraisal made by a licensed automobile damage appraiser employed or designated by the insurer, subject to the terms and conditions of the applicable insurance policy. Direct payments will be offered by each insurer electing to implement this industry plan to claimants for accidents on or after the insurer's implementation date but no sooner than January 1, 1989.

Unless such direct payment is refused by the claimant, the insurer shall make such payment at the time of, or within 5 business days after, the preparation of the said appraisal. In no event shall payment be made prior to provision of a copy of the appraisal to the claimant. Nothing in this section shall be construed to affect the right of any insurer to delay payment for a period of time reasonably necessary to investigate any claim before authorizing repair work or making payment on such claim.

If the claimant refuses such direct payment, the insurer shall comply with applicable laws and regulations relating to such payments without regard to the plan.

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[1]The insured cost of repairs describe in an appraisal may differ from the actual cost of repairs due to the replacement of used or depreciated components by new components in the actual course of repairs, so-called "betterment". Common examples of betterment are tires, batteries and the use of new parts in place of used parts at the direction of the insured. Betterment will be excluded throughout this plan when referring to the insured cost of repairs.

2. Repair Certification Form

Each insured receiving a direct payment under collision, limited collision and comprehensive coverages shall receive, with the appraisal or direct payment check, a Repair Certification Form containing an explanation of the insured's rights. The insured shall return the Repair Certification Form to the insurer upon completion of repairs. If the completed Repair Certification Form is not returned to the insurer, the actual cash value of the insured vehicle will be reduced by the amount of the claim payment plus any applicable deductible. The sample Repair Certification Form for use with the industry plan is attached as Exhibit D.

3. Resolution of Consumer Disputes

If the claimant disputes the accuracy of the appraisal or the amount of the payment based thereon, the insurer shall resolve such dispute as follows:

(1) The claimant, or the claimant's representative or repair shop at the direction of the claimant, must notify the insurer by telephone or in writing if the insured cost of repairs, excluding betterment, is expected to exceed the amount of the payment plus any applicable deductible and the claimant is seeking to have the insurer pay any part of the difference. Such notice must be prior to, or in the course of, the repair work.

(2) The insurer shall promptly evaluate the source of any differences between the insurer's appraisal and the cost of repairs and either authorize or deny a supplemental payment within 3 business days after the notification of such difference and inspection of the vehicle. During such 3-day period, the insurer may inspect the vehicle, and if it so requests, the claimant or repair shop shall make the vehicle available for inspection by the insurer. The insurer shall not delay such inspection for more than 3 days without the consent of the claimant. If the insurer makes a timely request for inspection the insurer will either authorize or deny a supplemental payment within 3 business days after the inspection. The claimant may direct the insurer to make any supplemental payment to the repair shop, provided the repair shop is registered under M.G.L. c. 100A. Otherwise, any supplemental payment must be made directly to the claimant.

(3) If the claimant and the insurer are unable to reach agreement as to any dispute as to the amount of the payment by the insurer, either party may demand arbitration of the dispute. The demand for arbitration must be in writing and it must include an appraisal of the cost of the repair prepared by a licensed automobile damage appraiser and an itemized bill for the actual cost of the repair, if the repair has been completed. The arbitration will be conducted pursuant to General Provision Section 11 of the Massachusetts Standard Automobile Insurance Policy and the applicable provisions of M.G.L. c. 175, section 191A, attached as Exhibit E.

(4) If the repair is made at a repair shop which is on the insurer's list of referral shops prepared pursuant to paragraph 5 below, neither the repair shop nor the insurer shall require the claimant to pay more than the amount of the direct payment plus the amount of any applicable deductible to have the insured repair work, excluding betterment, completed, and any dispute as to the amount of the appraised damage shall be resolved between the referral repair shop and the insurer.

4. Disclosure of Insured Rights and Duties

Each direct payment shall be accompanied by a notice on the Repair Certification Form explaining to the insured his or her rights and duties under the Direct Payment plan including:

(1) the right to shop around and to obtain repairs at the repair shop of his or her choice for the amount of the insurer's appraisal.

(2) the right to be given a list of geographically convenient repair shops which will provide quality repairs, excluding betterment, for the amount of the payment made directly to the insured plus any applicable deductible. The insurer will guarantee the quality of the materials and workmanship used in making the repairs at any shop on its list.

(3) the duty to notify the insurer, by phone or in writing, prior to or in the course of repairs, if the insured cost of repairs, excluding betterment, exceeds the amount of the direct payment, plus any applicable deductible, and the claimant seeks payment for any part of that excess from the insurer. The insurer has the right to inspect the vehicle within three (3) business days of notification. The insurer has the duty to authorize or deny a supplemental payment within three (3) business days after the inspection.

(4) the right to pursue resolution of any differences in repair cost through contact with the insurer and the procedure established in General Provision Section 11 of the Massachusetts Standard Automobile Policy.

(5) the duty to return a completed Repair Certification Form when the vehicle is repaired. If the completed Repair Certification Form is not returned to the insurer, the actual cash value of the insured vehicle will be reduced by the amount of the claim payment plus any applicable deductible.

(6) the duty to allow the insurer, upon request, to reinspect the repaired vehicle after receipt of the Repair Certification Form. If the repaired vehicle is not made available for inspection within a reasonable amount of time, the actual cash value of the insured vehicle will be reduced by the amount of the claim payment plus any applicable deductible.

5. Referral Repair Shop Programs

(1) Consumer's Choice of Shop: No insurer in implementing the Industry Direct Payment Plan shall require a claimant to have repairs made at any specific repair shop or list of shops.

(2) Number of Shops: Unless the requirement is specifically waived by the Commissioner, the insurer shall provide that every claimant will be given a list of at least five repair shops geographically convenient for the claimant which will perform the repairs on referred claims without undue delay. The claimant may or may not choose to use a shop on the referral list.

(a) For the first year in which this Industry Plan is effective, i.e., calendar year 1989, the following transitional rule will apply:

Insurers implementing plans during calendar year 1989 shall provide a list of at least:

(i) two referral shops at any time a list is given to a claimant;
(ii) three shops by May 1, 1989;
(iii) four shops by September 1, 1989; and
(iv) five shops by January 1, 1990.

(b) Any individual insurer which wishes to implement the Industry Plan but does not meet the minimum requirements of (2) (a) above may petition the Commissioner for a waiver of those requirements. The insurer seeking such a waiver shall set forth the specific facts regarding market share, geographic location, availability of repair shops, or other circumstances in support of its petition. No insurer may implement the Industry Plan if it does not meet the requirements of section (2) (a) above unless and until the Commissioner has granted a petition for waiver using the Petition for Waiver form attached as Exhibit F or any other format. A copy of the Massachusetts Automobile Market Share for each insurer and each insurer group is attached as Exhibit G.

(3) Insurer's Choice of Shops

(a) An insurer's referral list shall include only shops:

(i) which are registered repair shops and,
(ii) which have entered into an agreement satisfactory to the insurer, to complete insured repairs, excluding betterment, for claimants referred by the insurer without undue delay, for the amount of the direct payment to the insured plus any

applicable deductible, plus any supplemental payment authorized by the insurer.

(b) In determining which registered repair shops will be put on such referral list, the insurer shall consider all of the following criteria, and only the following criteria: the quality and cost of repairs at a particular shop, the quality of the service given the customer, the responsiveness of the shop to the customer's needs, the ability of the shop to perform repairs without undue delay, the geographic convenience of the shop for the claimant, cooperation of the shop with pre- and post-repair inspections and the shop's compliance with applicable laws and regulations.

Each individual insurer shall maintain written guidelines incorporating these criteria as applied by the insurer in implementing its plan; such guidelines shall be deemed to be a part of the individual insurer's implementation of the Industry Plan. While individual insurers which implement the Industry Plan shall maintain such written guidelines, under no circumstances shall the Massachusetts Automobile Rating and Accident Prevention Bureau propose or maintain such guidelines. Individual insurers' guidelines shall be made available to the Commissioner upon his or her request and shall also be made available to any repair shop in the event the insurer denies that shop placement on, or strikes that shop from, its list.

A repair shop shall be included on the list prepared by the insurer if the shop agrees in writing to comply fully with the Industry Plan, unless the shop is denied placement on, or is stricken from, the list pursuant to paragraph four (4) below, and is determined by the insurer not to satisfy one or more of the criteria listed above. The form of agreement between the shops on the referral list and the insurer may provide adequate assurances that the repair shop will continue to satisfy the insurer as to such criteria.

(4) Development and Changes of Referral List

An insurer may strike a repair shop from a referral list, or deny placement thereon, provided the insurer files a statement with the Commissioner specifying the nature of the shop's failure to comply with the Industry Plan or with the agreement or proposed agreement between the insurer and the repair shop. A repair shop which claims that it has been improperly stricken from or denied placement on the list may demand arbitration. Such binding arbitration shall be conducted by a neutral arbitrator jointly agreed to the insurer and the repair shop, or, in the absence of such agreement, within 21 days of submission of the request for arbitration to the insurer, by an arbitrator selected by the Commissioner. The parties to the arbitration shall bear the costs of the arbitration equally, but the losing party shall be liable to the prevailing party for its costs, unless the arbitrator orders otherwise. If the arbitrator finds that the losing party acted in bad faith, he or she may also award the prevailing party attorney's fees, if any. The arbitrator shall determine whether the repair shop was improperly stricken from the list, but shall make no finding or order as to any

damages other than the award of costs and/or attorney's fees, if any. The decision of the arbitrator shall be final.

(5) Insurer's Guarantee

If a claimant has a repair performed at a repair shop included on the insurer's list, then the insurer shall guarantee the quality of the materials and workmanship used in making the repairs. No insurer may petition the Commissioner for a waiver of this requirement. This guarantee by the insurer shall be in addition to all other guarantees which may be made by the manufacturer and the repair shop. The agreement between the insurer and the repair shop may provide for indemnification of the insurer by the repair shop for any costs associated with such guarantee under such terms and conditions as the parties to the agreement shall specify.

6. Reinspection

The insurer shall have a licensed automobile damage appraiser reinspect vehicles following completion of repairs, excluding glass only claims, as follows:

(a) with respect to repairs as to which the appraisal indicates that the cost is expected to exceed $4,000, at least 75% of such vehicles shall be reinspected;
(b) with respect to repairs as to which the appraisal indicates that the cost is not expected to exceed $4,000, at least 25% of such vehicles shall be reinspected.

In no event shall the selection of vehicles for reinspection be based on the age or sex of the policyholder or of the customary operators of the vehicle, or on the principal place of garaging the vehicle.

If the repair vehicle is not made available for reinspection within a reasonable amount of time, the actual cash value of the insured vehicle will be reduced by the amount of the claim payment plus any applicable deductible.

7. Conflicts of Interest

(a) No employee or agent of an insurer with responsibility for creating, managing or maintaining a list of repair shops as prescribed above shall receive or ask for any payment, gift or any other thing of value from any repair shop included, or seeking to be included, on the insurer's list of repair shops. No repair shop, or employee or owner thereof, shall give, pay or offer to give or pay, any thing of value to any employee or agent of an insurer with responsibility for creating, managing or maintaining a list of repair shops. No repair shop, or employee, owner or agent thereof, shall give or pay, or offer to give or pay, any thing of value to any person in exchange for being included, or an inducement for being included, on an insurer's list of repair shops. For purposes of this paragraph, the words "employee", "owner" and

"agent" shall also include any spouse or child of an employee, owner or agent.

(b) 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 (7) (a) above.

8. Disclosures to Consumers

Every claimant under a plan shall be given full and adequate disclosure with the appraisal, and at such other times as the insurer may determine, explaining that:

(a) the claimant may elect to accept direct payment under the plan and receive a list of referral shops, or he or she may choose to pursue the claim without regard to the plan;

(b) if the claimant accepts direct payment, he or she may choose to have repairs made at any repair shop, whether or not the shop appears on the insurer's referral list;

(c) if the claimant accepts direct payment, the claimant may choose a shop on the insurer's referral list, in which case the insurer will guarantee the materials and workmanship of the repair, and the cost of the insured repair, excluding betterment, to the claimant will not exceed the amount of the insurer's direct payment to the claimant plus any applicable deductible.

(d) the procedure for resolving claimants' disputes under the plan; and,

(e) such other information as will aid the claimant in exercising his or her rights under the plan.

Memorandum

Differences Between Regulations 211 CMR 123 And the Industry Direct Payment Plan

Regulation 211 CMR 123, Direct Payment of Motor Vehicle Collision and Comprehensive Coverage Claims and Referral Repair Shop Program, was issued on an emergency basis effective December 8, 1988. The Bureau is filing a direct payment plan on behalf of its member companies (The "Industry Plan") prior to any hearing on the Regulation in order to have an Industry Plan in effect on January 1, 1989. Since the filing deadline for an Industry Plan is December 15, 1988, the Bureau takes this opportunity to clarify the Regulation and to recommend changes where necessary. This memorandum will explain the differences between the Industry Plan and relevant parts of the Regulation.

1. Section 123.03 Definitions

Regulation	Industry Plan
"Claimant" means any person making a claim for motor vehicle damage or loss for first or third party damages.	"Claimant" means any person making a claim for motor vehicle damage or loss for first party damages

Explanation

The Direct Payment and Referral Shop program rules and regulation should apply to claims made by first parties under the auto physical damage coverages of collision, limited collision and comprehensive. The title of the regulation and Sections 24 and 51 of c.273 refer to the physical damage coverages only. Although the extension of the plan to third party property damage liability coverage seems to be voluntary with the company (123.05(1)), it should be made clear that these regulations will apply to first party payments only. Some of the reasons for excluding property damage liability claims from the Industry Plan are that (I) a direct payment system is already in place for appropriate PDL claims; (2) direct payments and appraisals may not make sense and/or may duplicate effort for some PDL claims, such as subrogated claims; (3) PDL claim settlements may be delayed or reduced depending upon the determination of liability and comparative negligence; and (4) the restoration of the decrease in value and/or reinspection of repairs through a completed repair certification form would be meaningless on third party claims.

Regulation	Industry Plan
"Repair Shop" means a motor vehicle repair shop as defined in M.G.L. c100A, Section 1, including glass specialty shops, but not including a shop which primarily sells tires	"Repair Shop" means a motor vehicle shop as defined in M.G.L. c100A, Section 1, but not including glass. Specialty shops or shops which primarily sell tires.

Explanation

The Direct Payment and Referral Shop Program should not apply to glass claims under comprehensive coverage. There currently exists an active and efficient system of insurer referral shops for glass claims. The glass shop referral system allows the claimant to have glass damage repaired by a referral shop at the request of the insurer and at the convenience of the insured. The system allows for direct payment to the referral shop at negotiated rates for labor and parts discounts.[1] Allowing the insured to "shop around" with a direct payment in hand, but with broken glass, would (1) tend to increase the cost of the system[2] by requiring appraisals, reinspections and the inability to direct insureds to specific referral shops[3] and (2) tend to increase the hazard to safe driving by having active motorists with broken windshields who are either "shopping around" or have decided not to repair.

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[1]According to the State Rating Bureau, glass discounts averaged 36% (1987 Bodyshop Hearing, Ex. 11).

[2]The 1987 average glass claim was about $275.

[3]This requirement might prove costly in light of the newly enacted $100 deductible glass coverage.

Regulation	Industry Plan
None.	"Cost of Repair" shall mean the insured cost to restore the damaged vehicle to a condition equal to that prior to the accident under the terms of the policy. The (insured) cost of repair does not include any increase in value, so-called "betterment", due to the replacement of used components with new components during the actual course of repairs, such as in the case of tires and batteries.

Explanation

The exclusion of betterment seems to have been implicitly recognized in Section 123.05(1), Payment to the Claimant by the use of the terms "subject to the terms and conditions of the applicable insurance policy".

Other parts of the Regulation, specifically Sections 123.05(3) (d) and 123.07(1) (c), convey the (incorrect) impression that the claimant will pay only the deductible and the amount of the direct payment for repairs completed at the insurer's referral shops. Although this indeed may be true in a large number of cases, there will often be times when the vehicle will increase in value due to the repairs (repair of old damage, new tires, etc.) and the increase in value, so-called betterment, must be paid for the claimant. The Industry Plan emphasizes this important distinction throughout the text of the plan.

2. Section 123.04 Procedure for Approval of Plans

The MARB interprets sections 123.04(1) and (2) as allowing each member insurer to adopt the approved industry plan in its entirety, with the Industry Plan effective date of January 1, 1989, and to implement that plan on or after January 1, 1989 by filing a notice of election of the Industry Plan (Exhibit B) at least 14 days prior to the implementation date and by receiving the approval of the Commissioner of Insurance. The principal reason for this interpretation of these sections is the impracticality of the 14 day notice requirements combined with the January 1 effective date and the extremely tight filing/hearing/decision schedule for this initial plan.

For each individual insurer adopting the Industry Plan in its entirety, the benefits of the Industry Plan shall be made available to all claimants submitting claims arising from accidents or other losses occurring on or after the implementation date. (Compare 123.04(7)).

3. Section 123.05: Direct Payment Plans: Required Provisions

(1) Payment to Claimant

MARB interprets "cost of repair" to exclude betterment (Sec 123.03 above).

MARB recognizes the voluntary nature of the offer (direct payment) to the claimant under property damage liability, but believes it is unnecessary (See 123.03 above).

MARB also recognizes that the intention of the Regulation requirement to "make such payment at the time of, or within 2 business days after, the preparation of said appraisal" is to minimize the time between the claimants' receipt of the appraisal and his or her receipt of the direct payment check. The recognition of actual diverse claim department check writing and accounting systems among companies, however, leads MARB to substitute a more realistic time frame of 5 business days to cover all cases. For some company operations it will be possible to present a claimant with all necessary material at once (appraisal, Repair Certificate Form, general instructions, and check). For others the process, especially for drive-in claim service, may separate the issuance and mailing of the direct payment check from the completion of the appraisal. A five (5) business days limit should accommodate all operational forms in a direct payment plan. MARB notes that the current payment limitation after receiving the completed Work Claim Form on repairs is seven (7) days.

(2) Repair Certification

MARB has recognized the inappropriateness of asking the insured to certify that repairs were made "in accordance with the appraisal" and has designed the Industry Repair Certification Form (RCF) to certify only the fact and the location of the repairs. Appraisers doing reinspections are asked to note on the RCF the items of repair that differ from the appraisals. It seems appropriate to delete that phase for the insured in order (1) to minimize the ambiguity of the RCF, and (2) to allow return of the RCF without the involvement of the repair shop in determining whether its repair was "in accordance" with the appraisal.

MARB has also chosen to allow the decrease in value (DIV), whether or not the claimant repairs the vehicle, in all cases where the RCF is not returned. The DIV will be eliminated upon the subsequent receipt of the completed RCF.

(3) Resolution of Consumer Disputes

The various "3-day" requirements of subsection (b) seem inconsistent. The MARB has replaced the overall 3-day requirements of the Regulation by requiring the authorization or denial-of a supplemental payment "within 3 business days" after the notification of such difference and inspection of the vehicle. The two individual notification and inspection 3-day constraints of the Regulation still apply for the Industry Plan.

Under subsection (d), the repair shop and the insurer may require the payment of betterment by the insured. (Sec 123.03 – "cost of repairs" above).

4. Section 123.06 Referral Repair Shop Programs

The MARB has assumed in its filing that the procedure for the registration of repair shops, required for (3a) and (3b) will be in place and that a sufficient number of such registered shops will be available for the implementation of the plan. To the extent that this assumption is not realized, the implementation of a viable direct payment plan program will be delayed.

The MARB knows of no subsection (4) of the Regulation.

The MARB has added to the requirements of subsection (7), Reinspection, the allowance of a decrease in value (DIV) if the reinspection is not permitted by the claimant and/or the repair shop within a reasonable time.

5. Section 123.07 Disclosures to Consumers

MARB expects that individual insurers will advise claimants of the election of direct payments (1) (a) through revised company claim process literature that is normally distributed to claimants.

NOTICE OF ELECTION
OF
INDUSTRY DIRECT PAYMENT PLAN

The Honorable Nonnie Burnes
Commissioner of Insurance
Massachusetts Division of Insurance
One South Station, 5th Floor
Boston, MA 02110-2208

Dear Commissioner Burnes:

Please be advised that the undersigned auto insurance company(s) elects to implement a modification of the Industry Direct Payment Plan as filed by the Massachusetts Automobile Rating and Accident Prevention Bureau in accordance with 211 CMR 123 and approved by you. If approved, the effective date of our implementation of the modified industry plan will be _____.

The extent of our modifications to the industry plan are detailed on the attached page(s).

Company Name(s) _____

_____

_____

Company Officer _____
Name

_____
Signature

_____
Title

_____
Telephone Number

_____
Date

NOTICE OF ELECTION
OF
INDUSTRY DIRECT PAYMENT PLAN

Differences from the Industry Direct Payment Plan

Company Name _____

1. Effective Date _____

2. Payment to Claimant

3. Repair Certification Form (Attach Modified Form)

4. Resolution of Consumer Disputes

5. Repair Shop Referral Lists

6. Disclosure to Consumers

REPAIR CERTIFICATION FORM

(to be returned to your insurance company upon completion of repairs)

Company Information

Insured _____

Claim Number _____

Date of Accident _____

Policyholder Information

I. Explanation of Your Rights and Duties for Repairing Damaged Vehicle

1. It is your right to shop around and to obtain repairs at the repair shop of your choice for the amount of our appraisal.

2. It is your right to be given a list of geographically convenient repair shops which will provide quality repairs for the amount of the payment made directly to you plus any applicable deductible plus any increase in value due to the repairs. We guarantee the quality of the materials and workmanship used in making the repairs at any shop on our list.

3. It is your duty to notify us, by phone or in writing, prior to or in the course of repairs, if the cost of repairs is expected to exceed our payment plus any applicable deductible and increase in value and you wish us to pay any part of that excess cost. We have the right to inspect the vehicle within three (3) business days of your notification and we have the duty to authorize or deny any supplemental payments within three (3) business days after inspection.

4. It is your right to pursue resolution of any differences in repair costs through contact with us and the procedure established in General Provision Section 11 of the policy.

5. It is your duty to complete and to return this Repair Certification Form when the vehicle is repaired. If the completed Repair Certification Form is not returned to us, the actual cash value of the insured vehicle will be reduced by the amount of the claim payment plus any applicable deductible.

6. It is your duty to allow us, upon request, to reinspect the repaired vehicle after receipt of the Repair Certification Form. If the repaired vehicle is not made available for reinspection within a reasonable amount of time, the actual cash value of the insured vehicle will be reduced by the amount of the claim payment plus any applicable deductible.

II. Certification of Repair

I certify that my damage vehicle has been repaired by:

Repair Shop Name _____

Address _____

_____

Telephone _____

Policyholder Name: _____

Policyholder Signature: _____

Date: _____

Company Reinspection

(check one) _____ Repair work completed in accordance with appraisal

_____ Other (explain) _____

_____

Licensed Appraiser _____

Date _____

24 General Provisions and Exclusions (continued)

11. If we Disagree on the Amount of Damage to Your Auto	Sometimes there may be a disagreement as to the amount of money we owe for losses or damage to an auto under Collision, Limited Collision and Comprehensive (Parts 7, 8 and 9). If so, Massachusetts law provides for a method of settling the disagreement. Either you or we can, within 60 days after you file your proof of loss, demand in writing that appraisers be selected. The appraisers must then follow a procedure set by law to establish the amount of damage. Their decision will be binding on you and us. You and we must share the cost of the appraisal.
12. Sales Tax	Under Collision, Limited Collision and Comprehensive (Parts, 7 8 and 9) we will pay, subject to your deductible, all sales taxes applicable to the loss of an auto or damage to an auto.
13. Secured Lenders	When your Coverage Selections Page shows that a lender has a secured interest in your auto, we will make payments under Collision, Limited Collision and Comprehensive (Parts 7, 8 and 9) according to the legal interests of each party. The secured lender's right of payment will not be invalidated by your acts or neglect except that we will not pay if the loss of or damage to your auto is the result of conversion, embezzlement, or secretion by your or any household member. When we pay any secured lender we shall, to the extent of our payment, have the right to exercise any of the secured lender's legal rights of recovery. If you do not file a proof of loss as provided in this policy, the secured lender must do so within 30 days after the loss or damage becomes known to the secured lender. In order for us to cancel the rights of any secured lender shown on the Coverage Selections Page, a notice of cancellation must be sent to the secured lender as provided in this policy.
14. No Benefits to Anyone in the Auto Business	Coverage under Collision, Limited Collision and Comprehensive (Parts 7, 8 and 9) shall not in any way benefit any person or organization having possession of your auto for the purpose of servicing, repairing, parking, storing, or transporting it or for any similar purpose.
15. If Two or More Autos are Insured Under this Policy	Two or more autos may be insured under this policy. There may be different limits for each auto. If so, when someone covered under this policy is injured while a pedestrian or is using an auto other than your auto at the time of the accident, the most we will pay under any applicable Part is the highest limit shown for that Part for any one auto on your Coverage Selections Page.

175:191A. Notice and Arbitration Provisions in Policies Insuring Against Physical Damage to Motor Vehicles of Assured.

Section 191A. No company shall issue a policy or contract which insures against physical damage to a motor vehicle of the insured unless said policy contains in substance the following provisions:

In case of any loss or damage insured against under the policy, the named insured shall give notice thereof as soon as practicable to the company or any of its authorized agents and also, in the event of larceny, robbery or pilferage, to the police, and within sixty days after filing proof of loss the company shall pay the amount of loss as provided in the policy.

If the named insured and the company fail to agree as to the amount of loss, each shall, on the written demand of either, made within sixty days after receipt of proof of loss by the company, select a competent and disinterested appraiser, and the appraisal shall be made at a reasonable time and place. The appraisers shall first select a competent and disinterested umpire, and failing for fifteen days to agree upon such umpire, then, on the request of the named insured or the company, such umpire shall be selected by a judge of a court of record in the county and state in which such appraisal is pending. The appraisers shall then appraise the loss, stating separately the actual cash value at the time of loss and the amount of loss, and failing to agree shall submit their differences to the umpire. An award in writing of any two shall determine the amount of loss. The named insured and the company shall each pay his or its chosen appraiser and shall bear equally the other expenses of the appraisal and umpire.

The company shall not be held to have waived any of its rights by any act relating to appraisal.

PETITION FOR WAIVER OF MINIMUM
NUMBER OF SHOPS ON REFERRAL SHOP LISTS

The Honorable Nonnie Burnes
Commissioner of Insurance
Massachusetts Division of Insurance
One South Station, 5th Floor
Boston, MA 02110-2208

Dear Commissioner Burnes:

Please be advised that the undersigned auto insurance company(s) petitions for a waiver from the requirements of 211 CMR 123.06 (2), the minimum number of geographically convenient referral repair shops to be provided claimants, under the Industry Direct Payment Plan. For the reasons set forth on the attached page(s), we will be unable to comply with the Regulation minimum of 2 repair shops after January 1, 1988, 3 repair shops after May 1, 1989, 4 repair shops after September 1, 1989 and 5 repair shops after January 1, 1990. Our Massachusetts Auto Market Share for 1987 was _____%.

Company Name(s) _____

_____

_____

Company Officer _____
Name

_____
Signature

_____
Title

_____
Telephone Number

_____
Date

PETITION FOR WAIVER OF MINIMUM
NUMBER OF SHOPS ON REFERRAL SHOP LISTS

Company Name _____

1987 Market Share _____

We request a waiver from the minimum number requirement for referral repair shops on our referral shop list under 211 CMR 123.6 (2) for the following reasons:

COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF CONSUMER AFFAIRS
AND BUSINESS REGULATION
DIVISION OF INSURANCE

DOCKET NO. G89-10

AMENDMENTS TO RULE 13 OF THE RULES OF OPERATION OF COMMONWEALTH AUTOMOBILE REINSURERS

DECISION AND ORDER

BACKGROUND

On February 16, 1989 the Governing Committee of Commonwealth Automobile Reinsurers ("CAR") filed a proposed amendment to Rule 13 (A) (2) (a) of the CAR Rules of Operation ("the Rules") with the Division of Insurance ("the Division"). On March 16, 1989 the CAR Governing Committee filed an additional proposed amendment to Rule 13(A)(2)(a). Rule 13 of the Rules details the obligations of CAR member companies who have been appointed as servicing carriers.

United States Fidelity and Guaranty Company ("USF&G") requested a hearing on both proposed amendments to Rule 13(A)(2)(a). Pursuant to M.G.L. c. 175, §113H and the CAR Plan and Rules, a public hearing on the proposed amendments was hold on April 14, 1989 at 9:30 a.m. at the Division. Interested parties were invited to submit oral and written testimony at the hearing. Parties were also given the opportunity to submit additional post-hearing statements and rebuttal.

Representatives from CAR and two insurance companies presented oral and written testimony concerning the proposed amendments. Testimony in support of the proposed amendments was offered by Joseph J. Maher, Jr., Vice President and General Counsel of CAR, and Fran Delage, a member of CAR's Claims Advisory Committee and the Technical Claim Manager of the New England Branch of the Hanover Insurance Company. USF&G and Holyoke Mutual Insurance Company ("Holyoke Mutual"), both presented testimony in opposition to the proposed amendments.

ISSUES

In order to assure the protection of the public interest, Rule 13 (A) (2) (a) of the CAR Rules of Operation lists specific services which a member company must demonstrate it has the capability of performing in order to be considered for appointment as a servicing carrier. Once appointed, a servicing carrier must continue to satisfy those requirements. There are currently six (6) specific requirements, which include the ability to 1) provide policy issuance and premium collection to all eligible classes of risks; 2) service claims in every state; 3) administer a direct billing program for private passenger risks; 4) provide an installment payment plan; 5) maintain a special investigative unit; 6) report information to CAR in an accurate and timely manner.

CAR's proposed amendments place an additional requirement upon servicing carriers, namely, to adopt and maintain an approved direct payment plan. CAR proposed this additional requirement for servicing carriers in response to the recently enacted automobile insurance reform legislation, c. 273 of the Acts of 1998, specifically, §§ 24 and 31 of c. 273. CAR argues that, while §§ 24 and 51 of c. 273 do not require an insurer to have a direct payment plan, Insurers should take advantage of every cost-savings device available in Massachusetts. CAR claims that approval of its proposed amendments to Rule 13 will result in cost savings and improved service which is beneficial to both the industry and the consumer.

The two companies opposing the proposed amendments to Rule 13 argue that forcing servicing carriers to adopt and maintain an approved direct payment plan is contrary to the intent of §§ 24 and 51 of c. 273, since those sections do not require insurers to file a direct payment plan with the Division. They claim that each insurer should be left to determine, based an its own internal policies and methods, whether or not to establish a direct payment plan. They also point out certain aspects of the current regulation governing direct payment plans which cause them difficulty, such as potential exposure resulting from guarantees of repair shop workmanship and quality of materials, and the potential problems associated with creating and maintaining a referral shop list.

Holyoke Mutual emphasized that the increased staff costs associated with creating and maintaining a referral shop list are particularly burdensome to servicing carriers with a small market share. Holyoke Mutual also noted that those servicing carriers would be unable to demand significant discounts from repair shops due to the small volume of work to be offered to the repair shops. USF&G and Holyoke Mutual are not, however, opposed in principle to a direct payment plan; they argue only that a direct payment plan should not be required of a servicing carrier.

DECISION AND ORDER

M.G.L. c. 175, § 113H(C) clearly mandates that CAR "shall establish reasonable eligibility requirements for appointment as a servicing carrier, including but not limited to, the maintenance of a specific investigative unit to investigate suspicious or questionable motor vehicle insurance claims for the purpose of eliminating fraud." In the current Rule 13(A)(2)(a)(1-6), CAR has created six eligibility requirements, all for the purpose of protecting the public interest. CAR now seeks to add another requirement which was specifically created to benefit consumers as well as the insurance industry as a cost-saving and service-enhancing device; indeed, the Legislature, in enacting §§ 24 and 51 in c. 273, intended to encourage insurance companies to develop programs which would assure consumers the greatest possible savings in insurance

costs. Clearly, a requirement imposed upon servicing carriers which is beneficial to both the industry in general and the consumer is reasonable and will protect the public interest. I am not persuaded by the testimony presented that the potential problems insurers may encounter in establishing a direct payment plan are sufficient justification for disapproving the proposed amendments in their entirety, for two reasons: first, the problems are, by one opponents' own admission, hypothetical; second, of the eleven direct payment plans which I have approved and which arc currently in effect in the Commonwealth, ten have been filed by insurers who are CAR servicing carriers. In other words, approximately one half of the current servicing carriers have overcome whatever problems may exist in establishing a direct payment plan. I note, however, that the servicing carriers who have thus far established direct payment plans insure approximately 60% of the private passenger risks insured in the Commonwealth, and may be better able to afford the costs associated with establishing and maintaining such plans than are servicing carriers with a comparatively small private passenger market share. However, I see no reason why most policyholders should not have the opportunity to take advantage of this new, more efficient cost-saving device.

Therefore, it is ordered that the proposed amendments to Rule 13 filed by CAR Governing Committee on February 16, 1989 and March 16, 1989 are hereby approved, with the following modification: a CAR member who is currently appointed as a servicing carrier shall be required to establish and maintain a direct payment plan only if that servicing carrier's average Massachusetts private passenger market share for the years 1986, 1987, and 1988 equals or exceeds one percent (1%) of the total Massachusetts private passenger market for 1988. This criteria shall also apply to any CAR member appointed as a servicing carrier during the calendar year 1989. For CAR members appointed as a servicing carrier subsequent to 1989, this determination shall be made using the average market share percentage for the three years preceding the year of appointment compared to the total market for the year immediately preceding appointment. In view of the fact that an industry-sponsored direct payment plan has been filed and approved by the Division, it is further ordered that all servicing carriers shall have until January l, 1990 to establish a direct payment plan.

This decision may be appealed to the Superior Court pursuant to M.G.L. c. 175, § 113H.

Dated:
October 10, 1989

Timothy H. Gailey
Commissioner

CODE OF MASSACHUSETTS REGULATIONS
TITLE 212: AUTO DAMAGE APPRAISERS LICENSING BOARD
CHAPTER 2.00: THE APPRAISAL AND REPAIR OF DAMAGED MOTOR VEHICLES

2.04: Procedures for the Conduct of Appraisals and Intensified Appraisals

(1) Conduct of Appraisals.

(a) Assignment of an Appraiser. Upon receipt by an insurer or its agent of an oral or written claim for damage resulting from a motor vehicle accident, theft, or other incident for which an insurer may be liable, the insurer shall assign either a staff or an independent appraiser to appraise the damage. Assignment of an appraiser shall be made within two business days of the receipt of such claim. However, the insurer may exclude any claim for which the amount of loss, less any applicable deductible, is less than $1,500

(b) Repair Shop Appraisal. All repair shops shall maintain one or more licensed appraisers in their employment for the purpose of preparing motor vehicle damage appraisals. No staff or independent appraiser shall knowingly negotiate a repair figure with an unlicensed individual or an unregistered repair shop.

(c) Contact with Claimant and Selection of Repair Shop. No staff or independent appraiser, insurer, representative of insurer, or employer of an independent appraiser shall refer the claimant to or away from any specific repair shop or require that repairs be made by a specific repair shop or individual. The provisions of 212 CMR 2.04(c) shall not apply to any approved direct payment plan pursuant to 211 CMR 123.00.

(d) Requirement of Personal Inspection and Photographs. The appraiser shall personally inspect the damaged motor vehicle and shall rely primarily on that personal inspection in making the appraisal. As part of the inspection, the appraiser shall also photograph each of the damaged areas.

(e) Determination of Damage and Cost of Repairs. The appraiser shall specify all damage attributable to the accident, theft, or other incident in question and shall also specify any unrelated damage. If the appraiser determines that preliminary work or repairs would significantly improve the accuracy of the appraisal, he or she shall authorize the preliminary work or repair with the approval of the claimant and shall complete the appraisal after that work has been done. The appraisers representing the insurance company and the registered repair shop selected by the insured to do the repair shall attempt to agree on the estimated cost for such repairs. The registered repair shop must prepare an appraisal for the purpose of negotiation. No appraiser shall modify any published manual (*i.e.*, Motors, Mitchell or any automated appraisal system) without prior negotiation between the parties. Manufacturer warranty repair procedures, I-Car, Tec Cor and paint manufacturer procedures may also apply. Further, no appraiser shall use more than one manual or system for the sole purpose of gaining an advantage in the negotiation process.

If, while in the performance of his or her duties as a licensed auto damage appraiser, an appraiser recognizes that a damaged repairable vehicle has incurred damage that would impair the operational safety of the vehicle, the appraiser shall immediately notify the owner of said vehicle that the vehicle may be unsafe to drive.

The licensed auto damage appraiser shall also comply with the requirements of M.G.L. c. 26, § 8G the paragraph that pertains to the removal of a vehicle's safety inspection sticker in certain situations.

The appraiser shall determine which parts are to be used in the repair process in accordance with 211 CMR 133.00. The appraiser shall itemize the cost of all parts, labor, materials, and necessary procedures required to restore the vehicle to pre-accident condition and shall total such items. The rental cost of frame/unibody fixtures necessary to effectively repair a damaged vehicle shall be shown on the appraisal and shall not be considered overhead costs of the repair shop. With respect to paint, paint materials, body materials and related materials, if the formula of dollars times hours is not accepted by a registered repair shop or licensed appraiser, then a published manual or other documentation shall be used unless otherwise negotiated between the parties. All appraisals written under 212 CMR 2.00 shall include the cost of replacing broken or damaged glass within the appraisal. When there is glass breakage that is the result of damage to the structural housing of the glass then the cost of replacing the glass must be included in the appraisal in accordance with 212 CMR 2.04. The total cost of repairing the damage shall be computed by adding any applicable sales tax payable on the cost of replacement parts and other materials. The appraiser shall record the cost of repairing any unrelated damage on a separate report or clearly segregated on the appraisal unless the unrelated damage is in the area of repair.

If aftermarket parts are specified in any appraisal the appraiser shall also comply with the requirements of M.G.L. c. 90, § 34R that pertain to the notice that must be given to the owner of a damaged motor vehicle.

The appraiser shall mail, fax or electronically transmit the completed appraisal within five business days of the assignment, or at the discretion of the repair shop, shall leave a signed copy of field notes, with the completed appraisal to be mailed or faxed within five business days of the assignment. The repair shop may also require a completed appraisal at the time the vehicle is viewed. If the repair shop requires a completed appraisal, then the repair shop shall make available desk space, phone facilities, calculator and necessary manuals. A reasonable extension of time is permissible when intervening circumstances such as the need for preliminary repairs, severe illness, failure of the parties other than the insurer to communicate or cooperate, or extreme weather conditions make timely inspection of the vehicle and completion of the appraisal impossible.

(f) Determination of Total Loss. Whenever the appraised cost of repair plus the estimated salvage may be reasonably expected to exceed the actual cash value of a vehicle, the insurer may deem that vehicle a total loss. No motor vehicle may be deemed a total loss unless it has been inspected or appraised by a licensed appraiser nor shall any such motor vehicle be moved to a holding area without the consent of the owner. A total loss shall not be determined by the use of any percentage formula.

(g) Preparation and Distribution of Appraisal Form. All appraisers shall set forth the information compiled during the appraisal on a form that has been filed with the Board. Staff and independent appraisers shall, upon completion of the appraisal, give copies of the completed appraisal form to the claimant, the insurer, and the repair shop and shall give related photographs to the insurer.

(h) Supplemental Appraisals. If a registered repair shop or claimant, after commencing repairs, discovers additional damaged parts or damage that could not have been reasonably anticipated at the time of the appraisal, either may request a supplementary appraisal. The registered repair shop shall complete a supplemental appraisal prior to making the request. The insurer shall assign an appraiser who shall personally inspect the damaged vehicle within three business days of the receipt of such request. The appraiser shall have the option to leave a completed copy of the supplemental appraisal at the registered repair shop authorized by the insured or leave a

signed copy of his or her field notes with the completed supplement to be mailed, faxed, electronically transmitted or hand delivered to the registered repair shop within one business day. The appraiser shall also give a copy of the completed supplement to the insurance company in a similar manner. A reasonable extension of time is permissible when intervening circumstances such as the need for preliminary repairs, severe illness, failure of the parties other than the insurer to communicate or cooperate, or extreme weather conditions make timely inspections of the vehicle and completion of the supplemental appraisal impossible.

(i) Expedited Supplemental Appraisals.

If an insurer, a repair shop, and the claimant agree to utilize an expedited supplemental appraisal process, an insurer shall not be required to assign an appraiser to personally inspect the damaged vehicle. In such event, the repair shop shall fax or electronically submit to the insurer a request for a supplemental appraisal allowance in the form of an itemized supplemental appraisal of the additional cost to complete the repair of the damaged vehicle, prepared by a licensed appraiser employed by the repair shop, together with such supporting information and documentation as may be agreed upon between the insurer and the repair shop. The insurer shall then be required to fax or electronically submit to the repair shop within two business days its decision as to whether it accepts the requested supplemental appraisal allowance. Within this same period, a licensed appraiser representing the insurer and a licensed appraiser representing the repair shop may attempt to agree upon any differences. In the event that an insurer does not accept the repair shop's request for the supplemental appraisal allowance, or if the insurer fails to respond to the repair shop within two business days, the insurer and the repair shop shall be obligated to proceed in accordance with 212 CMR 2.04(1)(h), and within the time limits set forth in such provision. In such event, the date of the initial request for a supplemental appraisal allowance shall be the starting date for when the insurer must assign an appraiser to personally inspect the damaged vehicle.

No insurer or repair shop shall be obligated to utilize an expedited supplemental appraisal process and the determination of whether to utilize such process shall be made separately by an insurer or by a repair shop only on an individual claim basis. Utilization of an expedited supplemental appraisal process shall not be used as a criterion by an insurer in determining the insurer's choice of shops for a referral repair shop program under an insurer's direct payment plan; and being a referral shop shall not be a criterion in determining whether to utilize an expedited supplemental appraisal process.

(j) Completed Work Claim Form. If the insurance company does not have a direct payment plan or if the owner of the vehicle chooses not to accept payment under a direct payment plan then a representative of the insurer shall provide the insured with a completed work claim form and instructions for its completion and submission to the insurer.

(2) Temporary Licensing. The Board may grant at its discretion either an emergency or a temporary license to any qualified individual to alleviate a catastrophic or emergency situation for up to 90 days. The Board may limit the extent of such emergency authorization and in any event, if the situation exceeds 30 days, a fee determined by the Board shall be charged for all emergency or temporary licenses.

211 CMR: DIVISION OF INSURANCE
211 CMR 133.00: STANDARDS FOR THE REPAIR OF DAMAGED MOTOR VEHICLES

133.01: Purpose and Applicability

The purpose of 211 CMR 133.00 is to promote the public welfare and safety by establishing fair and uniform standards for the repair of damaged motor vehicles. 211 CMR 133.00 is promulgated to be read in conjunction with 212 CMR 2.00, *The Appraisal and Repair of Damaged Motor Vehicles*, as promulgated by the Auto Damage Appraiser Licensing Board. 211 CMR 133.00 shall apply to all motor vehicles insured in the Commonwealth and only when an insurer pays for the cost of repairs.

133.02: Authority

211 CMR 133.00 is promulgated pursuant to the authority granted to the Commissioner of Insurance by M.G.L. c. 175, §§ 3A, 4 and 113B, c. 90, §34O, and c. 176D, §11.

133.03: Definitions

Appraisal - a written motor vehicle damage report as defined in M.G.L. c. 26, §8G and in compliance with the provisions of M.G.L. c. 93A, c. 100A, c. 90, §34R, c. 26, §8G and 212 CMR 2.00.

Appraiser - means any person licensed by the Auto Damage Appraiser Licensing Board to evaluate motor vehicle damage and determine the cost of parts and labor required to repair the motor vehicle damage.

Claimant - means any person making a claim for damage to a motor vehicle for either first or third party damages.

Intensified appraisal - means the combination of the appraisal of a motor vehicle before its repair and the reinspection of the vehicle subsequent to its repair.

133.04: Determination of Damage and Cost of Repair

(1) Appraisers shall specify that damaged parts be repaired rather than replaced unless: the part is damaged beyond repair, or the cost of repair exceeds the cost of replacement with a part of like kind and quality, or the operational safety of the vehicle might otherwise be impaired. When it is determined that a part must be replaced, a rebuilt, aftermarket or used part of like kind and quality shall be used in the appraisal unless:

(a) the operational safety of the vehicle might otherwise be impaired;
(b) reasonable and diligent efforts to locate the appropriate rebuilt, aftermarket or used part have been unsuccessful;

(c) a new original equipment part of like kind and quality is available and will result in the lowest overall repair cost;
(d) for vehicles insured under policies written on or before December 31, 2003, the vehicle has been used no more than 15,000 miles unless the pre-accident condition warrants otherwise; or.
(e) for vehicles insured under policies written or renewed on or after January 1, 2004, the vehicle has been used no more than 20,000 miles unless the pre-accident condition warrants otherwise.

A part is of like kind and quality when it is of equal or better condition than the preaccident part.

(2) When an insurance company specifies the use of used, rebuilt, or aftermarket parts, the source and specific part(s) must be indicated on the appraisal. If the repairer uses the source and specified part(s) indicated on the appraisal and these parts are later determined by both parties to be unfit for use in the repair, the insurance company shall be responsible for the costs of restoring the parts to usable condition. If both parties agree that a specified part is unfit and must be replaced, the insurer shall be responsible for replacement costs such as freight and handling unless the repair shop is responsible for the part(s) being unfit, or unless the insurer and repairer otherwise agree. As to such costs, nothing in 211 CMR 133.00 shall preclude an insurer from exercising any available rights of recovery against the supplier.

(3) Damage to motor vehicle glass shall be repaired rather than replaced if:

(a) damage to the windshield is outside the critical viewing area, which is that area covered by the sweep of the wipers originally provided by the vehicle manufacturer, exclusive of the outer two inches within the perimeter of that sweep; and
(b) damage to the glass is minor, including, but not limited to, a crack less than six inches in length and stone breaks or bruises, bullseyes and star breaks less than one inch in diameter; and
(c) the repair will not impair the operational safety of the motor vehicle.

Insurers shall use reasonable efforts to ensure that, before any decision is made to replace glass, the damage is inspected to determine whether is it suitable for repair.

133.05: Determination of Values

(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 the 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.

(2) Salvage Value: Whenever the appraised cost of repair plus the probable salvage may be reasonably expected to exceed the actual cash value, a staff or independent appraiser licensed pursuant to 212 CMR 2.00 shall complete a total loss report on a form that has been filed with the Division of Insurance. If the claimant retains title to the vehicle, the appraiser shall obtain bids from two geographically convenient licensed salvage companies. The average of the two bids shall be used as the salvage value. The appraiser shall provide to the claimant the names and addresses of the potential salvage buyers, the amount of each salvage estimate used by the appraiser in computing the salvage value, and the expiration dates of offers, if any, made by potential salvage buyers.

133.06: Option for Contract Repair

(1) With respect to a claim presented under either Limited Collision, Collision or Comprehensive Coverage, if the insurer deems a motor vehicle a total loss, the claimant may, with the consent of the insurer, enter into an agreement to have the vehicle repaired by any registered repair shop for the contracted cost of repair if:

(a) the insurer allows the claimant to retain possession and ownership of the vehicle; and
(b) the claimant obtains a salvage title for said vehicle in compliance with M.G.L. c. 90D.

(2) Under such an agreement, the insurer shall not be required under any circumstance to pay more than the actual cash value less the actual salvage value as determined under 211 CMR 133.05. There shall be no supplements paid by the insurer under this agreement. The claimant or the repair shop and not the insurer shall be responsible for any charges that may exceed the agreed contract price. The insurer shall make no payments to the registered repair shop until it receives a completed work claim form and the vehicle has been reinspected by the insurer.

(3) Nothing in 211 CMR 133.06 shall be construed to conflict with, or alter, the duties and rights of an insurer under M.G.L. c. 175, §113S. Nothing in 211 CMR 133.06 shall restrict the right of an insurer to take title to a vehicle that the insurer has deemed a total loss.

133.07: Intensified Appraisals

An insurer shall have licensed appraisers conduct intensified appraisals of at least 25% of all damaged motor vehicles for which the appraised cost of repair is less than $4,000.00 and at least 75% of all damaged vehicles for which the appraised cost of repair is more than $4,000.00 for Collision, Limited Collision and Comprehensive claims.

The appraiser shall determine whether the repairs were made in accordance with the initial appraisal and any supplements. The information compiled during the intensified appraisal shall be set forth on a form acceptable to the Auto Damage Appraiser Licensing Board and the Division of Insurance. A copy of an intensified appraisal shall be given to the insurer, and, upon request, to the person making the repairs or the claimant.

133.08: Penalties

A violation of any provision of 211 CMR 133.00 shall be considered to be an unfair or deceptive act or practice, in violation of M.G.L. c. 176D.

An alleged violation of 211 CMR 133.00 by a licensed auto damage appraiser may be reported to and penalized by the Auto Damage Appraisers Licensing Board in accordance with its governing statute and 212 CMR.

Nothing herein shall be deemed to preclude the claimant or policyholder, the Commissioner, the Attorney General or the Director of the Division of Standards from pursuing any other remedy or penalty provided by law including any remedy provided under M.G.L. c. 93A or M.G.L. c. 100A.

An insurer or repair shop shall be responsible for the actions of all of its appraisers whether staff or independent, and shall be subject to the applicable penalties under law for any violation of 211 CMR 133.00 or 212 CMR 2.00.

133.09: Severability

If any provision contained herein is found to be unconstitutional or invalid by a Court of competent jurisdiction, the validity of the remaining provisions will not be so affected.

211 CMR 94.00: PRE-INSURANCE INSPECTION OF PRIVATE PASSENGER MOTOR VEHICLES

Section

94.01: Authority

211 CMR 94.00 is issued pursuant to the authority granted the Commissioner of Insurance by M.G.L. c. 175, § 113S.

94.02: Scope and Purpose

The purpose of211 CMR 94.00 is to establish standards and procedures for the inspection of certain motor vehicles prior to Insurers' issuance of Physical Damage Coverages. 211 CMR 94.00 applies to all Private Passenger Motor Vehicles insured in the Commonwealth of Massachusetts (Commonwealth), unless specifically exempted or waived under 2 I 1 CMR 94.00.

94.03: Definitions

As used in 211 CMR 94.00, the following words will have the meanings indicated:

Applicant means the named insured or individual applying as the named insured, as that term is defined in a Motor Vehicle Liability Policy.

Authorized Representative means any person or legal entity, other than the Applicant, authorized by an Insurer to conduct pre-insurance inspections pursuant to 211 CMR 94.00 and may include an employee of the Insurer, an insurance producer of the Insurer, or an Inspection Service.

Book of Business means all Motor Vehicle Liability Policies written by one insurance producer with one Insurer.

Certificate of Mailing means a notice by regular mail with a certificate of mailing endorsed by the United States Postal Service.

Commissioner means the Commissioner of Insurance appointed under the provisions of M.G.L. c. 26, § 6, or his or her designee.

Division means the Division of Insurance created pursuant to M. G.L. c. 26, § 1.

Existing Customer means an Applicant for a Motor Vehicle Liability Policy who has been insured for three years or longer, without interruption, under a Motor Vehicle Liability Policy or Policies which include(s) Physical Damage Coverage, issued by the Insurer to which the Applicant's application is submitted.

94.03: continued

Inspection Service means any person or legal entity, other than the Applicant, authorized by the Insurer to perform inspections required by 211 CMR 94.00. In determining whether to authorize an Inspection Service an Insurer may take into consideration the Inspection Service's professionalism, efficiency and cost effectiveness.

Insurer means any insurance company authorized to write Motor Vehicle Liability Policies in the Commonwealth.

Motor Vehicle Liability Policy means a motor vehicle liability policy, including the coverage selections page and any endorsements, or motor vehicle liability bond, as defined in M.G.L. c. 90, §§ 34A, 340, and M.G.L. c. 175.

Nonowned Motor Vehicle means a Private Passenger Motor Vehicle in the possession of the Applicant, or being operated by the Applicant, which is neither owned by nor furnished for the regular use of either the Applicant or any relative (as defined in a Motor Vehicle Liability Policy), other than a Temporary Substitute Motor Vehicle, as defined in 211 CMR 94.03.

Physical Damage Coverage means the optional coverages in a Motor Vehicle Liability Policy for collision or limited collision and/or fire and theft or so-called comprehensive coverages, as defined in M.G.L. c. 90, § 340 and M.G.L. c. 175, § 1130.

Private Passenger Motor Vehicle means any owned or leased four-wheeled motor vehicle including, but not limited to, sedans, coupes, hatchbacks, station wagons, jeep-type vehicles, pick-up trucks, panel trucks, delivery sedans and vans, except motor vehicles which have a gross weight in excess of 10,000 pounds.

Temporary Substitute Motor Vehicle means any Private Passenger Motor Vehicle not owned by the Applicant, which is used by the Applicant, with the permission of the owner, as a temporary substitute due to the breakdown, repair, servicing, loss or destruction of the Applicant's own motor vehicle.

94.04: Inspection Requirements

(1) No Motor Vehicle Liability Policy for a Private Passenger Motor Vehicle including Physical Damage Coverage shall be issued or renewed in the Commonwealth unless the Insurer has inspected the motor vehicle in accordance with 211 CMR 94.00.

(2) Physical Damage Coverage shall not be effective on an additional or replacement Private Passenger Motor Vehicle under an existing Motor Vehicle Liability Policy until the Insurer has inspected the motor vehicle in accordance with 211 CMR 94.00.

94.05: Mandatory Waiver of Inspection Requirements

(1) The Insurer shall waive an inspection of a Private Passenger Motor Vehicle under the following circumstances:

(a) the Private Passenger Motor Vehicle is a new, unused motor vehicle from a franchised automobile dealership where the Insurer is provided with either: a copy of the bill of sale which contains a full description of the motor vehicle including all options and accessories; or a copy of the RMV Form I provided by the Registry of Motor Vehicles (RMV), which establishes the transfer of ownership from the dealer to the customer and a copy of the window sticker or the dealer invoice showing the itemized options and equipment in addition to the total retail price of the motor vehicle. The Physical Damage Coverage on such new, unused Private Passenger Motor Vehicle shall not be suspended during the term of the Motor Vehicle Liability Policy due to the Applicant's failure to provide the required documents. Payment of a Physical Damage Coverage claim, however, shall be conditioned upon the receipt by the Insurer of such documents and no Physical Damage Coverage loss occurring after the effective date of the coverage shall be payable until the documents are provided to the Insurer. If the documents are not submitted by the Applicant at least 60 days prior to the Applicant's policy renewal date, the Insurer, upon renewal of the Physical Damage Coverage, shall require an inspection as set forth in 211 CMR 94.00;

94.05: continued

(b) the Applicant for Physical Damage Coverage is an Existing Customer;

(c) the Private Passenger Motor Vehicle already is insured for such Physical Damage Coverage with the Insurer by the Applicant;

(d) the Insurer waives the inspection pursuant to 211 CMR 94.06;

(e) the Private Passenger Motor Vehicle is a Temporary Substitute Motor Vehicle;

(f) the Private Passenger Motor Vehicle is leased for less than six months, provided the Insurer receives a copy of the lease or rental agreement containing a description of the leased motor vehicle including its condition. Payment of a Physical Damage Coverage claim shall be conditioned upon receipt of a copy of the lease or rental agreement;

(g) the inspection would cause a serious hardship to the Insurer or the Applicant; or

(h) the Insurer has no Authorized Representative or Inspection Service either in the city or town in which the Private Passenger Motor Vehicle is principally garaged, or within five miles of said city or town.

(2) An Insurer may require an inspection of a Private Passenger Motor Vehicle otherwise exempt from such inspection pursuant to 211 CMR 94.05(1) provided that the decision to inspect is based on underwriting criteria uniformly applied, and such decision is reasonable and supported by objective facts. The decision to require such an inspection shall not be based on the age, nice, sex, marital status, creed, national origin, religion, occupation, income, education, credit information or homeownership of the Applicant or the customary operators of the motor vehicle, the principal place where the motor vehicle is garaged, or the fact that the Motor Vehicle Liability Policy has been issued through the residual market.

An Insurer shall indicate the reasons for requiring an inspection, pursuant to 211 CMR 94.05(2), in the Applicant's policy record.

94.06: Optional Waiver of Inspection Requirements

(I) An Insurer may waive an inspection of a Private Passenger Motor Vehicle under any of the following circumstances:

(a) for Motor Vehicle Liability Policies issued or renewed with Physical Damage Coverage during the current calendar year, when the difference between the current calendar year and the model year designated by the manufacturer of the motor vehicle is ten years or more. For example, if the calendar year is 2002, the Insurer may waive the inspection for all 1992 and older model year motor vehicles. An Insurer may elect to inspect specified motor vehicles included within this optional waiver. Such exceptions to this optional waiver shall be subject to underwriting criteria uniformly applied, and shall be reasonable and supported by objective facts. The decision to require such an inspection shall not be based on the age, race, sex, marital status, creed, national origin, religion, occupation, income, education, credit information or homeownership of the Applicant or the customary operators of the motor vehicle, the principal place where the motor vehicle is garaged, or the fact that the Motor Vehicle Liability Policy has been issued through the residual market;

(b) where a Nonowned Motor Vehicle is insured under a Motor Vehicle Liability Policy providing Physical Damage Coverage issued by an Insurer which has inspected such motor vehicle in accordance with the provisions of 211 CMR 94.00;

(c) where the Private Passenger Motor Vehicle is insured under a commercially-rated Motor Vehicle Liability Policy;

(d) when an insurance producer is transferring a Book of Business from one Insurer to one or more Insurers;

(e) when an insurance producer is transferring an individual Applicant's coverage from one Insurer to another Insurer. The new Insurer may require the insurance producer to provide the inspection information completed on behalf of the former Insurer, provided the Private Passenger Motor Vehicle previously was inspected by the former Insurer. If the new Insurer does not receive the inspection information 60 days prior to the first policy renewal date of the Physical Damage Coverages, the new Insurer may require an inspection as set forth in 211 CMR 94.00 prior to the first policy renewal;

(f) when the Private Passenger Motor Vehicle is insured for Physical Damage Coverage on the Applicant's expiring or cancelled Motor Vehicle Liability Policy, providing there is no lapse in coverage, or when the prior pre-insurance inspection information is provided; or

94.06: continued

(g) when the Applicant has been the customer of the insurance producer of record or the Insurer for at least three years under a Motor Vehicle Liability Policy which included Physical Damage Coverage.

(2) An Insurer also may waive an inspection if it files a plan for waiving pre-insurance inspections on Private Passenger Motor Vehicles, subject to the approval of the Commissioner. Such pre-insurance inspection plans shall comply with the following requirements:

(a) the Insurer's plan shall comply with the provisions in 211 CMR 94.05 and 211 CMR 94.08(4);

(b) the Insurer's plan shall require the following documentation be included in the Insurer's policy records for the Applicant:

1. The reason for requiring a pre-insurance inspection;
2. The reason for any exceptions to any other provisions of the Insurer's plan; and
3. The notification(s) made to the Applicant in connection with any required pre-insurance inspections.

(c) the decision criteria for waiving the pre-insurance inspections required by 211 CMR 94.00 set forth in the Insurer's plan shall not consider the Applicant's membership in any group subject to a group marketing plan approved by the Commissioner pursuant to M.G.L. c. 175, § 193R;

(d) the decision criteria for waiving the pre-insurance inspections required by 211 CMR 94.00 set forth in the Insurer's plan shall not be based on the loss ratio for an insurance producer, where such loss ratio is calculated using premium and loss experience incurred prior to December 31, 2008 for personally-rated Motor Vehicle Liability Policies;

(e) any provisions of the Insurer's plan that permit the Insurer to elect to inspect a Private Passenger Motor Vehicle for which inspection customarily is waived under such plan shall be based on underwriting criteria uniformly applied, and the decision to inspect such motor vehicle shall be reasonable and supported by objective facts. The decision to require such an inspection shall not be based on the age, race, sex, marital status, creed, national origin, religion, occupation, income, education, credit information or homeownership of the Applicant or the customary operators of the motor vehicle, the principal place where the motor vehicle is garaged, or the fact that the Motor Vehicle Liability Policy has been issued through the residual market; and

(f) any provisions of the Insurer's plan that set forth a period of time for the completion of a pre-insurance inspection following the effective date of a Motor Vehicle Liability Policy shall be based on underwriting criteria uniformly applied, and shall be reasonable and supported by objective facts. The period of time for obtaining the pre-insurance inspection shall not be based on the age, race, sex, marital status, creed, national origin, religion, occupation, income, education, credit information or homeownership of the Applicant or the customary operators of the motor vehicle, the principal place of where the motor vehicle is garaged, or the fact that the Motor Vehicle Liability Policy has been issued through the residual market.

(3) An Insurer's decision to waive or not to waive a pre-insurance inspection of a Private Passenger Motor Vehicle pursuant to 211 CMR 94.06(1) or (2) shall be based on underwriting criteria uniformly applied and shall be reasonable and supported by objective facts. The decision to require a pre-insurance inspection shall not be based on the age, race, sex, marital status, creed, national origin, religion, occupation, income, education, credit information or homeownership of the Applicant or the customary operators of the motor vehicle, the principal place where the motor vehicle is garaged, or the fact that the Motor Vehicle Liability Policy has been issued through the residual market.

(4) When an Insurer does not waive the pre-insurance inspection requirement, the Insurer shall indicate the underlying reason in the Applicant's policy record.

94.07: Deferral of Inspection Requirements

(1) An Insurer may defer an inspection for ten calendar days (not including legal holidays and Sundays) following the effective date of coverage or the date on which the Insurer or the insurance producer of record issued notice to the Applicant that the Private Passenger Motor Vehicle must be inspected, whichever is later, if an inspection at the time of the request for coverage would create a serious inconvenience for the Applicant.

(2) If the Insurer is required, pursuant to M.G.L c. 175, § 113H, to provide Physical Damage Coverage at the option of the Applicant, it shall provide immediate coverage upon an Applicant's request for such Physical Damage Coverage, and may defer the inspection for ten calendar days (not including legal holidays and Sundays) following the effective date of such coverage or the date on which the Insurer or the insurance producer of record issued notice to the Applicant that the Private Passenger Motor Vehicle must be inspected, whichever is later.

(3) (a) When an inspection is deferred pursuant to 211 CMR 94.07(1) or (2), an Insurer or its insurance producer, shall either:

1. immediately obtain written acknowledgment from the Applicant if the Applicant has applied for coverage in person; or

2. immediately confirm Physical Damage Coverage on the Private Passenger Motor Vehicle and issue a notice to the Applicant, if the Applicant has applied for coverage either by mail, phone, or internet.

(b) In addition to the notice requirements of 211 CMR 94.07(3)(a), the Insurer, or its insurance producer, shall furnish the Applicant, at the time Physical Damage Coverage is effected, with a list of Inspection Services, including location(s), at which the inspection can be conducted. The list of Inspection Services may be provided to the Applicant in writing, through a toll free number or by electronic access, as convenient for the Applicant. The Applicant immediately shall be notified of the location of the Inspection Service(s), as well as the consequences of the Applicant's failure to obtain a timely inspection of the motor vehicle. Documentation of such notice, including the name of the person providing such notice to the Applicant, shall be contained in the Applicant's policy record.

(4) Insurance producers immediately shall notify the Insurer that the Applicant has acknowledged or has been issued notice that the Private Passenger Motor Vehicle must be inspected in accordance with 211 CMR 94.07(3)(a). In the case of a so-called courtesy transfer, the insurance producer confirming Physical Damage Coverage shall be responsible for obtaining the Applicant's acknowledgment pursuant to 211 CMR 94.07(3)(a) 1., unless the application for Physical Damage coverage is submitted by a person other than the Applicant. In such cases, the insurance producer of record shall remain responsible for notification pursuant to 211 CMR 94.07(3)(a) 2 and 94.07(3) (b). The insurance producer confirming coverage shall notify immediately the insurance producer of record who then shall be responsible for notifying the Insurer as required by 211 CMR 94.07(4).

(5) Any decision to defer or not to defer an inspection pursuant to 211 CMR 94.07 shall be based on underwriting criteria uniformly applied and shall be reasonable and supported by objective facts. The decision to defer or not to defer an inspection shall not be based on the age, race, sex, marital status, creed, national origin, religion, occupation, income, education, credit information, or homeownership of the Applicant or the customary operators of the motor vehicle, the principal place where the motor vehicle is garaged, or the fact that the Motor Vehicle Liability Policy has been issued through the residual market.

94.08: Standards and Procedures for Inspection

(1) Pre-insurance inspections required or permitted pursuant to 211 CMR 94.00 shall be conducted by an Authorized Representative of the Insurer at a time and place reasonably convenient to the Applicant. A reasonably convenient time shall include, in addition to customary business hours, sufficient early morning, evening and weekend hours. A reasonably convenient place shall not be more than five miles from the city or town where the Private Passenger Motor Vehicle is principally garaged.

94.08: continued

(2) (a) Any forms issued by the Insurer to the Applicant for presentation to the Authorized Representative shall not contain the Vehicle Identification Number (VIN) of the motor vehicle to be inspected.

(b) The inspection shall:

1. be recorded in a format mutually agreeable to the Authorized Representative and the Insurer;

2. include two color photographs of the Private Passenger Motor Vehicle, taken as directed by the Insurer;

3. include a close-up color photograph (using a special camera attachment if necessary) showing the Vehicle Identification Number (VIN) located on the Environmental Protection Agency/Federal Certification Label (EPA) sticker affixed to the driver's side door jamb. The photograph shall be of sufficient clarity that the information contained on the EPA sticker and the VIN is legible. If the EPA sticker is damaged, faded, missing or otherwise not legible, a photograph of the EPA sticker or of the area of the door jamb where the sticker normally is located still is required.

(c) The Authorized Representative shall take additional photographs showing any damaged areas of the Private Passenger Motor Vehicle, as required by the Insurer.

(d) The inspection information and photographs shall be sent immediately to the Insurer which shall retain this information in the Applicant's policy record for three years from the date of the inspection, except as provided by 211 CMR 94.08(6)(c). The Authorized Representative shall also provide a receipt to the Applicant at the time of the inspection indicating that the inspection has been completed and the date upon which it has been completed.

(3) The Insurer shall maintain an up-to-date list of all Authorized Representatives and Inspection Service(s) performing inspections for the Insurer. The list shall include the names, addresses and business telephone numbers of all Authorized Representatives and Inspection Services, and the Insurer shall make such list available to the Division upon request.

(4) There shall be no additional or separate charge to the Applicant in connection with an inspection of a Private Passenger Motor Vehicle.

(5) The competency and trustworthiness of all Authorized Representatives in the conduct of the inspections provided by 211 CMR 94.00 shall be the responsibility of the Insurer.

(6) An Insurer shall utilize Authorized Representatives who shall:

(a) verify the accuracy, completeness and signature of the inspector for each inspection in writing;

(b) maintain a control system on such inspections, and maintain records of the inspection information for a period of time agreed to by the Insurer and the Authorized Representative;

(c) provide an optional service, on an additional fee basis, to Insurers whereby the original inspection information and photographs are retained by the Authorized Representative, who shall maintain such original inspection information and photographs in a manner so as to facilitate their rapid retrieval for a period of at least three years from the date of inspection. The inspection information and photographs shall be provided to the Insurer. The Authorized Representative shall, upon the request of the Insurer, mail or otherwise deliver the original inspection information and photographs to the Insurer within two business days of such request.

(7) (a) The inspection information and photographs shall be used by the Insurer to document previous damage, prior condition, options and mileage of the Private Passenger Motor Vehicle on Physical Damage Coverage claims whenever:

1. the appraisal of the motor vehicle indicates prior damage; or
2. the motor vehicle is a total loss or unrecovered theft.

(b) The inspection information and photographs shall be utilized and made a part of the Insurer's claim file in the settlement of all total loss claims. The inspection information and photographs shall be made a part of the claim file regardless of whether payment 011 the claim is reduced based on such information. Such inspection information shall come from the Applicant's policy record.

94.09: Standards for Suspension of Physical Damage Coverage for Failure to Inspect

(1) If the inspection is not conducted prior to the expiration of the deferral period specified in 211 CMR 94.07(1), Physical Damage Coverage on the Private Passenger Motor Vehicle shall be suspended at 12:01 AM. of the day following the tenth calendar day allowed by 211 CMR 94.07(1), and shall continue until the inspection is effected. The Insurer shall reinstate Physical Damage Coverage (effective at the time of the inspection) if the Applicant thereafter requests an inspection. The Applicant's ability to reinstate the Physical Damage Coverage upon inspection, however, shall lapse if the Insurer already has made *a pro-rata* premium adjustment pursuant to 211 CMR 94.09(2). Thereafter, a reinstatement of Physical Damage Coverage only shall be effective upon inspection and payment by the Applicant to the Insurer of the adjusted premium for the Physical Damage Coverage, either in full or in accordance with the Insurer's normal premium payment plan, at the Insurer's option.

(2) Whenever Physical Damage Coverage is suspended, the Insurer shall, within five business days from the effective date of suspension, mail to the Applicant, the insurance producer of record, and any lienholders a notice that Physical Damage Coverage has been suspended under the Motor Vehicle Liability Policy. The Insurer shall complete a Certificate of Mailing of such notice of suspension of Physical Damage Coverage to the Applicant and shall include this information in the Applicant's policy record. Whenever there is a suspension of Physical Damage Coverage for more than ten days, the Insurer shall make a *pro-rata* premium adjustment (return premium or credit) which shall be mailed to the Applicant no later than 45 days after the effective date of such suspension.

(3) If the Private Passenger Motor Vehicle is not inspected pursuant to 211 CMR 94.00 because the Insurer or its insurance producer failed to provide the notice(s) or to obtain the acknowledgement(s) required by 211 CMR 94.07(3), Physical Damage Coverage on the Motor Vehicle Liability Policy shall not be suspended. The failure of the Insurer to act promptly does not relieve it of its obligation to inspect the motor vehicle. In the event that the Insurer or its insurance producer fails to comply properly with the notice or acknowledgement required by 211 CMR 94.07(3), the Insurer or the insurance producer shall issue a notice for a pre-insurance inspection and the Applicant has ten calendar days to comply. An Insurer's failure to comply with the provisions of211 CMR 94.09(2), however, does not restore Physical Damage Coverage, but shall subject the Insurer to a penalty pursuant to 21 1 CMR 94.12.

94.10: Inspection Services

(1) Inspection Services shall maintain a record of the name, address and signature of all persons authorized by such Inspection Service to perform inspections on motor vehicles, prior to that person performing any inspections on behalf of an Insurer pursuant to 211 CMR 94.00. Such record shall be made available to the Division upon request.

(2) An Inspection Service shall be authorized by the Insurer for which it will be conducting inspections. In determining whether to authorize an Inspection Service an Insurer may take into consideration the service's professionalism, efficiency and cost effectiveness.

94.11: Conflicts of Interest

An Authorized Representative shall not have any conflicts of interest which may prevent him or her from conducting a thorough and accurate pre-insurance inspection on behalf of the Insurer. It shall be a conflict of interest for an Authorized Representative to accept, in connection with an inspection, anything of value for conducting such inspection from any source other than the Insurer.

94.12: Enforcement

(J) A violation of any provision of 211 CMR 94.00 by an Insurer shall be deemed a violation under the statutes or regulations under which such Insurer is licensed and shall be sufficient grounds, after hearing, for the imposition of fines as prescribed in the licensing statutes or regulations. Any such violation also shall be considered an unfair or deceptive act or practice in the business of insurance in violation of M.G.L. c. 176D.

(2) A violation of any provision of 211 CMR 94.00 by an Authorized Representative shall be deemed a violation under the statutes or regulations under which such Authorized Representative is licensed by the Division, if so licensed, and shall be sufficient grounds, after hearing, for the suspension or revocation of such license and for the imposition of fines as prescribed in the licensing statutes or regulations. Any such violation also shall be considered an unfair or deceptive act or practice in the business of insurance in violation of M.G.L. c. 176D.

(3) The competency and trustworthiness of all Authorized Representatives in the conduct of inspections provided by 211 CMR 94.00 shall be the responsibility of the Insurer.

(4) Nothing contained in 211 CMR 94.00 shall be deemed to preclude the Applicant, the Commissioner or the Attorney General from pursuing any other remedy or penalty provided by law for a violation of 211 CMR 94.00, including any remedy or penalty provided under M.G.L. c. 93A or M.G.L. c. 176D.

94.13: Records and Audits

Insurers shall be responsible for auditing pre-insurance inspections received from their Authorized Representatives. Insurers may provide Authorized Representatives with status reports indicating the total number of completed inspections, including the number of inspections that were incomplete or incorrect, at the option of the Insurer.

94. 14: Severability

If any section or portion of a section of 211 CMR 94.00 or its application to any person, entity or circumstance is held invalid by any court of competent jurisdiction, the remainder of 211 CMR 94. 00, or the applicability of such provision to other persons, entities or circumstances, shall not be affected thereby.

REGULATORY AUTHORITY

211 CMR 94.00: M.G.L. c. 175, § 113S.

7/24/09

TITLE XIV.
PUBLIC WAYS AND WORKS.

CHAPTER 90D. MOTOR VEHICLE CERTIFICATES OF TITLE.

Chapter 90D: Section 20. Application for salvage title for total loss salvage motor vehicle; surrender of certificate of title.

Section 20. (a) Whenever an insurer acquires ownership of a motor vehicle which it has determined to be a total loss salvage motor vehicle, it shall, within ten days from the date of acquisition, surrender the certificate of title to the registrar and shall apply for a salvage title.

(b) Whenever an insurer makes a total loss settlement on a vehicle which it has determined to be a total loss salvage motor vehicle and the insured owner or claimant retains possession and ownership of the vehicle, the insurer shall notify the registrar of such retention on a form prescribed by the registrar and the owner shall, within ten days of such settlement, surrender the certificate of title to the registrar and shall apply for a salvage title. The insurer shall notify the insured owner or claimant of said owner's or claimant's responsibility to comply with the provisions of this section.

(c) Whenever a motor vehicle which is not the subject of an insurance settlement is damaged to such an extent that the owner determines said vehicle to be a total loss salvage motor vehicle, the owner shall surrender the certificate of title to the registrar and shall promptly apply for a salvage title.

(d) A total loss salvage motor vehicle shall not be titled under this chapter or registered for operation under chapter ninety unless the owner complies with the provisions of section twenty D. The owner of a total loss salvage motor vehicle shall not transfer such vehicle except in accordance with section twenty C.

CHAPTER 175. INSURANCE.

Chapter 175: Section 24D. Lump sum insurance payments; exchange of claimant information between IV-D agency and insurance companies; withholding of past-due child support subject to lien.

Section 24D. (a) Prior to making any nonrecurring payment equal to or in excess of $500 to a claimant under a contract of insurance, every company authorized to issue policies of insurance pursuant to chapter 175 shall exchange information with the IV-D agency, as set forth in chapter 119A, to ascertain whether such claimant owes past due child support to the commonwealth or to an individual to whom the IV-D agency is providing services, and is subject to a child support lien pursuant to section 6 of said chapter 119A. To determine whether a claimant owes past due child support, the company shall either provide the IV-D agency with information about the claimant, or examine information made available by the IV-D agency and updated not more than once a month. If the company elects to provide the IV-D agency with information about such claimant, the company shall provide to the IV-D agency, no less than ten business days prior to making payment to such claimant, the claimant's name, address, date of birth and social security number as appearing in the company's file, and such other information appearing in the company's file as the commissioner of revenue may require by regulation in consultation with the commissioner of insurance. The company shall use a method and format prescribed by the commissioner of revenue. If the company is unable to use a method and format prescribed by the commissioner of revenue, such company shall cooperate with the IV-D agency to identify another method or format, including submission of written materials. If the company elects to examine information made available by the IV-D agency and such claimant owes past due child support and is subject to a lien, the company shall notify the IV-D agency, no less than ten business days prior to making payment to such claimant, of the claimant's name, address, date of birth and social security number as appearing in the company's file, and such other information appearing in the company's file as the commissioner of revenue may require by regulation in consultation with the commissioner of insurance, using a method and format prescribed by the commissioner of revenue. The company may remit to the IV-D agency the full amount of the lien or the full amount otherwise payable to the claimant at the time that it so notifies the IV-D agency at any time prior to making payment to the claimant, without regard to the ten business day period. If, at any time prior to payment, the IV-D agency notifies the company of its child support lien against such claimant by giving the company a notice of levy pursuant to section 6 of said chapter 119A, the company shall withhold from the payment the amount of past due support as set forth in the notice of levy and shall provide such amount to the IV-D agency for disbursement to the obligee. The child support lien shall encumber the right of the claimant to payment under the policy and the company shall disburse to the claimant only that portion of the payment, if any, remaining after the child support lien has been satisfied.

For the purposes of this section, the word "claimant" shall mean an individual who brings a claim against an insured under a liability insurance policy or the liability coverage portion of a multiperil policy, or a beneficiary under a life insurance policy.

(b) This section shall not apply to that portion of a claim resulting in payments on behalf of the claimant issued to a third party where there is documentation showing that the third party has provided or agreed to provide the claimant with a benefit or service related to the claim including, but not limited to, the services of an attorney or a medical doctor, or to any portion of a claim based on damage to or a loss of real property. The commissioner of

revenue, in consultation with the commissioner of insurance, shall promulgate regulations setting forth procedures for making payment to the IV-D agency when a third party has either provided or agreed to provide goods or services to the claimant, and the insurance company cannot reasonably determine the remaining amount payable to the claimant.

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

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

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

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

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

Appendix J

CAR Compliance Audit Claim Review Process
Section 1 - MAIP Policies

Effective April 2010 the Performance Standards Claims and SIU Reviews have been incorporated into the Hybrid Audit Plan approved by the Governing Committee in February 2010 and forwarded to the Division of Insurance. The Hybrid Audit Plan includes the Premium and Claims Statistical audits, Claims Performance Standards reviews, and SIU reviews.

The following procedures replace the Claims Review process contained in Appendix K effective November 13, 2009.

One of the four primary objectives of the audit is to verify adherence to statutory requirements. The review will evaluate the company's compliance with the key statutory requirements of MGL, c. 175, § 113 H:

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

Performance Standards

The Performance Standards approved by the Commissioner of Insurance on November 13, 2009 will remain in effect. Completion of the Questionnaire by the ARC will certify that its claims handling programs comply at a minimum with the Performance Standards.

Cycle and Sample

For all private passenger business, the current claim audits have transitioned to a three year cycle. In this new cycle, every actively reporting Member and ARC will be audited. The cycle will be continually evaluated as new Members enter the Massachusetts private passenger automobile insurance market. The ARC Questionnaire and internal documentation including, but not limited to, claim manuals, reserving and claim settlement procedures, and internal audits will be reviewed at the onset of the examination.

Under the Hybrid Audit Plan all of an individual Member or ARC compliance audits will be conducted concurrently using a consistent sample selection. The sample size will be 270 policies with at least one claim. Data for the Audit is verified at a 90% confidence level with a standard error rate of + 5% through stratified random sample audits for all functions.

Measurements & Penalties

Rather than measuring the individual Performance Standards on the benchmark of 90% for claim procedures Voluntary and MAIP claims will be reviewed for compliance with policy provisions and applicable statutes, rules, and regulations for the following Best Practices:

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

The benchmark for compliance with these Best Practices is 93% in accordance with the NAIC error tolerance of 7% for standards involving claim resolution.

Compliance will be measured as YES, NO, or NA. If NO, a COMMENT will be entered into the worksheet with an explanation. Chi square testing will be conducted on each Best Practice Voluntary and MAIP score to determine if there is any statistical difference in handling. If the aggregate score is less than 93% or the difference is statistically significant the Member or ARC will be required to address the reasons in their response and submit a remedial action plan. The Governing Committee will determine if a penalty should be assessed based on the recommendation of the Compliance Audit Committee.

Private Passenger Ceded Pool Run-off

As the volume of claims in the Private Passenger Ceded Pool diminishes the remaining ceded claims will be reviewed with a twofold approach:

Ad Hoc Reviews - Large Loss/Indemnity/Reserve Review

As part of the current Large Loss review procedures ceded claims will be selected quarterly from the Loss Limitations Report. Criteria for selection include large reserve and indemnity payments, litigation files, payments over a certain threshold, and allocated expenses. CAR will request a summary of the claim file which should include large loss reports, settlement reports, and/or adjuster notes. CAR will reserve the right to review the entire file if necessary but on the majority of the cases the summary information would be sufficient.

Bodily Injury Claim Reviews

A random sample of ceded bodily injury claims will be reviewed during the course of the triennial audit. Files selected will have claim activity including indemnity and/or expense payments and reserves within the rolling 12 month audit period. The sample would be on approximately 5 to 10 percent of the claims having activity. Results of this review will be included in the Audit Summary Report. The Compliance Audit Committee will review the volume of ceded claims and these run-off review procedures annually.

Definitions

Contact: Under the PIP and BI Standards Contact must be either in person or by telephone call. If the injured party cannot be reached on this initial contact a letter or email may be sent as a follow-up.

IME (Independent Medical Examination): A physical examination of the injured party to document the injury and provide an opinion on whether the treatment is reasonable, necessary, and appropriate for the injury sustained. Cut off dates may be established.

Medical Audit: Peer reviews of some or all of a claimant's medical bills and/or records by doctors, nurses, or other medical professionals.

MBR (Medical Bill Review): A review of medical bills using a computerized/expert system, PPO, or provider of the same medical discipline as the provider bills being reviewed. Bills are checked for reasonableness of cost and modality. Duplication of treatments or unnecessary modalities are eliminated and not paid.

Appendix K

CAR SIU File Review Process
Section 1 - MAIP Policies

The following procedures will replace the SIU Review process contained in Appendix L Claims Review process contained in Appendix L effective November 13, 2009:

ARCs are required by MGL, c. 175, § 113 H and Rule 30 to maintain a Special Investigative Unit to investigate suspicious or questionable motor vehicle insurance claims for the purpose of eliminating fraud. Rule 32 C. requires that special investigative units investigate claims on any policies that are issued through MAIP and on policies issued on a voluntary basis by ARCs. An SIU must have at least one full time employee whose responsibility is principally directed towards the recognition and investigation of fraud.

ARCs will continue to report SIU activity - assignments, denials, compromises, and savings to CAR on a quarterly basis along with their log identifying those cases. During the triennial audit a sample of cases selected from the SIU log will be reviewed to determine the effectiveness of the Carriers' fraud screening and quality of the SIU investigations.

Definitions

SIU: Special Investigations may be performed by SIU personnel or other personnel trained to handle suspicious claims using activity checks, surveillance, accident reconstruction, statements or examinations under oath. Special investigations also include third party expert analysis of documents associated with suspicious claims. Liability investigations are not considered to be special investigations.

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RALPH A. IANNACO
PRESIDENT

Questionnaire

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

Massachusetts General Laws Chapter 175, Section 113H requires Commonwealth Automobile Reinsurers (CAR) to establish Performance Standards designed to contain costs, ensure prompt customer service and payment of legitimate claims, and resist inflated, fraudulent, and unwarranted claims.

The Performance Standards which C.A.R. has developed require Assigned Risk Carriers to establish various plans and programs. In many instances, this only required formalizing and/or enhancing current practices and procedures. In other instances, detailed plans and programs needed to be developed by the Assigned Risk Carriers to comply with the Standards.

This Questionnaire will be sent to the Assigned Risk Carriers approximately 30 days prior to the commencement of its periodic review and will be used by CAR Compliance Audit Staff to provide background information on claims handling programs established by the Assigned Risk Carrier.

Effective April 1, 2008 Commissioner of Insurance Nonnie S. Burnes approved competitive rating for Massachusetts Automobile Insurance. Assigned Risk Carriers should identify any additional coverages and services they are offering that may exceed specific approved Performance Standards. In the event that a difference exists between the Standard and a coverage offered by the Assigned Risk Carrier the policy coverage will supersede the Standard.

Company Name: _____

Signature: _____

Name & Title: _____

I. Auto Physical Damage & Property Damage Liability Claims

A. Auto Body Payments

2. Direct Payment Plan

a. Do you have a Direct Payment Plan? **YES** **NO**

5. Total Loss Payments

a. What procedures do you use to determine the actual cash value of a vehicle?

B. Normal Claims Handling

1. Initial Screening of Reports of Accidents & Losses

- Briefly describe your procedures for the initial screening of accidents and losses to identify warning signs requiring special investigation and the assignment of these losses to a person with sufficient experience and training.

2. Initial Investigation

a. What procedures does your company utilize for the review of policy information to resolve coverage issues including garaging and operators, and to notify Underwriting where appropriate?

c. What is your company's documented policy for establishing initial reserves on physical damage claims?

C. Fraud Handling

1. Briefly describe the operation of your Special Investigative Unit. Include staff level and number, types of cases handled, screening process, and procedures for referrals to the SIU.

D. Glass

3. What is your percentage of glass claims repaired to total paid glass claims?

Please list any additional coverages and/or services you offer that may conflict with the Auto Physical Damage & Property Damage Liability Claims, i.e. deductible forgiveness, OEM parts replacement. Indicate how this coverage is identified in the claim documentation.

_____
_____
_____
_____
_____
_____

II. Bodily Injury and Uninsured/Underinsured Motorist

A. Normal Claims Handling

1. Initial Screening of Reports of Accidents & Losses

   - Briefly describe your procedures for the initial screening of accidents and losses to identify warning signs requiring special investigation and the assignment of these losses to a person with sufficient experience and training.

2. Initial Investigation

   a. What procedures does your company utilize for the review of policy information to resolve coverage issues including garaging and operators, and to notify Underwriting where appropriate?

   c. What is your company's documented policy for establishing initial reserves on bodily injury claims? What is your policy for changing reserves to insure they are timely and reasonable?

4. Loss Management

   - What procedures has your company established to determine whether the disability claimed, medical treatment, and medical expenses are reasonable, necessary, and related to the auto accident?

5. Follow Up & Continuing Investigation

- What diary systems do you employ for bodily injury claims?

- How do you determine that authority levels are followed?

6. Settlement Negotiations or Denial

   - What procedure does your company use to evaluate bodily injury and UM claims? Do you use any third party evaluation tool?

7. Cases in Suit

   a. Briefly describe your Litigation Management Program designed to bring cases to the earliest conclusion at a reasonable value.

B. Fraud Handling

1. Screening Process for Suspected Fraudulent Claims

   - Briefly describe your process for referring suspicious bodily injury claims for special investigation.

3. Evaluation and Settlement

   - Describe your procedure for resolving cases that have been referred for special investigation.

III. No Fault Personal Injury Protection Benefits Handling

A. Screening Reports and Initial Investigation

1. Briefly describe your procedures for the initial screening of accidents and losses to identify warning signs requiring special investigation and the assignment of these losses to a person with sufficient experience and training

C. Medical Management

1. What procedures has your company established to determine whether medical treatment and expenses are reasonable, necessary, and related to the auto accident?

2. What procedures has your company established for consideration of Independent Medical Exams, 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?

F. Claim Payment

1. Describe your Litigation Management Program on PIP claims designed to bring cases to the earliest conclusion at a reasonable value.

IV. Voluntary/Ceded Claim Handling Differential

- How do you insure that involuntary claims are processed with the same degree of diligence as are voluntary claims?

V. Expenses

- What procedures has your company established for controlling legal defense costs, including reviewing legal bills for accuracy and reasonableness and utilizing alternative dispute resolution programs?

- What procedures has your company established to insure that allocated expenses are reported properly as defined in the statistical plan and that extra-contractual and unallocated expenses are not reported as allocated?

Appendix M – Industry Best Practices - Performance Standards

Assignment

I A 1 c	Appraisal Assignment
I B 1 a	Physical Damage Screening & Assignment
II A 1 a	Bodily Injury Assignment & Screening
III A 1	PIP Assignment

Coverage Analysis

I B 2 a & f	Physical Damage Coverage
II A 2 a	Bodily Injury Coverage
III A 2 a to f	PIP Coverage

Initial Contacts

I B 2 b	Physical Damage Contact
II A 3 a to c	Bodily Injury Contact
III B 1 to 4	PIP Contact

Investigation

I B 1 & 2	Physical Damage Initial Screening & Investigation
II A 1 & 2	BI Initial Screening & Investigation
III A 1 & 2	PIP Initial Screening & Investigation

Follow-Up/Control

I B 4	Physical Damage Prompt Evaluation & Settlement
II A 5	BI Follow-Up & Continuing Investigation
III F 1	PIP Claim Payment

Evaluation

I B 4	Physical Damage Evaluation & Settlement
II A 6 a to f	Bodily Injury Settlement Negotiations or Denial
II B 3	Bodily Injury Fraud Handling Evaluation & Settlement
III F	PIP Claim Payment

Loss Management

I A 5 & 7	Physical Damage Total Loss Payments & Appraisal
I B 3	Physical Damage Normal Handling Appraisal Program
II A 4	Bodily Injury Loss Management
III C	PIP Medical Management

Appendix M – Industry Best Practices - Performance Standards

Reserving

I B 2 f	Physical Damage Initial Investigation
II A 2 e	Bodily Injury Initial Investigation
II A 5 e	Bodily Injury Follow-Up & Continuing Investigation
III A 3	PIP Initial Investigation

Litigation Management

II A 7 a to e	Bodily Injury – Cases in Suit
III F 1 g	PIP Claim Payment
V B	Expense – Legal Expense

Settlement

I B 4	Physical Damage Prompt Evaluation & Settlement
II A 6 a	Bodily Injury Settlement Negotiations or Denial
III F	PIP Claim Payment

Salvage

I A 5	Physical Damage Total Loss Payments

Recovery/Offsets

I B 6	Physical Damage Recovery
II B 9	Bodily Injury Recovery
III E	PIP Subrogation

Overpayment Analysis (Leakage)

I C 4	Physical Damage Evaluation & Settlement
II A 6 a	Bodily Injury Settlement Negotiations or Denial
III F	PIP Claim Payment

Appendix N

NAIC Standards - CAR Rule 32 & Performance Standards
Section 2 - MAIP Policies

The NAIC Standards for Claims as defined in the NAIC Market Conduct Examiners Handbook Chapter VIII are based on two model acts, the Unfair Claims Settlement Practices Act and the Unfair Property and Casualty Claims Settlement Practices Model Regulation. In Massachusetts unfair claim settlement practices are defined in G.L. c. 176D §3 Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance. CAR Rule 32 is modeled on this statute and contains the elements of unfair claim settlement practices defined in §3 (9). The following identifies where the NAIC Standards are contained in Rule 32 and the Performance Standards.

NAIC Standard 1
The initial contact by the company with the claimant is within the required time frame.

Performance Standards
PS I B 2 B Physical Damage Contact

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

PS II A 3 a to c Bodily Injury Contact

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.

PS III B 1 to 4 PIP Contact

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.

NAIC Standard 2
Timely Investigations are conducted.

CAR Rules of Operation
Rule 32

A. Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:
1. Comply with the standards for prompt investigation of claims;

Performance Standards
PS I B 2 Physical Damage Initial Screening & Investigation

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

PS II A 2 BI Initial Investigation

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

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.

PS III A 2 PIP Initial Screening & Investigation

1. 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, workers compensation.

NAIC Standard 3
Claims are resolved in a timely manner.

CAR Rules of Operation
Rule 32
A. Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:
3. Effectuate prompt, fair and equitable settlements of claims in which liability is reasonably clear;
B. In the handling of residual market claims, ARCs shall not:
3. Fail to promptly settle claims, where liability is reasonably clear, under one portion of the policy coverage in order to influence settlements under other portions of the policy coverage.

Appendix N - NAIC Standards PP

Performance Standards
PS I B 4 Physical Damage Prompt Evaluation & Settlement
a. After initial investigation is complete, a decision must be made to promptly process for settlement or refer case for special investigation.

PS II A 6 Bodily Injury Settlement Negotiations or Denial
b. Evaluate and pursue warranted settlements when the injury and expense end result can be established.

PS III F PIP Claims Payment
1. There should be no payment until the claimed loss has been verified and:

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

NAIC Standard 4
The Company responds to claim correspondence in a timely manner.

CAR Rules of Operation
Rule 32
A. Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:
7. Acknowledge and act promptly upon communications regarding claims.

NAIC Standard 5
Claim files are adequately documented.

Performance Standards
I B 4 b Physical Damage Evaluation & Settlement
a. The file must clearly document the basis for the decision and result.

II A Bodily Injury Settlement Negotiations or Denial
4b. ARCs should have a settlement evaluation plan to obtain reasonable negotiated settlements of warranted claims. Settlements should be within approved range or the reason clearly documented if exceeded.

II B Bodily Injury Fraud Handling Evaluation & Settlement
3. The file should clearly document the basis for the decision and result.

III F PIP Claim Payment
3. The file should clearly document the basis for the decision and result.

NAIC Standard 6
Claims are properly handled in accordance with policy provisions and applicable statues, rules, and regulations.

Performance Standards
Introduction: 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.

Several regulations and statutes are referenced in the Performance Standards and copies of these are contained in the Appendices.

NAIC Standard 7
Company uses the reservation of rights and excess of loss letters, when appropriate.

II A Bodily Injury Initial Investigation
2a. Reservation of Right letters and Excess of Loss letters should be used when and where appropriate.

II B Bodily Injury Cases in Suit
7b. Reservation of Right letters and Excess of Loss letters should be used when and where appropriate.

NAIC Standard 8
Deductible reimbursement to insureds upon subrogation recovery is made in a timely and accurate manner.

I B Physical Damage Claims Recovery
6b. Upon subrogation recovery the deductible should be reimbursed in a timely and accurate manner when and where appropriate.

NAIC Standard 9
Company claim forms are appropriate for the type of product.

The use of required State forms is included in the Standards. ARC claim forms are reviewed as they are encountered in the claim reviews and commented on in the Summary of Review if inappropriate.

NAIC Standard 10
Claim files are reserved in accordance with the company's established procedures.

CAR Rules of Operation
Rule 32
A. Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:
4. Maintain claim reserving procedures for claims arising out of residual market business commensurate with their procedures for claims arising out of voluntary business;

Performance Standards
PS I B 2 Physical Damage Initial Investigation
f. The setting of initial reserves should be timely, reasonable, and follow documented ARC policy.

PS II A 2e & 5 e Bodily Injury Initial & Follow-Up Investigation
The setting of initial reserves should be timely, reasonable, and follow documented ARC policy. Changes to reserves should be timely, reasonable, and follow documented ARC policy.

PS II A 3 PIP Initial Investigation

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

Standard 11
Denied and closed-without-payment claims are handled in accordance with policy provisions and state law.

CAR Rules of Operation
Rule 32
A. Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:
8. Promptly provide a reasonable explanation for denial of a claim or for the offer of a compromise settlement.

Performance Standards
I C 4 Physical Damage Evaluation & 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.

II B 3 Bodily Injury Fraud Handling Evaluation and Settlement
After special investigation is complete, a decision must be made to pay the claim or resist. The file must clearly document the basis for the decision and result.

III F 3 Claims Payment
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.

Note: Denials of claims are evaluated in SIU reviews.

NAIC Standard 12
Canceled benefit checks and drafts reflect appropriate claim handling practices.

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

NAIC Standard 13
Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies but offering substantially less than is due under the policy.

CAR Rules of Operation
Rule 32
A. Claim practices of each ARC shall correspond with those followed for voluntary business, and ARCs shall, in accordance with the Performance Standards and Best Practices:
3. Effectuate prompt, fair and equitable settlements of claims in which liability is reasonably clear;
B. In the handling of residual market claims, ARCs shall not:
3. Fail to promptly settle claims, where liability is reasonably clear, under one portion of the policy coverage in order to influence settlements under other portions of the policy coverage.

Performance Standards

I B 4 Physical Damage Prompt Evaluation & Settlement

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

II A 7 Bodily Injury – Cases in Suit

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

III F 1 PIP Claim Payment

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

NAIC Standard 14

Loss statistical coding is complete and accurate.

PS V Expenses

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

Note: Loss statistical coding is audited as part of the HAP audit.

2008-12 Clarification of Coordination of Benefits under M.G.L. c. 90, §34A and the Interrelationship by and among PIP, Health Insurance and Medical Payments

TO: **Motor Vehicle Insurers, Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations**

FROM: **Nonnie S. Burnes, Commissioner of Insurance**

DATE: **September 16, 2008**

RE: **Clarification of Coordination of Benefits under M.G.L. c. 90, §34A and the Interrelationship by and among PIP, Health Insurance and Medical Payments**

This bulletin clarifies certain provisions of Massachusetts Division of Insurance (the "Division") Coordination of Benefits; PIP, MedPay and Health Insurance/Self-funded Employee Benefit Plans, issued on September 21, 1990 (" Bulletin B-1990-2 "). In light of the recent Massachusetts Supreme Judicial Court ("SJC") decision in Metropolitan Property and Casualty Company v. Blue Cross Blue Shield of Massachusetts, Inc., 451 Mass. 389 (2008), the Division issues this bulletin to address the order for the coordination of benefits by and among Personal Injury Protection ("PIP") coverage, Medical Payments ("MedPay") coverage, and health coverage by a health insurance carrier for motor vehicle accident claimants. This bulletin clarifies Section 1 of Bulletin No. 90-02; it does not change Sections 2 and 3

PIP is a compulsory coverage included in all Massachusetts motor vehicle liability insurance policies. It pays up to $8,000 for a claimant's medical expenses and lost wages. M.G.L. c. 90, §§34A and 34M define PIP benefits under a standard Massachusetts motor vehicle insurance policy and §34A provides for the coordination of benefits between health insurance carriers and motor vehicle insurers.

MedPay is motor vehicle insurance coverage that pays for medical and funeral expenses incurred as a result of a motor vehicle accident. M.G.L. c. 175, §111C. Although motor vehicle insurers are required to offer MedPay coverage of "at least five thousand dollars" under M.G.L. c. 175, §113C, coverage is optional.

On May 12, 2008, the SJC held in Metropolitan that a health insurance carrier may defer coverage of medical costs in excess of $2,000 in instances where the claimant has a motor vehicle insurance policy that provides coverage for MedPay and where the health coverage policy contains a clause stating that coverage is secondary to other coverage for health care services ("deferral" language). 451 Mass. at 394-97.

The SJC found that, under M.G.L. c. 90, §34A, PIP benefits under a motor vehicle policy cover medical expenses in excess of $2,000 only if the medical expenses are not covered by a health coverage policy. It held that when a health insurance carrier defers coverage on the ground that MedPay benefits exist and that a clause in its contract permits it to do so in light of the existence of such other insurance, the motor vehicle insurer must pay those expenses from the MedPay benefits, rather than from the PIP benefits. Id. at 395. The SJC acknowledged that this holding was consistent with the Division's position, previously announced in Bulletin No. 90-02.

No question or dispute exists among health insurance carriers and motor vehicle insurers that the initial $2,000 in medical expenses must be submitted to the motor vehicle insurer to be paid under PIP. Metropolitan, 451 Mass. at 390. Coordination of benefits becomes necessary after the initial $2,000 in benefits is exhausted. For example, where a claimant has health coverage, any claims in excess of $2,000 must be submitted to the health insurance carrier for coverage determination and the health insurance carrier is prohibited from denying payment on the basis that the claimant also has PIP coverage. PIP is not required to cover claims denied by a health insurance provider, however, where the claimant has failed to comply with the requirements of the health coverage policy, for example, by seeking out-of-network care. Id. at 392. See Dominguez v. Liberty Mut. Ins. Co., 429 Mass. 112, 112-113, 706 N.E.2d 647 (1999).

Where a claimant has no health coverage, PIP covers the first $8,000 in medical expenses. If a claimant has no health coverage, but has MedPay, MedPay benefits are triggered only for costs in excess of $8,000 after the PIP benefit is exhausted, subject to the MedPay policy limits. Where a claimant has health coverage and MedPay, a claimant must submit any bills in excess of $2,000 first to the health insurance carrier, consistent with Massachusetts case law. Mejia v. American Cas. Co., 55 Mass. App. Ct. 461, 771 N.E.2d 811 (2002). If, however, the health coverage policy contains a clause stating that coverage is secondary to other coverage for health care services, the health insurer may deny coverage, thus placing the responsibility for the claims in excess of $2,000 on MedPay. A health insurance carrier may deny coverage under these circumstances, but the health insurance carrier is not required to do so.

A final point of clarification of Bulletin No. 90-02 relates to the process for submission of claims for expenses in excess of the $2,000 PIP threshold. Regardless of whether deferral language exists in the health coverage policy, claims in excess of the $2,000 PIP threshold should be submitted first to the health insurance carrier. Metropolitan, at 396. If the health insurance carrier denies coverage, the motor vehicle insurer can determine whether PIP or MedPay applies based upon the reason for the denial. This amends the provision of Bulletin No. 90-02, that states that claims may be submitted to the health insurance carrier, motor vehicle insurer or both

Examples of Coordination of Benefits:

1. **Claimant does not have health coverage or MedPay.**

   PIP will pay up to $8,000 in medical expenses and lost wages.

2. **Claimant has health coverage and does not have MedPay.**

   The first $2,000 in medical expenses is covered by PIP and any medical expenses in excess of $2,000 are submitted to the health insurance carrier to determine whether coverage exists. The health insurance carrier cannot deny payment for medical expenses on the basis of the existence of PIP coverage. If the health insurance carrier denies payment for a claim, the claimant may resubmit the claim to the motor vehicle insurer for consideration of coverage under PIP. PIP would not be required to cover a claim that was denied by the health insurance carrier for the claimant's failure to comply with the requirements of the health coverage policy, such as the claimant's receipt of medical services from an out-of-network provider, but PIP must pay costs for items such as dental visits or chiropractic visits if they are not included in the claimant's health coverage policy.

3. **Claimant has MedPay and does not have health coverage.**

   The first $8,000 in medical expenses is covered by PIP and any medical expenses in excess of $8,000 are submitted to MedPay for coverage.

4. **Claimant has health coverage and MedPay.**

   The first $2,000 in medical expenses is covered by PIP and any medical bills in excess of $2,000 are submitted to health insurance carrier for review. If the health coverage policy contains deferral language, the health insurance carrier may deny coverage on the grounds that the claimant has MedPay and MedPay will then be responsible for any medical expenses in excess of $2,000 up to the MedPay policy limits. If the MedPay limits are exhausted, PIP coverage will then be required to cover claims up to $8,000. If the health coverage policy does not contain deferral language, the health insurance carrier is responsible for payment of claims in excess of $2,000, except where the health insurance carrier denies coverage for a legitimate reason, such as the out-of-network example in 2. The denied claim is then resubmitted to the motor vehicle insurer for consideration under PIP and, where PIP is not required to pay for a claim that the health insurance carrier denied (for example, because of the claimant's failure to comply with the health coverage policy), the claim must be covered fully by MedPay.