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 through e)

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

Appendix J - CAR 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 L – 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 Assigned Risk Companies

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 through 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. Subrogation/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 and consideration given to referring the claim to IFB, NICB, or appropriate law enforcement agency for prosecution

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, and workers compensation.

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

B. Contacts

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

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

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

4. Necessary forms should be mailed 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 is unresolved (see list of indicators in Appendix A).

3. Evaluation and Settlement

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

IV. **Voluntary/ Involuntary Claim Handling Differential**

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