COMMONWEALTH AUTOMOBILE REINSURERS

PRIVATE PASSENGER CLAIMS PERFORMANCE STANDARDS

FOR THE HANDLING AND PAYMENT OF CLAIMS BY ASSIGNED RISK COMPANIES

REVISED THROUGH MAY 31, 2016

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Performance Standards

Appendices

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

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

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

A. Motor Vehicle Body Payments

1. Service Times

   a. Assigned Risk Companies (ARCs) must establish programs and procedures to ensure prompt settlements of warranted motor vehicle physical damage claims.

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

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

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

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

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

2. Direct Payment Plan

   a. All ARCs must have a Direct Payment Plan.

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

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

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

   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 its 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 (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

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

5. Total Loss Payments

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

    b. The actual cash value of any motor vehicle must be determined based on the following requirements of Regulation 211 CMR 133.05 Determination of Value (Appendix E).

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

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

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

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

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

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

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

6. Towing and Storage Costs

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

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

c. 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 2.04 – The Appraisal and Repair of Damaged Vehicles (Appendix D).

2) Scoping and completing an appraisal

3) Use of aftermarket, rebuilt, LKQ parts

4) Open items and supplements

5) Refinishing

6) Depreciation and betterment

7) Unrelated damage

8) Structural Damage

9) ACV estimating

10) Screening for fraudulent claims

b. 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 its independent appraisers.

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

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

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

B. Normal Claim Handling

1. Initial screening of reports of accidents and losses

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

b. The initial screening shall determine whether accident circumstances, facts, and information reported are consistent and sufficient to establish the occurrence.

c. The initial screening shall identify losses involving theft or arson, which always require detailed investigation.

d. The fraud indicators of CAR Special Investigations Unit (SIU) Standards and Fraud Profile shall be considered to determine possible warning signs of fraud (Appendix A).

e. A determination shall be made of the type and extent of further investigation that may be necessary if the initial screening identifies discrepancies or inconsistencies.

2. Initial Investigation

The initial investigation shall include:

a. Reviewing policy information to verify coverage, resolve any issues including garaging or operators, and notifying Underwriting where appropriate.

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

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

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

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

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

3. Appraisal Program

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

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

4. Prompt Evaluation and Settlement

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

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

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

5. Department of Revenue (DOR) Requirements

    Prior to making any payment equal to or in excess of $500 to a third-party claimant, the ARC must comply with the requirements of the Insurance Claim Payment Intercept Program, G.L.c.175, §24D NOTE: Failure to comply with G.L.c.175, §24D will subject the ARC to penalties proscribed by the DOR. These penalties will be in lieu of those penalties imposed for noncompliance with the Performance Standards (Appendix H).

6. Subrogation/Recovery

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

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

C. Fraud Handling

1. Screening process for suspected fraudulent claims

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

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

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

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

2. Appraisal Program

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

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

3. Special Investigation

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

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

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

4. Evaluation and Settlement

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

D. Glass

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

2. 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 motor vehicle, or the principal place of garaging of the motor 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 its customer service representatives.

A. Normal Claim Handling

1. Initial Screening of Reports of Accident and Losses

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

   b. The initial screening shall determine whether accident circumstances, facts, and information reported are consistent and sufficient to establish the occurrence.

   c. The initial screening shall include checking policy information and accident history, and reporting to the Central Index Bureau (CIB) to evaluate for possible warning signs.

   d. The fraud indicators of CAR SIU Standards and Fraud Profile shall also be considered for possible warning signs (Appendix A).

   e. A determination shall be made of the type and extent of further investigation that may be necessary if the initial screening identifies discrepancies or inconsistencies.

2. Initial Investigation

   The initial investigation shall include:

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

   b. Contacting involved parties and securing sufficient documentation of facts involving the accident circumstances to verify occurrence and to establish degree of fault.

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

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

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

3. Contacts

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

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

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

4. Loss Management

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

5. Follow-Up and Continuing Investigation

    The continuing investigation shall include:

    a. Verifying and evaluating the type and extent of injury substantiated by available reports and/or independent examinations.

    b. Confirming and documenting that treatment and expenses are reasonable, necessary, and related to the accident.

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

    d. Employing proper diary systems and ensuring ARC reporting and authority levels are followed.

    e. Timely and reasonable changes to the reserves that follow the documented company policy.

6. Settlement Negotiations or Denial

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

b. Settlements shall be evaluated and pursued when the injury and expense end result can be established.

c. Mitigating factors that may reduce settlement value, such as comparative negligence or joint tortfeasor situations shall be evaluated.

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

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

f. Underinsured motorist claims shall document when no other party is identified as liable.

7. Cases in Suit

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

b. Reservation of Right letters and Excess of Loss letters shall be used when and where appropriate.

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

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

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

f. ARCs shall have an Alternative Dispute Resolution Program.

8. DOR Requirements

Prior to making any payment equal to or in excess of $500 to a third-party claimant, the ARC must comply with the requirements of the Insurance Claim Payment Intercept Program, G.L.c.175, §24D. NOTE: Failure to comply with G.L.c.175, §24D will subject the ARC to penalties proscribed by the DOR. These penalties will be in lieu of those penalties imposed for noncompliance with the Performance Standards (Appendix H).

9. Subrogation/Recovery

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

B. Fraud Handling

1. Screening Process for Suspected Fraudulent Claims

   If in the course of the screening process or initial investigation discrepancies develop of a sufficiently serious nature or indications of potential fraud (such as accident of unusual circumstances, severity of accident, unusual number of injured passengers, prior index history, recognition of a pattern related to prior cases of fraud), the case shall be referred for special investigation and consideration given to referring the claim to IFB, NICB, or appropriate law enforcement agency for prosecution. (See Appendix A for other indicators)

2. Special Investigation

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

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

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

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

3. Evaluation and Settlement

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

C. Fraud Training

1. 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.

A. Screening Reports and Initial Investigation

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

2. Initial investigation shall confirm that coverage is appropriate:

   a. Date of loss within policy period and all policy coverage is in order.

   b. Injured persons are eligible for no-fault benefits.

   c. Private health insurance availability shall be verified and documented.

   d. Injuries arise from use of a motor vehicle.

   e. Massachusetts statute applies.

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

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

B. Contacts

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

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

3. The insured operator, if not identified in B.1 or B.2, shall be contacted within 3 business days of receipt of notice of injury for purposes of investigation and verification.

4. Necessary forms shall be mailed or, if preferred by the injured party, electronically sent to the address specified within 5 business days after notice of injury.

C. Medical Management

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

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

D. Fraud Handling

Screening Process for Suspected Fraudulent Claims

If in the course of the screening process or initial investigation discrepancies develop of a sufficiently serious nature or indications of potential fraud exist (such as accident of unusual circumstances, severity of accident, unusual number of injured passengers, prior index history, recognition of a pattern related to prior cases of fraud), the case shall be referred for special investigation and consideration given to referring the claim to IFB, NICB, or appropriate law enforcement agency for prosecution. (See Appendix A for other indicators)

E. Subrogation/Recovery

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

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

F. Claim Payment

1. No payment shall be made until the reported loss has been verified and:

   a. The deductible applied if applicable.

   b. Benefits coordinated in conjunction with existing health carrier and wage continuation plans.

c. Medical bills verified prior to payment and reviewed for reasonableness, medical necessity, and relationship to the accident.

d. Wage rate/working hours verified with employer, using wage/salary verification forms.

e. Lost wages confirmed by employer's statement as to time missed and by physician's statement verifying disability for that period of time.

f. Investigations promptly conducted. Upon agreement to pay, checks shall be issued within 10 business days.

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

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

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

3. Evaluation and Settlement

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

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

B. Voluntary and residual market claims shall 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 shall be conducted on each Best Practice Voluntary and MAIP score to determine if there is any statistical difference in handling.

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 shall be documented.

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

   3. ARCs shall have an Alternative Dispute Resolution Program.

C. ARCs must establish a program to review vendor bills for accuracy, and deduct 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 shall not be reported as allocated expenses.

A. Measurements

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

- That claims handling is consistent for voluntary and residual market claims.
- That each ARC maintains a SIU which provides effective fraud control procedures.

Voluntary and residual market 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 and 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 its response and submit a remedial action plan.

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

B. 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.