COMMONWEALTH AUTOMOBILE REINSURERS
101 Arch Street, Suite 400 Boston, Massachusetts 02110
www.commauto.com 617-338-4000
NATALIE A. HUBLEY
PRESIDENT

ADDITIONAL INFORMATION

TO MEMBERS OF THE CLAIMS SUBCOMMITTEE

FOR THE MEETING OF:

Wednesday, August 19, 2020 at 10:00 a.m.

CLMS
20.04 Claims Performance Standards

Attached, in redlined formatting, are draft modifications to the Private Passenger and Commercial Claims Performance Standards (Standards) for the Subcommittee's consideration. The attachment includes only those Standards for which modifications are proposed. The complete versions of the current Standards are located on CAR's website under the Manuals tab. Also included is a memorandum to provide additional explanation regarding two of the proposed changes to the Standards. (Docket #CLMS20.04, Exhibit #1)

MARK ALVES
Director – Compliance Audit

Attachment

Boston, Massachusetts
August 12, 2020

Private Passenger and Commercial Claim Performance Standards – August 19, 2020

Memorandum of Changes

The Performance Standards and Appendices for the handling and payment of claims are reviewed every two years in accordance with Massachusetts G.L. c. 175 sec. 113H.

For the purpose of this review, 'redlined' formatting is used to identify only proposed substantive modifications. However, similar to the prior two review processes, staff has continued to make several minor changes that either added or modified existing language but were not included in the 'redlined' material because it does not alter meaning or intent.

Private Passenger Specific Modifications:

Standard II: Bodily Injury & Uninsured/Underinsured Motorist
Standard III: No-Fault Personal Injury Protection Benefits Handling

- The Presiding Officer commented during the 2019 public hearing that the phrasing in Standard III, Section D.2 Special Investigation that the SIU Standards for the investigation of suspicious claims must be 'consulted and considered' was too vague. Therefore, staff recommends changing the phrase to 'adhered to' to better emphasize the requirements.
- The same reference to SIU Requirements is located in both Standard II and Standard III.

Measurements & Penalties

- The SIU audit description is detailed including each measured Best Practice. Also, staff is recommending an 80% aggregate compliance rate of all Best Practices tested in the SIU review. For those ARCs that don't achieve 80% compliance, a tiered penalty program is suggested beginning with a warning if determined not in compliance at the time of the HAP audit.
    - Note that a memorandum further explaining this recommendation is also included with the Additional Information.

Appendix A: CAR Special Investigative Unit Standards

- The industry currently uploads all claim referral activity to CAR using the secure SIU application available on CAR's website. Also the template for required claim data points is prescribed by CAR. Both the claim upload and the claim referral template were approved by the DOI in the April 26, 2019 finalized changes.
- CAR staff is recommending that underwriting SIU referrals also be reported to CAR in the same manner. The language is drafted to result in the least amount of wording changes while accomplishing consistency between the underwriting and claims referrals.
    - Note that Appendix J for Private Passenger business contains wording that the SIU audit samples include both claim and underwriting referral activity.
    - CAR Rule 32.C. also requires that the SIU shall investigate suspicious circumstances surrounding underwriting, rating, and premium issues and that the SIU shall conduct an audit on a representative sample of policies to verify garaging and policy facts.
        - Note that a memorandum further explaining this recommendation is also included with the Additional Information.

Appendix J: CAR SIU File Review Process – MAIP Policies

- Staff is recommending additional language to standardize how companies calculate the Saved Amount field included on the claims SIU Quarterly Activity Log. The accuracy of reported savings is considered in the SIU evaluation.
- Also pertaining to the CAR Rule 32.C. requirement that SCs must conduct audits of policies to verify garaging and policy facts, staff has added the requirement that the completed audit reports be attached and emailed to the CAR SIU group email (siulog@commauto.com).

Commercial Specific Modifications:

Standard II: Bodily Injury & Uninsured/Underinsured Motorist
Standard III: No-Fault Personal Injury Protection Benefits Handling

- The Presiding Officer commented during the 2019 public hearing that the phrasing in Standard III, Section D.2 Special Investigation that the SIU Standards for the investigation of suspicious claims must be 'consulted and considered' was too vague. Therefore, staff recommends changing the phrase to 'adhered to' to better emphasize the requirements.
- The same reference to SIU Requirements is located in both Standard II and Standard III.

Measurements & Penalties

- The SIU audit description is detailed including each measured Best Practice. Also, staff is recommending an 80% aggregate compliance rate of all Best Practices tested in the SIU review. For those SCs that don't achieve 80% compliance, staff is recommending that the SC be subject to the Schedule of Penalties for Type I Penalty by Year already included in the current Measurements and Penalties of the current Standards.
    - Note that a memorandum further explaining this recommendation is also included with the Additional Information.

Appendix A: CAR Special Investigative Unit Standards

- The industry currently uploads all claim referral activity to CAR using the secure SIU application available on CAR's website. Also the template for required claim data points is prescribed by CAR. Both the claim upload and the claim referral template were approved by the DOI in the April 26, 209 finalized changes.
- CAR staff is recommending that underwriting SIU referrals also be reported to CAR in the same manner. The language is drafted to result in the least amount of wording changes while accomplishing consistency between the underwriting and claims referrals.
    - Note that Appendix J for Commercial business includes wording that SIU audit samples include both claim and underwriting referral activity.
    - CAR Rules 10.C. also requires that the SIU shall investigate suspicious circumstances surrounding underwriting, rating, and premium issues and that the SIU shall conduct an audit on a representative sample of policies to verify garaging and policy facts.
        - Note that a memorandum further explaining this recommendation is also included with the Additional Information.

Appendix J: CAR SIU File Review Process

- Staff is recommending additional language to standardize how companies calculate the Saved Amount field included on the claims SIU Quarterly Activity Log. The accuracy of reported savings is considered in the SIU evaluation.
- Also pertaining to the CAR Rules 10.C. requirement that SCs must conduct audits of policies to verify garaging and policy facts, staff has added the requirement that the completed audit reports be attached and emailed to the CAR SIU group email (siulog@commauto.com).

To: Claims Subcommittee
From: Mark Alves; Compliance Audit - Director
Re: Claims Performance Standards – Staff Recommendations
Date: August 12, 2020

Overview:

This memorandum provides further explanation regarding two of the staff proposed changes to the Private Passenger and Commercial Performance Standards (The Standards) detailed in the Memorandum of Changes. Each proposed modification pertains to company Special Investigative Unit (SIU) responsibilities and is designed to improve the quality and completeness of SIU referral activity provided to CAR in accordance with the Standards and CAR's Rules of Operation.

The Compliance and Operations Committee (COPC) has oversight responsibilities for the compliance audit program that closely examines industry claims reporting and claims handling. The Claims Subcommittee (CS) recommendations assist the COPC in determining its recommendations to CAR's Governing Committee.

Proposed Updates to Appendix A – CAR SIU Standards

CAR Rule 10.C. and CAR Rule 32.C. are commercial and private passenger companion rules that define Servicing Carrier (SC) and Assigned Risk Company (ARC) Special Investigative Unit (SIU) requirements. Both of these Rules outline three specific requirements for all companies writing in Massachusetts:

1. All companies must investigate suspicious claims for the express purpose of eliminating fraud regardless of whether the policy is written voluntarily or through the residual market.
2. The SIU shall investigate suspicious circumstances surrounding underwriting, rating, and premium issues.
3. The SIU shall conduct an audit on a representative sample of policies to verify garaging and policy facts.

Currently, Appendix A – CAR SIU Standards requires that all SIU *claim* referral activity be reported to CAR on a quarterly basis. In September 2018, staff developed a SIU system designed to improve the consistency of the SIU claim referral data reported by companies. Insurers are now required to upload SIU Quarterly Activity Log data into the SIU application accessible from CAR's website. The requirement to upload the claim referral activity into the application was added to Appendix A for both private passenger and commercial business, and approved by the DOI on April 26, 2019.

Staff is now proposing that SIU *underwriting* referral activity also be reported to CAR on a quarterly basis, and uploaded into the same SIU system to centralize both referrals. While most company SIUs have maintained private passenger and commercial underwriting referral logs, the requirement as to how this data shall be provided to CAR is not currently documented in the Standards. Staff is proposing that Appendix A of the Standards, for both private passenger and commercial, be updated to require that SIU underwriting referrals be reported to CAR through the same system as claim referrals, using a consistent industry format as prescribed by CAR.

Other supportive references for this recommendation already exist in the Standards. The SIU audit procedures for both private passenger and commercial testing that are included in Appendix J – CAR SIU File Review Process reference that *claim* and *underwriting* referrals are eligible for sample inclusion and reference the underwriting referral requirements of Rule 10.C. and Rule 32.C., including the need for

companies to conduct an audit of a representative sample of policies to verify garaging and policy facts. Appendix J, considers the underwriting investigations a SIU responsibility and a component of the SIU evaluation. Therefore, staff is not recommending any adjustments to Appendix J. Including the underwriting referrals into the SIU System upload already referenced in Appendix A of the Standards will enable CAR to automate the data collection of both underwriting and claim referrals into the SIU sample and provide a more complete representation of the audited company's overall SIU program.

Proposed Penalty Program: SIU Noncompliance

Staff currently has the ability to develop penalties for noncompliance in all private passenger and commercial audit components except the SIU evaluation. The private passenger Hybrid Audits in particular have included noncompliant findings pertaining to the SIU statutory requirement. In these instances, the COPC has adopted the CS recommendation of 2016 that the Committee take appropriate action in accordance with the Manual of Administrative Procedures or ARC Procedures Manual when the audited company is considered not compliant with the SIU statute.

Four ARCs were previously determined not compliant in Hybrid Audit results. In each instance, staff was directed by the Committee to conduct focus audits to verify future compliance. Subsequent auditing confirmed that each company modified its procedures in compliance with the ARC Procedures Manual. However, a documented penalty program would deter continued noncompliance. Therefore, staff is recommending a tiered penalty provision for both private passenger and commercial audit programs.

Conceptually, the proposed penalty provision mirrors the current plan in the Commercial Standards Measurements and Penalties section of the Standards. A penalty based on three sequential audits is recommended. A noncompliant finding at the initial point of an audit result would result in a warning only. After the first and second focus audits, penalties of $6,000 and $30,000, respectively, would be applied. If a third focus audit results in continued noncompliance, the company would be referred to the Governing Committee for potentially more substantive penalty considerations. Note that the inclusion of underwriting referrals referenced above (Proposed Updates to Appendix A – CAR SIU Standards) provides ARCs additional opportunity to surpass the minimum 25 SIU referrals necessary for SIU testing in accordance with Appendix J that outlines SIU audit procedures.

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. Refer to 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 be documented 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. Refer to 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 with consideration given to referring the claim to IFB, NICB, or appropriate law enforcement agency for prosecution. Refer to Appendix A for other indicators.

2. Special Investigation

   a. Claims identified as suspicious or suspected fraudulent shall be referred for more detailed special investigation with 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~~ adhered to 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 to provide training for 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: (i) timely independent medical examinations; (ii) medical bill reviews, including but not limited to a determination of usual and customary charges, with or without the use of medical fee databases; (iii) use of preferred provider organizations, managed care programs, and/or expert medical systems; and (iv) other 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 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. Refer to Appendix A for other indicators.

2. Special Investigation

   a. Claims identified as suspicious or suspected fraudulent shall be referred for more detailed special investigation with 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~~ adhered to 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.

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 are issued within 10 business days.

g. A litigation management program is 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. Refer to Appendix A for a list of indicators.

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.

CAR | **Private Passenger Claims Performance Standards Measurements & Penalties**
Revision Date | **2020.08.19**
Page | **Page 1 of 2**

A. Measurements

1. 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.

2. SIU referrals sampled for audit will be reviewed for compliance with policy provisions and applicable statutes, rules and regulations for the following Best Practices:

   - Quality of Investigation
   - Timeliness of Investigation
   - Resolution
   - Statutory Requirements
   - Accurate Savings

   The benchmark for compliance with these Best Practices is 80%. The aggregate score for these Best Practices will be calculated. If the score

is less than 80% the ARC will be required to address the reasons in its response and submit a remedial action plan.

B. Non-Compliance Penalties

1. In the case of non-compliance pertaining to the Claims Performance Standards, 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 and Operations Committee.
2. In the case of non-compliance pertaining to the SIU evaluation, the ARC will be subject to the type of penalty using the following Schedule of Penalties.

Schedule of Penalties			
Penalty by Consecutive Audit Occurrence			
HAP	Focus 1	Focus 2	Focus 3
Warning	$6,000	$30,000	Governing Committee

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

- Successful resistance to the payment of fraudulent claims
- The establishment of a deterrent to fraud
- 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 its SIU.

A. CAR SIU

The CAR SIU, as part of the Compliance Audit Department 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 SIU of each ARC as part of the HAP audit to evaluate its effectiveness.

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

B. CAR Standards for ARC SIU

CAR evaluations of an ARC's SIU will be based on its performance in accordance with the following guidelines:

1. Each Servicing Carrier is required by Article IV of the Plan of Operation to maintain a SIU to investigate suspicious claims for the purpose of eliminating fraud. A SIU shall be staffed by experienced salaried employees who are adequately trained in the recognition and investigation of insurance fraud. A 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 SIU may be supplemented by closely supervised independent adjusters or investigators.

2. Each ARC shall ensure that all motor vehicle insurance claims, where there is a suspicion of fraud, are referred promptly to its SIU.

3. Each ARC SIU shall maintain ~~a~~ SIU Quarterly Activity Logs of claims and underwriting referrals. ~~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~~

   The logs shall be uploaded by each ARC to a secure SIU application located on CAR's website in the format prescribed by CAR. The claim and underwriting SIU Quarterly Activity Log templates are available on CAR's website. The log files shall be transmitted at the end of each quarter and no later than the 15th of the following month.

4. Regulation 211 CMR 75.00 establishes the NICB as the central organization engaged in motor vehicle loss prevention as required by G.L.c.175, §113O. It also requires certain actions by insurers with respect to theft claims. An insurer must, among other things:

   - Report all thefts to NICB
   - Obtain NICB's acknowledgement before paying claims
   - Report disposition of salvage
   - Investigate and report evidence of fraud
   - Defer payment in certain circumstances

5. The 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 an 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 Motor Vehicle Fraud Profile described in Section D. identifies circumstances in which a motor vehicle 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 G.L. c.93A and c.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 a 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 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 a SIU, or the file should reflect the reasons why it was not. Refer to Sections C. and D. for these guidelines.

C. 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 motor 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 motor vehicle

     Year, make, model, VIN; when purchased, from whom, amount paid, motor vehicle traded in, amount allowed; if used, condition, odometer reading, improvements by

     insured; amount borrowed, from whom, term of loan; where kept when not in use, who uses the motor vehicle, purpose; service, inspection, repair; problems.

2. Insurance

   How long insured by this company; if short time, former carrier; any other insurance; recent changes of coverage; history of claims.

3. The Loss

   Date, time, and place; description of event; when and how the motor vehicle got to that location; purpose of its presence there; identity of witnesses; was car locked; who had keys; activities between leaving motor vehicle and discovery of loss; time, place, and method of report to police; identity of those responsible.

4. Police

   The owner or custodian of a motor 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 motor 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.

5. Claim History

   A record of the policyholder's prior losses should be obtained. The record is not necessarily evidence of impropriety. However, 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.

6. Insurance File

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

7. 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 motor vehicle.

8. 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 motor vehicle.

9. Betterment

   It is often claimed that the value of a motor 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.

10. Service and Repair

    The interview with the policyholder and the examination of the motor vehicle should cover the service and repair history of the motor 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 motor vehicle.

11. The Motor Vehicle Examination

    A careful, thorough, and early examination of the motor vehicle when it is available is important.

    a. Start with the plate bearing the VIN. 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 motor vehicle and consistent with the policy.

    b. Obtain abundant clear photographs 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 motor 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. Consider or give consideration 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.

D. Motor Vehicle 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 motor vehicle claims. None of these indicators is necessarily incriminating. Perfectly appropriate claims can often bear these characteristics. These items are present only to provoke further thought on the part of the 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 SIU.

Collision & Comprehensive Fraud Indicators

Motor Vehicle

- Late model motor vehicle with unusually high mileage
- Completely burned
- High value extras on inexpensive motor vehicle
- Allegedly numerous repairs prior to theft
- Extensive collision damage, especially if no collision coverage
- Inspection sticker expired, altered, or otherwise defective
- Ignition or steering lock intact
- Excessive mileage on leased motor vehicles
- Previous total loss
- Missing parts surgically removed
- Registered other than in the state of residence
- Grey market foreign car or American diesel
- NICB difficulty in matching the VIN to the motor vehicle
- 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 motor vehicle
- Insured avoids use of mail
- Loan payments late
- Insured is suspiciously knowledgeable of insurance terminology and the claim process
- Insured exceptionally anxious to settle
- Insured uses a PO Box, hotel, or motel as his/her address
- Insured in obvious financial difficulty
- Insured is unemployed and without visible means of support
- Insured or friend locates the stolen motor vehicle
- No report to police
- Bad loss record
- Insured is evasive as to identity of prior owner of motor vehicle
- Insured wants to retain total loss
- Insured recently purchased stated value policy
- Insured has no phone and cannot be contacted at work

Coverage

- Coverage increased just prior to loss

Purchase

- Title is a duplicate or none available

- No lienholder on new model, or lienholder is an individual rather than lending institution
- 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 motor vehicle in 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
- Injuries appear to be excessive in light of details of the accident or appear unrelated to the accident

Injuries and Damages

- 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

The Motor Vehicle

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

A. ARCs are required by G.L. c.175, §113H and Rule 30 to maintain a SIU to investigate suspicious or questionable motor vehicle insurance claims for the purpose of eliminating fraud. The SIU must have at least one full time employee whose responsibility is principally directed towards the recognition and investigation of fraud. ARCs are required to report SIU activity - assignments, denials, compromises, and savings to CAR using the standardized SIU Quarterly Activity Log.

During the triennial Hybrid Audit, a sample of 25 voluntary and/or MAIP claims or underwriting cases selected from the SIU log will be reviewed to determine the effectiveness of the ARC's fraud screening and quality of the SIU investigations. The cases will be evaluated on the quality of investigation, timeliness of investigation, resolution, statutory requirements, and accuracy of savings.

The evaluation of savings is based on the Saved Amount reported in the claims activity log. The Saved Amount reported for physical damage losses should be based upon the appraisal. Property Damage savings should also be based on the appraisal. If there is no appraisal available, the current reserve should be reported as the Saved Amount. PIP savings should be based on the total amount of medical bills less any cost containment results and should be reported as the Saved Amount. If there were no medical bills submitted, the current reserve should be reported as the Saved Amount. Bodily Injury savings and the reported Saved Amount should be based on the settlement evaluation referenced in Section A.6.a.-f. of Standard II: Bodily Injury & Uninsured/Underinsured Motorist.

B. Rule 32 requires that the ARC's SIU investigate suspicious claims on all policies whether issued through the MAIP or issued voluntarily. Also, the SIU shall investigate suspicious circumstances surrounding underwriting, rating, and premium issues. Additionally, Rule 32.C. requires the ARC to conduct an audit of voluntary and MAIP policies to verify garaging and policy facts. The completed audit reports verifying garaging and policy facts conducted by the ARC shall be emailed to siulog@commauto.com at the end of each quarter and no later than the 15th of the following month. The SIU relevant components are included in the Hybrid Audit report and considered by the Compliance and Operations Committee upon completion.

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.

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. Refer to Appendix A.

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

2. Initial Investigation

   The initial investigation shall include:

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

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

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

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

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

3. Contacts

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

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

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

4. Loss Management

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

5. Follow-Up and Continuing Investigation

   The continuing investigation shall include:

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

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

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

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

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

6. Settlement Negotiations or Denial

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

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

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

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

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

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

7. Cases in Suit

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

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

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

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

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

f. SCs shall have an Alternative Dispute Resolution Program.

8. DOR Requirements

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

9. Subrogation/Recovery

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

B. Fraud Handling

1. Screening Process for Suspected Fraudulent Claims

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

2. Special Investigation

   a. Claims identified as suspicious or suspected fraudulent shall be referred for more detailed special investigation with 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~~ adhered to as part of the special investigation process.

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

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

3. Evaluation and Settlement

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

C. Fraud Training

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

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

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

A. Screening Reports and Initial Investigation

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

2. Initial investigation shall confirm that coverage is appropriate:

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

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

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

   d. Injuries arise from use of a motor vehicle.

   e. Massachusetts statute applies.

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

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

B. Contacts

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

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

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

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

C. Medical Management

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

2. Any plan shall include historically utilized techniques such as: (i) timely independent medical examinations; (ii) medical bill reviews, including but not limited to a determination of usual and customary charges, with or without the use of medical fee databases: (iii) use of preferred provider organizations, managed care programs, and/or expert medical systems; and (iv) other 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 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. Refer to Appendix A for other indicators.

2. Special Investigation

a. Claims identified as suspicious or suspected fraudulent shall be referred for more detailed special investigation with 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~~ adhered to as part of the special investigation process.

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

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

E. Subrogation/Recovery

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

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

F. Claim Payment

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

e. The deductible applied if applicable.

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

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

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

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

j. Investigations promptly conducted. Upon agreement to pay, checks are issued within 10 business days.

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

l. 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. Refer to Appendix A for a list of indicators.

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. Measurements

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

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

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

2. SCs are evaluated on the effectiveness of their claim handling in meeting industry best practices as well as for their compliance with the Performance Standards and the NAIC Standards. SCs are measured against the benchmarks listed and industry averages as well as their own prior performance. Both quantitative and qualitative aspects of the claims process are evaluated. The most readily quantifiable standards are the ones that involve specific timeframes, averages, and counts. Other standards are qualitative such as reserving, medical management, evaluation, and settlement. The benchmark for compliance with the best practices and standards is 80%. The measurements for glass, re-inspections, and ICPIP are set at MA statutory levels.

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

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

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

5. SIU referrals sampled for audit will be reviewed for compliance with policy provisions and applicable statutes, rules and regulations for the following Best Practices:

- Quality of Investigation
- Timeliness of Investigation
- Resolution
- Statutory Requirements
- Accurate Savings

The benchmark for compliance with these Best Practices is 80%. The aggregate score for these Best Practices will be calculated. If the score is less than 80%, the SC will be required to address the reasons in its response and submit a remedial action plan.

B. Non Compliance Penalties

1. Minor non-compliance indicates that a SC is not in compliance with the Standards in one or more areas but the quality of claim handling is unaffected and no overpayments result from this situation.
2. Major non-compliance indicates that a SC has failed the Standards in one or more areas. Claim handling is affected and overpayments may be occurring as a result. The SC will be notified of the extent and areas in which non-compliance exists and will be warned that the subsequent review of the SC must reflect compliance in all of the cited areas to avoid penalty.

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

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

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

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

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

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

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

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

~~7.~~8. In the case of non-compliance pertaining to the SIU evaluations, the SC will be subject to the Schedule of Penalties for Type I Penalty by Year.

~~8.~~9. Should a SC achieve compliance after being penalized for non-compliance with the Standards, it must maintain compliance for two years before it is returned to pre-warning status.

~~9.~~10. Should a SC disagree with the findings of the CAR Compliance Audit Department, it will notify the Governing Committee and a meeting will be held to discuss the findings. If agreement cannot be reached, the SC may appeal the decision to the Commissioner of Insurance in accordance with Rule 20.

~~10.~~11. The compliance status of the Commercial SC's will be reported to the Compliance and Operations Committee, the Governing Committee, and the Division of Insurance.

~~11.~~12. The following benchmarks and measurements are used to compare the SCs performance to the Industry on commercial claims handling. Except where noted, the benchmark compliance is 80%.

Best Practices	NAIC Standard	Measurement	Benchmark
Physical Damage/Property Damage			
Assignment/Contact	NAIC 1	• Appropriate assignment and contact to establish loss fact	
Coverage	NAIC 3, 7	• Coverage verified, garaging and operator issues resolved if applicable	
Appraisal	NAIC 6	• Appraisal assignment within 2 business days • Transmittal of appraisal within 2 business days • Quality of appraisal - Aftermarket/LKQ, betterment, screening for fraud, photos, recognition of fraud, and cause and origin.	
Reserving	NAIC 10	• Timely, reasonable, follow documented company policy	
Screening and Investigation	NAIC 2, 3, 6	• Screening for fraud, recognition of fraud indicators • Timely investigation • Liability apportioned correctly	
Settlement	NAIC 3, 6	• Depreciation and ACV calculations appropriate • Salvage disposal proper • On property damage, comparative negligence recognized • Payment within 5 days under Direct Payment Plan; 7 days CWCF	
Subrogation/Recovery	NAIC 8	• Subrogation recognized and pursued • Reimbursement of deductible is timely and accurate when and where appropriate	

Best Practices	NAIC Standard	Measurement	Benchmark
Reinspections	NAIC 6, 9	• Compliance with Regulation 212 CMR 2.04	75%>$4,000; 25%<$4,000
Glass	NAIC 6	• Program for repair of glass in place • Carrier tracks percent of repair	100%
Litigation Management	NAIC 13	• Bring cases to the earliest conclusion at a reasonable value	
No Fault Personal Injury Protection Claims			
Contact	NAIC 1, 9	• Injured party - 2 days • Uninjured party - 3 days • PIP form mailing - 5 days	Contact
Reserving	NAIC 10	• Initial and subsequent reserves timely and appropriate; follow documented company policy	
Medical Management	NAIC 4, 5, 6, 11	• Claims warranting IME referral vs. claims referred for IME • Appropriate utilization of IME results to cut off claim, reduce bills • Appropriate utilization of Medical Bill Review program	
Loss Management/Special Investigation	NAIC 4, 11	• Claims warranting special investigation vs. claims referred for special investigation	
Subrogation/Recovery	NAIC 8	• Subrogation recognized and pursued • Reimbursement of deductible is timely and accurate when and where appropriate	
Bodily Injury/Uninsured Motorist Claims			
Contact	NAIC 1	• Injured party - 2 days • Uninjured party - 3 days	
Reserves	NAIC 10	• Initial and subsequent reserves timely and appropriate; follow documented company policy	

Best Practices	NAIC Standard	Measurement	Benchmark
Loss Management/Special Investigation	NAIC 4, 11	• Claims warranting special investigation vs. claims referred for special investigation	
Litigation Management	NAIC 7, 13	• Reservation of Rights and Excess letters used when and where appropriate	
Settlement	NAIC 3, 5, 6	• Evaluation range documented and appropriate • Settlement within range or documented why exceeded	
Subrogation/Recovery	NAIC 3	• Recovery potential recognized and pursued • Contribution from joint tortfeasor obtained	
Expenses	NAIC 14	• Reported properly as defined in the Statistical Plan	
Voluntary/Ceded Claim Handling Differential			
Claim Handling	NAIC 6	• A comparison of the compliance results for each of the resolution standards in the Ceded and Voluntary claims will be calculated • Statistical testing will be performed on the aggregate results of each of the three applicable sections: Physical Damage/Property Damage, PIP, and BI • If the difference is statistically significant, the carrier will be required to address the reasons in response • Following the response, CAR will make a determination on whether the Voluntary/Ceded Standard was in compliance	

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

- Successful resistance to the payment of fraudulent claims
- The establishment of a deterrent to fraud
- The reduction of losses, with the consequent improvement in insurance rates

In order to achieve these results, SCs must pursue the investigation of fraud by establishing a commitment to support and encourage the activities of its SIU.

A. CAR SIU

The CAR SIU, as part of the Compliance Audit Department exists under the authority of Article III of the Plan of Operation. It is charged with monitoring the efforts of SCs to control fraud. In addition, it will assist Members and SCs on request. CAR will perform a biennial audit of the SIU of each SC as part of the commercial audit to evaluate its effectiveness.

Assistance of the CAR SIU is intended to provide expert investigation beyond the capabilities of the average SC's investigator. The basic investigation of a suspicious claim is the responsibility of the SC. CAR SIU will also assist with the coordination of an investigation involving several SCs.

B. CAR Standards for SC SIU

CAR evaluations of a SC's SIU will be based on its performance in accordance with the following guidelines:

1. Each SC is required by Article IV of the Plan of Operation to maintain a SIU to investigate suspicious claims for the purpose of eliminating fraud. A SIU shall be staffed by experienced salaried employees who are adequately trained in the recognition and investigation of insurance fraud. A 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 SIU may be supplemented by closely supervised independent adjusters or investigators.

2. Each SC shall ensure that all motor vehicle insurance claims, where there is a suspicion of fraud, are referred promptly to its SIU.

3. Each SC SIU shall maintain ~~a~~ SIU Quarterly Activity Logs of claims and underwriting referrals. ~~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~~

   The logs shall be uploaded by each SC to a secure SIU application located on CAR's website in the format prescribed by CAR. The claim and underwriting SIU Quarterly Activity Log templates are available on CAR's website. The log files shall be transmitted at the end of each quarter and no later than the 15th of the following month.

4. Regulation 211 CMR 75.00 establishes the NICB as the central organization engaged in motor vehicle loss prevention as required by G.L. c.175, §113O. It also requires certain actions by insurers with respect to theft claims. An insurer must, among other things:

   - Report all thefts to NICB
   - Obtain NICB's acknowledgement before paying claims
   - Report disposition of salvage
   - Investigate and report evidence of fraud
   - Defer payment in certain circumstances

5. The 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 SC should forward a complete photocopy of the claim file to NICB for further consideration and action.

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

6. The Motor Vehicle Fraud Profile described in Section D identifies circumstances in which a motor vehicle 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 G.L. c.93A and c.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 a 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 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 a SIU, or the file should reflect the reasons why it was not. Refer to Section C. for these guidelines.

C. 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 motor 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 motor vehicle

     Year, make, model, VIN; when purchased, from whom, amount paid, motor vehicle traded in, amount allowed; if used, condition, odometer reading, improvements by insured; amount borrowed, from whom, term of loan; where kept when not in use, who uses the motor vehicle, purpose; service, inspection, repair; problems.

2. Insurance

   How long insured by this company; if short time, former carrier; any other insurance; recent changes of coverage; history of claims.

3. The Loss

   Date, time, and place; description of event; when and how the motor vehicle got to that location; purpose of its presence there; identity of witnesses; was car locked; who had keys; activities between leaving motor vehicle and discovery of loss; time, place, and method of report to police; identity of those responsible.

4. Police

   The owner or custodian of a motor 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 motor 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.

5. Claim History

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

6. Insurance File

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

7. 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 motor vehicle.

8. 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 motor vehicle.

9. Betterment

   It is often claimed that the value of an motor 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.

10. Service and Repair

    The interview with the policyholder and the examination of the motor vehicle should cover the service and repair history of the motor 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 motor vehicle.

11. The Motor Vehicle Examination

    A careful, thorough, and early examination of the motor vehicle when it is available is important.

    a. Start with the plate bearing the VIN. 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 motor vehicle and consistent with the policy.

    b. Obtain abundant clear photographs 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 motor 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. Consider or give consideration 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.

D. Motor Vehicle 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 motor vehicle claims. None of these indicators is necessarily incriminating. Perfectly appropriate claims can often bear these characteristics. These items are present only to provoke further thought on the part of the 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 SIU.

Motor Vehicle

- Late model motor vehicle with unusually high mileage
- Completely burned
- High value extras on inexpensive motor vehicle
- Allegedly numerous repairs prior to theft
- Extensive collision damage, especially if no collision coverage
- Inspection sticker expired, altered, or otherwise defective
- Ignition or steering lock intact
- Excessive mileage on leased motor vehicles
- Previous total loss
- Missing parts surgically removed
- Registered other than in the state of residence
- Grey market foreign car or American diesel
- NICB difficulty in matching the VIN to the motor vehicle
- 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 motor vehicle
- Insured avoids use of mail
- Loan payments late
- Insured is suspiciously knowledgeable of insurance terminology and the claim process
- Insured exceptionally anxious to settle
- Insured uses a PO Box, hotel, or motel as his/her address
- Insured in obvious financial difficulty
- Insured is unemployed and without visible means of support
- Insured or friend locates the stolen motor vehicle
- No report to police
- Bad loss record
- Insured is evasive as to identity of prior owner of motor vehicle
- Insured wants to retain total loss
- Insured recently purchased stated value policy
- Insured has no phone and cannot be contacted at work

Coverage

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

Purchase

- Title is 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 motor vehicle in 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
- Injuries appear to be excessive in light of details of the accident or appear unrelated to the accident

Injuries and Damages

- 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

The Motor Vehicle

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

A. The CAR SIU is charged with monitoring the efforts of the SCs to control fraud. A biennial evaluation of each SC's SIU is conducted to examine the overall SIU operation and quality of investigations.

File Selection and Review

B. A random sample of approximately 25 voluntary and ceded referrals from the SIU Quarterly Activity Log pertaining to claims or underwriting is selected. Files are reviewed to determine the ability of the staff to recognize potentially fraudulent claims and the quality of the SIU investigations. In addition, CAR reviews the accuracy of the savings reported to CAR. An examination of the effectiveness of the carriers' fraud screening and the SIU referral process has been incorporated into the biennial Claims Reviews. Cases will be evaluated on the quality of investigation, timeliness of investigation, resolution, statutory requirements, and accuracy of savings.

The evaluation of savings is based on the Saved Amount reported in the claims activity log. The Saved Amount reported for physical damage losses should be based upon the appraisal. Property Damage savings should also be based on the appraisal. If there is no appraisal available, the current reserve should be reported as the Saved Amount. PIP savings should be based on the total amount of medical bills less any cost containment results and should be reported as the Saved Amount. If there were no medical bills submitted, the current reserve should be reported as the Saved Amount. Bodily Injury savings and the reported Saved Amount should be based on the settlement evaluation referenced in Section A.6.a.-f. of Standard II: Bodily Injury & Uninsured/Underinsured Motorist.

C. Rule 10 requires that the SC's SIU investigate suspicious circumstances surrounding underwriting, rating and premium issues. Also that a claim shall not be investigated by the SIU solely on the basis that the claim arises from a ceded policy. Additionally, Rule 10.C. requires the SC to conduct an audit of a representative sample of policies to verify garaging and policy facts. The completed audit reports verifying garaging and policy facts conducted by the SC shall be emailed to siulog@commauto.com at the end of each quarter and no later than the 15th of the following month. The SIU relevant components are included in the Commercial Claims Performance Standards Report and SIU Evaluation. This report is considered by the Compliance and Operations Committee upon completion.