Performance Standards For the Handling and Payment of Claims By Servicing Carriers

Commonwealth Automobile Reinsurers
100 Summer Street
21st Floor
Boston, MA 02110

Mandated by
Chapter 273, Acts of 1988
Automobile Insurance Reform Legislation

Revised:
November 2003

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Of Claims By Servicing Carriers

Introduction

Automobile Insurance Reform Legislation, Chapter 273 of the Acts of 1988, Sections 41 and 44, require Commonwealth Automobile Reinsurers (CAR) to establish Performance Standards for Servicing Carriers designed to contain costs, ensure prompt customer service and payment of legitimate claims, and resist inflated, fraudulent, and unwarranted claims. Section 41 further requires that these Performance Standards be reviewed two years after such Standards are approved.

The Performance Standards, which CAR has developed, require Servicing Carriers to establish and maintain plans and programs to comply with the Standards. In some situations, time frames have been established to ensure prompt customer service.

Measurements of performance and compliance with the Standards are conducted through periodic surveys of claims, enhanced by relevant Statistical Plan data and procedures established by CAR. In addition to Statistical Plan data, Servicing Carriers are required to report savings brought about by SIU activities for physical damage, bodily injury, and personal injury protection claims.

The Performance Standards are in addition to and require compliance with Massachusetts laws and regulations regarding automobile insurance and the CAR Rules of Operation. Any revisions to existing laws or regulations or any new laws or regulations will become part of the Performance Standards when they are promulgated.

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

Appendix A – Special Investigative Unit Standards

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

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

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

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

Appendix E – Regulation 211 CMR 93.00
Cost and Expense Containment Standards for Motor Vehicle Insurers

The Performance Standards have also been designed to assist Servicing Carriers to respond to Regulation 211 CMR 93.00, which was promulgated by the Commissioner of Insurance pursuant to passage of the cost containment law. All Servicing Carriers should be familiar with the regulation, which addresses the areas of Auto Body Payments, Fraud, Glass, Voluntary/Ceded Claim Handling, and Expenses, which are the focus of these Standards.

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

Regulation 212 CMR 2.00 was promulgated to promote public welfare and safety by improving the quality and economy of the appraisal and repair of damaged motor vehicles. This regulation was revised effective February 23, 1996 and is intended to be read in conjunction with 211 CMR 133.00, which follows in Appendix G.

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

Regulation 211 CMR 133.00 was promulgated on February 23, 1996 to promote the public welfare and safety by establishing fair and uniform standards for the repair of damaged motor vehicles when an insurer pays for the cost of repairs. It is intended to be read in conjunction with 212 CMR 2.00 in Appendix F.

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

This regulation was revised effective May 10, 2002 by Commissioner of Insurance Julianne M. Bowler.

Appendix I – Salvage Title Law, Chapter 90D, Section 20 (a..e).

Appendix J - M.G.L. Chapter 175:Section 24D
Insurance Claim Payment Intercept Program and

Appendix J - Regulation 830 CMR 175.24D.1.1
Intercept of Insurance Payments to Satisfy Child Support Liens

Appendix K - CAR Claim Department File Review Process

This section was revised to update the procedures followed since the implementation of the new **CAR Claims Review System.**

Appendix L - SIU File Review Process

This section was revised to reflect the current procedures for the SIU File Reviews.

Appendix M - Questionnaire

The Questionnaire was updated to incorporate changes in the Performance Standards since it was completed by the Servicing Carriers. The revised Questionnaire will be distributed to the Servicing Carriers for completion.

The Performance Standards may be revised by CAR at any time.

If you have any questions, please contact staff at CAR to discuss them.

Performance Standards

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

I. Auto Body Payments

A. Service Times

1. Servicing Carriers (hereafter referred to as "carriers") must establish programs and procedures to ensure prompt settlements of warranted auto physical damage claims.

2. Carriers must establish procedures to permit prompt inspection of damage at drive-in locations or in the field and to make prompt claim payments of auto physical damage claims.

3. 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.

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

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

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

B. Direct Payment Plan

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

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

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

   c. Carriers can develop and submit for approval their own plan.

2. Any Direct Payment Plan developed by a carrier must include a referral shop program.

3. If a Direct Payment is initially rejected and the vehicle is later not repaired, the carrier will pay only the decrease in value caused by the damage.

C. *Parts Cost*

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

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

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

D. *Labor Rates and Times*

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

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

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

E. *Total Loss Payments*

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

2. The actual cash value of any vehicle must be determined based on the following requirements of Regulation 211 CMR 133.05 Determination of Value (see Appendix G, attached).

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

   a. the retail book value for a motor vehicle of like kind and quality, but for the damage incurred.

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

c. the decrease in value of the motor vehicle resulting from prior unrelated damage which is detected by the appraiser; and

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

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

4. Carriers must be in compliance with the Salvage Title Law, Chapter 90D, section 20 (a..e).

F. Towing and Storage Costs

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

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

3. Carriers must have a plan to control storage costs including the prompt disposition of salvage.

G. Appraisal of Damage and Reinspections

1. Carriers must have basic guidelines for appraisers, which include the following areas:

a. Compliance with Regulation 212 CMR 2.00 – The Appraisal and Repair of Damage Motor Vehicles

b. Scoping and completing an appraisal

c. Use of aftermarket, rebuilt, LKQ parts

d. Open items and supplements

e. Refinishing

f. Depreciation and betterment

g. Unrelated damage

h. Structural damage

i. ACV estimating

j. Screening for fraudulent claims

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

3. Carriers must have a plan for periodic evaluation of the quality and accuracy of independent appraisers used by carriers.

4. Reinspections must be completed on 75 percent of all repaired vehicles whose damage exceeded $4,000, whether paid under a Direct Payment Plan or not.

5. Reinspections must be completed on 25 percent of all repaired vehicles whose damage was less than $4,000, whether paid under a Direct Payment Plan or not.

H. Carriers shall report any repair shop which engages in any of the following practices identified in the Automobile Insurance Reform Legislation, Section 32 (8), directly to the Division of Standards, Office of Consumer Affairs and Business Regulation, One Ashburton Place, Boston, MA 02108:

1. Advertise for motor vehicle repair in the Commonwealth without including either the number of its certificate of registration issued by the director or the words "unregistered repair shop", as part of the advertisement.

2. Fails to charge all or any part of the applicable deductible to be paid by the insured.

3. Gives any rebate, gift, prize, premium, bonus, fee, or any other monetary or tangible thing to the insured or any other person not in the employ of the repair shop as an inducement to have the repair made at the repair shop. A discount on parts, glass, labor rate or other item or customer service in connection with the repair of motor vehicles offered by a repair shop to an insurer shall not constitute a "payment, gift, or any other thing of value" for purposes of Regulation 211 CMR 123.06 (8) (a).

4. Charges or offers to charge a higher rate or discount for an insured repair than for an uninsured repair. Discounts for insured repairs may be offered through the Direct Payment Plan approved by the Commissioner.

5. Makes any false or fraudulent statement in connection with any repair or attempt to collect for a repair.

6. Without lawful authority, prevents the owner of a motor vehicle from recovering the same.

I. Carriers must establish procedures to comply with the various claims requirements of the mandatory preinsurance inspection program established by Regulation 211 CMR 94.00 (see Appendix H, attached).

II. Standards for Fraudulent Claims Definition Established Under Regulation 211 CMR 93.00 – (see Appendix E, attached)

A. Claims for nonexistent incidents, damages, or injuries.

B. Claims for substituted or nonexistent vehicles.

C. Claims for exaggerated damage or injury, such as inflated doctor's bills, repair shop bills, or wage statements.

D. Duplicate claims for the same incident, damage, or injury.

E. Claims for incidents which the claimant has arranged, such as theft, arson, or vandalism, in an effort to receive an insurance payment.

F. Any circumstances resulting from a claim submitted with the intent of receiving a larger payment from the insurer than the amount, if any, to which the claimant is entitled under the policy.

III. Fraud – Auto Physical Damage and Property Damage Claims

A. Normal Claim Handling

1. Initial screening of reports of accidents and losses.

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

   b. Initial screening should determine that accident circumstances, facts, and information reported are consistent and sufficient to establish the occurrence.

   c. Initial screening should identify losses involving theft or arson, which always require detailed investigation.

   d. The fraud indicators of Commonwealth Automobile Reinsurers Special Investigative Unit (hereafter referred to as "CAR SIU") Standards and Fraud Profile (Appendix A, attached) should be considered to determine possible warning signs of fraud.

   e. If the initial screening identifies discrepancies or inconsistencies, a determination of the type and extent must be made to evaluate extent and nature of further investigation necessary.

2. Initial Investigation

   a. Contact involved parties and secure sufficient documentation of facts involving accident circumstances or loss, to verify occurrence and to establish degree of fault.

   b. Secure documentation of ownership and existence of said vehicle in appropriate cases, especially total losses.

   c. Secure documentation of the damages or value of the vehicle.
   d. Review and evaluate discrepancies and fraud indicators to determine the scope of further investigation.

3. Appraisal Program

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

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

4. Prompt Evaluation and Settlement

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

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

5. Prior to making any payment equal to or in excess of $500 to a third-party claimant the Company must comply with the requirements of the Insurance Claim Payment Intercept Program, M.G.L. Chapter 175, Section 24D. NOTE: Failure to comply with M.G.L. Chapter 175, Section 24D will subject Company to penalties proscribed by the Department of Revenue. These penalties will be in lieu of those penalties imposed for non compliance with the Performance Standards.

B. Fraud Handling

1. Screening process for suspected fraudulent claims

   a. When discrepancy is of such weight as to raise substantial questions of fraud (example: all keys accounted for and the

vehicle shows no ignition damage), the case should be referred for special investigation.

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

c. Unresolved discrepancies, such as VIN problems, prior total loss or salvaged vehicle, title inconsistencies, or other verifiable documents should result in the case being referred for special investigation.

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

2. Appraisal program

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

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

3. Special Investigation

a. Claims identified as suspicious or suspected fraudulent should be referred for more detailed special investigation.

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

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

4. Evaluation and Settlement

a. After special investigation is complete, a decision must be made to pay the claim or resist and consider referral to IFB, NICB and/or the appropriate law enforcement agency for prosecution.

b. The file must clearly document the basis for the decision and result.

C. ***Fraud Training***

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

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

IV. Fraud – Bodily Injury Claims

A. Normal Claim Handling

1. Initial screening of reports of accident and losses

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

   b. Initial screening should determine that accident circumstances, facts, and information reported are consistent and sufficient to establish the occurrence.

   c. Initial screening should include checking policy information and accident history, and reporting to Central Index Bureau (hereafter referred to as "CIB") to evaluate for possible warning signs.

   d. The fraud indicators of the CAR Fraud Profile should also be considered for possible warning signs.

   e. If the initial screening identifies discrepancies or inconsistencies, a determination of the type and extent of discrepancies or inconsistencies must be made to evaluate extent of further investigation necessary.

2. Initial Investigation

   a. Contact involved parties and secure sufficient documentation of facts involving accident circumstances to verify occurrence and to establish degree of fault.

   b. Secure documentation to verify that all alleged injured parties were actually involved in the accident.

   c. Review and evaluate discrepancies and fraud indicators to determine scope of further investigation.

3. Follow-Up and Continuing Investigation

   a. Verify and evaluate type and extent of injury and substantiate by available reports and/or independent examinations.

b. Confirm and document that treatment and expenses are reasonable, necessary, and related to the accident.

c. Review and evaluate discrepancies and fraud indicators to determine the scope of further investigation.

4. Settlement Negotiations or Denial

a. Carriers should have a settlement evaluation plan to obtain reasonable negotiated settlements of warranted claims.

b. Evaluate and pursue warranted settlements when the injury and expense end result can be established.

c. Evaluate mitigating factors that may reduce settlement value, such as comparative negligence or joint tort feasor situations.

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

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

5. Damage Disputed Cases – Cases in Suit

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

b. Carriers should have an Alternative Dispute Resolution Program.

6. Prior to making any payment equal to or in excess of $500 to a third-party claimant the Company must comply with the requirements of the Insurance Claim Payment Intercept Program, M.G.L. Chapter 175, Section 24D. NOTE: Failure to comply with M.G.L. Chapter 175, Section 24D will subject Company to penalties proscribed by the Department of Revenue. These penalties will be in lieu of those penalties imposed for non compliance with the Performance Standards.

B. Fraud Handling

1. Screening Process for Suspected Fraudulent Claims

a. If in the course of the screening process or initial investigation discrepancies develop of a sufficiently serious nature or there are indications of potential fraud, such as:

Accident of unusual circumstances
Severity of accident
Unusual number of injured passengers

Prior index history
Recognition of a pattern related to prior cases of fraud
See Appendix A for other indicators

The case should be referred for special investigation.

2. Special Investigation

a. Claims identified as suspicious or suspected fraudulent should be referred for more detailed special investigation.

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

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

3. Evaluation and Settlement

a. After special investigation is complete, a decision must be made to pay the claim or resist and consider referral to **IFB**, NICB or appropriate law enforcement agency for prosecution.

b. The file should clearly document the basis for the decision and result.

C. Fraud Training

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

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

V. No-Fault Personal Injury Protection Benefits Handling

A. Screening Reports and Initial Investigation

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

2. Initial investigation should confirm that:

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

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

c. Injuries arise from use of motor vehicle.

d. Massachusetts's statute applies.

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

B. Contacts

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

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

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

4. Necessary forms should be mailed within 5 business days after notice of injury.

C. Medical Management

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

2. Any plan must include consideration for arranging 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.

D. Subrogation

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

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

E. Claim Payment

1. There should be no payment until the claimed loss has been verified and:

    a. Deductible applied.

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

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

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

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

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

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

VI. Glass

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

B. Carriers 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.

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

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

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

F. Carriers shall report any repair shop which engages in any of the following practices identified in the Automobile Insurance Reform Legislation, Section 32(8), directly to the Division of Standards, Office of Consumer Affairs and Business Regulation, One Ashburton Place, Boston, MA 02108:

1. Advertise for motor vehicle repair in the Commonwealth without including either the number of its certificate of registration issued by the director or the words "unregistered repair shop", as part of the advertisement.

2. Fails to charge all or any part of the applicable deductible to be paid by the insured.

3. Gives any rebate, gift, prize, premium, bonus, fee, or any other monetary or tangible thing to the insured or any other person not in the employ of the repair shop as an inducement to have the repair made at the repair shop. A discount on parts, glass, labor rate, or other item or customer service in connection with the repair of motor vehicles offered by a repair shop to an insurer shall not constitute a "payment, gift, or any other thing of value" for purposes of Regulation 211 CMR 123.06 (8)(a).

4. Charges or offers to charge higher rate or discount for an insured repair than for an uninsured repair. Discounts for insured repairs may be offered through the Direct Payment Plan approved by the Commissioner.

5. Makes any false or fraudulent statement in connection with any repair or attempt to collect for a repair.

6. Without lawful authority, prevents the owner of a motor vehicle from recovering the same.

VII. Voluntary/Ceded Claim Handling Differential

A. There will be no differences in claims handling between policies insured voluntarily and those ceded to CAR.

B. Other than required statistical coding, there will be no evidence in claim file handling as to voluntary vs. ceded business.

VIII. Expenses

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

B. Carriers must establish an Alternative Dispute Resolution Program, with guidelines to control legal defense costs.

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

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

Measurements and Penalties
Introduction

Measurements & Penalties

Introduction

Section 44 of Chapter 273 requires that CAR purpose rules to govern the application of penalties, among other things, the failure to meet the PERFORMANCE STANDARDS FOR THE HANDLING AND PAYMENT OF CLAIMS BY SERVICING CARRIERS, as approved by the Commissioner of Insurance on July 10, 1989.

CAR monitors and evaluates the performance of a Servicing Carrier by considering three sources of information:

a. responses to a questionnaire,
b. a review of claim files, and
c. a review of statistical data.

If it is determined that a Servicing Carrier is not in compliance with the Performance Standards, the CAR Claim Department will then determine the degree to which the non-compliance exists in the following areas addressed by the Standards. Specifically, the areas are:

a. AUTO BODY PAYMENTS,
b. FRAUD – AUTO PHYSICAL DAMAGE AND PROPERTY DAMAGE,
c. FRAUD – BODILY INJURY CLAIMS,
d. NO-FAULT PERSONAL INJURY PROTECTION BENEFITS,
e. GLASS
f. VOLUNTARY/CEDED CLAIM HANDLING DIFFERENTIAL, and
g. EXPENSES.

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

Major non-compliance indicates that a carrier is not in compliance with the Standards in one or more areas and claim handling is affected and overpayments may be occurring as a result. The carrier will be notified of the extent and areas in which non-compliance exists and will be warned that the subsequent review of the carrier must reflect compliance in all of the cited areas to avoid penalty.

Should a carrier disagree with the findings of the CAR Claim Department, it will notify the Vice President of Claims and a meeting will be held to discuss the findings. If agreement cannot be reached, the carrier may appeal the decision to the Claims Advisory Committee.

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

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

A penalty will be assessed in each area of the Standards in which major non-compliance is found. The amount of the penalty will be determined by the type of penalty and the volume of business written by the carrier.

Carriers will be categorized into one of three levels, based on volume of business. Carriers with a larger volume of business will be assessed higher penalties than those with a smaller volume of business. Level three will include carriers with a market share of 5% or over, level two carriers with 1% or more of the market but less than 5%, and level one for carriers under 1%. The latest complete calendar year's market share at the time of the review will be used.

In the event that non-compliance continues beyond two years, the penalties will increase for the third year according to the attached "Schedule of Penalties". If non-compliance continues beyond three years, the Governing Committee will be advised and subsequent penalties will be based upon its recommendation.

Should a carrier 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.

The following appendices attached outline the review process in further detail:

1. Appendix K - CAR Claim Department File Review Process

2. Appendix L - CAR SIU File Review Process

3. Appendix M - Questionnaire

If you have any questions, please contact staff at CAR to discuss them.

Schedule of Penalties

Schedule of Penalties

Type I Penalty by Year

	1st Year	**2nd Year**	**3rd Year**	**4th Year**
Carriers in Level 1	W	$3,000	$15,000	GC
Carriers in Level 2	W	$6,000	$30,000	GC
Carriers in Level 3	W	$9,000	$45,000	GC

Type II Penalty by Year

	1st Year	**2nd Year**	**3rd Year**	**4th Year**
Carriers in Level 1	W	$10,000	$50,000	GC
Carriers in Level 2	W	$20,000	$100,000	GC
Carriers in Level 3	W	$30,000	$150,000	GC

Penalties are assessed for non-compliance in the following areas of the PERFORMANCE STANDARDS FOR THE HANDLING AND PAYMENT OF CLAIMS BY SERVICING CARRIERS: Auto Body Payments, Fraud – Auto Physical Damage and Property Damage, Fraud – Bodily Injury, No-Fault Personal Injury Protection Benefits, Glass, Voluntary/Ceded Claim Handling Differential, and Expenses.

W = Warning
GC = Governing Committee

Company	Market Share *	Level
Commerce	23.2%	3
Traveler's	12.0%	3
Arbella	10.8%	3
Safety	10.4%	3
Metropolitan	7.4%	3
Liberty Mutual	7.0%	3
Premier	6.8%	3
C N A Commercial	6.8%	3
Hanover	6.3%	3
One Beacon	5.9%	3
Plymouth Rock	3.5%	2
Amica	3.3%	2
Harleysville	3.0%	2
USAA	2.5%	2
Zurich	2.4%	2
St. Paul	2.3%	2
Encompass	2.1%	2
Empire	1.4%	2
Norfolk & Dedham	1.4%	2
Fireman's Fund	1.3%	2
Pilgrim	1.3%	2
National Grange	1.3%	2
Quincy	1.2%	2
Royal	1.1%	2
Great American	1.0%	1
Holyoke	0.9%	1
Horace Mann	0.8%	1
Sentry	0.7%	1
Concord Group	0.6%	1
State Farm	0.5%	1
Electric	0.5%	1
MassWest	0.2%	1

* 2001 Calendar Year Market Share

Appendix A

Special Investigative Unit Standards

Appendix A

CAR Special Investigative Units Standards

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

1. Successful resistance to the payment of fraudulent claims,

2. The establishment of a deterrent to fraud, and

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

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

CAR Special Investigative Unit

The CAR Special Investigative Unit exists under the authority of Article III of the Plan of Operation. It is charged with monitoring the efforts of Servicing Carriers to control fraud. In addition, it will assist member companies on request. CAR will perform one annual audit of the Special Investigative Unit of each Servicing Carrier to evaluate its effectiveness.

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

CAR Standards for Servicing Carrier Special Investigative Units

CAR evaluations of Servicing Carrier Special Investigative Units will be based on their performance in accordance with the following guidelines:

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

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

3. Each Servicing Carrier SIU shall maintain on paper **or electronically**, a log of cases referred to it containing at least the following information:

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

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

   Commonwealth Automobile Reinsurers
   100 Summer Street
   Boston, MA 02110

   ATTN: Special Investigative Unit

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

   A. report all thefts to National Insurance Crime Bureau,

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

   C. report disposition of salvage,

   D. investigate and report evidence of fraud, and

   E. defer payment in certain circumstances.

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

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

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

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

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

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

CAR Standards for investigation of Collision and Comprehensive Losses

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

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

The Individual Interviewed

Name, Address, Date of Birth, Occupation, Employer

The Vehicle

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

Insurance

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

The Loss

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

2. **Police**

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

3. **Claim History**

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

4. **Insurance**

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

5. **Mortgagee**

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

6. **Ownership and Value**

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

7. **Betterment**

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

8. **Service and Repair**

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

9. **The Vehicle (When available)**

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

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

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

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

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

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

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

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

H. Record date on service or oil change stickers.

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

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

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

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

Auto Fraud Profile

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

Collision & Comprehensive Fraud Indicators

Vehicle

•Late model vehicle with unusually high mileage

•Completely burned

•High value extras on inexpensive vehicle

•Allegedly numerous repairs prior to theft
residence.

•Extensive collision damage, especially if no
diesel.
collision coverage

•Inspection sticker expired, altered or
the
otherwise defective

•Ignition or steering lock intact

•Excessive mileage on leased vehicles

•Previous total loss

•Missing parts surgically removed

•Registered other than in the state of

•Gray market foreign car or American

•NICB difficulty in matching the VIN to

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 vehicle
vehicle

•Insured avoids use of mail

•Loan payments late

•Insured is suspiciously knowledgeable of insurance
owner
terminology and the claim process

•Insured exceptionally anxious to settle

•Insured uses PO Box, hotel, or motel as his or her
policy
address

•Insured in obvious financial difficulty

•Insured is unemployed and without visible
means of support

•Insured or friend locates the stolen

•No report to police

•Bad loss record

•Insured is evasive as to identity of prior

of vehicle

•Insured wants to retain total loss

•Insured recently purchased stated value

•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 a lending institution

Purchase

•Title a duplicate, or none available

•Previous owner cannot be located

Bodily Injury, Including No-Fault

The Accident

- No witness
- Police report fails to verify accident, or presence of claimants fails to verify any injury on the part of any claimant

- Other auto in the accident denies involvement
- Too many claimants for described accident
- Any allegation of intentional involvement
- Description of accident does not support injuries claimed
- Claimant or insured is difficult to find, claims to be self employed, or employed by another family member

The Vehicle

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

Injuries & Damages

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

Appendix B

Regulation 211 CMR 123.00

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

Section

123.01: Authority
123.02: Purpose and Scope
123.03: Definitions
123.04: Procedure for Approval of Plans
123.05: Direct Payment Plans: Required Provisions
123.06: Referral Repair Shop Programs
123.07: Disclosures to Consumers
123.08: Penalties
(123.09: Reserved)
123.10: Severability

123.01: Authority

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

123.02: Purpose and Scope

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

123.03: Definitions

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

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

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

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

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

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

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

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

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

123.03: continued

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

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

123.04: Procedure for Approval of Plans

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

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

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

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

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

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

123.04: continued

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

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

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

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

123.05: Direct Payment Plans: Required Provisions

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

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

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

123.05: continued

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

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

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

(a) An explanation of the claimant's rights and obligations with respect thereto.
(b) Certification that the repair work has been completed.
(c) Identification of the repair shop or individual who performed the repair work.
(d) An agreement that the claimant will permit the insurer to reinspect the repaired vehicle within a reasonable period of time after the return of the repair certification form.

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

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

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

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

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

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

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

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

123.06: Referral Repair Shop Programs

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

(2) Number of Shops:

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

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

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

(3) Insurer's Choice of Shops:

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

1. which are registered repair shops; and

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

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

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

123.06: continued

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

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

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

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

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

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

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

(7) Conflicts of Interest:

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

123.06: continued

(b) A discount on parts, glass, labor rate or other item or customer service in connection with the repair of motor vehicles offered by a repair shop to an insurer shall not constitute a "payment, gift or any other thing of value" for purposes of 211 CMR 123.06(7)(a).

123.07: Disclosures to Consumers

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

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

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

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

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

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

123.08: Penalties

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

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

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

(123.09: Reserved)

123.10: Severability

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

REGULATORY AUTHORITY

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

Appendix C

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

AUTOMOBILE INSURANCE RATE FILING

OF THE

MASSACHUSETTS AUTOMOBILE RATING AND ACCIDENT PREVENTION BUREAU

Docket 88-57

Industry Direct Payment Plan
(Line of Business)

December 15, 1988
(Date of Filing)

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

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

The Industry Plan

1. Payment to the claimant:

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

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

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

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

2. Repair Certification Form

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

3. Resolution of Consumer Disputes

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

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

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

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

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

completed, and any dispute as to the amount of the appraised damage shall be resolved between the referral repair shop and the insurer.

4. Disclosure of Insured Rights and Duties

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

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

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

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

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

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

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

5. Referral Repair Shop Programs

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

(2) Number of Shops: Unless the requirement is specifically waived by the Commissioner, the insurer shall provide that every claimant will be given a list of at least five repair shops geographically convenient for the claimant which will perform the repairs on referred claims without

undue delay. The claimant may or may not choose to use a shop on the referral list.

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

Insurers implementing plans during calendar year 1989 shall provide a list of at least:
(i) two referral shops at any time a list is given to a claimant;
(ii) three shops by May 1, 1989;
(iii)four shops by September 1, 1989; and
(iv) five shops by January 1, 1990.

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

(3) Insurer's Choice of Shops

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

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

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

Each individual insurer shall maintain written guidelines incorporating these criteria as applied by the insurer in implementing its plan; such guidelines shall be deemed to be a part of the individual insurer's implementation of the Industry Plan. While individual insurers which implement the Industry Plan shall maintain such written guidelines, under no circumstances shall the Massachusetts Automobile Rating and Accident Prevention Bureau propose or maintain such guidelines. Individual insurers'

guidelines shall be made available to the Commissioner upon his or her request and shall also be made available to any repair shop in the event the insurer denies that shop placement on, or strikes that shop from, its list.

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

(4) Development and Changes of Referral List

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

(5) Insurer's Guarantee

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

6. Reinspection

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

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

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

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

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

7. Conflicts of Interest

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

(b) A discount on parts, glass, labor rate or other item or customer service in connection with the repair of motor vehicles offered by a repair shop to an insurer shall not constitute a "payment, gift or any other thing of value" for purposes of (7)(a) above.

8. Disclosures to Consumers

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

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

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

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

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

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

Memorandum

Differences Between Regulation 211 CMR 123
and the Industry Direct Payment Plan

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

1. Section 123.03 Definitions

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

Explanation

The Direct Payment and Referral Shop program rules and regulation should apply to claims made by first parties under the auto physical damage coverages of collision, limited collision and comprehensive. The title of the regulation and Sections 24 and 51 of c.273 refer to the physical damage coverages only. Although the extension of the plan to third party property damage liability coverage seems to be voluntary with the company (123.05(1)), it should be made clear that these regulations will apply to first party payments only. Some of the reasons for excluding property damage liability claims from the Industry Plan are that (1) a direct payment system is already in place for appropriate PDL claims; (2) direct payments and appraisals may not make sense and/or may duplicate effort for some

PDL claims, such as subrogated claims; (3) PDL claim settlements may be delayed or reduced depending upon the determination of liability and comparative negligence; and (4) the restoration of the decrease in value and/or reinspection of repairs through a completed repair certification form would be meaningless on third party claims.

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

Explanation

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

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[1]According to the State Rating Bureau, glass discounts averaged 35% (1987 Bodyshop Hearing, Ex. 11).

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

specific referral shops[3] and (2) tend to increase the hazard to safe driving by having active motorists with broken windshields who are either "shopping around" or have decided not to repair.

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

Explanation

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

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

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

so-called betterment, must be paid for by the claimant. The Industry Plan emphasizes this important distinction throughout the text of the plan.

2. Section 123.04 Procedure for Approval of Plans

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

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

3. Section 123.05: Direct Payment Plans: Required Provisions

(1) Payment to Claimant

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

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

MARB also recognizes that the intention of the Regulation requirement to "make such payment at the time of, or within 2 business days after, the preparation of said appraisal" is to minimize the time between the claimants' receipt of the appraisal and his or her receipt

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

(2) Repair Certification

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

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

(3) Resolution of Consumer Disputes

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

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

4. Section 123.06 Referral Repair Shop Programs

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

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

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

5. Section 123.07 Disclosures to Consumers

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

NOTICE OF ELECTION
OF
INDUSTRY DIRECT PAYMENT PLAN

The Honorable Roger M. Singer
Commissioner of Insurance
The Commonwealth of Massachusetts
Department of Banking and Insurance
280 Friend Street
Boston, MA 02114

Dear Commissioner Singer:

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

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

Company Name(s) ______________________________

____

____

Company Officer ______________________________
Name
____
Signature
____
Title
____
Telephone Number
____
Date

Please send copy to:

Richard A. Derrig
Vice President - Research
Massachusetts Rating Bureaus
40 Broad Street
Boston, MA 02108

NOTICE OF ELECTION
OF
INDUSTRY DIRECT PAYMENT PLAN

Differences from the Industry Direct Payment Plan

Company Name ______________________________

1. Effective Date ______________________

2. Payment to Claimant

3. Repair Certification Form (Attach Modified Form)

4. Resolution of Consumer Disputes

5. Repair Shop Referral Lists

6. Disclosure to Consumers

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

Company Information

Insured ______________________________

Claim Number ______________________________

Date of Accident ______________________________

Policyholder Information

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

1. It is your right to shop around and to obtain repairs at the repair shop of your choice for the amount of our appraisal.
2. It is your right to be given a list of geographically convenient repair shops which will provide quality repairs for the amount of the payment made directly to you plus any applicable deductible plus any increase in value due to the repairs. We guarantee the quality of the materials and workmanship used in making the repairs at any shop on our list.
3. It is your duty to notify us, by phone or in writing, prior to or in the course of repairs, if the cost of repairs is expected to exceed our payment plus any applicable deductible and increase in value and you wish us to pay any part of that excess cost. We have the right to inspect the vehicle within three (3) business days of your notification and we have the duty to authorize or deny any supplemental payments within three (3) business days after inspection.
4. It is your right to pursue resolution of any differences in repair costs through contact with us and the procedure established in General Provision Section 11 of the policy.
5. It is your duty to complete and to return this Repair Certification Form when the vehicle is repaired. If the completed Repair Certification Form is not returned to us, the actual cash value of the insured vehicle will be reduced by the amount of the claim payment plus any applicable deductible.
6. It is your duty to allow us, upon request, to reinspect the repaired vehicle after receipt of the Repair Certification Form. If the repaired vehicle is not made available for reinspection within a reasonable amount of time, the actual cash value of the insured vehicle will be reduced by the amount of the claim payment plus any applicable deductible.

II. Certification of Repair

I certify that my damaged vehicle has been repaired by:

Repair Shop Name ______________________________

Address ______________________________

____

Telephone ______________________________

Policyholder Name: ______________________________

Policyholder Signature: ______________________________

Date: ______________________________

Company Reinspection

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

____ Other (explain) ______________________________

____

Licensed Appraiser ______________________________

Date ______________________________

24

General Provisions And Exclusions (Continued)

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

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

Section 191A. No company shall issue a policy or contract which insures against physical damage to a motor vehicle of the insured unless said policy contains in substance the following provisions:— 1 2 3

In case of any loss or damage insured against under the policy, the named insured shall give notice thereof as soon as practicable to the company or any of its authorized agents and also, in the event of larceny, robbery or pilferage, to the police, and within sixty days after filing proof of loss the company shall pay the amount of loss as provided in the policy. 4 5 6 7 8

If the named insured and the company fail to agree as to the amount of loss, each shall, on the written demand of either, made within sixty days after receipt of proof of loss by the company, select a competent and disinterested appraiser, and the appraisal shall be made at a reasonable time and place. The appraisers shall first select a competent and disinterested umpire, and failing for fifteen days to agree upon such umpire, then, on the request of the named insured or the company, such umpire shall be selected by a judge of a court of record in the county and state in which such appraisal is pending. The appraisers shall then appraise the loss, stating separately the actual cash value at the time of loss and the amount of loss, and failing to agree shall submit their differences to the umpire. An award in writing of any two shall determine the amount of loss. The named insured and the company shall each pay his or its chosen appraiser and shall bear equally the other expenses of the appraisal and umpire. 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23

The company shall not be held to have waived any of its rights by any act relating to appraisal. 24 25

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

The Honorable Roger M. Singer
Commissioner of Insurance
Department of Banking and Insurance
Commonwealth of Massachusetts
280 Friend Street
Boston, MA 02114

Dear Commissioner Singer:

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

Company Name(s) ____________________

____

____

Company Officer ____________________
Name
____
Signature
____
Title
____
Telephone Number
____
Date

Please send copy to:

Richard A. Derrig
Vice President - Research
Massachusetts Rating Bureaus
40 Broad Street
Boston, MA 02108

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

Company Name ______________________________

1987 Market Share ______________________________

We request a waiver from the minimum number requirement for referral repair shops on our referral shop list under 211 CMR 123.06 (2) for the following reasons:

Appendix D

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

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

DOCKET NO. G89-10

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

DECISION AND ORDER

BACKGROUND

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

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

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

ISSUES

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

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

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

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

DECISION AND ORDER

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

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

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

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

Dated:
October 10, 1989

Timothy H. Gailey
Commissioner

Appendix E

Regulation 211 CMR 93.00

211 CMR 93.00: COST AND EXPENSE CONTAINMENT STANDARDS FOR MOTOR VEHICLE INSURERS

Section

93.01: Authority
93.02: Purpose and Scope
93.03: Definitions
93.04: Filing Requirements
93.05: Determination of Adequacy of Programs
93.06: Adjustment of Premium Charges
93.07: Severability

93.01: Authority

211 CMR 93.00 is promulgated in accordance with the authority granted to the Commissioner by M.G.L. c. 175, § 113B.

93.02: Purpose and Scope

211 CMR 93.00 establishes cost and expense containment standards pursuant to St. 1986, c. 622 for use in connection with the fixing and establishing of motor vehicle insurance rates by the Commissioner.

93.03: Definitions

For the purposes of 211 CMR 93.00, the following words shall have the following meanings:

Bodyshop payments, payments made for or related to the repair and replacement of damaged motor vehicles, including reimbursements to automobile bodyshops for repair work done;

CAR, Commonwealth Automobile Reinsurers, created pursuant to M.G.L. c. 175, § 113H, or any successor organization;

Commissioner, the Commissioner of Insurance appointed under the provisions of M.G.L. c. 25, § 6, or his designee;

Division, the Division of Insurance within the Department of Banking and Insurance;

Fraudulent claims, claims submitted with the intent of receiving a larger payment from the insurer than the amount, if any, to which the claimant is entitled under the policy, including claims for (i) non-existent losses; (ii) amounts in excess of actual losses; or (iii) incidents which the claimant has arranged in an effort to receive an insurance payment;

Glass claims payment, payments associated with any Comprehensive or collision claim involving damaged glass;

Insurer, any insurance company authorized to write motor vehicle insurance in the Commonwealth;

MARB, the Massachusetts Automobile Rating and Accident Prevention Bureau or any successor licensed by the Division as a rating organization to act on behalf of insurers;

Motor vehicle insurance, motor vehicle policies or bonds, both as defined in M.G.L. c. 90, §§ 34A and 34O and M.G.L. c. 175, §§ 113A, 113C and 113L;

Presiding Officer, means the Commissioner or any person or persons designated by the Commissioner who shall preside over the hearing and render the findings, order and decision;

93.03: continued

Representative group of insurers, a group of insurers, representing at least 50% of the market in premium volume and 25% in number of insurers writing private passenger motor vehicle insurance in the Commonwealth in the most recent calendar year, selected so that the group is representative of the entire private passenger motor vehicle insurance industry in the Commonwealth. The group shall at a minimum be representative with respect to the following characteristics:

(a) the proportions of non-servicing carriers and of servicing carriers in the group by premium volume shall be similar to the proportions of non-servicing carriers and of servicing carriers, respectively, in the industry as a whole;

(b) the proportions of agency companies and of direct writers in the group by number of insurers shall be similar to the proportions of agency companies and of direct writers, respectively, in the industry as a whole; and

(c) the proportions of stock companies and of mutual companies in the group by number of insurers shall be similar to the proportions of stock companies and of mutual companies, respectively, in the industry as a whole.

The group shall also be selected so that it meets at a minimum the following additional specific criteria:

(a) It shall include companies of varying sizes, including at least one insurer with less than 1% of the market by premium volume;

(b) It shall include companies with varying loss ratios, including at least one insurer whose loss ratio for all automobile coverages combined is among the lowest 10% and one whose loss ratio is among the highest 10% of companies which write more than 2% of the market by premium volume; and

(c) It shall include at least one insurer which writes motor vehicle insurance in the Commonwealth only, one interstate insurer, one insurer whose policyholders reside primarily in towns with high territorial relativities, and one primarily in towns with low territorial relativities.

The selection of specific companies comprising the representative group shall be changed from year to year so that substantially all companies writing motor vehicle insurance in the Commonwealth will, over any six-year period, have been included in a representative group.

Servicing carrier, an insurer appointed pursuant to the Plan and Rules of Operation of CAR to issue and service motor vehicle insurance policies ceded to CAR;

Voluntary/ceded claims handling differential, differences in the manner in which insurers process claims of voluntary insureds versus claims of insureds under policies ceded to CAR as provided in M.G.L. c. 175, § 113H.

93.04: Filing Requirements

(1) Time of MARB Filing. Unless the Presiding Officer prescribes a different filing schedule, the MARB shall file with the Division a St. 1986, c. 622 filing which conforms to the requirements of 211 CMR 93.00 at the same time that insurers make their advisory filing pursuant to 211 CMR 77.00.

(2) Scope of MARB Filing. The MARB's St. 1986, c. 622 filing shall address insurers' cost and expense containment programs in the following areas:

(a) bodyshop payments;
(b) voluntary/ceded claims handling differential;
(c) fraudulent claims;
(d) expenses; and
(e) glass claims payments.

The Presiding Officer may, in his direction, limit the specific areas which the MARB filing must address in any particular year's hearing. In its filing, the MARB may present evidence of significant cost containment efforts in areas other than those designated in 211 CMR 93.04(2).

93.04: continued

(3) Content of MARB Filing. Unless otherwise ordered by the Presiding Officer, the MARB filing shall comply with all applicable provisions of 211 CMR 77.00. Except as limited by the Presiding Officer, for each of the specific cost and expense containment program areas identified in 211 CMR 93.04(2), the MARB filing shall include a narrative description of insurers' cost containment programs, together with the direct testimony, data and exhibits which the MARB would like considered in the hearing to fix and establish motor vehicle insurance rates. With respect to the bodyshop payments issue, the fraudulent claims issue, and the glass claims payment issue the MARB narrative shall describe and document the activities of a representative group of insurers. The MARB shall identify the insurers comprising the representative group in the format set out in Attachment A.

In describing and documenting each cost and expense containment program, the MARB filing must provide at a minimum the following: the name and title of the person responsible for the program; the number of employees and non-employees involved; the length of time the program has been in effect; the form of the program (e.g., formal program based on written plan, manual, or rules; or informal programs or procedures); the coverages and types of losses affected by the program; and the methods for auditing, monitoring and evaluating the program and its results.

The MARB filing must also document, for each cost and expense containment program, the amounts expended on the program in the most recently completed year and budgeted for the current year and the succeeding year; and the savings realized in the most recently completed year and anticipated in the current year and the succeeding year, in dollar amount, percentage of loss payments, and in terms of the impact on insurance rates. The MARB filing must demonstrate that each cost or expense containment program results in genuine cost or expense containment and not simply cost or expense transfer.

(4) MARB Filing on Bodyshop Payments Issue. In addressing the bodyshop payments issue, the MARB's filing shall address, at a minimum, issues raised in the Decision on 1987 Rates, including the following:

(a) Parts costs - efforts insurers make to pay less than the full retail price for parts and to locate and, where appropriate, insist on the use of aftermarket parts and used and rebuilt parts;

(b) Labor rates - efforts to determine whether labor rates are reasonable, to resist increases, or to lower rates;

(c) Labor times - efforts to determine whether labor times are reasonable and whether they reflect times actually spent on the repair;

(d) Bodyshop recommendations - to the extent permitted under 212 CMR (Auto Damage Appraisers Licensing Board), as interpreted by the Massachusetts courts, efforts to suggest or recommend that insureds use specific bodyshops, and that insureds do not use bodyshops whose methods or equipment are inefficient or outdated or whose charges are excessive;

(e) Fraud - efforts to control fraud in the payment of bodyshops' or insureds' claims for repairs, towing or storage, or insureds' claims for reimbursement for total losses;

(f) Total losses - efforts to ensure that insurers are not declaring a car a total loss which prudent claims evaluation would have shown could have been repaired at less cost;

(g) Storage - efforts to ensure that storage times and charges are reasonable, or to reduce times or charges;

(h) Towing - efforts to ensure that towing charges are reasonable or to reduce charges; and

(i) General - efforts to ensure that bodyshops are not reimbursed for unauthorized repairs or charges, and efforts to provide formal training and continuing education for appraisers.

(5) MARB Filing on Voluntary/ceded Claims Handling Differential Issue. In addressing the voluntary/ceded claims handling differential issue, the MARB filing must demonstrate that ceded claims are processed with the same degree of diligence as are voluntary claims. The MARB filing must also specifically provide the following information:

93.04: continued

(a) the identity of each servicing carrier whose internal systems or procedures enable persons handling claims to differentiate between ceded claims and voluntary claims;
(b) the identity of each servicing carrier which has different programs, procedures or personnel for handling ceded claims and voluntary claims, with complete documentation for each such servicing carrier describing the different programs, procedures and personnel responsibilities; and
(c) a comparison of claims which differ only in their status as ceded or voluntary claims.

For the purpose of this comparison, the MARB must evaluate a set of ceded claims and a set of voluntary claims, on the basis of criteria enumerated in the CAR "Tyler" audit, discussed in the Decision on 1987 Rates, including but not limited to, investigation and documentation in the following areas:

1. theft losses;
2. Personal Injury Protection and bodily injury claims;
3. salvage recoveries;
4. attempts to locate and use aftermarket parts;
5. storage charges;
6. appropriateness of labor charges; and
7. total losses.

The set of ceded claims must be randomly selected from the entire population of private passenger ceded claims made against all servicing carriers for the selected policy year. The sample size must be sufficiently large to be representative of the entire population of ceded claims.

The set of voluntary claims must be randomly selected from the entire population of private passenger voluntary claims made against all servicing carriers for the same policy year from which the ceded claims were selected. The sample size must be sufficiently large to be representative of the entire population of voluntary claims paid by the servicing carriers.

The selection techniques and sample sizes must be determined according to generally accepted statistical procedures, so that each set of claims is a statistically valid subset of the entire population from which each set was selected. The MARB filing shall explain in detail the specific methods by which each set of claims was selected.

(6) MARB Filing on Fraudulent Claims Issue. In addressing the fraudulent claims issue, the MARB filing must address efforts insurers make to identify all fraudulent claims, including but not limited to:

(a) claims for non-existent incidents, damage or injury;
(b) claims for substituted or non-existent vehicles;
(c) claims for exaggerated damage or injury, such as inflated doctor's bills, repair shop bills, or wage statements;
(d) duplicate claims for the same incident, damage or injury; and
(e) claims for incidents which the claimant has arranged, such as theft, arson, or vandalism, in an effort to receive an insurance payment.

The MARB filing must also identify all efforts insurers make to implement internal and external programs and procedures to discourage or prevent the filing, processing and payment of fraudulent claims, including the efforts of each servicing carrier in the representative group to implement the anti-fraud program mandated by M.G.L. c. 175, § 113H, and the requirements of St. 1987, c. 44.

(7) MARB Filing on the Expenses Issue. In addressing the expenses issue, the MARB filing shall focus upon costs relating to allocated and unallocated claim adjustment expenses, general expenses, other acquisition expenses, and expense reimbursements to agents and brokers. With respect to these areas, the MARB filing shall address insurers' efforts to contain costs through the productive use of personnel, the use of computers and other methods of automation, and efforts to avoid duplication of the work of agents and payment of excessive salaries and other compensation.

93.04: continued

(8) MARB Filing on the Glass Claims Payments Issue. In addressing the issue of glass claims payments, the MARB's filing shall document insurers' efforts to reduce fraud connected with this coverage and to policy excessive pricing of parts and services. Specifically, the filing shall address:

(a) Fraud - efforts to control fraud in the payment of glass claims for work not done or damage intentionally caused by the insureds, in order to, among other things, obtain promotional give-aways such as free tanks of gas;

(b) Replacement glass costs - efforts insurers make to receive the maximum discount on replacement glass;

(c) Labor times - efforts to determine whether labor times are excessive and whether they accurately reflect time spent on the repairs; and

(d) Promotional give-aways - efforts insurers make to halt the practice of promotional give-aways such as free tanks of gas with windshield replacements covered by comprehensive insurance.

(9) Other Filings. Any other party to the hearing on motor vehicle insurance rates, including any statutory intervenor or the State Rating Bureau of the Division of Insurance, may file a response to the MARB filing submitted under 211 CMR 93.04, and may file any other information, documentation, written testimony, or hearing exhibits which are relevant or may assist the Commissioner in evaluating the adequacy of insurers' cost and expense containment programs. Unless the Presiding Officer directs otherwise, all submissions by other parties must be filed at the same time the other parties submit their filings pursuant to 211 CMR 77.00, and must comply with all relevant sections of 211 CMR 77.00.

93.05: Determination of Adequacy of Programs

(1) The Commissioner shall evaluate the adequacy of insurers' cost and expense containment programs based upon the MARB filing, any other St. 1986, c. 622 filings made and the evidence introduced at the hearing to fix and establish motor vehicle insurance rates.

(2) The MARB must demonstrate that insurers are making reasonable efforts to contain costs and expenses. The Commissioner shall evaluate insurers' programs in light of sound management practices, due diligence and the legal obligations of insurers to pay claims. In determining whether insurers' cost and expense containment efforts are adequate and reasonable, the Commissioner may consider alternative programs which exist elsewhere, or which he finds could reasonably be implemented.

(3) The MARB will not be required to show that every insurance company has the same cost and expense containment programs. It will be sufficient to show that the practices and programs of a representative group of insurers, as defined above, meet applicable standards.

93.06: Adjustment of Premium Charges

(1) In the event that the MARB fails to make the filing required by 211 CMR 93.04, that its filing is deficient, or that the Commissioner determines that insurers' cost and expense containment programs are inadequate, he may refuse to allow any increase in premium charges for affected coverages which insurers recommend in their filing pursuant to 211 CMR 77.00.

(2) The Commissioner may make such other adjustments in premium charges to reflect the adequacy or inadequacy of insurers cost and expense containment programs based on the evidence introduced during the hearing to fix and establish motor vehicle insurance rates as he determines to be appropriate.

93.07: Severability

If any section or portion of a section of 211 CMR 93.00 is held invalid by a court either on its face or as applied, the remaining portions and sections of 211 CMR 93.00 shall not be affected thereby.

REGULATORY AUTHORITY

211 CMR 93.00: M.G.L. c. 175, § 113B as amended by St. 1986, c. 622.

93.00: continued

<u>Name of Companies Selected to Comply with 211 CMR 93.00 Requirements</u>

Insurer with less than 1% of the market	______________________
Insurer with loss ratio in lowest 10% of those companies writing more than 2% of the market by premium volume	______________________
Insurer whose policyholders reside primarily in towns with high territorial relativities	______________________
Insurer whose policyholders reside primarily in towns with low territorial relativities	______________________

93.00: continued

Name of Company	% of Market by Premium Volume	Servicing/ Non-servicing	Agency Direct Writer	Stock/ Mutual Company	Loss Ratio for All Coverages Combined	Interstate or Commonwealth Only

Appendix F

Regulation 212 CMR 2.00

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

2.01: Scope of Regulations

(1) Purpose and Applicability . The purpose of 212 CMR 2.00 is to promote the public welfare and safety by improving the quality and economy of the appraisal and repair of damaged motor vehicles. Any licensed appraiser, individual or corporate entity who employs licensed appraisers shall be bound by 212 CMR 2.00.

212 CMR 2.00 is intended to be read in conjunction with 211 CMR 133.00, Standards for the Repair of Damaged Motor Vehicles.

(2) Authority. 212 CMR 2.00 is promulgated under the authority granted to the Auto Damage Appraiser Licensing Board by M.G.L. c. 26, § 8G, as added by St. 1981, c. 775, § 1.

(3) The Board may from time to time issue Advisory Rulings and shall do so in compliance with M.G.L. c. 30A, § 8.

(4) Definitions.

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

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

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

Independent appraiser - means any appraiser other than a staff appraiser who makes appraisals under an assignment by an insurer or repair shop and shall include the owner or employee of a repair shop who makes appraisals under a contract with an insurer.

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

Staff appraiser - means an appraiser who is an employee of an insurer and whose job duties include the making of appraisals for his or her employer.

Supervisory appraisal - means an appraisal conducted by an insurance company or appraisal company supervisor solely for the purpose of evaluating the appraisal ability of one of his or her

appraiser employees or for the purpose of providing on-the-job training of an appraiser employee.

2.02: Licensing Requirements and Standards for Appraisers

(1) Requirement That License Be Obtained and Displayed. No person in Massachusetts shall appraise or estimate damages to motor vehicles or otherwise present himself or herself as an appraiser unless he or she has first obtained a license from the Auto Damage Appraiser Licensing Board. This license shall be valid for one year or less and shall be renewed annually on July 1st. Any appraiser, while making an appraisal, shall carry his or her license and shall, upon request, display it to any person involved in the claim or to any representative of the Board.

(2) Qualifications for a License. Any applicant for a license shall be 18 years of age or over and of good moral character. He or she shall furnish satisfactory proof to the Board that he or she possesses the educational qualifications required for graduation from high school or that he or she possesses relevant work experience deemed satisfactory by the Board. No applicant shall be considered competent unless the applicant has assisted in the preparation of appraisals for at least three months under the close supervision of a licensed appraiser. He or she shall complete an approved appraisal course or at the Board's discretion work experience may be substituted for said schooling.

(3) Application and Examination Fee for a License. Any applicant for a license shall complete an application to be prescribed by the Board and shall sign it under the penalties of perjury. He or she shall submit this application and non-refundable fee of $100 to the Board. After an application is received and approved, the applicant shall be required to pass an examination given under the supervision of the Board. All successful applicants will be issued a numbered license. Any applicant failing to pass an examination, upon the payment of a further nonrefundable fee of $50.00, shall be entitled to a reexamination after the expiration of six months from the date of the last examination. Any applicant failing to pass an examination shall be allowed to review his or her examination.

(4) Renewal of License. The Board shall mail to each licensed appraiser an application for renewal. Such application shall be completed and returned to the Board. Each application shall be accompanied by a renewal fee of $50.00. After verification of the facts stated on the renewal application, the Board shall issue a renewal license dated July first, and this license shall expire on the June thirtieth of the year following. Any licensed appraiser who fails to renew his or her license within 60 days after notification by the Board of his or her license expiration

date, before again engaging in the practice of a licensed appraiser within the Commonwealth, shall be required to re-register, pay a penalty fee determined by the Board and any back license fees, or may be required by the Board to be reexamined and pay applicable fees.

(5) Procedure for Auto Damage Appraisals.

(a) All forms used for auto damage appraisals must be approved by the Board.

(b) All forms used are required to have an itemization of parts, labor and services necessary for repairs thereof. The prepared appraisal shall be sworn to under the penalties of perjury and shall include the appraiser's name, signature, license number, seal or stamp, employer, insurance company, repair shop registration number if applicable, fee charged, the date the vehicle was appraised and the name of the manual used (if any) in preparing the appraisal. The appraisal seal or stamp shall be of a design approved by the Board. All appraisals sent electronically need not include the appraiser's signature and his or her seal or stamp.

(6) Schedule of Appraisal Fees.

(a) The Board may consider the appraisal fees charged within the territories where said appraiser operates. Any appraiser shall establish his or her own fee schedule unless limited by the Board. Any appraiser must post his or her appraisal fee schedule in a conspicuous location at his or her work place. The Board may establish a maximum schedule of fees by territory, type of business or complexity of work. Fees charged in excess of maximums approved by the Board shall result in penalties as established by the Board.

(b) Fees paid by a claimant for an appraisal that was requested by the insurer are recoverable from the insurer. Fees for auto damage appraisals not requested by the insurer in first party claims are not recoverable from the insurer.

(7) Conflict of Interest. It shall be a conflict of interest for any appraiser who has been assigned to appraise a damaged motor vehicle to accept, in connection with that appraisal, anything of value from any source other than the assignor of that appraisal.

Further, it shall be a conflict of interest for any appraiser employed by a repair shop to accept the assignment of an appraisal from an insurer unless that appraiser's employment contract prohibits the repair shop from repairing damaged motor vehicles that have been so appraised. In addition, it shall be a conflict of interest for any appraiser who owns or has an interest in a repair shop to have a vehicle repaired at that shop if that appraiser has appraised that vehicle at the request of an insurer.

It shall be a conflict of interest if any licensed appraiser operates a Drive-in Appraisal Service for an insurer at a repair shop.

(8) Revocation or Suspension of a License. The Board may revoke or suspend any appraiser's license at any time for a period not exceeding one year if the Board finds, after a hearing, that the individual is either not competent or not trustworthy or has committed fraud, deceit, gross negligence, misconduct, or conflict of interest in the preparation of any motor vehicle damage report. The following acts or practices by any appraiser are among those that may be considered as grounds for revocation or suspension of an appraiser's license:

(a) material misrepresentations knowingly or negligently made in an application for a license or for its renewal;

(b) material misrepresentations knowingly or negligently made to an owner of a damaged motor vehicle or to a repair shop regarding the terms or effect of any contract of insurance;

(c) the arrangement of unfair and or unreasonable settlements offered to claimants under collision, limited collision, comprehensive, or property damage liability coverages;

(d) the causation or facilitation of the overpayment by an insurer of a claim made under collision, limited collision, comprehensive, or property damage liability coverage as a result of an inaccurate appraisal;

(e) the refusal by any appraiser who owns or is employed by a repair shop to allow an appraiser assigned by an insurer access to that repair shop for the purpose of making an

appraisal, supervisory reinspection, or intensified appraisal.

(f) the commission of any criminal act related to appraisals, or any felonious act, which results in final conviction;

(g) knowingly preparing an appraisal that itemizes damage to a motor vehicle that does not exist: and

(h) failure to comply with 212 CMR 2.00.

(9) Drive-in Claim and Appraisal Facilities. Drive-in claim and appraisal facilities shall possess the following equipment:

(a) Operating telephone service.

(b) A calculator.

(c) Current collision, paint and body cost estimating guide manuals or an automated system.

(d) An operating flash light.

(e) A tape measure of at least 30 feet.

(f) An operating camera and film.

(g) A fax machine or other device capable of transmitting data.

2.03: Duties of Insurers and Repairers

(1) Responsibilities for Actions of Appraisers. An insurer or repair shop shall be responsible for the actions of all of its appraisers whether staff or independent, and shall be subject to the applicable penalties under law for any violation of 212 CMR 2.00 by its appraiser.

The Board may assess penalties against either the appraiser, the insurer, the repair shop or all three. In the event of default by the appraiser, the insurer or the repair shop may be responsible for penalties.

(2) Records and Analysis of Appraisals. Every insurer or repair shop appraiser shall retain for at least two years, copies of all records related to appraisals and inspection. Every insurer shall retain copies of all records including photographs in accordance with state law.

2.04: Procedures for the Conduct of Appraisals and Intensified Appraisals

(1) Conduct of Appraisals.

(a) Assignment of an Appraiser. Upon receipt by an insurer or its agent of an oral or written claim for damage resulting from a motor vehicle accident, theft, or other incident for which an insurer may be liable, the insurer shall assign either a staff or an independent appraiser to appraise the damage. Assignment of an appraiser shall be made within two working days of the receipt of such claim. However, the insurer may exclude any claim for which the amount of loss, less any applicable deductible, is less than $500.00.

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

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

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

(e) Determination of Damage and Cost of Repairs. The appraiser shall specify all damage attributable to the accident, theft, or other incident in question and shall also specify any unrelated damage. If the appraiser determines that preliminary work or repairs would significantly improve the accuracy of the appraisal, he or she shall authorize the preliminary work or repair with the approval of the claimant and shall complete the appraisal after that work has been done. The appraisers representing the insurance company and the registered repair shop selected by the insured to do the repair shall attempt to

agree on the estimated cost for such repairs. The registered repair shop must prepare an appraisal for the purpose of negotiation. No appraiser shall modify any published manual (i.e., Motors, Mitchell or any automated appraisal system) without prior negotiation between the parties. Manufacturer warranty repair procedures, I-Car, Tec Cor and paint manufacturer procedures may also apply. Further, no appraiser shall use more than one manual or system for the sole purpose of gaining an advantage in the negotiation process.

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

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

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

If aftermarket parts are specified in any appraisal the appraiser shall also comply with the requirements of M.G.L.

c. 90, § 34R that pertain to the notice that must be given to the owner of a damaged motor vehicle.

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

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

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

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

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

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

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

2.05: Penalties

(1) Violations of M.G.L. c. 26, § 8G, and 212 CMR 2.00 may result in penalties including administrative costs, revocation or suspension of license or both. All administrative costs are subject to the discretion of the Board. The administrative costs may be assessed against the appraiser, the appraiser's employer, the insurer, or the repair shop.

An alleged violation of 212 CMR 2.00 by a licensed appraiser at the direction of an insurer may be reported to the Division of Insurance which may impose applicable penalties against such an insurer.

2.06: Severability

If any provision of 212 CMR 2.00 or its application to any person or circumstances is held invalid, such invalidity shall not affect the validity of other provisions or applications of 212 CMR 2.00

Appendix G

Regulation 211 CMR 133.00 Standards for the Repair of Damage Motor Vehicles

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

Section

133.01: Purpose and Applicability
133.02: Authority
133.03: Definitions
133.04: Determination of Damage and Cost of Repair
133.05: Determination of Values
133.06: Option for Contract Repair
133.07: Intensified Appraisals
133.08: Penalties
133.09: Severability

133.01: Purpose and Applicability

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

133.02: Authority

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

133.03: Definitions

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

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

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

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

133.04: Determination of Damage and Cost of Repair

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

(a) the operational safety of the vehicle might otherwise be impaired;

(b) reasonable and diligent efforts to locate the appropriate rebuilt, aftermarket or used part have been unsuccessful;

(c) a new part of like kind and quality is available at the same or lower cost; or

(d) the vehicle has been used no more than 15,000 miles unless the pre-accident condition warrants otherwise.

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

133.04: continued

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

133.05: Determination of Values

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

(a) the retail book value for a motor vehicle of like kind and quality, but for the damage incurred;

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

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

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

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

133.06: Option for Contract Repair

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

(a) the insurer allows the claimant to retain possession and ownership of the vehicle; and

(b) the claimant obtains a salvage title for said vehicle in compliance with M.G.L. c. 90D.

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

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

133.07: Intensified Appraisals

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

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

133.08: Penalties

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

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

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

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

133.09: Severability

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

REGULATORY AUTHORITY

211 CMR 133.00: M.G.L. c. 90, § 340; c. 175, §§ 3A, 4 and 113B; c. 176D, § 11.

Appendix H

Regulation 211 CMR 94.00

2002-10 Implementation of amendments to 211 CMR 94.00

TO:	**All Massachusetts Private Passenger Automobile Insurers**
FROM:	**Julianne M. Bowler, Commissioner of Insurance**
DATE:	**June 12, 2002**
RE:	**Implementation of amendments to 211 CMR 94.00**

In November, 2001 the Automobile Insurers Bureau proposed changes to 211 CMR 94.00, the regulation addressing mandatory pre-insurance inspections of private passenger motor vehicles. A hearing on the proposed changes took place on April 2, 2002, and the regulation, in final form, was published in the Massachusetts Register of May 10, 2002, and took effect on that day. At no time during the review process did the AIB or any individual insurer request a future effective date for the regulatory changes.

The AIB thereafter asked to postpone the effective date of those changes to permit the companies to reprogram their computer systems and to set up the additional methods for providing lists of inspection sites to consumers that the regulation allows. Rather than amend the regulation, we are issuing this bulletin on procedures for phasing-in the new requirements.

1. Insurers are expected to complete the reprogramming of their systems promptly and, in any event, by August 15, 2002.
2. Insurers must immediately train their staff and their agents to take appropriate steps to override notices directed to consumers that do not comply with the requirements of the revised regulation.
3. Insurers must promptly develop systems for notifying consumers of inspection sites that comply with the new regulation. Such systems shall be in place by August 15. In the interim, they may continue to provide that information in the form of hard copy.

So long as insurers comply with the timetables in this bulletin, the Division will not take any enforcement action against insurers for failure to comply immediately with the requirements of the regulation, as amended.

211 CMR 94.00: Mandatory Pre-Insurance Inspection of Private Passenger Motor Vehicles

SECTION:

94.01: Authority
94.02: Scope and Purpose
94.03: Definitions
94.04: Mandatory Inspection Requirements
94.05: Exemptions to Inspection Requirement
94.06: Waivers of Inspections
94.07: Deferral of Inspections
94.08: Standards and Procedures for Inspections
94.09: Standards for Suspension of Insurance Coverage
94.10: Inspection Services
94.11: Conflicts of Interest
94.12: Enforcement
94.13: Records and Audits
94.14: Effective Date
94.15: Severability
94.16: Forms

94.01: Authority

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

94.02: Scope and Purpose

The purpose of 211 CMR 94.02 is to establish standards and procedures for the inspections of certain used cars prior to the issuance by insurers of physical damage insurance coverages. 211 CMR 94.00 applies to all private passenger motor vehicles insured in the Commonwealth unless specifically exempted or waived under 211 CMR 94.00.

94.03: Definitions

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

Applicant means the named insured, as defined in the Standard Massachusetts Motor Vehicle Insurance Policy or an applicant for a motor vehicle liability policy or bond.

Authorized representative means any person or legal entity, other than the applicant, authorized by an insurer to conduct pre-insurance inspections pursuant to 211 CMR 94.00 and may include an employee of the insurer, or a producer or inspection service.

Book of business means all motor vehicle insurance written by one producer with one insurer.

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

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

Division means the Division of Insurance within the Department of Banking and Insurance.

Existing Customer means an applicant for a motor vehicle liability policy or bond who has been insured for three years or longer, without interruption, under a motor vehicle liability policy or policies which include(s) physical damage coverage, issued by the insurer to which the application is submitted. An existing customer shall include any applicant involuntarily transferred to another insurer due to the applicant's original insurer's withdrawal from the Commonwealth, if the applicant otherwise qualifies under 211 CMR 94.00.

Inspection service means any person or legal entity, other than the applicant, designed and operated to perform inspections required by 211 CMR 94.00 and which is approved by the insurer. In determining whether to approve an inspection service an insurer may take into consideration the service's professionalism, efficiency and cost effectiveness.

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

Motor vehicle liability policy or bond means an insurance policy or bond as defined in M.G.L.c. 90, §§ 34A, 34O, and M.G.L. c. 175.

Nonowned motor vehicle means a private passenger motor vehicle in the possession of the applicant or being operated by the applicant which is neither owned by nor furnished for the regular use of either the applicant or any relative (as defined in the policy) other than a temporary substitute motor vehicle, as defined below.

Physical damage coverage means the optional coverages in a motor vehicle liability policy or bond for collision or limited collision and/or fire and theft or so-called comprehensive coverages as defined in M.G.L. c. 90, § 34(O) and M.G.L. c. 175, § 113O.

Private passenger motor vehicle means any owned or leased four-wheeled motor vehicles including, but not limited to, sedans, coupes, hatchbacks, station wagons, jeep-type vehicles, pick-up trucks, panel trucks, delivery sedans and vans, except vehicles which have a gross weight in excess of 8,000 pounds.

Producer means an agent or broker licensed pursuant to M.G.L. c. 175, §§ 163 or 166, to write property and casualty insurance in the Commonwealth, including a representative producer as defined by the rules for the Commonwealth Automobile Reinsurers established pursuant to M.G.L. c. 175, § 113H.

Temporary substitute motor vehicle means any private passenger motor vehicle not owned by the applicant, which is used by the applicant, with the permission of the owner, as a temporary substitute due to breakdown, repair, servicing, loss or destruction of the applicant's own motor vehicle.

94.04: Mandatory Inspection Requirements

(1) No motor vehicle liability policy or endorsement insuring a private passenger motor vehicle for physical damage coverage, shall be issued or renewed in the Commonwealth unless the insurer has inspected the motor vehicle in accordance with 211 CMR 94.00.

(2) Physical damage coverage shall not be effective on an additional or replacement motor vehicle under an existing policy, unless otherwise exempted, until the insurer has inspected the motor vehicle in accordance with 211 CMR 94.00.

94.05: Exemptions to Inspection Requirement

(1) The requirement of an inspection *shall not* apply to the following:

(a) a new, unused motor vehicle from a franchised automobile dealership where the insurer is provided with either: a copy of the bill of sale which contains a full description of the motor vehicle including all options and accessories; or a copy of the RMV Form 1 provided by the Registry of Motor Vehicles, which establishes the transfer of ownership from the dealer to the customer and a copy of the window sticker or the dealer invoice showing the itemized options and equipment in addition to the total retail price of the vehicle. The physical damage coverage on such new, unused motor vehicle shall not be suspended during the term of the policy due to the applicant's failure to provide the required documents. Payment of a claim, however, shall be conditioned upon the receipt by the insurer of such documents and no physical damage loss occurring after the effective date of the coverage shall be payable until the documents are provided to the insurer. If the above documents are not submitted by the applicant at least 60 days prior to the applicant's annual renewal date, the insurer, upon renewal of the physical damage coverage, must require an inspection as set forth in 211 CMR 94.00;

(b) the applicant is an existing customer;

(c) the motor vehicle is already insured for such physical damage coverages with the insurer by the applicant;

(d) an inspection is waived by the insurer pursuant to 211 CMR 94.06;

(e) a temporary substitute motor vehicle;

(f) a motor vehicle which is leased for less than six months, provided the insurer receives the lease or rental agreement containing a description of the leased motor vehicle including its condition. Payment of a physical damage claim shall be conditioned upon receipt of the lease or rental agreement;

(g) when requiring an inspection would cause a serious hardship to the insurer or the applicant and such hardship is documented in the applicant's policy record; or

(h) when the insurer has no inspection facility or authorized representative either in the city or town in which the motor vehicle is principally garaged or within five miles of said city or town.

(2) An insurer shall indicate in the applicant's policy record the reason a vehicle is being exempted from the inspection requirement under 211 CMR 94.00.

(3) An insurer may require an inspection of a motor vehicle otherwise exempt pursuant to 211 CMR 94.05(1) provided that the decision to inspect such motor vehicle is reasonable and supported by objective facts. The decision to require such an inspection shall not be based on the age, race, sex, or marital status of the applicant or the customary operators of the vehicle, the principal place of garaging, or the fact that the policy has been ceded to the residual market mechanism. A written record of the reasons for requiring an inspection, pursuant to 211 CMR 94.05(3) shall be placed in the applicant's policy record.

94.06: Waiver of Inspection

(1) An insurer <u>may</u> waive an inspection under any of the following circumstances:

(a) for policies issued or renewed during calendar year 2002, all 1992 and older model year vehicles. For policies issued or renewed during each calendar year thereafter, the applicable model year shall be moved forward by one year. For example: in 2002 an insurer must inspect 1993 and newer model year vehicles and in 2003 an insurer must inspect 1994 and newer model year vehicles. An insurer may elect to inspect specified vehicles included within this waiver. Such exceptions to this optional waiver must be based on underwriting criteria uniformly applied;

(b) where a nonowned motor vehicle is insured under a policy providing physical damage coverage issued by an insurer which has inspected such motor vehicle in accordance with the provisions of 211 CMR 94.00;

(c) where the insured motor vehicle is insured under a commercially-rated policy which insures a fleet of five or more motor vehicles owned by the same person or legal entity;

(d) when a producer is transferring a book of business from one insurer to one or more insurers; or

(e) when an individual applicant's coverage is being transferred by an independent insurance agent to a new insurer and said agent provides the new insurer with a copy of the inspection report completed on behalf of the previous insurer, provided the independent agent represents both insurers, and the insured vehicle was physically inspected by the previous insurer. However, if the new insurer does not receive a copy of the inspection report 60 days prior to the first annual renewal date, the insurer must, upon renewal of the physical damage insurance, require an inspection as set forth in 211 CMR 94.00; or

(f) When the motor vehicle is insured for physical damage on the applicant's expiring Massachusetts Automobile Insurance Policy, or when a copy of a prior Pre-Insurance Inspection is provided ; or

(g) When the applicant has been the customer of the producer for at least three (3) years under a Massachusetts Automobile Insurance Policy which included physical damage coverage.

(2) Any decision to waive or not to waive an inspection pursuant to 211 CMR 94.00, shall not be based on the age, race, sex, or marital status of the applicant or the customary operators of the vehicle, the principal place of garaging, or the fact that a policy has been ceded to the residual market mechanism.

(3) An insurer shall indicate in the applicant's policy record the reason a waiver has been granted.

94:07: Deferral of Inspection

(1) An insurer may defer an inspection for ten calendar days (not including legal holidays and Sundays) following the effective date of coverage or the date on which the insurer or the producer of record mailed the Notice of Mandatory Pre-Insurance Inspection Requirement (Form B) whichever is later on new business and on additional or replacement vehicles to an existing policy, if an inspection at the time of the request for coverage would create a serious inconvenience for the applicant.

(2)

(a) When an inspection is deferred pursuant to 211 CMR 94.07(1) or (4), an insurer, through its producer, shall either:

1. immediately obtain the prescribed acknowledgement (Form D) signed by the applicant if the applicant has applied for coverage in person; or

2. immediately confirm physical damage coverage and remind the applicant of the inspection requirement on a prescribed notice letter (Form B) if the applicant has applied for coverage either by mail or by phone.

(b) In addition to the notice requirements of 211 CMR 94.07(2)(a), the insurer, through its producer, shall furnish the applicant, at the time coverage is effected, with a list of inspection sites where the inspection can be conducted. The list of inspection sites may be provided in writing, through a toll free number or by electronic access, as convenient for the applicant. The location of an inspection site or sites and the consequences of the applicant's failure to obtain a timely inspection shall be furnished immediately to the applicant either in person, if the applicant has applied for coverage in person, or by telephone, if the applicant has applied for coverage by phone. Documentation of such notice, including the name of the person giving the notice must be contained in the applicant's policy record.

(3) Producers must use the prescribed NOTICE OF MANDATORY PRE-INSURANCE INSPECTION REQUIREMENT letter (Form B) or the prescribed ACKNOWLEDGEMENT OF REQUIREMENT FOR PRE-INSURANCE INSPECTION letter (Form D) (see 211 CMR 94.16) and immediately send a copy to the insurer. A copy of the confirmation letter addressed to the applicant, and Certificate of Mailing thereof, or the completed acknowledgment letter shall be retained by the producer in the applicant's policy record. In the case of a so-called courtesy transfer, the producer confirming coverage shall be responsible for the immediate notification to the applicant pursuant to 211 CMR 94.07(2)(a)1. above, unless the application for coverage is submitted by a person other than the applicant. In such cases, the producer of record shall remain responsible for notification pursuant to 211 CMR 94.07(2)(a)2. and 94.07(2)(b). The producer confirming coverage shall immediately forward a copy of the acknowledgement (Form D) to the producer of record who shall then be responsible for forwarding a copy to the insurer as required by 211 CMR 94.07(3).

(4) If the insurer is required, pursuant M.G.L c. 175, s. 113H, to provide physical damage coverage at the option of the applicant, it shall provide, upon an applicant's request for such physical damage coverage, immediate coverage and may defer the inspection for the ten calendar days (not including legal holidays and Sundays) following the effective date of coverage or the date on which the insurer or the producer of record

mailed the Notice of Mandatory Pre-Insurance Inspection Requirement (Form B) whichever is later.

(5) Any decision to defer or not to defer an inspection pursuant to 211 CMR 94.00 shall not be based on the age, race, sex, or marital status of the applicant or the customary operators of the vehicle, the principal place of garaging, or the fact that a policy has been ceded to the residual market mechanism.

94.08: Standards and Procedures for Inspections

(1) Inspections required or permitted pursuant to 211 CMR 94.00 shall be made by a designated authorized representative of the insurer at a time and place reasonably convenient to the applicant. A reasonably convenient time shall include, in addition to customary business hours, sufficient early morning, evening and weekend hours. A reasonably convenient place shall not be more than five miles from the city or town where the motor vehicle is principally garaged.

(2)

(a) Any inspection authorization forms issued by the insurer to the applicant, for presentation to the authorized representative, *shall not* contain the Vehicle Identification Number (VIN) of the vehicle to be inspected.

(b) The inspection shall:

1. be recorded on the prescribed MOTOR VEHICLE PRE-INSURANCE INSPECTION REPORT (Form A) (See 211 CMR 94.16);

2. include two color photographs of the motor vehicle, taken as directed on the inspection report, which shall be attached to the report;

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

(c) The authorized representative may take additional photographs showing any damaged areas, which shall also be attached to the report.

(d) The original report and photographs shall be immediately sent to the insurer who shall retain the report and photographs in the applicant's policy record for three years from the date of the inspection, except as provided by 211 CMR

94.08(6)(d). The authorized representative shall also provide a copy of the report, without photographs, to the applicant at the time of the inspection.

(3) The insurer shall maintain an up-to-date list of all authorized representatives and inspection sites performing inspections for the insurer. The list must include the names, addresses and business phone numbers of all authorized representatives and the insurer shall make such list accessible to the Division upon request.

(4) There shall be no charge either directly or indirectly to the applicant in connection with an inspection, except that such charge may be considered in accordance with M.G.L. c. 175, § 113B or other applicable laws.

(5) The competency and trustworthiness of the authorized representative in the conduct of the inspections provided for in 211 CMR 94.08 shall be the responsibility of the insurer.

(6) An insurer shall utilize authorized representatives who shall:

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

(b) maintain a control system on such inspection reports including the use of sequentially numbered reports;

(c) retain and supply to an insurer, upon request, a copy of any inspection report which was completed within three years of the date of inspection.

(d) provide an optional service, on an additional fee basis, to insurers whereby the original inspection reports and photographs are retained by the authorized representative who shall maintain such original inspection reports and photographs in a manner so as to facilitate rapid retrieval for a period of at least three years from the date of inspection. A copy of the inspection report shall be provided to the insurer. The authorized representative shall, upon the request of the insurer, mail or deliver the original inspection report and photographs to the insurer within two business days of such request.

(7)

(a) The inspection report and photographs shall be used by the insurer to document previous damage, prior condition, options and mileage of the motor vehicle on physical damage claims whenever:

1. the appraisal indicates prior damage;

2. the vehicle is a total loss or unrecovered theft; or

3. the damage exceeds $1,000.

(b) A copy of the inspection report and photographs must be utilized, and made a part of the insurer's claim file, in the settlement of all total loss claims. The inspection report must be made a part of the claim file regardless of whether or not the payment is reduced based on the information contained therein. Such inspection report must come from the applicant's policy record.

94.09 Standards for Suspension of Physical Damage Coverages

(1) If the inspection is not conducted prior to the expiration of the ten calendar days deferral period specified in 211 CMR 94.07(1), motor vehicle physical damage coverage on the motor vehicle shall be suspended at 12:01 a.m. of the day following the tenth calendar day, and such suspension shall continue until the inspection is effected. The insurer must inspect the motor vehicle and reinstate physical damage coverage (effective at the time of the inspection) if the applicant thereafter requests an inspection. The applicant's ability to reinstate the physical damage coverage upon inspection, however, shall lapse if the insurer has already made a pro-rata premium adjustment pursuant to 211 CMR 94.09(2). Thereafter a reinstatement shall only be effective upon inspection *and* payment by the applicant to the insurer of the adjusted premium for the physical damage coverage in full or in accordance with the insurer's normal payment plan, at the insurer's option.

(2) Whenever physical damage coverage is suspended, the insurer shall, between the 21st and 30th calendar day after the effective date of the coverage or the date on which the insurer or the producer of record mailed the Notice of Mandatory Pre-Insurance Inspection Requirement (Form B) whichever is later, mail to the applicant, the producer of record, and any lienholders a prescribed NOTICE OF SUSPENSION OF PHYSICAL DAMAGE COVERAGE (Form C) (see 211 CMR 94.16). The insurer shall complete a certificate of mailing of the suspension to the applicant and shall retain the certificate and a copy of the suspension in the applicant's policy record. Whenever there is a suspension of physical damage coverage for more than 10 days, the insurer shall make a pro-rata premium adjustment (return premium or credit) which shall be mailed to the applicant no later than 45 days after the effective date of the suspension.

(3) If the motor vehicle is not inspected pursuant to this regulation due to the fault of the insurer, or if its producer fails to give the verbal or telephone notice required by 211 CMR 94.07(2) of this regulation or mail or deliver the NOTICE OF MANDATORY PRE-INSURANCE INSPECTION REQUIREMENT (Form B) or obtain the ACKNOWLEDGEMENT OF REQUIREMENTS FOR PRE-INSURANCE INSPECTION (Form D) as set forth in 211 CMR 94.07(2) and the insurer or the producer of record has failed to issue the Mandatory Pre-Insurance Inspection Requirement (Form B), physical damage coverage on the motor vehicle shall not lapse. The failure of the insurer to act promptly does not relieve it of its obligation to inspect. In the event that the producer of record fails to properly communicate to the applicant the Mandatory Pre-Insurance Inspection Requirement (Form B) or an Acknowledgement of Requirement for Pre-Insurance Inspection (Form D), the insurer or the producer of record must issue the Mandatory Pre-Insurance Inspection Requirement (Form B) and the applicant has ten

calendar days to comply. An insurer's failure, however, to comply with the provisions of 2111 CMR 94.09(2) does not restore physical damage coverage, but shall subject the insurer to a penalty pursuant to 211 CMR 94.12.

94.10: Inspection Services

(1) Inspection services shall maintain a record of the name, address and signature of all persons authorized by such inspection service to perform inspections, prior to that person performing any inspections pursuant to this regulation. Such record shall be made available to the Division upon request.

(2) An inspection service must be approved by the insurer for which it will be conducting inspections. In determining whether to approve an inspection service an insurer may take into consideration the service's professionalism, efficiency and cost effectiveness.

94.11: Conflicts of Interest

An authorized representative shall not be deemed trustworthy if there exists any conflict of interest which may prevent him or her from conducting a thorough and accurate inspection. It shall be a conflict of interest for an authorized representative to accept, in connection with an inspection, anything of value from any source other than the insurer.

94.12: Enforcement.

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

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

(3) The competency and trustworthiness of all authorized representatives in the conduct of the inspections provided by 211 CMR 94.00 shall be the responsibility of the insurer.

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

94.13: Records and Audits

(1) Insurers shall maintain records as to the costs and savings related to 211 CMR 94.00 and shall make such records available to the Division upon request.

(2) Insurers shall be responsible for the monthly auditing of inspection reports received from their authorized representatives and shall provide such authorized representatives, excluding producers, with monthly status reports indicating the total number of reports received including the number of incomplete or incorrect reports received.

94.14: Effective Date

211 CMR 94.00 shall become effective on March 1, 1989.

94.15: Severability

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

94.16: Forms

Sample forms for Motor Vehicle Pre-Insurance Inspection Report (Form A), Notice of Mandatory Pre-Insurance Inspection Requirement (Form B), Notice of Suspension of Physical Damage Coverage (Form C) and Acknowledgment of Requirement for Pre-Insurance Inspection (Form D) as referred to in 211 CMR 94.00 are available from:

Division of Insurance - Legal Section
One South Station
Boston, MA 02110

REGULATORY AUTHORITY

- 211 CMR 94.00: M.G.L. c. 175, § 113S.

INSURANCE COMPANY LETTERHEAD
OR
INSPECTION SERVICE LETTERHEAD

.OL NUMBER ________ SITE I.D. # ________

ATE OF INSPECTION	TIME OF INSPECTION AM PM	INSURANCE COMPANY NAME	INSURED'S POLICY NUMBER	NUMBER OF PHOTOS

NSURED'S NAME	INSURED'S ADDRESS	TEL. NO.

NSPECTOR'S NAME	INSPECTION SITE NAME & ADDRESS	TEL. NO.

EAR: ____________
AKE: ____________
ODEL: ____________

STYLE
___ 2 DR ___ STG WGN
___ 4 DR ___ VAN
___ CPE ___ HTCHBK

COLOR
MAJOR ______
MINOR ______

INTERIOR
___ CLOTH ___ LEATHER
___ VINYL ___ COLOR

ODOMETER READING	PRINCIPAL PLACE OF GARAGING	VEHICLE IDENTIFICATION NUMBER (NOT FROM REGISTRATION FORM)	LICENSE PLATE NO. & STATE

/ / / / / / / / / / / / / / / / / / / /
V.I.N. location:

ACCESSORIES & OPTIONAL EQUIPMENT
(COMPLETE FOR ALL VEHICLES INCLUDING VANS)

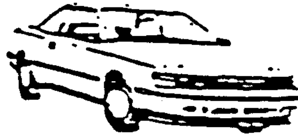
[ ] AIR CONDITIONER
[ ] MANUAL TRANSMISSION
[ ]3 SPD [ ]4 SPD [ ]5 SPD
[ ] AUTOMATIC TRANSMISSION
[ ] OVERDRIVE
[ ] AM RADIO
[ ] AM/FM RADIO [ ] STEREO
[ ] CASSETTE PLAYER
BRAND ____________
BUILT IN [ ] YES [ ] NO
[ ] COMPACT DISC PLAYER
BRAND ____________
BUILT IN [ ] YES [ ] NO
[ ] CAR PHONE
BRAND ____________
BUILT IN [ ] YES [ ] NO
[ ] CAR PHONE ANTENNA
[ ] CAR PHONE TRANSMITTER
[ ] C.B. RADIO
BRAND ____________
BUILT IN [ ] YES [ ] NO
[ ] EIGHT TRACK PLAYER
BRAND ____________
'ILT IN [ ] YES [ ] NO
EREO AMPLIFIER
.AND ____________
BUILT IN [ ] YES [ ] NO

[ ] CRUISE CONTROL
[ ] REAR DEFROSTER
[ ] REAR WIPER
[ ] TILT WHEEL
[ ] TINTED GLASS
[ ] POWER STEERING
[ ] POWER BRAKES
[ ] POWER WINDOWS
[ ] POWER LOCKS
[ ] POWER ANTENNA
[ ] VINYL TOP/ROOF
[ ] T-TOP ROOF
[ ] SUNROOF
FACTORY INSTALLED
[ ] YES [ ] NO
TYPE ____________
[ ] SPECIAL ROOF
TYPE ____________
[ ] BUCKET SEATS
[ ] SPECIAL WHEELS
[ ] SPECIAL TIRES
TYPE ____________
[ ] SPECIAL HUB CAPS
[ ] RADAR DETECTOR
BRAND ____________

[ ] ANTI THEFT DEVICE
TYPE ____________
[ ] CAR ALARM
BRAND ____________
[ ] HIGH MOUNTED BRAKE LIGHT
[ ] ROOF RACK
[ ] SPARE TIRE (OUTSIDE MOUNT)
[ ] CARPETING
[ ] INSTRUMENTATION
TYPE ____________
____
____
[ ] SPECIAL MIRRORS
TYPE ____________
[ ] TRAILER HITCH
[ ] AUTO RECOVERY SYSTEM
TYPE ____________
[ ] SPECIAL CUSTOM OPTIONS OR ADDITIONS (LIST)
____
____
____
____
____
____
____

PHOTOGRAPHS OF VEHICLE (MUST BE COLOR PHOTOS)

...TACH AT LEAST TWO (2) COLOR PHOTOGRAPHS
... THE AUTOMOBILE TAKEN FROM THE ANGLES
...WN ON THE DIAGRAMS TO THE RIGHT. ALSO
... CLOSE-UP PHOTO OF THE E.P.A.
...R (INCLUDING THE V.I.N.) FROM
...VER'S SIDE DOOR JAMB.



Front and Passenger Side

Rear and Driver Side

PHYSICAL CONDITION OF VEHICLE
(CHECK DAMAGED AREAS OR AREAS IN POOR CONDITION AND DESCRIBE BELOW)

...AGED/RUSTED		
[ ]	[ ]	FRONT BUMPER
[ ]	[ ]	LEFT FRONT FENDER
[ ]	[ ]	LEFT FRONT DOOR
[ ]	[ ]	LEFT REAR DOOR
[ ]	[ ]	LEFT REAR QUARTER PANEL
[ ]	[ ]	REAR BUMPER
]	[ ]	REAR DOOR/TRUNK LID
]	[ ]	RIGHT REAR QUARTER PANEL
]	[ ]	RIGHT REAR DOOR
]	[ ]	RIGHT FRONT DOOR
]	[ ]	RIGHT FRONT FENDER
]	[ ]	HOOD PANEL
]	[ ]	ROOF PANEL
]	[ ]	GRILL

DAMAGED	
[ ]	WINDSHIELD
[ ]	LEFT FRONT SIDE GLASS
[ ]	RIGHT FRONT SIDE GLASS
[ ]	LEFT REAR SIDE GLASS
[ ]	RIGHT REAR SIDE GLASS
[ ]	REAR WINDOW
[ ]	REARVIEW MIRROR
[ ]	WHEEL COVERS
[ ]	WORN/TORN OR SOILED INTERIOR
[ ]	OTHER DAMAGE OR RUST (LIST)

____
____
____
____

[ ] CHECK HERE IF NO EXISTING DAMAGE, RUST OR MISSING PARTS

...BE EXISTING DAMAGES OR RUST:

____

...ANY MISSING PARTS:

____

...IBE ANY ALTERATIONS FROM FACTORY DESIGN:

____

...BOVE IS A TRUE STATEMENT OF ANY EXISTING DAMAGE, RUST, OR MISSING PARTS AS OF THE ... OF THIS INSPECTION. I CERTIFY THAT THIS INSPECTION REPORT IS TRUE AND COMPLETE AND ... I HAVE SEEN AND PHOTOGRAPHED THE VEHICLE IDENTIFIED ABOVE.

______________ INSPECTOR'S SIGNATURE: ______________

... ADDRESS OF PERSON ...TING VEHICLE FOR INSPECTION	SIGNATURE	RELATIONSHIP TO INSURED

FORM B

(COMPANY LETTERHEAD)

NOTICE OF MANDATORY PRE-INSURANCE INSPECTION REQUIREMENT
(This is not a safety inspection)

IMMEDIATE ACTION REQUIRED TO AVOID LOSS OF INSURANCE COVERAGE

____
(Date of mailing)

Name of Insured: ____________________
Address: ____________________
____
____

EFFECTIVE DATE OF COVERAGE: __________ (Date)
INSPECTION MUST BE COMPLETED BY: __________ (Date)

POLICY #: ____________________

Dear Policyholder,

This will confirm coverage for FIRE AND THEFT/ COMPREHENSIVE ______; COLLISION _______; LIMITED COLLISION ________; on your

	YEAR	MAKE	MODEL
1.			
2.			
3.			

Please disregard this notice if you have already had your car inspected.

This notice will also serve as a reminder that the above described car(s) must be inspected by the date indicated above, or your physical damage coverages will be suspended effective 12:01 A.M. on ____________________.
(Date)

If you have your car inspected after the above deadline your coverage will only be restored after your car has been inspected and the adjusted premium due for the coverages listed above has been paid. You will have no coverage for any physical damage loss that occurs during the suspension period.

FOR FURTHER INFORMATION PLEASE CALL:

____
Name and phone no. of Company Representative

Very truly yours,

____

cc: INSURANCE COMPANY
PRODUCER OF RECORD

FORM C

(COMPANY LETTERHEAD)

NOTICE OF SUSPENSION OF PHYSICAL DAMAGE COVERAGE

YOU ARE NO LONGER INSURED FOR PHYSICAL DAMAGE TO YOUR CAR

____
(Date of Mailing)

Name of
Insured: ________________________
Address: ________________________
____
____

RE: Policy #: ________________________

Dear Policyholder:

The vehicle(s) listed below is (are) no longer covered for FIRE AND THEFT/COMPREHENSIVE _____; COLLISION _____; OR LIMITED COLLISION:

1. ________, ____________, ____________
2. ________, ____________, ____________
3. ________, ____________, ____________
YEAR MAKE MODEL

DATE COVERAGE WAS REQUESTED ________________
DATE COVERAGE WAS SUSPENDED ________________

The physical damage coverage(s) indicated above, has (have) been suspended on the vehicle(s) described, effective 12:01 a.m. on the suspension date. Such coverage has been suspended due to your failure to comply with the Mandatory Physical Damage Pre-Insurance Inspection Regulation (211 CMR 94.00), as required by Massachusetts General Law Chapter 175, Section 113S.

If your coverage has been suspended for more than ten (10) days, you will receive a premium adjustment (return premium or credit) for the suspended coverage(s) within forty-five (45) days from the date of suspension.

The coverage(s) will be restored when you have your vehicle(s) inspected and the adjusted premium due for such coverage(s) has been paid.

____
INSURER REPRESENTATIVE

____
PHONE NUMBER

cc: PRODUCER OF RECORD
LIENHOLDER

FORM D

(COMPANY LETTERHEAD)

ACKNOWLEDGMENT OF REQUIREMENT FOR PRE-INSURANCE INSPECTION
(This is not a safety inspection)

NAME OF INSURED
OR APPLICANT: ______________________
ADDRESS: ______________________
____
____

EFFECTIVE DATE
OF COVERAGE: __________
(Date)
INSPECTION MUST BE
COMPLETED BY: __________
(Date)

VEHICLE(S) TO BE INSPECTED

	YEAR	MAKE	MODEL
1.	______,	______,	______.
2.	______,	______,	______.
3.	______,	______,	______.

BY MY SIGNATURE BELOW I CERTIFY THAT I HAVE BEEN INFORMED THAT MY VEHICLE(S) WHICH IS (ARE) BEING INSURED FOR FIRE AND THEFT/COMPREHENSIVE AND/OR COLLISION OR LIMITED COLLISION COVERAGE MUST BE INSPECTED BY A REPRESENTATIVE OF THE INSURER. THIS INSPECTION MUST BE COMPLETED WITHIN SEVEN (7) CALENDAR DAYS (NOT INCLUDING LEGAL HOLIDAYS) AFTER THE EFFECTIVE DATE OF COVERAGE, AND IN NO EVENT LATER THAN THE DATE SHOWN ABOVE TO AVOID A SUSPENSION IN COVERAGE.

I UNDERSTAND THAT FAILURE TO SUBMIT TO THE REQUIRED INSPECTION(S) WILL RESULT IN THE SUSPENSION (LOSSES WILL NOT BE COVERED) OF THE PHYSICAL DAMAGE COVERAGES (FIRE AND THEFT/COMPREHENSIVE, COLLISION, LIMITED COLLISION) AS OF 12:01 A.M. OF THE DAY FOLLOWING THE DATE BY WHICH THE INSPECTION MUST BE COMPLETED, AS SHOWN ABOVE.

I UNDERSTAND THAT IF COVERAGE IS SUSPENDED IT WILL BE RESTORED ONLY AFTER THE INSPECTION HAS BEEN COMPLETED AND THE ADJUSTED PREMIUM DUE FOR SUCH COVERAGE(S) HAS BEEN PAID.

SIGNATURE OF INSURED
OR APPLICANT : ______________________ __________
(Date)

SIGNATURE OF PRODUCER
OR INSURANCE COMPANY
REPRESENTATIVE: ______________________ __________
(Date)

NAME, ADDRESS & TELEPHONE NUMBER
OF PRODUCER OR INSURANCE REPRESENTATIVE
COMPLETING THIS FORM: ______________________
____
____

INSURED/APPLICANT MUST RECEIVE A COMPLETED COPY OF THIS FORM

cc: INSURANCE COMPANY
PRODUCER OF RECORD

Appendix I

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

TITLE XIV.
PUBLIC WAYS AND WORKS.

CHAPTER 90D. MOTOR VEHICLE CERTIFICATES OF TITLE.

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

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

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

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

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

CHAPTER 175. INSURANCE.

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

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

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

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

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

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

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

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

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

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

Appendix J

M.G.L. Chapter 175 § 24D
ICPIP

CODE OF MASSACHUSETTS REGULATIONS

TITLE 830: DEPARTMENT OF REVENUE

CHAPTER 175.00: INSURANCE

830 CMR 175.24D.1.1 (2002)

175.24D.1.1: Intercept of Insurance Payments to Satisfy Child Support Liens

(1) Purpose, General Rule, and Outline

(a) Purpose. The purpose of 830 CMR 175.24D.1.1 is to implement M.G.L. c. 175, § 24D, under which the Department of Revenue identifies insurance payments on which there are child support liens, and intercepts such payments to satisfy the liens in full or in part.

(b) General Rule. Prior to making a non-recurring payment of $ 500 or more under a liability insurance policy or under the liability coverage portion of a multiperil policy or to a beneficiary under a life insurance contract, a company shall compare the claimant's identifying information to child support lien information maintained by DOR to determine whether there is a child support lien on the payment. If, based on information exchanged between the company and DOR, there is a child support lien on the payment, DOR shall issue a Notice of Lien and Levy to the company and the company shall distribute the proceeds according to the priorities listed in 830 CMR 175.24D.1.1(6). A payment meets the $ 500 threshold if the entire payment, prior to any deductions allowed under 830 CMR 175.24D.1.1(6)(a), is equal to or greater than $ 500.

(c) Outline. 830 CMR 175.24D.1.1 is organized as follows:

1. Purpose, General Rule, and Outline

2. Definitions

3. Exempt payments

4. Collection of claimant's Social Security number

5. Methods of Searching Child Support Lien Information

6. Priorities

7. Process for Issuing Payments

8. Audits

9. Penalties for Failure to Comply

(2) Definitions. For the purposes of 830 CMR 175.24D.1.1 the following terms have the following meanings:

Claimant, an individual 13 years of age or older or an estate who brings a claim against an insured party under a liability insurance policy issued in the Commonwealth or under the liability coverage portion of a multiperil policy issued in the Commonwealth, a beneficiary 13 years of age or older under a life insurance contract issued in the Commonwealth, or a beneficiary 13 years of age or older living in the Commonwealth who is designated to receive payment under a life insurance contract issued by a company licensed in the Commonwealth.

Company, all corporations, associations, partnerships or individuals engaged as principals in the business of insurance including reciprocal exchanges as defined in M.G.L. c. 175, § 1.

DOR, the Child Support Enforcement Division of the Department of Revenue, which is the single state agency for the Commonwealth responsible for establishing parentage and establishing, modifying and enforcing child support orders pursuant to Title IV, Part D of the Social Security Act, *42 U.S.C. § 651* et seq., and M.G.L. c. 119A.

Non-recurring Payment, payment of a liability settlement or award in a lump sum, payment of a liability settlement or award under a structured settlement, payment to the issuer of an annuity by a liability insurer under a structured settlement of a liability claim, payment of a life insurance death benefit in a lump sum, or payment of a life insurance death benefit under a life insurance contract authorizing payment in installments. Periodic disability insurance payments, payments under annuity contracts, Workers' Compensation payments and life insurance dividend payments are not non-recurring payments, and are not subject to 830 CMR 175.24D.1.1. Such payments are subject to reporting and intercept through other means, pursuant to M.G.L. c. 62E and M.G.L. c. 119A.

Obligee, an individual to whom support is or may be owed or in whose favor a support order has been issued or a judgment of paternity has been or may be rendered, or a state or political subdivision to which rights under a child support obligation have been assigned or which has independent claims based on financial assistance provided to an individual obligee.

Service Provider, an individual or entity which documents that it has provided or will provide a benefit or service related to the claim, including but not limited to an attorney, a repair shop, a health care facility, a funeral home, a medical doctor or other health care professional.

(3) Exempt Payments. Payments based on damage to or loss of real property are not subject to 830 CMR 175.24D.1.1.

(4) Collection of Claimant's Identifying Information. An individual making a claim governed by 830 CMR 175.24D.1.1 shall provide his current address, date of birth and Social Security number to the insurance company, upon the request of the company. If a Social Security number has not been issued to the claimant, the company shall make and retain a photocopy of an identification card issued by a governmental agency bearing the claimant's likeness and date of birth. Any claimant who refuses to provide the information required by 830 CMR 175.24D.1.1(4) shall not receive payment on the claim, and the company that declines payment on this basis shall be exempt from suit and immune from liability.

(5) Methods of Searching Child Support Lien Information.

(a) Instant Match Method. Except as provided in 830 CMR 175.24D.1.1(5)(b), no more than 30 days before making a non-recurring payment of $ 500 or more to a claimant or to the claimant's attorney or agent, a company shall search child support lien information provided through such means as shall be prescribed by DOR, to determine whether there is a child support lien on the payment. In conducting the search, the company shall compare the claimant's Social Security number to DOR's child support lien information. If, based on information provided by the company to DOR, there is a child support lien on the payment, DOR shall immediately forward a Notice of Child Support Lien and Levy to the company. Upon receipt of the Notice of Child Support Lien and Levy, the company shall distribute the funds according to the priorities listed in 830 CMR 175.24D.1.1(6).

(b) Ten Business Day Wait Method. Companies that do not access child support lien information using the means prescribed by DOR pursuant to 830 CMR 175.24D.1.1(5)(a) shall use the Ten Business Day Wait Method. No more than 30 days before making a non-recurring payment of $ 500 or more, a company using the Ten Business Day Wait Method shall forward the name and Social Security number of the claimant to DOR, using a form and means of transmittal prescribed by DOR. If the company is unable to use a form and means of transmittal prescribed by DOR, it shall cooperate with DOR to identify another form and means of

transmittal. If a Social Security number has not been issued to the claimant, the company shall forward the claimant's name, address and date of birth to DOR. DOR shall compare the information received from the company against child support lien information. If there is a child support lien on the payment, DOR shall forward a Notice of Child Support Lien and Levy to the company within ten business days of receiving the claimant information from the company, and the company shall distribute the funds according to the priorities listed in 830 CMR 175.24D.1.1(6). If, upon expiration of the ten business days, the company has not received a Notice of Child Support Lien and Levy, the company may issue payment on the claim in accordance with its usual practice.

(6) Priorities. In issuing payments pursuant to 830 CMR 175.24D.1.1(7), a company or claimant's attorney shall apply the following priorities to the payment:

(a) First Priority. The first priority of payment is to any service provider as compensation for benefits or services related to the claim. The service provider's right to be compensated for benefits or services unrelated to the claim shall be junior to any child support lien.

(b) Second Priority. The second priority of payment is to DOR, up to the amount of the child support lien, if any funds remain.

(c) Third Priority. The third priority of payment is to holders of liens not arising from benefits or services related to the claim, if any funds remain.

(d) Fourth Priority. The fourth priority of payment is to the claimant, if any funds remain. Payments made by insolvent companies shall be governed by M.G.L. c. 175, § § 180A through 180Q.

(7) Process for Issuing Payments.

(a) Funds Remitted Directly to DOR. When allocating a payment pursuant to the priorities listed in 830 CMR 175.24D.1.1(6), the company shall remit funds directly to DOR, and shall not include any other party as a payee on the instrument remitted to DOR. The company shall include the claimant's name and Social Security number on the instrument and attach a copy of the child support lien. The company shall also submit a completed insurance company remittance form prescribed by DOR. The company shall certify on the remittance form that no funds payable to any service providers under 830 CMR 175.24D.1.1(6)(a) are included in the funds remitted to DOR. If a company cannot make such a certification, the company shall remit funds in accordance with 830 CMR 175.24D.1.1(7)(b) if the claimant is represented by an attorney or in accordance with 830 CMR 175.24D.1.1(7)(c) if the claimant is not represented by an attorney. When remitting funds to DOR, the company shall send a copy of the Notice of Lien and Levy to the claimant or his or her attorney, within twobusiness days of remitting funds to DOR. A company that does not allocate a payment pursuant to the priorities listed in 830 CMR 175.24D.1.1(6) and fails to either notify the claimant's attorney of the existence of a child support lien in accordance with 830 CMR 175.24D.1.1(7)(b) or to remit the funds in accordance with 830 CMR 175.24D.1.1(7)(c) shall be subject to penalty pursuant to 830 CMR 175.24D.1.1(9)(b).

(b) Funds Remitted to the Claimant's Attorney. If a company cannot allocate a payment pursuant to the priorities listed in 830 CMR 175.24D.1.1(6) and the claimant is represented by an attorney, then the company shall remit the payment to the claimant's attorney along with a copy of the Notice of Child Support Lien and Levy and a memorandum regarding insurance claim payment intercept prescribed by DOR. When remitting funds pursuant to 830 CMR 175.24D.1.1(7)(b), a company shall not include the Commonwealth as a payee. The claimant's attorney shall distribute the payment according to the priorities listed in 830 CMR 175.24D.1.1(6) within ten business days of receipt of the funds, notwithstanding the claimant's right to request an administrative review pursuant to M.G.L. c. 119A, § 17. The claimant's attorney shall transmit to DOR a completed attorney remittance form prescribed by DOR, whether or not funds remain after the claimant's attorney has satisfied debts owed to service providers pursuant to 830 CMR 175.24D.1.1(6)(a). The claimant's attorney shall transmit the attorney remittance form to DOR with the payment. In cases where

there is no payment to DOR, the claimant's attorney shall transmit the completed attorney remittance form within 20 business days of the attorney's receipt of the funds from the company. The claimant's attorney shall certify on the remittance form that he or she has distributed the payment according to the priorities listed in 830 CMR 175.24D.1.1(6). The claimant's attorney shall not apply an insurance payment towards his or her services rendered in connection with the claim prior to disbursing any funds due DOR.

(c) Remittance of Funds When Claimant Not Represented by Attorney. If a company cannot allocate a payment pursuant to the priorities listed in 830 CMR 175.24D.1.1(6) and the claimant is not represented by an attorney, the company shall request that the claimant provide a signed statement that no funds are payable to any service providers under 830 CMR 175.24D.1.1(6)(a) or a signed statement that funds are payable to service providers under 830 CMR 175.24D.1.1(6)(a), accompanied by sufficient identifying information about such service providers to enable the company to allocate a payment. Upon receipt of the claimant's signed statement, the company shall allocate the payment pursuant to the priorities listed in 830 CMR 175.24D.1.1(6) and remit any funds due to DOR. The insurance company shall also submit to DOR the insurance remittance form and the claimant's signed statement. If the claimant fails to return a signed statement to the company within 30 days of the company's request, the company shall remit any funds due to DOR and shall certify on the insurance remittance form that it has requested a signed statement from the claimant pursuant to 830 CMR 175.24D.1.1(7)(c) and the claimant has failed to provide such a statement. When remitting funds to DOR, the company shall send copies of the Notice of Lien and Levy and the insurance remittance form to the claimant within two business days of remitting funds to DOR.

(d) Funds Erroneously Remitted to DOR. A company that sends funds to DOR in error shall immediately send written notice thereof to DOR personnel with operational responsibility for the program authorized by M.G.L. c. 175, § 24D and 830 CMR 175.24D.1.1 Upon receiving such written notice, DOR shall return any such funds in its possession to the company. Notwithstanding the foregoing, DOR shall not be liable to the company, claimant, claimant's attorney or service provider for any funds sent in error to DOR which DOR sent to the obligee prior to the date that is two business days from the date on which DOR received notice of the erroneous remittance.

(8) Audits. DOR or an agent acting on its behalf may periodically audit a company's compliance with 830 CMR 175.24D.1.1. Pursuant to M.G.L. c. 119A, § 14, DOR or its agent may request, and a company shall provide, a list of non-recurring payments made during a time period specified by DOR or its agent. The list shall be in a format designated by DOR or its agent, and shall include the name and Social Security number of each claimant for whom a non-recurring payment of $ 500 or more was made, the date and amount of each such payment, the name of the claimant's attorney, if any, and any other information DOR or its agent may request. The list shall include all non-recurring payments of $ 500 or more made during the specified time period, or a random sample of such payments, as specified by DOR or its agent. If the company is unable to use the format designated by DOR or its agent, the company shall cooperate with DOR or its agent to determine another format by which the information may be furnished. A company shall not be required to provide such a list more frequently than once a calendar quarter. The list shall be subject to examination by DOR, its agent and the Division of Insurance. Pursuant to M.G.L. c. 119A, § 15, DOR may subpoena any information necessary to determine whether a company or claimant's attorney is in compliance with 830 CMR 175.24D.1.1.

(9) Penalties for Failure to Comply.

(a) Failure to Determine Whether Payments are Subject to Child Support Liens. A company that has knowingly failed to ascertain whether payments are subject to a child support lien, as determined by DOR or its agent through an audit, shall be subject to a penalty assessed by DOR, as follows:

Failure Rate	Penalty
5% - 9.9%	$ 1,000
10% - 14.9%	$ 2,000
15% - 19.9%	$ 3,000

20% - 24.9%	$ 4,000
25% - 29.9%	$ 5,000
30% - 49.9%	$ 10,000
50% or higher	$ 25,000

The "failure rate" for any consecutive 12-month period under audit is the number of claims for which the company knowingly failed to ascertain whether a payment was subject to a child support lien and which would, in fact, have been subject to a child support lien had such search been made, divided by the number of claims for which the company knowingly failed to ascertain whether a payment was subject to a child support lien.

(b) Failure by a Company to Comply with a Child Support Lien. A company that distributes funds that are subject to a child support lien directly to a claimant, or that distributes funds that are subject to a child support lien to a claimant's attorney without notifying the attorney of the existence of a child support lien in accordance with 830 CMR 175.24D.1.1(7)(b), shall be subject to penalties in accordance with M.G.L. c. 119A, § 6. These penalties may be imposed whether or not the company determined if a payment was subject to a child support lien and are separate and distinct from any penalties under 830 CMR 75.24D.1.1(9)(a) for failure to determine if a payment is subject to a child support lien.

(c) Failure by a Claimant's Attorney to Comply with a Child Support Lien. An attorney in receipt of unallocated funds pursuant to 830 CMR 175.24D.1.1(7)(b) who has been notified of a child support lien on the funds, but fails to distribute the funds in accordance with the priorities listed in 830 CMR 175.24D.1.1(6) within ten business days of receipt of the funds, shall be subject to penalties in accordance with M.G.L. c. 119A, § 6.

(d) Administrative and Judicial Review. DOR shall provide written notice of a penalty assessed pursuant to 830 CMR 175.24D.1.1. Such notice shall inform the company or individual subject to the penalty that the company or individual must either pay the penalty within 30 days of the date of the notice, or request an administrative hearing by DOR within 30 days of the date of the notice. Failure to request an administrative hearing within 30 days of the date of the notice shall constitute a waiver of any and all administrative remedies, which waiver shall preclude the company or individual from any further review of or appeal from the agency action. Any administrative hearing shall be conducted by a Hearing Officer designated by DOR, and shall be governed by M.G.L. c. 30A, § § 10 and 11. Judicial review of the decision of the Hearing Officer shall be governed by G.L. c. 30A, § 14.

REGULATORY AUTHORITY

830 CMR 175.24D.1.1: M.G.L. c. 14, § 6(1); c. 62C, § 3 and c. 175, § 24D.

Appendix K

CAR Claim Department File Review Process

Appendix K – CAR Claim Department File Review Process

Rule 10 of the CAR Rules of Operation states: "The Governing Committee, or it's Vice President, Claims, shall establish and supervise procedures for the review of claim practices of Servicing Carriers". To satisfy this rule CAR conducts annual claim reviews to evaluate the effectiveness of cost containment measures employed by the Servicing Carriers. The reviews are conducted using a systems application that has been built specifically for the purpose of evaluating claim handling practices and compliance with the Performance Standards.

The **CAR Claims Review System** is accessed through the CAR Intranet. After establishing the criteria for the types of claims to be reviewed, the System **downloads** selected claims from the CAR mainframe. The mainframe contains all loss records reported by the Servicing Carriers to CAR.

Once the downloaded loss information has been received into the Claim System, the loss records are displayed and a member of the Claim Department selects from 50 to 120 losses for review. The size of the sample depends on the size of the company being reviewed.

Factored into the selection process are considerations such as the size of the Servicing Carrier, the carrier's past performance in Claim Reviews, the need to verify corrective action taken as a result of prior Claim Reviews, and the dollar amount of each claim.

The sample includes both ceded and voluntary losses with an approximately equal representation of Bodily Injury, Personal Injury Protection, and Physical Damage claims.

File request letters are generated by the Claims System to the selected Servicing Carriers complete with a list of files that are required for review. Once the designated files are received they are **logged into** the Claims System and statistical information residing in CAR's Loss Files relevant to the claims selected is imported to an application called **Claim Review**. This information tells the examiner if the claims are ceded or voluntary, if the claims are from a personal policy or a commercial policy, the policy number, and the claim number. This information appears on every Claim Form thus eliminating the need for data entry by the examiners.

In the **Claim Review** a Claims Examiner selects a loss, locates the associated physical claim file, and completes an on-line worksheet titled **Claim Review Form**. An important feature of the Claim Review Form is weighted fraud indicators. The indicators are each assigned a point value and appear on the Personal Injury Protection and Bodily Injury Claim Forms. Any fraud indicators appearing in a claim file are identified and if the point total from the indicators registers a sufficiently high score the examiner looks to see what, if any, investigation took place to address the questions raised by the indicators.

After all of the files have been reviewed and the information has been entered, the Claims System generates three reports titled **Summary of Review, Salvage Report**, and **ICPIP Report.**

Each **Summary of Review** contains information imported from the examiners' worksheets on compliance rates, average reporting time, average storage costs, and type of loss breakdowns. Also provided is text to assist the examiners in summarizing these findings. The reviews also contain extensive commentary related to claim handling practices.

The **Salvage Report** is on a spreadsheet and provides data on costs associated with total losses as well as averages for length of storage, cost of storage, and towing costs. All of the data on this worksheet is downloaded from the Claim Form prepared by the examiners. This avoids duplicate entry of information by the examiners.

The **ICPIP Report** (Insurance Claim Payment Intercept Program) is a spreadsheet that contains data downloaded from the Claim Form. This report lists all liability claims that are eligible to have been reported by the Servicing Carriers to the Department of Revenue. Massachusetts General Law Chapter 175, section 24D requires that all third party settlements exceeding $500 must be reported to the Department of Revenue for the purpose of resolving child support liens. This report indicates whether or not the necessary inquiries were made and the overall compliance rate of the Servicing Carrier with this law. The results are submitted to the Department of Revenue by the CAR Claim Department after a review of the report by the Servicing Carrier. As was the case in the Summary of Review and Salvage Report the download of information eliminates duplicate entry.

As mentioned previously, once all of the data is assembled in each of the reports the examiners add their comments to the Summary of Review. These comments are on areas that require some degree of subjectivity such as the overall quality of claim handling and specific areas that may be in need of attention.

The Summary of Review, Total Loss Report, ICPIP Report and the examiners' worksheets, all of which are produced by the Claims Review System, are sent to the Servicing Carrier. A cover letter accompanies these reports summarizing the results and identifying areas of non-compliance or substandard claim handling. In all cases a written response from the Servicing Carrier is requested.

At the conclusion of the calendar year an Annual Report of Compliance is compiled and submitted the Commissioner of Insurance. This report is a requirement of Massachusetts General Law Chapter 273, Section 41 which states, "The plan shall collect and maintain data on compliance with the Performance Standards by the Servicing Carriers. Such information shall be reported annually to the Commissioner of Insurance and may be the basis for adjustments to premiums."

COMMONWEALTH AUTOMOBILE REINSURERS

2002 Physical Damage Claim Review

Examiner Exam Date ClaimID Loss Type:

Co Policy Id P/C V/C Loss Date Loss Notice Cal Days Reported By

Insured's Last Name First Name MI

Operator's Last Name First Name MI

Permissive Use

Vehicle 1 Year Make Model Mileage

Appraisal Assigned Completed Received Type At a DI

Business Days Before: Assigned Transmitted

Appraisal Items

Photographs Overlap Eliminated LKQ Parts After Market Parts Parts Discount

Reinspection Completed Frame Damage Cost Labor Rate

Disposition Totaled

Storage: Days Per Diem Total

Tow Charge

Salvage: Charge Total Pickup Date

Gross Selling Price Net Selling Price

Claim: Claim Paid Date Supplemental Amount

RCF CWCF CWCF Received

Business Days Before Payment Issued

Further Commentary

Total Loss Documented
Payments Documented
Coverage Verified

Title Obtained Properly
Distinguished as Ceded
Prior Claim

Subrogation Recognized
Proper Payments
Car Rental

Pre-Inspection:
SIU Referral

Standards Met
Repair Form Received

In File Code

Comprehensive Claims Checklist

Police Theft Report
NICB Notified Promptly

Police Recovery Report
Investigation Establishes Loss

Official Fire Report
Betterment Receipts Secured

Additional Notes

Requested Reimbursement: Amount Reason

Additional Notes:

COMMONWEALTH AUTOMOBILE REINSURERS

2002 PIP Claim Review

Examiner: **Exam Date:** **Claim:** **Loss Type:**

Co **Policy Id** **C/V** **P/C** **Loss Date** **Loss Notice** **Cal Days** **Reported By**

Insured's Last Name **First Name** **MI**

Operator's Last Name **First Name** **MI** **Permissive Use**

Liability Explained:

Insured/Operator: **Injured** **Contact Date** **Compliance**

Subrogation: **Recognized** **Pursued** **Satisfied**

Claimant

Claimant Last Name **First Name** **MI**

Injury Notice **Contact Date** **Days to Contact** **Injured Compliance**

PIP Mailed **Days To Mailing** **PIP Compliance** **Tort Carrier Notified**

Lost Wages **Med Payments** **Settlement Amount**

Independant Med Exam **IME Date** **Received Date** **Suggested Cutoff** **Cutoff Date** **Notification Date**

IME Date to Received **Suggested Cutoff to Actual** **Received Date to Notified**

Completed CIB **Health Carrier** **No Carrier Verified** **MBR Completed** **Adequate Med Doc** **Bill Peer Review**

Savings **SIU Amount** **MBR Amount** **IME Amount** **Total Amount**

Fraud Indicators

Phantom Veh	Veh Unavail	No Police Rpt	Dam Minor for inj
Dam does not match	Acord List No Inj	Soft Tissue/Long Recov	Idx Show clm Hist
Clmnts Similar Diag	Passenger # Conflict	Eff Dte Close to Loss	Treatment Gaps
Police Rpt has no Inj	Clmnt Not on Police Rpt	Excess Injury Treatment	Unverified Wage Loss
Freq Law/Doc Combo	Clmnts Priors Together	Seating Discrepancies	Kinetics not Sensible
No ER/Not Timely	Not Rpt by Ins/Late	Scene does not Match	Med Bills Altered
Signatures Don't Match	Multi SSn's, DL's, Alias	POB Address	Clmnts Loss Facts Differ

Weight: 0.00

COMMONWEALTH AUTOMOBILE REINSURERS

2002 PIP Claim Review

Type Warranted:	SIU	IME	MBR	Other	Referred For:	SIU	IME	MBR	Other

	SIU	IME	MBR	Total
Total Amount:	0	0	0	0

SIU Referral Reason:

Additional Notes

	Amount	Reason
Requested Reimbursement:		

Additional Notes:

COMMONWEALTH AUTOMOBILE REINSURERS

2002 Bodily Injury Claim Review

Examiner: Exam Date: Claim: Loss Type:

Co Policy Id C/V P/C Loss Date Loss Notice Cal Days Reported By

Insured's Last Name First Name MI

Operator's Last Name First Name MI

Permissive Use

Coverage Limit | Liability Explained | Settlement Clearly Documented | Comparative Negligence | Joint Tortfeasor | DOR Eligible

Claimant

Claimant Last Name | First Name | MI | Date Settled | Settlement Amt | Cov Typ

Completed CIB | DOR Notified | DOR Lien | Lien Satisfied | Lien Amount | Method of Satisfaction

SIU Amount | MBR Amount | IME Amount | Total Amount

Fraud Indicators

Phantom Veh	Veh Unavail	No Police Rpt	Dam Minor for inj
Dam does not match	Acord List No Inj	Soft Tissue/Long Recov	Idx Show clm Hist
Clmnts Similar Diag	Passenger # Conflict	Eff Dte Close to Loss	Treatment Gaps
Police Rpt has no Inj	Clmnt Not on Police Rpt	Excess Injury Treatment	Unverified Wage Loss
Freq Law/Doc Combo	Clmnts Priors Together	Seating Discrepancies	Kinetics not Sensible
No ER/Not Timely	Not Rpt by Ins/Late	Scene does not Match	Med Bills Altered
Signatures Don't Match	Multi SSn's, DL's, Alias	POB Address	Clmnts Loss Facts Differ

Weight: 0.00

Type Warranted: SIU IME MBR Other

Referred For: SIU IME MBR Other

	SIU	IME	MBR	Total
Total Amount:	$0	$0	$0	$0

SIU Referral Reason:

Additional Notes

Requested Reimbursement: Amount Reason

Additional Notes:

Appendix L

SIU File Review Process

Appendix L – CAR SIU File Review Process

The CAR Special Investigative Unit exists under the authority of Article III of the Plan of Operation and is charged with monitoring the efforts of the Servicing Carriers to control fraud. They conduct an annual evaluation of each Servicing Carrier's Special Investigative Unit. This evaluation includes a review of fire and theft claims as well as injury claims taken from the Detail Claims Database to examine the overall SIU operation and quality of investigations.

File Selection and Review

Approximately fifty claims are selected from the SIU Physical Damage Savings Log, as reported to CAR by the Servicing Carriers, and from the DCD. These files are reviewed to determine the ability of the staff to recognize potentially fraudulent claims and the quality of the S.I.U. investigations. In addition, CAR reviews the accuracy of the savings reported to both CAR and the Detail Claim Database. An examination of the effectiveness of the Carriers' fraud screening and the S.I.U. referral process has been incorporated into the Annual Claims Reviews.

Analysis and Presentation

A Summary of Review is presented to each Servicing Carrier at the conclusion of the review. The Summary includes an analysis of the time lags for settlement, referral and resolution of the investigated cases. In addition the accuracy of the savings reported to CAR and the D.C.D. is commented upon.

1. **SIU Evaluation**
   Discusses the results of the file review including commentary on the quality of the investigation on the selected files which involve all types of losses, but concentrate on those involving automobiles. Commercial and personal lines, where applicable, are reviewed and include both ceded and non-ceded business. Case comments are included for reference where departures from the Standards are noted. Supervisory practices and descriptions of records kept are discussed when appropriate, as well as the adherence to reporting requirements and to referral procedures.

2. **SIU Assignment Timeliness Evaluation**
   Discusses the time lags for settlement, referral and resolution of investigated cases.

3. **Savings**
   An analysis of the accuracy of the savings as reported to both CAR and the D.C.D.

4. **Conclusions and Recommendations**
   Evaluates the adequacy of staffing, experience, effectiveness, quality of investigations, accuracy of reported savings, and compliance with the Standards and reporting requirements. The review concludes with a general statement of whether the S.I.U. meets compliance with the Performance Standards and is acceptable.

SIU Log Review Worksheet

Company: **Claim#:** **Policy#:** **Effective Date:** **Date of loss:** **Date Reported:**

Insured: #Error

Type of loss?

PIP? **BI?** **Collision?** **Fire?** **Theft?** **Property Damage?**

What type of investigation caused this claim to be placed on the DCD log?

SIU? **IME?** **Engine Oil analysis?** **Ignition analysis?**

Medical bill review? **Other**

Date referred

Reason referred to SIU

How was the quality of the investigation?

What is the basis for your finding?

SIU Log Review Worksheet

Who was the investigator?

Who referred the file to the investigator?

How long to make a decision on payment?

Was reservation of rights letter sent?

Was one needed?

Do the savings claimed match your figure?

Savings claimed?

If not, amount of discrepancy?

Were savings reported correctly?

Is there a threat of 93A action?

Comments?

DCD Log Review Worksheet

Company: Claim#: Policy#: Effective Date: Date of loss: Date Reported:

Insured: #Error

Type of loss?

PIP? BI? Collision? Fire? Theft? Property Damage?

What type of investigation caused this claim to be placed on the DCD log?

SIU? IME? Engine Oil analysis? Ignition analysis?

Medical bill review? Other

Date referred

Reason referred to SIU

How was the quality of the investigation?

What is the basis for your finding?

DCD Log Review Worksheet

Who was the investigator?

Who referred the file to the investigator?

How long to make a decision on payment?

Was reservation of rights letter sent?

Was one needed?

Do the savings claimed match your figure?

Savings claimed?

If not, amount of discrepancy?

Were savings reported correctly?

Is there a threat of 93A action?

Comments?

Appendix M

Questionnaire

Questionnaire

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

Chapter 273 of the Acts of 1988, Sections 41 and 44, requires Commonwealth Automobile Reinsurers (CAR) to establish Performance Standards designed to contain costs, ensure prompt customer service and payment of legitimate claims, and resist inflated, fraudulent, and unwarranted claims.

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

The original questionnaire was completed by Servicing Carriers in 1990 and updated in 1995. The questionnaire has been revised in 2002 to incorporate changes in the Performance Standards and has been distributed to Servicing Carriers for completion.

Company Name: ______________________________

Signature: ______________________________

Name & Title: ______________________________

Date: ______________________________

Company Code ________

I. Auto Body Payments

A. Service Times

1. What procedures does your company utilize to ensure prompt settlements of warranted physical damage claims?

   What internal measurements and controls do you maintain to determine the effectiveness of your procedures?

2. What procedures has your company established to permit prompt inspection of damage and payment of auto physical damage claims?

   What internal measurements and controls do you maintain to determine the effectiveness of your procedures?

B. Direct Payment Plan

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

C. Parts Cost

1. What procedures does your company utilize to obtain discounts and pay less than full retail price for parts?

2. What procedures does your company utilize to allow for the use of aftermarket, rebuilt, and LKQ parts in lieu of new or cost of repair, whenever appropriate?

   What internal measurements and controls do you maintain to determine the effectiveness of your procedures?

D. Labor Rates and Times

1. What procedures does your company utilize to:
   a. Seek the most competitive labor rates?
   b. Resist rate increases and reduce labor rates?
   c. Verify labor repair and replacement times with industry recognized sources?

   What internal measurements and controls do you maintain to determine the effectiveness of your procedures?

   What labor rate are you paying on referral shop business?

   What labor rate are you paying on non referral shop business?

E. Total Loss Payments

1. How do you determine whether a pre-insurance inspection was completed on a vehicle?

   How do you comply with the requirements that pre-insurance inspection reports are reviewed and placed in the claim file on all total losses?

F. Towing and Storage

1.. What procedures does your company utilize to:
   a. Enforce towing and storage rates and conditions as regulated?
   b. Resist and reduce non-regulated charges if they are unreasonable?

   What internal measurements and controls do you maintain to determine the effectiveness of your procedures.

G. Appraisal of Damage and Reinspections

1. What guidelines does your company provide to appraisers to ensure quality appraisals, screening for suspicious claims, and compliance with existing regulations?

2. What continuing education does your company provide to staff appraisers, including training on fraud awareness?

3. What procedures does your company use to periodically evaluate the quality and accuracy of independent appraisers?

   What internal measurements and controls do you maintain to determine the effectiveness of your procedures?

4. What procedures does your company utilize to ensure that reinspections are completed on 75% of all repaired vehicles with damage over $4,000 and 25% with damage under $4,000, whether paid under a Direct Payment Plan or not.

   What internal measurements and controls do you maintain to determine the effectiveness of your procedures?

H. 1. Do you have a procedure to report any repair shop that is in violation of any section of Chapter 100A to the Division of Standards, Office of Consumer Affairs and Business Regulations, One Ashburton Place, Boston, MA 02108? YES NO

I. 1. What procedures has your company established to comply with the claim requirements of the mandatory preinspection program, Regulation 211 CMR 94.00?

   What internal measurements and controls do you maintain to determine the effectiveness of your procedures?

II. Fraud – Auto Physical Damage and Property Damage Claims

A. Normal Claims Handling

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

B. Fraud Handling

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

   What internal measurements and controls do you maintain to determine the effectiveness of your handling of suspicious physical damage claims?

C. Fraud Training

1. What on-going training does your company provide for claim handlers on fraud awareness and the identification of suspicious claims?

2. What on-going training does your company provide for special investigators in the investigation and handling of suspected fraudulent claims?

III. Fraud – Bodily Injury Claims

A. Normal Claims Handling

1. Damage disputed cases – cases in suit
   a. What procedures has your company established for a Litigation Management Program?

   b. What procedures has your company established for an Alternative Dispute Resolution Program?

   What internal measurements and controls do you maintain to determine the effectiveness of your programs?

B. Fraud Handling

1. Briefly describe your process for referring suspicious bodily injury claims and PIP claims for special investigation.

Does your Special Investigative Unit handle bodily injury claims and PIP claims?

YES NO

If no, explain the number and level of staff to whom suspicious bodily injury claims and PIP claims are referred.

2. What procedures has your company established to deal with claims involving exaggerated damages or injuries including a strategy for concluding those cases at a reasonable amount?

3. What procedures has your company established to insure compliance with MGL Chapter 175, Section 24D, the Insurance Claim Payment Intercept Program.

What internal measurements and controls do you maintain to insure that prior to making payment equal to or in excess of $500 to a third party the requirements of the ICPIP are met?

IV. No Fault PIP Benefits Handling

C. Medical Management

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

2. What procedures has your company established for consideration of Independent Medical Exams, Medical Bill Reviews including but not limited to a determination of usual and customary charges, use of Preferred Provider Organizations, Managed Care Programs, and/or Expert Medical Systems?

What internal measurements and controls do you maintain to determine the effectiveness of your procedures?

V. Glass

1. What procedures does your company utilize to insure prompt repair or replacement of damaged or broken glass at a fair and competitive cost including obtaining reasonable discounts of market price lists and labor costs.?

2. What procedures does your company utilize to address fraudulent glass claims including inspection or reinspection of a representative sampling of all glass losses?

   What internal measurements and controls do you maintain to determine the effectiveness of your procedures?

VI. Voluntary/Ceded Claim Handling Differential

1. Is there any difference in claim handling between policies insured voluntarily and those ceded to C.A.R., with the exception of statistical coding? YES NO

VII. Expenses

1. What guidelines has your company established to control claim adjustment expenses?

2. What guidelines has your company established for controlling legal defense costs, including an alternative dispute resolution program?

   What internal measurements and controls do you maintain to determine the effectiveness of your program?

3. What procedures has your company established to review vendors' bills for accuracy and deduct unauthorized services?

   What internal measurements and controls do you maintain to determine the effectiveness of your program?

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