COMMONWEALTH AUTOMOBILE
REINSURERS

PRIVATE PASSENGER CLAIMS PERFORMANCE STANDARDS

FOR THE HANDLING AND PAYMENT OF CLAIMS BY ASSIGNED RISK COMPANIES

REVISED THROUGH APRIL 06, 2021

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BOSTON, MA 02110

Performance Standards

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

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

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

A. Motor Vehicle Body Payments

1. Service Times

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

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

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

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

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

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

2. Direct Payment Plan

a. All ARCs must have a Direct Payment Plan.

1) The Industry Plan can be adopted. Refer to Appendix C.

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

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

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

3. Parts Cost

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

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

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

4. Labor Rates and Times

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

5. Total Loss Payments

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

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

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

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

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

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

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

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

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

6. Towing and Storage Costs

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

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

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

7. Appraisal of Damage and Reinspections

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

1) Compliance with Regulation 212 CMR 2.04 – The Appraisal and Repair of Damaged Vehicles. Refer to Appendix D.

2) Scoping and completing an appraisal

3) Use of aftermarket, rebuilt, LKQ parts

4) Open items and supplements

5) Refinishing

6) Depreciation and betterment

7) Unrelated damage

8) Structural Damage

9) ACV estimating

10) Screening for fraudulent claims

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

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

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

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

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

B. Normal Claim Handling

1. Initial screening of reports of accidents and losses

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

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

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

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

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

2. Initial Investigation

The initial investigation shall include:

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

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

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

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

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

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

3. Appraisal Program

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

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

4. Prompt Evaluation and Settlement

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

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

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

5. Department of Revenue (DOR) Requirements

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

6. Subrogation/Recovery

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

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

C. Fraud Handling

1. Screening process for suspected fraudulent claims

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

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

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

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

2. Appraisal Program

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

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

3. Special Investigation

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

b. The CAR SIU Standards for investigation of suspicious claims must be adhered to as part of the special investigation process. Refer to Appendix A.

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

4. Evaluation and Settlement

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

D. Glass

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

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

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

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

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

E. Fraud Training

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

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

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

A. Normal Claim Handling

1. Initial Screening of Reports of Accident and Losses

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

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

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

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

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

2. Initial Investigation

   The initial investigation shall include:

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

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

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

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

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

3. Contacts

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

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

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

4. Loss Management

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

5. Follow-Up and Continuing Investigation

   The continuing investigation shall include:

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

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

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

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

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

6. Settlement Negotiations or Denial

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

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

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

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

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

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

7. Cases in Suit

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

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

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

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

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

f. ARCs shall have an Alternative Dispute Resolution Program.

8. DOR Requirements

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

9. Subrogation/Recovery

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

B. Fraud Handling

1. Screening Process for Suspected Fraudulent Claims

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

2. Special Investigation

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

   b. The CAR SIU Standards for investigation of suspicious claims must be adhered to as part of the special investigation process.

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

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

3. Evaluation and Settlement

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

C. Fraud Training

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

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

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

A. Screening Reports and Initial Investigation

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

2. Initial investigation shall confirm that coverage is appropriate:

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

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

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

   d. Injuries arise from use of a motor vehicle.

   e. Massachusetts statute applies.

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

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

B. Contacts

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

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

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

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

C. Medical Management

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

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

D. Fraud Handling

1. Screening Process for Suspected Fraudulent Claims

   If in the course of the screening process or initial investigation discrepancies develop of a sufficiently serious nature or indications of potential fraud exist (such as accident of unusual circumstances, severity of accident, unusual number of injured passengers, prior index history, recognition of a pattern related to prior cases of fraud), the case shall be referred for special investigation. Refer to Appendix A for other indicators.

2. Special Investigation

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

   b. The CAR SIU Standards for investigation of suspicious claims must be adhered to as part of the special investigation process.

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

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

E. Subrogation/Recovery

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

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

F. Claim Payment

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

   a. The deductible applied if applicable.

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

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

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

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

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

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

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

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

3. Evaluation and Settlement

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

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

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

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

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

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

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

   3. ARCs shall have an Alternative Dispute Resolution Program.

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

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

A. Measurements

1. The key claim requirements of G.L.c.175, §113H that will be measured by the Compliance Audit Plan are:
   - That claims handling is consistent for voluntary and residual market claims.
   - That each ARC maintains a SIU which provides effective fraud control procedures.

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

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

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

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

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

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

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

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

B. Non-Compliance Penalties

1. In the case of non-compliance pertaining to the Claims Performance Standards, the ARC will be required to submit a remedial action plan to CAR. The Governing Committee will determine if further action including penalties is warranted based on the recommendation of the Compliance and Operations Committee.
2. In the case of non-compliance pertaining to the SIU evaluation, the ARC will be subject to the type of penalty using the following Schedule of Penalties.

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

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

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

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

A. CAR SIU

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

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

B. CAR Standards for SC SIU

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

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

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

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

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

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

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

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

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

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

6. The Motor Vehicle Fraud Profile described in Section D identifies circumstances in which a motor vehicle theft or fire claim should be considered suspicious. Such claims warrant careful investigation into the possibility of fraud.

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

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

C. CAR Standards for Investigation of Collision and Comprehensive Losses

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

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

   - The individual interviewed
   - Name, address, date of birth, occupation, employer
   - The motor vehicle

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

2. Insurance

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

3. The Loss

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

4. Police

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

5. Claim History

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

6. Insurance File

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

7. Mortgagee

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

8. Ownership and Value

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

9. Betterment

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

10. Service and Repair

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

11. The Motor Vehicle Examination

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

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

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

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

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

    e. Report whether the glove or trunk compartments contain the usual articles. Take possession of bills related to service, repair, or improvements. A thief has no interest in the usual contents; their

absence may suggest removal by the owner in anticipation of a loss.

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

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

h. Record date on service or oil change stickers.

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

j. Consider or give consideration to wear and tear, mechanical and electrical failures, and missing parts and equipment.

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

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

D. Motor Vehicle Fraud Profile

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

Motor Vehicle

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

Loss

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

Insured

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

Coverage

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

Purchase

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

Bodily Injury, Including No-Fault

The Accident

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

Injuries and Damages

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

The Motor Vehicle

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

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
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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.

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.

(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.

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 demandfor 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 (8 1/2 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.

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, are 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.

(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 producer, 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.

MASSACHUSETTS AUTOMOBILE RATING AND ACCIDENT PREVENTION BUREAU
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January 6, 1989

CIRCULAR LETTER TO CLAIM PERSONNEL

Direct Payment Plan - Approval of Industry Plan

The Commissioner of Insurance has approved the Industry Plan of direct payment for the settlement of insured vehicle damage repairs under the auto physical damage coverages of collision, limited collision and comprehensive, excluding glass claims, effective January 1, 1989, as filed by the Bureau on December 15, 1988. A copy of the Decision and Order on the Application for Approval of the Massachusetts Automobile Rating and Accident Prevention Bureau Direct Payment Plan ("Industry Plan") is attached to this letter. An additional copy of the Industry Plan (Circular Letter to Claims Personnel, December 16, 1988) is enclosed for your convenience.

Company Options

With the approval of the Industry Plan each individual insurer writing automobile insurance in Massachusetts has the following four options for the method of payment for physical damage claims, beginning January 1, 1989.

Option 1 - **Adoption of Industry Plan in Entirety**

The insurer files a Form to Elect the Industry Plan with the Commissioner of Insurance stating the date on which the Industry Plan will be implemented in its entirety by that insurer. Three copies of Election Form 1 are enclosed with this letter. Insurers must also file at this time, and at such future times as are necessary, a petition for a waiver of the requirement for a minimum number of referral shops (Section 5(2) of the Plan) when the insurer is unable to provide at least two referral shops geographically convenient for each potential claimant. Six copies of the Industry Plan Wavier Form are enclosed, together with a listing of Insurance Company 1987 market shares for use in completing the Waiver Form. Insurers may begin implementation of the Industry Direct Payment Plan on receipt of approval from the Commissioner of Insurance.

Prior to the implementation date under this option, each insurer must have in place written guidelines for the determination of placement of referral repair shops on that insurer's referral shops lists (Plan Section 5(3)b). Insurers should also have a clear understanding of the nature and extent

of the guarantee of repairs which must be extended to all claimants receiving direct payments for repairs completed at the insurer's referral shops (Plan Section 5(5)).

Once the Industry Plan is implemented each claimant must be offered a direct payment by providing (1) a copy of the insurer's appraisal of damage repair costs, (2) a repair certification form (three prototype copies are enclosed), (3) a list of the insurer's geographically convenient referral shops, (4) a direct payment check for the appraisal cost of repair, less any applicable deductible and betterment, and (5) the insurer's own informational literature on the claim settlement process. The direct payment check may, if necessary, follow the other four items within five (5) business days (Plan Section 1). Some further claim processing for supplementals, the receipt of the repair certification form or the setting of a decrease in value, and the reinspection of repairs will be needed depending upon the circumstances of each claim. If the direct payment is refused by the claimant, the current process using a completed work claim form is to be followed.

Option 2 - **Adoption of Modified Industry Plan**

An insurer wishing to adopt all Industry Plan provisions, except for some provisions which do not substantially deviate from the Industry Plan, may file a form to elect a **Modified Industry Plan** (three (3) copies of Election Form 2 are enclosed) citing whatever differences from the Industry Plan are requested by the insurer. Modifications to the Industry Plan may be filed at any time subsequent to the effective date of the Industry Plan, January 1, 1989. Insurers may implement their Modified Industry Plan upon receipt of approval from the Commissioner of Insurance. Except for the possible modifications requested by the insurer, the requirements for referral shop guidelines, guarantees of repairs, and offers of direct payment outlined in Option 1 would apply to this option as well.

Option 3 - **Insurance Company Direct Payment Plan**

Each Insurer has the option now, or in the future, to file its own Direct Payment Plan. A copy of Regulation 211 CMR 123.00, prior to being amended by the Decision on the Industry Plan, governing the filing of all such plans is attached to the Industry Plan as Exhibit A in the enclosed copy of our December 16, 1988 Circular Letter to Claims Personnel.

Option 4 - **No Direct Payment Plan**

The implementation of any Direct Payment Plan is by statute at the option of the insurer. Although the opportunity for such plans has been found by the Legislature to provide overall savings in loss costs, there may be circumstances where savings would not be realizable by an individual insurer. In that event, an insurer need not adopt or file any Direct Payment Plan. No

further action is necessary. Future auto physical damage claims would be settled on the same basis, using a completed work claim form, as under the current system and regulations.

Filing Direct Payment Plan Forms

A package of forms has been provided with this letter. When applicable, one copy should be filed for approval with the Commissioner of Insurance (attention Mary Wiatr), one copy should be sent to the Bureau (attention Richard A. Derrig), and one copy retained for the company records.

Questions pertaining to the governing Regulation 211 CMR 123, or the various Division of Insurance approval processes, may be directed to Mary Wiatr (617/727-7189, Ext. 411) at the Division of Insurance. Questions pertaining to the Industry Plan may be directed to Richard A. Derrig at the Bureau (617/542-5080, Ext. 215).

GEORGE D. MORISON
President

RAD/jkj

Enclosures

DECISION AND ORDER ON
THE APPLICATION FOR APPROVAL OF THE
MASSACHUSETTS AUTOMOBILE RATING AND ACCIDENT
PREVENTION BUREAU DIRECT PAYMENT PLAN

In accordance with Chapter 90, §34O, Chapter 175, §113O of the Massachusetts General Laws, as amended by Sections 24 and 51 of Chapter 273 of the Acts of 1988, and 211 CMR 123.00, a consolidated hearing, Docket No. 88-57, was held on December 22, 1988.

The purpose of the hearing was to afford all interested persons an opportunity to provide testimony regarding several plans for the direct payment to consumers by insurers for motor vehicle collision and comprehensive claims. The Massachusetts Automobile Rating and Accident Prevention Bureau ("MARB"), filing the plan addressed in this order (the "Industry Plan"), was respresented by Richard A. Derrig and E. Michael Sloman. The Massachusetts Auto Body Association ("MABA"), the Massachusetts Glass Dealers Association ("MGDA"), the Attorney General ("AG"), Liberty Mutual Insurance Company, and representatives of three individual automobile repair shops participated as interested persons.

The Industry Plan submitted in final form on December 15,

1988 by the MARB is hereby APPROVED under 211 CMR 123.04(6).

Although this regulation does not require that the reasons for this approval be set forth in this Order and Decision, because this plan is among the first three plans approved under the provisions of the recently enacted automobile insurance reform legislation (Chapter 273 of the Acts of 1988), a number of additional issues are addressed in this order.

1. AMENDMENTS TO DIRECT PAYMENT REGULATIONS

The approved Industry Plan differs in two respects from 211 CMR 123.00 as originally promulgated on an emergency basis on December 8, 1988. However, for the reasons set forth below, the regulations will be amended. The Industry Plan conforms with and is approved under the regulations as amended.

(a.) Exclusion of Glass Claims:

The Industry Plan excludes glass specialty shops from the definition of "repair shop." This contravenes 211 CMR 123.03 as originally promulgated. The MARB argues, however, that glass claims should be excluded from the scope of the regulation. According to the MARB, there already exists an active and efficient system of insurer referral shops for glass claims, and subjecting insurers to 211 CMR 123.00 for glass claims would not only increase costs but also would pose a threat to safe driving. The Executive Director of the Massachusetts Glass Dealers Association, representing approximately 80 percent of the glass dealers in Massachusetts,

testified essentially that some measure of consumer choice is desirable under any referral system, but expressed no specific position as to whether or not 211 CMR 123.00 should apply to glass claims. The Attorney General maintained that glass repairs do fall within the scope of repairs the statute and regulation were designed to cover. MABA concurred with the AG. The AG claimed that not all insurers now have glass referral programs. He proposed that an insurer be allowed an exemption from 211 CMR 123.00 for glass claims only if it could demonstrate that it has an effective glass referral system already in place. The MARB responded that such a proposal would only delay the implementation of the plans, and might well discourage some companies from participating at all.

In the interest of consumer safety, direct payment plans shall be permitted to exclude glass claims. Moreover, while no thorough examination of the glass specialty shop referral system currently in place has been conducted, it has not been shown that subjecting glass claims to the requirements of 211 CMR 123.00 would contribute to cost containment.

(b.) Timing of Direct Payment:

The provisions of 211 CMR 123.05(1) as originally promulgated allowed an insurer two days to issue a direct payment check following an appraisal. The MARB asserted that because of diverse claim department check-writing and accounting systems among the companies, a two-day limit was unrealistic and that a limit of five days would accommodate all

operational forms in a direct payment plan. No evidence was presented nor argument made that five days is an unreasonable period of time within which to require an insurer to provide a consumer with a direct payment check following an appraisal. The plan provisions to that effect are therefore approved.

2. REGISTRATION OF REPAIR SHOPS

The Industry Plan provides that only registered repair shops be included on a company's referral list and that only registered shops qualify for supplemental payments sent directly from the insurer. Unavoidable delay in the registration process being administered by the Division of Standards under M.G.L. c. 100A, however, will preclude the immediate use of registered repair shops. In the interest of assuring consumers the greatest possible savings as anticipated by the Legislature, the requirement contained in 211 CMR 123.06(3)(i), that shops appearing on insurers' referral lists be registered shops, and the prohibition contained in 211 CMR 123.05(3)(b), that no insurer may make any supplemental payment directly to an unregistered shop, are therefore waived until such time as shops are legally able to acquire registered status. It is expected that by March 1, 1989, the delay in registration of shops will have been eliminated. Therefore, the provisions in the Industry Plan limiting participation to registered repair shops are suspended during January and February, 1989. Insurers will thereafter be expected to revise

or modify their referral lists to comply with the regulation as written.

3. EXCLUSION OF SO-CALLED "BETTERMENT" FROM COST OF REPAIR

The MARB excludes so-called "betterment," i.e., the replacement of used or depreciated components (tires, batteries, sheet metal parts) with new components, from the "cost of repair," as that term is used throughout the Industry Plan. Because of the use of this term, MABA argued that the Industry Plan should be disapproved. MABA argued that approval of the plan would in effect give regulatory approval to a concept that may not be legally valid in many instances. The AG joined MABA in noting that the term "betterment" itself does not appear in the Standard Massachusetts Automobile Insurance Policy, and both were concerned that the MARB's proposal could operate as a subtle policy coverage change, limiting insurers' liability.

As pointed out by the MARB, however, 211 CMR 123.05(1) requires that direct payments be made "subject to the terms and conditions of the applicable insurance policy." It was not the intent of the Division to expand or contract the legal liability of insurers for the "cost of repair," only to administer a new method by which such liability may be discharged. The Industry Plan's use of the term "betterment" should not be construed as changing in any respect the determination of such liability. The definition of "cost of

repair" remains a question to be resolved by the parties in accordance with their contract.

4. NUMBER OF SHOPS ON REFERRAL LISTS, SUPPLEMENTAL PAYMENTS AND DISCOUNTS

MABA also questioned the propriety of the number of shops to be on insurers' referral lists, the right of insurers to make supplemental payments to their referral shops, and the propriety of repair shops offering discounts to insurers. All these issues turn on the statutory construction of the enabling statute. Only a strict, literal interpretation of the statute might prohibit the transitional rule governing the number of shops as set forth in 211 CMR 123.06(2), the allowance of supplemental payments in appropriate circumstances as set forth in 211 CMR 123.05(3)(b), and the clarification of the statute's conflict of interest provisions set forth in 211 CMR 123.06(8). The Legislature could not have intended such an application of the statute.

Direct payment plans, as contemplated by the statute, are to be implemented at the option of the insurers. If the plans are too stringently regulated, their appeal to insurers, and thus their value to consumers, will be lost. The Division has been granted authority to promulgate regulations which will promote such plans in order to achieve savings in insurance costs, the ultimate goal of the legislation. To the extent that that goal may be realized through flexibility and the

exercise of some discretion in regulating the plans, the regulations, and the approval of the plans in accordance with the regulations, must focus on that goal. Therefore, without a convincing argument as to the need for such a strict reading of the statute which, as a practical matter, would undermine the spirit and intent of the law as a whole, MABA's recommendations are not adopted.

5. PROCEDURAL OBJECTIONS

MABA objected to the hearing on procedural grounds, arguing that it was not given ten days' notice of the hearing on the plan, and that the plan on which the hearing was held was not timely filed with the Division.

An Industry Plan was originally submitted on November 15, 1988, at which time no regulations had yet been issued. Conceivably, even in the absence of regulations, that initial plan could have been the subject of the hearing since Sections 24 and 51 of Chapter 273 of the Acts of 1988 require only that a hearing be held prior to approval of any such plan; the statute is permissive as to the Commissioner's authority to promulgate regulations. As a practical matter, however, the Division made every effort to obtain the input of "persons affected," including MABA, in the review of the plans as they were submitted and in the preparation of the regulations. When the regulations were issued, on December 8, 1988, all persons affected were provided a better idea of the conditions under

which a plan would be approved. This afforded MABA adequate notice in that it was able to submit a thorough and comprehensive analysis of the plan on the day of the hearing.

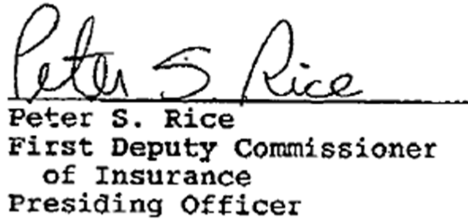
MABA also questioned the need for emergency regulations and an expedited hearing process. However, Chapter 273 was enacted with an emergency preamble, demonstrating the clear intent of the Legislature that direct payment plans be in place for policy year 1989. The promulgation and amendment of the regulations on an emergency basis, as well as special provisions within those regulations for plans expected to be effective on January 1, 1989, are therefore necessary and appropriate actions for the Division to have taken.

6. RECORDKEEPING REQUIREMENTS

As noted above, the AG participated in the hearing as an interested person. The AG supported the emergency regulations and immediate approval of the plan in light of the legislative mandate compelling prompt action. However, the AG also recommended establishing clearly-defined, uniform recordkeeping requirements and standards by which the plan could be monitored. MABA agreed with the AG on this point. The MARB countered that this was neither the time nor the forum for development of such data requirements and that to demand that additional data be kept as part of the regulation might increase the costs of implementing the system and would surely delay the proposed January 1, 1989 effective date. The AG

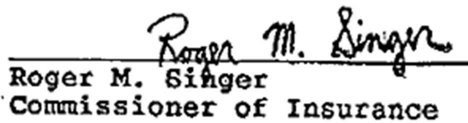
agreed that the prompt implementation of the plan was his paramount concern. Therefore, notwithstanding the importanceof data collection and plan monitoring, initiation of the plan will not be postponed and uniform recordkeeping will not be mandated at this time. This ruling should not be interpreted, however, as relieving the industry of any obligations pursuant to Chapter 622 of the Acts of 1986, or any other provision of law, which require that adequate records be kept in the ordinary course of business.

Any individual insurer intending to adopt the Industry Plan may implement the plan immediately upon notice to the Commissioner.



Peter S. Rice
First Deputy Commissioner
of Insurance
Presiding Officer

Approved:



Roger M. Singer
Commissioner of Insurance

Date: Dec. 30, 1988

Industry Direct Payment Plan Forms

Contents

1. Three (3) copies of Election Form 1 to file to adopt the Industry Direct Payment Plan in its entirety.

2. Three (3) copies of Election Form 2 to file to adopt a Modified Industry Direct Payment Plan.

3. Six (6) copies of Industry Plan Waiver Form to request a waiver from the requirement for a minimum number of geographically convenient referral repair shops. A listing of 1987 company automobile insurance market shares is included for help in completing the Waiver Form.

4. Three (3) copies of the Industry Plan Repair Certification Form prototype. Insurers adopting the Industry Plan may reproduce this form with their own company identification and information added.

January 6, 1989

Election Form 1

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 the Industry Direct Payment Plan in its entirety, as filed by the Massachusetts Automobile Rating and Accident Prevention Bureau in accordance with 211 CMR 123 and approved by you. If approved, the date of our implementation of the industry plan will be ______________________.

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

Election Form 2
Page 1

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

Election Form 2
Page 2

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

Exhibit F
Industry Plan
Waiver Form
Page 1

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, 1989, 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

Exhibit F
Industry Plan
Waiver Form
Page 2

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:

[Individual Company Identification and Information may be added]

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 ______________________________

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

2.04: Procedures for the Conduct of Appraisals and Intensified Appraisals

(1) Conduct of Appraisals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

133.01: Purpose and Applicability

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

133.02: Authority

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

133.03: Definitions

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

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

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

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

133.04: Determination of Damage and Cost of Repair

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

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

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

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

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

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

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

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

133.05: Determination of Values

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

(a) the retail book value for a motor vehicle of like kind and quality, but for the damage incurred;
(b) the price paid for the vehicle plus the value of prior improvements to the motor vehicle at the time of the accident, less appropriate depreciation;
(c) the decrease in value of the motor vehicle resulting from prior unrelated damage which is detected by the appraiser; and

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

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

133.06: Option for Contract Repair

(1) With respect to a claim presented under either Limited Collision, Collision or Comprehensive Coverage, if the insurer deems a motor vehicle a total loss, the claimant may, with the consent of the insurer, enter into an agreement to have the vehicle repaired by any registered repair shop for the contracted cost of repair if:
(a) the insurer allows the claimant to retain possession and ownership of the vehicle; and
(b) the claimant obtains a salvage title for said vehicle in compliance with M.G.L. c. 90D.

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

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

133.07: Intensified Appraisals

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

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

133.08: Penalties

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

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

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

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

133.09: Severability

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

211 CMR: DIVISION OF INSURANCE

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

Section

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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 94.00 is to establish standards and procedures for the inspection of certain motor vehicles prior to Insurers' issuance of Physical Damage Coverages. 211 CMR 94.00 applies to all Private Passenger Motor Vehicles insured in the Commonwealth of Massachusetts (Commonwealth), unless specifically exempted or waived under 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 or individual applying as the named insured, as that term is defined in a Motor Vehicle Liability Policy.

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

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

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

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

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

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

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

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

Motor Vehicle Liability Policy means a motor vehicle liability policy, including the coverage selections page and any endorsements, or motor vehicle liability bond, as defined in M.G.L. c. 90, §§ 34A, 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 a Motor Vehicle Liability Policy), other than a Temporary Substitute Motor Vehicle, as defined in 211 CMR 94.03.

Physical Damage Coverage means the optional coverages in a Motor Vehicle Liability Policy for collision or limited collision and/or fire and theft or so-called comprehensive coverages, as defined in M.G.L. c. 90, § 34O and M.G.L. c. 175, § 113O.

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

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

94.04: Inspection Requirements

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

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

94.05: Mandatory Waiver of Inspection Requirements

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

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

(b) the Applicant for Physical Damage Coverage is an Existing Customer;
(c) the Private Passenger Motor Vehicle already is insured for such Physical Damage Coverage with the Insurer by the Applicant;
(d) the Insurer waives the inspection pursuant to 211 CMR 94.06;
(e) the Private Passenger Motor Vehicle is a Temporary Substitute Motor Vehicle;
(f) the Private Passenger Motor Vehicle is leased for less than six months, provided the Insurer receives a copy of the lease or rental agreement containing a description of the leased motor vehicle including its condition. Payment of a Physical Damage Coverage claim shall be conditioned upon receipt of a copy of the lease or rental agreement;
(g) the inspection would cause a serious hardship to the Insurer or the Applicant; or
(h) the Insurer has no Authorized Representative or Inspection Service either in the city or town in which the Private Passenger Motor Vehicle is principally garaged, or within five miles of said city or town.

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

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

94.06: Optional Waiver of Inspection Requirements

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

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

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

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

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

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

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

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

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

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

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

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

(c) the decision criteria for waiving the pre-insurance inspections required by 211 CMR 94.00 set forth in the Insurer's plan shall not consider the Applicant's membership in any group subject to a group marketing plan approved by the Commissioner pursuant to M.G.L. c. 175, § 193R;
(d) the decision criteria for waiving the pre-insurance inspections required by 211 CMR 94.00 set forth in the Insurer's plan shall not be based on the loss ratio for an insurance producer, where such loss ratio is calculated using premium and loss experience incurred prior to December 31, 2008 for personally-rated Motor Vehicle Liability Policies;
(e) any provisions of the Insurer's plan that permit the Insurer to elect to inspect a Private Passenger Motor Vehicle for which inspection customarily is waived under such plan shall be based on underwriting criteria uniformly applied, and the decision to inspect such motor vehicle shall be reasonable and supported by objective facts. The decision to require such an inspection shall not be based on the age, race, sex, marital status, creed, national origin, religion, occupation, income, education, credit information or homeownership of the Applicant or the customary operators of the motor vehicle, the principal place where the motor vehicle is garaged, or the fact that the Motor Vehicle Liability Policy has been issued through the residual market; and
(f) any provisions of the Insurer's plan that set forth a period of time for the completion of a pre-insurance inspection following the effective date of a Motor Vehicle Liability Policy shall be based on underwriting criteria uniformly applied, and shall be reasonable and supported by objective facts. The period of time for obtaining the pre-insurance inspection shall not be based on the age, race, sex, marital status, creed, national origin, religion, occupation, income, education, credit information or homeownership of the Applicant or the customary operators of the motor vehicle, the principal place of where the motor vehicle is garaged, or the fact that the Motor Vehicle Liability Policy has been issued through the residual market.

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

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

94.07: Deferral of Inspection Requirements

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

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

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

1. immediately obtain written acknowledgment from the Applicant if the Applicant has applied for coverage in person; or
2. immediately confirm Physical Damage Coverage on the Private Passenger Motor Vehicle and issue a notice to the Applicant, if the Applicant has applied for coverage either by mail, phone, or internet.

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

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

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

94.08: Standards and Procedures for Inspection

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

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

(b) The inspection shall:

1. be recorded in a format mutually agreeable to the Authorized Representative and the Insurer;
2. include two color photographs of the Private Passenger Motor Vehicle, taken as directed by the Insurer;
3. include a close-up color photograph (using a special camera attachment if necessary) showing the Vehicle Identification Number (VIN) located on the Environmental Protection Agency/Federal Certification Label (EPA) sticker affixed to the driver's side door jamb. The photograph shall be of sufficient clarity that the information contained on the EPA sticker and the VIN is legible. If the EPA sticker is damaged, faded, missing or otherwise not legible, a photograph of the EPA sticker or of the area of the door jamb where the sticker normally is located still is required.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) If the Private Passenger Motor Vehicle is not inspected pursuant to 211 CMR 94.00 because the Insurer or its insurance producer failed to provide the notice(s) or to obtain the acknowledgement(s) required by 211 CMR 94.07(3), Physical Damage Coverage on the Motor Vehicle Liability Policy shall not be suspended. The failure of the Insurer to act promptly does not relieve it of its obligation to inspect the motor vehicle. In the event that the Insurer or its insurance producer fails to comply properly with the notice or acknowledgement required by 211 CMR 94.07(3), the Insurer or the insurance producer shall issue a notice for a pre-insurance inspection and the Applicant has ten calendar days to comply. An Insurer's failure to comply with the provisions of 211 CMR 94.09(2), however, 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 on motor vehicles, prior to that person performing any inspections on behalf of an Insurer pursuant to 211 CMR 94.00. Such record shall be made available to the Division upon request.

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

94.11: Conflicts of Interest

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

94.12: Enforcement

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

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

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

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

94.13: Records and Audits

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

94.14: Severability

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

REGULATORY AUTHORITY

211 CMR 94.00: M.G.L. c. 175, § 113S.

PART I ADMINISTRATION OF THE GOVERNMENT
TITLE XIV PUBLIC WAYS AND WORKS
CHAPTER 90D MOTOR VEHICLE CERTIFICATES OF TITLE
Section 20 Total loss salvage motor vehicles; surrender of certificate of title; salvage title

Section 20. (a) Except as provided for in subsection (e), 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.

(e)(1) Whenever an insurer acquires a motor vehicle which it has determined to be a total loss salvage motor vehicle but is unable to obtain the certificate of title, the insurer may apply for a salvage title in its name without surrendering the certificate of title. Such application shall be accompanied by evidence that the insurer has paid a total loss claim on the vehicle and made at least 2 written attempts, addressed to the last known owner of the vehicle and any known lienholder, to obtain the certificate of title. In lieu of a salvage title, the insurer may similarly apply for a certificate of title in its name for a vehicle if the age of the vehicle precludes issuance of a salvage title.

(2) Whenever an insurer requests that Class 2 or Class 3 dealer take possession of a motor vehicle that is the subject of an insurance claim and subsequently a total loss claim is not paid by the insurer with respect to such motor vehicle, the Class 2 or Class 3 dealer may, if such motor vehicle has been abandoned at the facility of the Class 2 or Class 3 dealer for more than 30 days, apply for a salvage title in such dealer's name without surrendering the certificate of title. Such application shall be accompanied by evidence that the Class 2 or Class 3 dealer made at least 2 written attempts, addressed to the last known owner of the vehicle and any known lienholder, to have the vehicle removed from the facility. In lieu of a salvage title, the Class 2 or Class 3 dealer may similarly apply for a certificate of title in the dealer's name for a vehicle if the age of the vehicle precludes issuance of a salvage title.

PART I ADMINISTRATION OF THE GOVERNMENT
TITLE XXII CORPORATIONS
CHAPTER 175 INSURANCE
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 this chapter 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 a claimant, the company shall provide to the IV-D agency, not 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 files and such other information appearing in the company's files 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 but if the company is unable to use a method and format prescribed by said 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, not 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 files and such other information appearing in the company's files 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 a claimant by giving the company a notice of levy pursuant to said 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 purpose 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.

This section incorporates the selection of the sample, review procedures, and criteria to conduct these examinations following the guidelines in Chapter VIII G. Claims of the NAIC Market Conduct Examiners Handbook.

A. Introduction

Rule 10 of the CAR Rules of Operation requires CAR to conduct periodic audits of SCs claims including policies ceded to CAR and voluntarily written as specified in G.L. c.175 §113H. To satisfy this rule CAR conducts claim examinations to evaluate the effectiveness of claim handling in meeting Industry Best Practices as well as compliance with the Performance Standards and NAIC Standards. Procedures for the examination are based on Chapter VIII G. of the NAIC Market Conduct Examiners Handbook and are further defined in the Manual of Administrative Procedures Chapter IV - Claims. The Compliance Audit Claim Questionnaire and internal documentation including, but not limited to, claim manuals, reserving and claim settlement procedures, and internal audits will be reviewed at the onset of the examination. 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.

B. Scope and Sample

1. The SCs will be audited biennially. The scope of the audit includes the review of a randomly selected sample of records for the account year being evaluated from the CAR loss statistical data base.

2. The sample consists of 220 claims (55 for each coverage type: Physical Damage, Property Damage, PIP and Bodily Injury) selected based on company reporting from each commercial class type. The audit provides for the inclusion of all types of transactions from all classifications of business. It allows for the extrapolation of data, provides a standard for measuring the performance of an audited company, and the comparison of one audited company to another.

3. The audited company is required to supply the claim file and any other pertinent documentation supporting the company's handling of the loss. Ceded and voluntary claims are selected randomly in proportion to the total claim population. Statistical testing is completed to determine if any significant difference exists in the handling of voluntary and ceded claims. Each audited company is assigned an overall compliance value and a ceded compliance value.

A penalty is assessed when the audited company does not attain an 80 percent compliance rate for the handling of ceded claims.

4. At the conclusion of each audit, a preliminary report is issued. In any instance that the audited company does not agree with an audit finding and appropriate documentation can be supplied, the necessary adjustments are included in the final report. The company is asked to submit a written response to the audit findings to be included in the final report. The report and response letter is distributed to the Compliance and Operations Committee and the Massachusetts Division of Insurance.

5. The Division of Insurance Summary of Commercial Audits – Annual Report will be submitted biennially to the Compliance and Operations Committee, Governing Committee, and the Division of Insurance.

C. Commercial Ceded Pool Run-Off

1. Run-off Claim Reviews

   A sample of ceded claims will be reviewed biennially from those companies that are no longer SCs. Files selected will have ceded claim activity including indemnity and/or expense payments and reserves within the accounting year being evaluated. The sample will be approximately 5 to 10 percent of the claims having activity. A Summary of Review will be prepared for the carrier.

2. Ad Hoc Reviews - Large Loss/Indemnity/Reserve Review

   As part of the current Large Loss review procedures, ceded claims are selected quarterly from the Loss Limitations Report. Criteria for selection include a large dollar reserve or indemnity payments, litigation files, payments over a certain threshold, and allocated expenses. CAR will request a summary of the claim file which shall include large loss reports, settlement reports, and adjuster notes. CAR will reserve the right to review the entire file if necessary. Additionally each quarter, a number of files requested by the Loss Reserving Committee are reviewed.

D. Definitions

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

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

3. Major Non-Compliance:
   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.

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

5. Minor Non-Compliance:
   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 result from this situation. Neither a warning nor penalty will result from a finding of minor non-compliance.

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

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

8. Type 1 Penalty:
   A Type 1 penalty is assessed when a carrier remains in non-compliance in the review subsequent to being warned but has improved its claim handling practices significantly.

9. Type 2 Penalty:
   A Type 2 penalty is assessed when a carrier fails to improve its claim handling practices in the review subsequent to being warned for non-compliance.

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

File Selection and Review

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

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

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

Pursuant to G.L. c.175, §113H, CAR is required to establish Performance Standards designed to contain costs, ensure prompt customer service and the payment of legitimate claims, and resist inflated, fraudulent, and unwarranted claims. These Performance Standards require that all SCs establish plans and programs to meet these objectives. Often this only requires that the SC formalize or enhance its current practices and procedures. In other instances, SCs may need to develop new practices and procedures to become compliant with these Performance Standards.

This Compliance Audit Claim Questionnaire included below is distributed to every SC prior to the Commercial Audit scheduled start date. The purpose of the questionnaire is to gather information from the SC relative to plans and programs it maintains. The SC is required to provide detailed responses to the questions included in the questionnaire, and return by the date established by CAR staff. The Claim Questionnaire shall be signed by a SC staff member with appropriate authority to provide this information to CAR on behalf of the SC.

Commonwealth Automobile Reinsurers
Compliance Audit Claim Questionnaire
Claims Performance Standards

Certification of Authority

Printed Name:	
Title:	
Company Name:	
Signature:	

1. Does the company offer a Direct Payment Plan for physical damage and property damage losses as referenced in Performance Standard I. A. 2. a.?

   Click here to enter text.

2. How does the company determine actual cash value for total loss payments? Is there an evaluation process in place to determine that the actual cash value is comparable to other vehicles?

   Click here to enter text.

3. What procedures are used during the initial screening of a loss to identify warning signs requiring special investigation? What specific information is sought during the screening process? Do these procedures and the information sought vary depending on the type and level of coverage? Are these procedures and resulting information considered in the assignment of the claim to staff with sufficient experience and training?

   Click here to enter text.

4. What method is used to ensure that the losses processed and paid are consistent with the associated policy, including listed operators, coverage, and garaging information provided? What procedures are used to resolve coverage issues? What triggers notification to underwriting? For Commercial losses, how is the Principal Place of Business verified?

   Click here to enter text.

5. What methods are used to establish initial reserves and what procedure is used to update reserves throughout the duration of the claim? Are different methods used for losses involving injuries?

   Click here to enter text.

6. What components comprise the SIU, including staffing? How many and what types of cases are handled? Describe the SIU screening and referral procedures. What type of fraud awareness training is provided to the claim staff and SIU on a yearly basis?

   Click here to enter text.

7. What is the percentage of glass claims repaired to total paid glass claims as referenced in Performance Standard I. D. 1.?

   Click here to enter text.

8. What diary systems are used for bodily injury claims as referenced in Performance Standard II A. 5. d.?

   Click here to enter text.

9. How are payment authority levels established for the handling of bodily injury claims? Does this process change when policy limits will be exhausted?

   Click here to enter text.

10. What procedure does the company use to evaluate BI and UM claims? Is a third party evaluation tool used in this process?

    Click here to enter text.

11. Describe the company's litigation management program used to bring cases to conclusion during a reasonable time frame and at a reasonable cost on all types of losses?

    Click here to enter text.

12. What process is used to refer suspicious BI claims for SIU? Does this process occur at the screening process or initial investigation level?

    Click here to enter text.

13. How are SIU claims resolved and settled? What is the screening and referral process for losses that require special investigation?

    Click here to enter text.

14. What methods are used to determine whether medical treatment and expenses are reasonable, necessary and related to the automobile accident? Does the company maintain staff with medical training as consultants to assist or contribute to claim handling, evaluation of reasonable and necessary treatment, causality, etc? If yes, describe this process.

    Click here to enter text.

15. What role does an Independent Medical Examination, Medical Audit or Medical Bill Reviews have in the medical management process? After any of these are concluded, what process is in place to determine if payments should then be issued?

    Click here to enter text.

16. What controls ensure that residual market claims are processed with the same degree of diligence as voluntary claims?

    Click here to enter text.

17. How are legal defense costs including legal bills controlled? What type of Alternative Dispute Resolution program is in place?

    Click here to enter text.

18. How does the company ensure that allocated expenses are properly reported and unallocated expenses are not reported as defined in the Statistical Plan?

    Click here to enter text.

A. Assignment

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

B. Coverage Analysis

I.B.2.a.	Physical Damage Coverage
II.A.2.a.	Bodily Injury Coverage
III.A.2.a. – f.	PIP Coverage

C. Initial Contacts

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

D. Investigation

I.B.1. a. – c.	Physical Damage Initial Screening and Investigation
I.B.2.a.	Physical Damage Initial Screening and Investigation
II.A.1.a. – e.	BI Initial Screening and Investigation
II.A.2.a. – d.	BI Initial Screening and Investigation
III.A.1. – 2.	PIP Initial Screening and Investigation

E. Follow-Up/Control

I.B.4. a. – c.	Physical Damage Prompt Evaluation and Settlement
II.A.5.a. – e.	BI Follow-Up and Continuing Investigation
III.F.1.a. – h.	PIP Claim Payment

F. Evaluation

I.B.4.a. – c.	Physical Damage Evaluation and Settlement
II.A.6.a. – f.	Bodily Injury Settlement Negotiations or Denial
II.B.3.	Bodily Injury Fraud Handling Evaluation and Settlement
III.F.1.a. – h.	PIP Claim Payment

G. Loss Management

I.A.5. a. – d.	Physical Damage Total Loss Payments and Appraisal
I.A.7. a. – d.	Physical Damage Total Loss Payments and Appraisal
I.B.3. a. – b.	Physical Damage Normal Handling Appraisal Program
II.A.4.	Bodily Injury Loss Management
III.C.1. – 2.	PIP Medical Management

H. Reserving

I.B.2.f.	Physical Damage Initial Investigation
II.A.2.e.	Bodily Injury Initial Investigation
III.A.3.	PIP Initial Investigation

I. Litigation Management

II.A.7.a. – f.	Bodily Injury – Cases in Suit
III.F.1.g.	PIP Claim Payment
V.B.1. – 3.	Expense – Legal Expense

J. Settlement

I.B.4 a. – c.	Physical Damage Prompt Evaluation and Settlement
II.A.6.a. – f.	Bodily Injury Settlement Negotiations Or Denial
III.F.1. – 3.	PIP Claim Payment

K. Salvage

I.A.5.a. – d.	Physical Damage Total Loss Payments

L. Recovery/Offsets

I.B.6. a. – b.	Physical Damage Recovery
II.A.9. a.	Bodily Injury Recovery
III.E.1. – 2.	PIP Subrogation

M. Overpayment Analysis (Leakage)

I.C.4.	Physical Damage Evaluation and Settlement
II.A.6.a. – f.	Bodily Injury Settlement Negotiations or Denial
III.F.1. – 3.	PIP Claim Payment

The NAIC Standards for Claims as defined in the NAIC Market Conduct Examiners Handbook Chapter VIII are based on two model acts, the Unfair Claims Settlement Practices Act and the Unfair Property and Casualty Claims Settlement Practices Model Regulation.

- In Massachusetts unfair claim settlement practices are defined in G.L.c.176D, §3 Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance.
- CAR Rule 10 is modeled on this statute and contains the elements of unfair claim settlement practices defined in §3 (9).

The following identifies where the NAIC Standards are contained in Rule 10 and the Performance Standards:

A. NAIC Standard 1

1. Description

   The initial contact by the company with the claimant is within the required timeframe.

2. Performance Standards References

   a. Standard I.B.2.b.: Physical Damage Contact

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

   b. Standard II.A.3.a. – c.: Bodily Injury Contact

      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.

      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.

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

   c. Standard III.B.1. – 4.: PIP Contact

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.

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.

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.

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

B. NAIC Standard 2

1. Description

   Timely Investigations are conducted.

2. CAR Rules of Operation

   Rule 10

   Claim practices of each SC shall correspond with those followed for voluntary business, and SCs shall, in accordance with the Performance Standards and Best Practices:

   Comply with the standards for prompt investigation of claims.

3. Performance Standards References

   a. Standard I.B.2.b.: Physical Damage Initial Screening and Investigation

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

   b. Standard II.A.2.a. – d.: BI Initial Investigation

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

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

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

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

c. Standard III.A.1. – 2.: PIP Initial Screening and Investigation

Initial investigation should confirm that coverage is appropriate:

- Date of loss within policy period and all policy coverage is in order.
- Injured persons are eligible for no-fault benefits.
- Private health insurance availability should be verified and documented.
- Injuries arise from use of motor vehicle.
- Massachusetts statute applies.
- No exclusions apply, such as drunk driving, stolen car, and workers compensation.

C. NAIC Standard 3

1. Description

Claims are resolved in a timely manner.

2. CAR Rules of Operation

a. Rule 10

Claim practices of each SC shall correspond with those followed for voluntary business, and SCs shall, in accordance with the Performance Standards and Best Practices:

Effectuate prompt, fair and equitable settlements of claims in which liability is reasonably clear.

In the handling of residual market claims, SCs shall not:

Fail to promptly settle claims, where liability is reasonably clear, under one portion of the policy coverage in order to influence settlements under other portions of the policy coverage.

3. Performance Standards References

   a. Standard I.B.4.a.: Physical Damage Prompt Evaluation and Settlement

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

   b. Standard II.A.6.b.: Bodily Injury Settlement Negotiations or Denial

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

   c. Standard III.F.1.f.: PIP Claims Payment

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

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

D. NAIC Standard 4

1. Description

   The Company responds to claim correspondence in a timely manner.

2. CAR Rules of Operation

   Rule 10

   Claim practices of each SC shall correspond with those followed for voluntary business, and SCs shall, in accordance with the Performance Standards and Best Practices:

   Acknowledge and act promptly upon communications regarding claims.

E. NAIC Standard 5

1. Description

   Claim files are adequately documented.

2. Performance Standards References

   a. Standard I.C.4..: Physical Damage Evaluation and Settlement

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

   b. Standard II.A.6.a.: Bodily Injury Settlement Negotiations or Denial

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

   c. Standard II.B.3.: Bodily Injury Fraud Handling Evaluation and Settlement

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

   d. Standard III.F.3.: PIP Claim Payment

      The file shall clearly document the basis for the decision and result.

F. NAIC Standard 6

1. Description

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

2. Performance Standards References

   Introduction

   The Performance Standards are developed to establish a benchmark for the handling of commercial motor vehicle insurance claims. Also, these standards are designed to require compliance with Massachusetts laws and regulations regarding motor vehicle insurance and the CAR Rules of Operation. Any revisions to existing laws or regulations are incorporated into the Appendices as these are promulgated.

   Several regulations and statutes are referenced in the Performance Standards and incorporated in the Appendices.

G. NAIC Standard 7

1. Description

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

2. Performance Standards References

   a. Standard II. A.2.a.: Bodily Injury Initial Investigation

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

   b. Standard II.A.7.b.: Bodily Injury Cases in Suit

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

H. NAIC Standard 8

1. Description

   Deductible reimbursement to insured upon subrogation recovery is made in a timely and accurate manner.

2. Performance Standards References

   Standard I.B.6.b.: Physical Damage Claims Subrogation/Recovery

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

I. NAIC Standard 9

1. Description

   a. Company claim forms are appropriate for the type of product.

   b. The use of required State forms is included in the Standards. SC claim forms are reviewed as found in the claim reviews and commented upon in the Claims Performance Standards Review if not appropriate.

J. NAIC Standard 10

1. Description

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

2. CAR Rules of Operation

   Rule 10

   Claim practices of each SC shall correspond with those followed for voluntary business, and SCs shall, in accordance with the Performance Standards and Best Practices:

   Maintain claim reserving procedures for claims arising out of residual market business commensurate with their procedures for claims arising out of voluntary business.

3. Performance Standards References

   a. Standard I.B.2.f.: Physical Damage Initial Investigation

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

   b. Standard II.A.2.e.: Bodily Injury Initial and Follow-Up Investigation

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

   c. Standard II.A.5.e.: Bodily Injury Initial and Follow-Up Investigation

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

   d. Standard III.A.3.: PIP Initial Investigation

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

K. NAIC Standard 11

1. Description

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

2. CAR Rules of Operation

   Rule 10

   Claim practices of each SC shall correspond with those followed for voluntary business, and SCs shall, in accordance with the Performance Standards and Best Practices:

   Promptly provide a reasonable explanation for denial of a claim or for the offer of a compromise settlement.

3. Performance Standards References

   a. Standard I.C.4.: Physical Damage Evaluation and Settlement

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

   b. Standard II.B.3.: Bodily Injury Fraud Handling Evaluation and Settlement

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

   c. Standard III.F.3.: Claims Payment

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

      Note that denials of claims are evaluated in SIU reviews.

L. NAIC Standard 12

   Canceled benefit checks and drafts reflect appropriate claim handling practices.

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

M. NAIC Standard 13

   1. Description

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

2. CAR Rules of Operation

Rule 10

Claim practices of each SC shall correspond with those followed for voluntary business, and SCs shall, in accordance with the Performance Standards and Best Practices:

Effectuate prompt, fair and equitable settlements of claims in which liability is reasonably clear.

In the handling of residual market claims, SCs shall not:

Fail to promptly settle claims, where liability is reasonably clear, under one portion of the policy coverage in order to influence settlements under other portions of the policy coverage.

3. Performance Standards References

   a. Standard I.B.4.c.: Physical Damage Prompt Evaluation and Settlement

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

   b. Standard II.A.7.a.: Bodily Injury – Cases in Suit

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

   c. Standard III.F.1.g.: PIP Claim Payment

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

N. NAIC Standard 14

1. Description

Loss statistical coding is complete and accurate.

2. Performance Standards References

Standard V.D.: Expenses

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

Note that loss statistical coding is audited as part of the Commercial Statistical Audit.

To: Automobile Insurers, Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations

From: Gary D. Anderson, Commissioner of Insurance

Date: November 22, 2017

Re: Clarification of Coordination of Benefits under 211 CMR 38.00 for Medical Claims Associated with Motor Vehicle Accidents

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On October 7, 2016, the Massachusetts Division of Insurance ("Division") adopted new rules and amendments to its Coordination of Benefits ("COB") regulation, 211 CMR 38.00. In light of the update to 211 CMR 38.00, the Division issues this Bulletin to address the coordination of benefits for accident-related medical claims between fully-insured health policies and the Personal Injury Protection ("PIP") and Medical Payments ("MedPay") benefits of motor vehicle liability policies. This Bulletin and the current version of the COB regulation replace and supersede any prior guidance regarding coordination of benefits, including B-1990-2 and Bulletin 2008-12.

Applicability of Coordination of Benefit Rules to Insured Health Plans

The provisions of 211 CMR 38.00 apply to insured health plans issued or renewed in Massachusetts. Carriers should refer to the definition of "Plan" in 211 CMR 38.02, which specifies that a Plan does not include the following:

1. Hospital Indemnity Benefits coverage or other fixed indemnity coverage;
2. Accident only coverage;
3. Specified disease or specified accident coverage;
4. Insured contracts that pay a fixed daily benefit without regard to which expenses are incurred or services received;
5. Medicare Supplement policies;
6. School accident-type coverages that cover students for accidents only, including those contracts covering students for accidents or athletic injuries, either on a 24 hour basis or on a "to and from school" basis;
7. Benefits provided in long-term care insurance policies for non-medical services or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
8. A state plan under Medicaid; or
9. A governmental plan when, by law, its benefits are in excess of those of any private insurance plan or other nongovernmental plan.

Self-funded employment-sponsored health plans are not subject to state insurance rules and, therefore, are not bound by the provisions of 211 CMR 38.00[1]. However, many self-funded employment-sponsored health plan administrators may elect to adopt the rules established within 211 CMR 38.00 to ease the administration of payments for motor vehicle accident-related medical claims.

Medical Expense Benefits within Motor Vehicle Liability Policies

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

MedPay is coverage offered as part of a motor vehicle liability insurance policy. MedPay can pay for reasonable medical and funeral expenses incurred as a result of a motor vehicle accident, as noted in M.G.L. c. 175, §111C. Although automobile insurers are required to offer MedPay coverage of "at least five thousand dollars" under M.G.L. c. 175, §113C, coverage is optional.

Coordination of Health and Automobile Insurance Benefits

The first $2,000 in medical and funeral expenses incurred as a result of a motor vehicle accident must be submitted to the automobile insurer to be paid under PIP[2]. Coordination of benefits becomes necessary after the first $2,000 in medical and funeral expenses is paid under PIP.

The remaining amount in PIP coverage is coordinated between the claimant's health and motor vehicle insurance plans. Once the first $2,000 of PIP has been exhausted, any medical-related claims must be submitted to the health insurance carrier for coverage determination, if health coverage exists. The health insurance carrier cannot deny payment for medical expenses on the basis of the existence of PIP coverage. If there is a MedPay benefit within the motor vehicle policy, MedPay coverage is always secondary to and in excess of the benefits of the health coverage and the PIP benefit up to the limits of the MedPay benefit. *See* 211 CMR 38.05(1)(b).

PIP is not required to cover claims denied by a health insurance provider when the claimant has failed to comply with the requirements of the health coverage policy, e.g., by seeking out-of-network care that could have been obtained through one's health maintenance organization health insurance policy. *Dominguez v. Liberty Mut. Ins. Co.*, 429 Mass. 112, 112-113 (1999). However, if MedPay benefits are available, such denied claims would be payable under the MedPay coverage. *Mejia v. American Cas. Co.*, 55 Mass.App.Ct. 461, 466 (2002).

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[1] Since self-funded employee benefit plans are exempt from state insurance laws, a self-funded plan may contain language deferring primary coverage to the automobile insurer, but is not required to do so. If the self-funded plan does contain such deferral language, then the PIP insurer will not be able to rely on the coordination provisions in 211 CMR 38.00. PIP must cover up to $8,000 in medical expenses, replacement services, funeral expenses and lost wages, and when PIP is exhausted, the Medical Payments coverage, if any, will apply.

[2] "[P]ersonal injury protection provisions shall not provide for payment of more than two thousand dollars of expenses incurred within two years from the date of accident for medical, surgical, X-ray and dental services, including prosthetic devices and necessary ambulance, hospital, professional nursing and funeral services if, and to the extent that, such expenses have been or will be compensated, paid or indemnified pursuant to any policy of health, sickness or disability insurance or any contract or agreement of any group, organization, partnership or corporation to provide, pay for or reimburse the cost of medical, hospital, dental or other health care services." *Creswell v. Medical West Community Health Plan, Inc.*, 419 Mass. 327, 332 (1995).

Coordination of benefits between health coverage, PIP and MedPay under 211 CMR 38.00[3]:

1. **Claimant does not have health coverage or MedPay.**
PIP will pay up to $8,000 in medical expenses, replacement services, lost wages, and funeral expenses incurred as a result of an automobile accident.

2. **Claimant has health coverage and does not have MedPay.**
The first $2,000 in medical and funeral expenses is covered by PIP and any medical expenses in excess of the $2,000 PIP threshold are submitted to the health insurance carrier. If the health insurance carrier denies payment for a claim, the claimant may resubmit the claim to the motor vehicle insurer for consideration of coverage under PIP. PIP would not be required to cover a claim that was denied by the health insurance carrier for the claimant's failure to comply with the requirements of the health coverage policy, but PIP must pay for reasonable expenses not covered under the claimant's health coverage policy (*e.g.*, copayments; deductibles; and treatment that is not covered by health insurance, such as acupuncture).

3. **Claimant has MedPay and does not have health coverage.**
The first $8,000 in medical expenses, replacement services, lost wages, and funeral expenses is covered by PIP. Once PIP has been exhausted, medical and funeral expenses are submitted to MedPay for coverage up to the limits of the coverage purchased.

4. **Claimant has health coverage and MedPay.**
The first $2,000 in medical and funeral expenses are covered by PIP and any medical bills in excess of the $2,000 PIP threshold are submitted to the health insurance carrier. The health insurance carrier is responsible for payment of claims in excess of the $2,000 PIP threshold, except where the health insurance carrier denies coverage for a legitimate reason (*e.g.*, claim for non-covered service). After payment is made by the health insurance carrier, the outstanding balance on the claim is then resubmitted to the motor vehicle insurer for consideration under PIP and, where PIP is unavailable or not required to pay for a claim denied by the health insurance carrier (for example, because of the claimant's failure to comply with the terms of the health policy), the claim must be covered by MedPay up to the limits of the MedPay coverage purchased.

Generally, the MedPay benefit of a motor vehicle liability policy pays for:
- applicable patient copayments, coinsurance or deductibles under the health coverage;
- health care services that are not covered services under the claimant's health coverage; or
- health care services from providers that are not part of the health coverage's network or were provided without prior authorization under the health coverage.

[3] Please note that these are general coordination of benefit rules between a fully-insured health plan and the PIP and MedPay coverages of a motor vehicle policy. Under certain circumstances, the PIP and MedPay benefits of a motor vehicle policy may be unavailable, reduced, or eliminated. *See* M.G.L. c. 90, §§34A and 34M; standard Massachusetts automobile insurance policy.

Restrictions on Billing Automobile Carriers for Amounts Beyond Health Carrier Payments

Where the PIP and MedPay coverages of a motor vehicle liability policy are secondary to coverage under a health plan, the coordination of benefits rules may not be used by a provider to increase the amount of payment to the provider for a service beyond the amount that the provider agreed to accept from the health insurance carrier as payment for the services. Thus, the provider may not bill the motor vehicle liability policy or the insured the difference between the provider's negotiated payment with the health insurance carrier and the provider's charge. Unless otherwise permitted under 211 CMR 38.00, the coordination of benefits rules may not be used to circumvent contractual agreements between providers and health plans by increasing the provider payment or decreasing the amount the provider has negotiated to accept in payment for services, less any required deductibles, coinsurance or copayments. Health plans should include provisions in their provider contracts to account for payments under coordination of benefits.

Limitations to Coordination of Benefits within Insured Health Plan Documents

Fully-insured health benefit plans *may not* include a "coordination of benefits" provision in their contracts making their coverage secondary to other coverage for health care services, including MedPay. Automobile insurers may continue to determine whether PIP or MedPay pays first based on the reason for the health insurance carrier's denial or based upon an exclusion under M.G.L. c. 90, §34A (e.g., felonious conduct) or under the terms of the automobile insurance policy. The Division expects all health carriers to submit amendments to existing policy form materials that remove coordination of benefits provisions that are impermissible under 211 CMR 38.00 (*i.e.*, deferral to MedPay).

Effective Date of Amended Coordination of Benefits Rules

The Division expects all health and automobile insurance carriers to establish systems by no later than January 1, 2018 that comply with the provisions of 211 CMR 38.00 when responding to medical claims associated with automobile accidents that occur on and after that date.

If you have any questions about this Bulletin, please contact Kevin Beagan, Deputy Commissioner, Health Care Access Bureau, at 617-521-7323 or kevin.beagan@state.ma.us.