THE WORKERS' COMPENSATION
RATING AND INSPECTION BUREAU

Massachusetts Workers Compensation
Assigned Risk Pool

November 10, 2010

MASSACHUSETTS WORKERS' COMPENSATION
ASSIGNED RISK POOL

SPECIAL BULLETIN NO. 14-10

MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL
PLAN OF OPERATION
UPDATES TO PERFORMANCE STANDARDS

Attached is a copy of the Performance Standards that were approved by the Division of Insurance, to be **to be effective July 1, 2011**. Additions to the Performance Standards are shown in blue underline, deletions are shown in the right-hand margin, and text that was moved is green. A clean copy of the Performance Standards can be found at www.wcribma.org in the Residual Market area of the website.

If you have any questions, please feel free to contact me at dcrowley@wcribma.org or 617-646-7594 or Christine Cronin at ccronin@wcribma.org or 617-646-7544.

DANIEL M. CROWLEY, CPCU
Vice President – Customer Services and Residual Market

PERFORMANCE STANDARDS FOR ASSIGNED CARRIERS

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PERFORMANCE STANDARDS FOR ASSIGNED CARRIERS

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The following are the minimum performance standards for Servicing Carriers and Voluntary Direct Assignment Carriers whether or not the carriers perform the services in-house or contract with outside service providers. Standards that apply to both Servicing Carriers and Voluntary Direct Assignment Carriers will reference "assigned carriers." Certain standards are only applicable to servicing carriers and will be identified as such. Assigned carriers are also responsible for complying with all statutes, regulations, and Pool rules and performance standards.

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These Performance Standards ("Standards") have been created and are maintained by the Workers' Compensation Rating and Inspection Bureau of Massachusetts ("WCRIBMA") in its role as the administrator of the Massachusetts Workers' Compensation Assigned Risk Pool and have been approved by the Massachusetts Commissioner of Insurance ("Commissioner").

Failure to maintain these standards may result in penalties being imposed upon the assigned carrier by the WCRIBMA in accordance with Article VII of the Pool's Plan of Operation and Article V of the VDAC Program and the other provisions in this Appendix. An assigned carrier's failure to maintain these standards could be used as a factor in determining whether a Servicing or Voluntary Direct Assignment Carrier's Designation should be rescinded.

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Each servicing carrier shall locate and provide all files, or exact duplicates, within the time allotted by the Pool or any of its on-site auditors appointed pursuant to the "Determining the Servicing Carrier Fee" section of this Appendix, no. 8. Failure to provide such files will result in the effects described in no. 4 of the section entitled, "Translating Compliance Ratios into an Effect on the Servicing Carrier Fee."

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For purposes of these standards, the following meanings shall apply:

- The day following the date of receipt, issuance, or other required action is counted as the first day.
- 'Days' shall refer to calendar days, unless otherwise specified.
- 'New Business' is defined as the first year that an employer is assigned to the carrier by the WCRIBMA. Block transferred policies are considered 'new business' to the receiving carrier, while policies that have been reassigned to the same carrier with a gap of no more than six months are not considered 'new business.'
- 'Good faith' is defined as an observance of reasonable commercial standards of fair dealing.

A. UNDERWRITING AND AUDIT

1. POLICY ISSUANCE

a. General Information

Assigned carriers shall have operational responsibility for issuing policies accurately, utilizing forms prescribed by the WCRIBMA and/or approved by the Commissioner.

Assigned carriers must attach the most recent version of the following endorsements onto all Massachusetts assigned risk policies:

- Notification of Change in Ownership Endorsement
- MA Terrorism Risk Insurance Program Reauthorization Act Endorsement
- MA Limits of Liability Endorsement
- MA Assessment Charge
- MA Notice to Policyholder Endorsement
- MA Limited Other States Insurance Endorsement
- MA Assigned Risk Pool Eligibility Endorsement
- MA Premium Due Date Endorsement
- MA Cancellation Endorsement
- MA Policy Definition Endorsement

All policies shall be issued in consideration of premiums and additional fees and charges as may be authorized by the WCRIBMA and approved by the Commissioner. Assigned carriers shall not impose unauthorized charges to the employer to defray carrier costs of either paper or electronic billing or policy distribution.

Assigned carriers are responsible for maintaining adequate safeguards to assure insurer compliance with all statutes, regulations, pool procedures, these Performance Standards, and all terms and conditions of the policy contract, including endorsements.

Proof of coverage (state filing) effective periods shall coincide with policy coverage periods.

b. New Business

Within five (5) business days of the assigned carrier's receipt of the Notice of Assignment from the WCRIBMA, the carrier must send a letter to the insured that includes:

- Carrier telephone numbers
- Key contact information
- Information on where and how to file claims
- Where and how to obtain certificates of insurance
- The policy number or other means of policy identification.

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The policy will be accurately issued within 30 days from the date the Notice of Assignment, required premium, and properly completed application are received from the WCRIBMA.

If the application sent by the WCRIBMA to the insurer along with the Notice of Assignment is not properly completed, any missing information shall be requested from the producer and/or the insured.

If a question of eligibility arises, the carrier shall contact the WCRIBMA. If the employer is found to be ineligible for assigned risk coverage, the time standard for policy issuance is suspended as of the date of documented contact with the WCRIBMA. If the assigned carrier cannot resolve the eligibility issue within five days of contacting the WCRIBMA, the carrier must notify the WCRIBMA immediately, and the WCRIBMA will advise if the coverage should be rescinded or the policy should be cancelled. The time standard restarts on the date the resolution of the eligibility issue is communicated by the assigned carrier to the WCRIBMA. When the time standard is restarted, the assigned carrier has the balance of the 30-day time period or ten days, whichever is greater, to issue the policy.

c. Renewal Policies and Non-Renewal Notices

At least 45 days, but not more than 100 days prior to the expiration of the policy, the assigned carrier shall send a renewal proposal as appropriate to the employer and the producer of record and retain a copy of the proposal for its record. The renewal proposal must contain the following:

- The expiration date of the current policy
- The amount of the deposit premium
- The Due Date for the deposit premium, which shall be twenty (20) days prior to the current policy's expiration date ("Due Date").
- The following statement: "Payment of the deposit premium will constitute the employer's acceptance of and agreement to the terms and conditions of the policy."

If the required deposit premium is received by the Due Date, the assigned carrier will issue an accurate renewal policy within thirty (30) days after the receipt of the required deposit premium.

If the required deposit premium is not received by the Due Date, the assigned carrier must send a Notice of Non-Renewal to the employer, the producer and the WCRIBMA. The Notice of Non-Renewal must include the reason for nonrenewal and must state, "Your policy will terminate on the policy expiration date, xx/xx/xxxx." (Provide the exact date.) The Notice of Non-Renewal must be sent in enough time so that the insured and the WCRIBMA receive the Notice at least ten (10) days prior to the expiration date of the current policy. The assigned carrier

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must, at a minimum, retain for its records a certificate of mailing receipt from the United States Postal Service showing the name and address of the insured as stated in the policy.

2. PAYROLL AND CLASSIFICATION VERIFICATION

Prior to the issuance of a policy, and during the policy period as new information becomes available, the assigned carrier shall review the name of the business, the description of operations, the payroll and classification codes, and any information the carrier has available to ensure that the policy premium being charged is reasonable.

When there is reason to doubt the accuracy of the annual exposure base or whether the insured has been properly classified, the assigned carrier shall verify the information provided through interim audit or by obtaining additional information from the employer. The carrier should make sound underwriting judgments in adjusting the annual exposure.

If the assigned carrier has reason to believe that the risk is improperly classified, the carrier shall provide the WCRIBMA with sufficient information to determine whether a classification change is appropriate. Note that assigned carriers are not required to notify the WCRIBMA before adding or deleting classifications for temporary employment agencies and construction operations.

The assigned carrier shall consider the effects of inflation, economic trends in the insured's industry, employment level changes in the insured's operation, and utilize the latest available audit and claim history information to develop current policy premium and deposit premium.

During the policy term, the carrier may discover or receive, either through audit, claim information, loss control survey, or other means, verifiable payroll information that is not consistent with the annual exposure base or classification information that raises doubts about the accuracy of the policy's classifications. The assigned carrier must investigate and decide whether a change is necessary and determine a course of action within 30 days of the discovery or receipt of the new information.

3. ENDORSEMENTS

a. When an endorsement is requested by the insured, the assigned carrier must:
   1) Within 10 days of the receipt of the request, either:
      a) Issue a denial of the endorsement along with an explanation of the reason(s) of the denial, or

Deleted: If the policy is to be non-renewed, the servicing carrier shall give at least 10 calendar days written notice to the employer and the Workers Compensation Rating and Inspection Bureau of Massachusetts of its intention not to renew.¶

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b) Request any additional information that may be required. The request should state that if the additional information is not received within 20 days, the endorsement request will not be honored.

2) Accurately issue the endorsement within 20 days of the receipt of the request or all requested information.

b. When it is determined by the assigned carrier that an endorsement is necessary, the carrier must issue such endorsement within 45 days of making that determination. The assigned carrier must have procedures in place to compare final audit reports with renewal payrolls and other information to determine if any additional endorsements are necessary. The assigned carrier must issue an additional premium endorsement if the additional premium generated is at least $500 or 25% of the estimated annual premium, whichever is the lesser amount.

4. CANCELLATIONS

a. Cancellations Initiated by the Insured or Their Authorized Representative

Written requests for cancellation submitted by the insured or their authorized representative (for example, the producer or finance company with Power of Attorney,…) must be processed and a Notice of Cancellation must be issued within five business days after the receipt of the request and required documentation.

The effective date of the cancellation must be determined by the assigned carrier to ensure that either 1) ten (10) days written notice of such cancellation is given to the WCRIBMA, or 2) the cancellation date coincides with a record of replacement coverage that is on file with the WCRIBMA.

A Notice of Cancellation, reflecting the reason and effective date of cancellation, must be sent to the WCRIBMA, the insured and any authorized representative or finance company.

The assigned carrier must, at a minimum, retain for its records a certificate of mailing receipt from the United States Postal Service showing the name and address of the insured as stated in the policy.

b. Cancellations Initiated by the Assigned Carrier

Cancellation and notification procedures will be initiated by the assigned carrier in accordance with M.G.L., Chapter 152, Sections 63 and 65B, in the following cases as permitted by Section 55A:

(i) nonpayment of premium
(ii) fraud or material misrepresentation affecting the policy or insured; or
(iii) a substantial increase in the hazard insured against.

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For cancellations for nonpayment of premium, refer to Standards A-8, Billings.

In accordance with the Massachusetts Assigned Risk Pool Eligibility Endorsement, WC200307, the employer's compliance with the following eligibility requirements is material to the continuation of assigned risk pool coverage. The assigned carrier may initiate a mid-term cancellation if, after two documented, good faith attempts made by the assigned carrier, one by certified mail, the employer fails to comply with any of these policy conditions:

If the employer fails to…	And the assigned carrier cancels the policy, then the assigned carrier must…
Fully cooperate with attempts to conduct premiums audits or inspect the premises for loss control purposes, …	Report the cancellation citing the reason 'Material Misrepresentation / Fraud' (WCIO reason code #21).
Keep records of information needed to compute premium and provide the assigned carrier with copies of those records when asked for them, …	Report the cancellation citing the reason 'Material Misrepresentation / Fraud' (WCIO reason code #21).
Comply with the assigned carrier's reasonable, critical loss control recommendations (see Standard C-4), …	Report the cancellation citing the reason 'Material Misrepresentation / Fraud' (WCIO reason code #21).
Allow the assigned carrier to make a careful inspection of their operation for the purpose of measuring the hazards, making recommendations for the health and safety of employees and determining the rate or rates which will be adequate and reasonable for the policy, …	Report the cancellation citing the reason 'Material Misrepresentation / Fraud' (WCIO reason code #21).

The effective date of the cancellation must be determined by the assigned carrier so that ten (10) days written notice of such cancellation is given to the WCRIBMA and the insured.

A Notice of Cancellation, reflecting the reason and effective date of cancellation, must be sent to the WCRIBMA, the insured and any authorized representative or finance company known to the insurer at the time the Notice of Cancellation is being sent. If the cancellation is due to non-payment of premium, the amount due must be shown on the Cancellation Notice.

The assigned carrier must, at a minimum, retain for its records a certificate of mailing receipt from the United States Postal Service showing the name and address of the insured as stated in the policy.

Assigned carriers must report non-compliance and subsequent compliance to the WCRIBMA in accordance with Standard E.

Deleted: (1) . Pay an undisputed outstanding premium obligation on a present or prior workers' compensation insurance policy. The former carrier, if different than the current carrier of record, shall notify the Pool Administrator of such undisputed outstanding premium obligation for the prior policy.¶
(2) . Afford access to its operations for inspection and auditing purposes, after the carrier has made at least two good faith attempts to contact the insured, one of which has been by certified mail - return receipt requested.¶
(3) . Demonstrate, in writing, that it has, within 90 calendar days, substantially complied, or intends to so comply within a reasonable time, with the carrier's reasonable recommendations aimed at reducing a substantial increase in the hazard insured against (i.e., those recommendations addressing exposures of imminent danger or directed towards preventing losses which are expected to increase substantially).
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Deleted: A failure by an insured to comply with b.(1), b.(2), or b.(3) above shall be deemed reasons permitting the mid-term cancellation of a policy pursuant to M.G.L., Chapter 152, Section 55A.

5. REINSTATEMENTS

A request for reinstatement must be accepted or denied and communicated to the insured within five business days after receipt of request. Notification of the reinstatement must be sent to the WCRIBMA within five (5) business days of issuance.

6. CERTIFICATES OF INSURANCE

If the policy has been issued, the assigned carrier will issue and distribute a Certificate of Insurance by facsimile to each fax number provided, within two (2) business days of its receipt of a fully and accurately completed Massachusetts Assigned Risk Pool Request for Certificate of Insurance Form or a like form, where the first day is defined as the day after the request was received. If no fax number is provided for a person or persons to whom the Certificate of Insurance should be issued, then carrier will mail the Certificate of Insurance to the mailing address(es) provided on the form, if any.

For new business where the policy has not yet been issued, the time standard is ten (10) days from the date the assigned carrier is in receipt of both 1) the assignment package and deposit premium from the WCRIBMA and 2) a fully and accurately completed Massachusetts Assigned Risk Pool Request for Certificate of Insurance Form.

If an assigned carrier notified a Certificate Holder named on a Certificate of Insurance of a pending cancellation, and that policy is subsequently reinstated, then the carrier must also notify the Certificate Holder of the reinstatement within five (5) business days of issuance.

Assigned carriers must not authorize producers of record or other parties to issue certificates of insurance.

7. PRODUCER FEES

Producers with valid Massachusetts producers' licenses will be paid by the assigned carrier as premium is collected, except that premium collected by a collection agency or an attorney engaged and remunerated by the assigned carrier will not be subject to a producer fee. The following fee schedule is applicable to assigned risk policies:

PRODUCER FEE SCHEDULE	
First $1,000	9% of Standard Premium
Next $4,000	5% of Standard Premium
Next $95,000	4% of Standard Premium
Over $100,000	3% of Standard Premium

The assigned carrier is required to process and mail fee payments within thirty (30) days from the date the policy is issued or thirty (30) days from the receipt of premium, whichever is later. The fee payment may also be applied to commissions which the producer owes to the carrier from other assigned risk policies.

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8. BILLINGS

a. Billing Cycle

Servicing carriers should complete billing procedures within 45 calendar days for premium or deductible balances due, installments, interim audits, endorsements, and final audits. The 45-day billing cycle begins on the date of the billing and includes 30 days from the date of billing and a 15 day period for follow up.

b. Billing Statements

- Billing statements for less than $100 will not be required to be billed, excluding final billing, until the cumulative amount of premium due for a single policy period exceeds $100.
- Billing statements for additional premium of $100 or greater shall be mailed within ten (10) business days of posting the transaction on the company records. If billing is on an installment basis, and an installment is due within the next 30 days, the additional premium may be allocated among all remaining installments.
- Billing statements must indicate that the amount due must be *received* by the due date (as opposed to being *postmarked* by the due date).
- Billing statements must include a clear explanation of the bill and specific information on how the employer may inquire about the billing determination.
- Billing procedures, where all or a portion of the amount due is disputed, shall include prompt redetermination of the amount due and reasonable explanation of the basis for the billing, as necessary; as well as information on how the employer may appeal the billing determination.

c. Collection Attempts

Servicing carriers must make at least two documented attempts to collect the premium within the billing cycle. Billings, notifications of delinquent accounts, cancellation notices and telephone contact are all considered attempts to collect.

On all accounts with an outstanding balance of $10,000 or more, a documented phone call to the employer must be made by the servicing carrier in addition to the initial billing and one written follow-up collection attempt.

d. Cancellation

If premium amounts for current or prior policies are not received within 45 calendar days from the date of mailing the billing statement, the servicing carrier should implement cancellation procedures in accordance with the provisions of M.G.L., Chapter 152, Sections 55A, 63 and 65B. Cancellation Notices must be mailed in accordance with Standard A-4-b.

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Deleted: one additional written follow up collection attempt must be made within the billing cycle, prior to initiation of cancellation.

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The policy may not be cancelled if:

- A payment plan has been signed by the insured and the assigned carrier, and all payments have been received in accordance with their agreement, or
- A bona fide dispute exists and the assigned carrier has received the non-disputed premiums, or
- The premium due was not billed.

e. Return Premium

Return premium adjustments will be mailed by the assigned carrier within ten (10) business days of recording on company records.

Any return premium checks shall be made payable to the insured, unless a valid power of attorney is on file, in which case the return premium checks shall be made payable to the party with power of attorney. The check shall be mailed to the payee.

In cases in which a financed policy is cancelled midterm and the policyholder does not cooperate with audit requests, the assigned carrier may not retain more than three times the prorated premium, with a short rate penalty applied, unless the carrier has evidence that the original premium estimate was significantly deficient. The balance of the premium shall be returned to the finance company.

The check shall be made on the gross amount of the return premium, unless the insured owes the assigned carrier premium on other Massachusetts assigned risk workers' compensation policies. In that case, the assigned carrier shall either return or bill the net of the return premium and the owed premium, as appropriate.

A bill for the unearned commission shall be sent to the producer of record or an offset may be made against other commissions due to the same producer from the assigned carrier on other assigned risk business.

9. COLLECTION AGENCY PROCEDURES

Premium Past Due	Collection Activity
$0 - $999	Collections are important, but are at servicing carrier discretion.
$1,000 and Over	Uncollectible accounts must be referred by the servicing carrier to a collection agency on file with the WCRIBMA for further collection activity within 15 days of the completion of the 45-day billing cycle, unless: • potential for imminent settlement is evident, or • the premium is in dispute and the dispute is being actively resolved. Servicing carriers must obtain preapproval from the WCRIBMA to refer to outside counsel instead of pursuing collection activity.

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The producer will be paid by the carrier as premium is collected. The carrier is required to process and mail fee payments within thirty (30) days from the date the policy is issued or thirty (30) days from the receipt of premium, whichever is later. The fee payment may also be applied to commissions which the producer owes to the carrier from other assigned risk policies.¶

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10. AUDITS

a. Preliminary Physical Audits

Preliminary Physical Audits (PPAs) must be completed by the servicing carrier for all qualifying employers in accordance with 10-c and must be completed within 120 days of the policy effective date, or receipt of assignment, whichever is later.

Exception: Commonwealth of Massachusetts Regulation 211 CMR 111.00 requires that all carriers audit policies issued to employee leasing companies within 90 days of the policy effective date.

Prior to PPAs, auditors must be provided access to complete policy information, including but not limited to payroll and claims data, experience rating factors, adverse loss conditions, suspected payroll and classification discrepancies.

If the employer did not qualify for a PPA at policy issuance but the policy was endorsed within 120 days of the policy effective date and now meets the PPA requirement, then the assigned carrier must conduct the PPA within 75 days of the endorsement date.

If the employer did qualify for a PPA at policy issuance but the policy was endorsed within 120 days of policy issuance and no longer qualifies for a PPA, then the assigned carrier is not required to conduct the PPA.

b. Final Physical Audits

Final physical audits must be completed by the servicing carrier for all qualifying employers in accordance with 10-c. Final physical audits must be completed, billed and recorded on the assigned carrier's records within:

- 90 days of the notification of cancellation if initiated by the employer,
- 90 days of the policy expiration or cancellation date if initiated by the assigned carrier,

Prior to Final Audits, auditors must be provided access to complete policy information, including but not limited to payroll and claims data, experience rating factors, adverse loss conditions, suspected payroll and classification discrepancies.

If a Final Physical Audit is not required, then the assigned carrier must conduct a final mail or telephone audit. Assigned carriers must obtain, via a documented attempt, the most recent applicable state and/or federal tax forms on all mail and telephone audits to assess the reasonableness of all reported payroll.

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The servicing carrier shall initiate a diligent effort to obtain the most recent IRS 940 form or its equivalent from the insured on all mail and telephone audits to assess payroll.

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c. Qualifying Employers

Audits are to be conducted by servicing carriers in accordance with 10.a-g based on the following minimum frequencies, premium ranges and governing classifications for all employers except domestic servants. While these are the minimum requirements, servicing carriers are not precluded from physically auditing non-qualifying employers based on sound underwriting judgment.

NEW BUSINESS	
Premium Range	
$50,000 +	A Preliminary Physical Audit and a Final Physical Audit must be completed, regardless of governing classification.
$10,000 - $49,999	A Preliminary Physical Audit and a Final Physical Audit must be completed on all risks with the following governing class codes. All other risks must receive a Final Physical Audit.
	0016 0036 0037 0042 0046 0050 0106 2702 3365 3724 3726 5020 5022 5037 5040 5057 5059 5069 5102 5146 5160 5183 5188 5190 5213 5215 5221 5222 5223 5348 5402 5403 5437 5443 5445 5462 5472 5473 5474 5478 5479 5480 5506 5507 5508 5509 5538 5545 5547 5606 5610 5645 5651 5701 5703 5705 6003 6005 6204 6217 6229 6233 6251 6252 6306 6319 6325 6400 7219 7230 7231 7502 7515 7538 7539 7601 7720 7855 8018 8227 8380 8393 8742 8745 8829 9014 9016 9079 9529 9534
$5,000 - $9,999	A Preliminary Physical Audit and a Final Physical Audit must be completed on all risks with the following governing class codes. All other risks must receive a Final Physical Audit.
	3365 5040 5057 5059 5069 5022 5183 5213 5221 5403 5437 5445 5474 5479 5538 5545 5547 5606 5645 5651 7219
$1 - $4,999	A Final Physical Audit must be completed on all risks with the following governing classifications. A final mail or telephone audit must be completed on all risks not receiving a Final Physical Audit.
	3365 3726 5020 5022 5037 5040 5057 5059 5069 5102 5146 5160 5183 5188 5190 5213 5215 5221 5222 5223 5348 5402 5403 5437 5443 5445 5462 5472 5473 5474 5478 5479 5480 5506 5507 5508 5509 5545 5547 5606 5610 5645 5651 5701 5703 5705 6003 6005 6204 6217 6229 6233 6251 6252 6306 6319 6325 6400 7219 7230 7231 7538 7601 7855 8227 9529 9534
ALL	A Preliminary Physical Audit and a Final Physical Audit must be completed on all risks engaged in leasing employees to others or in providing temporary help to others, regardless of premium size.

Deleted: Physical audits will be made whenever requested by the policyholder with reasonable grounds.¶
e. . Physical audits are to be conducted in accordance with the following minimum frequencies for all risks except domestic servants. All preliminary physical audits must be completed within 120 calendar days[1] of the policy effective date.¶

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RENEWAL BUSINESS	
Premium Range	
$10,000 +	A Final Physical Audit must be completed every year for all risks.
$1 - $9,999	A Final Physical Audit must be completed at least once every three years for all risks. A final mail or telephone audit must be completed on all risks not receiving a physical audit.
ALL	A Preliminary Physical Audit and a Final Physical Audit must be completed every year on all risks engaged in leasing employees to others or in providing temporary help to others, regardless of premium size.

d. Mail and Telephone Audits

Mail and telephone audits, during which the employer submits externally verifiable payroll, tax or other requested information through the mail or by electronic means, are only permitted when a physical audit is not required. The assigned carrier shall make a documented, good faith effort to obtain the most recent IRS 941 form(s) or its equivalent from the insured on all mail and telephone audits to assess payroll.

e. Employer Requested Audits

Physical audits will be performed by the assigned carrier whenever requested by the employer with reasonable grounds. The requested audit must be completed, billed, recorded and closed on the company records within 90 days of the receipt of the request.

f. Scheduling and Uncooperative Employers

Assigned carriers must make reasonable attempts to schedule physical audits or obtain audit information for mail or telephone audits. The attempts to begin scheduling appointments must be made early in the process to ensure the timeliness requirements are met. These 'attempts' include written correspondence (mail, e-mail or fax), telephone contact, or other, depending on the carrier's documented procedures.

If at least two documented, good-faith attempts to conduct a physical audit or obtain audit information for a mail or telephone audit have been made (one by certified mail), and the insured has not complied, then the assigned carrier should initiate cancellation procedures on the current policy for 'material misrepresentation' since the policyholder has not complied with the agreed upon terms of the policy contract. (See Standard A-4-b.)

Assigned carriers must report non-compliance and subsequent compliance to the WCRIBMA in accordance with Standard E. (See Standard E-1.)

If an insured disputes an audit, the assigned carrier should contact the insured and resolve the accuracy of the audit within 60 days from the date of receipt of written

Deleted: 1) . New Policies:¶
(i) . Premium range $50,000 and over: A preliminary physical audit and a final physical audit must be completed on all risks regardless of governing class code.¶
(ii) . $49,999 to $10,000: ¶
. Special Category . Applicable¶
. . Class Codes¶
¶
Amusements . 9016¶
¶
Auto Sales/Service . 8380, 8393¶
¶
Construction/Carpentry/Masonry . All Classes2¶
¶
Farm Related . 0016, 0036,¶
. 0037, 0050¶
¶
Food Service/Restaurant . 9079¶
¶
Fuel Related/Oil/Gas/Energy . 7502, 7515, 7539¶
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Health Care . 8829¶
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Janitorial . 90i4¶
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1 Commonwealth of Massachusetts Regulation 211 CMR 111.00 requires that carriers audit policies issued to employee leasing companies within 90 days of the policy effective date.¶
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2 3365, 3726, 5020, 5022, 5037, 5040, 5057, 5059, 5069, 5102, 5146, 5160, 5183, 5188, 5190, 5213, 5215, 5221, 5222, 5223, 5348, 5402, 5403, 5437, 5443, 5445, 5462, 5472, 5473, 5474, 5478, 5479, 5480, 5506, 5507, 5508, 5509, 5545, 5547, 5606, 5610, 5645, 5651, 5701, 5703, 5705, 6003, 6005, 6204, 6217, 6229, 6233, 6251, 6252, 6306, 6319, 6325, 6400, 7538, 7601, 7855, 8227, 9529, 9534.
Page Break
¶
Landscaping . 0042, 0046, 0106¶
¶
Lumbering . 2702¶
¶
Millwright Work . 3724¶
¶
Salesperson-Outside . 8742, 8745¶
¶ ... [2]

Deleted: $4,999 to $1: A final physical audit must be completed on all risks with a construction, carpentry, masonry or trucking governing class code. A final mail or telephone audit must be completed for all other risks.¶
<#>All premium ranges: A preliminary physical audit and a final physical audit must be completed on all risks engaged in leasing employees to others.¶
2) . Renewal Policies:¶ ... [3]

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notice of the dispute. The dispute should be concluded either by revising the audit billing, or by written notice to the insured that the original audit is accurate.

g. Documentation

Assigned carriers must document the following in their files:

- All attempts to schedule and conduct physical audits
- All attempts to conduct mail and telephone audits
- All requests for, or receipt of, audit information
- Any other item or decision that impacts policy premium or coverage

B. CLAIMS

1. REGISTERING/RECORDING

a. All First Reports of Injury will be screened upon receipt and separated by lost-time and medical-only claims. First Reports of Injury should either be manually date stamped or electronically stamped with the date received.

b. All claims for medical or indemnity benefits reported by telephone, facsimile, mail or any other means should be established with a claim number and assigned to a file handler within one working day of the date received, with the assignment date documented.

2. INVESTIGATION

a. Investigations should include obtaining medical and other pertinent records as well as securing detailed statements from the employer, employee and witnesses, to the extent they are granted and appropriate. The extent of the investigation should be based on consideration of the following issues: severity of injury, potential extent of disability, potential for an employers' liability action, jurisdiction, causal relationship of the workplace incident to the disability, lateness of reported claim, lack of witnesses in claims where liability is questionable, and other such factors surrounding the compensability of the claim. The documentation should be prepared in anticipation of being presented at the Massachusetts Department of Industrial Accidents ("DIA").

Detailed statements should be taken for the following:

- Fatalities
- Spinal cord injuries
- Paralysis injuries
- Head injury/brain damage
- Serious Psychological stress
- Burns and severe disfigurement
- Heart attack
- Serious Occupational disease
- All injuries where issues of origin exist

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Detailed statements should also be taken for:

- Incidents with delayed disability, additional periods of disability, or late reporting, to investigate potential intervening accidents
- Controverted cases with expectations of litigation
- Incidents involving potential recovery (i.e., third-party and second - injury fund cases)

All lost-time accidents should be investigated at least to the extent of:

- contacting either any person to whom the claimant or survivor reported the injury or the person held responsible at the employer for confirming the facts of the injury;
- attempting to contact the claimant; and
- attempting to contact the treating physician. The treating physician may be contacted by the servicing carrier's utilization review vendor representative.

b. Contact, or documented attempts of contact, with the injured worker or representative in cases involving serious injury shall be made within one working day of receipt of assignment.

c. Initial investigation of assigned claims should be completed within the 14 day statutory requirement, or if paid without prejudice, no more than 60 days.

d. Investigation will also include, but not be limited to, the following:

1) Contact with the employer/supervisor, and any witnesses as needed, within two business days of receipt of assignment, to verify accident details and to lay the foundation for the injured worker's return to light or full duty.

2) Where the employee has not returned to work, contact with the treating clinician's office within two business days of receipt of assignment in the absence of medical documentation from the onset to gather information concerning medical history, diagnosis, treatment, causal relationship, and return to work target date.

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3) Verification of average weekly wage consistent with jurisdictional requirements.

4) Report all lost-time injury claims to the Index Bureau. Investigation should include Inquiry Reports with other insurers/administrators, when appropriate.

Either a full captioned report to the file should be completed with the conclusion of investigation, or the assigned carrier must maintain an automated system which includes as data elements all the items relevant to the investigation. Such terms shall include but not be limited to coverage, jurisdiction, claim date, accident description, compensability, disability, medical

history, subrogation, Second Injury Fund potential, potential employer's liability exposure, reserves, average weekly wage, and outstanding issues as well as plans for future handling.

5) On claims involving payment of benefits under section 34A (Permanent And Total) or section 31 (survivors benefits) contact will be made at least once each calendar year with the claimant. On cases involving payment of Section 34, (Temporary Total) or section 35, (Temporary Partial) benefits contact with the claimant will be made at least once a quarter. Personal contact with a claimant is required where allowed and subject to an individual's legal representation.

6) A subrogation investigation shall be conducted simultaneously with the compensability investigation, including statements, photographs, diagrams, engineering opinions and preservation of evidence to support a recovery, where appropriate.

Each file should contain a documented determination as to the appropriateness of subrogation, based on this investigation. Insureds should have access to this information at any time upon request. In addition, in any case of an injury resulting from a motor vehicle accident involving a third party, if subrogation is not pursued, then upon request a letter explaining the reasons for the insurer's non-pursuit should be provided to the employer within nine months of the incident or sixty days of the employer's request, whichever is the later date.

e. Continuing items of investigation and/or development (which should be addressed in the file):

1) Consideration of Second Injury Fund possibilities.

2) Possibility of apportionment or contribution.

3) Social Security or other applicable offsets.

4) Need for physical or vocational rehabilitation.

5) On claims involving payment of benefits under section 34A (Permanent And Total) where there is a question of disability, fraud, or where otherwise appropriate, activity checks/surveillances should be conducted by the assigned carrier or its representative at least every six months. Claims where widow's or dependent benefits are being paid should receive activity checks or contact at least annually.

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3. ACCEPTANCE OR DENIAL

a. If claim is compensable, issue first payment within fourteen days of assigned carrier's receipt of an employer's first Report of Injury, or an initial written claim for

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weekly benefits on a form prescribed by the DIA, whichever is received first, and in accordance with statutory requirements.

b. If denial of compensability is in order, ensure that prompt and legally sufficient denial is made with clear, factual basis and grounds for denial to the proper parties, followed up with timely administrative filings, where required, consistent with vigorous defense for non-meritorious claims.

4. RESERVING

a. Establish initial medical and indemnity loss reserves within fourteen calendar days of assignment to the file handler commensurate with all known factors. Adequate reserves represent the file handler's judgment of the potential costs involved in achieving maximum medical improvement and a return to work on full duty based upon known information and claims judgment.

b. Revise loss reserves whenever developments occur that change the ultimate claim exposure. Document with reserve worksheets, or other appropriate means, the basis for reserve changes.

c. In reporting estimates on fatal and permanent total cases, utilize authorized tables where appropriate and provide comments on any deviation.

d. Reserve estimates should be reviewed by a qualified member of the claim department, other than the assigned adjuster, at regular 120 day intervals.

5. DISABILITY MANAGEMENT

a. Arrange for adequate and reasonable medical care necessary to treat the injury or illness.

b. Dependent upon the case circumstances, the nature of the injury, and the extent of the disability, all consistent with sound claims practice and law, initiate, determine, and/or implement the following:

1) Promote a team approach to limiting disability through continuing follow-up contact with injured worker, employer, and physician at intervals consistent with the injury and estimated length of disability and establishment of return-to-work target dates.

Make a good faith attempt to provide the treating physician with a complete job description to facilitate an objective evaluation of the injured worker's ability to return to the job.

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2) Independent medical examinations (where allowed by law) should be utilized where questions of disability, causal relationship, need for surgery and/or existing treatment, or where reports of treating physician are not forthcoming.

3) If return to the individual's regular job with the insured does not appear medically feasible or is unavailable, explore the availability or return to other employment, modified or light work duties consistent with medical capabilities.

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4) Provide Vocational rehabilitation in the form of alternative work, modified work, job placement, on-the-job training, schooling, ensuring compliance with statutory and/or regulatory provisions.

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6. MEDICAL CARE AND COST CONTROL

a. An integrated medical management program that includes pre-accident medical care arrangements, timely reporting of accidents, PPO/PPN/HMO/and similar contracts, utilization review as required by the DIA regulations in effect, hospital pre-certification/pre-admission review, return-to-work programs and catastrophic case management shall be developed and applied to individual claims, consistent with the severity of injury.

b. Periodic paper or electronic reports must be obtained from the treating physician and/or other medical practitioners for the status of the worker's injury and medical care and for use in conjunction with medical bill screening.

c. Screen all medical bills to ensure treatment is related to the injury, and charges are reasonable and necessary; review and approve all medical invoices in accordance with applicable statutes and regulations, relative value studies and/or professional medical cost surveys.

d. Where no questions of compensability or reasonableness exist and physician reports have been received, pay all bills within 30 days or earlier.

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e. Where questions of compensability or reasonableness exist, notify the medical vendor within 30 days, explaining the reasons for the need for further information or investigation.

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7. HEARINGS AND SETTLEMENTS

a. Ensure that all cases are properly prepared prior to conciliation, conference, hearing, trial, or arbitration, including but not limited to the following:

1) Documentation of complete pre-trial preparation in the areas at issue, such as coverage, liability and disability and casual relationship issues, including proper instructions and authorization of the insurer representative at conciliation.

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2) Have available all necessary lay and professional witnesses or their depositions prior to formal hearing, trial, or arbitration.

3) If proceeding encompasses issues relative to extent of disability and/or permanent impairment, the appropriate medical reports, opinions, witnesses should be made available and ready for testimony or deposition, in accordance with statutory requirements.

4) If the proceeding is to be handled by an attorney, ensure timely delivery of the file material for preparation. Document attorney's receipt of claim file and the insurer's communications to its attorney regarding the merits of the issues to be litigated and the probable success of the litigation. If an adverse finding is made, the attorney should comment about the costs and the merits of the appeal and case law issues, including the potential impact on future claims costs.

5) Review attorney bills to ensure that they reflect billing practices and expense controls that are consistent with the attorney/carrier agreement.

6) When outside counsel is utilized by the assigned carrier, the defense attorney's Initial Report should be produced within 30 days of receipt of assignment. A Pre-Trial Report should be produced by any outside defense counsel at least 30 days prior to a hearing or, if such counsel receives less than 40 days notice of a hearing, no later than ten days from receipt of such notice. In all instances, Initial Reports and Pre-Trial Reports shall be completed prior to the applicable proceedings.

b. Assuming plaintiff attorney willingness and consistent with sound claims judgment, conduct settlement negotiations promptly after completion of investigation. Do not, as a matter of tactics or standard operating procedure, wait until day of pre-trial, conference or hearing. Prior to settlement negotiations the file will be documented relative to estimated settlement value.

c. Base all settlements of permanency or compromise settlements on sound claims judgment consistent with compensability investigation, medical evidence developed and exposure, in accordance with the law and benefit structure.

8. PAYMENT CONTROL

All benefit payments and filings required to be made to the DIA will be documented and made timely in accordance with statutory provisions and regulations.

9. SUPERVISION

Document team review or supervisor/management direction and control of claim handling consistent with the injury severity.

10. FILING REPORTING

All file activity will be fully documented either by paper or electronically, and shall include:

a. Sources of information and dates of activity.

b. Copies of police reports, marriage and/or birth certificates, etc., when appropriate.

C. LOSS CONTROL

The primary objective of these Loss Control Performance Standards is to eliminate, reduce and/or control sources of occupational injury and illness to employers' workers.

1. NOTIFICATION OF LOSS CONTROL SERVICES

Upon policy issuance, the policyholder and producer will be notified by the assigned carrier, in writing, of available loss control services and safety information, including instructions for obtaining services and information.

2. EMPLOYER-REQUESTED LOSS CONTROL SERVICES

Any assigned risk policyholder may request loss control services from its assigned carrier regardless of the size of its operation or its claim history. The assigned carrier is responsible for allocating financial resources, qualified personnel, and time in reasonable amounts sufficient to provide comprehensive loss control services to its policyholders.

a. The assigned carrier will provide appropriate consultation in the form of accident prevention programs, accident trending, safety seminars, safety literature and other administrative aids which will support the loss control efforts of the policyholder.
b. The assigned carrier will encourage the policyholder to designate a specific individual(s) as safety coordinator and contact person.
c. When an on-site visit is requested by the insured or when an on-site visit is deemed necessary by the assigned carrier, the carrier will assign a designated loss control representative to oversee the delivery of services to the policyholder.
d. When the policyholder requests loss control services, the assigned carrier will respond to the policyholder within 15 business days of the receipt of the request. The assigned carrier must either provide requested loss prevention materials (as described in 2a. above) or, when appropriate, conduct a loss control survey (as described in 3. below) within 60 days from the date of the policyholder's request.

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Requests for assistance in the evaluation and control of imminent danger exposures will be given high priority.

3. LOSS CONTROL SURVEYS

Loss Control Surveys ("LCS") are generally initiated by the assigned carrier in accordance with the requirements set forth in this Standard, but may also be requested by the employer as provided in Standard C-2.

a. Contents of a Loss Control Survey

An LCS includes, but is not limited to:

1) An analysis of all available accident experience to determine causes and trends, supported by loss runs or other related documentation.
2) An on-site review of potential employer exposures, specifically identifying conditions and operations that could cause loss. Imminent danger hazards must be discussed with policyholder management during the LCS.
3) Review and documentation of policyholder loss control program and activities including, employee training programs, safety representation (organization), safety policy, procedures, goals and funding, etc.
4) A description of the nature and size of the operations, number of locations and loss potential for classification and underwriting purposes.

b. Recommendations

Recommendations are the result of an LCS and must be presented to the policyholder in accordance with Standard C-4.

c. Timelines and Procedures

1) New Policies

An LCS must be performed for a qualifying employer (as defined in Standard C-3-d), at all qualifying locations (as defined in Standard C-3-e), within 120 days of the policy effective date or receipt of the Notice of Assignment by the assigned carrier, whichever is later.

In addition, regardless of whether an employer would be considered a 'qualifying employer' for the current policy period, the assigned carrier must perform an LCS if the employer meets the following conditions:

- the assigned carrier has knowledge of a prior LCS that contained critical recommendations, and
- the assigned carrier has no knowledge that the critical recommendations in that prior LCS have been satisfied.

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2) Renewal Policies

An LCS must be performed for a currently qualifying employer, at all qualifying locations, within 120 days of the policy effective date if an LCS has not been conducted within the last three policies, regardless of whether or not the employer qualified during the last three policy periods.

In addition, regardless of whether an employer would be considered a 'qualifying employer' for the current policy period, the assigned carrier must perform an LCS if the assigned carrier's prior LCS contained critical recommendations.

d. Qualifying Employers

LCSs are to be conducted with the following premium ranges, governing classifications, experience rating modifications, and locations for all policies except domestic servant policies. While these are the minimum requirements, assigned carriers are encouraged to perform LCSs for non-qualifying employers based on sound underwriting judgment.

Premium Range	Governing Classification Codes				
$25,000 and higher	All employers, regardless of governing classification codes				
$10,000 - $24,999	0008	0037	0042	0046	0050
	0083	0106	1438	1624	1748
	1924	2081	2095	2143	2220
	2501	2688	2702	2710	2802
	2883	3030	3076	3081	3085
	3110	3111	3179	3180	3188
	3241	3257	3365	3372	3400
	3507	3620	3632	3634	3685
	3724	3726	3808	3821	4034
	4130	4279	4410	4439	4459
	4470	4484	4493	4511	4512
	4557	4558	4583	4665	4740
	4741	4779	4828	4829	5022
	5037	5040	5057	5059	5069
	5160	5183	5190	5191	5213
	5221	5222	5223	5348	5403
	5462	5472	5473	5474	5479
	5538	5545	5547	5606	5610
	5645	5651	5701	5703	5705
	6003	6005	6204	6217	6229
	6251	6252	6319	6504	6824
	6826	6834	6836	6854	6872
	6874	6882	6884	7309	7350
	7360	7370	7403	7422	7502
	7539	7580	7590	7610	7704
	8017	8018	8021	8031	8106
	8111	8203	8204	8215	8227

Deleted: The carrier will provide the following:¶
For any policyholder not meeting the criteria in C.2.a. and C.2.b., the carrier will conduct a consulting survey if the carrier deems it necessary, taking into consideration; location exposures, claim activity, nature of business, Best's Loss Control Rating, incident rate, request of the insured, and the like.Within 60 calendar days of receipt of the notice of assignment of new business, the carrier will contact each policyholder who qualifies under C.2.a. and C.2.b., above, to schedule a consulting survey.For the purpose of this section, a consulting survey will consist of an actual visit to the policyholder's site, identification of potential hazards, discussion and closing conference with the designated safety contact and a report documenting the activity with risk reduction recommendations, if any. ... [4]

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	8263	8265	8279	8293	8500
	8829	8831	8833	8835	9014
	9015	9016	9019	9040	9063
	9154	9156	9178	9179	9180
	9182	9186	9403	9410	9501
	9505	9533	9534	9545	9549
	9552	9553			
Experience Rating					
1.40 and higher, with an estimated annual premium of $10,000 and higher	All employers, regardless of governing classification code and status of experience rating.				

e. Qualifying Locations

For all qualifying employers with a single location, the assigned carrier must conduct the LCS at the single location.

For all qualifying employers with multiple locations, the assigned carrier must conduct the LCS at each location that has an annual premium of $10,000 or higher for the qualifying class codes. If no single location has an annual premium of $10,000 or higher for the qualifying class codes, then an LCS should be conducted at the principal location of the insured as determined by the assigned carrier.

4. RECOMMENDATIONS

Recommendations are the result of a Loss Control Survey and include written guidance for the policyholder which addresses actual or potential exposures and, where applicable, make suggestions for program activities or management principles. There are two types of recommendations:

a. Critical Recommendations

Critical recommendations address exposures of imminent danger or serious loss potential or continuing losses, which indicate uncontrolled exposures expected for the type of operation as indicated in Best's Loss Control Manual or similar materials.

The assigned carrier must notify both the employer and the producer of critical recommendations in writing within 14 days of the completion of the LCS. The notification must advise that failure to comply with these recommendations may result in cancellation of coverage, as provided in the Massachusetts Assigned Risk Pool Eligibility Endorsement

Within 60 days from the date the notification is sent, the assigned carrier must contact the employer to ensure compliance with the recommendations. The

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b. . A minimum of one consulting survey annually for each single location policyholder with estimated annual premium between $10,000 and $25,000, and Best's Loss Control Rating of 7 or greater.¶
c. . For any policyholder meeting the criteria in C.2.a. and C.2.b. above, with multiple locations, the carrier will conduct a minimum of one consulting survey annually at the following locations:¶
1) . Each location meeting the criteria in C.2.a. and C.2.b.;¶
2) . If the total annual premium in Massachusetts meets the criteria in C.2.a. and C.2.b., but no single location of the insured meets these criteria, survey the principal location of the policyholder as determined by the servicing carrier.¶
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¶
4. . LOSS CONTROL SERVICES:¶
d. . Written recommendations for policyholder control of actual or potential exposures and, where applicable, program activities or management principles;¶
e. . Safety training seminars designed to familiarize management and supervisory personnel with applicable loss control techniques;¶
f. . Description of operations and loss potentials for classification and underwriting purposes; and¶
g. . The status, in writing, of recommendations submitted on all prior surveys.¶
5. . RECOMMENDATIONS¶

employer can demonstrate compliance with critical recommendations with written notification, signed by an officer or owner of the insured employer.

If the insured has not demonstrated that it has, within 90 days, substantially complied or intends to so comply within a reasonable time, with the carrier's reasonable, critical recommendations, then the assigned carrier may initiate cancellation proceedings in accordance with Standard A-4. The reason for the cancellation must be reported as 'fraud / material misrepresentation', WCIO Cancellation Reason Code 21.

Assigned carriers must report non-compliance and subsequent compliance to the WCRIBMA in accordance with Standard E.

b. Advisory Recommendations

Advisory recommendations address minor exposures that exist but do not present an imminent danger or serious loss potential.

Advisory recommendations must be provided to the employer and the producer in writing within 30 days of the completion of the LCS.

Additional loss control services may be provided where, at the assigned carrier's discretion, they determine the services will be effective in reducing losses.

D. CUSTOMER SERVICE

The assigned carrier shall establish written customer service standards that include, but are not limited to:

1. Responding to written policyholder, producer or injured employee initial inquiries and complaints regarding a particular matter within 10 business days. If telephone inquiries are received, the assigned carrier should require that a written request be submitted.
2. Resolving issues other than audit disputes within 30 days of the date of receipt of written correspondence,
3. If requested, making loss records available within 30 days,
4. Creating written internal procedures and management accountabilities for monitoring compliance with these Performance Standards.

If the insured makes a request for a review of the method by which their classifications, rates, premiums or audit results were determined, as permitted by the MA Notice to Policyholder Endorsement, the assigned carrier must convey the results of that review within 30 days. If the policyholder is not satisfied with the results of the review, the assigned carrier shall notify the policyholder that pursuant to the MA Notice to Policyholder Endorsement, the insured may submit a written request for review to the WCRIBMA.

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6. LOSS RECORDS:¶
Loss records will be maintained and made available by the carrier to allow for analysis of accident causes and to assist the policyholder to identify accident trends.¶

7. ABILITY TO PROVIDE LOSS CONTROL SERVICES:¶
Carriers must demonstrate that they have allocated financial resources, qualified personnel and time in amounts sufficient to provide comprehensive loss control services to their policyholders.¶

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E. POLICY, UNIT STATISTICAL AND DATA REPORTING

All assigned carriers are responsible for timely reporting data in accordance with the Massachusetts Workers' Compensation Statistical Plan and the WCIO Workers' Compensation Data Specifications Manual. The following must be reported:

- Policies
- Endorsements
- Cancellations, Reinstatements, Nonrenewals
- Noncompliance and Compliance Transactions
- Unit Statistical Reports
- Annual Financial Aggregate Data (as required in Part II of the MA Statistical Plan)

1. Noncompliance and Subsequent Compliance Transactions

Assigned carriers must report noncompliance and subsequent compliance to the WCRIBMA. The purpose of this requirement is:

- Noncompliance Reporting - to identify risks that are ineligible for participation through the assigned risk pool and exclude them from assigned risk coverage until such time as the eligibility issue has been resolved
- Compliance Reporting - to reestablish the eligibility for assigned risk coverage for a risk that was previously reported as noncompliant

The noncompliance and subsequent compliance transactions must either be reported electronically as a WCIO Record Type Z1, Transaction Code 17 or through the Member's Area of the WCRIBMA's website.

Noncompliance transactions must be reported to the WCRIBMA within five (5) business days of the determination of ineligibility. In situations that assigned carrier is currently providing coverage for the employer, the noncompliance transaction should be reported along with the cancellation transaction.

Compliance transactions must be reported to the WCRIBMA within five (5) business days of the event correcting the previously reported noncompliance issue.

2. Quarterly Actuarial and Financial Reporting to NCCI

Servicing carriers are also responsible for segregating and reporting actuarial and financial servicing carrier data to NCCI in accordance with NCCI's Servicing Carrier Reference Guide, including any Massachusetts exceptions that have been communicated to the servicing carriers.

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a. Collect and store data required to carry out all necessary accounting, Statistical Plan and results reporting requirements.¶
b. Prepare and file accurate reports within the time constraints required by the Pool.¶
c. File all data in the format and detail specified by the Pool.

TRANSLATING COMPLIANCE RATIOS INTO AN EFFECT ON THE SERVICING CARRIER FEE

1. **DEFINITIONS.** For the purposes of this section the following terms are defined below.

   a) "Aggregate Rating" means the servicing carrier's total score for each audit category.

   b) "Compliance Ratio" means a value, expressed as a percentage, reflecting the servicing carrier's performance with respect to a Standard. When a standard is missed through no fault of the servicing carrier, the carrier will in that instance be treated as complying with that Standard and no deduction will be taken from the servicing carrier's score.

   c) "Rating Value" means the result of comparing the Compliance Ratio for any Standard to the Scoring Range for that Standard. All Rating Values shall be one of the following: commendable, satisfactory, marginal or unsatisfactory. Carriers will receive from four points to one point, respectively, for each commendable, satisfactory, marginal and unsatisfactory Rating Value.

   d) "Scoring Range" or "Scoring Ranges" shall refer to the ranges set forth in the second and fourth paragraphs of no. 2, below.

   e) "Standard" or "Standards" refers to any of the Performance Standards set forth in the section entitled, "Performance Standards for Servicing Carriers," within the audit categories.

   f) "Weight Factor" means any of the factors assigned in the Aggregate Rating Tables that follow this section.

2. **SCORING.** In any year in which the on-site audit program is undertaken pursuant to an order of the Commissioner as provided in the Appendix, "Determining the Servicing Carrier Fee," no. 6, each servicing carrier's Compliance Ratio for each Standard tested during the on-site audit will be compared to the Scoring Ranges. In any such audit, the Compliance Ratios will be determined using samples of at least 125 claims files, 100 underwriting files and 40 loss control files.

   For the categories of Underwriting and Audit, Claims Handling and Loss Control, the servicing carrier shall receive a commendable Rating Value for any Compliance Ratio between 99% and 100%, inclusive. The servicing carrier shall receive a satisfactory Rating Value for any Compliance Ratio of at least 95% but less than 99%. The servicing carrier shall receive a marginal Rating Value for any Compliance Ratio of at least 80% but less than 95%. The servicing carrier shall receive an unsatisfactory Rating Value for any Compliance Ratio lower than 80%.

   The Standards in the Financial Reporting audit category shall be divided into quantitatively measured Standards and qualitatively measured Standards.

The quantitative Standards included in the fee calculation shall be:

- accurate reporting of policy information,
- accurate reporting of claim information,
- accurate premium calculation,
- accurate calculation and reporting of producer fees,
- proper coding and reporting of losses and expenses, and
- accurate reporting of outstanding loss information.

The qualitative Standards included in the fee calculation shall be

- financial reporting systems and procedures,
- timely reporting of uncollectibles,
- accurate reporting of uncollectibles,
- accurate reporting of recoveries,
- claims processing controls,
- premium processing controls, and
- proper application of producer fee and servicing carrier allowance percentages.

For the quantitative performance Standards in the Financial Reporting category, the servicing carrier shall receive a satisfactory Rating Value for any Compliance Ratio between 95% and 100%, inclusive. The servicing carrier shall receive a marginal Rating Value for any Compliance Ratio of at least 80% but less than 95%. The servicing carrier shall receive an unsatisfactory Rating Value for any Compliance Ratio lower than 80%.

The auditors will directly assign Rating Values for the qualitative Performance Standards in the Financial Reporting category, rather than use any Scoring Ranges.

3. **EFFECT ON THE SERVICING CARRIER FEE.** The auditors shall determine Aggregate Ratings, and a corresponding effect on the servicing carrier fee, for each servicing carrier audit as follows:

a) Points for each Standard are calculated by multiplying the respective Weight Factor by the points corresponding to the Rating Value awarded for each Standard.

b) The products of the points and the Weight Factors are then added together for each audit category (Underwriting and Audit, Claims Handling, Loss Control and Financial Reporting) to determine the Aggregate Rating for each category.

c) Each Aggregate Rating is then converted into an effect on the servicing carrier fee using the table, “Effect of Performance Standards on Servicing Carrier Fee,” that follows the “Determining the Servicing Carrier Fee” section.

d) The effects on the servicing carrier fee for each of the four audit categories are added together yielding the post rating servicing carrier fee.

e) Any adjustments for a servicing carrier’s failure to provide requested files are calculated as provided in no. 4, below.

f) The off-balance factors are calculated and applied.

4. **ADJUSTMENT FOR MISSING FILES.** If a servicing carrier fails to provide one or more files requested by the Pool or the on-site auditor as required in the third paragraph of the "Performance Standards for Servicing Carriers" section, no replacement files will be requested, and the servicing carrier's post rating fee will be multiplied by the ratio of total provided files for all categories to total requested files for all categories to calculate the servicing carrier fee, before application of off-balance factors.

   Example 1. Servicing carrier A is requested to provide 250 claims files for audit, 200 underwriting and audit files and 75 loss control files. A cannot locate 10 of the requested claims files. A's post rating servicing carrier fee is 21%. A's servicing carrier fee, before off-balancing, is 20.6% (21% * 515/525).

   Example 2. Servicing carrier B is requested to provided 250 claims files for audit, 200 underwriting and audit files and 75 loss control files for audit. B cannot locate 5 of the requested loss control files. B's post rating servicing carrier fee is 21%. B's servicing carrier fee, before off-balancing, is 20.8% (21% * 520/525).

ON-SITE AUDIT AGGREGATE RATING TABLE
FINANCIAL REPORTING

	(A) Weight Factor	x	(B) Rating Value	=	(C) Rating
Accurate Reporting of Policy Information	4		S = 3 M = 2 U = 1		
Accurate Reporting of Claim Information	4				
Financial Reporting Systems and Procedures	4				
Accurate Premium Calculation	3				
Accurate Calculation and Reporting of Producer Fees	3				
Proper Coding and Reporting of Losses and Expenses	3				
Timely Reporting of Uncollectibles	2				
Accurate Reporting of Uncollectibles	2				
Accurate Reporting of Outstanding Loss Information	2				
Accurate Reporting of Recoveries	2				
Claims Processing Controls	2				
Premium Processing Controls	2				
Proper Application of Producer Fee and Servicing Carrier Allowance Percentages	2				
Totals	35				

ON-SITE AUDIT AGGREGATE RATING TABLE
UNDERWRITING AND AUDIT PERFORMANCE STANDARDS

	(A) Weight Factor	x	(B) Rating Value	=	(C) Rating
Additional Premium Endorsements	4		C = 4		
Compliance with Audit Frequency Requirements	4		S = 3		
			M = 2		
Proper Application of Experience Modifications	4		U = 1		
Completion and Billing of Final Audits	4				
Compliance with Established Collection Procedures	3				
Issuance of Renewal Quotes	3				
Policy Issuance	3				
Processing of Requested Endorsements and Processing of Cancellations	3				
Proper Application of Required State Endorsements	2				
Totals	30				

ON-SITE AUDIT AGGREGATE RATING TABLE
LOSS CONTROL PERFORMANCE STANDARDS

	Weight Factor	Rating Value
Loss Control Consulting Surveys	4	C = 4
Loss Control Services and Recommendations	4	S = 3
Accounting/Statistical and Results Reporting	3	M = 2
Customer Service	2	U = 1
Loss Records	2	
Notification of Loss Control Services	2	
Total	17	

ON-SITE AUDIT AGGREGATE RATING TABLE
CLAIM PERFORMANCE STANDARDS

	Weight Factor	Rating Value
Investigation	4	C = 4
Disability Control	4	S = 3
Medical Costs Control	4	M = 2
Reserving	4	U = 1
Acceptance/Denial	3	
Hearings	3	
Settlements	2	
Supervision/File Reporting	2	
Claim Recording	1	
Total	27	

DETERMINING THE SERVICING CARRIER FEE

1. For policy year 1993, the starting servicing carrier fee will be 30%. An off-balance factor must be applied to obtain an overall premium weighted servicing carrier fee equal to 27% minus the ratio of reimbursements received by all servicing carriers for expenses (e.g. medical cost containment, allocated loss adjustment expenses, etc.) to the total pool premium. This off-balance procedure will be implemented at each adjustment to the servicing carrier fee.

2. For policy year 2000, the initial servicing carrier fee will be 22%. An off-balance factor must be applied to obtain an overall premium weighted servicing carrier fee equal to 22% minus the ratio of reimbursements received by all servicing carriers for expenses to the total pool premium. This off-balance procedure will be implemented at each adjustment to the servicing carrier fee. These reimbursements will not include allocated loss adjustment expenses, which will be reported with losses and reimbursed as losses are. In addition, carriers will retain that portion of the premium which reflects the expense constant most recently approved by the Commissioner.

3. For all policies written on or after October 1, 2002, the servicing carrier fee will be 22.2%. An off-balance factor must be applied to obtain an overall premium weighted servicing carrier fee equal to 22.2% minus the ratio of reimbursements received by all servicing carriers for expenses to the total pool premium. This off-balance procedure will be implemented at each adjustment to the servicing carrier fee. These reimbursements will not include allocated loss adjustment expenses, which will be reported with losses and reimbursed as losses are. In addition, carriers will retain that portion of the premium which reflects the expense constant most recently approved by the Commissioner.

4. For all policies written on or after July 1, 2004, the servicing carrier fee will be 18.8%. Ann off-balance factor must be applied to obtain an overall premium weighted servicing carrier fee equal to 18.8% minus the ratio of reimbursements received by all servicing carriers for expenses to the total pool premium. This off-balance procedure will be implemented at each adjustment to the servicing carrier fee. These reimbursements will not include allocated loss adjustment expenses, which will be reported with losses and reimbursed as losses are. Carriers will continue to retain that portion of the premium which reflects the expense constant most recently approved by the Commissioner. In addition, effective 7/1/04, the Insolvency Fund Assessment will be excluded from the calculation of the servicing carrier fee. Servicing carriers will be reimbursed for payments they made to the Insolvency Fund, as they are for other statutory assessments.

5. The paid loss ratio incentive program will provide a ±9% swing. Servicing carriers' minimum and maximum relativity factors under the paid loss ratio incentive program are as follows:

Premium Size Group	Minimum Relativity Factor	Maximum Relativity Factor
Less than $2.5 mil.	None	None
$2.5 mil. - $10 mil.	.900	1.100
>$10 mil. - $30 mil.	.925	1.075
>$30 mil. - $50 mil.	.950	1.050
Over $50 mil.	.975	1.025

6. For policy years 1993 and 1994, the servicing carrier fee is subject to an overall minimum of 15% and an overall maximum of 35%.

7. The performance standards program has been devised to provide a swing on each of the four on-site audit aggregate rating categories: underwriting and audit, loss control performance standards, claim performance standards, and financial reporting. The total swing from performance standards would be +2% to -14%.

8. On or before December 31 of each year, the Commissioner shall indicate whether an on-site audit of all servicing carriers by a firm designated by the Bureau and approved by the Commissioner shall be undertaken the following year to measure each servicing carrier's performance during one or more completed calendar years. In making a determination on this matter, the Commissioner shall consider whether use of an outside firm for an annual audit would be economically feasible because of the size of the Pool or the segment of the Pool serviced by servicing carriers. The Bureau may order that carriers perform self-audits during any years that outside audits are not ordered by the Commissioner; provided, however, that no servicing carrier fee shall be affected by any self-audit or result or evaluation relating thereto. Each audit by a firm designated by the Bureau and approved by the Commissioner shall encompass the preceding three years, or all the years since the last such audit was conducted, whichever is the shorter period. However, in no event shall any audit encompass any year prior to calendar year 2001. All the servicing carrier fees for the entire period that is the subject of a one-year or multi-year outside evaluation shall be adjusted to reflect the score or scores given each carrier on such evaluations in accordance with this Plan.

9. The performance based servicing carrier fee in its entirety is effective as of 1/1/94. In calendar year 1994 the auditing process will be implemented. When the auditing process is completed for all servicing carriers, servicing carrier fees will be adjusted based on the results of the performance evaluations subject to items 1 and 2 above. Subsequent adjustments will be made based on the results of the Paid Loss Incentive Program. For policy year 1993 the servicing carrier fee is subject only to the Paid Loss Incentive Program and the overall balancing and capping constraints discussed above.

10. For the purpose of determining the service carrier fees under this program, percentages are of standard premium, i.e., not including ARAP surcharges or MARRP adjustments. Standard premium is defined and described in Appendix F – Massachusetts Residual Market Premium Algorithm of the Massachusetts Workers' Compensation and Employers Liability Insurance Manual.

Deleted: Section VI of the Massachusetts Workers' Compensation Unit Statistical Plan (see "Total Standard Premium")

EFFECT OF PERFORMANCE STANDARDS ON SERVICING CARRIER FEE

*Effect on Servicing Carrier Fee	Score on Audit of Underwriting and Audit Performance Standards
0.0%	90-120
-0.5%	85-89
-1.0%	80-84
-1.5%	75-79
-2.0%	70-74
-2.5%	65-69
-3.0%	60-64
-3.5%	45-59
-4.0%	30-44

Total weight of subcategories is 30.

*Effect on Servicing Carrier Fee	Score on Audit of Financial Reporting Performance Standards
0.0%	96-105
-0.5%	93-95
-1.0%	82-92
-1.5%	70-81
-2.0%	35-69

Total weight of subcategories is 35.

*Effect on Servicing Carrier Fee	Score on Audit of Claims Performance Standards
1.0%	102-108
0.5%	95-101
0.0%	81-94
-0.5%	77-80
-1.0%	73-76
-1.5%	69-72
-2.0%	66-68
-2.5%	62-65
-3.0%	58-61
-3.5%	54-57
-4.0%	45-53
-4.5%	36-44
-5.0%	27-35

Total weight of subcategories is 27.

*Effect on Servicing Carrier Fee	Score on Audit of Loss Control Performance Standards
1.0%	65-68
0.5%	60-64
0.0%	51-59
-0.5%	48-50
-1.0%	44-47
-1.5%	41-43
-2.0%	37-40
-2.5%	34-36
-3.0%	17-33

Total weight of subcategories is 17.

*Effects are as percentage of premium.