



**THE WORKERS' COMPENSATION
RATING AND INSPECTION BUREAU**

*Administrator
Massachusetts Assigned Risk Pool*

**MASSACHUSETTS WORKERS' COMPENSATION
ASSIGNED RISK POOL
PLAN OF OPERATION**

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**MASSACHUSETTS WORKERS' COMPENSATION
ASSIGNED RISK POOL**

PLAN OF OPERATION

ARTICLE I

NAME

Name. The reinsurance pool contemplated by G.L. c. 152, § 65C, as amended, shall be known as the Massachusetts Workers' Compensation Assigned Risk Pool (the "Pool").

ARTICLE II

DESIGNATION OF ADMINISTRATOR

Designation of Administrator. The Pool shall be administered, in accordance with G.L. c. 152, § 65A et seq., as amended, by The Workers' Compensation Rating and Inspection Bureau of Massachusetts (the "Bureau").

ARTICLE III

PURPOSE AND LIMITATIONS

1. Purpose. It is the purpose of the Pool to provide a mechanism for the equitable distribution among insurers of risks entitled to coverage under G.L. c. 152, § 65A, as amended, and to provide, in accordance with G.L. c. 152, § 65C, as amended, for the equitable allocation among all insurers authorized to write workers' compensation insurance in the Commonwealth of the losses incurred on policies issued to employers under § 65A.

Under delegation from the Commissioner of Insurance (the "Commissioner"), the Bureau shall make equitable assignments of risks entitled to coverage under G.L. c. 152, § 65A, as amended, including assignments to servicing carriers or voluntary direct assignment carriers. The Bureau shall each year submit to the Commissioner a report of the assigned risks for the preceding year.

The Bureau is authorized to enter into agreements on behalf of the members of the Pool to carry out the purposes of this Plan including but not limited to servicing carrier agreements. The Bureau is authorized to select servicing carriers under the terms set forth in Article VII of this Plan. The Bureau is empowered to act as attorney-in-fact for each member of the Pool, to enforce any rights of the members of the Pool, including without limitation, any rights against any other member of the Pool upon insolvency, to enforce the obligations of membership on behalf of all

members of the Pool, to prosecute, to defend, to submit to arbitration, to settle and to propose or to accept a compromise with respect to any claim existing in favor of, or against, such member based on or involving any matter relating to this Plan or to intervene in any action or proceeding related thereto.

2. Limitations. This Plan of Operation shall apply only to workers' compensation policies including any one or more of the following coverages provided under such policies:

- a. Statutory workers' compensation and occupational disease as provided in G.L. c. 152.
- b. Employers' Liability when written in combination with coverage as specified in (a) above.
- c. Such other coverages as the Bureau may file for approval by the Commissioner for inclusion in the standard Workers' Compensation and Employers' Liability Insurance Policy.

Nothing in this Plan of Operation shall affect the enforceability of any applicable bankruptcy, receivership, or other similar laws affecting the enforcement of creditors' rights in general.

If any article, section, paragraph, sentence, or clause of this Plan of Operation is held invalid by any court of competent jurisdiction, such decision shall not affect any of the remaining provisions of this Plan of Operation.

This Plan of Operation shall apply to policies issued to employers whose risks have been assigned to and accepted by members of the Pool in accordance herewith, and to become effective on or after 12:01 a.m. of the effective date.

ARTICLE IV

MEMBERSHIP

1. Membership. Every insurer, as defined in G.L. c. 152, § 1(7), and any insurance company, reciprocal or interinsurance exchange which has contracted with an employer to pay the compensation provided for by G.L. c. 152, that is authorized to write or to continue to write workers' compensation insurance in the Commonwealth shall be a member of the Pool.

2. Insolvency.

- (a) In the event any member company shall become insolvent, as hereinafter defined, membership of such company in the Pool shall be deemed terminated at the time such company becomes insolvent subject to the further provisions of subparagraph 2(g) hereunder. As used herein, "insolvent" means being the subject of receivership, conservatorship, rehabilitation, liquidation, or similar proceedings, whether voluntary or involuntary, in any jurisdiction.

- (b) Upon notice to the Bureau of the insolvency of a member company which is acting as a servicing carrier or as a voluntary direct assignment carrier, the Bureau shall reassign all risks previously assigned to the insolvent company to one or more servicing carriers or voluntary direct assignment carriers in accordance with the procedures set forth in this Plan.
- (c) In the event a servicing carrier becomes insolvent, the Bureau, acting on behalf of each of the members, shall have the option to:
 - (i) pay to The Massachusetts Insurers Insolvency Fund, or to the receiver, conservator, rehabilitator, liquidator or other appropriate representative all losses and expenses for which such insolvent company shall have become liable upon risks to which this Plan of Operation applies; or
 - (ii) subject to the approval of the receiver, conservator, rehabilitator, liquidator or other representative, and subject to the approval of any court having jurisdiction over the proceedings, terminate the obligation of the members of the Pool to such insolvent company to reinsure such insolvent company for losses and expenses for which the insolvent company shall have become liable upon risks to which this Plan of Operation applies. If this option is exercised, the Bureau shall make arrangements to reassign all risks being serviced by such insolvent member to a successor servicing carrier. Such successor servicing carrier shall assume all the duties and obligations of the insolvent carrier and shall accede to the reinsurance provided by the members of the Pool. Payment made on account of such risks, including expenses for the servicing thereof, shall be apportioned ratably among the remaining members of the Pool in accordance with the method provided for the apportioning of assessments.
- (d) The outstanding liability to the members of the Pool of any insolvent member, whether in its capacity as a servicing carrier, or as a member, except for the unexpended portion of any premium retained by a servicing carrier for servicing an assigned risk, shall, in the event of insolvency, be assumed by and apportioned among the remaining members of the Pool in the same manner as liability for assessments is apportioned under this Plan. The right of such insolvent member to participate in the Pool or the funds thereof, except as to any refund if the right to such refund shall have accrued before the date of insolvency, shall thereupon terminate. No refund shall be made to such insolvent company until all its liabilities to the members of the Pool and all liabilities assumed by members of the Pool by virtue of the provisions of this Plan shall have been fully settled and satisfied.

In the event a direct assignment carrier becomes insolvent, the Pool shall have no obligation to pay any losses and expenses for which such insolvent company shall have become liable upon risks to which the Plan of Operation applies except to the extent, if any, that the Massachusetts Insurers Insolvency Fund or any successor entity is not obligated to pay such losses and expenses under the provisions of G.L. c. 175D.

Massachusetts Assigned Risk Pool Plan of Operation

The Pool members shall have all the rights allowed by law against the estate or funds of insolvent carriers for recovery of funds disbursed (including the payment of losses and servicing expenses) on risks carried by insolvent members as herein provided. The Bureau may assert and enforce such rights on behalf of the members of the Pool.

The provisions of this section are subject to any other or further provisions with respect thereto which may be from time to time embodied in the rules and procedures adopted hereunder.

- (e) Any insolvent member company which fails or has failed to make timely payment of any assessment made under this Plan of Operation shall become liable to the members of the Pool, as of the earliest date on which such failure to pay occurs, for an additional amount equal to the commuted value on such date of all future assessments to be made against such member company. For the purposes hereof, such commuted value shall be the total amount of unearned premium reserves and loss reserves then allocated to such member company hereunder, as determined by the Bureau. The liability of the insolvent member company for such commuted value under this provision shall be deemed fixed, liquidated, and non-contingent as of the date of such failure to pay. The Bureau may assert and enforce such liability on behalf of the members of the Pool by taking actions which may include those set forth below in section 3. Member Obligations, including parts (a) - (d) of that section.
- (f) The Bureau shall have the discretion to terminate the membership of any or all affiliated companies of the insolvent company. No termination of an insolvent company or any or all companies described in this Section shall be deemed in abrogation of the membership requirement in Article IV, Section 1.
- (g) Anything in this Section to the contrary notwithstanding, the Bureau may, in the event such action is in its judgment feasible and desirable, and in a manner equitable to all members, elect not to terminate the membership of such insolvent company, and permit such company to continue to be a member of the Pool upon such conditions as it may prescribe and subject in all respects to this Plan of Operation and the rules and procedures hereunder as then constituted.
- (h) No member of any Committee of the Bureau representing an insolvent company or affiliate thereof may vote in any proceeding under this Section.
- (i) Nothing in this Section relating to the insolvency of a member company shall, without the express approval of the Bureau, increase the total liability of all members of the Pool (excluding the obligations of the insolvent member) to an amount greater than what the liability would have been if the insolvency had not occurred.

3. Member Obligations. Any or all member companies shall, at the discretion of the Bureau, be required to periodically provide, at intervals to be determined by the Bureau, information on the ability to pay return premiums, losses and expenses which may be assessed pursuant to Article XIII, Section 7 for all risks which are subject to this Plan of Operation. Member companies shall provide all further information necessary for the Bureau to ascertain a company's ability to pay its obligations to the Pool members, and for the Bureau to determine if there is any significant likelihood that the company's future reserves will be inadequate to meet future obligations. Member companies shall cooperate fully in assisting the Bureau in making these determinations, and shall cooperate fully in the conduct of any auditing procedure necessary to these determinations. Should the Bureau determine that a company's reserves are not adequate to meet its obligations to the Pool members, or that there is a significant likelihood that future reserves will be inadequate to meet future obligations, or should the Bureau determine that the member company has not cooperated to the extent necessary to make these determinations, the Bureau shall have the authority to ensure that the member company shall meet its obligations to the other members of the Pool by taking actions which may include, any or all of the following as set forth in (a) through (d) below. When a member company fails to make timely payment of its assessment or otherwise fails to honor its financial obligations to the Pool members, or if a member company is under the supervision of the insurance department or other regulatory authority of any jurisdiction, or when the insurance department or other regulatory authority of any jurisdiction represents, in writing, that a member company is unable to meet its financial obligations, or when a member company is in run-off, the Bureau shall have the authority to protect the other members of the Pool by ensuring that the member company can meet its obligations to the Pool on a timely basis by taking actions which may include any or all of the following:

- (a) Ordering that all or a portion of premium distributions or refunds due the member company be paid into escrow or trust with the Bureau to secure or pay any of the member's current or future obligations and liabilities.
- (b) Ordering that all or a portion of premium distributions or refunds due the member company be paid in trust with a third party to secure or pay any of the member's current or future obligations and liabilities.
- (c) Upon approval by the Commissioner, ordering that the member company obtain a letter of credit approved by the Bureau to secure or pay any of the company's current or future obligations and liabilities.
- (d) Upon approval by the Commissioner, ordering that all, or a portion of, premium distributions or refunds which have been distributed to the member company be placed into escrow or trust for the benefit of the Pool, with the Bureau, or with a third party designated by the Bureau, to secure or pay any of the company's current or future obligations and liabilities.

Compliance with any such order within the time specified therein shall be an obligation of membership.

ARTICLE V

MEETINGS AND VOTING RIGHTS

1. Regular Meetings. An annual meeting of the Pool membership shall be held in the City of Boston, Massachusetts, on such date and at such time and place as may be specified in the notice of meeting.

In case the annual meeting for any year shall not be duly called or held, the Residual Market Committee shall cause a special meeting to be held as soon as may be practicable thereafter, in lieu of and for the purpose of such annual meeting, and all proceedings at such special meeting shall have the same force and effect as if taken at the regular annual meeting.

2. Special Meetings. Special meetings of the Pool membership may be called at any time by the President of the Bureau, and shall be held in the City of Boston, Massachusetts, at such time and place as may be specified in the notice of meeting. Special meetings shall be called by the President of the Bureau upon the written request of a majority of the Residual Market Committee, or of five members of the Pool.

3. Notice of Meetings. At least ten days' written notice of all meetings of the Pool membership shall be given and in each case an agenda of matters to be considered shall accompany the notice of meeting. Only those matters which are noted in the agenda shall be considered at such meetings, provided, however, that other matters may be considered upon unanimous consent of the members present.

4. Quorum. At an annual or special meeting of the Pool membership, members writing not less than 51% of the total net workers' compensation insurance premiums written by all members of the Pool during the latest calendar year for which information is available, shall constitute a quorum.

5. Voting Rights. In any meeting of the Pool membership, each member of the Pool shall be entitled to one vote.

At any meeting of the Pool membership, proposed actions shall be deemed adopted when an affirmative vote has been cast by members writing not less than 51% of the total net workers' compensation insurance premiums written by all members of the Pool during the latest calendar year for which information is available. Action may also be taken, without a meeting, by mail or telephone upon affirmative vote of members writing not less than 51% of the total net workers' compensation insurance premiums written by all members during the latest calendar year for which information is available, provided all members of the Pool are polled. In the event of a tie vote, the motion fails adoption.

6. Proxies. Members may be represented at any meeting by proxy. Members may record their votes by mail on written propositions, and such votes shall have the same standing as if cast by such members in person or by proxy.

7. Records of Meetings. Records of all meetings of the Pool shall be provided to members of the Pool and to the Commissioner.

ARTICLE VI

RESIDUAL MARKET COMMITTEE

1. Appointment and Composition. At each annual meeting of the Bureau, the members of the Governing Committee shall appoint the members of the Residual Market Committee who shall serve until the next annual meeting. The Committee shall be composed of not more than ten (10) members. The President of the Bureau shall be a member ex officio of the Committee, but shall not have the right to vote. The Committee shall have a mixture of eight (8) Pool and two (2) non-Pool members. One non-Pool member shall represent policyholders' interests and the other shall represent producers' interests. No more than six (6) of the eight (8) Pool members shall be servicing carriers. Pool memberships shall be in the name of the member company, which shall designate knowledgeable representatives of suitable senior standing. Each company member of the Committee shall select two (2) alternates of similar standing.

2. Powers. The Residual Market Committee shall monitor and administer the Pool, unless the Governing Committee of the Bureau otherwise directs.

3. Organization and Procedure. The Committee shall be presided over by a Chairperson, who shall have the right to vote, chosen by it from among its members by an election at its first meeting following the annual meeting of the Bureau. A Vice Chairperson shall be elected in the same manner and shall preside in the absence of the Chairperson.

4. Meetings; Time, Place and Notice. Meetings shall be held at such times and places as the Committee may from time to time determine, and may be called at any time by the President of the Bureau, and shall be so called by the President upon the written request of any two members of the Committee. At least ten days' written notice of all meetings of the Residual Market Committee shall be given and in each case an agenda of matters to be considered shall accompany the notice of meeting. Only those matters which are noted in the agenda shall be considered at such meetings, provided, however, that other matters may be considered upon unanimous consent of the members present.

5. Quorum and Voting Rights. A majority of the members of the Committee shall constitute a quorum. An affirmative vote of a majority of the members present and voting shall be necessary for the adoption of any proposed action, subject to the requirement that there be at least one affirmative vote of a stock carrier and one affirmative vote of a non-stock carrier. A mail vote or a telephone vote may be taken and such vote shall be binding unless the dissenting voter(s) requests a meeting at the time of such vote. Voting by proxy shall be permitted.

6. Conditions. The Committee may fix the conditions upon which assigned risks are afforded coverage and upon which claims shall be handled by servicing carriers. All risks serviced by servicing carriers shall be insured and all claims shall be handled by such carriers in accordance with such conditions.

7. Disputes and Appeals. In addition to the powers elsewhere conferred upon it by this Plan of Operation, the Residual Market Committee may sit as an "Appeals Committee" or may designate a subcommittee of at least three but not more than five members, to act as an Appeals Committee to pass upon all disputes arising with respect to this Plan of Operation, or rules promulgated thereunder, including without limitation, any questions as to the application, scope and effect of this Plan of Operation. Any subcommittee designated to act as an Appeals Committee shall include the appointment of a public member and, at the least, one stock and one non-stock carrier member of the Residual Market Committee. A ruling of a majority of the Appeals Committee shall be final, unless within thirty (30) calendar days after the mailing of notice of the Committee's ruling, the aggrieved party shall have appealed the ruling in writing to the Commissioner. The aggrieved party shall send a copy of such appeal to the Committee. The action of the Commissioner upon such ruling shall be final.

8. Servicing Carriers. The Committee shall establish qualifications and other conditions for designating servicing carriers.

9. Audit and Inspections. The Bureau shall have the right, through its representatives, at all reasonable times during the business day, to audit and inspect the books and records of any voluntary direct assignment carrier or servicing carrier with respect to any policy or policies and claims thereunder coming within the purview of this Plan of Operation.

10. Rules of Operation. The Committee shall have the power, subject to the approval of the Commissioner, to promulgate and adopt Rules of Operation for the purpose of implementing this Plan. Such Rules may be made at the direction of the Commissioner, upon reasonable notice to the Bureau and after a hearing.

11. Records of Meetings. Records of all meetings of the Residual Market Committee shall be provided to its members and to the Commissioner.

ARTICLE VII

SERVICING CARRIERS

1. Servicing Carriers. One or more insurers may become servicing carriers through designation by the Bureau, subject to approval of the Commissioner or through selection by the Bureau pursuant to a competitive bid process. Nothing in this Plan of Operation or any contract between the Bureau and a servicing carrier shall affect the Commissioner's authority under G.L. c. 152, §65A to require one or more insurers to be servicing carriers issuing policies of insurance to employers qualified under section 65A.

12. Designation. The Bureau may recommend the designation of one or more insurers as servicing carriers to issue policies of insurance to employers qualified for coverage under G.L. c. 152, § 65A, as amended, subject to the approval of the Commissioner. The servicing carrier shall continue as a servicing carrier for subsequent years, unless it gives the Commissioner ninety days advance written notice of its intention to resign as a servicing carrier, or unless such designation is rescinded by the Commissioner. The designation may also be rescinded for cause by the Bureau, subject to the approval of the Commissioner. The Bureau may rescind a designated servicing carrier's authority to issue new or renewal policies if the Bureau gives at least sixty days advance written notice to each designated carrier following its selection of any servicing carrier pursuant to a competitive bid process.

3. Selection. Pursuant to a competitive bid process, the Bureau may select one or more insurers as servicing carriers to issue policies of insurance to employers qualified for coverage under G.L. c. 152 § 65A, as amended. Each servicing carrier shall continue as a servicing carrier for subsequent years in accordance with the terms of its written servicing carrier contract with the Bureau, unless such selection is rescinded by the Bureau or the Commissioner for cause.

4. Servicing Carrier Competitive Bid Selection Process. No Request for Proposal (RFP) shall be issued by the Bureau without the Commissioner's prior approval of its contents. Any RFP submitted by the Bureau for the Commissioner's approval shall not be subject to a public hearing. Any RFP that is submitted to the Commissioner by the Bureau for her approval may be withdrawn by the Bureau at any time. Any RFP that is approved by the Commissioner or is issued by the Bureau may be withdrawn by the Bureau at any time. The issuance of any RFP shall not commit or require the Bureau to award any servicing carrier contracts.

5. Criteria for Selection. No member of the Pool may be a servicing carrier, unless such member:

- (a) has been writing workers' compensation insurance in the Commonwealth of Massachusetts during at least the five (5) years immediately preceding the request to be designated a servicing carrier;
- (b) has and maintains a record of financial stability and strength;
- (c) has and maintains, at a minimum, a workers compensation voluntary market share of 1% in the Commonwealth of Massachusetts; and
- (d) has and maintains the capacity to conform to such standards of performance ("Standards") as are from time to time promulgated in this Plan of Operation.

A servicing carrier's failure to maintain eligibility shall be considered cause for rescinding its designation or selection as a servicing carrier.

6. Performance-Based Programs. The Performance-Based Programs that shall apply to any designated servicing carrier are set forth in the Appendix to this Plan. The Performance-Based Programs that shall apply to any servicing carrier selected pursuant to Article VII, Section 3 shall be set forth in the modified Appendix attached to any RFP, and shall be at least as demanding as the programs set forth in the Appendix to this Plan. The Servicing Carrier contract between the Bureau and the selected servicing carrier shall contain any enhancements to the Performance-Based Programs in the modified Appendix.

7. Compensation. Servicing carriers designated pursuant to Article VII, Section 2 shall be compensated in the manner approved by the Commissioner and described in the Appendix. Servicing carriers selected pursuant to Article VII, Section 3 shall be compensated as set forth in the servicing carrier contract between the Bureau and the selected servicing carrier.

ARTICLE VIII

VOLUNTARY DIRECT ASSIGNMENT CARRIERS

1. Designation. Any Pool member may apply to the Commissioner of Insurance for designation as a voluntary direct assignment carrier based upon selection criteria approved by the Commissioner. The Commissioner may rescind this designation for cause.

2. The performance standards applicable to servicing carriers as set forth in Article VII, Section 3, shall also apply to voluntary direct assignment carriers.

ARTICLE IX

FISCAL MATTERS

1. Fiscal Year. The fiscal year for the purpose of administering this Plan shall be the calendar year unless otherwise established by the Residual Market Committee.

2. Deposits. Funds held temporarily by the Bureau for the benefit of members of the Pool, may be kept on deposit in such banks, trust companies or other depositories as may from time to time be designated and prescribed by the Residual Market Committee; and such designation shall be evidenced by an instrument signed by the Chairperson or the Vice-Chairperson of the Residual Market Committee, and countersigned by the President of the Bureau or the Treasurer. Accurate records shall be kept to identify the funds so deposited.

3. Withdrawals. Any two (2) officers of the Bureau duly authorized by the Residual Market Committee shall have power to sign and countersign all checks, drafts or other orders for payment of money and to cause the endorsement of all commercial paper payable under this Plan.

4. Special Accounts. Funds temporarily held for the benefit of members also may be kept on deposit with any authorized depository, but in a special account designated as such, subject to withdrawal upon check signed by any two (2) of the officers of the Bureau duly authorized by the Residual Market Committee if authorized by, and subject to, the terms and conditions contained in a written instrument signed by any two (2) of the officers of the Bureau authorized by the Residual Market Committee. Accurate records shall be kept to identify the funds so deposited.

5. Safe Deposit. Access may be had to any safe deposit box, hired vault, or like place of safekeeping, standing in the name of the Pool, by any two (2) officers of the Bureau, duly authorized by the Residual Market Committee.

6. Investment Income. All income on the funds held for the benefit of members of the Pool shall, upon receipt thereof, become subject to all the appropriate provisions of this Plan.

ARTICLE X

INDEMNIFICATION

Indemnification. Any person or insurer made, or threatened to be made, a party to any action, suit or proceeding (except an action to collect amounts billed by the Pool), because such person or insurer was a member of the Pool, or a servicing carrier, or served as a member or representative of a member on the Residual Market Committee or other Bureau committee, or was an officer or employee of the Bureau acting on behalf of the Pool, shall be indemnified against all judgments, fines, amounts paid in settlement, reasonable costs and expenses including attorney's fees, and any other liabilities that may be incurred as a result of such action, suit or proceeding, or threatened action, suit or proceeding, except in relation to matters as to which he, she or it shall be adjudged in such action, suit or proceeding to be liable by reason of willful misconduct in the performance of his, her or its duties or obligations to the Pool and, with respect to any criminal actions or proceedings, except when such person or insurer had reasonable cause to believe that his, her or its conduct was lawful. Such indemnification shall be provided whether or not such person or insurer is a member of the Pool, or a servicing carrier, or is holding office, or is employed at the time of such action, suit or proceeding, and whether or not any such liability is incurred prior to the adoption of this Article. Such indemnification shall not be exclusive of other rights such person or insurer may have, and shall pass to the successors, heirs, executors or administrators of such person or insurer. The termination of any such civil or criminal action, suit or proceeding by judgment, settlement, conviction or upon a plea of nolo contendere, or its equivalent, shall not in itself create a presumption that any such person or insurer was liable by reason of willful misconduct, or that he, she or it had reasonable cause to believe that his, her or its conduct was unlawful. If any such action, suit or proceeding is compromised, it must be with the approval of the Residual Market Committee; provided, however, that the Residual Market Committee may delegate to the President

of the Bureau the authority to approve any such compromise of financial liability requiring payment by the Pool which is less than an amount as may be fixed from time to time by the Residual Market Committee.

In each instance in which a question of indemnification arises, entitlement thereto, pursuant to the conditions set forth in this Article, shall be determined by the Residual Market Committee, which shall also determine the time and manner of payment of such indemnification; provided, however, that a person or insurer who or which has been wholly successful, on the merits or otherwise, in the defense of a civil or criminal action, suit or proceeding of the character described in this Article shall be entitled to indemnification as authorized herein. The Residual Market Committee may delegate to the President of the Bureau the authority to determine, in a manner consistent with this Article, entitlement to indemnification, and the time and manner of payment of such indemnification, for any indemnification requiring payment by the Pool which is less than an amount as may be fixed from time to time by the Residual Market Committee. Nothing herein shall be deemed to bind a person or insurer who or which the Residual Market Committee has determined not to be entitled to indemnification, or to preclude such person or insurer from asserting the right to such indemnification by legal proceedings. Such indemnification as is herein provided shall be apportioned among all members, including any named in any such action, suit or proceeding pursuant to this Plan of Operation.

ARTICLE XI

AMENDMENTS

Amendments. Amendments to this Plan of Operation may be made by the Bureau or may be made at the direction of the Commissioner upon reasonable notice to the Bureau and after a hearing, pursuant to G.L. c. 152, § 65C. All amendments to the Plan of Operation proposed by the Bureau shall be submitted to the Commissioner for approval and shall be effective as of the date indicated in the Commissioner's approval.

ARTICLE XII

EFFECTIVE DATE

Effective Date. This Plan of Operation, as amended, shall become effective on July 1, 2000, or at such later time as it has been approved by either the Residual Market Committee or the Governing Committee of the Bureau, and the Commissioner of Insurance.

ARTICLE XIII

ASSIGNMENTS, ASSESSMENTS AND EXPENSES

1. Application. This Plan shall apply to all risks that are insured or seek to be insured through the Massachusetts Workers' Compensation Assigned Risk Pool. An application for workers' compensation insurance to be written through the Pool must be submitted to the Bureau on a form and in the manner prescribed by the Residual Market Committee.

2.a. Assignment of Risks. The Bureau shall review the information contained in an application for assignment and determine whether the applicant is eligible for assignment under G.L. c. 152, § 65A.

If the Bureau determines that an applicant is eligible for assignment, the Bureau shall assign the applicant to a servicing carrier or voluntary direct assignment carrier. The Bureau will equitably assign applicants to each voluntary direct assignment carrier based on each such carrier's percentage of the total net workers' compensation insurance premiums written, as adjusted by any applicable take-out credit, for all carriers in that policy year. Applicants not assigned to a voluntary direct assignment carrier will be assigned to each servicing carrier based either on the terms of its servicing carrier contract with the Bureau or based on each designated servicing carrier's percentage of the total net workers' compensation insurance written premiums for all servicing carriers in the most recent policy year for which data is available. A reconciliation procedure for voluntary direct assignment carriers shall be established in accordance with such rules and procedures as the Residual Market Committee may adopt, subject to the approval of the Commissioner. Assignments may also be made in accordance with other specific rules and procedures as the Residual Market Committee may adopt, subject to the approval of the Commissioner pursuant to G.L. c. 152, § 65A. The Bureau shall, upon the request of any servicing carrier or voluntary direct assignment carrier, provide such servicing carrier, or voluntary direct assignment carrier with a copy of the records used as the basis for assigning eligible applicants.

2.b. Confidentiality of Assigned Risk Information. The designated carrier shall keep in confidence and shall not, except as directed by the insured or the producer of record or as otherwise may be required by law or regulatory authority, disclose to any third party, such detailed information as it may obtain by virtue of its position as the designated carrier.

3. Premiums. With the exception of voluntary direct assignment carriers, the Bureau shall distribute the premiums received from Servicing Carriers to the members of the Pool in proportion to their workers' compensation insurance premiums written in the state on a calendar year basis, or as otherwise determined by the Residual Market Committee. The premiums distributed are subject to each member's obligations to the Pool as set forth in this Plan of Operation.

4. Expenses and Payments. The amount of net workers' compensation insurance premiums written and used as the basis of all computations in this Section, or elsewhere in this Plan of Operation, shall also be used as the basis for allocating each member's share of expenses which are

not allocable directly to any assigned risk and which are incurred by the Bureau in the administration of the Pool. A record shall be kept of all such expenses, and the amount thereof may be recovered from members who satisfy their obligations under the Plan by participating in the reinsurance pool, by a charge against funds held by the Bureau on behalf of such members, or, in the discretion of the Bureau and when deemed necessary, by an assessment levied under Section 7 of this Article. Voluntary direct assignment carriers shall be separately billed for their portion of such administrative expenses. In addition, voluntary direct assignment carriers shall be separately billed for expenses associated with inspection and audit and such other expenses of oversight as may be appropriate, which are directly allocable to risks assigned to such carriers. Except with respect to claims, the cost of the interpretation of physical and X-ray examinations of employees in assigned dust hazard risks, shall be a proper charge against, and shall be paid from, the general funds held on behalf of the members of the Pool provided the employer pays for the making of such examinations. Except as the Residual Market Committee shall otherwise direct, payments to or on behalf of members shall be limited to administration expenses, reimbursement for losses paid under policies to which these Articles apply, and for return premiums on such policies, and the payment of such refunds as may be allowed under this Plan of Operation. Except for costs of premium collection as established by the Bureau or any third party designated by the Bureau, the Pool shall not assume for payment, and shall not be liable to pay, any expenses of any nature whatsoever incurred by members.

5. Examinations and Reserves. The Residual Market Committee shall make or cause to be made such review as they may deem necessary of loss payments by members and reserves held by members for outstanding claims, which reserves, until the Committee shall have determined upon a different reserve, shall be the estimated value of the claims reported by the servicing carrier under the applicable servicing carrier agreement.

6. Transactions, Accounts and Financial Statements. Separate accounts shall be maintained by the Bureau covering transactions for each policy year. The Bureau shall prepare and deliver to the members a financial statement showing the apportionment of the expense of administration provided for herein and the condition of each account.

7. Assessments and Refunds. Assessments shall be levied or refunds allowed by the Bureau as it may from time to time deem reasonable and necessary. Assessments or refunds for account of a specified policy year shall be levied upon or allowed to all members who were such during the calendar year corresponding to such policy year, and each member shall pay such proportion of such assessment, and shall receive a proportionate share of such refund, as is determined by the relation which the net workers' compensation insurance premiums written during such calendar year by such member shall bear to the total net workers' compensation insurance premiums written during such calendar year by all members. A member may satisfy its obligation under this section by becoming a voluntary direct assignment carrier, and by satisfactorily discharging its responsibilities as a voluntary direct assignment carrier in accordance with this Plan and the rules governing the Voluntary Direct Assignment Program.

The amount of net workers' compensation insurance premiums written, which shall serve as the basis of all computations in this Section or elsewhere in this Plan of Operation and in any applicable servicing carrier agreement, shall be that shown by the records of the Bureau. If the amount of net workers' compensation insurance premiums written for a specified calendar year is not available at the time of the levying of any assessment or the distribution of any refund, net workers' compensation insurance premiums written for the preceding calendar year shall be used as the basis for a preliminary assessment or refund, but such preliminary assessment or refund shall be adjusted as soon as the net workers' compensation insurance premiums written for the specified calendar year become available. For the purposes of this section, the net written workers' compensation insurance premiums associated with large deductible policies which are written or renewed on or after January 1, 1994, or are in effect on or after January 1, 1995, shall be deemed to be the amount equal to the standard premium plus any applicable All Risk Adjustments Program amounts associated with such policies.

Unless otherwise approved by the Commissioner or the Bureau, as Administrator of the Pool, the amount of any assessment levied shall be paid by the due date indicated on the quarterly invoice, or other statement, and the amount of any refund allowed shall be distributed within such reasonable time as may be determined by the Residual Market Committee, following the submission of the quarterly invoice, or other statement referred to herein.

If a member fails to pay its assessment by the due date indicated on the quarterly invoice, or other statement, the member shall pay a late payment fee of 1½ percent of the amount due for each 30-day period of delay or portion thereof. If a member has not paid its assessment, the Bureau, or any third party designated by the Bureau, will send a written notice of default to the member. Any balance owed to the Pool must be paid on or before the fifteenth calendar day following the date of mailing of the written notice of default. If such balance remains unpaid as of the fifteenth calendar day following the date of mailing of the written notice of default, the member shall compensate the Pool for all damages and expenses incurred by the Bureau, as Administrator of the Pool, or any third party designated by the Bureau as a result of its failure to pay any balance owed to the Pool under this Plan of Operation. Damages and expenses as used herein shall include but not be limited to the reasonable attorney's fees incurred by the Bureau, as Administrator of the Pool, or any third party designated by the Bureau directly or indirectly with the collection of the balance due, the cost of all Bureau staff time or staff time of any third party designated by the Bureau spent in connection with staff efforts to collect the balance outstanding, all financial losses resulting from nonpayment, and all other expenses and losses relating thereto.

In accordance with G.L. c.152 § 65G, any member shall be entitled to appeal to the Commissioner of Insurance any assessment, late payment fees, damages or expenses which were levied in accordance with this Plan of Operation. However, before commencing an appeal under § 65G or any other appeal arising out of a dispute regarding the Plan of Operation, the member shall pay all undisputed outstanding assessments and all other undisputed amounts owed to the Pool but not disputed late payment fees, damages, expenses or attorney fees that the Bureau has previously levied, and shall remain current on all amounts owed to the Pool while any appeal is pending. If the Commissioner of Insurance rules in favor of the member, a proper adjustment,

including interest at the prime rate and any damages and expenses assessed, will be made by the Pool to the member's account.

In order to protect the other members of the Pool, the Bureau shall have the authority to ensure that a member company pays all amounts owed to the Pool by taking actions which may include, any or all of those set forth in Article IV, 3. Member Obligations including parts (a) - (d) of that section.

Compliance with any order under Article IV, 3. Member Obligations (a) - (d) within the time specified therein shall be an obligation of membership.

The Bureau shall, upon request of a member, provide such member with a copy of the records used as the basis of calculating the member's assessment or refund within 10 business days of its receipt of the member's written request. Such a request for records, or any matters regarding the request for records, shall not suspend or abrogate the member company's obligation to pay and remain current on all amounts billed by the Pool.

Any member that wrote Massachusetts workers' compensation insurance in the voluntary market in 1990, but that was not assessed or allowed a refund for account of policy year 1990 in connection with any deficit or surplus resulting from the operation of the workers' compensation insurance assigned risk pool in Massachusetts, may apply to the Commissioner to be certified for lump sum payments of pool liabilities for account of policy years 1991, 1992 and 1993. The lump sum payment shall equal the product of the eligible member's pool participation ratio and the present value at the time of the lump sum payment of the residual market results, for each respective policy year.

The Commissioner shall determine the present value of the residual market deficit for policy year 1991 in 1/1/94 dollars based on a discounted cash flow analysis with appropriate inputs selected by the Commissioner.

The Commissioner, if he or she deems it appropriate and necessary, shall determine the present value of the residual market results for policy years 1992 and 1993 in 1/1/95 dollars and 1/1/96 dollars, respectively. These determinations shall be made prior to 1/1/95 and 1/1/96 for each respective policy year. Certified members shall be eligible for lump sum payments for policy years 1992 and 1993, unless the Commissioner deems it inappropriate or unnecessary to determine the above mentioned residual market results.

These lump sum payments for policy year 1991 shall be paid to the pool by February 1, 1994 or an eligible member may elect to make payments on an installment plan whose term will end not later than December 31, 1995 and at an annual interest rate of 5% or at such other rate as the Commissioner may determine. These payments shall be used to pay pool liabilities for policy year 1991. Eligible members that elect to make a lump sum payment for policy year 1991 shall have their otherwise determined participation ratios set equal to zero for that policy year. Members that do not make these lump sum payments shall have their participation ratios increased in proportion to their otherwise determined participation ratio so that the sum of all members' participation ratios

equals unity. Lump sum payments for policy years 1992 and 1993 shall be implemented in an analogous manner as described above.

In order to be certified for lump sum payments for policy years 1991, 1992 and 1993, the following requirements must be met:

- (a) By January 20, 1994, the member must file with the Division of Insurance documentation demonstrating to the satisfaction of the Commissioner that its failure to be certified for lump sum payments would threaten its technical solvency pursuant to statutory accounting principles. At such time the member shall indicate whether it will, if certified, elect the lump sum payment option for policy year 1991 or whether such filing is solely for financial reporting requirements as set forth below. Within thirty days of any determination by the Commissioner of the present value of the residual market results for policy year 1992 or policy year 1993, the member shall indicate whether it is electing the lump sum payment option.
- (b) Prior to issuance of an order of certification the Commissioner shall require such member to demonstrate that it can meet its obligations under the lump sum payment plan set forth herein as well as obligations for pool liabilities and voluntary writings for policy years 1994 and beyond. In order to so demonstrate, such member must submit a satisfactory business plan describing the changes that would be made in the business and operations of the member in order to meet such obligations. The Commissioner may require such alterations to said plan as he or she deems necessary and may require that an independent actuarial review be performed at the member's expense.

Members who are certified and elect to make a lump sum payment for their pool liabilities for policy year 1991 shall reflect these liabilities in all required statutory filings (including Quarterly and Annual Statements) with the Division of Insurance beginning with their 1993 Annual Statement. Members who are certified and do not elect to make a lump sum payment for their pool liabilities for policy year 1991 shall reflect their pool liabilities for policy year 1991 as if they had elected to make the lump sum payment as described above in all statutory filings made in 1994 (including the 1993 Annual Statement). In addition, for all such statutory filings made in 1994 (including the 1993 Annual Statement) certified members shall not reflect any results of pool operations for policy years 1992 and 1993. For all statutory filings made after 1994, the Commissioner shall determine the manner in which certified members shall reflect their pool liabilities for policy years 1991, 1992 and 1993.

Any funds in escrow accounts established for an eligible member for those policy years where a lump sum payment will be made shall be returned to the pool.

For policy years 1994 and beyond, all pool members may apply to the Commissioner to be certified for lump sum settlement in a manner analogous to that set forth above.

8. Netting Out. Notwithstanding any contrary provisions in this Plan, and notwithstanding any contrary forms of accounting methods or reports that may for convenience be used to determine the underlying amounts of particular member or servicing carrier rights or obligations for any or all policy years, in computing at any given time the balance due to any member from the Pool or to the Pool from any member, whether or not a servicing carrier, all accounts for that member shall be netted out, with only the net amount to be due either the member company or the Pool at that time.

9. Distribution Upon Termination of the Pool. Upon termination of the Pool, distribution by way of refund (if any) shall be made to the members of the Pool entitled to participate therein, subject to provisions of Section 2 (g) of Article IV of this Plan of Operation, within such reasonable period of time as the Residual Market Committee in its sound discretion shall determine; and all provisions of this Plan of Operation and the Rules of Operation adopted hereunder relative to administration of the Pool shall remain in full force and effect until final distribution shall have been made.

ARTICLE XIV

OBLIGATION OF MEMBERS AFTER TERMINATION OF MEMBERSHIP

Obligation of Members after Termination of Membership. Any company whose membership in the Pool has been terminated by withdrawal or by expulsion shall, nevertheless, with respect to risks subject to the Plan of Operation prior to midnight of the effective date of such termination, continue to be governed by this Plan of Operation and Rules of Operation promulgated hereunder.

ARTICLE XV

DEFINITIONS

1. The term "net workers' compensation insurance premiums written," wherever used in this Plan of Operation, shall mean the gross direct premiums charged, less all premiums (except dividends and savings refunded under participating policies) returned to policyholders for all Workers' Compensation and Occupational Disease Insurance, exclusive of premiums for risks subject to this Plan of Operation, and for risks written under Special National Defense Comprehensive Rating or Special National Defense Premium Discount Plans and under excess policies; provided, however, that in the case of risks written or renewed on large deductible policies on or after January 1, 1994, or in effect on or after January 1, 1995, the net workers' compensation insurance premiums written shall be deemed to be an amount equal to standard premium plus any applicable All Risk Adjustments Program amounts. The term "net workers' compensation insurance premiums written" shall also include all premium received by non-admitted carriers on policies issued by such carriers for coverage in the state if such policies are deemed to meet employer obligations under the workers' compensation statute of the state.

2. The term "servicing carrier" wherever used in this Plan of Operation shall include any member company servicing coverage written by such member and subject to this Plan of Operation.
3. The term "voluntary direct assignment carrier" shall mean an insurer that has elected to receive direct assignments, in lieu of participating in the Pool, and that has obtained prior approval from the Commissioner of Insurance authorizing such form of participation. Subject to the approval of the Commissioner, an insurer can be both a servicing carrier and a voluntary direct assignment carrier.
4. The term "run-off" wherever used in this Plan of Operation shall refer to a state of affairs in which a member company is not writing any new or renewal business but: 1) continues to pay its outstanding claims; 2) has transferred its Pool obligations/losses to a related entity; or 3) has transferred its Pool obligations/losses to an unrelated entity.
5. The term "group" or "company group" wherever used in this Plan of Operation shall refer to companies controlling, controlled by, or under common control with other companies.
6. Standard premium is defined and described in Section VI of the Massachusetts Workers' Compensation Unit Statistical Plan (see "Total Standard Premium"). For the purpose of determining the servicing carrier fees as provided in the Appendix, percentages are of standard premium, i.e., not including ARAP surcharges or MARRP adjustments.

**APPENDIX TO THE
MASSACHUSETTS ASSIGNED RISK POOL
PLAN OF OPERATION**

**MASSACHUSETTS WORKERS' COMPENSATION
ASSIGNED RISK POOL
PAID LOSS RATIO INCENTIVE PROGRAM**

The following incentive program for servicing carriers in Massachusetts has been developed based on paid loss ratio relativities. For each servicing carrier, paid loss ratio relativities will be calculated by policy year for Massachusetts assigned risks by dividing the servicing carriers' paid loss ratio (to written minus uncollectible premium) by the average paid loss ratio for all servicing carriers in the Massachusetts Pool.

Program Applicability

A servicing carrier with premium less than \$2.5 million in the Massachusetts Pool is not subject to any incentive or disincentive in this Commonwealth. This is meant to reduce the administration cost in dealing with a relatively small servicing carrier.

This program will be effective beginning with policy year 1993. In other words, the first year of paid loss ratios evaluated will be policy year 1993.

Calculation of Incentives and Disincentives

There is an aggregate limit on incentives/disincentives of 9% of premium subject to the program. The formulas for calculating the incentives and disincentives are in Exhibit 1.

Annual Evaluation of Paid Loss Ratios

Each policy year will have five annual evaluations. The first evaluation will be at the completion of the policy year (policy year 1993 at 12/31/94, etc.). The final evaluation for policy year 1993 will be based on experience reported as of 12/31/98.

Incentives/disincentives will be calculated on an annual basis in accordance with the page entitled "Determining the Servicing Carrier Fee." To avoid the back and forth transfer of funds and to consider the fact that more immature data is less reliable, not all of the calculated incentive/disincentive will be dispensed/billed for preliminary adjustments. The portion of the incentive/disincentive dispensed will depend upon the evaluation number. See the chart below as an example for policy year 1993.

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Evaluation Number	Date	Portion of Incentive/Disincentive Dispensed
1	December 31, 1994	20%
2	December 31, 1995	40%
3	December 31, 1996	60%
4	December 31, 1997	80%
5 (Final)	December 31, 1998	100%

Each evaluation for a policy year considers losses paid since the beginning of the policy year. Because of this, the incentive/disincentive calculated on a subsequent evaluation will net out any payments made or received from earlier evaluations.

Experience Used

The experience data referred to is the assigned risk portion of business for servicing carriers. The data used for calculating incentives will be servicing carrier paid losses, written premium, and uncollectible premium as reported quarterly.

Loss ratios will be calculated to written premium minus uncollectible premium. However, to the extent that Massachusetts Pool rules for a given policy year allow appeals, any uncollectible premium which the servicing carrier appeals to obtain servicing carrier allowance and wins, will be included.

Medical Cost Containment Expenses/Allocated Loss Adjustment Expense

To the extent Massachusetts pool rules for a given policy year provide for reimbursements of servicing carriers for medical cost containment, allocated loss adjustment expenses, etc., reimbursed expenses will be added to paid losses to calculate the relativities. Since such expenses should serve to lower losses, the addition of any such reimbursed expenses should not adversely impact a servicing carrier. The average pool paid loss ratios would also be adjusted to include any such reimbursed expenses. The purpose of including reimbursed expenses would be to discourage servicing carriers from requesting reimbursement of costs which are not effective in reducing losses. The statewide average servicing carrier fee will be adjusted to the extent that any reimbursements are made for such expenses. [See items 1 and 2 on the page entitled "Determining the Servicing Carrier Fee."]

Capping of Losses

In order to limit the impact of very large losses, paid losses will be capped at \$250,000 per claim/\$500,000 per occurrence. Losses will be capped at \$100,000 per claim/\$200,000 per occurrence for preliminary adjustments at the first and second evaluations.

For several reasons, the limit on large losses used in the calculation is lower for earlier evaluations of a policy year. Very large losses are not considered in earlier evaluations to avoid discouraging servicing carriers from making lump sum payments. Additionally, a very large paid loss could have a bigger impact on a servicing carrier's paid loss ratio when the policy year is immature.

Since cumulative paid loss amounts are not reported by claim, this would require servicing carriers to report losses which should be capped. The loss cap was selected large enough so that the administrative burden of reporting individual large paid loss amounts is not burdensome.

Carriers

This program will be applied on a group basis. The definition of a group is to be found in the Pool Plan of Operation.

Formula for Calculating Incentives and Disincentives

Definition of Variables

MR	=	Maximum Relativity Factor
mR	=	Minimum Relativity Factor
P	=	Carrier written premium minus uncollected premium
SLR	=	State average paid plus case loss ratio
Carrier Rel	=	Carrier paid loss relativity
	=	Carrier paid loss ratio/ state average paid loss ratio

Disincentive

$$\begin{aligned} \text{If } MR < \text{Carrier Rel,} \\ &= P \times SLR \times (\text{Carrier Rel} - MR) \end{aligned}$$

Incentive

$$\begin{aligned} \text{If } mR > \text{Carrier Rel,} \\ &= P \times SLR \times (mR - \text{Carrier Rel}) \end{aligned}$$

Note: The maximum Incentive/Disincentive is capped at 9% of premium subject to this program.

PERFORMANCE STANDARDS FOR ASSIGNED CARRIERS
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PERFORMANCE STANDARDS FOR ASSIGNED CARRIERS

The following are the minimum Performance Standards for Servicing Carriers and Voluntary Direct Assignment Carriers. These Standards apply whether a carrier performs the services in-house or contracts 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.

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.

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 or remote 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.”

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. Premium shall be calculated in accordance with the Massachusetts Residual Market Premium Algorithm. Assigned carriers shall not impose unauthorized charges to the employer to defray carrier costs or for any other reason.

All policies must have the proper experience rating applied, in accordance with the approved rules of the Experience Rating Plan Manual and the published Massachusetts Exceptions.

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.

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

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- The policy number or other means of policy identification.

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 Quotes and 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."
- In accordance with MA 211 CMR 113.00, assigned carriers must offer medical and indemnity benefits deductibles on all assigned risk policies. As the WCRIBMA notifies applicants of the availability during the application process, the carriers are only required to notify their insureds upon renewal.

If the required deposit premium is postmarked 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. Note that if the postmark date is not legible, then the receipt date should be utilized.

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If the required deposit premium is not postmarked 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 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 or 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:

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- 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
 - 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

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(iii) a substantial increase in the hazard insured against.

For cancellations for nonpayment of premium, refer to Standard A8, 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 C4), ...	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.

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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 email or facsimile to each contact 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 email address or 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 or a like 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.

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

- Amounts due 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 postmarked 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. Note that if the postmark date is not legible, then the assigned carrier must rely on the receipt date. Cancellation Notices must be mailed in accordance with Standard A4b.

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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 or is not delinquent.

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: <ul style="list-style-type: none">• potential for imminent settlement is evident, or• the premium is in dispute and the dispute is being actively resolved. Serviceing carriers must obtain preapproval from the WCRIBMA to refer to outside counsel instead of pursuing collection activity. An uncollectible account must have been with a collection agency for at least 60 days from the date of referral by the servicing carrier before the servicing carrier can report the initial chargeback to NCCI.

10. AUDITS

a. Preliminary Physical Audits

Preliminary Physical Audits (PPAs) must be completed by the servicing carrier for all qualifying employers in accordance with Standard 10c 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 Standard 10c. 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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c. Qualifying Employers

Audits are to be conducted by servicing carriers in accordance with Standard 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.

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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. WCRIBMA Requested Audits

The WCRIBMA may at any time request that an assigned carrier perform a physical audit on a policyholder. The carrier shall perform that audit as instructed and then provide a copy of the completed audit and the audit notes and workpapers to the WCRIBMA within 15 days of the audit's completion.

g. 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 A4b.)

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Assigned carriers must report non-compliance and subsequent compliance to the WCRIBMA in accordance with Standard E. (See Standard E1.)

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 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.

h. 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

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- 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

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.
 - 3) Verification of average weekly wage and computation of indemnity benefits consistent with jurisdictional requirements.

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- 4) Report all lost-time injury claims to the ISO Claims Search. Investigation should include the filing of Inquiry Reports with other insurers/administrators, when appropriate.
- 5) 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.
- 6) 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.
- 7) 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

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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.

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 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

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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.

- 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.
- 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.

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.
- 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.

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.
 - 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 consistency 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.

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- 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. 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 C2.

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 C4.

c. Timelines and Procedures

1) New Policies

An LCS must be performed for a qualifying employer (as defined in Standard C3d), at all qualifying locations (as defined in Standard C3e), within 120 days of the policy effective date or receipt of the Notice of Assignment by the assigned carrier, whichever is later.

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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.

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	

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	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
	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

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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 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 A4. 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.

E. POLICY, UNIT STATISTICAL AND DATA REPORTING

1. Policy Data

All assigned carriers are responsible for timely reporting data to WCRIBMA 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, Non-renewals
- Noncompliance and Compliance Transactions
- Unit Statistical Reports
- Annual Financial Aggregate Data (as required in Part II of the MA Statistical Plan)

2. 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.

3. 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 and Pool Data Reporting Guide, including any Massachusetts exceptions that have been communicated to the servicing carriers.

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.

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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% ($21\% * 520/525$).

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**ON-SITE AUDIT AGGREGATE RATING TABLE
FINANCIAL REPORTING**

	(A)	x	(B)	=	(C)
	<u>Weight</u>		<u>Rating</u>		<u>Rating</u>
	<u>Factor</u>		<u>Value</u>		
Accurate Reporting of Policy Information	4		S = 3		
			M = 2		
Accurate Reporting of Claim Information	4		U = 1		
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				

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

	(A)	x	(B)	=	(C)
	<u>Weight</u>		<u>Rating</u>		<u>Rating</u>
	<u>Factor</u>		<u>Value</u>		
Additional Premium Endorsements	4		C = 4		
Compliance with Audit Frequency Requirements	4		S = 3		
Proper Application of Experience Modifications	4		M = 2		
			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**

	<u>Weight Factor</u>	<u>Rating Value</u>
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**

	<u>Weight Factor</u>	<u>Rating Value</u>
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%. An 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

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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.

EFFECT OF PERFORMANCE STANDARDS ON SERVICING CARRIER FEE

*Effect on Servicing Carrier Fee	Score on Audit of Underwriting and Audit Performance Standards	*Effect on Servicing Carrier Fee	Score on Audit of Financial Reporting Performance Standards
0.0%	90-120	0.0%	96-105
-0.5%	85-89	-0.5%	93-95
-1.0%	80-84	-1.0%	82-92
-1.5%	75-79	-1.5%	70-81
-2.0%	70-74	-2.0%	35-69
-2.5%	65-69		
-3.0%	60-64		
-3.5%	45-59		
-4.0%	30-44		

Total weight of subcategories is 30.

Total weight of subcategories is 35.

*Effect on Servicing Carrier Fee	Score on Audit of Claims Performance Standards	*Effect on Servicing Carrier Fee	Score on Audit of Loss Control Performance Standards
1.0%	102-108	1.0%	65-68
0.5%	95-101	0.5%	60-64
0.0%	81-94	0.0%	51-59
-0.5%	77-80	-0.5%	48-50
-1.0%	73-76	-1.0%	44-47
-1.5%	69-72	-1.5%	41-43
-2.0%	66-68	-2.0%	37-40
-2.5%	62-65	-2.5%	34-36
-3.0%	58-61	-3.0%	17-33
-3.5%	54-57		
-4.0%	45-53		
-4.5%	36-44		
-5.0%	27-35		

Total weight of subcategories is 27.

Total weight of subcategories is 17.

*Effects are as percentage of premium.