ANNUAL REPORT
FY'91

Massachusetts Workers' Compensation Advisory Council

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INTRODUCTION

This is the fifth annual report of the workers' compensation Advisory Council. It surveys the Department of Industrial Accidents and the workers' compensation system primarily over the 1991 fiscal year, which encompasses the period from July 1, 1990 through June 30, 1991. A descriptive overview of the Advisory Council and some of its major activities during the past fiscal year is included in the introduction.

Those who follow workers' compensation in Massachusetts know that the 1991 fiscal year was a difficult period for the commonwealth's workers' compensation system. At every level of the system, there were widespread complaints about inefficiencies and costs.

Prompted by the system's troubles, virtually all media outlets devoted significant attention to workers' compensation throughout the year. Along with their news coverage of workers' compensation matters, both print and broadcast media devoted features and editorials to such issues as problems of the system, reform proposals, and other related stories. The system is entering its ninth decade and as it does so the parties for whom it was established- employees and employers- wrestle with numerous issues in their efforts for continued improvement.

The Workers' Compensation Advisory Council

The Massachusetts Workers' Compensation Advisory Council was established by the 1985 amendments to monitor the workers' compensation system and make recommendations for its continued improvement. As an extension of the cooperative precedent set by the mid-1980s workers' compensation reform effort, the Council is comprised of representatives of the major constituencies in the workers' compensation system.

Ten voting members serve on the Council, five representing employers and five representing employees. In addition, four nonvoting members are appointed to represent the claimant's bar, the medical community, vocational rehabilitation providers, and the insurance industry. The Secretary of Labor and the Secretary of Economic Affairs are ex-officio members. A list of the Council members and their respective affiliations is set forth in Appendix A.

The Advisory Council meets on a monthly basis to review various issues concerning the Department of Industrial Accidents and the workers' compensation system. In FY'91 the Council conducted 13 full meetings and 2 subcommittee meetings. Since its inception in late 1986, the full Council has to date held 58 meetings. Five subcommittee meetings have also been held. Formal action by the Council requires an affirmative vote of seven voting members. A list of the Council's agendas for the past fiscal year is set forth in Appendix B.

Several changes in Council membership were made during the past year. Amy Vercillo of Rehab Re-employments replaced Evelyn Wedding as the rehabilitation representative on the Council. At the beginning of the 1992 fiscal year, employer manufacturing representative Jim Cronin of Raytheon Corporation was replaced by Antonio Frias, Sr., of S and F Concrete and his term expires on June 25, 1996. In addition, Paul Meagher's resignation was submitted as the statutory representative from the Associated Industries of Massachusetts, and he was replaced as a Council member in October of 1991 by John Gould, CEO of Associated Industries of Massachusetts, to a term which expires on June 25, 1995. John Marr of Travelers Insurance was appointed to replace John Antonakes as the insurance representative in October of 1991 and his term expires June 25, 1992. Edward Sullivan, Jr., of Local 254 of the Service Employees International Union, AFL-CIO was

appointed as Council member in October, 1991 to a term expiring on June 25, 1996, replacing Joseph Faherty.

Council Studies

Dispute Resolution Study

Since shortly after the implementation of the reform law in 1985, there has been widespread concern with the existence of lengthy delays for proceedings at the DIA. Much of the discussion on reducing these delays has focused upon possible ways to make improvements in the dispute resolution system. Discussions by the Advisory Council have tended to question whether existing procedures could be substantially improved through administrative initiatives or, alternatively, whether new procedures would have to be introduced through legislative action. In order to provide some basis for understanding where flaws in the system exist, or how resources could be better used, the Advisory Council decided to sponsor a study of the current dispute resolution system. The Council contracted with BDO Seidman and Endispute, Inc. to perform this study. A copy of the Executive Summary is included as Appendix C.

In observing the state of the dispute resolution system, the research team concluded that the system was not managed. The point did not simply refer to the supervisory aspects of management, but more generally to the lack of coherent strategies and structures for mobilizing diverse resources towards the achievement of particular DIA goals. The study was primarily concerned with the expeditious processing and resolution of workers' compensation cases. The project was not confined to studying either the output of administrative judges or the division of dispute resolution.

The report cites the absence of formalized orientations or staff development programs for dispute resolution personnel, including administrative judges, administrative law judges, conciliators, managers, and support staff, as an example of how the system is not managed. The report suggests that organizational effectiveness would be enhanced with the provision of training opportunities to improve skills, as well as for lateral and upward mobility.

Some examples are offered of how skill enhancement could improve operations. One recommendation is to encourage judges to become part of a functioning work team with

colleagues, other employees, and administrators. It is also recommended that conciliators be brought within the division of dispute resolution to support this goal. The report suggests that judges' secretaries be used for case management in order to broaden their responsibilities, fitting them into the team approach, and perhaps improve case management.

The report notes the diverse backgrounds and experiences of judges as instrumental for staff development programs. The report also stressed the importance of a timely and efficient appointment process for judges. Appointment criteria and thorough evaluations were seen to be critical to the system's future effectiveness since the majority of terms expire over a five month period in 1992. The report recommended informing employees of the process and the outcome by the latter part of 1991 in order to avoid mass departures and make timely replacements possible.

Most of the recommendations outlined in the report would not require legislative action, but were instead geared to the administrative authority already vested in the DIA. The report was provided to the department on July 2, 1991.

Public Employee Study

The Council also released a study concerning public employees and the workers' compensation law. The report identifies the need for a comprehensive and reliable information base for monitoring the workers' compensation system for public employees. Since the law is elective for all public employers except the commonwealth, accurate information on which public employers have accepted the law, and which of their employees are covered, is a necessary prelude to further examination of public employee issues.

The report also notes the uncertainty faced by employees of public entities that have not accepted the act or have chosen not to include certain employment categories in their acceptance of the law. For instance, many communities do not include teachers in their coverage. A question exists as to what remedy may be available for those workers injured in the course of employment if they are not covered. Many of the report's recommendations are intended to generate discussion of the fiscal and administrative implications of the current law, while some simply seek to update the statute with respect to amendments that would clarify the law for the current situation.

SECTION 1
Overview of the
Department of Industrial Accidents

The Department of Industrial Accidents is empowered with the authority under Chapters 23E and 152 of the Massachusetts General Laws to administer the workers' compensation system. This system covers nearly all civilian employees in the private sector and most employees in the public sector. The DIA's enabling legislation is set forth in Massachusetts General Law Chapter 23E. The majority of the substantive and procedural elements of the system are set forth in c. 152. The department is situated within the Executive Office of Labor, but is not subject to its jurisdiction, pursuant to Massachusetts General Law Chapter 6A §17C.

Departmental Activities

During the past fiscal year, the department issued six circular letters. While not necessarily binding as precedent in any formal context, they have provided background and guidance for parties and practitioners since initially promulgated in 1934. The letters issued during the past fiscal year with their corresponding topics are:

254 10/1/90 COLA Reimbursements, Maximum and Minimum Weekly Compensation Rates

255 10/12/90 Agreement Between Insurers Providing Claims Handling Services replacing the Agreement appended to Circular Letter #243 dated August 30th, 1989

256 12/6/90 Supplemental Requests for Additional Reimbursement under Section 37 or 37A of M.G.L.c.152

257 12/15/90 Reimbursement for Latency Benefits

258 5/15/91 Motion Sessions for Expedited Conferences

* # 159 5/16/91 1991 Certified Vendors The Office of Education and Vocational Rehabilitation Certification of (91) Vocational Rehabilitation Providers In the Commonwealth.

(* Circular Letter #159 should be Circular Letter #259)

Publication of Reviewing Board Decisions/ Annual Statistics

As noted in last year's report, the decisions of the reviewing board are being published after long delay. At this writing, four volumes have been printed. They contain digests of the cases, subject indexes and official citations for the decisions issued. As the extent of the case law interpreting the 1985 changes grows, these volumes should assist parties in evaluating the merits of their respective positions.

The Council receives statistical information from the DIA as mandated by §12 of c. 23E. In addition to ongoing requests for information and reports, the Council is provided with biannual data on a number of areas of departmental activity. It does not appear that the DIA has furnished statistics to the legislature, as required by statute. Since the 1985 amendments were enacted, the DIA has published only one document containing some of the statistics relevant to the discussion of the workers' compensation system. The Council has in the past supported the DIA's use of its administrative authority, as set forth in §63 of c. 152, for research purposes, including assignment of a person to generate information, analysis, and research papers.

Department Rules

The DIA is empowered to enact rules to augment and provide clarity to chapter 152. The need for such regulations is widely accepted. Regulations should supplement the legislation, but not exceed the scope of the law to the detriment of any party. The Supreme Judicial Court has held that a single member or the reviewing board may not disregard rules that have been properly promulgated by the rule making body to the prejudice of a party's essential rights. DaLomba's Case, 352 Mass 598,603 (1967).

In amending a number of its rules during the past fiscal year, the department abandoned some of the procedures regarding notification and solicitation of input that had previously been followed. At a hearing held on January 25, 1991 on certain proposed rule changes for self-insurance, the Council was unable to review or take a position on the proposed changes because it was not notified of the hearing. The Council was later informed that no one was in attendance to speak either in favor of or against the proposed changes. A notice of the hearing was published in the Massachusetts Register of January 18, 1991.

Two proposed changes were initially envisioned for 452 CMR 5.04, which deals with the requirements for a new applicant for a self-insurance license. In §2(c), the minimum level of standard unmodified premium was increased from $300,000 to $750,000. A second change, which would have amended 5.04 2(e) by changing the inter or intra state experience modification factor from "1.25 or higher" to "1.25 or lower", was not promulgated.

The former rule has had a brief history. This entire section was filed as an emergency regulation on November 9, 1989. The filing indicated that, along with the other proposed rules, it would have no fiscal effect on either the public or private sector. The amount was set at $300,000, although an amount of $500,000 was considered. The department's explanation for this change was that it is generally not cost effective to self-insure with a smaller premium due to the fixed costs, surety bond, legal expenses, reinsurance, and the variable costs, mainly consisting of the self-retention of all workers' compensation payments. As of April 26, 1991, the minimum level for new applicants is $750,000. This increase in the minimum level of unmodified manual premium by 150% was noted as having no fiscal effect on either the public or private sector.

The DIA proposed additional rule changes, a notice of which was published in the Massachusetts Register on June 18, 1991. Copies of the proposed changes were provided by the department and reviewed by the Council at its July 10, 1991 meeting. The changes concerned the addition to the definitions of the term "filed" and "necessary expenses", as well as the establishment of certain penalties for the nonpayment of referral fees.

The Council reviewed the proposed changes in accordance with current law and regulations. It unanimously decided to not support any of the proposed changes as written. A copy of the proposed rules is enclosed as Appendix D. The Council expressed particular concern with a proposal to deprive insurers of their defenses for nonpayment of the referral fee. While citing a number of issues in its discussion on this rule, it emphasized that the penalty was inconsistent with the statute and that the rule would harm employers by charging them for losses in cases where the insurer could not raise a defense. Through higher losses, employers would pay for insurer behaviors over which they had no control.

At the hearing on July 22, 1991, the parties in attendance were informed that the DIA had changed some of its proposed rules. While some of the changes were apparently in response to the position provided by the Council to the DIA on July 12, 1991, the Council requested the DIA's future consideration in providing sufficient notice to interested parties to allow them an opportunity to discuss the changes with their respective constituencies. The DIA has not taken any action on its proposed rules as of this writing.

Penalties/Fees

The level of attorney involvement is a continuing focus of discussion. Information is still incomplete on the cost of legal payments in the workers' compensation system. In the rate-making process, payments for defending claims are included in expenses and payments for prosecuting claims included in losses. The Council has requested this information at rate hearings and the Commissioner of Insurance has suggested that the data be developed. The industry has attempted to produce this information in a good faith effort to document the legal costs associated with workers' compensation, but to date the information is not available.

Since the 1985 reform, all claimant attorney fees for disputed matters falling under the relevant amendments have been paid by insurers where the claimant prevailed. Until additional information is available, the Council will utilize data provided by the Department. Figures utilized here reflect voluntary compliance and will likely underestimate amounts since information is often not provided to the DIA as required by law. The totals for matters in DDR are believed to be more accurate. Listed below are the amounts reported for the last three years. The first series of figures are generated by the filing of agreements, pay forms, or resume forms in the Division of Claims Administration and the second cover matters before judges in the Division of Dispute Resolution and include conferences, hearings, lump sums and reviewing board cases.

TABLE I
Attorney Fees & Penalties Awarded
Prior to DDR For Event Dates In Fiscal Year (RPT 306)

	FY'1989		FY'1990		FY'1991	
	NO.	AMOUNT	NO.	AMOUNT	NO.	AMOUNT
§7 Pen.	97	$109,548	60	$76,789	46	$54,638
§8 Pen.	4	$1,806	11	$5,800	9	$7,572
Atty.Fees	1,309	$1,070,343	1,493	$1,371,981	2,290	$1,912,290
Atty.Fees With §7 or §8	82	$67,755	43	$35,343	33	$26,664

Attorney Fees & Penalties Awarded
In DDR For Disposition Date In Fiscal Year (RPT 307)

	FY'1989		FY'1990		FY'1991	
	NO.	AMOUNT	NO.	AMOUNT	NO.	AMOUNT
§7 Pen.	41	$36,868	48	$94,139	21	$30,578
§8 Pen.	8	$4,612	11	$17,089	9	$14,818
Atty.Fees	13,939	$50,712,048	19,853	$74,990,649	23,224	$88,840,224
Atty.Fees With §7 or §8	35	$37,918	38	$49,241	25	$33,092

In matters prior to referral to the DDR, §7 penalties have continued to drop and are less than half of the FY'89 totals, while §8 penalties have slightly increased. While the number of attorney fee awards have risen over 50%, the total amount has increased 39%, possibly indicating that where information is reported, it includes lower fees. The totals and individual amounts of fees with the penalties continue to drop. If the information reported is reflective of the system as a whole, it would indicate greater conformance with the law's requirements. However, given the lack of complete information, there may simply be a greater reluctance to file information indicating penalty payments.

Attorney fees awarded for disposition dates in the last fiscal year grew 18.4% over FY'90 and have increased 75% over FY'89. The average award for FY'91 was $3,825, while in the prior two years the averages were $3,777 and $3,638, respectively. The small growth in average awards has not kept pace with the increases in the SAWW, the relevant determinant for the computation of many of the fee awards. This information is maintained not just to calculate penalties awarded, but also to provide data to verify that their costs are not utilized in the establishment of premium rates. The information is provided to both the Council and to the Commissioner of Insurance (see §7F of c. 152). No amounts paid as a result of failure to comply with the pay or deny process under §7 of the law or penalties awarded when an insurer terminates, reduces, or fails to make payments required under the law and additional compensation is later ordered may be used in any formula to set premium rates (see §7(2) and §8(5)). Additionally, §13A (a) precludes the inclusion of attorney fees payable for proceedings at which a §7 penalty is awarded to be utilized in the rate-making process.

A total of $107,606 in penalties were awarded in the last fiscal year, down from $193,817 in FY'90.

Penalties of $454,257 are indicated for the last three fiscal years. Attorney fees awarded in penalty matters also have dropped. In cases prior to referral to a judge, 33 awards (1.4% of the total attorney fees) consisting of $26,664 (1.4% of the total) are to be excluded from the rates. The figures were even lower for cases referred to DDR, where 25 (.1% of the total) for $33,092 (.04% of the total) cannot be utilized in the rate-making process. The two reports for FY'91 show a total of 58 attorney fees (.2% of the total) in penalty cases, which resulted in a total of $59,756 (.06% of the total of $90,752,515) to be excluded.

The total amount for exclusion in the last three fiscal years is $250,013 (.1%) of the total fees of $218,897,535. The low number of fees awarded and the small total amounts are evidence that parties are not raising penalty issues in an attempt to generate fees. This may result from voluntary resolution of the issue and the system not capturing the information or from a reluctance to pursue both a fee and a penalty before a judge. During the last half of FY'91, totals ranged from 52% to 93% of the yearly figures. It it too early to determine whether this is a trend towards increasing involvement of these issues in the dispute resolution process, but it may bear watching.

The Commissioner of Insurance is to establish a procedure for the identification and separate annual reporting by each insurer of the various amounts to be excluded from the rate making formula [see §53A (11)]. The DIA reports are intended to provide verification for the accuracy of such reports. We have been unsuccessful in verifying if such a procedure at DOI exists.

Section 65 -
Employees Of Uninsured Employers

As noted in previous Annual Reports, there has been a steady increase in the number of claims filed against the private employer trust by employees of companies which violate the law by failing to carry insurance.

Although the Council was informed in 1990 that statutory fines would be levied for failure to file a first report by uninsured employers, such fines had not been imposed as of the close of FY'91. The Council is concerned about the potential consequences of the reluctance to follow the letter and the logic of the law. The fact

that an employer has not complied with legal requirements regarding insurance coverage should not insulate it from the fine, and it is inequitable to enforce the law against those who are insured while ignoring those who are not. Although there may be little possibility of recouping fines against uninsured employers, the differential administration of the statute is a policy issue that the DIA should consider addressing.

The Council has suggested a number of times over the last few years that the agency send a circular letter to the various municipalities to remind them of the obligations set forth in §25C (6) and (7). These sections require acceptable evidence of compliance with insurance coverage provisions prior to authorizing permits, licenses and contracts. This has recently been done and, according to the DIA, has generated a significant response.

The Council has also suggested for the last few years that the DIA consider issuing press releases that highlight the enforcement of the law. Not only would this provide a positive image to the public of DIA activity, but it might also induce violators of the law to obtain coverage and avoid unfavorable publicity.

TABLE II

UNINSURED EMPLOYER CASES 7/1/88-6/30/91

	FY'89	FY'90	FY'91
Initial cases referred	330	391(+18%)	474(+21%)
Cases not yet reaching disposition	145(44%)	185(47%)	209(44%)
Cases reaching disposition	185(56%)	206(53%)	265(56%)
- employee not receiving benefit	77(42%)	78(38%)	119(45%)
- employee receiving benefits (closed)	71(38%)	94(46%)	100(38%)
(open)	37(20%)	34(16%)	46(17%)

The average weekly wage for §65 employees was $244 in FY'91, entailing the smallest jump in the average weekly rate since the figures were available in FY'88. The rate was $235 in FY'90, $219 in FY'89, and $192 in FY'88. While last year 94 employees received compensation from the trust fund, this year the total rose 50% to 141. The increase in the number of weekly

claims has risen 182% since FY'88 and initial referrals have increased 44% since FY'89. This continued growth is a constant drain on employer assessments.

It is difficult for the DIA to defend the private employer trust fund since the customary contractual relationship between insurer and employer does not exist. To bolster DIA efforts, the Council requested and strongly supported the filing of legislation which would empower the department to utilize the fund itself to pay the expenses of defending the trust fund.

A total of $900,000 was included in the FY'91 trust fund budget to be utilized in defending the fund. Areas in which the agency proposed spending private and public employer assessments included about $250,000 on private investigators and $80,000 for outside legal counsel to assist in recovering payments for uninsured matters. However, the DIA estimated it would spend a maximum of $191,712 of this money and none on private investigators. Since FY'91 uninsured payments exceeded the assessment budget of $5.5 million, and $8 million has been budgeted for FY'92, this is one area where the administration should consider spending the employer assessments it has already collected. One positive note, as outlined in the next section, is the continuing increase in receipts of reimbursements for §65 costs. If outside counsel is utilized in this aspect, this amount should increase even more.

Administration of the Section 65 Funds and Special Fund

In addition to the administrative and adjudicatory functions set forth in the law, the DIA has statutory and fiduciary responsibility for administering the special fund and the two trust funds. The special fund is used to pay for the operating expenses of the DIA, while the trust funds provide reimbursements and payments for certain benefits set forth in chapter 152. The revenue for these funds is primarily generated by assessments on employers.

Funding for the operating expenses of the agency is initially appropriated through the legislative process, with reimbursement made to the State for all funds expended. Private employers are also assessed for fringe benefit costs which are collected and deposited directly into the special fund. Additional revenues are generated by the various fines, fees, and penalties set

forth in the law, if they are applied by the Department. In accordance with §65, the various funds are maintained separately under the statutory responsibility of the Commissioner.

While the staffing level fluctuates, at the end of FY'91 there were 28 vacant positions allocated to the special fund and 15 vacant positions allocated to the trust funds. Initial personnel expansion requests by the agency for FY'91, which were not approved, were projected at $489,292 for 23 positions. In the 2 previous years, personnel expansion requests were for 24 positions/$505,241 (FY'90) and 23 positions/$485,340 (FY'89). Examples of expenditures other than salaries, fringes, and rent are $203,000 for postage and about $10,000 for the 800 phone line in FY'91. The Council requested information on the amount of chargebacks for OMIS and workers' compensation (12 employees in the agency collected in 1991), as well as the amount of interest credited to the General Fund on fringe benefits, but has not received a response.

The two trust funds are funded by assessments on both public and private employers and have grown extensively in the past few years, partially because eligibility for certain elements did not become effective until after the law was passed in 1985. The assessment process socializes certain benefit costs and spreads them among private employers who have complied with the insurance mandates of the act and public employers which have opted to accept the provisions of the law. Private and public assessments are required by statute to be completely segregated.

Financial figures on the funds are listed in Appendix E. Assessment receipts for the special fund were down $5,724,481 from FY'90 figures provided by the DIA and were $7,234,384 less than the budget assessed for FY'91. This 39% drop in assessments may be partially related to lower premium collections, which would decrease assessments collected. Since lower premium collections are related to the overall economy, it is imperative that all other sources of revenue be judiciously pursued in order to avoid possible shortfalls.

Filing fees rose 48% and have increased 495% since FY'88, a further indication of the contentiousness of the system. Total receipts for late first report fines dropped 2%, although this may be a result of waivers

granted administratively (over $118,000) and briefly discussed later in this report. Interest receipts increased by over 36%, which is one example of the ongoing efforts of the administration to maximize private employer assessments even as investment rates have fallen. As of October 1991, the DIA has over $15 million in short term investments paying 5.35% in interest. Through 12/31/91, the interest earned by the respective funds was: $210,391 - Special; $324,154 - Private Trust; and $37,506 - Public Trust. The Council has been unable to ascertain from the DIA the amount of interest credited to the General Fund for revenues from assessments for fringe benefits and indirect costs pursuant to §65(6).

Referral fees paid by insurers after conciliation are 30% of the SAWW in most instances and are 130% of the SAWW when the insurer fails to attend a conciliation. These fees are paid into the special fund, which is also funded by assessments on private sector employers. The additional referral fees for not attending a conciliation cannot be included in calculations for premium rates (see § 10(5) of chapter 152).

Over the period 2/15/89 - 2/7/92, 4,030 fees totalling $2,416,444 were levied. The vast majority (71%) of these fees have been paid, although 1,025 remain due.[1] Since the initial billing in FY'89, there has been a marked decrease in penalty referral fees. The balances for the last 5-6 months have been somewhat higher, but this may reflect the overall economy as well as the billing cycle.

Expenditures rose $878,685 in FY'91, part of which was a one time $93,748 payment to satisfy the judgement in the Daly Case. The difference in expenditures would have been greater, but the furlough statute lessened the agency's payment obligation in this fiscal year. However, the relationship between receipts and expenditures in FY'91 is a cause of concern. Only 55% of the budgeted special fund assessments was collected. If not for the large balance at the start of the year and the increased interest and fees, total expenditures would have caused serious problems for the fund. Total special fund actual expenditures exceeded total receipts by over $2 million in FY'91. Total collections exceeded expenditures by $3,709,258 in FY'90. As it is, the employer-assessed balance was decreased significantly, which obviously severely lessens the chance for lower

assessments due to the balance offset outlined in §65(4)(C).

The estimated special fund budget for the assessment process was fairly close to actual expenditures, which were affected by furloughs and vacant positions. In terms of other revenue sources, the amount for filing fees, although low, was similar to the previous year's receipts. While the interest estimate was low, it was based on a balance which was much lower than the actual amount. No revenue was listed in the estimates for fines under §6 or penalties for unpaid assessments as mandated by under §65(5).

Information is available on the extent of unpaid assessments. As of October 1990, there were approximately $2 million outstanding in unpaid assessments, with $16,395 due from private employers and $1,983,487 due from public employers. While the majority was unpaid from FY'90, over $280,000 was unpaid from FY'87/88 and one insurer had not reported assessments due for 7 quarters. At that time (October 1990), the DIA noted that pursuant to a decision by both the agency and the Executive Office of Labor, a modification of the penalty provision would be proposed and that the statutory penalty was not being imposed due to its harsh nature.

The Council noted in its FY'90 report that it was awaiting a response from the DIA on whether $3,117,000 in uncollected eligible fees, fines and late charges during FY'87 and FY'88, outlined by the State Auditor in his report, was being collected. The Council was informed in June of 1991 that the DIA had collected about $1 million of this amount. Only about 23% of the billed late first report fines were collected and DIA management decided not to apply late charges for assessments. The Council has also inquired whether the DIA monitored reimbursement requests and assessment receipts from carriers which insure political subdivisions in order to ascertain that the proper fund was used. While we noted last year that some analysis in this area was to be done, and that results were expected soon, the project was not completed. There has therefore been no review in the almost 6 years that the funds have been in operation to verify if the proper funds have been used.

In the FY'92 assessment report, it was noted that

$3,540,709 had not yet been paid into the public trust fund as of the end of FY'91 for that year. However, the Council was informed that in October 1991 adjustments were made to account for PERA and the MBTA and $352,000 had been collected. This left an outstanding balance of $771,446. Had any penalties been assessed, they would have been payable to the special fund and would have been used to offset private employer assessments.

As of February of 1991, $305,550 of the state-appropriated money had been spent on backlog judges. As of the week ending 11/19/90, these judges began taking "prolog" cases, and separate time sheets were kept to account for money expended from employer assessments. The state hiring freeze implemented in early 1991 was put in place when there were 14 positions available, and over the last half of the fiscal year led to an estimated savings of $206,850. This figure does not include savings from normal staff turnover.

At its June 1991 meeting, the Council raised a number of questions concerning investment policy for employer paid assessments. It appeared that funds were being held for up to a month without earning interest. The DIA was very cooperative in resolving the questions and worked diligently with other agencies to rectify the concern. It informed the Council within a few weeks that it intended to ensure that in the future all funds would be invested and credited to the proper funds in a timely manner.

One positive note on the credit side of the ledger for the special fund was the receipt of payments for costs awarded under §14. The language of the statute is broad and this permits the awarding of costs to the DIA when a determination has been made that a case is frivolous. Interest rose in part due to the large balance at the end of FY'90, but due to the significant drop at the end of the year, this may not be as high in FY'92. As in past years, there were no receipts listed for any fines for late assessments or late medical reports.

The public trust fund budget for the FY'91 assessment was $6,780,668, but assessment receipts equaled $4,322,654, or 64% of the amount assessed. No interest was credited to the fund in FY'91. COLA payments rose $700,813 or 25%, while first time payments for both second injury reimbursements and vocational rehabilitation payments were made this year. Overall

total expenditures increased 29%, but since assessment receipts exceeded expenditures by $733,638 for the year, the balance at the close of the year was more than double that of FY'90.

The private employer trust fund had a surplus $1,734,403 of receipts to expenditures in FY'91. In terms of receipts, $14,120,932 was received in assessments, 64% of the total assessment budget amount of $21,913,201. Reimbursements for §65 uninsured cases again increased significantly, $83,902 (39%), over the previous year. There were no receipts in FY'88 and this total is the result of DIA efforts to seek and collect payments for benefits paid to employees of uninsured employers.

Stop work order fines more than doubled in FY'91. Interest credited to the fund dropped from $533,914 in FY'90 to $16,446 in FY'91. While the fund balance was much larger at the onset of FY'90, the interest credited was about .6% of the beginning balance at the start of the fiscal year. The employer paid assessments should earn more interest, and in the future it is anticipated that employer paid assessments will generate larger interest credits.

The total payment for §65 increased $2,416,334 (71%) over FY'90. First time reimbursements for second injury petitions totaled $613,897 in the last fiscal year. The estimated expenditure for assessment purposes was more than ten times greater at $6,573,798. COLA payments dropped $4,618,834, or 42% from the previous year and were $4,126,786 less than the projected budget in the assessment calculation. The fund was fortunate that the estimated amounts were off because these liabilities, if they had occurred, would have eliminated the fund balance. However, these estimated amounts were part of the assessment budgets which employers paid and highlight the absolute need for accurate estimates.

COLA payments for the last four fiscal years have exceeded $37 million. The ratio of public trust fund COLA reimbursements to private trust fund COLA reimbursements continues to grow. The ratio of pay-outs was 19% in FY'88, 21% in FY'89, 26% in FY'90 and 55% in FY'91. This data appears to support the premise outlined in the FY'90 assessment calculation that there is a greater utilization of COLA requests in the public sector than in the private sector. If it continues, this trend should be of concern to public employers.

In the special fund alone, $3,772,322 was generated in fines, fees and interest in FY'91, which was equal to 43% of the assessment collection. This is up from 20% last fiscal year and indicates the fund's greater dependence on these sources of revenue. For the private trust fund, $357,886 was produced through non-assessment mechanisms, equal to 2.5% of the assessments collected. These ratios can change as a result of adjustments to succeeding assessments based upon ending balances, but they are nonetheless an indication that the statutory mechanisms provide the DIA with sources of revenue apart from the assessment and appropriation process.

State Furloughs

The state's deficit impacted the entire state and economy. At one point the possibility of a shutdown of state government was considered, which would have resulted in $37,450 in daily cash savings at the DIA. One part of the solution ultimately agreed upon by the legislative and executive branches of government called for the furlough of state employees based upon the salary of the worker, with higher wage employees losing more days. The law directed that any monies saved via the furlough program be returned to the General Fund.

The Council strongly opposed the reversion of employer paid assessments to the state. The Council pointed out that the agreement between private employers and the state in 1985, whereby employers would pay the operating expenses of the DIA, did not include the possibility that employer funds return to state coffers. In a meeting with the Executive Secretary for Administration and Finance under the previous administration, the Council received a written commitment that monies would not revert to the state. In correspondence to the legislative and executive branches following the furlough program's approval, as well as in testimony in public hearings, the Council noted its position that application of the furlough legislation to the DIA was a clear breach of the earlier agreement.

One furlough program option was for employees to work during the furlough and receive additional time off in lieu of unpaid days. Thus, some DIA employees worked without pay and accrued additional paid vacation. However, the monies for the extra vacation days were to be paid from the assessments generated by private employers. Money that was assessed and collected premised upon the work the DIA is mandated to perform

was instead allocated to pay time off. Fortunately, as of this writing, no monies have reverted from the special revenue fund to the general fund, although the law clearly allows this to occur.

A total of $1,227.47 was deducted by the Office of the Comptroller from the private trust fund for the furlough program. For the agency's 277 active employees, there were 221 furlough employees. The number of obligated furlough days reported to the Council by the DIA was 1,238.12 for a possible furlough savings of $202,642.80. The DIA informed us that this figure did not include monies that would apply for reversion of special leave days and that reversions would be considered expenditures for the purpose of computing the balance of the various funds for the statutory assessment calculation. In addition, the law required a 1% reduction in consultant and personal service contracts. This affected 33 DIA contracts with a maximum total obligation of $662,663.76. The Council was informed that this money would not revert to the general fund.

In April 1991 the Executive Office for Administration and Finance issued Administrative Bulletin 91-4 to all agency and department heads concerning fiscal guidance related to the state employee furlough program. This directive stated as follows:

> For trust funds (MMARS account type 03), reduction of payroll expense will occur in any account where an employee position is scheduled to a trust fund account, and such savings generated in a trust fund account will be transferred to the budgetary funds by the Comptroller's Office, **unless an exemption, based upon restrictions by the funding source**, is approved by the Executive Office for Administration and Finance. (emphasis ours)

There were at that time three positions scheduled to a trust fund account. Although the opportunity existed to request that the money not be reverted, the DIA chose not to try to protect employer paid assessments by obtaining an exemption. It is clear under c.152, or on the basis of legislative intent, that employer paid assessments were never meant to be a petty cash fund for the state. The funding source has restrictions in chapter 152. While an exemption request by the DIA may not have been successful, and the trust fund reversion was minimal in comparison to the possible special fund

reversion, the Council is concerned that agency management made no attempt to obtain an exemption for employer monies.

The furlough law had an adverse impact upon judicial scheduling in FY'92. Each judge was entitled to a maximum of 15 additional vacation days for the payless work days in FY'91. A total of 16 judges opted for this package, entailing the loss of 240 judicial scheduling days in FY'92. Many of these vacations were approved by the DIA for the summer months because it was considered a slow period. This loss of scheduling capacity was almost equivalent to one AJ for an entire year, which under the current format would on average involve the loss of 797 conferences and 332 hearings. This loss adds costs for both employees and employers.

Budgetary Process

By statute, the Council is permitted to review the annual DIA operating budget, as prepared by the Commissioner and as submitted to the Executive Secretary of Labor. Upon an affirmative vote of seven of its members, the Council may prepare and submit an alternative budget. The Council has exercised this right in the past.

Beginning in the Fall of 1990, the Council made numerous requests to the department for the budget for FY'92. At the Advisory Council's meeting on May 8, 1991 the new administration promised an annual operating budget shortly. The Council received a proposed annual operating budget for FY'92 on May 24, 1991. This budget proposal was based upon what would have been presented by the agency to the administration the previous fall, although it differed significantly from the budget actually submitted. It was reviewed by the Council at its June 19, 1991 meeting.

The agency's minimal contact with the Advisory Council during the budgetary process is a matter of concern. The decision to limit contact and relegate discussions to a few phone conversations would not appear to provide the proper input for the spending of employer paid assessments. Review of the budget is integral to oversight of the system. Although Council members represent different constituencies, each in its own right also represents a party which pays for the system. Review of the budget by those who pay for it provides a reasonable check and balance in the operation of the

system. Denial of this opportunity, in any way that does not allow for a meaningful, timely and realistic review of the annual operating budget, is a direct circumvention of both the spirit and language of the law. While time constraints due to the change in DIA administration may have hindered the process this year, neither outgoing or incoming administrations made certain that the obligation was met. DIA management made absolute assurances at the May Council meeting that this will not occur again. The Council is hopeful that subsequent spending plans will provide greater involvement with the DIA management, inasmuch as the agency has statutory and fiduciary responsibility for the employer assessed funds.

On May 23, 1991 the House of Representatives voted on the House Ways and Means proposal for enactment and sent the budget to the Senate. The House proposal (House 5600) initially contained a total of $13,795,899 and a personnel cap of 286 positions. This represented a reduction of 21 positions from the level approved in the FY'91 budget. The budget that was passed by the House of Representatives (House 5700) contained an amendment (adding a new section 1A to the budget) which reduced the appropriation amount for the DIA's line item by 2%. This thereby cut the budget by $275,918.

The Senate Ways and Means Committee reported out its version for the FY'92 budget on June 12, 1991. This proposal contained an appropriation for the DIA of $13,310,740 and a personnel cap of 285 positions. This was the same amount that the legislature appropriated for DIA operations in the previous fiscal year.

The final budget included an amount of $13,310,740 and was executed by the Governor on July 10, 1991. Although the amount was the same as in FY'91, the personnel cap was vetoed for the agency. This should provide management with additional flexibility and make it more accountable for the expenditure of private employer assessments.

Departmental Offices

Office of Claims Administration

The Office of Claims Administration processes all incoming and outgoing correspondence, maintains files and records, handles first report appeals, and seeks to

ensure timely entry of disputed matters into the dispute resolution process. The Office is comprised of the claims processing unit and the conciliation unit. An appeals review function for first report fines was added to the unit in August of 1989.

The claims processing unit manages the DIA's record room, reviews and processes incoming documents and claims, and sends out departmental forms. Processing involves the review and sorting of a wide variety of materials, and many incoming documents must be returned due to incorrect or insufficient information.

The Council's FY'90 report noted a significant improvement in reducing delays for entering information onto the computer processing system, and additional improvements were achieved in FY'91. There is a one week time lag for entering first reports, down from 53 days at the close of FY'89. Improvements were also evident in other categories. This increased efficiency enables the DIA to better survey trends in the system.

Figures for the past fiscal year's office transactions are presented below, along with the corresponding total from FY'90 and the percentage difference from last year.

TABLE III

Transactions	FY'91	FY'90	%
pieces of corresp. received	385,855	389,497	(1)
# of first reports received	56,647		
# first reports entered	51,447	52,342	(2)
# of Agreements	8,343	7,087	18
# of quarterly reports received	45,000		
# of correspondence entered	184,253		
# of claims entered	21,856	20,292	8
# S.36 entered	3,777	3,790	(.3)
# S.37 entered	10	12	(17)
# discontinuances entered	10,908	10,974	(.6)
# denies entered	9,573	10,892	(12)
# terminations entered	16,130	11,591	39
# lump sums requested entered	9,144	9,514	.04
# pays entered	31,122	47,288	(34)
# extends entered	4,407	3,410	29
# resumes entered	1,702	1,404	21
# third party liens entered	752	1,137	(34)
# third party claims entered	1,201	903	33

The Division of Administration administers the first report fines. There were 5,256 cases backlogged from the previous year and 7,870 violation notices were

issued in FY'91. A total of 4,134 appeals were received and 9,390 administrative reviews conducted. There were 4,950 denials and 4,440 waivers permitted. Pursuant to the Commissioner's directive, 638 matters were waived at the first report compliance level and 544 hearings at the Commissioner's level. This totaled $118,200.00 that might have gone into the Special Fund. An audit run in FY'89 indicated that 19% of the late first report bills were produced from pay forms **(RPT 61)**, while the rest were produced from the first report. This underscoress the importance of submitting pay forms if they generate almost 20% of the late first report bills when there is voluntary compliance. Available information on first report filings for the last 4 calendar years is as follows: 1987 - 56,686; 1988 - 48,473; 1989 - 55,222; and 1990 - 53,232.

There were 632 appeals (an increase of 73% from FY'90) of the administrative findings and 88 hearings held by the Commissioner. In FY'90, 303 hearings were held. There were 89 orders (one matter remained from FY'90), with 23 affirming the compliance officer (26%) and 66 (74%) overruling the initial determination. Last fiscal year, there were 255 orders, of which 38% affirmed the compliance officer. As noted above, the remaining 544, representing 86% of the total appeals, were waived by the Commissioner. In total, 1,182 matters were waived pursuant to the Commissioner's directive, which was equal to 24% of the denials for the year. The number of appeals increased dramatically over the last fiscal year, but there was a significant drop in both the number of hearings and orders by the Commissioner's office. While the purpose of the statute is not to produce revenue through fines, it is important that the law be enforced equitably. The large number of waivers may not only have created a cost shifting to all employers because of the possible revenue that was due, but also may have treated some employers differently based upon when the fine was appealed.

Computer totals on **(RPT 7)** first report and pay statistics of forms entered for the last three fiscal years are as follows:

TABLE IV

	FY'89	FY'90	FY'91
Total 1st Reports	59,138	52,342	54,292
Total 1st Rep. w/ss#	58,657	51,896	53,835
Total 1st Rep. with no injury type	3	3	1
Total Pays	63,542	58,180	45,592
Total Pays with no injury type	3,752	3,122	2,014

The first reports cover the loss of five workdays, and while totals have fluctuated, they have not changed dramatically. In each year, over 99% have contained a social security number. Even with this percentage reflected in DIA records, on June 25, 1991 the DIA informed interested parties that as of that day, the employee's social security number would be required on all DIA prescribed forms and failure to comply with the requirement would result in rejection of the document. While the policy raised a number of issues, the primary concern was whether such a mandate was in conformance with federal law. As of 7/2/91, the policy was terminated until further notice.[2]

It is noteworthy that when there is a filing generated by the allegation of an injury, injury type is almost always specified. On pay forms, for which there has been some determination as to entitlement, between 4-6% do not include injury type. The number of pay forms decreased this year by 21.6%, and since FY'89 the totals have dropped 28.2%. While any analysis of pay forms must be reviewed in terms of the voluntary nature of compliance, the decrease may be a result of either a reluctance to pay in light of the extensive delays before a discontinuance is heard or may indicate an increased propensity to dispute the increasing numbers of claims.

As noted in last year's report, information is available that provides some indication of the nature of the cases in dispute **(RPT 28)**. The information that is generated by computer report captures data prior to review in claims administration and referral to conciliation. Employee claims entered (exclusive of §36 or third party claims) increased 14.5% in the last year, representing 46.7% of the total, up 2.1% from FY'90. Claims for loss of function or disfigurement (§36) rose 3.4%, but the percentage of the total dropped slightly, from 8.3% to 7.9% this fiscal year. Insurer requests to discontinue or modify increased 4.3% and accounted for 23% of the matters entered, a decrease of 1.1% from FY'90. Third party matters showed the largest jump, up 39% in the last year and accounting for 2.5% of total entries. While lump sum requests filed and entered rose 3.7%, the percentage of the total dropped 1.1%.

The increase in the number of cases was expected, but the shift among the classifications is a new development. The growth in the number of employee

claims has superseded that of discontinuances and §36 cases, making those matters a smaller percentage of the total universe of disputes at the DIA. Anecdotal information indicated that discontinuance requests were increasing, and while they have grown, the growth is far less than that of employee claims and represents a smaller portion of the total disputes than in FY'90. Lump sum requests continue to decline as a percentage of the total. However, this data captures information as entered in claims administration. Many matters involve lump sum requests at latter stages of the dispute resolution process. The large jump in third party cases, particularly those concerning medical treatment, is indicative of the perception that bills to providers are not paid in a prompt manner. It also may indicate that insurers are questioning treatment more routinely and are not automatically issuing checks for every bill.

The ratio of the percentage of total cases entered of employee claims (including §36) to discontinuances was 54.6/23 =2.37. This ratio of claims to complaints has risen from 2.18 in FY'89 and 2.20 in FY'90. The total number of cases entered rose 9.3% from FY'90, to 49,725, and has risen 19.6% since FY'89.

There were no significant changes in the percentages relating to the sections of the law for which benefits were sought.[3] Claims seeking temporary total benefits continue to be about one-third of all cases and about 70% of all claims. Claims for medical benefits also continue to grow slightly. Figures for the last three fiscal years are available in Appendix F.

The DIA's weekly fatal report **(RPT 56)** listed 125 deaths in FY'91, a significant increase over the FY'90 total of 92, but less than the FY'89 figure of 182. In FY'89 when descriptions were provided on the report, 60 listed the injury as a heart condition and 15 listed asbestosis. In the last two years these figures have been 30 and 3 (FY'90) and 42 and 7 (FY'91), respectively. As noted last year, the report appears to support the notion that many employees allegedly injured by asbestos exposure seek alternative remedies outside of c. 152 for their injuries. As last year, there was no record of opinions from medical examiners, as mandated by §7 of c. 37, that the death of the employee was caused by or related to the occupation of the deceased.

Multiple permanent injury claims, pursuant to §36 of the

law, have grown according to DIA statistics **(RPT 372)**. The Council requested information in this area a few years ago as a result of concerns that multiple cases might be filed under §36 in order to obtain multiple attorney fees. As of 10/4/88 there were only 6 claimants with more than 1 §36 claim, all represented by counsel and none of which received multiple attorney fees. All 6 had 2 §36 claims. A year later, the cumulative total had risen to 173 claimants, involving 96 separate lawyers, with 163 claimants filing 2 §36 claims and 10 filing 3 §36 claims. As of 4/30/91, the cumulative total had grown to 620 claimants with 259 different attorneys. Three claimants filed 4 §36 claims, 114 filed 3 §36 claims, and 503 filed 2 §36 claims. Due to the growing size of the computer report, it became impractical for the agency to individually check all the files in order to ascertain if multiple fees were paid.

Record Room

The Record Room is located in the Boston office and is responsible for filing, storing, and retrieving the DIA's case files. When files are needed by regional offices, they must be transported from the Boston office by courier. Inactive files are kept in an off-site storage facility.

In its report to the Advisory Council on the dispute resolution system, the authors stated that "the records of the DIA Dispute Resolution system can only be described as abysmal." The report noted problems in collection, filing, retrieval, handling and availability of case records, and cited complaints from virtually all participants interviewed by the research team.

Improvements during the last year in the management of records and in the retrieval of files from the Record Room were acknowledged in the report. There still remain serious problems. According to the report:

"...even if the manila file folder with the claimant's name can be retrieved and delivered to the conciliators or judges, it may still be missing one or more major component parts; it is still unbound and unpunched; there is still no list of expected document contents; and there is the frustration of having all the files held centrally so that each time a file is needed, it must be retrieved from the Record Room and driven by courier to the Regional office."

In order to improve the record system, the report recommended that a Work Group be formed to design and develop a standardized Record format and identify a process to enter and maintain material in the files. It also recommended that case files be regionalized and physically maintained in the appropriate regional office, rather than relying upon a centralized system.

Conciliation Unit

The conciliation unit seeks to informally resolve claims or complaints before referring them to the division of dispute resolution, where procedures may be more formal. Not all cases must go through conciliation. However, parties are required to cooperate when they are assigned to a conciliation. There is general agreement that the informal aspects of conciliation make it a more appropriate procedure for some cases than others. This is reflected in the statistics on conciliation outcomes.

The Report on Dispute Resolution devoted significant attention to the conciliation process and made several points which merit emphasizing here. The report underscores a long-standing perception that not all parties treat conciliation as a serious opportunity to resolve disputes and settle cases. Some parties, for instance, do not submit sufficient or requisite materials for reaching agreement, or at times do not send representatives who are authorized to approve resolution.

However, the report also states that not all conciliators fully utilize their authority to require parties to make serious efforts to resolve disputes. For instance, some conciliators do not hold cases until the moving party appears and provides requested information, as they are entitled to do. Additionally, some conciliators are said to feel obligated to hold conciliations on complex cases that have no chance of being resolved at this stage.

Several recommendations were offered to improve the effectiveness of conciliation. It was suggested that guidelines be developed for conciliators so that they have a better understanding of their authority and how to exercise it. Another recommendation was to develop criteria for conciliators to use in identifying cases which should be immediately referred to Dispute Resolution without conciliation.

Conciliation could also be improved if duplicate cases

were joined to existing cases rather than enter the system anew. In order to facilitate this process, the report suggested providing conciliators with computer access to allow them to review case data. The report also suggested that the conciliator offices in Fall River and Boston be improved to enhance privacy in making the process more effective.

During FY'91, **(RPT 16)** the conciliation unit scheduled 55,702 matters (an increase of 12.1% from FY'90 and 32.3% from FY'89) and entered dispositions for 39,080 (an increase of 12.3%). A total of 16,149 cases (29%) were rescheduled -- a figure which has increased over the last 3 years. While the total numbers have grown, the percentages of the various dispositions have remained about the same. In the last three years, a slightly higher percentage are adjusted at conciliation, while a lower percentage are adjusted prior to conciliation. The percentage of claims referred has increased slightly, while the figures for complaints has been fairly constant. Figures for the last three fiscal years are set forth in Appendix G.

Some information is available on the disposition of certain types of cases at conciliation **(DIA Report 39)**. The data provides a number of elements for finished cases in three fiscal years. It delineates the number of matters closed or referred through this stage of the process. It also delineates the results when both parties are present at a conciliation. The first percentage for such cases indicates the percent of the total of finished cases, while the second identifies the impact of having conducted a conciliation.

TABLE V

	Cases	Closed	Referred	Accepted	Rejected
			Heart Claims		
FY'89	450	24.4	75.6	14.2	68.2
				17.3	82.7
FY'90	438	28.3	71.7	17.6	63.9
				21.6	78.4
FY'91	427	23.9	76.1	16.6	70.0
				19.2	80.8
			Infection Claims		
FY'89	154	44.8	55.2	32.5	48.7
				40.0	60.0
FY'90	168	45.2	54.8	30.4	47.6
				38.9	61.1
FY'91	186	57.0	43.0	37.6	40.0
				47.9	52.1

TABLE V (cont'd)

		Mental Claims			
FY'89	161	18.0	82.0	11.2	70.2
				13.7	86.3
FY'90	171	26.3	73.7	19.3	66.7
				22.4	77.6
FY'91	202	29.7	70.3	18.8	64.9
				22.5	77.5
		Toxic Claims			
FY'89	456	33.8	66.2	12.3	48.5
				20.2	79.8
FY'90	516	25.8	74.2	16.5	60.7
				21.4	78.6
FY'91	487	29.4	70.6	18.7	60.2
				23.7	76.3
		Claims With Return To Work Date			
FY'89	156	71.2	28.8	41.0	25.0
				62.1	37.9
FY'90	219	86.8	13.2	46.1	9.6
				82.8	17.2
FY'91	369	86.4	13.6	56.4	13.0
				81.3	18.8

Claims have increased in 3 of the categories since FY'89 and only the "heart" category has shown a steady decrease in the number of disputes. The greatest increase (137%) has occurred when there is a return to work date where the vast majority of cases are not referred to DDR. In each of the 5 categories for FY'91, the success of the actual conciliation process is an improvement over FY'89, although the numbers have not all increased consistently. Conciliation is most successful when both parties attend the event.

A total of 20,503 cases were referred to dispute resolution in FY'91 **(Report 316)**, an increase of 2,285 (12.5%) over FY'90. The change from FY'89 to FY'90 was 13.6%, a total increase of 2,185. There were 4,470 more referrals, or 27.8% in the last 2 fiscal years. The table below indicates the totals and the percentage of totals, by regional office, of the matters referred to DDR in the last 3 fiscal years.

TABLE VI

REGION	CLAIMS	COMPLAINTS	TOTAL
FY'89			
BOSTON	4123 (54%) (45%)	3498 (46%) (52%)	7621 (48%)
FALL RIVER	1393 (59%) (15%)	961 (41%) (14%)	2354 (15%)
LAWRENCE	1138 (56%) (12%)	889 (44%) (13%)	2027 (13%)
SPFLD.	1356 (72%) (15%)	516 (38%) (8%)	1872 (12%)
WORCESTER	1238 (57%) (13%)	921 (43%) (14%)	2159 (13%)
TOTALS	9248 (58%)	6785 (42%)	16033
FY'90			
BOSTON	4470 (54%) (44%)	3834 (46%) (48%)	8304 (46%)
FALL RIVER	1583 (57%) (15%)	1174 (43%) (15%)	2757 (15%)
LAWRENCE	1302 (52%) (13%)	1180 (48%) (15%)	2482 (14%)
SPFLD.	1387 (66%) (14%)	700 (34%) (9%)	2087 (11%)
WORCESTER	1502 (58%) (15%)	1086 (42%) (14%)	2588 (14%)
TOTALS	10244 (56%)	7974 (44%)	18218
FY'91			
BOSTON	5652 (57%) (48%)	4203 (43%) (48%)	9855 (48%)
FALL RIVER	1800 (56%) (15%)	1400 (44%) (16%)	3200 (16%)
LAWRENCE	1204 (55%) (10%)	972 (45%) (11%)	2176 (11%)
SPFLD.	1552 (64%) (13%)	884 (36%) (10%)	2436 (12%)
WORCESTER	1612 (57%) (14%)	1224 (43%) (14%)	2836 (14%)
TOTALS	11820 (58%)	8683 (42%)	20503

As in the last three years, the numbers remain fairly consistent in 4 of the 5 offices. The ratio of referred claims and complaints is the same as it was two years ago and deviated little over the three year period. Referrals translate into potential conference slots before AJs. Under the current (FY'92) DIA scheduling format, each AJ is scheduled for an average of 797 conferences a year. Full capacity for FY'91 for 21

positions would provide for 6,737 slots. If the seven one-term judges were included, a total of 22,316 slots would be available. Although not all positions were in use for the entire fiscal year, inasmuch as all "backlog" conferences have been scheduled, it indicates that a full complement of adjudicators should have the capacity to handle the current level of referrals.

During the last fiscal year, conciliation statistics for finished cases **(RPT 42)** showed that the unit handled 22,624 claims, a 14% increase above FY'90 and 26.4% rise over FY'89. The percentage of claims closed has decreased slightly in each of the last three fiscal years: 52.1% in FY'89; 51.2% in FY'90 and 50.4.% in FY'91. While referral totals increased, the percentage of claims adjusted/paid without prejudice rose from 16.3% in FY'89 to 18% in FY'90 to 20% in FY'91. One reason may be that the percentage adjusted prior to conciliation continues to decrease, dropping from 11.4% in FY'89 to 7% in FY'91. Overall, the percentage of total finished claims resolved when both parties attend the event has grown from 30.6% in FY'89 to 33.9% in FY'90 to 36.8% in FY'91. In addition, the portion of matters resolved when the event takes place continues to increase, clearly indicating that the process works best when parties take part in the process.

Claims for §36 benefits rose 8.7% in the last fiscal year after increasing 27% in FY'90. The percentage closed rose from 87.8% in FY'90 to 92%, while the percentage resolved when conciliation was held rose from 87.5% to 90.6% this year. The high success rate of §36 claims is evidence that the ability to resolve disputes through the less formal conciliation process is enhanced when specific parameters exist, such as those for §36. When determinations must be reached through the adversarial process on such issues as extent of disability, the chances for resolution diminish. In those cases, the stakes for the parties are often greater and the possibility of litigation increases.

Discontinuance requests by insurers grew by 5.4% over FY'90, while the previous year's growth was 15%. The percent of cases referred (75.8% versus 75.3%) and the matters resolved where the event occurred rose (19.4% to 19.9% this year) were largely unchanged. In FY'89 only 72.6% were referred, while 20% were resolved when conciliation took place.

Third party cases continue to exhibit rapid growth,

rising 28% this year following a 58% increase last year. The percentage referred dropped slightly from 12.2% in FY'90 to 11.6% in FY'91. The increasing use of the conciliation process for 3rd party claims, while extremely successful for the types of disputes, may be evidence of other systemic influences causing parties to file claims in order to receive what they believe are the appropriate payments.

Tables for the last three years for finished cases **(RPT42)** provide an indication of the types of cases represented in the closures and referrals.

TABLE VII
CONCILIATION STATISTICS FOR FINISHED CASES
DURING FISCAL YEARS
RPT42

	FY'89	FY'90	FY'91
Total	30,707	35,089	39,080
Closed	14,859	16,752	18,790
% of Total	48.4	47.7	48.1
Referrals	15,848	18,337	20,290
% of Total	51.6	52.3	51.9

CLAIMS

	TOTAL	% OF TOT. CASES	CLOSED	% OF CLOSED	REF.	% OF REFERRED
FY'91	22,624	57.9	11,406	60.7	11,218	55.3
FY'90	19,782	56.3	10,131	60.5	9,651	52.6
FY'89	17,901	58.3	9,318	62.7	8,583	54.2
	60,307		30,855		29,452	

§36

FY'91	3,928	10.1	3,615	19.2	313	1.5
FY'90	3,614	10.3	3,172	18.9	442	2.4
FY'89	2,837	9.2	2,449	16.5	388	2.4
	10,379		9,236		1,143	

DISCONTINUANCES

FY'91	11,382	29.1	2,757	14.7	8,626	42.5
FY'90	10,798	30.8	2,663	15.9	8,135	44.4
FY'89	9,399	30.6	2,579	17.4	6,820	43.0
	31,579		7,999		23,581	

THIRD PARTY CLAIMS

FY'91	1,145	2.9	1,012	5.4	133	.7
FY'90	894	2.5	785	4.7	109	.6
FY'89	566	1.8	510	3.4	56	.4
	2,605		2,307		298	

Note: There were four finished cases in FY'89 classified as "Other", three of which were closed and one referred.

The conciliation unit finished 11.4% more cases than in FY'90 and 27.3% more than in FY'89. Closed cases have remained at 48%. In finished cases where the parties appeared, the success rate improved from 33.6% to 35.5% in FY'91. In three years, only 627 of 104,876 finished cases (.6%) were conciliated with a disposition of pay without prejudice.

Information is available on the types of cases which are referred.[4] The following table outlines the statistics by the major categories and the corresponding percentage of referrals.

TABLE VIII (RPT 29)
Statistics For Sections Of The Law Being Claimed
(excluding reschedules With Scheduled Date in Fiscal Year)

	FY'1989	FY'1990	FY'1991
Employee Claims Held	17,901	19,975	22,929
No. Referred	8,583	9,565	11,218
% Referred	47.95	47.88	48.92
§36 Claims Held	2,837	3,669	3,987
No. Referred	388	440	313
% Referred	13.68	11.99	7.85
Disc. Held	9,399	10,846	11,478
No. Referred	6,819	8,093	8,628
% Referred	72.55	74.62	75.15
3rd Party Claims Held	566	897	1,159
No. Referrals	56	107	133
% Referred	9.89	11.82	11.48
Totals Held	30,707*	35,388*	39,553
No. Referred	15,847*	18,204	20,290

*Totals include 4 cases, one of which was referred, in FY'89 and 1 case in FY'90 entered as "other".

One significant change is the increase in §36 cases. The drop in referrals may stem from parties becoming acclimated to conciliator recommendations and greater standardization in the evaluation process. The highest percentage of referrals come from matters seeking §34A (permanent/total) §31 (death) and §28 (serious/willful misconduct). Cases concerning the computation of the employee's average weekly wage had a lower referral percentage this year and this could be related to the decision in Borofsky's Case.

Third party claims for sections 13/or 30 (medical benefits) show the largest percentage increase. Despite growing about 143% in the last two years, over 89% were resolved at conciliation each year. The increase in disputes with the high stable resolution rate appears to indicate that providers are seeking recourse through the system for payments owed. Prompt payment of medical providers not only saves limited dispute resources for other matters (claims/discontinuances), but is also likely to encourage access. If increasing numbers of providers must file claims to obtain legitimate payments (this may provide one explanation of the low referral rate, while another explanation could be withdrawals by moving parties), access to medical treatment may suffer. Many other issues concerning access should be addressed by the Health Care Services Board, so perhaps the trend of increasing disputes will end as of FY'91.

This year, 51 of the 20,290 referred cases concerned attorney fees with employee claims. Another 28 cases involved third party claim referrals. Over a 3 year period covering 105,648 cases held and 54,341 referrals (51.4% of the total), 194 referrals (employee and third party claims), or .4% of the total referrals, concerned cases with the attorney fee section claimed.

While the percentage of referrals has decreased slightly, indicating a greater success rate, the average percentages have remained static. The fact that percentages remained stable, while total numbers rose, suggests that the system may have established its success level a few years ago. Previously, the relative newness of the conciliation procedure discouraged analysis of its efficacy. Since the DIA's statistics have changed little over the last three years, it would appear that the basic contours of the system were observable two years ago.

A question raised frequently by the Council in the last two years has concerned whether cases at conciliation were new matters or disputes that had previously been filed. During the last fiscal year the DIA reported that 12,308 (31%) of conciliations had a prior claim filed. The same percentage of the 20,458 referrals had a prior claim filed. In addition, the Council has asked for information regarding the types of cases being brought to the agency at conciliation. This might show, for example, whether a disputed matter at conciliation was initially paid without prejudice or perhaps resulted

in a termination due to a medical from a treating MD, in conformance with the statutory language.

The conciliation unit conducted a survey of matters before them this fall for cases involving claims for §34, temporary total benefits. In a sample of 196 cases, 89 (45.4% of the total sample) were paid without prejudice, with 2 of these (2.3%) terminated due to a treating MD report, while 70 (78.7%) were terminated due to an IME and 17 (19.1%) terminated for a reason classified as "other". Of the 103 (52.6% of the total sample) denied initially, 17 (16.5%) were subsequently paid, 16 (15.5%) were terminated due to an IME, 7 (6.8%) were terminated for a reason classified as "other", and 63 (61.2%) had never been paid. Only 4 (2% of the total sample) were cases listed as being at conciliation with no prior knowledge of the injury.

The cases indicating a payment without prejudice only encompass matters when the employee still sought benefits after termination. They do not show cases where there has been such a payment and the employee has returned to work. This data may provide the agency with an initial base upon which it could, with its resources and personnel, perform additional research into just what type of case is being presented at conciliation.

DIA data, **(RPT 390)** establishes some changes in referrals from conciliation. The range in the percent of claims referred for the 25 insurers with the highest caseloads at the DIA was 39%-67% in FY'89 and 41%-75% in FY'91. Dispostions entered for referred claims indicate a smaller rate of referrals without a conciliation. The percentage of referrals for claims after a conciliation has increased in each of the last three fiscal years from 86%-89%-93%, which may be evidence of improved participation in the process. During the same period, dispositions for adjustments, 32%-37%-40%, and pay-without-prejudice, 1%-2%-4%, rose while withdrawals prior, 17%-13%-9%, and acceptances prior to conciliation, 22%-18%-15%, decreased. The percentage of §36 cases, 9%-11%-15%, adjusted prior to conciliation also rose in each of the last 3 fiscal years.

Referral rates for discontinuances rose in each of the last 3 fiscal years, 79%-84%-86%, and the total number of referrals has grown 23% since FY'89. Withdrawals prior to conciliation have dropped, 30%-23%-19%, while withdrawals at conciliation have increased, 50%-55%-58%. Since a smaller percentage are referred without conciliation (11% in FY'89/90 and 6% in FY'91) and the portion withdrawn by the DIA has risen (7%-11%-14%), it would appear that the conciliation event may have more of an impact on certain resolutions than in the past.

The Council has long encouraged DIA management to explore use of its administrative authority, with a specific suggestion that steps be taken to ensure that parties appear prepared at conciliation. The exercise of this authority is evidenced by the DIA notification to parties (on 6/11/91) that the rescheduling of initial conciliations would only be allowed if the Conciliation Manager determined that circumstances had made it impossible for the moving party to attend. In addition, if the moving party at a conciliation failed to appear or present causal relationship and/or other relevant documentation, the matter would be withdrawn. As a means of ensuring the integrity of proceedings, the DIA also notified parties that it would not accept documents on behalf of a claimant with only the attorney's signature without the production of the claimant's power of attorney or other express written authorization.

This new policy was effective July 15, 1991. Its impact can be initially seen in conciliation statistics for the first half of FY'92. Reschedules entailed 22.4% of the cases scheduled in that period, a significant drop from the 28-29% rate in the last few years. Withdrawals for no shows totaled 4.5% of the scheduled conciliations which, while a small portion of the cases, is more than double the most recent rates in the last two years. The half year totals also show a more than 2% increase in the closure rate at conciliation, decreasing the need for conference slots and thereby improving the DIA's ability to reduce the backlog. While other factors may have contributed to these results, it appears that the implementation of this policy has been successful and is an example of positive action taken by the agency for which it deserves credit.

Office of Safety

The Office of Safety was created by the 1985 reform law to reduce work-related injuries by expanding health and safety awareness and education. To this end, the office provides funding for programs which promote safe and healthful workplaces.

The Office of Safety awarded its fourth round of safety grants during the 1991 fiscal year. A total of 3,730 persons received training under the 15 grants that were awarded at a total expenditure of $377,450.74 which averages to just over $100 per person. The total number of person hours for training was 12,685.5. In the first four years of funding a total of 53 contracts have been awarded and $1,352,058 has been expended, about $81 per person, to train 16,698 persons. In FY'92 there are 14

grants awarded. Seven grants went to nonprofit groups, two each to labor organizations, joint labor-management groups and public employers and one to a public educational institution.

A total of $400,033.22 was awarded in FY'92. The target populations are evenly divided between employers/ employees and employees. The geographic areas covered encompass the entire state. A list of the grants for FY' 92, with their titles, is set forth in Appendix H.

Office of Education and Vocational Rehabilitation

The Office of Education and Vocational Rehabilitation is responsible for carrying out agency responsibilities for providing information to the public, ensuring the availability of vocational rehabilitation for qualified claimants, and monitoring the use of lump sum awards. Three distinct units are charged with discharging these responsibilities: The Public Information Unit, the Vocational Rehabilitation Unit, and the Lump Sum Counseling Unit.

The Public Information Unit

The Public Information Unit provides a number of outreach services to the public. The unit maintains an informational telephone line and walk-in information desk at the Boston office. It also prepares and distributes information booklets for both employers and employees.

The unit is headed by a senior information officer and staffed by four additional information officers. These employees provide information and assistance to all parties in the system. Such help can involve explanations on the statute and departmental forms, as well as referrals to other entities that would have jurisdiction over the issue in question. Numerous questions are received on a daily basis in writing, on the main telephone line, or on the toll free number within Massachusetts, 1-800-323-3249. The staff prepares informational booklets on the law and has in the past year worked on informational video components. It also publishes an in-house newsletter for the agency. All staff work in the Boston office.

The Vocational Rehabilitation Unit

The Vocational Rehabilitation Unit oversees the provision of rehabilitation services to workers'

compensation claimants whose injuries prevent them from returning to their prior jobs in their current conditions.

The office seeks to ensure that those employees needing vocational rehabilitation in order to return to work receive expeditious attention and guidance in developing a rehabilitation plan. The overriding philosophy of the office is to facilitate voluntary agreements between insurers and employers on services designed to return the worker to suitable employment. However, when a voluntary agreement isn't reached, the law provides that workers qualifying for vocational rehabilitation benefits are eligible for up to 52 weeks of vocational rehabilitation training that may be paid out of the trust fund.

Services provided by this unit, or through designated rehabilitation providers, include vocational evaluation, counseling, workplace modification, retraining, and education. Programs may either be oriented towards returning the worker to the previous employer in a different or modified capacity or towards preparation for a new vocation.

In conducting its work, the office attempts to identify and contact persons requiring vocational rehabilitation at an early stage, since the prospects for a successful return to the workforce are undermined by long delays. The initial action of the office is to screen workers' compensation claims to identify likely candidates for rehabilitation. These persons are contacted and scheduled for a meeting with one of the office's rehabilitation counselors. When confirmation is made that some form of vocational rehabilitation is in order, the office works with the employee in developing a rehabilitation plan, while also seeking the insurer's consent to provide the program.

An indication of the unit's activity is offered by aggregate statistics for the period from 1987 through June 1991. During this time, which represented the history of the unit in its entirety, the office contacted 58,015 people to determine the appropriateness of rehabilitation services and scheduled mandatory meetings for 20% (11,531) of those contacted. Of these, 54% (6,331) were determined to be eligible for services, and 48% of the eligible candidates (3,011) signed Individual Work Rehabilitation Plans (IWRPs). A total

of 1,273 people had returned to work following rehabilitation, while 1,086 cases remained open and 652 were closed unsuccessfully.

A closer depiction of what is taking place in rehabilitation was shown in a recent caseload breakdown over a two year period. Of 675 cases, 43% (299) were declared eligible for rehabilitation and referred to private providers for the development of IWRPs. Another 23% (154) opted to settle and showed no interest in rehabilitation, while 7% refused the rehabilitation option for other reasons, and 26% (178) were still receiving treatment. Of the 299 cases referred, 62% (185) signed IWRPs, while the rest were awaiting further evaluation and rehabilitation plan development. 68% (125) of the IWRPs were closed, with 81 considered rehabilitated, and 44 closed unsuccessfully. The unsuccessful cases included 8 medical relapses, 3 deemed inappropriate, 17 which lump summed, and 2 which settled and closed out rehabilitation rights.

Another DIA analysis of 622 closed cases from July 1988 through December 1990 provides some profiles of injured employees. The sample was 68% men and 32% women. 56% were between 20 and 39 years of age, 40% between 40 and 59, 4% between 60 and 69, and there was 1 teenager and 1 person about 70 years old. On education level, 2% had no formal education, 8% completed grade school, 11% completed junior high school, 6% completed trade school, 64% completed high school, 10% had an associates/college degree, and less than 1% had a masters degree.

Return to active productive employment is a primary goal of rehabilitation and some comparisons are available from DIA analysis of closed cases of rehabilitated employees.

TABLE IX

	1988	1991
Return to former job	51%	36%
Ret. similar work/new employer	12%	11%
New employer/new job	37%	42%
Req. retraining to find work	2%	9%
Returned in less than 1 yr.	96%	92%
Returned more than 1 yr.	4%	8%
Returned at lower wage	2%	25%
Returned at higher wage	15%	41%
Returned at about same wage	83%	34%

The higher number of jobs available in 1988 may explain some of these differences. In addition, the composition of the economy has changed as the state continues to lose manufacturing jobs and has added more jobs in the service area. This may explain the greater percentages of returning employees at higher and lower wages.

In 1985, 463 injured employees were considered for vocational rehabilitation programs and 2,000 cases awaited a decision from the voluntary advisory board which reviewed these cases. The statistics indicate that the rehabilitation unit has been extremely active in attempting to contact and consult with injured employees.

There has not yet been a qualitative assessment of the rehabilitation program and its success in preparing and steering injured employees to gainful employment. However, from a rehabilitation standpoint, the figures suggest an uneven success in realizing the aims of the 1985 reform. Perhaps the most telling shortfall is an inability to channel more prospective lump sum settlements into rehabilitation programs. A closed case survey of 622 participants in rehabilitation between July 1988 and December 1990 revealed that 44% of those participating in vocational rehabilitation programs opted for a lump sum settlement at some point. There could be added to this an additional 23% of eligible employees who have already refused rehabilitation services and opted for a lump sum settlement.

Since the lump sum issue is clearly a system problem, whatever shortcomings exist in relation to vocational rehabilitation cannot be wholly or primarily attributed to the existing vocational rehabilitation program. It seems clear, however, that coordinated efforts will have to be made to strengthen the appeal of vocational rehabilitation to injured employees.

Lump Sum Counseling Unit

Lump sum counseling was introduced by the 1985 reform law in an effort to control the injudicious use of lump sum settlements by injured employees not fully aware of the full implications of their settlements. The lump sum review function seeks to ensure that employees understand the legal and financial aspects of the lump sum settlement prior to signing an agreement and that the settlement is not obviously against the employee's best interest, as well as assess the impact of such

settlement on the employee's rights under c. 152.

By statute, lump sum counselors are to conduct reviews within 14 days of the office's receipt of a request by an employee to lump sum. Following the review, counselors submit a report to the Reviewing Board, where final approval over lump sum settlements takes place. During the past fiscal year, 14,572 **(RPT 83)** lump sum interviews were scheduled by counselors, a 12% increase over the FY'90 figure of 13,030. In each year, 89.2% were referred to the ALJs for approval and 2.9% were withdrawn prior to the interview. This year, 1.0% were voluntarily adjusted, and last year the percentage was .7%. The percentage of referrals in FY'89 was the same as in the last two years. However, there has been a 68% increase in the number of scheduled dates, which offers further evidence regarding increased usage of the lump sum process. Another difference is that the percentage of withdrawals prior to the interview has decreased over the last two years, while it would appear that it has been replaced by reschedules.

Office of Insurance

Virtually all private employers in the commonwealth must carry workers' compensation insurance, either through purchasing insurance in the private market or by self-insuring. The Office of Insurance monitors insurance coverage and enforces penalties against those who break the law.

The office is comprised of a records unit, a self-insurance unit, and an investigation unit. The records unit monitors insurance coverage for employers by maintaining and reviewing records of expired and renewed policies, while the self-insurance unit monitors those companies which self-insure. The investigation unit conducts investigations of businesses believed to be operating without valid workers' compensation insurance policies and is authorized to close down uninsured businesses upon the approval of the Commissioner of the DIA when they fail to purchase insurance after they have been warned to do so.

One change within the jurisdiction of the office was established by Circular Letter 255, issued on October 10, 1990, in replacing Circular Letter 243. The following was noted as part of the directive.

"Please be advised that in accordance with a determination by the Office of the Attorney General that

Commerce clause and equal protection provisions of the United States Constitution are implicated in Departmental regulations of self-insurance, Departmental practice shall be understood as follows:

No policies or procedures of the Department of Industrial Accidents shall distinguish between foreign and domestic insurance carriers and their ability to provide claims handling services to Massachusetts licensed self-insurers, provided that these activities are permitted under their bylaws and domiciliary state laws and provided further that all requirements of Massachusetts law have been satisfied."

As a result, self-insurers and self-insurance groups can use insurance companies as third party administrators for their claims, contingent upon requisite statutory authorization and the filing of proper agreement with the DIA and the Division of Insurance.

There were a total of 135 licensed self-insurers, including 81 subsidiaries in FY'91. The office received 32 applications to self-insure, and 15 (including subsidiaries) were approved. While 11 applications were not approved, they were not technically denied and such companies were encouraged to reapply at a later date. Four applications were withdrawn. The Council requested clarification of the term "new" in 452 CMR 5.05(2), as to whether it referred to any application or just initial applications, but did not receive a response.

The office received 195 insurance claim complaints and assigned a total of 2,100 investigations, which includes those determined to have reinstated coverage at the time of assignment. There were 924 coverage noncompliance investigations. This figure includes companies that are out of business, have no employees, or are viable but are operating without insurance at the time of the initial assignment to an investigator. The Council was unable to obtain the number of investigations which resulted in a determination of no coverage in order to compare it to last year's figures.

A total of 85 stop work orders were issued and $33,700.00 in fines collected. The department brought 64 criminal actions and held 3 administrative stop work order hearings. DIA records for FY'91 show that 531 §65 investigations were completed and that investigators had 501 conciliation appearances. From 1987 through the end

of FY'91, a total of 186 stop work orders were issued and $63,000 in fines collected.

Division of Dispute Resolution

The Division of Dispute Resolution is composed of the Industrial Accident Board and the Reviewing Board.

The composition of the industrial accident board currently provides for a full complement of 21 administrative judges, not more than 11 of whom may be members of the same political party. These positions are appointed by the Governor for 6 year terms. In addition, there is authority for the agency to hire 7 other members, without respect to any statutory party affiliation. The agency also has the authority to recall former members for up to one year.

Due to the extensive delays in the current system, and the corresponding costs for employees and employers created by those delays, the division of dispute resolution continues to receive the brunt of scrutiny by all interested parties in the system. The addition of 7 temporary administrative judges enabled the DIA to schedule all of the 12,202 cases which were defined as the "backlog" in June 1988. However, there is a new "backlog" which must be addressed and this has generated much of the discussion of additional reform in the last few years.

Industrial Accident Board

The department prepares monthly totals on the number of decisions mailed out and the number of cases resolved. While statistics may provide some indication of performance, the Council has long maintained that they should not be the sole criteria for evaluating members of the industrial accident board. In addition, the raw numbers, as noted in the appendices, do not take account of when the DIA has taken an individual "off line." This has been done when individuals are not going to be reappointed, and was done this year when funding for the temporary judges was not initially included in the agency's appropriation.

The agency lost almost 200 weeks over the past year when judges were off line and more than 55% of this total lost capacity concerned the backlog judges. When the agency management takes a judge off line, no new conferences are scheduled for that judge. Due to the

scheduling cycle, each week off line may not necessarily be a week scheduled for conferences. Judges continue to conduct hearings, hear rescheduled hearings and conferences, as well as write decisions and resolve disputed matters. However, taking judges off line clearly hinders the capacity of the division to keep up with burgeoning caseloads. Since the most discussed delays in the system are between conciliation and conference, it is in the best interest of all parties to minimize this from happening.

In June of 1990 a new schedule (effective about 8/20/90) was implemented that raised the average number of conferences scheduled annually to 708. Gains from such increases - as when conference capacity was increased in July of 1991 by 11.2%, for an average of 797 per year, and hearing capacity by 21%, for an average of 332 per year - must be tempered by the realization that all judges are not on line for the entire year. Even though available capacity has once again been increased, it can easily be offset when judges are not available for the complete period. This is shown in the appendices where a judge did not have cases assigned for a specific month.

Approximately 1,500 hardships requests were filed with the agency in FY'91, but no statistics are available on the number approved. A total of 211 late appeals were filed, pursuant to §11C, to the Commissioner of the DIA. The Commissioner denied 62 and allowed 149. The only comparison figures available show for a 6 month period in 1988 there were 2,401 appeals filed, of which 131 were late. All 29 of the petitions to file a late appeal were approved.

The number of decisions mailed out in FY'91 increased 4.7%, from 1,475 to 1,545 (Appendix I). Since FY'89, there has been a 20% increase. There were 16,685 cases resolved in the last fiscal year, 1.8% less than the previous year's total of 17,005 (Appendix J) and 47.6% higher than in FY'89.

Hearing statistics for scheduled dates in FY'91 showed 8,069 dispositions, for which 758 (9.4%) decisions were filed. At nearly the same time last year, the report indicated 8,728 dispositions and 871 (10.0%) decisions filed. The percentage of cases referred to lump sum, or for which a lump sum was recommended, increased from 33.7% of the total last year to 37.5% of the total this year. When this report is run directly after the close

of the year, there has been a significant number of cases without dispositions--18.7% this year and 17.7% last year. The percentage of cases rescheduled this year dropped from 11.7% to 6.6%, which should indicate that the resources at the DIA are being used more efficiently, particularly since in FY'89 the figure was 15.5% of the total that were rescheduled.

The DIA has provided updated reports for scheduled dates for FY'89 and FY'90 (Appendix K), run on September 27, 1991. For scheduled dates 7/1/88-6/30/89, there are still 35 (.5%) cases without dispositions, and from the 7/1/89-6/30/90 period, there are 180 (2.1%) cases without dispositions. An August 29, 1990 run showed 146 FY'89 cases without dispositions, with 35 cases, scheduled anywhere from 39 to 27 months earlier, still not finalized in the computer. A total of 57 additional decisions were filed for FY'89 during FY'91.

In the 14 month period from the computer run date for FY'90, an additional 743 decisions were filed, bringing the total to 1,614. (See Appendix K) This figure was 18.4% of the total cases, up from 10% at the time of the previous computer report. While there were minor increases in the totals for other dispositions (e.g. withdrawals, voluntary adjustments, lump sums), the majority of the 1,366 new dispositions were for decisions filed. These latest reports suggest that decisions are more prevalent final dispositions for matters litigated to this point in the process. At the same time, these decisions are being filed well beyond the scheduled dates and this lapse may confound recollections of the case. Management and interested parties may wish to focus some attention here, since the implication is that the majority of disputed matters in the system for longer periods are not resolved by the parties, but rather by a judicial decision.

In FY'91, there were 19,268 conference scheduled dates, a 2.4% decrease from the FY'90 total. Orders for conference scheduled dates in the last fiscal year rose by 2%, from 10,261 in FY'90 to 10,437. There were 489 fewer voluntary adjustments in FY'91. In each year the percentage of the total for orders and adjustments has been 63.7%.

In the last three fiscal years, from FY'89-FY'91, the percentage of voluntary adjustments has dropped from 12.1% to 11.7% to 9.5%. These figures indicate a trend

to fewer percentage resolutions before an order is issued, thereby continuing the litigation cycle. Voluntary adjustments have also decreased the hearings from FY'89 - FY'91 from 6.9% - 6.9% - 6.6% - 5.7%. This appears to indicate that as the stakes increase as the length of time draws on, there are far fewer voluntary adjustments.

The average of all appeal rates of conference orders for the DIA in FY'90 was 76%. Percentages ranged from 67.1% to 86.2%, and the median appeal rate was 76.4%. In FY'91 the average was 78.9% while the range was from 73.4% to 88.2%. The median figure was 78.7%. The appeal rates have risen in the last fiscal year and this year 10 of the 28 AJ's had appeal rates of 80% or more.

Lump sums are far more of a factor at the hearing stage. Using the most recent computer reports, the total percentage of lump sum dispositions for hearing dates in the last three years was 41% (FY'89); 42.8% (FY'90) and 41.9% (FY'91). The conference totals are 17% (FY'89; 17.6% (FY'90) and 18.7% (FY'91). These differences may be generated by parties concerned about winning or losing at the hearing level or a strategy to use the previously issued conference order as leverage. While the lengthy time periods to hearing dates clearly have an economic impact on the parties, time may not be the sole motivation to lump sum. Other reasons, such as uncertainty over prospective outcomes or factors endemic to the system, may generate the atmosphere to settle.

Statistics for meetings held are listed in Appendix K, sheet 2. The 11% decrease in conferences and 14% drop in hearings held may be attributable to the fact that judges were off line. The conference figures for FY'91 are below FY'89 by 408, while lump sums have increased 32% since FY'89.

Reviewing Board

The Reviewing Board is comprised of 4 members appointed for 6 year terms, with no more than 2 members belonging to the same political party. The board is responsible for issuing decisions on appeal from the decisions of administrative judges, as well as approving all lump sum agreements and third party settlements. Two former administrative judges were again recalled last year to assist with lump sums. The board instituted a procedure of holding pre-hearing conferences with parties which has been successful in resolving outstanding appeals.

Oral arguments are held a few times a month, with approximately 10-12 cases heard per session.

In FY'91 a total of 522 cases were appealed to the board, a 12.3% increase, of which 307 (59%) concerned injuries with dates after 11/1/86. A total of 146 decisions were issued, up by 67 (85%) over FY'90. Parties appealed 24 decisions to the Appeals Court, which is a significant jump above the 7 last year. There were 1,263 cases pending before the board, of which 241 had been heard at a prehearing conference during FY'91. While this number has risen from 1,076 in November of 1991, the board began with an inherited caseload of 700 in 1986, and while 12 additional AJ positions have been authorized in recent years (thereby increasing possible appeals), the composition of the reviewing board has remained stagnant. Totals are listed in Appendix K.

The board issued a number of decisions during the past year which addressed some important questions with respect to chapter 152. A small portion of the decisions that the Council believes merit special attention are reviewed below.

The Court of Appeals vacated a reviewing board decision in King's Case, 3 Mass Workers' Comp. Rep. 210 (1989). In its initial decision, the board held that the filing of an agreement, without approval, relieved the employee of the burden of proof, particularly with respect to liability. Benefits were awarded to the employee. The Court of Appeals held that the agreement signed by the parties and filed, but not approved by the department pursuant to the law, was not final and binding with respect to the insurer's liability. In its decision on remand, (Brd. No. 024931-82, filed 1/17/91) the board affirmed the single member's decision denying and dismissing the employee's claim.

In Van Nguyen's Case, 4 Mass. Workers' Comp. Rep. 281 (1990), the board addressed a case where the claimant's attorney sought a fee because the insurer had not paid compensation at the proper rate within 14 days, even though the facts agreed to by the parties indicated that every effort was made to determine the correct rate voluntarily. The majority wrote that this claim was an abuse of the law and the system and was better rewarded with costs under §14. Since there were no costs, it was not applied. The concurring opinion expressed an

additional concern with the impact of such behavior on the relationship between the parties and on the dispute resolution process set forth in the statute.

In another decision issued by the reviewing board, the question of coverage for a public official was litigated. Judge's Case, 4 Mass. Workers' Comp. Rep. 335 (1990). The employee was a gubernatorial appointee[4] to the Board of Registration of Hairdressers for the Commonwealth, who incurred an injury while in the performance of her duties. An administrative judge denied the claim on the grounds that as a public official, the employee was excluded from coverage under the act. The majority did not overturn the finding that the employee was a public official, but reversed the decision denying benefits. The majority held that a review of the evidence in its totality required a finding that the claimant, although an appointee, was treated by the employer and performed her duties in exactly the same manner as an employee in state service. The employee's conduct, the restrictions of the appointment statute, the statutory classification plan, and the expectations of the Commonwealth warranted the finding of an implied contract of hire. The majority rejected the reliance on the holding in Attorney General v. Tillinghast, 203 Mass 39 (1909), which established criteria to determine whether a person was an employee or a public official and was issued prior to the enactment of the statute which provided workers' compensation benefits to state employees.

In an equally compelling dissent, it was stated that it was an antithetical result under either chapter 152 or case law to hold that a claimant is both an appointed official and an employee. In analyzing the criteria set forth in Tillinghast, the claimant was an office holder, not an employee. The powers and duties of the members of the Board of Registration of Hairdressers entrusted them with a significant portion of sovereign authority. The dissent also noted the definition of employee under Massachusetts General Law chapter 150E (the public employee collective bargaining law) as seeming to exclude appointed officials from the definition of employee. However, case law has determined that such employees are in fact a subset of managerial employees and are only excluded from the coverage of the law if the statutory requirements are met.[6] In addition, the statutory definition under the collective bargaining statute focuses on the responsibility of the position,

not the title,[7] and is not determined by the fact that an appointment is made by the executive branch of government.[8] In this CAS petition (which is a mechanism to clarify or amend an existing recognized or certified bargaining unit), the Labor Relations Commission held that the mere fact that a position is filled by an executive appointment, or is denominated a department head, is insufficient to require its exclusion unless job responsibilities meet the statutory criteria.[9] This case is currently on appeal to the Appeals Court.

A final decision in the appellate courts should resolve the issue as to whether a gubernatorial appointment is covered for work-related injuries. It is unknown how many such appointees have been informed that the Commonwealth does not consider them covered under c. 152 for work-related injuries. A suggestion offered in the Council's Public Employee report was that notification be provided so that individuals could be aware of coverage limitations and thereby able to independently purchase some form of disability insurance.

An issue that has created discussion, confusion, debate and frustration since 1985 is the application of the provision of §7 of the law. In Dennen's Case, Brd. No. 087701-87, filed 8/2/91, three members of the reviewing board stated that a violation of §7(1) does not mean that a claimant's right to benefits is automatically established. The decision states that the legislature did not use wording to create either a conclusive presumption or prima facie evidence of compensability and the board held that it is unequivocal that an employee is not entitled to compensation simply by an insurer's failure to comply with §7. The claimant must produce the evidence on all elements of a claim.

The decision examined the goals of the law with respect to prompt payment and avoidance of the pre-1985 situation of calculated ambushes in the form of last minute disclosures regarding the reasons for denying compensation. As long as the penalty is paid and the defense outlined in advance, the harm to which the law is directed is avoided. In addition, the board held that certain adjudicatory rules were invalid [452 CMR 1.05(1), 1.11(2), 1.02, 1.04(2), and 1.05(5)].

The majority noted that the timeframes set forth in the law invite a stopwatch mentality whereby parties too often address the calendar rather than the merits of the

instant case and, as a result, timeframes themselves create litigation. These disputes have added to the backlogs, as parties are confronted by a morass of adjudicatory rules which defy comprehension but demand compliance. The opinion outlines one premise for the notification of denial, including the grounds for such denial, which is to avoid defense by calculated ambush at the last moment before a conference. It is unclear, given the interpretation set forth by the majority, at what point in time, if ever, this perceived problem from the pre-amendment period would again be relevant.

The decision suggests to the General Court that as additional changes are discussed, there may be other proscriptions better suited to creating the delay-free environment necessary for workers' compensation. The case was remanded to the AJ for subsidiary findings of fact and general findings, as well as for a decision anew, in light of the majority's opinion.

A dissenting opinion was filed on September 19, 1991 which agreed with the order of recommittal, but not with the majority's reasoning. The dissent raised questions over the board's authority to investigate the case by reviewing the case file. Given the scope of review set forth in the law, the opinion questions whether the board could act as it did on a credibility issue of lay witnesses. The holding disagrees with the majority interpretation that defenses may be raised after paying the penalty set out in §7. The opinion believes that the majority is thwarting the legislative intent to have insurers act promptly and opines that the decision may decrease the incentive to pay without prejudice, thereby re-creating certain problems that the 1985 changes intended to rectify.

Another decision stated that interest is mandatory under §50 even if not requested by the claimant. Racine's Case, Board No. 36539-78, filed 1/31/91. The rate of compensation due to an employee on the filing date is purely a question of law which should be addressed by an AJ, even if the claimant fails to raise it at the hearing. Arruda's Case, Brd. No. 057187-78nr filed 1/17/91. The board noted in a footnote, Number 3, p. 3, that other sections, including §7A and §35B, must also be considered, irrespective of the fact that they are not raised by a party. Additionally, at Footnote 4 p.3, the board noted the insurer's argument that the application of §51A (final decision takes into

consideration compensation rate on decision date, rather than injury date) to a §36 claim would effectively mean that the insurer was penalized for waiting until a medical end result was achieved before paying. That argument may have some force with a different fact pattern, but in this matter the insurer's denial went to all claims, including §36, not on a failure to reach an end result, but due to contention that the injury was not causally related to the job.

The sole issue in another decision was whether the AJ acted properly in awarding an attorney's fee to the claimant's lawyer Serino's Case Brd No-807021-70 (2/12/91). The initial issue in the case arose when the self-insurer refused to voluntarily pay a COLA set forth in §34B, which states that the benefit is to be paid without application. The reviewing board held that the failure to pay the COLA without application and the resistance to the claim up through the hearing stage was unreasonable, the defenses purely specious and, as a result, the award of the fee was proper and warranted under §14(1).

In DiMartino's Case, Brd. No. 14664-85 (3/7/91), the board reviewed an appeal and failed to discover anything which might have constituted a marginally reasonable basis of prosecuting the appeal. The decision noted that the AJ took the time to carefully analyze the testimony and write a decision with clarity and logic which totally supported the final conclusion. The AJ's decision was affirmed and the board retained jurisdiction for a month in order to permit the successful party to file a motion under §14 seeking assessment of the whole cost of the proceeding against the losing party or the party's attorney.

In Gateley's Case, 4 Mass. Workers' Comp. Rep. 260 (1990), the board addressed the definition of purely voluntary recreational activity as set forth in §1 (7A) of the act. In this case, the employee had been playing "nerf" football while waiting to get paid at a construction site. The claimant and another employee left the waiting area and went to another construction site nearby where, while throwing the ball, the employee slipped and was injured. The majority of the board affirmed the AJ's decision, which concluded that the injury took place while engaged in voluntary recreational activity.

The third Administrative law judge on the panel concurred and dissented in part. The dissenting portion of the decision held that it was not voluntary recreational activity, stating that the legislature did not intend to sweep into the statutory exclusion of recreational activity anything and everything that an employee might do beyond "nose to the grindstone" work. If the injury had occurred in the initial area, it would have been compensable, the provisions of §1(7A) notwithstanding. However, when the employee left the location where the checks were to be delivered, he departed from the sphere and scope of employment, and the resulting injury occurred while he was engaged in a deviation from work and was therefore not compensable.

In another case, the board stated that the nature of the employee's recreational activity should be measured by an objective standard and not be based on an employee's purely subjective perceptions. Bengston's Case, Board No.92228-86, Filed 1/8/91.

The necessity of a qualitative method for evaluating performance is suggested by certain reviewing board cases. In Boulrice's Case, Brd. No. 072164-81nr, issued June 6, 1991, the board reversed the same member for the fifth time based upon the refusal of the member to allow parties to depose physicians. This also speaks to the possible need to have issues in cases reviewed.

The board's decision in Cowe's Case Brd. No. 095601-88, issued April 23, 1991, also illustrates the point. All four members of the reviewing board signed on to the decision. In this matter, a continued hearing was never held, but a decision was issued. The board, citing Meunier's Case, 319 Mass 421 (1946), stated that constitutional due process requirements apply to board hearings and decisions and, as a result, vacated the award and remanded the matter to the director of dispute resolution to assign to a different administrative judge for a hearing.

Similarly, the board remanded a case for a new hearing when a judge's infant was present at the hearing because the board was troubled by the disruptive atmosphere of the hearing. Moser's Case, 4 Mass. Workers' Comp. Rep. 242 (1990). Constitutional due process clearly applies to agency hearings and the right of the parties to a full and fair hearing is paramount.

The reviewing board decision in Gurley's Case, 4 Mass. Workers' Comp. Rep. 349 (1990), addressed a number of issues relating to the procedural requirements of the law. One of the issues was whether the self-insured employer had received notice of the claim. The Board noted that §10 of the act does not require a claimant to mail or deliver a copy of the claim to the insurer, nor is the issue addressed in the adjudicatory rules promulgated by the DIA. Although the claimant asserted that the claim had been sent to the employer, there was no evidence submitted to buttress that argument and the board noted that evidence as to the mailing of the claim, postage prepaid and properly addressed, would be prima facie evidence of its receipt by the employer. As a result, the board did not accept the claimant's argument that the provisions of §6 and §7 should be invoked in order to establish the claimant's entitlement to benefits by default.

The majority opinion also restated that the insurer's obligation to pay or deny is only triggered by the employer's notice of injury. The perceived legislative rationale behind that mandate is that the employer would have direct and personal knowledge of the injury, or at least the best chance to verify it, thereby imputing to the first report greater reliability and credibility than attaches to a claim. In a footnote, the majority opinion stated that the instant case did not present the issue of whether a proven violation of §7 means that all elements of the claim are established as a matter of law and that benefits are due.

The dissenting opinion noted the potential pitfalls that exist when parties choose to go "off the record" [also noted in Murphy's Case, 4 Mass. Workers' Comp. Rep.169, (1990)] in a proceeding. It also noted that affidavits presented in the case indicated that the insurer had received the claim. The dissent would have imposed the penalty set forth under §6 of c. 152 because of the employer's failure to file a first report of injury.

An employee's argument that an insurer should be deprived of defenses for failure to include in its denial notification that the employee could file a claim was held meritless because the employee suffered no harm, having filed a claim directly after receipt of the denial. Noel's Case, 4 Mass. Workers' Comp. Rep. 158 (1990). Determinations of incapacity must be supported by evidence and are not governed by what benefits have

been paid, particularly when paid without prejudice under §7. The fact that an employee is paid without prejudice under §7 is not determinative as to incapacity. Lally's Case, 4 Mass. Workers' Comp. Rep. 164 (1990).

Dependents of individuals who engage in wrongful activity outside the scope of employment are not entitled to recover under §27, which requires that the employee's conduct be in the course of employment Houeiss' Case, 4 Mass. Workers' Comp. Rep. 247 (1990).

The question of concurrent jurisdiction between c.152 and the LWHCA for a land-based injury sustained by a maritime worker is best resolved in a federal forum. Khoury's Case, 4 Mass. Workers' Comp. Rep. 290 (1990). Oral notice of the employee's claim on the day of hearing intruded on the insurer's fundamental right to defend the matter and justified vacating an award based upon the claim. Harris' Case, 4 Mass. Workers' Comp. Rep 308 (1990).

Remands were also required to determine, in an alleged emotional injury case, on which side of the "wear and tear" line the facts fall [see Zerofski's Case, 385 Mass. 590 (1982)]. Cennerazzo's Case, 4 Mass. Workers' Comp. Rep. 253 (1990); Walczak's Case, 4 Mass. Workers' Comp. Rep. 303 (1990).

Guidance to litigants often is costly to both the system and the parties. Given the large number of cases at the reviewing board level, an appellee who requests §14(1) costs can expect to receive them when an appeal is transparently without merit. Donais' Case, 4 Mass. Workers' Comp. Rep. 192 (1990). Numerous instances were noted by the board where parties, particularly appellants, did not file briefs or appear before the board or the AJ or prosecute their cases. Waldron's Case, 4 Mass. Workers' Comp. Rep. 298 (1990); Tramonte's Case, 4 Mass. Workers' Comp. Rep. 300 (1990); Murray's Case, 4 Mass. Workers' Comp. Rep. 333 (1990); Day's Case, 4 Mass. Workers' Comp. Rep. 312 (1990); Nova's Case, 4 Mass. Workers' Comp. Rep. 377 (1990); Kerivan's Case, 4 Mass. Workers' Comp. Rep. 379 (1990); Maliff's Case, 4 Mass. Workers' Comp. Rep. 126 (1990-FY'90); and Donais' Case, supra; Gifford's Case, Board Number 21368-68 (3/28/91); Marzal's Case, Board Number 080629-83, (1/17/91).

Amendments to the definition of personal injury in 1(7A)

for a mental or emotional disability have been deemed substantive and applicable to injuries occurring on or after the effective date. Leak's Case 4 Mass. Workers' Comp. Rep. 322 and Week's Case, 4 Mass. Workers' Comp. Rep. 322 (1990). Also, actions by fellow workers, as opposed to supervisors, are probably not bona fide personnel actions.

Employers should not be proscribed from good faith changes in the nature of an employee's work, good faith evaluation or critiques, or the changing of an employee's co-workers. Beaudry's Case, 4 Mass. Workers' Comp. Rep. 239 (1990).

Questions over attorney fees for pre-11/1/86 injuries, settled by Arbogast v. Employers Insurance of Wausau, 26 Mass. App. Ct. 719 (1988), were noted in decisions this fiscal year, Svedberg's Case, 4 Mass. Workers' Comp. Rep 160 (1990); Hammarberg's Case, 4 Mass. Workers' Comp. Rep. 269 (1990); Brady's Case, 4 Mass. Workers' Comp. Rep. 306 (1990); Rossborough's Case, 4 Mass. Workers' Comp. Rep. 326 (1990); Papageotpaulos' Case, 4 Mass. Workers' Comp. Rep. 348 (1990); and DiBlasi's Case, 4 Mass. Workers' Comp. Rep. 367 (1990); Racine's Case, Board Number 36539-78, filed 1/31/91. This is one indicia of the delays at this level inasmuch as the issue on appeal was moot a number of years ago. In noting that application of the law and rules was necessary for determining if a claimant prevailed, the board (in a footnote) waxed philosophical as to whether the continuous fine-tuning of the rules improved the system and whether sufficient attention was paid to the mandate to keep the process "simple and summary". Napolean's Case, 4 Mass. Workers' Comp. Rep. 374,376,(FT.3) (1990).

While the board remanded a number of matters for subsidiary findings, it also commended an AJ for the use of brevity in fashioning a decision. Silveira's case, Board Numbers 807965-82; 805223-83 (filed 2/6/91). Errors in attorney fees, and other issues were allowed to stand because a party had not raised or appealed the issue. Sweezy's Case, 013831-87 (filed 5/17/91); Speed's Case, 045640-82 (filed 3/25/91). Yet in Dennen's Case, noted supra, the board invalidated a rule which was not at issue in the case. Reconciling when the board will or will not address an issue on its own may create inconsistent approaches towards litigation strategy by the parties. Although it is safe and professional to

raise every issue that impacts one's case, a party may be at a loss to support or defend any issue not raised by the litigants that the board chooses to address sua-sponte.

Some rationales for recommittals are matters which can be addressed by agency management. Where there was no transcript for one of two days of hearing (Mignacca's Case, Board Number 35917-83, filed 4/22/91), where the DIA hearing notice created confusion (Torlai's Case, Board Number 78900-86, filed 3/12/91), and where the transcript revealed the AJ discussing a second hearing date which ultimately didn't occur (Aquino's Case, Board Number 101249-86, filed 2/16/91), reasonable administrative controls could avoid such problems in the future.

Evidentiary issues are also important, particularly in light of the potential "domino" problem if one piece of evidence is erroneously placed into the record and subsequent findings are related to the error. Gresham's Case, Board Number 94531-85, filed 2/20/91.

Lump Sums

While the merit of the lump sum mechanism is widely debated, this option is presently the means of case resolution for a large number of claimants. Concern has been frequently raised over the last few years about the length of time needed for parties to obtain approval of the mutual agreement. As of the end of July of 1991, average delays between receipt of a lump sum request or lump sum referral and the conference date were 7 weeks in Boston and Worcester and 6 weeks in Springfield, Lawrence and Fall River.

Another way to place such delay in perspective is to view it in terms of costs to employers and employees. A worker receiving the maximum compensation payment ($490.57 as of 10/1/90) scheduled for Boston could collect $3,434 during the period following the mutual agreement and the date of the conference when the settlement was approved. If liability had not yet been established, the worker would wait an additional seven weeks for approval, and then up to two weeks more (the length of time the insurer has to make the payment promptly) before receiving a check. The delays create economic and social costs for employees and employers. As a possible solution, legislation was filed at the behest of the Advisory Council which sought to expand the authority of approval, and also to expedite the

process to allow filing by affidavit when an employee has attorney representation.

The time and schedule of the reviewing board has increasingly involved lump sums. Efforts to decrease delays in the last few years include the expansion of scheduling capacity from 240 to 320 per week, scheduling additional days and sessions in regional offices, and having AJs review settlements which could be recommended for approval by an ALJ. Circular letter 252, noted in last year's report, established an expedited lump sum process for Boston in July 1990 that was to be employed in the regional offices if successful. While this procedure appears to have helped, the Council has been unable to determine from the DIA when it became effective in the regional offices.

Last year the number of scheduled lump sum conferences increased 23%, and this fiscal year the number was an additional 8% above FY'90. **(RPT 86).** A total of 19,614 lump sum conferences were scheduled this year, and 16,998 (86.7%) were approved. While the total may double count scheduled events (a rescheduled conference later becomes an approval), the number approved is a 10.5% increase over FY'90.

As noted in last year's report, one of the most striking statistics of departmental events is the percentage of lump sum disapprovals. Only .6% of total scheduled lump sums were disapproved in each of the last two years.[10] Over FY'90, FY'91 and the last 6 months of FY'91, there has been a slow increase in the percentage of approvals, even as the percentage of disapprovals remains the same. What is changing is the percentage of matters withdrawn, down from 11.4% in FY'90 to 9.7% in FY'91 to 9.4% for 1/1/91-6/30/91.

One factor the Council attempted to examine during FY'91 was the age of employees at the time of a lump sum. A report was produced by the DIA of approved lump sums for disposition dates 6/21/88 to 9/21/90. There were 32,627 cases during this 27 month period, with ages ranging from 10 to 86. Just over 41% of the cases involved a person less than 30 years old. A breakdown of the ages listed is as follows:

Age 19 or less	470
Age 20 to 29	4,002
Age 30 to 39	3,242
Age 40 to 49	1,724
Age 50 to 59	907
Age 60 to 69	404
Age 70 and above	32
Total	10,781

The highest totals range from age 23 to 33 and the totals gradually decrease as the age of the claimant increases. This report only identifies approvals by disposition date and includes cases both before and after the 1985 changes. The 15 year range from 21-35 covers 55% of the total, possibly suggesting that the market for vocational rehabilitation may be large.

The data does not indicate whether these agreements were negotiated by the parties before or after establishment of liability, nor does it address the potential job market for successful rehabilitation. It does indicate how the system resolves disputes. The use of the lump sum to resolve a case may be more of a symptom of the problems of the system, rather than a problem in and of itself. In light of suspicions that one reason for increasing numbers of disputes may be connected to the aging of the workforce and the problems entailed in the retraining and successful placement of such employees, it may be of interest to note that those employees are not the subject of lump sums according to this DIA report.

An updated computer report for lump sums provides more detailed information on the amount of lump sums based upon the date of injury. This report **(RPT 309)** was run by the DIA on 12/6/91. The following table lists total amounts and averages for awards pursuant to §48 (lump sums) and §13A (attorney fees) only for injury dates in years 1983-1991 and disposition years of 1988-1991, as of the date the report was run.

TABLE X

	Tot.#	Tot.Amt§48	Tot.§13A	Tot.Amt.§13A
DOI '83	1,966	$42,638,637	1,822	$11,396,595
AVG		21,688		6,255
DOI '84	4,812	98,856,833	4,569	22,342,408
AVG		20,544		4,890
DOI '85	7,883	139,036,081	7,504	31,302,410
AVG		17,637		4,171
DOI '86	7,714	138,370,821	7,376	33,376,689
AVG		17,938		4,566
DOI '87	10,094	187,341,984	9,743	43,499,106
AVG		18,560		4,465
DOI '88	11,677	204,861,982	11,270	47,722,317
AVG		17,544		4,234
DOI '89	10,410	175,918,491	10,118	40,431,463
AVG		16,899		3,996
DOI '90	5,690	82,965,565	5,541	18,982,850
AVG		14,581		3,426
DOI '91	483	5,108,089	467	1,112,235
AVG		10,576		2,382
Totals:	60,729	$1,075,098,483	58,410	$250,466,073
AVG		$17,703		$4,288

While these figures provide some insight, the large number of cases involved create the possibility of entry errors. For example, there were a number of entries for which an attorney was listed but no fee was included, which may mean that some of the §13A figures are lower than they should be.

Cases with dates of injury in the last few years do not reflect the total numbers because many of these matters are still open. Averages for injuries prior to the 1985 changes were greater because parties were not restricted to lump summing future medical/rehabilitation benefits. The total amount from the report for §48 and §13A was $1,325,564,556, for an average of $21,828 for the 60,729 lump sums listed. A small percentage, 2.2%, were pro se and although the small numbers may skew comparisons, there were entries in the DIA's report where the average §48 award was significantly higher when the employee was not represented by counsel.

In FY'89 the total amount reported by the DIA for 12,251 lump sums awarded (initial **RPT 309**) was $194,508,378.03, for an average award of $15,876.94. In FY'90 the corresponding totals were for 15,512 awards totalling $266,428,762, an average of $17,175.06. These figures can be broken down as follows:

	Number	Total Amount	Average Award
Date Of Injury Prior To 11/1/86			
FY'89	4,849	$ 88,450,113.76	$18,240.90
FY'90	4,334	$ 80,128,776.65	$18,488.41
Date Of Injury After 11/1/86			
FY'89	7,402	$106,058,264.26	$14,328.33
FY'90	11,178	$186,299,986.15	$16,666.67

An additional $71,920,384.77, or 37%, was approved in FY'90 and the average award increased $1,298.72 or 8%. The most significant change occurred in cases with injury dates after 11/1/86, where the average award rose 16.3%. In these cases, where liability has been established, parties could not redeem future medical benefits or vocational rehabilitation. Another factor possibly influencing the increase in the average settlement is the benefit level which, when computed with the durational limits, could increase amounts agreed upon by the parties.

The revised lump sum report covers dispositions for years 1988-1991 and dates of injury from 1983-1991. The averages for lump sums entered in the same year as the

date of injury (ex. DOI 1989 - Disposition entered 1989) were much less than the overall averages for that disposition year and in some cases were about 40% of the highest average amount. Dates of injury in 1987 that lump summed in 1989, 1990, or 1991 tended to average more than other injury dates for post 1986 cases. The highest averages tended to occur for injury dates that preceded the disposition date by 3-4 years. This could reflect matters for which liability was established during that time period, although the lower averages closer to the date of agreement could reflect uncertain liability.

These figures suggest a possible trend towards larger average lump sums. For example, in 1991 cases with a date of injury in 1988 averaged over $25,000 per §48 award and almost $26,000 per award for 1987 injury dates. A number of the averages exceed the figures from the initial report format. It may be of interest that the reports show a drop after 1983 in average attorney fees, not just in terms of overall average amounts, but also in the average §13A for similar §48 awards. This report establishes that over $1.3 billion has been awarded in the last four years, indicating where a good portion of the system's costs are being expended.

Operations Unit

The Operations Unit includes the Judicial Support Unit, the Court Reporting Unit, and the Scheduling and Docketing Unit. The Judicial Support Unit provides secretarial and administrative support to the Industrial Accident and Reviewing Boards. The Court Reporting Unit is comprised of court reporters who furnish verbatim transcripts of hearings. The Scheduling Unit coordinates the scheduling of cases in dispute resolution and the impartial physician lists used in the dispute process. A total of 8,440 appeals were entered in the past fiscal year, up from 7,732, or 9%, in FY'90.

As noted elsewhere in this report, the Report on Dispute Resolution recommended that judges be encouraged to use their secretaries for case administration. The report noted that some judges use their secretaries to carry out a variety of conference and hearing administration tasks, while others do not. It is also recommended that judges be encouraged to contact the judicial support manager when they feel additional training might be useful for secretaries, or when secretaries have exceptionally high workloads, and that the judicial support manager be allowed to assign work to secretaries during low-workload periods.

Motion Session

As part of its report to the legislature on the feasibility of a markup session for case scheduling, the Council suggested implementation of a motion session to handle certain cases. The Council also included this administrative recommendation to the legislature as part of its testimony at the April 10, 1991 hearing. The DIA notified all interested parties, via circular letter 258, dated 5/15/91, that effective immediately the reviewing board would accept motions for expedited conferences alleging illegal discontinuances of weekly benefits or the procurement of weekly benefits by fraud. This was implemented as a pilot program which was not intended to be an alternate forum for the adjudication of present disability disputes. This proactive step was commended in writing by the Council. By using the program on a pilot basis, its effectiveness could be tested on a small scale prior to any decision to adopt it as a more general practice.

As of September of 1991, parties had filed 69 requests, of which 56 have been scheduled or heard. Included in the total were matters withdrawn prior to the date or on the date of the scheduled motion before a reviewing board member. Out of the 56: 19 motions were approved for expedited conference (usually scheduled six weeks after disposition date); 5 were filed by insurers alleging fraud; 14 were filed by employees alleging illegal discontinuance; 14 motions were denied; 2 were filed by insurers alleging fraud; 12 were filed by employees alleging an illegal discontinuance; 21 motions were withdrawn; 7 were filed by insurers; 14 were filed by employees; and 2 still had an open disposition, both of which were filed by employees. Out of the 13 waiting to be scheduled/heard as of September: 3 were filed by insurers alleging fraud and 10 were filed by employees alleging an illegal discontinuance.

SECTION 2
The State of the Workers' Compensation System

Workers' Compensation Premium Rate Filing

The Workers' Compensation Rating and Inspection Bureau of Massachusetts (WCRIB) submitted a rate filing to the Division of Insurance on behalf of its subscribers on November 2, 1990. The filing sought a statewide average 21.6% increase in rates to be effective January 1, 1991.

The Council filed a Notice of Intent to Appear as an Interested Party on November 27, 1990, which was approved by the Division of Insurance on November 29, 1990. As in previous years, the Council voted to expend up to $20,000 for an objective review of the filing and to provide the information to each of the parties in the case. The firm of Tillinghast, Inc. was engaged by the Council to provide the analysis. Hearings on the filing were scheduled for December 14, 20 and 26, 1990.

The Council's analysis was finalized on December 13 and presented to the parties, as well as submitted with the Council's statement for the record on the initial day of the proceedings. In the analysis prepared for the 1989 filing, the Council's consultant noted that the profit provision might not be sufficient to permit insurers to post sufficient statutory earnings to support the current market. The review of this year's filing noted that the proposed profit provision would permit insurers to post a statutory profit if all other aspects of the proposal developed as approved.

The filing implied a slowdown in premium due to a moderation in the growth of average weekly wages which was not dependent on projected economic indices. The Advisory Council's analysis noted that, given the anticipated Massachusetts business climate slowdown, there could be a slower rate of growth in wages than was indicated in the filing. The Council's report also noted that calculations for loss development factors were not estimated separately by individual insurers in certain segments of the filing, nor did the filing attempt to estimate the impact of revisions by chapter 572 of the Acts of 1985 on losses. The estimates might consequently be affected if the industry's estimate of the 1985 amendments was too low, since the trend aspect of the filing would then be too high.

The revision of the loss development factors in the filing was noted as a substantial improvement over the prior methodology. However, the reliability of tail factors on a company to company basis and the application to the adjustments to reported losses for escalation of benefits raised questions, although data availability may have impeded this area of analysis. Also, the variations on projected rates by the three classes were seen to merit further consideration in evaluating the differences between the voluntary and residual markets. In raising a number of issues deemed

to be more substantive, and acknowledging the existence of others considered to be of minimal impact, the analysis cited the WCRIB's filing as a much more thorough and comprehensive approach to rate-making than the consultants had experienced in other jurisdictions.

A decision on the proposed rate increase (Docket No.G90-44) was issued by the Division of Insurance on December 27, 1990 as a result of a stipulated settlement between the WCRIB and the Commonwealth. It provided for an 11.3% overall average increase in existing rates, to be effective for new and renewal policies on or after January 1, 1991. The increase included 8.8% in expenses, .8% in benefit change, .4% in change in expenses, and 1.3% in change in underwriting profit provision. The average increase by industry group was 20.6% for manufacturing, 15.4% for construction, and 5% for all other.

A breakdown of limited classification rates and percentage increases is included as Appendix L. It should be noted that the increase in premium is in addition to that which resulted from the elimination of premium discounts in the Assigned Risk Pool and that the combined impact, according to the industry, is equivalent to a 14.5% increase in rates.

Approximately 16 persons testified, and positions on the filing naturally varied between support and opposition. Insurers noted the high level of losses, particularly in the residual market, and the necessity of rate adequacy. Labor representatives and some employer groups voiced opposition on the basis of the economic impact of the requested increase, and noted the need to weed out those who abuse the system by manipulating payroll records. A number of parties testifying at the hearing raised concerns about the level of attorney involvement and the amount of the fees that have been paid out. At each day of the hearing, the Council stressed the need for accurate data concerning amounts paid to both claimant and defense attorneys in the workers' compensation system. This information is only found within the insurance industry, inasmuch as the industry pays almost all attorney fees, and its compilation might allow meaningful analysis to take place. The order executed by the Commissioner of the Division of Insurance urged the parties to explore this and other related issues.

Two other filings were also approved in the decision.

One established a Construction Classification Premium Adjustment Program which allows eligible construction employers to receive a premium credit based upon the average weekly wage of the employer. This program applies to contractors who pay an average of more than $18.00 per hour. The credit ranges from a low of 5% to a maximum of 25% where more than $28.00 per hour is paid on average. Also, the minimum individual payroll was raised from $100 to $200 for executive officers, spouses, co-partners or corporate officers, and elected/ appointed officials, while the maximum payroll was increased from $500 per week to $1,000. The stipulation also contained an agreement that the All Risk Adjustment Program (ARAP) would continue for 1991 policies and set a date after 10/31/91 for the next filing.

Additional Filings

The WCRIB submitted four filings to the Division of Insurance on September 28, 1990, which issued a Notice of Hearing the same day. The four filings concerned the recoupment of the Massachusetts Insurer Insolvency Fund, the elimination of premium discounts for employers in the residual market, a revision of the experience rating plan, and the institution of Qualified Loss Management Plan.

At a hearing conducted on October 23, 1990, the parties entered into a stipulation whereby each of the filings was approved. It was also agreed that the Assigned Risk Rating Plan (ARRP) would not be submitted before January 1, 1993 unless the State consented in writing. The Council testified at the hearing and stated that it supported the establishment of a guaranty fund due to the security it might bring to an often volatile market.

The loading for the assessment increased from the previous year from .5% to .6%, and the net assessment cost increased over $3 million, or 38.9%. These assessments are one-time loadings into the rates which, based upon the accepted calculations, should mean that future allowances for these assessments will not be necessary. The Advisory Council's testimony noted that even though assessments are currently needed, if and when the fund is able to recoup expenditures from the assets of insolvent insurers, a process is available to review the assessment passed into premiums in order to avoid any unreasonable burden upon carriers or insureds. The 1990 filing incorporated amounts assessed for 18 companies for premium years back to 1974.

The Council also noted its previous support for the Qualified Loss Management Plan. As of the summer of 1991, 23 firms were able to provide credits, ranging to a high of 10%. In order to become certified by the WCRIB, a careful review is conducted of a firm's qualifications in the areas of safety, post-injury response, early return to work and the personnel involved. The amount of credit which the loss management company can offer upon approval is determined by an actuarial examination of its ability to reduce costs for the previous five years. New companies lacking such experience may be approved as "new entrants" and may offer credits (up to) of 5%, or until sufficient data exists to evaluate them as experienced programs. Most of the approved firms are currently in this category.

An employer becomes eligible for the credit after six months with the approved firm. This is intended to ensure that employers recognize the commitment necessary to seriously address loss experience and to prevent companies signing up specifically for a quick credit. The credit is applied when the policy is audited by the insurer. The bureau also conducts an audit of the insured to establish that the appropriate activity is being performed.

While it will take a year or two for policy information to be accumulated that can ascertain the program's effectiveness, success would result in a depopulation of the assigned risk pool. The intent of the filing is to encourage those insureds who are able to obtain a discount to obtain coverage in the voluntary market. Although its success is still to be decided, the insurance industry's efforts in establishing such a program should be noted as a proactive effort to improve the state's workers' compensation system.

The proceeding also involved the elimination of premium discounts for insureds in the assigned risk pool. The intent of this filing was to encourage insureds capable of obtaining discounts to procure coverage in the voluntary market. The discounts are taken out of the expense flow and put into the premium flow in rate making. This front loading of the premium discount was found to be reasonable by the Division of Insurance in 1987. The Council pointed out that since discounts are considered part of expenses, it was unclear whether expenses were greater for those larger insureds in the

involuntary market. If expenses are the same in both markets for larger insureds, but losses greater in the pool, the Council questioned whether the voluntary market would be open for those risks for which the discounts were eliminated.

As of October 1990, premium discounts for insurers in the assigned risk pool were estimated as approximately 4.2% of the current rate filing. If the premium discounts had not been eliminated, the 4.2% in rates would be built in. Only employers with premiums over $5,000 are eligible for the discounts. At the time, it was estimated that about 24%, or from 12,000 to 15,000 employers, were eligible for the discount.

At the time of the filing, there were five servicing carriers using non-stock premium discounts and five using stock premium discounts. Premium discounts are given to larger firms because of the economy of scale involved for insuring larger risks. In effect, they apply to the cost of administering the insurance contract, and discounts may be applied at increasing amounts as the premium level grows. This aspect of the filing is not to be reconsidered until January 1, 1992.

Also reviewed was a proposal to revise the experience rating plan which sought to increase equity between insureds whose premium is subject to experience rating. An employer's history of loss costs or benefit payments is used to modify the manual classification through experience rating. The manual rate of an employer with lower costs and better safety could be reduced, while the company with higher costs and poorer safety could experience a premium increase. As a result of improvements in actuarial calculations, the purpose of the new plan is to more accurately reflect the hazards inherent in each experience rated employer's operation. The filing's effective date is January 1, 1991.

FY'92 Assessment

The Council reviewed the estimated assessment for FY'92 at its June 19, 1991 meeting. A final report was issued on June 26, 1991 for approval by the Secretary of Labor. The estimated assessment rate for public employers was .05574, for a FY'92 budget of $4,532,322. The rate in FY'91 was .09164 and in FY'90 was .10416, while the estimated budgets for those two years were $6,774,015 and $6,819,909, respectively. The budget estimate for the public fund dropped 33% from FY'91 to FY'92, while

the assessment rate dropped 39%. This reverses a trend from the last few years which has seen the public rate increase dramatically.

The private assessment rate increased this year from 0.03630 to 0.04284. The rate has been increasing steadily in the last four years, after dropping from a level of 0.03790 in FY'88. While the total estimated budget for private employer assessments jumped 37%, from $38,023,383 in FY'91 to $51,965,510 in FY'92, most of the increase is expected to come from the private trust fund, not the special fund, which pays for the operating expenses of the DIA. Assessment figures for the last five years are incorporated in Appendix M.

The estimated budget for the special fund decreased by 14%, from $16,099,708 to $13,816,227 for the upcoming fiscal year. This was due to both a change in the budget estimate from FY'91 and an increase in revenues generated by the law. The estimated operating budget was $17.2 million for FY'92, but with the various revenues and investment income, only $13.8 million had to be funded through assessments, even though this year's legislative appropriation includes the funding for the backlog personnel.

The growth in the estimated expenditures for the private employer trust fund constitutes the most significant portion of the assessment increase. In FY'91, the budget was $21,923,675, although it was facing a deficit of $7.7 million as of July of 1991. The FY'92 budget of $38,149,283 represents a 77% increase in one year and exceeds the total private and special fund assessment of the previous year.

The Council raised a number of questions regarding both the methodology and the content of the analysis. The most serious issue was the projected deficit of $7.7 million in the private trust fund which, according to the actuary, was due in part to an unanticipated increase in COLA reimbursements. The estimated paid and outstanding COLA's at the end of FY'91 was $14,127,673. However, the estimated budget upon which the FY'91 assessment was made was $10.4 million, almost $4 million less than the level of reimbursements. The large deficit was also said to result from the premium estimate used in the calculation of the assessment rate being much lower than expected. As a result, the money collected was insufficient to pay the required amount of reimbursements.

In addition, the FY'91 assessment included a projected 7.2% increase in the average weekly wage, although the actual 3.4% increase was less than half that amount. Additionally, approximately $900,000 was budgeted for paying the expenses for the defense of the trust funds, but only about $200,000 was expended. These factors provided a cushion for the fund that still experienced an extremely large shortfall. Although these costs are attributed to the private fund and budgeted there accordingly, the DIA has stated that when services are performed for the public fund, the monies for expenses will be transferred.

The estimate included a "leverage ratio" on COLA reimbursements, which should provide a better analytical approach to future projections. The Council noted that its inclusion of cumulative increases resulting from standard average weekly wage changes should improve the accuracy of assessments. The Council commended the analysis for utilizing the most current data, allowing for a more accurate picture of the various funds for the computation of the assessments.

Questions were raised concerning variation in the inflation factors for public and private COLAs, revenues assessed by the DIA pursuant to §30H for successful rehabilitations paid by the trust funds, the wide variation in the annual percentage increases in the number of uninsured claims against the private trust fund, and offsets to the budget due to the balances exceeding the statutory levels as set forth in §65 (4)(c). Some changes were integrated into the final assessment report as a result of issues raised by the Advisory Council.

A total of $56,497,832 was calculated in the computation of the estimated budgets for the agency's operation and the payment of the statutorily required benefits for FY'92. This total represents an increase of 26% and $11,797,398[11] over the previous fiscal year and is another indication of the system's rising cost. As the economy continues to struggle, increased assessments, along with rising premiums, place additional burdens on the business community.

The Council noted that the draft assessment report projected no recoupment of monies expended by the trust funds for successful rehabilitations. Since assessment reports in earlier years noted the development and

funding of programs, the issue was whether funds were recouped for successful programs. Section 30H of the law states:

"If, upon completion of the program, the office determines that the program was successful and returned the employee to suitable employment, it shall assess the insurer no less than twice the cost incurred by the office and such assessment shall be paid into said trust fund."

In fact, there have been successful programs, with some of the data on these programs outlined below.

	FY'89	FY'90	FY'91
# requested	8	21	37
# plans approved	5	16	15
# employees in programs	2	10	12
# successful programs	2	6	2
Amt. spent successful	$10,748.07	$23,068.58	$1,392.50
Amt. spent unsuccessful	$3,024.20	$4,866.00	$2,745.64

This information indicates that a minimum of $70,418.30 should have been assessed for successful rehabilitation programs. Although the prior administration did not apply the law in the last few years, the new administration has indicated that it will assess for successful programs. Funds thereby accumulated would offset monies paid by employers in assessments. The final assessment analysis contained data on the revenues to be recouped under this section. For FY'92, the estimate in recoveries for the private fund is $48,050, and for the public is $22,367, which would cover those outstanding recoveries. It would appear that the assessment analysis does not include additional recoveries for programs currently in progress.

Included in the anticipated revenue for FY'92 in the public trust fund was $3,540,709 of unpaid FY'91 assessments, representing 52.2% of the FY'91 assessment amount. No penalties have yet been levied pursuant to §65(5), which mandates a 10% per month fine on any unpaid assessments. Any such fines that were assessed would be paid into the special fund, not only thereby reducing assessments but, since the fund requires an appropriation by the legislature, subject to reimbursements, potentially reducing taxes, which must be raised to cover the appropriation. The public fund

should not have a deficit this year, and the estimate of payments assumes that no reimbursements will be made unless assessments are collected.

The report noted that the actual figures for adjustments to the funds based upon the year-ending balance was off last year. Inasmuch as the analysis is an estimate, there was no way to know the actual balances when the books closed for the year. The Council was initially informed that the FY'92 assessment would reflect the adjustment. The DIA noted that retroactive adjustment of the figures for FY'91 would increase assessments this year. The excess funds flowed forward into the FY'91 account and were used to pay expenditures. Although an offset was calculated for the public trust fund assessment, the actual balance, which was unavailable at the time of the assessment, would have required an exclusion of an additional $125,000.

The actual balance at the end of FY'91 for the Public Trust fund was $1,495,574, which would have required an offset of $520,770 for the FY'92 assessment. This was $125,369 above the estimate, and the DIA informed the Council in January of 1992 that it intended to apply the amount to the FY'93 calculation.

Estimates on latency claims have been $0 in the last two years for the trust funds. This year, estimates are $60,000 for the public and $750,000 for the private fund, based upon DIA estimates of the costs of the claims awaiting processing. The DIA projected between 25-30 private and 2-3 public reimbursements with each proper claim estimated to cost between $25,000 and $30,000 in continuing and back compensation due. Although no requests were filed in prior years, the DIA has nevertheless reported that it has on hand a number of good claims.

This year's report included a far a more extensive breakdown of revenue estimates, which are estimated to increase 151%. One point noted in the discussions was a decrease from $910,492 (actual receipts in FY'90) in §6 (first report fines) to $300,000 for FY'92. The DIA anticipates greater compliance and hence fewer fines. Since the intent of imposing fines is to encourage compliance with the statutory reporting requirements rather than generate revenue, the Advisory Council is hopeful that the agency's projection is accurate, since it would indicate that the law is being followed. However, the law must be evenly and consistently

enforced in order to avoid any perception that costs, through assessments, are being shifted from violators to law-abiding employers, as would be implied if appropriate fines were not collected.

The assessment rates were finalized on July 16, 1991 and the WCRIB notified its subscribers on July 17 in circular letter 1573 of the new rates. The calculations set forth in the law incorporate a number of interesting figures on losses and premiums. The aggregate losses for insurers noted this year for calendar year 1990 were $1,134,979,245 and in 1989 were $986,866,985, an increase of $148,112,260 (15%). The standard earned premium for 1990 was $1,349,314,501, up $70,235,623 (5%) from 1989. However, after application of the adjustment factors, the estimated calendar year 1992 written premiums decreased 14% from $1,860,000,000 in 1991 to $1,605,000,000 in 1992.

The analysis states that premiums are estimated to decline at an annual rate of about 1%, whereas last year the estimate was for an annual growth of 5%. The decrease was attributed to the recent decline in the state's economy. While the estimate for premiums is dropping, losses have increased, and the ratio between the aggregate base amount and the aggregate written estimated premium has increased from .531 to .707 as a result. When this is multiplied by the assessment rate on the basis of losses, the overall rate increased significantly.

The FY'90, FY'91, FY'92 assessment analyses noted the possibility that requests for reimbursement for §35C latency cases may be commingled with COLA requests in the public trust fund. This possibility is similar to an issue raised by the Council in January of 1990 in asking whether insured public assessments were allocated to the public fund. To date, this research has not proved fruitful, but it merits consideration by the agency in the management of the funds. In addition, the latest assessment recommended that the DIA create a database that could capture the necessary data to permit the monitoring of COLA information on an ongoing basis. This also merits serious consideration in light of the increasing costs of COLAs. Finally, the DIA informed the Council that the medical malpractice pass-through as enacted by Chapter 351 of the Acts of 1986 would impact the administration of the trust funds, which must pay for certain medical care, but was not considered in the

FY'92 assessment. Figures should be available at the end of the fiscal year that will delineate the specific effect on the fund.

Second Injury Fund

The exposure of the second injury fund continues to be a source of concern for all parties. As noted in previous reports, the administrative mechanism for reviewing reimbursement requests and making payments was substantially delayed beyond the statutory timeframe for the initial payments. The DIA advertised prior to the start of FY'91 for legal assistance in handling these cases but no assistance was procured, despite available funding. One circular letter, #244A, dated 7/90, (replacing #244 of 10/89) was issued to advise parties of the procedures for processing §37 cases.

The DIA notified the Council in January 1991 that 182 petitions with an injury date after 12/10/85 were received by the Attorney General's Office in 1990. A total of 88 were denied. The state tendered offers to pay reimbursement on 37 petitions, totalling $781,640, and 26 of these offers for $573,207 were accepted and approved for payment. In 16 of the accepted cases, weekly indemnity payments by insurers were projected to represent an additional $157,664 yearly in reimbursements. The remaining cases were lump summed prior to the approval date and no further reimbursements are anticipated. The largest lump sum reimbursement sought as of January 1991 was around $91,000 and no §37 request exceeded $250,000.

At the same time, the Office of Claims Administration had received 59 §37 petitions and 1 §37A petition. Thirty of the §37 petitions were for a subsequent injury after 11/1/86. A total of 13 were for a second injury between 12/10/85 and 11/1/86, while 16 were for subsequent injuries prior to the enactment of the 1985 changes. With the payment of the judgement in the Daly Case, the "old" second injury fund (then called the special fund) was depleted. The single §37A claim was for an injury between 12/10/85 and 11/1/86.

The DIA provided information at the 3/20/91 Council meeting as follows: 220 §37 claims received; 106 denied; 43 approved; and 10 pending. At that point, $756,814 in payments had been approved for the 43 cases for FY '91 and $107,917 in payments approved for FY'92. In addition, the DIA stated that the total FY'91 obligation

was over $681,000, and $750,000 had been identified by the actuarial analysis for the FY'91 assessment process. Certain delays existed at the time because there was nobody from the AG's office designated to approve reimbursements or defend cases. A number of matters were denied due to improper filing, and scheduling of cases awaited the appointment of an agency head.

In May of 1991 the DIA reported 248 reimbursement requests had been made and $705,773 paid out of $1,362,496 offered. This amount covered 62 approved requests, of which 28 lump summed and 34 concerned continuing compensation. The obligations from FY'91 for FY'92 were listed as $1,079,086, with an estimate of $1,812,120 for new approved reimbursements, providing for an estimated budget of $2,891,206.

During FY'91, a total of 184 requests for reimbursement pursuant to §37 and §37A were made against the trust fund, bringing the total as of 6/30/91 to 268 over an 18 month period. A total of 63 were approved and 35 (27 at 75% and 8 at 50%) paid by 6/30/91. By early FY'92, 23 of those remaining had been paid, 17 of which were reimbursed at 75% and 6 at 50%. Five of these paid cases were quarterly reimbursements. As of 9/26/91, 95 requests for a §37/37A proceeding had been submitted to the claims department and the AG had denied 64, which were under appeal, and approved 7. DIA financial documents show that $613,897 was reimbursed from the private employer trust fund and $91,866 reimbursed from the public employer trust fund in FY'91.

The estimated costs in the FY'92 assessment calls for $4,373,139 to be paid from the private fund and $192,073 to be paid from the public employer trust fund. There was a projected cost of $129,931 for unreported claims with injury year prior to 1989 for the public fund and $1,841,159 for the private fund. On the public side, there is no FY'91 liability payable in FY'92, while the total is $656,723 for the private fund. The assessment report provided projections for FY'92 for prior known claims only for the private fund, indicating that these cases must have been redeemed since there were payments from the public fund this year. The estimated cost of $18,525 per case is the same for each of the funds.

The concern for trust fund exposure continues as the extent of unreported cases remains unknown. The divergence in figures over a few months highlights the absolute necessity for accurate assessment budgets.

State Auditor's Report

In June of 1991, the Office of the State Auditor, Division of Local Mandates (DLM), issued a report on the public employer trust fund, containing its analysis of trust fund assessments and disbursements. The report was prompted by the concerns of a number of cities and towns about soaring assessments and inequities in the assessment process. On the basis of its analysis, the report recommended that §65 of c.152 be amended to allow for optional participation by public sector employees and self-insurance groups representing political subdivisions.

Among its major findings, the report indicated that the majority of cities and towns pay assessments into the Trust Fund and take nothing out in reimbursements, while a small minority receive reimbursements far in excess of their assessment payments. The report also concluded that mandatory participation in the Trust Fund has created disincentives for utilizing cost control measures in claims handling practices.

According to the report, total annual public sector assessments have grown from $524,005 in FY'87 to $4,811,038 in FY'91, an increase of 818%. Assessments for the commonwealth's 58 self-insured cities and towns increased 1,200% over the same period. However, thirteen of the self-insured cities received $3.24 from the trust fund for every dollar of contribution, and accounted for 89% of all cost of living adjustment (COLA) payments. The remaining 254 self-insured municipalities and group self-insured public entities received little or no benefit for their assessment contributions. The report further noted that the Public Employee Retirement Association (PERA), the commonwealth's workers' compensation agent, had not made assessment payments in FY'87, FY'88 and FY'90. Four municipalities did not pay any assessments between FY'87 and FY'90, while another six municipalities failed to pay total assessments.

The report contrasted the situation in the public trust fund with that of the private employer trust fund to underscore the problems with the former. While the assessment rate for the public sector trust fund increased from .01620 in FY'87 to .09173 in FY'91 (466%), the private sector rate in FY'91 of .03629 was slightly lower than the .03730 rate in FY'87.

The report noted that while the trust fund was

established to pay for several types of compensation payment, all public employer trust fund payments since 1987 have been allocated for COLA claims. In contrast, COLA claims against the private trust fund accounted for 38% of total assessments. Further comparison showed that the private sector's COLA reimbursements were only 2.65 times greater than public sector COLA reimbursements, despite a private sector workforce eight times larger than the public sector workforce.

Part of the disparity between public and private sector disbursements is attributed to the greater propensity for the private sector to settle claims through lump sum settlements. While private sector insurers often seek to close out claims through lump sum settlements before they qualify for COLA payments, the commonwealth and 27 cities and towns are responsible for almost all COLA claims in the public sector, effectively forcing those public employers who have established lump sum reserves or avoided the need to pay COLAs to subsidize the rest.

The report also analyzed the cost-benefit ratio of the trust fund system for 58 self-insuring municipalities and 213 public employers who are members of the Massachusetts Interlocal Insurance Association. The "cost" for employers was represented by assessments paid into the fund, while "benefits" were indicated by reimbursement. Along with the statistics cited earlier regarding the disproportional benefits for 13 self-insured cities and towns, the analysis indicated that 14 self-insured employers - or 5% of municipal employers - received 27 cents for every dollar of assessment paid. No COLA benefits were received by 89% of the 271 participating public employers.

The Auditor is also required to perform biennial audits of the special fund and trust fund pursuant to §65(10). The Auditor's report for 1987 and 1988 was published last year, and an audit is currently in progress for the 1989 and 1990 period.

An issue noted in the last report was the DIA's failure to collect $3,117,000 in eligible fees, fines and late charges in FY'87 and FY'88. At the time of publication of the last annual report, the Advisory Council had not received a response on whether the DIA had undertaken any action regarding collection of these funds. A response was provided by the DIA in June of 1991. The DIA had billed approximately $1.5 million in late first report fines and collected about $328,000, about 23%, as

of June. There were approximately $1.6 million in referral fees, of which the DIA had collected $700,000. Although the prior administration had decided not to bill for late charges, the DIA has indicated it will maintain its efforts to collect the rest of the money owed the fund.

Legislation Affecting The Workers' Compensation System

Bills Enacted

During the past fiscal year, a number of bills were enacted by the General Court which impacted the workers' compensation system. Numerous minor changes were enacted by Chapter 177 of the Acts of 1990, which was signed on August 7, 1990. The legislation made some technical changes in §1 (9)-(11), §30I, and §31 of chapter 152 to correspond to the changes in the Department of Employment and Training. An additional change was made in §13C of Chapter 40, which is the local option statute which permits municipalities to establish reserve funds for their workers' compensation expenditures. Chapter 263 of the Acts of 1990, approved 11/30/90, empowered the Commissioner of Labor and Industries to suspend the application or operation of laws regulating the employment of persons, or of minors over 16 under chapter 149, until 7/1/92. The workers' compensation act, §28, defines serious and willful misconduct as the employment of minors in violation of certain provisions of chapter 149.

Chapter 338 of the Acts of 1990, executed on December 19, 1990, created a fraud bureau within the Automobile Insurers Bureau of Massachusetts. The purpose of the fraud bureau is to investigate and prevent fraudulent insurance transactions in the state. While the bureau is situated in the rating organization for insurers writing auto insurance, its mandate is not exclusively limited to issues relating to auto insurance fraud. In fact, the bureau noted in televised broadcasts that it will examine issues concerning workers' compensation.

The law mandates that any licensed insurer or any person engaged in the insurance business exempted from the licensing requirements who has reason to believe that a fraudulent insurance transaction has taken place, or is about to take place, report the transaction to the bureau within thirty days. The fraud bureau will then

review the report sent in by the insurer and undertake further investigation as it deems necessary. When the bureau is satisfied that a material fraud, deceit, or intentional misrepresentation has been committed in an insurance transaction, it shall refer the matter to the proper prosecuting offices. Reports by the bureau and Attorney General containing appropriate information shall be filed every six months beginning in August of 1991. The bureau is funded by an assessment upon the Automobile Insurers Bureau of Massachusetts and any person convicted of insurance fraud shall be ordered to pay restitution to the insurer.

A second piece of legislation enacted this year concerned the administration of the assigned risk pool. The assigned risk pool was established by chapter 489 of the Acts of 1939 and effective as of November 10 of 1939. Between its inception and 1990, minimal changes were made, with many of the changes purely technical, such as changing the word "division" to "department".

Despite statutory language in chapter 152 to the contrary, the rating bureau had been administering the plan since November 1, 1943 as the result of an agreement between the agency and the bureau with respect to a "Temporary Voluntary Assigned Risk Plan". At an October 22, 1943 meeting between the DIA, the Department of Insurance, and the Workers' Compensation Rating and Inspection Bureau of Massachusetts concerning implementation of the plan to supplant the agency's statutory procedures under §65A, it was agreed that a staff person from the Bureau would go to the DIA with support staff to "administer the plan". Records indicated that this agreement was never rescinded, and eventually the Bureau assumed all duties under §65A.

The recent legislation was initially filed as Senate Bill 1821 of 1990, and a hearing was held on November 27, 1990. Finalization of the legislation came on December 29, 1991, when Chapter 462 of the Acts of 1990 was executed, and an emergency preamble was signed two days later in order to facilitate implementation for policies effective January 1, 1991. The law placed into the statute the actual practice of administering one pool and using servicing carriers to write the policies out of the pool. The pool will be administered by the rating organization designated by the Commissioner of Insurance, in this case the WCRIB. In addition to some technical changes in the statute, the bill repealed §65F in order to end the anachronistic requirement that an

insurer that picks up a pool risk voluntarily also repay the pool for losses incurred by that employer. This deletion will hopefully encourage insurers to write policies voluntarily from pool risks and thereby reduce the size of the involuntary market. During discussions over the bill, an amendment was filed which would have reinstated the use of premium discounts for the pool, which were eliminated as a result of a decision by the Commissioner of Insurance in November of 1990. The final bill was executed without the amendment.

The importance of the plan's administration is born out by the Supreme Judicial Court decision in Westland Housing Corporation v. Commissioner of Insurance, 353 Mass. 374 (1967). A focal issue in the case was whether the statutory framework for assignments was followed. The lower court found that the agency had not certified a rejected risk since 1951 (at 379) and that the agency's usual practice was to refer the applicant to the rating bureau upon presentation of two rejection letters. The Superior Court stated the noncompliance with §65A to be "technical", but the Supreme Court decision stated the non compliance was total rather than technical, and that when the legislature provides specific statutory procedures to be followed in assigning risks to insurance companies, it is not to be presumed that the procedures may be disregarded.[12]

One statutory change which is related to Chapter 152 reconstituted the Commission on the Employment of the Handicapped. As part of its statutory mandate under §30I of chapter 152, the DIA is to work with other state and federal agencies in assisting disabled workers in getting jobs or training. The head of the DIA has been a member of the Commission and in the past has sent a representative[13] to participate in these discussions. Chapter 456 of the Acts of 1990, effective 2/1/91, expanded the Commission from 28 members to 44 and changed its name to the Commission on the Employment of People with Disabilities. The enabling legislation is set forth in M.G.L. c. 6, sections 105-107, inclusive. The scope of its purpose was expanded in what appears to encourage more of an advocacy role for the body. It is still to report annually to the Governor and the General Court on its activities and recommendations.

Chapter 464 of the Acts of 1990 was signed into law December 29, 1990 . While this statute did not directly amend c. 152, it further clarified the nonpayment of

wage law with respect to independent contractors. The law states that the failure to withhold workers' compensation from an employee's wages shall not be used for the purpose of making a determination under §148B of chapter 149 of the General Laws. This amendment apparently sought to clarify the coverage of so-called "independent contractors" and to remove the defense that an employee was not covered under a workers' compensation policy and that premiums were not paid for the position. The Council is not aware of any instance in which there is legal authority to withhold workers' compensation from an employee's wages.

Bills Proposed

Due to the many problems threatening the workers' compensation system, over 50 bills were filed this year seeking to introduce various changes. The Council reviewed available bills prior to the April 10, 1991 hearing before the Joint Commerce and Labor Committee. The Council testified at the hearing and submitted its positions on proposed pieces of legislation to both the Commerce and Labor Committee and the Insurance Committee. A bill related to recommendations from the Friction Cost study was filed on behalf of the Council. This material is included as Appendix N.

Medical Reimbursement Rates

There was no change in medical reimbursement rates during the past fiscal year. The last changes were instituted by the Massachusetts Rate Setting Commission in September 1989.

The issue of the medical fee schedule has continued to be a major source of discussion and concern by numerous parties. A number of the proposed bills before the legislature sought amendments to the current fee schedule. Fee schedules are in place in over 20 states and are considered by some as a major factor in containing costs for workers' compensation.

On another front, questions have been raised about the fee schedule's application to out of state providers. This issue has been presented to an administrative judge in at least two instances, and the decisions offer divergent interpretations on the proper way to proceed. In Tedeschi's Case, Brd. No. 96790-88, filed 6/17/91, the administrative judge ruled that c. 152 is the prevailing statute to determine whether such rates should be applied. In this case, §13 of the law requires that the rates not be in excess of the amount

set by the Rate Setting Commission. In another matter, Alderson's Case, Brd. No. 95155-88, filed 6/20/90, the judge held that Rate Setting Commission rates do not apply to providers not licensed in the state. This holding is based upon the Commission's lack of jurisdiction over out of state providers. While each case presented into the record the same 1980 Advisory Opinion from the Rate Setting Commission, the results were completely inapposite. This case has been appealed to the reviewing board.[14]

Medical reimbursement rates for workers' compensation were revised by the Rate Setting Commission in new regulations (see 114.3 CMR 40.00), published 1/31/92 (see Massachusetts Register V. 679 1/31/92), with a 12/1/91 effective date. In outlining the fiscal effect of the new regulations, the Commissioner noted that although some rates have changed, the fiscal impact of the changes cannot be estimated due to the variety of payers and a lack of utilization statistics.

The task of converting to the CPT coding system has been finalized. This was one of the recommendations of the Council's Medical Access study and should make the administrative aspects of billing easier for providers/payers. A malpractice pass-through code (X9156) was also implemented. The Commission previously promulgated regulations, 114.CMR 42.00, which set forth the total malpractice adjustment payable by payers under c. 152. This code builds in the malpractice pass-through prospectively, with providers to be reimbursed an additional 2.35% for services rendered between 12/1/91 and 6/30/92. The initial comprehensive office visit, code X9157, remains at $90, while the comprehensive special written report, code X9158, is now $16 for fifteen minutes, which does not include expenses, i.e. photocopying, but covers time only and outlines a 14 day period for filing reports. The regulations provide in 114.3 CMR 40.04 that any provider aggrieved by the rate established pursuant to 114.3 CMR 40.00 may file an appeal, pursuant to M.G.L. chapter 6A §36 and 820 CMR with the Division of Administrative Law Appeals to the extent permitted by law.

In terms of industrial accident patients, the Rate Setting Commission is not to apply or use a discount from the primary standard used by the Commission in establishing such rate in its computations to determine the rate of payment for prescribed drugs (M.G.L. c. 6A

§48). Inasmuch as there are no utilization statistics, the economic impact of not being able to use the discount is unknown.

The medical malpractice pass-through noted above was enacted as part of chapter 351 of the Acts of 1986 to address the serious situation existing in Massachusetts at the time. The legislation was limited to the period 7/1/87-7/1/91 and its application has been the focus of numerous discussions. Physician concerns with delays in payments and insurer concerns with how payments were to be made, along with corresponding administrative issues, were raised in a number of settings.

In 1989 the Rate Setting Commission promulgated the initial provisions (114.3 CMR 42.00 et. seq.) for an additional 3.5% year end payment. The liability by payers was $2,187,000 to physicians and $2,550 to dentists for FY'89. In FY'90 the amount calculated was $3,659,400 for physicians and $40.50 for dentists, which was to be added to the FY'91 adjustment rather than distributed (see 114.3 CMR 42.03(4) dated 3/16/90 and effective 7/1/90). After 6/30/90 each industrial accident payer was to pay each eligible physician who treated an injured worker in FY'90 an amount equal to 3.7% of the total reimbursement paid to the doctor during that year. Physicians were to receive a 3.3% percent payment by payers, for a total liability of $3,347,300 in FY'91 and a 1.37% year-end payment for a total liability of $1,717,980 in FY'92. This was codified, as noted above, in the new rates and annualized at 2.35% for the last seven months of FY'92. The total amount of medical malpractice passthrough liability for the four years was $10,911,980.

SECTION 3
Ongoing Concerns
Of the Advisory Council

Delays in the Resolution of Cases

Delays in the finalization of cases continued to plague the system during the past year. These delays have various causes which are not all controllable. Any environment which is predicated upon adversarial involvement and that maintains an overreliance on formal dispute resolution mechanisms will create additional friction costs, uncertainty for employers/employees, and delays not only in final closure of the matter, but also in the delivery of benefits to deserving participants.

During the last year, the number of matters requiring

adjudicatory resources increased. A decision to send all second injury cases (§37) directly to conference appeared to have little impact on delays. The anticipated number of requests involving §37, which could have created additional backlogs for scheduled conferences, did not occur.

A matter of some potential consequence is the impending expiration of the majority of judicial terms within a short period of time. As noted in our last report, the appointment process has in the past proceeded slowly. Funded positions which are not filled add costs, in addition to those associated with increased delays, in that employers have been assessed for salaries and fringes, but neither employees nor employers have received any benefit from the ability of the position to resolve disputes. In addition, during the last portion of FY'91, seven one-year judges (positions created as part of Chapter 691 of the Acts of 1987 to address the backlog) were taken off line for almost 3 months while an administrative determination was made as to the funding for the positions in FY'92. This funding would have been repaid to the state by private employers through assessments. The agency decided to take the judges off line in case a lack of funding required them to leave while adjudicating cases.

As in prior years, the extent of delay varied at different times. As of October 11, 1990, the median time from conciliation to conference was 176 days in Boston, 218 days in Fall River, 307 days in Lawrence, 212 days in Springfield, and 246 days in Worcester. These delays indicate that cases being heard in October in Boston had been referred in May, in Lawrence in December of 1990, and in the other 3 regions in March of 1990.

In December 1990, the DIA reported delays for the median case to reach conference after referral from conciliation to be 192 days statewide, 174 days in Boston, 223 days in Fall River, 294 days in Lawrence, 218 days in Springfield, and 231 days in Worcester. This encompasses the period 4/1/90-4/30/90. More recent figures would not have been accurate because as of the date of the computer report, most cases referred after 4/30/90 in Lawrence had not yet reached conference. This is the median wait for the last month of referrals for which most cases reached conference by 12/14/90. The cases which reached a conference as of mid-December in Boston had a median wait of 183 days (referred July 1990), a median wait of 211 days (referred June 1990) in Fall River, a median wait of 200 days (referred June 1990) in Springfield, and a median wait of 246 days (referred May 1990) in Worcester.

As of 3/7/91, the statewide median time between hearing close and disposition filed was 42 days. The median time was 40 days in Boston, 12 days in Fall River, 108 days in Lawrence, 68 days in Springfield, and 90 days in Worcester. The Council was informed in July of 1991 that the average length of time statewide was 29.7 weeks between conciliation referral and conference scheduled date and 11.8 weeks between receipt of appeal and hearing scheduled date.

Over the last half of 1990, the median case took 21 days from receipt by the DIA to conciliation statewide. By region, the figures were 20 days for Boston and Lawrence, 21 for Springfield, 26 for Worcester and 27 for Fall River. During this same period the median case took 22 days from receipt of a lump sum request to get an interview with a disability analyst statewide and 29 days (in total, not additional) to get to a lump sum hearing. The respective median times for the two events in total days were: Boston - 22 and 27; Fall River - 27 and 43; Lawrence - 20 and 25; Springfield - 21 and 39; and Worcester - 20 and 31.

In the second half of the fiscal year, the average case took 22 days from filing to conciliation. The wait in Boston was 20 days, while in Lawrence it was 21, in Springfield 22, and in the other two regions 24. The time in days/weeks from referral to conference was 207/29 statewide, 183/26 in Boston, 216/31 in Fall River, 300/43 in Lawrence, 199/28 in Springfield, and 226/32 in Worcester. The number of days for orders to issue after the conference was 4.6 statewide; 5.4 - Boston; 2.7 - Fall River; 5.6 - Lawrence; 1.9 - Springfield and 5.8 - Worcester.

While Boston had the shortest time frame for conference and Lawrence the longest, the opposite existed for the time period from appeal to hearing. Figures for Boston were 99 days/14 weeks and in Lawrence 71.5 days/10 weeks. The statewide average was 88 days/12 weeks, while the respective figures for the other regions were: Fall River, 72.6/10; Springfield, 86.2/12; and Worcester, 83.6/12. The average time for decisions (which is affected by the fact that many matters have open dispositions) again indicated a wide variation for this 6 month period. The figures (days/weeks) were: statewide-88/12; Boston-88/12; Fall River-38/5; Lawrence-115/16; Springfield-101/14 and Worcester-129/18.

Improvements have been made in the DIA statistical report which examines the timeframes for the various

stages between steps in the statutory dispute process **(RPT 491)**. Last year's report was programmed to detail timeframes from stages in the process to scheduling dates in the future. Currently the data examines the time period actually occurring between scheduled events, thereby increasing the sample of cases examined and presenting a more accurate picture of what took place.

Statistics provided by the DIA for FY'91 are listed in Appendix O. Again, as in last year's report, the timeframes from receipt of a dispute to conciliation meet the statutory timeframes for all matters in the system. The longest delay continues to occur between referral from conciliation to conference, which is over 6 months statewide. While the statewide median is 1 day from the close of the conference to the issuance of the order, well below the statutory mandate, the median time for decisions was 77 days, while the average was 125. The statute, although it has been interpreted as advisory (Rapo's Case, 2 Mass. Workers' Comp. Rep. 245 (1988), has a 28 day period from the close of the hearing for the decision to issue. In order for the average to be 47 days more than the median, many of the 1,441 decisions in the computer system would have to entail fairly lengthy time periods.

As noted in last year's annual report, the regions show considerable variation. The median timeframes from conciliation to a conference range from 181 days in Boston to 301 days in Lawrence, a difference of almost 4 months. Conversely, the median time from appeal of a conference order to hearing ranged from 55 in Lawrence to 104 in Boston. As last year, Fall River had the shortest median period from the close of a decision to hearing, 13 days, well below the statutory requirement. The longest period was in Worcester, where the median time was 134 days, a difference of almost 4 months.

Lump sum approvals continue to experience delays. In the two categories for the 5 offices, the median ranges from 27 to 44 days. The second category, referral to lump sum, accounts for cases where an AJ has referred a recommended lump sum to an ALJ for approval. This process takes longer than the filing of a lump sum request for approval, with a 6½ week statewide average. Reducing these time periods, which entail the approval of a mutual agreement, is of crucial importance for the entire system.

Reducing these time periods, which entail the approval of a mutual agreement, is clearly a crucial need for the entire system. The Council has in the past filed

legislation seeking to provide the agency with greater flexibility in handling lump sums (See Appendix N). Without the additional assistance of 2 recall AJ's to shorten the approval process by making recommendations, the wait would be even greater. The reviewing board stated to the Commissioner in January 1990 that, "Any long term solution to the backlog of §11C reviews is bound up in a resolution of the long festering lump sum problem. It is clear, at least to us, that the interested parties and the public will not indefinitely continue to tolerate the present absurd system. Multiple appearances at the department and an eight week delay between reaching agreement and getting approval is expensive, unnecessary, and unacceptable". The need for change has been recently accelerated by an increase over the last 6 months of 1991 in the median times for the two categories by 14 and 13 days respectively, while the average times were 44 and 56.6 days statewide.

One component of the law that may affect the number of disputed matters is the direct payment process enacted by the 1985 reform. This component, along with the pay without prejudice process, were intended to not only reduce litigation, but also to provide a more effective and efficient system for all parties. Some data on this procedure is available, although the information is imperfect because pay forms are often not filed with the DIA, despite a legal mandate to do so, and the information therefore only captures instances in which the law has been complied with. There are cases where claims are paid, but no form is filed, and these will not be reflected in available DIA statistics. A summary of the first report and pay/deny statistics **(RPT 354)** from the past four fiscal years is provided in Table XI.

TABLE XI

	FY'88	FY'89	FY'90	FY'91
# of FR w/o pay or deny:	20,767	19,571	23,815	25,010
% of FR w/o pay or deny:	33.6	33.3	52.0	46.8
# of FR w/ pay or deny:	40,966	39,115	21,998	28,439
% of FR w/ pay or deny:	66.4	66.7	48.0	53.2
# of FR w/ pay:	38,561	35,591	18,815	24,039
% of FR w/ pay:	94.1	91.0	85.5	84.5
# of FR w/ deny:	2,405	3,524	3,183	4,400
% of FR w/ deny:	5.9	9.0	14.5	15.5

For the first two fiscal years, the numbers are very similar in most of the categories. The number of first reports with a pay or deny increased in the last year after dropping significantly in FY'90. The total is still well below the figures for the first two fiscal years. The DIA figures indicate that more cases are being denied where a first report is filed and that the percentage of first reports with pay forms filed continues to drop. It is disturbing that a much higher percentage of first reports were filed without pay or deny forms over the last two years, since it would be reasonable to expect greater compliance as more parties became acclimated to the 1985 changes. The Council has suggested that the DIA consider notifying insurance CEOs that it will publish these statistics in order to provide a possible incentive for improvement.

While requests for adjudication steadily increased from 1987-1991, information available to the DIA suggests that alleged work-related incidents decreased. In this context, "incidents" includes all first reports filed, plus pay forms, deny forms, or claims where no first report was filed with the agency. The numbers available **(RPT 405)** for the last five fiscal years appear in the following Table.

TABLE XII
Requests for Proceedings vs. Incidents

Note: The report provides statistics on claim types and incidents based upon the date of injury and the date entered by the DIA.

Year	Total Requests (A)	Total Incidents (B)	Ratio A/B
1987	29,619*	90,627	32.6%
1988	28,232*	91,845	27.8%
1989	34,846	88,223	39.5%
1990	37,510	86,927	43.2%
1991	40,573	77,690	52.2%

*Includes lump sum requests entered prior to 6/21/88 and reopened claims.

Requests for Proceedings
- Percentage of Claims to Complaints

Year	Total Requests	Claims	%	Disc.	%
1987	25,107*	17,928	71.4	7,179	28.6
1988	26,610*	18,279	71.4	7,341	28.6
1989	34,846	24,155**	69.3	10,688	30.7
1990	37,510	26,384**	70.3	11,117	29.6
1991	40,573	29,200**	72.0	11,373	28.0

* Doesn't include reopened claims
**Doesn't include §37 requests

Requests for Proceeding* with Lump Sums vs. Incidents

Year	Total Requests (A)	Total Incidents (B)	Ratio A/B
1987	29,618	90,627	32.7%
1988	33,389	91,845	36.4%
1989	44,131	88,223	50.0%
1990	47,415	86,927	54.5%
1991	50,044	77,690	64.4%

* Requests = Claims, §36, Lump Sum Requests, Third Party Claims, §37, and Discontinuances

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The data indicate that requests are now 64.4% of the total incidents, up from 32.7% four years ago. This suggests that there is far more litigation at present, that workers are more aware of their rights, or that both factors are at work. The ratio of claims to complaints has not deviated greatly in the last five years. The Council has previously noted that this ratio might change if more employees were to receive benefits, since it would then follow that a larger percentage of the requests would be initiated by insurers to modify or discontinue. The report does not indicate if the claims are a result of initial denials or initial payments/ terminations under the pay without prejudice process. Reopened claims are not included in this category because it can't be determined whether they are claims or complaints.

A review of all requests versus incidents not only shows a 10.6% drop in the number of incidents, but a 5.5% increase in requests in the last year. Almost two-thirds of the incidents in 1991 generated a request for some sort of action by the DIA. Because a single incident could result in multiple requests, there is a potential for multiple counts in each of the years for which the DIA has provided information. During the last three years, the percentage of requests entered each year with a date of injury from a prior year has continued to increase. Since the ratio of claims to complaints has altered little, this may indicate that claimants are waiting longer to file or that payment was made without prejudice, then terminated, and that benefits are being sought by a claimant. Whatever the reason, the entry of requests for adjudication with injuries in prior years

can make analysis of potential changes difficult since ascertaining the results may take longer. It can also make the administration, adjudication and adjustment of matters more complex because different statutory provisions will apply.

Statistics showing the point in time that cases achieve a disposition in the dispute resolution process could provide some insight into delays. At the request of the Council, the Department prepared a computer report indicating when in the dispute resolution process matters are resolved. Included as Appendix P are charts which reflect the time periods centered around the hearing and conference events when the various dispositions occurred. This report may in the future provide a barometer for the impact of various changes if it can be used to identify certain patterns.

For disputes that are appealed to a hearing, resolutions drop as the hearing date approaches. The vast majority of withdrawals occur either at the hearing or within a week of the hearing. Few entered dispositions (3.5%) prior to the hearing concern a withdrawal or adjustment. A total of 3,233 (46%) of the cases having a final disposition concerned one of the three lump sum categories at or after the hearing, and almost one half (49.6%) of the matters for which there was an entered disposition dealt with a lump sum. Over one-third of the lump sum dispositions (34.6%) occur more than 28 days after the hearing.

Withdrawals for claims and complaints varied. While 17.8% of the claims had a withdrawal disposition, 25.8% of total discontinuance dispositions were withdrawn. Claims were voluntarily adjusted in 7% of the cases after a hearing, while 3.8% of the discontinuances had that disposition entered. AJs recommended lump sums in 25% of the claims and 17% of the discontinuances post hearing, and lump sums were recommended in 29% of the claims and 21% of the discontinuances. While totals for lump sum requests received were almost identical, 47% of the discontinuances were prior to/at the hearing, but only 37% of the claims were in that category. A total of 2,147 (51%) of the claims had a lump sum disposition and 16% occurred prior to/at the hearing. While 48% of the discontinuance dispositions concerned lump sums, 23% occurred prior to/at the hearing. Claims appear to lump sum later, as suggested by additional statistics indicating that 36% of claim dispositions are entered more than 28 days after the hearing, versus only 25% of

Overall conference statistics show a much higher percentage of entered dispositions for orders, 55%, than for decisions at the hearing level, 13%. One reason for this is the time factor involved in issuing an order, which also explains the smaller number of open dispositions at the conference stage. The majority of withdrawals (51%) and voluntary adjustments (58%) occur in the week following the conference.

Lump sum dispositions are more likely to take place within the week after the conference than the week after the hearing, which may indicate that the conference event has an impact sooner than the hearing event. Conversely, although the percentages are small for each event, the moving party is four times more likely to withdraw at the hearing than at the conference.

Comparing withdrawals by the moving party indicates that discontinuance withdrawals (9%) are almost twice as likely to occur as withdrawals for claims (5%). In the week after the conference, the three lump sum dispositions equal 11.2% for the discontinuances and 8% for claims. Only 3.4% of the discontinuances were voluntarily adjusted, compared to 13.5% of the claims. Seventy-five percent of the order dispositions for both claims and discontinuances occur at or within a week of the conference, indicating that differences in the percentage of dispositions for various categories, or the time when they occur, would appear to be reflective of the parties and not the adjudicators.

The disposition for lump sum requests received is more prevalent numerically for discontinuances for both conferences and hearings, even though there are more claims in the system. At the hearing level there is a difference of 1, while at conference there is a difference of 131 (55%). The large majority of these dispositions for both claims and discontinuances are entered prior to or at the conference. The majority of dispositions at the hearing level occur after the hearing. This indicates movement to resolve the matter through that category either before the process begins or after it ends, leaving a large timeframe in the middle where there is no apparent movement.

To date, the DIA has kept up with the increased caseload in scheduling matters for conciliation, but the length of time between referral from conciliation to conference remains a serious stumbling block to the statute's effectiveness and is also a major cost factor. One positive note is that the system increased its scheduled dates for conciliations, conferences and hearings to

83,039, a 6.2% increase over FY'90. Reschedules rose slightly, .8%, and were involved in 22.1% of the scheduled dates.

In 1984 it took 510 days to receive a hearing, 379 days beyond the statutory timeframe. There were waits of 168 days in 1988 and 207 days in 1989. As of the year ending 4/90 the delay was 265 days, while in FY'91 it was 329 days. While the later figures still represent an improvement over 1984, the continuing growth in the timeframes is a serious concern. The fact that the initial stage of the dispute process is basically within the statutory timeframes remains encouraging and every effort within the realm of reasonable caseload scheduling should be explored to prevent delays from developing here.

The current scheduling format (increased July 1991) provides an average of 797 conferences and 332 hearings for each AJ. Due to expansion of scheduling capacity, it is unclear if initial time allocation figures provided by the DIA and judges (.5 hr. needed for conference and order; 1.76 hrs. needed for hearing and 5 hrs. needed for a decision) still apply. With 28 positions filled, it provides capacity for about 22,316 conferences per year. If conciliation continues to resolve 50% or more of its cases, there is a capacity to eliminate the backlog. Any decrease in disputed matters or increases in judicial positions/conciliation success rates should shorten the time required to eliminate the backlog.

Increases in Judicial Requests

Since the 1985 amendments to c. 152, requests for adjudication have risen from 14,103 in 1984 to 40,494 in calendar 1991, an increase of 187%. The following table presents the figures for adjudication requests provided by the DIA for the last fiscal year.

TABLE XIII

	# of Req.	Wkly. Avg. Per Month	#Refer. Concil.	Wkly. Avg. Per Month
July(90):	3,570	893	2,905	726
Aug (90):	4,556	911	4,006	801
Sept(90):	3,271	818	2,658	665
Oct (90):	3,575	894	3,082	771
Nov (90):	4,730	946	3,564	713
Dec (90):	3,489	872	2,919	730
Jan (91):	3,568	892	2,875	719
Feb (91):	3,870	968	3,237	809
Mar (91):	5,176	1035	4,302	860
Apr (91):	3,865	966	3,270	817
May (91):	4,427	885	3,864	773
June(91):	3,851	951	3,224	806
Total:	47,948	922	39,906	767

The numbers have continued to grow since the 1985 changes, thereby burdening the system and impacting the ability of intended improvements to fully take hold. While the number of requests increased again in calendar year 1991 (by 8.2%), the average weekly figures per month began a downward trend as of September of 1991. Included as Appendix Q is a series of graphs which show the growth in requests for adjudication over the last five calendar years. The influx of disputes was 8.5% higher in the second half of FY'91, indicating a potential for increased delays in the first half of 1992. Incoming disputes were 11.1% higher overall than the previous fiscal year.

These graphs indicate the upward movement of requests for adjudication over the last few years. Except for the last quarter of 1987 and the first few quarters of 1988, growth has been fairly constant. One tendency noted in past analyses, and illustrated by the graphs, is that on average there tend to be a higher number of requests in May. While requests for adjudication have risen, the number of incidents, as noted earlier, has dropped. The increase in litigation is a primary ingredient in the increased cost of the system.

Administration of Employer Funds

One subset of the cost issue for employers is the administration of monies assessed to run the system. Apart from the costs of insurance, private employers also fund the operating costs of the agency, which are 5 times greater than pre-1985, when the state picked up the cost. Private and public employers are also assessed for payments and reimbursements from the respective trust funds.

As part of its oversight role, the Council has endeavored to review these costs. It has been involved in issues such as ensuring the proper amount of interest was allocated to the respective accounts as mandated by law and in resolving concerns on the reversion of assessments to the General Fund. It worked extensively on the legislative process to enable the trust fund to expend assessments for the defense of the fund. The Council seriously pursued its statutory role in the review of budgets and assessment rates.

While the trust funds have assessed for over $1.7 million for defense of the fund over 2 years, projections indicate that less than one-third will have actually been expended. The Council's support for this

process did not contemplate that funds would remain idle, since employers could arguably put those dollars to better use in their businesses. The present value factor of monies assessed but not spent is an issue that the DIA has stated will be rectified in the upcoming fiscal year.

On another financial matter, the Council believes that diligent effort must be made to collect all monies due to the DIA, whether through fines, fees, penalties or assessments. In FY'91 the agency expended over $2 million more than it collected, while waiving or failing to enforce fines and fees payable to the special fund. Only a balance from previous years prevented a shortfall and the need for an additional assessment. There was a difference of $17,484,667 between the FY'91 budget for assessments and FY'91 collections. Only 61% overall, and 55% for the special fund, was collected. The explanation provided by the DIA for the discrepancy was that only the previous administration could account for it, but that perhaps inexperience in the calculation and the faltering economy contributed.

There is a delicate balance between the assessment computation and the actual spending needs for the respective funds, a point which has been noted by the State Comptroller.[15] While sufficient revenue (tied through the assessment formula to payroll as a result of premium computations) is needed, it is important that projections not be overextended. The goal is to have the necessary resources to meet the statutory needs. While there is a mechanism to use balances in the fund to offset future assessments, that formula has rarely been met, and assessments have in the past been needed to meet requirements of the upcoming year.

Administration of private employer funds also entails fiscal planning. Rental agreements have requirements for legislative notification (M.G.L. c.7 §40G) and except in emergencies, must be done when the legislature is in session. While 4 of the 5 DIA leases expired in the fall of 1991, funds initially requested for a possible move were not included in the final budget requests. As the fiscal year closed, bids were not solicited, but the Council was informed that the goal for the Boston lease entailed a savings of $500,000.

Employers do not get a refund or a credit. They expect that all of the statutory duties will be efficiently

performed and the mandates of the law fulfilled in return for their financial backing. If too much money remains, this is an indication of overly high expectations, but the real result is that employers lose the value of their money for a year. In an economy such as presently exists, it is even more important that assessments be accurate and that the parties who pick up the tab receive their money's worth for their dollar.

The DIA's Special Fund is a budgeted line item and subject to appropriation. The Council has in the past noted variation in fund balances entered by the DIA, the Comptroller, the Treasurer's Office and the budgetary process. Some of the differences result from time factors, such as the timing of deposits or payments, and some may result from differences in the Massachusetts Management Accounting System (MMARS) which is utilized for internal purposes. The variances in timeframes, or the fact that some of the reports are not as detailed as others, can partially explain the divergent figures. In addition, the payment of funds for accrued liabilities is somewhat fluid, given the nature of the system, and this often creates differences between the "bottom lines" of the various reports. While the Council retains its confidence in the totals prepared and supplied by the DIA, any possibility that the mechanisms could be made more consistent should be explored in order to avoid uncertainty and ensure more complete credibility in the system.

Premium Rates

Discussion of the overall impact of premium rates often centers upon average increases. Certain classifications and manual rates have risen at a much higher percentage, while some manual rates may have even decreased. An informative explanation of the last two rate increases included in a letter from the WCRIB on the calculation for the yearly assessments is quoted below.

FY'91 Assessment: "Effective 1/1/90 the average rate increased 26.2%. However, 5% of that increase was due to the introduction of the All Risk Adjustment Program (ARAP). ARAP adjustment premiums are not part of standard premiums. Therefore, the increase in standard premiums was 1.262/1.050= 1.202. Also, there was a one time allowance of .5% in the rates to recoup amounts paid by insurers to the insolvency fund. Thus, the total increase in standard premium was 20.2% +.5%=20.7%."

FY'92 Assessment: "Effective 1/1/91 the average rate increased 14.5%. However, 2.9% of that increase was due

to the elimination of premium discounts for insureds in the assigned risk pool. Since premium discounts are not part of standard premium, the increase in standard premium was 1.145/1.029 =1.113. Also, there was an increase of .2% in the allowance in the rates to recoup amounts paid by insurers to the insolvency fund. Thus, the total increase in standard premium was 11.3% +.2%=11.5%."

While the above outlines the extent of the last two increases, the rising cost of premiums is still a serious concern for the system. The cumulative effect of rate increases in the state has risen over 182% from 1980-1991 and is primarily due to factors related to the experience in the Massachusetts system. More of the premium in the voluntary market is dedicated to offset the losses of the assigned risk pool. In the decade 1980 -1990, the cumulative nationwide change in premium level was 70.3%, while in Massachusetts it was 153.5%.

The Massachusetts Construction Premium Adjustment program was established to lessen the disparity between employers of high wage and lower wage earners in that industry. This program, one of 2 in the nation, offers credits to construction employers whose premiums are higher, due to payroll, to assist them in paying lower rates. As shown in Appendix L, where many of the manual rates rose more than 100% from 1987-1991, the large increases when computed as part of payroll have had a serious impact on the construction industry.

Changes in the weights used to calculate experience modification factors, which in the past worked in favor of small employers, should reduce modifications for losses for larger employers as they are phased in over the next two years. Employers can now challenge the level of reserves, which affects experience modifications, through the aggravated inequity rule which can, if successful, result in a reallocation or return of premium.

Backlog

The Council was informed in February 1991 that there were 482 open "backlog" cases before the 7 two-year administrative judges. A breakdown of these matters establishes 368 at the hearing stage, while 73 were at the conference stage and 41 were at the lump sum stage. While all of the cases had been scheduled for a conference by the end of FY'91, as of 10/3/91 there were

still 253 backlog cases in progress, a significant drop from the 1,088 in progress as of 8/27/90. In addition, in order to fill out their schedules and target the growing delays for non-backlog cases, these judges were also assigned "prolog cases," which were not paid for by the general fund but rather by the private sector employers in the state.

DIA data **(RPT 404)** offers another source of information on delays, although figures from the report are imperfect because judges are in different points of their cycles and weekly referral rates from conciliation affect the ability to schedule cases in DDR. The following are the total number of cases, taken from board numbers, awaiting a scheduled conference date.

FY' 90	FY' 91	% Change From FY'90
07/06/89- 4,609	07/05/91- 7,513	63%
08/07/89- 5,369	08/09/90- 8,259	54%
09/07/89- 5,088	09/11/90- 8,084	59%
10/05/89- 5,427	10/04/90- 8,363	54%
11/09/89- 5,895	11/08/90- 7,972	35%
12/07/89- 5,966	12/05/90- 8,012	34%
01/04/90- 5,918	01/03/91- 7,914	33%
02/02/90- 6,392	02/07/91- 8,153	27%
03/01/90- 6,012	03/07/91- 8,441	40%
04/05/90- 6,166	04/04/91- 8,721	41%
05/03/90- 6,848	05/02/91- 8,578	25%
06/07/90- 7,352	06/06/91- 9,226	25%

These matters are not the "backlog" cases for which the additional positions were created and state funding initially provided. The fact that the number of cases awaiting a scheduling date more than doubled between July of 1989 and July of 1991 underscores the need for corrective measures.

Incoming requests continue to beset the system's ability to expeditiously process cases. Requests for adjudication have grown since the 1985 reform (See Appendix Q). The 1985 changes were predicated upon events occurring within specific time periods, and once the backlog grew, the effectiveness of the amendments diminished. The backlog of 12,000+ cases, which the 7 two-year appointments were created to resolve, has basically been eliminated, but a new set of unresolved cases threatens the effectiveness of the system.

System Abuse

Systemic abuse of the workers' compensation system takes

numerous forms and must be addressed by diligent efforts. Numerous licensing statutes for professional accreditation as well as statutory proscriptions (M.G.L. c.266 §30, §111A, c.175 §'s 186 and 194, and c. 274 for example) have provided serious punishments for the types of abuse which can exist in the workers' compensation system. State government has had the authority for over twenty years, through its Fraudulent Claims Commission, to investigate instances where workers' compensation abuse exists in conjunction with certain forms of assistance from the state (M.G.L. c. 7, §'s 30R-30T). It has exercised this authority at least once to review DIA records in the last 5 years. We have been unable to ascertain if additional reviews have been performed in recent years.

Chapter 152 §25C has for many years set out both criminal and civil sanctions for non-compliance with the insurance mandate of the law. More recently, in response to the growing number of claims against the private employer trust fund, it has been enhanced with stop work order provisions. In addition, §14 of the law provides limited recourse for frivolous actions and fraud, but it would appear that these possible sanctions have been insufficient to deter abuse.

The enactment of the Insurance Fraud Bureau in December of 1990 was a beneficial first step in this arena. As an important follow-up, the AG has indicted individuals for fraudulently collecting benefits. Enforcement must target all offending parties. Effort has been made to curtail the practice of manual rate misclassification which, if successful, could bring about a more competitive environment in industries so affected by this form of abuse. While statutes have been on the books for centuries proscribing abuse, enforcement and prosecution require commitment. Published accounts of stricter enforcement will hopefully deter abuse. The Fraud Bureau has established a toll free line, 800-32-FRAUD, for the reporting of insurance abuse.

Chapter 175H of the General Laws (added by chapter 295 of the Acts of 1988 and approved on November 25, 1988) provides penalties for filing false statements or misrepresentation of a material fact in any application for the payment of a health care benefit if done in a knowing and willful manner. This law also addresses persons who make or present an application for health benefits if they fail to disclose certain events with an intent to fraudulently secure benefits either in an amount greater than is due or when no such benefit is due. Penalties include fines up to $10,000 and imprisonment. While the law addresses seeking benefits

from health care corporations, it does not appear to exclude actions under c. 152. It also permits restitution to health care corporations or insurers, as well as the reasonable payment of attorney fees.

Potential problems are identified in a study done in conjunction with auto insurers, Medical Costs and Automobile Insurance: A Report on Bodily Injury Claims in Massachusetts, by Sarah Marter and Herb Weisberg, in the April 1991 Journal of Insurance Regulation. The study identified the possibility of abuse between individuals and various professionals for auto claims and notes that the information compiled is valuable as a mechanism for developing incentives to control costs. While it pertains to a different line of insurance, the research establishes that there are methods available to identify potential patterns of abuse not only by individual claimants, but also among the various professionals which represent and treat them.

Concern with abuse is not relegated to Massachusetts. The National Insurance Crime Bureau also has established a hotline, 1-800-TEL-NICB. In its first 6 weeks of operation, the line received 2,200 calls and 10-15% led to investigations. It will employ about 200 investigators, and work with insurers, the FBI and other law enforcement officials. Callers are eligible for up to $1,000 for tips. The Insurance Crime Prevention Institute began to examine workers' compensation fraud in 1988, and although only a small number of matters have been taken up by law enforcement officials, it did discover a physician who was generating $50-60 million in yearly payments by filing false injury claims.

One trend noted in last year's report was the use of employee leasing. This mechanism, which has economic appeal for some employers whose businesses have been hurt by rising premiums, has been addressed by the Division of Insurance through approval of a filing to amend the Experience Rating Plan Manual in June of 1990. Circular letter 1538, issued by the WCRIB, outlines the changes, which state that the experience used by an employer prior to terminating its employment relationship with its employees in order to lease them back from the leasing company will still apply.

The NCCI has been active in taking steps to curtail this form of system abuse and, through the use of RICO, has been able to recoup over $10 million in premium that should have been paid to carriers. Misclassification of employees by reporting workers in lower rated manual

classifications not only constitutes insurance fraud, but provides such employers with a competitive advantage over companies which report their employees accurately. The result has been that some states have increased auditing capabilities and permitted damage suits to employers who lose work as a result of such practices.

There are a number of perceived costly practices that should be addressed. Extension of disability periods beyond those necessary adds costs, as does the filing of frivolous matters at the agency. Efforts to return employees to work should be encouraged in order to curtail any perception that an injured person is somehow damaged goods. Proper medical and rehabilitation treatments should not be exaggerated because workers' compensation, for the most part, has not yet introduced any of the variety of cost containment mechanisms that exist under other areas of health care treatment. The lump summing of cases for smaller amounts to get rid of them, when there is a real question of liability, can add significant costs to the system over time.

Although anecdotes are heard on the conduct of the bar or other practitioners, issues alleging abuse are not being raised to the DIA in any formal manner. The DIA reported to the Council that no complaints of any kind were filed in FY'91 concerning practices of lawyers, doctors, etc., despite the sanctions available to the agency pursuant to 452 CMR 1.18(5).

The perception that insurers are paying the costs, and that society, consumers, or even employees are not, must change. Any party who engages in any abuse must be sanctioned to the fullest extent of the law.

Information and Data Collection

There is an acute need for pertinent data that would provide a basis for monitoring various areas of the workers' compensation system. Under the current law, the DIA is mandated to report its statistical findings to both the Council and the legislature. While the Council does receive biannual computer reports, the agency has prepared only one report containing statistical findings for the legislature or public at large since 1985.

In theory, the DIA has access to a great deal of data. The agency has within its power the ability to assist the system, legislature, courts[16] and the parties by providing meaningful analysis and data. Section 63 of

c. 152 states: "Insurance companies insuring employers under this chapter shall, at the request of the department, furnish it in writing any information in connection with the administration by said department of this chapter, including any statistics and the names of all employers insured by them".

This can be a useful mechanism to augment the agency's own data, through the use of such reasonable requests, and provide all parties with useful information on the operation of the system. During the initial years of the law early in this century, a great deal of information was available from the Annual Reports[17] of the agency and examples are listed in Appendix R.

There is a need to compile injury and illness data in order to establish the nature and causes of work-related injuries as a necessary prelude for targeting safety programs. Effort should be made to make coding uniform across agency borders in order to facilitate data exchanges. As noted in the FY'91 report, legislation was finally passed on August 2, 1990 (§31 of Chapter 154 of the Acts of 1990) to provide the DIA with access to information held by the Department of Employment and Training. The DIA unequivocally stressed the importance of the information in assisting the agency to fulfill its functions under the law. The Council supported the efforts to obtain access and repeatedly asked about the progress made to obtain the data, but 18 months later, the DIA had not yet been provided with the information.

It is unclear why two state agencies, each empowered with the public trust, would take so long to formulate a process of information transfer that would assist in bettering the system. In fact, while the DIA informed the Council that it had received little cooperation from DET to supply the information under the law, the Department of Revenue, for whom there was no statutory mandate, voluntarily reached an agreement with the DIA to provide an employer tape every month in FY'91.

The Council's Friction Cost Study suggested consideration of the NAIC Model Bill, which contains proposals for data that should be collected by insurance regulators. Such data might not only provide useful information on what is occurring within the system, but might also permit more accurate interstate comparisons.

On a national level the International Association of Industrial Accident Boards and Commissions (IAIABC) has proposed that uniform elements be a part of an agency's

data base so that in the future national statistics can be compiled easily. The NCCI has agreed to expand its Detailed Claim Information to conform with the NAIC model. Massachusetts was one of the initial states to take part in this program, which is intended to improve access to sorely needed data on legal and medical costs. Massachusetts does not participate in the U.S. Department of Labor's Supplementary Data System, which tracks workplace injuries in many states, and as a result there is no readily available mechanism with which to make any meaningful interstate comparisons on injury rates or types.

Within the agency, tremendous improvements have been made in data collection and availability since 1985 as a result of the hard work of the DIA's data processing unit. However, the necessity for additional data has been noted by the Council and other interested parties and legislators. A comprehensive and reliable data base through which parties can frame issues is essential for administrators and legislators in order to ensure that sound policy decisions are made.

Insurance Market

Since the 1985 reform, employers have been permitted to form self-insurance groups. This change was meant to extend to small employers the opportunity to self-insure which was otherwise only available to larger firms. Initially, there was little activity in this area, but more groups have been licensed by the Division of Insurance in recent years. As of July of 1991, there are eight licensed groups operating in the state. Two groups cover public entities, while there is one each covering retail merchants, private colleges, and religious affiliates. There are also three groups established by the same organization, covering hospitals, manufacturing, and nursing homes.

The obvious advantage of this mechanism is that employers in groups should not only gain greater incentive to manage their costs, but also far more control over their costs. In addition, group self-insurers do not pay assessments for the assigned risk pool. If the pool continues to grow this additional cost factor may encourage the formation of new groups. This is an insurance mechanism that could increase in the next few years as employers who would normally have competing interests, such as retail or health care, realize that a means to control costs is available through their own initiative. This will require additional regulatory review since there is no guaranty fund for such entities.

Industry figures for 1989 show that the top ten carriers had 70.8% of the total market and wrote 60% of the voluntary market, with 52.1 % of the market covered by the five largest writers. In 1989 these were, in order, Liberty Mutual, Aetna, Travelers, Employers of Wausau, and Cigna. During the period from the 1985 changes to 1989, the number of policyholders in the assigned risk pool more than doubled and operating losses increased more than 2 1/2 times. Information supplied in rate filings showed insurance losses of over $2 billion from 1986-1990, and while yearly loss totals have decreased in the last 3 years due to rate hikes, Massachusetts has been identified by one study as one of the 4 leading states for workers' compensation rate suppression.[18]

The National Association of Insurance Commissioners has noted that insurance profits as a percent of earned premium dropped precipitously from 1985-1988. While the picture improved a bit in 1989, it was still less profitable in Massachusetts than it was overall in the nation. In addition to reporting losses of over $2 billion between 1986 and 1990 writing workers' compensation in Massachusetts, the industry reported that in 1989 the losses for the residual market were over $280 million, 11% of the national total.

The assigned risk pool has grown to well over 50% of the premium and to an estimated 70-80% of the risks. The pool assessment has grown to the point where it is equivalent to 50¢ of every dollar in the voluntary market, leaving half of the premium dollar to pay for claims. Although a number of incentives have been proposed by the industry and approved by the Division of Insurance in recent years to address this growing concern, the facts suggest that these good faith efforts have fallen short. Due to legislation consolidating the assigned risk pool, the WCRIB withdrew from the national workers' compensation reinsurance plan. Agents handling out of state risks consequently had to find coverage in the voluntary market here, or in the pool from the other jurisdiction. The potential loss of the voluntary market increases if a remedy is not forthcoming in the near future to offset this problem.[19]

Self-insurance remains a possibility for some employers. Applications for self-insurance must be scrutinized with care inasmuch as Massachusetts is one of the minority of states that does not have a guaranty fund for self-insurance. As a result, if the security provided by a licensed self-insurer is insufficient to meet its

liabilities, the only employees who would not possibly receive their accrued benefits would be workers for such companies.

Pay without Prejudice Process

The absence of adequate data continues to confound efforts to ascertain the effectiveness of the pay without prejudice procedure. Certain information is available from the DIA computer system that provides some indicia of the process. This computer report notes discontinuance requests filed within the first 120 days of disability, which would encompass the 60 day pay without prejudice process and the possibility of a 60 day extension.

In the period 6/21/88-12/31/89, 2,072 (13.4%) of 15,419 discontinuances were filed prior to the 120th day of disability. A total of 210 (1.3%) were filed by the 60th day of disability. Almost a year later (6/21/88-12/4/90), 3,107 (12%) of the 25,824 discontinuances filed were filed prior to the 120th day. It should be noted that for cases in 1990, only 1,035 (9.9%) of 10,405 discontinuances filed were filed prior to the 120th day. Only 1% were filed prior to the 60th day. The figures continue to improve in 1991, with 10,484 discontinuances filed over approximately the first 11 months of the year. Those filed prior to the 120th day totaled 650 (6.2%), of which 66 (.6%) were filed before the 60th day. The decrease in filings over time would appear to indicate that perhaps insurers are taking greater advantage of the pay without prejudice option.

A cumulative report for the period 6/21/88-6/30/91 established 32,433 discontinuances filed, of which 3,557 (11%) were entered prior to the 120th day of disability. These were further broken down between 60-119 days - 3,196 or 9.9% and less than 60 days - 361 or 1.1%. These filings were broken down as follows:

Days After Disability	#	Days after Disability	#
0-9	17	60-69	334
10-19	22	70-79	457
20-29	21	80-89	519
30-39	46	90-99	609
40-49	83	100-109	581
50-59	172	109-119	696

Almost half of those filed prior to 9 days (8/17) were

filed by the 4th day, while two thirds of the total were filed after the 80th day. In the three year period, a sample of the 17 insurers with the highest number of requests indicates these companies filed about 64% of the discontinuances prior to the 120th day and 61% of the matters prior to the 60th day. The percentage of pre-60 day filings average about 10% for the total filings for these larger insurers. However, the range by individual insurer indicated anywhere from 3% to 18% of the total discontinuances filed prior to the 120th day coming in the first 60 days.

The number of discontinuances filed within the pay without prejudice period has resulted in possible costs being passed on to employers. A rough example of the cost can be estimated from the last rate filing to have been fully reviewed by the state (11/90). That filing estimated the average weekly wage of claimants at $472 a week, 2/3 of which is $315. Over an 11 month period in 1990 (closest time period to date of rate filing), the report noted above listed 112 cases filed prior to the 60th day. Delays between conciliation and conference were about 7 months, or 30 weeks on average at that time, and DIA records indicate a small percentage of discontinuances are resolved at conciliation. This means there were about 21 weeks of indemnity, for 100 cases (estimating 12 resolved at conciliation) multiplied by $315 a week for a total of $661,500. While this is a rough approximation, it indicates possible cost savings using the unilateral pay and discontinuance process provided by the law.

Section 4
Possible Future Issues

Rehabilitation Issues

An area in need of improvement is the employment of people with disabilities. Chapter 456 of the Acts of 1990, effective 2/1/91, revamped the Commission on the Employment of the Handicapped. The Commissioner of the Department of Industrial Accidents is a member of this body, which is charged with promoting employment in order to maximize the independence, productivity, and integration of all Massachusetts citizens with disabilities. Each year the commission is to report to the legislature on its activities and recommendations.

The participation of the agency in this effort is

important, since the return to active employment of any injured employee is one of the primary goals of workers' compensation. The expertise of other panel members is undoubtedly an invaluable resource for the department. In the past, the agency has worked with the Commission in promoting a program for jobs on the major infrastructure work envisioned for the central artery and third harbor tunnel. The Council requested from the DIA in July of 1991 the status of the Commissioner on the Commission and the DIA's involvement in it role, but the department has not responded to date.

Rehabilitation for injured workers is not solely relegated to the DIA. Many vendors and insurers provide such services. Massachusetts law, §81 of chapter 6 of the General Laws, outlines that the Massachusetts Rehabilitation Commission is to cooperate with the department. (The actual language notes the Division of Industrial Accidents in the Department of Labor and Industries which is in fact no longer the case).

The issue of mandatory rehabilitation has been the focus of national discussions. The experience in California has established that costs can increase when the process is mandated, as data there indicate that 13¢ of every claim dollar went into rehabilitation. Surveys by the IAIABC have indicated that some states do not even define vocational rehabilitation. The report of the 1989 Workers' Compensation Congress devoted significant attention to this topic, stressing the need of incentives for employees and employers in a voluntary setting, with appropriate administrative oversight. A mandate for rehabilitation in an adversary setting can increase costs and, as this paper established from a number of jurisdictions, early intervention with a professional program can lower costs.

Americans With Disabilities Act

As noted in the FY'90 Annual report, a major piece of federal legislation that will have an impact on workers' compensation is the Americans with Disabilities Act of 1990 (ADA, Public Law 101-336, 42 USC 12101). This law was enacted on July 26, 1990 and will take effect on July 26, 1992. The premise behind the law is evident from findings noted in the statute itself. Congress found that 43,000,000 Americans have one or more physical or mental disabilities and this number is increasing as the population as a whole ages. In addition, despite some improvements, history has shown

that society has tended to isolate and segregate persons with disabilities and this form of discrimination continues to be a serious and pervasive social problem.

The law is initially effective for employers with 15 or more employees, while taking effect for businesses with 24 or fewer workers beginning on July 26, 1994. The law bars discrimination against a person who is a qualified individual with a disability and bars a required medical examination before an offer of employment is tendered. The identification of a disability either by a medical examination or in an interview before an offer is made is also prohibited. Prospective employees may be asked about ability to perform the related duties that are inherent in the job but may not be asked if they have a disability. Once an offer of employment is made, an examination may be required if it is a uniform requirement and the results are not disclosed. An employer may be required to make a reasonable accommodation, such as modifying a work station, in order to help the qualified person to meet the reasonable requirements of the job.

Enforcement of the law is similar to any claim alleging a violation of a person's civil rights under Title VII. The EEOC has prepared technical assistance information on workers' compensation and work-related injuries under the ADA which offers an overview of legal obligations and provides information on whether an injured employee is protected by the ADA. The fact that an employee is awarded benefits does not automatically mean that the employee falls under the ambit of this law. The employee must have an impairment that substantially limits a major life activity or have a record of or be regarded as having such an impairment. Work injuries often do not substantially impair a major life activity or may cause non-chronic impairments which heal in a short time. Since the law's impact is still unknown, it would be advisable for all parties to be fully cognizant of their rights and obligations.

Employers may inquire about a person's workers' compensation history in a medical inquiry or examination that is required of all applicants in the same job category after a conditional offer of employment has been made. This may be used by employers to screen out applicants with a history of fraudulent workers' compensation claims and to provide information if required for the purposes of a second injury fund. The ADA requirements will supersede any conflicting state

workers' compensation laws. Filing a claim under a state act for a work-related injury does not prevent an injured worker from filing a charge under the ADA. There is some concern that the statute's restrictions on obtaining medical information may increase claims, which creates the implication that workers with disabilities, if such disability were known, would not be hired in order to avoid the possibility of future claims. This statute has the potential of wide reaching repercussions for both employees and employers and its administration, as well as its interpretation, will surely impact every workers' compensation system.

System Concerns

The administration of the law is crucial to its success, not only for the employees and employers for which it was created to serve, but for the economy as a whole. This is the reason that representatives of labor and business wrote to the incoming administration urging that positive steps be taken and that a strong administrative approach could assist in resolving many of the concerns experienced by all parties to the system. Such positive administrative steps as the motion session, conciliation changes, a tougher emphasis on abuse, and dissemination of information on insurance requirements were finally implemented. Other areas deserve attention. Again, another fiscal year has passed without the DIA fulfilling its mandate to promulgate rules pursuant to c. 23E §11(4), which states as follows:

"The office of insurance shall promulgate rules providing guidelines to insurers and self-insuring employers concerning behavior that may be construed as questionable claims handling techniques, questionable patterns of claims, repeated unreasonably controverted claims, or poor payment practices."

Since passage of the reform law in 1985, the DIA has not promulgated any series of specific rules which would put parties engaging in such practices on notice that certain behavior is unacceptable. Failure to promulgate the appropriate rules may contribute to an atmosphere where parties believe that there will never be any sanctions for the manner in which claims are handled and may have added costs to the system.

Information on injuries at sheltered workshops was finally developed this year. Pursuant to §28 of the law, the DIA is mandated to notify the Department of Mental Retardation if there appears to be a pattern of injuries at a particular workshop. Since shortly after

passage of the 1985 reform law, the Council has inquired as to when and how this mandate would be fulfilled. While the computer printout run by the agency indicated that many had but a handful of alleged accidents, some had more than 25 listed. In September 1991, the DIA indicated that it would review the information and send the proper notification where appropriate. The Council has been unable to determine if there has been any positive result or action in this effort.

Some of the frustrations exhibited since the 1985 changes have been caused by the reluctance of the DIA to take proactive steps for improving the system. There should be no need for anyone to micro-manage agency activity. However, the many problems besetting the workers' compensation system demand active efforts by the agency to improve operations. Administrative recommendations for improving medical access and the dispute resolution system have not been addressed despite two reports which provided management with a variety of options to explore. In the specific case of the medical access study, this means that 2 years of possible improvements and cost savings have been lost. The Health Care Services Board was not convened and as a result savings from the utilization review set out in the law were not forthcoming. The position of medical consultant was advertised and funded but not filled, despite the receipt of almost 100 resumes.

Reports on the pretrial process implemented by the reviewing board indicate that it has been very instrumental in reducing the level of appeals. In other areas, perhaps consideration should be given to the legal possibility of reviewing issues pending before the reviewing board for possible consolidation. This may preserve reviewing board resources. A case in point is Boulrice's Case, noted above, which marked the fifth time the reviewing board reversed the same AJ for the same reason. A similar issue can be seen from Borofsky's Case, where shortly after its filing there were 15 decisions addressing the same issue. If there is a mechanism for consolidating issues for review, or dealing with appeals summarily, which could lessen the workload and reduce delays without violating the due process rights of parties, it would be worthy of exploration. In managing the dispute resolution process the DIA should be cognizant of duplications, whether in

similar appeals, such as Borofsky, or in identical issues with the same adjudicator, as in Boulrice.

In a similar vein, another issue concerning judicial economy is evidenced by Concepcion's Case, where the claimant, after requesting a continuation of the hearing, failed to appear at the hearing and the claim was dismissed. There was no attendance at the pre-hearing conference scheduled by the reviewing board after the case was appealed. The board denied and dismissed the matter and assessed costs pursuant to §14. While this is an example of the agency bending over backwards to accommodate parties to ensure due process rights, it is unfortunate that time and effort must be afforded to any party which has such callous disregard for the system when delays are already so disruptive.

The issue of costs, as set forth in §14(1), is a prime example of an existing mechanism to enforce economy. There have been more decisions at the reviewing board level which have assessed costs. Decisions that have assessed the penalties may create confusion as to whether §14 must be raised by a party. It would appear from the law that an AJ or the reviewing board can assess the costs even if the issue has been not raised by a party. However, the board has held the record open for a party to file a motion for costs and has also indicated that if such a motion had been filed, §14(1) would have been applied. It can be inferred that the board believes in these instances that the standard set forth in the law was breached, yet has not applied costs because the issue was not raised. While there may be no "bright line" rule for parties to follow (it may be that judges will know when to apply it when they see it), it might be helpful to indicate when and how the penalty will be applied.

The law has for decades (since 5/26/15 the enactment of c. 275 of the Acts of 1915) contained a statutory directive that procedures within the litigation sphere of the statute be as simple and summary as reasonable. In seeking to effectuate this process, the courts have noted the intent many times, while also noting that the parties themselves must decide whether to proceed in an amicable or adversary fashion Kareske's Case, 250 Mass 220, 225 (1924). See also Belezarians Case, 307 Mass 557, 560 (1940). In Re Hunnewell, 220 Mass 351, 354 (1915) - procedure to be as flexible as possible to

accomplish aim of act with as little formality as possible.

Neither has in fact occurred, and perhaps it is too much to expect otherwise. The agency has a myriad of rules to supplement the law, while in the past there were a handful. Inherent in the statute, with all of its legal entanglements reside a number of contradictory precepts. In fulfilling the mandate to be simple and summary, a ruling could fail to contain the necessary factual findings to withstand appellate scrutiny. It is a delicate balance to afford due process while meeting the statutory mandate.

Delays in the system exist both within the agency and without. If an AJ directs depositions to be filed on a certain date, and one or both parties have requested extensions which are approved, the decision process can carry over to a different point in the judge's cycle. The person to be deposed may not be available during the established time period. It is unclear just how far an adjudicator should go if the parties request the opportunity to depose and extensions are denied without running afoul of the holding in Boulrice's Case. (which stated that where a judge who denies the parties permission to present medical testimony in person or by deposition acts arbitrarily and capriciously and in violation of fundamental due process rights.)

The importance of the judicial appointment process cannot be emphasized enough, since timely appointments have a profound impact upon delay and cost. Adjudicators have been taken "off line" (we were informed this year that the current policy is about 90 days prior to term expiration) in order to finish outstanding disputes. New judges need time to be orientated, which results in additional time where cases are not scheduled. Delays in the process create delays in case resolution. This adds costs to the system for both workers and employers.

Positions have remained unfilled despite assessments against employers to fund them. Although there were questions about the status of the 7 backlog positions, the DIA unequivocally informed the Council that the appointments were not "recalls" and, as a result, there were no statutory restrictions on who could fill the slots. The expectation is that the employer funded system will use all adjudication positions to resolve

disputes. The sooner positions are filled, the greater the chance that costs will decrease. This year an expedient appointment process is even more critical due to the large percentage of terms which expire.

The process must be done in an equitable and expeditious manner, considering the needs of the system and the human resource factor of appropriate notice for terms that will not be renewed. The Dispute Resolution Study recommended that this be done in the Fall of 1991. The Council is hopeful that this delay will not add to the system's problems.

Turnover of personnel is endemic to any enterprise and partially beyond the control of any employer. What is within the agency's control is the management of caseloads. The DIA reported that notice by three judges in the last fiscal year resulted in 368 unresolved cases at the hearing level and 7 at the conference level, while one judge left no cases. If these matters must be brought before another judge for resolution, particularly if tried anew, the workload of existing staff is increased and delays and costs are exacerbated. It adds to the frustration of the parties who may have to prepare and litigate their case again after a prolonged wait for an initial opportunity, with potentially stale facts and less accurate memories of witnesses.

This same issue was noted in our report a few years ago. It was anticipated that some evaluation mechanism might be available to assess performance and identify when individual caseloads may be too high. The need for an equitable evaluation process has been noted for years, but none was established through the fall of 1991. Although the DIA informed the Council that a daily productivity system would be created and, in response to almost monthly inquiries, that evaluation guidelines and job descriptions would be developed, none was forthcoming. The DIA provided data that stated that job performance standards would not only create higher quality decisions and more uniformity, but also result in a .5% savings. Applying this to the oft quoted figure of $2.4 billion in premium translates into a $12 million savings that employers have lost.

Quantity must be tempered with quality when determining how the system can be improved. Since the vast majority of judicial appointments expire this year, it may be a

disservice to the Governor and the individuals involved that evaluations have not been done for over 5 years. The managerial decision to forego evaluations may place additional administrative burdens on the system, as well as costing millions of dollars in unrealized savings.

There are a number of points that deserve discussion from the brief analysis of the reviewing board's decisions. The reviewing board's decision in Gurley's Case, noted supra, reveals the problems associated with the procedural requirements of the law. The system, as set forth in the law, is predicated upon the timely filing of first reports and the necessary decisions which follow such filing. While the requirements of §6, §7, and §8 initially created some confusion, it is evident that for the system to operate as planned by the legislature, these sections must be followed and enforced in order to effectuate the intent of the law.

The application of agency rules is an issue that has arisen in the last few years, particularly with respect to the reviewing board's holding in Dennen's Case. The Council has stated in the past that the rules should supplement and augment the law,[20] not replace it. However, it must be clear as to the authority of the dispute resolvers within the agency as to whether rules may be invalidated. The economy of justice requires that parties be aware of what to expect, and if rules must wait in limbo until some form of determination is forthcoming from the court system, the twin problems of cost and delay are certain to worsen.

Some issues appear to keep surfacing in board decisions. A number of cases in the last year have noted that the filing date of the conference order or decision is irrelevant to the issue of when incapacity begins or ends. The board has noted this point often enough that all parties should be cognizant of it by now. The application of §7A was at issue in a number of cases indicating obvious uncertainty over its interpretation. Problems concerning the litigation of alleged occupational disease cases are noteworthy because these matters may take on additional significance in the workers' compensation system as technology and medical science improve. A number of these issues were outlined in the Council's report on Occupational Diseases.

In terms of the level of practice before the board, it

is disheartening to note the number of references to appellants not filing briefs or failing to appear, either before the AJ or ALJ. This not only places clients at a serious disadvantage, but also lowers the public perception of the DIA. The adjudicatory rules (452 CMR 1.15(14) permit a party to "elect" to file a brief, but do not mandate it. Yet the failure to brief the issues has not only been noted as creating judicial problems for the board, leaving to it the burden of sifting through the record for errors, but it also obviously impacts the ability of a party to prevail.

Clarification should be considered concerning the precise role of the adjudicators in the agency. The agency has promulgated a rule, 452 CMR 1.09(4), which states that as part of the investigative power granted to an AJ who is assigned a case under the law, the judge shall examine the board file. Another rule, 452 CMR 1.10(3), permits a judge to make such inquiries and investigations deemed necessary at a conference in order to determine whether benefits are due.

It is unclear if the role of the AJ or the reviewing board extends to investigations on their own, and if so, what limitations should be placed on such activities.[21] This may raise due process issues for all parties concerned and can be seen in the decisions of the reviewing board in two cases. In Dennen's Case, supra, the board reviewed the DIA's records in the file. The dissent raised questions over the board's authority to act in this manner since it impacted on the creditability of a lay witness. The entire focus of the board's scope of review under §11C has been at issue since the 1985 changes and has been the subject of numerous proposed legislative amendments after the issuance of Lettich's Case, 403 Mass 389, 530 N.E. 2d 159 (1988). The reviewing board has itself held that in arriving at a decision, an AJ is confined to the evidence presented and it is not open for the adjudicator to search other sources which he/she believes might be of assistance in reaching a just result. Castillo's Case, 4 Mass. Workers' Comp. Report 110, (1990). In that decision, the board clearly stated that independent inquiry or research by a judge is antithetical to our adjudicatory system. id, at 113. Given the analysis of the study on the Dispute Resolution process with respect to the files, this is an aspect which may merit attention.

Future Considerations for Improvement

--Administrative Action

The Advisory Council has noted on occasion that efforts to improve the workers' compensation system have largely centered upon statutory change, and that this focus has frequently overlooked the potential for administrative action to improve the system. Agency management bears a responsibility for maintaining overall organizational efficiency, implementing administrative improvements within its statutory purview, and discharging the duties for which it is statutorily obligated. There are a number of areas in which administrative efforts could be suitably engaged.

--The DIA should consider publicizing its issuance of stop work orders in enforcing insurance coverage requirements. Broad exposure of such action will potentially reduce non-compliance with the law. This is one area of system abuse which is not widely publicized.

--Specific rules for claims handling practices have yet to be promulgated. Such rules were intended to provide appropriate notice of unacceptable practices.

--Data needs increase as the demands of the system grow. The DIA should consider the judicious use of its authority under §63 to improve the systems' ability to analyze what is occurring. The point has been noted for years that data on injuries could improve the focus and cost effectiveness of safety grants. Reports have noted the desirability of data improvements for assessments calculations and for system study. Statistical data should be presented to the legislature yearly.

--The DIA and the system needs a proactive Health Care Services Board. It can play a vital role for improving the system and controlling costs. It was envisioned as a key participant in the implementation of the Council's Medical Access Study, which has not been acted on in the last 2 years.

--Addressing delays
The need to preserve due process rights and ensure equity to all parties will likely make dispute resolution a continuing source of delay. Administrative mechanisms may nevertheless be available to allow better use of resources.

--One possible means of reducing delays at the appellate level is to provide for the review of disputed issues in cases for consolidation. It is not unusual for decisions to address identical issues alone, Borofsky's Case, or by the same adjudicator, Boulrice's Case. There may be a mechanism for reducing the duplication of effort in such instances without impairing due process rights.

--Effort should be made to curtail abuses of dispute resolution procedures which tie up valuable departmental resources. An example is noted above in Concepcion's Case. It is promising that §14 appears to be utilized more frequently. It may be helpful to clarify its application to ensure uniform enforcement and put the parties on notice. In the same vein, if issues continue to be raised as to the investigative role of adjudicators, this may warrant clarification.

--Consideration should be given to the administrative recommendations contained in the Council's Dispute Resolution Study provided to the DIA at the start of FY'92. Many of these ideas may improve the system while some, such as evaluating judicial performance, have been quantified as saving money.

--Administration of Funds
While there have been issues concerning the management of the funds in recent years, these have generally been resolved in a professional manner. The DIA has a statutory and fiduciary responsibility to spend only the necessary assessments, while ensuring that statutory revenues are billed and collected. Solutions to problems in this area are administrative in nature, and they hold the promise of reducing costs without resorting to legislation.

--The Advisory Council has taken a position against cost shifting to private employers through furlough programs or reversion to the state of assessments. While involving a small amount of money, the failure to seek an exemption from reversions of furlough money is exactly the type of omission that employers cannot afford. Agency administrators have statutory and fiduciary responsibility to ensure that employer-generated funds are handled responsibly.

--Fiscal planning for employer funds should focus on services that the agency provides. Legislative costs to employers cannot be avoided but administrative actions, such as having to take judges off line or not evaluating them, can be.

--Trust Funds have assessed over $1.7 million for defense of the fund in FY'91 and FY'92, while projections indicated that less than one-third of this amount will have been expended. It stands to reason that idle funds may represent an unnecessary expense for employers, and effort should be made to minimize the level of idle funds. A similar concern with assessed employer funds exists when positions remained unfilled.

--Despite indications by the agency that it would levy certain statutorily prescribed fines, it has failed to do so, while other fines have been waived or not enforced. The integrity of the statute demands that all revenue procedures be practiced and enforced in an efficient and equitable manner.

--It is equally imperative that reliable assessment figures be available and assessment budgets be prepared. A difference of over $17 million in collections for the year is a serious concern. Employers lost over $2 million in the special fund balances because expenditures exceeded collections.

Other Areas of Consideration

--Another financial issue with implications for the Trust Funds is the recoupment of monies expended under §30H for successful vocational rehabilitation issues paid by the Trust Fund. The Council had raised this issue for a number of years and as noted above the DIA is finally enforcing the law.

If the funds are assessed at two times or more of the amount expended, there is a question as to whether the additional losses, (those in excess of the original cost) should be built into the overall insurance rate-making process or an employer's experience modification. The additional cost is similar in intent to other aspects of the statute and perhaps consideration should be given to excluding the additional costs, as §7F already does for other payments, from the rate making process.

--In 1992 the vast majority of judicial terms expire. 1998 will present the same issue and in 1994 another large group of terms end. This places stress on the system. Prior to 1985 all terms were staggered which made any transition smoother. One possible area for consideration is to look at staggered terms at some point in the future. Any attempt to do this at present would most likely create an administrative nightmare for all parties.

One possible means of alleviating the problem, initially discussed a few years ago, would be to fill openings in judicial slots prior to expiration with full 6 year terms, rather than having the individual complete the unexpired term. Limits could be established as to when in the term this would occur (e.g. only in first 2 years) and, if considered, any such change could have a terminal date (sunset clause) for it to take place. If no one leaves under such a scenario, the problem still exists. However, if a few judges leave it means that the burden of making the large number of appointments in a short time is eased. There may be additional alternatives suitable for consideration that deserve exploration in order to provide the proper time for a full discussion before the next series of appointments must be done.

Improvement in the system requires the hard work and dedicated efforts of all concerned parties. While a number of the concerns raised herein concern decisions from the past, we remain confident that the positive approach offered by many new participants bodes well for the future betterment of the system. The Council welcomes the opportunity to work with others in the ongoing efforts for constructive change.

FOOTNOTES

1. The report was run 2/13/92. At that point none of the invoices billed for 2/7/92 had been paid for obvious reasons. In addition a number of referral fees were adjusted (148) and this accounts for the difference in the paid and due invoices.

2. Federal law states as follows: Disclosure of social security number. Act December 31, 1974 P.L. 93-579, §7, 88 Stat. 1909, provided:
"(a) (1) It shall be unlawful for any Federal, State or local government agency to deny to any individual any right, benefit, or privilege provided by law because of such individual's refusal to disclose his social security account number.
"(2) the provisions of paragraph (1) of this subsection shall not apply with respect to--
"(A) any disclosure which is required by Federal statute, or
"(B) the disclosure of a social security number to any Federal, State,, or local agency maintaining a system of records in existence and operating before January 1, 1975, if such disclosure was required under statute or regulation adopted prior to such date to verify the identity of an individual.
"(b) Any Federal, State, or local government agency which requests an individual to disclose his social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by what statutory or other authority such number is solicited, and what uses will be made of it." The law highlights the importance of privacy interests associated with social security information (U.S. v. $2,000,000 in United States Currency), 590 F. Supp. 866, 871 (1984).

   The Council is not aware of any statute or regulation subsequent to 1/1/75 which authorized mandatory disclosure of Social Security numbers nor is it aware of any documentation which fulfills the requirements of § (b). DIA forms specifically state that disclosure is voluntary. Another concern was that the policy was implemented through a posting on the bulletin board at the DIA, not mailed, and since it was effective at once parties would not be aware of it, or would rely on the DIA forms which stated that disclosure was voluntary. Employer assessments had to pay for the labor and postage costs, which the DIA stated was negligible. Another possible result would have been the rejection of insurer filings if it did not have the employee's social security number. The Claims Processing Manager was directed on 7/2/91 to cease rejecting forms without the number until further notice was given.

3. For purposes of this analysis, the computer collects data and collates by a hierarchical structure by the sections of the law being claimed. The data for the claim are counted under the highest ranked category. For example, a claim listing benefits under sections 34, 13 & 30, and 7 would be counted under §34. A claim listing benefits due under sections 13 & 30 and 7 would be listed under §13 & 30. In this way, each matter is counted once.

4. The DIA report collates the data in the same hierarchical fashion as noted in footnote 3, supra, and has been consolidated into the major categories of disputed matters.

5. In an Opinion of the Attorney General, Public Document 12, dated 2/14/84, page 106,108, the following requirements were enunciated: " In Massachusetts, a gubernatorial appointment is complete upon the written or oral appointment of the governor. The only requirement remaining is the "qualification" of the appointee be established by the taking of the qualifying oaths prescribed by the laws of the Commonwealth." The opinion cites both the Massachusetts Constitution, Part 2, c.6, art. 1, and M.G.L. c. 30 §8. The opinion goes on to state that there is no form prescribed by law for such appointments, which can be made orally, in writing, or in some other manner.

6. Town of Dartmouth, 1 MLC 1257 (1975); Town of Duxbury, 3 MLC 1733 (1977) and Town of Tyngsboro, 5 MLC 1600 (1979).

7. Town of Agawam, 13 MLC 1364 (1986).

8. City of Lawrence, 13 MLC 1157 (1986).

9. id, at 1160.

10. Approval figures only show final actions. If an indication is made in the course of the review process that the agreement may not be approved in its current form, it may be amended to address the concern raised. Such changes would not be reflected in these numbers.

11. These figures were computed using the same exhibits in the actuarial analysis done by the DIA and approved by the Secretary of Labor- See Exhibit 1,sheet 1 in each of the last two reports- The number does not correspond to the estimated budget which includes other revenue services listed on the first page of the FY'91 report so we used the breakout in the exhibits.

12. Westland Housing Corporation v. Commissioner of Insurance, 353 Mass 374, 400 (1967).

13. The Director of the Office of Education and Vocational Rehabilitation, as noted in our FY'89 Annual Report, p. 38.

14. In a decision filed 4/16/92 the Reviewing Board issued a ruling on these cases. The holding, which was noted as one of first impression and relied upon new developments not in effect at the time of the initial decisions or drafting of this report, stated that Massachusetts rates apply to out of state providers.

15. The most recent State Comptroller's Report, Comprehensive Annual Financial Report for the Fiscal year Ended June 30, 1991 recommended the following at page 20/21.

"Regarding financial management, the Office of the Comptroller believes that increased Executive and Legislative attention should be directed to the budgeting and management of non-tax revenues. For years, expenditure planning and control has been emphasized, but this has not been matched by an emphasis on non-tax revenue management. As a result, the Commonwealth does not have official or authoritative budgets for non-tax revenue, and there are insufficient computer systems to support revenue planning, monitoring, or reporting. There are several alternative ways to implement revenue budgeting, and, after consideration of the options, relevant legislation should be enacted. Systems, policies and procedures need to be modernized, requiring additional resources and, in many cases, legislation. The Commonwealth should also examine incentives for revenue management.

Consistent with the prior recommendations, the Office of the Comptroller believes the Commonwealth's current fund structure should be streamlined. The proliferation of special purpose, budgeted Special Revenue Funds has fractured, not strengthened, the budget process. As special interest groups have enjoyed political success in carving out dedicated revenues and removing operations from the General Fund budget, the capacity for centralized planning and control has diminished. The numerous non-budgeted Special Revenue Funds and Capital Projects Fund further complicate efforts to obtain a comprehensive view of state finance."

While the accounts noted above are not in use at the DIA, the overall intent is equally applicable to the DIA funds.

16. One of the most debated decisions in the last decade, Ferriter v. Daniel O'Connell's Sons, Inc., 381 Mass 507,539, (J. Quirico concurring in part and dissenting in part) indicates that jurists rely on DIA data in formulating their ultimate opinions. Employer assessments have been extremely generous in providing the agency with the resources and staffing to accomplish some format of information gathering and analysis by those most familiar with the system. The Council has supported the redeployment of agency personnel, where feasible, to assist in the improvement of the department's research capacity in the past. The decision as to whether such information will be forthcoming rests with the DIA.

17. In 1914 the First Annual report of the agency could determine that the average number of days lapsing from the time of injury to actual date of payment was 25. (First Annual Report of the Industrial Accident Board, 7/1/12-6/30/13,p. 96) A subsequent report stated that the statistics and tables compiled by the agency are intended to help determine the cause of injuries and are of a tremendous value to the State Board of Labor and Industries in its safety campaigns. (Eighth Annual report of the Industrial Accident Board, 7/1/19-6/30/20, 1921, p. 1) Given the advances in modern technology, not only for the agency but also for the parties, it is unclear why identical statistics and assistance should not be available today.

18. See The Standard, p.3, of 12/6/91 citing a study by Orin S. Kramer.

19. Problems associated with the insurance market were not solely relegated to Massachusetts. Liberty Mutual, CIGNA, USF&G, Commercial Union, and the Hartford have discontinued writing policies in Rhode Island. USF&G will no longer write in Mississippi, and AIG, the 2nd largest carrier in Texas stopped writing workers' compensation in that state in April, 1991. The assigned risk pool in Maine has but three of its servicing carriers in the assigned risk pool, which is 87% of the market up from 67% in 1987, as a result of new assessment procedures. The size of rate requests across the nation underscore the position. In Massachusetts, Reliance Insurance Company, which left the market in 1988, has agreed to return and offer a full line of policies, while Aetna, the second largest writer in the workers' compensation market in 1989 has ceased issuing auto insurance.

20. Judicial decisions have clearly held that a properly promulgated regulation has the force of law. Solomon v. School Committee of Boston, 395 Mass 12, 478 N.E.2d 137 (1985). In addition, whereas rules may be properly revoked or amended, they may not be arbitrarily disregarded by individual members of the rule-making body to the prejudice of a party's essential rights. DaLomba's Case, 352 Mass 598,603 (1967). This appears to be the only case where the SJC has discussed whether a state administrative agency is bound by its own rules and it is a workers' compensation case. (See Alexander Cella, Massachusetts Practice Series v. 2, West Publishing p.99) The question then becomes whether an adjudicator within the agency can make a binding determination as to the validity of a rule properly promulgated by the agency.

21. Prior rulings appear to create ambiguity. Reports on file with the department can be acted on by the board without being put in evidence formally. Carroll's Case, 225 Mass. 203, 208 (1916). Investigation of the agency's records by the board was appropriate in order to establish if proper notice had been provided for a hearing. Avisais's Case, 285 Mass 57, 58 (1933). However, the court has also stated that parties are entitled to a decision based on evidence presented at the hearing and nothing can be considered or treated as evidence which is not introduced as such. Haley's Case, 356 Mass. 678, 681, 682 (1970). The difference in the holdings may be based upon the fact that the first two cases addressed administrative functions (first report/hearing notice), while the last concerned the reliance on a medical report not in evidence in reaching the decision.

APPENDIX A

MEMBERS OF THE ADVISORY COUNCIL AND STAFF FY'91

Voting Members	Term Exp.Date
Joseph Faherty, Chairman (Labor)	6/25/91
Jim Cronin (Business)	6/25/91
Douglas Mure, Vice Chair (Business)	6/25/92
Kevin Mahar (Labor)	6/25/92
Samuel Berman (Business)	6/25/93
James Donovan (Labor)	6/25/93
Edmund Corcoran (Self-Insurer)	6/25/94
John Goglia (Labor)	6/25/94
James Farmer (Labor)	6/25/95
Paul Meagher (Business)	6/25/90

Non-Voting Members:

John Antonakes (Insurance)	6/25/92
Emily Novick, Esq. (Claimants' Bar)	6/25/93
Edwin Wyman, Jr.MD (Medical)	6/25/94
Amy Vercillo (Rehab)	6/25/95
Christine Morris Executive Office of Labor	Ex-Officio
Daniel Gregory Executive Office of Economic Affairs	Ex-Officio

Staff
Stevens Day
Richard Campbell
Ann Helgran

APPENDIX B

AGENDA FY 1991

July 18, 1990

Working Paper
Second Injury Subcommittee Update
Employee Leasing
Public Employee Report (Handout)
Miscellaneous

August 22, 1990

Conciliation Discussion
Daly Case
Working Paper
Scope of Services
Annual Report Update
Miscellaneous

September 19, 1990

Recommendations
Annual Report Draft
Upcoming Rate Filing
Miscellaneous

October 11, 1990

Continued Discussion: Recommendations from Friction Costs Study - Attorney Fees
Annual Report
Rate Filing
Miscellaneous

November 14, 1990

Premium Rate Filing.
The Attorney Fee Aspect of our study.
The Commissioner and the Judges to finish our discussion.
Discussion of the Legislation on the Assigned Risk Pool.
Discussion - Office of Insurance

December 12, 1990

Legislation
- Assigned Risk Bill
- Section 48

Kszepka's Case
Annual Report- Final Draft
Rate Filing
Miscellaneous

January 9, 1991

Expenses for Trust Fund Bi-Annual Report - Michael Simmons
Legislation
- Assigned Risk Pool
- Premium Deductible
- Section 48 - Lump Sums

RFP - Dispute Resolution
Final Draft - Annual Report - Handout

January 28, 1991 - Subcommittee

Selection Committee - Dispute Resolution Study

February 13, 1991

January Minutes
BDO Seidman/Endispute
Section 25C - Uninsured Employers
Fiscal 1991 - Fiscal 1992 Budget

March 20, 1991

February Minutes
Second Injury Fund
Legislation 1991

March 29, 1991

Legislation

April 10, 1991

Testimony For Joint Commerce And Labor Committee
Hearing At 10:30 AM, April 10, 1991

May 8, 1991

Minutes
Commissioner Lane
BDO/Endispute
Legislation Update
Public Employee Report Review
Miscellaneous

June 19,1991

Minutes
BDO/Endispute Report
Budget FY'92
Assessment FY'92

June 27, 1991 (Subcommittee)

BDO/Endispute Report

EXECUTIVE SUMMARY

Introduction

In January 1991, ENDISPUTE Inc. and BDO Seidman were selected by the Massachusetts Workers' Compensation Advisory Council to conduct a comprehensive evaluation of the efficiency and effectiveness of dispute resolution in the Department of Industrial Accidents (DIA). Our study evaluated dispute resolution management issues and dispute resolution procedures (including conciliation, conference, hearing and Reviewing Board review).

Our methodology included interviews with Advisory Council members, DIA staff, members and staff of relevant Legislative committees, and dispute resolution system participants (e.g. workers, employers, insurers, medical providers, attorneys, etc.), as well as statistical analysis of data from DIA's DIAMETER computer system.

This report is particularly indebted to the many DIA staff who generously shared their time and thoughtful ideas with us. They should surely not be held responsible for the findings and recommendations presented here. They must, however, be acknowledged for their professionalism, understanding, and commitment to improving a system currently in trouble.

Key Findings and Recommendations

Despite significant legislative reform of the Workers' Compensation statute enacted in 1985, the Department of Industrial Accidents continues to struggle with a high incidence of disputed cases and long delays in resolving disputes. These delays reflect fundamental, systemic management and procedural problems. Our recommendations for improving the dispute resolution system aim to address these problems through wide-ranging and participatory management reforms, without major statutory changes.

1. Dispute Resolution in the Department of Industrial Accidents is a single interrelated system, with many component parts. For better or worse, it cannot be improved by one quick fix, or three or four major changes. Effective improvement will only result from analyzing this system as a whole, and putting into effect many focused changes in a consistent, steady manner.

- Recommended changes to dispute resolution procedures should be adopted and implemented as a group, not on a piecemeal or impulsive basis. Changes should be discussed and refined with the assistance of current participants in this system, including the Advisory Council, who are knowledgeable and committed to making improvements.

2. DIA is mandated by statute to administer an Alternative Dispute Resolution (ADR) system, not a substitute court system. There is strong evidence that this system can be made to work in the way the statute intended, without establishing additional or external ADR mechanisms.

   - DIA should focus its efforts on reforms that will decrease formality, promote early fact-finding, and encourage voluntary resolution of disputes.

   - DIA should increase its outreach to the worker and employer communities to encourage earlier, cooperative approaches to dispute resolution.

3. The system is not being managed to promote swift and fair dispute resolution. DIA does not monitor and guide the behavior of workers, employers or their representatives to enhance settlements and prevent misuse of the system, nor has it established clear standards and goals to define and direct its own staff's activities.

   - DIA should clarify, expand, and enforce guidelines for system participants. The guidelines should provide incentives for early resolution, identify and sanction system abusers, and recognize and reward collaborative behavior.

   - DIA should develop performance standards and conduct performance review for all staff, starting with the AJs and ALJs.

4. The DIAMETER computer system for recording case information is being used primarily as a centralized case tracking and scheduling mechanism. It does not provide useful management information in a timely fashion.

   - Working with representative system participants, the Department should identify information needed for effective management, and should redesign DIAMETER data entry and data analysis procedures to provide new management and case tracking reports. Additionally,

judges, conciliators, and regional managerial staff should be given expanded access to this system.

5. The Department's managerial decision-making structure is not consistent with its organizational structure. Central control of scheduling and staff supervision undermines regionalized service delivery.

   - Regional Managers, along with judges, conciliators and staff in regional offices, should be held accountable for providing dispute resolution services to the workers and employers in the geographic areas they serve, and should be given authority to carry out their jobs with less direct central control.

6. All components of a dispute resolution system should be coordinated and managed as a whole. Presently, the conciliation unit -- the first opportunity for successful resolution of DIA disputes -- is separated from the rest of the system, and is located under Claims Administration in the Administration Division. This does not encourage effective coordination with other dispute resolution activities.

   - The Conciliation unit and management should be transferred to the Division of Dispute Resolution, in order to encourage early settlement, improve coordination, and facilitate monitoring and assessment of the ADR system as a whole. This may require discussions within the context of collective bargaining.

7. The single most important issue currently facing the Department is the appointment, or reappointment, of the twenty judges whose terms are slated to expire between now and September, 1992. If a timely and thorough process is not immediately initiated, the dispute resolution system will, quite literally, come to a halt.

   - The Department and Administration should decide on criteria for reappointment, and conduct evaluations of sitting judges to determine which ones, if any, will be reappointed. All should be informed of the process and the outcome by early fall, in order to prevent mass departures.

   - The Administration should initiate the nomination, review and appointment process (presumably using the same criteria) as quickly as possible in order to have new appointments available as soon as former judges leave.

Section III - Dispute Resolution System Management

Overall Finding: The system is not being managed.

A. Management of the Dispute Resolution System

Finding One

The Department has not focused on the overriding goal of the Dispute Resolution system -- to resolve disputes over compensation for injuries and lost wages as quickly, effectively, informally, and efficiently as possible -- and has not established its expectations and procedures to reinforce this goal. The DIA is not mandated to operate a substitute court system; it is mandated to manage an Alternative Dispute Resolution system.

Recommendations:

1. Provide -- throughout the dispute resolution system -- incentives to encourage early settlement of claims, as well as disincentives to moving forward unless necessary.

2. Revise DIAMETER to assist in evaluating Conciliators, AJs and ALJs more on the basis of their success rate in settling claims than on the numerical statistics of how many meetings, conferences or hearings they are holding, or how many decisions they are writing.

Finding Two

The Department has failed to monitor the behavior of parties in the system effectively, in order to determine whether there are patterns of behavior -- either by groups, specific companies or specific individuals -- which contribute to excessive use of the system and hence to the delays. We are not talking about fraud, but rather about patterns of behavior which adversely affect the intended functioning of the dispute resolution system.

Recommendations:

1. The Department should, after redesigning the DIAMETER system (see below, Section III-D), monitor the system regularly in order to evaluate the occurrence and extent of such adverse behavior as excessive or inappropriate filing among insurance companies and attorneys.

2. Where such patterns are found to exist, the Department should use its regulatory power to sanction the behavior, and should monitor carefully in the future to assure that it does not re-occur.

3. The Advisory Council should, in cooperation with the Massachusetts Bar Association, encourage the development of new MCLE programs to improve attorney understanding of and skills in using mediation and other ADR strategies in the DIA dispute resolution system.

B. Management of Administrative Responsibilities

Finding One:

There is a minimal and, we believe, inadequate body of administrative rules, guidelines and forms to guide participants once they enter the DR system to carry out their responsibilities and to meet their obligations.

Recommendations:

1. Establish an Advisory Committee composed of representatives of the claimants' bar, the insurers' bar, large and small employers, organized labor, AJs and ALJs, the Conciliation Manager, and a senior DIA manager, to consider and propose needed rules and forms.

2. The Department should develop forms for use in the Dispute Resolution process which would simplify and facilitate its own processes and clarify the responsibilities of participants in the system such as physicians and other health care providers.

Finding Two

There are serious problems in the administrative relationships between the central Boston office and the regional offices which contributes to the slowness of the dispute resolution process.

Recommendations

1. Make the Regional Offices independent, accountable administrative units responsible for all aspects of the dispute resolution process, including conciliation.

2. Give Regional Managers managerial responsibility, including direct supervision of staff in their respective offices and increased access to the DIAMETER system.

Finding Three

The records of the DIA Dispute Resolution system can only be described as abysmal.

Recommendations

1. The Director of Administration, in cooperation with the Conciliation Manager, the Director of Dispute Resolution, one or more Regional Managers, the Records Manager, and representatives from the AJs and ALJs (possibly two of their secretaries), should constitute a Work Group to design and develop a standardized Record format for the Department, and identify a new DIA process to enter and maintain material in these files.

2. We also recommend that case files be regionalized, and physically maintained in the office which serves the area in which the claimant lives.

C. Management of Human Resources

Finding One

The DIA dispute resolution system (and particularly the Division of Dispute Resolution) has an ambivalent attitude toward the role and accountability of the intended dispute resolvers -- called conciliators and judges.

Recommendations:

1. We believe that the ADR and non-judicial character of this system for resolving disputes should be recognized and affirmed, or the law should be changed.

2. The work of the AJs or ALJs, on a day to day basis, should be managed by a senior and experienced member of the judges' "team," who might be called the Chief or Senior Judge.

3. The Conciliation staff, under the management of the Conciliation Manager, should be transferred into the Division of Dispute Resolution.

Finding Two

The Department has never developed AJ/ALJ job descriptions or job performance standards, nor has it conducted annual reviews or other evaluations of the performance of ALJs or AJs in the last five years.

Recommendation:

In cooperation with the Judges' Committee, the Department leadership should first define the purpose and functions of AJs and ALJs in the dispute resolution system, their norms and expectations of these roles in the context of existing legislation.

Special Finding

Between now and September 1, 1992, nine Administrative Judges and four Administrative Law Judges, who are a major proportion of the dispute resolution system, are up for re-appointment. The terms of seven backlog judges will also expire. As a group they represent an impressive reservoir of experience, skill, judgment and energy. Many of them are serving with extraordinary commitment and distinction, in the face of an enormous backlog, no control over their own schedules, cramped and crowded facilities, unclear leadership, fragmented administrative policies, no salary increases since 1986, and an uncertain future.

It is amazing that in the last six months only two of these judges have indicated their intention to resign. However, it is certain that without clear signals from the new administration, and a fair and early mutual discussion

of what they can expect, many of the best of them will soon be gone. This will certainly result in a major increase in the already critical backlog, and an undermining of current efforts to improve the system, and will send an unfortunate message to prospective judges about the DIA situation. It would also be an unfortunate waste of competent, often gifted and committed, human resources.

Special Recommendation:

The Department and the Administration should review the statutory roles and responsibilities for Administrative Judges and Administrative Law Judges, and the nominating process. Together, they should clarify the process and criteria the Administration will use in appointments.

We are completely convinced that without this process, and clear notification to sitting judges as to whether or not they may be reappointed, many judges will leave and the DDR system will be in crisis within a very short period of time.

D. Management of Information

Finding

The DIAMETER system was designed as a centralized way to schedule and track cases. It does not produce useful management information in a timely fashion.

Recommendations

1. The Department should decentralize the DIAMETER system so that each regional office has access to its own scheduling functions and can control more of the input to bring the existing information system into step with the DIA organizational structure.

2. The Department should establish a DIAMETER Users' Group, composed of representatives of participants in the dispute resolution system. This group should include both regional and central office staff, as well as representatives of employers, workers, attorneys and insurers. The group should be asked to develop recommendations for what information is needed by managers, judges, conciliators, and other participants in the

system in order to monitor, manage, and understand patterns and trends in the system, as well as to track events.

Section IV - The Stages of Dispute Resolution

A. The Dispute Resolution System

Finding:

The Department is not attempting to change the historic adversarial relationship between workers and employers, or to clarify that the 1985 statute has mandated an Alternative Dispute Resolution system, not a court system, to resolve Workers' Compensation disputes.

Recommendations:

1. The Department should improve its public information to the Workers' Compensation attorney community and should consider joint sponsorship of attorney training programs about ADR.

2. The Department should encourage union business agents to represent workers, and claims adjustors to represent insurers.

3. The Department should examine the experience of other states such as Connecticut, where the Workers' Compensation Commission actively discourages claimants from retaining an attorney.

B. Conciliation

Finding One

1. The time lag from conciliation to conference creates significant disincentives for parties to come prepared to resolve issues at conciliation.

2. Some conciliators are not making full use of their authority to require that parties make a serious effort to resolve issues at conciliation.

Recommendations:

1. Encourage conciliators to perform the role of "gatekeeper." Develop clear guidelines for conciliators' use of their statutory authority to hold and to forward cases.

2. Encourage conciliators to require additional conciliation meetings, reschedule meetings, and increase the time for meetings as appropriate to resolve disputed issues.

Finding Two

Conciliators currently feel obligated to meet with parties on highly complex cases that are clearly not amenable to conciliation.

Recommendation:

Develop criteria for conciliators to identify cases which should be referred to conference without conciliation, and allow conciliators to refer these cases based on a review of written materials only.

C. Conference and Hearing

Finding One

The current conference and hearing scheduling procedure provides standardized assignment of cases to judges, but it does not give judges enough discretion to manage their case loads for maximum efficiency.

Recommendation:

Review and revise case scheduling procedure for judges.

Finding Two

1. Judges often do not have adequate information when reviewing cases in preparation for conference.

2. Some judges do not actively promote informal case resolution before issuing a conference order.

3. Some judges are not maximizing the dispute resolution potential of their conferences before scheduling a hearing.

Recommendations:

1. Improve transfer of records from Conciliation to AJs.
2. Encourage and assist judges to seek informal resolution of disputes at conference.
3. Encourage judges to reschedule conferences, schedule additional conferences and lengthen the time for conferences when appropriate, rather than issuing orders or scheduling hearings.
4. Change MGL 152 Section 13A to allow AJs to reduce attorney fees when appropriate.
5. Enforce statutory penalties (under Sec. 14) on worker and insurer representatives who repeatedly fail to produce necessary information prior to conference.

Finding Three

Some judges have difficulty writing decisions expeditiously.

Recommendations:

1. Provide judges with opportunities to sharpen their decision-writing skills.
2. Clarify the Department's standards and expectations on how decisions should address issues of fact and law.
3. Consider the use of summary and short-form decisions for some cases.

D. Reviewing Board and Lump Sum Settlement

Finding One

The Reviewing Board is experiencing severe and increasing delay in disposing of cases appealed from hearing.

Recommendations

1. Consider limiting the Board to review of issues of law and oversight of AJ decisions.

2. Consider ways to expedite review of appealed cases, such as increased use of pre-hearing conferences and expanded use of law clerks.

Finding Two

1. The Reviewing Board has been overwhelmed by the demand for lump sum conferences (over 15,000 in FY 1990).

2. Mandatory meetings with disability analysts and reports from disability analysts are widely perceived as unhelpful to workers and judges.

Recommendations

1. Amend statutory Sec. 48 to remove the requirement for the Reviewing Board to review lump sum agreements.

2. Make worker meetings with disability analysts voluntary, but allow judges discretion to require a meeting with disability analysts in cases where a worker does not appear to be fully informed.

E. Recommended Demonstration Projects

We recommend that DIA use demonstration projects to test three additional dispute resolution procedures:

1) AJ-conciliator joint case management;

2) "Final offer" procedures for resolving earning capacity and medical disability disputes; and,

3) Limited order power for conciliators.

APPENDIX D

Testimony of the Workers' Compensation Advisory Council
on Proposed Rules of the Department of Industrial Accidents
July 22, 1991

The Massachusetts Workers' Compensation Advisory Council has reviewed the proposed rules as written in conformance with the current regulations and statute. The position of the Council is unanimous in not supporting any of the proposed changes as written. The Council offers the following commentary on the rules as proposed.

With respect to the definition of Filed for 452 CMR 1.02, the proposal seeks to have an appeal filed no later than the thirteenth day when appealing the decision of an administrative judge pursuant to §11C. Chapter 152 §11C provides parties with thirty (30) days in which to file an appeal. It is unclear if this is a typographical error or if the DIA is seeking to curtail the appeal period in contradiction with the law. In addition, the rule proposes defining the term Filed as used in 452 CMR 1.11(1) and 1.15(2). This term does not exist in these sections under the current rules. There is no proposed change for those sections which the definition is purported to refer to, and this could lead to confusion by parties if the rule and the statute are not integrated in a cohesive manner. If there are going to be proposed changes to those rules, the Council would request the opportunity to review them.

The Council did not support the proposed definition of Necessary Expenses for 452 CMR 1.02. However, the Council's concern centers upon the phrasing for out-of-pocket costs. As an alternative, the Council suggests that "only reasonable out-of-pocket expenses" be used instead of the phrase "all out-of-pocket costs".

Finally, the Council has reviewed the proposed elimination of the current 452 CMR 1.09 (2) and its replacement with new language. There are a number of serious concerns with the proposed rule on a constitutional, statutory, substantive, and procedural basis, but we will confine our comments to two areas. One concern is that Chapter 152 does not authorize a loss of defenses or penalties for the failure to pay a referral fee. Section 5 of the law requires that rules be consistent with the statute. For a rule to be enforced, there must be a sanction set forth in the law. Grant's Case, 3 Mass. Workers' Comp. Rep. 204, 208 (1989). It is the

Council's belief that the proposed rule is entirely inconsistent with the law and, as a result, will create additional litigation, which will inevitably increase costs and delays for all concerned.

In addition, this proposed rule will potentially have an extremely unfair and detrimental impact on employers. Employers would be faced with additional costs because their loss experience would

reflect losses due to an insurer being barred from raising defenses in cases where the referral fee has not been paid. At a time when parties are working diligently to ensure that the system treats everyone equitably and to address rising costs, this proposed rule has the potential to increase costs for actions over which employers have absolutely no control.

We would note in closing that in the past, many dedicated individuals have donated their time, expertise and effort in serving on the DIA Rules Committee. This process provided a knowledgeable group of individuals to review and discuss the impact of possible rule changes prior to the agency deciding to promulgate them. We believe that this open and inclusive process was beneficial to the system and request that the administration consider its use in the future.

APPENDIX E

COLLECTIONS & EXPENDITURES
FY'91

PRIVATE TRUST FUND			
BEGINNING BALANCE 7/1/90			2,599,572
Assessments	14,120,932		
Reimbursement	301,340		
Stop Work Order	40,100		
Interest	16,386		
Interest*	60		14,478,818
TOTAL RECEIPTS			17,078,390
PRIVATE TRUST EXPENDITURES			
SEC. 34 PAYMENTS	2,322,737		
SEC. 35 PAYMENTS	376,775		
LUMP SUM	987,387		
SEC. 36	307,399		
SEC. 31	109,357		
EMPLOYEE REIMB.(MEDICAL)	16,703		
EMPLOYEE REIMB. TRAVEL	11,513		
EMPLOYEE REIMB. BOOKS, ETC.	7,070		
WELFARE LIENS	52,283		
VETERANS LIENS	4,369		
VOC REHAB-LEGAL	56,678		
VOC REHAB. SEC. 30H	47,553		
BURIAL EXP.	2,000		
IME'S	73,910		
MEDICAL	886,627		
LEGAL	447,772		
TEMP. SERVICES	17,082		
CLAIMS ADJUSTER	26,491		
MEDICAL ADJUSTER	39,000		
STENO SERVICES	158		
PAYROLL & FRINGE	32,522		
FURLOUGH BUYBACK	1,227		
SHERIFFS	982		
TOTAL SEC. 65 PAYMENTS		5,827,595	
JUDGEMENT-DALY		12,480	
SEC. 37		613,897	
COLA PAYMENTS		6,290,443	
TOTAL PAYMENTS			12,744,415
ENDING BALANCE PRIVATE TRUST			4,333,975

* Interest from unknown source. The Treasurer's office has been notified and a credit allocated for FY '92.

APPENDIX E
FY'91 FUNDS
RECEIPTS & EXPENDITURES

SPECIAL FUND		
BEGINNING BALANCE 7/1/90		5,295,760
Assessment	8,801,672	
Filing Fees	2,181,833	
Late 1st Report Fine ($5600. from IV's)	890,330	
Sec. 14	950	
Interest	699,209	12,573,994
TOTAL RECEIPTS		17,869,754
EXPENDITURES		
Judgement - Daly	93,748	
Operating Expenditures	14,496,314	
TOTAL EXPENDITURES		14,590,062
ENDING BALANCE		3,279,692

PUBLIC TRUST		
BEGINNING BALANCE 7/1/90		761,936
Assessment		4,322,654
TOTAL RECEIPTS		5,084,590
PUBLIC TRUST FUND EXPENDITURES		
COLA PAYMENTS	3,485,966	
SEC. 37	91,866	
VOC REHAB	11,184	
TOTAL EXPENDITURES		3,589,016
ENDING BALANCE		1,495,574

APPENDIX E

REPORTS OF THE STATE TREASURER
FILED PURSUANT TO M.G.L. CHAPTER 152 § 65(9)

	PUBLIC (1)	PRIVATE (2)	SPECIAL (3)
	FISCAL YEAR 1987		
STARTING BALANCE	0	21,940	0
COLLECTIONS	541,465	6,088,110	7,130,943
TOTAL	541,465	6,110,050	7,130,943
EXPENDITURES	0	672,249	0
ENDING BALANCE	541,645	5,437,801	0
	FISCAL YEAR 1988		
STARTING BALANCE	541,465	5,437,801	0
COLLECTIONS	857,706	12,641,672	12,049,532
TOTAL	1,399,171	18,079,473	12,049,532
EXPENDITURES	1,364,992	8,741,647	0
ENDING BALANCE	34,179	9,337,826	0
	FISCAL YEAR 1989		
STARTING BALANCE	34,179	9,339,313	0
COLLECTIONS	1,050,742	8,750,125	15,548,851
TOTAL	1,084,921	18,089,438	15,548,851
EXPENDITURES	889,481	7,419,273	13,961,549
ENDING BALANCE	195,440	10,670,165	1,587,302
	FISCAL YEAR 1990		
STARTING BALANCE	195,440	10,670,165	1,586,503
COLLECTIONS	3,351,648	6,251,235	17,420,635
TOTAL	3,547,088	16,921,400	19,007,138(4)
EXPENDITURES	2,758,153	14,310,060	13,711,377
ENDING BALANCE	788,935	2,611,340	5,295,761
	FISCAL YEAR 1991		
STARTING BALANCE	761,936	2,599,572	5,295,760
COLLECTIONS	4,322,654	14,478,818	12,573,994
TOTAL	5,084,590	17,078,390	17,869,754
EXPENDITURES	3,589,016	12,744,415	14,590,062
ENDING BALANCE	1,495,574	4,333,975	3,279,692

1) This Trust Fund is utilized for Public Entities (the Commonwealth and its political subdivisions.)
2) This Trust Fund is utilized for private employers.
3) Pursuant to M.G.L. c 152, revenues collected for the Special Fund are expended to support the Department's operational costs and their related fringe/indirect costs.
(4) Includes a FY'90 receipt of $9,471.65 processed in FY'91.

APPENDIX F

FISCAL YEAR 1989

DIA REPORT 28

STATISTICS FOR SECTIONS OF THE LAW BEING CLAIMED

FOR CASES ENTERED

ON 7/1/88 THRU 6/30/89

CLAIM TYPE	SECTIONS OF THE LAW	NUMBER OF CASES	PERCENT OF TOTAL (ROUNDED)
EMPLOYEE CLAIM	34+	13173	31.68
	34A+	887	2.13
	35+	531	1.28
	31+	145	0.35
	28+	153	0.37
	13 or 30+	2302	5.54
	30 w/letter	50	0.12
	13A+	143	0.34
	34B+	54	0.13
	35B	25	0.06
	7+	100	0.24
	8+	106	0.25
	33+	5	0.01
	35A+	36	0.09
	1+	452	1.09
	Nothing	54	0.13
	Other	42	0.10
(CLAIM SUBTOTAL)		**18258**	**43.91**
INJURY CLAIM (§36)		3063	7.37
INS REQUEST FOR DISC		9766	23.49
LUMP SUM REQUEST		9859	23.71
THIRD PARTY CLAIM		637	1.53
TOTAL NUMBER OF CASES:		**41583**	**100.00**

APPENDIX F
FISCAL YEAR 1990

DIA REPORT 28
STATISTICS FOR SECTIONS OF THE LAW BEING CLAIMED
FOR CASES ENTERED
ON 7/1/89 THRU 6/30/90

CLAIM TYPE	SECTIONS OF THE LAW	NUMBER OF CASES	PERCENT OF TOTAL (ROUNDED)
EMPLOYEE CLAIM	34+	14206	31.23
	34A+	1071	2.35
	35+	610	1.34
	31+	171	0.38
	28+	134	0.29
	13 or 30+	2789	6.13
	30 w/letter	43	0.09
	13A+	191	0.42
	34B+	59	0.13
	35B	25	0.05
	7+	157	0.35
	8+	143	0.31
	33+	7	0.02
	35A+	34	0.07
	1+	555	1.22
	Nothing	41	0.09
	Other	56	0.12
(CLAIM SUBTOTAL)		**20292**	**44.61**
INJURY CLAIM (§36)		3790	8.33
INS REQUEST FOR DISC		10974	24.13
LUMP SUM REQUEST		9514	20.92
THIRD PARTY CLAIM		903	1.99
SECTION 37 REQUEST		12	0.03
TOTAL NUMBER OF CASES:		45485	100.00

APPENDIX F

FISCAL YEAR 1991

DIA REPORT 28

STATISTICS FOR SECTIONS OF THE LAW BEING CLAIMED

FOR CASES ENTERED

ON 7/1/90 THRU 6/30/91

CLAIM TYPE	SECTIONS OF THE LAW	NUMBER OF CASES	PERCENT OF TOTAL (ROUNDED)
EMPLOYEE CLAIM	34+	16157	32.49
	34A+	1388	2.79
	35+	788	1.58
	31+	237	0.48
	28+	121	0.24
	13 or 30+	3224	6.48
	30 w/letter	43	0.09
	13A+	238	0.48
	34B+	98	0.20
	35B	21	0.04
	7+	148	0.30
	8+	128	0.26
	33+	5	0.01
	35A+	24	0.05
	1+	520	1.05
	Nothing	36	0.07
	Other	64	0.13
(CLAIM SUBTOTAL)		**23240**	**46.74**
INJURY CLAIM (§36)		3918	7.88
INS REQUEST FOR DISC		11450	23.03
LUMP SUM REQUEST		9864	19.84
THIRD PARTY CLAIM		1253	2.52
SECTION 37 REQUEST		0	0.00
TOTAL NUMBER OF CASES:		49725	100.00

APPENDIX G

CONCILIATION STATISTICS
DIA REPORT 16
FOR SCHEDULED DATES IN FISCAL YEAR

DISPOSITION	FISCAL YEAR 1989		FISCAL YEAR 1990		FISCAL YEAR 1991	
	# OF CASES (Scheduled Dates) (7/1/88 - 6/30/89)	%	# OF CASES (Scheduled Dates) (7/1/89 - 6/30/90)	%	# OF CASES (Scheduled Dates) (7/1/90 - 6/30/91)	%
NO DISPOSITION ENTERED			552	1.1	470	0.8
CLAIM REFERRED TO DISPUTE RESOLUTION AFTER CONCILIATION	7,847	18.6	9,011	18.1	10,858	19.5
CLAIM REFERRED TO DISPUTE RESOLUTION WITHOUT CONCILIATION	1,255	3.0	1,190	2.4	841	1.5
COMPLAINT REFERRED TO DISPUTE RESOLUTION AFTER CONCILIATION	5,971	14.2	7,164	14.4	8,033	14.4
COMPLAINT REFERRED TO DISPUTE RESOLUTION WITHOUT CONCILIATION	774	1.8	847	1.7	558	1.0
CONCILIATED - PAY WITHOUT PREJUDICE	97	0.2	149	0.3	379	0.7
CONCILIATED - ADJUSTED	4,641	11.0	5,759	11.6	6,723	12.1
REFERRED TO LUMP SUM	880	2.1	1,404	2.8	1,893	3.4
RESCHEDULE FOR CONCILIATION	11,383	27.0	14,315	28.8	16,149	29.0
WITHDRAWN PRIOR TO CONCILIATION	2,238	5.3	1,881	3.8	1,532	2.8
WITHDRAWN AT CONCILIATION	3,341	7.9	3,598	7.2	4,083	7.3
WITHDRAWN BY DEPARTMENT FOR NO SHOW	649	1.5	841	1.7	l,028	1.8
ADJUSTED PRIOR TO CONCILIATION	2,425	5.8	2,231	4.5	2,355	4.2
WITHDRAWAL OF PROCEEDINGS RECEIVED					3	0.0
LUMP SUM REQUEST RECEIVED	589	1.4	757	1.5	797	1.4
TOTALS:	42,090		49,699		55,702	

APPENDIX G

CONCILIATION STATISTICS
DIA REPORT 17
For All Finished Cases
7/1/89 - 6/30/90

DISPOSITION	CASES		CLOSED		REFERRED		ACCEPTED		REJECTED	
	FY'89	FY'90	FY'89	FY'90	FY'89	FY'90	FY'89	FY'90	FY'89	FY'90
101 Claim ref. to DR after Conc.	7847	9006			25.6	25.9			25.9	25.9
102 Claim ref. to DR w/o Conc.	1255	1190			4.1	3.4				
103 Complaint ref. to DR after Conc.	5971	7161			19.4	20.6			19.4	20.6
104 Complaint ref to DR w/o Conc.	774	847			2.5	2.4				
105 Conciliated - Pay w/o Prejudice	97	148	0.3	0.4			0.3	0.4		
106 Conciliated - Adjusted	4641	5755	15.1	16.5			15.1	16.5		
107 Referred to Lump Sum Counselor	880	1404	2.9	4.0			2.9	4.0		
109 Withdrawn prior to Conciliation	2238	1881	7.3	5.4						
110 Withdrawn at Conciliation	3341	3588	10.9	10.3			10.9	10.3		
111 Withdrawn by Dept. for No Show	649	841	2.1	2.4						
112 Adjusted prior to Conciliation	2425	2231	7.9	6.4						
114 Lump Sum Request Received	589	755	1.9	2.2			1.9	2.2		
TOTALS	30707	34807	48.4	47.7	51.6	52.3	31.1	33.5	45.0	46.4

APPENDIX G

CONCILIATION STATISTICS
DIA REPORT 17
For All Finished Cases
7/1/90 - 6/30/91

DISPOSITION	CASES		CLOSED		REFERRED		ACCEPTED		REJECTED	
	FY'90	FY'91	FY'90	FY'91	FY'90	FY'91	FY'90	FY'91	FY'90	FY'91
101 Claim ref. to DR after Conc.	9006	10858			25.9	27.8			25.6	27.8
102 Claim ref. to DR w/o Conc.	1190	841			3.4	2.2				
103 Complaint ref. to DR after Conc.	7161	8033			20.6	20.6			20.6	20.6
104 Complaint ref to DR w/o Conc.	847	558			2.4	1.4				
105 Conciliated - Pay w/o Prejudice	148	379	0.4	1.0			0.4	1.0		
106 Conciliated - Adjusted	5755	6723	16.5	17.2			16.5	17.2		
107 Referred to Lump Sum Counselor	1404	1893	4.0	4.8			4.0	4.8		
109 Withdrawn prior to Conciliation	1881	1532	5.4	3.9						
110 Withdrawn at Conciliation	3588	4083	10.3	10.4			10.3	10.4		
111 Withdrawn by Dept. for No Show	841	1028	2.4	2.6						
112 Adjusted prior to Conciliation	2231	2355	6.4	6.0						
114 Lump Sum Request Received	755	797	2.2	2.0			2.2	2.0		
TOTALS	34807	39080	47.7	48.1	52.3	51.9	33.5	35.5	46.4	48.3

APPENDIX H

PROPOSALS FUNDED BY THE DIA'S OFFICE OF SAFETY FISCAL YEAR 1992

Safety Council of Western Massachusetts
90 Berkshire Avenue
Springfield, MA. 01109
Title: Working Safely With Video Display Terminals
Category of Applicant: Nonprofit Organization
Target Population: Employers/ees
Total Funds Awarded: $31,190.00

Utility Workers' union, Local 369, AFL-CIO
120 Bay State Drive
Braintree, MA. 02184
Title: Cumulative Trauma Disorders
Category of Applicant: Labor Organization
Target Population: Employees
Total Funds Awarded: $32,250.00

Western MassCOSH
Western Mass Coalition for Occupational Safety & Health
458 Bridge Street
Springfield, MA. 01103
Title: The Hazards of Lead Exposure
Category of Applicant: Nonprofit Organization
Target Population: Employees
Total Funds Awarded $32,907.69

Roofers Union Local Union No. 33
Joint Apprenticeship and Training Committee
51 Neponset Avenue
Dorchester, MA. 02122
Title: Safety and Healthy Awareness For Roofing Apprentices
Category of Applicant: Labor Org./Nonprofit Org.
Joint Labor-Management Committee
Target Population: Employees
Total Funds Awarded: $32,106.03

MassCOSH
Mass Coalition for Occupational Safety and Health
555 Amory Street
Boston, MA. 02130
Title: Health & Safety for Hospital Laundry Workers
Category of Applicant: Nonprofit Organization
Target Population: Employers/ees
Total Funds Awarded: $32,249.85

Massachusetts Respiratory Hospital
2001 Washington Street
Braintree, MA. 02184
Title: Occupational Health Service
Health and Safety for Iron Workers
Category of Applicant: Nonprofit Org., Pub.Emp.
Target Population: Employees
Total Funds Awarded: $31,955.88

City of Boston
Office of Personnel Management
Boston City Hall
Boston, MA. 02201
Title: Boston Labor Management Cooperation Program
Category of Applicant: Public Employer
Target Population: Employers/ees
Total Funds Awarded: $32,969.92

Technology Education Clearing House
One Summer Street
Somerville, MA. 02143
Title: Office Technology Education Training Project (OTEP)
Category of Applicant: Nonprofit
Target Population: Employees
Total Funds Awarded: $32,211.70

I.C.B.M., Inc.
The Joint Labor/Mgr. Subcommittee on Occupation Health
20 West Howell Street
Dorchester, MA. 02125
Title: The Boston School Bus Drivers Ergonomic Project
Category of Applicant: Private Employer/Joint Labor/
Management Committee
Target Population: Employers/ees
Total Funds Awarded: $31,527.13

Coalition for a Better Acre
741 Merrimack Street
Lowell, MA. 01854
Title: Community Occupational Health & Safety Program
Category of Applicant: Nonprofit Organization
Target Population: Employees
Total Funds Awarded: $22,498.91

Cambridge Medical Care Foundation
Macht Building, 4th Floor
The Cambridge Hospital
1493 Cambridge Street
Cambridge, MA. 02139
Title: Training Confectionery Workers in the Recognition and
Prevention of Musculoskeletal Disorders
Category of Applicant: Nonprofit Organization
Target Population: Employers/ees
Total Funds Awarded: $30,999.75

United Electrical, Radio & Machine Workers
Of America, Local 274
80 School Street
Greenfield, MA. 01301
Title: Preventing Cumulative Trauma Disorders
Category of Applicant: Labor Organization
Target Population: Employees
Total Funds Awarded: $17,782.16

Chinese American Civic Association
90 Tyler Street
Boston, Ma. 02111
Title: Occupational Health & Safety for Chinese Restaurant Workers
Category of Applicant: Nonprofit Organization
Target Population: Employers/ees
Total Funds Awarded: $ 7,157.21

Maurice A. Donahue Institute for Governmental Services
University of Massachusetts
250 Stuart Street
Boston, MA. 02116
Title: Reduction of Back Related Injuries for DMR Institutions
Total Funds Awarded: $32,227.00

APPENDIX I

ADMINISTRATIVE JUDGE DECISIONS MAILED OUT BY MONTH FY'91

SUMMARY OF NUMBER OF DECISIONS MAILED OUT

NAME	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	TOTAL
Beard/Male	2	5*	6	4	6	7	2	7	4	4	5	**	52
Brooker	10	5	5	11	3	0	9	10	14	6	7	15	95
Cleary	12*	7	5	4	4	3	4	0	8	3	3	5	58
Coleman	3	4	6	8	3	3	4	5	3	3	7	2	51
Cox	4	3	8	2	4	6	9	5	8	4	4	4	61
DaDalt	3	3	2	3	3	2	3	3	3	**	**	**	25
D'Esti	-	-	-	-	-	-	0	0	0	0	1	3	4
Elliott	1	1	3	5	22	5	7	4	4	7	3	7	69
Evers	-	-	-	-	-	-	-	-	-	-	-	-	--
Ferin	0	3*	2	6	4	4	0	2	5	2	6	3	37
Fischel	9*	5	6	6	5	7	5	6	4	3	5	5	66
Gallo	7	6	5	7	6	7	7	6	8	4	6	5	74
Gromelski	2	3	4	4	3	3	4	4	4	2	3	3	39
Heffernan	9	5	3	11	7	5	4	5	2	8	7	1	67
Jackson	1	6	6	0	0	0	0	6	4	3	4	2	32
Jennings	6	7	8	7	7	14	5	5	8	7	8	5	87
Joyce	1	1	1	3	7	9	3	8	3	4	8	30	78
Lee	5	6	2	1	5	2	2	5	3	4	3	5	43
Leroy	2	1	5	12	13	6	2	8	13	2	2	4	70
McGuinness	7	8	8	5	3	2	10	11	3	4	2	2	65
McKinnon	5	8	2	2	1	4	4	6	6	2	7	7	54
Moreschi	2	8	4	5	3	0	12	0	0	4*	**	7	45
Rogers	3	8	4	5	4	2	9	8	8	1	2	4	58
Romm	5	6	6	-	-	-	-	-	-	-	-	-	17
Ryan	5	5	3	6	5	10	6	6	7	5	6	0	64
St. Amand	5	5	5	4	4	3	4	7	4	4	4	3	52
Solomon	5	5	5	4	7	5	5	5	3	5	5	5	59
Taub	0	3	7	7	4	2	5	8	10	4	4	8	62
Tirrell	5	4	3	6	6	5	1	4	5	7	6	9	61
Totals:	119	131	124	138	139	116	126	144	144	102	118	144	1,545

* Two month total - includes previous month

** No Stats submitted

Judge Evers began medical leave July, 1990
Judge Romm resigned, 11/2/90
Judge D'Esti started, 12/23/90
Judge Cleary out sick February, 1991

APPENDIX J

CASES RESOLVED BY ADMINISTRATIVE JUDGES FY'91
(lump summed, withdrawn, adjusted, others)

NAME	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	TOTAL
Beard/Male	40	131*	76	88	65	59	65	75	56	67	82	**	804
Brooker	44	56	59	79	73	64	77	72	50	94	79	71	818
Cleary	76	59	64	38	26	13	97	0	68	5	104	34	584
Coleman	44	82	54	47	51	66	107	63	19	18	64	39	654
Cox	32	36	46	34	60	32	56	82	53	74	57	63	625
DaDalt	37	46	51	59	71	56	57	51	50	**	**	**	478
D'Esti	-	-	-	-	-	-	19	30	27	12	15	7	110
Elliott	23	3	90	51	38	117	40	32	21	31	21	55	522
Evers	-	-	-	-	-	-	-	-	-	-	-	-	--
Ferin	0	61*	25	22	51	25	44	37	14	9	35	91	414
Fischel	121*	39	36	117	51	68	84	66	39	68	67	62	818
Gallo	66	81	56	66	62	38	60	56	61	59	64	19	688
Gromelski	21	90	47	60	61	41	80	35	32	72	53	54	646
Heffernan	75	40	53	83	51	42	41	65	50	63	53	50	666
Jackson	22	16	123	28	23	48	35	47	55	39	50	31	517
Jennings	52	37	30	70	47	47	102	31	47	101	52	25	641
Joyce	33	54	83	34	64	84	98	47	42	15	18	37	609
Lee	50	56	64	29	40	31	59	43	16	17	39	53	497
Leroy	46	57	47	54	76	52	62	125	56	65	79	53	772
McGuinness	62	73	69	51	69	36	72	76	64	68	45	2	687
McKinnon	60	69	52	43	40	63	43	46	45	61	42	35	599
Moreschi	42	33	47	64	25	54	46	0	74*	83	**	132	600
Rogers	44	78	22	68	31	62	120	52	56	31	47	25	636
Romm	30	22	37	-	-	-	-	-	-	-	-	-	89
Ryan	45	32	80	103	38	94	57	78	59	50	67	81	784
St.Amand	71	50	75	74	41	76	61	50	80	50	62	80	770
Solomon	39	51	49	68	67	27	49	61	78	51	60	5	605
Taub	N/A	58	40	32	36	29	56	55	40	30	51	22	449
Tirrell	35	93	54	59	36	59	57	32	29	44	68	37	603
Totals:	1210	1503	1529	1521	1293	1383	1744	1407	1281	1277	1374	1163	16685

* Two month total - includes previous month

** No Stats submitted

Judge Evers began medical leave July, 1990
Judge Romm resigned, 11/2/90
Judge D'Esti started, 12/23/90
Judge Cleary out sick February, 1991

APPENDIX K

Lump Sum Conference Statistics For Cases Scheduled For FY'91

	Lump Sums Sch.	Lump Sums Approved
July	1,617	1,330 (82.3%)
August	1,785	1,458 (82%)
September	1,508	1,266 (84%)
October	1,638	1,348 (82.3%)
November	1,581	1,344 (85%)
December	1,485	1,121 (81.5%)
January 1991	1,660	1,438 (86.6%)
February	1,648	1,403 (85.1%)
March	1,804	1,550 (85.9%)
April	1,536	1,328 (86.5%)
May	1,722	1,436 (83.4%)
June	1,487	1,237 (83.2%)
Totals:	19,471	16,259 (84%)

Total Lump Sums

FY'91	19,471	16,259 (84%)
FY'90	18,155	15,386 (85%)
FY'89	14,704	12,177 (83%)
1984		9,369

Claims For Review Filed

	FY'91	FY'90	FY'89	FY'88
Pre 11/1/86 Inj.	215	227	200	350
1st Half	N/A	112	88	201
2nd Half	N/A	115	112	149
Post 11/1/86 Inj.	307	239	277	147
1st Half	N/A	117	146	43
2nd Half	N/A	122	131	104
Total	522	465	477	497
Decisions Issued	146	79	120	192
Amended Decisions	2	3		
Memoranda of Disposition	153	93	110	210
Rev. Board Decisions Appealed	24	7	10	29
Lump Sums of Cases on Appeal to Rev.Bd.	90	136	85	

APPENDIX K

MEETINGS HELD STATISTICS

	BOS	FR	LAW	SPR	WOR	TOTAL
FY 1990						
Hearings	4,067	1,414	819	996	1,431	8,727
Conferences	9,216	3,247	2,296	2,371	2,615	19,745
Lump Sum Conf.	9,002	2,985	2,318	1,514	2,334	*18,153
FY 1991						
Hearings	3,403	1,162	889	794	1,252	7,500
Conferences	7,846	2,648	2,047	2,288	2,754	17,583
Lump Sum Conf.	9,034	3,457	2,250	1,801	2,810	19,352

* Please note that this figure for scheduled lump sums differs by 2 from the other figure used due to a difference in when the report was run. Since the difference is only 2, and due to the different nature of the information we have used the two figures.

APPENDIX K

CONFERENCE STATISTICS FOR SCHEDULED DATES
IN FISCAL YEAR
DIA REPORT 45

	FY'89	%TOT.	FY'90	%TOT.	FY'91	%TOT.
Total	17,917		19,745		19,268	
Orders Issued	9,216	51.4	10,261	52.0	10,437	54.2
Withdrawn	1,780	9.9	1,690	8.5	1,420	7.4
Voluntarily Adjusted	2,159	12.1	2,314	11.7	1,825	9.5
Dismissed	188	1.0	159	.8	98	.5
Referred To Lump Sum	1,570	8.8	1,999	10.1	1,191	10.3
Lump Sum Req. Received	700	3.9	634	3.2	611	3.2
Lump Sum Recommended	778	4.3	856	4.3	994	5.2
Rescheduled	1,472	8.2	1,375	7.0	1,673	8.7

HEARING STATISTICS FOR SCHEDULED DATES
IN FISCAL YEAR
DIA REPORT 46

	FY'91	%Tot.	FY'90	%Tot.
Run Date of Report	7/26/91		7/20/90	
Total	8,069		8,728	
Decisions Filed	758	9.4	871	10.0
Withdrawn	1,393	17.2	1,376	15.8
Voluntarily Adjusted	457	5.7	519	5.9
Dismissed	24	.3	48	.5
Referred To Lump Sum	1,249	15.5	1,702	19.5
Lump Sum Req. Received	358	4.4	406	4.7
Lump Sum Recommended	1,777	22.0	1,234	14.2
Rescheduled Tot.	330	6.6	1,022	11.7
No Disposition	1,506	18.7	1,546	17.7

DIA REPORT 46 SUBSEQUENT COMPUTER RUN

	FY'90	% Tot.	FY'89*	%Tot.	FY'89*	%Tot.
Run Date of Report	9/27/91		8/29/90		9/27/91	
Total	8,753		7,117		7,118	
Decisions Filed	1,614	18.4	1,262	17.7	1,319	18.5
Withdrawn	1,518	17.3	1,158	16.3	1,180	16.6
Voluntarily Adjusted	582	6.6	480	6.7	494	6.9
Dismissed	55	.6	56	.8	56	.8
Referred To Lump Sum	1,817	20.8	1,191	16.7	1,194	16.8
Lump Sum Req. Received	475	5.4	481	6.8	486	6.8
Lump Sum Recommended	1,456	16.6	1,238	17.4	1,248	17.5
Rescheduled Tot.	1,056	12.1	1,102	15.5	1,103	15.5
No Disposition	180	2.1	146	2.1	35	.5

* 3 Different dispositions of "other" totalling 1 each not included.

APPENDIX L

MASSACHUSETTS W.C. CLASSIFICATION	CODE	1987 RATE	1988 RATE	% CHANGE 87 - 88	1989 RATE	% CHANGE 88 - 89	% CHANGE 87 - 89	1990 RATE	% CHANGE 89 - 90
Boiler Installation or Repair - Steam	3726	$ 9.65	$14.33	48%	$19.07	33%	98%	$25.34	33%
Building Moving	5703	$19.66	$29.21	49%	$35.49	21%	81%	$44.18	24%
Carpentry - Cabinet Interior Trim & Floors	5437	$ 4.77	$ 7.08	48%	$ 9.42	33%	97%	$12.04	28%
Carpentry - N.O.C	5403	$19.00	$28.23	49%	$26.89	-5%	42%	$30.31	13%
Carpentry - Private Residences	5645	$ 8.83	$12.98	47%	$12.60	-3%	43%	$14.16	12%
Construction - in construction of dwellings - not exceeding three stories in height	5651	$ 8.83	$12.98	47%	$12.60	-3%	43%	$14.16	12%
Clerical Employees	8810	$ .25	$ .31	24%	$ .29	-7%	16%	$ .39	34%
Concrete or Cement Work - Floors, driveways, yards or sidewalks	5221	$ 5.85	$ 8.69	49%	$11.56	33%	98%	$15.36	33%
Concrete Construction - Bridges or Culverts	5222	$14.78	$21.96	49%	$29.22	33%	98%	$34.42	18%
Concrete Construction - N.O.C	5213	$13.33	$19.80	49%	$25.38	28%	90%	$33.73	33%
Conduit Construction	6325	$ 9.71	$14.42	49%	$15.48	7%	59%	$18.04	17%
Contractors - Executive Supervisors - not in immediate charge of construction or erection work	5606	$ 4.81	$ 5.41	12%	$ 5.94	10%	23%	$ 6.29	6%
Contractors' Permanent Yards	8227	$ 2.73	$ 4.05	48%	$ 5.39	33%	97%	$ 6.98	29%

MASSACHUSETTS W.C. CLASSIFICATION	CODE	1990 RATE	1991 RATE	% CHANGE 90 - 91	% CHANGE 87 - 91
Boiler Installation or Repair - Steam	3726	$25.34	$33.57	32.5	248
Building Moving	5703	$44.18	$58.34	32	197
Carpentry - Cabinet Interior Trim & Floors	5437	$12.04	$15.65	30	228
Carpentry - N.O.C	5403	$30.31	$38.79	28	104
Carpentry - Private Residences	5645	$14.16	$16.67	18	89
Construction - in construction of dwellings - not exceeding three stories in height	5651	$14.16	$16.67	18	89
Clerical Employees	8810	$ .39	$ .37	-5	48
Concrete or Cement Work - Floors, driveways, yards or sidewalks	5221	$15.36	$20.02	30	242
Concrete Construction - Bridges or Culverts	5222	$34.42	$33.93	-1	130
Concrete Construction - N.O.C	5213	$33.73	$38.80	15	191
Conduit Construction	6325	$18.04	$20.48	13.5	111
Contractors - Executive Supervisors - not in immediate charge of construction or erection work	5606	$ 6.29	$ 7.17	14	49
Contractors' Permanent Yards	8227	$ 6.98	$ 8.46	21	210

MASSACHUSETTS W.C. CLASSIFICATION	CODE	1990 RATE	1991 RATE	% CHANGE 90 - 91	% CHANGE 87 - 91
Door, Door Frame or Sash Erection - Metal	5102	$16.23	$21.73	34	162
Electric Light or Power Line Construction	7538	$11.57	$15.29	32	247
Electric Wiring within Buildings	5190	$ 6.21	$ 8.05	30	121
Elevator Erection or Repair	5160	$ 6.48	$ 8.78	35	62
Excavation and Grading of Land - N.O.C.	6217	$ 9.34	$11.21	20	102
Gas or Water Mains or Connections	6319	$ 8.89	$11.67	31	49
Glaziers - away from shop	5462	$21.21	$23.45	11	168
Iron, Brass or Bronze Work - ornamental - erection within buildings	5102	$16.23	$21.73	34	162
Iron or Steel Erection - erecting iron or steel	5040	$83.51	$93.51	12	192
Iron or Steel Erection - iron or steel frame structures not riveted or welded and not over two stories in height	5059	$48.66	$65.15	34	115
Iron or Steel Erection - metal bridges	5040	$83.51	$93.51	12	192

MASSACHUSETTS W.C. CLASSIFICATION	CODE	1987 RATE	1988 RATE	% CHANGE 87 - 88	1989 RATE	% CHANGE 88 - 89	% CHANGE 87 - 89	1990 RATE	% CHANGE 89 - 90
Door, Door Frame or Sash Erection - Metal	5102	$ 8.29	$12.31	48%	$16.38	33%	98%	$16.23	-1%
Electric Light or Power Line Construction	7538	$ 4.41	$ 6.55	49%	$ 8.71	33%	98%	$11.57	33%
Electric Wiring within Buildings	5190	$ 3.64	$ 4.99	37%	$ 4.99	0%	37%	$ 6.21	24%
Elevator Erection or Repair	5160	$ 5.43	$ 6.77	25%	$ 5.63	-17%	4%	$ 6.48	15%
Excavation and Grading of Land - N.O.C.	6217	$ 5.54	$ 8.23	49%	$ 9.76	19%	76%	$ 9.34	-4%
Gas or Water Mains or Connections	6319	$ 7.85	$ 9.06	15%	$ 7.53	-17%	-4%	$ 8.89	18%
Glaziers - away from shop	5462	$ 8.74	$12.98	49%	$17.27	33%	98%	$21.21	23%
Iron, Brass or Bronze Work - ornamental - erection within buildings	5102	$ 8.29	$12.31	48%	$16.38	33%	98%	$16.23	-1%
Iron or Steel Erection - erecting iron or steel frame structures	5040	$32.06	$47.22	47%	$62.84	33%	96%	$83.51	33%
Iron or Steel Erection - iron or steel frame structures not riveted or welded and not over two stories in height	5059	$30.28	$37.63	24%	$50.08	33%	65%	$48.66	-3%
Iron or Steel Erection - metal bridges	5040	$32.06	$47.22	47%	$62.84	33%	96%	$83.51	33%

MASSACHUSETTS W.C. CLASSIFICATION	CODE	1987 RATE	1988 RATE	% CHANGE 87 - 88	1989 RATE	% CHANGE 88 - 89	% CHANGE 87 - 89	1990 RATE	% CHANGE 89 - 90
Iron or Steel Erection - N.O.C	5057	$30.28	$37.63	24%	$50.08	33%	65%	$48.66	-3%
Iron or Steel Works - Shop - Structural	3030	$16.03	$16.01	0%	$20.42	28%	27%	$21.44	5%
Iron or Steel Works - Shop - Ornamental	3040	$11.03	$14.27	29%	$15.67	10%	42%	$19.56	25%
Iron or Steel Works - Shop - Decorative	3041	$ 6.77	$ 7.93	17%	$ 9.51	20%	40%	$10.81	14%
Landscaping Gardening	0042	$ 7.76	$ 7.54	-3%	$ 9.18	22%	18%	$11.85	29%
Lathing	5443	$ 6.33	$ 9.40	48%	$11.51	22%	82%	$15.19	32%
Masonry - N.O.C.	5022	$10.94	$16.25	48%	$21.62	33%	98%	$23.65	9%
Millwright Work - N.O.C.	3724	$ 5.85	$ 8.69	48%	$ 9.58	10%	64%	$12.00	25%
Painting, Decorating or Paper Hanging - Interior work	5474	$11.47	$17.04	49%	$14.97	-12%	31%	$14.05	-6%
Painting Metal Bridges - Shopmen & Drivers	5037	$33.42	$49.66	49%	$58.09	17%	74%	$69.27	19%
Pile Driving	6003	$14.78	$20.06	36%	$19.73	-2%	33%	$26.22	33%
Plastering - N.O.C.	5480	$ 7.52	$11.17	49%	$14.61	31%	94%	$15.99	9%
Plumbing - N.O.C.	5183	$ 5.46	$ 6.82	25%	$ 7.41	9%	36%	$ 9.21	24%
Rigging - N.O.C. - including drivers	9530	$32.06	N/A	N/A	N/A	N/A	N/A	N/A	N/A

MASSACHUSETTS W.C. CLASSIFICATION	CODE	1990 RATE	1991 RATE	% CHANGE 90 - 91	% CHANGE 87 - 91
Iron or Steel Erection - N.O.C	5057	$48.66	$65.15	34	115
Iron or Steel Works - Shop - Structural	3030	$21.44	$23.71	11	48
Iron or Steel Works - Shop - Ornamental	3040	$19.56	$23.17	18	110
Iron or Steel Works - Shop - Decorative	3041	$10.81	$12.31	14	82
Landscaping Gardening	0042	$11.85	$11.01	-7	42
Lathing	5443	$15.19	$20.25	33	220
Masonry - N.O.C.	5022	$23.65	$28.90	22	164
Millwright Work - N.O.C.	3724	$12.00	$13.73	14	135
Painting, Decorating or Paper Hanging - Interior work	5474	$14.05	$17.32	23	51
Painting Metal Bridges - Shopmen & Drivers	5037	$69.27	$89.00	28	166
Pile Driving	6003	$26.22	$35.19	34	138
Plastering - N.O.C.	5480	$15.99	$16.51	3	120
Plumbing - N.O.C.	5183	$ 9.21	$10.89	18	99
Rigging - N.O.C. - including drivers	9530	N/A	N/A	N/A	N/A

MASSACHUSETTS W.C. CLASSIFICATION	CODE	1990 RATE	1991 RATE	% CHANGE 90 - 91	% CHANGE 87-91
Roofing - Built-up - including Yard Employees - Drivers	5547	$39.19	$43.85	12	106
Roofing - N.O.C. - including Yard Employees - Drivers	5545	$79.41	$85.93	8	55
Salesman	8742	$ .86	$ .75	-13	15
Sand or Gravel Digging	4000	$ 9.19	$10.07	10	60
Sewer Construction - all operations	6306	$12.56	$16.18	29	105
Sheet Metal Work Erection - shop & outside	5538	$13.85	$18.18	31	138
Snow Plowing - Street Cleaning	9402	$ 7.43	$ 9.21	24	35
Street or Road - Paving or Repairing	5506	$21.79	$29.25	34	117
Street or Road - Subsurface work	5507	$12.62	$16.64	32	246
Tile, Stone or Mosaic Work	5348	$13.21	$17.63	34	200
Truckmen - N.O.C.	7219	$18.85	$20.75	10	145
Wrecking or demolition of Buildings or Structures	5701	$65.27	$84.50	29	207

MASSACHUSETTS W.C. CLASSIFICATION	CODE	1987 RATE	1988 RATE	% CHANGE 87 - 88	1989 RATE	% CHANGE 88 - 89	% CHANGE 87 - 89	1990 RATE	% CHANGE 89 - 90
Roofing - Built-up - including Yard Employees - Drivers	5547	$21.29	$31.63	49%	$42.09	33%	98%	$39.19	-7%
Roofing - N.O.C. - including Yard Employees - Drivers	5545	$55.36	$82.26	49%	$86.25	5%	56%	$79.41	-8%
Salesman	8742	$ .65	$ .78	20%	$ .83	6%	28%	$ .86	4%
Sand or Gravel Digging	4000	$ 6.28	$ 6.65	06%	$ 7.49	13%	19%	$ 9.19	23%
Sewer Construction - all operations	6306	$ 7.89	$11.04	40%	$12.54	14%	59%	$12.56	0%
Sheet Metal Work Erection - shop & outside	5538	$ 7.63	$11.28	48%	$10.81	-4%	42%	$13.85	28%
Snow Plowing - Street Cleaning	9402	$ 6.83	$ 5.93	-13%	$ 5.42	-9%	-21%	$ 7.43	37%
Street or Road - Paving or Repairing	5506	$13.45	$17.44	30%	$16.40	-6%	22%	$21.79	33%
Street or Road - Subsurface work	5507	$ 4.31	$ 4.81	48%	$ 9.50	33%	98%	$12.62	33%
Tile, Stone or Terrazzo Work - Interior Construction Work only	5343	$ 5.38	$ 8.73	48%	$ 9.94	14%	69%	$13.21	33%
Truckmen - N.O.C.	7219	$ 8.48	$11.60	37%	$13.76	19%	62%	$18.85	37%
Wrecking or demolition of Buildings or Structures	5701	$27.54	$40.92	49%	$49.11	20%	78%	$65.27	33%

APPENDIX M

ASSESSMENT INFORMATION FOR THE THREE FUNDS- PUBLIC EMPLOYER TRUST FUND, PRIVATE EMPLOYER TRUST FUND, AND SPECIAL FUND

	PUBLIC	PRIVATE	SPECIAL
		FY'87	
Est. Assess. Base	$62,607,000	$486,581,000	$486,581,000
Ben. Payment Ratio	.0170	.0170	
Non-Ben. Pay. Ratio	.0000	.0211	
Revenue Ratio	.0008	.0008	
Adjustment Ratio			
Assessment Ratio	.0162	.0373	
Est. Budget	$ 1,014,000	$ 7,899,000	$ 10,250,000
Est. Assessment Rate	0.0162	0.0373	
		FY'88	
Est. Assess. Base	$74,483,000	$578,880,000	$578,880,000
Ben. Payment Ratio	.0216	.0216	.0000
Non-Ben. Pay. Ratio	.0000	.0000	.0174
Revenue Ratio	.0000	.0000	.0011
Adjustment Ratio			
Assessment Ratio	.0216	.0379	.0163
Est. Budget	$ 1,609,000	$ 12,504,000	$ 9,436,000
Est. Assessment Rate	0.0216	0.0379	
		FY'89	
Est. Assess. Base	$62,420,000	$702,515,000	$702,515,000
Ben. Payment Ratio	0.05241	0.02040	0.00000
Non-Ben. Pay. Ratio	--	0.01704	0.01704
Revenue Ratio	--	0.00057	0.00057
Adjustment Ratio	(0.00761)	0.01455	0.00000
Assessment Ratio	0.06002	0.02232	N/A
Est. Budget	$ 3,746,000	$ 4,110,000	$ 11,568,000
Est. Assessment Rate	0.06002	0.02232	
		FY'90	
Est. Assess. Base	$65,473,000	$856,672,000	$856,672,000
Ben. Payment Ratio	0.07466	0.01817	--
Non-Ben. Pay. Ratio	--	0.01804	0.01804
Revenue Ratio	0.00000	0.00161	0.00055
Adjustment Ratio	(0.02951)	0.01064	--
Assessment Ratio	0.10416	0.02397	--
Est. Budget	$ 6,819,909	$ 6,451,156	$ 14,985,000
Est. Assessment Rate	0.10416	0.02397	--

FY'91

Est. Assess. Base	$73,191,852	$1,047,476,125	$1,047,476,125
Ben. Payment Ratio	0.09123	0.02248	-----
Non-Ben. Pay Ratio	-----	0.01537	0.01537
Revenue Ratio	0.00000	0.00155	-----
Adjustment Ratio	(0.00041)	0.00000	-----
Assessment Ratio	0.09164	0.03630	-----
Est. Budget	$6,774,015	$21,923,675	$16,099,708
Est. Assessment Rate	0.09164	0.03630	

FY'92

Est. Assess. Base	$81,311,837	$1,213,013,754	$1,213,013,754
Ben. Payment Ratio	0.10565	0.03193	-----
Non-Ben. Pay. Ratio	-----	-----	0.01428
Revenue Ratio	0.04505	0.00048	0.00289
Adjustment Ratio	0.00486	0.00000	0.00000
Assessment Ratio	0.05574	0.03145	0.01139
Est. Budget	$4,532,322	$38,149,283	$13,816,227
Est. Assessment Rate	0.05574	0.04284	

APPENDIX N

ADVISORY COUNCIL POSITIONS

April 10, 1991

The Honorable Lois Pines
Senate Chair
Commerce and Labor Committee
State House - Room 421
Boston, Massachusetts 02133

The Honorable Susan Bump
House Chair
Joint Commerce and Labor Committee
State House - Room 43
Boston, Massachusetts 02133

RE: Proposed Legislation in the Joint Commerce and Labor Committee-Spring 1991

Dear Senator Pines and Representative Bump:

The Advisory Council, at its last two meetings, reviewed the following bills currently before your committee, in compliance with our charge under the statute. Each bill has been reviewed exactly as proposed with respect to the current statute. The Council has taken positions to support or not support based upon the requisite number of votes. Where the Council has indicated a neutral position it means that there were not the requisite number of votes to take an position on the bill as proposed. In addition action by the Council does not indicate what individual Council members may, on their own, feel about any of the proposed legislation.

As a result of our review, we would like to offer the following:

House Bills

House 154
The Council took a neutral position on this bill as proposed. While we recognize that the fines may be high as a result of a lack of clarity in the law at present, the Council felt that the proposed bill left future fines too much to the discretion of the Commissioner.

House 310
The Council felt that this bill, and the concept it seeks to address, needed further study to determine if it impacts other industries. In addition there is nothing in the current law that would implicitly or explicitly make the law elective for health care facilities.

House 692
Council took a neutral position on this bill as proposed.

House 924
The Council believes that §35B of the current act requires clarification with respect to its interpretation and supports the concept. This may be accomplished through regulations as the DIA has done with §35C and perhaps should be considered for §51A as well.

House 1130
This bill has already been enacted as Chapter 462 of the Acts of 1990 and was signed on December 29, 1990.

House 1318
The Council took a neutral position on this bill. It was felt that rules mandated by c.23E §11(4) should be promulgated before any changes are made to §25D.

House 1474
The Council does not support this bill as proposed. The Council believes that the insurance market must improve before initiating a state mutual fund. Most existing state funds have a long history, and it may be instructive to monitor the performance of the more recently created state funds in Rhode Island and New Mexico before considering action in this area. In addition current events establish that despite legislative mandates that funds be earmarked for specific purposes there are no iron clad guaranty's that such mandates will not be abandoned in periods of fiscal distress.

House 1699
The Council took a neutral position on this bill. The Council does recognize the need to reduce litigation, particularly in the area of earning capacity. However, one concern deals with the constitutional questions raised by the proposed bill, as dealt with by the Massachusetts Supreme Judicial Court in Meunier's Case, 319 Mass 421, 66 NE 2d 198 (1946). It also raises questions as to the determination of legal issues and may impact the current law with respect to the holding in Lettich's Case, 403 Mass 389, 530 NE 2d 159 (1988).

House-1710 and House-2233
The Council does not support these bills as proposed.
The Council believes that the preclusion of fines, penalties, and loss of rights should not be done by regulations. Consideration of changing the pay/deny period should take account of the 30 day period for filing a claim, which was initiated to give first report notices and the pay/deny process time to work. Any alteration of first report and pay/deny procedures must also consider the 30 day period or risk a return to the pre-1987 practices wherein claims were often filed before the pay/deny period ended. The Council supports lump sum approvals by Administrative Judges or Administrative Law Judges, but would also like to see Conciliators receive authority to approve lump sums.

The Council supports the receipt of statistical lists and this may be able to be accomplished without a statutory change.

House-2242
The Council does not support this bill as proposed. The Council has concerns with the elimination of language regarding judicial responsibility during ordinary business hours, as well as potential conflict regarding statutory authority over the Division of Dispute Resolution. The bill proposes potential increases for certain judicial personnel which is unclear under the given statutory formula. Additionally, the Council is concerned about its ability to conduct appropriate judicial reviews in light of its mandate under the open meeting law. The Council also believes that removal of any Council member should not be automatic, and that members should be afforded an opportunity to explain absences, with the Council voting on continuation of membership. The Council believes that the current terms for members is appropriate and has concerns over the possible costs for a newsletter.

The Council does support the concept of having a more defined and qualitative review of judicial performance and would welcome the opportunity to have input into the selection of the Commissioner, inasmuch as we believe that Council's function in its oversight responsibility is predicated upon the fact that it represents the parties which are most directly affected by the system and which pay for it. We also believe that the establishment of a quality data system would improve the functions of the Office of Safety.

House-2248 and House 2259
The Council supports these bills as proposed.

House 3168
The Council voted to not support this bill as proposed. However, the intent to remove competitive advantages that parties obtain from circumventing the workers' compensation law is a concept that merits attention. As proposed, this language may not encompass certain abuses which take place and may cover other areas which perhaps could be clarified.

House-3179
The Council did not support this bill as proposed. It is unclear how much information would be required in order to comply with proposed bill and as stated might create confusion with other laws, such as ERISA, COBRA etc.

House-3358
The Council took a neutral position on this bill.
House-3361
The Council did not support this bill as proposed. This may lead to workers' compensation becoming an alternative medical care policy and it is unclear what impact it would have in terms of the licensing requirements for insurance carriers.

House-3911
The Council took a neutral position on this bill. The Council recognizes that while inequities may arise in reimbursements, the proposed bill permits a public entity to opt out up to the day before the assessment must be promulgated. It also permits retroactive application of non-participation if notice was given by June 30, 1990, potentially offering advantages to some public entities since no such right existed at that time.

House-3915
The Council took a neutral position on this bill, which is the same as House 215 currently before the Public Service Committee.

House-4096
The Council did not support this bill as proposed.

House-4273
The Council did not support this bill as proposed. We concur with the premise that pre-approval should not be required, but the proposed bill requires submission of an invoice, not a report or diagnosis as to injury, for which payments must be made within a specific timeframe.

House-4459
The Council did not support this bill as proposed. Deductibles may provide employers with some cost savings and encourage a greater awareness of their workers' compensation costs. However, if the nonpayment of the deductible is treated in the same manner as the nonpayment of premium, this could result in exposure for the trust fund when a deductible is not paid and the insurance cancelled. It could open up civil liability as well. It is also unclear from the proposed legislation which laws it seeks to repeal.

House-4462
The Council did not support this bill as proposed. Fraud by any party in the system, be it by an employee, insurer, employer, provider, or advocate, is not condoned. Our concern is with the possibility that "attempts" to claim benefits may promote excessive litigation because it is unclear to what it refers.

House-4465
The Council supports this bill as proposed. In addition the Council would welcome the opportunity to take part in any such study and believes that it could provide a positive role in effectuating an examination of this issue.

House-4646
The Council did not support this bill as proposed. Any change in the notice requirements should take into account the 30 day period enacted in 1987 for the filing of claims. The proposed language could extend the time for insurers to make their decision well beyond the waiting period for the filing of a claim.

House-4650
The Council did not support this bill as proposed. Since its inception, pursuant to §24, the act has been elective for

employees, although it is unclear how this proposed exemption from the policy, and not the act, would be handled. This may create issues under the laws regulating insurance, such as Chapter 175 which would appear to not be encompassed by the bill. It is unclear if this would allow civil actions for a potential work related injury and if the private coverage envisions that paid by the executive or the corporation. It is unclear how such an exemption would interact with §46, which bars agreements by employees to waive their rights to compensation. At the current time, the corporate officer rate is often the under the clerical classification which is $.37 per $100 of payroll. Even with the increase in the payroll cap for corporate officers from $26,000 to $52,000 this year, it would appear to require a premium of about $192. It is unclear as to what becomes of the premium obligation if an officer exempts himself/herself from coverage and when such an exemption must take place.

House-4853
The Council did not support this bill as proposed. Under the current format there is a differentiation on the amounts based upon the placement of the scar. In addition, the use of the phrase "daily dress" may create confusion as to application of the proposed changes.

House-4854
The Council did not support this bill as proposed.

House-4856
The Council did not support this bill as proposed. The Council firmly believes in the effective use of vocational rehabilitation but feels that the proposed bill would place administrative burdens on the system with its mandated weekly meetings.

House-4859
The Council did not support this bill as proposed. The current law permits employers to bring such actions (§14), as well as insurers and employees. The current law requires reimbursement to an insurer while the proposed bill is unclear how such reimbursement would take place.

House-4860
The Council did not support this bill as proposed.

House-4861
The Council did not support this bill as proposed.

House-5138
The Council did not support this bill as proposed inasmuch as variances already exist for risk classifications and there is an appeal mechanism in place for parties who wish to question a classification.

House 5139
The Council did not support this bill as proposed. This bill may create confusion in the determination of earning capacity and may encourage cost shifting of health care insurance.

House 5348
The Council supports this bill as proposed.

Senate Bills

Senate-38 and Senate 64
The Council took a neutral position on each of these bills. Each of these bills proposes far-reaching changes to the current system. The Council agrees with the premise that there should be a more qualitative review of performance but believes that the current law, if applied, could accomplish this. It agrees that additional information included with matters before the agency would be beneficial. The authority of judges to increase attorney fees should be accompanied by a corresponding authority to decrease such fees. The scope of review of the reviewing board should be clarified in order to minimize the number of issues appealed. Application of any changes should be viewed in terms of the effect of §2A of the act. The Council agrees with the concept of providing more personnel with the authority to approve lump sums, but feels that such authority should be delineated specifically in the law. We agree that lump sum interviews should be mandatory for pro se employees only and that approval by affidavit may expedite the process.

There is an absolute necessity to improve the daily operation of the system in order to not only reduce litigation, but to ensure that justice is expended in a fair and expeditious manner. The Council feels that steps should be taken to ensure that the second injury fund operate effectively. The binding nature of disability determinations, as noted previously, raises certain constitutional issues. A complete data base for use in directing safety programs could be useful in preventing injuries. Reviewed exactly as proposed under the existing law, there was not a requisite number of votes to express support or non-support, but the some of the perceived intentions may merit further discussion.

Senate-51 and Senate-53
The Council did not support this bill as proposed. We do not believe the proposed language would accomplish the intent of the bill.

Senate-54
The Council did not support this bill as proposed.

Senate-55
The Council did not support this bill as proposed.

Senate-56
The Council did not support this bill as proposed. The Medical Access study published by the Council indicated that the issue of

reimbursements, while a factor, is not the sole area of concern in the treatment of injured employees. The treatment and payment for treatment is an issue that should be addressed. However, as proposed, there is concern how such language may be employed under the current system.

Senate-59
The Council did not support this bill as proposed. The experience rating of an insured is determined by the size of the premium, not solely by classification.

Senate-62
The Council did not support this bill as proposed. The Council supports the concept of a more qualitative review for judges but believes that the current law can be utilized to provide such information. The Council is at present working on a study to analyze the dispute resolution process and would prefer to withhold comment on the efficacy of alternative mechanisms until such is completed. The compilation of an accurate data base could be useful in the work of the Office of Safety in designing programs to prevent future injuries.

Senate-63
The Council did not support this bill as proposed.

Senate-65
The Council supports the concept, as noted above, of improving the data base on injuries. It also supports the concept of using the investigators as effectively as possible in order to reduce the number of scofflaws which are creating administrative and economic costs and placing workers in potential jeopardy. The Council has explored with the DIA the publication of the booklet in other languages and which would not require a statutory change to accomplish.

Senate-66
The Council strongly supports this bill as proposed. The computerization of insurance policy cancellations would make the system far more efficient and effective. The Council has supported these efforts for a number of years. The cooperation of the Massachusetts Workers' Compensation Rating and Inspection Bureau should be noted in achieving this goal.

Senate-103 and Senate 104
The Council did not support these bills as proposed.

Senate-117
The Council did not support this bill as proposed for the same reasons enumerated in its position to House 4459.

Senate-121
The Council took a neutral position on this bill.

Senate-1005
The Council took a neutral position on this bill. It would appear

that the current holding of the Supreme Judicial Court in Kszepka's Case, 408 Mass 843 (1990) may make this bill moot.

The Council agrees that the current system needs improvement. The Workers' Compensation System is not operating as envisioned when the previous large scale changes were enacted in 1985. There are a number of areas that may be receptive to administrative changes that would not necessitate amendments to the law. Some may be effective, while others may not be. We will never know whether any will be an improvement until they are tried.

We taken the liberty of providing for your consideration some proposals we have offered in the last few years that could conceivably be implemented without changing the law. This list by no means exhausts all of the possibilities, but it may offer an opportunity to experiment, in order to ascertain if something works, before changing the law.

We thank you both, and all the other Committee members for your time. Please do not hesitate to contact us if we can be of any assistance in this matter. We look forward to working with the legislature in the coming months in order to achieve the necessary changes to improve our workers' compensation system.

Sincerely

Joseph Faherty
Chairman

Douglas Mure
Vice-Chairman

CC: Advisory Council Members
Commissioner, Department of Industrial Accidents

MASSACHUSETTS WORKERS' COMPENSATION
ADVISORY COUNCIL
600 Washington Street
Boston, Massachusetts 02111
(617) 727-4900 EXT. 378

Chairman
Joseph Faherty
Vice-Chairman
Douglas V. Mure

Executive Director
Stevens M. Day

April 10, 1991

The Honorable Linda Melconian
Senate Chair
Insurance Committee
State House Room 254
Boston, MA 02133

The Honorable Francis Mara
House Chair
Insurance Committee
State House Room 254
Boston, MA 02133

RE: Proposed Legislation for 1991 before the Joint Insurance Committee

Dear Senator Melconian and Representative Mara:

The Advisory Council, at its last two meetings, reviewed the following bills currently before your committee, in compliance with our charge under the statute. Each bill has been reviewed exactly as proposed with respect to the current statute. The Council has taken positions to support or not support based upon the requisite number of votes. Where the Council has indicated a neutral position it means that there were not the requisite number of votes to take an position on the bill as proposed. In addition action by the Council does not indicate what individual Council members may, on their own, feel about any of the proposed legislation.

As a result of our review, we would like to offer the following:

House 1351
The Council did not support this bill as proposed.

House-1769
The Council voted to take a neutral position on this bill.

House 4707
The Council did not support this bill as proposed. There is a credit program which has been approved by the Commissioner of Insurance which will provide incentives for smaller risks, whose premiums were previously too small to be experienced rated (about 36% of the market) to control their costs. If all insureds were experienced rated it would appear to have the most dramatic impact upon small businesses, where one severe accident would increase payments significantly.

We thank you for the opportunity to express our thoughts in these areas and if we can be of any assistance to your committee please do not hesitate to contact us.

Sincerely

Joseph Faherty
Chair

Douglas V. Mure
Vice-Chair

CC: Advisory Council
Commissioner, Department of Industrial Accidents

MASSACHUSETTS WORKERS' COMPENSATION
ADVISORY COUNCIL
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Chairman
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Douglas V. Mure

Executive Director
Stevens M. Day

May 8, 1991

The Honorable Lois Pines
Senate Chair
Commerce and Labor Committee
State House - Room 421
Boston, Massachusetts 02133

The Honorable Suzanne M. Bump
House Chair
Joint Commerce and Labor Committee
State House - Room 43
Boston, Massachusetts 02133

RE: Proposed Legislation in the Joint Commerce and Labor Committee-Spring 1991: Changes In Advisory Council Positions on H-1474 and S-63

Dear Senator Pines and Representative Bump:

The Advisory Council, at its May 8, 1991 meeting, agreed to reconsider the position it had taken on H-1474 and S-63. The initial position taken was to not support the bills as proposed. After reconsideration the Council has agreed to take a neutral position on those bills as proposed. I would be grateful if your records could note the change in our position.

Thank you again for your assistance in this matter, and I apologize for any inconvenience or confusion.

Sincerely,

Stevens M. Day
Executive Director

SMD/ah

APPENDIX N

House # 5348

Filed by Mr. Brewer of Barre, petition of Suzanne M. Bump relative to workers' compensation. Commerce and Labor

An Act Relative To Workers' Compensation

Section 48 of Chapter 152 of the General Laws, as appearing in the 1988 Official Edition, is hereby amended as follows:

(1) Under the conditions and limitations specified in this chapter, the insurer and the employee may be agreement redeem any liability for compensation, in whole or in part, by the payment by the insurer of a lump sum of an amount to be approved by a conciliator, administrative judge, or administrative law judge.

(2) When the insurer and the employee reach such agreement subsequent to insurer acceptance of liability or subsequent to a decision of an administrative judge, the reviewing board, or an appeals court of the commonwealth finding insurer liability which decision is in effect at the time such agreement is entered into, said agreement shall not redeem liability for the payment of medical benefits or vocational rehabilitation benefits with respect to such injury.

No lump sum agreement made prior to the establishment of liability for compensation shall prohibit an employee from subsequently filing a claim for medical benefits only, in any instance in which such employee has suffered a substantial deterioration of his medical condition which (i) could not reasonably have been foreseen at the time and agreement was entered into, and (ii) is the result of an injury for which the insurer would have been liable under this chapter, absent the lump sum settlement. Claims under this paragraph shall be considered only if brought within one year of the date the employee first became award to the causal relationship between the substantial deterioration and the employment. Claims shall be consistent with the procedures set forth in section ten, ten A, and eleven. No liability for such claims shall be redeemed by any additional lump sum settlement.

(3) Prior to approval of any lump sum settlement, the office of education and vocational rehabilitation may review the following factors with the employee and his attorney:

(a) the employee's rights under this chapter and the effect a lump sum settlement would have upon such rights:

(b) in the case of a lump sum settlement that includes the redemption of future medical benefits, the likelihood that the employee may require such services and the present cost of insurance or other means of defraying such potential expenses:

(c) the total income and financial prospectus of the employee including all means of support:

(d) the purpose for which the settlement is requested:

(e) the employee's post-injury earnings and prospects, including the projected income and financial security of any proposed project of employment, self employment, business venture, or investment and the prudence of consulting with a financial or other expert to review the likelihood of success of such projects: and,

(f) any other information, including the age of the employee and of his dependents, which would bear upon whether the settlement is in the best interest of the claimant.

If the employee is not represented by an attorney, such a review shall be mandatory. If an employee is represented by an attorney, such review shall be at the discretion of the employee. The department may establish a procedure for the filing and approval by affidavit of proposed lump sum agreements for an employee who is represented by an attorney.

The office of education and vocational rehabilitation shall initiate such review within fourteen days of its receipt of a request by an employee for a settlement review. A report on the review shall be transmitted to the proper authority for approval within five days of completion of the review.

(4) No lump sum shall be approved by a conciliator administrative judge, or administrative law judge unless he/she deems such settlement to be in the employee's best interest.

(5) No lump sum agreement shall be approved which contains as part of a settlement a general or specific release that would serve as a bar to (i) employment with any employer, (ii) the receipt by the employee of any pay or benefits due him by an employer, (iii) the bringing of any future workers' compensation claim or (iv) the bringing of any claims of wrongful discharge or breach of contract. All such general or specific releases shall be null and void. Any employer, insurer, or attorney attempting to obtain such release from an employee shall be punished by a fine of ten times the average weekly wage in the commonwealth. The department shall inform each employee seeking a lump sum settlement of the unlawfulness of such general or specific releases.

(6) Whenever a lump sum agreement or payment has been approved by a conciliator, administrative judge, or administrative judge, or administrative law judge in accordance with the terms of this section, such agreement shall affect only the insurer and employee who are parties to such lump sum agreement and shall not affect any other action or proceeding arising out of a separate and distinct injury resulting in an incapacity whether the injury precedes or arise subsequent to the date of settlement.

APPENDIX N

ADVISORY COUNCIL TESTIMONY

ADVISORY COUNCIL TESTIMONY
JOINT COMMERCE AND LABOR COMMITTEE APRIL 10, 1991

Good morning. My name is Joseph Faherty and I am here today as the chairman of the Massachusetts Workers' Compensation Advisory Council. I serve on the Council as a representative of employees, whose interests I also represent as the president of the Massachusetts AFL-CIO. Appearing with me is Douglas Mure, vice chairman of the Advisory Council and a representative of construction employers. On behalf of all the members of the Council, we wish to thank you for the opportunity to make a few brief remarks to your committee.

Let me emphasize at the outset that the joint appearance of labor and management representatives from the Advisory Council is a reflection of both the spirit and the structure of this volunteer body, which was created by the 1985 amendments to monitor the workers' compensation system and make recommendations for the system's continued improvement. Labor interests and employer interests may not be in accord on every issue which comes before the Council, but the voting membership is evenly constituted of five labor and five employer representatives, and any action taken by the Council requires an affirmative vote of at least 70% of the voting membership. We are therefore speaking to you with a united voice.

The Council has reviewed all bills available to it that are before the Joint Commerce and Labor Committee. The Council has indicated its position on each of these bills as a whole and as proposed, on a separate document. The Council has only taken positions on bills which had the requisite statutory support of the voting membership. Some bills, or sections of bills, on which the Council has taken no position may have the support of individual Council members. In addition, we have noted concepts in a number of the bills that the Council voted to support that may merit your consideration, even though as drafted there was not a requisite amount of support for the bill taken in its entirety.

In its capacity as an oversight and monitoring body, the Advisory Council has taken an active role in attempting to research weaknesses in the workers' compensation system and proposing corrective measures. The Council has benefited in this activity from the representation of all parties in the system. Additionally, the Council has been aided by ongoing contact with the Department of Industrial Accidents. On the basis of its observations, the Advisory Council has gone on record on numerous occasions with suggestions for legislative or administrative change. Attached to our positions on the bills is a series of administrative recommendations that we offer for your consideration. We also wish to share some of our foremost concerns regarding prospective reforms.

---The costs of the system and the delays in administrative proceedings must be brought under control. Cost and delay are invariably intertwined and cast a determining influence on other aspects of the system. Without resolution of these fundamental problems, the system will remain in chaos.

---Workers must have access to quality medical care in an expeditious fashion. While medical costs as a percentage of workers' compensation premiums approach 40% nationally, in Massachusetts recent data shows our state in the 20% range. If we approach the national average, what then will happen to our costs?

---Abuse of the system cannot be tolerated. There is no way to calculate the extent of practices which either casually or deviously attempt to reap unwarranted reward. Abuse may take many forms and involve any of the system's actors. There is a real danger in allowing even minor abuses to go unchecked, since they can contribute to an overall workers' compensation culture in which misuse of the system may be construed as tolerable or even legitimate. Accordingly, we strongly support any efforts to identify and curtail abuse.

---The cost of workers' compensation insurance must be brought under control and a comprehensive solution must be implemented toward this end. The prohibitive and skyrocketing cost of insurance is a significant contributor to the fragile business climate in which we find ourselves. We fear that a failure to implement fair insurance rates will encourage more business entities to unlawfully operate without insurance and further erode the commonwealth's competitive edge. The livelihoods of employers and employees depend on the ability to bring insurance costs under control.

---More attention must be devoted to improving the day-to-day operation of the system. To date, concern with costs and delays has tended to concentrate upon large-scale and visible phenomena, such as budgets, medical costs, insurance costs, and so on. With the introduction of a new administration at the DIA, this is a fruitful time to appraise smaller scale practices and procedures, and perhaps pilot projects, and make necessary improvements. We look forward to working with the new administration.

---In examining the way we do things at the most basic level, we must make an effort to reduce the extent of litigation. As a start, we look forward to receiving information from the insurance industry regarding expenditures for plaintiff and defense attorney fees.

---The backlog of cases awaiting settlement at the DIA must not be allowed to increase. To this end, we support the return of backlog judges to the DIA's FY'92 budget.

The law was initially enacted in 1911. In the 80 years many things have changed. Some remain the same. I would like to share the following quotes which many here might agree with.

--- "The difficulty under the new law will not be so much in the determination of matters of legal liability as in the ascertained of physical incapacity of the injured man."

--- "The successful administration of the act requires the assistance of skilful physicians and surgeons of the highest integrity."

--- "The Industrial Accident Board can render invaluable service to employers by co-operating with them in the practical study of accident prevention."

--- "In regard to industrial accidents, with which this report is concerned, the lack of definite and reliable information is particularly marked. Every one who is at all acquainted with modern industrial operations knows that disabling accidents are frequent and often distressing in their results, but in the absence of carefully compiled statistics no real measurement of this element in the cost of production is possible."
Report on the Commission for Compensation for Industrial Accidents Published in 1912.

---"Malingering by the industrial workers of this state is inconsequential.... A regrettable fact is that in the few such cases which occur the workman is seldom alone in his attempted deception; he too is often the misguided victim of unscrupulous professional advisors or persons with abnormal desires to debase others."
2ND Annual Report of the Industrial Accident Board

I would like to make an additional observation to the Committee. My own concerns regarding the state of the workers' compensation system in the commonwealth do not stem solely from my ties to the labor movement or to the Advisory Council. I also find myself in a third role--that of an employer. The Massachusetts AFL-CIO, like other employers, is required under Massachusetts law to provide workers' compensation insurance coverage for its employees and to pay assessments levied under Section 65 of M.G.L. c.152. Over the last several years, my organization has noted with alarm the rapidly escalating costs associated with workers' compensation. We share the concerns of other employers that the prohibitive and seemingly uncontrolled increases in insurance premiums and assessment payments will hinder our organization's effectiveness.
Of course, outright costs are only part of the problem. All parties in the workers' compensation system agree that fundamental and widespread corrections are necessary in order to stabilize the system. The severity and breadth of current problems, from lengthy delays in case settlement to inconsistent medical treatment for injured employees, have by most accounts resulted in a crisis situation, and this is reflected in the large number of bills that have been filed to amend the workers' compensation statute and related laws. The sense of urgency is quite clear. However, there is not likely to be full agreement on where change should be made or how it is to be implemented.

In closing, I would be remiss if I did not express our dismay and concern at the recent actions of government with respect to the reversion of employer paid assessment funds at the DIA. The Council would never presume to speak for all employees and employers, and there are many here today who I am sure will articulate their own frustrations. However, on no issue has the Council ever been more united. When the employers agreed to pay for the operating expenses of the department, it was with both the statutory protection and explicit trust that employer funds would not become a petty cash fund for the state. The law has been circumvented and the trust has been broken.

In the labor movement, as in other areas of endeavor, a party's word is law. It is a contract. Employers believed that they had both a law and a good faith agreement to protect them. A conscious and deliberate choice has been made to breach the trust engendered by the 1985 changes. Reversion of employer funds is nothing more than a tax--potentially a double tax if future assessment must assume the costs of the furlough/ deferred compensation program. We ask the consideration of each of you to do your best to prevent such actions from happening again.

I thank all members of the Committee for their energetic efforts and time on behalf of the workers' compensation system. For the Advisory Council, I sincerely thank you for this opportunity to share our concerns with you.

Workers' Compensation Advisory Council: Administrative Recommendations

In its role as overseer of the workers' compensation system, the Advisory Council has undertaken research which has sought to identify trouble spots in the system that might be improved through either administrative or legislative action. The Council has shared its recommendations from these studies with appropriate parties, both in the Department of Industrial Accidents and in the legislature.

Among the reports issued by the Advisory Council are: a comprehensive study of the workers' compensation system (prepared by Peat Marwick Main and Company); a study of friction costs in the workers' compensation system and Department of Industrial Accidents (prepared by Milliman & Robertson, Inc. and John Lewis); a study of medical access for work-injured employees (prepared by Lynch Ryan & Associates and the Boylston Group); and studies of a "mark up" form of case scheduling, occupational diseases, and competitive rating prepared primarily by the Council.

In issuing recommendations from its research, the Advisory Council has been careful to distinguish between those which would have to be implemented by legislative action and those which could be put in place by administrative decision at the Department of Industrial Accidents.

Several recommendations targeted practices or procedures within the Department of Industrial Accidents while some are systemic in nature. A sample of some of those suggestions include the following:

--The report on the "mark up" system suggested that a motion session could act as an administrative mechanism which would cut down on fraud and abuse, as well as resolve disputes over whether information is discoverable prior to the scheduled date. Motion sessions were seen as a potential means for expediting case flow by allowing attorneys needing to withdraw from cases to do so before a hearing and by alerting parties to sanctions against fraud or other abusive practices.

--The study by Peat Marwick Main and Company of the overall workers' compensation system included several suggestions that could be carried out at the department level. One recommendation was to automate the Insurance Register in the DIA's Office of Insurance. Through the cooperation of the Workers' Compensation Rating and Inspection Bureau, this is currently being done. This should allow for a better use of staff, improved investigatory efforts, and elimination of the register's entry backlog. The report also recommended that remittances and assessments be audited, and that support for the Office of the Legal Counsel be enhanced. Another recommendation was to modify the DIAMETER software program to

permit the processing and tracking of multiple claims and to validate and edit existing data and purge inaccurate information. This would improve access to information and cut down on system abuse.

--The study by Lynch Ryan and the Boylston Group on medical access recommended that the DIA make better use of the Health Care Services Board in order to improve medical services and identify abuses. Among the specific tasks recommended for the Board were: promotion of the development and use of standard protocols for the treatment of lower back injuries; development of a database on workers' compensation medical practice; and improvement of provider perceptions of work-injured individuals. It was also recommended that provider reimbursement procedures be streamlined, that a prototype coordinated care initiative be established, and that there be a greater application of stress management techniques to workplace injuries.

--The Council has recommended in its Report on Occupational Diseases that greater attention should be devoted to industrial diseases and illnesses, particularly in surveillance, diagnosis, treatment, education and training.

-- The Council has recommended in its competitive rating study that before consideration of a competitive rating system for insurance pricing is implemented market conditions must improve. There have been changes intended to depopulate the assigned risk pool which will hopefully assist in this area.

The Advisory Council has itself made a number of suggestions in its annual reports and elsewhere that would not necessarily require legislative action in order to be implemented.

--The Council has recommended the use of a formal performance appraisal to evaluate judicial personnel. This would provide the appointing authority with relevant information in the appointment process inasmuch as the law mandates that the a review by the department be provided to the Nominating Committee. It is especially critical since the majority of judicial terms expire in the next year. Delays in the appointment process exacerbate the backlog of cases.

--The Council has recommended that relevant medical information be attached to claims/complaints in order to provide parties with the necessary information which could decrease litigation.

--The Council has recommended the promulgation of rules to monitor claims handling techniques, as set forth in M.G.L. c.23E 11(4). This would provide a more active oversight capacity in order to discourage unwarranted claims and litigation by insurers.

--The Council suggested increasing settlement agreement information for the lump sum process in order to allow more rapid evaluation and approval.

--The Council has encouraged the administration to provide conciliators with the flexibility and tools for enhancing their effectiveness.

--The Council requested that the insurance industry provide information on legal costs in the workers' compensation system, and in his December 27, 1990 decision on insurance rates, the Commissioner of Insurance urged the parties to explore the issue.

--The Council urged that steps be taken to educate governmental entities regarding workers' compensation insurance requirements and to publicize the enforcement authority of the DIA.

--The Council suggested the provision of greater in-house training for DIA staff in order to improve productivity and morale and also recommended on-going training for judicial staff.

--The Council identified misuse of Section 65 funds drawn from assessments on employers and sought to explain to appropriate authorities the rationale and structure for the assessment mechanism. The Council strongly emphasized the need to maintain the integrity of the assessment process in relation to its original purposes.

--The Council has urged the DIA to notify the CEOs of insurance companies of the obligation to file "pay" forms. The filing of these forms may provide the system with more accurate data on not only the pay without prejudice process, but attorney fees as well.

--A mechanism exists for parties to formalize complaints where they believe the system has been abused. The DIA received a total of three complaints in FY'90. Parties should exercise their rights if they believe the system has been abused.

--The Council has supported the adoption of a Qualified Loss Management Program to depopulate the assigned risk pool. This program is intended to provide incentives for employers to lessen costs. This program is in its infant stages but may in time decrease costs.

--The Council has raised the problem concerning parties appearing before the agency with "apparent", but not perhaps "actual" authority to resolve cases. There may be additional administrative mechanisms that could be employed to curtail this activity.

--The Council has supported in the past additional resources for the DIA to function as envisioned by the 1985 changes. Funds alone are not the sole answer to problems which exist but can complement a sound administrative format to enforce the law.

APPENDIX O

Case Timeframe Statistics

End Date In Range

For Events Ending From 7/1/90 to 6/30/91

RPT 491

	DAYS TO FIRST SCHEDULED EVENT								
	STATEWIDE			BOSTON			FALL RIVER		
EVENTS	COUNT	MEAN	MED	COUNT	MEAN	MED	COUNT	MEAN	MED
CLAIM receipt to CONC.	22,885	22.7	21	11,230	21.1	20	3,845	25.7	26
§36 CLAIM receipt to CONC.	3,976	22.5	21	1,480	20.2	20	661	25.1	25
DISC. receipt to CONC.	11,470	22.2	20	5,629	20.4	20	1,924	25.5	25
TPC receipt to CONC.	1,159	23.6	21	725	22.7	20	191	26.7	28
CONC. meeting to CONF.	15,680	211.4	202	7,050	180.6	181	2,251	217.6	222
CONF. close to Order	10,372	4.5	1	4,722	5.3	1	1,560	3.5	1
AH to receipt to HEAR.	6,929	90.2	90	3,084	100.1	104	1,093	74.9	65
HEAR. close to Decision	1,441	124.8	77	631	134.1	75	253	58.1	13
LSR receipt to LUMP	10,039	32.1	29	4,812	27.8	27	1,842	38.0	39
REF to LS	5,292	45.3	33	2,311	36.9	28	876	47.2	43

	DAYS TO FIRST SCHEDULED EVENT								
	LAWRENCE			WORCESTER			SPRINGFIELD		
EVENTS	COUNT	MEAN	MED	COUNT	MEAN	MED	COUNT	MEAN	MED
CLAIM receipt to CONC.	2,158	21.3	21	3,018	25.9	25	2,634	22.6	21
§36 CLAIM receipt to CONC.	292	22.0	20	796	25.2	25	747	21.9	21
DISC. receipt to CONC.	1,208	20.8	20	1,613	25.7	25	1,096	21.9	21
TPC receipt to CONC.	66	23.7	22	58	25.6	25	119	23.1	22
CONC. meeting to CONF.	1,633	300.6	301	2,523	239.3	246	2,223	205.9	209
CONF. close to Order	1,103	3.3	2	1,622	6.0	3	1,365	2.3	1
AH to receipt to HEAR.	832	79.1	55	1,168	85.0	77	752	92.2	101
HEAR. close to Decision	194	125.6	118	218	154.6	134	145	132.5	86
LSR receipt to LUMP	1,192	29.7	28	1,225	36.2	35	968	40.4	39
REF to LS	644	40.7	31	1,041	57.3	38	420	64.7	44

KEY: AH = Appeal to Hearing
CONC. = Conciliation
CONF. = Conference
DISC. = Discontinuance
HEAR = Hearing
REF = LS Referral From AJ
LSR = Lump Sum Request
LUMP = Lump Sum Conference
MED = Median
TPC = Third Party Claim

APPENDIX P

Case Tracking And Scheduling System

Hearing Disposition Entry Stats

For Hearings Scheduled From 7/01/90 To 06/30/91

Over All

Disposition----------Days Before/After Meeting----------

Code	Description	Total	> 15	15-6	5-1	@Hearing	1-7	8-28	> 28
0	Open Disposition	1015	0	0	0	0	0	0	1015
01	Withdrawn By Moving Party	1257	54	73	76	331	373	147	203
02	Withdrawn By AJ	46	2	0	0	5	9	8	22
03	Dismissed by AJ	25	0	0	0	2	11	4	8
04	Voluntarily Adjusted	555	6	4	9	130	126	79	201
05	Referred To Lump Sum	1284	28	15	31	381	434	133	262
06	Reschedule For Hearing	570	117	45	19	20	114	75	180
07	Decision Filed	926	1	0	0	5	39	47	834
08	Withdrawal Proceedings Recd.	18	5	5	4	1	0	0	3
09	Lump Sum Request Recd.	369	94	31	26	4	37	36	141
10	AJ Lump Sum Recommended	1846	21	7	13	221	485	383	716
11	Withdrawn By Department	156	6	2	1	0	9	12	126
Total		8067	334	182	179	1100	1637	924	3711

* Please note that certain dispositions are most likely the result of entry errors this and the succeeding charts. Open dispositions refers to dispositions not yet entered into the system as of the date the report was run and in fact these cases may be actually resolved.

Case Tracking And Scheduling System
Hearing Disposition Entry Stats
For Hearings Scheduled From 7/01/90 To 06/30/91
Claim

Disposition----------Days/Before/After Meeting----------

Code	Description	Total	> 15	15-6	5-1	@Hearing	1-7	8-28	> 28
0	Open Disposition	669	0	0	0	0	0	0	669
01	Withdrawn By Moving Party	617	30	33	39	170	178	62	105
02	Withdrawn By AJ	34	1	0	0	5	5	4	19
03	Dismissed by AJ	18	0	0	0	1	9	2	6
04	Voluntarily Adjusted	390	6	2	3	83	84	52	160
05	Referred To Lump Sum	746	10	10	18	224	246	86	152
06	Reschedule For Hearing	368	83	24	10	15	65	53	118
07	Decision Filed	552	1	0	0	5	25	28	493
08	Withdrawal Proceedings Recd.	8	3	1	3	1	0	0	0
09	Lump Sum Request Recd.	183	42	16	10	0	21	15	79
10	AJ Lump Sum Recommended	1218	13	4	6	128	297	234	536
11	Withdrawn By Department	96	4	1	0	0	8	5	78
Total		4899	193	91	89	632	938	541	2415

Case Tracking And Scheduling System
Hearing Disposition Entry Stats
For Hearings Scheduled From 7/01/90 To 06/30/91
Discontinuance

Disposition----------Days Before/After Meeting----------

Code	Description	Total	> 15	15-6	5-1	@Hearing	1-7	8-28	> 28
0	Open Disposition	316	0	0	0	0	0	0	316
01	Withdrawn By Moving Party	608	24	38	36	159	195	61	95
02	Withdrawn By AJ	9	1	0	0	0	3	3	2
03	Dismissed by AJ	6	0	0	0	1	1	2	2
04	Voluntarily Adjusted	155	0	1	5	47	40	23	39
05	Referred To Lump Sum	522	17	5	13	155	181	44	107
06	Reschedule For Hearing	184	29	21	7	5	44	21	57
07	Decision Filed	357	0	0	0	0	12	17	328
08	Withdrawal Proceedings Recd.	10	2	4	1	0	0	0	3
09	Lump Sum Request Recd.	184	52	15	16	4	16	21	60
10	AJ Lump Sum Recommended	563	7	3	6	91	180	125	151
11	Withdrawn By Department	59	2	1	1	0	1	7	47
Total		2973	134	88	85	462	673	324	1207

Case Tracking And Scheduling System
Conference Disposition Entry Stats
For Conferences Scheduled From 07/01/90 to 06/30/91
Over All

Disposition----------Days Before/After Meeting----------

Code	Description	Total	> 15	15-6	5-1	@Conf.	1-7	8-28	> 28
0	Open Disposition	96	0	0	0	0	0	0	96
01	Withdrawn By Moving Party	1323	60	45	61	213	687	149	108
02	Withdrawn By AJ	57	1	0	0	4	29	9	14
03	Dismissed by AJ	101	2	3	1	10	57	11	17
04	Voluntarily Adjusted	1833	47	20	40	289	1055	235	147
05	Referred To Lump Sum	1997	16	16	29	290	1255	295	96
06	Reschedule For Conference	1688	1116	128	37	36	168	85	118
07	Order Issued	10493	10	9	39	1112	6752	1725	846
08	Withdrawal Proceedings Recd.	14	8	1	3	1	0	0	1
09	Lump Sum Request Recd.	612	285	97	41	13	77	60	39
10	AJ Lump Sum Recommended	1010	7	2	3	94	446	278	180
11	Withdrawn By Department	44	11	4	0	6	11	6	6
Total		19268	1563	325	254	2068	10537	2853	1668

Case Tracking And Scheduling System
Conference Disposition Entry Stats
For Conferences Scheduled From 07/01/90 to 06/30/91
Claim

Disposition----------Days Before/After Meeting----------

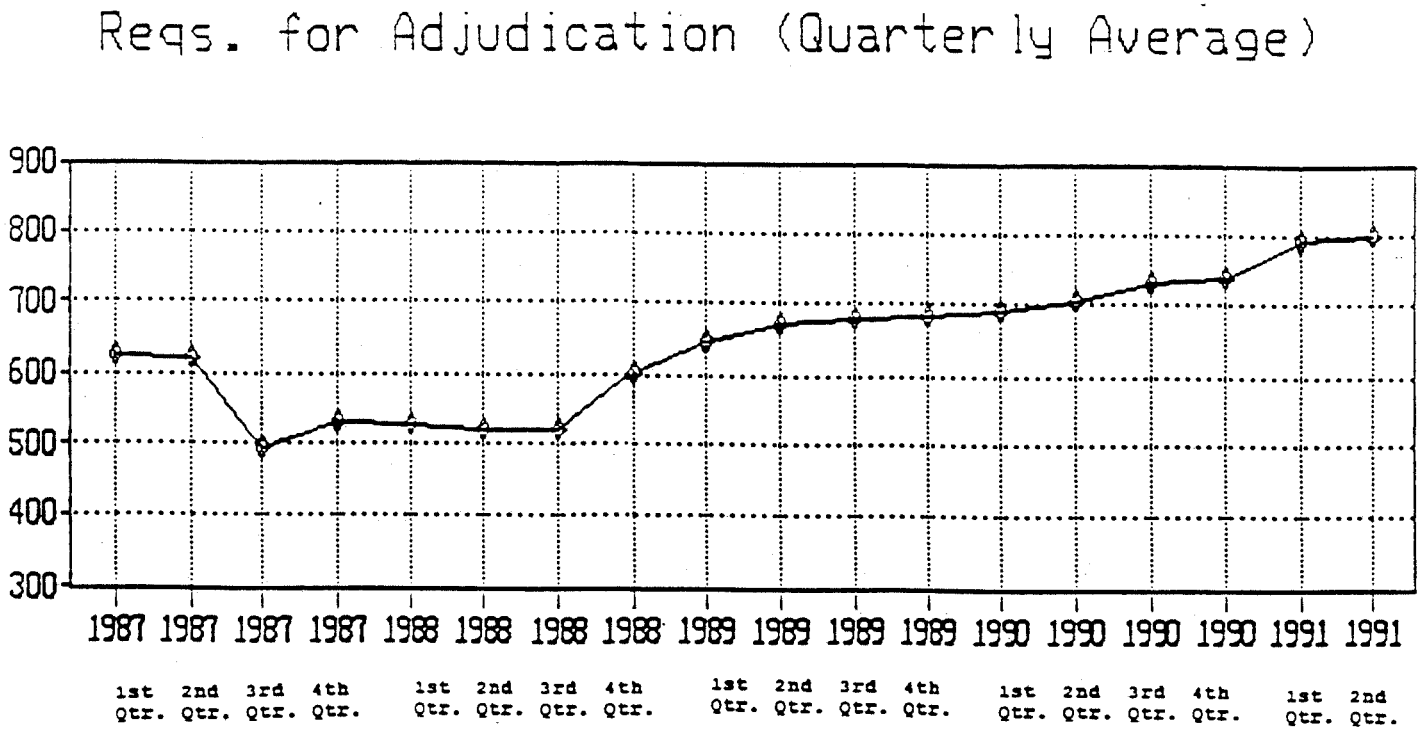
Code	Description	Total	> 15	15-6	5-1	@Conf.	1-7	8-28	> 28
0	Open Disposition	62	0	0	0	0	0	0	62
01	Withdrawn By Moving Party	614	25	19	25	97	327	67	54
02	Withdrawn By AJ	44	1	0	0	4	23	7	9
03	Dismissed by AJ	68	2	1	1	6	35	10	13
04	Voluntarily Adjusted	1537	40	17	31	259	883	197	110
05	Referred To Lump Sum	1031	8	5	13	150	644	151	60
06	Reschedule For Conference	1066	679	88	16	21	105	58	99
07	Order Issued	6152	5	5	22	622	4007	979	512
08	Withdrawal Proceedings Recd.	5	4	0	1	0	0	0	0
09	Lump Sum Request Recd.	237	104	31	13	4	34	34	17
10	AJ Lump Sum Recommended	548	3	1	1	47	236	150	110
11	Withdrawn By Department	26	6	2	0	5	5	5	3
Total		11390	877	169	123	1215	6299	1658	1049

Case Tracking And Scheduling System
Conference Disposition Entry Stats
For Conferences Scheduled From 07/01/90 to 06/30/91
Discontinuance

Disposition----------Days Before/After Meeting----------

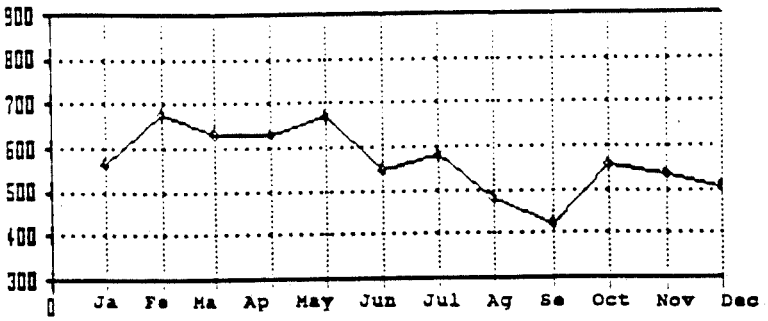
Code	Description	Total	> 15	15-6	5-1	@Conf.	1-7	8-28	> 28
0	Open Disposition	24	0	0	0	0	0	0	24
01	Withdrawn By Moving Party	694	34	26	34	115	350	81	54
02	Withdrawn By AJ	12	0	0	0	0	5	2	5
03	Dismissed by AJ	24	0	2	0	3	16	1	2
04	Voluntarily Adjusted	261	6	1	8	29	151	35	31
05	Referred To Lump Sum	958	8	11	15	140	607	142	35
06	Reschedule For Conference	611	431	39	21	14	61	26	19
07	Order Issued	4216	5	4	16	483	2673	711	324
08	Withdrawal Proceedings Recd.	9	4	1	2	1	0	0	1
09	Lump Sum Request Recd.	368	175	65	28	9	43	26	22
10	AJ Lump Sum Recommended	442	4	1	2	46	206	119	64
11	Withdrawn By Department	16	5	2	0	1	6	0	2
Total		7635	672	152	126	841	4118	1143	583

APPENDIX Q


Reqs. for Adjudication (Quarterly Average)
900
800
700
600
500
400
300
1987 1987 1987 1987 1988 1988 1988 1988 1989 1989 1989 1989 1990 1990 1990 1990 1991 1991
1st Qtr. 2nd Qtr. 3rd Qtr. 4th Qtr.
1st Qtr. 2nd Qtr. 3rd Qtr. 4th Qtr.
1st Qtr. 2nd Qtr. 3rd Qtr. 4th Qtr.
1st Qtr. 2nd Qtr. 3rd Qtr. 4th Qtr.
1st Qtr. 2nd Qtr.

APPENDIX Q

Reqs. for Adjudication -- CY 1987



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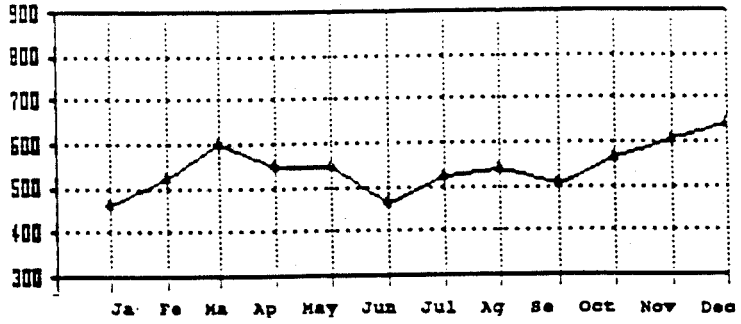
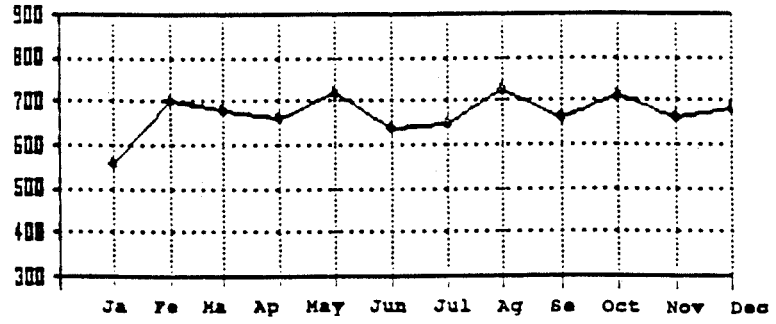
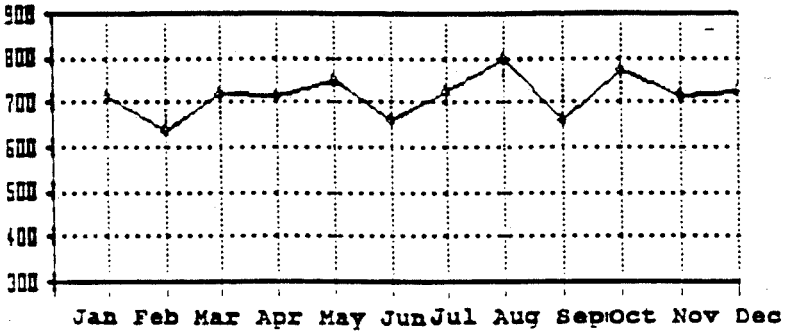


Reqs. for Adjudication -- CY 1989

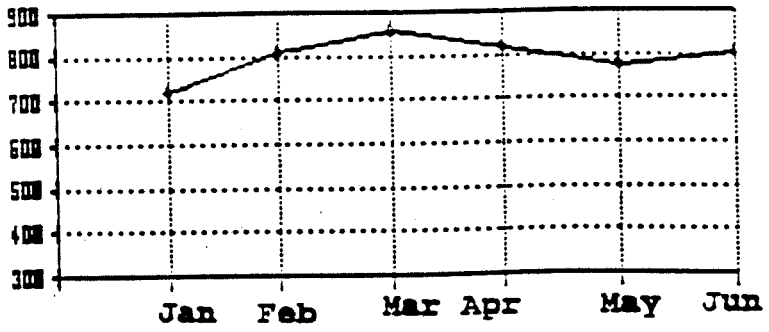


APPENDIX Q

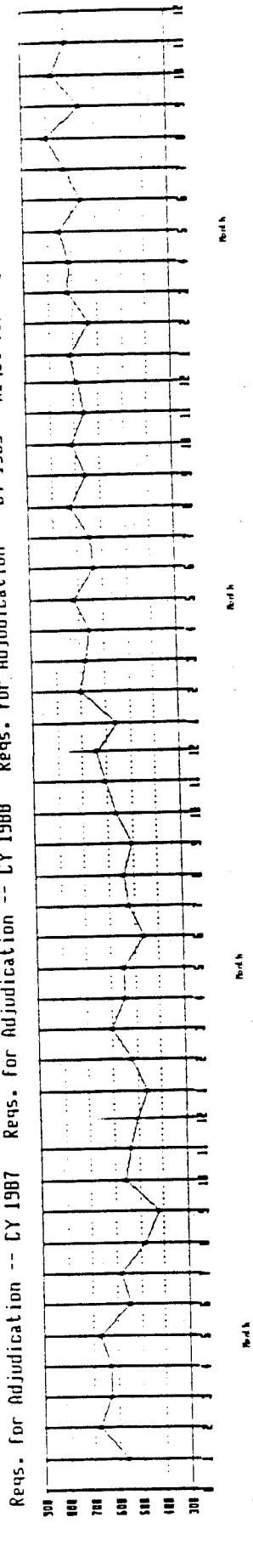
Reqs. for Adjudication -- CY 1990



Reqs. for Adjudication -- CY 1991



APPENDIX Q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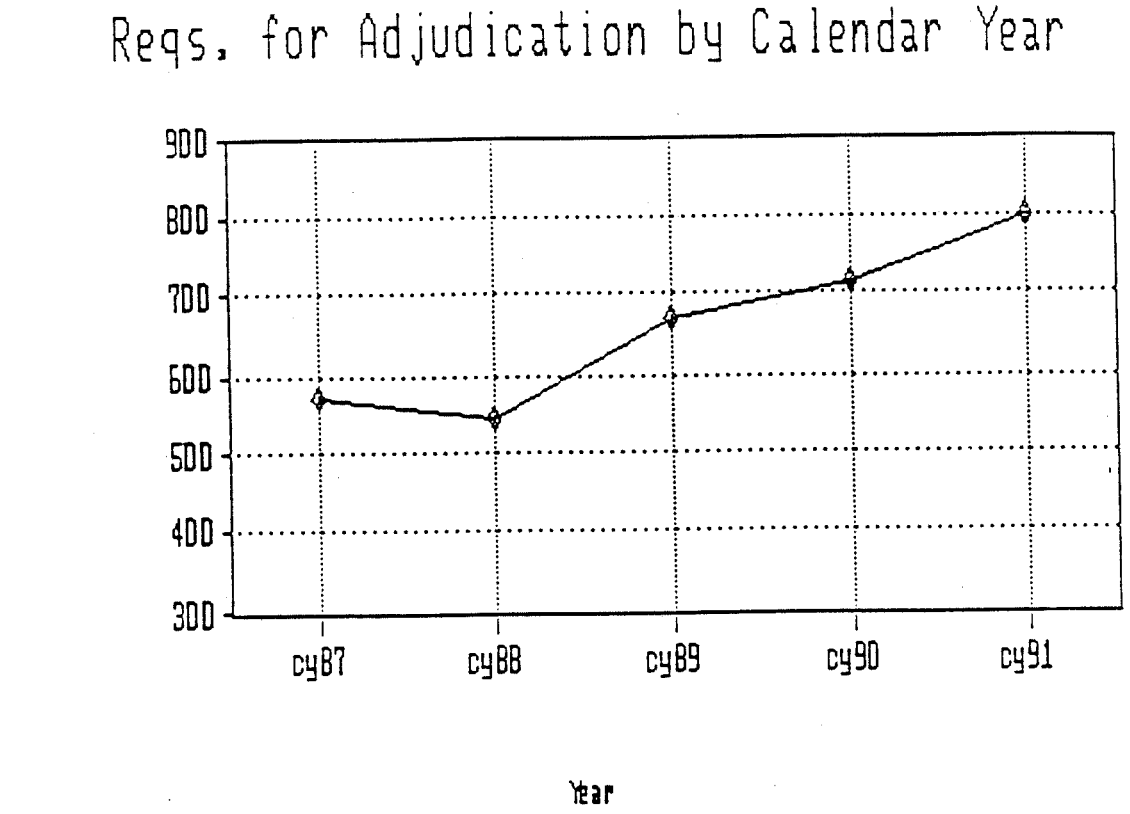
Reqs. for Adjudication -- CY 1988
Reqs. for Adjudication -- CY 1989
Reqs. for Adjudication -- CY 1990

APPENDIX Q


Reqs. for Adjudication by Calendar Year
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800
700
600
500
400
300
cy87
cy88
cy89
cy90
cy91
Year
Disputes

APPENDIX R

STATISTICS IN 5th ANNUAL REPORT OF INDUSTRIAL ACCIDENT BOARD
Period 7/1/16 - 6/30/17

Number of Accident Reports by month for each month first 5 years.
Average monthly receipt of accident report first 5 years.

Number of Hearings under workers' comp act first 5 years.
8 other categories of cases disposition for first 5 years.

Cost of administration first 5 years.

Number of Fatal
Number percent Insured or not.
Number which had dependents by total dependency, or partial marital status of fatals.

Duration of total disability/ incapacity for 174,372 cases by number and percent.

---Broken down by 11 categories from less than 1 day to more than a year.

I. Total Injuries, Fatal and Nonfatal Combined.
   - A. Insurance
     1. Number of cases insured.
     2. Percentage distribution.
   - B. Industries
     1. Total number of tabulated injuries.
     2. Percentage distribution of total.
   - C. Causes
     1. Frequency of all cases.
     2. Percentage distribution.
   - D. Wages
     1. Distribution of all cases by wage groups.
     2. Percentage distribution.
   - E. Basis of wage payments
     1. Distribution of all cases.
     2. Percentage distribution.
   - F. Sex
     1. Distribution of all cases.
     2. Percentage distribution.
   - G. Age
     1. Distribution of all cases by age groups.
     2. Percentage distribution.

II. Fatal Cases
   - A. Insurance
     1. Number of cases insured.
     2. Percentage distribution.

B. Industries
   1. Number of cases by industries.
   2. Percentage.
C. Causes
   1. Frequency by causes.
   2. Percentage.
D. Dependency
   1. Number of cases by nature of dependency.
   2. Percentage distribution.
   3. Number of persons totally and partially dependent.
   4. Number of persons per case.
E. Conjugal condition
   1. Number of cases by marital condition.
   2. Percentage distribution.
F. Wages
   1. Number of cases by wage group.
   2. Percentage.
G. Basis of wage payments
   1. Number of cases of piece and time workers.
   2. Percentage.
H. Sex
   1. Number of cases by sex.
   2. Percentage.
I. Age
   1. Number of cases by age group.
   2. Percentage.

III. Nonfatal Cases
A. Insurance
   1. Number of reported and tabulatable cases insured.
   2. Percentage distribution.
B. Industries
   1. Number of tabulatable injures.
   2. Percentage distribution.
C. Causes
   1. Frequency of reported and tabulatable cases.
   2. Percentage distribution.
D. Duration of total disability
   1. Number of tabulatable injuries by periods of disability.
   2. Percentage distribution of cases.
E. Specified injuries
   1. Number of cases by nature of injury.
F. Wages
   1. Number of reported and tabulatable cases by wage group.
   2. Percentage distribution.
G. Basis of wage payments
   1. Number of reported & tabulatable cases by piece and time workers.
   2. Percentage distribution.
H. Sex
   1. Number of reported and tabulatable cases by sex.
   2. Percentage distribution.
I. Age

1. Number of reported and tabulatable cases by age periods.
2. Percentage distribution.

J. Insurance transactions
1. Payments made and estimated payments to be made.
2. Number and type of benefit cases.

Comparative compensation payments by category and by amount each year.
Average cost per benefit case.
Number of benefit cases reported by insurance companies.
Percentage, distribution of benefit cases by type of payment.

Settlements in non insured fatal cases and comparison of settlements and amounts due under workers' compensation act.

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II. Fatal injuries - insured, not insured, common-law rights
III. Tabulatable non-fatal injuries, classified by industries and by causes.
IV. Fatal injuries, classified by industries and by causes.
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VI. Occurrence of fatal injuries by months and days of the month.
VII. Distribution of tabulatable non-fatal injuries by sex, age and basis of wage payments.
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Acknowledgments

A number of individuals deserve thanks for their assistance in helping the staff prepare this report. The DIA warrants thanks for its efforts in answering our requests and providing information throughout the year and in preparation for this report. In particular, Walter Horn, former Deputy Director of Administration at the DIA, has provided invaluable assistance in the last few years in providing data and statistics for the Council. Joe Constantine and the staff of the DIA's data processing unit have labored to assist us in our efforts to obtain computer information on the system's effectiveness. Elaine Lydston, former member of the Council's staff, has formulated many of the charts that we hope make the information readily understandable.

Our thanks to all DIA employees and interested parties that provided their time and insight in our dispute resolution study.