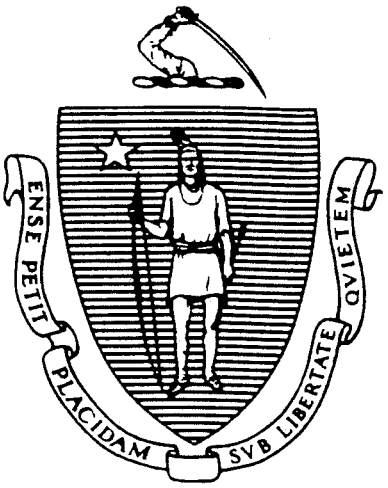

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

STATE OF THE WORKERS' COMPENSATION SYSTEM

FISCAL YEAR 1993

STATE OF THE MASSACHUSETTS WORKERS' COMPENSATION SYSTEM

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

FISCAL YEAR 1993 ANNUAL REPORT

March 30, 1994

ANNUAL REPORT
FISCAL YEAR 1993

Massachusetts Workers' Compensation Advisory Council

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Staff: Executive Director, **Matthew A. Chafe**, J.D.; Research Analysts **Jeremy Teres**, B.A., and **Ann Helgran.**

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Approved by: Philmore Anderson III, State Purchasing Agent

Advisory Council

The Massachusetts Workers' Compensation Advisory Council was created by the Massachusetts General Court on December 10, 1985 with passage of the Workers' Compensation Reform Act of 1985, chapter 572 of the Acts of 1985. Its function is to monitor, recommend, give testimony, and report on all aspects of the workers' compensation system, except the adjudication of particular claims or complaints. The council also conducts studies from time to time on various aspects of the workers' compensation system.

The Advisory Council is required to issue an annual report evaluating the operations of the Department of Industrial Accidents and the Massachusetts workers' compensation system. In addition, members are required to review the annual operating budget of the Department of Industrial Accidents, and, when necessary, submit its own recommendation.

The Advisory Council is comprised of leaders from labor, business, the medical profession, the legal profession, the insurance industry and government. Its sixteen members are appointed by the governor for five year terms and include: five employee representatives (each of whom is a member of a duly recognized and independent employee organization); five employer representatives (representing manufacturing classifications, small businesses, contracting classifications, and self-insured businesses); one representative of the workers' compensation claimant's bar; one representative of the insurance industry; one representative of the commonwealth's medical providers; and one representative of vocational rehabilitation providers.

The employee and employer representatives comprise the voting members of the council, and the council cannot take action without the affirmative vote of at least seven voting members. The council's chairperson and vice-chairperson rotate between an employee representative and an employer representative.

The Advisory Council is required by law to meet when the chairperson calls for a meeting or upon the petition of a majority of members. It usually meets on the second Wednesday of each month at 9:00 a.m. at 600 Washington Street, 7th Floor Conference Room, Boston, Massachusetts.

Meetings are open to the general public pursuant to the Open Meeting Laws (M.G.L., ch. 30A, sec. 11A½).

Studies

The Advisory Council over the years has conducted a number of studies on workers' compensation in Massachusetts. Some of these

studies were performed at the request of the legislature, and others council members chose to conduct.

The following are studies conducted by the council:

The Analysis of Friction Costs Associated with the Massachusetts Compensation System, Milliman & Robertson, John Lewis, (1989).

Analysis of the Massachusetts Department of Industrial Accidents Dispute Resolution System, Endispute, Inc., B.D.O. Seidman, (1991).

Assessment of the Department of Industrial Accidents & Workers Compensation System, Peat Marwick Main, (1989).

Medical Access Study, Lynch-Ryan, The Boylston Group (1990).

Report on Competitive Rating, Tillinghast, (1989).

Report to the Legislature on Competitive Rating, Massachusetts Workers' Compensation Advisory Council, (1989).

Report to the Legislature on the Mark-up System for Case Scheduling, Massachusetts Workers' Compensation Advisory Council, (1990).

Report to the Legislature on Occupational Disease, Massachusetts Workers' Compensation Advisory Council, (1990).

Report to the Legislature on Public Employees, Massachusetts Workers' Compensation Advisory Council, (1989).

The Advisory Council's studies are available for review Monday through Friday, 9:00 a.m. - 5:00 p.m. at the Massachusetts State Library, State House, Room 341, Boston, Massachusetts, 02133 or by appointment at the offices of the Advisory Council, 600 Washington Street, 2nd Floor, Boston, Massachusetts (617) 727-4900 ext. 378.

The Advisory Council is also in the process of conducting two studies mandated by the legislature as part of the chapter 398 reform act in 1991.

Study of Workers' Compensation Wage Replacement Rates, Tillinghast; Professor Peter Kozel.

This study will examine the impact of the 1991 legislative changes in wage replacement rates for partial and temporary total benefits under the workers' compensation law.

Under chapter 398 of the Acts of 1991, temporary total workers' compensation benefits were reduced from 66 2/3 of a

claimant's average weekly wage to 60%, while the maximum duration for collecting benefits was reduced from 260 weeks to 156 weeks. Partial incapacity benefits were reduced from 66 2/3 of the difference between the pre-injury average weekly wage and the average weekly wage the claimant is capable of earning after the injury, to 60% of that difference. The eligibility period was reduced from a maximum of 600 weeks to, under certain conditions, a maximum of 520 weeks.

The determination of optimal wage replacement rates is central to workers' compensation systems. Until the recent legislative initiative, Massachusetts utilized the standard recommended by the National Commission on Workers' Compensation Laws in 1972, which suggested that benefit levels be set at two-thirds of the injured employee's average weekly wage. However, concern with the increasing cost of workers' compensation insurance and the number of workers' compensation claims filed led to the reduction of certain benefits under the new law.

While research has shown that utilization rates increase as benefit levels rise, there are few equivalent studies that explore the impact of decreases in benefit levels. Since the change in wage replacement benefits under chapter 398 is intended to reduce costs and induce cost-saving behaviors, and because the maintenance of adequate benefit levels is of paramount importance to the commonwealth's workers' compensation system, this study will provide policy-makers with data on the new law in order to assess its impact.

Study of Workers' Compensation Insurance Rate Methodology, The Wyatt Company.

This study will evaluate the advantages and disadvantages of adopting hours worked as a methodology for establishing workers' compensation insurance premiums.

Massachusetts and most other states utilize employer payroll in establishing manual rates for employers in various industry categories. Some have argued that the payroll method of rate determination itself provides low wage employers with a competitive advantage in the marketplace. It is suggested that substituting the number of hours worked by an employer's work force will provide a more equitable policy and will result in a more competitive marketplace. This is seen to be particularly pertinent to the construction industry, where payroll disparities vary widely.

This study will provide the quantitative data needed to assess the potential implications of adopting the hours worked methodology in determining premiums for Massachusetts construction employers, as well as other key employer classes.

Claims Administration

When an employee is disabled or incapable of earning full wages for five or more calender days due to an injury, occupational disease, or death, the employer must file a First Report of Injury with the office of claims administration at the DIA, the insurer and the employee within seven days of notice of injury. If the employer does not file the required First Report of Injury with the DIA, they may be subject to a fine.

The insurer then has 14 days upon receipt of an employer's first injury report to either pay the claim or to notify the DIA, the employer, and the employee of refusal to pay.[1]

When the insurer pays a claim, they may do so without accepting liability for a period of 180 days.[2] This is the "pay without prejudice period" that establishes a window where the insurer may refuse a claim and stop payments at their will. Up to 180 days, the insurer can unilaterally terminate or modify any claim as long as they specify the grounds and factual basis for so doing. The purpose of the pay without prejudice period is to encourage the insurer to begin payments to the employee instead of outright denying the claim.[3]

After a conference order or the expiration of this 180 day period, the insurer may no longer unilaterally stop payments. The insurer must request a modification or termination of benefits based on an impartial medical exam and other statutory

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[1] If there is no notification or payment has not begun, the insurer is subject to a fine of $200 after 14 days, $2,000 after 60 days, and $10,000 after 90 days.

[2] The pay without prejudice period may be extended up to one year under special circumstances. The DIA must be notified seven days in advance.

[3] According to MGL 152 §8,"An insurer may terminate or modify payments at any time within such one hundred eighty day period without penalty if such change is based on the actual income of the employee or if it gives the employee and the division of administration at least seven days written notice of its intent to stop or modify payments and contest any claim filed. The notice shall specify the grounds and factual basis for stopping or modifying payment of benefits and the insurer's intention to contest any issue and shall state that in order to secure additional benefits the employee shall file a claim with the department and insurer within any time limits provided by this chapter."

requirements. A discontinuance or modification of benefits may take place no sooner than 60 days following referral to the division of dispute resolution.

Dispute Resolution Process

Requests for adjudication may be filed by either an employee seeking benefits, or an insurer seeking a modification or discontinuance of benefits following the payment without prejudice period. The claim can be resolved at any point during the DIA's three step dispute resolution period either by voluntary means (which may include a lump sum settlement) or by the decision of an administrative judge or administrative law judge.

At any point in the process, conciliators and administrative judges may review and approve any lump sum settlements negotiated. More commonly, however, settlements are approved at a lump sum conference conducted by an administrative law judge[4] after a determination the lump sum is in the employee's best interest.

Dispute resolution begins at **conciliation**, where a conciliator will attempt to resolve the dispute by informal means. Disputes should go to conciliation within 15 days of receipt of the case from the division of administration.

Disputes not resolved at conciliation are then referred to a **conference** where it is assigned to an administrative judge who must retain the case throughout the process if possible. The insurer will pay an appeal fee of 65% of the state average weekly wage (SAWW), or 130% of the SAWW if the insurer fails to appear at conciliation. The statute requires the conference to take place within 28 days of the receipt of the case by the division of dispute resolution. The purpose of the conference is to compile the evidence and to identify the issues in dispute. The administrative judge may require injury and hospital records as well as signed statements from the employee and any witnesses. The administrative judge is required to make a decision within seven days of the conclusion of the conference. This order may be appealed to a hearing within 14 days (which, by statute, is to take place 28 days after the appeal is received).

At the **hearing**, the administrative judge reviews the dispute according to oral and written documentation. The procedure at a hearing is formal and a verbatim transcript of the proceedings is recorded. Witnesses are examined and cross-examined according to modified rules of evidence. A decision is required within 28 days

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[4] An administrative judge (AJ) presides over conferences and hearings. The administrative law judges (ALJ) preside over the lump sum conferences and appeals of hearings decisions at the reviewing board. The ALJs are required to have a law background whereas it is only recommended for an AJ.

of the conclusion of the hearing. The administrative judge may grant a continuance for reasons beyond the control of any party.

Either party may appeal the hearing decision within 30 days. This time limit may be extended up to one year for reasonable cause. A fee of 30% of the state average weekly wage must accompany the appeal. The claim will then proceed to the reviewing board where a panel of administrative law judges will hear the case.

At the **reviewing board,** a panel of three administrative law judges will review the evidence presented at the hearing and may ask for oral arguments from both sides. They can reverse the administrative judge's decision only if they determine that the decision was beyond the scope of authority, arbitrary or capricious, or contrary to law. The panel is not a fact finding body, although it may recommit a case back to an administrative judge for further findings of fact.

All cases from the dispute resolution process may be enforced by the Superior Court of the Commonwealth. Cases may also be appealed to the Appeals Court or the Supreme Judicial Court. The cost of appeals are reimbursed to the claimant (in addition to the award of the judgement) if the claimant prevails.

Alternative Dispute Resolution Measures:

Arbitration

At any time prior to five days before a conference, the case may be referred to an independent arbitrator. The arbitrator must make a decision whether to vacate or modify the compensation pursuant to §12 and §13 of chapter 251. The parties involved may agree to bring the matter before an independent mediator at any stage of the proceeding. Mediation shall in no way disrupt the dispute resolution process and any party may proceed with the process at the DIA if they decide to do so.

Collective bargaining

An employer and a recognized representative of its employees may engage in collective bargaining to establish certain binding obligations and procedures related to workers' compensation. Agreements are limited to the following topics: supplemental benefits under §34, 34A, 35, 36; alternative dispute resolution (arbitration, mediation, conciliation); limited list of medical providers; limited list of impartial physicians; modified light duty return to work program; adoption of 24 hour coverage plan; establishing safety committees and safety procedures; establishing vocational rehabilitation or retraining programs.

Summary of Benefits under Chapter 152

An employee who is injured during the course of employment, or suffers from work related mental or emotional disabilities, as well as occupational diseases, is eligible for workers' compensation benefits. The largest expense for benefits is the weekly indemnity payments which provide compensation for lost income during the period the employee cannot work. Indemnity payments vary, depending on the average weekly wage of the employee (AWW) and the degree of incapacitation.

In addition to direct indemnity payments, the insurer is required to furnish the worker with adequate and reasonable medical and hospital services, and medicines if needed. The insurer must also pay for vocational rehabilitation services if the employee is determined to be suitable by the DIA.

The following are the various forms of indemnity and supplemental benefits employees may receive, depending on their average weekly wage and their degree of disability:

Temporary Total Disability (§34): Compensation will be **60% of the employee's average weekly wage (AWW)** before injury while remaining above the minimum and below the maximum payments that are set for each form of compensation. The maximum weekly compensation rate is 100% of the state average weekly wage (SAWW), while the minimum is 20% of the SAWW. The limit for temporary benefits is **156 weeks.**

Partial Disability (§35): Compensation is **60% of the difference** between the employee's AWW before the injury and the weekly wage earning capacity after the injury. This amount cannot exceed 75% of temporary benefits under §34 if they were to receive those benefits. The maximum benefits period is **260 weeks** for partial disability, but may be extended to 520 weeks.

Permanent and Total Incapacity (§34A): Payments will equal **2/3 of AWW** before the injury following temporary (§34) and partial (§35) payments. The payments must be adjusted each year for cost of living allowances (COLA benefits).

Death Benefits for Dependents (§31): The widow or widower that remains unmarried shall receive 2/3 of the worker's AWW, but not more than the state's AWW or less than $110 per week. They shall also receive $6 per week for each child, as is the case for the other forms of compensation (this is not to exceed $150 in addition to normal compensation). There are also benefits for other dependents. The limit on benefits paid to all dependents cannot exceed 250 times the state AWW plus any cost of living increases (COLA). Children under 18 may, however, continue to receive payments even if the maximum has been reached.

Burial expenses may not exceed $4000.

Supplemental (§36): There are also additional benefits to compensate for injuries such as loss of an eye, hearing, amputation, and scars on the face, neck and hands. Each payment is calculated according to the loss. For example, the loss of use of a foot would be compensated at the rate of 29 times the state AWW.

Subsequent Injury (§35B): An employee who has been receiving compensation, has returned to work for two months or more, and is subsequently re- injured, will receive compensation at the rate in effect at the time of the new injury (unless the old injury was paid in lump sum). If the old injury was settled with a lump sum, then the employee will be compensated only if the new claim can be determined to be a new injury.

Section 1: Department of Industrial Accidents

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Office of Claims Administration

The office of claims administration consists of the processing unit and the data entry unit (OCA) (where all DIA forms are reviewed and entered into the database), the record room (where all case records are filed and stored), and the first report compliance office (where fines are levied and collected). It is the responsibility of the Deputy Director of Claims Administration to answer all subpoena requests, certified mail and file copy requests. During FY'93, the office was also responsible for running the mail room.

Claims administration is responsible for reviewing, maintaining, and recording the massive number of forms DIA receives on a daily basis, and ensuring that claims forms are processed in a timely and accurate fashion. Quality control is the office's highest priority and is essential to ensure that each case is recorded in a systematic and uniform way.

At the close of FY'93, a backlog existed in the entry of some forms not pertaining to a scheduled appearance before the division of dispute resolution. Moreover, the record room was filled beyond capacity with a volume of material and case files breaching the walls of the room. Older case files have been reported missing as a result of this overcrowding.

Claims Processing Unit

The processing unit must open, sort, and date stamp all mail that comes into OCA. It then must review each form for accuracy, and return incomplete forms to the sender. Forms are then forwarded to data entry operators who enter each form into the Diameter database.

Data Entry Unit

The data entry unit enters all of the forms and transactions into DIA's Diameter database. As data entry personnel update the computerized records with new forms, they review the entire record of each claim being updated, both to ensure that duplicate forms are not contained in the database and that all necessary forms have been entered properly. While quality control measures slow down the entry of cases into the system, they are necessary for accurate and complete record keeping. Forms are entered in order of priority, with the need for scheduling at dispute resolution as the main criteria. All conciliations are scheduled upon entry of a claim through the Diameter case tracking system.

There is a backlog in the processing of some forms in the data entry unit. Because the volume of forms received on a daily basis is so high, forms are grouped and prioritized. Any form

that involves a meeting before the division of dispute resolution, such as a claim requiring a conciliation, must be entered within 24 hours.

Other forms, however, are entered as time allows. Many insurer forms and First Reports of Injury are relegated a lower priority and their entry has been delayed by as much as five months. At the close of fiscal year 1993, the OCA Weekly Report for week ending July 2, 1993 indicated the following delays: last date entered for First Report, April 6; Insurance Pay forms, February 17; Insurance Deny forms, February 8; and five other insurance forms with last date of entry in March.

According to the office, delays are unavoidable because of the volume of forms and the detail of information collected for each case. To help alleviate this problem, one temporary worker from the Department of Revenue (DOR) has been loaned to OCA for the exclusive purpose of processing first reports of injury. Because DOR relies on data on first reports filed to enable them to pursue "deadbeat dads" in delinquency payments for child support, this relationship constitutes a free exchange.

Delays are not new to the data entry unit, and the administration is now seeking ways to confront this problem. Much of the process could be automated with scanners and other time saving devices that will modernize the department and allow the capacity to increase. Plans to automate the processing unit and modernize the record room may be realized in the near future.

First Report Compliance Office

All employers are required to file a First Report of Injury (Form 101) within seven days of receiving notice that an employee has been disabled for at least five days. The first report compliance office issues fines to employers who do not file the First Report form in the allotted time.

Fines accrue at $100 per day, and rise to $200 per day when collection goes into demand status. Employers may appeal fines to the first report compliance officer for preliminary review. If the fine is sustained, then an appeal may be heard by the director of administration.

In fiscal year 1993, $85,707 was collected in fines out of 1,496 bills sent.

In FY'93, as in previous years, the majority of fines were contested. Out of 439 first report appeals, 151 fines were waived. Employers pursued the appeal process to the hearing stage in 69 cases, which resulted in 22 fines waived.

According to the office, many employers are unaware of their responsibility to file the First Report with DIA because their insurance company handles most aspects of an employee's injury

claim. Other employers simply ignore the filing of first reports of injury even though they know it is their responsibility.

The office also records on a separate database cases that are suspected of being fraudulent. Information is obtained from many sources (including the public, a DIA judge or employee), and the database is shared with the Insurance Fraud Bureau and the Attorney General's Office.

In addition, the first report compliance officer is responsible for recording in the database third party liens from the Department of Public Welfare, as well as notices of bankruptcy.

Record Room

The record room, located in DIA's Boston office, is responsible for filing, maintaining, storing, retrieving and keeping track of all files pertaining to a case in the dispute resolution process. Included in case files are copies of all briefs, settlement offers, medical records, and supporting documents that accumulate during the dispute resolution process. Couriers transfer files to and from the regional offices and Boston twice a week.

Records are kept in DIA's Boston office for about five years, depending on space. After this time they are brought to the State Record Center in Dorchester where they are kept for 80 years. Employees continuously box the files in preparation for storage at the State Center in an effort to create space in the record room itself.

An overall lack of space and storage facilities impedes the organization of the record room. Many of the files become very large as a hard copy of every document must be saved in them. Larger case files called "red ropes" (because of the accordion folders they are stored in) are retained in a different section of the room because they do not fit in their original place. File folders become tattered and worn down as they are stored in cabinets not suited to handle so many folders. This makes it more difficult and time consuming for their filing and retrieval.

Because conciliators, judges, and vocational rehabilitation officers frequently request case files, they must be easy to retrieve. It is essential that every document be accounted for, and with the current facilities, this is a slow process.

OCA is currently attempting to modernize the record room, along with the automation of data processing. They have put out proposals to modernize its storage and filing facilities similar to that of many hospitals. This would create greater capacity and efficiency for the storage of case files.

DIA Diameter Reports

The Diameter system at the DIA is the central database for all information regarding workers' compensations claims. The database tracks each case from the initial First Report of Injury to the conclusion of the case (conference order, hearing decision, withdrawal, or settlement). The database contains information regarding the claimant, insurer, as well as scheduled dates for dispute resolution and any dispositions issued.

Many of the statistics used in the annual report are from reports that originate from this database. The data processing unit handles all requests for information and runs the reports from the computer.

Reports for dispute resolution (conciliation, conference, and hearing) can be run by either *scheduled date* or *disposition date*. The difference between the two is that data pertaining to cases may be entered either according to the date a case was scheduled for a particular meeting, or according to the date of disposition. A disposition refers to the end result of the meeting whether the claim is withdrawn, resolved, rescheduled or referred for that stage of dispute resolution.

All the reports collected for the annual report are by *scheduled date* to remain consistent with previous annual reports and to make the data collection as consistent as possible for each department. The dispute resolution department now uses *disposition dates* for their internal analysis, while the conciliation department uses *scheduled date*.

Conciliation reports note whether cases originate from the employee or the insurer. According to these reports, an employee request for compensation is referred to as a *claim*, whereas an insurer's request for a discontinuance or modification is referred to as *complaint*.

For the purpose of the annual report, use of the term "claim" refers to a request for adjudication originating from either the employee or the insurer. We do not distinguish between the employee (claim) and the insurer (complaint).

Conciliation statistics are also available in two reports that differentiate between "finished" and "unfinished" cases. DIA report 17 only includes data for finished cases while Report 16 has two categories of "unfinished" cases, one for "no disposition entered" which may capture the lag in data entry or other minor discrepancies. The other "unfinished" category is to allow for reschedules.

The term "finished cases" is not used on conference and hearing reports because a judge may reschedule a case off the

computer system without creating a disposition for that action. Furthermore, conference and hearing dispositions do not necessarily indicate the case is completed, it just means it has finished one process.

Conciliation

The main objective of the conciliation process is to remove from the dispute resolution system those cases that can be resolved on an amicable basis. Conciliation requires that cases have the necessary documentation to substantiate the dispute and a conciliator is empowered to withdraw or reschedule a case until adequate documentation is presented. About half of the cases that proceed through conciliation are "resolved" as a result of this process. Such resolved cases take on a broad range of dispositions[5] including withdrawals, lump sums, and conciliated. The other half of the cases at conciliation are referred to a conference.

The Conciliation Process

Conciliations are scheduled automatically by computer at the office of claims administration. They usually take place less than 15 days after the OCA receives a request for modification/ discontinuance by the insurer or a claim for benefits by an employee. The insurer and employee are required to attend the conciliation, although the employer and other third parties involved (such as a doctor) may choose to attend as well.

In the Boston office, conciliations are scheduled for a certain day and time, but the case is directed to the first available conciliator. This is more efficient than the previous system of scheduling each conciliator with a set number of cases per day because it is difficult to determine how long a particular conciliation will last. Each conciliation may range from five minutes to almost an hour, making it difficult to accurately schedule a given number of cases per conciliator. In the regional offices, individual conciliators are scheduled for particular meetings every day.

Due to this scheduling format in Boston, conciliators do not have an opportunity to review the dispute beforehand. They must quickly review the information before the discussion begins, making it more difficult to review all the background information. This may impede the understanding of the case, but in most circumstances it is not necessary that the conciliator know the details of each case. Each case is distinct in its content, but it must be reviewed in a consistent manner. The conciliators ask for documentation to substantiate the dispute and they initiate

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[5] A *disposition* refers to the conclusion or end result of a particular process or meeting. The disposition of a case does not necessarily mean it is completed entirely, but reflects the conclusion of a particular meeting whether the case is "referred" or "conciliated."

discussion, but they do not analyze the case. Conciliators may reschedule cases and retain them to facilitate the process.

Conciliations are held five days a week until 2:15 in the afternoon. The rest of the day is devoted to writing reports, checking lump sum settlements for accuracy, and writing referrals to the judges. The background of the conciliators vary from attorneys to employees promoted from other departments of the DIA. Their training consists of a two week apprenticeship period. Each conciliator develops their own style, but they must all know in detail the workers' compensation statute and regulations.

In fiscal year 1993, the number of cases scheduled for conciliation drastically decreased. The results of the conciliation process, however, were consistent with other years.

The following graphs represent the changes occurring at conciliation:

exhibit 1, volume of cases at conciliation
exhibit 2, conciliation dispositions FY'93
exhibit 3, conciliation dispositions FY'92
exhibit 4, conciliation dispositions FY'91

Decrease in Volume at Conciliation

The total number of cases[6] scheduled for conciliation dropped by almost 18%, from 38,249 in FY'92 to 31,484 in FY'93.[7] The number of cases at conciliation is indicative of the total volume of disputed claims entering the system because nearly every case to be adjudicated will first go through conciliation. Over the past two fiscal years, the volume of cases has been declining after marked increases in previous years.

Cases Referred to Conference

Despite changes in overall volume, the disposition of conciliated cases has remained remarkably consistent for the last three fiscal years, varying only by a few percentage points for each category. Cases at conciliation may be assorted into two major categories: referred to conference, or resolved. In FY'93, 54% of the 31,484 cases at conciliation were referred to conference, the next step of dispute resolution.

Not all of these cases passed through the required conciliation, however. Three percent of cases scheduled for

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[6] Total cases refer to all "finished" cases. These figures do not include cases scheduled for conciliation that are rescheduled or cases that do not have a disposition.

[7] DIA report 17

conciliation were referred to conference without conciliation. This can only occur when the respondent (or party that is not putting forth the case) does not show up for the conciliation. Therefore, 51% of scheduled cases at conciliation were actively referred to a conference following a conciliation, and a total of 54% of cases scheduled for conciliation were referred to conference.

Resolved Cases

The remaining 46% of cases at conciliation were not referred to conference, and were thus considered to be resolved.

There is a wide range of dispositions that fall into the resolved category reflecting the broad goals of the conciliation process. Cases may be withdrawn or rescheduled when information is deficient or the procedure is not followed properly, thereby removing incomplete cases from proceeding to conference. Most importantly, however, conciliation provides the employee and the insurer with the opportunity to resolve the dispute by their own means in a congenial forum directed by the conciliator.

Resolved Cases- withdrawn

Withdrawn cases were the most substantial percentage of cases considered to be resolved. Of all the cases not referred to conference, 45% were withdrawn by either the conciliator or the moving party. (Withdrawn cases constituted 20.6% of all the cases scheduled for conciliation).[8]

The following is a breakdown of withdrawn cases at conciliation for FY'93:

breakdown of cases withdrawn -	cases	percentage of all cases[9]	percentage of resolved cases
withdrawn at conciliation	2,959	9.4%	20%
withdrawn prior to concil.	1,705	5.4%	12%
withdrawn by department for no shows	1,814	5.8%	13%
total withdrawn	6,478	20.6%	45%

[8] This is a percentage of all cases excluding those that are rescheduled or those cases that do not have a disposition. When these two categories of cases are excluded, the total amount of cases is referred to as "finished cases."

[9] This is a percentage of all finished cases. Data from DIA report 17.

"Withdrawn at conciliation" -- The power to withdraw a case is one of the major tools that the conciliator may use to make sure the employee or insurer has the necessary documentation to substantiate the case. According to §10 of chapter 152, "the assigned conciliator shall withdraw without prejudice the claim or complaint of any party that fails to cooperate or produce the requested material." The moving party may appeal the conciliator's decision to withdraw the case to the Senior Judge.

"Withdrawn prior to conciliation" -- The conciliator may withdraw a case at the conciliation or the moving party (the party bringing forth the case) may withdraw their dispute at any time.

Resolved Cases - lump sum settlements

Conciliators may "approve as complete" lump sum settlements or make a referral to a lump sum conference. This method of resolving cases occurred less frequently than cases withdrawn, but it was still significant. Lump sums at the conciliation level are broken down into the following categories:

breakdown of lump sums -	cases	percentage of all cases[10]	percentage of resolved cases
lump sum reviewed-approved as complete	379	1.2%	2.5%
directed to lump sum conference:			
- referred to lump sum	735	2.3%	5%
- lump sum request received	301	1.0%	2%
total lump sums	1,415	4.5%	10%

"Lump sum reviewed - approved as complete" -- Pursuant to §48 of chapter 152, conciliators have the power to "review and approve as complete" lump sums settlements when both parties arrive at conciliation with the settlement already negotiated. This aspect of the 1991 reform act has increased the authority of conciliators as they were previously required to refer every lump sum request to a judge, even when the settlement was already complete. In practice, however, this authority has been under utilized. Conciliators approved only 379 cases for lump sum settlements in the whole fiscal year.

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[10] This is a percentage of all finished cases (does not include reschedules). Data from DIA report 17.

"Referred to lump sum" -- Most lump sums are settled at a lump sum conference conducted by an administrative law judge. Conciliators and administrative judges often refer cases to lump sum conferences where an administrative law judge will determine if it is in the best interest of the employee to settle. Many lawyers prefer to have a case referred to a lump sum conference rather than have a conciliator approve a settlement. This insulates them from the risk of a malpractice suit if the employee's settlement money runs out. At the lump sum conference the ALJ will render a judgement by either approving or determining the settlement amount, whereas a conciliator may only approve an amount negotiated by the attorney.

"Lump sum request received" -- A lump sum conference may also be requested without attending a conciliation or any part of the dispute resolution process. The parties would fill out a form to request this event and the disposition would then be recorded as "lump sum request received."

Resolved cases- conciliated

Cases may also be "conciliated" in two ways. 31% of the resolved cases (or 14.6% of all cases) were "conciliated - adjusted" meaning both parties have agreed to initiate, modify, or terminate the compensation.

Cases may also be "conciliated - pay without prejudice" (2% of resolved cases) meaning the pay without prejudice period has been extended up to one year by the conciliator. The insurer agrees to benefits without accepting liability during this period and has the right to discontinue the compensation without prejudice.

Cases Rescheduled

Conciliators also have the power to reschedule a case. The purpose of rescheduling is basically to allow for a continuation of the case to a time when the proper information and documents can be submitted. The conciliators have no power to render a legal judgement, but they may check medical documentation and other essential sources of information to facilitate the resolution of the case. Out of all the cases at conciliation, 28% were rescheduled in FY'93, as compared to 22.1% in FY'92 and 29% in FY'91.[11]

While conciliation does not resolve all rescheduled cases, the process does serve to clarify the issues. Conciliation assures that the case is complete in terms of necessary documentation before it is referred to conference. Proper documentation and the conciliator's recommendations should accompany any referral to a judge with a "paper trail" that will provide the administrative judge with a good background on the case.

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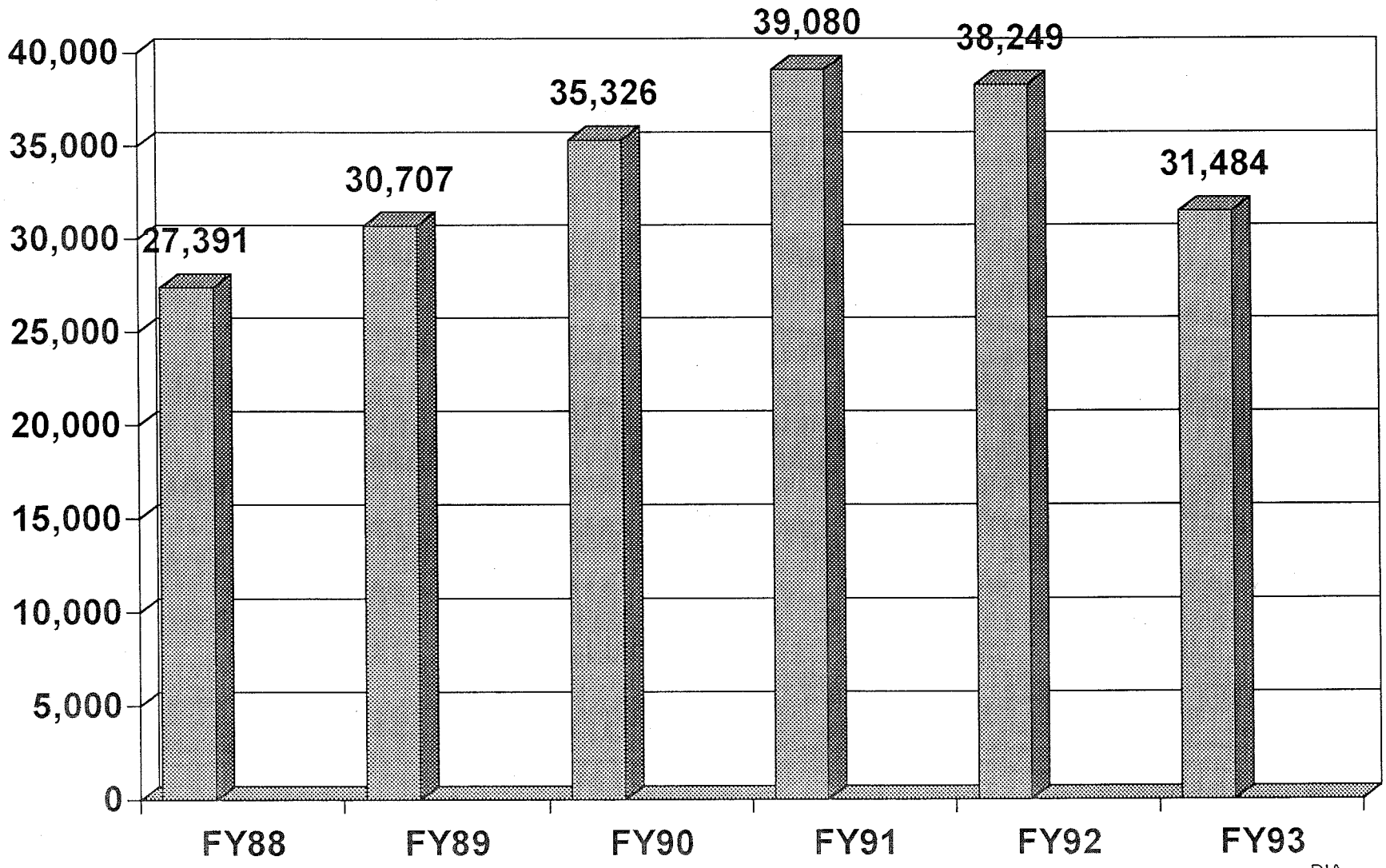
[11] DIA report 16

exhibit 1

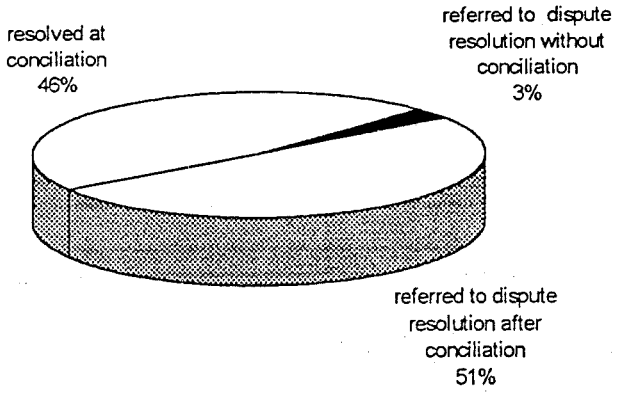
volume of cases at conciliation



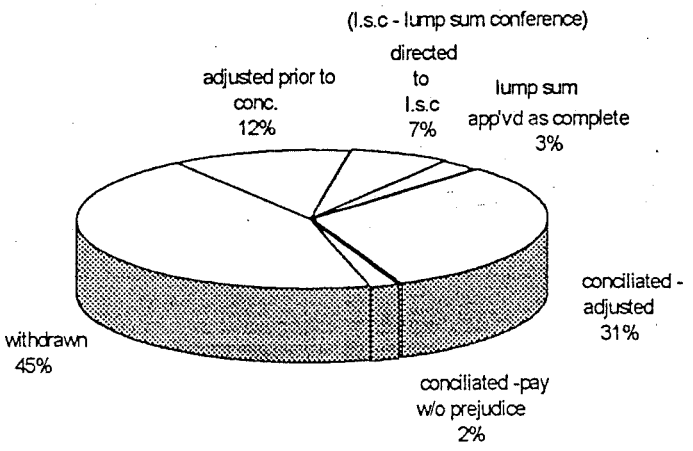
source: DIA report 17

exhibit 2

FY93: Disposition of cases at conciliation



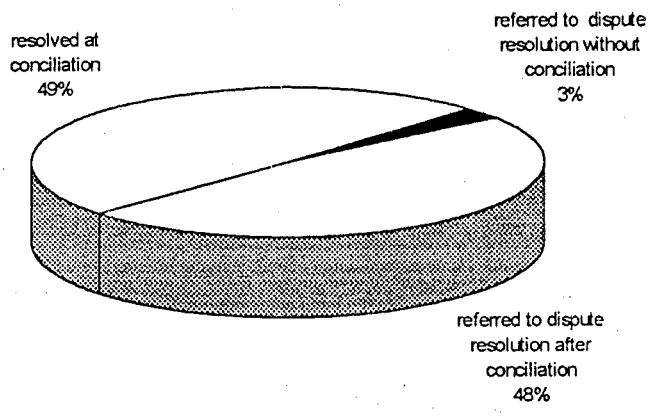
FY93: Cases resolved at conciliation



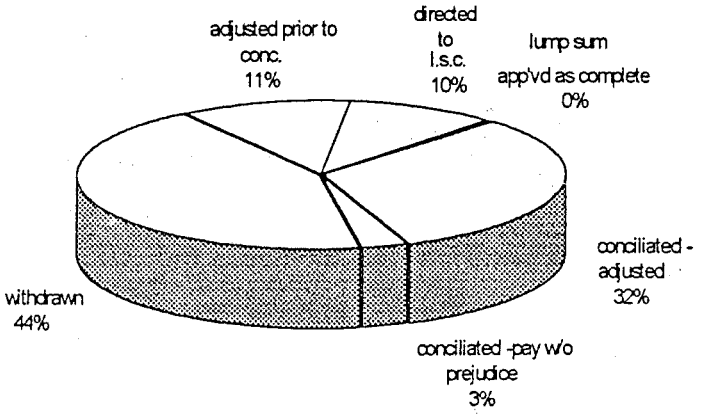
source: DIA report 17

exhibit 3

FY92: Disposition of cases at conciliation



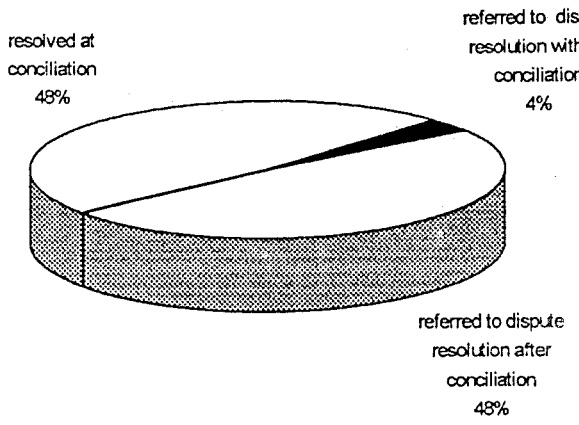
FY92: Cases resolved at conciliation



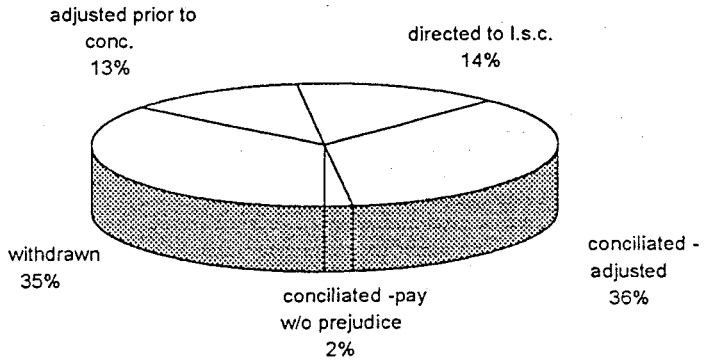
source: DIA report 17

exhibit 4

FY91: Disposition of cases at conciliation



FY91: Cases resolved at conciliation



source: DIA report 17

Conference

Each case referred to a conference is assigned to one of the 32 administrative judges who should retain the case throughout the entire process if possible. The statute requires the conference to take place within 28 days of the receipt of the case, although there is little relation between this statutory time allowance and the actual system.

The statute states that a conference is intended to compile the evidence and to identify the issues in dispute. The administrative judge may require injury and hospital records as well as signed statements from the employee and witnesses. The administrative judge is required to issue an order within seven days of the conclusion of the conference. This order may be appealed to a hearing within 14 days.

In fiscal year 1993, the number of conferences held dramatically increased. The DIA made a great effort to reduce the backlog and the amount of time to appear before a judge. The results were impressive with an 81% reduction in the conference queue, and a drop of 84.1 days to see a judge after conciliation.

The following graphs represent changes occurring at conference:

exhibit 5, waiting time between each step of dispute resolution
exhibit 6, conference queue -- backlog
exhibit 7, conference dispositions FY'93
exhibit 8, conference dispositions FY'92

Administrative Judges

During FY'92, the DIA had an inadequate number of judges. The number of judges available to hear conferences reached a low of 16 when two judges had to take a leave of absence because of illness, and an early retirement bill induced several judges to retire. At the outset of fiscal year 1993, however, the number of administrative judges that were on-line and available to hear conferences doubled from 16 to 32. This allowed a unique opportunity to increase the number of conferences and reduce the backlog of cases awaiting a conference.

Judges that have an inordinate number of conferences or hearings to complete may be taken "off- line" and not assigned new cases in order to complete their outstanding case load. This is one method of sanctioning judges, while also providing them an opportunity to catch up on their personal backlog of cases. At the same time, however, a judge that is taken off- line is no longer available to hear new cases. This becomes problematic when there is a large number of cases awaiting a conference or hearing.

In FY'93, two judges were taken off- line, thereby reducing the number of available judges from 32 to 30 for much of the year.

The scheduling cycle of the judges in FY'93 changed a few times throughout the year to meet the needs of the new judges and to deal with the backlog of cases. In general, the DIA's administrative judges are assigned cases for both conference and hearings according to a 13 week cycle.

In FY'93, the first three weeks of the cycle were allotted for conferences (13 conferences a day, four days a week). The fourth week was a continued week for unfinished conferences and the fifth week was a writing week. Weeks six through eleven consisted of both conferences and hearings (three hearings a day, five days a week; two conferences a day). The last two weeks were continued and writing weeks. There were 3.8 cycles throughout the fiscal year.

Conference Backlog and Case Timeframe

The capacity of judges to hold conferences virtually doubled with the increase in available judges from 16 to 32. This translated into an opportunity to reduce the conference backlog. In FY'93, the number of cases awaiting scheduling for a conference substantially decreased.

This backlog (or conference queue) was reduced by 81%, from a high of 8,421 at the beginning of FY'93 to 1,673 at the close of the fiscal year (June 30, 1993). The backlog had reached a high of almost 10,000 cases in 1991. The reduction of the backlog was a priority for the department as its enormity had produced significant delays in the resolution of every case.

The optimal level of the conference queue should be around 1,500 cases given the number of judges on line. Anything above that amount could produce another backlog and delays in reaching a judge. A queue much less than 1,500 would not generate enough work for the 32 judges.[12]

The reduction in the conference backlog produced a corresponding reduction in the conciliation to conference timeframe. In FY'92, the average amount of time for a dispute to reach conference from conciliation was 223.1 days. With the

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[12] A queue of 1,500 would generate approximately 47 conferences for each of the 32 judges. In the 13 week cycle, every judge can hear approximately 156 conferences (13 conferences a day x 4 days a week x 3 weeks = 156). Therefore, in one week every judge can handle at least 12 conferences (156 conference/ 13 weeks) and it would take no more than four weeks to handle the queue.

intensive efforts to reduce the queue, the timeframe dropped to an average of 139 days in FY'93.[13] [14]

Increase in Volume of Conferences

The department reduced the conference backlog by increasing the number of judges, thereby scheduling more conferences. In FY'93, 25,446 claims were scheduled for conferences, compared to 19,708 in FY'92 and 17,567 in FY'91.[15] This increase of 22.5% over last year represents the department's success in reducing the backlog by scheduling more conferences.[16] In fact, as seen by conciliation statistics, the actual number of claims filed decreased by 18%. Therefore, cases in the queue accounted for almost 41% of the conferences scheduled.[17]

Conference Dispositions

Over time, administrative judges have been remarkably consistent in issuing each type of conference disposition at a similar rate. Over the last three fiscal years, the results from a conference have remained within one percentage point.

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[13] Due to the continuing nature of a claim, the reduction of the queue will not be reflected in the timeframe statistics until some time after the actual reduction. It must also be noted that the overall timeframe for a claim to reach a decision at hearing has only slightly decreased because of the increasing time it takes for a claim to be resolved after a conference.

[14] DIA report 491 : Case Timeframe statistics - total days to event or disposition (mean)

[15] DIA report 45A - Conference statistics, for scheduled dates. The total does not include reschedules or those claims that do not have a disposition. See section on *Diameter reports* for more on terminology.

[16] In FY'93 fewer disputes were referred to conciliation, and the percent of cases referred from conciliation remained roughly equal to previous years. Hence, the increase of 22.5% represents the DIA's effort to reduce the backlog rather than an increase in the volume of claims entering the dispute resolution system.

[17] The reduction in volume of cases scheduled for conciliation of 18% when added to the increase in scheduled conferences of 22.5%, equals the 41% of conferences scheduled.

The following are conference dispositions for all cases in FY'93:

disposition at conference	cases	percentage
withdrawn	2,359	9%
lump sum pursued	5,639	22%
settlement approved by judge	2,310	
directed to lump sum conf.	3,329	
voluntarily adjusted	2,326	9%
order issued	15,115	60%
other	7	0%
total	25,446	100%

When cases are withdrawn, directed to lump sum conference, or voluntarily adjusted, the claim may never actually reach the conference as it could be settled before review by the administrative judge. Cases may be withdrawn at or before the conference either by the moving party or the department although the case was scheduled for a conference.

Lump sum settlements may be obtained in two ways. The administrative judge could approve a lump sum settlement at the conference just as it is done at a lump sum conference. This occurred in 2,310 cases in FY'93. The more common approach was to direct the claim to a separate lump sum conference where an administrative law judge would decide if it is in the best interest of the involved parties to settle. This occurred in 3,329 cases.[18]

A judge will issue an order for the majority of disputes at a conference. In FY'93, 60% of all cases had an "order issued" to modify, terminate, or begin indemnity benefits or health care.

While the conference order could conclude the case, a significant portion are appealed to hearing every year. This appeal rate was lower in FY'93 than previous years at 73.6% as compared to 82.3% in FY'92 and 81.1% in FY'91.[19]

Related topics:

- Lump Sum Settlements .... p. 44
- Judicial Appointments .... p. 50

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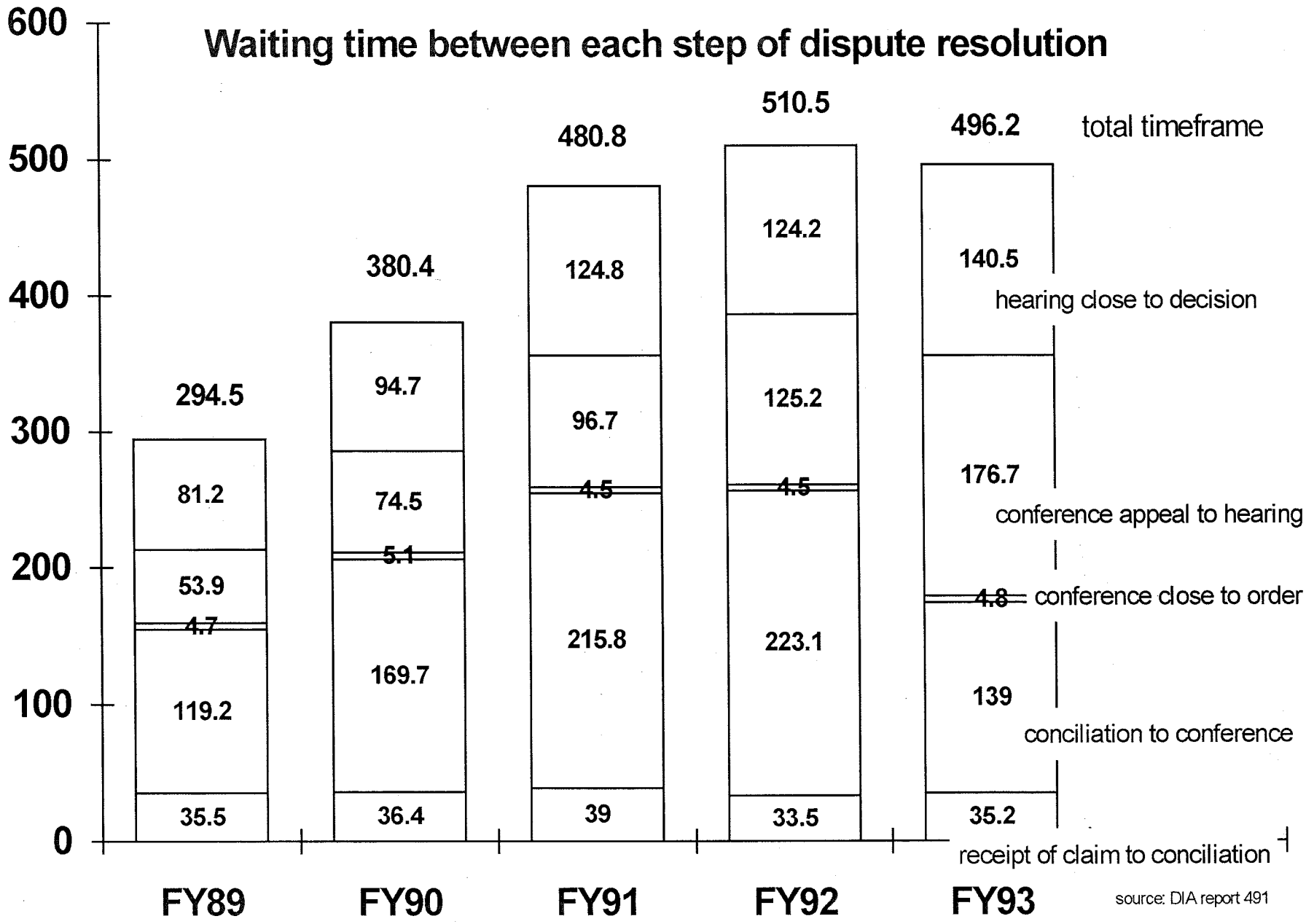
[18] The 3,329 cases include two conference dispositions: "Referred to lump sum" - 2,880 (referred by the AJ at conference) + "lump sum request received" - 449 (the parties submit this request).

[19] DIA report 319A

exhibit 5


days
600
500
400
300
200
100
0
Waiting time between each step of dispute resolution
294.5
380.4
480.8
510.5
496.2
total timeframe
81.2
53.9
4.7
119.2
35.5
94.7
74.5
5.1
169.7
36.4
124.8
96.7
4.5
215.8
39
124.2
125.2
4.5
223.1
33.5
140.5
hearing close to decision
176.7
conference appeal to hearing
4.8
conference close to order
139
conciliation to conference
35.2
receipt of claim to conciliation
FY89
FY90
FY91
FY92
FY93
source: DIA report 491

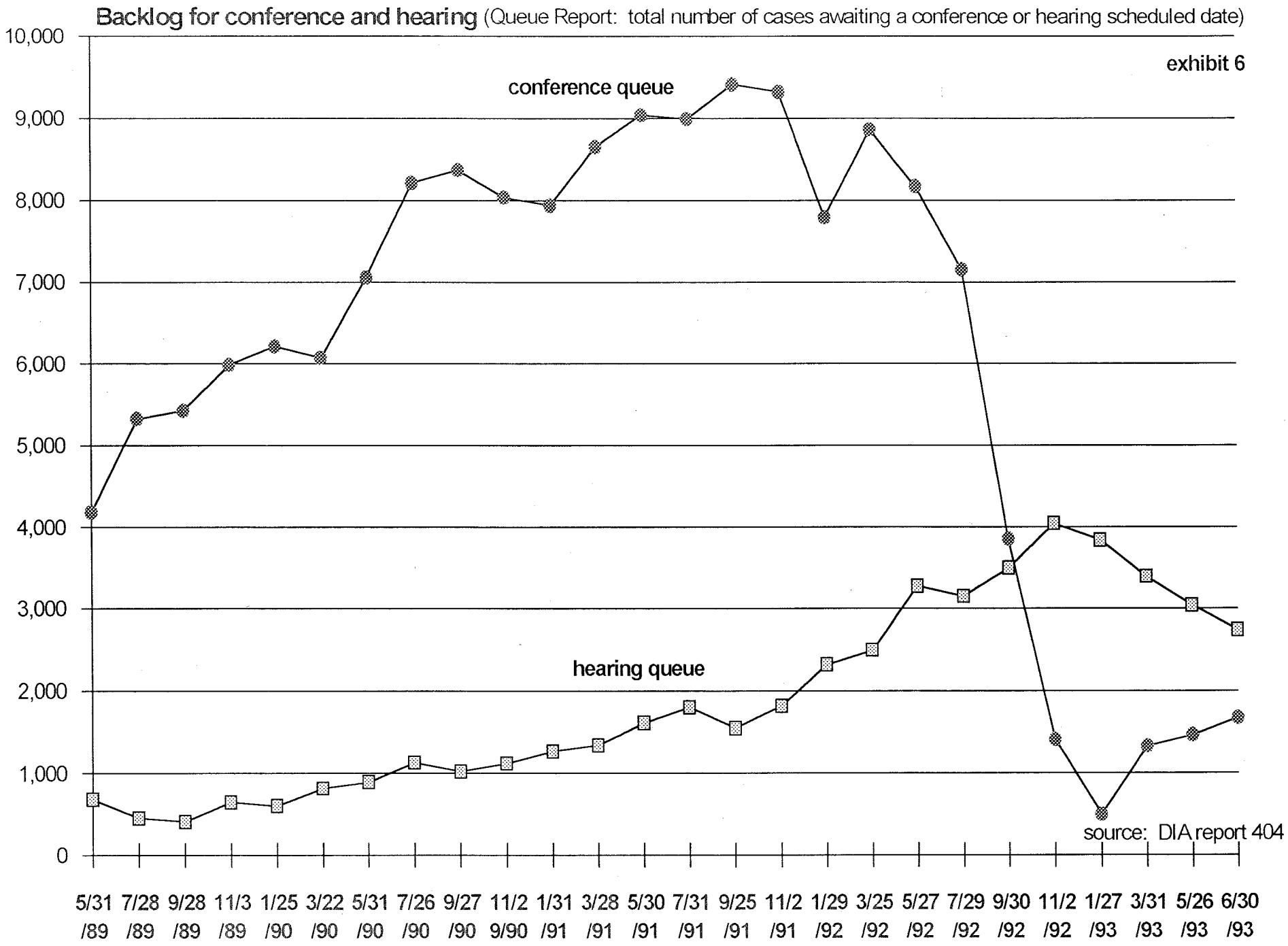
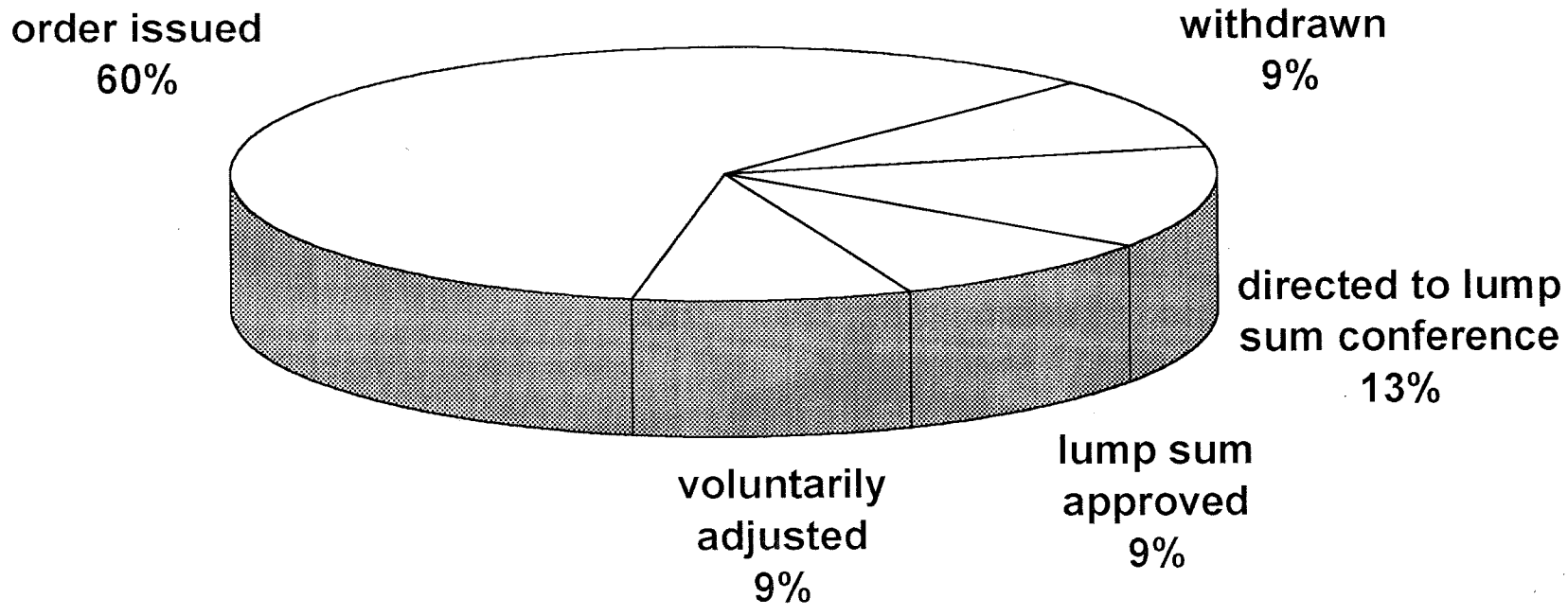

Backlog for conference and hearing (Queue Report: total number of cases awaiting a conference or hearing scheduled date)
exhibit 6
conference queue
hearing queue
source: DIA report 404
10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
5/31 /89
7/28 /89
9/28 /89
11/3 /89
1/25 /90
3/22 /90
5/31 /90
7/26 /90
9/27 /90
11/2 9/90
1/31 /91
3/28 /91
5/30 /91
7/31 /91
9/25 /91
11/2 /91
1/29 /92
3/25 /92
5/27 /92
7/29 /92
9/30 /92
11/2 /92
1/27 /93
3/31 /93
5/26 /93
6/30 /93

exhibit 7

Fiscal Year 1993: Conference dispositions

note: 73.6% of the orders issued in FY93 were appealed

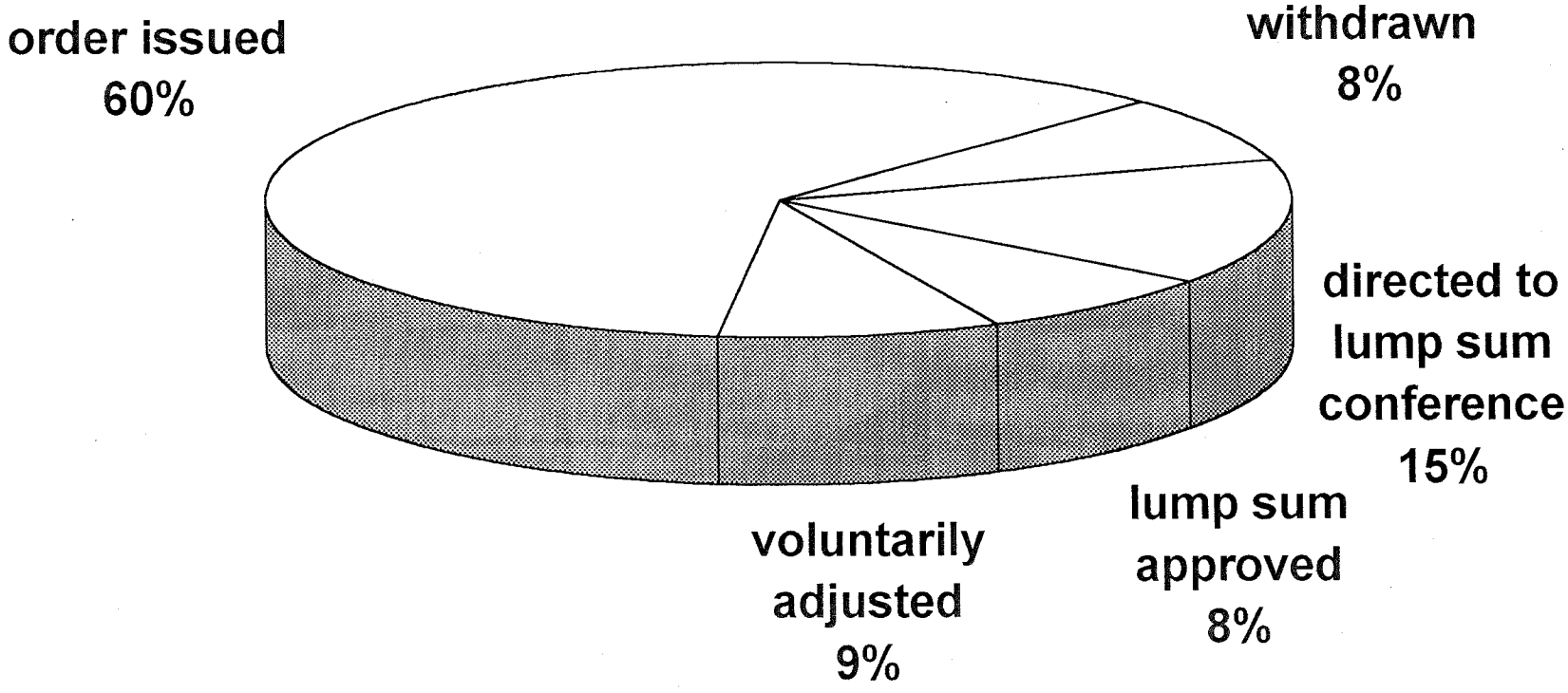


source: DIA report 45A

exhibit 8

Fiscal Year 1992: Conference dispositions

note: 82.3% of the orders issued in FY92 were appealed



source: DIA report 45A

Hearings

According to the workers' compensation statute, the administrative judge that presided at the conference will review the dispute at the hearing. The procedure is formal and a verbatim transcript of the proceedings is recorded. Written documents are presented and witnesses are examined and cross-examined according to modified rules of evidence. A decision should be issued within 28 days of the conclusion of the hearing. As in conference, the actual timeframe does not correspond to the statutory recommendations. The administrative judge may grant a continuance for reasons beyond the control of any party.

Any party may appeal the hearing decision within 30 days. This time limit may be extended up to one year for reasonable cause. A fee of 30% of the state average weekly wage must accompany the appeal. The claim will then be sent to the reviewing board.

The following graphs represent changes occurring at the hearing:

exhibit 5, waiting time between each step of dispute resolution
exhibit 6, hearing queue -- backlog
exhibit 9, hearing dispositions FY'93
exhibit 10, hearing dispositions FY'92

Administrative Judges

The 32 administrative judges and 13 week schedule are utilized for hearings as in conferences. In FY'93, weeks 6 through 11 of the 13 week cycle were devoted to hearings. Three hearings were held a day, five days a week for this five week period. The last two weeks of the cycle were allocated for continuations and writing.

The scheduling of hearings is more difficult than conferences because the hearing must be assigned to the judge who heard the case at conference. This is especially problematic since judges have different conference appeal rates. A judge with a high appeal rate will generate more hearings than a judge with a low rate of appeal. This can create difficulties in scheduling and hearing queues may thus arise for judges with high appeal rates.

Hearing Backlog and Case Timeframe

The reduction of the conference backlog in FY'93 resulted in some residual effects on the rate of hearings. The number of cases awaiting a scheduled date for hearing (or the queue) began increasing at the end of 1991 as the increase in conferences caused a subsequent increase in hearings. At the beginning of fiscal year 1993, the queue for hearings was 3,266, reaching a

high of 4,046 on November 25, 1993, before dropping to 2,746 at the end of the fiscal year.

It is difficult to compare the hearing queue with the conference queue because of differences in the two proceedings. Hearings must be scheduled with the same judge who presided at conference, whereas conferences are scheduled according to availability.

Nevertheless, an increasing hearing queue creates a longer timeframe for the case to be resolved. The average time from filing a conference appeal to the actual hearing rose to 176.7 days in FY'93 from 125.5 days in FY'92 and 96.7 days in FY'91. The average time to file a decision after the hearing was closed increased to 140.5 days from 124.2 in FY'92 and 124.8 in FY'91.[20] In total, in FY'93 it took 67.5 more days to reach a final decision following a conference than it did in FY'92 and 92 more days than in FY'91.

Waiting Time to Reach Hearing

In FY'93, the average waiting time to reach a hearing following a conference appeal significantly increased to six months.

This may be a temporary increase due to the large number of backlog cases making their way through the system. The timeframe between conference and hearing may diminish as these cases are heard and the volume of hearings stabilize.

At the same time, this six month period between conferences and hearings may be necessary and the timeframe may not decrease as the case load is stabilized. According to Senior Judge Jennings, a waiting period is beneficial in some circumstances. The same judge that presided over the conference will hold a hearing. If the hearing follows the conference too quickly, the judge will be apt to issue the same decision. Some time is needed for medical conditions and other facts to develop before the case warrants another look.

A six month period may also be necessary to give adequate time to complete the impartial process. Any case involving a dispute over medical reasons will require an impartial exam at the hearing. Enough time must be allowed to schedule the impartial physician and receive the report before the hearing takes place. Given current restraints on the availability of impartial

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[20] DIA report 491: Case Timeframe statistics - total days to event or disposition (mean). It must be noted that this report does not reflect how long the case was on schedule for the judge and shows the inactive dead time as well the time it was on schedule. It does not show the average scheduled time and therefore cannot be used to show the performance of the judges.

physicians, this can take up to six months, and if too little time is allowed a bifurcated hearing may be required (one hearing to address non medical issues and another hearing to review the impartial report).

Many of the parties involved, however, would like to see the hearing follow the conference as quickly as possible so that benefits can be determined and paid, rehabilitation can be pursued, settlements can be negotiated, and back to work arrangements can be made.

The parties see the hearing as a continuation of a preliminary conference and as chance to introduce facts and testimony that were unavailable at the conference, including an impartial exam. To them, this must happen as soon as possible.

While six months may be necessary for practical and administrative reasons, it collides with the expectancy of employees and insurers that they should receive the department's final judgement as soon as possible. If the DIA decides that six months is the optimal time period between conference and hearing, the parties involved must be made aware that this is not a temporary situation.

The statute addresses the issue of the timeframe between each step of the dispute resolution with "recommended" intervals. It states that a hearing should follow an appeal of a conference order within 28 days. This timeframe recommendation must be updated in light of the current situation so insurers and employees can know what to expect.

Increase in Volume of Hearings and Dispositions

The total number of hearings rose in FY'93 to 8,365, from 6,338 and 7,359 in the last two fiscal years. This reflects the increase in conferences scheduled of almost 6,000 (about half of which will continue to hearing).[21]

The disposition of hearings are remarkable in that "lump sums" consist of the majority of cases while "decision filed" are a minority, virtually the opposite of the situation at conference. Hearing dispositions for FY'93 are listed below:

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[21] In FY'93, 44% of all cases scheduled for conference continued to a hearing. [73.6% of the 15,115 conference orders were appealed, or 11,124. This number appealed is 44% of the 25,446 scheduled conferences.

Note: appealed conference orders for FY'93 will not show up for cases scheduled at hearing in FY'93 because of the time lag between the two.

dispositions at hearing	cases	percentage[22]
withdrawn	1,926	23%
lump sum pursued	4,308	52%
settlement approved by judge	2,509	
directed to lump sum conf.	1,799	
voluntarily adjusted	607	7%
decision filed	816	10%
schedule medical hearing	705	8%
total	8,362	100%

As in conference, lump sums may be either approved by the administrative judge at the hearing or referred to a lump sum conference that is conducted by an administrative law judge. In FY'93, 2,509 lump sum settlements were approved by the judge at hearing. The remaining 1,799 lump sums hearing dispositions were directed to a lump sum conference.[23]

While the administrative judge has the authority to approve lump sum settlements at the conferences or hearing, they often refer cases to a lump sum conference where an administrative law judge will decide whether or not to approve settlements. The procedure to approve settlements is the same at both conference, hearing, and lump sum conferences. Judges refer cases to lump sum conferences at the request of the parties or if the judge feels they have prejudice in the case because of information they have already heard.

The ability to create medical hearings was authorized by the reform act of 1991 and must occur when any dispute over medical issues is the subject of an appeal of a conference order. Chapter 152, section 11A requires that under these circumstances, the parties must agree upon an impartial medical examiner from a roster developed by the DIA. The medical examination must be completed and a report filed at least one week prior to the beginning of the hearing. The report of the medical examiner must be admitted into evidence at the hearing, and the medical examiner may be deposed for purposes of cross-examination.

The "schedule medical hearing" disposition indicates that non medical testimony has been completed at the hearing and a subsequent meeting is required to address the impartial

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[22] DIA Report 46: This is a percentage of all cases, excluding any cases with rescheduled dispositions.

[23] The 1,799 cases include two hearing dispositions: "Referred to lump sum"- 1,590 (referred by the AJ at hearing) + "lump sum request received" - 209 (the parties submit this request).

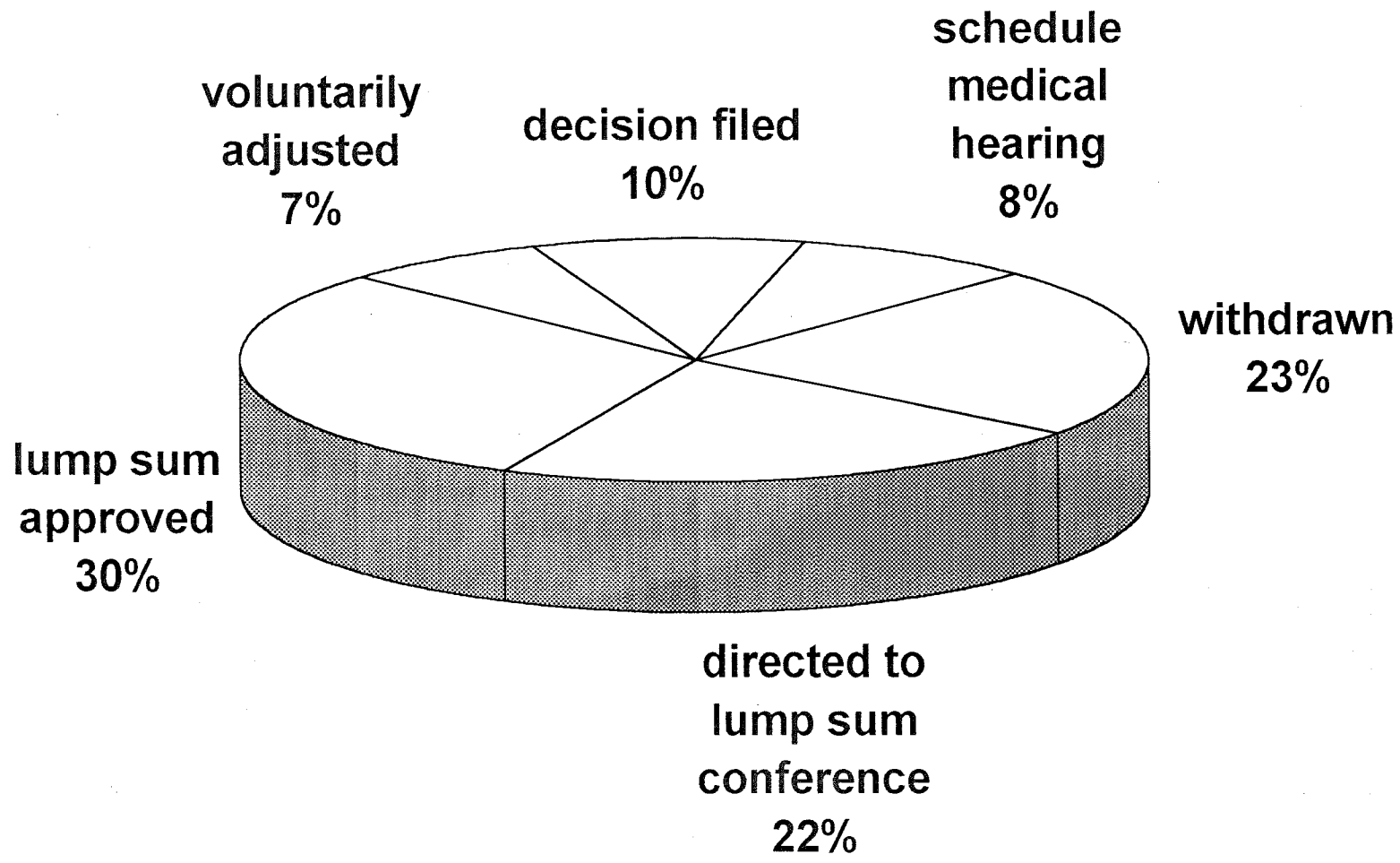
physician's report. While the report is supposed to be completed before the hearing begins, approximately 20% are completed after the hearing date. Therefore, a separate medical hearing is required to address the impartial exam.

Related topics:

- Lump Sum Settlements p.44
- Judicial Appointments p.50

exhibit 9

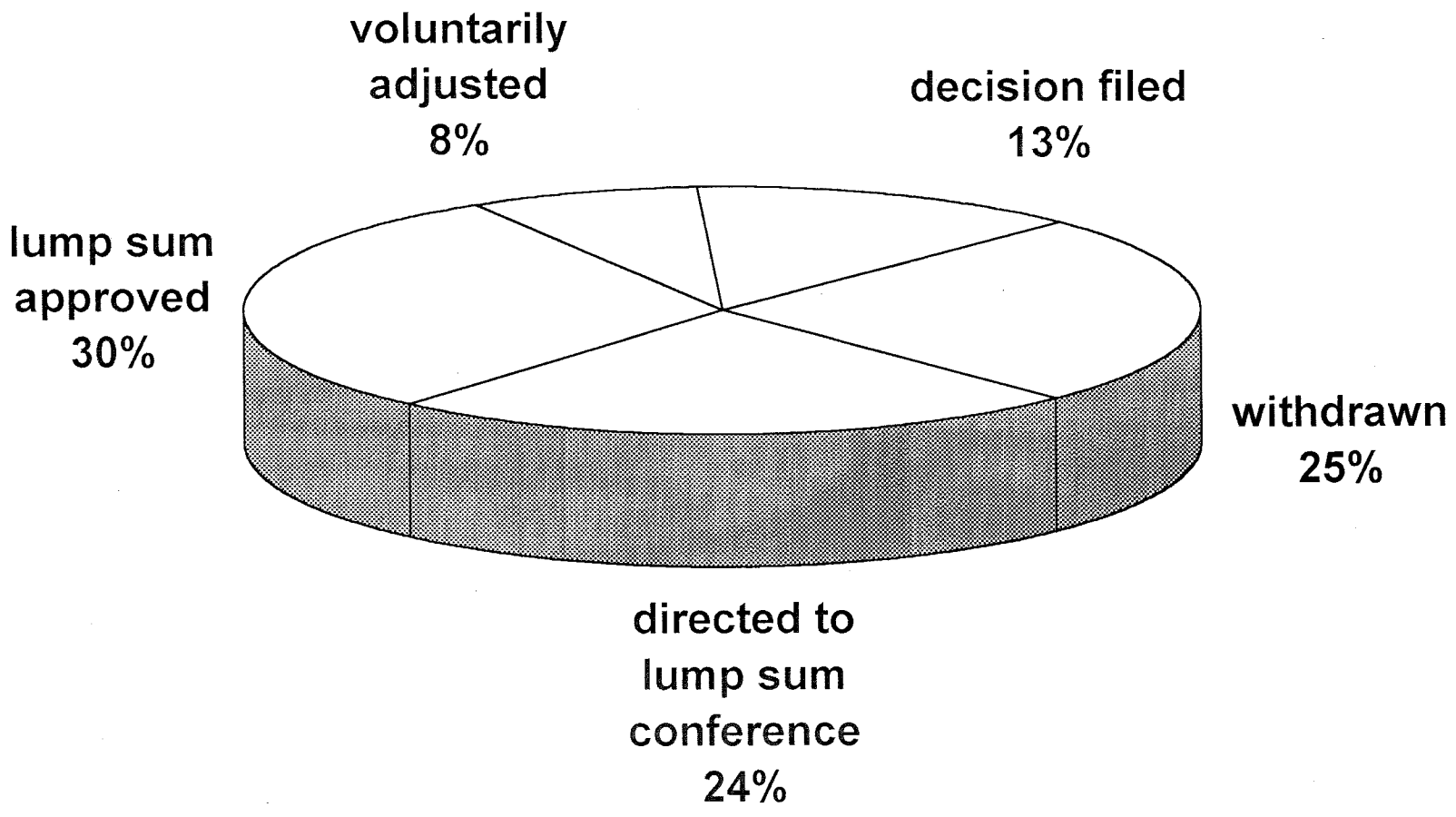
Fiscal Year 1993: Hearing dispositions



source: DIA report 46

exhibit 10

Fiscal Year 1992: Hearing dispositions



source: DIA report 46

Reviewing Board

The reviewing board consists of six administrative law judges (ALJs) whose primary function is to review appeals of hearing decisions. While appeals are heard by a panel of three ALJs, initial pre- hearing conferences are held by individual ALJs. The administrative law judges also work independently to perform three other statutory duties-- to preside at lump sum conferences, review third party settlements (§15), and discharge and modify liens against an employee's lump sum settlement (§46A).

Appeal of Hearing Decisions

An appeal of a hearing decision must be filed with the reviewing board no later than 30 days from the date of the decision. A filing fee of 30% of the state's average weekly wage, or a request for waiver of the fee must accompany any appeal.

Pre- hearing conferences are held before a single ALJ to consider whether oral argument will be heard, to identify and narrow the issues, and to chart the course of the future proceedings. This is an important step that can clarify the issues in dispute and encourage some parties to settle or withdraw the case. Approximately 20 to 25% of the cases are withdrawn or settled after this first meeting.

After the pre-hearing conference, the parties are entitled to a verbatim transcript of the appealed hearing. The appellant must file a brief in accordance with the board's regulations and the appellee must also file a response brief.

Cases that are not withdrawn or settled ultimately proceed to a panel of three ALJs. The panel reviews the evidence presented at the hearing as well as any findings of law made by the AJ. The briefs are submitted by the parties to assist the ALJs, and a oral argument may be scheduled. The panel may reverse the administrative judge's decision only when it determines that the decision was beyond the AJ's scope of authority, arbitrary or capricious, or contrary to law. The panel is not a fact finding body, although it may recommit a case to an administrative judge for further development of the evidence.

In fiscal year 1993, 412 hearing decisions were appealed to the reviewing board, a drop from 493 in FY'92, and 513 in FY'91. The reviewing board continued in FY'93 to have a large number of cases awaiting review. At the beginning of FY'93, 1,118 cases were pending before the board, while at the close of the fiscal year the queue numbered 1,005. Many of the cases the board is now hearing were appealed almost two years ago. In FY'93, the reviewing board disposed of 521 cases.

Decisions written by the reviewing board are often lengthy, as analysis of a multitude of technical issues is necessary. Some cases require substantial research, writing, and debate between the three judges on the panel. Moreover, once a decision is reached by the panel, it is not finalized until the other three ALJs have had the opportunity to review the decision. The time it takes to issue a decision for one case varies, but the process is time consuming.

The reviewing board is mindful of its responsibility to deliberate over each decision with precision and accuracy since appeals can only be made to the Massachusetts Court of Appeals, the second highest court in the commonwealth. Cases decided at the reviewing board are also published annually and comprise the body of law relied upon as precedent by judges and parties alike. Because of the legal authority of reviewing board decisions, each case must be deliberated so thoroughly that it actually impedes the flow of cases.

The reviewing board has a staff of two attorneys and three part time law clerks to assist the six ALJs with the legal research involved with the cases. An increase in the reviewing board's staff could help to alleviate the backlog of cases.

Lump Sum Conferences

The ALJs, along with two recall AJs, are individually assigned to preside at lump sum conferences. The purpose of the conference is to determine if a settlement is in the best interest of the employee. In FY'93 these conferences were scheduled on an average of six sessions per week across the state (two sessions on two days in the Boston office, and two sessions on one day in one of the regional offices).

A lump sum conference may be requested at any point during the dispute resolution process upon agreement of both the employee and insurer. Lump sum conferences are identical to the approval of settlements by administrative judges at the conference and hearing. However, many judges and attorneys at the conference and hearing prefer to have settlements determined at the lump sum conference. Conciliators also refer cases to this lump sum conference at the request of the parties.

See section on *DIA - Lump sum settlements*

Third Party Subrogation (§15)

When a work related injury results in a legal liability for a party other than the employer, a claim may be brought against the third party for payment of damages. The injured employee may collect workers' compensation indemnity and health care benefits under the employer's insurance policy, and may also file suit against the third party for

damages. For example, an injury sustained by an employee as the result of a motor vehicle accident in the course of a delivery would entitle the employee to workers' compensation benefits. The accident, however, may have been caused by another driver who is not associated with the employer. In this case, the employee could collect workers' compensation benefits and simultaneously bring suit against the other driver for damages.

Monies recovered by the employee in the third party action must be reimbursed to the workers' compensation insurer. However, any amounts recovered that exceed the total amount of benefits paid by the workers' compensation insurer may be retained by the employee.

The statute provides that the reviewing board may approve a third party settlement. A conference must be held to evaluate the merits of the settlement, as well as the fair allocation of amounts payable to the employee and the insurer. Guidelines were developed to ensure that due consideration is given to the multitude of issues that arise from settlements.

During FY'93, administrative law judges heard approximately 900 §15 petitions on Fridays on a rotating basis.

Compromise and Discharge of Liens (§46A)

Administrative law judges are also responsible to determine the fair and reasonable amount to be paid out of lump sum settlements to discharge liens under MGL ch. 152, sec. 46A.

A health insurer or hospital providing treatment may seek reimbursement under this section for the cost of services rendered when it is determined that the treatment provided arose from a work related injury. The Commonwealth's Department of Public Welfare can make a similar claim for reimbursement after providing assistance to an employee whose claim has subsequently been determined to be compensable under the workers' compensation laws.

In those instances, the health insurer, hospital, or Department of Public Welfare may file a lien against either the award for benefits or the lump sum settlement. When a settlement is proposed and the employee and the lienholder are unable to reach an agreement, the reviewing board must determine the fair and reasonable amount to be paid out of the settlement to discharge the lien.

The reviewing board handles approximately five cases per week.

Lump Sum Settlements

A lump sum settlement is an agreement between the employee, the employer (where applicable), and the employer's workers' compensation insurer whereby an employee will receive a one time payment in place of weekly compensation benefits. While settlements close out indemnity payments for lost income, medical and vocational rehabilitation benefits must remain open and available to the employee if needed.

Lump sum settlements can occur at any point in the dispute resolution process, whether it is before the conciliation or after the hearing. As a result of the 1991 reforms, conciliators have the power to "review and approve as complete" lump sum settlements that have already been negotiated. Administrative judges may approve lump sum settlements at conference and hearings just as an ALJ does at a lump sum conference. At the request of the parties involved, conciliators and judges may also refer the case to a separate lump sum conference where an administrative law judge or one of the two recall AJs will decide if it is in the best interest of the employee to settle.

The following statistics represent all cases scheduled for a lump sum conference before either an administrative law judge or one of the two recall administrative judges whose sole purpose is the review lump sum settlements:

Total Lump Sums	Lump Sum Scheduled	Lump Sums Approved[24]
FY'93	16,325	13,068 (80%)
FY'92	17,210	12,679 (74%)
FY'91	19,471	16,259 (84%)
FY'90	8,155	15,386 (85%)
FY'89	4,704	12,177 (83%)

There are four dispositions that indicate lump sum settlement for conciliations, conferences, hearings and medical hearings.

"Lump sum reviewed - approved as complete" -- Pursuant to §48 of chapter 152, conciliators have the power to "review and approve as complete" lump sum settlements when both parties arrive at conciliation with a settlement already negotiated.

"Lump sum approved" -- Administrative judges at the conference and hearing may approve settlements and they have the same authority as an ALJ at a lump sum conference to determine if the settlement is in the best interest of the employee.

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[24] Statistics compiled from monthly dispute resolution reports.

Conciliators do not have this authority as they must just check the settlement for completeness.

"Referred to lump sum" -- Most lump sums are settled at a lump sum conference conducted by an administrative law judge or one of the two recall administrative judges. Conciliators and administrative judges often refer cases to lump sum conferences where it will be determined if it is in the best interest of the employee to settle.

Many lawyers prefer to have a case referred to a lump sum conference rather than have a conciliator approve a settlement. The ALJ renders a judgment regarding the adequacy and appropriateness of the settlement amount, whereas a conciliator merely approves an amount submitted by the attorney. This would insulate the attorney from the risk of a malpractice suit.

The parties involved at the conference and hearing often prefer to have the settlement referred to a separate lump sum conference if they believe the judge has a prejudice. Judges may also suggest it go to this separate conference if they have already heard part of the case that could affect their decision.

"Lump sum request received" -- A lump sum conference may also be requested after a case has been scheduled for a conciliation, conference, or hearing. The parties would fill out a form to request this event and the disposition would then be recorded as "lump sum request received." Lump sum conferences may also be requested without scheduling a meeting.

Lump sum settlement dispositions become increasingly prevalent at the later stages of the dispute resolution process:

Meeting	Lump sum pursued[25]	Percentage of Cases Scheduled
Conciliation	1,415	4.5%
Conference	5,639	22%
Hearing	4,308	52%

[25] Lump sum pursued refers to four dispositions for lump sum settlements: lump sum request received; lump sum reviewed-approved as complete; lump sum approved; referred to lump sum conference.

Impartial Medical Examinations

Impartial medical examinations have become an integral component of the dispute resolution process. The requirement that an impartial physician examine a claimant was a key aspect of the 1991 reform act designed to eliminate the perennial "dueling doctor" phenomenon. Prior to 1991, judges were often faced with making medical judgments only after weighing the report of an examining physician retained by the insurer against the report of the claimant's physician.

The statute requires that the Senior Judge appoint an impartial physician when a claim involving a dispute over medical issues is the subject of an appeal of a conference order (ch. 152, §11A).

Section 8(4) permits an insurer to request an impartial exam if there is a delay in a conference order. Also, any party may request an impartial exam to assess the reasonableness or necessity of a particular course of medical treatment, with the impartial physician's opinion binding the parties until a subsequent proceeding.

Impartial Unit

The impartial unit within the division of dispute resolution will choose a physician from the impartial physician roster when parties have not selected one or when an AJ has not appointed one. While it is rare that the specialty is chosen by the impartial unit, in most cases it must choose the actual physician. The unit is also required to collect filing fees, schedule examinations, and to ensure that medical reports are promptly filed and that physicians are compensated after the report is received.

Impartial Physician Roster

The Senior Judge, in coordination with the Medical Care Consulting Consortium of the commissioner's office, is responsible for establishing and maintaining the roster of impartial physicians. In FY'93, the creation of a roster, diverse in occupational health specialties and geographical location, was a priority of the Commissioner and the Senior Judge because of the central role impartial exams play in the dispute resolution process as mandated by Chapter 398.

At the beginning of FY'93 (July 1, 1992), the roster consisted of 203 physicians with various specialties associated with occupational medicine. As of July 1, 1993, the roster had

increased to 354. The department continues to augment the roster in order to fulfill the mandate.[26]

The challenge presented in creating and maintaining the roster rests in attracting specialists to evaluate workers' compensation claimants. The specialties most in demand include orthopedists and neurosurgeons. Demand for specialists in these fields far outweighs their availability for all types of patients seeking treatment whether or not they are within the workers' compensation system. When the real and perceived troubles associated with treating workers' compensation patients are factored in, it is difficult to attract physicians to perform this vital function.[27] What is more, physicians are retained under a state contract with confidentiality and indemnification requirements that appear unattractive and burdensome to physicians.[28]

To compensate for the limited number of orthopedists and other specialists, the Medical Consortium has developed a triage system for use by judges. The administrative judge typically evaluates each case where an orthopedist is requested to conduct the impartial exam to determine if a physician in a related specialty can perform the exam. In many cases, an alternate

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[26] As of January 1994, the roster has increased to 521 physicians.

[27] The Advisory Council reported in its Medical Care Access Study in June of 1990 that the medical specialist community perceives work related injuries as much more difficult and much less desirable to treat than other cases, as a result of: 1) the number of non medical interests-- lawyers, insurers, and employers-- that interfere with treatment; 2) the motivation of injured workers; 3) the level of reimbursement; 4) the amount of paperwork. While focusing on the treatment of workers' compensation patients as compared to the mere examination of workers' compensation claimants, the findings of the study also indicate reluctance to become involved with the impartial examination process.

[28] Under state regulations, all entities contracting to provide goods and services to the Commonwealth of Massachusetts must submit to the terms and conditions of the standard state contract. Of particular concern to physicians was the requirement under the indemnity section that they pay for the costs of defending the Commonwealth against law suits arising out of or in connection with the services performed by them. Moreover, physicians were also concerned that restrictions contained within the confidentiality section of the contract could conflict with the terms of subpoenas served upon them in related law suits. The contract requires that the contractor cooperate with the department to enjoin or prevent misuse, regain possession and protect the Commonwealth against divulging personal information protected by law.

specialty and physician is selected that is amenable to both parties, thereby reducing the demand for orthopedists and alleviating related delays.

Scheduling Impartial Exams

The impartial unit is responsible for scheduling appointments with the physicians. Scheduling depends upon the availability of physicians, which varies by geographic region and the specialty sought. A queue for scheduling may arise according to certain specialties and regions in the state. In FY'93, the impartial unit scheduled 5,448 examinations. Out of this, 3,220 exams were actually conducted in the fiscal year (the remainder of the scheduled exams were either cancelled due to settlements and withdrawals or they took place in FY'94).

Medical reports are required to be submitted to the department and to each party within 14 calendar days after completion of the examination. During FY'93, hearings occasionally could be heard more quickly than exams could be scheduled thereby requiring that hearings be bifurcated. Two sessions were sometimes scheduled so that disputes not dependent on a medical report could be presented to the AJ and a second hearing would be scheduled to consider the impartial medical report when it was submitted. This has actually increased the time it takes to issue a hearing decision in some cases.[29]

Filing Fees

In FY'93, the filing fee structure delineated in chapter 152, §11A was contested as to its constitutionality. In Murphy v. Campbell, Murphy, a claimant represented by counsel, contested the requirement in §11A that any claimant represented by counsel pay a fee equal to the state average weekly wage to defray the cost of the medical examination. Those not represented by counsel were not required to pay a filing fee. It was Murphy's claim that the Commonwealth had failed to provide equal protection to all citizens by creating an unjust classification exempt from the filing fee-- that is those who are not represented by counsel. The Supreme Judicial Court agreed and ruled that filing fees had to be required evenhandedly for all classes seeking a medical hearing - whether represented by counsel or not.

The preliminary decisions in Murphy v. Campbell created some administrative delays in the scheduling of exams while the final decision was pending. In FY'93, the filing fee was the average weekly wage in the state, $543. As the result of the Supreme

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[29] As the timeframe from conference to hearing decreases, a need to rely more heavily on bifurcated hearings could arise. As hearings can be scheduled faster, the period in which impartial exams can be conducted becomes shorter. This could cause delays in issuing hearing decisions.

Judicial Court's decision in Murphy v. Campbell, the filing fee was set by regulation by the Commonwealth's Executive Office of Administration & Finance at $350. The impartial physician may also receive $75 for appointments that are missed, and $90 for supplemental reports.

Judicial Appointments

DIA administrative judges and administrative law judges are appointed by the governor with the advice and consent of the Governor's Council. Candidates for the positions are first screened and recommended by the Industrial Accidents Nominating Panel.

The nominating panel is comprised of eleven members, including the Governor's Legal Counsel, the Secretary of Labor, the Secretary of Economic Affairs, the DIA Commissioner, the DIA Senior Judge, and six members appointed by the governor (two from business, two from labor, a health care provider, and a lawyer not practicing workers' compensation law).

When a judicial position becomes available, the nominating panel convenes to review applications for appointment and reappointment. When reviewing applications, the panel considers an applicant's skills in fact finding, and understanding of anatomy and physiology. In addition, an AJ must have a minimum of a college degree or four years of writing experience. All ALJs must either be an attorney admitted to the Massachusetts bar, or be a current AJ or ALJ, or have served as an AJ or ALJ. Consideration of sitting judges applying for reappointment includes a review of their written decisions, an evaluation written by the Senior Judge reviewing the judge's judicial demeanor, average time for disposition of cases, total number of cases heard and decided, and appellate record.

The Advisory Council has statutory authority to review and vote on those candidates listed for appointment and reappointment. In fiscal year 1993, the council continued to fulfill its role in the nomination process by reviewing 23 candidates. Letters were submitted to the governor conveying the rating of "highly qualified, qualified, or unqualified."

Council members expressed concern that its deliberations occur in a timely fashion to allow the council's recommendations to be conveyed to the governor while he is considering the nominating panel's report.

For a list of the appointment and expiration dates of the 32 administrative judges and the 6 administrative law judges, see appendix I.

Office of Education and Vocational Rehabilitation (OEVR)

The office of education and vocational rehabilitation (OEVR) serves two major functions: 1) to provide the public with information regarding the DIA, as well as the rights and obligations of injured workers, employers, and insurers under the commonwealth's workers' compensation laws; and 2) to promote return to work for disabled workers through vocational rehabilitation services. In addition, OEVR administers the safety grant program through the office of safety.[30]

Public Information Office

The public information office is responsible for the dissemination of information at the information desk in Boston and the regional offices. Four information officers, under an information supervisor, answer an estimated 300 questions daily from the DIA's toll free telephone number and in person at the DIA's waiting room. The unit maintains a list of answers to the most asked questions. The staff also refers questions to other departments within the DIA as well as other agencies involved with workers' compensation (such as the Division of Insurance).

An average of 200-400 people come to the department every day for a variety of procedures and other appointments. The information officers serve as a first point of contact, assisting visitors requesting help, and directing people to the appropriate destination. The public information office also produces informational brochures for employees, employers and insurers explaining the dispute resolution procedure, vocational rehabilitation and other provisions of the statute.

A brochure entitled "Your Guide to Workers' Compensation" is provided to inform injured workers of their rights under the workers' compensation laws. While the guide provides a general overview of workers' compensation benefits and the dispute resolution process, it does not provide details regarding what injuries may be compensable, the duties of the employer and insurer, how the dispute resolution process works, when and under what circumstances vocational rehabilitation services must be provided, as well as how to complete and submit any forms that must be filed. Moreover, booklets entitled "An Employer's Guide to Workers' Compensation" and "An Insurer's Guide to Workers' Compensation" similarly provide a general overview of the system without specifics.

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[30] The office of safety and the public information office were units of OEVR in FY'93. As of October 1993, they are now part of the office of administrative services.

Perhaps if written information further detailing the process could be provided then the enormous number of phone calls would decrease, fewer erroneous claims would be filed, and fewer filing errors would be made.

Vocational Rehabilitation Office

The vocational rehabilitation office of OEVR oversees the rehabilitation of certain disabled workers receiving workers' compensation with the primary objective of return to work. OEVR encourages the voluntary development of rehabilitation services between the disabled worker and the insurer, but frequently mandates services for injured workers determined to be suitable for rehabilitation.

Vocational rehabilitation is defined in MGL ch. 152 as "non-medical services to restore the disabled worker to employment as near as possible to pre-injury wage." In order of priority, the objectives of OEVR include: return to work; return to work with modifications in either equipment, working hours, or working conditions; new work with the old employer or with a different employer; retrain the employee for a new job.

The office stresses that it does not provide career enhancing services, and therefore retraining is seen as a last option. Retraining is reserved exclusively for those who are more seriously disabled and unable to return to their pre-injury position. Generally, those with a minimum of 15% loss of function and a salary greater than $400 a week are eligible for retraining.[31]

Rehabilitation for workers' compensation does not allow for a lengthy recovery process. Because the emphasis in vocational rehabilitation is return to work, the time element becomes critical. Rehabilitation may also include vocational training, job placement assistance, interviewing seminars, and resume courses designed to give disabled workers the necessary skills to find employment.

Procedure for Vocational Rehabilitation

It is the responsibility of OEVR to identify those disabled workers' who may benefit from rehabilitation services. OEVR identifies rehabilitation candidates according to injury type after liability has been established, or through referrals from sources outside of OEVR. These include internal DIA sources (including the office of claims administration and the division of

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[31] These guidelines are not formal since each case must be analyzed individually.

dispute resolution), insurers, certified providers, attorneys, hospitals, doctors, employers and injured employees themselves.[32]

Before requiring that an injured worker be interviewed at a mandatory meeting, a rehabilitation review officer must first consider whether the employee has functional limitations, whether medical reports indicate some work capability, and whether light duty or job modification is available at the place of employment.

Mandatory Meeting: At the initial interview (or Mandatory Meeting), the rehabilitation review officer will gather information necessary to determine whether voc rehab services are "necessary and feasible".

The information gathered includes the employee's functional limitations, employment history, education, transferrable skills, work habits, vocational interests, pre-injury earnings, financial needs, and medical information. The insurer may be authorized to discontinue weekly compensation benefits if the employee fails to attend.

Determination of Suitability: OEVR utilizes the information gathered to determine whether a disabled employee could benefit from vocational rehabilitation. If so, a determination of suitability form is completed and sent to all parties. The insurer is notified to retain the services of a DIA certified vocational rehabilitation provider. Employees that are determined to be suitable for rehabilitation must follow and complete an individual written rehabilitation plan (IWRP) designed exclusively for that employee. The services are paid by the insurer. If the employee fails to follow the plan, the insurer is entitled to reduce weekly compensation benefits by 15%.

If the insurer refuses to pay for services, OEVR will offer rehabilitation to the worker to be paid by the DIA's trust fund. OEVR may, however, demand reimbursement of two times the cost of the program provided the rehabilitation is successful and the employee returns to work. This double billing is rarely collected because insurers often appeal OEVR's decision to require rehab. When this occurs, OEVR often settles to collect only the cost of the rehabilitation services.

A rehabilitation review officer monitors all cases in which suitability has been determined. The provider is required to develop an appropriate IWRP within 90 days. Sometimes the review officer assists by facilitating agreement of the plan between the employee, the insurer and the provider.

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[32] M.G.L. c. 152 secs. 30 E-H. 452 C.M.R. 4.00

Once all parties agree to the IWRP, OEVR will monitor each case until completion of the IWRP or successful employment for 60 days. Monthly progress reports are required to be submitted regarding each case.

When OEVR determines that an employee is suitable for rehabilitation services, a lump sum settlement can only be approved with the consent of OEVR. In the past, disabled and unemployed workers have settled for lump sum payments without receiving adequate job training or education on how to find employment. Settlement money would run out quickly and employees would be left with no means of finding suitable work. OEVR tries to have disabled employees complete rehabilitation before the lump sum settlement is approved. This is difficult to accomplish in a short time. Nevertheless, a lump sum settlement will be approved if the insurer agrees to continue to provide rehabilitation benefits.

Fiscal Year 1993

In Fiscal Year 1993, the office consisted of seven disability analysts and 13 certified vocational rehabilitators, one of whom is a registered nurse.

OEVR certified 95 vocational rehabilitation providers in the last fiscal year to be available to develop and implement the individual written rehabilitation plan (IWRP).

The standards and qualifications for a certified provider are found in the regulations, 452 CMR 4.03. Any state vocational rehabilitation agency, employment agency, insurer, self insurer, or private voc rehab agency may qualify to perform these services. Credentials must include at least a masters degree, certification, or a minimum of 10 years of experience. A list of the providers is available from the OEVR.

Use of Vocational Rehabilitation

Over the last two fiscal years, the use of vocational rehabilitation services has increased dramatically. In FY'93, 3,882 employees were referred to certified vendors for vocational rehabilitation, up by 113% from FY'91. Of these referred, there were 1,789 IWRP plans completed and 1,367 return-to-works (a return to work is at least 60 days of consecutive employment in a job compatible with the IWRP).

While these numbers were slightly lower than the previous fiscal year (due to a decrease in overall claims), they were greater than any year before the c. 398 reform. For example, in FY'91 there were only 952 IWRP plans and 493 return-to-works.[33]

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[33] Statistics provided by OEVR

Successful rehabilitation can be defined as the number of employees that return to work for 60 consecutive days. This number has risen dramatically in FY'93, up from 493 two years ago.

Rate of Return to Work

The number of employees returning to work reflects an increase in utilization of voc rehab services over the last two years, but does not necessarily indicate the effectiveness of the voc rehab services themselves. Not every employee who is referred to a certified vendor will complete a rehabilitation plan or return to work. Therefore, the effectiveness of voc rehab should be measured in terms of the rate of return to work.

Out of the 6,882 mandatory meetings that took place in FY'93, 3,882 employees were referred to a certified vendor. 1,789 employees (46%) of those referred to a vendor completed the IWRP. The number of employees that returned to work after completing the IWRP was 1,367 (76%).

One method to determine the rate of return to work would be to calculate the percentage of disabled workers that return to work after completing a rehabilitation plan (the IWRP). Out of 1,789 IWRPs completed in fiscal year 1993, there were 1,367 employees who returned to work (for 60 consecutive days). The return to work rate for those completing the IWRP was therefore 76% in FY'93, as compared to 78% in fiscal year 1992 and 52% in fiscal year 1991. The percentage of employees returning to work has improved tremendously and can be attributed to both the selection by OEVR of employees who are suitable for voc rehab and to the rehabilitation providers and employees themselves.

The return to work rate can also be calculated for employees who are referred to certified vendors and return to work. In FY'93, 35% of those referred to a vendor returned to work for 60 consecutive days. This is a slight increase from 34% and 27% in the last two years.

While most disabled employees that complete the IWRP return to work (76% in FY'93), a smaller number of those who are referred to a certified vendor return to work (35%). This may indicate that many employees referred to a vendor do not complete their rehabilitation for a variety of reasons including medical factors and unrealistic goals and they therefore do not get back to work.

Cost

Every worker that returns to work will save the insurer a considerable amount in indemnity payments, the cost of which are eventually passed on to employers. While rehabilitation services no doubt provide substantial long term savings, they are costly to administer.

The average plan lasts from five to six months with an estimated cost ranging from $3,000 to $3,500. Only 20% of employees are eligible for retraining because it is limited to seriously disabled employees with substantial loss of function.

In FY'93, there were 132 requests by insurers to decrease weekly compensation by 15% for a worker refusing voc rehab. 60 of those requests were authorized by OEVR, an increase of 52 from the previous year.

The cost to the trust fund in FY'93 (§30H) was $37,146 to provide vocational rehabilitation for an employee who had no insurer or the where insurer would not cooperate. The amount collected from insurers to reimburse successful rehabilitation funded through the DIA's trust fund was $16,833, well under the amount expended by the fund.

Office of Safety

The function of the office of safety is to reduce work related injury and illnesses by "establishing and supervising programs for data collection on workplace injuries and for the education and training of employees and employers in the recognition, avoidance and prevention of unsafe or unhealthful working conditions in employment and advising employees and employers on these issues."[34] In pursuit of this objective, the office administers the DIA Occupational Safety and Health Education and Training Program.

This program has a $400,000 annual budget. The office issues a request for proposal yearly to notify the general public that these grants are available. In FY'93, proposals could be submitted up to a maximum of $35,000.

There were some changes made in the FY'93 grant selection process which caused the House Post Audit and Oversight Committee to issue a preliminary report indicating concerns with the FY'93 process. According to the report, in previous years the selection committee consisted of six volunteers from outside the DIA and the director of the office of safety. In FY'93, the committee was comprised of five members, all of whom were employees of the DIA. The report also indicated that an interview process was instituted for the highest scoring candidates and the written review process was less stringent than previous years.[35]

The office of safety modified the selection process by adding an Occupational Health Physician to the committee, developing and implementing a new evaluation process, and improving its record keeping process.

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[34] MGL c. 23E, §3(6)

[35] House Post Audit and Oversight Committee, December 1993.

The selection committee awarded 14 FY'94 safety program grants ranging from $16,962.37 to $34,435.37. The training and education programs included the prevention of infectious disease (including HIV and TB), safety in construction, and carpal tunnel syndrome. A complete list of the grant recipients, area of study, and amount of award is listed in appendix G.

Office of Insurance

The office of insurance enforces the mandate that all employers have adequate workers' compensation insurance coverage for their employees. The office also regulates self insured employers and issues an annual licence to those who self insure. The office is broken down into two sections; the insurance unit and the self insurance unit.

Insurance Unit

The role of the insurance unit is to monitor all employers in the state to make sure they have the necessary insurance coverage for workers' compensation. The unit has access to a database at the Workers' Compensation Rating and Inspection Bureau (WCRB) that is a repository for information on all policies written by commercial carriers in the state. From this database, it can be determined which employers have cancelled or not renewed their commercial insurance policies. Any employer suspected of lacking insurance should be investigated to determine if they have insurance or alternative forms of financing (self insurance, self-insured group, reciprocal exchange).

The WCRB database documents only those employers that currently have or had a commercial insurance policy, and therefore is only one method of finding uninsured employers in the state. The database does not capture employers that have never had a commercial policy.

The insurance unit also employs investigative personnel that pursue leads on employers working without insurance. Their lead may originate from the WCRB database, from claims filed against the trust fund, or from tips from the public. Investigators are authorized to issue stop work orders to employers without the necessary insurance. The employer must cease work until it obtains insurance and pays a fine for every day it does not have the coverage. In the fiscal year, the unit had nine investigators and one chief.[36]

Stop Work Order: The Commissioner of the DIA is empowered to issue a stop work order to any employer determined by him to have failed to provide workers' compensation insurance. Such an order requires the cessation of all business operations at the place of employment or job site. The order is effective immediately upon service, unless the employer provides evidence of having secured necessary insurance. A fine must be paid into the private

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[36] NOTE: As of October 4, 1993, investigative personnel are no longer a unit of the office of insurance. There is now a separate investigative section.

employer trust fund of $100 a day starting the day the stop work order is issued and continuing until adequate coverage is obtained.

An employer aggrieved by the stop work order has ten days to appeal. A hearing must take place within 14 days of such appeal, during which time the stop work order will not be in effect. A stop work order and penalty will be rescinded if the employer proves it had insurance. If at the conclusion of the hearing, the department finds the employer has not obtained adequate insurance coverage, the employer must pay a fine of $250 a day fine beginning from the original issuance of the stop work order and continuing until insurance is obtained.[37]

The number of stop work orders issued in FY'93 was 194, up dramatically from 110 in FY'92 and 86 in FY'91. The amount collected in fines was $32,000 in FY'93, down slightly from the $32,400 collected in FY'92.

Another responsibility of the unit is to investigate fraudulent claims against the trust fund. In FY'93, there were 601 of these §65 investigations.

Self Insurance

The self insurance unit monitors all self insured employers, and issues an annual licence to each. For an employer to qualify to become self insured, it must post a surety bond of at least $100,000 to cover for losses that may occur. The amount varies for every company depending on their previous reported losses and predicted future losses. The average bond is usually over $1 million.[38] [39]

Self insurance is generally available to larger employers with at least 300 employees and $750,000 in annual standard premium.[40] These regulations may be waived by the Commissioner of the DIA for employers that have strong safety records and can produce the necessary bond to cover for all incurred losses. In addition, employers who are self insured must purchase reinsurance of at least $500,000. Each self insured may engage the services of a law firm or a third party administrator (TPA) to handle claims administration or administer their own claims. The office

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[37] M.G.L. c.152, §25C

[38] M.G.L. 452 CMR 5:00

[39] Interview with Richard Lundregan, manager of the office of insurance, December 1, 1993.

[40] CMR 5.00: Code of Massachusetts Regulations concerning insurers and self insurers.

of insurance evaluates employers every year to determine their eligibility and to establish new bond amount.

In fiscal year 1993, the office of insurance approved an additional 49 employers and their subsidiaries to self insure for workers' compensation. This follows the trend of the last two years where a large volume of employers turned to self insurance as a means of financing their workers' compensation responsibilities. The total number of self insured employers is now over 200, which consists of more than 700 companies (when their subsidiaries are included) and approximates almost $530 million in equivalent premium dollars.

Four semi- autonomous public employers are also licenced to self insure including the Massachusetts Bay Transportation Authority (MBTA), the Massachusetts Turnpike Authority, the Massachusetts Port Authority, and the Massachusetts Water Resource Authority (MWRA).[41] [42]

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[41] The Commonwealth of Massachusetts does not fall under the rubric of self insurance although its situation is analogous to self insured employers. It is not required to have a licence to self insure because of its special status as a public employer and it therefore funds workers' compensation claims directly from the treasury as a budgetary expense. The agency responsible for claims management, the Public Employee Retirement Administration, has similar responsibilities to an insurer but the state does not pay insurance premiums or post a bond for its liabilities (MGL c.152 §25B).

[42] Interview with Dick Lundregan, manager of the office of insurance, DIA, December 1, 1993.

Private and Public Trust Funds & Special Fund

The DIA is charged with maintaining two separate trust funds-- one for the benefit of employees and insurers in the private sector, and another for the benefit of the public sector. These two trust funds are managed by the DIA's trust fund department. Its functions are to levy and collect assessments on both private and public employers, provide benefits from the fund to certain injured employers, reimburse certain employers, investigate claims for benefits and reimbursements, defend the fund against undeserving claims, and maintain the viability of both funds.

In addition, the DIA is required to collect assessments and maintain a special fund to be used to pay its operating expenses. The special fund is administered by the DIA's budget office.

Revenues for the three funds are deposited into the accounts of the Treasurer of the Commonwealth. The funds are entrusted to that office where they are maintained and where reimbursements are made.

Defense of legal actions against the public and private trust Funds falls under the jurisdiction of the office of the DIA legal counsel.

Assessments

The workers' compensation statute requires that the DIA determine the assessments to be charged to the employers of the commonwealth for the support of the trust funds and the DIA operating budget.[43] Those assessments are paid as part of an employer's annual insurance premiums, and are forwarded to the DIA by the insurer.

Each year the DIA projects the needs of both trust funds and the special fund, and calculates the amount of money needed to maintain the solvency of each in the following fiscal year. Based on these budget projections, an assessment rate is calculated by the DIA. The assessment rate is multiplied by an employer's standard premium and is applied to the employer's insurance bill. Separate assessment rates are calculated for self-insurers, group self insurers, and public employers.

Employers each year may opt out of certain trust fund assessments. Private employers may opt out of most assessments, but must remain subject to assessments for the special fund, as well as vocational rehabilitation benefits and uninsured employer

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[43] MGL c. 152, §65

claims. Public employers may, however, become completely exempt from all assessments. In exchange for reduced assessments, employers opting out lose entitlement to reimbursement for those exempted portions of the law. Employers choosing to opt out must give notice to the DIA by March 1 to be effective July 1.

Modified assessments rates are calculated for employers who opt out of trust fund benefits.

Fiscal 1994 Assessments

In fiscal year 1994, private employers with workers' compensation coverage through an insurance carrier were assessed at 3.2% of premium. Both private self-insured employers and members of self-insurance groups paid assessments based on what their premium would have been had insurance been obtained through an insurance carrier (calculated premium).[44]

Public employers were assessed at much lower rates. The public trust fund has virtually no uninsured employer payments pursuant to section 65(2), and the likelihood of any is minimal. Public employers also are not required to support the DIA through the special fund assessments.

For a review of the assessment rates since 1987, see appendix H.

Trust Fund Liabilities

The worker's compensation statute requires that both the private and public trust funds pay benefits and reimbursements to eligible injured employees and insurers. Throughout the statute, in various sections, provisions are made for benefits and/or reimbursements to be made from either trust fund.

Armed Forces-- Section 26 requires that benefits be paid directly to employees injured by the activities of fellow employees where those activities are traceable solely and directly to a physical or mental condition resulting from the service of that fellow employee in the armed forces of the United States.

Vocational Rehabilitation-- Section 30H requires that if an insurer refuses to provide vocational rehabilitation services the DIA has deemed necessary and feasible, the cost of the program will be paid for by the trust fund. If after completion of the program, OEVR determines that the program was successful, it will assess the insurer no less than twice the cost incurred by the office, with that assessment paid into the trust fund.

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[44] Assessment ratios were determined by the actuarial firm of Tillinghast according to projections determined by it, the budget office and the trust fund.

COLAs-- Section 34B requires that cost of living adjustments (COLAs) be provided in the form of supplemental benefits to employees receiving benefits under sections 31 and 34A, whose date of personal injury was at least 24 months prior to the review date. The supplemental benefit is equivalent to the difference between the claimant's current benefit and his/her benefit after an adjustment of the change in the statewide average weekly wage between the review date and the date of injury.

Section 35C requires that benefits be paid for injuries where there is at least a five year difference between the date of injury and the date of benefit eligibility. Benefit levels are based on those in effect on the date of eligibility. The trust fund is required to reimburse the insurer for "adjustments to compensation" under this section.

Second Injuries-- Section 37 requires that reimbursement be provided to insurers in an amount not to exceed 75% of the cost of an employee's second injury which are exacerbated in part due to a previous accident, disease or congenital condition. (This is sometimes referred to as the Second Injury Fund).

Section 37A requires that reimbursement be made to insurers for the cost of an employee's injuries that are aggravated or prolonged by a previous disability arising out of military or naval service.

Uninsured employers-- Section 65(2) requires that employees injured while working for employers who have failed to obtain adequate workers' compensation insurance coverage will have their benefits paid by the appropriate trust fund. The trust fund is required to seek reimbursement and to collect fines from the offending employer, but often does so in vain as uninsured employers frequently are insolvent and/or no longer in business.

COLLECTION & EXPENDITURE REPORT
FY'93

SPECIAL FUND

ENDING FY'92 BALANCE		**2,621,052**
COLLECTIONS		
INTEREST	**217,797**	
ASSESSMENT	13,743,804	
RETURNED CHECKS	-88,274	
LESS REFUNDS	-9,022	
SUB-TOTAL	**13,646,508**	
FILING FEES	3,483,110	
LESS REFUNDS	-4,743	
RETURNED CHECKS	-2,131	
SUB-TOTAL	**3,476,236**	
SEC. 7 PENALTIES	6,000	
LATE ASSESSMENT FINES	21,970	
1ST REPORTS FINES	85,707	
SUB-TOTAL	**113,677**	
MISCELLANEOUS	**880**	
TOTAL COLLECTIONS	**17,455,098**	**17,455,098**
BALANCE		**20,076,150**
EXPENDITURES		
A90[45] SALARY	9,797,077	
D09 FRINGE	2,666,838	
E90 NON-PERSONAL COSTS	3,957,815	
E16 INDIRECT COSTS	613,250	
SUB TOTAL EXPENDITURES	17,034,980	
UMASS	5,280	
TOTAL EXPENDITURES	**17,040,260**	
EXPENDITURES		17,040,260
ENDING BALANCE		**3,035,890**

[45] A90, D09 ... refer to expenditure classifications.

PUBLIC TRUST

ENDING FY'92 BALANCE		**3,056,655**
COLLECTIONS		
INTEREST	**98,627**	
ASSESS	1,632,650	
LESS REFUND	-205	
	1,632,445	
TOTAL COLLECTIONS	**1,731,072**	**1,731,072**
BALANCE		**4,787,727**
EXPENDITURES		
COLA BENEFITS	2,464,967	
SECTION 37 BENEFITS	30,794	
TOTAL	**2,495,761**	
EXPENDITURES		2,495,761
ENDING BALANCE		**2,291,966**

PRIVATE TRUST

ENDING FY'92 BALANCE		**3,652,610**
COLLECTIONS		
INTEREST	**187,259**	
ASSESS	25,187,627	
LESS RETURNED CHECKS	-143,490	
LESS REFUNDS	-23,843	
	25,020,294	
SECTION 30H (VOC.REHAB REIMBURSEMENTS)	16,833	
REIMBURSEMENTS	572,170	
RETURNED CHECK	-1,818	
	570,352	
STOP WORK ORDERS	31,150	
SUB-TOTAL	**618,335**	
TOTAL COLLECTIONS	**25,825,888**	**25,825,888**
BALANCE		**29,478,498**
EXPENDITURES		21,890,386
ENDING BALANCE		**7,588,112**

PRIVATE TRUST -- Expenditures

BENEFIT PAYMENTS CLAIMANTS	TOTAL EXP.
SEC. 34	2,783,111
SEC. 35	714,888
LUMP SUM	1,146,409
SEC. 36	490,492
SEC. 31	106,862
COLA ADJUSTMENT	11,160
EE MEDICAL	18,832
EE TRAVEL	8,618
EE BOOKS,ETC.	122
LEGAL FEE	599,323
LEGAL EXPENSES	35,292
MEDICAL	1,854,762
BURIAL	4,000
VETERAN LIENS	1,711
REHABILITATION	6,954
WELFARE	61,741
TOTAL BENEFITS	**7,844,276**
INSURER REIMBURSEMENTS	
COLAS	11,325,195
LATENCY CLAIMS	246,407
SEC. 37	1,896,753
TOTAL INSURER	**13,468,355**
MM TUITION	22,490
TOTAL RR-LEGAL	**21,335,122**
OEVR	
BENEFITS SEC. 30H	13,795
EE TRAVEL	2,458
BOOKS, ETC.	297
MM TUITION	20,596
TOTAL OEVR	**37,146**
TOTAL BENEFITS	**21,372,268**

PRIVATE TRUST -- Expenditures

DEFENSE OF THE FUND

	TOTAL EXP.
AA SALARIES	196,223
DD FRINGE	61,810
DD UNIV. HEALTH	112
DD MEDICARE	2,728
SUB-TOTAL	**260,873**
EE ADVERTISING	513
TRAVEL	448
TRAIN./TUIT.	724
MV RENTAL	1,028
SUPPLIES	1,972
IP APPEALS	10,783
SUB-TOTAL	**15,468**
HH WILSON	59,975
ACCUMED	16,369
STENO	621
MAXIMUS	13,920
FOLEY & HOAG	7,936
R. GOLDMAN	2,343
JJ ACE TEMP	39,655
SHERIFFS	851
KK EQUIPMENT	15,918
MM IME'S	83,388
RR PENALTIES	800
SUB-TOTAL OTHER	**241,776**
TOTAL DEFENSE	**518,117**
TOTAL EXPENDITURE	**21,890,385**

Below is an index for codes in the budget.

AA	Regular Employee Compensation
BB	Regular Employee Related Expenses
CC	Special Employees/Contracted Services
DD	Pension & Insurance Related Expenses
EE	Administration Expenses
FF	Facility Operational Supplies & Related Expenses
GG	Energy Cost and Space Rental
HH	Consultant Serv. (To Depts.)
JJ	Operations Services
KK	Equipment purchases
LL	Equipment Lease-Purch, Lease Rental, Maint/Repair
MM	Purchased Client Services
RR	Benefit Programs

Health Care Initiatives

The Commissioner of DIA is charged with ensuring that adequate and necessary health care services are provided to the Commonwealth's injured workers. Specifically the Commissioner is charged with monitoring health care providers for appropriateness of the service, whether the treatment is necessary and effective, the proper costs of services, and the quality of treatment.

The statute directs the Commissioner to appoint medical consultants (the Medical Consultant Consortium), as well as members of the Health Care Services Board. In FY'92, the Commissioner appointed several members to the Medical Consultant Consortium and the Health Care Services Board. Both bodies met consistently throughout that year and the years following in an effort to implement the chapter 398 mandates as quickly and efficiently as possible.

In fiscal year 1993, the Commissioner's Office began efforts to implement a utilization review system to bring into the mainstream the outliers in the health care system-- that is those patients, health care providers, and insurers who over utilize, over prescribe, over charge, or underpay. Moreover, the Commissioner created an office of health policy to address these health care related issues handled by the DIA including the Utilization Review and Quality Assessment Program. The office is also the liaison with the HCSB and MCC.

Chapter 398 established a rigorous schedule for implementation of managed care initiatives to control workers' compensation health care costs. The Health Care Services Board (HCSB) was required to draft and distribute treatment guidelines by July 1, 1992, which it did. By January 1, 1993, the HCSB was required to endorse the first version of these guidelines for use by health care providers. Further, by July 1, 1993, the Commissioner was required to promulgate regulations regarding provisions of adequate and reasonable health care services utilizing the treatment guidelines. At that time, the final version of the treatment guidelines were endorsed by the HCSB and published in conjunction with the July 1, 1993 utilization review regulations.

Health Care Services Board

The DIA's Health Care Services Board (HCSB) is an appointed voluntary committee of physicians, health care providers, and employer and employee representatives in the workers' compensation system. The HCSB is charged with reviewing and investigating complaints regarding providers, developing criteria for appointment of physicians to the impartial physicians roster, and developing written treatment guidelines.

The HCSB is required to receive and investigate complaints from employees, employers and insurers regarding the provision of health care services. Such complaints include a provider's discrimination against compensation claimants, over-utilization of procedures, unnecessary surgery or other procedures, and other inappropriate treatment of workers' compensation patients. Upon a finding of a pattern of abuse by a particular provider, the HCSB is required to refer its findings to the appropriate board of registration.

In FY'92 and FY'93, the HCSB established the mechanism to review these complaints.

The HCSB is also required to develop eligibility criteria to select and maintain a roster of qualified impartial physicians to conduct medical examinations pursuant to §§8(4) and 11A. (See section *DIA - Impartial Unit)*.

In FY'92 and FY'93, the HCSB issued criteria calling for the selection of eligible roster participants. According to the criteria, physicians must be willing to prepare reports promptly and timely; submit reports for depositions; submit reports of new evidence; submit to the established fee schedule; and sign a conflicts of interest statement and disclosure of interest statement. Requirements of §§8(4) and 11(A) roster's differ pursuant to M.G.L. c. 152.

Treatment Guidelines

Under section 13 of chapter 152, the Commissioner is required to ensure that adequate and necessary health care services are provided to injured workers by utilizing treatment guidelines developed by the HCSB, include appropriate parameters for treating injured workers.

The HCSB met its statutory goals of endorsing and distributing treatment guidelines by July 1, 1992 and publishing them by January 1, 1993. After that time, the HCSB convened a subcommittee to develop treatment guidelines. The subcommittee examined the guidelines originally developed by various groups including the American Academy of Orthopedic Surgeons (AAOS), the State of Washington Department of Labor Insurance, and the National Institutes of Health. The subcommittees adopted some of these guidelines and went on to develop several of their own. By July 1, 1993, twenty-five guidelines were published covering many conditions including carpel tunnel syndrome, herniated disks, and acute and chronic back pain and injuries.

Utilization Review

In coordination with the implementation of treatment guidelines, on July 1, 1993, the Commissioner promulgated regulations mandating utilization review. A public hearing was

held on May 19, 1993 for public comment regarding utilization review and the treatment guidelines.

According to the regulations (452 CMR 6.00), utilization review is a system for reviewing the "appropriate and efficient allocation of health care services" for the purpose of determining whether those services should be covered or provided by an insurer.

The regulations specify that all utilization review programs must be approved by the DIA. Insurers, self insurers and self insurance groups must either develop their own utilization review programs for DIA approval or contract with approved agents who can provide the required utilization review services for them.

The regulations require that utilization review must be performed on all medical claims using the DIA's treatment guidelines and criteria. UR agents must review claims submitted by workers' compensation claimants for compliance with the guidelines. Review may either be prospective (examining treatment before it is provided), concurrent (review in the course of treatment), or retrospective (review after the treatment was provided).

When coverage for a treatment plan is denied by an agent, it must be communicated to the treating physician and the injured employee. Either the injured employee or the treating practitioner may appeal the denial. Appeals of prospective or concurrent treatment may be made by telephone to the UR agent with the opportunity for review by a practitioner on an expedited basis. The appeal must be resolved within two business days. Appeals for retrospective treatment must be settled within 20 business days. Review of any utilization review appeal can be made by filing a claim with the DIA division of dispute resolution.

The HCSB is required to review and update the DIA's treatment guidelines at least once per year.

Quality Assessment Program

According to the regulations (452 CMR 6.07), the DIA will monitor the quality of care for injured employees using outcome measures, medical record audits, analysis of employee health status and patient satisfaction measurements. Should a provider's plan of care be found to be outside a particular guideline, the provider will be informed of the aberration with instructions on means to correct it. Should the provider remain statistically outside the guideline, the matter will be referred to the HCSB for appropriate action under the HCSB's complaint's review process.

Medical Trending and Tracking System

The DIA also plans to gather billing data on patterns of treatment of injured workers in Massachusetts. This data will be used to find the outliers in the system and to further develop and revise treatment guidelines.

In FY'93, the DIA began discussions with a consulting firm to examine the feasibility of developing a computer system and database for the trending and tracking system.

Section 2: The Workers' Compensation System

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Workers' Compensation Insurance

Employer mandated insurance is the veritable backbone of the Massachusetts workers' compensation system because it is the source of funding for no fault workers' compensation coverage to employees. A healthy insurance market is therefore essential not only to the insurance industry, but to employers and employees as well. In fiscal year 1993, the workers' compensation insurance market continued to adjust to the many challenges it faced. Programs and polices were developed and refined to deal with a large residual market, high premiums for employers, and the high cost of medical and indemnity claims. Fiscal year 1993 was a dynamic one for the insurance market, and the tide seems to have turned in favor of a more stable climate.

Insurance coverage - private employers: Every private employer in the Commonwealth of Massachusetts is required to have workers' compensation insurance. This mandate includes sole proprietors that are incorporated, domestics and seasonal workers that average over 16 hours of work a week, and any family member who is working in a family business. There are certain categories of workers for whom this insurance is not required. Seamen, some professional athletes, and unincorporated sole proprietors are exempt.

Public employers: Public employers fall outside the compulsory insurance mandate that requires workers' compensation insurance for all private employers.[46] The Workers' Compensation Act (M.G.L. chapter 152) is elective for all public employers including municipalities, counties, towns, and school districts and therefore insurance coverage is optional for those jurisdictions. All state employees are covered under the act, however, as well as most other public employers. Other public employee groups such as the police and fire departments, and some teacher groups have special provisions for occupational injuries that are separate from the workers' compensation act.

Public employers that elect workers' compensation coverage under chapter 152 are still not required to obtain insurance coverage in the same manner as the private sector. The Commonwealth of Massachusetts funds workers' compensation claims directly from its budget. The agency which administers claims for workers' compensation by state employees is the Public Employee Retirement Administration (PERA), which also handles the retirement system for the Commonwealth. Other public employers,

[46] MGL c.152, §25B

especially smaller towns, do have insurance coverage that is similar to that of private employers.[47]

Enforcement: The office of insurance at the Department of Industrial Accidents (DIA) monitors employers in the state to make sure they have the required insurance. They may issue fines and close down any business that is operating without adequate coverage for their workers. If an employee is injured while working for a company without a workers' compensation policy, the DIA's trust fund will pay for the claim. In actuality, it is every employer in the state who pays for the claim because the trust fund is maintained by assessments on all employers. In most cases, the DIA will seek repayment from the uninsured company. Reimbursement is often difficult to obtain, however, because the company may not have any assets and collection must proceed with a civil suit.

Employers in the state may obtain coverage through a commercial insurance plan, self insurance, self insurance group (SIGs), or a reciprocal exchange. Public employers may also insure themselves through self insurance, commercial policies, and public self insurance groups.

I. The Insurance Market

Commercial Insurance

The most common method of providing workers' compensation coverage is through a traditional commercial insurance plan whereby a company will pay an annual premium that is approved each year by the Division of Insurance. The "manual premium" of a company is based on the employer's payroll combined with the appropriate classification of its employees (roofing, plumbing, service, etc.). The premium is then adjusted by the "experience modification" to produce the "standard premium." The experience modification reflects the losses of a particular employer compared to the average employer in the same classification. It is computed by comparing actual losses to expected losses for a three year period.

In exchange for an annual standard premium, the insurance company will administer employee disability claims and pay for any medical, indemnity (weekly compensation), rehabilitation, or supplemental benefits due under the workers' compensation act. While the insurer may dispute claims that it and the employer deem to be noncompensable, it is the insurer's responsibility, not the employer's, to represent their position throughout the adjudication process.

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[47] For more information of the coverage of public employees see Report to the Legislature on Public Employees, Massachusetts Workers' Compensation Advisory Council, 1989.

Assigned Risk Pool

Any employer who seeks a commercial insurance policy and is rejected by two insurers within five days will be assigned an insurer by the Workers' Compensation Rating and Inspection Bureau (WCRB). Many companies with high risk classifications or poor experience ratings cannot obtain insurance in the "voluntary market." They will then be assigned a carrier in the "residual market", otherwise known as the "assigned risk pool." The pool is intended to be the market of last resort, but in FY'93 it comprised over half the amount of premium written in the state.

The insurance companies that administer the policies of employers in the pool are referred to as "service carriers." Reimbursement for their services varied during FY'93 between 25%-27% of the total written premium of the policy administered. Another 9% may be authorized by the Division of Insurance to promote and reward a more interactive approach between the insurer and the employer whose policies they administer.[48]

In the assigned risk pool, overall losses have exceeded the allowable premium approved each year. Since the losses are greater than the revenues (the premium), the policies in the assigned risk pool will have a deficit. The aggregate of these losses constitute the residual market deficit.

Every commercial insurer who writes workers' compensation insurance in the state must pay for this deficit in direct proportion to the amount of premiums they write in the voluntary market. For example, an insurer that writes 5% of all premiums in the voluntary market will have to pay for 5% of the residual market's deficit.[49] In 1992, 27.6¢ of every dollar written in the voluntary market was used to pay for the pool's deficit.[50] This

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[48] There has been some criticism that companies forced into the residual market to obtain insurance receive poor service from the servicing carriers. There was no incentive such as in the voluntary market for the insurer to provide extensive service to the insured. In 1994, servicing carriers are subject to "performance standards" and a "paid loss incentive program." The paid loss incentive program is effective for policy year 1993 and will provide up to a 9% bonus or penalty. The "performance standards" effective in 1994 will provide an additional swing of +2% to -14% based on four categories of on-site audit: underwriting and audit, loss control performance standards, claim performance standards, and financial reporting.

[49] Note: Theoretically, the residual market loads works in a direct proportion to the amount of premium each insurer writes in the voluntary market. However, programs such as the Take Out Credit Program affect assessable premiums and may affect the residual market load.

[50] National Council on Compensation Insurance

amount is incorporated into rates which are based on total workers' compensation experience. Theoretically, part of the voluntary market rate is to pay for the expected residual market loss.

In FY'93, reducing the size of the assigned risk pool was one of the greatest challenges facing the workers' compensation system. Costs for medical and indemnity benefits had escalated rapidly in the past few years, outpacing insurance rates. While many theories abound as to why the residual market is so large, it is clear that large insurance losses have contributed to an inflated residual market.

In 1992, 64.7% of every premium dollar was written in the residual market.[51] In the previous year, the pool's premiums amounted to 50.4% of the entire market, more than double the national average of 22.2%.[52] (See Exhibit 1)

The insurance market is placed in a precarious situation when the voluntary percentage of the market is so small. Assessments for the pool's losses are based directly on the size of the voluntary market. If the voluntary market and the corresponding assessment base decreases, the growing responsibility of the deficit is placed on the remaining insurers who must bear this burden.

Fortunately, in FY'93 the growth of the deficit has slowed. The residual market burden (percentage of each voluntary market dollar used to pay for the assigned risk pool) has had a significant decrease. Estimated figures show a drop from a high of 58.8% in 1989 to 27.6% in 1992.[53] (See exhibit 2)

Loss ratios have had a corresponding decrease. The residual market loss ratio measures the amount of losses and expenses to the premiums written (roughly money out divided by money in). A loss ratio greater than 1.00 indicates that losses are greater than revenues (premiums). In 1992, the estimated loss ratio was 0.80, down from 1.48 in 1989, 1.19 in 1990, and 0.83 in 1991.[54] (See Exhibit 3)

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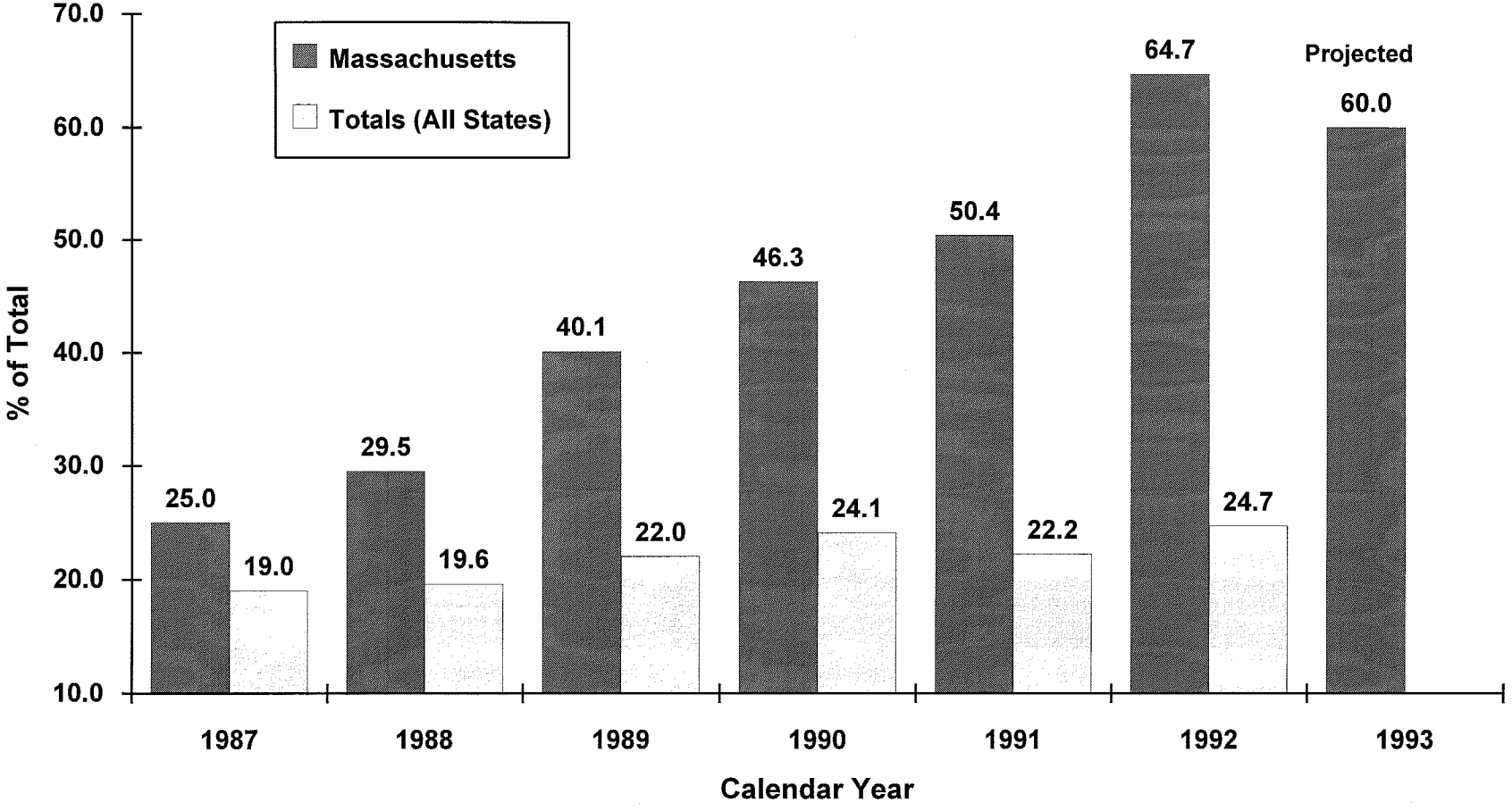
51 Data preliminary -- WCRB

52 WCRB

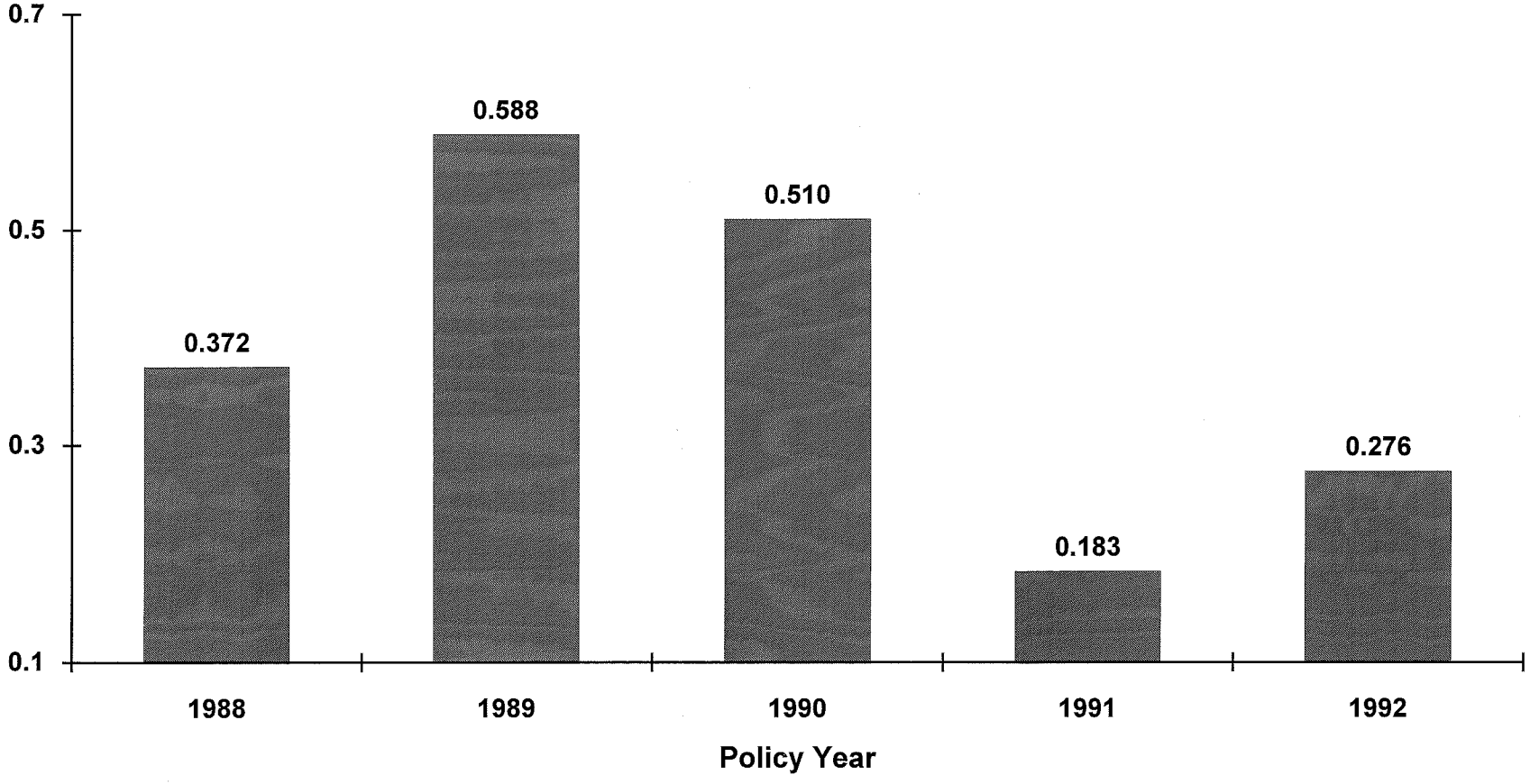
53 National Council on Compensation Insurance

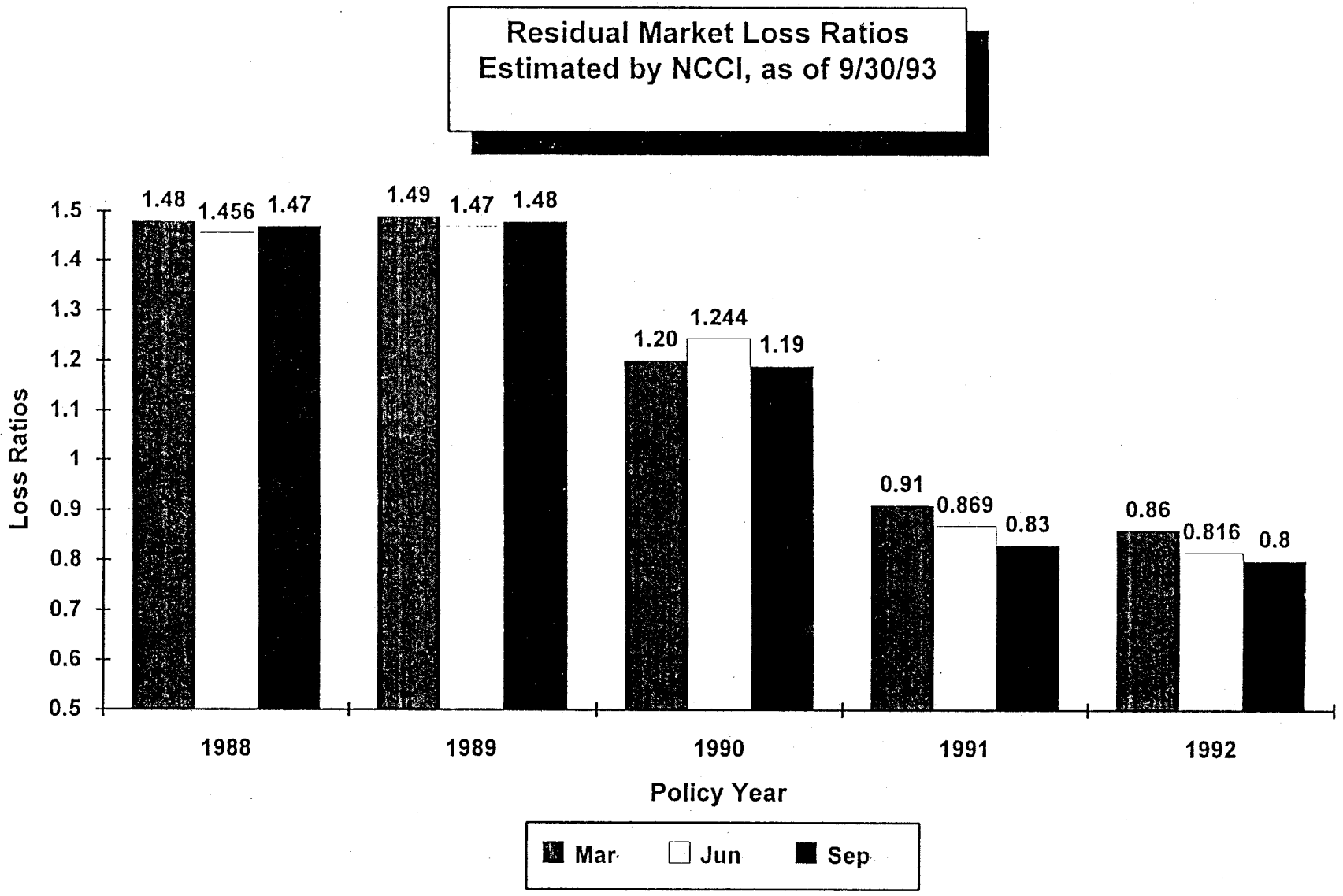
54 National Council on Compensation Insurance

Residual Market Share



Residual Market Burden
Estimated by NCCI, as of 9/30/93




Residual Market Loss Ratios
Estimated by NCCI, as of 9/30/93
Loss Ratios
1.5
1.4
1.3
1.2
1.1
1
0.9
0.8
0.7
0.6
0.5
1.48
1.456
1.47
1.49
1.47
1.48
1.20
1.244
1.19
0.91
0.869
0.83
0.86
0.816
0.8
1988
1989
1990
1991
1992
Policy Year
Mar
Jun
Sep

Programs and Policies in Commercial Insurance

There are many variations of commercial insurance policies that seek to equate the actual losses incurred by the employer with the amount they pay in premium. These programs make employers more accountable for their losses and can result in considerable savings under certain circumstances. Some of the programs are also a means of reducing the number of employers in the assigned risk pool by providing incentives for employers to seek coverage in the voluntary market and for insurers to write workers' compensation insurance in the voluntary market.

ARAP - Surcharge for Poor Experience: In January 1990, the WCRB instituted the All Risk Adjustment Program (ARAP) calculated in addition to the experience modification for employers in and out of the pool. Its purpose is to establish adequate premiums to encourage more insurers to write voluntary business. ARAP measures actual losses against expected losses, but it differs from the experience modification in that it measures severity and not frequency of claims. ARAP can add a surcharge up to 49% of an employer's experience modified standard premium.

MARRP - Retrospective Program in Pool - Mandatory: In FY'93, every policy in the pool with an annual premium greater than $140,000 was subject to the Massachusetts Assigned Risk Rating Plan (MARRP). This was a retrospective plan for assigned risks that based an employer's premium on its actual losses. The employer paid a premium derived directly from its own experience for the policy year in question. The premium can be no lower than an established minimum and no higher than an established maximum. After the policy year expires, the employer is issued a credit (up to 25% of premium) for a good experience rating or a surcharge (up to 75%) for poor experience and losses. These credits or surcharges are applied in the following years until all losses are known and closed.[55]

Large Risk Rating Option: Large risk retrospective programs are an option for insureds with an annual premium greater than $500,000. It is used to match the employer's actual losses with the premiums they pay. The employer pays a standard premium (like a deposit), but the ultimate premium is determined by a formula based on the incurred losses of the employer. The employer receives either a credit or a surcharge based on the amount of losses they have in that year.

Large and Small Deductibles: Deductible policies, available since 1991, function like a retrospective plan and large deductible policies can provide the advantages of a retrospective and self insurance policy in one. They also save on

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[55] As of January 1, 1994, MARRP was eliminated as part of the 1994 rate filing.

premium payments and increase the up front cash flow for an employer. A typical policy with a $5,000 per claim deductible will have a 10.6% reduction in premium. The insurer pays for all benefits under the workers' compensation act and then seeks reimbursement from the employer up to the amount of the deductible.

Large deductibles are also designed strategically to avoid some of the residual market load. Because these polices have lower premiums than full coverage policies, the assessment to pay for the pool's deficit is likewise lower. These programs are controversial as the pool's deficit is shifted onto smaller employers who cannot subscribe to large deductible policies. The Division of Insurance is currently developing regulations to account for the fair distribution of the pool's deficit relative to large deductibles.[56]

While deductible policies reduce the amount employers pay in insurance premiums, some employers with small deductible policies are concerned with the effect of deductibles on their experience modification because the modification is calculated using any losses that fall under the deductible amount. These employers are therefore, in essence, paying for both the loss up to the deductible amount as well as a penalty with their experience modification. Employers with large deductibles do not have the same concern because they are virtually self insured with little interest in their experience modification.

The experience modification is intended to predict future loss experience rather than recoup past losses paid. The experience rating system reflects both frequency and severity. According to the WCRB, if an employer has a number of small injuries that are covered by their deductible amount, it is a good indicator that at some point they will experience one or more severe occurrences. Since the premium amounts paid by the small insureds over many years frequently do not cover the cost of even one serious injury, it is only fair that the impact of a number of small accidents be included in their experience modification. To do otherwise would force a tremendous surcharge whenever an insured had a serious injury.[57]

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[56] After the close of FY'93, the Division of Insurance promulgated regulations that now base assessments for large deductible policies on standard premium. This alleviates the problem of shifting residual market loads plus ARAP.

[57] Interview with Paul Meagher and Howard Mahler, The Massachusetts Workers' Compensation Rating and Inspection Bureau, February 24, 1994.

Self Insurance and Self Insurance Groups (SIGs)

Self insurance and self insurance groups (SIGS) have increased in popularity in the past few years, largely due to the increase in the size of the assigned risk pool. Employers who fund their own workers' compensation claims avoid paying all of the onerous residual market loading that is incorporated into the rates for commercial insurance. Employers may also choose to self insure or join a SIG rather than obtain a policy from the pool. Self insurance and SIGs are a viable alternative to the pool, but they do pose some problems to the system and exacerbate some of the pool's problems.

Self insurance: For an employer to qualify to become self insured, it must post a surety bond of at least $100,000 to cover for losses that may occur (M.G.L. 452 CMR 5:00). This amount varies for every company depending on their previous reported losses and predicted future losses. The average bond, however, is usually over $1 million.[58]

Self insurance is generally available to larger employers with at least 300 employees and $750,000 in annual standard premium.[59] These regulations may be waived by the Commissioner of the DIA for employers that have strong safety records and can produce the necessary bond to cover incurred losses. In addition, employers who are self insured must purchase reinsurance of at least $500,000. Each self-insured employer may administer their own claims or engage the services of a law firm or a third party administrator (TPA) to handle claims administration. The office of insurance evaluates employers every year to determine their continued eligibility and set a new bond amount.

See section on *DIA - Office of Insurance* for fiscal year 1993 statistics on self insurance.

Self- Insurance Groups (SIGs): Companies in related industries may also join forces to form a self insurance group (SIG). The Division of Insurance regulates SIGs and furnishes the office of insurance at the DIA with a list of all SIGs and their member companies. SIGs may include public employers, non-profit groups, and private employers in the same industry or trade association. According to Division of Insurance regulations, the definition of a SIG is:

> a public employers group or a not for profit unincorporated association or a corporation formed under the provisions of M.G.L. c. 180, consisting of five or

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[58] Interview with Richard Lundregan, December 1, 1993.

[59] 452 CMR 5.00: Code of Massachusetts Regulations concerning insurers and self insurers.

more employers who are engaged in the same or similar type of business, who are members of the same bona fide industry, trade or professional association which has been in existence for not less than two years, or who are parties to the same or related collective bargaining agreements, and who enter into agreements to pool their liabilities for workers' compensation benefits and employers' liability in the Commonwealth.[60]

SIGs were permitted in 1985 to provide an alternative to the assigned risk pool and the first group was approved in 1987. After a few years of modest interest, five SIGs were formed in 1990 and 12 in 1992. As of September 1993, the number doubled to 25 SIGs in the state, consisting of 1,922 employers. SIGs have very stringent reporting procedures, but it is difficult to determine how many equivalent premium dollars are accounted for by the SIGs at any given time because each SIG is assessed on a separate basis at different time intervals. A rough estimate from the Division of Insurance puts the amount between $50 and $100 million.[61]

Advantages of self insurance and SIGs: Employers may choose to self insure or join a SIG to avoid the current insurance market and to gain direct control over costs and administration of claims. A company that is denied insurance in the voluntary market may decide to self insure or join a SIG rather than go into the pool, where there are few incentives to control costs and insurance carriers are often cited as offering poor service to the employer. Another factor and incentive to self insure or to join a self insurance group is to avoid the effects of residual market loading. This can provide a large savings considering that in 1989 and 1990 over 50% of every premium dollar written in the voluntary market was used to pay for the assigned risk pool.

There are also more direct advantages that are inherent to self insurance. Employers are directly responsible for their losses because they must pay for every claim incurred. This adds greater incentives to control losses through more effective safety measures and return to work programs.

Disadvantages of self insurance and SIGs: There are some problems associated with the increase in self insurance and SIGs. Administration and regulation of self insurance must keep up with the demand. The DIA has been inundated with requests to self insure, and the Division of Insurance has had many request to join or create SIGs.

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60 Division of Insurance regulations -- 211 CMR 67.02

61 Jim Wright, Division of Insurance, December 3, 1993

The increase in self insurance and SIGs makes it more difficult for the DIA to monitor employers for required insurance. When employers cancel their commercial policies in favor of SIGS, the DIA is notified of the cancellation, but may be unaware that employers have enrolled in a SIG. This makes it more difficult to enforce insurance provisions mandated by the workers' compensation statute.

In addition, self insurers and SIGs do not have guarantee funds, as in commercial policies, to pay for losses if profits turn for the worse. For self insurers, it is possible that the security they have provided may be insufficient to meet the liabilities of employee losses should they encounter economic difficulties.

SIGs have their own unique problems and risks. Companies who join these groups rely heavily on the solvency and safety records of fellow members. The insurance risks are spread among a small group of companies in a related industry. If one of the employers in their group goes bankrupt or suffers an unusual amount of claims for benefits, the whole group must absorb the losses because there is no guarantee fund.

The increase in self insurance and SIGs also affects the distribution of the residual market assessments. As employers turn to self insurance and SIGs, the size of the voluntary market (and hence the assessment base for the pool's deficit) becomes smaller. Commercial insurers will then have to pay a greater share of any losses that occur in the pool.

Reciprocal or Inter- insurance Exchange

A reciprocal exchange is a group of employers from diverse industries who pool their funds to insure themselves. An exchange is not self insurance or a self insurance group, but a way to provide commercial insurance to small and medium sized companies without resorting to the residual market.

In 1993, the controversy continued surrounding the sole reciprocal exchange for workers' compensation in the state. The Massachusetts Employer Insurance Exchange (MEIE) was formed by Associated Industries of Massachusetts (AIM) in 1989 as a reciprocal exchange with over 400 members who pool their risks by exchanging contracts. MEIE now consists of over 800 small and medium sized employers in the state.

In 1990, chapter 462 of the Acts of 1990 clarified the statute to determine that an exchange must contribute to the assigned risk pool's deficit just as other commercial insurers. Propac Mass, the attorney- in- fact for MEIE,

contended that the member companies insure themselves in a similar manner to a self insurance group. They are an unincorporated, nonprofit organization and cannot benefit from the pool as a servicing carrier. Therefore, they should not have to pay for any of the pool's deficit.[62]

MEIE, however, has many structural and procedural differences from a SIG. Employers in MEIE bear limited liability, whereas companies in a SIG are liable for all risks and losses. MEIE is covered by the guarantee fund if the insurer becomes insolvent. SIGs are liable for all losses even if a member company or the group becomes insolvent. Decisions are made in MEIE by its attorney in fact as opposed to SIGs where trustees of the employers make all decisions.

Two hearings were held at the Division of Insurance on October 30, 1992 and another on May 31, 1993 on proposed regulations concerning MEIE and pool assessments. MEIE testified to defend its position as a nonprofit self insurance alternative to the assigned risk pool. The matter was not resolved at the close of FY'93.

II. Priorities for Workers' Compensation Insurance Rate Stabilization

The foremost concern of employers in the state was the stabilization of insurance rates. Double digit increases have placed a heavy burden on the employers, and many believe Massachusetts is at a competitive disadvantage because rates are higher than many other competing high technology and industrial states. From the insurers perspective, however, rates have been inadequate and costs have exceeded the revenue from workers' compensation insurance premiums. Insurers contend that the Division of Insurance has historically suppressed the rates at the cost of insurers resulting in a large residual market and insurer losses.

One way to compare the costs for insurance in Massachusetts with other states is through the average amount that employers spend on workers' compensation insurance

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[62] Testimony of John Gould, President, A.I.M, Joint Committee on Commerce and Labor Massachusetts General Court on April 10, 1993

premiums (this does not take into account costs for self insurers or SIGs). In 1989, the average premium rate in Massachusetts was 2.51% of payroll. This was the 14th highest of the 47 states where commercial insurance is sold, and 13% above the national average.[63] [64]

Premium rates in Massachusetts ranked above those of other industrial and high technology states, where, on average, 2% of payroll was paid for workers' compensation insurance. In New England, however, Massachusetts was more competitive. Only Vermont and New Hampshire had lower rates as a percentage of payroll.[65]

In 1990, insurance rates continued to increase with a 26.2% rate hike and another double digit increase in 1991 of 11.3%. There was a rate filing made by the WCRB for 1992 but rates did not change until January 1, 1993. The trend in rates began to change when, for the first time in five years, the increase slowed to a single digit increase of 6.24% for rates effective January 1, 1993. Rates are predicted to stabilize or decline, and the position of Massachusetts relative to other states should improve once rates are stabilized.

Reduction of the Assigned Risk Pool

The residual market is a symptom of rate inadequacy and escalating costs associated with workers' compensation. If the size of the pool grows (in 1992, 64.7% of all premiums were written in the Pool), the future of the Massachusetts insurance market would be in jeopardy. It is essential to reverse this trend and there are various programs that provide incentives to further its reduction.

In addition to programs such as ARAP and MARRP that are intended to increase cost control and rate adequacy, the following programs were instituted to help depopulate the pool and to provide an incentive to control costs:

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[63] The Competitive Disadvantage of Massachusetts, The Taxpayers Association of Massachusetts, December 1993

[64] Adjusted Manual Premiums from: Burton, John Workers' Compensation Desk Book; LRP Publications, 1992.

[65] Adjusted Manual Premium rates in Massachusetts (as a percentage of payroll) : 1958- 0.859; 1962- 1.034; 1978- 1.374; 1987-1.673

Take out credit program: This program is intended to provide incentives for insurers to offer voluntary coverage to employers in the pool. An insurer that removes from the pool a risk with a premium greater than $150,000 is entitled to credits against its share of the pool deficit at the rate of 75% of the premium for the first year, 62% for the second year, and 50% for the third year. For risks with standard premium below $5,500, the insurer would receive $1.50 for each dollar of premium written over the next three years. For risks with standard premium between $5,500 and $150,000, the insurer would receive a $1.00 credit for each dollar premium written over next three years.

Revised Qualified Loss Management Program (QLMP): The purpose of the QLMP is to encourage employers to get professional assistance to lower their loss experience. Employers in the pool who contract with an approved loss control firm are eligible to receive a maximum credit of 15% (up from 10%) of their premium. Employers can reduce their premiums for three years if they stay in the program. This program began in November, 1990.[66]

Mandatory Direct Assignments: A more drastic and direct approach to depopulate the pool are the proposed mandatory direct assignments that may take place in 1994 pending Division of Insurance regulations. There are two target dates to depopulate the pool to make it a certain percentage of the overall market. If the target goals are not achieved voluntarily, the Division of Insurance will assign employers in the Pool to a carrier until the goal is reached.

Enforcement of Mandatory Coverage

One of the priorities for the office of insurance at the DIA is to make sure all employers have the necessary insurance coverage. In FY'93, the DIA's private trust fund spent $7,844,276 on benefits for employees who were working for uninsured employers. All employers in the state must pay for these employees as the trust fund is maintained by assessments on all employers.

The DIA is now "on line" with the database at the WCRB which enables the office of insurance to get current information on employers who cancel their insurance policies. Investigators from the office then check to see if the employer has reinstated coverage through a commercial policy, self insurance, or SIG before they issue a stop work order or impose fines.

See Section on *DIA - office of insurance* for more information on the enforcement of workers' compensation coverage.

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66 Effective 1/1/94, the credits were extended to a fourth year.

III. Workers' Compensation Insurance Organizations --

Commonwealth of Massachusetts Division of Insurance (DOI)
470 Atlantic Avenue, Boston, 02110. 617-521-7794

- regulates all insurance programs
- monitors and licenses self insurance groups
- **State Rating Bureau** is the section of the DOI that testifies at rate hearings with respect to insurance rates
- Commissioner of DOI holds hearings on rate filings and issues a decision

The Workers' Compensation Rating and Inspection Bureau of Massachusetts - (WCRB)
101 Arch Street, 5th floor, Boston, 02110. 617-439-9030

- private nonprofit body funded by insurers
- licensed rating organization
- WCRB submits workers' compensation insurance rates, rating plans, and forms for approval (rates are subject to approval by the Commissioner of Insurance)
- WCRB is the statistical agent for workers' compensation for the Commissioner of Insurance
- administers assigned risk pool
  - designates insurance carriers for employers who cannot obtain policy in voluntary market
  - collects statistical data from insurers
  - NCCI handles some of the accounting procedures for the pool

National Council on Compensation Insurance (NCCI)
750 Park of Commerce Drive, Boca Raton, Florida, 33487.
407-997-1000

- NCCI is a national organization devoted to workers' compensation insurance. It has a somewhat limited role in Massachusetts

In Massachusetts;

- does some of the accounting for the assigned risk pool under contract with the WCRB
- determines residual market loss reserves

Other states;

- In 34 other states, NCCI is the organization that files for insurance rates or loss costs (in Massachusetts, it is the WCRB that files for rate changes)
- NCCI also administers various state funds where the state acts as an insurance carrier for workers' compensation

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This revision provides a 25% applicable credit for a fourth year

Department of Industrial Accidents - office of insurance
600 Washington Street, Boston, 02111. 617-727-4900 x408
800-323-3249 x408

- monitors insurance coverage
- issues stop work orders and fines to employers without workers' compensation insurance
- issues annual license for self insurance

Rate Setting Commission
2 Boylston Street, Boston, 02116. 617-451-5340

- sets reimbursement rates for medical services in workers' compensation

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of participation in the program.

Insurance Fraud Bureau of Massachusetts

The Insurance Fraud Bureau of Massachusetts (IFB) is the primary organization in the state to combat fraud in the workers' compensation system. The IFB is an insurance industry supported agency authorized by the state to detect, prevent and refer for criminal prosecution suspected fraudulent insurance transactions involving all lines of insurance. It was created originally by automobile insurers in 1990 (MGL c. 338) and further amended in 1991 to include workers' compensation.[67] While its mission statement is to include all lines of insurance, the focus is on automobile and workers' compensation insurance and it is funded by those two industries.

The IFB has a staff of 35 individuals (as of 7/31/93), including a 25 member investigative division, a legal division, and a research division. The revised budget for 1993, shared equally by the Automobile Insurers Bureau and the Workers' Compensation Rating and Inspection Bureau, was $3.6 million.

An annual report and semi- annual report from the IFB document the progress of the Bureau since its inception.

Referrals from companies and other insurance organizations for workers' compensation: running totals, as of --
12/31/91- **4** 7/29/92- **127** 7/30/93- **495**

Total referrals (which includes referrals from public on hot-line):
(hotline #; 1-800-32-FRAUD) running totals, as of --
12/31/91- **24** 7/29/92- **412** 7/30/93- **1132**

Value of referrals: running totals, as of --
12/31/91- **$174,574** 7/29/92- **$9,700,196** 7/30/93-**$34,516,028**

Workers' compensation represents the greatest proportion of losses for all lines of insurance investigated by IFB. In 1992, workers' compensation fraud comprised 52% of the value of all cases investigated (loss value), as opposed to automobile insurance, which comprised 34% of the IFB's loss value. The remainder of the loss value constituted the other lines of insurance.

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[67] MGL St. 1990, c. 338 as amended by St. 1991, c. 398, Section 99.

The IFB works closely with the Attorney General's office to pursue convictions in fraud cases. Three full time prosecutors devoted exclusively to the investigation of insurance fraud are paid out of funds provided by the IFB. In addition, the IFB actively refers cases that have been investigated to the Attorney General's office.

The results of these referrals (shown above) account for both workers' compensation and automobile insurance fraud. From December 31, 1991 (the inception of the IFB) to July 30, 1993, there were 110 completed cases referred to a prosecutor. Out of these, 87 received separate court action (individuals with indictments returned or criminal complaints filed). Final dispositions (convictions, pleading, etc.) number 31 since the creation of the IFB.

The types of workers' compensation cases that are investigated vary greatly. Fraud can be perpetrated by the employee, employer, medical provider, attorney and in some cases the insurance agent, although the majority of IFB cases arise out of employee misconduct. IFB personnel investigated the following types of workers' compensation fraud in 1992:

- cases involving single and multiple suspects with duplicate identities who worked while receiving workers' compensation benefits;

- employer premium evasion cases;

- disability claims where health care documentation or lost wage documentation has been forged;

- conspiracy cases including large multi- line fraud rings, including automobile and workers' compensation, which cross suspects, carriers, legal service and health care providers.

While fraud continues to be a major concern for everyone involved in workers' compensation, the IFB and the Attorney General's office took unprecedented steps in FY'93 to curtail its perpetration. It is difficult to establish criminal intent in fraud cases, but the pursuit of these cases and publicizing any convictions will establish a precedent warning those who consider defrauding the workers' compensation system that fraud will not be tolerated.

Collective Bargaining

Employers and their unionized employees may agree to establish binding obligations and procedures relating to workers' compensation through the collective bargaining process. Agreements may provide for:

1. supplemental benefits under §§34, 34A, 35, 36

2. an alternative dispute resolution system (arbitration, mediation, conciliation)

3. an established list of medical providers the injured employee must visit first for treatment

4. an established list of impartial physicians to examine an injured employee should a dispute on compensability arise

5. modified light duty return to work program

6. adoption of 24 hour coverage plan

7. establishment of safety committees and safety procedures

8. establishment of vocational rehabilitation or retraining programs

Bechtel and Pioneer Valley Building and Trades Council

The first example of a collective bargaining agreement dealing with workers' compensation was negotiated by the Bechtel Construction Company and the Pioneer Valley Building and Construction Trades Council representing 15 labor unions. The agreement covered employees on the construction site of a cogeneration plant for the Monsanto Company in Springfield. While construction began in September, 1992, the agreement was not effective until December. It was in place for six months, to the conclusion of the project.

The agreement utilized many of the allowed alternatives stated above including: (1) supplemental benefits under §§34, 34A, 35, 36; (2) alternative dispute resolution (arbitration, mediation, conciliation); (3) a limited list of medical providers; and (4) a limited list of impartial physicians.

Under the agreement, injured workers were eligible to receive benefits above the statutory requirements. Temporary total disability benefits were increased to 66.7% of the employee's average weekly wage instead of the statutory 60%. The pay without prejudice period was reduced from 180 days to 90 days. Bechtel agreed to increase benefits to workers because costs were expected

to decrease as a result of a more efficient adjudication process and control of access to medical providers.

The parties instituted a three step alternative dispute resolution procedure with a maximum duration of 60 days. All disputes would first go to the company ombudsman to deal with minor problems. If the dispute could not be resolved after five days, the case would proceed to a mediator. There are no attorneys involved for these first two steps. Finally, if necessary, the dispute could reach arbitration. An arbitrator amenable to both sides was pre-selected to avoid any delays. Judge Ryan, a retired worker's compensation judge from the state, was chosen.

Under the labor-management agreement, a health care network was created to provide both cost effective and superior medical services to injured employees. The network consisted of over 400 physicians statewide and employees were allowed one second opinion. In order to get the most qualified doctors and to assure access to quality medical care, providers were paid between 8%-25% more than determined by the state.

The plan reduced costs by limiting physician choice, inhibiting doctor shopping and promoting return to work. The plan also combined the medical network with the impartial medical exam so the same physician could testify if needed in case of a dispute. This was designed to eliminate any "dueling doctors" or a separate impartial examination. Return to work and education of the patients regarding their rights and responsibilities was facilitated by early intervention and a patient advocate.

This first example of collective bargaining in the state seems to have been extremely successful. Preliminary results indicate a reduction in claims. Before the agreement, 11 lost time cases occurred out of 225,000 hours worked. Following the agreement, only two lost time cases have been reported in 220,000 hours worked.[68]

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[68] Business Insurance, May 31, 1993, p.21-22

Legislation

Since implementation of the workers' compensation reform act in December, 1991, attempts to further alter the system have been held in abeyance, although numerous bills have been filed by legislators. In fiscal year 1993, 46 bills were filed in the House and Senate to further amend the system, none of which was implemented.

The Advisory Council, in reviewing legislation prior to the Joint Committee on Commerce and Labor hearing in April 1993, voted to recommend that no further law changes be made to workers' compensation statutes until the full impact of the 1991 reforms could be evaluated. In forming this position, the Advisory Council was mindful of its mandate under Chapter 398 to conduct a study evaluating the economic impact of the decrease in partial and temporary total disability benefits from 2/3 to 60% of an injured employee's average weekly wage.

The AFL-CIO submitted H-4068 calling for revision of 17 sections of chapter 152. This bill called for restoration of the pre-1991 wage benefit levels to 2/3 of an injured employee's average weekly wage for permanent partial and temporary total disability. Furthermore, the legislation would reduce the pay without prejudice period from the current 180 days to 60 days, making compensation payable to date of injury when incapacity exceeds five days. In addition, the bill would modify what constitutes a switch in health care provider by the employee, alter the duties of employees and physicians when independent medical exams are conducted, and prohibit insurers from reducing the amount paid to employees in lump sum settlements by the amount of attorney fees.

Associated Industries of Massachusetts (AIM) submitted House 1957 that also called for substantial changes to the workers' compensation system. Highlights of this bill included streamlining the dispute resolution process by eliminating the conference step. In addition, the bill called for altering the award of attorney's fees by reducing the fees paid for a lump sum settlement and by requiring that every party pay their own attorneys fees. In addition, this legislation would have allowed employers the opportunity to obtain resignations when a lump sum agreement includes future wages. It also proposed altering the impartial examination process by requiring direct payment of an impartial physician by the insurer thereby eliminating the need for execution of state contracts.

The DIA submitted its own proposal, House 230, that called for revisions to 34 sections of chapter 152. While many of the department's proposals could be characterized as technical in nature (e.g., clarifying ambiguities within the statute), several

changes also called for substantive revision. For example, employers would be required to furnish notice of injury when employees are incapacitated for six or more calendar days, rather than five. Moreover, the legislation would have required that insurers be restricted from using penalties and fees resulting in additional litigation costs and attorney's fees in setting premiums or experience modifications for insureds.

Dispute Resolution -- case timeframe

While the department has reduced the conference level backlog and the time it takes to get to a judge initially at conference, the case timeframe for each step of the dispute resolution process still exceeds the statutory time requirements for each step of the process. In FY'93, the average time to reach a hearing decision following the appeal of the conference order has increased significantly.

The Council recommends that the department attempt to meet the statutory requirement for each step of the dispute resolution process. Particular attention must be made to the timeframe to reach the hearing decision. In FY'93, it took an average of 317.2 days to reach a final decision following an appeal of a conference order. This is an increase of 67.5 days from the previous fiscal year. It is also 259.2 days above the statutory requirements of 58 days to reach a hearing decision following the appeal of a conference order.

If these statutory timeframe requirements are unrealistic or unattainable, the Council recommends that the DIA reevaluate the requirements and file legislation to reflect adequate and feasible timeframes. Employees, employers, and insurers have a right to know how long it will take to reach each step of the dispute resolution process.

Dispute Resolution -- number of judges

The department has made great strides in eliminating the conference backlog, and as a consequence the average amount of time it took to get to a conference in FY'93 decreased. At the same time, however, the amount of time it took in the past fiscal year to reach the hearing increased substantially.

There are currently six three year judges whose terms will expire on February 1, 1995. These six positions were temporary ones created in 1991 to handle the backlog of cases. The Council suggests that the Department evualate the number of judges that are needed in order to handle the current case load without delays and to handle any increases in cases that may arise.

The current level of administrative judges at the department is 32 including these six judges. A determination must be made whether 26 judges will be capable of handling all cases expeditiously or if there is enough demand to necessitate 32 judges.

Dispute Resolution -- judges' performance

Concern was expressed in FY'93 that the number of cases outstanding for some judges was unacceptably high, particularly when compared to other judges. In fact, in a few instances the Senior Judge was compelled to take a few judges "off-line", that is to require that they no longer hear any new cases.

While placing a judge on off-line status is necessary to keep a judge's personal backlog from expanding, it has contributed to the overall backlog at the conference and hearing stages of dispute resolution. Taking a judge off-line is used both as a practical method of allowing a judge to catch up, but also places the judge on notice that their inability to keep up has been recognized as negatively affecting the dispute resolution system.

Despite the punitive implications of being off-line, those judges in this status have only very slowly reduced their backlogs. Moreover, an AJ was reappointed on two occasions for six month terms on the condition that they hear no additional cases and that their backlog be extinguished.

The Advisory Council was encouraged by the prospect that salary increases can be related to performance of judges, and used as an additional incentive to issue orders and decisions in a timely manner. The Senior Judge has been capable of sanctioning judges only by taking them off-line and associating this with the reappointment process. This was his only recourse short of recommending removal for egregious failure to perform.

The ability of the Senior Judge to provide direct financial incentives for good performance should prove to be a motivating force for administrative judges to improve performance. The Advisory Council strongly recommends that performance evaluations for merit pay increases for the judges directly relate to their ability to meet the demands of their personal case load.

Office of Claims Administration (OCA)

The backlog in data entry of certain forms at OCA had been a persistent problem because of the tremendous number of forms that are filed every year. The record room at OCA is poorly equipped with old file cabinets and it does not have the capacity to file and store all the numerous forms and paperwork that are required for each case.

The Advisory Council recommends that OCA proceed with their plans to modernize the unit so they are able to manage without delays the entry and processing of all forms. Modernization of the record room is also essential so all information can be stored safely and retrieved at will.

Statistics and Information

The DIA should publish an annual report and statistical summary detailing activity at the Department. The last annual report published by the DIA was a report assessing fiscal years 1985 - 1989. There have been no annual reports or statistical summaries since that time. The data processing unit does provide a variety of statistics upon request from the Diameter database. Most of these reports are difficult to comprehend without a lengthy explanation for each report. An annual report with a statistical summary is vital to assessing the efficacy of the current system.

Office of Education and Vocational Rehabilitation (OEVR)

The information office at OEVR is responsible for the dissemination of information to everyone involved in workers' compensation. Particular attention must be focused on those who are directly affected by the system including employees, employers, insurers, and medical providers.

Information supplied to employees detail only the minimum requirements. There should be more detailed informational pieces distributed to employees that explain their rights and responsibilities.

Personnel

In the past few years, the DIA has been funded for 332 positions while staffing levels have not gone beyond 302. According to the Department, hiring freezes within state government and lack of funds in the budget have impeded hiring up to the 332 level.

The Advisory Council recommends that the Department reevaluate staffing needs and determine the appropriate number of maximum positions.

Acknowledgments

This report would not be complete without the assistance of many individuals in the workers' compensation field. The beginning stages of the report required collection of various statistics and reports. Joe Constantine and Corinne Collins from the data processing unit at the DIA were very helpful in running these reports from the Diameter database and describing their contents.

Each section of the annual report concerning a DIA office was written and then submitted to the department heads so they could review the section for factual accuracy. The department heads deserve thanks for their time and thorough insights, especially into procedural matters. Senior Judge Jennings deserves special credit for his careful review and explanation of the division of dispute resolution.

On matters relating to workers' compensation insurance, it proved quite a challenge describing this complex market in basic terms. Input from Howard Mahler and Paul Meagher of the Massachusetts Workers' Compensation Rating & Inspection Bureau as well as Walter Horn of the Division of Insurance was invaluable.

The greatest source of information for the report was the monthly meetings held by the Advisory Council. Every second Wednesday of the month, the Advisory Council members provided a forum that delineated the problems, challenges, and success stories in the workers' compensation system. Debate and discussion between labor and management themselves or between the Council and the administrative agencies have provided dialogue that is essential to the success of the workers' compensation system.

Special thanks goes out to all who have participated in these meetings.

Table of Contents - Appendix

APPENDIX A

ADVISORY COUNCIL MEMBERS IN FISCAL YEAR 1993

Jeanne-Marie Boylan, Boston Sand and Gravel Company, 169 Portland Street, Boston, MA 02114 Tel: 617-227-9000 FAX 617-523-7947
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James Farmer, Local 1044, AFL-CIO, Glaziers & Glass Workers' Union, 25 Colegate Road, Roslindale, MA 02131 Tel: 617-524-2365 FAX 617-524-2623
John Gould, Associated Industries of Massachusetts, 222 Berkeley Street, P.O.Box 763, Boston, MA 02117-0763 Tel: 617-262-1180 FAX 617-536-6785
Antonio Frias Jr., S & F Concrete Company, 166 Central Street, P.O.Box 427, Hudson, MA 01749 Tel: 508-562-3495 FAX 8-1-508-562-9461
John Goglia, International Association of Machinists & Aerospace Workers, AFL-CIO, 73 Auburn Street, Saugus, MA 01096 Tel: 617-233-3675 FAX 617-233-7777
Edmund Corcoran, Raytheon, 141 Spring Street, Lexington, MA 02173 Tel: 617-860-3811 FAX 617-860-2408
Samuel Berman, 11 Barberry Road, Lexington, MA 02173 Tel: 617-862-4760 FAX 617-863-8509
William H. Carnes, Teamsters Union Local 25, 544 Main Street, Boston, MA 02129-1113 Tel: 617-241-8831 FAX 617-242-4284
James Donovan, 4 Poplar Street, Danvers, MA 01923 Tel: 508-762-0230

Amy Vercillo, Rehab Re-employment, 470 Totten Pond Road, Waltham, MA 02154 Tel: 617-890-5122 FAX 617-890-3065
Edwin Wyman, Jr.MD
MGH, Ambulatory Care Center, Room 531, 15 Parkman Street, Boston, Massachusetts 02114 Tel: 617-726-3544 FAX 617-726-7587
Emily Novick, Esq.
Kehoe,Doyle, Playter & Novick, 20 Winthrop Square, Boston, MA 02110 Tel: 617-338-0070 FAX 617-338-2160
Stephen P. Tocco, Secretary of Economic Affairs, Executive Office of Economic Affairs, Room 2101, One Ashburton Place, Boston, MA 02108 Tel: 617-727-8380 FAX 617-727-4426
Christine Morris, Secretary of Labor, Room 2112, One Ashburton Place, Boston, MA 02108 Tel: 617-727-6573 FAX 617-727-1090

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

Chairman
Jeanne-Marie Boylan
Vice-Chairman
Edward Sullivan, Jr.

Executive Director
Matthew A. Chafe

Voting Members	Term Exp.Date
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
John Gould (Business)	6/25/95
Edward Sullivan, Jr. (Labor)	6/25/96
Antonio Frias, Sr. (Business)	6/25/96
William Carnes (disabled worker-labor)	6/25/97
Jeanne-Marie Boylan (Business)	6/25/97
Non-Voting Members:	
Emily Novick, Esq. (Claimants' Bar)	6/25/93
Edwin Wyman, Jr.MD (Medical)	6/25/94
Amy Vercillo (Rehab)	6/25/95
John Marr (Insurance) (resigned 1993)	6/25/97
Christine Morris Executive Office of Labor	Ex-Officio
Stephen Tocco Executive Office of Economic Affairs	Ex-Officio

APPENDIX B

AGENDA
FISCAL YEAR 1992

July 8, 1992

Judicial Appointments
Minutes
DIA Updates - IME's/Budget/Backlog/Fraud/Office of Safety
Rate Filing
Discussion - Scheduling Position/Report
Miscellaneous

August 19, 1992

Judicial Appointments
Minutes
Court Litigation - Update
DIA Updates
Medical Guidelines
Supplemental Report
Miscellaneous

September 9, 1992

Minutes - July and August
DIA Updates
Rate Filing Update
Personnel
Miscellaneous

October 9, 1992 - Sub-committee Meeting

Selection Committee - Position of Executive Director
Testimony Oversight Hearing

October 14, 1992

Minutes - September
DIA Updates
Fraud Bureau - Daniel J. Johnston
Executive Director Position
Rate Hearing Update
Oversight Hearing Update
Miscellaneous

October 29, 1992

Selection of Executive Director

November 18, 1992

Minutes
DIA Updates
Executive Director Position
Miscellaneous

December 9, 1992

DIA Updates
Budget
Executive Director Position
Minutes - October 14, October 29, and November 18, 1992
Miscellaneous

January 21, 1993

DIA Update
Judicial Appointments
Executive Director Position
Minutes - December 9, 1993
FY'94 Contracts
Miscellaneous

February 10, 1993

DIA Update
Judicial Appointments
Executive Director Position
Minutes - January, 1993
FY'94 Contracts
Miscellaneous

February 12, 1993 - Subcommittee Meeting

Executive Director Position

March 10 1993

DIA Update
Executive Director Position
Minutes - February 10th and Subcommittee February 12th
Legislation
Miscellaneous

April 7, 1993

Legislation

May 12, 1993

Proposed Utilization Review Regulations Hearing -
Dr.Troyan A. Brennan, Harvard School of Public Health
DIA Update - Senior Judge Jennings
RFP's/Wage Replacement Rates and study of Insurance
Rate Methodology

May 12, 1993

Hearing before the Joint Committee on Commerce and Labor
Update by Chair/Vice Chair
Rate Setting - Diane Jacobs
Upcoming Hearings
Minutes - March & April
Miscellaneous

June 9, 1993

DIA Update - Senior Judge Jennings
Judicial Nominations
Annual Report
Scope of Services
Hearings Update
Minutes - May
Miscellaneous

APPENDIX C

ADMINISTRATIVE JUDGE DECISIONS FILED FY '93

NAME	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	TOTAL
Bean				0	0	2	6	2	2	1	4	1	18
Beard	2	5	8	8	5	11	1	2	5	4	3	1	55
Bradford				0	0	0	1	0	6	5	1	5	18
Brooker	4	0	0	0	0	0	0	0	0	0	0	0	4
Carroll				0	0	1	1	4	2	6	4	4	22
Chivers				0	2	2	2	3	12	7	5	18	51
Cleary	5	1	0	0	0	0	0	0	0	0	0	0	6
Coleman	4	6	2	4	6	2	9	8	8	7	9	6	71
Cox	2	6	2	5	2	3	9	5	4	2	0	7	47
D'Esti	4	2	7	3	4	2	10	7	6	7	3	8	63
Donnelly				0	0	0	1	7	4	7	8	3	30
Ferin	14	1	0	0	0	0	0	0	0	0	0	0	15
Fischel	2	4	0	1	0	0	0	0	0	0	0	0	7
Gallo	0	0	0	0	0	0	0	0	0	0	0	0	0
Gromelski	2	5	2	3	2	4	4	5	7	4	2	3	43
Heffernan	1	6	10	1	4	7	8	11	8	3	2	9	70
Jackson	4	7	0	0	13	3	5	6	16	20	3	2	79
Johnson				0	0	0	1	9	1	6	4	2	23
Lamothe				0	0	2	2	2	4	5	4	6	25
Lee	2	0	0	0	0	0	0	0	0	0	0	0	2
Leroy	10	7	5	8	16	7	10	12	19	10	10	6	120
Levine				1	0	1	1	2	3	5	2	1	16
Maze-Rothstein				0	0	0	0	0	0	0	2	0	2
McGillen				0	0	0	0	0	2	2	1	2	7
McGuinness	3	13	0	6	0	2	13	7	4	8	6	8	70
McKenna	8	3	2	1	3	3	0	2	1	1	1	5	30
McKinnon	7	2	11	2	2	11	6	8	6	5	0	13	73
McLaughlin				0	0	1	1	1	4	0	9	9	25
Merlo				0	4	1	2	4	3	0	6	5	25
Moore				0	0	0	3	0	0	3	3	3	12
Moreschi	12	7	8	3	7	8	1	6	6	3	1	2	64
O'Shea				0	1	2	1	1	6	2	8	7	28
Rogers	1	0	0	0	0	0	0	0	0	0	0	0	1
Solomon	2	7	5	3	4	6	6	6	5	11	4	0	59
St. Amand	4	0	3	3	1	2	1	1	3	0	8	5	31
Sumner	-	1	0	0	0	0	1	1	2	3	0	3	11
Taub	1	1	4	0	9	0	6	11	2	5	11	4	54
Thompson	3	3	4	5	4	2	2	0	5	3	2	1	34
Tirrell	6	8	6	8	6	1	7	5	9	11	10	5	82
Woodward	-	-	2	0	0	0	0	3	4	7	7	0	23
Totals:	103	95	81	65	95	86	121	141	169	163	143	154	1416

Taken from reports 431 and 488B

APPENDIX D

CASES RESOLVED BY ADMINISTRATIVE JUDGES FY'93
(lump summed, withdrawn, adjusted, others)

NAME	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	TOTAL
Bean	-	1	37	73	109	68	83	59	41	63	95	33	662
Beard	39	48	68	50	67	27	55	68	44	80	9	34	589
Bradford	-	1	34	54	89	82	52	77	50	37	62	41	579
Brooker	7	0	0	0	3	0	0	0	0	0	0	0	10
Carroll	6	61	120	94	94	96	42	23	91	94	25	72	818
Chivers	-	1	19	66	90	103	57	91	44	20	73	35	599
Coleman	31	34	59	84	36	32	63	45	58	64	59	29	594
Cox	39	42	75	24	33	62	73	50	47	61	63	52	621
D'Esti	60	50	32	85	31	38	42	46	41	46	41	33	545
Donnelly	4	53	108	80	77	98	50	40	90	25	26	48	699
Ferin	8	0	0	0	0	0	0	0	0	0	0	0	8
Fischel	6	3	2	2	0	1	0	0	0	0	0	0	14
Gallo	2	1	0	0	0	0	0	0	0	0	0	0	3
Gromelski	66	81	73	43	90	50	51	41	77	42	34	85	733
Heffernan	63	96	21	52	40	97	52	37	88	41	29	62	678
Jackson	44	33	3	4	4	9	7	23	12	18	6	4	167
Johnson	9	61	121	76	129	86	33	64	61	55	37	46	778
Lamothe	8	39	106	67	73	102	50	31	50	46	32	75	679
Lee	6	0	1	0	0	0	0	0	0	0	0	0	7
Leroy	61	38	110	58	70	81	47	53	83	40	27	70	738
Levine	30	68	96	83	99	72	57	68	87	28	29	55	772
Maze-Rothstein		1	39	62	103	120	94	69	77	37	72	40	714
McGillen	38	82	81	101	103	81	30	59	59	41	32	74	781
McGuinness	42	62	91	53	55	25	75	62	22	44	47	26	604
McKenna	53	80	64	41	33	62	35	36	101	54	37	81	677
McKinnon	53	62	74	59	112	50	71	44	52	45	42	22	686
McLaughlin	-	1	15	74	50	80	86	58	55	26	42	38	525
Merlo	35	80	95	75	95	99	37	58	51	29	38	65	757
Moore	-	1	29	53	84	77	75	80	23	27	54	60	563
Moreschi	37	78	43	68	82	58	30	49	55	38	45	92	675
O'Shea	-	1	25	62	129	89	42	81	23	30	61	48	591
Rogers	1	0	0	0	0	0	0	0	0	0	0	0	1
Ryan	0	0	0	1	0	0	0	0	0	0	0	0	1
Solomon	53	60	124	66	77	47	85	60	63	86	7	38	766
St.Amand	107	6	65	77	94	39	43	55	55	60	53	43	697
Sumner	36	81	59	88	66	70	58	68	57	31	49	34	697
Taub	70	39	44	82	52	51	86	38	43	69	35	52	661
Thompson	71	21	109	38	75	66	41	48	89	39	42	54	693
Tirrell	64	40	115	52	42	59	62	43	67	66	35	59	704
Woodward	32	78	74	87	80	57	44	61	52	34	46	31	676
Totals:	1181	1484	2231	2134	2466	2234	1808	1785	1908	1516	1384	1631	21762

Taken from reports 45B, 346 and 319B

APPENDIX E

REQUESTS FOR ADJUDICATION
FY'1993

Comparison Fiscal Year

Total Lump Sums	Lump Sums Scheduled	Lump Sums Approved
FY'93	16,325	13,068 (80%)
FY'92	17,210	12,679 (74%)
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 and Discontinuance

	Claims/Discontinuances		# Referred to Conciliation	
	Average Per Month	Average Per Week	Average Per Month	Average Per Week
Monthly Total				
July, 1992	3691/5	738	3082/5	616
August, 1992	2893/4	723	2420/5	605
September, 1992	2680/4	670	2258/4	565
October, 1992	3436/5	687	3019/5	605
November, 1992	2575/4	644	2249/4	562
December,1992	2994/5	599	2676/5	535
January, 1993	2756/4	689	2443/4	611
February, 1993	2873/4	718	2552/4	638
March, 1993	2890/4	723	2516/4	629
April, 1993	3354/5	671	3018/5	604
May, 1993	3065/4	766	2650/4	662
June, 1993	2914/4	729	2259/4	565
Total:	36,121/52	695	31,142/52	599

APPENDIX F

	PUBLIC TRUST (1)	PRIVATE TRUST (2)	SPECIAL FUND (3)	IMPARTIAL MEDICAL (4)
6/30/92 Balance	$3,056,655	$3,652,611	$2,621,052	- 0 -
7/1/92 thru 6/30/93 Collections	1,731,069	25,825,887	17,455.098	2,981,687
TOTAL	$4,787,724	$29,478,498	$20,076,150	$2,981,687
7/1/92 thru 6/30/93 Expenditures	2,495,760	21,890,386	17,040,260	1,027,985
6/30/93 Ending Balance	$2,291,964	$ 7,588,112	$ 3,035,890	$1,953,702

(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) Pursuant to Chapter 398 of the Acts of 1991, §11A revenue collected for the Impartial Medical Unit is expended to reimburse for impartial medical examinations.

APPENDIX G

PROPOSALS FUNDED BY THE DIA'S OFFICE OF SAFETY FISCAL YEAR 1994

1. Technology Education Clearing House, Inc. (Tech)
   1 Summer Street
   Somerville, MA 02143
   (617) 776-2777

   Title: Office Technology Education Project (OTEP)
   Category of Applicant: Non-profit Organization
   Target Population: Employees/ers/Supervisory Personnel
   Geographic Area: Quincy
   Program Administrator: Beverly Tillery
   Total Funds Requested: $34,961.13 **Revised 5/4: $34,434.72**
   Problem Addressed: Cumulative Trauma Disorders (CTD)

2. Western MassCOSH (Western Massachusetts Coalition for Occupational Safety and Health)
   458 Bridge Street
   Springfield, MA 01103
   (413) 731-0760

   Title: Preventing Workplace Transmission of Infectious Disease (HIV, HBV, TB)
   Category of Applicant: Non-profit Organization
   Target Population: Employees
   Geographic Area: Western Massachusetts
   Program Administrator: Philip Korman
   Total Funds Requested: $33,927.67 **Revised 5/5: $33,665.81**
   Problem Addressed: HIV, HBV, TB

3. Centro Hispano de Chelsea
   5 Everett Avenue
   Chelsea, MA 02150
   (617) 884-3238

   Title: Job Safety Education and Training
   Category of Applicant: Non-profit Organization
   Target Population: Employees
   Geographic Area: Chelsea
   Program Administrator: Jose Fernandez
   Total Funds Requested: $33,310.00 **Revised 5/5: $30,508.40**
   Problem Addressed: CTD/General Safety

4. MassCOSH
   555 Amory Street
   Boston, MA 02130
   (617) 524-6686

   Title: Health and Safety for High Technology Workforce
   Category of Applicant: Non-profit Organization
   Target Population: Employees
   Geographic Target: Central/Eastern Massachusetts
   Program Administrator: Laurie Stillman
   Total Funds Requested: $34,994.30 **Revised 5/6: $34,294.30**
   Problem Addressed: CTD

5. Heat, Frost and Asbestos Workers Local # 43
1053 Burts Pitt Road
Northampton, MA 01060
(413) 584-0028

Title: Preventing Asbestos Related Diseases in the Building Trades
Category of Applicant: Labor Organization or Federation
Target Population: Employees
Geographic Area: Central/Western Massachusetts
Program Administrator: Robert Starr
Total Funds Requested: $21,736.64 **Revised 5/4: $21,486.64**
Problem Addressed: Asbestos

6. Safety Council of Western MA
90 Berkshire Avenue
Springfield, MA 01109
(413) 737-7908

Title: VDT Corporate Awareness and Safety Program
Category of Applicant: Non-profit Organization
Target Population: Employees/ers/Supervisory Personnel
Geographic Area: Central/Western Massachusetts
Program Administrator: James Moynihan
Total Funds Requested: $28,445.00 **Revised 4/26: $20,949.94**
Problem Addressed: CTD

7. Southern New England District Council
International Ladies Garment Workers Union
Garment Workers Square
Fall River, MA 02720
(508) 674-5762

Title: Health/Safety Education for the Needle Trades in Southeastern MA
Category of Applicant: Labor Organization/Federation
Target Population: Employees
Geographic Target: Southeastern Massachusetts
Program Administrator: Nicholas Roussos
Total Funds Requested: $35,000.00 **Revised 5/4: $31,001.01**
Problem Addressed: CTD

8. City of Boston
Office of Personnel Management Rm 612
Boston City Hall
Boston, MA 02201
(617) 635-3369

Title: Boston Labor Management Cooperation Program
Category of Applicant: Public Employer
Target Population: Employees/ers/Supervisory Personnel
Geographic Area: Boston Area
Program Administrator: William Kessler
Total Funds Requested: $34,952.08 **Revised 4/16: $24,531.88**
Problem Addressed: CTD/HIV/HBV/TB

9. Roofers Union Local #33
Joint Apprenticeship and Training Committee
51 Neponset Avenue
Dorchester, MA 02122
(617) 288-7451

Title: Health and Safety Awareness of Apprentice Roofers
Category of Applicant: Non-Profit/Labor/Joint Management
Target Population: Employees
Geographic Target: Boston
Program Administrator: James Hayden
Total Funds Requested: $34,923.58 **Revised 5/6: $34,423.59**
Problem Addressed: CTD/General Safety

10. American Red Cross of Massachusetts Bay
61 Medford Street
Somerville, MA 02143
(617) 623-0033 ext.

Title: Preventing Disease Transmission
Category of Applicant: Non-profit Org.
Target Population: Employees/Employers/Supervisory
Geographic Area: Eastern Massachusetts
Program Administrator: Jan Bober
Total Funds Requested: $34,932.00 **Revised 5/4: $27,994.00**
Problem Addressed: Blood Born Pathogens

11. Division of Occupational Hygiene
MA Department of Labor and Industries
1001 Watertown Street
West Newton, MA 02165
(617) 727-3982

Title: Preventing Lead Poisoning on Massachusetts Bridge Projects
Category of Applicant: Public Employer
Target Population: Employee/ers/Supervisory
Geographic Target: Statewide
Program Administrator: Paul Aboody
Total Funds Requested: $34,974.00 **Revised 5/10: $32,344.00**
Problem Addressed: Lead Poison

12. Harbor Health Services, Inc.
398 Neponset Avenue
Dorchester, MA 02122
(617) 282-3200

Title: Think Safety/Work Safely-an education, training and prevention program
Category of Applicant: Non-profit Organization
Target Population: Employees/ers/Supervisory Personnel
Geographic Area: Boston/Dorchester
Program Administrator: Paulette Shaw Querner
Total Funds Requested: $29,677.06 **Revised 5/6: $26,176.96**
Problem Addressed: HIV/HBV

13. Massachusetts Carpenters Training Program
13 Holman Road
Millbury, MA 01527
(508) 792-5443

Title: Safety in Construction 10 & 30 Hour Courses
Category of Applicant: Labor Org./Non-profit Org./Trade
Target Population: Employees/ers/Supervisory Personnel
Geographic Area: Statewide
Program Administrator: James O'Leary
Total funds Requested: $34,929.34 **Revised 5/5: $31,262.70**
Problem Addressed: Construction Safety

14. Marlborough Hospital/The Health Care Manager
57 Union Street
Marlborough MA 01752
(508) 481-5000 ext. 361

Title: Medworks
Category of Applicant: Non-Profit Organization
Target Population: Employees/Employers/Supervisory
Geographic Area: Central/Eastern Massachusetts
Program Administrator: Gail Army
Total Funds Requested: $34,571.64 **Revised 4/26: $16,958.92**
Problem Addressed: CTD

APPENDIX H

ASSESSMENT RATES

PUBLIC

Fiscal Year		
1987	7/1/86-6/30/87	.0102
1988	7/1/87-6/30/88	.0153
1989	7/1/88-6/30/89	.2900
1990	7/1/89-6/30/90	.1271
1991	7/1/90-6/30/91	.0864
1992	7/1/91-6/30/92	.08113
1993	7/1/92-6/30/93	.00107
1994	7/1/93-6/30/94	.02789

PUBLIC GROUP

1987	.0125
1988	.0216
1989	.06002
1990	.10416
1991	.09164
1992	.05574
1993	.00091
1994	.00227

INSURED

Fiscal Year	PUBLIC	PRIVATE	SPECIAL		PRIVATE	
1987	.013	.030		.43		.57
1988	.012	.020		.55		.45
1989	.029	.013		.78		.22
1990	.050	.012		.70		.30
1991	.049	.019	*(.05)	.42	*(.95)	.58
1992	.039	.030		.27		.73
1993	.001	.026		.38		.62
1994	.03	.032		.375		.625

*3rd Quarter change only.

Self Insured OPT-OUT

1993	.01847	.356	.68	.32
1994	.02490	.325	.66	.34

SELF-INSURED

	RATE	BASE RATE
1987	.0373	.3679
1988	.0379	.41501
1989	.0262	.38914
1990	.0240	.44742
1991	.0363(**.0173)	.47939
1992	.0428	.37661
1993	.03295	.356
1994	.04084	.325

PRIVATE GROUP

1990	.02397
1991	.03630
1992	.04284
1993	.03295
1994	.00862

**Incorrect rate - rebilled

PRIVATE GROUP OPT-OUT

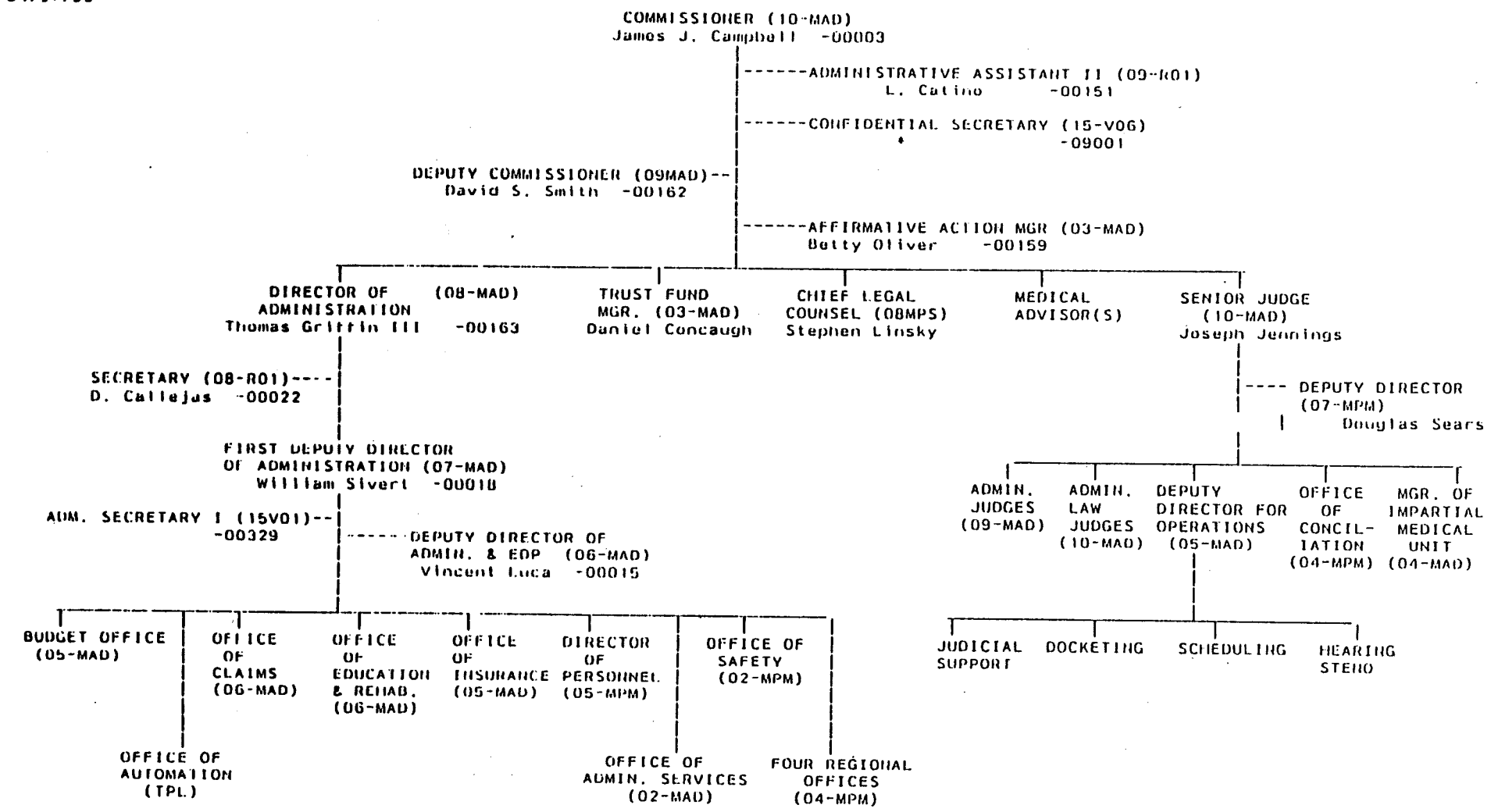
1994	.00525

APPENDIX I

SUMMARY OF JUDGES' APPOINTMENT DATES (12/29/93)

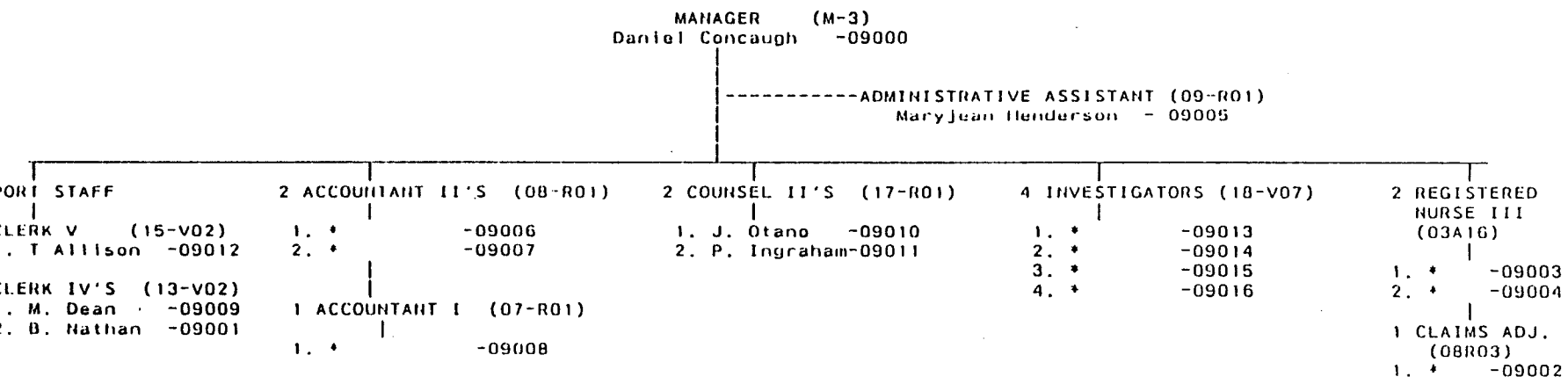
	NAME	INITIAL	PRESENT	EXPIRE
INDUSTRIAL ACCIDENT REVIEWING BOARD SIX YEAR TERMS				
1.	Carolynn Fischel	5/21/86(AJ)	6/10/92	5/28/98
2.	James Kaplan	6/10/92	6/10/92	6/10/98
3.	William McCarthy	8/23/78(AJ)	5/21/92	5/21/98
4.	Suzanne Smith	6/03/92	6/03/92	6/03/98
5.	Sara Holmes Wilson	7/08/92	7/08/92	5/28/98
6.	OPEN (B Pearson resigned effective 1/13/94)			5/28/98
INDUSTRIAL ACCIDENT BOARD SIX YEAR TERMS				
1.	Douglas Bean	7/22/92	6/30/93	6/26/99
2.	Vivian Beard	7/27/88	7/27/88	7/27/94
3.	Martine Carroll	6/18/92	12/29/93	1/31/00
4.	David Chivers	7/08/92	7/08/92	5/28/98
5.	Janet Cox	7/13/88	5/21/92	5/21/98
6.	Fran Gromelski	3/16/89	1/25/89	9/04/97
7.	Emogene Johnson	6/18/92	6/18/92	7/29/94
8.	James Lamothe	6/03/92	6/03/92	7/06/94
9.	Jacques LeRoy	7/13/88	7/13/88	7/13/94
10.	Susan Maze-Rothstein	7/22/92	7/22/92	5/28/98
11.	John McLaughlin	7/29/92	7/29/92	5/28/98
12.	James McGuinness	8/01/84	8/01/84	7/05/96
13.	John McKenna	7/31/91	7/31/91	1/31/97
14.	John McKinnon	12/10/80	6/26/92	6/26/98
15.	Theodore Merlo	6/03/92	6/03/92	5/28/98
16.	Helen Moreschi	8/03/88	8/03/88	8/03/94
17.	Daniel O'Shea	7/22/92	7/22/92	5/21/98
18.	James St. Amand	5/14/86	5/14/92	5/14/98
19.	Dianne Solomon	8/10/98	8/10/94	8/10/94
20.	Jo'Anne Thompson	8/28/91	9/18/92	9/18/98
21.	Francis Woodward	5/13/92	5/13/92	5/26/95
INDUSTRIAL ACCIDENT BOARD THREE YEAR TERMS				
1.	John Bradford	8/05/92	8/05/92	2/01/95
2.	Lawrence Donnelly	7/24/92	7/24/92	2/01/95
3.	Frederick Levine	5/20/92	5/20/92	2/01/95
4.	James McGillen	5/20/92	5/20/92	2/01/95
5.	Richard Moore	7/08/92	7/08/92	2/01/95
6.	Stephen Sumner	5/20/92	5/20/92	2/01/95
INDUSTRIAL ACCIDENT BOARD ONE YEAR TERMS				
1.	Norris Coleman	7/06/88	12/22/93	7/15/94
2.	Joellen D'Esti	12/12/90	7/17/93	7/17/94
3.	Richard Heffernan	5/28/86	7/15/93	7/15/94
4.	Fred Taub	5/02/89	7/01/93	7/01/94
5.	Richard S. Tirrell	10/04/89	7/01/93	7/01/94

04/27/93


COMMISSIONER (10-MAD)
James J. Campbell -00003
ADMINISTRATIVE ASSISTANT II (09-R01)
L. Catino -00151
CONFIDENTIAL SECRETARY (15-V06)
-09001
DEPUTY COMMISSIONER (09MAD)
David S. Smith -00162
AFFIRMATIVE ACTION MGR (03-MAD)
Betty Oliver -00159
DIRECTOR OF ADMINISTRATION (08-MAD)
Thomas Griffin III -00163
TRUST FUND MGR. (03-MAD)
Daniel Concaugh
CHIEF LEGAL COUNSEL (08MPS)
Stephen Linsky
MEDICAL ADVISOR(S)
SENIOR JUDGE (10-MAD)
Joseph Jennings
SECRETARY (08-R01)
D. Callejas -00022
DEPUTY DIRECTOR (07-MPM)
Douglas Sears
FIRST DEPUTY DIRECTOR OF ADMINISTRATION (07-MAD)
William Sivert -00018
ADM. SECRETARY I (15V01)
-00329
DEPUTY DIRECTOR OF ADMIN. & EDP (06-MAD)
Vincent Luca -00015
ADMIN. JUDGES (09-MAD)
ADMIN. LAW JUDGES (10-MAD)
DEPUTY DIRECTOR FOR OPERATIONS (05-MAD)
OFFICE OF CONCIL-IATION (04-MPM)
MGR. OF IMPARTIAL MEDICAL UNIT (04-MAD)
BUDGET OFFICE (05-MAD)
OFFICE OF CLAIMS (06-MAD)
OFFICE OF EDUCATION & REHAB. (06-MAD)
OFFICE OF INSURANCE (05-MAD)
DIRECTOR OF PERSONNEL (05-MPM)
OFFICE OF SAFETY (02-MPM)
JUDICIAL SUPPORT
DOCKETING
SCHEDULING
HEARING STENO
OFFICE OF AUTOMATION (TPL)
OFFICE OF ADMIN. SERVICES (02-MAD)
FOUR REGIONAL OFFICES (04-MPM)

** 9440-0204

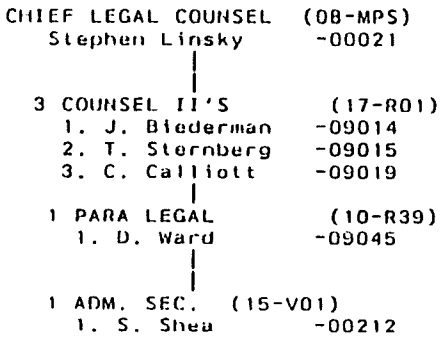
TRUST FUND



Positions Filled	Vacancies	Total
7	10	17

* = Vacant

LEGAL COUSEL

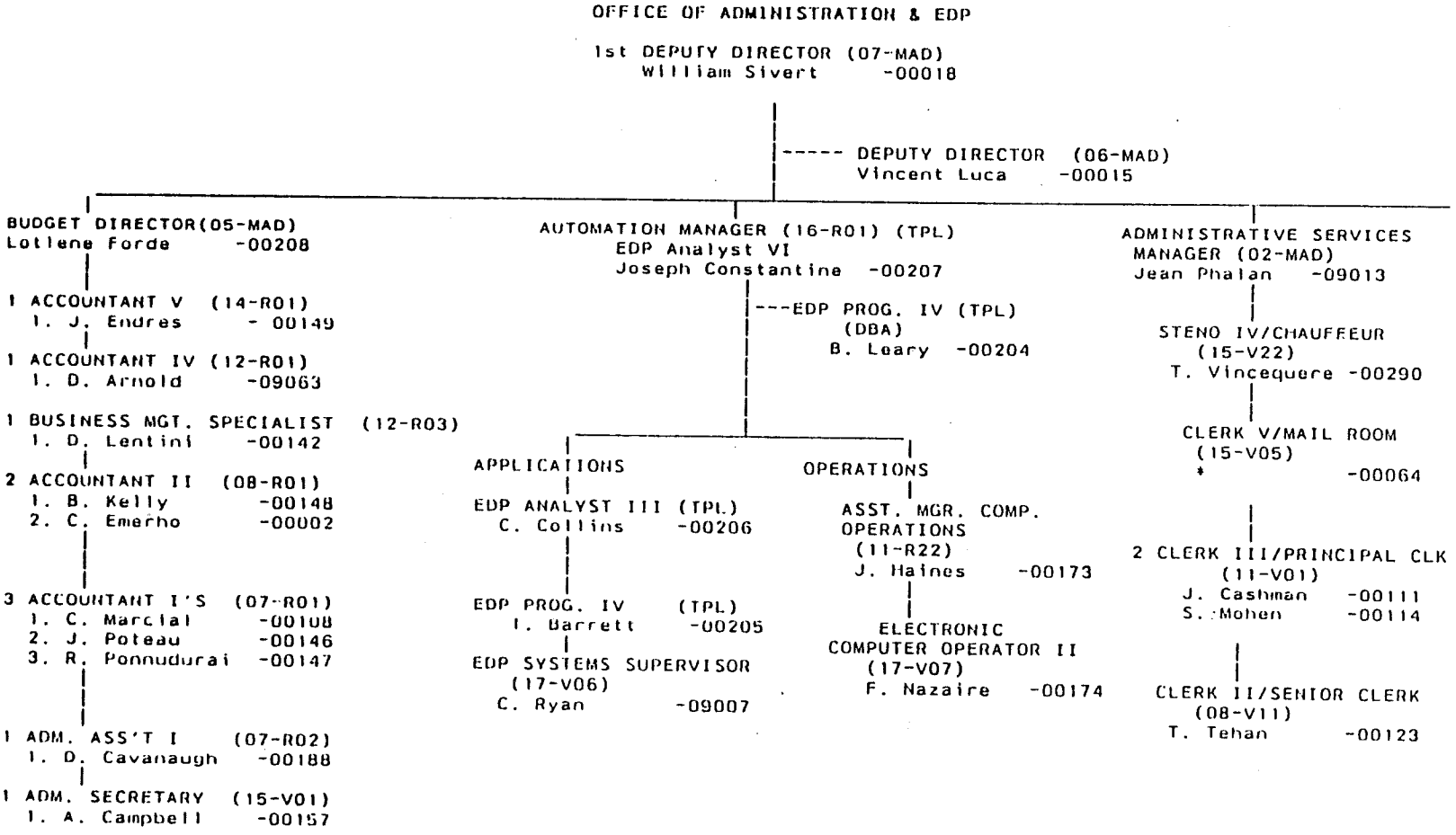


Positions Filled	Vacancies	Total
6	0	6

(3)

* = Vacant

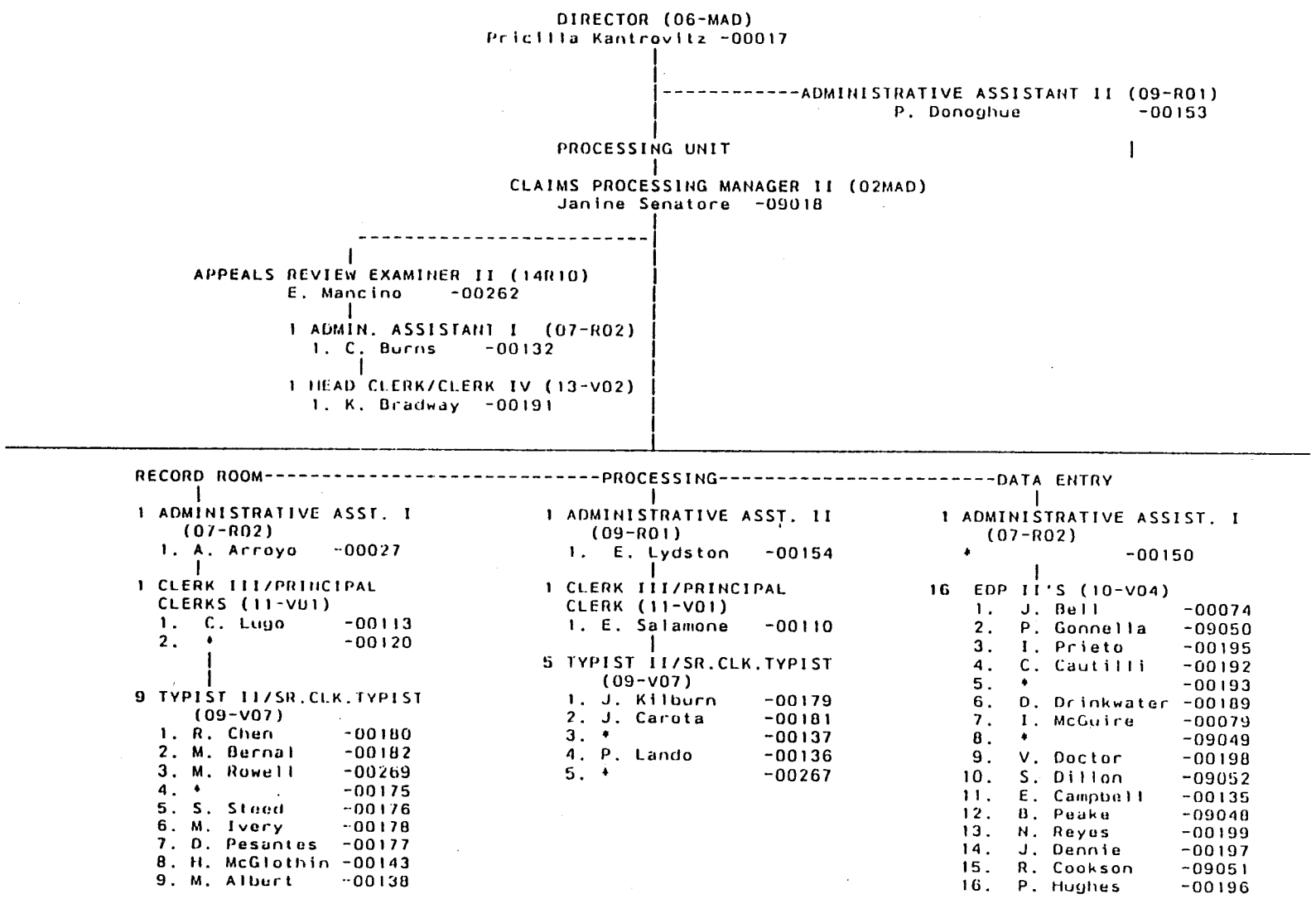
OFFICE OF ADMINISTRATION & EDP



POSITIONS FILLED	VACANCIES	TOTAL
25	1	26

*=Vacant

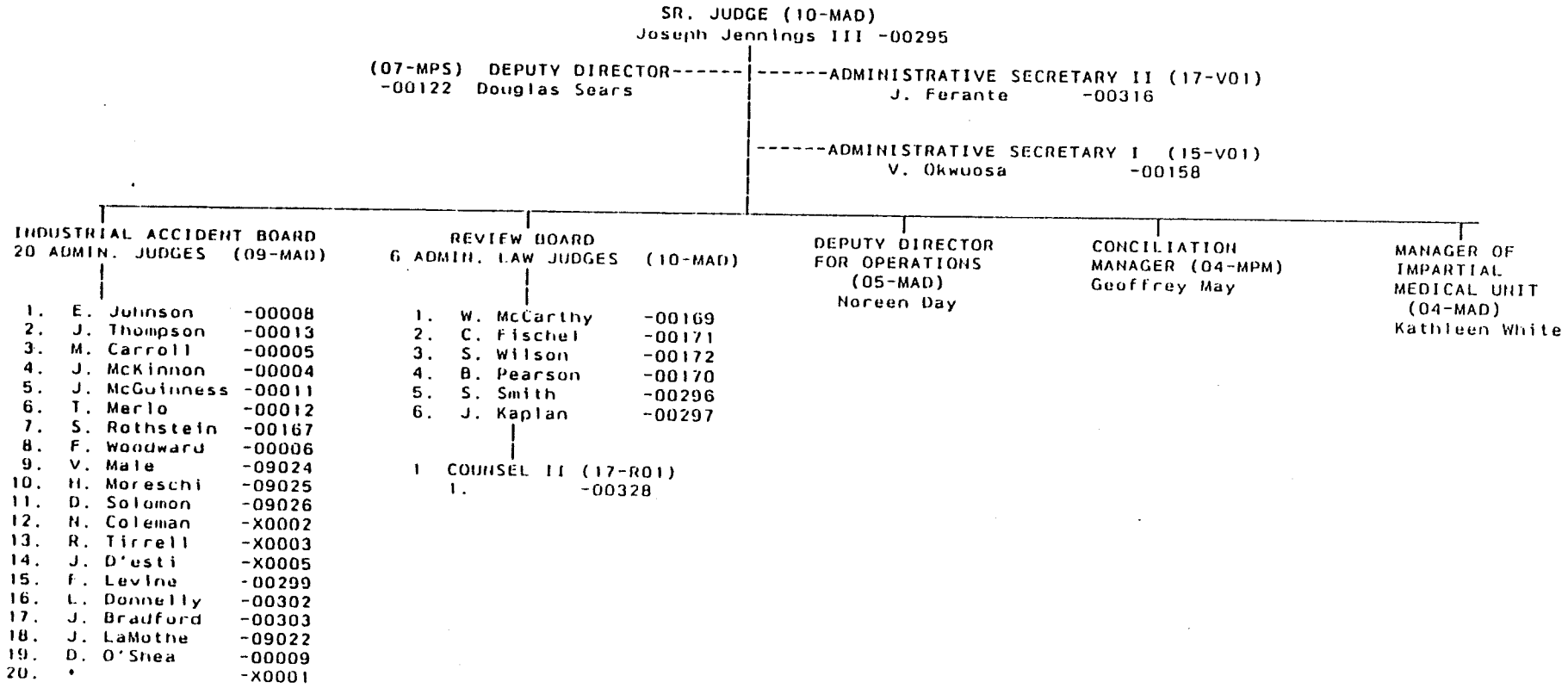
OFFICE OF CLAIMS ADMINISTRATION



Positions Filled	Vacancies	Total
35	7	42

* = Vacant

DIVISION OF DISPUTE RESOLUTION



•=Vacant

ONTINUED

DIVISION OF DISPUTE RESOLUTION

DEPUTY DIRECTOR FOR OPERATIONS (05-MAD)
Noreen Day -09020

JUDICIAL SUPPORT MGR. (01-MAD)
D. Pierre -09021

21 ADMIN. SECRETARY I (15-V01)

1.	N. Nunes	-00213
2.	L. Carroll	-00220
3.	J. Marshall	-00310
4.	V. Faiella	-00231
5.	C. Shidler	-09030
6.	C. Sullivan	-00216
7.	T. Thompson	-00219
8.	K. Magnotta	-00211
9.	S. Williams	-09029
10.	P. Webb	-00234
11.	P. Garrett	-09032
12.	*	-X0014
13.	J. Samuel	-X0010
14.	M. Browne	-X0012
15.	K. Ivers	-00307
16.	E. Lauzon	-00215
17.	C. Williams	-00156
18.	L. Pray	-00227
19.	D. Dellolacono	-09034
20.	J. Cruickshank	-00214
21.	*	-X0011

7 REVIEW BOARD

1.	E. Wallace	-09033
2.	H. Boulder	-00233
3.	C. Giordano	-00311
4.	R. Boykin	-00229
5.	A. Anderson	-00304
6.	M. Medicke	-00308
7.	R. Callahan	-00305

2 FLOATING SECRETARIES

1.	E. Mclaughlin	-00209
2.	W. Perebee	-00306

DOCKETING UNIT

1 PARA LEGAL (10-R39)
1. M. Fitzpatrick -09046

2 CLERK IV (13-V02)
1. T. Courage -00222
2. * -09036

1 PRINCIPAL CLK/CLERK III (11-V01)
1. B. Costales -00116

1 SEN CLK./TYPIST II (09-V07)
1. G. Webb -00141

SCHEDULING UNIT

1 PARA LEGAL (10-R39)
S. Ragucci -09047

1 EDP III (12-V04)
L. Soto -00121

1 EDP II (10-V04)
1. N. Tesler -00190

2 CLERK IV/HEAD CLERK (13-V02)
1. A. Porfido -00210
2. J. Dapsys -09027

HEARING STENO. MANAGER (01-MAD)
* -00033

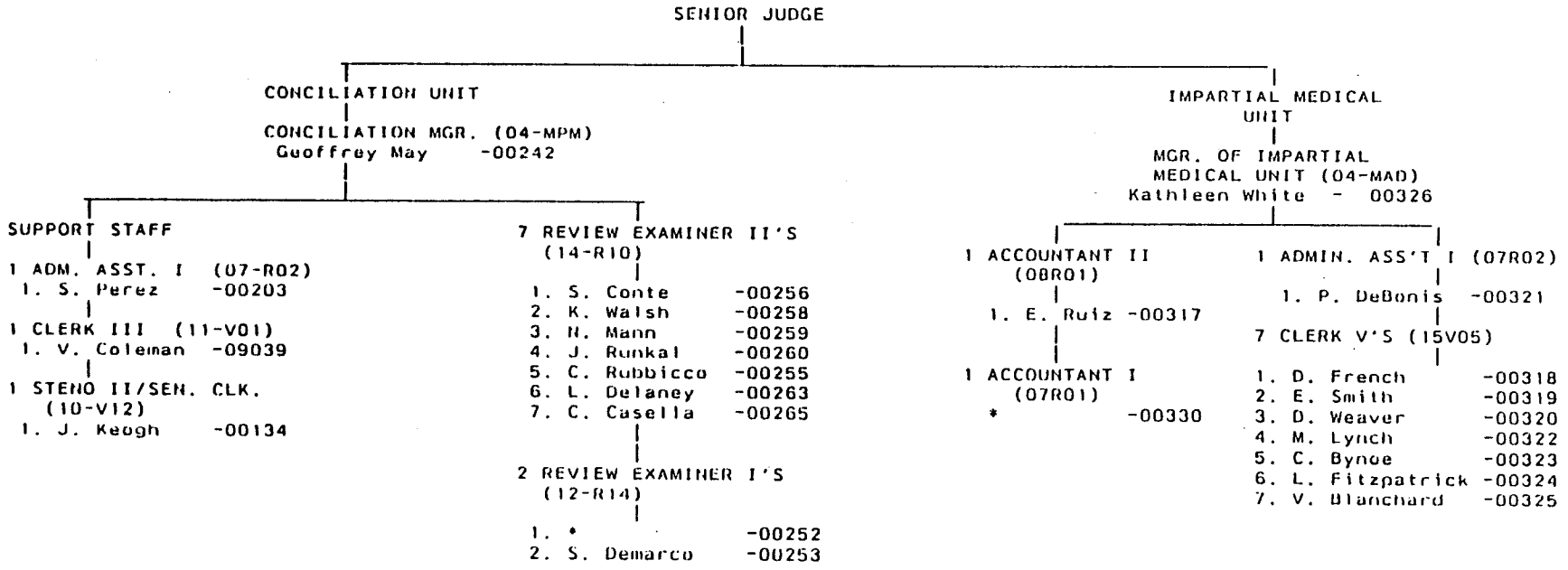
20 HEARING STENOGRAPHERS (17-V09)

1.	C. Brown	-00036
2.	J. Monique	-09002
3.	B. Pike	-00043
4.	L. Verrochi	-00030
5.	M. Flaherty	-00048
6.	B. Obrien	-00044
7.	L. Person	-00039
8.	N. Ramella	-00038
9.	P. Phelan	-00041
10.	D. Washington	-00045
11.	*	-X0019
12.	*	-X0020
13.	*	-X0018
14.	P. Foisy	-00051
15.	*	-00042
16.	C. Nee	-00312
17.	P. Finelli	-00313
18.	C. Marquis	-00314
19.	J. Luongo	-00032
20.	T. Valis	-00034

* = Vacant

INUED

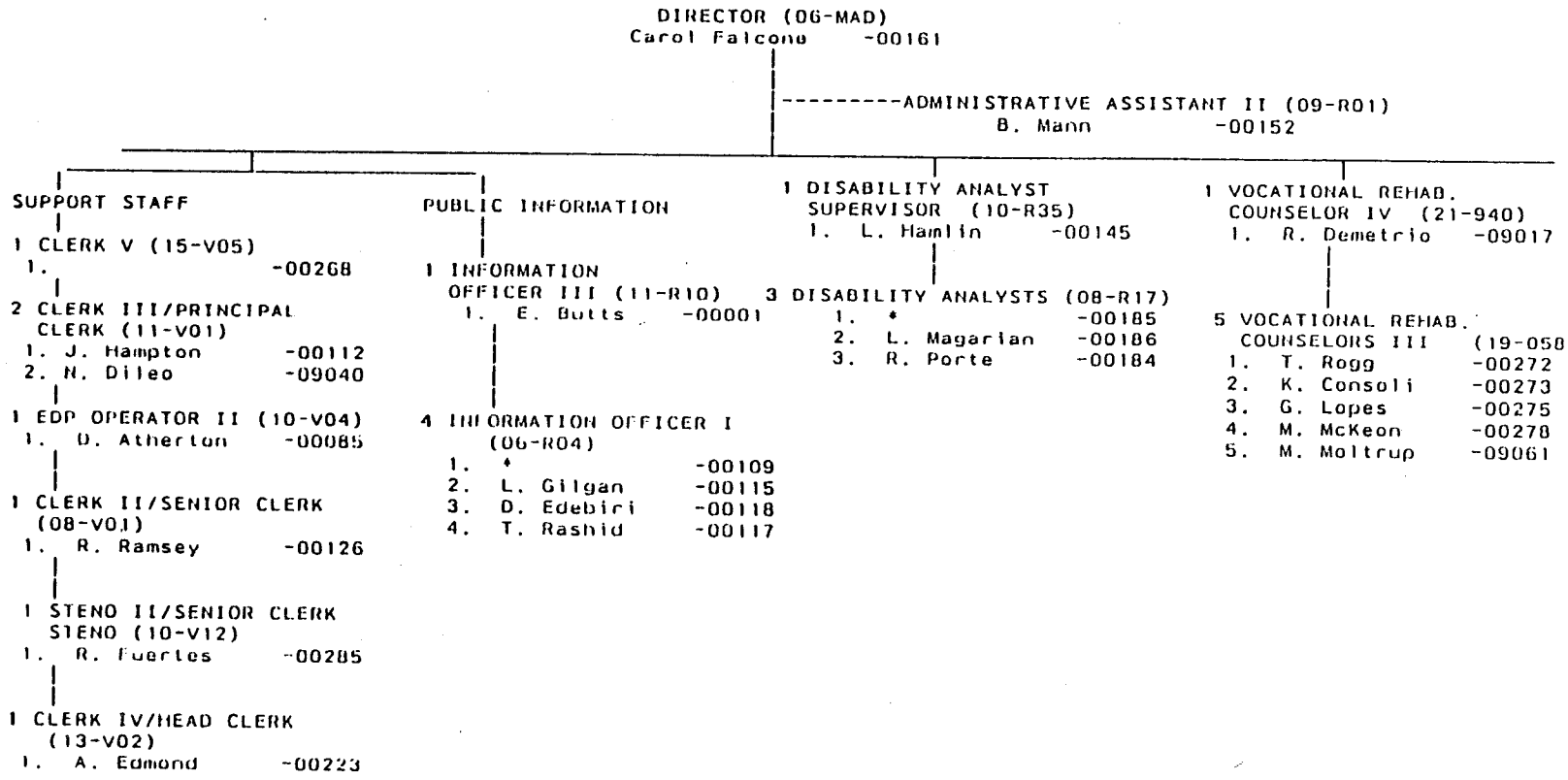
DIVISION OF DISPUTE RESLOUTION



Total Positions Filled	Vacant	Total
106	12	118

*=Vacant

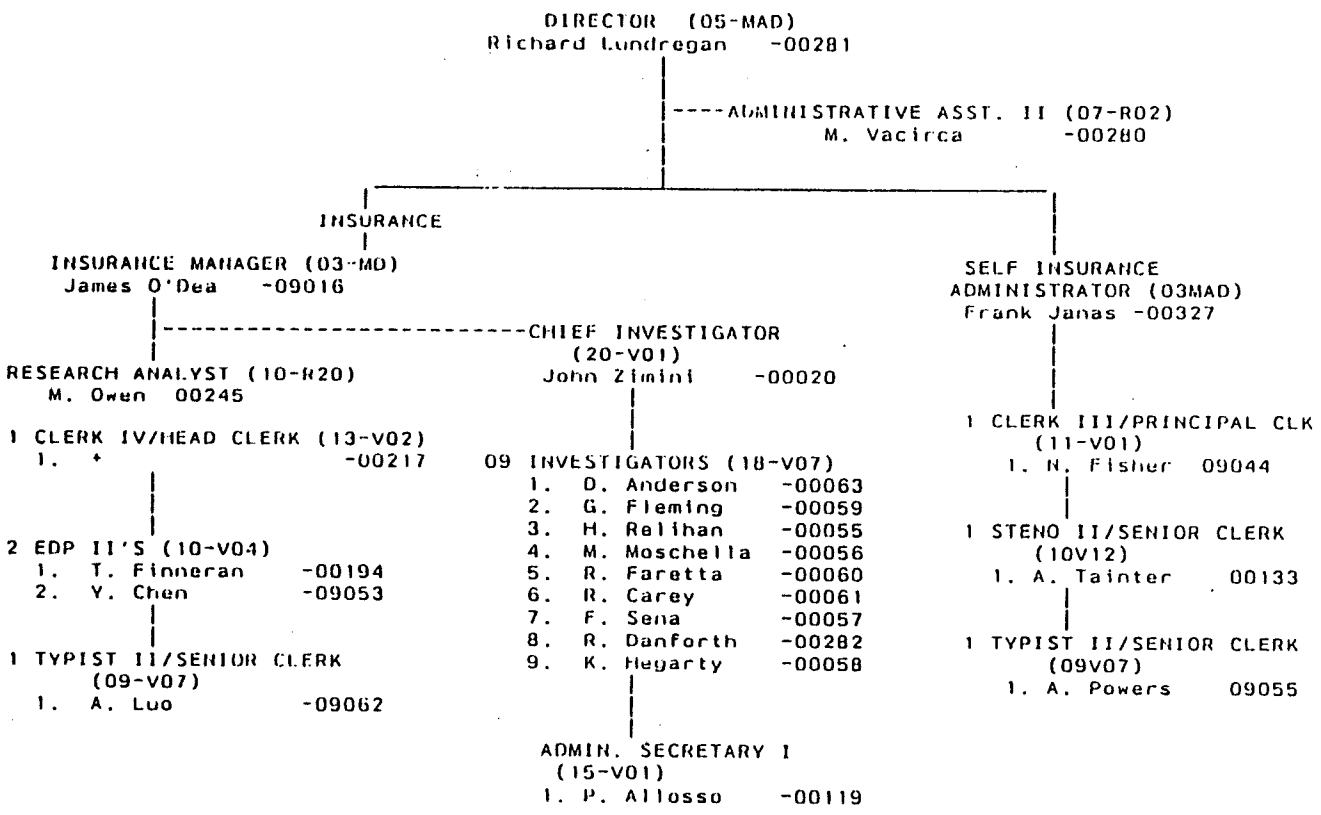
OFFICE OF EDUCATION AND REHABILITATION



Positions Filled	Vacancies	Total
21	3	24

* = Vacant

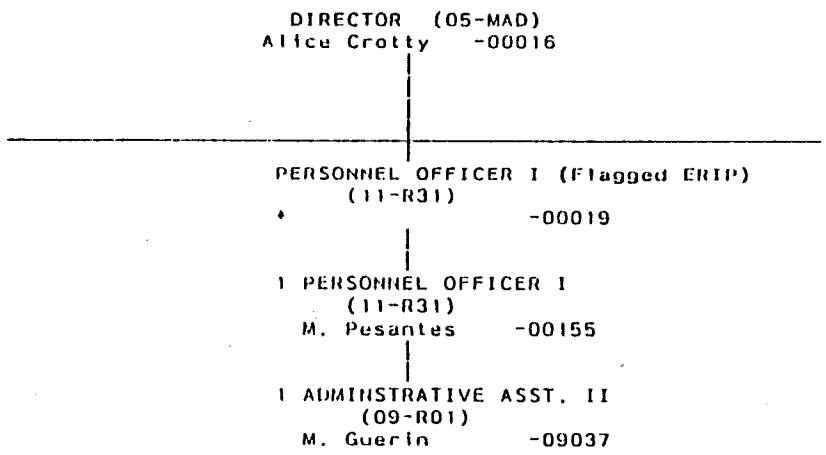
OFFICE OF INSURANCE



Positions Filled	Vacancies	Total
22	1	23

* = Vacant

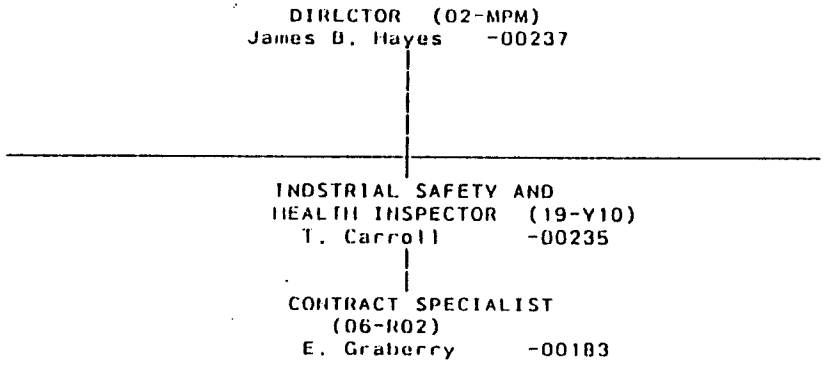
OFFICE OF PERSONNEL



POSITIONS FILLED	VACANCIES	TOTAL
3	1	4

•=Vacant

OFFICE OF SAFETY



POSITIONS FILLED	VACANCIES	TOTAL
3	0	3

= Vacant

DIA REGIONAL OFFICES

FALL RIVER

MANAGER (04-MPM)
Henry Mastey -00240

4 ADMIN. JUDGE (09-MAD)
1. J. Mclaughlin-00166
2. J. Cox -00164
3. J. McGillen -00300
4. R. Moore -00009

3 HEARING STENO'S (17-V09)
1. B. Gomes -00046
2. S. Hill -00037
3. T. Parker -00040

1 ADMIN. ASSIST. I (07R02)
M. Quintal -00226

4 ADMIN. SEC. I (15-V01)
1. L. Baptiste -00025
2. * -00218
3. F. Moniz -00232
4. D. Briggs -00221

1 CLERK III/PRINC. CLERK (11-V01)
M. Pacheco - 09041

1 EDP OPERATOR II (10-V04)
D. Tripp -00202

1 DISABILITY ANALYST (08-R17)
P. Dowd -09057

2 VOCATIONAL REHAB. COUNSELOR III (19-058)
1. A. Gonsales -00276
2. U. Maranhas -00279

2 REVIEW EX. I (12-R14)
1. S. Sharek -00247
2. Y. Cardoza -00250

1 REVIEW EXAMINER II (14-R10)
J. Phelps -00264

LAWRENCE

MANAGER (04-MPM)
Maritza Nieves -00238

2 ADMIN. JUDGE (09-MAD)
1. J. McKenna -00010
2. D. Bean -00165

2 HEARING STENO (17-V09)
G. Signorelli -00031
T. O'Keefe -00315

1 ADMIN. ASST. I (07R02)
I. Gonzalez -00228

2 ADMIN. SEC. I (15-V01)
1. L. Kuntamukkala -00309
2. E. Alfiere -00230

1 CLERK III/PRINC. CLERK (11-V01)
1. J. Chapman -09042

1 EDP OPERATOR II (10-V04)
1. * -00200

1 VOCATIONAL REHAB. COUNSELOR III (19-058)
I. Gerrish -00271

1 REVIEW EX. II (14-R10)
P. Whelton -00254

2 REVIEW EXAMINER I (12-R14)
G. Ramirez -00246

1 DISABILITY ANALYST (08-R17)
L. Connolly -00187

WORCESTER

MANAGER (04-MPM)
Leonard Gabrilla -00241

4 ADMIN. JUDGE (09-MAD)
1. R. Heffernan -X0004
2. F. Gromelski -00014
3. F. Taub -X0006
4. S. Sumner -00298

2 HEARING STENO (17-V09)
1. N. Adair -00047
2. C. Nelsnik -00035

1 ADM. ASST. I (07R02)
C. Rafferty -00225

4 ADM. SEC. I (15-V01)
1. P. O'Melia -X0009
2. D. Layton -09031
3. D. Miller -X0013
4. P. Vincequere-09035

1 CLERK III/PRINC. CLK. (11V01)
* -09043

1 EDP OPERATOR II (10-V04)
L. Chenevert -00201

2 VOCATIONAL REHAB. COUNSELORS III (19-058)
1. K. Fleming -00270
2. D. Thibault -00277

3 REVIEW EX. I (12-R14)
1. W. Trybulski -00248
2. J. Brunelle -00251
3. D. Candia -00249

1 DISABILITY ANALYST (08-R17)
A. Tavano -09058

SPRINGFIELD

MANAGER (04-MPM)
Marc Joyce -00239

4 ADMIN. JUDGE (09-MAD)
1. J. St. Amand -00007
2. * -X0007
3. J. Leroy -09023
4. D. Chivers -00168

2 HEARING STENO (17-V09)
1. L. DeMarco -00049
2. L. King(parttm)-00037
3. M. Allen 00050

1 ADMIN. ASST. I (07R02)
M. Sullivan -00029

4 ADMIN. SEC. I (15-V01)
1. G. Gosselin -00028
2. * -X0008
3. J. Holve -09028
4. M. Woodfine -00224

1 EDP II (10-V04)
G. Urbina -00080

1 VOC. REHAB. COUNSELOR IV (21-940)
1. E. Bajgier -09060

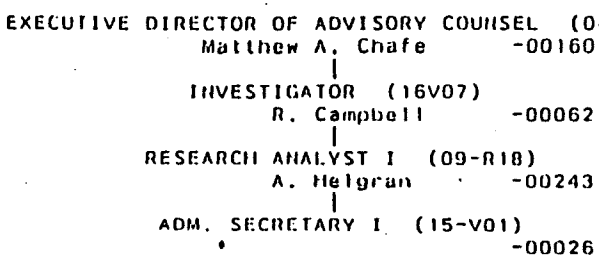
1 VOCATIONAL REHAB. COUNSELOR III (19-058)
R. Fitzgerald -00274

2 REVIEW EX. II (14-R10)
1. N. Hicks -00257
2. T. Sullivan -00261

1 DISABILITY ANALYST (08-R17)
G. Bradshaw -09059

Positions Filled	Vacancies	Total
68	5	73

ADVISORY COUNSEL



Positions Filled	Vacancies	Total
3	1	4

TOTAL DIA POSITIONS FILLED	TOTAL VACANCIES	TOTAL POSITIONS	
298	34	332	9440-0200
•• 07	10	17	9440-0204

• = Vacant