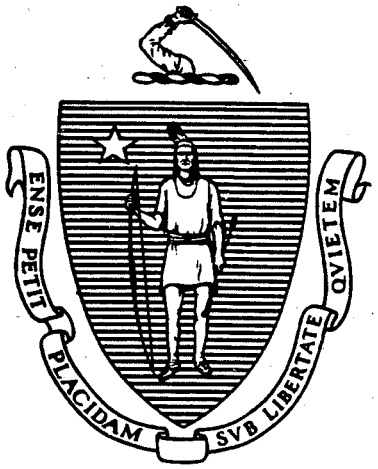

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

STATE OF THE WORKERS' COMPENSATION SYSTEM

FISCAL YEAR 1994

THE STATE OF THE MASSACHUSETTS WORKERS' COMPENSATION SYSTEM

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL
FISCAL YEAR 1994 ANNUAL REPORT

February 8, 1995

ANNUAL REPORT

FISCAL YEAR 1994

Massachusetts Workers' Compensation
Advisory Council

Current Advisory Members and Staff:

Edward T. Sullivan, Jr., *Chair (Service Employees International Union, Local 254);* Jeanne-Marie Boylan, *Vice-Chair (Boston Sand & Gravel Company);* William H. Carnes *(International Brotherhood of Teamsters, Local 25);* J. Bruce Cochrane *(Cochrane and Porter Insurance Agency);* Edmund C. Corcoran *(Raytheon);* James L. Farmer (*Glaziers & Glass Workers' Union, AFL-CIO, Local 1044);* Antonio Frias, Jr. *(S & F Concrete Company);* John Gould *(Associated Industries of Massachusetts);* Robert L. Jones *(Surety Insurance Agency);* Gloria Larson *(Secretary of Economic Affairs);* Christine Morris *(Secretary of Labor);* John J. Perry *(International Brotherhood of Teamsters, Local 82);* Amy Vercillo *(Rehab Re-employment, Inc.)*

Matthew A. Chafe *(Executive Director);* Jeremy A. Teres, Ann M. Helgran *(Research Analysts)*

THE STATE OF THE MASSACHUSETTS WORKERS' COMPENSATION SYSTEM

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FISCAL YEAR 1994 IN REVIEW

Fiscal year 1994 (July 30, 1993 to July 1, 1994) has been a very positive one for both the Department of Industrial Accidents and the workers' compensation system in general. Insurance rates (effective January 1, 1994) were reduced by an average of 10.2% from 1993 levels, the first rate reduction in over twenty years. This represents an improved workers' compensation system with fewer claims being filed and costs under control.

While the total number of cases filed at the DIA has continued to decline, there was a slight increase (3%) in employee claims (request for litigation) from 19,196 to 19,734 after two years of decreases. Fewer insurer's request for discontinuances and a reduction in requests for lump sum conferences have accounted for much of the reduction in the FY'94 case load. The total number of cases at the DIA has decreased by 36% since FY'91. The number of claims paid by insurance companies has gone down for the fourth year in a row. *see - workers' compensation case demographics*

The dispute resolution system at the DIA now has a manageable level of cases at both the conference and hearing stages. The Reviewing Board meanwhile has a large backlog of cases awaiting review on appeal. *see DIA - dispute resolution*

The reduction of fraud in the workers' compensation system was a major component of the 1991 reforms, and the Insurance Fraud Bureau (IFB) and the Attorney General's office have taken proactive steps to curtail this abuse of the system. In FY'94 a record number of groundbreaking investigations and prosecutions were pursued and successfully litigated. *see section II - Insurance Fraud Bureau of Massachusetts.*

Fees and fines were collected aggressively by the DIA in the year, and the mandate that all employers carry workers' compensation insurance was enforced with vigorous efforts by the investigations office. *see DIA - Office of Investigations*

Medical protocols required by the 1991 reform act were implemented this year with the release of 25 treatment guidelines developed by medical consultants working with the DIA. The utilization review program also went into effect during the year. *see DIA - Office of Health Policy*

While the workers' compensation system has improved markedly in the last two years, it is still in a period of transition. Continued effort is necessary to ensure that improvements made to the system are institutionalized and that new areas for improvement are addressed. The dispute resolution system is still a lengthy and complicated process and the system is far from becoming the no fault system it was originally intended to be, as each year a large portion of claims are disputed. Insurance issues continue to improve, but the volatile assigned risk pool still comprises a large portion of the insurance market.

The final section of the report discusses concerns of the Advisory Council and recommendations for improvement.

ADVISORY COUNCIL

The Massachusetts Workers' Compensation Advisory Council was created by the Massachusetts General Court on December 10, 1985 with passage of 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 periodically conducts studies 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. 11A)

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' Workers' 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 has recently conducted 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, (1994).

This study examines 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 provides policy-makers with data on the new law in order to assess its impact.

Study of Workers' Compensation Insurance Rate Methodology, The Wyatt Company, (1994).

This study evaluates 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 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.

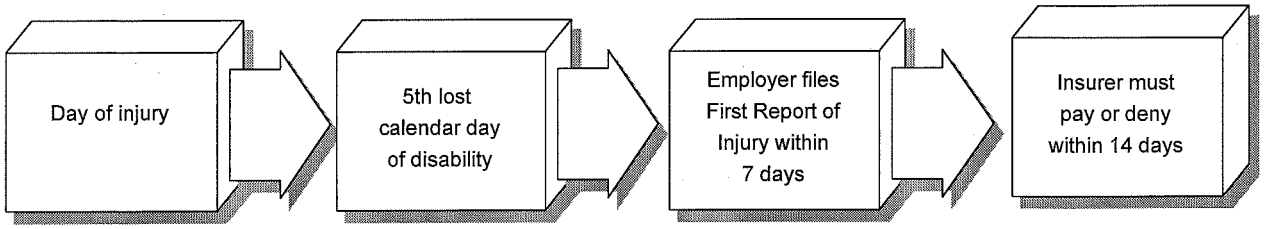
This study provides the quantitative data needed to assess the potential implications of adopting the hours worked methodology in determining premiums for Massachusetts construction employers, as well as other key employer classes.

STATUTORY PROVISIONS TO RESOLVE DISPUTED CLAIMS

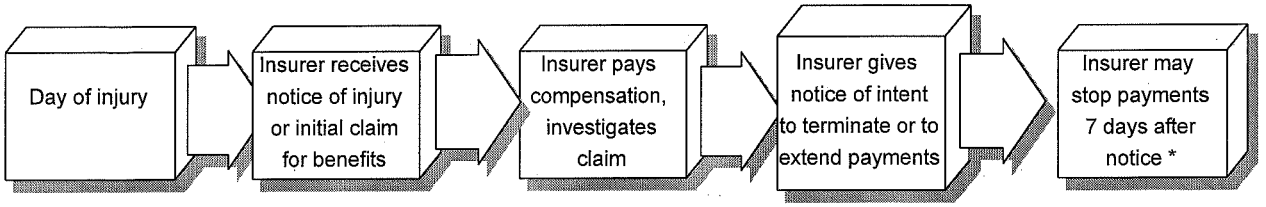
Claims Administration

When an employee is disabled or incapable of earning full wages for five or more calendar 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.

Notification of injury



Voluntary payment



* The insurer may only stop payments unilaterally (with seven days notice) if the case remains within the 180 day "pay without prejudice period", and the insurer has not been assigned or accepted liability for the case. Otherwise, the insurer must file a "complaint" and go through the dispute resolution process.

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

[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.

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 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

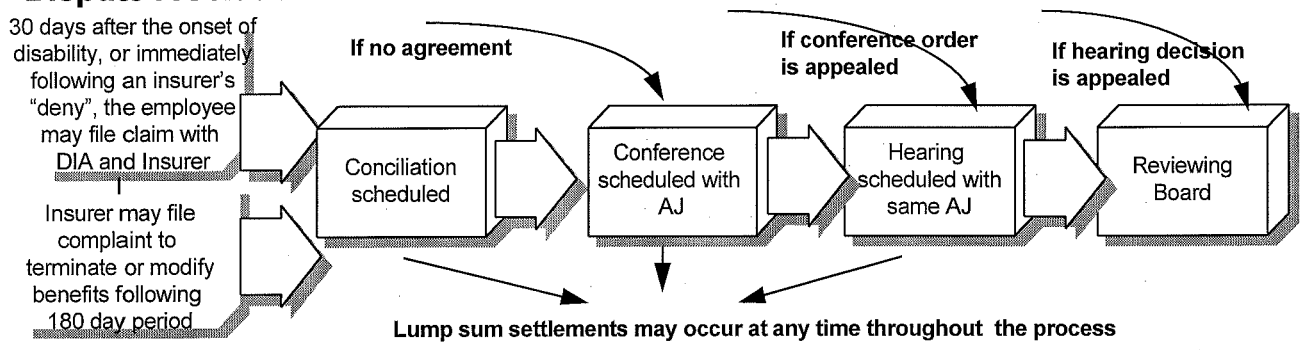
Requests for adjudication may be filed by either an employee seeking benefits, or an insurer seeking a modification or discontinuance of benefits following the payment without prejudice period. A case can be resolved at any point during the DIA's three step dispute resolution period either by voluntary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

Conciliators may "review and approve as complete" lump sum settlements, a standard that only allows the conciliator to review a completed lump sum settlement. Conciliators or the parties at conciliation may also refer a case to a separate lump sum conference where an administrative law judge will decide if a lump sum settlement is in the best interest of the parties.

Administrative judges at the conference and hearing may approve lump sum settlements in the same manner that an ALJ approves a settlement at the separate lump sum conference. AJs and the ALJs must determine whether a settlement is in the best interest of the employee, and a judge may reject a settlement offer if it appears to be inadequate.

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

Dispute resolution



[3] According to M.G.L. 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 ad-dittoing benefits the employee shall file a claim with the department and insurer within any time limits provided by this chapter."

A dispute not resolved at conciliation will then be referred to a conference where it will be 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 and the administrative judge may require injury and hospital records. 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 by a stenographer. Witnesses are examined and cross-examined according to the Massachusetts Rules of Evidence. According to the statute, a decision should be filed within 28 days of the conclusion of the close of the hearing record. The administrative judge may grant a continuance for reasons beyond the control of any party. Either party may appeal a hearing decision within 30 days.

This time limit for appeals 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 orders from the dispute resolution process may be enforced by the Superior Court of the Commonwealth. Reviewing board cases may also be appealed to the Appeals Court. The cost of appeals are reimbursed to the claimant (in addition to the award of the judgment) if the claimant prevails.

Alternative Dispute Resolution Measures

Arbitration & Mediation

At any time prior to five days before a conference, a 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 M.G.L. 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 a 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.

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.

WORKERS' COMPENSATION CASE DEMOGRAPHICS

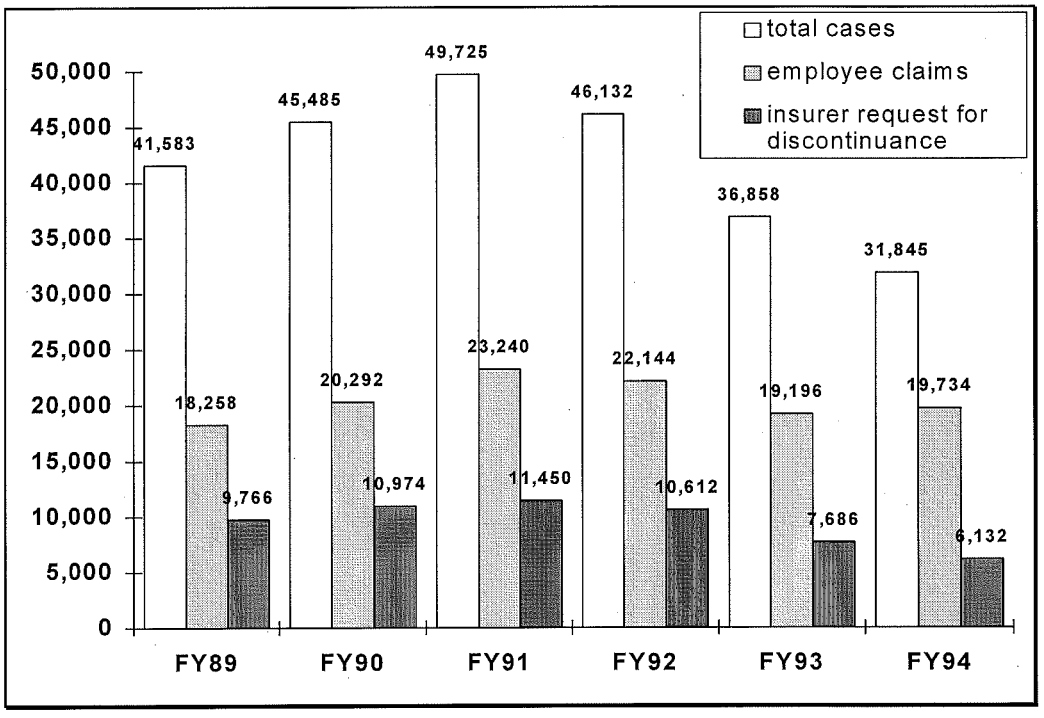
This section of the report presents data on characteristics and trends of cases at the DIA and for workers' compensation cases in general as reported by the insurance industry.

Cases at the DIA

Cases originate at the DIA through an employee's "claim" for benefits, an insurer's request to have an employee's benefits reduced or modified, lump sum requests, third party claims, and section 37/37A claim (second injury benefits). All these cases indicate a request for review by the DIA.

Figure 1 shows a slight increase (3%) in employee claims from 19,196 to 19,734 after two year of decreases, while the total number of cases has continued to go down. Fewer insurer's request for discontinuances and a reduction in requests for lump sum conferences have accounted for much of the reduction in the FY'94 case load. The total number of cases at the DIA has decreased by 36% since FY'91.[4]

Figure 1: Total cases, employee claims, and insurer requests for discontinuance; fiscal year 1989 - fiscal year 1994. NOTE: Total cases include employee claims, insurer request for discontinuance, lump sum requests, third party claims, and section 37/37A requests.



Source: DIA report 28

[4] DIA report 28: Statistics for sections of the law being claimed (indicates cases that are received at the DIA for litigation)

Claim Characteristics

The workers' compensation system comprises a diversity of claimants and on the job injuries/ illnesses. Within this cohort of claimants, there exists some common injury types and claimant characteristics.[5]

- 55% of claimants are male, while nearly 30% are female (Gender is not specified for 15% of claimants)
- Average claimant age is 41
- The average for the employee's average weekly wage is $443.20
- The majority of injuries are strains and sprains (52%), while contusions, crushing, and bruises represent over 10% of injuries.

Table 1: Most common body part injured

Body Part	*Percentage of Injuries*
Back	30%
Knees	6%
Shoulders	6%
Neck/Cervical Vertebrae	5%
Wrists	4%
Hands	4%

Source: Analysis of Wage Replacement Rates, Tillinghast (1992/1993 claims).

Case characteristics from insurance carriers

The following tables and statistics originate from the Massachusetts Rating and Inspection Bureau (WCRB). The WCRB is a licensed rating organization for workers' compensation funded by the insurance industry. It is also the statistical agent for workers' compensation for the Commissioner of Insurance.

The data reported to the WCRB comprises all claims paid by the commercial insurers writing policies in the state, and does not include data from self insured employers or self insurance groups (SIGs). Each year of the data is developed to the fifth report so the years can be compared equally. In other words, each year of the data is at a comparable maturity.[6]

[5] The actuarial consulting firm Tillinghast included a demographic analysis as part of its wage replacement study that it conducted for the Workers' Compensation Advisory Council. This data is derived from First Reports of Injury filed between 1992 and 1993.

[6] A "claim" from the WCRB data does not correspond to a DIA "claim". A claim on the following tables is a claim for benefits that was paid by an insurance company. A DIA claim is a request for litigation originating from the employee.

Insurance data is not considered reliable until several years from the policy year in which the claims occurred. For this reason, the most recent year to which we may look for reliable data is the 1991/1992 policy year. Since that time, however, many changes have occurred in the nature of the workers' compensation system that are not reflected by insurance data.

These tables demonstrate trends, by injury type, on the number of claims, average claim cost, distribution of losses, and frequency for the five most recent years.

Some conspicuous trends can be derived from this data. The number of claims for all injury types have been declining for the last four years. This is congruent with data from the DIA that has seen a major decline in case load.

The average claim cost is down for most injury types from the last year, but on a five year trend the average claim cost has been rising.

The major change in costs relates to a shift in the distribution of losses. In the 1987/88 policy year, almost 80% of the losses were paid out in indemnity (wage replacement) benefits, while the other 20% paid for medical benefits. In the 91/92 policy year, this distribution was 70% indemnity benefits versus 30% medical. While the portion of benefits that are paid for medical benefits is still low on a national scale, this represents a major shift in distribution of costs.

NOTE: The WCRB claim categories do not necessarily correspond to specific sections of M.G.L. chapter 152. (For example, the permanent total category includes predominantly section 34A benefits, but it may also include benefits under section 30 and section 36).

Case Data By Injury Type

Table 2: Claim Counts

Composite Policy Year	*Fatal*	*Permanent Total*	*Permanent Partial*	*Temporary Total*	*Medical Only*
1987/88	73	50	13,876	54,990	123,875
1988/89	67	53	14,796	51,612	115,267
1989/90	77	37	13,855	44,510	100,127
1990/91	64	21	10,011	39,036	88,805
1991/92	57	28	5,897	31,899	82,462

Source: WCRB, schedule z data by injury type (developed to 5th report)

Table 3: Average Claim Cost - "Indemnity + Medical"

Composite Policy Year	Fatal	Permanent Total	Permanent Partial	Temporary Total	Medical Only
1987/88	269,284	567,142	55,281	6,098	191
1988/89	247,449	753,634	54,964	6,732	220
1989/90	282,061	898,768	56,683	7,682	250
1990/91	300,791	1,025,907	56,813	8,690	281
1991/92	298,122	912,598	58,000	8,369	315

Source: WCRB, schedule z data by injury type (developed to 5th report)

Table 4: Average Indemnity Cost

Composite Policy Year	Fatal	Permanent Total	Permanent Partial	Temporary Total
1987/88	263,898	381,221	45,752	4,657
1988/89	242,317	388,693	45,324	5,098
1989/90	267,185	522,160	46,483	5,765
1990/91	296,907	681,959	45,810	6,343
1991/92	286,795	442,615	45,040	5,642

Source: WCRB, schedule z data by injury type (developed to 5th report)

Table 5: Average Medical Cost per claim

Composite Policy Year	Fatal	Permanent Total	Permanent Partial	Temporary Total	Medical Only
1987/88	5,386	185,921	9,529	1,441	191
1988/89	5,132	364,941	9,640	1,634	220
1989/90	14,876	376,608	10,200	1,917	250
1990/91	3,884	343,948	11,003	2,347	281
1991/92	11,327	469,983	12,960	2,727	315

Source: WCRB, schedule z data by injury type (developed to 5th report)

Distribution of paid claims (Incurred losses)

Table 6: Incurred Losses Distribution

Composite Policy Year	*Indemnity*	*Medical*
1987/88	79.15	20.85
1988/89	78.10	21.90
1989/90	77.90	22.10
1990/91	75.95	24.05
1991/92	70.01	29.99

Source: WCRB, schedule z data by injury type (developed to 5th report)

Table 7: Breakout of Indemnity Losses

Composite Policy Year	*Fatal*	*Permanent Total*	*Permanent Partial*	*Temporary Total*	*Total*
1987/88	1.64	1.62	54.07	21.81	79.15
1988/89	1.31	1.66	53.97	21.17	78.10
1989/90	1.70	1.60	53.35	21.25	77.90
1990/91	1.95	1.47	47.10	25.43	75.95
1991/92	2.41	1.83	39.21	26.56	70.01

Source: WCRB, schedule z data by injury type (developed to 5th report)

Table 8: Breakout of Medical Losses

Composite Policy Year	*Fatal*	*Permanent Total*	*Permanent Partial*	*Temporary Total*	*Medical Only*	*Total*
1987/88	0.03	0.79	11.26	6.75	2.01	20.85
1988/89	0.03	1.56	11.48	6.79	2.05	21.90
1989/90	0.09	1.15	11.71	7.07	2.07	22.10
1990/91	0.03	0.74	11.31	9.41	2.56	24.05
1991/92	0.10	1.94	11.28	12.84	3.83	29.99

Source: WCRB, schedule z data by injury type (developed to 5th report)

Claim Frequency

Table 9: Claim Frequency (Number of Claims per Million of Man- Weeks)

Composite Policy Year	Fatal	Permanent Total	Permanent Partial	Temporary Total	Medical Only
1987/88	0.65	0.44	123.46	489.27	1102.16
1988/89	0.61	0.49	135.53	472.75	1055.81
1989/90	0.76	0.36	136.32	437.93	985.15
1990/91	0.68	0.22	106.09	413.69	941.13
1991/92	0.67	0.33	69.49	375.88	971.70

Source: WCRB, estimated schedule z man-weeks base. Based on the claim count data developed to 5th report.

Section 1: Overview of the Department of Industrial Accidents

OFFICE OF CLAIMS ADMINISTRATION

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

The OCA consists of the processing unit, the data entry unit, the record room, and the first report compliance office. It is the responsibility of the Deputy Director of Claims Administration to answer all subpoena requests, certified mail and file copy requests, and to act as the liaison to the State Record Center.

In FY'94, the OCA also became responsible for all "freedom of information" requests, previously the responsibility of the public information office.

Claims Processing Unit / Data Entry 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 the data entry unit.

The data entry operators enter all forms and transactions into the 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.

The processing and data entry backlog that has existed in the OCA was reduced substantially in the fiscal year. Forms requiring a conciliation have always been entered within 24 hours of receipt, while forms such as the *first report of injury*, *insurer pay*, and *insurer deny* were relegated a lower priority. In past years, the OCA personnel could not enter the forms as fast as they were received, which produced a backlog of as much as 5 months in their entry into the Diameter system. For the last three years and continuing into FY'94, the DIA case load has steadily decreased. The OCA staff has worked diligently to take this opportunity to reduce and eliminate the backlog of these forms.

First Report Compliance Office & Fraud Data

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 are $100, and are doubled if it is referred to a collection agency.

In fiscal year 1994, $399,142 was collected in fines, a marked increase from the $85,707 collected in fiscal year 1993.

The office is also responsible for maintaining a data base on cases discovered by the DIA in which there is some suspicion of fraud. In fiscal year 1994, a total of 78 cases were reported to the office, 76 of which were referred to the Insurance Fraud Bureau and 2 to the Attorney General's office.

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.

In FY'94, the record room received new filing equipment with a greater capacity to store the records within the confines of the limited space. A scanning system was also purchased to expedite the distribution and retrieval of the 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 lump sum 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, hearing, medical hearing, and lump sum settlements) 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 to the next stage of dispute resolution.

For the annual report, conciliation reports were collected by scheduled date as in previous reports. This year, conference and hearing reports were collected by disposition dates. Reports issued by disposition date reflect a more accurate and complete portrayal of conferences and hearings because scheduled date reports often contain cases in which a disposition has not yet been issued.

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.

In this annual report, the use of the term "claim" is reserved specifically for cases originating from the employee. The term "case" refers to all cases, whether they are employee claims, insurer complaints, lump sum requests.

Conciliation statistics are also available in two reports that differentiate between "finished" and "unfinished" cases. DIA report 17 only includes data for finished cases. 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 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 resolved, it just indicate it has completed one step of the process.

CONCILIATION

The main objective of the conciliation process is to remove from the dispute resolution system those cases that can be resolved without formal adjudication. 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 including withdrawals, lump sums, and conciliated. The other half of the cases at conciliation are referred to a conference.

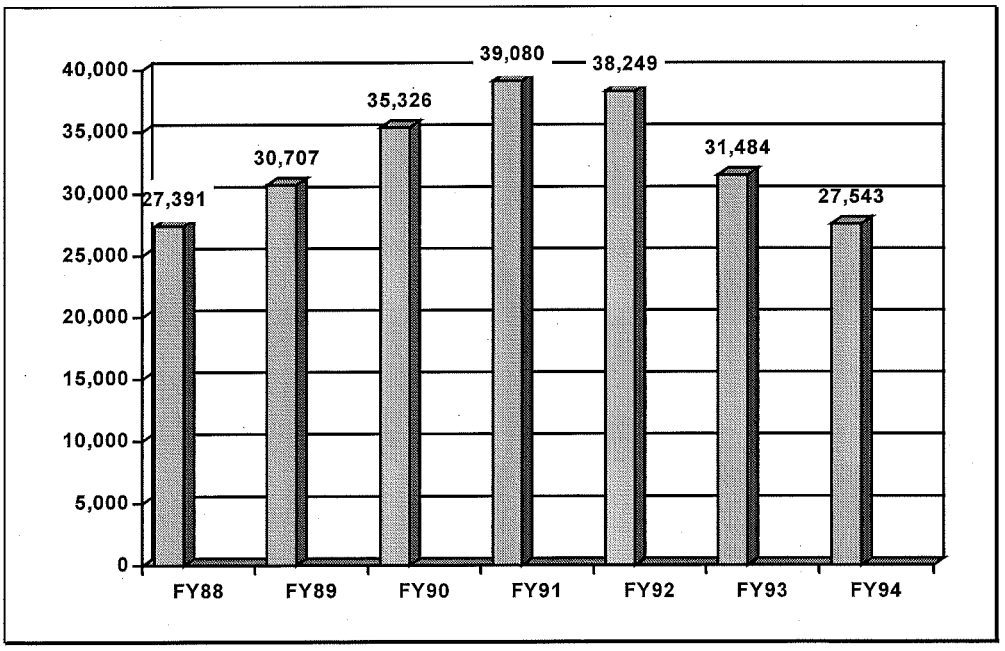
The Conciliation Process

Conciliations are scheduled automatically by computer at the office of claims administration (OCA). 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 attend as well.

Volume at Conciliation

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 three fiscal years, the volume of cases has been declining after marked increases in previous years.

Figure 2: Volume of cases scheduled for conciliation



Source: DIA report 17

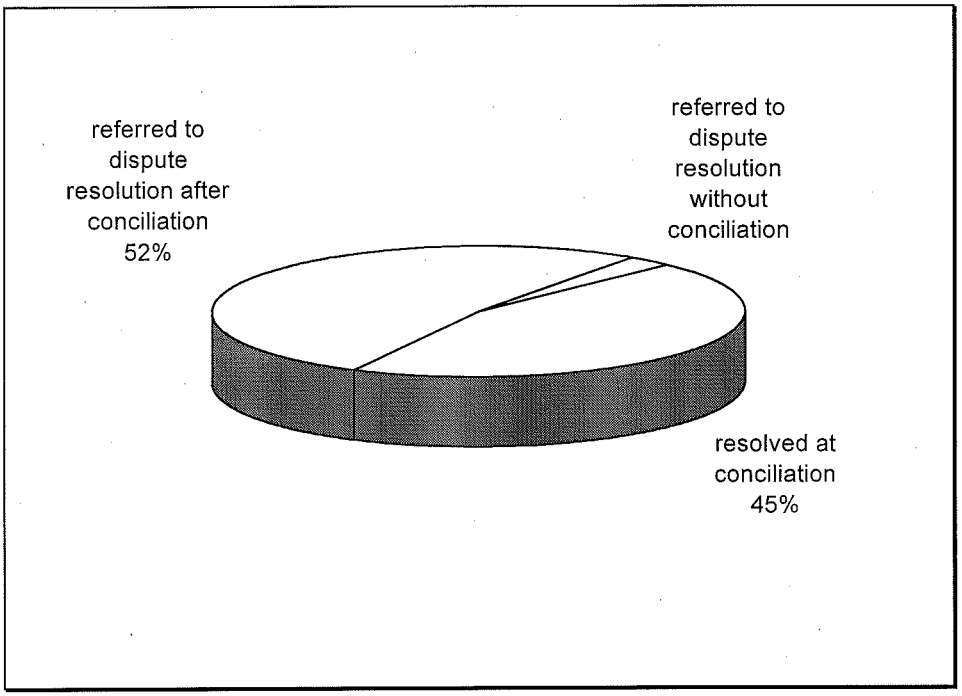
Figure 2 indicates the number of conciliations that were scheduled in FY'94, but it also includes cases that were withdrawn or adjusted prior to the actual conciliation. To get a more accurate measure of the number of conciliations that took place, certain dispositions must be subtracted from the total. Out of the 27,543 scheduled conciliations, 22,025 conciliations actually occurred.[7]

Conciliation Dispositions - (1) cases referred to conference

Cases at conciliation may be assorted into two major categories: referred to conference, or resolved. In FY'94, 55% of the 27,543 cases scheduled for conciliation were referred to conference, the next stage of dispute resolution. This compares very closely to last year's referral percentage of 54%.[8]

As in previous years, three percent of cases scheduled for a conciliation were referred to conference without conciliation. This occurs when the respondent (or party that is not putting forth the case) does not show up for the conciliation.

Figure 3: Fiscal year 1994, conciliation statistics



Source: DIA report 17

Conciliation Dispositions - (2) resolved cases

The remaining 45% of conciliation cases in FY'94 were not referred on to conference and are considered to be resolved. This slight decrease from previous percentages of cases that are resolved (FY'93 -46%, FY'92 -49%, FY'91 - 48%) may be due to a lower volume of overall cases. It could be argued

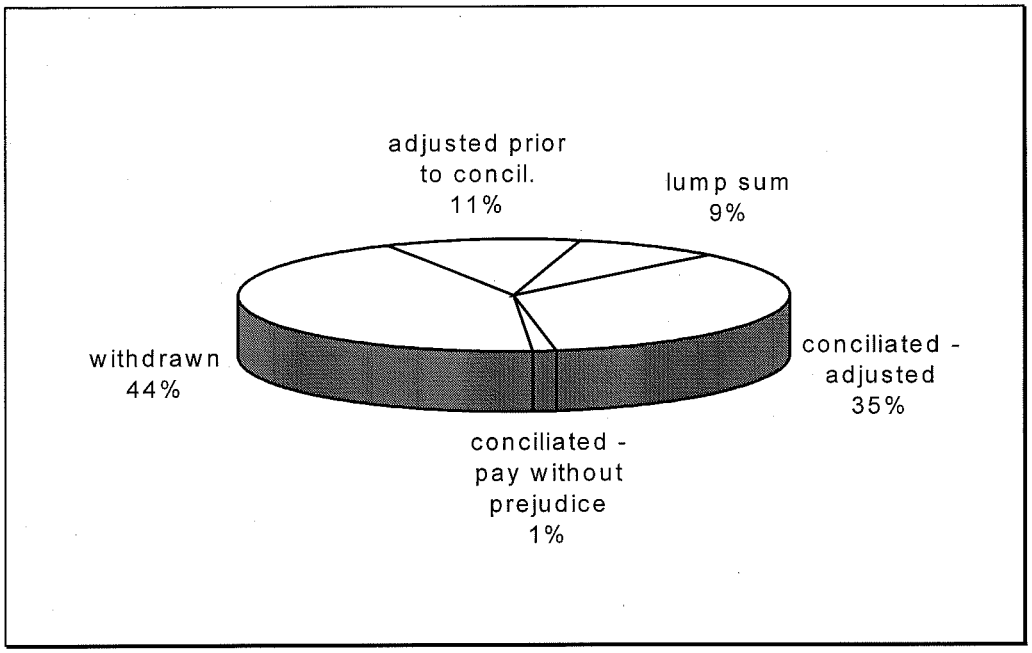
[7] "Referred to conference" (14,319), "conciliated - adjusted" (4,361), "conciliated- pay without prejudice" (179), "withdrawn at conciliation" (2,315), "lump sum approved as complete" (328), "referred to lump sum" (523) = 22,025

[8] DIA report 17 (Finished cases, not including reschedules).

that since a smaller number of claims and complaints are filed, there were less frivolous cases and more complicated ones that required review by an administrative judge at conference.

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.

Figure 4: Fiscal year 1994, "resolved at conciliation" (breakout of block from Figure 3)



Source: DIA report 17

Resolved Cases- withdrawn

Table 10: Fiscal year 1994, withdrawn cases at conciliation

breakdown of cases withdrawn, FY'94	*number of cases*	*percentage of all cases*[9]	*percentage of resolved cases*
withdrawn at conciliation	2,315	8.4%	18.5%
withdrawn prior to conciliation	1,498	5.4%	12.0%
withdrawn by department for no shows	1,578	5.2%	12.7%
total withdrawn	5,391	19.6%	43.3%

Source: DIA report 17

[9] This is a percentage of all finished cases (DIA report 17).

Table 11: Fiscal year 1993, withdrawn cases at conciliation

breakdown of cases withdrawn, FY'93	*number of cases*	*percentage of all cases*[9]	*percentage of resolved cases*
withdrawn at conciliation	2,959	9.4%	20.2%
withdrawn prior to conciliation	1,705	5.4%	11.7%
withdrawn by department for no shows	1,814	5.8%	12.4%
total withdrawn	6,478	20.6%	44.3%

Source: 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 moving party (the party bringing forth the case) may withdraw their dispute at any time.

"Withdrawn by the department for no shows" - If the moving party does not show up for a scheduled conciliation, the case may be withdrawn.

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.

Table 12: Fiscal year 1994, lump sum settlements at conciliation

breakdown of lump sums, FY'94	*number of cases*	*percentage of all cases*[9]	*percentage of resolved cases*
lump sum reviewed- approved as complete	328	1.2%	2.6%
directed to lump sum conference:			
- referred to lump sum	523	1.9%	4.1%
- lump sum request received	220	0.8%	1.8%
total lump sum settlement	1,071	3.8%	8.6%

Source: DIA report 17

Table 13: Fiscal year 1993, lump sum settlements at conciliation

breakdown of lump sums, FY'93	*number of cases*	*percentage of all cases* [9]	*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%	5.0%
- lump sum request received	301	1.0%	2.0%
total lump sum settlement	1,415	4.5%	9.7%

Source: DIA report 17

"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 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 328 cases for lump sum settlements in the whole fiscal year, approximately the same percentage as the last year.

"Referred to lump sum"— Conciliators often refer cases to lump sum conferences where an administrative judge or 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 as a means of protection from accusation of malpractice surrounding the size of a settlement. At the lump sum conference the AJ or ALJ will render a judgment 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. 35% of the resolved cases (or 16% of all cases) were "conciliated - adjusted" meaning an agreement was reached at conciliation between the parties to initiate, modify, or terminate the compensation. This is an increase from 31% of resolved cases (or 15% of all cases) last fiscal year.

Cases may also be "conciliated - pay without prejudice" (1% of resolved cases in FY'94, 2% FY'93) meaning the pay without prejudice period has been extended up to one year by the conciliator. The insurer agrees to pay benefits without accepting liability during this period and has the right to discontinue the compensation without prejudice.

Cases Rescheduled

Conciliators cannot render a legal judgment on the case, but they make sure the parties have the necessary medical documentation and other sources of information to facilitate the resolution of the case. The purpose of rescheduling a case is to allow for further discussion to occur or to allow for a continuation of the case so all the documentation can be gathered. Out of all the cases at conciliation, 31% were rescheduled in FY'94. This is an increase from the 28% rescheduled in FY'93, 22.1% in FY'92, and 29% in FY'91.[10]

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 serving to provide the administrative judge with a good background on the case.

[10] DIA report 16

CONFERENCE

Each case referred to a conference is assigned to one of the 32 administrative judges who must retain the case throughout the entire process if possible.

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 statements from witnesses. The administrative judge is required to issue an order within seven days of the conclusion of the conference. This judge's order may be appealed within 14 days to a hearing.

Administrative Judges

There are 32 administrative judges (AJs) in Boston and the regional offices who preside over the conference and hearing stages of dispute resolution. There are 21 judges with six year terms, six judges with three year terms, and five judges with one year terms. The three year term positions all expire in February 1995 unless legislation is filed to keep on these positions that were expressly created in the 1991 reform act to handle the backlog of cases. Former members of the board may be recalled for a one year term if the workload requires it. See appendix G for a list of the judges and their terms.

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. The administrative practice of taking a judge off-line is relatively rare and occurred three times in the last year for limited amounts of time.

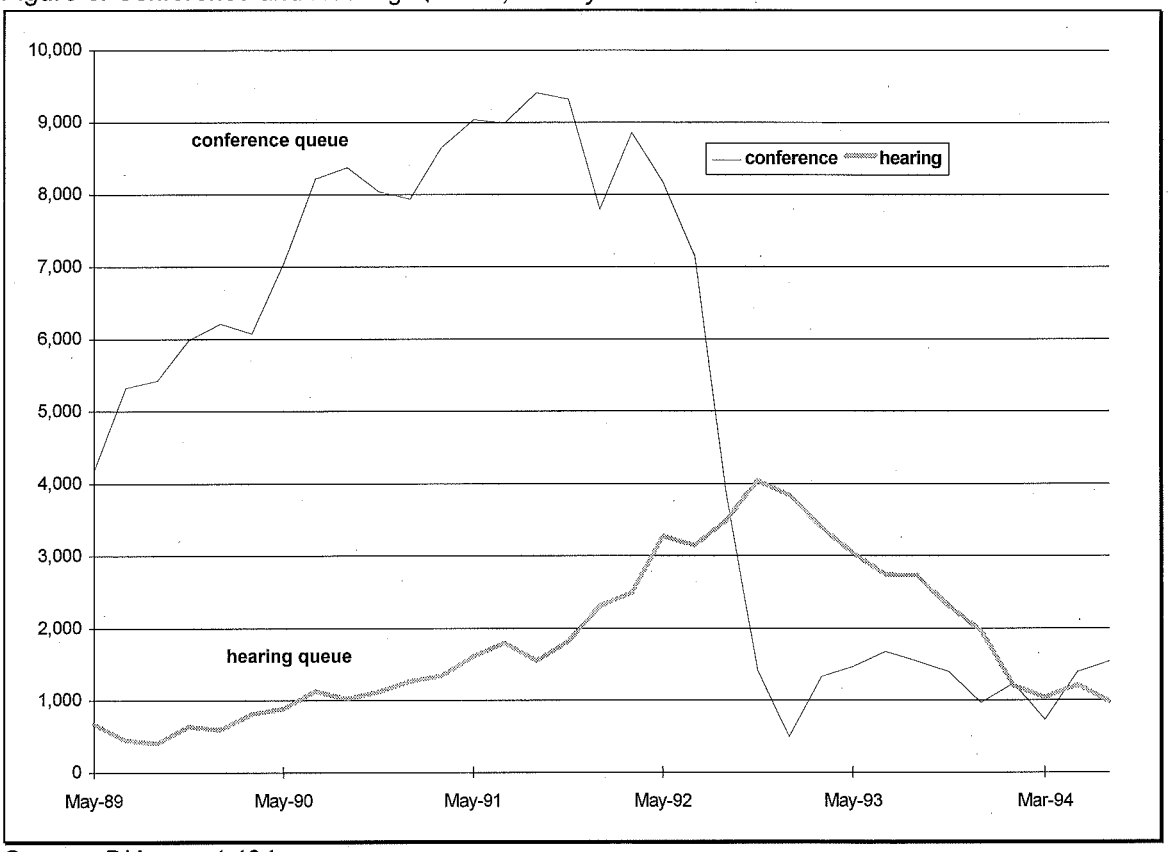
Another three judges were taken off-line towards the expiration of their terms when they were not expected to be reappointed. This enables the judge that is leaving to complete the hearings they have in queue. This practice facilitates the transition of judges so that the cases that have already been heard at conference will not have to be re-assigned.

The scheduling of the judges is based on a 13 week cycle. The first three weeks of the cycle were allotted for conferences (10-13 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 (up to three hearings a day, four-five days a week; two conferences a day). The last two weeks were continued and writing weeks. There were 3.69 cycles throughout the fiscal year.

Conference Backlog

The conference queue has remained steady in FY'94 since its precipitous decline in the last year.

Figure 5: Conference and Hearing Queues; fiscal years 1990 - 1994

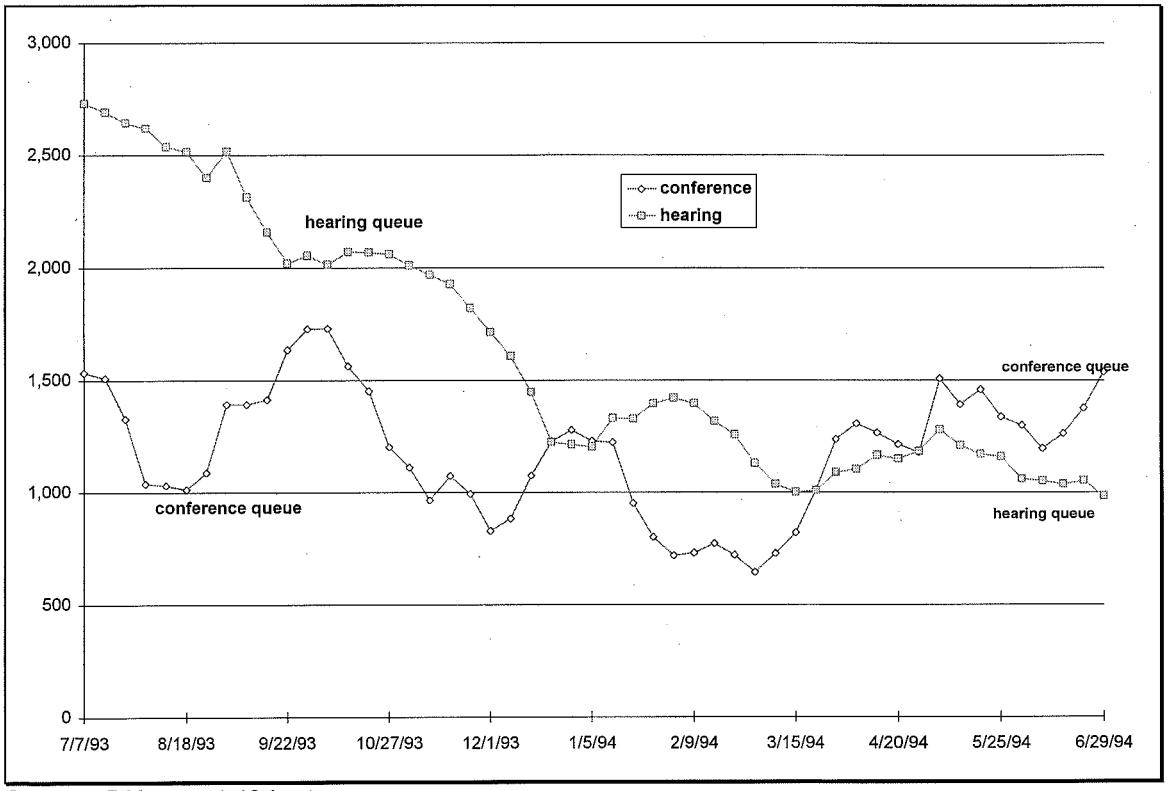


Source: DIA report 404

The conference queue remained stable throughout FY'94, beginning and ending the year at virtually the same levels (1,535 on 7/7/93 and 1,538 on 6/29/94). The queue fluctuated up and down throughout the year, mirroring the scheduling cycle of the judges. The queue reached a high of 1,731 on 10/6/93 and a low of 645 on 3/2/94.

A conference queue of 1,500 is not considered a backlog because all the cases in the queue are likely to be scheduled within the next 13 week scheduling cycle. A queue much lower than 1,500 will not provide enough cases for the judges and a queue higher than that will likely produce a backlog.

Figure 6: Conference and Hearing Queue; fiscal year 1994



Source: DIA report 404

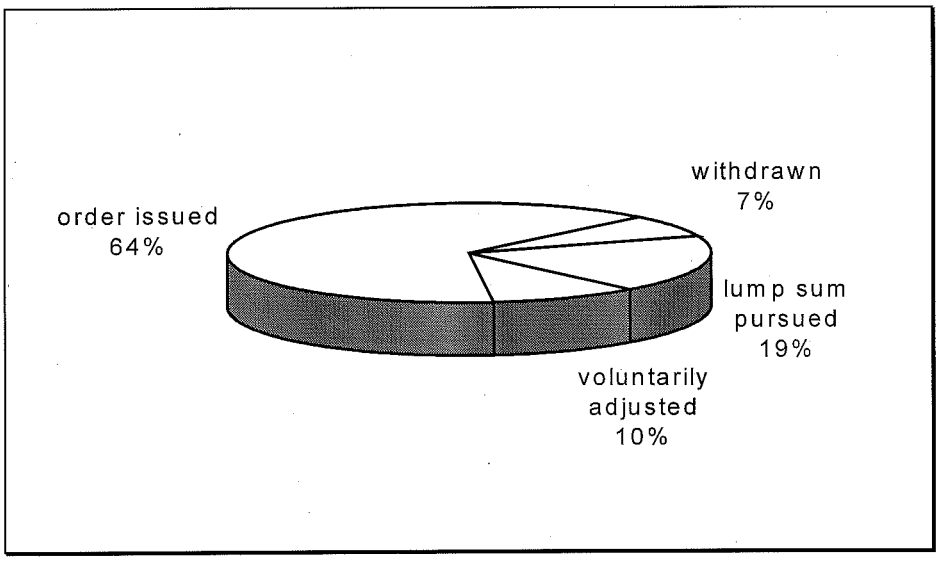
Volume of Conferences

The number of conference dispositions decreased significantly in FY'94 to 16,137 from 25,285 in the previous year. Historically, the number of conferences has represented approximately half of the cases scheduled for conciliation (the referral rate is usually around 50%). The fiscal year 1994 numbers are in this range, whereas in FY'93 the volume of conferences was well above 50% because of the backlog of cases in previous years.

The actual number of conferences that took place in the year is lower than the 16,137 dispositions because a case may have more than one disposition or the case may be withdrawn before conference. The "order issued" disposition and the "settlement approved by judge" disposition are both final ones that conclude the case. "Referred to lump sum" and "voluntarily adjusted" may also be included in this category. Together they number 14,734 conferences which took place and were completed in the year.

Conference Dispositions

Figure 7: Fiscal year 1994, conference dispositions



Source: DIA report 45B

Table 14: Fiscal year 1994, conference dispositions

disposition at conference, FY'94	*cases*	*percentage*
withdrawn	1,189	7.4%
lump sum pursued	3,003	18.6%
settlement approved by judge	1,738	
referred to lump sum	1,092	
(Administrative Judges may enter this disposition to hold their own lump sum conference)		
lump sum request received	173	
(Directed to separate lump sum conference before ALJ)		
voluntarily adjusted	1,615	10.0%
order issued	10,289	63.8%
other	41	0.3%
total	16,137	100.0%

Source: DIA report 45B - Conference statistics, for disposition dates (not including reschedules)

Table 15: Fiscal year 1993, conference dispositions

disposition at conference, FY'93	*cases*	*percentage*
withdrawn	2,338	9.2%
lump sum pursued	5,632	22.3%
settlement approved by judge	2,301	
referred to lump sum	2,883	
(Administrative Judges may enter this disposition to hold their own lump sum conference)		
lump sum request received	448	
(Directed to separate lump sum conference before ALJ)		
voluntarily adjusted	2,360	9.3%
order issued	14,949	59.1%
other	6	0.0%
total	25,285	100.0%

Source: DIA report 45B

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

A judge's order to modify, terminate or begin indemnity or medical benefits occurs in the majority of dispositions, 64% in FY'94 (a higher percentage than the last fiscal year). The conference order could conclude the case, but a significant number are appealed every year. 76.6% of conference orders were appealed in fiscal year 1994, compared to 73.6% in FY'93, 82.3% in FY'92, and 81.1% in FY'91.

Lump sum settlements may be approved either at the conference or a separate lump sum conference. The procedure is the same for both meetings, but at the lump sum conference an ALJ or a former AJ (whose sole purpose is to review settlements) will preside over the meeting. Most lump sum settlements are approved directly at the conference or the hearing rather than scheduling a separate meeting. Overall, the pursuit of lump sum settlements comprised a lower percentage of the dispositions in FY'94 (18.6%) than in FY'93 (22%).

HEARINGS

According to the workers' compensation statute, the administrative judge that presided over 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 Massachusetts Rules of Evidence. The judge should issue the hearing decision within 28 days from the close of the record.

Any party may appeal the hearing decision within 30 days. This appeal time 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.

Administrative Judges

The 32 administrative judges and 13 week schedule are utilized for hearings as in conferences. In FY'94, weeks 6 through 11 of the 13 week cycle were devoted to hearings. Up to three hearings were held a day, plus two medical hearings or conferences, four to five days a week for this six 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 evenly distributing cases, since scheduling and hearing queues may arise for individual judges with high appeal rates.

Hearing Backlog

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 over the conference, whereas conferences are scheduled according to availability (when judge ownership is not a factor). Hearings are also more time consuming than conferences making it slower to dispose of a hearing queue than a conference queue.

The hearing queue in FY'94 continued its downward trend, beginning the year at 2,731 (7/7/93) and ending the year at 984 (6/29/94). This is an improvement from the last year where the hearing queue began to inch up. In the last five years, the hearing backlog has been as low as 409 cases in September 1989 and as high as 4,046 in November 1992.

Volume of Hearings

Approximately 7,700 cases were appealed to the hearing stage of dispute resolution (76% of the 10,289 conference orders were appealed in FY'94). This represents 48% of the number of conference dispositions entered in FY'94. Some of these appealed cases may be withdrawn in the interim period between conference and hearing which lowers the number of cases continuing to hearing. The number of appeals that actually proceed must be added to any existing queue of cases at the hearing to get the total number of hearings in FY'94.

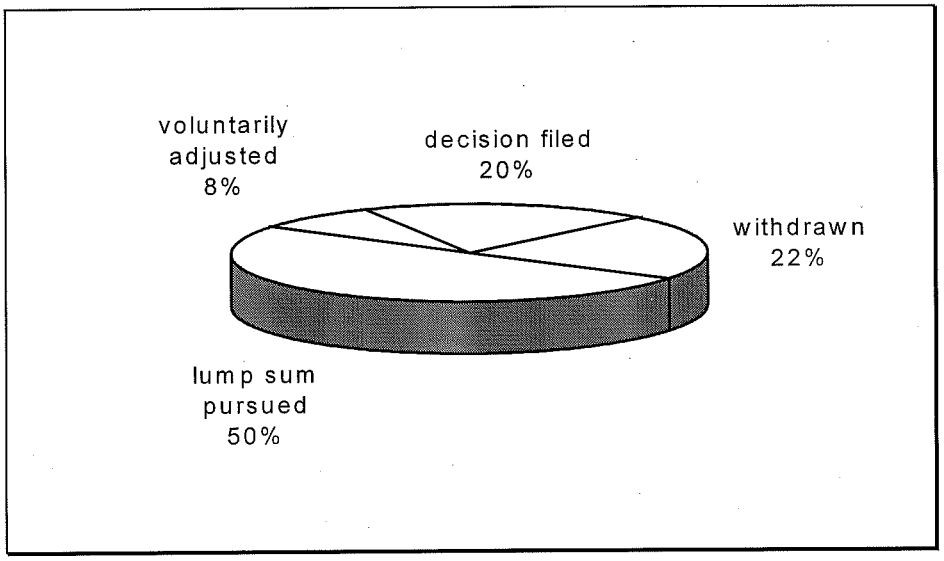
The number of hearings dispositions rose again in FY'94 to 10,176 from 9,010 in the last year. Hearing levels have not been affected by the overall decline in volume of cases entering the system because some of the residual 1991 backlog cases are still making their way through the hearing stage.

There is usually a greater number of dispositions than the actual number of hearings because some cases have more than one disposition or cases are withdrawn before the hearing. For hearings, the "schedule medical hearing" disposition is not a final one because it does not conclude the case. "Lump sum request received" also does not conclude the case but refers it to a separate meeting. If these categories are subtracted from the total number of dispositions of 10,176, it leaves 8,697 final dispositions. This number can be further reduced if cases with a "withdrawn" disposition are subtracted. This equals 6,789 cases, which approximates the total number of hearings that took place in the year.

Hearing Dispositions

The dispositions of hearings are striking in that "lump sums" consists of half of all the cases while "decision filed" accounts for only 20%, virtually the opposite of the situation at conference.

Figure 8: Fiscal year 1994, hearing dispositions



Source: DIA report 346

Table 16: Fiscal Year 1994, Hearing Dispositions

disposition at hearing, FY'94	*cases*	*percentage*
withdrawn	1,908	18.8%
lump sum pursued	4,401	43.2%
settlement approved by judge	3,316	
referred to lump sum	899	
(Administrative Judges may enter this disposition to hold their own lump sum conference)		
lump sum request received	186	
(Directed to separate lump sum conference before ALJ)		
voluntarily adjusted	736	7.2%
decision filed	1,731	17.0%
schedule medical hearing	1,293	12.8%
other	107	1.1%
total	10,176	100.0%

Source: DIA report 346 - Hearing Statistics, for disposition dates (not including reschedules)

Table 17: Fiscal Year 1993, Hearing Dispositions

disposition at hearing, FY'93	*cases*	*percentage*
withdrawn	1,942	21.6%
lump sum pursued	4,406	48.9%
settlement approved by judge	2,558	
referred to lump sum	1,604	
(Administrative Judges may enter this disposition to hold their own lump sum conference)		
lump sum request received	244	
(Directed to separate lump sum conference before ALJ)		
voluntarily adjusted	634	7.0%
decision filed	1,413	15.7%
schedule medical hearing	609	6.8%
other	6	0.1%
total	9,010	100.0%

Source: DIA report 346

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'94, 3,316 lump sum settlements were approved by the judge at hearing. The remaining 1,085 cases with lump sum dispositions will most likely also be approved by an AJ or an ALJ. The majority of lump sum settlements are approved by the AJ at conference or hearing because the judge knows most of the facts of the case and can decide if the settlement is in the best interest of the employee. Parties may also request to move directly to a lump sum conference rather than go through the conference or hearing process. This is usually indicated with a "lump sum request received" disposition.

When any dispute over medical issues is the subject of an appeal of a conference order to a hearing, an impartial medical exam is required (ch. 152 sec. 11A). Hearings are sometimes split with lay testimony presented at one session and medical testimony from the impartial report at another. This occurs when the impartial physician's report arrives after the scheduled date of the hearing. Judges will often go ahead with lay testimony when the impartial report is not yet available and the Diameter system will automatically schedule a separate medical hearing at a later date. The need for a second medical hearing occurred in approximately 13% of the cases in FY'94.[11]

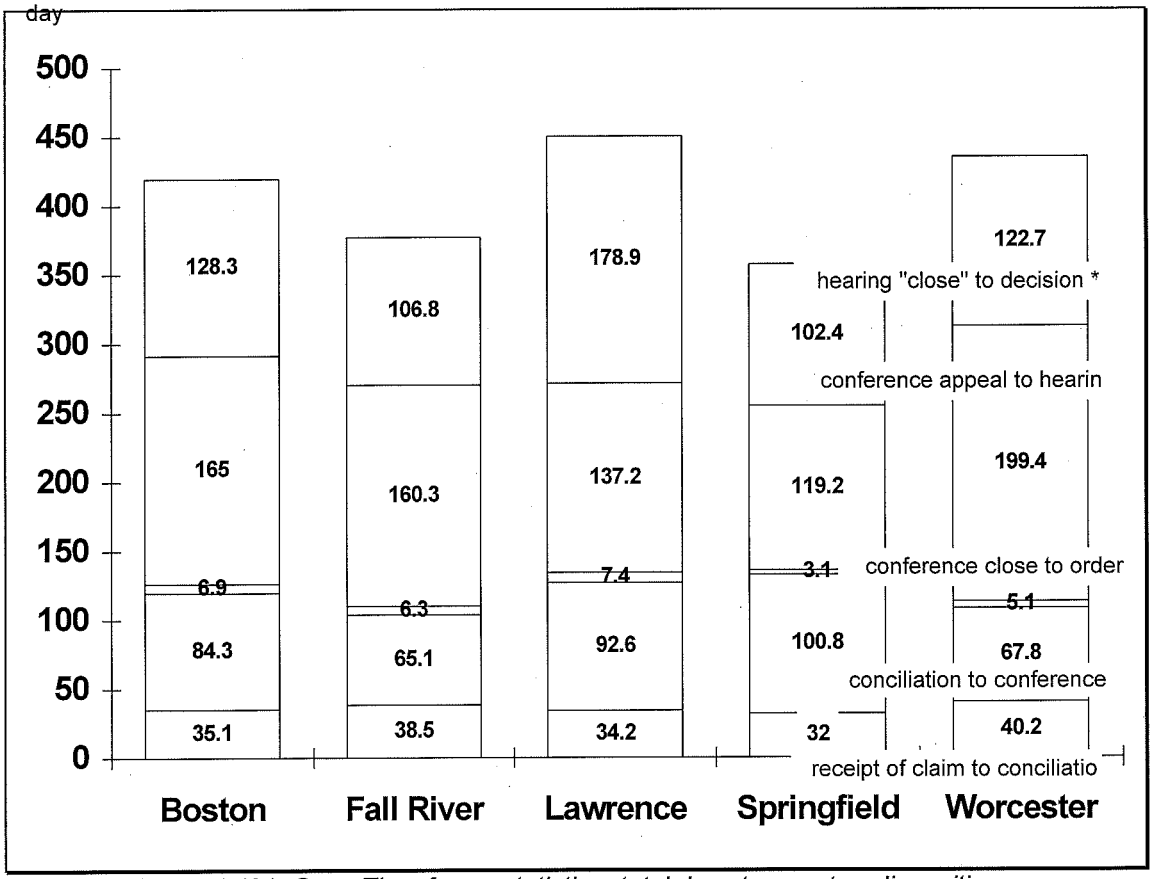
[11] DIA report 346

CASE TIME FRAMES

The workers' compensation act specifies time spans during which cases should proceed through the various stages of dispute resolution. For several years, attempts have been made by the DIA to capture the average number of days that it takes cases to get to and proceed through the conciliation, conference, and hearing stages of dispute resolution.

Figure 9 and Figure 10 present DIA case time frame data obtained from report 491. The average time it took to reach conference, hearing, and a hearing decision declined from FY'93 to FY'94, while the time it took to reach conciliation and the conference order increased slightly.[12]

Figure 9: Case Time Frame -- Average waiting time between each stage of dispute resolution; fiscal year 1994, by region. NOTE: These time frames are not continuous and their total should not equal the total average time frame of cases at the DIA.



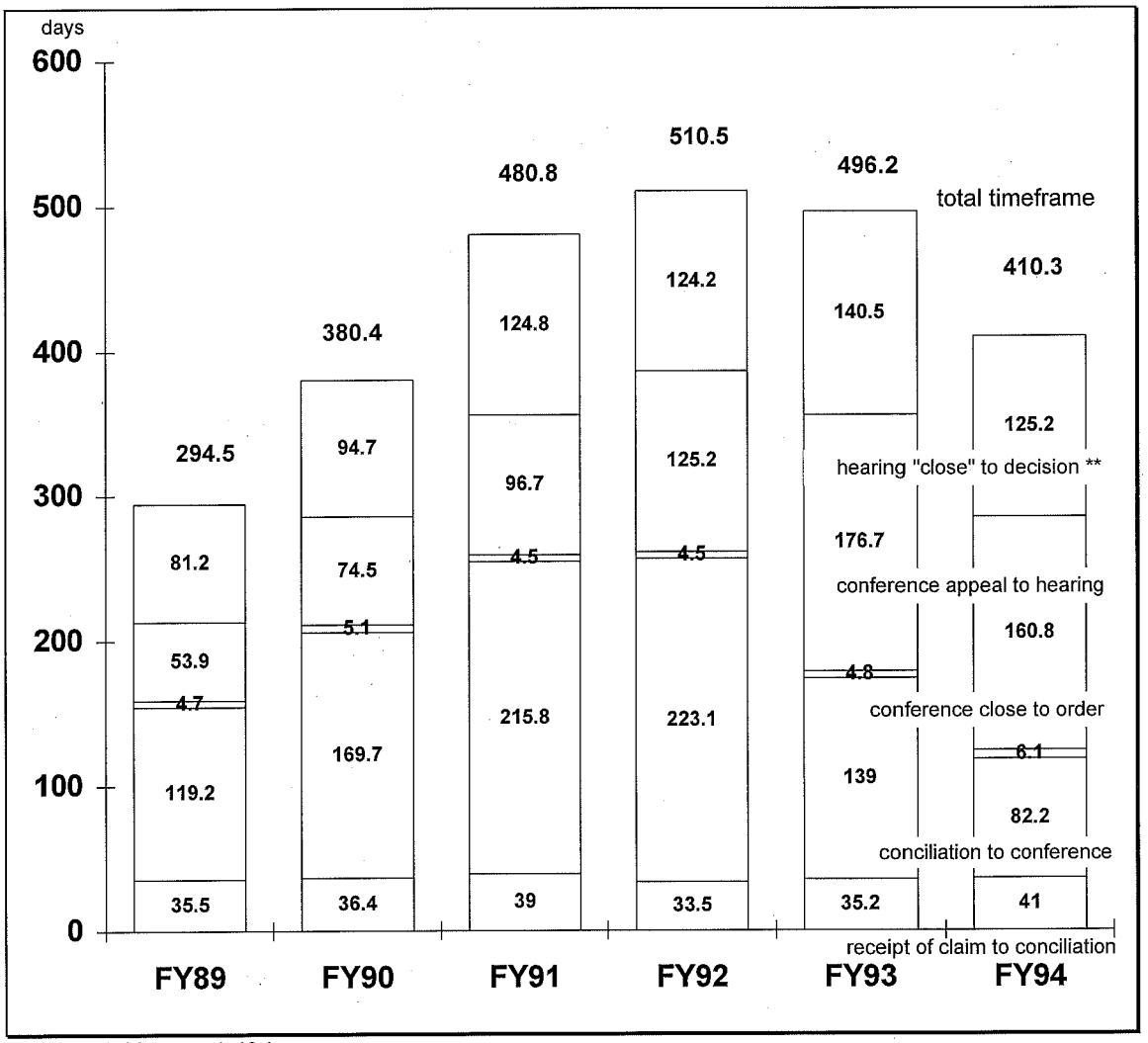
Source: DIA report 491: Case Time frame statistics- total days to event or disposition (mean)

[12] It should be noted that Figures 9 and 10 depict "inactive" time, that is periods during which the claim is awaiting a meeting before a conciliator or AJ. Also, the graphs do not depict the filing time of an appeal from the conference order (within 14 days of the filing of a conference order).

Upon examination of DIA report 491, it is clear that discrepancies exist between the method of measurement and the time frames as categorized. Most specifically, the hearing close on report 491 does not necessarily correspond to the close of testimony as specified by the statute. DIA computer programmers acknowledge that the close of testimony is not systematically recorded and therefore a default date is used. The time frame is mostly measured from the opening of the hearing (the first scheduled meeting) to the close of all hearing depositions.

In fiscal year 1994, the Advisory Council began to address these discrepancies in the reporting of case time frames.

Figure 10: Case Time Frame -- Average waiting time between each stage of dispute resolution; fiscal year 1989- fiscal year 1994, statewide.



Source: DIA report 491

*** hearing close is not measured consistently and the hearing close may actually be recorded as the first scheduled hearing.*

Advisory Council Study of Case Time Frames

The Advisory Council, following on its recommendation from the FY'93 annual report, began to study the issue of case time frames in FY'94. The following is the introduction to this study.

> In an effort to reevaluate case time frames in chapter 152, the Advisory Council proposes to work with all interested parties to develop a guide on how long it should take a case to be resolved.
>
> The DIA has a unique opportunity now with a stable flow of cases and the elimination of a backlog to revise time frames between each step of dispute resolution that appear in chapter 152.
>
> In the Advisory Council's FY'93 Annual Report, it recommends that case time frames be evaluated and that new time frames be developed if necessary.
>
> > *While the department has reduced the conference level backlog and the time it takes to get to a judge initially at conference, the case time frame 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[...].*
> >
> > *If these statutory time frame requirements are unrealistic or unattainable, the Council recommends that the DIA reevaluate the requirements and file legislation to reflect adequate and feasible time frames. Employees, employers, and insurers have a right to know how long it will take to reach each step of the dispute resolution process.*
>
> A report by the Senate Committee on Post Audit and Oversight in May 1993 also brought up this issue of the statutory case time frames. The report found that the "DIA was not processing workers' compensation claims within the time period allowed by law, resulting in financial hardships to insurers and claimants." The DIA's response was that "some of the specific time frames within the dispute resolution process that have been in the Act for many years are unrealistic standards and should be extended by legislation to conform to current experience."
>
> For at least the last five years, the actual time it takes to resolve a case has exceeded the statutory time frames. In 1966, the Supreme Judicial Court ruled that a judge's decision cannot be invalidated if not issued within the statutory time frames. [13] In light of the Court's ruling, time frames are taken as advisory in nature.
>
> Even if they serve the purpose of recommendations, case time frames in the statute can serve an important role and they should, at a minimum, reflect current practices and act as a guide for participants of the system.

The Advisory Council has formed a committee, with the cooperation of seven administrative judges, two administrative law judges, and the Senior Judge, to discuss time frames in the dispute resolution system.

[13] Monico's Case, 350 Mass 183 (1966)

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.

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 appellant must file a brief in accordance with the board's regulations and the appellee must also file a response brief. An 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.

The number of hearing decisions appealed to the reviewing board in FY'94 was 657. This is a large increase from previous years where 412 (FY'93), 493 (FY'92), and 513 (FY'91) hearing decisions were appealed to the board.

The reviewing board continued in FY'94 to have a large number of cases awaiting review. At the end of FY'94 (6/30/94), there were 1,044 cases awaiting review, a slight increase from the 1,005 cases pending before the board at the close of FY'93.

The reviewing board disposed of 558 cases in FY'94 compared to 521 in the previous fiscal year.

Table 18: Reviewing Board statistics, FY'94

Disposition of cases, FY'94	*number of cases*
decision by full panel	217
lump sum settlement	91
withdrawn after conference with single ALJ	215
other	35
total	**558**

Source: DIA Reviewing Board

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.

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. Conciliators and judges may refer cases to this lump sum conference at the request of the parties or the parties may request a lump sum conference directly.

In FY'94, 6,041 lump sum conferences were scheduled before the reviewing board.

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 hearing 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'94, administrative law judges heard 901 §15 petitions on a rotating basis, virtually the same number as the last year.

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 M.G.L. ch. 152, section 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 and the employer's workers' compensation insurer whereby the employee will receive a one time payment in place of weekly compensation benefits. In most instances, the employer must ratify the lump sum settlement before it can be implemented. 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. 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, conciliators and administrative 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.

Table 19: Lump sum conference statistics

Fiscal Year	*Total lump sum conferences scheduled*	*Lump sum settlements approved*
FY'94	13,605	12,578 (92.5%)
FY'93	17,695	15,762 (89.1%)
FY'92	18,310	16,019 (87.5%)
FY'91	19,724	17,297 (87.7%)
FY'90	18,213	15,682 (86.1%)
FY'89	14,739	12,384 (84.0%)

Source: DIA report 86A: lump sum conference statistics, for scheduled dates

The number of lump sum conferences has declined by 31% since FY'91. Scheduled conferences are now at the lowest level for at least the last six years, while the percentage of lump sum settlements approved is at the six year high. In FY'94, only 17 lump sum settlements were disapproved in the whole fiscal year, (0.1%) of the total. The remainder of the scheduled lump sum conferences without an "approved" disposition were either withdrawn or rescheduled.

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.

"Referred to lump sum"— Lump sums settlements may also be reviewed at a lump sum conference conducted by an administrative law judge or one of the two recall administrative judges. Conciliators and administrative judges may refer cases to lump sum conferences to 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. An 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.

"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:

Table 20: Lump sum settlements pursued, at each step of dispute resolution, FY'94.

Meeting	*Lump sum pursued*[14]	*Percentage of Total Cases Scheduled*
Conciliation	1,071	3.8%
Conference	3,003	18.6%
Hearing	4,401	43.2%

Source: see previous sections on conciliation, conference and hearing

The percentage of lump sum settlements pursued at the hearing level approaches 50% if the disposition "schedule medical hearing" is removed from the total.

Table 21: Lump sum settlements pursued, at each step of dispute resolution, FY'93.

Meeting	*Lump sum pursued*	*Percentage of Total Cases Scheduled*
Conciliation	1,415	4.5%
Conference	5,632	22.3%
Hearing	4,406	48.9%

[14] 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. (M.G.L. ch. 152, sec. 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 impartial unit chooses the specialty, 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.

The number of physicians on the roster has steadily increased since its inception. As of 7/1/94, there were 581 physicians on the roster consisting of 46 specialties. This is an increase from 354 as of 7/1/93, and 203 as of 7/1/92.

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'94, the impartial unit scheduled 7,787 examinations. Out of this, 4,804 exams were actually conducted in the fiscal year (the remainder of the scheduled exams were either canceled due to settlements and withdrawals or they took place in the next year). Medical reports are required to be submitted to the department and to each party within 21 calendar days after completion of the examination. The number of exams scheduled in FY'93 was 5,448, and 3,229 were conducted in the year.

Filing fees for the examinations are 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. In FY'94, $1,843,800 was collected in filing fees.

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 rate those candidates recommended for appointment and reappointment as highly qualified, qualified or unqualified.

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

OFFICE OF EDUCATION AND VOCATIONAL REHABILITATION

The primary purpose of the office of education and vocational rehabilitation (OEVR) is to promote return to work for disabled workers through vocational rehabilitation services. 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.

OEVR oversees the rehabilitation of certain disabled workers receiving workers' compensation with the primary objective of return to work. While OEVR seeks to encourage the voluntary development of rehabilitation services between the disabled worker and the insurer, it has the authority to mandate services for injured workers determined to be suitable for rehabilitation.

Vocational rehabilitation is defined in M.G.L. 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; retraining the employee for a new job.

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 dispute resolution), insurers, certified providers, attorneys, hospitals, doctors, employers and injured employees themselves.[15]

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 vocational rehabilitation services are "necessary and feasible".

The information gathered includes the employee's functional limitations, employment history, education, transferable 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

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

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 without good cause, 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 at least two times the cost of the program provided the rehabilitation is successful and the employee returns to work.

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.

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, the employee must seek the consent of OEVR before a lump sum settlement can be approved. 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 initiate, if not complete, rehabilitation before the lump sum settlement is approved. This is difficult to accomplish in a short time. Nevertheless, OEVR will consent to a lump sum settlement if the insurer agrees to continue to provide rehabilitation benefits.

Use of Vocational Rehabilitation

In FY'94 the office consisted of 8 disability analysts and 13 rehabilitation review officers, one of whom is a registered nurse.

OEVR certified 104 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 C.M.R. 4.03. Any state vocational rehabilitation agency, employment agency, insurer, self insurer, or private vocational rehabilitation agency may qualify to perform these services. Credentials must include at least a masters degree, rehabilitation certification, or a minimum of 10 years of experience. A list of the providers is available from the OEVR.

Table 22: Utilization of voc. rehab. services, FY92-FY94

Fiscal Year	Referral to OEVR	Mandatory Meetings	Referrals to Insurer for VR	IWRPs approved	Return to work	% RTW after plan development
FY94	3,756	3,190	1,706	948	470	50%
FY93	4,494	3,882	2,253	1,078	554	51%
FY92	6,014	3,367	2,106	1,010	583	58%

Source: DIA - OEVR

When an insurer refuses to pay for vocational rehabilitation services and, after review, OEVR determines the employee suitable for services, the office may utilize moneys from the trust fund to fund the rehabilitation services.

The amount expended by the trust fund for insurer denials has decreased substantially from FY'92 levels. Two factors could explain this. Insurers could be increasingly providing vocational rehabilitation on a voluntary basis, without an OEVR mandate. Or, the DIA could be increasingly unwilling to fund rehabilitation services for employees denied services by their insurer. Given that the overall number of rehabilitation plans approved has only slightly decreased, it is likely that both scenarios are true.

Table 23: Private Trust Fund Expenditures for §30H voc rehab services

Fiscal Year	Expenditures
FY94	10,970
FY93	37,146
FY92	68,973

OEVR is required to seek reimbursement from the insurer when the trust fund pays for the rehabilitation and the services are deemed successful (e.g., the employee returns to work). The DIA may assess the insurer a minimum of two times the cost of the services. In FY'94, $41,842 was collected to reimburse the private trust for vocational rehabilitation services funded. This is a dramatic increase from the $16,833 collected in FY'93 and $9,702 collected in FY92.

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."[16] 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'94, proposals could be submitted up to a maximum of $35,000.

See appendix C for a list of proposals funded in FY'94.

[16] M.G.L. c. 23E, 3(6)

OFFICE OF INSURANCE

The office of insurance is broken down into two sections; the self insurance unit and the insurance unit. The self insurance unit issues self insurance licenses and monitors all self insured employers. The insurance unit maintains the insurer register and monitors insurer complaints.

Self Insurance

A license to self insure is available for qualified employers with at least 300 employees and $750,000 in annual standard premium.[17] To be self insured, employers must usually have enough capital to cover the expenses associated with self insurance. Many smaller and medium sized companies have also been approved to self insure, however. The office of insurance evaluates employers every year to determine their eligibility and to establish new bond amounts.

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.[18] The amount varies for every company depending on their previous reported losses and predicted future losses. The average bond is usually over $1 million and depends on many factors including loss experience, the financial state of the company, the hazard of the occupation, the number of years as a self insured, and the attaching point for the re-insurance.

Employers who are self insured must purchase reinsurance of at least $500,000. The per case deductible of the re-insurance varies from the minimum $500,000, which is a relatively modest amount, to much higher amounts. Smaller self insured companies may also purchase aggregate excess insurance to cover multiple claims that exceed a set amount. Many self insured employers engage the services of a law firm or a third party administrator (TPA) to handle claims administration.

In FY'94, the trend toward self insurance abated somewhat but continued to increase. In the year, 23 new licenses were issued to bring the total number to 224. Each self insurance license provides approval for a parent company and its subsidiaries to self insure. From the 224 licenses, 688 companies including subsidiaries were self insured in FY'94. This amounts to approximately $570 million in equivalent premium dollars.

[17] C.M.R. 5.00: Code of Massachusetts Regulations concerning insurers and self insurers. 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.

[18] M.G.L. 452 C.M.R. 5:00

Four semi- autonomous public employers are also licensed 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).[19]

Insurance Unit

The insurance unit maintains a record of the workers' compensation insurer for every employer in the state. This record known as the insurer register, dates back to the 1920's and consists of a listing of employers and their insurance carriers so that claims can be made and investigated after many years.

This record keeping system consisted of information manually recorded on 3x5 notecards, a time consuming and inefficient method for storing files and researching insurers. Every time an employer made a policy change, the insurer sent in a form and the notecard and file was changed.

Through legislative action, the Workers' Compensation Rating and Inspection Bureau (WCRB) became the official repository of insurance policy coverage in 1991, and the DIA was provided with computer access to this database. The WCRB repository has policy information for the eight most current years. The remainder of policy information must be researched through the files at the DIA.

In FY'94, the insurance unit completed a project to convert all of its notecards to microfilm. All insurance policy information can now be traced with the files on microfilm or the WCRB database.

The insurance unit is also responsible for handling insurance complaints. Complaints are often registered by telephone and the unit will provide the party with the necessary information to handle the case.

[19] 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 license 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 (M.G.L. c.152 25B).

OFFICE OF INVESTIGATIONS

The investigations office enforces the mandate that all employers have adequate workers' compensation insurance coverage for their employees. Investigations became an office separate from the office of insurance on October 4, 1993.

The unit has access to the Workers' Compensation Rating and Inspection Bureau (WCRB) database 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 canceled 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-insurance group, reciprocal exchange).

The WCRB database documents only those employers that currently have or have 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.

Investigators 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.

Stop Work Orders: 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 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.[20]

In FY'94, 1,860 stop work orders were issued as a result of 7,344 investigations conducted. The amount collected in fines in the year was $160,150. The number of stop work orders has increased dramatically in the last few years. In FY'93, 194 stop work order were issued, up from 110 in FY'92 and 86 in FY'91. The amount collected in fines was $32,000 in FY'93, and $32,400 in FY'92.

[20] M.G.L. c.152 §25C

DIA SPECIAL FUND AND TRUST FUNDS

The DIA Special Fund and Trust Funds assume a broad array of functions vital to the operation of the workers' compensation system. Their establishment was a major component of the 1985 reform act to ensure that the DIA has adequate funding and to fulfill other key legislative mandates-- to provide benefits to injured workers whose employers failed to secure adequate insurance coverage, to provide reimbursement to insurers when benefits are paid to employees with latent and second injuries, and to provide cost of living adjustments to benefits.

The special fund, the private employer trust fund, and the public employer trust fund are each funded through assessments levied against employers as part of workers' compensation insurance premiums. Revenues for the three funds are deposited into the accounts of the Treasurer of the Commonwealth.

Defense of legal actions against the public and private trust funds fall under the jurisdiction of the office of the DIA general counsel.

Assessments

The workers' compensation act requires that the DIA determine the assessments to be charged to the employers of Massachusetts for the support of the trust funds and the special fund. (M.G.L. ch. 152, sec. 65) Those assessments are paid as part of an employer's annual insurance premiums, and are forwarded to the DIA by the insurer.

While the governor and legislature appropriate amounts the DIA may expend to cover its operating expenses through the annual budget process, the DIA's funding is derived from the special fund. No moneys from the general fund are utilized for DIA operations.

Each year the DIA projects the needs of both trust funds and the special fund for 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 premium. Separate assessment rates are calculated for self-insurers, group self-insurers, and public employers.

Self insured private employers each year may opt out of paying assessments to cover most trust fund liabilities, but must remain subject to assessments for the special fund, as well as vocational rehabilitation benefits and uninsured employer 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 by July 1 if their assessment is paid in full.

In FY'94, 21 self insured private employers opted out of paying complete assessments for the private trust fund. 34 public employers opted out of paying complete public employer assessments.

Modified assessment rates are calculated for employers who opt out of trust fund benefits. For a review of the assessment rates since 1987, see appendix F.

Special Fund

The special fund was established to pay the operating expenses of the DIA. The sources for income of the special fund consist of assessments levied against the private employers of the commonwealth, and any fines or fees collected by the department for violations as enumerated by the act.

Fines & Fees

M.G.L. ch. 152, section 6B requires that "any proceeds resulting from the imposition of any fine levied under this chapter shall be paid into the Special Revenue Fund, established pursuant to section sixty-five." After a long history of neglecting to assess and collect fines and fees owed, the DIA has substantially increased its efforts both in identifying employers and insurers who have violated the law, in charging them with fines and fees, and in collecting outstanding fines and fees. (See collection and expenditure report on following pages for amounts of fines and fees collected).

Private & Public 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.

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. COLAs are also available under section 35F. 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.

Latency claims -- 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).

Veterans benefits -- 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 AND EXPENDITURE REPORT

Table 24: Special Fund

SPECIAL FUND	*FINAL FY'94* AS OF 10/25/94	*FY'93*	*FY'92*
COLLECTIONS			
INTEREST	365,817	217,797	323,960
ASSESSMENT	17,537,534	13,743,804	11,023,312
LESS RET. CHECKS	0	88,274	0
LESS REFUNDS	98,514	9,022	0
SUB-TOTAL	**17,439,020**	**13,646,508**	**11,023,312**
FILING FEES	4,744,199	3,483,110	2,511,501
LESS RET. CHECKS	4,447	4,743	0
LESS REFUNDS	5,192	2,131	0
SUB-TOTAL	**4,734,560**	**3,476,236**	**2,511,501**
1ST REPORT FINES	402,442	85,707	144,200
LESS RET. CHECKS	300	0	0
LESS REFUNDS	2,200	0	0
SUB-TOTAL	**399,942**	**85,707**	**144,200**
LATE ASSESS. FINES	33,822	21,970	0
STOP WORK ORDERS	166,600	see Private Fund	see Private Fund
SEC. 7 FINES	0	6,000	4,000
MISCELLANEOUS	7,867	880	350
SUB-TOTAL	**208,289**	**28,850**	**4,350**
TOTAL COLLECTIONS	**23,147,628**	**17,455,098**	**14,007,323**
BALANCE BRGT FWD	3,035,890	2,621,052	3,279,692
TOTAL	**26,183,518**	**20,076,150**	**17,287,015**
LESS EXPENDITURES	20,167,636	17,040,260	14,665,963
BALANCE	**6,015,882**	**3,035,890**	**2,621,052**
EXPENDITURES			
SALARIES	10,984,604	9,797,077	8,616,722
FRINGE BENEFITS	3,513,989	2,666,838	2,331,860
INDIRECT COSTS	578,985	613,250	613,250
NON-PERSONNEL COSTS	5,093,478	3,957,815	3,104,131
SUB TOTAL	20,171,056	17,034,980	14,665,963
misc.	-3,420	5,280	
TOTAL EXPENDITURE	**20,167,636**	**17,040,260**	**14,665,963**

COLLECTION AND EXPENDITURE REPORT

Table 25: Public Trust

PUBLIC TRUST	*FY'94*	*FY'93*	*FY'92*
COLLECTIONS			
INTEREST	53,222	98,627	93,549
sec 30H	0	0	1,875
ASSESSMENTS	819,613	1,632,650	4,896,637
REFUNDS	93	205	0
SUB-TOTAL	**819,520**	**1,632,445**	**4,896,637**
TOTAL COLLECTIONS	**872,742**	**1,731,072**	**4,992,061**
BALANCE BRGT FWD	2,291,964	3,056,655	1,495,574
TOTAL	**3,164,706**	**4,787,727**	**6,487,635**
LESS EXPENDITURES	2,879,379	2,495,761	3,430,980
BALANCE	**285,327**	**2,291,966**	**3,056,655**
EXPENDITURES			
RR COLAS	2,621,503	2,464,967	3,413,611
OEVR sec 30H	0	0	741
RR SEC. 37	254,676	30,794	16,628
RR LATENCY CLAIMS	3,200	0	0
TOTAL EXPENDITURES	**2,879,379**	**2,495,761**	**3,430,980**

COLLECTION AND EXPENDITURE REPORT

Table 26: Private Trust

PRIVATE TRUST	*FY'94*	*FY'93*	*FY'92*
COLLECTIONS			
INTEREST	354,842	187,259	658,729
ASSESSMENTS	28,974,039	25,187,627	26,012,517
LESS RET. CHECKS	0	143,490	0
LESS REFUNDS	160,718	23,843	0
SUB-TOTAL	**28,813,321**	**25,020,294**	**26,012,517**
REIMBURSEMENTS	1,029,263	572,170	452,905
RET. CHECK	200	1,818	0
SUB-TOTAL	**1,029,063**	**570,352**	**452,905**
STOP WORK ORDER *	0	31,150	28,600
LESS RET. CHECKS	0	0	0
SUB-TOTAL	*** see Special Fund**	***31,150**	***28,600**
SEC. 30 H	41,842	16,833	9,702
TOTAL COLLECTIONS	**30,239,068**	**25,825,888**	**27,162,453**
BALANCE BRGT FWD	7,588,112	3,652,610	4,333,975
TOTAL	**37,827,180**	**29,478,498**	**31,496,428**
LESS EXPENDITURES	25,463,695	21,890,386	27,843,817
BALANCE	**12,363,485**	**7,588,112**	**3,652,611**

* Stop work orders fines transferred to Special Fund from Private Trust Fund in FY'94.

COLLECTION AND EXPENDITURE REPORT

Table 27: Private Trust -- Expenditures, benefits

EXPENDITURES	*FY'94*	*FY'93*	*FY'92*
SEC. 34	2,591,989	2,783,111	2,959,303
SEC. 35	795,556	714,888	527,439
LUMP SUM	1,373,464	1,146,409	1,255,442
SEC. 36 *	484,297	490,492	253,110
SEC. 31	109,928	106,862	113,973
COLA ADJ	12,459	11,160	3,758
EE MEDICAL REIMB.	29,158	18,832	14,513
EE TRAVEL	5,627	8,618	15,296
EE BOOKS & SUPPLIES	0	122	915
FUNERAL EXPENSES	8,000	4,000	4,000
VETERANS SERVICES	4,690	1,711	0
LEGAL FEES	716,184	599,323	546,142
LEGAL EXPENSES	72,862	35,292	----------
MEDICAL EXPENSES	1,797,948	1,854,762	1,497,815
REHAB SERVICES	5,172	6,954	17,253
REHAB. SERV. TRAVEL	323	----------	----------
WELFARE LIENS	209,069	61,741	64,370
SUB-TOTAL RR (benefits for uninsured claimants)	**8,216,726**	**7,844,277**	**7,273,329**
TUITION	2,828	22,490	18,368
TOTAL BENEFITS	**8,219,554**	**7,866,767**	**7,291,697**
INSURERS			
COLA	10,924,588	11,325,195	19,627,352
LATENCY CLAIMS	4,768,138	246,407	0
SEC. 37	699,185	1,896,753	575,652
TOTAL INS.	**16,391,911**	**13,468,355**	**20,203,004**
TOTAL RR-LEGAL	**24,611,465**	**21,335,122**	**27,494,701**
OEVR			
SEC. 30H	1,530	13,795	18,700
EE TRAVEL	0	2,458	5,903
EE BOOKS & SUPPLIES	0	297	347
TUITION	9,440	20,596	44,023
TOTAL OEVR	**10,970**	**37,146**	**68,973**
TOTAL BENEFITS	**24,622,435**	**21,372,268**	**27,563,674**

COLLECTION AND EXPENDITURE REPORT

Table 28: Private Trust -- Expenditures, defense of the fund

EXP.-DEFENSE OF THE FUND	*FY'94*	*FY'93*	*FY'92*
AA SALARIES	306,588	196,223	54,577
DD FRINGE	100,412	61,810	15,968
DD UNIVERSAL HEALTH	155	112	0
DD MEDICARE	4,197	2,728	860
SUB-TOTAL	**411,352**	**260,873**	**71,405**
BB TRAVEL	834		
TRAINING/TUITION	110		
EE MV RENTALS	542		
EE ADVERTISING	355		
SUPPLIES/BOOKS	2,914		
IMPARTIAL APPEALS	10,575		
HH WILSON ASSOC.	5,000		
ACCUMED	28,977		
STENO IND.	0		
STENO CORP.	127		
CONSULTANT	18,444		
CONSULTANT	30,996		
CONSULTANT	46,875		
CONSULTANT	23,900		
CONSULTANT	37,175		
JJ ACE TEMP.	45,997		
TEMP. EXPRESS	0		
KIRK/MAYER	0		
INVESTIGATORS	710		
SHERIFFS	1,602		
KK EQUIPMENT	19,270		
MM IME'S IND.	0		
IME'S CORP.	144,505		
RR PENALTIES	11,000		
SUB-TOTAL	**429,908**	**257,244**	**208,738**
TOTAL DEFENSE OF FUND	**841,260**	**518,117**	**280,143**
TOTAL EXPENDITURES	**25,463,695**	**21,890,385**	**27,843,817**

OFFICE OF HEALTH POLICY

The DIA commissioner created the office of health policy to address the health care related issues handled by the DIA, including the implementation and enforcement of the DIA's utilization review and quality assessment program. The office is also the liaison with the Health Care Services Board (HCSB) and the Medical Consultant Consortium (MCC).

The commissioner 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 to the MCC, as well as members of the Health Care Services Board.

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. 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. 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.

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'94 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. The requirements of the §8(4) and the §11(A) rosters differ pursuant to M.G.L. c. 152.

The members of the MCC and the HCSB are in appendix E of the report.

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, including appropriate parameters for treating injured workers. In FY'94, the commissioner formed an advisory group on treatment guidelines and recruited specialists to work in sub-groups to develop guidelines in specific areas.

At the beginning of FY'94 (July 1, 1993), the HCSB published twenty-five treatment guidelines covering many conditions common to workers' compensation patients. Of particular note were guidelines on the treatment of carpel tunnel syndrome and herniated discs. The HCSB examined guidelines from various groups including the American Academy of Orthopedic Surgeons (AAOS), the State of Washington Department of Labor Insurance, and the National Institutes of Health. They adopted some of these guidelines and went on to develop several of their own.

The HCSB is required to conduct an annual review of the guidelines and update them based on the experience of the year. They are also in the process of developing three new treatment guidelines on chronic pain, chronic injury, and asthma.

Utilization Review

In coordination with the implementation of treatment guidelines, on July 1, 1993, the commissioner promulgated regulations mandating utilization review (UR). A hearing was held on May 19 seeking public comment regarding utilization review regulations and the treatment guidelines. Utilization Review and Quality Assessment regulations were promulgated July 1 and published September 1. On October 1, 1993 the UR program began to operate in the state.

According to the regulations (452 C.M.R. 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. In FY'94, the DIA approved 48 UR agents for a two year period.

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.

Medical Trending and Tracking System and Quality Assessment Program

The commissioner is required to implement within the department a quality control system to "monitor the medical and surgical treatment provided to injured employees and the services of other health care providers, and monitor hospital utilization as it relates to the treatment of injured employees. The monitoring shall include determinations concerning the appropriateness of the service, whether treatment is necessary and effective, the proper costs of services, and the quality of treatment." (M.G.L. ch. 152, sec. 13).

According to the regulations promulgated in furtherance of this directive (452 C.M.R. 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 treatment guideline (see above), the provider will be informed of the aberration with instructions on the 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.

The DIA has begun a program to gather data on compliance with treatment guidelines from insurers and utilization review agents. Specifically, the department will look to billing data to discern trends in costs as well as 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.

Implementation of this program involves an enormous data gathering process. In FY'94, the department worked with consultants including individuals at the National Design Group, a New York state company, to draft a request for proposals on this project. The department indicated it intends to spend between $500,000 and $1 million per year for at least three years to contract with a firm to assemble a computer network to gather insurer, self insurer, and self insurance group data on the costs and medical practices associated with treating workers' compensation claimants. The department does not intend to buy equipment, but rather contract with a vendor to collect data. Data from this project is expected to be available in three to five years.

THE REGIONAL OFFICES

The Department of Industrial Accidents has offices in Boston, Lawrence, Worcester, Fall River, and Springfield. Headquarters are located in Boston, with the commissioner, his staff, the general counsel's office, the budget department, the trust fund, data operations, claims administration, the safety office and impartial unit completely housed there. In addition, all DIA case records are stored in Boston.

The Senior judge and the managers of the conciliation and vocational rehabilitation units are located in Boston, but each has managerial responsibility for the operations of their respective departments at the regional offices.

Each regional office has a regional manager, a staff of conciliators, stenographers, vocational rehabilitation counselors, disability managers, administrative secretaries, clerks, and data processing operators. In addition, administrative judges make a particular office the base of their operations, with an assigned administrative secretary.

Administration and Management of the offices

Each regional manager is responsible for the administration of his or her regional office. Each office is equipped with conference rooms and hearings rooms in which conciliations, conferences, hearings and other meetings are held. A principle clerk and a data processing operator manage the scheduling of these proceedings and the assignment of meeting rooms through the Diameter case scheduling system.

Cases are assigned to administrative judges by the Diameter system in coordination with the Senior judge. Conciliators are assigned cases according to availability on the day of the meeting, and report to the conciliation manager located at the Boston office. Likewise, stenographers are assigned when needed, but report to the stenographer manager at the Boston office. The vocational rehabilitation personnel report directly to the OEVR manager in the Boston office, and take assignments as delegated from Boston.

When an employee or insurer files a workers' compensation claim or complaint with the department, the case is assigned to the office geographically closest to the home of the claimant. Assignments are based on zip codes, with each regional office accounting for a fixed set of zip codes. In general, cases from the Boston metropolitan area are assigned to the Boston office, those from central Massachusetts to Worcester, northeastern Massachusetts to Lawrence, southeastern Massachusetts, Cape Cod, and Plymouth county to Fall River, and western Massachusetts to Springfield.

Since most regional employees report directly to a manager at the Boston office, regional managers raised concerns that they are not authorized to hold employees accountable for mishandling of responsibilities (including employment matters such as prompt arrival at work). They felt this problem affects the morale of other employees whose daily operations are monitored directly by them. A more formalized system of communication between the regional managers and the unit managers to address work habit issues would help.

Each regional office occupies space rented from a private realtor. The manager is responsible for working with building management to ensure the building is accessible and that the terms of the lease are met. Moreover, each regional manager is responsible for maintenance of utilities, including the payment of telephone, electricity, and other monthly services. The costs of operating each office is therefore managed by each regional manager.

Public Information Inquiries

Even though the department maintains a toll free telephone number so that telephone inquiries can be handled by information specialists at the Boston office, the regional offices are presented with numerous phone calls on a daily basis. The regional offices did not appear to have a consistent method for handling telephone inquiries.

As no information specialists are assigned to the regional offices, telephone inquiries must be handled by the principal clerk, the data processing operator, the regional manager, or others who may be available. These employees, while knowledgeable about the DIA, are not periodically trained or updated on developments in the law in a consistent and uniform fashion. While complex questions are often referred to an appropriate DIA unit, every attempt is made to answer questions at the time of the call.

Costly delays in the processing and filing of claims can occur when inaccurate information is conveyed to claimants and insurers. Moreover, inaccurate information can lead claimants to file faulty claims. A more uniform and coherent policy for the dissemination of public information is needed with training programs and sufficient resources to ensure questions are answered accurately according to the most up to date information.

Resources of the Offices

Each of the regional offices, except Fall River, has moved to expanded and enhanced office space within the last four years. Requests for proposals have been issued to procure office space in the southeastern Massachusetts region. Each office appears to have adequate space for all personnel. Court rooms have been updated and modernized according to the needs of each regional office, including handicap accessibility and security systems. Moreover, each regional office is equipped with video equipment to assist with the presentation of court room evidence.

Each office has been provided with personal computers networked to the Boston office, and with a CD ROM for access to software on the Mass. General Laws, Mass. court reporters, and DIA reports. This is a great improvement given that in the past, library resources at the regional offices were particularly scant.

The following are the addresses of the regional offices.

Fall River
30 Third Street
Fall River, MA 02722
508/676-3406
Henry Mastey, Manager

Lawrence
11 Lawrence Street
Lawrence, MA 01840
508/683-6420
Maritza Nieves, Manager

Springfield
436 Dwight Street
Springfield, MA 01103
413/784-1133
Marc Joyce, Manager

Worcester
44 Front Street
Worcester, MA 01608
508/753-2073
Leonard Gabrila, Manager

Section II: The Workers' Compensation System

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 FY'94, the insurance market improved dramatically with a rate reduction after many years of rising costs. The residual market also improved considerably in the year.

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.[21] 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, especially smaller towns, do have insurance coverage that is similar to that of private employers.[22]

Enforcement - The office of investigations at the Department of Industrial Accidents (DIA) monitors employers in the state to make sure they have the required insurance. The office may issue fines and close down any business that is operating without adequate coverage for its 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

[21] M.G.L. c. 152 §25B

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

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, a self insurance group (SIG), or a reciprocal exchange. Public employers may also obtain coverage 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.

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 1993 the residual market comprised 61% of the overall market. This is still a high percentage but an improvement from the last year.

The insurance companies that administer the policies of employers in the pool are referred to as "servicing carriers." In 1994, servicing carriers were subject to "performance standards" and a "paid loss incentive program." The paid loss incentive program began in policy year 1993 and provides up to a 9% bonus or penalty. The "performance standards" effective in 1994 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.

In the assigned risk pool, if the overall losses exceed the allowable premium approved each year (revenues), 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.[23]

This 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.

This residual market burden (percentage of each voluntary market dollar used to pay for the assigned risk pool) has significantly decreased over the past three years. In 1992 and again in 1993, the burden was actually a positive number which would in fact reimburse companies for a positive profit in the pool. This is an unusual circumstance reflecting much better than expected loss experience.

Loss ratios have also continued to decline. 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 100% indicates that losses are greater than revenues (premiums). In 1993, the estimated loss ratio was 68.2%, down slightly from 68.7% in the previous year and a high of 156.3% in 1987.[24]

In 1993, 61% of every premium dollar was written in the residual market, breaking the trend of the rising market share of the assigned risk pool that peaked at 64.7% in 1992. Although calendar year 1993 still shows that over 60% of the total premiums were written in the residual market, it must be noted that calendar year premiums include any premiums' activities recorded in that year regardless of the policy effective date. Therefore, the calendar year data may be somewhat misleading since it reflects older market conditions.

It is estimated that for 1994, the residual market was at or below 50% of total premium, indicating a much healthier and improved insurance system.[25]

[23] 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.

[24] National Council on Compensation Insurance

[25] Massachusetts Workers' Compensation Rating and Inspection Bureau - policy file system.

Table 29: Massachusetts workers' compensation residual market information

Policy year	Loss Ratios (@ 6/30/94)	Residual Market Burden* (@6/30/94)	Calendar Year	Market Share
86	135.9%	-21.0%	86	20.4%
87	156.3	-34.0	87	25.0
88	147.6	-37.4	88	29.5
89	147.3	-57.7	89	40.1
90	116.7	-46.3	90	46.3
91	76.1	-10.2	91	50.7
92	68.7	9.3	92	64.7
93	68.2	1.8	93	61.0

Source: National Council on Compensation Insurance

* Per dollar of voluntary assessable premium

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 for 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 - As part of the 1994 rate filing, the Massachusetts Assigned Risk Rating Plan (MARRP) was eliminated effective January 1, 1994.

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 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. In FY'94 the Division of Insurance promulgated regulations that now base assessments for large deductible policies on standard premium to account for the fair distribution of the pool's deficit relative to large deductibles. This alleviates the problem of shifting residual market loads plus ARAP.

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, 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 and have 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 within their deductible, 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.[26]

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 C.M.R. 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. Self insurance is generally available to larger employers with at least 300 employees and $750,000 in annual standard premium.[27] 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

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

[27] 452 C.M.R. 5.00: Code of Massachusetts Regulations concerning insurers and self insurers

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 1994 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 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.[28]

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.

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, since in the past there have been few incentives to control costs and servicing carriers were often cited as offering poor service to the employer. Another incentive to self insure or join a self insurance group has been to avoid the effects of residual market loading. In the past, employers turned to self insurance and SIGs since participation provided a large savings -- consider 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

[28] Division of Insurance regulations -- 211 C.M.R. 67.02

inundated with requests to self insure, and the Division of Insurance has had many request to join or create SIGs.

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, since the insurance risks are spread among a small group of companies in a related industry. If one of the employers in a 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.

Insurance rate filing

In Massachusetts, insurance rates for workers' compensation are determined by the Workers' Compensation Rating and Inspection Bureau (WCRB) and approved by the commissioner of insurance.

By agreement with the State Rating Bureau of the Division of Insurance, the WCRB submits a classification of risks and premiums, referred to as the rate filing, by the third week of November. Insurance rates become effective January 1 of the following year. According to the workers' compensation act, the commissioner of insurance must conduct a hearing within sixty days of receiving the rate filing to determine whether the classifications and rates are "not excessive, inadequate or unfairly discriminatory" and that "they fall within a range of reasonableness." (M.G.L. ch. 152, sec. 53A(2)).

By law, a rate filing must be submitted at least every two years, and no classifications or premiums may take effect until approved by the commissioner. If the commissioner takes no action on a rate filing within six months, then the rates are deemed to be approved. If the commissioner disapproves the rates, then a new rate filing may be submitted. Finally, the commissioner may order a specific rate reduction if after a hearing it is determined that the current rates are excessive. Determinations by the commissioner are subject to review by the Supreme Judicial Court.

1994 Rate Filing - On January 13, 1994, the commissioner of insurance approved an agreement[29] on workers' compensation insurance rates effective January 1, 1994, at levels on average 10.2% less than those for 1993. This marked the first rate reduction in over twenty years.

In addition to the reduction in rates, the agreement required that:

- rate level changes for each classification cannot deviate more than +/- 15% of the average rate level change for construction classes, and 20% for manufacturing and all other classes;
- elimination of the pool retro program (MARRP);
- extending the Qualified Loss Management Program (QLMP) program to a fourth year;
- eliminating enhanced ARAP (restoring the All Risk Adjustment Program to pre - 1/1/93 terms);
- a future rate filing shall not be made before November 15, 1994.

II. Priorities for Workers' Compensation Insurance

Rate Stabilization

The decrease in workers' compensation insurance rates in Massachusetts has begun to reverse an earlier trend in rising rates that has made workers' compensation insurance an economic burden for employers.

One of the foremost concern of employers in the state was the stabilization of insurance rates. Double digit increases had placed a heavy burden on the employers, and many believed Massachusetts was at a competitive disadvantage because rates were higher than many other competing high technology and industrial states.[30] 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 had 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

[29] After a lengthy negotiations process following submission of the rate filing on December 6, 1993, the Workers' Compensation Rating and Inspection Bureau (WCRB) and the State Rating Bureau of the Division of Insurance agreed to rates insurance carriers could charge policy holders. This agreement obviated the need for the Commissioner to conduct hearings on the rates.

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

insurance 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.[31] 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.

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 for 1994 declined by an average of 10.2%, the first rate reduction in over twenty years. Rates are predicted to continue to stabilize or decline, and the position of Massachusetts relative to other states should improve as this occurs.

Reduction of the Assigned Risk Pool

The residual market consists of employers who could not get an insurance policy in the voluntary market. This assigned risk pool has comprised more than half of the premium dollars in the state for calendar years 1991, 1992, and 1993 and it is a priority to lower this percentage. Estimates for 1994 show that the percentage may be at or below 50% of total premium, but the situation is still a precarious one that must closely monitored.

In addition to ARAP, which is 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:

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 the 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 four years if they stay in the program. This program began in November, 1990 and it was extended to its fourth year beginning January 1, 1994. This revision provides a 25% applicable credit for a fourth year.

[31] John Burton's Workers' Compensation Desk Book; LRP Publications, 1992. Adjusted Manual Premium rates in Massachusetts (as a percentage of payroll) : 1958- 0.859; 1962- 1.034; 1978- 1.374; 1987-1.673

Enforcement of Mandatory Coverage

One of the priorities for the office of investigation at the DIA is to make sure all employers have the necessary insurance coverage. In FY'94, the DIA's private trust fund spent $8,219,554 on benefits for employees who were working for uninsured employers, up from $7,844,276 in FY'93. 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 investigations 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 investigation* for more information on the enforcement of workers' compensation coverage.

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 (M.G.L. ch. 338) and further amended in 1991 to include workers' compensation.[32] 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.

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

Total referrals to the IFB for workers' compensation number 1,758 from the inception of the IFB to July 30, 1994.

Workers' compensation represents the greatest proportion of losses for all lines of insurance investigated by the 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.

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 it has 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, 1994, there were 170 completed cases referred to a prosecutor. Out of these, 143 received court action (individuals with indictments returned or criminal complaints filed). Final dispositions (convictions, pleading, etc.) number 57 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 again made great

[32] M.G.L. St. 1990, c. 338 as amended by St. 1991, c. 398, Section 9

strides in FY'94 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.

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 1994, forty bills were filed by legislators seeking to amend the workers' compensation system. Of those bills, twenty-four had been submitted in prior legislative sessions. Proposals ranged in scope from establishing a code of judicial conduct for DIA judges, to establishing a competing state insurance fund, to restoring benefits to pre-1991 levels, to reconfiguring the DIA dispute resolution system. This year the legislature withheld from enacting any of these bills.

After receiving testimony on April 4, 1994, the Joint Committee on Commerce and Labor reviewed all bills relative to the workers' compensation system in executive session.

Two bills were reported to the clerk of the house with the rating "ought to pass." H. 2377 ("An Act Relative to Enhancing Accountability to the Employers and Employees of the Workers' Compensation Advisory Council"), would require removal of all serving Advisory Council members; extinguish the Governor's authority to make appointments to the Council and designate organizations to make appointments; extinguish the Secretary of Labor and Economic Affairs oversight and ex-officio membership status; and reduce Council members terms from five to three years. This bill was sent to the House Committee on Ways and Means on May 23. No action has been taken as of this time of this printing.

H. 1213 ("An Act Insuring the Impartiality of Administrative Judges and Administrative Law Judges under the Workers' Compensation Act"), would amend Chapter 23E, section 8 so that the DIA Senior judge, administrative judges and administrative law judges would all be subject to the Code of Judicial Conduct promulgated by the Supreme Judicial Court. Furthermore, a complaint for removal of a judge could be initiated by any person affected by the official duties of the judges. This bill has not been acted upon.

Budget Outside Sections

In December, the House attached outside sections to the Fiscal Year 1994 Supplemental Budget affecting the workers' compensation system. One called for reconfiguring the Advisory Council in a manner similar to that called for in H. 2377. Another would have stricken from Chapter 152, section 35E the requirement that an employee who is "at least 65 of years of age" and "has been out of work force for at least two years" must prove that they would have remained active in the work force but for the work related injury when that employee is receiving old age benefits under social security or a pension plan.

The Senate opted not to adopt outside sections of the budget relating to workers' compensation. The conference committee budget contained only one workers' compensation amendment, which the Governor signed in its entirety. Section 37 amended Ch. 152, section 25A(4) to require that insurance carriers offer policy holders the option of a policy with an aggregate deductible.

The Fiscal Year 1995 budget also contained outside sections that would have amended the workers' compensation act. Those vetoed by the Governor included plans to restore eligibility for scar-based disfigurement benefits to pre-1991 criteria; plans to reconfigure the Advisory Council to above mentioned terms; a requirement that the DIA Trust Fund conduct a financial needs analysis of the Second Injury Fund to determine future claims and financial exposure for the fund; a formal requirement that all candidates for administrative judge and administrative law judges have a working knowledge of workers compensation and related laws; and creation of a task force to determine whether or not workers' compensation should be mandatory subject for collective bargaining between the Commonwealth and its unionized employees.

Governor Weld accepted requirements that state administrative agencies pay, in the form of charge backs, workers' compensation costs incurred on behalf of the employees of the agencies. Also, the Governor approved the requirement that the WCRB pay assessments totaling $500,000 to pay for the Division of Insurance State Rating Bureau's expenses for workers' compensation, including personnel costs, operating expenses, administrative overhead costs, and consulting expenses.

WORKERS' COMPENSATION ORGANIZATIONS

The following are government, private, and non-profit organizations that have a role in the Massachusetts workers' compensation system. Many of the organizations noted below are advocacy groups that are funded by a specific group to represent and promote their particular view.

This is meant to be informative only, and is by no means an exhaustive list of all groups involved with workers' compensation. Inclusion of an organization's name does not indicate an endorsement of any particular viewpoint or organization nor does it relate to their effectiveness or reliability in advocating a particular view.

The categories are Massachusetts State Government, Insurance, Medical, Public Policy/Research, Fraud, Safety, Legal, and Federal Government/National Organizations.

Massachusetts State Government

Department of Industrial Accidents (DIA)
600 Washington Street
Boston, MA 02111 (Boston Office)
617-727-4900 Information office - 800-323-3249 x470

The DIA is a state agency funded by employer assessments to operate and administer the state's workers' compensation system. The duties of the DIA are described throughout part one of the report.

Massachusetts Workers' Compensation Advisory Council
600 Washington Street
Boston, MA 02111
617-727-4900 x378

The Advisory Council is a labor/management committee appointed by the Governor to oversee the workers' compensation system. Its membership and mandate is described on pages one through three of the report.

Joint Committee on Commerce and Labor
State House Room 43
Boston, MA 02133
617-722-2030

The Commerce and Labor Committee consists of elected state representatives and senators. One of their duties is to review all legislation relating to workers' compensation. They issue recommendations to the full legislature on whether the legislation should pass or not. The committee often refers the proposals before them to conference for further study and analysis.

Office of the Governor
State House Room 360
Boston, MA 02133
617-727-7238

The Governor appoints the Secretary of Labor, the Secretary of Economic Affairs, the Commissioner of the DIA, the judges at the DIA, and the members of the Workers' Compensation Advisory Council.

Governor's Council
State House Room 184
Boston, MA 02133
617-727-2795

All DIA judges are appointed by the Governor subject to the consent and approval of the Governor's Council, an elected body of eight members that meets once a week in the Governor's office.

Executive Office of Labor
One Ashburton Place
Boston, MA 02108
617-727-6573

The Secretary of Labor's office is charged with promoting and protecting the legal, safety, health and economic interests of the Commonwealth's workers and preserving productive and fair paying jobs. The Department of Industrial Accidents in one of five departments that fall under the Executive Office of Labor. The Secretary of Labor is an ex officio member of the Workers' Compensation Advisory Council.

Executive Office of Economic Affairs
One Ashburton Place
Boston, MA 02108
617-727-8380

The Secretary of Economic Affairs is charged with promoting the economy of the Commonwealth by fostering economic and employment opportunities. The Secretary of Economic Affairs is an ex officio member of the Workers' Compensation Advisory Council.

Office of the Attorney General
One Ashburton Place
Boston, MA 02108
617-727-2200

The Attorney General's office prosecutes workers' compensation fraud and enforces state labor laws. It also held a series of meetings for its task force on waste, fraud, and abuse in the workers' compensation system. A series of "White Papers" are available from the office on issues brought up at those meetings.

Massachusetts Rehabilitation Commission
59 Temple Place
Boston, MA 02108 (Boston District)
617-482-1780
There are also district offices throughout the state

The purpose of this commission is "to provide comprehensive services which maximize quality of life and economic self-sufficiency for people with disabilities. This is accomplished through multiple programs including vocational rehabilitation, independent living rehabilitation, and the Massachusetts disability determination for social security benefits." (Massachusetts Rehabilitation Commission Annual Report 1992)

The Rate Setting Commission and the Division of Insurance are also State Agencies (described in following sections).

Insurance

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

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

DIA- Office of Insurance
600 Washington Street
Boston, MA 02111
617-727-4900 x371

Issues annual licenses for self insurance; monitors insurance complaints; maintains the insurer register.

DIA- Office of Investigations
617-727-4900 x409

Issues stop work orders and fines employers without workers' compensation insurance.

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

Private non profit body funded by insurers;

- Licensed rating organization for workers' compensation; 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, FL 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.

Medical

Commonwealth of Massachusetts Rate Setting Commission
2 Boylston Street
Boston, MA 02116
617-451-5340
The Rate Setting Commission sets reimbursement rates for medical services in workers' compensation.

DIA- Office of Health Policy
617-727-4900 x578
This office coordinates the utilization review program, the Medical Consultant Consortium, and the Health Care Services Board at the DIA.

Massachusetts Medical Society
1440 Main Street
Waltham, MA 02154-1649
617-893-4610 / 800-322-2303
Private, non-profit professional association representing the Massachusetts physician community.

Massachusetts Hospital Association
5 Executive Park
Burlington, MA 01803
617-272-8000
Private, non-profit association representing its membership of Massachusetts hospitals.

Massachusetts Orthopedic Association
45 Broad Street
Boston, MA 02109
617-451-9663
Private, non-profit professional association representing physicians practicing in the specialty area of orthopedic surgery.

Massachusetts Chiropractic Society
7 Woodland Street
Methuen, MA
800-442-6155

Massachusetts Chapter of American Physical Therapy Association
18 Tremont Street
Boston, MA 02108
617-523-4285
National Chapter: 800-999-2782

American Occupational Therapy Association
1383 Piccard Drive
P.O. Box 1725
Rockville, MD 20849-1725

Public Policy/ Research

Workers' Compensation Research Institute (WCRI)
101 Main Street
Cambridge, MA 02142
617-494-1240

WCRI is a nonpartisan, not-for-profit public policy research organization funded primarily by employers and insurers. The WCRI research takes several forms, according to their statement of purpose: "original research studies of major issues confronting workers' compensation systems; original studies of individual state systems where policy makers have shown an interest in reform and where there is an unmet need for that objective information; source book that brings together information from a variety of sources to provide unique, convenient reference works on specific issues; periodic research briefs on significant new research, data, and issues in the field." (WCRI Annual Report/Research Review, 1992).

Associated Industries of Massachusetts (AIM)
Workers' Compensation Oversight Committee
222 Berkeley Street, P.O. Box 763
Boston, MA 02117
617-262-1180

Private, non-profit association of employers from various industrial sectors in Massachusetts.

Massachusetts AFL-CIO
8 Beacon Street
Boston, MA 02117
617-227-8260

Umbrella organization representing its member local offices of unions in Massachusetts.

International Association of Industrial Accident Boards and Commissions (IAIBC)
1575 Aviation Center Parkway, Suite 512
Daytona Beach, FL 32114
904-252-2915

Fraud

Insurance Fraud Bureau of Massachusetts (IFB)
101 Arch Street
Boston, MA 02110
617-439-0439 Toll free hotline (1-800-32FRAUD).

The IFB is a non profit association created and empowered to "detect, investigate, and prevent fraudulent insurance transactions, for all lines of insurance." (IFB annual report 1993). Its funding is split equally between automobile and workers' compensation insurers.

The DIA - Office of Investigations (see above "insurance") and the Attorney General's Office, Insurance Fraud Unit (see above "state government") also fall under the fraud category.

Safety

Office of the Attorney General
Fair Labor and Business Practices Division
617-727-3477
This division is responsible for the enforcement of the state labor laws, including workplace safety (formerly the responsibility of the Department of Labor and Industries).

DIA- Office of Safety
617-727-4900 x377

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." (M.G.L. c. 23E, 3(6)). The office issues approximately $400,000 in safety grants each fiscal year (17 grants were funded last year).

Massachusetts Coalition of Occupational Safety and Health (MassCOSH)
555 Armory Street
Jamaica Plain, MA 02130
617-524-6686

The following safety councils provide publications, videos, training programs, speakers and other information for a fee.

- **Safety Council of Western Massachusetts** (Springfield) 413-737-7908
- **National Safety Council** , Central Massachusetts Chapter (West Boylston) 508-835-2333
- **Massachusetts Safety Council** (Braintree) (Serves Eastern Massachusetts) 617-356-1633

American Society of Safety Engineers (ASSE) is a non profit association that provides monthly educational seminars and training. It can be reached through the local safety councils.

See also OSHA and NIOSH under federal government

Legal

Massachusetts Bar Association
Workers' Compensation Committee
20 West Street
Boston, MA
617-542-3602

Private, non-profit professional association representing the Massachusetts legal community.

Massachusetts Academy of Trial Attorneys
15 Broad Street
Boston, MA
617-248-5858

Private, non-profit professional association representing the plaintiff's attorneys in Massachusetts.

DIA Reviewing Board decisions, chapter 152 (workers' compensation statute) and Code of Massachusetts Regulations are available in the State House Library.

Federal Government / National Organizations

While most programs for workers' compensation are administered at the state level, there are various safety, labor, and workers' compensation programs administered by the federal government.

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Planning, Policy and Standards
200 Constitution Avenue, N.W.
Washington, D.C. 20210
202-219-7491

The Division of Planning, Policy and Standards at the Office of Workers' Compensation Programs serves as a liaison to the states regarding state workers' compensation matters. They produce two major publications: State Workers' Compensation Administration Profiles and State Workers' Compensation Laws.

The Office of Workers' Compensation Programs also administers three other divisions: Division of Longshore and Harbor Workers' Compensation (202-219-8721); Division of Federal Employee's Compensation (202-219-7552); and the Division of Coal Mine Workers' Compensation (202-219-6692).

Department of Labor
Occupational Safety and Health Administration (OSHA)
200 Constitution Avenue, NM
Washington, D.C. 20210

Regional Office: 133 Portland Street
Boston, MA 02114
617-565-7164

National Institute for Occupational Safety and Health (NIOSH)
944 Chestnut Ridge Road
Morgantown, WV 26505-2888
800-356-4674
Federal agency under the Department of Health and Human Service. Clearinghouse information on workplace safety, health, and illness.

Occupational Health Foundation
815 16th Street, N.W. Suite 312
Washington, D.C. 20006
202-842-7840

The OHF is a labor- sponsored, non profit organization delivering service to the American labor movement and individual members of the workforce. OHF's mission is to improve occupational safety and health conditions for workers. (OHF 1993 Annual Program Report)

United States Chamber of Commerce
1615 H Street, NW
Washington, D.C. 20062-2000
202-659-6000

Publishes an analysis of state workers' compensation statutes

CONCERNS AND RECOMMENDATIONS

M.G.L. ch. 23E, section 17 directs the Advisory Council to include in its annual report "an evaluation of the operations of the [DIA] along with recommendations for improving the workers' compensation system." The Advisory Council submits the following areas it finds of concern along with recommendations for addressing those concerns.

The DIA has made many positive strides in the past few years to improve the functioning of the agency and the delivery of workers' compensation services. The large backlog at the conference and hearing levels and the long case time frames have been reduced. The medical requirements of chapter 398 have been implemented with the development of treatment guidelines and a utilization review program. Investigations of employers not having workers' compensation insurance have dramatically increased and have in turn had a positive effect on the insurance market.

The Advisory Council encourages these continued initiatives. Nevertheless, there are certain areas at the DIA and in the workers' compensation system in general that require further attention.

Reviewing Board

Of primary concern to employees, employers, insurers, is the large backlog facing this last stage of dispute resolution. Currently, appeals from hearing take almost two years to be heard at the reviewing board.

There are several possible solutions to the reviewing board backlog, some of which may require statutory or regulatory changes. Some options are addressed below.

1. There are currently two panels of three ALJs at the reviewing board. The addition of a third panel could ameliorate the situation by providing more judges to hear and rule on appeals.

   While this is one of the most apparent solutions, adding three new ALJs may only provide limited benefits. The addition of a second panel in 1991 did not double the productivity of the reviewing board. As more judges are added, each decision from one panel must be reviewed by the other to ensure consistency. This has kept the addition of the second panel from doubling productivity. Without changing the procedure for review by the entire board, adding a third panel would seemingly produce a similar result.

   Adding a third panel would also require changes to M.G.L. chapter 23E.

2. The DIA could hire more support staff to assist the ALJs with research, writing and administrative work. Currently the reviewing board has two staff attorneys, and several part time law clerks who are law students. Some judges believe that additional full time attorneys would be a significant help in reducing the backlog.

   Furthermore, there apparently exists a backlog in the number of cases awaiting a hearing transcript. Before a case can be reviewed by a panel, a

transcript of the proceedings at hearing must be produced. It is unclear whether additional stenographers are needed to reduce this backlog, but attention to this matter is needed so that cases can become ready for review at a faster pace.

3. Procedure at the board could be changed to allow for a streamlined and expedited decision making process.

   For example, reconsideration ought to be made as to the importance of the entire reviewing board examining each decision produced. A regulation could be promulgated permitting recommital to an AJ by an unpublished decision of a single ALJ. (For example, the Massachusetts Appeals Court has a rule allowing a single justice to issue a decision for workers' compensation appeals).

   In addition, greater emphasis on consolidating cases with similar issues could also expedite the process.

4. It has been suggested that AJs or retired AJs could perform certain functions of ALJs to increase the productivity of the board (e.g., lump sum conferences and review of settlements in third party suits). This has already been implemented and it could be expanded further.

The Senior Judge and the reviewing board acknowledge the delay and backlog at this stage of dispute resolution and they have begun to take administrative steps to address it. The Senior Judge now systematically assigns a set number of cases to each panel in order to keep the cases flowing. Further examination of these proposals and exploration of new solutions to reduce the backlog is needed.

Data Collection System at the DIA

Accurate data collection and retrieval is essential for the DIA and other groups to review how the workers' compensation system is functioning. Currently the most reliable data is available from the insurance industry through the WCRB. Unfortunately, this data relates to losses paid by carriers and is not considered reliable until some years after a given policy year. What is more, the information does not relate to the overall body of workers' compensation claims made but rather only where liability has been accepted by the carrier or established by the DIA. Furthermore, insurance industry data does not capture claims filed against self insured employers, self insurance groups, reciprocal exchanges, etc. Insurance data also does not reflect information reflected in the body of first reports of injury.

The Advisory Council has attempted to rely on DIA data to gather demographic information as well as specific claims information for a given period of time, in order to better understand how the workers' compensation system is functioning. Unfortunately, we have found that in many instances information from forms entered into the Diameter system is missing, and sometimes unreliable.

We have also found that on several occasions the DIA's reports purport to measure certain variables but in fact take into account other factors. Also, the

reports use terms that refer to very specific concepts and a technical explanation is required to understand the content of the reports.

It is critical for accurate data to be available to actuarial consultants who must determine the annual assessments to support the private and public trust funds. In the past years, the actuaries have had to rely on incomplete or miscoded data. In the FY'95 annual assessment report, the consulting firm stated that

> *estimation of workers' compensation claim costs, particularly for some elements such as cost of living adjustments which will be paid for by the trust funds, is subject to potentially large errors of estimation. Although the quantity and quality of information for this review continues to improve, there are still several areas where the available data is sparse and where significant judgments had to be made.*[33]

The Diameter system at the DIA, from which their reports are generated, is used mainly as a scheduling and database system. While reports can be run from this database, the data is not developed fully to produce understandable and reliable statistics. There is also no statistician or actuary on staff or consulted on regular basis to create reports.

The Advisory Council recommends an analysis be conducted to determine the feasibility of using the Diameter system for generating statistical reports and to see if there is a need to update, modernize or replace the Diameter system for the purposes of statistical reports. Further, the DIA should determine if there is a need for a full time or a consulted statistician /actuary to assist with department statistics.

Status of FY'93 recommendations

Case time frames

In last year's report, the Advisory Council recommended that the DIA evaluate case time frames that exceeded those set by statute.

The Advisory Council began to conduct a study in fiscal year 1994 to evaluate the issue of case time frames. A committee was formed between the Advisory Council staff, DIA judges, and the Senior Judge. Results from the first part of the study are available from the Advisory Council. (see *DIA - Case Time Frames* for introduction to the study).

[33] Tillinghast, Massachusetts Department of Industrial Accidents: Section 65 Trust Funds, (June 1994), p.2.

Number of judges

In the FY'93 annual report, the Advisory Council stated that it must be determined whether the overall number of administrative judges should remain at 32. This question arose because there were six judges with three year terms that would expire in February, 1995. After February 1, these positions would cease to exist.

The department made the determination to seek the replacement of the six judges whose terms expire with six judges for one year recall terms (any former administrative judge may be recalled for a one year term). This would keep the overall number of AJs at 32 if all six judges were recalled.

This solution continues to pose two concerns. The first is that a determination must be made again in February, 1996 on how many judges should exist at the DIA when the terms of these six judges again expire.

The second concern is the heavy reliance on the one year recall positions. The addition of six recall judges in February 1995 would bring the total number of recall judges to 11. One judge was not reappointed bringing the number of recall judges to 10 in February, 1995. The use of recall positions is authorized by the statute and it serves the positive purpose of allowing a degree of flexibility in judicial staffing to cope with fluctuating case levels.

It seems, however, that the use of recall positions should remain as limited as possible. The continuous recall of judges delays the process, as a one year judge must go through many administrative steps to be recalled. The reliance on recall positions also severely limits the number of available candidates because only former members of the board are eligible to be recalled. Finally, if a few of the recall judges choose not to seek reappointment, the pool of candidates dwindles.

The Advisory Council recommends that the reliance on the one year terms be as temporary as possible. The limited use of these one year terms is acceptable to prevent backlogs, but ten recall judges is too many.

There are some policy solutions to address the number of judges. Legislation could be introduced to create more permanent positions (six year terms). If legislation is introduced, it must be determined how many positions to add to the existing 21 six year terms.

If the DIA needs to operate with approximately 30 judges to handle the current case load that seems to have stabilized, then the majority of those judges should have permanent positions, rather than 21 with permanent positions and 10 with one year terms.

Therefore, the Advisory Council recommends that the DIA evaluate the number of judges that are necessary and how many of those positions should be permanent or one year recall terms.

Office of Claims Administration backlog

Delays in data entry and processing have been greatly reduced. The record room has been modernized, but the scanning system (that was purchased to keep track of records) is still not operating. Although the OCA has been greatly improved, the record room is still in need of expanded space, despite the new shelving, to maintain the large number of case files.

Statistics and Information

The Council expressed concern last year that the DIA has not published an annual report since 1989, as required by the statute.

The DIA is now in the process of completing their annual report for the last five fiscal years.

Information office

The quality of information to employees has remained the same. An updated version of the employer's brochure is now available.

The Advisory Council is concerned about the dissemination of information in the regional offices via telephone inquiries. There seems to be no uniform policy in the regional offices to deal with telephone inquiries. While a toll free number is available to the information office in the Boston office, employees and managers from the regional offices attempt to answer telephone inquiries as frequently as possible. Regional managers find that it is efficient and responsive to the needs of the parties to have employees in the regional offices answering questions as thoroughly as possible without being referred to the information office in Boston.

Nevertheless, there should be a policy in place to ensure that questions are answered accurately and consistently. The workers' compensation statute, regulations, and procedure can be very complex. Training is required to answer questions properly and to know when not to answer and refer the call to the proper DIA office, state agency or attorney referral service.

The Advisory Council recommends that a public information policy for all DIA employees be developed and implemented in the Boston and regional offices.

Personnel

The DIA has still not staffed up to its funded level of 332 positions. Assessment of the required number of employees ought to be made.

List of Appendices

APPENDIX A

Advisory Council Members in FY' 94

Jeanne-Marie Boylan (Chair), Boston Sand and Gravel Company 169 Portland Street, Boston, MA 02114 Tel: 227-9000 FAX 523-7947

Edward Sullivan, Jr. (Vice Chair), SEIU-Local 254 , 11 Beacon Street, Boston, MA 02108 Tel: 367-7360 FAX 367-7372

James L. Farmer, Local 1044, Glaziers & Glass Workers' Union, 25 Colegate Road, Roslindale, MA 02131 Tel: 524-2365 FAX 524-2623

John Goglia, International Association of Machinists & Aerospace Workers, AFL-CIO, 73 Auburn Street, Saugus, MA 01096 TEL: 233-3675

John Gould, President, AIM, 222 Berkeley Street, P.O. Box 763, Boston, MA 02117 Tel: 262-1180 FAX 536-6785

Antonio Frias, Jr., S & F Concrete Company, 1266 Central Street, P.O. Box 427, Hudson, MA Tel: (508) 562-3495 FAX: (508) 562-9461

Edmund C. Corcoran, Manager, Disability Program/WC, Raytheon, 141 Spring Street, Lexington, MA 02173 Tel: 860-3811 FAX 860-2408

Robert Jones, Surety Insurance, Inc. 609 State Street, Springfield, MA 01109 Tel: (413) 734-4902 FAX (413) 734-3667

William H. Carnes, Teamsters Union, Local 25, 544 Main Street, Boston, MA 02129 Tel: 241-8831 FAX 242-4284

John J. Perry, Teamsters, Local 82, 3330 Dorchester Street, South Boston, MA 02127 Tel: 269-6868 FAX 269-6914

Amy Vercillo, Rehab Re-employment, 28 Bradfield Avenue, Roslindale, MA 02131 Tel: 469-4481

J. Bruce Cochrane, Cochrane and Porter Insurance Agency, 70 Hastings Street, Wellesley, MA 02181 Tel: 239-1162 FAX 239-0737

Gloria C. Larson, Secretary of Economic Affairs, Room 2101, One Ashburton Place, Boston, MA 02108 Tel: 727-8380 FAX 727-442

Christine Morris, Secretary of Labor, Room 2112, One Ashburton Place, Boston, MA 02108 Tel: 727-6573 FAX 727-1090

Staff:
Matthew A. Chafe
Jeremy Teres
Ann Helgran

Terms of Advisory Council Members

Voting Members		**Term Exp. Date**
John Goglia	(Labor)	6/25/94
Edmund Corcoran	(Business)	6/25/94
James Farmer	(Labor)	6/25/95
John Gould	(Business)	6/25/95
Edward Sullivan, Jr.	(Labor)	6/25/96
Antonio Frias, Jr.	(Business)	6/25/96
William Carnes	(Labor)	6/25/97
Jeanne-Marie Boylan	(Business)	6/25/97
John J. Perry	(Labor)	6/25/98
Robert Jones	(Business)	6/25/98

Non-Voting Members

Edwin Wyman, Jr. MD	(Medical)	6/25/94
Amy Vercillo	(Vocational Rehabilitation)	6/25/95
J. Bruce Cochrane	(Insurer)	6/25/97
Christine Morris Executive Office of Labor		Ex-Officio
Gloria C. Larson Executive Office of Economic Affairs		Ex-Officio

AGENDA
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July 14, 1993

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Fiscal Year 1994 Budget
DIA Assessment Collection Hearing Update
RFP - Update
Fiscal Year 1992 Annual Report
Minutes
Miscellaneous

August 11, 1993

Commissioner Campbell
Assigned Risk Pool
DIA Update
RFP Update
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September 8, 1993

Presentation: W/C As A Subject of Collective Bargaining - Bechtel
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Division of Insurance Testimony
RFP Update
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October 13, 1993

Workers' Compensation in the Context of Nation Health Care Reform
DIA Update
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1993 Insurance Rate Filing
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November 10, 1993

DIA Update
Division of Insurance Hearings
1993 Insurance Rate Filing Update
Council Studies
Workers' Compensation Consensus-building Workshop
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DIA Update
Judicial Appointments
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DIA Budget Fiscal Year 1995
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Contract Update
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Carol Arrick - Director W/C Mental Retardation
Assignment of Earning Capacity in Partial Disability Cases
Workers' Compensation Legislation
Annual Report
Advisory Council Budget

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Jim Swanke - Wyatt
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DIA Update
Nominating Panel
Proposal to Evaluate Case Timeframes
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Professor Kozel
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Judicial Nominations
Minutes

APPENDIX C

Office of Safety Proposals Recommended for Funding:

Roofer Union Local #33
Joint Apprenticeship and Training Committee
51 Neponset Avenue
Dorchester, MA 02122
Title: Health Hazards of Coal Tar and Asphalt
Category of Applicant: Non-Profit/Labor/Joint Management
Target Population: Employees
Geographic Area: Boston/Worcester
Program Administrator: James Hayden
Total Funds Requested: $20,804.76

Massachusetts General Hospital
55 Fruit Street
Boston, MA 02114
Title: Train the Trainer: Back Injury Prevention Program
Category of Applicant: Private Employer
Target Population: Employers/Supervisory Personnel
Geographic Target: Boston
Program Administrator: Linda Lass-Schuhmacher
Total Funds Requested: $30,000.00 Rev. 2/10/94 $24,464.36

Boston Area Painter Training Program Trust
25 Colgate Road
Roslindale, MA 02131
Title Occupational Health and Safety: Prevention and Protection
Category of Applicants: Joint Labor/Management Committee
Target Population: Employees
Geographic Area: Boston, Fall River
Program Administrator: Joseph Calci
Total Funds Requested: $29,787.10 Rev. 2/23/94 $29,087.10

Medworks Occupational Health and Safety Program
Marlborough Hospital
57 Union Street
Marlborough, MA 01752
Title: Prevention of Work Related Musculoskeletal Injuries and CTDs in Massachusetts Workers
Category of Applicants: Non-Profit Organization

Target Population: Employees/Employers/Supervisory
Geographic Area: Central/Eastern Massachusetts
Program Administrator: Gail Army
Total Funds Requested: $29,197.22

Central Berkshire Chamber of Commerce
66 West Street
Pittsfield, MA 01201
Target Population: Employees/Employers/Supervisory
Geographic Area: Central Berkshire County
Program Administrator: Dennis Welcome
Total Funds Requested: $30,000.00 Rev. 2/10/94 $29,999.83

C.M.E.A.
30 Park Avenue
Worcester, MA 010165
Title: Cumulative Trauma Disorder Prevention Program
Category of Applicant: Non Profit Organization
Target Population: Employees/Employers/Supervisory
Geographic Area: Worcester
Program Administrator: Matthew Stapanski
Total Funds Requested: $29,975.00 Rev. 2.10/94 $29,974.20

MassCOSH
555 Armory Street
Boston, MA 02130
Title: Health, Safety, and Ergonomics Training for Sheet Metal Apprentices and Instructors
Category of Applicant: Non profit Organization
Target Population: Employees/Supervisors
Geographic Target: Boston, Fall River, Lawrence, Worcester
Program Administrator: Laurie Stillman
Total Funds Requested: $30,000.00

Massachusetts Respiratory Hospital
Center for Occ. and Envir. Medicine
2100 Washington Street
Braintree, MA 02184
Title: Safety in Tunneling
Category of Applicant: Public Employer/Non-Profit
Target Population: Employees/Employers/Supervisory
Geographic Area: Boston
Program Administrator: Dianne Plantamure
Total Funds Requested: $29,933,70 Rev. 2/10/94 $29,932.90

Heat, Frost and Asbestos Workers Local #43
1053 Burts Pitt Road
Northampton, MA 01060
Title: Preventing Asbestos Related Diseases in Building Trades
Category of Applicant: Labor Organization or Federation
Target Population: Employees
Geographic Area: Springfield
Program Administrator: Robert Starr
Total Funds Requested: $18,209.64

Kervick Enterprises, Inc.
40 Rockdale Street
Worcester, MA 01606
Title: Hazard Communication: Your Right To Know
Category of Applicant: Private Employer
Target Population: Employees/Employer/Supervisory
Geographic Area: Worcester
Program Administrator: Sandra Thorpe
Total Funds Requested: $ 5, 725.66

WorkRight, Inc.
386 Washington Street
Wellesley Hills, MA 02181
Title: Ergonomic Training for Companies at Risk for CTD's in Workers
Category of Applicant: Private Employer
Target Population: Employees/Employers/Supervisory
Geographic Area: Statewide
Program Administrator: Bette Hoffman
Total Funds Requested: $28,146,50

Commonwealth Gas Company
157 Cordaville Road
Southboro, MA 01772
Title: Ergonomics & Safety Training for Gas Operation Workers
Category of Applicant: Private Employer
Target Population: Employees/Supervisory/Employer
Geographic Target: Boston - Worcester
Program Administrator: Brian Hawkwsworth
Total Funds Requested: $24,217.00

Asian American Civic Association
90 Tyler Street
Boston, MA 02111
Title: Occupational Health and Safety Training for Chinese Restaurant Workers
Category of Applicant: Non-profit Organization
Target Population: Employee/Employers/Supervisory
Geographic Target: Statewide
Program Administrator: Chau-Ming Lee
Total Funds Requested: $11,654.63 Rev. 2/10/94 $11,605.48

Boston Carpenters Apprenticeship and Training Fund
385 Market Street
Brighton, MA 02135
Title: Massachusetts Asbestos Abatement Training Course for Supervisors
Category of Applicant: Trade Association/Non Profit Organization
Category of Applicant: Trade Association/Non Profit Organization
Target Population: Employees/Employers/Supervisory
Geographic Area: Statewide
Program Administrator: William K. Irwin, Jr.
Total Funds Requested: $25,256.30

Ironworkers Local #357
154 Grove Street
Chicopee Falls, MA 01020
Title: Health on the Job in the Western MA Building Trades
Target Population: Employees
Geographic Area: Worcester/Springfield
Program Administrator: Billy Wischerth
Total Funds Requested $17,705.90

City of Lynn
Lynn City Hall
Lynn, MA 01901
Title: Work Injury Prevention Project
Category of Applicants: Public Employer
Population: Employees/Employers/Supervisory
Geographic Area: City of Lynn
Program Administrator: Marie DeJoiw
Total Funds Requested: $29,938.00 Rev. 2/10/94 $24,988.00

Norton Hospital and Medical Center, Inc.
88 Washington Street
Taunton, MA 02780
Title: Morton Hospital and Medical Center Injury Prevention Program
Category of Applicant: Non-Profit Organization
Target Population: Employees/Supervisory
Geographic Area: Fall River
Program Administrator: Richard J. Slavick
Total Funds Requested: $14,142.00 Rev. 2/17/94 $10,945.76

APPENDIX D

INDUSTRIAL ACCIDENT NOMINATING PANEL

Mr. Joseph C. Faherty
President
Massachusetts. AFL-CIO
8 Beacon Street
Boston, MA 02108
Office - 227-8260
FAX - 227-2010

Ms. Christine Morris
* (Eric Wetzel)
Secretary of Labor
Commonwealth of Massachusetts.
One Ashburton Place
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Office - 727-6573
FAX - 727-1090

Mr. Louis A. Mandarini
Business Manager
Local 22
280 Medford Street
Malden, MA 02148
Office - 321-6616
FAX - 321-6662

Mr. James C. Cronin, Esquire
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100 Hayden Avenue
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Barros & Coyne
Richardo Barros, Esquire
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Mr. Brackett Denniston
* (Lon Povich)
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Ms. Gloria Larson
*(David Tibbetts)
Sec. of Economic Affairs
Room 360 - State House
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Mr. Gino Maggi
President
Inter-all Corp.
P.O.Box 586
Holyoke, MA 01041
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FAX (413) 467-7186

Mr. James J. Campbell
Commissioner
Dept. of Industrial Accidents
600 Washington Street
Boston, MA 02111
727-4900 Ext. 356
FAX - 727-6477

Joseph W. Jennings, III
Senior Judge
Dept. of Industrial Accidents
600 Washington Street
Boston, MA 02111
727-4900 Ext. 354
FAX 727-7122

* These people usually appear for the person listed above their name.

APPENDIX E

HEALTH CARE SERVICES BOARD
ROSTER - JUNE 1, 1994
Chris Oliver-Chair

Kevin R. Burchill, MHA, J.D.
Vice-President
The Medical Center of Massachusetts
119 Belmont Street
Worcester, Massachusetts 01605

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V.P. Development and Public Affairs
Lowell General Hospital
295 Barnam Street
Lowell, Massachusetts 01854

Henry W. DiCarlo
Director, Loss Prevention
Stride Rite Corporation
5 Cambridge, Massachusetts 02142

William F. Fishbaugh, Jr., M.D.
Director, Sports Medicine, Occupational Health
Braintree Hospital Rehabilitation Network
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Boston College School of Law
885 Center Street
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227 East Street
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New England Electric Sys. Cos.
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Department of Orthopedic Surgery
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Boston, Massachusetts 02115

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Mass General Hospital
55 Fruit Street
Boston, Massachusetts 02114

Barry Simmons, MD
Brigham Orthopedic Association

Harry L. Green II, MD
Executive Vice President
Massachusetts Medical Society
1440 Main Street
Waltham, Massachusetts 02154

ASSESSMENT RATES

PUBLIC

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
1995	7/1/94-6/30/95	.05012

PUBLIC GROUP

1987	.0125
1988	.0216
1989	.06002
1990	.10416
1991	.09164
1992	.05574
1993	.00091
1994	.00227
1995	.00519

INSURED

	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
1995	.062	.032	.42	.58

*3rd Quarter change only.

S.I. OPT-OUT

1993	.01847	.356	.68	.32
1994	.02490	.325	.66	.34
1995	.02207	.247	.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
1995	.04461	.247

**Incorrect rate - rebilled

PRIVATE GROUP

1990	.02397
1991	.03630
1992	.04284
1993	.03295
1994	.00862
1994	.00803

PRIVATE GROUP OPT-OUT

1994	.00525
1995	.00397

APPENDIX G

ROSTER OF JUDGES AND THEIR DATES OF APPOINTMENT (AS OF 6/30/94)

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 resigned 4/94
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. Barbara Pearson	(resigned effective 1/13/94)		5/28/98
Edward Kirby		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. Martini Carroll	6/18/92	2/29/93	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

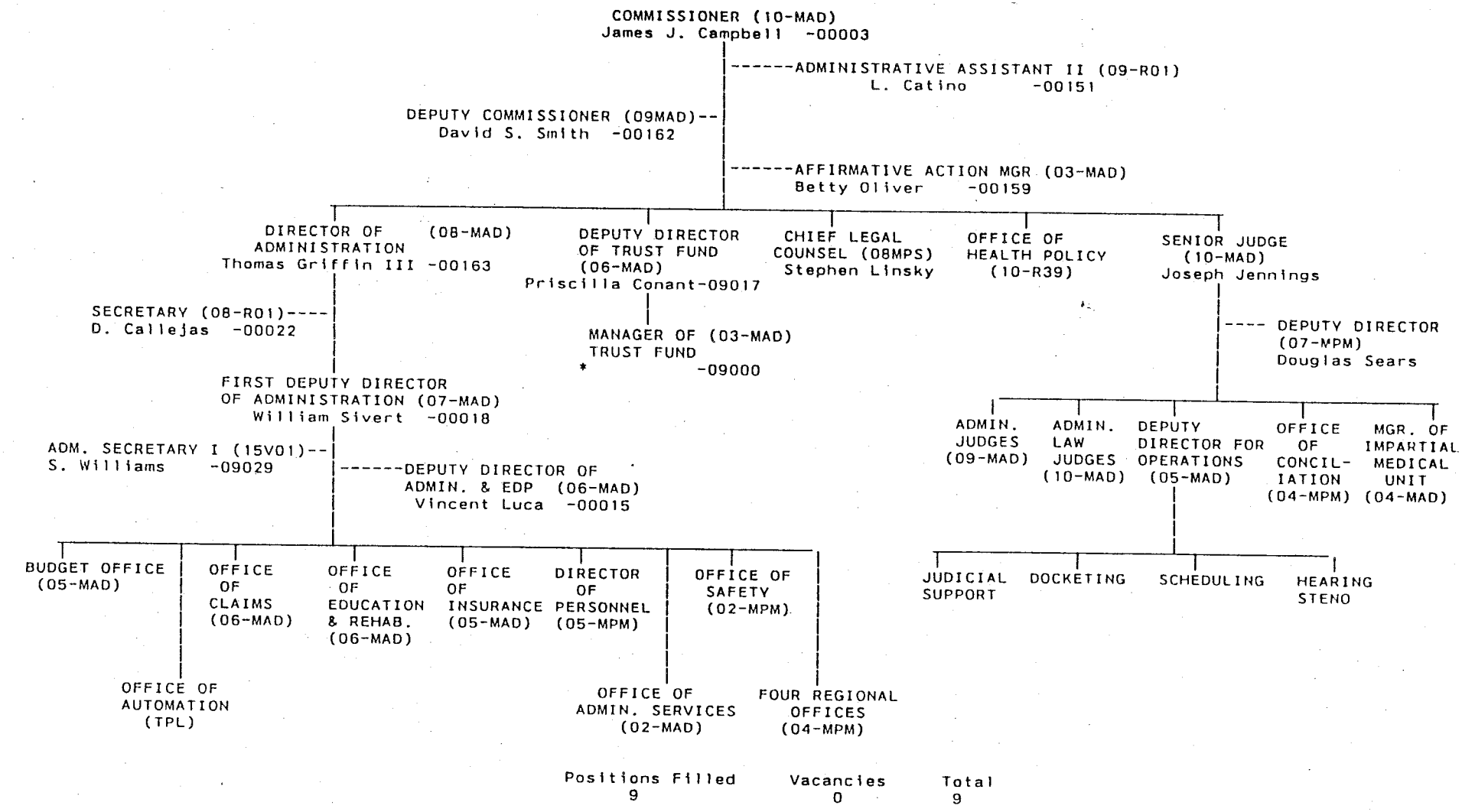
SUMMARY OF JUDGES EXPIRATION DATES (AS OF 2/1/95)

	NAME	AFFILIATION	EXPIRATION DATE
INDUSTRIAL ACCIDENT REVIEWING BOARD SIX YEAR TERMS			
1.	Carolynn Fischel	Unenrolled	5/28/98
2.	Edward Kirby	Republican	5/28/98
3.	Susan Maze-Rothstein	Democrat	6/10/98
4.	William McCarthy	Democrat	5/21/98
5.	Suzanne Smith	Republican	6/03/98
6.	Sara Holmes Wilson	Republican	5/28/98
INDUSTRIAL ACCIDENT BOARD SIX YEAR TERMS			
1.	Douglas Bean	Republican	6/26/99
2.	Karen Capeless	Democrat	7/06/00
3.	Martine Carroll	Unenrolled	1/31/00
4.	David Chivers	Republican	5/28/98
5.	Janet Cox	Unenrolled	5/21/98
6.	Fran Gromelski	Democrat	9/04/97
7.	John Harris	Republican	5/28/98
8.	Emogene Johnson	Unenrolled	7/29/00
9.	William Long	Democrat	8/03/00
10.	Douglas McDonald	Democrat	7/06/00
11.	James McGuinness	Democrat	7/05/96
12.	John McLaughlin	Republican	5/28/98
13.	John McKenna	Republican	1/31/97
14.	John McKinnon	Democrat	6/26/98
15.	Theodore Merlo	Republican	5/28/98
16.	Bridget Murphy	Republican	7/27/00
17.	Daniel O'Shea	Republican	5/21/98
18.	James St. Amand	Democrat	5/14/98
19.	Dianne Solomon	Unenrolled	8/10/00
20.	Jo'Anne Thompson	Republican	9/18/98
21.	Francis Woodward	Democrat	5/26/95
INDUSTRIAL ACCIDENT BOARD ONE YEAR TERMS			
1.	John Bradford	Republican	2/01/96
2.	Joellen D'Esti	Unenrolled	7/17/95
3.	Lawrence Donnelly	Democrat	2/01/96
4.	Richard Heffernan	Democrat	7/15/95
5.	James Lamothe	Republican	8/03/95
6.	Frederick Levine	Unenrolled	2/01/96
7.	Helen Moreschi	Unenrolled	2/01/96
8.	Stephen Sumner	Unenrolled	2/01/96
9.	Fred Taub	Democrat	7/01/95
10.	Richard Tirrell	Democrat	7/01/95

APPENDIX H

FISCAL YEAR 1994

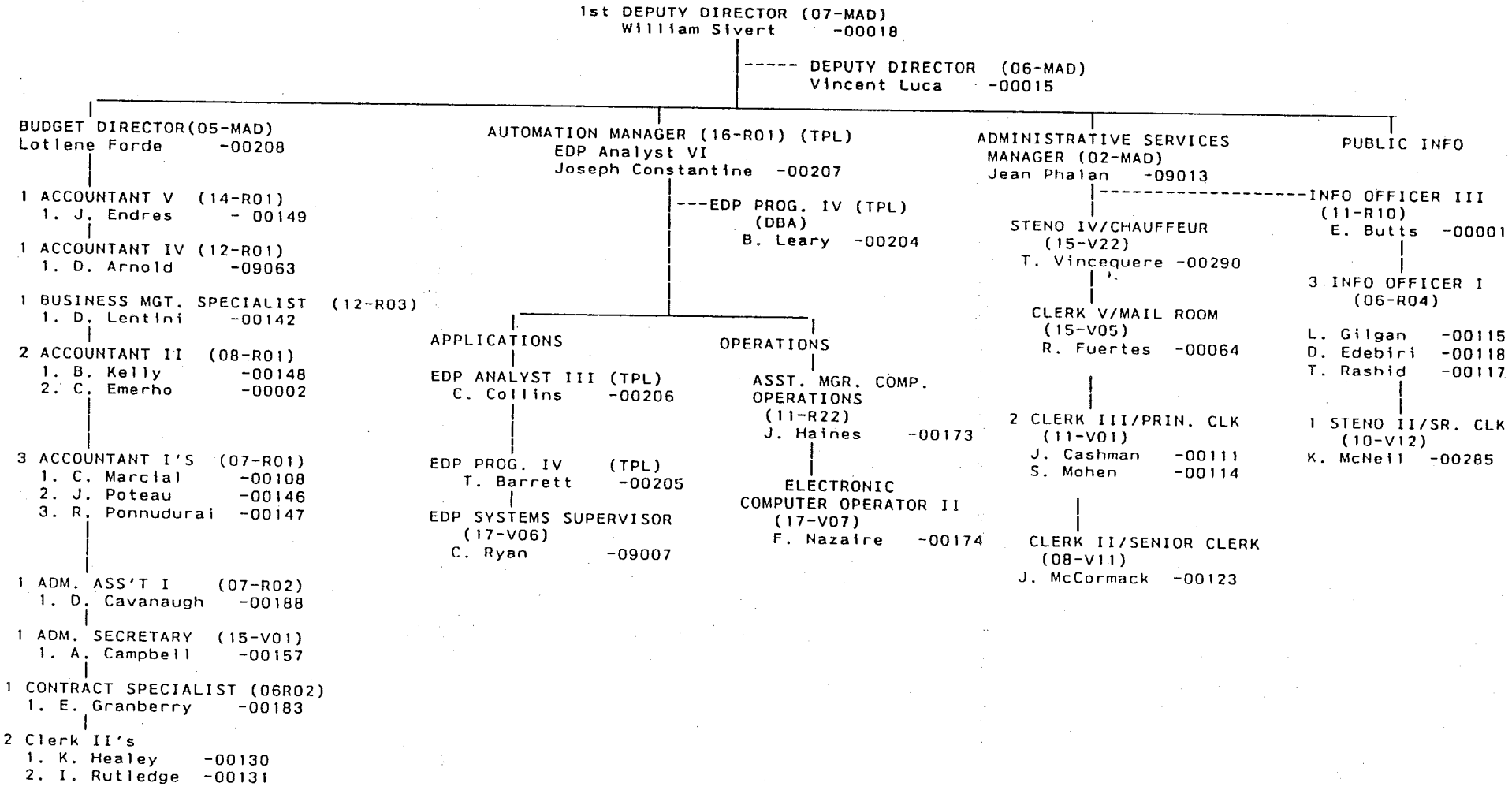
DEPARTMENT OF INDUSTRIAL ACCIDENTS ORGANIZATIONAL CHART



Positions Filled	Vacancies	Total
9	0	9

* = Vacant

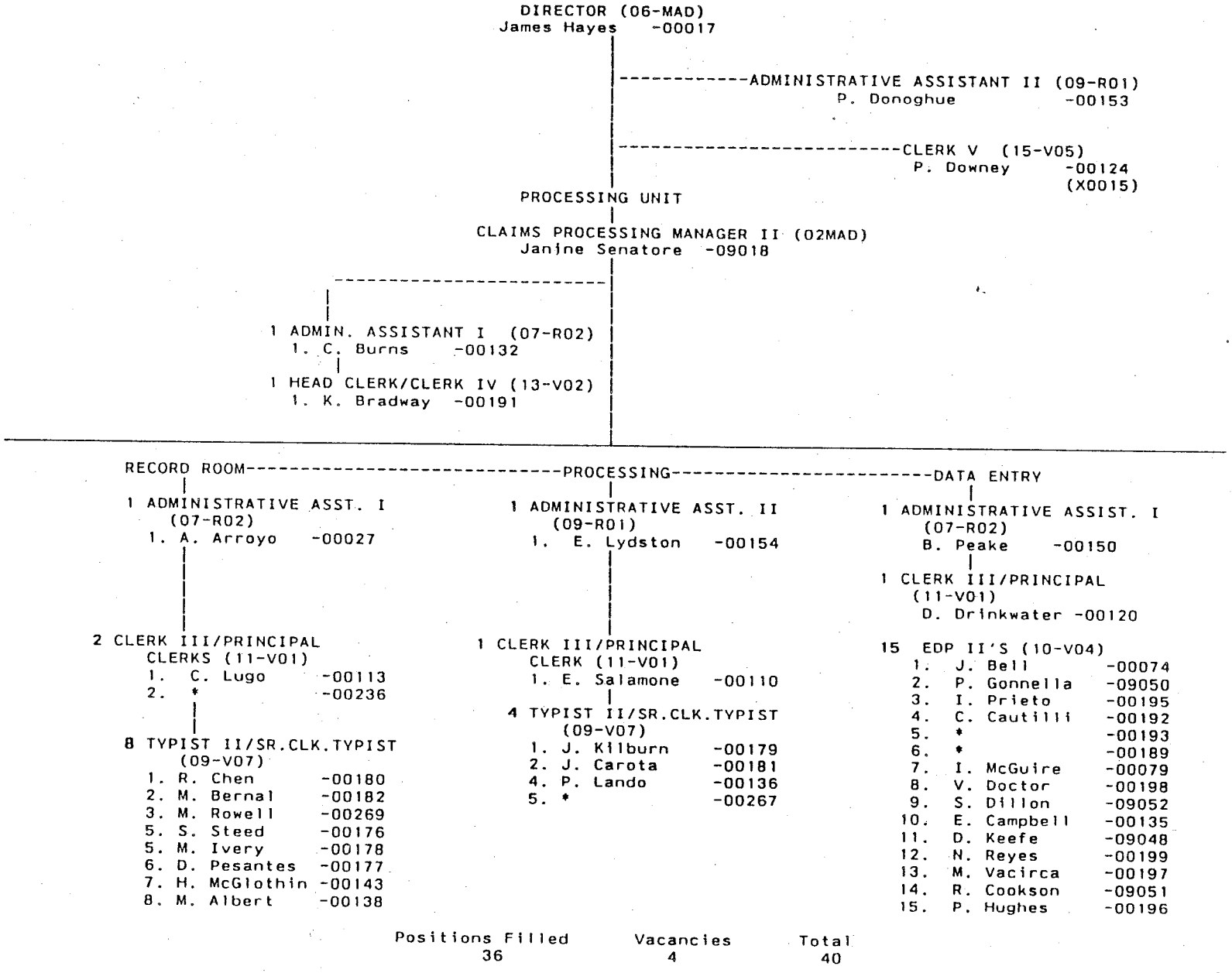
OFFICE OF ADMINISTRATION & EDP



POSITIONS FILLED	VACANCIES	TOTAL
32	0	32

*=Vacant

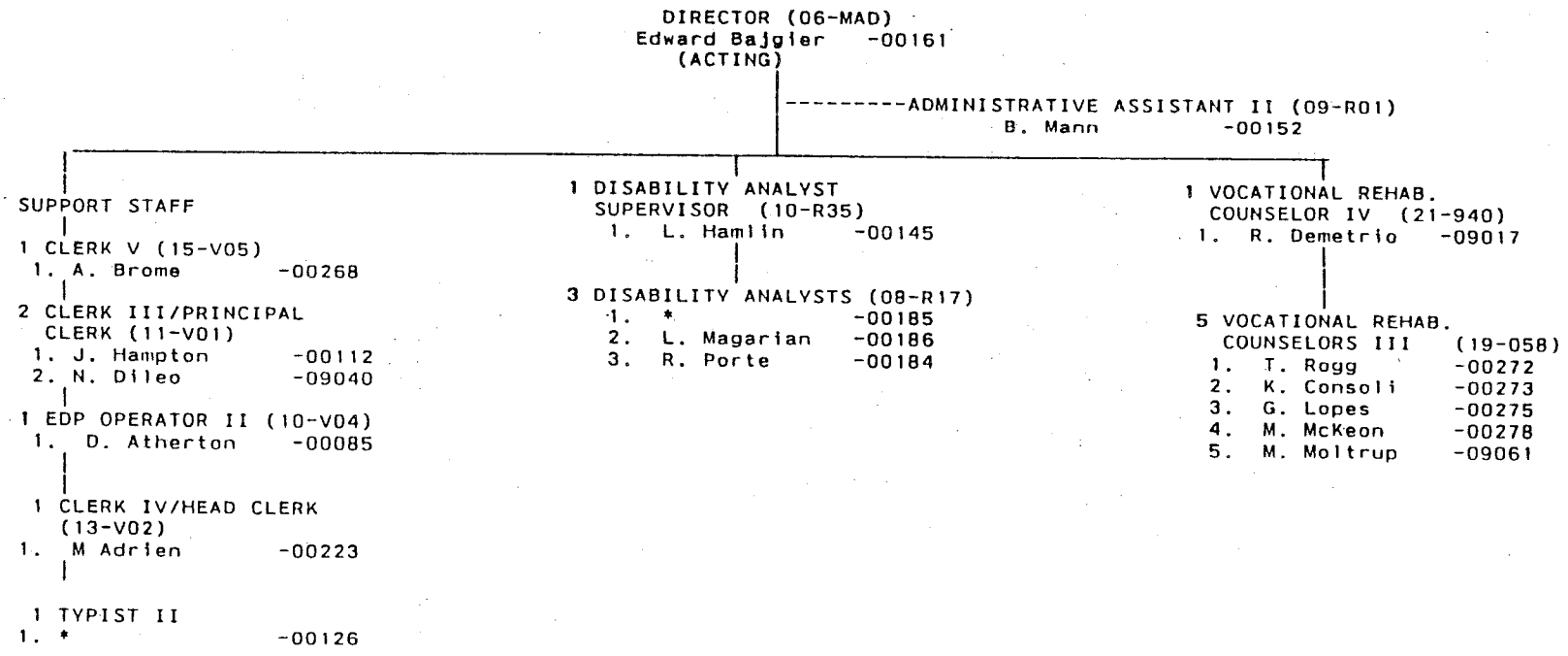
OFFICE OF CLAIMS ADMINISTRATION



Positions Filled	Vacancies	Total
36	4	40

* = Vacant

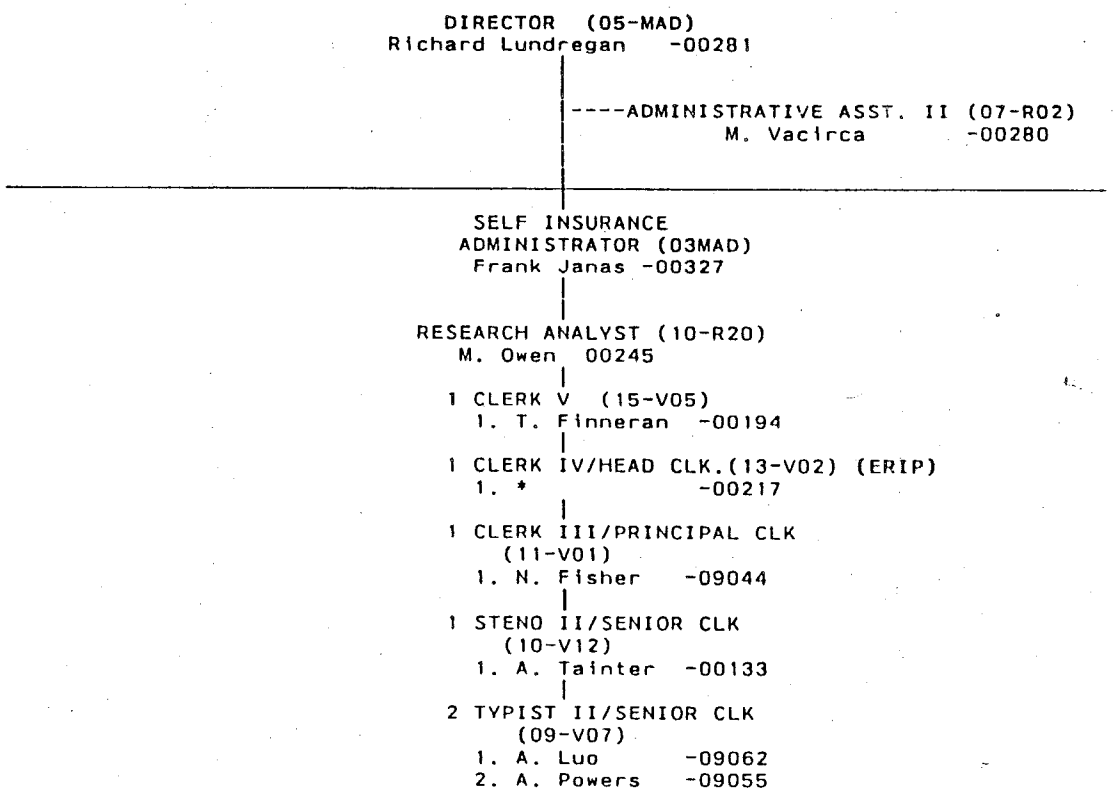
OFFICE OF EDUCATION AND REHABILITATION



Positions Filled	Vacancies	Total
15	3	18

* = Vacant

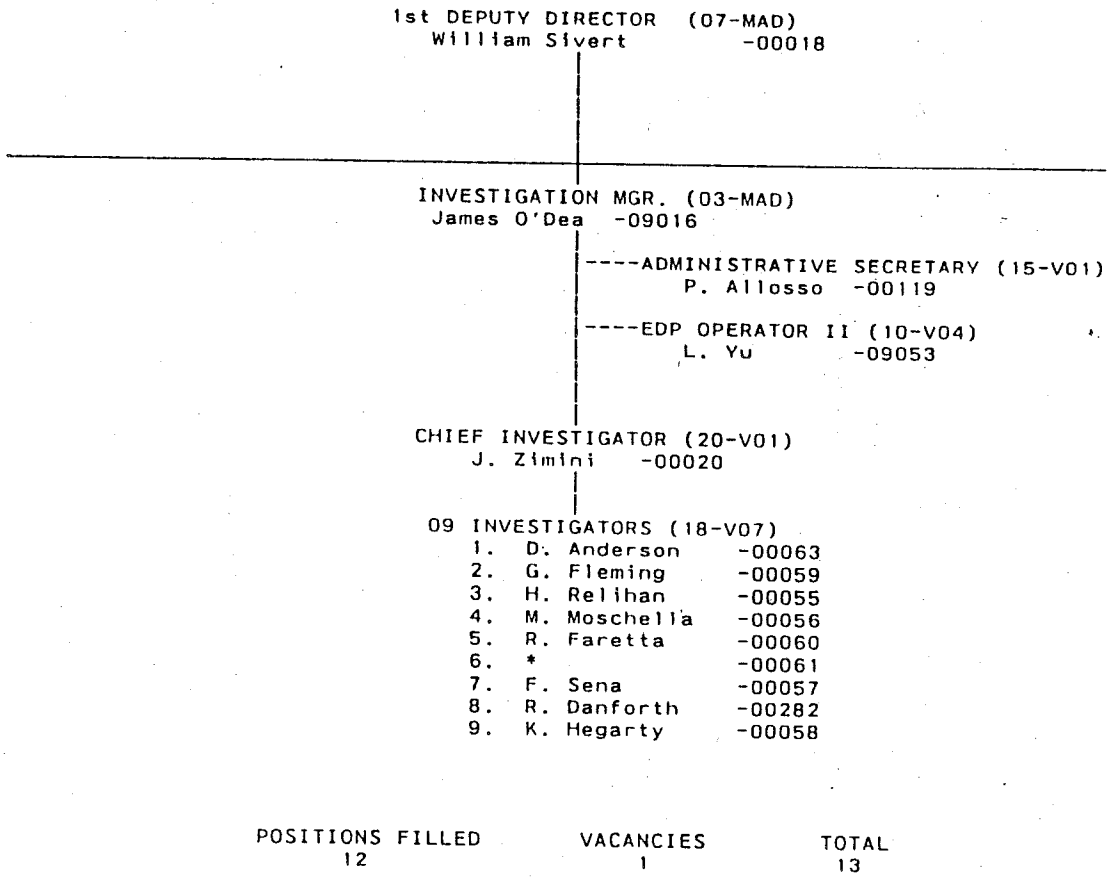
OFFICE OF INSURANCE



Positions Filled	Vacancies	Total
9	1	10

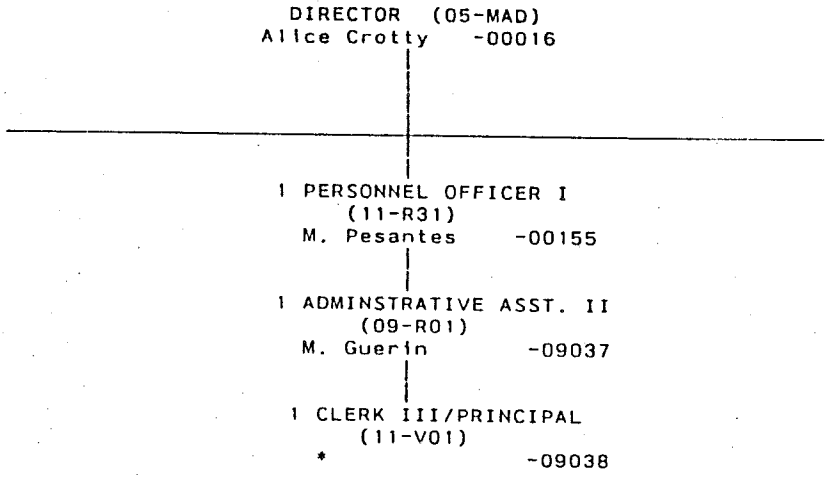
* = Vacant

OFFICE OF INVESTIGATIONS



POSITIONS FILLED	VACANCIES	TOTAL
12	1	13

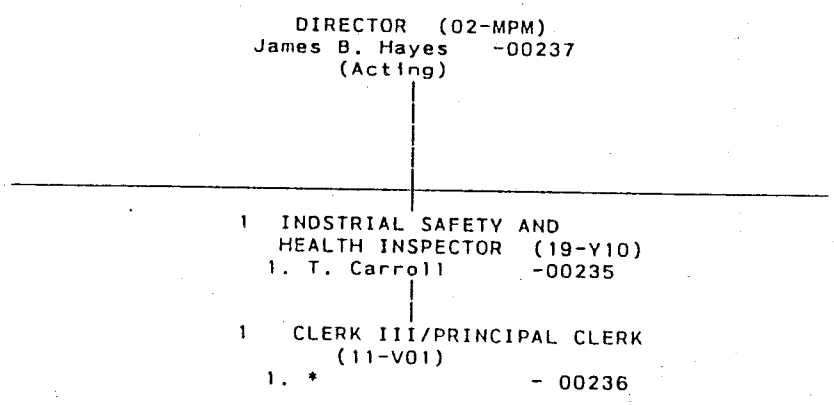
OFFICE OF PERSONNEL



POSITIONS FILLED	VACANCIES	TOTAL
3	1	4

*=Vacant

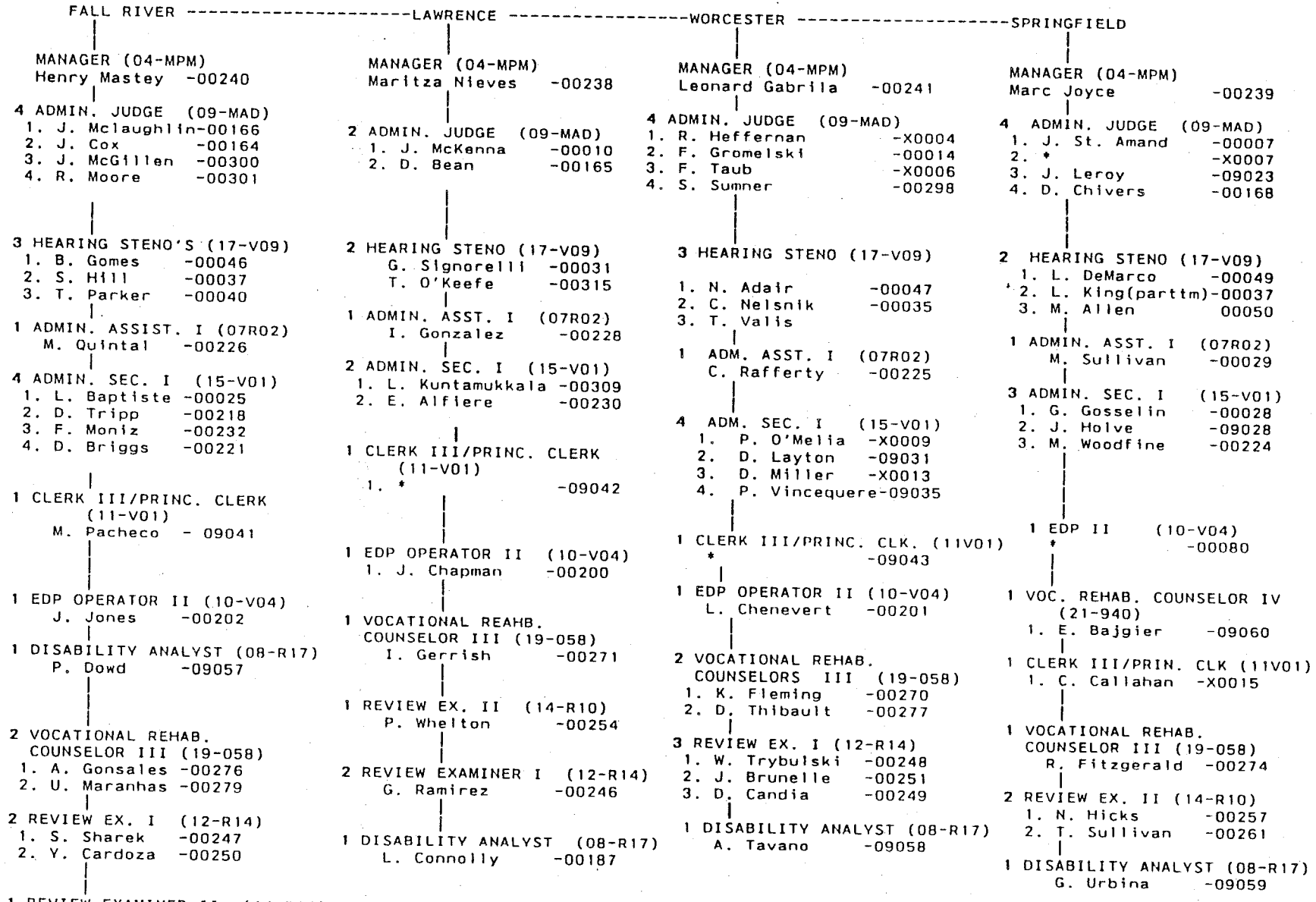
OFFICE OF SAFETY



POSITIONS FILLED	VACANCIES	TOTAL
1	2	3

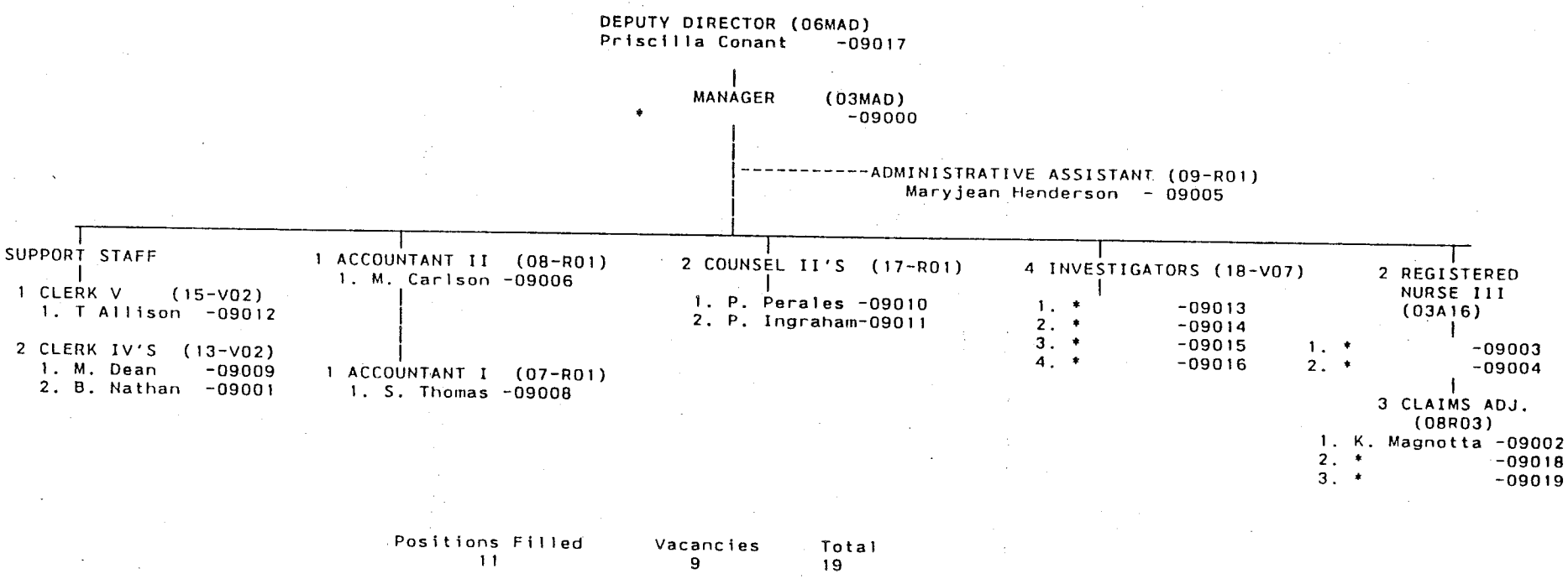
* = Vacant

DIA REGIONAL OFFICES



Positions Filled	Vacancies	Total
70	4	74

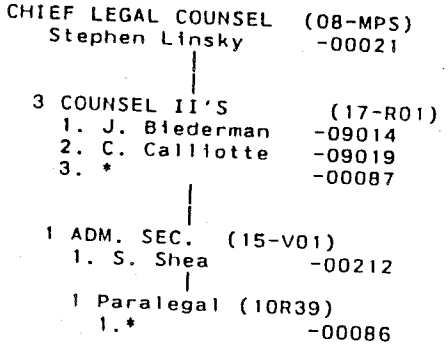
TRUST FUND



Positions Filled	Vacancies	Total
11	9	19

* = Vacant

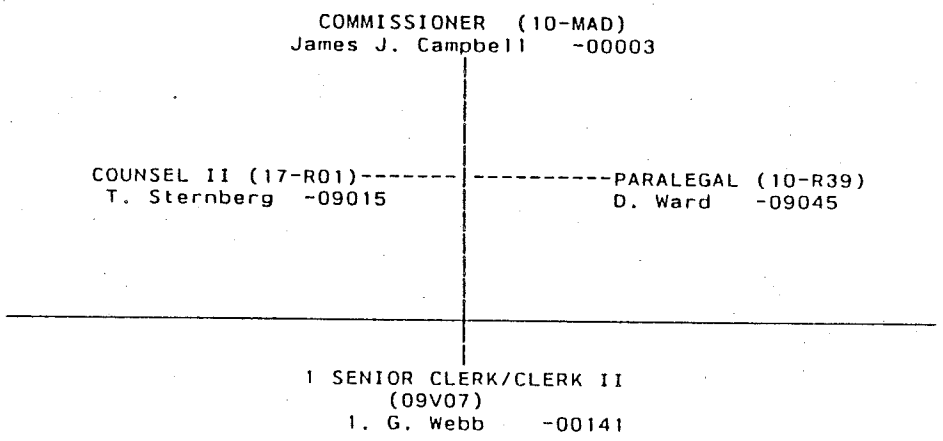
LEGAL COUSEL



Positions Filled	Vacancies	Total
4	2	6

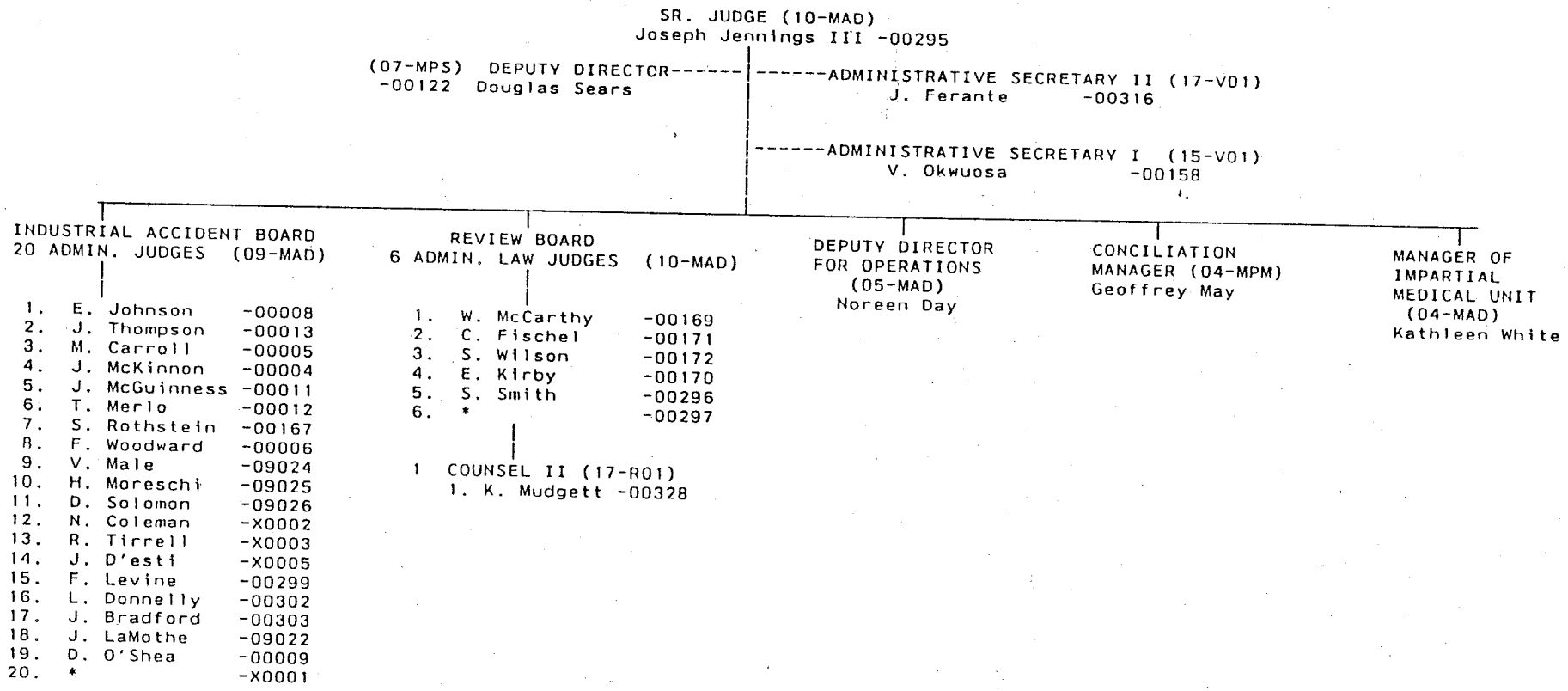
* = Vacant

OFFICE OF HEALTH POLICY



Total Positions Filled	Vacancies	Total
3	0	3

DIVISION OF DISPUTE RESOLUTION



*=Vacant

CONTINUED

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.	L. Battista	-00216
7.	T. Thompson	-00219
8.	C. Long	-00211
9.	A. Fortes	-00329
10.	P. Webb	-00234
11.	P. Garrett	-09032
12.	W. Ferebee	-00306
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. DelloIacono	-09034
20.	J. Cruickshank	-00214

7 REVIEW BOARD

1.	E. Wallace	-09033
2.	H. Houlder	-00233
3.	*	-00229
4.	B. Ciancetta	-00308
5.	A. Anderson	-00304
6.	*	-00311
7.	R. Callahan	-00305

2 FLOATING SECRETARIES

1.	E. McLaughlin	-00209
2.	E. Galarza	-X0011
3.	C. Sullivan	-X0014

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

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)
Nancy Ramella -00038

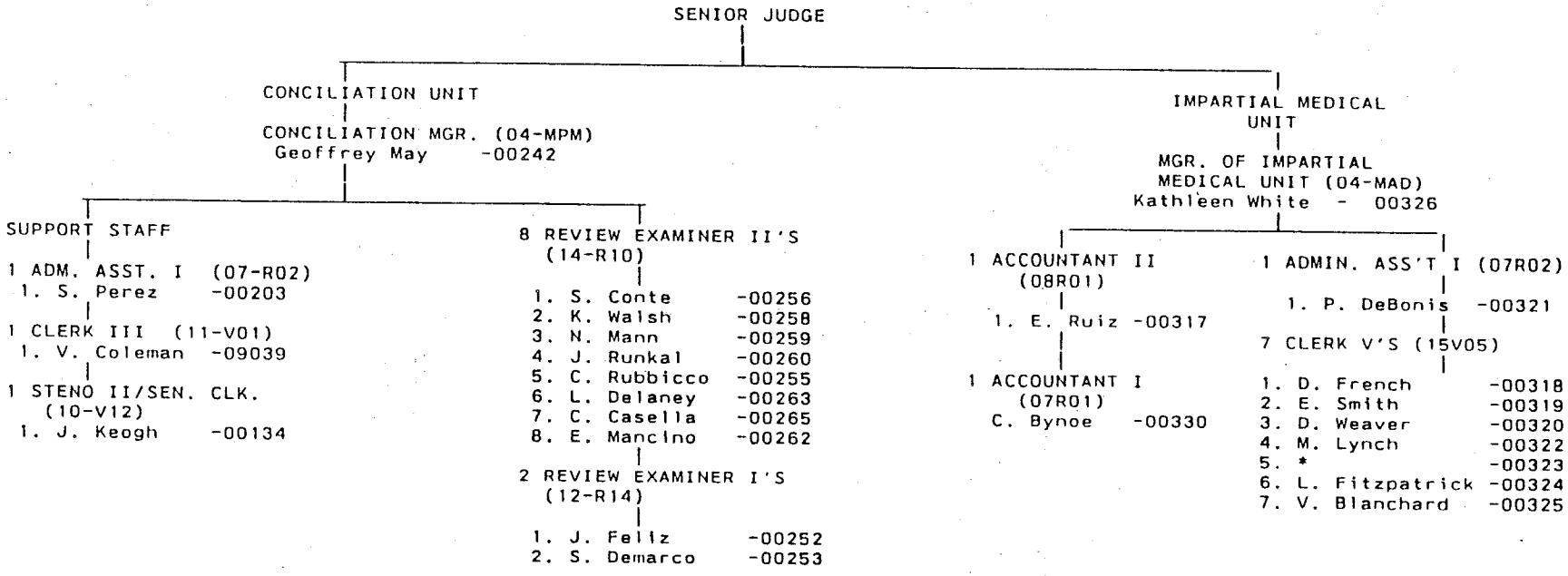
18 HEARING STENOGRAPHERS (17-V09)

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.	P. Phalen	-00041
9.	D. Washington	-00045
10.	*	-X0019
11.	*	-X0018
12.	*	-X0020
13.	P. Foisy	-00051
14.	P. Nelson	-00042
15.	C. Nee	-00312
16.	P. Finelli	-00313
17.	C. Marquis	-00314
18.	J. Luongo	-00032

* = Vacant

NTINUED

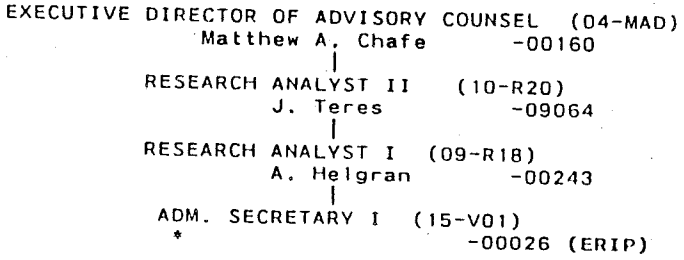
DIVISION OF DISPUTE RESLOUTION



Total Positions Filled	Vacant	Total
107	9	116

*=Vacant

ADVISORY COUNSEL



Positions Filled	Vacancies	Total
3	1	4

TOTAL DIA POSITIONS FILLED	TOTAL VACANCIES	TOTAL POSITIONS
304	28	332 9440-0200
** 09	10	19 9440-0204

* = Vacant