THE STATE OF THE MASSACHUSETTS WORKERS' COMPENSATION SYSTEM

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL
FISCAL YEAR 1995 ANNUAL REPORT

December 1, 1995

ANNUAL REPORT

FISCAL YEAR 1995

Massachusetts Workers' Compensation Advisory Council

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Massachusetts Workers' Compensation Advisory Council

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THE STATE OF THE MASSACHUSETTS WORKERS' COMPENSATION SYSTEM

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FISCAL YEAR 1995 IN REVIEW

Fiscal year 1995 marked a turning point in the Massachusetts workers' compensation system. During this year, debate shifted from whether the Chapter 398 reforms were just or fair, to how their implementation could be enhanced. While the effects of individual components of the reforms are still being debated, the majority of the system's participants seem convinced that the reforms have bettered the system, at least from an efficiency standpoint.

The costs of obtaining workers' compensation insurance in Massachusetts decreased dramatically in fiscal year 1995. Effective January 1, 1995, the insurance industry and the Division of Insurance agreed to lower workers' compensation insurance rates an average of 16.5%. In two years, rates have fallen over 25%.

The Assigned Risk Pool market share for calendar year 1995 is estimated to be 35%. This represents a dramatic decline over 1992, when nearly 65% of every premium dollar was written in the assigned risk pool.

Disputed claims continued to decline, with 8% fewer cases filed than the last fiscal year. While the conference and hearing queues fluctuated, they ended the year at lower rates. The case time frames also continued to decline. Efforts were made to relieve the backlog at the reviewing board. The number of appeals made to the reviewing board increased 69% since FY'93 as the parties continue to seek interpretation and clarification of the 1991 reform provisions. There still remains a two year wait for a reviewing board decision.

The Department of Industrial Accidents worked on "fine tuning" implementation of its reform programs. The Office of Health Policy drafted revised regulations governing utilization review of workers' compensation medical treatment. In addition, the office focused on drafting specifications for the Medical Utilization Trending and Tracking System (MUTTS), and the Health Care Services Board continued to draft new treatment guidelines on chronic pain, chronic injury and asthma.

The department's trust fund explored cost saving measures by pursuing settlements, and aggressively reviewing coverage and treatment of uninsured claimants. When the trust fund was ordered to make payments for Second Injury Fund claims pre-dating 1985, the department developed a plan to pay these claims by February, 1996 at a cost of $8 million.

The department continued to deliver personal computers to its employees, both in the Boston office and the regions, focusing particularly on the Division of Dispute Resolution. It embarked on its Court Room 2000 program, an effort to make the filing and retrieval of all case information fully automated, and to make the department a "paperless office."

The Insurance Fraud Bureau and the Massachusetts Attorney General's Office continued to battle fraud by pursuing the investigation and prosecution of alleged fraudulent practices. Since 1991, the Attorney General's Office has attained a total of 45 convictions and indictments of workers' compensation fraud.

During the fiscal year, the courts reviewed the mandates of Chapter 398. The SJC in Neff v. Commissioner of Industrial Accidents required the DIA to make provisions to waive the impartial medical examination fee for indigent workers' compensation claimants. In Scheffler's Case, the Supreme Judicial Court affirmed the role of the impartial medical exam but found that the impartial report need not be the only evidence considered by the administrative judge when reviewing earning capacity. Finally, the Reviewing Board in O'Brien's Case found that the department's practice of scheduling a hearing before receipt of the impartial report violated the workers' compensation act.

In the legislature, over 50 bills relating to workers' compensation were filed. Despite falling insurance rates, a bill was filed to deregulate insurance rates in favor of competition. Filed as House 4047, this competitive rating legislation gained momentum through the fiscal year resulting in the Advisory Council's agreement to conduct an in-depth examination of the bill.

Although improvements were seen in FY'95 in many areas, the workers' compensation system is far from perfect. Attention must be paid to identifying which aspects of the reform have had the greatest impact and which have been counterproductive.

The Advisory Council also established a subcommittee to review the DIA's fiscal year 1996 budget request. With the cooperation of the department, the subcommittee was able to examine the budget in greater detail than in prior years. While Council members had remaining questions about the DIA's fiscal planning, the department explained that the Council needs to follow the expenditure process throughout the year as this directly impacts the development of the next year's budget request. With this in mind, the Council has established a subcommittee to review expenditures throughout fiscal year 1996, and make reports to the full Council from time to time. The Advisory Council has issued a set of concerns and recommendations found in the last section of the report.

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 mandated 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 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, some of which were performed at the request of the legislature.

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).

Study of Workers' Compensation Wage Replacement Rates, Tillinghast; Professor Peter Kozel, (1994).

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

In 1995, the Advisory Council contracted with the firm of J.H. Albert to conduct an in-depth analysis of the effects of implementing a system of competitive rating of workers' compensation insurance in Massachusetts.

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.

STATUTORY PROVISIONS TO RESOLVE DISPUTES

Workers' Compensation Claims

When an employee is disabled or incapable of earning full wages for five or more calendar days, or dies, as the result of a work related injury or disease, the employer must file a First Report of Injury. This form must be sent to the Office of Claims Administration at the DIA, the insurer and the employee within seven days of notice of the injury. If the employer does not file the required First Report of Injury with the DIA, it may be subject to a fine.

Figure 1: Notification of Injury

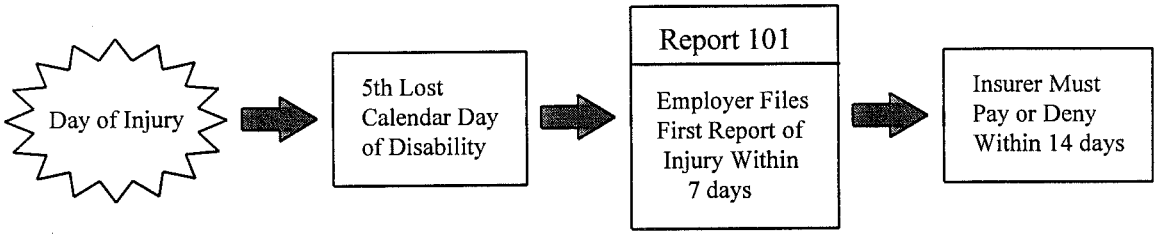
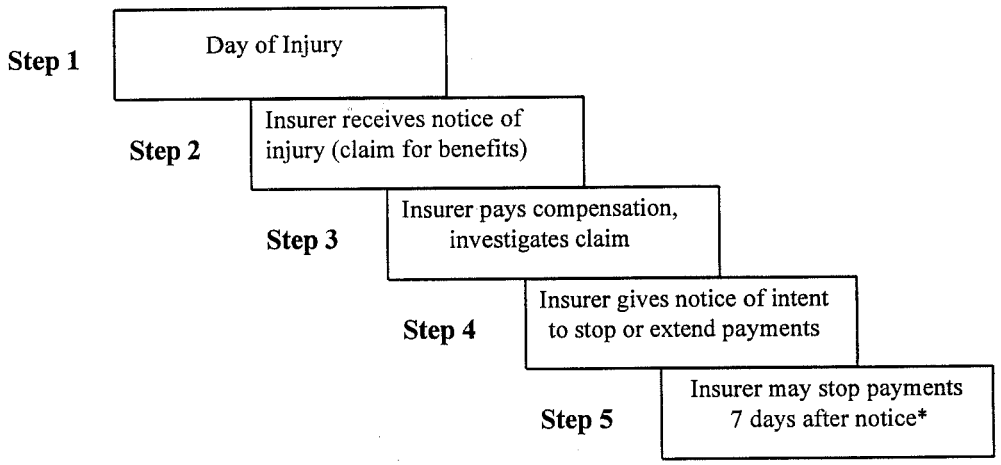


Figure 2: Voluntary Payment



*The insurer may stop payments unilaterally (with seven days notice) only 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, it 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 its will. Up to 180 days, the insurer can unilaterally terminate or modify any claim as long as it specifies the grounds and factual basis for so doing. The purpose of the pay without prejudice period is to encourage the insurer to begin payments to the employee instead of outright denying the claim.[3]

After a conference order or the expiration of this 180 day period, the insurer may no longer unilaterally stop payments. The insurer must request a modification or termination of benefits based on an impartial medical exam and other statutory 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 allows the conciliator to review a completed lump sum settlement. Conciliators or the parties at conciliation may also refer a case to a 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 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.

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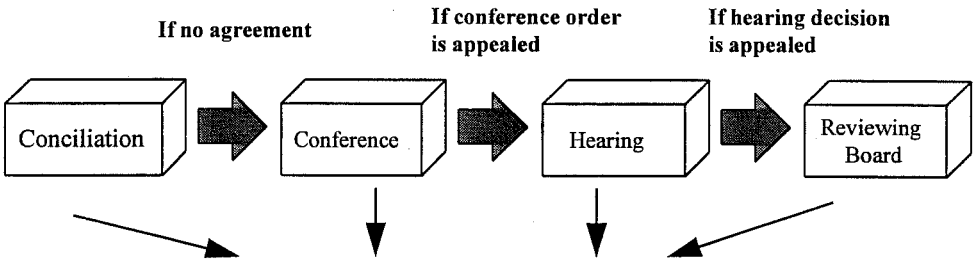
[1] If there is no notification or payment has not begun, the insurer is subject to a fine of $200 after 14 days, $2,000 after 60 days, and $10,000 after 90 days.

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

[3] According to 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."

Figure 3: Dispute Resolution

START: 30 days after the onset of disability, or immediately following an insurer's "deny", the employee may file a claim with the DIA and Insurer.



Lump sum settlements may occur at any time throughout the process

A dispute not resolved at conciliation will then be referred to a conference where it will be assigned to an administrative judge who will 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 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.

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. 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, 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 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 Statewide Average Weekly Wage (SAWW) is determined under subsection (2) of Chapter 151A §29 and promulgated by the Director of Employment and Training. As of October 1, 1995, the SAWW is $604.03. Below is a list of the SAWW's since 1991 and the maximum (SAWW) and minimum benefit levels for §34 and §34A claims:

Table 1: SAWW Benefits

	Maximum Benefit	Minimum Benefit
10/1/91-	**$515.52**	**$103.10**
10/1/92-	**$543.30**	**$108.66**
10/1/93-	**$565.94**	**$113.19**
10/1/94-	**$585.95**	**$117.19**
10/1/95-	**$604.03**	**$120.81**

Indemnity and Supplemental Benefits

The following are the various forms of indemnity and supplemental benefits employees may receive, depending on their average weekly wage, state 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 (**$604.03**), while the minimum is 20% of the SAWW (**$120.81**) if claims involve injuries occurring on or after October 1, 1995. 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 following the exhaustion of temporary (§34) and partial (§35) payments. The maximum weekly compensation rate is 100% of the state average weekly wage (**$604.03**), while the minimum is 20% of the SAWW (**$120.81**) if claims involve injuries that occurred on or after October 1, 1995. 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 (this is not to exceed $150 in additional compensation). There are also benefits for other dependents. 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.

Attorney's Fees

The dollar amounts specified for attorney's fees are listed in M.G.L. c.152 §13A(10). As of October 1, 1995 subsections 1 through 6 were updated to reflect adjustments to the State Average Weekly Wage. Below is a summary of the attorney's fee schedule.

(1) When an insurer refuses to pay compensation within 21 days of an initial liability claim, but prior to a conference agrees to pay the claim (with or without prejudice), the insurer must pay an attorney's fee of **$782.45** plus necessary expenses. If the employee's attorney fails to appear at a scheduled conciliation, the amount paid is **$391.25**.

(2) When an insurer contests a liability claim and is ordered to pay by an administrative judge at conference, the insurer must pay the employee's attorney a fee of **$1,117.85**. The administrative judge can increase or decrease this fee

based on the complexity of a case and the amount of work an attorney puts in. If the employee's attorney fails to appear at a scheduled conciliation, the fee may be reduced to $ **558.90**.

(3) When an insurer contests a claim for benefits other than the initial liability claim as in subsection (1) and fails to pay compensation within 21 days yet agrees to pay the compensation due, prior to conference, the insurer must pay the employee's attorney fee in the amount of **$558.90** plus necessary expenses. This fee can be reduced to **$279.45** if the employee's attorney fails to appear at a scheduled conciliation.

(4) When an insurer contests a claim for benefits or files a complaint to reduce or discontinue benefits by refusing to pay compensation within 21 days, and the order of the administrative judge after a conference reflects the written offer submitted by the claimant (or conciliator on the claimant's behalf), the insurer must pay the employee's attorney a fee of **$782.45** plus necessary expenses. If the order reflects the written offer of the insurer, no attorney fee should be paid. If the order reflects an amount different from both submissions, the fee should be in the amount of **$391.25** plus necessary expenses. Any fee should be reduced in half if the employee's attorney fails to show up to a scheduled conciliation.

(5) When the insurer files a complaint or contests a claim and then either a) accepts the employee's claim or withdraws its own complaint within 5 days of a hearing, or b) the employee prevails at a hearing, the insurer shall pay a fee to the employee's attorney in the amount of **$3,912.35** plus necessary expenses. An administrative judge may increase or decrease this amount based on the complexity of the case and the amount of work an attorney puts in.

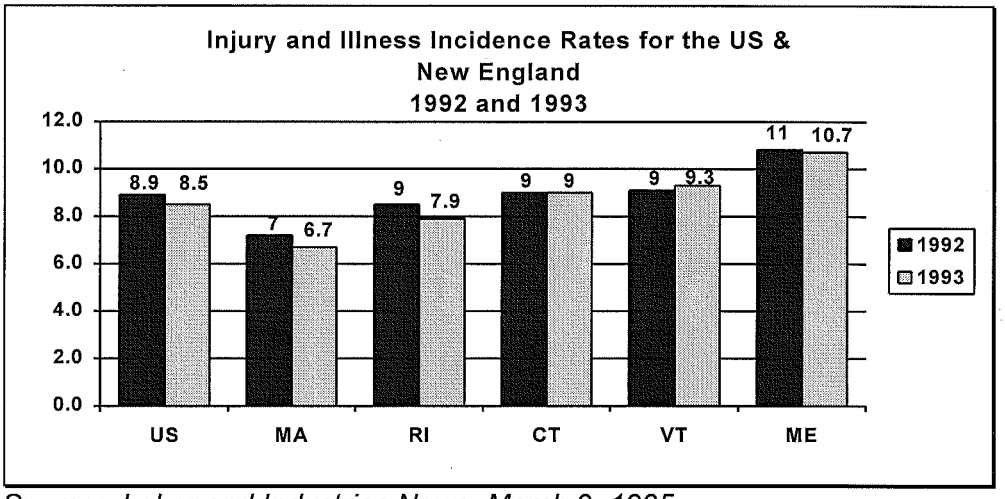
(6) When the insurer appeals the decision of an administrative judge and the employee prevails in the decision of the Reviewing Board, the insurer must pay a fee to the employee's attorney in the amount of **$1,117.85**. An administrative judge may increase or decrease this amount based on the complexity of the case and the amount of work an attorney puts in.

OCCUPATIONAL INJURIES AND ILLNESSES

Every year the Massachusetts Department of Labor and Industries in cooperation with the U.S. Department of Labor, Bureau of Labor Statistics, conducts an *Annual Survey of Occupational Injuries and Illnesses* in Massachusetts. The survey is based upon non-fatal injuries that occurred in the private sector workforce (not including the self-employed, farms with fewer than 11 employees, private households, and employees in Federal, State and local government agencies). A sample of 250,000 employer reports nationwide and 10,000 in Massachusetts are examined, in an effort to represent the total private economy for 1993.

The initial results of the 1993 annual survey were released in March of 1995. In 1993 the Commonwealth averaged 2,411,000 workers in the private sector workforce. Of these workers, 132, 400 experienced some sort of job-related injury or illness. This means that for every 100 full- time workers, 6.7 were injured in 1993 (incidence rate). This is a decline from 1992 when the incidence rate was 7.2 cases per 100 full-time workers. Out of the 132,400 cases, 59,400 were serious enough to keep workers from their jobs for at least a day (or required restricted work activity).

Figure 4: Injury and Illness Incidence Rates



Source: Labor and Industries News, March 9, 1995
Note: No state-specific data for N.H.

For the second year in a row, Massachusetts displayed the lowest overall rate of workplace injuries in New England with an incidence rate of 6.7. This makes the Commonwealth the only New England state to remain below the national average for two consecutive years.

Table 2: Injury Incidence Rates by Industry

Industry Division (Massachusetts)	1992	1993
Private Industry	**7.2**	**6.7**
Agriculture, forestry, and fishing	10.1	9.2
Construction	11.9	10.5
Manufacturing	7.3	7.3
Durable goods	6.6	6.8
Nondurable goods	8.6	8.4
Transportation and public utilities	8.3	9.0
Wholesale and retail trade	7.9	7.6
Wholesale trade	6.3	7.1
Retail trade	8.7	7.9
Finance, insurance, real estate	5.9	2.1
Services	6.3	6.1

Source: Labor and Industry News, March 9, 1995

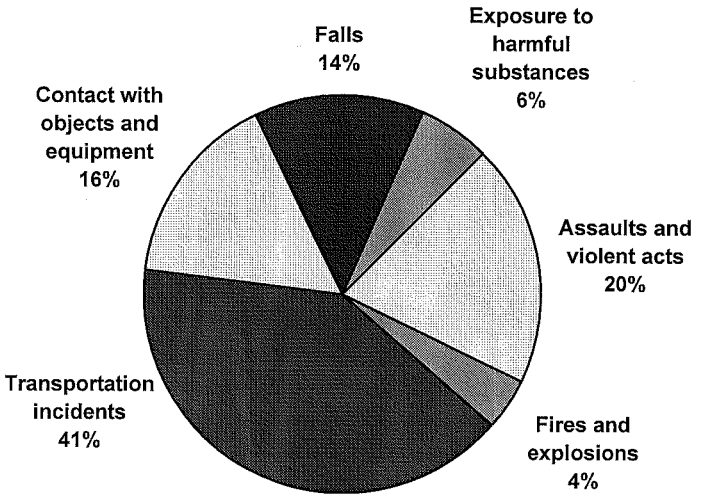
The survey also broke down the workforce into divisions displaying the incidence rate for different industries in Massachusetts. The construction industry clearly had the highest overall incidence rate in 1993 with 10.5 injuries for every 100 full time workers. Finance, insurance and real estate finished with the lowest incidence rate for the second year in a row with 2.1 injuries per 100 workers.

Fatal Work Injuries

Fatal work injuries in New England are calculated each year by the U.S. Department of Labor, Bureau of Labor Statistics. Data is taken from various state and federal administrative sources (including death certificates, workers' compensation reports and claims, reports to various regulatory agencies, and medical examiner reports) in an effort to better understand important safety issues in today's workplace. In 1994 there were a total of 160 fatal work injuries in New England. This calculates to be 2.4% of the 6,588 fatal work injuries nationally. Transportation incidents were the leading cause of workplace deaths in New England at 41% of the total cases in 1994. For the third consecutive year, assaults and violent acts accounted for almost one out of every five fatalities.

Figure 5: Percent Distribution of Fatal Occupational Injuries in N.E.

Percent Distribution of Fatal Occupational Injuries by Event in N.E.



Source: Bureau of Labor Statistics, News 10/25/95

CASE CHARACTERISTICS

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

The data reported to the WCRB comprises all insurance 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 degree of maturity.

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 1992/1993 policy year.

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 of available data.

Some trends can be derived from this data. The number of claims for all injury types have been declining for the last five years (see table 3). This corresponds with data from the DIA indicating a major decline in its case load. The average claim cost has been rising steadily on a five year trend (see table 3).

The major change in costs relates to a shift in the distribution of losses. In the 1988/89 policy year, about 78% of the losses were paid out in indemnity (wage replacement) benefits, while the other 22% paid for medical benefits. In the 1992/93 policy year, this distribution was 68% indemnity benefits versus 32% medical (see table 7). 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 3: Claim Counts

Composite Policy Year	Fatal	Permanent Total	Permanent Partial	Temporary Total	Medical Only
1988/89	67	51	15,098	51,338	115,073
1989/90	77	28	14,254	44,201	99,655
1990/91	68	24	10,585	39,020	87,194
1991/92	56	12	6,643	31,479	80,541
1992/93	57	16	5,539	27,174	72,267

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

Table 4: Average Claim Cost - "Indemnity + Medical"

Composite Policy Year	Fatal	Permanent Total	Permanent Partial	Temporary Total	Medical Only
1988/89	233,251	616,240	56,070	6,098	221
1989/90	314,194	829,672	57,404	6,806	259
1990/91	220,064	726,558	58,671	7,234	290
1991/92	253,746	976,185	56,039	7,188	330
1992/93	305,488	1,143,890	59,480	7,026	348

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

Table 5: Average Indemnity Cost

Composite Policy Year	Fatal	Permanent Total	Permanent Partial	Temporary Total
1988/89	224,209	338,870	46,111	4,596
1989/90	295,937	506,495	46,863	5,056
1990/91	215,358	541,327	47,106	5,175
1991/92	239,645	552,770	42,533	4,721
1992/93	296,424	538,511	44,293	4,523

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

Table 6: Average Medical Cost per claim

Composite Policy Year	Fatal	Permanent Total	Permanent Partial	Temporary Total	Medical Only
1988/89	9,042	277,370	9,959	1,502	221
1989/90	18,257	323,177	10,541	1,750	259
1990/91	4,706	185,231	11,565	2,059	290
1991/92	14,101	423,415	13,506	2,467	330
1992/93	9,064	605,379	15,187	2,503	348

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

Distribution of Paid Claims (Incurred losses)

Table 7: Incurred Losses Distribution

Composite Policy Year	Indemnity	Medical
1988/89	78.28	21.72
1989/90	77.87	22.13
1990/91	75.77	24.23
1991/92	69.31	30.69
1992/93	67.74	32.26

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

Table 8: Incurred Losses Distribution- "Medical"

Composite Policy Year	Fatal	Permanent Total	Permanent Partial	Temporary Total	Medical Only	Total
1988/89	0.05	1.15	12.20	6.26	2.07	21.73
1989/90	0.12	0.76	12.60	6.49	2.17	22.14
1990/91	0.03	0.46	12.74	8.36	2.63	24.22
1991/92	0.12	0.78	13.78	11.93	4.08	30.69
1992/93	0.09	1.67	14.47	11.70	4.33	32.26

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

Table 9: Incurred Losses Distribution- "Indemnity"

Composite Policy Year	Fatal	Permanent Total	Permanent Partial	Temporary Total	Total
1988/89	1.22	1.40	56.50	19.15	78.27
1989/90	1.91	1.19	56.02	18.74	77.86
1990/91	1.52	1.35	51.88	21.01	75.76
1991/92	2.06	1.02	43.40	22.83	69.31
1992/93	2.91	1.48	42.21	21.15	67.75

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

Claim Frequency

Table 10: Claim Frequency (Number of Claims per Million of Man- Weeks)

Composite Policy Year	Fatal	Permanent Total	Permanent Partial	Temporary Total	Medical Only
1988/89	0.614	0.468	138.44	470.74	1055.16
1989/90	0.760	0.276	140.71	436.33	983.75
1990/91	0.724	0.255	112.68	415.38	928.21
1991/92	0.664	0.142	78.76	373.23	954.92
1992/93	0.710	0.199	68.96	338.31	899.70

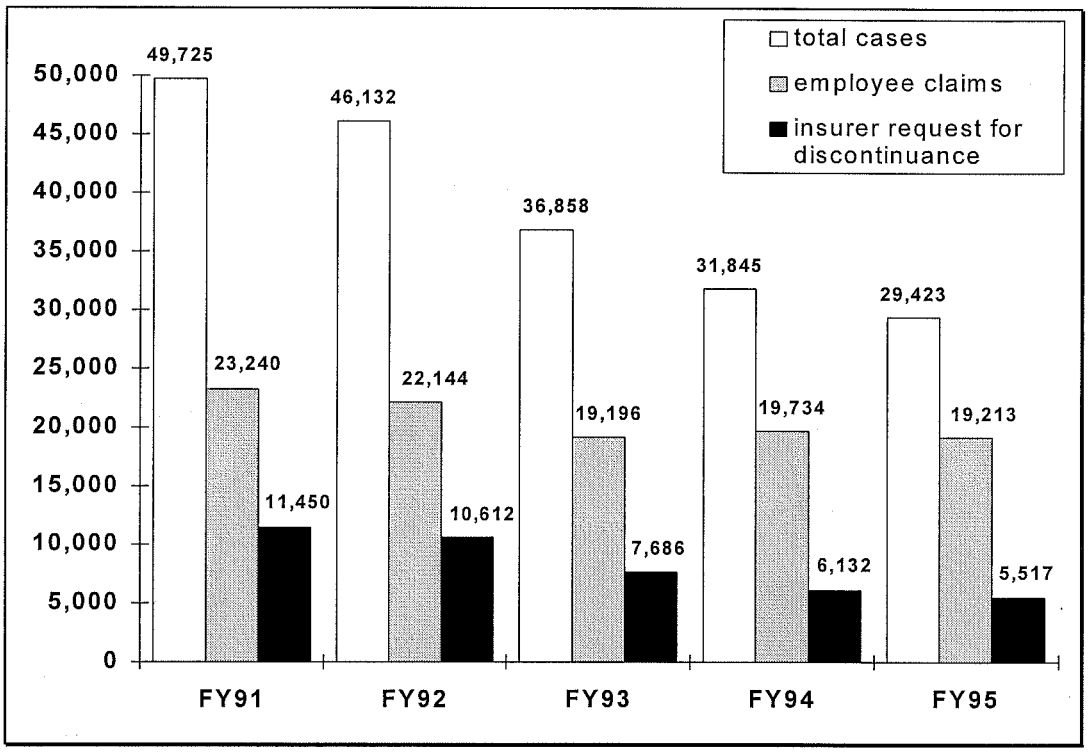
Source: WCRB, estimated schedule z man-weeks base. Based on the claim count data developed to 5th report.

CASES AT THE DIA

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

Figure 6 clearly indicates there has been a significant decline in cases (41%) at the DIA since the 1991 Reform Act. Employee's claims, which account for 65% of the total cases, declined slightly in 1995 to 19,213 and have decreased 17% since 1991. The most noticeable reduction since 1991 can be seen by insurer requests for discontinuances which have declined by 52%.[4]

Figure 6: Total cases, employee claims, and insurer requests for discontinuance; fiscal year 1991 - fiscal year 1995. 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)

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.

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.

In fiscal year 1995 the number of First Reports of Injury received by the Office of Claims Administration was 58,940. The number of claims, discontinuances and third party claims was 30,361. The total number of referrals to conciliation for the fiscal year was 25,815.

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 1995, $653,308 was collected in fines, an increase from the $399,142 collected in FY'94 and the $85,707 collected in FY'93.

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 1995, a total of 37 cases were reported to the office, all of which were referred to the Insurance Fraud Bureau or 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 between 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.

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 this annual report are from reports that originate in this database. The data processing unit handles all requests for information and runs the reports from the system.

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, or 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 its has completed one step of the process.

CONCILIATION

The main objective of the conciliation unit is to remove from the dispute resolution system those cases that can be resolved without formal adjudication. At this stage, cases are reviewed for documentation necessary to substantiate the dispute. Conciliators are empowered to withdraw or reschedule a case until adequate documentation is presented. Approximately 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 cases. The other half of the cases are referred from conciliation to a conference.

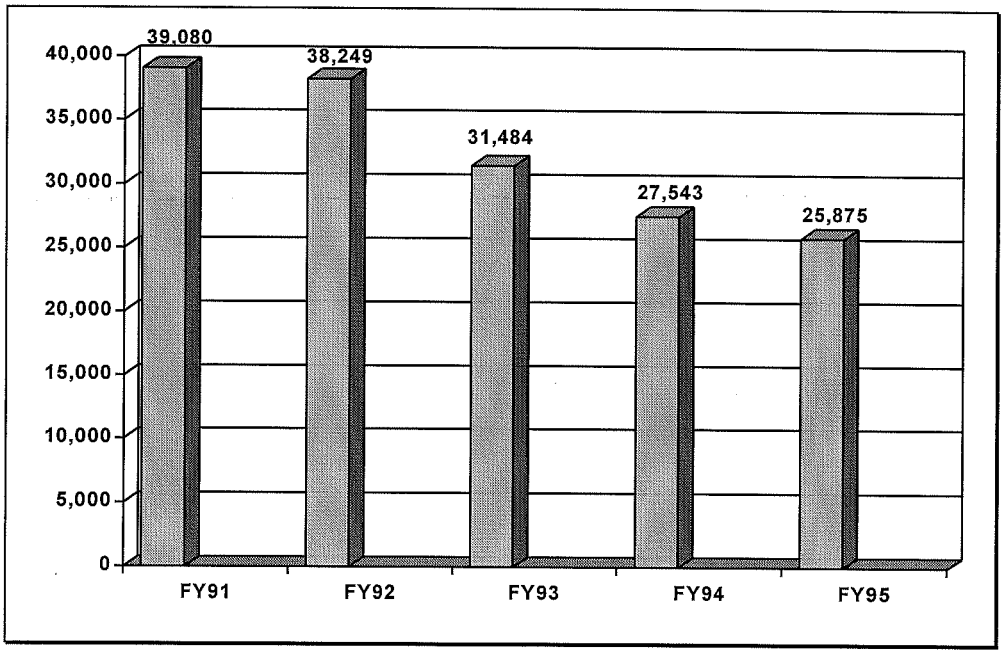
The Conciliation Process

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 from the insurer or a claim for benefits from an employee. The insurer and employee (or representative) are required to attend the conciliation, although the employer and other third parties involved (such as a doctor) may attend as well with permission of the parties. All relevant issues (including causal relationship, disability, medical condition, etc.) are reviewed at the meeting. When liability is not an issue but a claimant seeks additional compensation or the insurer seeks to modify or discontinue benefits, each party is required to submit a written settlement offer. If the employee fails to file, the conciliator must record either the last offer made by the employee or the maximum compensation rate. If the insurer fails to file, then the conciliator must record the last offer made by them or zero. In an effort to promote compromise, the last best offer should indicate what each party believes the appropriate compensation rate should be. A conciliator's recommendation is written for the case file, and the conciliator's disposition is recorded in the Diameter system.

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 must first go through conciliation. Up until 1991, the case load at conciliation had steadily increased to a high of 39,080 cases. After the 1991 Reform Act, the volume of cases at conciliation has consistently decreased to 25,875 in 1995 (34% less than 1991 levels).

Figure 7: Volume of cases scheduled for conciliation



Source: DIA report 17

Figure 2 indicates the number of conciliations that were scheduled in FY'95, 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 25,875 scheduled conciliations, 21,242 conciliations actually occurred.[5]

Conciliation Dispositions - (1) cases referred to conference

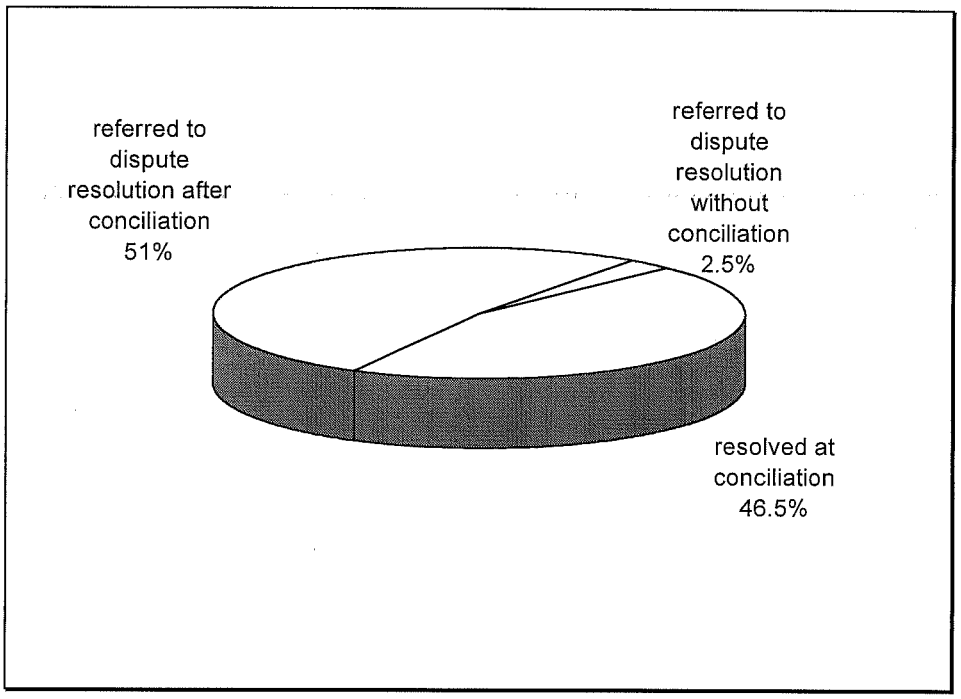
Cases at conciliation may be divided into two major categories: referred to conference, or resolved. In FY'95, 54% of the 25,875 cases scheduled for conciliation were referred to conference, the next stage of dispute resolution. This compares very closely to the prior year's referral rate of 55%.[6]

As in previous years, 2.5% of the 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 appear for the conciliation.

[5] "Referred to conference" (13,205), "conciliated - adjusted" (4,414), "conciliated- pay without prejudice" (162), "withdrawn at conciliation" (2,501), "lump sum approved as complete" (342), "referred to lump sum" (618) = 21,242

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

Figure 8: Fiscal year 1995, conciliation statistics



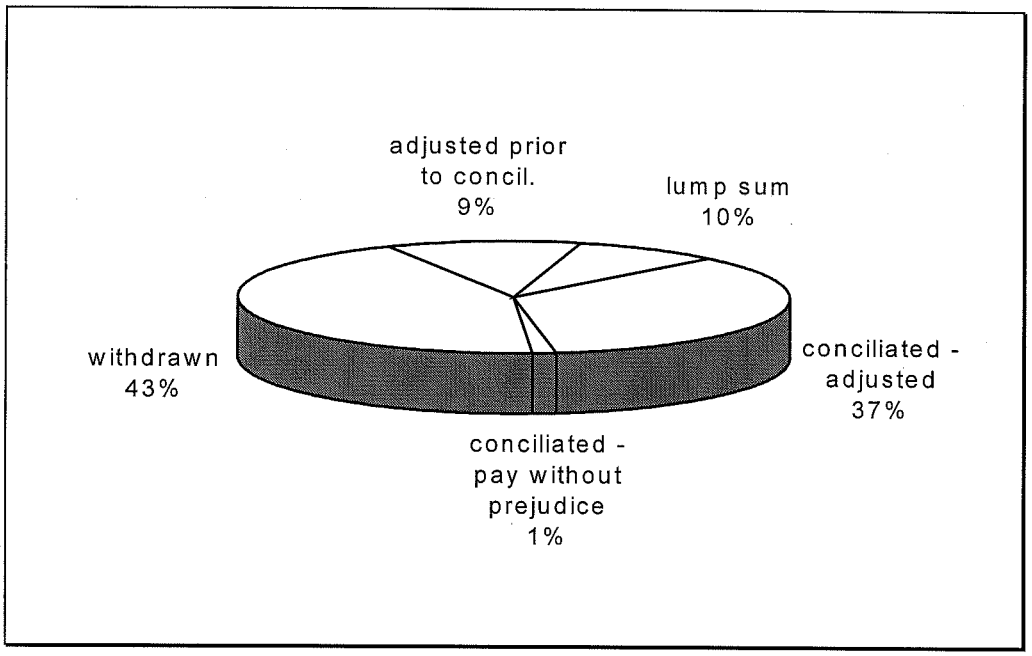
Source: DIA report 17

Conciliation Dispositions - (2) resolved cases

The remaining 46.5% of conciliation cases in FY'95 are considered to be resolved (that is they were not referred on to conference). These numbers are similar to previous years percentages of cases that were resolved (FY'94 -45%, FY'93 -46%, FY'92 - 49%, FY'91-48%). Although the case load has clearly decreased since the 1991 Reform Act, the percentage of cases resolved at conciliation has remained around 50%.

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 on their own terms.

Figure 9: Fiscal year 1995, "resolved at conciliation" (breakout of block from Figure 8)



Source: DIA report 17

Resolved Cases- withdrawn

Table 6: Fiscal year 1995, withdrawn cases at conciliation

Breakdown of Cases Withdrawn, FY'95	*Number of Cases*	*Percentage of All Cases*[7]	*% of Resolved Cases*
Withdrawn at Conciliation	2,501	9.7%	20.8%
Withdrawn Prior to Conciliation	1,125	4.3%	9.4%
Withdrawn by Dept. for No Shows	1,515	5.9%	12.7%
Total Withdrawn	**5,141**	**19.9%**	**42.8%**

Table 7: Fiscal year 1994, withdrawn cases at conciliation

Breakdown of Cases Withdrawn, FY'94	*Number of Cases*	*Percentage of All Cases*[8]	*% of Resolved Cases*
Withdrawn at Conciliation	2,315	8.4%	18.5%
Withdrawn Prior to Conciliation	1,498	5.4%	12.0%
Withdrawn by Dept. for No Shows	1,578	5.2%	12.7%
Total Withdrawn	**5,391**	**19.6%**	**43.3%**

"Withdrawn at conciliation" -- The power to withdraw a case is a major tool of the conciliator to ensure the employee or insurer has the necessary documentation to substantiate a case. According to §10 of Chapter 152, "the assigned conciliator shall withdraw without prejudice the claim or complaint of

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

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 may withdraw their dispute at any time.

"Withdrawn by the department for no shows"-- If the moving party does not appear at 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 8: Fiscal year 1995, lump sum settlements at conciliation

Breakdown of Lump Sums, FY'95	*Number of Cases*	*Percent of All Cases*[8]	*% of Resolved Cases*
Lump Sum Reviewed- Approved as Complete	342	1.3%	2.8%
Directed to Lump Sum Conference:			
■ Referred to Lump Sum	618	2.4%	5.1%
■ Lump Sum Request Received	191	0.7%	1.6%
Total Lump Sum Settlement	**1,151**	**4.4%**	**9.6%**

Source: DIA report 17

Table 9: Fiscal year 1994, lump sum settlements at conciliation

Breakdown of Lump Sums, FY'94	*Number of Cases*	*Percent of All Cases*[8]	*% 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

"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 342 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. 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 be "conciliated" in two ways. 37% of the resolved cases (or 17% 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 35% of resolved cases (or 16% of all cases) last fiscal year.

Cases may also be "conciliated - pay without prejudice" (1% of resolved cases in both FY'95 and FY'94) meaning the pay without prejudice period has been extended and the insurer may discontinue compensation without DIA or claimant approval.

Cases Rescheduled

Conciliators cannot render a legal judgment on a case, but can 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, 35% were rescheduled in FY'95. This is an increase from the 31% rescheduled in FY'94, 28% in FY'93, and 22% in FY'92.[9] An upward trend can be seen in regard to cases rescheduled at conciliation. This trend is likely a result from the greater emphasis placed on "completeness" of documentation in case's moving forward. If documentation is missing from a case at the conciliation level it could preclude resolution later on in the dispute resolution process.

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.

[9] DIA report 16

CONFERENCE

Each case referred to a conference is assigned an administrative judge 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. In FY'95, conference orders were issued on average within 10 days of the close of the conference. The judge's conference order may be appealed within 14 days to a hearing.

Administrative Judges

There are 30 administrative judges (AJs) in Boston and the regional offices who preside over the conference and hearing stages of dispute resolution. Of these, 21 have been appointed for six year terms, and nine have been appointed for one year re-call terms. In the past year, there has been a significant increase in the use of recall judges as the three year term positions that were created by the 1991 reforms to relieve the backlog of cases all expired in February 1995. The statute provides for the appointment of at least 21 AJs, but allows the governor to recall AJs whose terms have expired for one year terms. To maintain enough judges to handle the case load, all but two of the three-year AJ's have been reappointed. See Appendix F for a list of the judges and their terms.

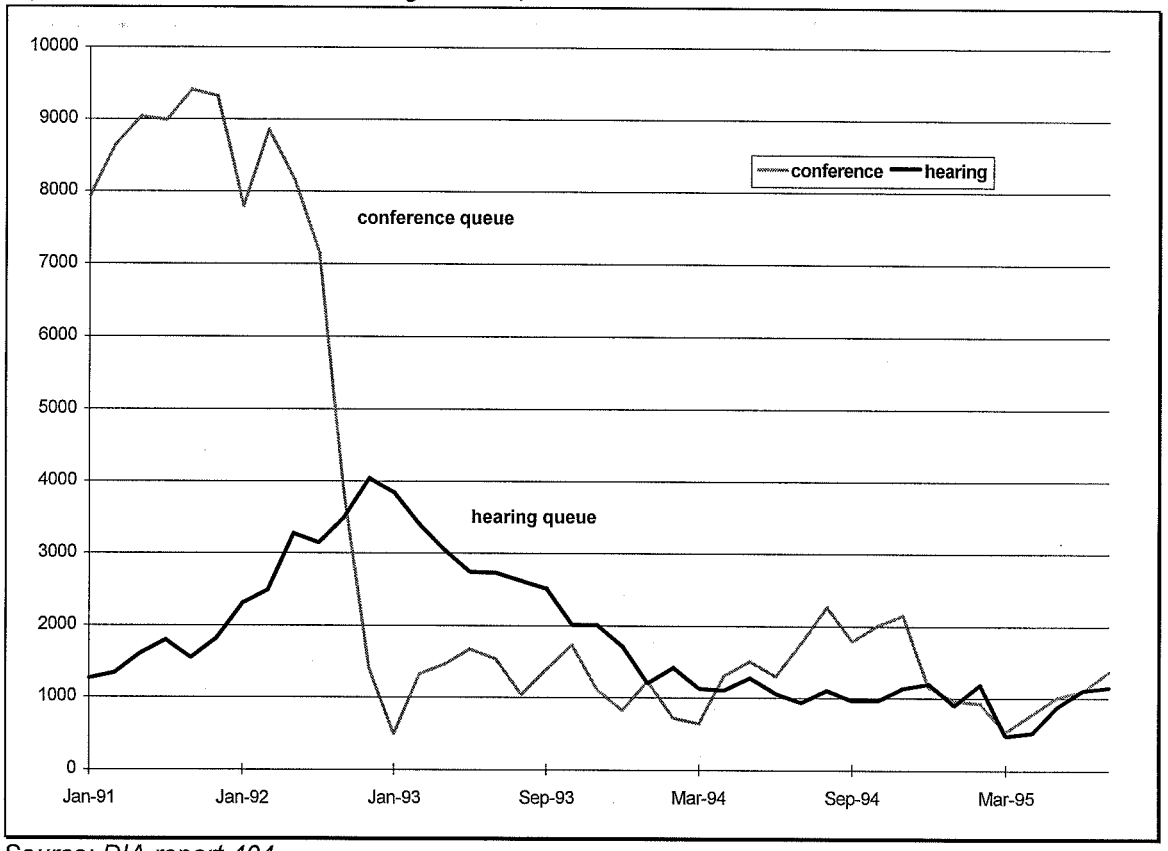
When judges have an inordinate number of hearing decisions outstanding, the Senior Judge may take them "off-line" by refusing to assign new cases so that they may complete their outstanding case loads. This is one method of sanctioning judges, while also providing them an opportunity to catch up on their 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 could become problematic if a large number of cases were awaiting a conference or hearing. The administrative practice of taking a judge off-line is relatively rare and occurs for limited amounts of time.

As the end of an AJ's term nears, the Senior Judge typically will take him or her off-line until reappointment is certain (e.g., the governor has made the appointment and the Governor's Council has assented). This enables the judges to complete their assigned hearings, thereby minimizing the number of cases that must be re-assigned to other judges after their term expires. This becomes problematic when approximately 1/3 of the AJ's are subject to reappointment each year.

The scheduling of the judges is based on a 12 week cycle. The first three weeks of the cycle are allotted for conferences (8 -13 conferences a day, four days a week). The fourth week is a continued week for unfinished conferences and the fifth week is a writing week. Weeks six through ten consist of both conferences and hearings (up to three hearings a day, four-five days a week; two conferences a day). The last two weeks are continued and writing weeks. There are 4 cycles throughout the fiscal year.

Conference Queue

Figure 10: Conference and Hearing Queues; Fiscal Years 1991 - 1995

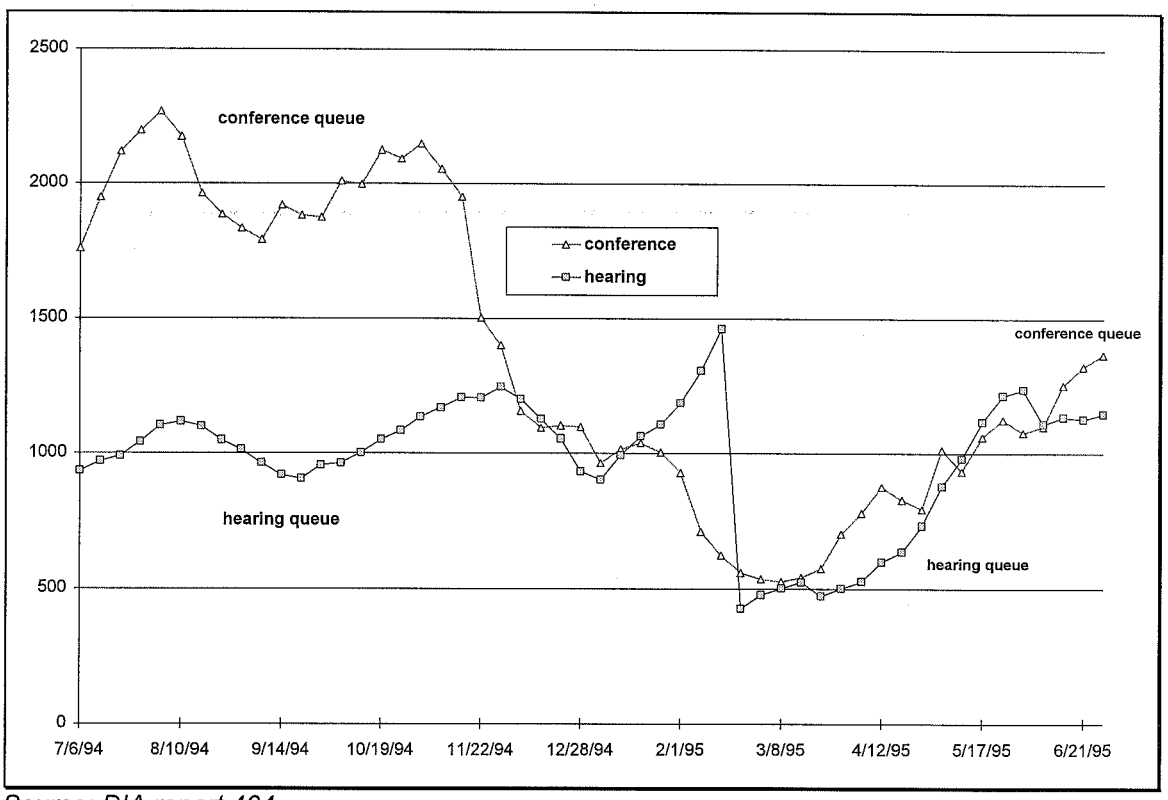


Source: DIA report 404

The conference queue remained stable throughout FY'95, ending below the start of the year (1,762 on 7/6/94 and 1,368 on 6/28/95). The queue fluctuated throughout the year, mirroring the scheduling cycle of the judges. The queue reached a high of 2,270 on 8/3/94 and a low of 528 on 3/8/95.

The Senior judge has indicated a conference queue of 1,500 cases is optimum. This 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 scheduling cycle and a queue higher than that will likely produce a backlog.

Figure 11: Conference and Hearing Queue; Fiscal Year 1995



Source: DIA report 404

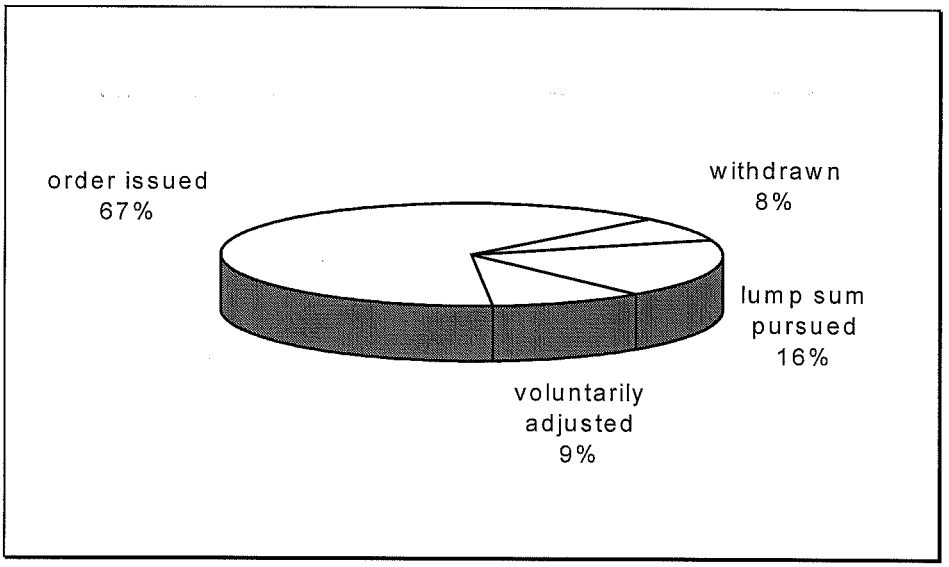
Volume of Conferences

The number of conference dispositions decreased in FY'95 from 16,137 in FY'94 to 15,117 this year. Historically, the number of conferences has represented approximately half of the cases scheduled for conciliation (the referral rate is usually around 50%). FY'95 numbers are in this range, whereas in FY'93 the volume of conferences (25,285) 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 15,117 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 13,713 conferences which took place and were completed in the year.

Conference Dispositions

Figure 12: Fiscal Year 1995, Conference Dispositions



Source: DIA report 45B

Table 10: Fiscal Year 1995, Conference Dispositions

Disposition at Conference, FY'95	*Cases*	*Percentage*
Withdrawn	1,175	7.8%
Lump Sum Pursued	2,450	16.2%
■ Settlement Approved by Judge	2,256	
■ Referred to Lump Sum (Administrative Judges may enter this disposition to hold their own lump sum conference)	62	
■ Lump Sum Request Received (Directed to separate lump sum conference before ALJ)	132	
Voluntarily Adjusted	1316	8.7%
Order Issued	10,079	66.7%
Other	97	0.6%
Total	**15,117**	**100.0%**

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

Table 11: 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 (Administrative Judges may enter this disposition to hold their own lump sum conference)	1,092	
■ Lump Sum Request Received (Directed to separate lump sum conference before ALJ)	173	
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)

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 even though 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, 67% in FY'95 (a higher percentage than the last fiscal year). The conference order could conclude the case, but a significant number are appealed every year. In fiscal year 1995 81.2% of conference orders were appealed, compared to 76.6% in FY'94, 73.6% in FY'93, 82.3% in FY'92, and 81.1% in FY'91.[10]

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'95 (14.9%) than in FY'94 (18.6%).

[10] DIA report 319A

HEARINGS

According to the department's regulations, 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. In FY'95, the average time from the beginning of a hearing to the issuance of the decision was 214 days.[11]

Any party may appeal a 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 30 administrative judges and 12 week cycle are also utilized for hearings. 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 Queue

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 yet a factor). Since hearings are also more time consuming than conferences it takes more time to handle a hearing queue than a conference queue.

The hearing queue in FY'95 increased, beginning the year at 936 (7/6/94) and ending the year at 1,148 (6/28/95), a 23% increase. In the last six years, the hearing queue has been as low as 409 cases in September 1989 and as high as 4,046 in November 1992.

Volume of Hearings

In FY'95 approximately 6,021 cases were appealed to the hearing stage of dispute resolution (60% of the 10,079 conference orders). Some of these appealed cases may be withdrawn before the actual hearing thereby lowering the number of cases heard at hearing. The number of appeals that actually proceed must be added to any existing queue of cases for hearings to get the total number of hearings held in FY'95. The number of hearing dispositions decreased in FY'95 to 7,801 from 10,176 in the last year.

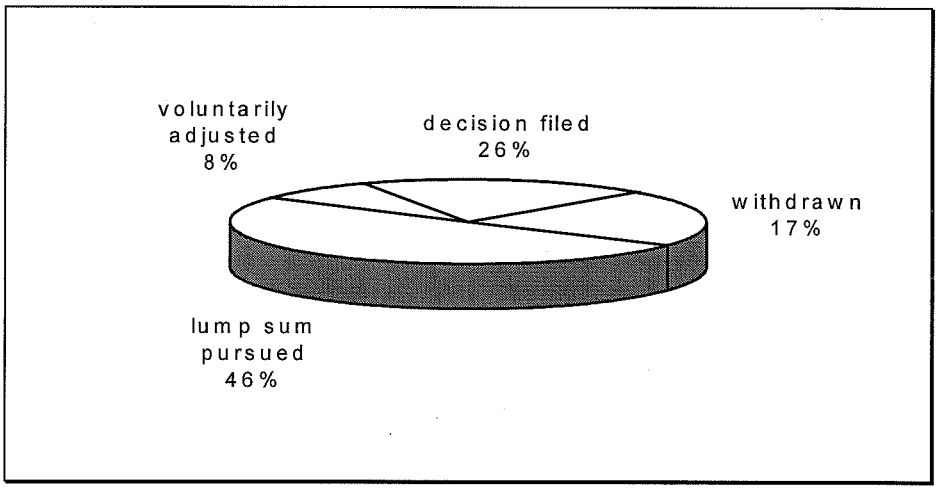
[11] DIA report 591

There is usually a greater number of dispositions than the actual number of hearings because some cases have more than one disposition and others are withdrawn before the hearing. For hearings, the "schedule medical hearing" disposition is not a final one because it does not conclude the case.[12] "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 7,801, it leaves 6,275 final dispositions. This number is further reduced if cases with a "withdrawn" disposition are subtracted. In FY'95 approximately 5,180 hearings were held.

Hearing Dispositions

The disposition of hearings are striking in that "lump sums" consists of almost half of all the cases while "decision filed" accounts for only 26%, virtually the opposite of the situation at conference.

Figure 13: Fiscal Year 1995, Hearing Dispositions



Source: DIA report 346 (minus "lump sum request received" and "schedule medical hearing"

[12] In February, 1995, the department ceased from scheduling separate medical hearings as the result of the reviewing board's decision in O'Brien. Hearings involving independent medical exams are no longer scheduled until the report is received by the department.

Table 12: Fiscal Year 1995, Hearing Dispositions

Disposition at Hearing, FY'95	Cases	Percentage
Withdrawn	1,095	14.0%
Lump Sum Pursued	2,881	36.9%
■ Settlement Approved By Judge	2,685	
■ Referred To Lump Sum (Administrative Judges may enter this disposition to hold their own lump sum conference)	64	
■ Lump Sum Request Received (Directed to separate lump sum conference before ALJ)	132	
Voluntarily Adjusted	528	6.8%
Decision Filed	1,629	20.9%
Schedule Medical Hearing	1,394	17.9%
Other	274	3.5%
Total	**7,801**	**100.0%**

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

Table 13: 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 (Administrative Judges may enter this disposition to hold their own lump sum conference)	899	
■ Lump Sum Request Received (Directed to separate lump sum conference before ALJ)	186	
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

As in conference, lump sums may either be 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'95, 2,685 lump sum settlements were approved by the judge at hearing. The remaining 196 cases with lump sum dispositions will most likely also be approved by an ALJ in the next fiscal year. 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 proceed

through the conference or hearing process. This is usually indicated with a "settlement approved by judge" 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). Until February, 1995, hearings were sometimes split with lay testimony presented at one session and medical testimony from the impartial report at another. This occurred when the impartial physician's report arrived after the scheduled date of the hearing. Judges would often go ahead with lay testimony when the impartial report was not available and the Diameter system would automatically schedule a separate medical hearing at a later date. The need for a second medical hearing occurred in approximately 18% of the cases in FY'95.[13] This practice ended in February, when the department decided that it would no longer enforce 452 C.M.R. 1.11(1)(d) calling for the separate medical hearing in the wake of the reviewing board's decision in O'Brien. No hearings involving a medical dispute will be scheduled until the impartial report is received.

[13] DIA report 346

CASE TIME FRAMES

For many years, the Advisory Council has been concerned about the length of time it takes disputed workers' compensation claims to proceed through the Department of Industrial Accidents' dispute resolution process. In 1991 when the Department faced a backlog approaching 10,000 cases, there was serious concern among the participants of the system as to whether a meaningful resolution of cases could occur when substantial delays in the system kept cases from reaching a judge at conference. For an injured worker awaiting benefits wrongfully denied, or for an insurer awaiting the go ahead to discontinue benefits, delays were found to have serious and profound economic consequences.

Since 1993 the DIA has been able to eliminate its backlog of cases. This was achieved by adding more judges to the DIA's division of dispute resolution, appointing a Senior Judge to manage the caseloads and assignments of the judges, utilizing management techniques to improve the functioning of the division of dispute resolution, and a lot of hard work and effort from the judges and their staffs.

Given the stable flow of cases and the elimination of the backlog, the DIA now has a unique opportunity to evaluate time frames between each step of dispute resolution.

Advisory Council Concerns

The Advisory Council, in its FY'93 Annual Report,[14] recommended 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

[14] State of the Workers' Compensation System Fiscal Year 1993, Massachusetts Workers' Compensation Advisory Council, (March 30, 1994), page 98.

will take to reach each step of the dispute resolution process.

A report by the Senate Committee on Post Audit and Oversight[15] 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."[16]

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.[17] In light of the court's ruling, time frames are taken as advisory in nature.

In an effort to evaluate case time frames in Chapter 152, the Advisory Council has proposed to work with all interested parties to develop a guide on how long it should take a case to be resolved.

Case Time Frames Study

One of the goals of this study was to investigate the difference between time frames specified by the statute and the actual time frames as recorded by the DIA in its database. Our investigation revealed that some of the time frames contained in the statute are illogical and contradict other procedural areas of the statute. Moreover, statistics captured by DIA report 491 can be misleading and even erroneous when used to gauge the length of each step of the dispute resolution process.

As a step in the process of determining the case time frames occurring at the DIA, the Advisory Council approached Senior Judge Jennings for input from the judges. He in turn organized a committee of administrative judges and administrative law judges who agreed to meet with us to discuss the time frames and surrounding issues regarding the dispute resolution system. This committee consists of Senior Judge Jennings, Judges Martine Carroll, Richard Heffernan, Theodore Merlo, William McCarthy, Susan Maze-Rothstein, James McGuiness, Diane Solomon, and Richard Tirrell.

The guide that was produced in conjunction with this committee delineates how long it takes a cases to go through the conciliation, conference,

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[15] Workers' Compensation in Massachusetts: Is it Temporarily or Totally Disabled?, Senate Committee on Post Audit and Oversight, (May 5, 1993), pages 18, 38 *citing* State Auditor's Report on the Activities of the Department of Industrial Accidents July 1, 1989 to October 31, 1991, No. 92-4011-3, (December 7, 1992), page 7.

[16] Ibid., Appendix: Auditee's Response to Draft Report.

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

and hearing stages of dispute resolution. There are many delays inherent to the system that include scheduling, administrative processing, and judicial consideration. The judges have helped to explain the procedural and judicial requirements involved in workers' compensation cases. It is their position that the process and the cases can be very complicated, and some delay is unavoidable and even beneficial to allow the most thorough review for each case. Other delay is inevitable due to the 12 week scheduling cycle of the judges and the nature of the system.

This report does not attempt to determine whether the time frames are optimal or excessive. It can be concluded, however, that time frames are on a downward trend.

Findings

1. Some of the time frames as measured cannot be compared to the time frames in the statute.

A. Two of the time frames appearing in the statute do not incorporate changes made by Chapter 398, and therefore are illogical.

Claim to Conciliation The time frame is measured from receipt of the claim/discontinuance to the first conciliation meeting at the division of dispute resolution.

The statute is incongruous and illogical. While ch. 398 amended section 10 so that the conciliation unit falls within the division of dispute resolution, the rest of section 10 was not modified to accommodate this change. Therefore, when the statute requires that *"any claim or complaint shall be referred to the industrial accident board within fifteen days of its receipt by the division of administration unless: (a) the moving party fails to appear on request of the conciliation unit or provide requested information; (b) a conciliator authorizes an extension of the conciliation period, attaching the reasons therefor to the case file, or . . ."* the conciliation process appears to have been overlooked.

One reasonable way to accommodate this misconstruction is to assume that since the legislature intended the conciliation unit to operate within the division of dispute resolution, the conciliation, as the first phase of the dispute resolution process, should be scheduled within fifteen days of the receipt of the claim/complaint by the division of administration. The time frame therefore could be construed as running from "the receipt of claim/discontinuance at the office of claims administration to the first conciliation meeting at the division of dispute resolution."

Conciliation to Conference The time frame is measured from the last conciliation meeting to the first meeting at conference.

According to section 10A, *"the administrative judge shall require the parties to appear before him for a conference within twenty-eight days of receipt of the case by the division of dispute resolution."*

Again, the statute appears to overlook the ch. 398 revision wherein the conciliation unit was transferred to the division of dispute resolution from the division of administration. The statute therefore is in variance with current procedure-- a conciliation would have to be scheduled, completed, referred for conference, and a conference scheduled within 28 days of referral to dispute resolution. Hence, the most logical application would require that a conference be scheduled within twenty-eight days of referral from the conciliation unit.

B. The statute requires time frames which are not measured by any DIA report.

Statute: "conference close to order"
Actual: "scheduled conference to order"

Ch 152, S. 10A (2) *Within seven days of the conclusion of the conference the administrative judge shall file: (a) a written order requiring or denying that weekly compensation or other benefits be paid; or (b) a written order modifying, terminating, or denying modification or termination of weekly compensation or other benefits.*

The "conference close" is not measured to any degree of reliability, although it is a category on report 491. In practice, most judges do not record the day the conference is closed. The overall length of the conference process from the first scheduled conference to the order is recorded.

Statute: "close of hearing testimony to decision"
Actual: "scheduled hearing to decision"

Ch. 152 S. 11B *Decisions shall be issued no more than twenty-eight days following the close of testimony, unless further extension is authorized in writing by the director of dispute resolution.*

There is currently no standard at the DIA to determine the "close of testimony" as defined in the statute. "Hearing close" is a category on report 491 but in most cases it actually records the hearing start to the decision rather than the hearing close to decision.

A new report was created to account for some of these inaccuracies and to state on the report what it actually records - the scheduled hearing to the hearing decision (see findings two and three).

2. The time frame statistics captured by report 491 are inaccurate for two categories.

It was determined that report 491 must be updated to capture two categories in a more consistent and accurate manner. The time frame categories on the report "conference close to order" and "hearing close to decision" do not measure what they state. In fact, the conference close and the hearing close are rarely recorded at all. When the close of the conference or the hearing is not entered (as in most cases) the report then takes the first scheduled date as a proxy for the close.

The data processing unit has created a new report at the Advisory Council's request (report 591). Four new categories have been added: scheduled conference to order, scheduled conference to disposition, scheduled hearing to decision, and scheduled hearing to disposition. These time frames measure the interval between the first actual meeting of the parties at conference and hearing through the day when the judge either issues an order or decision, or some other type of disposition.

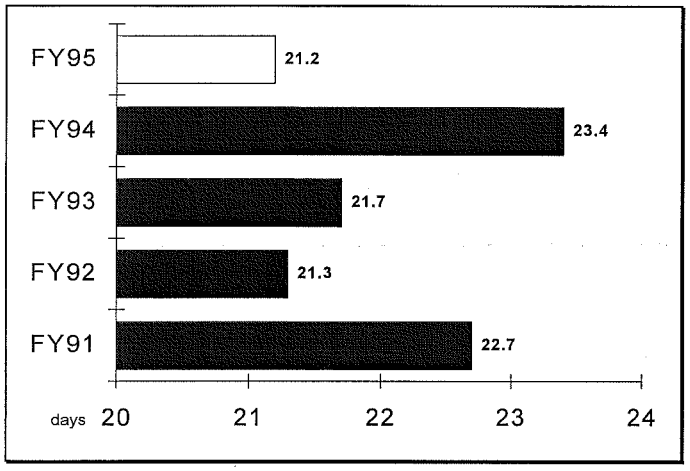
3. The following guide explains the time frame categories, the amount of time it takes at these steps of dispute resolution, and describes what occurs during these intervals.

Note on statistics: The time frames are derived from DIA report 591 for fiscal year 1995. Report 591 is a new report developed with the cooperation of the Senior Judge and the Data Processing Unit to measure certain time frames in a more accurate manner.[18]

Case Time Frames Guide

1. Claim to Conciliation When an **employee** files an *Employee's Claim* form (Form 110), or the **insurer** files an *Insurer's Notification of Denial* form (Form 104), an *Insurer's Notification of Acceptance, Resumption, Termination or Modification of Weekly Compensation* form (Form 107), or an *Insurer's Complaint for Modification, Discontinuance or Recoupment of Compensation* form (Form 108), with the Department of Industrial Accidents, a conciliation is automatically scheduled.

[18] DIA report 591: Case Time Frame Statistics, for events ending from 7/1/93-6/30/94. Days to first scheduled event, mean.



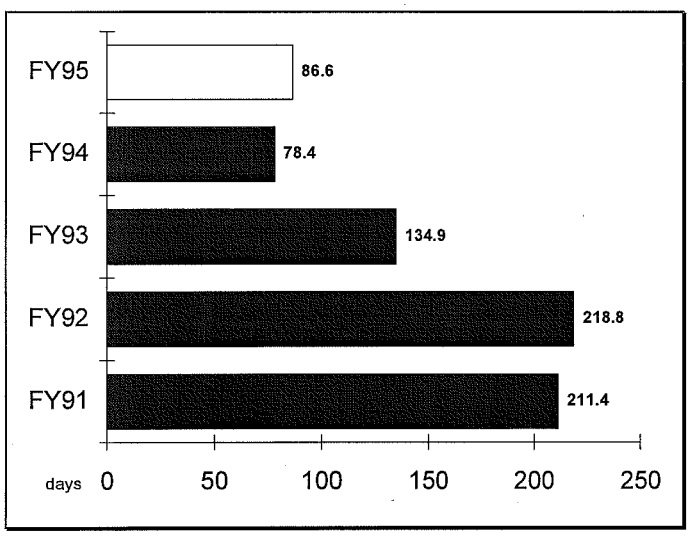
Claim to Conciliation

Start -- The day the department receives the employee's claim for benefits, measured by the time stamp on the correspondence when the department receives it (if there is no time stamp, the date that it is entered is used, however most claims have the date stamped).

End -- The day the conciliation starts.

2. Conciliation to Conference After the conciliation, the conciliator has the option of either referring the case to conference, withdrawing the case (either for lack of adequate evidence supporting the claim or if the claim has settled), or rescheduling the conciliation to allow either party to gather adequate evidence or pursue settlement further.

When the conciliator refers a case to conference, the computer scheduling system automatically assigns the case to an administrative judge who must maintain exclusive jurisdiction over the case throughout the conference and hearing stages.[19]



Conciliation to Conference

Start -- The day the conciliator enters a referral disposition for a conference.

End -- The start of the conference.

Administrative judges agree that this time frame will vary substantially from case to case. It is critical that enough time elapse so that the parties are able to develop the elements of their

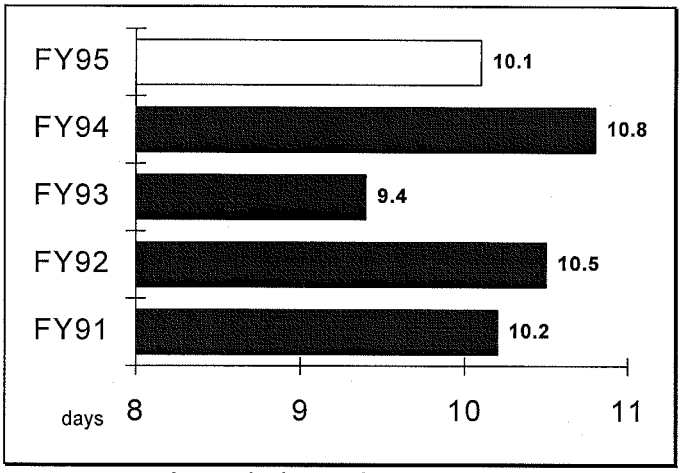
[19] Judge ownership may increase time frames because of the administrative requirements it creates, but it does have positive benefits according to the judges. It creates continuity for litigants, accountability for case development, and it prevents "judge shopping".

case. For example, a case involving complex medical issues will require substantiation of technical issues and of medical reports. Availability of expert's statements is a factor requiring adequate amounts of time.

Moreover, a conference resulting from an insurer's request for discontinuance will require that the same judge who presided over the conference at the outset of the claim again preside over the discontinuance conference. The availability of the particular judge will affect the time frame.

3. Scheduled Conference (Conference Start) to Conference Order At the conclusion of the conference, the administrative judge must issue a determination in the form of a conference order. The conference order is a short written document requiring an administrative judge's initial impression of compensability based on a summary presentation of facts and legal issues at the conference meeting. Conference orders give the parties an understanding as to how the judge might find at a full evidentiary hearing. It often provides incentives for the parties to pursue settlements or return to work arrangements.

It is critical to recognize that, on occasion, judges may decide to delay from issuing an order while the parties attempt to implement return to work arrangements. An administrative judge may also require that the parties define the legal and evidentiary issues by submitting written briefs. These measures may occur as an attempt to encourage resolution of the case prior to a full evidentiary hearing and may serve to lengthen the time frame in any given case. Nevertheless, successful resolution of a case will save time in future proceedings.



Conference scheduled (start) to order

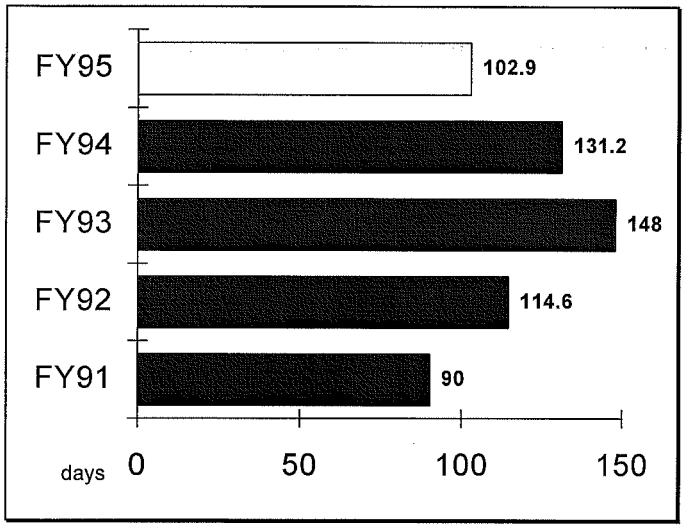
Start -- The first actual conference that takes place. If the scheduled conference is rescheduled, the start date will be the rescheduled conference.

End -- The date of the conference order.

This time frame will begin at the conference start and conclude on the date the conference order is issued. Judges may reschedule the conference to enable one or both of the parties to further develop their case by gathering additional evidence, or may issue a continuation of the conference to allow a return to work offer to be presented and verified.

4. Appeal of Conference Order to Hearing When either party appeals a conference order by filing an *Appeal of Conference Proceeding* form (Form 121), the Division of Dispute Resolution at the DIA will schedule a hearing. Because the Workers' Compensation Act requires that the same judge who presides over the conference must also preside over the corresponding hearing, scheduling of

hearings is dependent on the availability of the presiding judge. It is important to note that the rate of appeals of conference orders varies among the judges at the DIA. Since judges are available to hear only so many hearings during any particular scheduling cycle, the time frame from filing the appeal to the actual hearing will depend on the availability of the particular judge assigned to the case.



Appeal of Conference Order to Hearing

Start -- The day the department receives an appealed conference order to a hearing (measured by time stamped correspondence).

End -- The day the hearing starts.

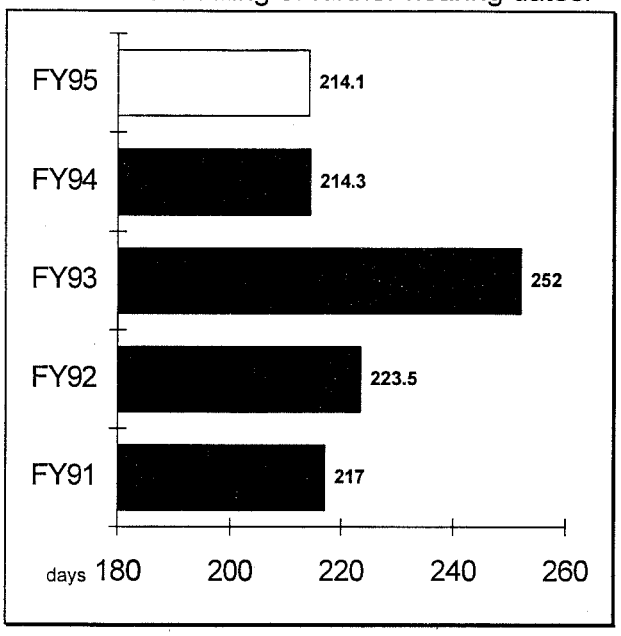
It is important to note that the shortest possible wait to hearing is not always in the best interest of either the moving or the responding party. It is often necessary that between four and six months elapse before the hearing begins to allow the medical condition of the employee to progress and stabilize so that the judge can make a determination as to the severity of injury and any earning capacity. Also, the parties need a significant period in which to prepare witnesses, testimony and evidence to present at the hearing. Finally, this period allows the employee and employers to pursue voluntary agreements.

5. Scheduled Hearing (Hearing start) to the Hearing Decision The time between the first hearing and the hearing decision marks the distinct beginning and end points of the most lengthy, complicated and formal stage of the dispute resolution process at the DIA. Within the time period of the hearing, there are various stages through which the case may have to proceed that involve not only the judges and the respective parties, but also impartial medical examiners. Often depositions and testimony of witnesses are necessary, which require time to prepare. As in the conference, many aspects of this time frame are determined by the actions of the parties.

Cases that involve medical disputes must be evaluated by an impartial medical examiner. This involves a review of the medical record and an examination of the employee. The impartial physician is then required to submit a report.

When the impartial report is submitted by the physician a hearing will be scheduled. In some cases, a party will wish to cross-examine the impartial physician at a deposition to clarify issues. The deposition would have to be scheduled at the convenience of the impartial physician. If the impartial medical report is found to be inadequate or too complex, then medical testimony from

treating and examining physicians may be necessary. This would require the scheduling of further hearing dates.



Hearing Scheduled (start) to Hearing Decision

Start -- The first hearing that actually takes place (hearing start).

End -- The judge's secretary enters the date of the issuance of the hearing decision into the Diameter system.

Cases vary in their complexity and individual circumstances. A case involving quasi-criminal conduct (section 28), multiple insurers, parties, witnesses or injuries, or psychological stress, chemical exposure, or AIDS may take longer, require more testimony and numerous depositions of medical testimony in comparison to other less complicated cases.

Moreover, the record is generally kept open by the judge for an agreed amount of time to allow for the submission of written briefs, memoranda, deposition transcripts, and hearing transcripts to assist the judge in preparing the decision.

After the close of the record, the judge then must write a decision. Decisions are lengthy, as they must provide a factual determination, cite controlling board and court decisions, and provide a final determination of liability or compensability.

The time for writing a hearing decision varies among the judges. Much of the differences relate to the work load and scheduling of the judge, and the complexity of the legal research involved .

Most scheduled hearings do not result in a judge writing a decision because the parties may agree to a lump sum settlement or the case may be withdrawn before it reaches that point.

The genesis of the study arose from some of the concerns delineated in the introduction, mainly that there existed a large discrepancy between statutory and actual time frames as reported by the State Auditor and the Advisory Council in previous annual reports. While the findings of this report indicate that this comparison can be misleading and even erroneous is some cases, it is important to demonstrate this original comparison to show some of the misconceptions and what a large violation there was thought to exist.

In the past, the Advisory Council looked to DIA report 491 to measure case time frames at the DIA's division of dispute resolution. The statistics from

the report have been used both by the Advisory Council in its annual reports and the State Auditor to compare the statutory time frames to those actually occurring at the DIA.

The following provides a comparison of the time frames created by the workers' compensation statute and the time frames recorded by report 491. Examination of these statistics reveal large discrepancies between what the legislature intended and what has been reported as actually occurring.

A new report (591) has been developed to replace report 491 as a result of our findings. These statistics are presented to illustrate the Council's original concerns surrounding the disparity between reported statistics and statutory time frames.

The text and time frames from report 491 are underlined, the text and time frames from the statute are in italics.

	Report 491 Median (Mean)	**Statute**
A. Report 491- Receipt of Claim to Conciliation	**21 days (39.9)**	***15 days***

M.G.L. Chapter 152 s.10 (2) Any claim or complaint shall be referred to the industrial accident board within fifteen business days of its receipt by the division of administration unless.

B. Report 491 - Conciliation Meeting to Conference	**77 days (80.4)**	***28 days***

S. 10A (1) The administrative judge shall require the parties to appear before him for a conference within twenty-eight days of receipt of the case by the division of dispute resolution.

C. Report 491 - Conference Close to Order	**5 days (6.6)**	***7 days***

S. 10A (2) Within seven days of the conclusion of the conference the administrative judge shall file: (a) a written order requiring or denying that weekly compensation or other benefits be paid; or (b) a written order modifying, terminating, or denying modification or termination of weekly compensation or other benefits.

D. Report 491- Appeal of Conf. Order to Hearing	**132 days (155.5)**	***28 days***

S. 10A (3) Any party aggrieved by an order of an administrative judge shall have fourteen days from the filing date of such order within which to file an appeal for a hearing pursuant to section eleven. Such hearing shall be held within twenty-eight days of the department's receipt of such appeal.

E. Report 491 - Hearing Close to Decision **90 days (118.5)** ***28 days***

S. 11B Decisions shall be issued no more than twenty-eight days following the close of testimony, unless further extension is authorized in writing by the director of dispute resolution.

F. Reviewing Board

The statute does not address time frames to reach the Reviewing Board. The Reviewing Board is not connected to the Diameter case tracking system making it more difficult to track time frames from appealed hearing decisions. The time frame to reach the Reviewing Board approaches two years.

G. Lump Sum Conferences

No statutory guidelines exist. Currently, the average time frame is approximately one month.

Assumptions

Time frames in the dispute resolution system depend on many factors at each stage of the process. Two essential components which determine the amount of time it takes to get through these stages are the number of judges that are able to hold conferences and hearings, and the number of cases that flow into the system. However, it is not just the number of cases that affects the time frames, but the complexity of those cases. This is difficult to quantify and for the purposes of this section, we assume that within the cohort of cases within each fiscal year, there are a great number of complicated ones.

There must be a balance or equilibrium between the number of available judges (capacity) and the number of cases they must handle (caseload). In 1991, there was a strong imbalance between the number of judges and the number of cases in the system, causing a tremendous backlog and long time frames. This situation has been rectified by the addition of more judges and a stable flow of cases to produce an effective balance between the caseload and number of judges. This has enabled the case time frames to be reduced to a constant level.

To look at the level of the actual time frames and predict or assume that they will remain at this level in future quarters and years, one must assume that this equilibrium will not be disturbed. If the caseload goes up drastically and the number of judges remains the same, case time frames will invariably go up. This will also occur if the number of judges is reduced and the caseload remains the same.

There are many factors that determine case time frames, and it is reasonable to assume that at least for the present time and near future a backlog of cases will not be one of those factors.

It is very difficult to predict the caseload that arrives each year at the department. It is also very difficult to determine the capacity of the judges. Capacity can depend on many factors including how many judges are on line at any given time, new judges requiring training and proceeding slower, unforeseen illnesses, etc.

The example below is intended to illustrate the basic concept that some sort of constant is needed between the judges (capacity of the system) and caseload (number of cases). This illustration is based on yearly data from fiscal year 1993.

A. All backlog cases from 1991 have gone through the system. (There are currently some residual backlog cases at the hearing level. Appeals from the backlog cases are now beginning to reach the Reviewing Board.)

B. **Caseload** - annual caseload of 31,000 (The amount of claims and discontinuances appears to have stabilized at this level according to FY'93 figures)

1. 31,000 cases scheduled for conciliation in the year - 50% are referred to conference.

2. 15,500 cases scheduled for conference in the year.

3. This should yield 9,300 orders issued (60% of the cases at conference had an order issued in FY'93).

   6,975 of these orders should be appealed (75% of the conference orders were appealed in FY'93). Approximately 45% of cases scheduled for conference will continue to the hearing.

4. 7,000 cases scheduled for hearings in the year.

C. **Capacity** - 30 AJs on line, 6 ALJs

1. Three of the 13 weeks in the scheduling cycle are devoted to conferences. In the cycle, each judge can handle 156 conferences (13 conferences a day x 4 days a week x 3 weeks = 156).

2. 156 conferences x 30 judges = 4,680 conferences.

3. 4,680 x 3.70 cycles per year = 17,316 conferences per year.

4. Six of the 13 weeks in the cycle are for hearings. In the cycle, each judge can handle 90 hearings (3 hearings a day x 5 days a week x 6 weeks = 90).

5. 90 hearings x 30 judges = 2,700 hearings per cycle.

6. 2,700 x 3.70 cycles per year = 9,990 hearings per year.

D. The remaining four weeks of the cycle are used for continuations (two weeks) and writing (two weeks).

Summary

The chart below signifies the caseload capacity if the six three year judges were not recalled for a one year term (26 judges) but the caseload remained the same (31,000 cases). It also show the capacity if there were only 21 six year judges on line.

Table 19: Caseload Capacity

Meeting	Caseload (based on 31,000 cases)	Capacity (based on 30 AJs)	Capacity (based on 26 AJs)	Capacity (based on 21 AJs)
Conference	15,500	17,316	15,007	12,121
Hearing	7,000	9,990	8,658	6,993

The capacity must be slightly greater than the presumed number of conferences and hearings to avoid any backlogs. Caseload is a variable that is difficult to predict and it may increase to a level greater than predicted.

There must be some leeway in the scheduling to take into account holidays, vacation, sick days, and judges that are taken off-line. A margin between the judges' capacity and annual caseload must also be allowed for any increase in the caseload (greater than 31,000 a year). In this example (see summary above), the capacity of the judges is approximately 20% higher than the expected caseload.

There are also factors unique to the system and the 13 weeks scheduling cycle that affect the rotation of the judges and the time frames. The 13 weeks cycle is needed to maintain the scheduling of conferences and hearings in blocks to accommodate the limited number of stenographers.

Judges are also required to travel to regional offices, especially when the caseload is low. This makes it more difficult to schedule the judges. In addition, the same judge that hears a case at conference must hear it at hearing, thereby affecting scheduling and time frames.

The appointment process of the judges may also affect the time frames. Not only do new judges require training and time to learn the system, the judges they replace must be taken off line from receiving new cases in advance of their departure so they can finish their hearings.

The continued re-appointment of one year term judges can have a considerable drain on the time frames as well. In the months preceding the expiration of their terms, when re-appointment is uncertain, these judges must be taken off line to prevent new cases from being assigned.

The following chart represents the average amount of time it took a case to proceed through each step of the dispute resolution process in FY'95 with respect to each district office. It is important to note that these time frames are not continuous and therefore their total should not be equal to the total average time frame of cases at the DIA.

Table 20: Regional Time Frames

FY '95	Claim to Conciliation	Conciliation to Conference	Conference scheduled (start) to Order	Appeal to Hearing receipt to Hearing	Hearing scheduled (start) to Hearing decision
Boston	21.1 days	81.5 days	11.1 days	105.9 days	206.5 days
Fall River	21.3 days	65.8 days	10.4 days	100.6 days	213.6 days
Lawrence	22 days	96.1 days	12 days	96.6 days	303.1 days
Springfield	21.7 days	96.6 days	4.6 days	104.8 days	149.9 days
Worcester	20.6 days	108 days	9.3 days	97.3 days	219.9 days

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- transcript 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- transcript 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-transcript 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 findings of fact.

Table 21: Hearing Decisions Appealed

FY'95	695 cases
FY'94	657 cases
FY'93	412 cases
FY'92	493 cases
FY'91	513 cases

The number of hearing decisions appealed to the Reviewing Board in FY'95 was 695. This is a slight increase from last year (657) but a large increase from previous years; 412 (FY'93), 493 (FY'92), and 513 (FY'91).

Table 22: FY'95 Backlog of Hearing Decisions on Appeal to Reviewing Board

Total # of Cases Awaiting Review	**1,087 cases**
■ awaiting a pre-transcript conference	278 cases
■ with stenographer for preparation of the hearing transcript	282 cases
■ awaiting briefs from the parties	214 cases
Total # of Cases Ready for Review	**313 cases**

The Reviewing Board continued in FY'95 to have a large backlog of cases. At the end of FY'95 (6/30/95), there were 1,087 cases awaiting review, a slight increase from the 1,044 cases pending before the board at the close of FY'94. It is important to note that of the 1,087 cases awaiting review, 278 were awaiting a pre-transcript conference, 282 were with the stenographer unit for preparation of the verbatim transcript, and 214 were awaiting briefs from the parties. Hence, 71% (774) of the cases awaiting review are not even ready for the judges review.

The Reviewing Board disposed of 679 cases in FY'95 compared to 558 in the previous fiscal year.

Table 23: Appeals Resolved by Reviewing Board, FY'95

Disposition of Cases, FY'95	*Number of Cases*
summary affirmation and decisions on the merits	328
lump sum settlement	158
withdrawn after conference with single ALJ	193
Total	**679**

Source: DIA Reviewing Board

Lump Sum Conferences

One recall AJ and one recall ALJ 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 AJs 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'95, 4,324 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'95, administrative law judges heard 891 §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 ALJ must determine the fair and reasonable amount to be paid out of the settlement to discharge the lien.

The number of section 46A conferences heard in 1995 was 66.

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 24: Lump Sum Conference Statistics

Fiscal Year	Total lump sum conferences scheduled	Lump sum settlements approved
FY'95	**10,297**	**9,864 (95.8%)**
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%)

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

The number of lump sum conferences has declined by 48% since FY'91. Scheduled lump sum conferences are now at the lowest level since the 1991 reforms, while the percentage of lump sum settlements approved is at a high since 1991. In FY'95, only 12 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 just as an ALJ at a lump sum conference, they must 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 the recall administrative law judge or the recall administrative judge. Conciliators and administrative judges may refer cases to lump sum conferences to determine if settlement 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; as indicated in table 25.

Table 25: Lump Sum Settlements Pursued, at each step of Dispute Resolution, FY'95.

Meeting	*Lump Sum Pursued*[20]	*Percentage of Total Cases Scheduled*
Conciliation	1,151	4.4%
Conference	2,450	16.2%
Hearing	2,881	36.9%

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.

[20] 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

The impartial medical examination has become a significant component of the dispute resolution process since it was created by the 1991 reform act. During the conciliation and conference stages, a disputed case is guided by the opinions of the employee's treating physician and the independent medical report of the insurer. Once a case is brought before an administrative judge at a hearing, however, the impartial physician's report is the only medical evidence that can be presented. Any additional medical testimony is inadmissible unless the judge determines the report to be "inadequate" or that there is considerable "complexity" of the medical issues that could not be fully addressed by the report.

The 1991 reforms were designed to solve the problem of "dueling doctors," which frequently resulted in the submission of conflicting evidence by employees and insurers. Prior to 1991, judges were forced to make medical judgments by weighing the report of an examining physician retained by the insurer against the report of the employee's treating physician.

Section 11A of the workers' compensation act now requires that the senior judge periodically review and update a roster of impartial medical examiners from a variety of specialized medical fields. When a case involving disputed medical issues is appealed to hearing, the AJ must appoint an impartial physician. An insurer may also request an impartial examination if there is a delay in the conference order.[21] Furthermore, any party may request an impartial exam to asses the reasonableness or necessity of a particular course of medical treatment, with the impartial physician's opinion binding the parties until a subsequent proceeding. Should an employee fail to attend the impartial medical examination they risk the suspension of benefits.[22]

Under section 11A, the impartial medical examiner must determine whether a disability exists, whether such disability is total, partial, temporary or permanent, and whether such disability has as its "major or predominant contributing cause" a work related personal injury. The examination should be conducted within 30 to 45 calendar days from assignment. The impartial report must be received by each party at least 7 days prior to the start of a hearing.

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 the 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. Filing fees for the examinations are set by regulation by the Commonwealth's Executive Office of Administration & Finance.

[21] M.G.L. c.152, § 8(4)
[22] §45 of M.G.L. c.152.

Below is the department's fee schedule:

Table 26: Fee Schedule

$350	impartial medical examination and report
$500	for deposition lasting up to 2 hours
$100	additional fee when deposition exceeds 2 hours
$225	review of medical records only
$90	supplemental medical report
$75	when worker fails to keep appointment (maximum of 2)
$75	for cancellation less than 24 hours before exam

The deposing party is responsible for paying the impartial examiner for services and the report. Should the employee prevail at the hearing, the insurer must pay the employee the cost of the deposition. In FY'95, $1,985,934[23] was collected in filing fees.

Although the number of physicians on the roster has steadily increased since its inception, in 1995 the number decreased. As of 7/1/95, there were 510 physicians on the roster consisting of 36 specialties. This is a decrease from 581 physicians and 46 specialties as of 7/1/94.

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'95 the impartial unit scheduled 7,618 examinations. Of these, 4,787 exams were actually conducted in the fiscal year (the remainder of the scheduled exams were either canceled due to settlements and withdrawals or 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'94 was 7,787, and 4,804 were conducted in the year.

Judicial Review of Section 11A

In FY'95, both the Massachusetts Appeals Court and the department's Reviewing Board reviewed the department's implementation of the impartial medical examination reforms in four significant cases.

[23] This figure does not include "interest" or "miscellaneous" revenue ($171,515.41)

Neff v. Commissioner of Department of Industrial Accidents[24] - On August 9, 1995, the Supreme Judicial Court ruled, in a 4-2 decision, that the Department of Industrial Accidents must waive its $350 filing fee for indigent workers' compensation claimants who appeal an AJ's benefit-denial order. The issue in this case stems from the interpretation of M.G.L. c. 152, sec. 11A. Since no waiver is mentioned in this section, it was argued the statute denies due process and equal protection.

Opting not to address this constitutional question, Chief Justice Liacos concluded that the intent of the Legislature was not "to force a claimant out of the workers' compensation dispute process merely because the claimant is indigent and cannot pay for an impartial medical examination, especially since an indigent claimant can apply for a fee waiver at every other stage where a fee is required." Although the current statute has no provisions that directs the commissioner to provide waivers for the impartial medical examination, Liacos concluded that reading "the entire statutory scheme for workers' compensation leads to the conclusion that the Legislature intended to confer on the commissioner the authority to grant to indigent individuals waivers of the fee required by sec. 11A."

O'Brien v. Blue Cross/Blue Shield - Two major issues were addressed by the Reviewing Board in the O'Brien case. The first involves whether the DIA's procedure of holding a hearing before the receipt of the impartial report and scheduling a separate "medical hearing" to address the report violates ch. 152, sec. 11A. The second, involves whether the section 11A impartial process violates due process under the U.S. Constitution.

The procedure at the DIA for cases involving section 11A impartial examinations required two hearings if the impartial report was not submitted in time for the scheduled hearing.[25] In many cases, the report was not available for the hearing so the judge would proceed on the scheduled date, allowing submission of lay testimony and other forms of non-medical evidence. A second "medical hearing" was then scheduled for review of the impartial report when it became available.

The Reviewing Board found that the DIA regulation authorizing this second medical hearing " violates the statute, as it is inconsistent with the clear language of §11A of the Act." Section 11A states that "the impartial medical examiner . . . shall examine the employee and make a report at least one week prior to the beginning of the hearing which shall be sent to each party. No hearing shall be commenced sooner than one week after such report has been received by the parties."

The Reviewing Board does not have the authority to revoke any DIA regulation. According to the statute, the Reviewing Board may only refuse to apply a regulation in a particular case, and advise the Commissioner of it's

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[24] In its 1993 decision on Murphy v. Comm'r of Dept. of Industrial Accidents, the Supreme Judicial Court found that section 11A violated equal protection principles because a filing fee was only required by those claimants represented by a counsel. On remand, a Superior Court judge ordered that portions of the statute be struck so that all claimants appealing an AJ's order at conference must pay a filing fee.

[25] In 1992, the department promulgated a regulation, 452 C.M.R. 1.11(1)(d), to allow for a two hearing process to avoid delays in the scheduling of hearings thereby exacerbating the hearing backlog.

conflict with the statute. Nevertheless, as a result of the decision, the DIA decided that it would no longer implement the regulation and would follow the process as spelled out in the statute. No hearing involving a medical dispute will be scheduled until the impartial report is received.

In this case, the Reviewing Board issued its decision but has delayed recommitting the case to an AJ until the parties have had the opportunity to raise these issues before the Massachusetts Court of Appeals. If the appeals court were to overturn the statute on these grounds, it would restore the pre-reform, "dueling doctors" system. It is conceivable, however, that the appeals court would attempt to maintain as much of the impartial system as possible. This could be achieved by defining broadly what is considered "inadequacy" or "complexity," and therefore the circumstances under which the judge must allow evidence to rebut the impartial report.

Martin Tallant Case - It is argued by the appellant in the Tallant case (as well as in O'Brien) that Chapter 152, section 11A violates an injured employee's constitutional right to due process. In both cases, the appellants argue that section 11A requires that impartial reports be treated as *prima facie* evidence with regard to medical and disability issues. It expressly prohibits the introduction of other medical evidence to rebut the report, unless the judge determines additional medical testimony is needed because the issues are complex or the report is inadequate.

The appellants argue that the Fourteenth Amendment of the United States Constitution, provides claimants with certain rights during a workers' compensation proceeding. According to case law, the Constitution requires that the parties have an opportunity to present evidence, to examine their own witnesses and to cross- examine witnesses of other parties. Parties have the right to know what evidence is presented against them and to have an opportunity to rebut such evidence. They also have the right to argue, in person or through counsel, on the issues of fact and law involved in the hearing.

According to the appellants, the section 11A provision that gives the impartial report the effect of *prima facie* evidence violates this due process requirement. Section 11A allows additional medical evidence only if the judge determines the report is inadequate or that the medical issues are complex. The decision to allow additional medical evidence is at the judge's discretion.

Frank L. Scheffler's Case - On December 22, 1994, the Supreme Judicial Court determined that an AJ was correct in concluding that the impartial report had *prima facie* effect only for medical issues. The impartial report does not have *prima facie* weight on the issue of the employee's earning capacity.

Judges at the DIA cannot determine earning capacity of employees based solely on the impartial report; they must take into account all evidence before them.

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 30 administrative judges and the 6 administrative law judges, see appendix F.

OFFICE OF EDUC. AND VOCATIONAL REHAB.

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.[26]

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

[26] 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'95 the office consisted of 8 disability analysts and 12 rehabilitation review officers (1 pending), 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 27: Utilization of Voc. Rehab. Services, FY92-FY95

Fiscal Year	Referral to OEVR	Mandatory Meetings	Referrals to Insurer for VR	IWRPs approved	Return to work	% RTW after plan development
FY95	3,219	2,833	1,370	811	517	48%
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 28: Private Trust Fund Expenditures for §30H Voc Rehab Services

Fiscal Year	Expenditures
FY95	8,826
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'95, $54,215 was collected to reimburse the private trust for vocational rehabilitation services funded. This is an increase from the $41,842 collected in FY'94 and $16,833 collected in FY'93.

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 unhealthy working conditions in employment and advising employees and employers on these issues."[27] 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'95, proposals could be submitted up to a maximum of $35,000.

See appendix C for a list of proposals funded in FY'95.

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

OFFICE OF INSURANCE

The Office of Insurance is divided in two units. 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.[28] 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. [29] 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'95, the trend toward self insurance abated. In the year, 11 new licenses were issued to bring the total number to 227 but the overall number of licenses increased by only 3. Each self insurance license provides approval for a parent company and its subsidiaries to self insure. From the 227 licenses, 734 companies including subsidiaries were self insured in FY'95. This amounts to approximately $368 million in equivalent premium dollars.

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).[30]

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[28] 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.

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

[30] 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).

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. The DIA was provided with computer access to this database which includes policy information for the eight most current years. The remainder of policy information must be researched through the files at the DIA, now stored on microfilm.

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.

OFFICE OF INVESTIGATIONS

The investigations office enforces the mandate that all employers have adequate workers' compensation insurance coverage for their employees.

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 identifying 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 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 per 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, 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 beginning from the original issuance of the stop work order and continuing until insurance is obtained.[31]

In FY'95, 3,960 stop work orders were issued as a result of 6,713 investigations conducted. The amount collected in fines in the year was $160,550 (160,150). The number of stop work orders issued has increased dramatically in the last few years. In FY '94 1,860 stop work orders were issued, up from 194 in FY'93, 110 in FY'92 and 86 in FY'91. The amount collected in fines was $160,150 in FY'94, $32,000 in FY'93, and $32,400 in FY'92.

[31] M.G.L. c.152 §25C

DIA FUNDING

One of the main objectives of the Advisory Council is to review the DIA's trust fund budgets. Chapter 23E of the Massachusetts General Laws directs the Advisory Council to review the Workers' Compensation Trust Fund budgets, and with the affirmative vote of seven members (when necessary), to submit an alternative budget to the Secretary of Labor.

Employer Assessments

In 1985, the legislature reorganized the Division of Industrial Accidents and expanded its scope of authority and responsibilities. In order to insure that the new Department of Industrial Accidents had adequate funding (and to avoid the upheavals associated with reliance on tax revenues) the legislature created a funding mechanism whereby the employers of Massachusetts, both public and private, would pay assessments in direct proportion to their workers' compensation losses.[32] In addition to these assessments, the DIA also derives revenue from the collection of fees (for various filing costs) and fines (for violations of the act).

Each year the DIA must determine an assessment rate that would yield revenues sufficient to pay the projected obligations of the workers' compensation trust fund and the operating costs of the DIA. This assessment rate multiplied by the insurer's standard premium is the DIA assessment, and is paid as part of the employer's premium.[33]

Some employers are entitled to "opt out" from paying a full assessment. By opting out, the employer agrees that it can not seek reimbursement for benefits paid under sections 34B, 35C, 37, 30H, 26, and 37A. Separate opt out assessment rates are determined each year (See Appendix I).

The Funding Process

In September of each year, the DIA begins to estimate the amount of money it will request for the next fiscal year. This amount is refined by December, when it is submitted to the governor's office for inclusion in the governor's budget, House 1.

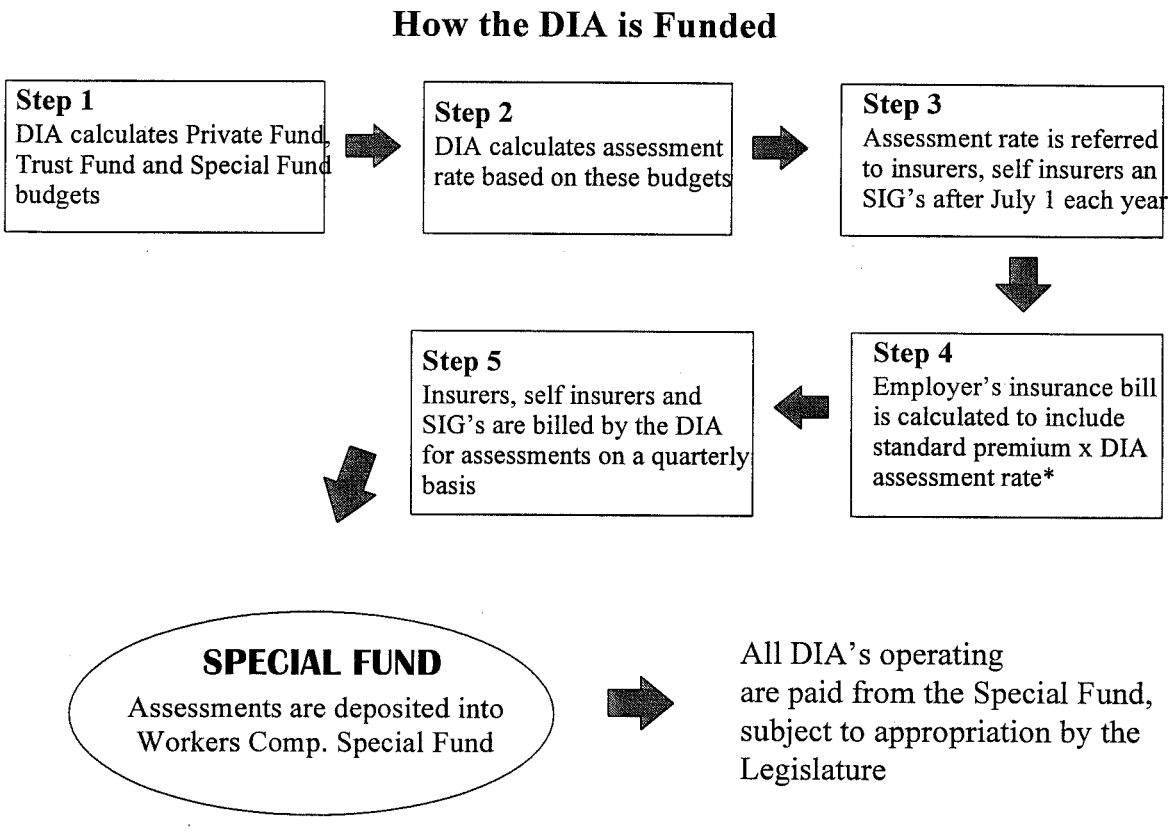
[32] Theoretically, this places the burden of supporting the department on those employers that use it the most.

[33] For employers that are self insured or are members of self-insured groups, an "imputed" premium is determined, whereby the WCRB will estimate what their premium would have been had they obtained insurance in the traditional indemnity market.

In May and June of each year, the department (with the assistance of consulting actuaries) considers the amounts of money necessary to meet demands from the special fund and the trust funds. With regard to the special fund, the department estimates expenditures based upon numbers that have been submitted to the governor's office. (See DIA Expenditures, page 76.) The special fund budget is added to the private trust fund budget to form the basis for the employer assessments. Public employers do not contribute to the Special Fund.

By July, the legislature appropriates an amount for the DIA to spend on operating expenses. Also at that time the DIA sends to insurance carriers notification of the assessment rates, to be collected quarterly. The assessments are deposited into the accounts of the Workers' Compensation Private Trust Fund (9440-0240), Public Trust Fund (9440-0290) and Special Fund (9440-0200) and are managed by the Commonwealth's Treasurer. Although DIA spending requires legislative appropriation, all of the DIA's operating expenses are allocated from the Special Fund.

Figure 14: DIA Funding Process



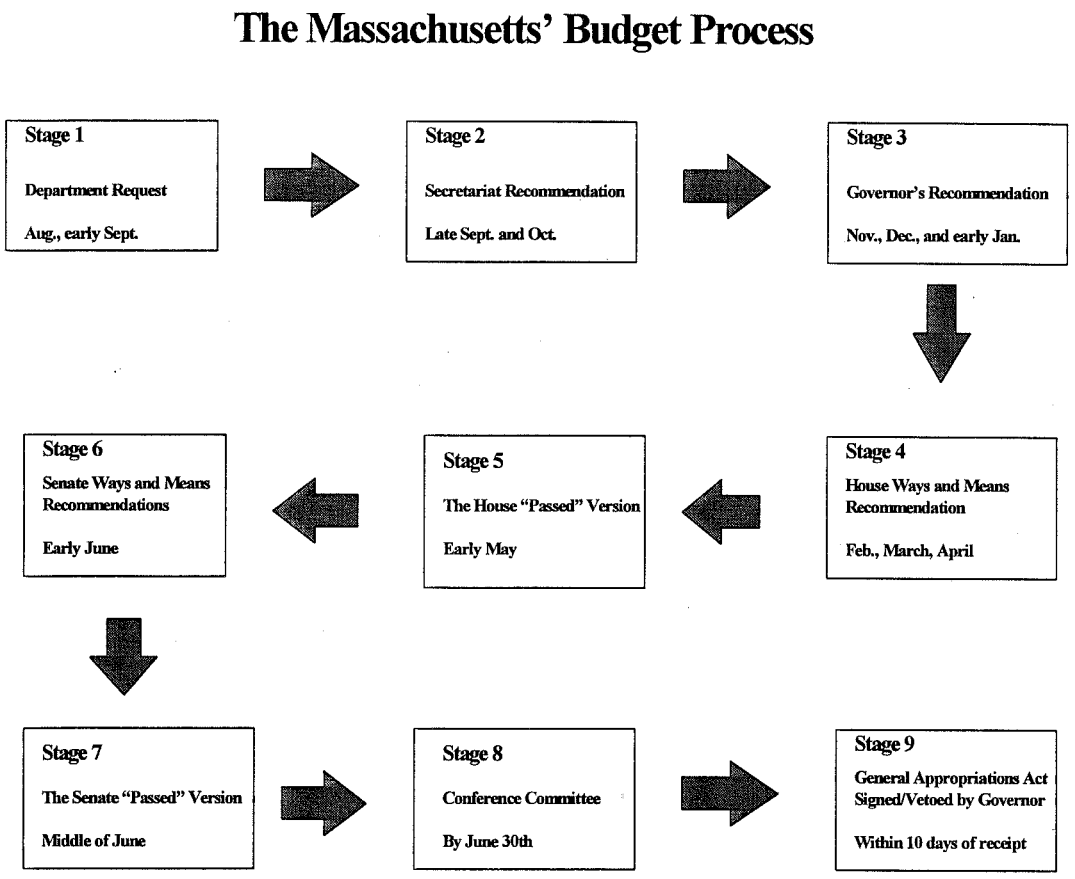
*Note: For self insurers and SIG's, the assessment is based upon an imputed standard premiu

DIA EXPENDITURES

Despite the unique way in which the Department of Industrial Accidents is funded (based upon employer assessments), the operating budget of the DIA is subject to appropriation by the legislature. Hence, the department must submit to the budget process in the same manner as most other government agencies.

It is helpful to view the budget process in Massachusetts as nine distinct phases that occur throughout the year.[34] The following is a brief description of the process.

Figure 15: Budget Process



[34] Making and Managing the Budget in the Commonwealth of Massachusetts, Donahue Institute for Government Services, University of Massachusetts.

Stage 1 Department Request *Time Frame: August and early September*

Each department submits to the Budget Bureau a budget for the next fiscal year and a spending plan for the current fiscal year.

Stage 2 Secretariat Recommendation *Time Frame: late Sept. and Oct.*

The Secretariats analyze each department's requests and meet with department heads to further review respective budgets. Each Secretary will then make their recommendations for the budget.

Stage 3 Governor's Recommendation (House 1) *Time Frame: Nov., Dec., and 1st weeks of Jan.*

The Governor's recommendation must be the first bill submitted to the House of Representatives each calendar year. On the fourth Wednesday in January copies of House 1 are distributed to members of the House and Senate, the Executive Secretaries and department heads, the media, and to any other interested parties. The Governor's recommended budget must be balanced and include all revenue accounts and all expenditure accounts.

Stage 4 House Ways and Means Committee Recommendations
Time Frame: Feb., March, April

House 1 is referred to the House Ways and Means Committee where each line item is analyzed. Public hearings are held in which testimony is taken from the Governor's staff, executive secretariats, departments, and any other interested parties. In April, a new version of the budget replaces House 1 and is traditionally given the label of House 5600.

Stage 5 The House "Passed" Version *Time Frame: early May*

The members of the House of Representatives take over by subjecting each line item in the budget to debate and amendments. The full House votes to pass a new version of the budget, traditionally known as House 5700.

Stage 6 Senate Ways and Means Committee Recommendations
Time Frame: early June

House 5700 is referred to the Senate Ways and Means Committee where hearings and testimony are held. Usually by early June a recommendation will be published and given to members of the Senate and interested parties. The Chairperson and members of the Committee will hold a press conference to address concerns with this new version of the budget.

Stage 7 The Senate "Passed" Version *Time Frame: middle of June*

The full Senate reviews each line item and section and subjects them to debate and amendment. Members of the Senate will then vote to pass the new updated budget.

Stage 8 Conference Committee *Time Frame: by June 30th*

A Conference Committee is created in an effort to resolve differences between the House passed version of the budget and the Senate version. Members of this committee include the chair of both Ways and Means Committees and ranking minority party members from both committees. The only budget information the Conference Committee can analyze is what survived from the House and Senate debates. Compromises are made on each line item by selecting either the budget amount from the House version, the Senate version, or a number in between the two versions. Finally, a new draft is created which must be ratified by both the House and Senate. If one branch does not ratify the budget it is sent back to Conference Committee for more work. Once the budget is ratified it is signed by the Speaker of the House and the President of the Senate. (An interim budget can be enacted by the legislature if the budget is late to allow the government to continue spending while the appropriation act is being finished.)

Stage 9 General Appropriations Act *Time Frame: within 10 day of receipt*

The Governor has 10 calendar days to decide his position on the budget. During this period the Governor may either sign the budget and approve as complete; veto selected line items (reduce to zero) but approve and sign the rest; or partially veto (reduce to a lower number) selected line items and approve and sign the rest. The legislature has the power to override a Governor's veto by a 2/3 vote in both chambers.

Legislative Appropriations, FY 1996

In House 1, the Governor requested a budget for the Department of Industrial Accidents totaling $17,505,987, a reduction of $43,874 from FY 1995 levels. The House of Representatives approved a budget of $17,549,861 (the FY 1995 appropriation) and the Senate approved appropriations totaling $17,360, 461. The final conference resolution appropriated $17,757,143, which was $251,156 more than the Governor's request.

The Department of Industrial Accidents' operating budget (to be spent from the Special Fund) has been appropriated as follows (round numbers):

FY 1991	$13.3 million
FY 1992	$14.6 million
FY 1993	$15.7 million
FY 1994	$17.2 million
FY 1995	$17.5 million
FY 1996	$17.8 million

Table 29: DIA Expenditures For FY'94 and FY'95

	FISCAL YEAR 1994				FISCAL YEAR 1995		
	Budgeted	Expended	Unexpended		Budgeted	Expended	Unexpended
AA	$ 11,091,871	$11,006,106	$ 85,765	AA	$ 11,653,759	$ 11,432,626	$ 221,133
BB	131,014	97,516	33,498	BB	136,711	112,775	23,936
CC	92,350	40,097	52,253	CC	77,475	53,129	24,346
DD	286,637	279,108	7,529	DD	396,682	239,041	157,641
EE	966,302	798,852	167,450	EE	770,850	685,877	84,973
GG	1,290,777	1,257,809	32,968	GG	1,321,720	1,295,214	26,506
HH	878,481	581,617	296,864	HH	1,214,925	853,818	361,107
JJ	800,097	712,484	87,613	JJ	1,007,336	896,481	110,855
KK	1,451,406	1,192,983	258,423	KK	718,703	690,023	28,680
LL	214,548	186,506	28,042	LL	270,575	173,113	97,462
	$ 17,203,483	$16,153,078	$ 1,050,405		$ 17,568,736	$ 16,432,097	$ 1,136,639

Budget Subsidiaries

Subsidiary AA: Regular Employee Compensation
This subsidiary includes regular compensation for employees in authorized positions including regular salary, overtime, and other financial benefits. All expenditures for this subsidiary must be made through the payroll system.

Subsidiary BB: Regular Employee Related Expenses
This subsidiary includes reimbursements to employees and payments on behalf of employees with the exception of pension and insurance related payments. This includes out of state travel (airfare, lodging, other); in state travel; overtime meals; tuition; conference, training, and registration; membership dues, etc.

Subsidiary CC: Special Employees/ Contracted Services
Payments to individuals employed on a temporary basis through contracts as opposed to authorized positions paid through subsidiary AA. (These employees are generally not eligible for benefits). Includes contracted faculty; contracted advisory board/commission members; seasonal; student interns, etc.

Subsidiary DD: Pension and Insurance-Related Expenditures
Pension and insurance related expenditure for former and current employees and beneficiaries. Includes retirement, health and life insurance, workers' compensation benefits; medical expenses; universal health insurance chargeback; universal health insurance payments, etc.

Subsidiary EE: Administrative Expenses
Expenses associated with departmental operations. Includes office and administrative supplies; printing expenses and supplies; micrographic supplies; central reprographic chargeback; postage, telephone, software, data processing; subscriptions and memberships; advertising; exhibits/displays; bottled water.

Subsidiary GG: Energy Costs and Space and Rental Expenses
Plant operations, space rentals, utilities, and vehicle fuel. Includes fuel for buildings; heating and air conditioning; sewage and water bills, etc.

Subsidiary HH: Consultant Services
Outside professional services for specific projects and for defined time periods, incurred when such services are not provided by, or available from state employees. Consultants advise and assist departments but do not provide direct services to clients. Includes accountants; actuaries/statisticians; information technology professionals; advertising agency; arbitrators; architects; attorneys; economists; engineers; health and safety experts; honoraria for visiting speakers; researchers; labor negotiators; management consultants; medical consultants, etc.

Subsidiary JJ: Operational Services
Expenditures for the routine functioning of the department. Services are provided by non employees (individuals or firms) generally by contractual arrangements, except when authorized by statute or regulation. Includes movers; snow removal services; messenger services; law enforcement (detail officer).

Subsidiary KK: Equipment Purchase
Purchase and installation of equipment. (See LL for equipment lease, repair). Includes information technology equipment (computers, software); educational equipment (overhead projectors, tape recorders); photocopying equipment, office equipment, etc.

Subsidiary LL: Equipment Lease-Purchase, Lease and Rental,Maintenance and Repair
Includes expenditures for the lease-purchase, lease, rental, maintenance and repair of equipment. Includes information technology equipment (computers, software); educational equipment (overhead projectors, tape recorders); photocopying equipment, office equipment, etc.

DIA ASSESSMENTS

To implement all of the objectives of the workers' compensation act, the legislature in 1985 developed a system for funding the DIA that relies on the collection of assessments charged to employers as part of their insurance premiums. In addition to these assessments, the DIA also derives revenue from the collection of fees (for various filing costs) and fines (for violations of the act).

Section 65 of the workers' compensation act sets forth the obligations of the DIA-- to make payments to uninsured injured employees, and employees denied vocational rehabilitation services by their insurers; and to reimburse insurers for benefits for second and latent injuries, injuries involving veterans, and for cost of living adjustments to benefits.

These obligations are paid out of the trust funds. One account is reserved for payments involving private sector employers (the private trust fund). The other is for payments involving public sector employers (the public trust fund).

In addition, section 65 requires that the DIA's operating expenses be paid from a special fund, which also derives its revenue from assessments charged to employers. The burden for funding the Special Fund is place solely on private employers, as it is the private employers assessments that include special fund levies.

The DIA is required to create a budget for the private and public trust funds, make assessments and disburse funds as obligations arise without appropriation from the legislature. DIA operating expenses paid from the special fund, however, must be appropriated by the legislature each year as part of the budget process.

The Advisory Council is required to review the trust fund budget. Upon the affirmative vote of at least seven voting members, the Advisory Council may submit its own estimate of the trust fund budget to the secretary of labor.

The Trust Fund Budgets

Every year costs must be anticipated for the private and public trust funds, as well as the special fund, so that appropriate assessments can be calculated to be charged employers. The budgets and the corresponding assessments must be submitted to the Executive Secretary of Labor by July 1 of each year.

Funds not disbursed in a given year may be carried over and disbursed in the next fiscal year. Section 65 does provide some guards against the "stock

piling" of assessment revenues. When either the private trust fund, the public trust fund or the special fund have a balance at the end of the fiscal year that exceeds 35% of the expenditures for the preceding fiscal year, that excess must be used to reduce the following year's assessments. In other words, any fund cannot carry forward a balance that is greater than 35% of the preceding year's expenditures. Nevertheless, an overage up to 35% can be maintained by that fund.

Fiscal Year 1996 - For several years, the department has contracted with the actuarial firm of Tillinghast to estimate the total amounts required by the special fund and trust funds starting July 1, 1995. Based upon these budgets, they must develop assessment rates to be charged to the employers of Massachusetts.

In June, 1995, Tillinghast conducted an analysis of anticipated expenditures for FY'96 for the trust funds. These projections were calculated according to actuarial principals by considering the rate of claims filed against the trust funds, past expenditures, anticipated legal developments, etc.

The following table sets forth the trust fund budget for FY '96, as well as what was budgeted in FY '95. For information on how much was expended by the trust funds in FY'95, refer to Collections & Expenditures Report, at Appendix D.

Table 30: TRUST FUND DISBURSEMENTS

Benefit	Amount Budgeted FY '96	Amount Budgeted FY '95
Second Inj. Fund (§37) Armed Services (§26) Armed Services (§37A) (Total)	$14.7M ($6.7M to pay pre-1985 §37 claims)	$8.0M
Uninsured Employers	$8.8M (all Private)	$9.0M
Voc. Rehab. (§30H)	$20,000 ($19,000-Private Trust) ($1,000-Public Trust)	$20,000
Latent Injuries (§35C)	$1.06M	$1.06M
COLA Payments	$18.3M ($14.4M-Private Trust) ($3.8M-Public Trust)	$16.1M ($13.2M-Private Trust) ($2.9M-Public Trust)
TOTAL	$42,900,000	$34,180,000

The operating expenses of the DIA (special fund budget) are to be added to the private employer trust fund budget to determine the amount to be assessed to private employers. The DIA directed Tillinghast to use a budget amount of $22.050 million for fiscal 1996. This amount includes salaries, fringe benefits, non-personnel costs and indirect costs.

According to Tillinghast, both the private trust and special fund balances as of 6/30/95 were in excess of $10 million-- enough so that the private employer assessments were reduced. This is in accord with section 65 mandates which avoid large carry-overs in the account from year to year. The 1996 private trust fund budget was reduced by $8M.

Tillinghast calculated the average 1996 private employer assessment rate to be 3.841% of standard premium. This represents a 21% increase from the 1995 private employer assessment rate of 3.176%. Thus, an employer's assessment increased by $6.65 for every $1,000 of premium. (For other assessment rates, including opt outs, see Assessment Rates at Appendix I.)

Costs Involving Staffing and Defense of the Funds - M.G.L. ch. 152, section 65(2) states that "[t]he reasonable and necessary costs of administering and representing the Workers' Compensation Trust Fund may be paid out, without appropriation, of said trust fund." Nevertheless, the trust fund budget does not account for these costs which include payment for the salaries and benefits of the trust fund employees, temporary employees, "03" consultants, defense costs (including IME's, travel, stenographers, expert witnesses, appeals fees, etc.).

It is unclear how these costs are accounted for in the assessments since they are not included in the trust fund budgets. Tillinghast stated that:

> *We have made no separate provision for costs associated with the defense of the trust funds. These costs, which represented approximately 3% of private fund expenditures in fiscal 1994, have instead been considered in our estimate of each of the cost components of the fund budgets. These costs have increased in both fiscal 1994 and 1995, suggesting that the potential savings associated with the 1991 reform legislation may not be realized for several years.*

Second Injury Fund Backlog - Over the years, concern has been expressed about assessments levied for section 37 (second injury) claims that were not paid by the DIA. Only since 1994 have any appreciable number of second injury fund claims been processed and paid by the trust funds, despite the fact that claims have steadily been filed and employers have been assessed for these projected payments. Much concern surrounding fiscal year 1996 assessments involved claims for second injury reimbursements pre-dating the 1985 reform act that were ordered to be paid by SJC in the Shelby Mutual case. The DIA plans to pay these claims over a three year period and has allocated $6.7 million in FY'96 for such purposes.

A backlog existed in the processing of post-1985 second injury fund claims, although it steadily declined over Fiscal Year 1995. Approximately $9 million was allocated to pay these claims.

Collections from Public Employers-- The Tillinghast report indicates that the DIA has done extremely well in collecting fees and fines owed (which are deposited into the special fund) and in collecting private employer assessments. These factors have created the necessity to adjust budgets and the assessments.

Nevertheless, the report indicates that the public trust fund had a shortfall in FY'95. According to the report, "the short fall in the public fund's cash flow is due to lower than expected assessments, which is inconsistent with the experience of the other two funds." Tillinghast suggests that the level of assessments collected from public employers may be the result of insufficient information on public employers, and perhaps a problem in the collections process. Several public entities are disputing their legal obligation to pay these assessments.

To fairly allocate the burdens of financing the workers' compensation system, it is critical that all eligible employers be identified, that assessments be calculated and charged to accordingly, and that appropriate action be taken to collect those amounts. With regard to any disputes, the act specifies that the commissioner "shall establish procedures for the review and adjudication of grievances by employers with respect to the propriety and accuracy of the assessed payment." (M.G.L. ch. 152, sec. 65(12) (1991)).

WORKERS' COMPENSATION TRUST FUND

Section 65 of the workers' compensation act establishes a trust fund in the state treasury to make payments to injured employees not covered by workers' compensation insurance and to reimburse insurers for certain payments under sections 26, 34B, 35C, 37, 37A, and 30H. The act goes on to direct the DIA to administer and represent the trust fund. The department has established procedures governing the administration and payment of trust fund claims at 452 C.M.R. 3.00. Moreover, Chapter 23E, section 10 directs the department's general counsel to be responsible for the investigation, defense and claims handling for claims against the trust fund.

The department has established a unit within the Division of Administration known as the Trust Fund to process requests for benefits, administer claims and respond to claims filed before the division of dispute resolution. The Commissioner has appointed a Deputy Director to manage the unit, as well as attorneys, accountants, claims adjusters, investigators, clerks, a paralegal and a registered nurse to administer the fund. In addition, the fund has seven consultants under contract. These employees work in conjunction with the five attorneys from the Office of Legal Counsel to administer the fund.[35]

Second Injury Claims (sections 37, 37A, and 26)

Reimbursement of payments to insurers who pay claims for "second injuries" was established early in the development of workers' compensation law. In an effort to encourage employers to hire previously injured workers, the legislature established a Second Injury Fund. It was recognized that many employers might refuse to hire disabled workers for fear that re-injury could expose them to severe losses. Since return to work is critical to workers' compensation, a system was designed to offset any financial disincentives associated with the employment of injured workers.

The Second Injury Fund functions as a reinsurance pool. Insurers are to make payments at the current rate of compensation to all claimants whether or not their injury was exacerbated by a prior injury. When the injury is determined to be a "second injury," insurers become eligible to receive reimbursement from the DIA's trust fund for a set proportion of the benefits paid. Employers theoretically are entitled to an adjustment to their experience modification factors as a result of these reimbursements.

§37A was enacted to encourage the employment of servicemen returning from World War II. The legislature created a fund to reimburse insurers for benefits paid for an injury aggravated or prolonged by a military injury. Insurers are entitled to reimbursement for up to fifty percent of the payments for the first

[35] Section 65 of the act specifies that the reasonable and necessary costs of administering and representing the Workers' Compensation Trust Fund may be paid out, without appropriation, of the trust fund.

104 weeks of compensation and up to one hundred percent for any amount thereafter.

Section 26 provides for the direct payment of benefits to workers' injured by the activities of fellow workers 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. (A negligible number of these claims are actually filed.)

Definition of Second Injury - An employee is considered to suffer a second injury when an on the job accident or illness occurs which exacerbates a pre-existing disability. How the preexisting condition was incurred is immaterial; the impairment may derive from any previous accident, disease, or congenital condition. The disability, however, must be "substantially greater"-- because of the combined effects of the preexisting impairment and the subsequent injury-- than the disability would have been from the subsequent injury alone.[36]

Reimbursement - The reimbursement rate has varied over the years, but was amended in 1991 to equal an amount up to 75% of all compensation paid. Insurers are eligible for reimbursement only for periods after the first 104 weeks of payment.

The source of the fund has varied over the years, but currently consists of assessments levied against employers as part of the DIA assessments. Originally, insurer assessments were the source of the fund.

Pre-1985 Claims - Historically the DIA underfunded the Second Injury Fund. From 1980 to 1985 SIF petitions filed totaled between $2.5 and $5 million, but the department only collected $1 million per year. At that time, assessments were levied against insurers to fund the Second Injury Fund. In 1985, with the passage of comprehensive workers' compensation reforms, the second injury fund was expanded to pay for all the objectives of the trust fund. The funding source was shifted from insurer based assessments to employer assessments. Many claims pre-dating 1985 went unpaid.

In May, 1995, the Massachusetts Supreme Judicial Court in Shelby Mutual v. Commonwealth of Mass. ruled that the Trust Fund could not escape liability for Second Injury Fund claims that pre-dated 1985. The Second Injury Fund was ordered to make back payments owed plus interest for second injury fund claims filed prior to 1985. The department estimates that approximately 1,400 reimbursement claims were filed under section 37 and 37A prior to 1985. The Trust Fund has made no payments on these claims to date.

In the wake of this decision, the department estimated that in FY'96 it could pay, through settlements, $8M in pre-1985 section 37 claims. According to the department, all such claims will be paid without interest by February of 1996, with no additional assessments anticipated.

[36] Mass. General Laws ch. 152, § 37 (1991).

Post-1985 Claims - From 1986 through 1991, insurers did not file many petitions for reimbursement of section 37 and 37A claims. It is estimated that perhaps two hundred claims were filed in that period. Those that were filed were not rigorously pursued by the insurance carriers.

Beginning in 1991 and 1992, insurers more readily filed Second Injury claims. It has been a matter of concern that second injury claims have languished and been ignored. At the close of FY'95, over 1,300 claims were pending under these sections. In 1994, initiatives were taken by the new Trust Fund director and Chief Legal Counsel to eliminate this backlog by vigorously pursuing settlements. A settlement mechanism was implemented allowing the department to close out cases, thereby avoiding costly future expenses.

In FY'95, the Trust Fund settled 312 section 37 and 37A cases for $8M. Within three years, it is expected that all outstanding claims in the backlog will be settled, withdrawn or litigated. According to the General Counsel, less than 15% of the Second Injury claims will remain open indefinitely, thereby eliminating 85% of the present §37 and 37A assessments from future fiscal years.

Uninsured Employers

Section 65 of the workers' compensation act directs the trust fund to pay benefits resulting from approved claims against Massachusetts employers who are uninsured in violation of the law. The trust fund must either accept the claim or proceed to dispute resolution over the matter. Every claim against the fund under this provision must be accompanied by a written certification from the department's Office of Insurance that the employer was not covered by a workers' compensation insurance policy on the date of the alleged injury, according to the department's records.[37]

In FY'95, $7.5 million was paid to uninsured claimants, down from $8.2 million in FY'94. According to the General Counsel, this reduction in payments represents the department's aggressive affirmative litigation strategy, the use of criminal complaints against employers under section 25C, and improved defense and claim handling practices.[38]

Vocational Rehabilitation (section 30H)

Section 30 H provides that if an insurer and an employee fail to agree on a vocational rehabilitation program, then the Office of Education and Vocational Rehabilitation (OEVR) shall determine if vocational rehabilitation is necessary and feasible to return the employee to suitable employment. If OEVR determines that vocational rehabilitation is necessary and feasible, it will develop a rehabilitation program for the employee for no greater than 104 weeks' duration. If the insurer refuses to provide the program to the employee, the cost of the program will be paid out of the Section 65 trust funds. If, upon completion

[37] 452 C.M.R. 3.00

[38] The trust fund realized approximately $2,6 million of recoveries and repayment agreements which has reduced the net cost of uninsured claims to $4.9 million.

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.

Payments made by the trust funds decreased significantly in FY'93 and subsequent years. In FY'95, $9,276 was paid for rehabilitation services (See OEVR, page 60). The DIA started collecting penalties under section 30H in FY'92, and as of March 31, 1995 $124,000 has been received from insurers.

Latency Claims (Section 35C)

Section 35C provides that benefits payable under sections 31, 34, 34A and 35 for injuries where there is at least a five year difference between the date of injury and the date of benefit eligibility will be based upon benefit levels in effect on the date of eligibility. The trust fund will reimburse the insurer or self-insurer for "adjustments to compensation" pursuant to section 35C.

While it would be expected that a number of these claims would be presented each year, through FY'92 there were no trust fund payments identified as being associated with section 35C. In FY'95, approximately $1.5 million in reimbursements were paid as latency claims, representing about 50 latency claims for the fiscal year.

Cost of Living Adjustments (section 34B)

Section 34B provides supplemental benefits to any person receiving or entitled to receive benefits under section 31 and section 34A, whose date of personal injury was at least 24 months prior to the review date. The supplemental benefit is equivalent to the difference between the claimant's current benefits and his/her benefit after an adjustment for the change in the statewide average weekly wage between the review date and the date of injury.

Insurers pay the supplemental benefit concurrently with the base benefit. They are then entitled to quarterly reimbursements for the supplemental benefits paid on all claims with dates of injury occurring prior to October 1, 1986. For injury dates subsequent to October 1, 1986, insurers will be reimbursed for any increase in supplemental benefit payments that exceed 5% annually. COLA payments for FY'95 totaled $1,514,040 for the public trust fund $12,865,203 for the private fund.

OFFICE OF HEALTH POLICY

The commissioner is charged with ensuring that adequate and necessary health care services are provided to the state's injured workers. Specifically the commissioner is charged with monitoring health care providers for appropriateness of care, whether 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 (see appendix G for current members).

Commissioner Campbell created an Office of Health Policy (OHP) to address the health care related issues undertaken 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). In addition, the OHP had 4 employees and 26 consultants.

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. 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.

Complaints Against Providers - HCSB is required to accept and investigate complaints from employees, employers and insurers regarding the provision of health care services. Such complaints include 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, HCSB is required to refer its findings to the appropriate board of registration.

IME Roster Criteria - 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).* HCSB issues criteria 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.

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 HCSB, including appropriate parameters for treating injured workers. HCSB has an advisory group on treatment guidelines and specialists to work in sub-groups to develop guidelines in specific areas.

HCSB has published twenty-five treatment guidelines covering many conditions common to workers' compensation patients. 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.

HCSB is required to conduct an annual review of the guidelines and update them based on the experience of the year. They continued to develop three new treatment guidelines on chronic pain, chronic injury, and asthma.

Utilization Review

According to the department's 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.

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.

During FY'95, the department drafted revised Utilization Review and Quality Assessment Regulations (452 CMR 6.00). The new regulations would require workers' compensation insurers to conduct Utilization Review and Quality Assessment; follow the Health Care Services Board Treatment Guidelines and Review Criteria when delivering health care services; and define the requirements for development and employment of internally derived treatment guidelines and review criteria where those published by the Health Care Services Board do not apply.[39]

Trending and Tracking 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

[39] On October 2, 1995, the department held a public hearing on the regulations.

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."[40]

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'95, 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 the next five 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.

Specifications for an RFP continued to be drafted in FY'95, for release in early FY'96.

Patient Satisfaction Survey

In accordance with 211 CMR 112.06 (3) the Commissioner of Insurance may conduct an ongoing review of Preferred Provider Arrangements (PPA's), including surveys of employees covered by these arrangements.[41] In FY'95 the department worked together with the Division of Insurance in an effort to design a patient satisfaction survey to measure injured workers' experiences with Preferred Provider Arrangements. Although the survey is aimed at the satisfaction of injured workers, it also has the dual purpose of analyzing whether PPA's are providing adequate education to subscribers who must proceed through an often confusing process. According to Massachusetts law, workers' compensation insurers may require that injured employees schedule their first

[40] M.G.L. ch. 152, sec. 13.

[41] The Commissioner of Insurance is required to license and monitor preferred provider arrangements pursuant to M.G.L. ch.152, §30 (1991) and 211 CMR 112.00.

scheduled appointment with a provider who is part of their PPA network. However, the law also allows the injured employee to select any provider after the first scheduled visit, or any provider from a specialty who is not on the PPA list. Results from the survey will display whether or not workers' compensation patients tend to stay with their original physician from the first scheduled visit.

The survey is currently undergoing revisions, and is expected to be sent out in FY'96.

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.

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.

Resources of the Offices

Each of the regional offices, except Fall River, has moved to expanded and enhanced office space within the last five years. Requests for proposals were issued to procure office space in the southeastern Massachusetts region. Proposals were received, and ten sites were visited by the department and the Division of Capital Planning and Operations (DCPO). A preferred site was identified and the department is in the midst of negotiating terms to fulfill the specifications of the request for proposals.

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.

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
508/753-2072
Leonard Gabrila, Manager

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'95, the insurance market improved dramatically with a rate reduction after 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 family businesses employing family members. 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.[42] The Workers' Compensation Act (M.G.L. Chapter 152) is elective for all municipalities, counties, towns, and school districts. 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 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.[43]

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 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.

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[42] M.G.L. c. 152 §25B

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

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.

The Commercial Insurance Market

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 within appropriate classifications 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 defend against the claim 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 1995 the residual market comprised 35% of the overall market. This is still a high percentage but an improvement from previous years.

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.[44]

The residual market load 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 1994 the burden was zero. In the past, the burden was a positive number which would in fact reimburse companies for a positive profit in the pool.

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.[45]

In 1992, 64.7% of every premium dollar was written in the residual market. Since that time the residual market has been declining. It is estimated that for 1995, the residual market was at or below 35% of total premium, indicating a much healthier and improved insurance system.[46]

Table 31: Massachusetts Workers' Compensation Residual Market Information

Policy year	Loss Ratios (@ 6/30/95)	Residual Market Burden* (@6/30/95)	Calendar Year	Market Share
86	134.6%	-20.7%	86	20.4%
87	155.2	-33.7	87	25.0
88	143.8	-35.7	88	29.5
89	144.0	-56.4	89	40.1
90	110.0	-42.6	90	46.3
91	71.0	-5.0	91	50.7
92	56.0	40.5	92	64.7
93	55.0	26.7	93	61.0
94	72.0	0.0	94	47.7

Source: National Council on Compensation Insurance

* Per dollar of voluntary assessable premium

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

[44] 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.

[45] National Council on Compensation Insurance

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

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.

Large and Small Deductibles - Available since 1991, large deductible policies can provide the advantages of a retrospective policy and self insurance. They can also save on premium payments, increasing the up front cash flow for an employer. A typical policy with a $5,000 per claim deductible will experience 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 can reduce the amount employers pay in insurance premiums, some employers with small deductible policies are concerned with the effect deductibles can have on their experience modification. 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 concerns because they are virtually self insured and are not affected in their experience modification factor.

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.[47]

Retrospective Rating Plans - Controlling the costs of workers compensation is in the interests of both employers and insurance companies. One measure of controlling costs that has become increasingly popular in Massachusetts is retrospective rating. Retrospective rating is an insurance rating system that bases premiums upon the insured's actual incurred losses after a policy period. With this type of system the insured is given direct control of insurance costs by monitoring and controlling its own loss experience. Retrospective rating is often confused with "experience rating" since both adjust the premium based on an employer's history. The main difference between the two is that experience rating adjusts premiums at the start of the policy period, whereas, retrospective rating adjusts premiums at the end of the policy period. In other words, experience rating tries to predict future costs while retrospective rating responds to the costs of past losses.

Although retrospective premiums are determined by complex formulas, they are generally based upon three factors: losses the employer incurs during a policy period, expenses that are related to the losses incurred, and a basic premium. Incurred losses have historically included both medical and indemnity losses, interest on judgments, and expenses incurred in third-party recoveries.[48] A basic premium is necessary to defray the expenses that do not vary with the losses incurred and to provide the insurance company with a profit. In order to control the cost of the premium in extreme cases it cannot be less than a specific minimum and cannot exceed a stated maximum. The standard formula used when deciding a premium is equal to the basic premium plus converted losses multiplied by the tax multiplier. The tax multiplier is determined by the combined charges for insurance company licenses, premium taxes, assessments, assigned risk surcharges, second injury fund assessments, and residual market loads.[49]

Retrospective rating plans were not designed for all businesses as eligibility is based upon a standard premium. In 1994, eligibility for a one year plan in the US was an estimated standard premium of at least $25,000 per year. For a three year plan the estimated standard premium was at least $75,000.[50] Although these eligibility standards count out many small businesses, one of the biggest misconceptions is that retrospective plans are only for large employers and high risk groups. In Massachusetts more small employers are purchasing retrospective plans in an effort to lower premiums by controlling company losses.

Under the right circumstances, retrospective rating can benefit both the insurer and buyer of insurance. Since the cost of the premium is determined by past work history, retrospective plans reward those businesses that maintain effective loss control programs. If losses are low, the insured will pay less than

[47] Interview with Paul Meagher and Howard Mahler, The Massachusetts Workers' Compensation Rating and Inspection Bureau, February 24, 1994.
[48] "Retrospective Rating," Risk Financing, Supplement No. 46, May 1995: III.D.7.
[49] Richard Carris, "The Mathematics of Retros," CPCU Journal, Vol. 46, No. 1, March 1993: 38-39.
[50] "Retrospective Rating Plans," Fire Casualty & Surety Bulletins, Sept. 1994.

what other rating systems would have allowed. Furthermore, retrospective rating provides an incentive to businesses to create safety programs which could lower premium costs. Advantages can also be seen from the insurer's standpoint since a poor loss experience obligates the insured to pay a greater premium. The insurance company also benefits when premiums are low because that means a business is controlling losses.

On the other hand, retrospective rating has many disadvantages to other insurance rating plans. To begin with, there is always going to be uncertainty regarding what the final premium will amount to since companies cannot predict the volume or severity of workplace accidents. Another disadvantage is that when a company joins a three year plan and has two good years of loss experience, the premium could still be high if there is one bad year. Finally, retrospective rating plans have a lower profit margin than with other plans an insurance company could supply.[51]

On April 1, 1995 Massachusetts added greater flexibility to the Retrospective Rating One Year Plan and Three Year Plan. Although the reform will have no impact on premiums, it will increase the availability of coverage. Reform efforts like these will only enhance the competitive market by allowing consumers a greater choice among rating options.

Premium Discounting - Insurance companies that provide workers' compensation insurance must factor in the various expenses of servicing policies to determine appropriate premium levels. However, a problem occurs for the insurance company when pricing premiums for large policy holders because as the premium increases, the proportion required to pay expenses decreases. In an effort to compensate for these differences, insurance companies often provide a premium discount to policy holders. The premium discount increases as the size of the policy premium increases, resulting in a premium that better reflects costs. In most states, policy holders are entitled to a premium discount if their paying over $5,000 in premiums.[52]

Dividend Plans - Insurance companies are constantly competing against one another to capture the workers' compensation market. One traditional method of competition is by offering employers dividend plans. A dividend plan can give the policy owner a partial return on a premium that was previously paid. This payment from the insurer takes into account investment income, expenses, and insurer's overall loss-experience in a given year. The dividend is usually paid to the policy owner in either cash or by applying it to the payment of future premiums due. Regardless of how the payment is issued, dividends are non-taxable since they are considered to be a return of a premium.[53]

Dividend plans may seem attractive to policy holders, but often they are deceiving. One problem that policy holders can face is that dividends promise more then they can deliver. Insurer's are not legally bound to pay what they may

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[51] Claude C. Lilly III, "Retrospective Rating: Pitfalls for Insurers to Avoid," CPCU Journal, Vol. 44, No. 4, Dec. 1991: 220.

[52] "Workers Compensation Insurance General Rules," International Risk Management Institute, February 1992: I.K.1.

[53] "Risk Management-Life, Health, and Income Exposures," Life Insurance, Part 4: 406.

have estimated a policy holder's return to be. To further complicate things, many insurer's strategically calculate a dividend only once between 18 and 24 months after a policy's inception, and not always to the advantage of the insured.[54]

Captive Insurance - As insurance rates fluctuate and annual premiums become harder to predict, many companies look for alternative risk management and risk financing tools. In an effort to control one's own destiny, companies often turn to captive insurance as a cost-saving alternative to the traditional insurance markets. The general idea behind a captive is that it allows non-insurance organizations to "create" and run their own insurance company to insure the risks of their shareholders.[55] Although captives are arguably just another form of self insurance, they are treated by the government as an insurance business and are subject to the same regulations.

Captives have historically been attractive to large multi-national firms whose financial strength and asset base is able to offset the expensive financial requirements of running an insurance company.[56] In fact, a company that wants to form it's own captive must be willing to invest the standard benchmark of about a million dollars in capital. The first initial years of a captive tend to be more expensive since re-insurance must be purchased to cover the possibility of a "bad" year. However, once a captive matures, re-insurance is no longer necessary since a poor loss experiences can be covered. Since captives are not economically feasible for smaller companies, they can enjoy the same benefits by joining together to form a group captive. A group captive can avoid the expense and burdens that go along with forming a captive since the risks and costs are spread out among it's members.

There are many reasons why a company might choose captive insurance as an alternative to traditional insurance. For starters, captives can fill the gap caused from lack of coverage in the traditional market. Often, as in the case of workers compensation, insurance companies refuse to write policies to companies that are considered "high risk" and prone to heavy losses. A captive, on the other hand, allows a company to insure their own risks while providing incentives for cost control measures and safety programs. Captives can also provide a company with greater control over it's insurance program by allowing it to bypass the uncertainty of hard and soft insurance markets that can lead to unpredictable premium rates.[57]

For many years, insurance companies have generated large underwriting profits by including investment income in their pricing of workers' compensation premiums. Furthermore, when insurance companies create a premium they are only guessing the costs of future losses which often results in overpricing during positive loss-experience years. Captives can recapture these underwriting profits that are otherwise earned by conventional insurers and produce considerable savings.[58]

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[54] "Thinking About the Work Comp Crisis," Merrit Risk Management Review, December 1991: 3.
[55] The Captive Insurance Manual, NILS Publishing Co., vol. 1, 1995 revision: 3.
[56] "Combined WC/EB Captives-Challenge With A Pay-Off," The Journal of Workers Compensation, September 26, 1994: 38.
[57] "When to Form a Captive," Risk Management, November 1, 1994: 73-74.
[58] Ibid.

Captive insurance is not for everyone. Often a company must invest a large portion of their assets when forming their own captive. In order to avoid the burdensome expense associated with forming a captive, many companies choose to rent a portion of another captive's holdings. This rent-a-captive system has much of the same benefits a captive is entitled to, yet costs individual companies much less. A downfall of the rent-a-captive system is that participants can become vulnerable to the losses of other members in the captive.[59]

The recent growth of captives in the United States has enhanced and diversified the insurance market. Captives now represent over one-third of commercial line business in the U.S. and take in over $60 billion in premium volume annually.[60] In fact, captives are now considered to be the second most common choice in the alternative market next to self-insurance.[61] Vermont has clearly set the pace in the captive industry as a result from a flexible regulatory environment, lower premium taxes, and a quality infrastructure.[62] Success in other states will solely depend upon the ability of governments to provide adequate incentives for captive formation.

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

See section on *DIA - Office of Insurance* for fiscal year 1995 statistics on self insurance.

[59] "Captive Plan Designed To Cut Workers' Comp. Costs," National Underwriter, November 28, 1994: 12.
[60] "Captive Market Matures: Growth Ahead?," Risk Management, August 1, 1995: 14.
[61] Ibid.
[62] "When to Form a Captive," Risk Management, November 1, 1994: 73-74.
[63] 452 C.M.R. 5.00: Code of Massachusetts Regulations concerning insurers and self insurers

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.*[64]

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 April, 1995, the number doubled to 33 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 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.

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

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.

1995 Rate Filing - On February 15, 1995, the commissioner of insurance approved an agreement[65] on workers' compensation insurance rates effective January 1, 1995, at levels on average 16.5% less than those for 1994. This marked the first rate reduction in over twenty years.

[65] 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.

The following chart displays the average rate changes for general classifications effective January 1, 1995:

Table 32: Average Rate Changes for General Classifications

Effective: Jan. 1, 1995	Manufacturing	Contracting	Office and Clerical	Goods and Services	Misc.
Average Rate Change	-17.9%	-15.6%	-9.1%	-15.3%	-24.3%
Maximum Rate Increase	2.3%	4.6%	11.0%	4.8%	-4.0%
Max. Rate Decrease	-28.4%	-27.2%	-24.0%	-27.1%	-31.5%

Rate Stabilization

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

One of the foremost concerns 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. From the insurers perspective, however, rates were inadequate and costs exceeded revenues received 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 insurance premiums (this does not take into account costs for self insurers or SIGs). The Massachusetts Taxpayers Foundation (MTF) released a study called "An Economy in Transition: Reducing the High Cost of Doing Business in Massachusetts" in September, 1995. The report was designed to compare Massachusetts with other states in regard to six key business costs: health care, electricity, manufacturing wages, unemployment insurance, workers' compensation and corporate income taxes.

Workers' Compensation Costs - The MTF report compared the costs of workers' compensation by examining insurance rates on a state-by-state basis. A 1993 study revealed that premium rates in Massachusetts were 14th highest in the nation and 13 percent above the national average. However, as of January 1, 1995 premium rates were only 2.8 percent above the national average and ranked 19th in the nation. As a result, Massachusetts can now be categorized as an "average cost" state.

The state with the highest net insurance costs was Maine, which was 86 percent above the national average. Both Rhode Island and New Hampshire were also above the national average by 46 and 20 percent respectively. However, Vermont and Connecticut had costs just below Massachusetts. Of the

seven competing industrial states four had higher costs then Massachusetts (New York, Michigan, Pennsylvania and Florida). Costs in New Jersey an Illinois fell just below Massachusetts. Among the high technology states both Texas and California had higher costs than Massachusetts, but North Carolina and Maryland fell well below the national average.

MTF analyzed workers compensation benefits by comparing statutory benefits on a state-by-state basis. Statutory benefits can be defined as the payments required by statute for a given injury type. As of January 1995, Massachusetts ranked 6th highest for average statutory benefits. Although this figure is high, payments to disabled workers in Massachusetts has actually declined. According to the MTF report, this is a result of better administration of the statute and fewer people staying in the workers' compensation system.

The MTF report also addressed the issue of benefits paid and benefit costs to workers in Massachusetts. Benefits paid includes all payments made in a calendar year on open claims. Benefit costs are the actual premiums paid by employers. Between 1992 and 1993, benefits paid to workers in Massachusetts declined by 19 percent. This decrease was higher than 43 other states. The average benefit costs per employee also declined between 1992 and 1993 by 20 percent (from $554 to $442). As of 1993, Massachusetts was ranked 18th in the country according to benefit costs, which is five percent below the national average of $466. On average, New England states spent $522 per employee, 18 percent more than Massachusetts. According to MTF President Michael J. Widmer, workers' compensation is now at a competitive level which "clearly results from the reforms of 1991."

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. In 1995, rates again dropped an average of 16.5%. 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 from 1991 through 1994 and it has been a priority to lower this percentage. Estimates for 1995 show that the percentage may be at or below 35% of total premium, still a large percentage.

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.

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'95, the DIA's private trust fund spent $7.5 million on benefits for employees who were working for uninsured employers, down from $8.2 million in FY'94. All employers in the state must pay for these employees as the trust fund is maintained by assessments on all employers.

The DIA is "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 Commonwealth to detect, prevent and refer for criminal prosecution suspected fraudulent insurance transactions involving all lines of insurance. It was created originally on behalf of automobile insurers in 1990 (M.G.L. ch. 338) and further amended in 1991 to include workers' compensation.[66] While its mission statement is to include all lines of insurance, the focus is on automobile and workers' compensation insurance and it is funded by those two industries.

The IFB's 1994 annual report documents the progress of the Bureau since its inception.

The Investigative Process

Referrals - Cases of suspected fraud for all types of insurance are referred to the IFB either through an insurance carrier or through a toll-free hotline (1-800-32FRAUD). For fiscal year 1994, 2,039 cases were referred to the IFB. This is a decline of 4% from 1993 levels. As in other years, the majority of referrals come from insurance carriers (which in FY'94 represented 1,224 referrals). This is a decline of 9.6% from 1993 in which insurance carriers referred 1,354 cases.

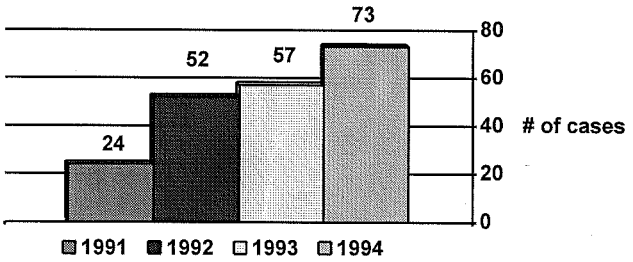
Evaluation - Once a referral is received by the IFB, an investigative staff has 20 working days to evaluate a suspected fraud case. During this time period, status letters are sent to the insurance companies indicating whether the case was referred to another agency or accepted for further investigation. A backlog had existed in investigations at this initial stage. In FY'94, however, the IFB continued to reduce the backlog of referrals pending an evaluation by 57% (pending referrals from December 31, 1994 versus 1993). From the 1,224 referrals in FY'94, 870 were accepted for further investigation.

Assigned Cases - Once resources become available, a referral is assigned to an investigator and officially becomes a "case". In FY'94 a total of 389 new cases were assigned to investigators.

Prosecution - After an investigator has completed their work on a case, it is either referred to a prosecutor (primarily the Massachusetts Attorney General's office), transferred to another agency, or closed due to lack of evidence. In FY'94, a total of 73 cases were referred to a prosecutor. This is an increase of 28% over 1993 levels. This total includes a continued increase in the percentage of workers' compensation cases referred for prosecution.

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

Figure 16: Cases Referred to a Prosecuter



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. The majority of IFB investigations, however, involve employee misconduct. IFB personnel investigated the following types of workers' compensation fraud in 1994:

> Cases involving avoidance fraud for allegedly underestimating employee payroll; misrepresentation of job classifications; falsely reporting the number of employees on payroll; subjects who worked for other employers while collecting workers' compensation benefits; falsely reporting job-related injuries that actually occurred away from the job-site.

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 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.

Attorney General's Office

The attorney General's Office is responsible for the enforcement of the state's insurance fraud laws. The Office has a total of four assistant AG's paid by the IFB whose sole responsibility is the prosecution of fraud. The AG's office receives referrals of suspected fraud cases from the IFB and also investigates "tips" from the public. Since the reform act of 1991 when the perpetration of workers' compensation fraud was made a specific crime, the Attorney General has convicted or procured indictments in 45 separate cases.

The Attorney General will launch a program in the district courts of the Commonwealth to contract workers' compensation and auto insurance fraud during FY'96.

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 1995, fifty-nine bills were filed by legislators seeking to amend the workers' compensation system and considered by the Joint Committee on Commerce and Labor. Proposals ranged in scope from deregulating the rate making process for workers' compensation insurance, to establishing a code of judicial conduct for DIA judges, to establishing an self insurance guarantee fund, to restoring benefits to pre-1991 levels, to reconfiguring the DIA dispute resolution system. Five bills were late files and were not considered by the committee in the fiscal year.

This year the legislature withheld from enacting any of these bills.

After receiving testimony on April 5, 1995, the Joint Committee reviewed all bills relative to the workers' compensation system in executive session. Five bills were reported to the Clerk of the House of Representatives with the rating "ought to pass." Two bills were reported with the unfavorable rating, and five were extended for further consideration. The rest were placed in "study."

For a list of members of the Joint Committee on Commerce and Labor see appendix J.

Bills with a Favorable Rating

Old Age Benefits - Under §35E, employees who are 65 years old or older cannot receive workers' compensation benefits if they have been out of the labor force for two years and are eligible for old age benefits (social security, private or public pensions), unless they can prove they would have remained in the labor force had they not been injured.

H. 1061, filed by Rep. Brewer would bring this section into conformity with federal prohibitions against age discrimination by removing the requirement that the employee be 65 years old or older. Any employee, regardless of age, would be ineligible to receive workers' compensation benefits if they have been out of the labor force for two years and are eligible for old age benefits (social security, private or public pensions), unless they can prove they would have remained in the labor force.

Code of Judicial Conduct - H. 1065, filed by Rep. Cabral would subject the AJs, ALJs and Senior Judge to the terms of the Code of Judicial Conduct.

The cannons of the code are:

1. A Judge should uphold the integrity and independence of the judiciary.
2. A Judge should avoid impropriety and the appearance of impropriety in all his activities.

3. A Judge should perform the duties of his office impartially and diligently.
4. A Judge may engage in activities to improve the law, the legal system, and the administration of justice.
5. A Judge should regulate his extra-judicial activities to minimize the risk of conflict with his judicial duties.
6. A Judge should regularly file reports of compensation received for quasi-judicial and extra-judicial activities.
7. A Judge should refrain from political activity.

Nominating Panel - H. 1073, filed by Rep. Kennedy, would eliminate the requirement that one of the 11 members of the industrial accident board nominating panel be "an attorney who does not practice workers' compensation law." This bill would replace this member of the panel with two attorneys; one who represents claimants before the board and another who represents employers or insurers.

Advisory Council - H. 4058, filed by Rep. Bosley, would require the 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.

Health Care Services Board - S. 35, filed by Sen. Berry, would add one person representing occupational therapists and another representing an occupational health nurse to the membership of the Health Care Services Board at the Department of Industrial Accidents.

Bills Extended for Further Consideration

Self Insurer Guaranty Fund - H. 1791, filed by Rep. Bosley, would require the DIA to authorize a private entity to administer a guaranty fund for self insurers to provide an adequate proof of financial reserves to pay workers' compensation benefits when the self insurer fails to meet its workers' compensation benefits obligations. Currently, workers' compensation trust fund liable for benefits when the self insurer is inadequately funded.

Subcontractors - H. 1794, filed by Rep. Hynes, would allow certain contractors to be excluded from the requirement of obtaining workers' compensation insurance in the hiring of subcontractors. The bill would exclude from the definition of "employee" any subcontractor who enters into a residential contracting contract with a residential contractor provided that the contractor informs the sub in writing that he does not provide workers' compensation insurance, and that the subcontractor signs a notarized statement that he enters into the subcontract freely accepting the condition of no workers' compensation insurance and waives any right to legal action pursuant to ch. 152.

Rate Setting Commission/Physicians Fees - H. 3088, filed by Rep. Serra, would strike from the workers' compensation act the ch. 398 requirement that insurers shall not be liable to pay higher rates for health care services regardless of where the services are performed (e.g., insurers are not required to pay a rate in excess of the rate established by the rate setting commission merely because it is performed in a hospital setting.)

H. 3088 would allow insurers to be liable for payments higher than those set by the rate setting commission for services performed in a hospital.

Section 28/Employer Willful Misconduct - S. 63, filed by Sen. Leahy, would allow an injured employee to sue the employer at common law if the employer is acting in some capacity other than as employer (e.g., employee staying in employer owned housing). The bill would also allow an employee to sue employer at common law for serious and willful misconduct.

Competitive Rating - H. 4047, filed by Rep. Bosley, would institute a system of competitive rating of workers' compensation insurance premiums.

In Massachusetts the current practice for issuing rates on workers' compensation insurance requires that WCRB (the sole licensed rating organization for workers' compensation in Massachusetts) submit to the Commissioner of Insurance its classification of risks and premiums in the form of a rate filing. This must be filed at least every two years.

The Commissioner of Insurance must provide for equitable distribution of premium among employers paying higher than average wages and those paying lower than average wages. The rates cannot take effect until the Commissioner of approves them as not excessive, inadequate, or unfairly discriminatory, and within a range of reasonableness. The rates must remain in effect for 12 months.

Any insurance company may request permission to use, in place of premium rates approved, a percentage decrease from approved rates uniform within any classification.

Several states, however, have enacted "competitive rating" laws that require each insurance company to prepare its own workers' compensation rates and allowing their use without first obtaining state approval. A bill has been filed to replace the current "Prior Approval" system in Massachusetts with "Competitive Rating."

In the proposed bill, the rating organization (WCRB) would file with the Commissioner of Insurance an advisory filing that includes only *pure premium*. Pure premium is a measure of "loss costs" which are benefits and loss expenses paid by an insurance company to settle workers' compensation claims. This information attempts to estimate what the expected losses will be for the coming year based on the actual losses incurred in recent years. It also includes expectations regarding trends or changes in benefit structures and economic conditions. The bill would prohibit the filing from including provisions for expenses, loss adjustment expenses, taxes and profit. (Currently expense

provisions and reasonable profit is included in the WCRB's filing.) The bill would also require that a rating organization develop a uniform classification system and uniform experience rating plan to which every insurer must adhere.

Under the proposed competitive plan, each insurer would file its own rates and classifications with the Commissioner of Insurance. Each insurer would utilize the advisory filing of the WCRB. The classifications of employers could differ, but the insurer would be required to adopt the uniform experience rating plan filed by the WCRB. The insurer would have to specify its allowances for expenses, loss adjustment expenses, taxes, contingencies, dividends and profits. It is the pricing of these costs that would create the competition between the insurance companies. To the extent that these costs could be kept at a minimum by a given insurance carrier, insurance rates could be priced lower than another carrier with higher expenses.

All filings by the insurance companies would be submitted to the Advisory Council.

The filing would have to be submitted at least thirty days before being used by the insurer. The Commissioner of Insurance could disapprove rates only if determined after the hearing that they "would tend to impair or threaten the solvency of an insurer, are unfairly discriminatory, or would create a monopoly in the market, based upon relevant tests of workable competition pertaining to market structure, and market conduct." (Currently, for rates to become effective they must be approved by the Commissioner of Insurer as "not excessive, inadequate, or unfairly discrimination for the rates to which they respectively apply, and as within a range of reasonableness." Also, the Commissioner of Insurer has six months to act on the filing.)

The WCRB would be required to file rates for the assigned risk pool in the same manner as required of all other insurers. The Commissioner would be required to approve the assigned risk pool rates so long as they are "not excessive, inadequate or unfairly discriminatory for the risks with which they respectively apply, and as within a range of reasonableness." The rates would be required to fully take into account the additional risk of doing business in the pool, and reflect the experience of the pool to the extent it is actuarially appropriate. Any insurer writing workers' compensation insurance in Massachusetts would be required to be a member of the pool.

Proposed **(Competitive Rating)**	**Current** **(Prior Approval)**
Advisory Filing by Rating Organization followed by individual insurance carriers filing own rates.	Uniform filing by Rating Organization. (Individual insurers may submit own filing according to same specifications.)
Rating Organization submits ***advisory filing*** based on **pure premium/loss costs***. Cannot contain provisions for: • expenses • loss adjustment expenses • taxes • profit **Benefits and loss adjustment expenses paid by insurers to pay w/c claims.	Rating Organization submits ***uniform filing*** for all carriers based on **pure premium/loss costs***, **expenses** and **reasonable profit.** Cannot contain provisions for: • dividends • unabsorbed premium deposits • excessive expenses and agent/broker commissions **Benefits and loss adjustment expenses paid by insurers to pay w/c claims.
Insurer files for own rates. Must specify allowances for: • **expenses** • **loss adjustment expenses** • **taxes** • **contingencies** • **dividends** • **profit**	N/A
Insurer can implement new rates and wait for Insurance Commissioner to disapprove them.	Insurer must continue to use old rates until Insurance Commissioner approves new rates. Individual insurance carriers may apply for permission to use a percentage decrease from premium rates.
Insurance Commissioner can deny individual carrier rates only if they would tend to impair or threaten the solvency of an insurer, are unfairly discriminatory, or would create a monopoly in the market.	Insurance Commissioner must approve rates if they are found to be not excessive, inadequate, or unfairly discriminatory, and within a range of reasonableness.

Late File Bills

The following bills were filed after the deadline, and were not assigned to the Commerce & Labor Committee in time for the legislative hearing on April 5th.

§ 24 / Employee's Right to Sue at Common Law - Sen. Swift introduced S. 2012 and S. 2013 to amend section 24 of the workers' compensation act, which prohibits employees from suing their employers in court for damages relating to personal injuries incurred on the job.

On December 14, 1993, at Simon's Rock College in Great Barrington, Massachusetts, a student went through the campus on a shooting spree with a

semiautomatic weapon. He killed and injured several students and college employees. One employee was shot at close range, but survived the attack. She has sought to recover damages in a personal injury lawsuit against the college on the grounds that school officials knew or should have known of the student's propensity for violent behavior and knew or should have known of his possession of a deadly weapon, and failed to act. Her suit has been barred under the "exclusive remedy" doctrine of the workers' compensation act.

According to section 24, an employee is considered to have waived his or her right of action at common law to recover damages for personal injuries unless the employee has given written notice that he or she claimed such right to the employer at the time of contract of hire. This provision is at the crux of the workers' compensation system, as employees were deemed to have been granted guaranteed and fixed benefits in exchange for relinquishing their right to sue at common law.

S. 2012 is the more expansive of the two bills filed. This bill would specify that any employee whose injury was caused by assault and battery by means of a dangerous weapon would be allowed to bring suit in a court of law, in addition to collecting workers' compensation benefits.

S. 2013 would specifically allow any employee of Simon's Rock College who suffered injury as a result of assault and battery by means of a dangerous weapon to file suit against the college in addition to collecting workers' compensation benefits. The committee, in executive session, voted to hold these bills for further consideration.

Extension of Health and Welfare Benefits - H. 4139, filed by Rep. Brewer on behalf of the AFL-CIO, would require any employer that provides accident, health and life insurance coverage or makes contributions to an employee welfare fund for any employee, to continue to provide such benefits while the employee is eligible to receive workers' compensation or is on sick leave for a work related injury.

In District of Columbia v. Greater Washington Board of Trade, 113 S.Ct.580 (1992), the U.S. Supreme Court struck an identical piece of legislation enacted in Washington, D.C. According to the Supreme Court the legislation in question impermissibly sought to regulate health benefits that "relate to" ERISA covered benefits, and as such were preempted by federal law.

Coverage of Sole Proprietors - H. 5337, filed by Rep. Sprague, would add a new section 18A making sole proprietors eligible to purchase workers' compensation insurance and would authorize insurance carriers to sell insurance to sole proprietors.

Calculation of Employee Average Weekly Wage - S. 1785, filed by Sen. Wetmore, would exclude from the calculation of an employee's average weekly wage holiday bonuses, vacation pay or holiday pay.

This late-file bill that was not considered by the committee.

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 an office within 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 unhealthy 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 & 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 them.

DIA Budget and Assessments

The Council is concerned about the steady increases in assessments levied against employers to pay the costs of the DIA. Between fiscal years 1995 and 1996, assessments increased 21%, from 3.176% of standard premium to 3.841%. Some of this increase is attributable to the diminishing assessment base, but certainly a portion accounts for the increase in the DIA operating and trust fund budgets.

The operating budget of the Department of Industrial Accidents has increased steadily from $13.3 million in fiscal year 1991 to $17.8 million in fiscal year 1996. This represents a 34% increase over five years. During this period, the effectiveness of the agency in performing its missions and objectives clearly has been enhanced. It is also certain that the 1991 reforms required additional outlays of money. According to the department, the mandates of chapter 398 required that $1.3 million be added to the fiscal year 1992 budget to pay for additional administrative judges, administrative law judges, and their support staff, as well as the staff of the impartial medical unit. Moreover, these personnel additions have contributed to escalating salary and benefits costs.

The Advisory Council is concerned about projected increases in the Department's request for fiscal year 1997. According to its FY'96 Spending Plan/FY'97 Maintenance Estimate, the agency will request $21 million, a 20% increase from last year.

Included in that increase is $1.9 million which has been attributed to the agency's continued purchase of computer equipment as per its paperless office initiative. Also, $1 million is planned to be spent on the trending and tracking initiative. It is expected that $465,000 will be paid in increased personnel costs.

The department is authorized to hire 332 full time employees (FTE's). While expenses for 332 employees has always been included in the calculation of employer assessments, the DIA has never achieved this staffing level. In prior years the number has hovered slightly around 300. Fiscal year 1995 closed with 316 FTE's, the greatest number ever, yet a shortfall of 16 positions.

The agency, however, has increasingly come to rely on the use of consultant contracts falling under the HH subsidiary and previously referred to as "03" consultants. The use of consultants can be an effective way for the department to involve experts in the development of policy and in the

performance of short-term, goal-specific projects. Independent contractors do not require payment of benefits, office space, computer equipment, supplies, etc. In many ways, the use of consultants can be the most economical way to achieve specific goals.

Nevertheless, the Council is concerned about the number of consultants under contract with the department. In fiscal year 1995, the agency had 71 separate contracts with independent consultants, 26 of which were contained within the Office of Health Policy. Many of these contracts were renewed in fiscal year 1996. The Council is concerned that the use of consultants be tied to short-term projects to achieve specific outcomes. The Council believes that all consultants, particularly those with multiple contracts spanning several years and dealing with long-term projects, should be evaluated for necessity and permanent employment status.

Following the department's expenditure process is difficult. As needs arise, the agency may make transfers between budgetary subsidiary accounts with authorization from the Commonwealth's Comptroller. While allowing transfers to occur between accounts gives the agency flexibility to respond to arising needs and crises, the frequency with which they occur makes inter-account transfers especially difficult to follow. The agency has been able to put on hold major expenditures (such as the trending and tracking system) while rapidly adopting new projects (such as the Court Room 2000 project). This is a luxury available to few other agencies, and can come to belie the budgetary planning and appropriations process.

The Council recommends that the agency's budget growth be closely monitored so that the benefits of lower workers' compensation costs are not diminished by increases in DIA assessments. Employer's should not be penalized by an increase in assessments when workers' compensation rates and caseloads are declining.

The Council further recommends that a detailed cost-benefit analysis be conducted by independent accountants to justify any new projects and new expenses. Cost-savings should be reflected in anticipated lower workers' compensation costs or direct improvements in services to injured employees or employers. Moreover, greater efforts should be made in planning the spending of the department to avoid the need for frequent inter-subsidiary transfers. Transfers made to cover expenses that are not attributable to unforeseen, extenuating circumstances, or that have not been articulated in a prior approved spending plan should be justified by a cost-benefit analysis.

Moreover, as in years past, the Advisory Council recommends that the agency carefully consider the number of FTE's needed, so that employers pay assessments based on the actual number of FTE's at the department.

Reviewing Board

During the past year, the department has made efforts to relieve the backlog of cases at the Reviewing Board. An additional attorney was hired to work with the judges to research and draft decisions. This brings the number of

attorneys to three, along with several law students working as part-time clerks. Moreover, the Senior Judge began assigning cases to the panels at the rate of approximately 70 per month. Most importantly, the administrative law judges and their staff have worked diligently to resolve cases as efficiently and quickly as possible without compromising quality.

These efforts appear to have yielded positive results. The number of disposed cases increased 22% (from 558 in FY'94 to 679 in FY'95) and 30% over FY'93 levels. Moreover, the ill-effects associated with the increase in the number of hearing decisions appealed in FY'94 (59% over FY'93 levels) were minimized.

Although an increase in productivity has occurred at the Reviewing Board, concern can be found with the backlog of cases awaiting review that has also increased for the second year straight. Currently it takes about two years to proceed from filing an appeal of a hearing decision to obtaining a Reviewing Board decision. In order for the backlog to decrease, the Reviewing Board must be able to increase its productivity at a greater rate than new cases coming into them.

In order to estimate the FY'96 Reviewing Board queue, both inputs (hearing decisions appealed) and outputs (appeals resolved by the Reviewing Board) must be examined carefully.

Fiscal Year	Hearing Decisions Appealed	Appeals Resolved by the Reviewing Board
1995	695	679
1994	657	558
1993	412	521

Source: DIA

In a comparison of FY'93 to FY'95, the "hearing decisions appealed" (inputs) increased by 69%. However, when examining the "appeals resolved by the Reviewing Board" (outputs) there is only an increase of 30% between FY'93 and FY'95. Clearly inputs are increasing at a greater rate than outputs (by as much as 39%) which could possibly suggest that the FY'96 backlog for the Reviewing Board will increase for a third straight year.

While it should be expected that the Reviewing Board can maintain its level of productivity, it is unlikely that the current staff of the Reviewing Board can again yield a substantial increase in the number of cases resolved over the last year. Another increase in the number of attorneys working with the administrative law judges on decisions could help. Furthermore, the appropriate number of ALJ's on the Reviewing Board should be studied. The possibility of adding more judges to the panel should only be considered if the backlog continues to increase at excessive rates. It also seems logical that new efforts to decrease the backlog could be placed on other areas.

When examining the status of the 1,087 cases awaiting review, it is revealed that over 70% of them are not ready to be heard by the Reviewing Board -- 25% (282) are awaiting a transcript from the stenographic unit; 25% (282) are awaiting a pre-transcript hearing; and 20% (214) are awaiting briefs from the parties. These cases cannot even be heard by the Reviewing Board.

These statistics reveal that close attention should be paid to the preparations that precede actual review of the cases. Faster scheduling of pre-transcript conferences would increase the number of cases withdrawn (as 28% of all cases resolved were withdrawn after this first conference). More importantly, it would make cases ready for review more quickly.

Keeping in stride with the "Courtroom 2000" agenda the department is undertaking, the stenographic unit should look into the benefits of purchasing new equipment that allows rapid transcription. While proceedings are recorded at the hearing, the process of transcription causes delay due to outdated equipment. Also, the department should consider implementing methods to increase the productivity of the stenographic unit. Emphasis should be placed on allowing each stenographer to produce transcripts as timely as possible. This could include the hiring of additional stenographers to allow each the time to produce transcripts, as well as requiring that the current staff of stenographers enhance their productivity and efficiency.

Competitive Rating

At the time of this printing, the Advisory Council has completed and submitted to the Governor and the legislature a study assessing the impact competitive rating would have on the Massachusetts workers' compensation insurance market. This study examined six key areas of concerns. Copies of this report are available at our office.

As outlined in the report, competitive pricing appears to offer many benefits when the market is populated with a multitude of carriers that are willing to vigorously pursue underwriting opportunities. Indeed, the Council is concerned about the maintenance of a truly competitive marketplace. The following are our recommendations

First, we have received negative reports regarding the California market. Effective January 1, 1995, workers' compensation insurance prices were deregulated and a host of other reforms were implemented affecting underlying costs (including benefit reductions and penalties against fraud). Concerns surround alleged practices of "predatory pricing" whereby very large carriers seek to dominate the market by undercutting the prices of smaller competitors. While the situation in California continues to evolve and is confounded by so many market and economic variables, it is our belief that the California insurance market should be closely scrutinized so that any legislation enacted here may avoid negative consequences experienced there.

Second, Council members wish to stress the report's recommendation that the legislation be amended to provide a mechanism to temporarily regulate rates if the market were no longer competitive. One example of a non-competitive market would be a concentration of a very limited number of carriers writing the majority of policies in Massachusetts. Council members believe special attention should be paid to ensure the viability of smaller niche carriers domiciled in Massachusetts, provided they offer services of value.

Third, the report emphasizes that a necessary corollary to implementing competitive rating would be ending subsidization of the residual market. It is the concern of the Council, however, that because so many small employers are written in the residual market, ending subsidies from the voluntary market could substantially increase the cost of coverage for small employers. Special efforts must be made to ensure that small employers can obtain coverage at a fair price.

Finally, as detailed in the report, a necessary aspect of competition involves "shopping" by employers. Adequate information must be provided to employers detailing how workers' compensation insurance is priced and the range of rates offered by carriers. A number of states with competitive rating have launched consumer information programs aimed at educating employers through informational materials and an insurance rate hot line.

Stop Work Orders

The number of stop work orders issued by the department has increased tremendously over the past few years. This increase has yielded positive effects on the insurance market-- the premium base has expanded while the potential exposure of the trust fund has diminished.

These enhanced efforts, however, have resulted in stop work orders being issued to organizations entirely staffed by uncompensated volunteers. The workers' compensation act is clear in its definition of an employer-- "an individual, partnership, association, corporation or other legal entity, employing employees." Moreover, the act defines an employee as "every person in the service of another under any contract of hire, express or implied, oral or written." Volunteers, by definition, are not under any contract of hire.

In response to numerous complaints from charitable organizations across the state, a bill was recently filed by Rep. Brewer in the House of Representatives that would amend the definition of employer so that employers would not include "nonprofit entities, as defined by the IRS code, that are exclusively staffed by volunteers." Passage of this bill would more clearly state the exclusion of charitable, volunteer organizations from the act.

But passage of the bill alone will not solve the problem. The law currently is clear in its exemption. It is up to the department, however, to develop guidelines to be issued to its investigators that spells out the exemption of volunteer organizations. It is unreasonable to expect citizens who volunteer their time for the good of their community to proceed through the lengthy and troublesome appeals process because of this oversight.

Massachusetts Workers' Compensation Advisory Council

List of Appendices

APPENDIX A

Advisory Council Members in FY' 95

Edward Sullivan, Jr. (Chair), SEIU-Local 254, 11 Beacon Street, Boston, MA 02108 Tel: 367-7360 FAX 367-7372
Jeanne-Marie Boylan (Vice Chair), Boston Sand and Gravel Company 169 Portland Street, Boston, MA 02114 Tel: 227-9000 FAX 523-7947
James Farmer, Local 1044, Glaziers & Glass Workers' Union, 25 Colegate Road, Roslindale, MA 02131 Tel: 524-2365 FAX 524-2623
John Gould, President, AIM, 222 Berkeley Street, P.O. Box 763, Boston, MA. 02117-0763 Tel: 262-1180 FAX 536-6785 (Donald F. Baldini)
Antonio Frias, S & F Concrete Company, 1266 Central Street, P.O. Box 427, Hudson, MA Tel: (508) 562-3495 FAX: 508-562-9461
Edmund 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 02129-1113 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
Lawrence Morrisroe, Carpenters' Union, Local 33, 10 Dry Dock Avenue, Boston, MA 02210, Tel: 350-0017 FAX: 330-1684
Amy Vercillo, Rehab Re-employment, 28 Bradfield Avenue, Roslindale, MA 02131-1902 Tel: 469-4481
J. Bruce Cochrane, Cochrane and Porter, 70 Hastings Street, Wellesley, MA 02181 Tel: 239-1162 FAX 239-0737
Alan S. Pierce, Alan S. Pierce & Associates, 27 Congress Street, Salem, MA 01970 Tel: 508-745-0914 FAX 508-745-1046
Gloria C. Larson, Secretary of Economic Affairs, Room 2101, One Ashburton Place, Boston, MA 02108 Tel: 727-8380 FAX 727-4426
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
as of 6-1-95

Terms of Advisory Council Members

Voting Members		**Term Exp. Date**
James Farmer	(labor)	6/25/95
John Gould	(business)	6/25/95
Edward Sullivan, Jr.	(labor)	6/25/96
Antonio Frias, Sr.	(business)	6/25/96
William Carnes	(disabled worker-labor)	6/25/97
Jeanne-Marie Boylan	(business)	6/25/97
John J. Perry	(labor)	6/25/98
Robert Lee Jones	(small business)	6/25/98
Edmund Corcoran	(self insurer)	6/25/99
Lawrence Morrisroe	(labor)	6/25/99
Non-Voting Members		
Amy Vercillo	(rehab)	6/25/95
J. Bruce Cochrane	(insurance)	6/25/97
Alan S. Pierce	(bar)	6/25/98
Christine Morris Executive Office of Labor		Ex-Officio
Gloria C. Larson Executive Office of Economic Affairs		Ex-Officio

APPENDIX B

AGENDA
Fiscal Year 1995

July 13, 1994

Trust Fund - Commissioner Campbell and John Tierney
Wyatt: Insurance Rate Methodology Study
DIA Update - Senior Judge Jennings
Minutes: June
Miscellaneous

August 10, 1994

Wyatt Insurance Rate Study
DIA Update - Senior Judge Jennings
Diane Jacobs - Rate Setting Commission
Case Time Frames Study--Update
National Health Care Bills and Workers' Compensation
Minutes - July
Miscellaneous

September 21, 1994

Blue Cross/Blue Shield/Liberty Mutual Workers' Compensation Program
DIA Update
Judges Appointments
Rate Setting Commission Hearings
Case Time Frames Study--Update
Tillinghast/ Kozel Study-- Update
Minutes - August
Miscellaneous

October 12, 1994

Bob Tuman - Compensation Claims Review, Inc.
Annual Report -- Dispute Resolution
DIA Update - Senior Judge Jennings
Tillinghast/Kozel Study
Case Time Frames Study Update
Minutes - September
Miscellaneous

November 9, 1994

DIA Update - Senior Judge Jennings
Tillinghast/Kozel Study - Ann Conway; Professor Peter Kozel

Rate Filing
Minutes - October
Miscellaneous

December 7, 1994

DIA Update
- Judge Jennings
- David Smith

Tom Griffin
DIA Judge Interviews
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- Tillinghast and Kozel Report on Wage Benefits
- Rate Filing Actuarial Analysis
- DIA Budget
- Judges Nominations
- Minutes - October and November 1994

Case Time Frames Study
Executive Director Update
Annual Report
Miscellaneous

January 11, 1995

DIA Update
- Judge Jennings
- David Smith

Case Time Frames Study
Rate Filing - Tim Koester
DIA Budget
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- Minutes December 1994

Executive Director Update
Miscellaneous

February 8, 1995

DIA Update
- Judge Jennings
- David Smith

Annual Report
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DIA Budget
Rate Filing Update
Action Items - Minutes January 1995
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March 8, 1995

DIA Update

Judge Jennings
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Action Items
    Minutes February 1995
Executive Director Update
Miscellaneous

March 8, 1995

DIA Update - Judge Jennings
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May 10, 1995

DIA Update
    Judge Jennings
    David Smith
Tom Griffin
    Coopers & Lybrand
Judicial Appointments
Executive Director's Update
    Managed Care in Workers' Compensation - Jeremy Teres
    Joint Commerce & Labor Hearing
    Competitive Rating Study
Action Items
    Minutes March 29, 1995
Miscellaneous

May 31, 1995

DIA Update - Judge Jennings
Judicial Appointments
Executive Director's Update
Action Items
Minutes May 10, 1995
Miscellaneous

APPENDIX C

Office of Safety Proposals Recommended for Funding

City of Worcester
City Hall
445 Main Street
Worcester, MA 01608
Title: Cumulative Trauma Disorder and Right to Know/AZACOM Prevention Program
Category of Applicant: Public Employer
Target Population: Employees
Geographic Area: Worcester
Program Administrator: Lori Favata
Total Funds Requested: $20,156.31

Asbestos Workers Local #43
1053 Burts Pit Road
Northampton, MA 01060
Title: Labor Organization/ Federation
Category of Applicant: Employees
Target Population: Employees
Geographic Target: Worcester/Lawrence/Springfield
Program Administrator: Robert E. Starr
Total Funds Requested: $19,946.99

Massachusetts Carpenters Training Program
13 Holman Road
Millbury, MA 01527
Title: Safety in Construction 30 hour Course
Category of Applicant: Non Profit Trade Association
Target Population: Employees/Employers/Supervisory
Program Administrator: James O'Leary
Total Funds Requested: $2, 923.50 approved $25,007.50

Bassette Printers
400 Cadwell Drive
Springfield, MA 01101
Title: Ergonomics Training Program
Category of Applicant: Private Employer
Target Population: Employees/Supervisory
Geographic Area: Springfield
Program Administrator: Glenn D. Colburn
Total Funds Requested: $2,300.70

Neles-Jamesbury Inc.
640 Lincoln Street
Worcester, MA 01615
Title: Occupational Safety & Health Education & Training Program
Category of Applicant: Public Employer
Target Population: Employees/Employers/Supervisory

Geographic Area: Worcester
Program Administrator: Kenneth S. Tumas
Total Funds Requested: $30,000.00 Approved: $26,400.00

Western Mass COSH
458 Bridge Street
Springfield, MA 01103
Title: Chemical Hazard Awareness/Springfield Dept.
Category of Applicant: Non Profit Organization
Target Population: Employees/Employers/Supervisory
Geographic Area: Springfield
Program Administrator: Philip Korman
Total Funds Requested: $29,987.00 Approved $25,607.00

WorkRight, Inc.
386 Washington Street
Wellesley Hills, MA 02181
Title: Controlling CTD's Through Ergonomics
Category of Applicant: Private Employer
Target Population: Employers/Supervisory Personnel
Geographic Area: Statewide
Program Administrator: Bette Hoffman
Total Funds Requested: $28,449.00 Approved: $25,249.00

Braintree Hospital
100 Baystate Drive
Braintree, MA 02184
Title: Work Injury Prevention
Category of Applicant: For Profit Corporation
Target Population: Employees/Employers/Supervisory
Geographic Area: Boston
Program Administrator: Mary Riley
Total Funds Requested: $28,865.00

C.M.E.A.
30 Park Avenue
Worcester, MA 01065
Title: Cumulative Trauma Disorder: Prevention Program
Category of Applicant: Non Profit Organization
Target Population: Employees/Employers/Supervisory
Geographic Area: Worcester
Program Administrator: Matthew Stepanski
Total Funds Requested: $30,000.00 Approved: $27,069.00

Boston Area Painters Training Program Trust
25 Colgate Road
Roslindale, MA 02131
Title: Occupational Health and Safety: Prevention & Protection
Category of Applicant: Joint Labor/Management Committee
Target Population: Employees
Geographic Area: Boston

Program Administrator: Joseph Calci
Total Funds Requested: $19,921,60

Millwright Local 1121 Apprentice Fund
90 Braintree Street
Allston, MA 02134
Title: An Ounce of Prevention
Category of Applicant: Labor Organization/Federation
Target Population: Employees
Geographic Area: Statewide
Program Administrator: Robert Anderson
Total Funds Requested: $12,370.00

Massachusetts Department of Public Health
150 Tremont Street
8th Floor
Boston, MA 02111
Title: Occupational Health and Safety for Working Youth
Category of Applicant: Public Employer
Target Population: Employees
Geographic Area: Boston
Program Administrator: Robin Dewey
Total Funds Requested: $29,897.00

Beloit Corp. Fiber Systems Division
401 South Street
Dalton, MA 02126
Title: Occupational Safety and Health Education and Training Program
Category of Applicant: Private/Joint Labor/Management
Target Population: Employees/Supervisory Personnel
Geographic Area: Springfield
Program Administrator: Lauren Ziemek
Total Funds Requested: $30,000.00 Approved $24,730.00

Massachusetts Easter Seal Society
484 Main Street
Worcester, MA 01608
Title: Keep People Working
Category of Applicant: Non Profit Organization
Target Population: Employee/Employers/Supervisory
Geographic Area: Fall River/Worcester/Boston
Program Administrator: Nancy Steele
Total Funds Requested: $13,874.50

Medworks Program/Marlborough Hospital
57 Union Street
Marlborough, MA 01752
Title: An Ergonomic training program for prevention of CTD's and back pain
Category of Applicant: Non Profit Organization
Target Population: Employees/Employers/Supervisory
Geographic Area: Worcester

Program Administrator: Lisa Doyle
Total Funds Requested: $17,570.00 Approved: $15,426.00

Iron Workers Local 7
Joint Apprenticeship Committee
P.O.Box 210
Allston, MA 02134
Title: Lead Paint Training for Iron Workers
Category of Applicant: Joint Labor/Management Committee
Target Population: Employees/Employers/Supervisory
Geographic Area: Boston
Program Administrator: Robert E. Banks
Total Funds Requested: $29,530.20 Approved: $26,905.80

Women in the Building Trades
555 Amory Street, Boston, MA 02130
Title: Reaching Tradeswomen-Reducing Trauma
Category of Applicant: Non Profit Organization
Target Population: Employees
Geographic Area: Boston
Program Administrator: Priscilla Golding
Total Funds Requested: $11,270.00

Lund International Corporation
571 Main Street
Hudson, MA 01749
Title: Safety Program Development: Training Safety Committee's Supervisors
Category of Applicant: Private Employer
Target Population: Employees/Supervisors
Geographic Area: Worcester
Program Administrator: Diane Michael
Total Funds Requested: $4,842.00

National School Bus Service, Inc.
115 Freeport Street
Dorchester, MA 02122
Title: Preventing Injury to School Bus Driver
Category of Applicant: Private Employer/Labor/Management
Target Population: Employees/Supervisory Personnel
Geographic Area: Boston
Program Administrator: Sandra Baldwin-Goncalves
Total Funds Requested: $28,776.00 Approved 21,402.00

Massachusetts Nurses Association
340 Turnpike Street, Canton, MA 02021
Title: Health & Safety Training f/Nurses/Focus: Back Injuries & Indoor Air Quality
Category of Applicant: Non Profit/Labor/Federation
Target Population: Employees
Geographic Area: Statewide
Program Administrator: Julie Betts Pinkham
Total Funds Requested: $29,992.00 Approved: $15,637.20

APPENDIX D

COLLECTIONS AND EXPENDITURES REPORT

SPECIAL FUND	*FY'95*	*FY'94*	*FY'93*	*FY'92*
COLLECTIONS				
INTEREST	585,191	365,817	217,797	323,960
ASSESSMENT	21,084,055	17,537,534	13,743,804	11,023,312
LESS RET. CHECKS	44	0	88,274	0
ADJUSTMENTS	3,241			
LESS REFUNDS	10,354	98,514	9,022	0
SUB-TOTAL	**21,070,416**	**17,439,020**	**13,646,508**	**11,023,312**
FILING FEES	3,281,447	4,744,199	3,483,110	2,511,501
COLLECTION FEE	10,354			
LESS RET. CHECKS	2,566	4,447	4,743	0
LESS REFUNDS	3,014	5,192	2,131	0
SUB-TOTAL	**3,805,513**	**4,734,560**	**3,476,236**	**2,511,501**
1ST REPORT FINES	665,226	402,442	85,707	144,200
LESS COLLECTION FEE	9,218			
LESS RET. CHECKS	1,200	300	0	0
LESS REFUNDS	1,500	2,200	0	0
SUB-TOTAL	**653,308**	**399,942**	**85,707**	**144,200**
LATE ASSESS. FINES	25,701	33,822	21,970	0
STOP WORK ORDERS	370,271	166,600	see Private Fund	see Private Fund
SEC. 7 FINES	10,400	0	6,000	4,000
MISCELLANEOUS	12,876	7,867	880	350
SUB-TOTAL	**419,248**	**208,289**	**28,850**	**4,350**
TOTAL COLLECTIONS	**26,533,676**	**23,147,628**	**17,455,098**	**14,007,323**
BALANCE BRGT FWD	6,015,882	3,035,890	2,621,052	3,279,692
TOTAL	**32,549,558**	**26,183,518**	**20,076,150**	**17,287,015**
LESS EXPENDITURES	20,504,906	20,167,636	17,040,260	14,665,963
BALANCE	**12,044,652**	**6,015,882**	**3,035,890**	**2,621,052**
EXPENDITURES				
SALARIES	11,432,627	10,984,604	9,797,077	8,616,722
FRINGE BENEFITS	3,613,307	3,513,989	2,666,838	2,331,860
INDIRECT COSTS	501,847	578,985	613,250	613,250
NON-PERSONNEL COSTS	4,954,835	5,093,478	3,957,815	3,104,131
SUB TOTAL	20,502,616	20,171,056	17,034,980	14,665,963
misc.	2,290	-3,420	5,280	
TOTAL EXPENDITURE	**20,504,906**	**20,167,636**	**17,040,260**	**14,665,963**

COLLECTIONS AND EXPENDITURES REPORT

PUBLIC TRUST	*FY'95*	*FY'94*	*FY'93*	*FY'92*
COLLECTIONS				
INTEREST	0	53,222	98,627	93,549
sec 30H	4,192	0	0	1,875
ASSESSMENTS	1,419,799	819,613	1,632,650	4,896,637
REFUNDS	9,024	93	205	0
SUB-TOTAL	**1,410,775**	**819,520**	**1,632,445**	**4,896,637**
TOTAL COLLECTIONS	**1,414,967**	**872,742**	**1,731,072**	**4,992,061**
BALANCE BRGT FWD	285,328	2,291,964	3,056,655	1,495,574
TOTAL	**1,700,295**	**3,164,706**	**4,787,727**	**6,487,635**
LESS EXPENDITURES	1,532,385	2,879,379	2,495,761	3,430,980
BALANCE	**167,910**	**285,327**	**2,291,966**	**3,056,655**
EXPENDITURES				
RR COLAS	1,514,040	2,621,503	2,464,967	3,413,611
OEVR sec 30H	0	0	0	741
RR SEC. 37	18,345	254,676	30,794	16,628
RR LATENCY CLAIMS	0	3,200	0	0
TOTAL EXPENDITURES	**1,532,385**	**2,879,379**	**2,495,761**	**3,430,980**

COLLECTIONS AND EXPENDITURES REPORT

PRIVATE TRUST	*FY'95*	*FY'94*	*FY'93*	*FY'92*
COLLECTIONS				
INTEREST	620,028	354,842	187,259	658,729
ASSESSMENTS	30,147,213	28,974,039	25,187,627	26,012,517
LESS RET. CHECKS	2,129	0	143,490	0
ADJUSTMENTS	92,088			
LESS REFUNDS	5,285	160,718	23,843	0
SUB-TOTAL	**30,047,711**	**28,813,321**	**25,020,294**	**26,012,517**
REIMBURSEMENTS	1,129,709	1,029,263	572,170	452,905
PLUS ADJUSTMENTS	95,899			
LESS COLLECTION FEE	23,739			
LESS ADJUST. COLL. FEE	3,810			
RET. CHECK	4,772	200	1,818	0
SUB-TOTAL	**1,193,287**	**1,029,063**	**570,352**	**452,905**
STOP WORK ORDER *	0	0	31,150	28,600
LESS RET. CHECKS	0	0	0	0
SUB-TOTAL	*** see Special Fund**	*** see Special Fund**	***31,150**	***28,600**
SEC. 30 H	54,215	41,842	16,833	9,702
TOTAL COLLECTIONS	**31,915,241**	**30,239,068**	**25,825,888**	**27,162,453**
BALANCE BRGT FWD	12,363,485	7,588,112	3,652,610	4,333,975
TOTAL	**44,278,726**	**37,827,180**	**29,478,498**	**31,496,428**
LESS EXPENDITURES	31,690,464	25,463,695	21,890,386	27,843,817
BALANCE	**12,588,262**	**12,363,485**	**7,588,112**	**3,652,611**

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

COLLECTIONS AND EXPENDITURES REPORT

EXPENDITURES	*FY'95*	*FY'94*	*FY'93*	*FY'92*
SEC. 34	2,646,319	2,591,989	2,783,111	2,959,303
SEC. 35	750,064	795,556	714,888	527,439
LUMP SUM	1,575,454	1,373,464	1,146,409	1,255,442
SEC. 36 *	182,747	484,297	490,492	253,110
SEC. 31	69,115	109,928	106,862	113,973
COLA ADJ	123,267	12,459	11,160	3,758
EE MEDICAL REIMB.	64,091	29,158	18,832	14,513
EE TRAVEL	2,682	5,627	8,618	15,296
EE MISC. EXPENSE	32,638			
EE BOOKS & SUPPLIES	176	0	122	915
FUNERAL EXPENSES	480	8,000	4,000	4,000
VETERANS SERVICES	1,522	4,690	1,711	0
LEGAL FEES	499,328	716,184	599,323	546,142
LEGAL EXPENSES	44,002	72,862	35,292	----------
MEDICAL EXPENSES	1,463,797	1,797,948	1,854,762	1,497,815
REHAB SERVICES	47,893	5,172	6,954	17,253
REHAB. SERV. TRAVEL	1,319	323	----------	----------
WELFARE LIENS	0	209,069	61,741	64,370
SUB-TOTAL RR (benefits for uninsured claimants)	**7,504,894**	**8,216,726**	**7,844,277**	**7,273,329**
TUITION	940	2,828	22,490	18,368
TOTAL BENEFITS	**7,505,834**	**8,219,554**	**7,866,767**	**7,291,697**
INSURERS				
COLA	12,741,936	10,924,588	11,325,195	19,627,352
LATENCY CLAIMS	749,166	4,768,138	246,407	0
LEGAL FEE SEC. 35	113,783			
SEC. 37	8,487,924	699,185	1,896,753	575,652
TOTAL INS.	**22,092,809**	**16,391,911**	**13,468,355**	**20,203,004**
TOTAL RR-LEGAL	**29,598,643**	**24,611,465**	**21,335,122**	**27,494,701**
OEVR				
IME CORP.	450			
SEC. 30H	6,018	1,530	13,795	18,700
TRAVEL - 30H	114			
EE TRAVEL	0	0	2,458	5,903
EE BOOKS & SUPPLIES	194	0	297	347
TUITION	2,500	9,440	20,596	44,023
TOTAL OEVR	**9,276**	**10,970**	**37,146**	**68,973**
TOTAL BENEFITS	**29,607,919**	**24,622,435**	**21,372,268**	**27,563,674**

COLLECTION AND EXPENDITURE REPORT

EXP.-DEFENSE OF THE FUND	*FY'95*	*FY'94*	*FY'93*	*FY'92*
AA SALARIES	495,141	306,588	196,223	54,577
DD FRINGE	151,436	100,412	61,810	15,968
DD UNIVERSAL HEALTH	624	155	112	0
DD MEDICARE	5,984	4,197	2,728	860
SUB-TOTAL	**653,185**	**411,352**	**260,873**	**71,405**
BB TRAVEL	7,926	834		
TRAINING/TUITION	1,035	110		
EE MV RENTALS	69	542		
EE ADVERTISING	0	355		
EE SUPPLIES/BOOKS/ BUS.CARDS	364,826	2,914		
EE PETTY CASH REIMB.	25			
EE IMPARTIAL APPEALS	19,125	10,575		
EE CENTRAL REPRO.	1,240			
EE OMIS CHARGEBACK	3,999			
EE CELLULAR PHONES	2,454			
HH WILSON ASSOC.		5,000		
ACCUMED	1,416	28,977		
MELCHIN & CO.	16,235			
STENO IND.		0		
STENO CORP.	499	127		
CONSULTANT	3,329	18,444		
CONSULTANT	32,960	30,996		
CONSULTANT	54,375	46,875		
CONSULTANT	24,125	23,900		
CONSULTANT	49,500	37,175		
CONSULTANT	36,013			
CONSULTANT	98,799			
CONSULTANT	22,500			
CONSULTANT	15,000			
CONSULTANT	3,550			
JJ ACE TEMP.	92,153	45,997		
PROJECT TRIANGLE	7,728			
INVESTIGATORS	140,475	710		
SHERIFFS	1,307	1,602		
SCHOOL ST. CAMERA	54			
CATAPULT, INC.	2,640			
KK EQUIPMENT	221,438	19,270		
MM IME'S IND.	0	0		
IME'S CORP.	142,461	144,505		
IME'S CORP. INT.	1,208			
IME'S CORP. SEC. 37	42,748			
RR PENALTIES	2,800	11,000		
RR BEARAK REPORTS	15,348			
SUB-TOTAL	**1,429,360**	**429,908**	**257,244**	**208,738**
TOTAL DEFENSE OF FUND	**2,082,545**	**841,260**	**518,117**	**280,143**
TOTAL EXPENDITURES	**31,690,464**	**25,463,695**	**21,890,385**	**27,843,817**

APPENDIX E

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 - Room 2112
Room 2101
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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
Raytheon
100 Hayden Avenue
Lexington, MA 02173

Dr. Grant Rodkey
11 Beatrice Circle
Belmont, MA 02178-02657
Office - 724-0110
FAX - 724-0113

Mr. Brackett Denniston
* (Lon Povich)
Chief Legal Counsel
Room 271
State House
Boston, MA 02133
Office - 727-2065
FAX - 727-8290

Ms. Gloria Larson
*(David Tibbetts)
Sec. of Economic Affairs
One Ashburton Place -
Boston, MA 02133

Mr. Gino Maggi
President
Inter-all Corp.
P.O.Box 586
Holyoke, MA 01041
Office (313)467-7181
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 F

SUMMARY OF JUDGES EXPIRATION DATES (AS OF 8/1/95)

	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.	William Constantino	Republican	5/26/01
6.	Janet Cox	Unenrolled	5/21/98
7.	Fran Gromelski	Democrat	9/04/97
8.	John Harris	Republican	5/28/98
9.	Emogene Johnson	Unenrolled	7/29/00
10.	William Long	Democrat	8/03/00
11.	Douglas McDonald	Democrat	7/06/00
12.	James McGuinness	Democrat	7/05/96
13.	John McLaughlin	Republican	5/28/98
14.	John McKenna	Republican	1/31/97
15.	John McKinnon	Democrat	6/26/98
16.	Theodore Merlo	Republican	5/28/98
17.	Bridget Murphy	Republican	7/27/00
18.	Daniel O'Shea	Republican	5/21/98
19.	James St. Amand	Democrat	5/14/98
20.	Dianne Solomon	Unenrolled	8/10/00
21.	Jo'Anne Thompson	Republican	9/18/98
INDUSTRIAL ACCIDENT BOARD ONE YEAR TERMS			
1.	John Bradford	Republican	2/01/96
2.	Joellen D'Esti	Unenrolled	7/17/96
3.	Richard Heffernan	Democrat	7/15/96
4.	James Lamothe	Republican	8/03/96
5.	Frederick Levine	Unenrolled	2/01/96
6.	Helen Moreschi	Unenrolled	2/01/96
7.	Stephen Sumner	Unenrolled	2/01/96
8.	Fred Taub	Democrat	7/01/96
9.	Richard Tirrell	Democrat	7/01/96

APPENDIX G

MEDICAL CONSULTANT CONSORTIUM

Troyen A. Brennan, MD, JD
The Harvard School of Public Health
Department of Health Policy & Mgmt.
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Murray M. Freed, MD
5550 Piping Rock Drive
Boyton Beach, Florida 33437

Dean Hashimoto, MD, JD
Boston College Law School
885 Center Street
Newton, MA 02159

Manuel Lipson, MD
Director, Spaulding Rehabilitation Hospital
125 Nashua St., 1st Floor
Boston, MA 02114

L. Christine Oliver, MD
Pulmonary/Critical Care Unit
Bullfinch #1/Mass General Hospital
55 Fruit Street
Boston, MA 02114

Barry Simmons, MD
Brigham Orthopedic Assoc.
Brigham & Women's Hospital
75 Francis Street
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DIA:

James J. Campbell
Commissioner, DIA
600 Washington St.
Boston, MA 02111

Donna M. Ward, Director
Office of Health Policy
600 Washington St.
Boston, MA 02111

HEALTH CARE SERVICE BOARD

Patricia Crane — Hospital Administrative Rep.
Vice-President Development and Public Affairs
Lowell General Hospital 295 Barnam Street
Lowell, MA 01854

Henry W. DiCarlo — Employers Representative
Director, Loss Prevention
Stride Rite Corporation
5 Cambridge Street
Cambridge, MA 02142

William F. Fishbaugh Jr., MD — Physician Representative
Director, Sports Medicine, Occup. Health
Braintree Hospital Rehabilitation Network
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Dean Hashimoto, MD, JD — Physician Representative
Boston College School of Law
885 Center Street
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Peter A. Hyatt, DC — Chiropractic Representative
227 East Street
Methuen, MA 01844

Catherine Lane, RPT — Physical Therapy Representative
Boston Center for Physical & Sports Medicine
653 Summer Street
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Charles E. Lutton, MD, PhD — Physician Representative
P.O.Box 428
Ashland, MA 01721

L. Christine Oliver, MD — Chair/Ex-Officio Member
Pulmonary/Critical Care Unit/Bulfinch #1
Mass General Hospital
55 Fruit Street
Boston, MA 02114

Jonathan Schaffer, MD — Physician Representative
Department of Orthopedic Surgery
Brigham & Women's Hospital
75 Francis Street
Boston, MA 02115

Willie Stephens, DDS — Dentist Representative
Brigham & Women's Hospital
75 Francis Street
Boston, MA 02115

APPENDIX J

Commerce & Labor Committee

Senator Robert Travaglini (Chair)
State House - Room 416A
Boston, MA 02133-1053

Senator Robert Durand (Vice Chair)
State House - Room 413D
Boston, MA 02133-1053

Senator Robert Wetmore
State House - Room 312
Boston, MA 02133-1053

Senator David Magnani
State House - Room 413A
Boston, MA 02133-1053

Senator Robert Antonioni
State House - Room 504
Boston, MA 02133-1053

Senator Jane Swift
State House - Room 407
Boston, MA 02133-1053

Representative Daniel Bosley (Chair)
State House - Room 431
Boston, MA 02133-1053

Rep. Stephen Brewer (Vice Chair)
State House - Room 431
Boston, MA 02133-1053

Representative Robert Koczera
State House - Room 167
Boston, MA 02133-1053

Representative Evelyn Chesky
State House - Room 33
Boston, MA 02133-1053

Representative Pamela Resor
State House - Room 33
Boston, MA 02133-1053

Representative Janet O'Brien
State House - Room A34
Boston, MA 02133-1053

Representative Daniel Valianti
State House - Room 450
Boston, MA 02133-1053

Representative Jay R. Kaufman
State House - Room 540
Boston, MA 02133-1053

Representative Steven Tolman
State House - Room
Boston, MA 02133-1053

Representative Bradley Jones
State House - Room 146
Boston, MA 02133-1053

Representative Cele Hahn
State House - Room 346
Boston, MA 02133-1053

APPENDIX K

The Governor's Executive Council

David F. Constantine
First District
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Kelly A. Timilty
Second District
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Boston, MA 02133
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Cynthia S. Creem
Third District
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Christopher A. Iannella
Fourth District
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(617) 227-1538 Ext. 4

Patricia A. Dowling
Fifth District
State House Room 184
Boston, MA 02133
(617) 727-2756 Ext. 5

Dorothy A. Kelly Gay
Sixth District
State House Room 184
Boston, MA 02133
(617) 727-2756 Ext. 6

Jordan Levy
Seventh District
State House Room 184
Boston, MA 02133
(617) 727-2756 Ext. 7

Edward M. O'Brien
Eighth District
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