

ANNUAL REPORT

FISCAL YEAR 1997

Massachusetts Workers' Compensation Advisory Council

Advisory Council Members:

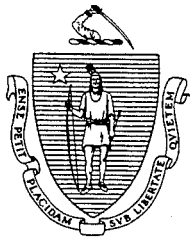
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January 14, 1998

His Excellency Argeo Paul Cellucci
Governor of Massachusetts

The Honorable Stephen F. Lynch
Senate Chair, Joint Committee on Commerce and Labor

The Honorable Robert M. Koczera
House Chair, Joint Committee on Commerce and Labor

Dear Governor Cellucci, Senator Lynch, Representative Koczera:

On behalf of the Massachusetts Workers' Compensation Advisory Council, I am pleased to submit to you our annual report on the State of the Massachusetts Workers' Compensation System for Fiscal Year 1997.

This report provides an overall picture of the workers' compensation system in Massachusetts, including the state's workplace injury and accident rate, the activity of the Division of Industrial Accidents, and an analysis of the workers' compensation insurance market. The Council has also identified areas of concern and provides recommendations to improve the workers' compensation system. Finally, the report recognizes areas of improvement where the Division of Industrial Accidents, the Division of Insurance, and other organizations have implemented promising programs to improve the workers' compensation system for all participants.

Thank you for your consideration of the Advisory Council's positions and recommendations, and for your efforts to ensure the workers' compensation system in Massachusetts continues to operate efficiently and effectively.

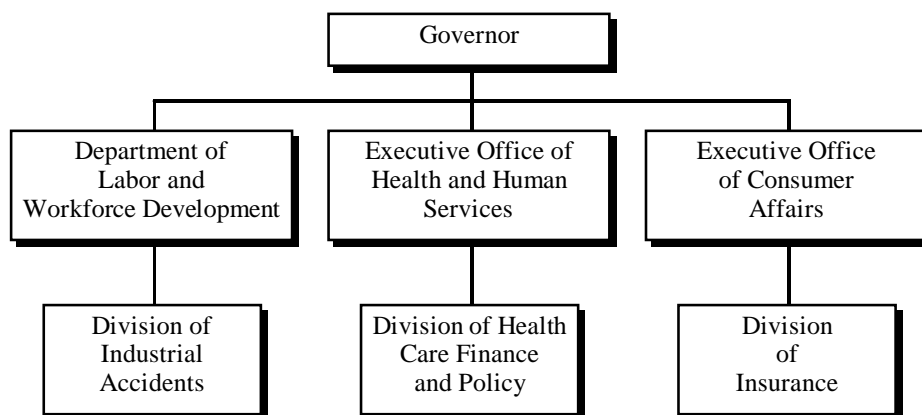
Sincerely,

A handwritten signature in cursive script, reading "Matthew A. Chafe".

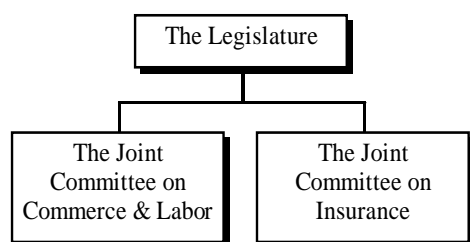
Matthew A. Chafe
Executive Director

Government Regulation of Workers' Compensation

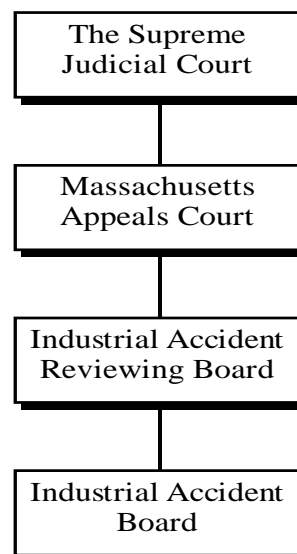
Administrative



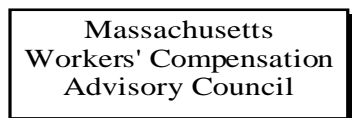
Legislative



Judicial



Oversight



Note: The Advisory Council monitors and reports on all aspects of the workers' compensation system.

**THE STATE OF THE
MASSACHUSETTS WORKERS' COMPENSATION SYSTEM**

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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 conducts studies on various aspects of the workers' compensation system and reports its findings to key legislative and administrative officials.

The Advisory Council is mandated to issue an annual report evaluating the operations of the Division of Industrial Accidents and the state of the Massachusetts workers' compensation system. In addition, members are required to review the annual operating budget of the Division of Industrial Accidents, and, when necessary, submit an independent recommendation. The Council is also charged with reviewing the insurance rate filing and participating in insurance rate hearings.

The Advisory Council is comprised of sixteen members, appointed by the governor for five year terms including: 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 Director of Labor & Workforce Development and the Director of Economic Development serve as ex officio members.

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

The Advisory Council customarily meets on the second Wednesday of each month at 9:00 a.m. at the Division of Industrial Accidents, 600 Washington Street, 7th Floor Conference Room, Boston, Massachusetts.

Meetings are open to the general public pursuant to the Commonwealth's open meeting laws (G.L., ch. 30A, sec. 11A).

Advisory Council Studies

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

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

Report on Competitive Rating, Tillinghast, (1989).

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

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

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

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).

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

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

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

Competitive Rating of Workers' Compensation in Massachusetts, J.H. Albert, (1995).

Review of WC Ratemaking Concepts and WCRIB 8/14/97 Filing, Ernst & Young LLP, (1997)

Analysis of Proposed Changes to Section 34 and 35 of Chapter 152 of the Massachusetts General Laws, Tillinghast, (1997)

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, 6th Floor, Boston, Massachusetts (617) 727-4900 ext. 378.

FISCAL YEAR 1997 IN REVIEW

During 1997, the Massachusetts Workers' Compensation system could only be described as healthy and thriving. Workplace accidents were down, as were the number of disputed insurance claims. The insurance rate decrease implemented in 1996 extended into 1997. During this period of relative tranquility, however, legislators began to reconsider benefit reduction measures implemented by the 1991 reforms. In addition, the Governor's office took measures to downsize the Division of Industrial Accidents.

In fiscal year 1997, the Division of Industrial Accidents continued to experience decreases in its workload. Cases filed at the DIA declined 7.5% from fiscal year 1996 levels, and are down 50% since fiscal year 1991. Employee claims decreased 4.8% (down 25% since fiscal year 1991), and insurer complaints decreased 13% (marking a 65% decrease since fiscal year 1991).

Recognizing this decrease in workload, the Governor has scaled back funding and staffing of the agency. The DIA's fiscal year 1998 operating budget was reduced from \$19 million to \$17.4 million. The number of full time employees authorized has also decreased, from 333 positions to 312 positions. Finally, the Governor has decreased the number of administrative judges within the agency by phasing out recall appointments.

During the year, the administration of the DIA underwent intense scrutiny. In October of 1996, the Boston Globe ran a series of articles focusing on the internal affairs of the agency including personnel decisions, contracting procedures for consultants, the size of the agency's budget, travel budgets, and allegations of abuse of authority. As a result of this series, Governor Weld ordered his Chief of Staff to investigate the agency, and the Joint Committee on Commerce & Labor conducted an oversight hearing. A department manager was relieved of his duties, as was a research analyst, and many consultant contracts were not renewed. A State Ethics Commission review found no cause for action, however.

The Executive Office of Administration and Finance conducted an audit of DIA procurement practices. The review encompassed a sample of transactions during fiscal years 1994 through 1997. The report cited multiple transgressions of regulations governing internal control procedures, bidding, and handling of consultant service contracts. As a result, the Office of the Comptroller and the Operational Services Division have required that all service contracts, lease orders, and purchase orders be forwarded directly to them for review and processing.

In compliance with Executive Order 384, in which the Governor ordered the revision and elimination of all unnecessary state regulations, the DIA modified its own regulations. Adjudicatory rules were simplified and updated to conform to Review Board and court decisions. Trust fund regulations and regulations regarding reevaluation of payment of benefits were also modified. Proposed changes to utilization review regulations were abandoned in light of the executive order. The Division of Insurance likewise simplified its regulations on preferred provider arrangements, deductible policies, experience modification factors, and conduct of rate filing hearings.

The WCRB promulgated a Manual on Workers Compensation and Employers' Liability Insurance to apply to all workers' compensation risks in Massachusetts. This was written after the NCCI had revised its manual so that it no longer applied in Massachusetts. The WCRB's manual, the first all-encompassing, self contained manual to be published in Massachusetts in sometime, was filed with the Insurance Commissioner for approval in November, 1996. After a hearing in early December, the rules section was approved but the classifications section was denied pending changes to account for objections from construction and human services employers. After meetings with those concerned, a redraft was submitted, and changes were again disapproved by the Commissioner in October, 1997. The WCRB plans to issue the manual without the contested changes to classifications.

In December, the Massachusetts Bar Association conducted its first survey of DIA judicial performance (see Appendix E). Questionnaires were mailed to 500 workers' compensation lawyers across the state asking them to evaluate each DIA administrative judge and administrative law judge. Criteria included knowledge of workers' compensation law and procedure, judicial demeanor, punctuality, quality of decisions, application of rules of evidence, and bias. This report was welcomed by all those involved in the reappointment process as it offers one more form of documentation of judicial performance.

In the 1997 session, legislators filed 62 bills to amend the workers' compensation system. Of those bills, four were extended for further consideration, 11 were given a favorable rating and the balance were placed in a study order. This session has been marked by a cautious inclination to redress the 1991 reform act. The members of the Commerce and Labor Committee have decided to carefully consider the implications of increasing §34 and §35 benefits and their durations to avoid substantial disruptions to the system. The Commerce and Labor Committee requested that the Council, the WCRB, and the WCRI conduct an analysis of the cost impact of raising benefits.

The insurance market continued to be extremely competitive in fiscal year 1997. A total of 19 new carriers were licensed by the state to sell workers' compensation insurance. Moreover, a total of 74 separate downward deviations were approved by the Commissioner of Insurance decreasing carrier rates from 10% to 35% off approved rates. In the midst of this competition came calls to implement open (or competitive) rating. This concept was met favorably by the Commerce and Labor Committee and H.3773 was reported out favorably.

CONCERNS & RECOMMENDATIONS

G.L. Ch. 23 E, 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 has concluded the following areas are in need of attention, and offers recommendations for improvements.

Employer Fines for Violation of Insurance Mandate

During fiscal year 1997, and as a follow-up to our fiscal year 1996 concerns, the Advisory Council developed a legislative proposal to address the adequacy of the current fines. Council members were concerned that the stop work order and fine provisions found at G.L. ch. 152, § 25C are not sufficiently punitive to deter employers from violating the mandate to obtain workers' compensation insurance coverage. Last spring, the Council consulted with officials from the insurance industry, the Insurance Fraud Bureau, and the Division of Industrial Accidents to address this issue. The group met twice and reviewed each subsection of section 25C of Ch. 152.

The committee voiced several concerns. Failure of a large number of employers to secure workers' compensation coverage was identified as an enormous problem. Although premium evasion accounts for 3% of the cases of the Fraud Bureau, it amounts to 47% of the dollar value of the cases referred. Moreover, each year 500 new cases are paid by the Trust Fund due to claims by uninsured employers. Moneys paid out by the Trust Fund account for 20% of the private employer assessment or \$10 million per year. As many as 400 stop work orders are issued by the DIA each month. It was estimated that of the 200,000 businesses in Massachusetts, somewhere between 5 and 10% are operating without workers' compensation insurance (20-40,000 businesses). Furthermore, half of the businesses ignore the warning letters notifying that they will be shut down if they don't obtain coverage.

Of particular concern to the Council was the flat fine of \$100 per day assessed against any employer that is found to be lacking insurance. This fine was established in 1987 and has not been adjusted since. It was agreed that the fine is insufficiently severe to serve as an effective deterrent from breaking the law. In amending the law, the Council believes it is important that the fine is based on a "sliding scale" so that employers that have avoided greater amounts of premium would be subject to a larger fine than employers that have avoided smaller premium. For this reason, the Council agreed to adopt the approach of several states which impose fines at the rate of three times premium avoided.

The Advisory Council drafted legislation to address these concerns which has been filed as Senate 1840 by Senator Stephen Lynch, Senate Chair of the Commerce & Labor Committee.

Section 1 of this bill would increase civil penalties for violations to three times premium the violating employer would have paid in the assigned risk pool for the entire period it operated without insurance. If the period is seven days or less, the fine imposed would total \$250 for each day the employer lacked insurance.

Section 2 would delete those provisions which require a higher fine for employers who appeal a stop work order and are found to lack insurance after a hearing.

Section 3 would increase the criminal fines for failure to carry insurance to \$5,000 for a first offense and \$10,000 for a second offense. It stipulates that no finding of criminal intent is necessary to prove a violation. It requires that fines be ordered in addition to restitution to be paid to the DIA Trust Fund.

Section 4 would enable a civil cause of action for loss of a competitive bid to be brought as an unfair or deceptive business practice under Ch. 93A. It allows for treble damages rather than the current \$15,000 maximum award.

Section 5 would amend section 65 to require that stop work order fines be deposited in the private employer trust.

Section 6 would create a 90 day amnesty program for violating employers to obtain insurance. It requires the Commissioner of the DIA, the Commissioner of Insurance, the Insurance Fraud Bureau and the Massachusetts Workers' Compensation Rating and Inspection Bureau to implement a promotional campaign to advise employers about the amnesty period, the worker's compensation requirement, and the penalties. It would encourage the general public to report suspected violators.

The bill was reported favorably by the Commerce & Labor Committee, and is currently before the Senate Committee on Ways & Means. The Advisory Council strongly urges that this bill be passed this legislative session.

Staggering of Terms & Appropriate Number of Judges

In fiscal year 1998, a total of 18 administrative judge and administrative law judge appointments are scheduled to expire. From the Industrial Accident Board, nine full (six year) term appointments, and three recall (one year) term appointments will expire. From the Industrial Accident Review Board, all six administrative law judge appointments expire.

Such a large turnover will stress the system. Judges will be taken "off-line" (cases will not be scheduled) as the term expiration date approaches. This is done to ensure that cases brought to hearing and awaiting a decision will not need reassignment to a different judge. Moreover, a large number of candidates will have to be evaluated and reviewed.

To address this issue, Representative Robert Koczera, House Chair of the Commerce and Labor Committee, and Senator Mark Montigny have filed House 5042 which would stagger the terms of the judges and increase the number of administrative judges to 25.

Section 1 of this bill would require the staggering of administrative judge appointments beginning in 1998, to avoid future problems of multiple terms expiring in one

year. In 1998, *five* administrative judges would be appointed to *six-year* terms; *three* to *four-year* terms; *three* to *three-year* terms; and *two* administrative judges would be appointed to a *one-year* term. In 1999, *three* would be appointed to *six-year* terms. In 2000, *four* administrative judges would be appointed to *six-year* terms; *one* would be appointed to a *five-year* term, and *two* would be appointed to *three-year* terms. After these appointments have expired, appointments would be made for a term of six years.

Section 2 of this bill amends G.L. ch. 23E, §4 by increasing the number of permanent administrative judges positions at the DIA from 21 to 25. Currently the DIA has 24 administrative judges (21 permanent and 3 recall judges). Under the bill, the number of administrative judges from any one political party could not exceed 13, up from the current 11.

Section 3 of this bill would amend Chapter 23E, §5 by staggering administrative law judge appointments. Beginning in 1998, *one* would be appointed to a *one-year* term; another would be appointed to a *two-year* term; another to a *three-year* term; another to a *four-year* term; another to a *five-year* term; and another to a *six-year* term. After these terms have expired, new appointments would be made for six year terms.

The Advisory Council supports this bill and recommends that it be passed. While the bill can do nothing to alleviate the problem facing the system in 1998, it nevertheless will prevent similar stresses in the future.

In addition, the Council believes that three year initial terms should be created for new administrative judge appointments. Initial terms should apply to any appointments to the Industrial Accident Board where the appointee has not previously served at least three years. The Council believes that being an effective administrative judge requires special skills and talents that are not always discernible or apparent when interviewing candidates. The rigors of handling a demanding caseload, applying the rules of evidence, conducting effective hearings, managing contentious litigants, and issuing opinions quickly and accurately are all factors that require special talents. The skill sets of a judge cannot be effectively evaluated without reviewing actual performance.

Under the Council's plan, new judges could only be appointed for a maximum of three years and would have to serve three years before being reappointed. If the appointment was to fill a vacant six year term, the judge would be appointed for three years and would be eligible for reappointment to serve the remaining three years.

Audit of Insurance Carrier Payments

Under Massachusetts law, the operating costs of the DIA and the costs associated with the Workers' Compensation Trust Fund are paid by the employers of the Commonwealth through the DIA assessment process. The act specifies that the DIA must calculate an assessment rate which, when multiplied by an employer's standard premium, yields an employer's assessment amount. Section 65 (5) of ch. 152 specifies that the DIA must bill self insured employers and self insurance groups for these assessments. The act states that insurance carriers, however, are responsible for billing

and collecting assessments from insured employers. It requires that assessments must be separately stated on insurance bills and that insurance carriers must pay amounts to the DIA on a quarterly basis.

While the DIA bills self insurance groups and self insured employers directly for assessments, it relies on insurance carriers to self-report and pay the appropriate amounts collected from employers. Since 1986, when the DIA's funding system was first implemented, these payments have never been reviewed for accuracy and have gone unaudited. This is troublesome given the magnitude of these assessments. In fiscal year 1997, the agency collected \$53.5 million in assessments.

While the DIA recognizes the benefits of conducting an audit, and has developed tentative plans for its performance, it has delayed conducting an audit for budgetary reasons. Concerns have been expressed about the costs of an audit, and the strains it would place on agency resources. The Council is of the opinion, however, that an audit of carrier payments is a project which it cannot afford to ignore any longer.

The Advisory Council urges the Division to conduct this audit as soon as possible, so that payments can be justified and the Division can be assured that all outstanding assessments are satisfied. If appropriate, the Advisory Council will investigate the ramifications of such an audit and the impact it could have on the agency. We will investigate the steps necessary for the DIA to obtain appropriate accounting services, the amount of money needed for the project, and will recommend a process by which it can occur.

Code of Judicial Conduct

Administrative judges and administrative law judges at the Division of Industrial Accidents deserve special credit for the vast improvements which have occurred in the workers' compensation system. Not only do the statistics prove that cases are assigned and heard more speedily than in years past, but the workers' compensation bar, representing both claimants and insurers, has voiced high regard for the judges serving at the DIA. This is witnessed by last year's Massachusetts Bar Association survey in which several judges received 90% (or better) approval ratings in several areas.

At this time when so many administrative judge appointments are about to be made, special attention should be paid to the ethical obligations of the administrative and administrative law judges at the Division of Industrial Accidents. The authority they exercise over the fate of injured employees and employers should be tempered by clearly defined standards to ensure the fair administration of justice.

In 1995, the National Conference of Administrative Law Judges of the American Bar Association endorsed A Model Code of Judicial Conduct for State Administrative Law Judges.¹ This code states five canons, followed by explanations and commentary on their application. The full text of each canon recognizes the special role that judges in administrative agencies play in interpreting statutes, applying law, and resolving disputes.

¹ Most of the text of this code is based on the ABA's 1990 Code of Judicial Conduct, which has been adopted by 47 states (including Massachusetts) to apply to state court judges.

Canon 1 states that “An administrative law judge shall uphold the integrity and independence of the administrative judiciary.” Canon 2 states that “A state administrative law judge shall avoid impropriety and the appearance of impropriety in all activities.” Canon 3 states that “A state administrative law judge shall perform the duties of the office impartially and diligently.” Canon 4 states that “A state administrative law judge shall all extra-judicial activities to minimize the risk of conflict with judicial duties.” Canon 5 states that “A state administrative law judge shall refrain from political activity inappropriate to the judicial office.”

Over the past few years, several legislative proposals have been introduced to amend the workers' compensation act to require that the Commonwealth's Code of Judicial Conduct (promulgated by the Supreme Judicial Court) apply to the DIA's AJs and ALJs. Adoption of a code specifically tailored to state administrative law judges, however, would provide a better set of standards given the differences in duties, powers, and obligations between administrative law judges and trial and appeals court judges.

Should this model code be adopted by legislation, it should be incorporated by reference into Section 8 of G.L. Ch. 23E, which governs the removal of a board or reviewing board member. Under this section, the Commissioner and the Senior Judge have authority to initiate procedures for removal when they both are of the opinion that a member “has been guilty of misconduct, material neglect of duty, inability to perform the duties required of a member, or incompetence in the conduct of office.” These standards are overly general, provide little guidance to policy makers, and the provision is believed by many to be a near impossibility to implement. By stating that removal could be made when judges have materially violated the canons, section 8 could be more easily implemented.

The Advisory Council recommends that a task force be created, consisting of the Senior Judge, administrative law judges, administrative judges, and attorneys from the claimant's bar and the defense bar, to review this Model Code. It should be carefully analyzed for application to DIA judges. A report discussing the merits and problems with applying this code should be written and submitted to the Commerce and Labor Committee for appropriate action.

Year End Balances

As reported by the Advisory Council in prior Annual Reports, the Division of Industrial Accidents has carried forward substantial funds from one year's budget to the next. These balances, as reflected in the Collections and Expenditures Report (see Appendix N), indicate that more than 50% of the DIA's annual operating expenses have been held over at the end of the last three years. In FY 1997, for example, the DIA spent \$22,124,993 in operating costs, but carried forward a balance of \$11,836,705.

The workers' compensation act is specific about limiting the amount of funds the agency can maintain, in a clear effort to prohibit “stockpiling” of funds. It specifically states that only 35% of a prior years expenditures can be brought forward in a new fiscal year. Any balance exceeding 35% of the prior year's expenditures must be used to reduce the employers assessment.

The DIA experienced dramatic increases in assessment collections between fiscal year 1993 and fiscal year 1995, with collections increasing 54%. In fiscal year 1994, assessments increased from \$13.7 million to \$17.4 million, and in fiscal year 1995, to \$21 million. Since that time, assessments have receded to \$16.8 million (FY '96) and \$14.5 million (FY '97). These large, assessment collections in 1994 and 1995 appear to have caused the large year end balances. While the DIA has adjusted its assessment rate to reduce year end balances as required by Section 65 of the act, they remain especially high.

During FY 1997, Commerce and Labor Committee Chairman Robert Koczera introduced legislation that would amend chapter 152 so that the DIA could not continue to hold over such large balances. House 3588, An Act Relative to the Department of Industrial Accidents, would require that any year end balance be completely expended in the next fiscal year by lowering employer's assessments.

The Advisory Council feels strongly that the DIA's year end balances have been excessive. Carrying over 50% of expenditures is excessive, and employers should not be required to pay large assessments when balances remain so high. We support legislation that would mandate smaller year end balances. The Council, however, recognizes that the agency must have funds to continue operations into a new fiscal year. We therefore are reluctant to amend the act to eliminate all carryover of funds. We recommend that the threshold be amended to reflect first quarter expenditures which would enable the agency to operate through its first collections cycle. We advise the DIA to determine what proportion of its yearly expenditures are made in the first quarter. That ratio should be the threshold incorporated into section 65 of the act.

LEGISLATION

During fiscal year 1997, sixty-two bills were filed by legislators seeking to amend the workers' compensation system (see Appendix G). Most bills concerning workers' compensation matters are referred to the Joint Committee on Commerce & Labor. Once legislation is referred to the committee, public hearings are held on the bills. A hearing covering most of these bills was held on April 30, 1997. On June 23, the committee met in executive session where the members voted to recommend that each bill either receive a favorable rating of "ought to pass," an unfavorable rating of "ought not to pass," to order further study, or to extend it for further examination until a particular date.

During the session, proposals ranged in scope from increasing the benefits to providing discounts for employers with drug testing programs.

The Advisory Council was asked to conduct a study on the cost impacts of increasing benefits, as contained in H. 1441, as well as other proposals. We were requested to complete the project by November, 1997.

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

Bills with a "Favorable Rating"

Lump Sum Settlements - (H.653, Rep. Koczera, attached to S.71, Sen. Morrissey)

This bill seeks to amend §48 of the act which pertains to lump sum settlements. This bill would elevate the role of the conciliator to approve lump sum settlements "as being in the claimant's best interest." Currently, the statute provides that conciliators may "approve as complete" lump sum settlements, a much lower standard.

Voluntary Payment of Benefits - (H.654, Rep Koczera, attached to S.70 Sen. Morrissey)

This bill would amend section 19 of the act which addresses agreements between an insurer and a claimant to voluntarily pay benefits. It seeks to allow insurers who do not make prompt payment within 14 days to have the benefit of the pay without prejudice period should the insurer agree to make future payments. This bill would broaden the circumstances under which disputes can be resolved amicably without a full evidentiary hearing.

Employee Leasing Companies - Exclusive Remedy - (H.881, filed by Rep. Kaufman)

This bill would amend §14A which allows the Commissioner of Insurance to regulate the terms of workers' compensation policies for employee leasing companies. The bill would extend the exclusive remedy doctrine to both the leasing company and the client company, as well as the provisions of the employer's liability provisions of a workers' compensation policy, in any given controversy.

Lump Sum Settlements - (H.2051, filed by Rep. Donovan)

This bill would amend §48 by requiring that a carrier's waiver of reimbursement under §15 could not be considered future weekly benefits. It would also remove the requirement that employers approve lump sum settlements.

Competitive Rating - (H.2238, Rep. Bosley, attached to H.3773, Rep. Koczera)

This bill would require a system of competitive rating of workers' compensation insurance rates. Insurance carriers would competitively price insurance coverage, rather than have the Commissioner of Insurance approve a uniform set of rates required for all carriers. This bill was extensively studied by the Council in the Fall of 1996, when a lengthy report was prepared by J.H. Albert and submitted to the Legislature. The Council endorsed the proposal, with some suggestions and cautionary remarks. The bill incorporates the concerns of the Advisory Council.

Special Fund & Trust Fund Budgets - Year End Balances - (H.3588, Rep. Koczera)

This bill was reported favorably with a Committee redraft. Section 1 of this bill would amend §65(4) to require that the Advisory Council vote and record its support or opposition to any proposed trust fund budget. Section 2 would amend how much money the DIA can carry forward each year from year-end balances. Currently, only 35% of a prior year's expenditures can be brought forward in a new fiscal year. Any balance exceeding 35% of the prior year's expenditures must be used to reduce the employers special fund assessment. This bill, as it is written, would make it nearly impossible to reduce year end balances because it would require reductions only when the balance exceeds a prior year's expenditures. To ensure that balances are reduced to a greater extent than current practice, a lower amount than 35% of expenditures ought to be the threshold. The bill should be amended to read some percent less than 35%.

Workplace Safety Programs - (H.3589, Rep. Koczera)

This bill would create within the DIA an Office of Safety, Training and Injury prevention, responsible for the implementation and enforcement of safety programs for employers of the Commonwealth. Employers with ten or more employees would be required to prepare a written safety program and establish a management loss control committee to carry out workplace safety programs that encourage injured employees to return to work and educate employees on workplace safety. This bill would require the Commissioner of the Division of Industrial Accidents to develop a list of the ten lowest experience modification employers for each policy year in an effort to recognize employers for their safety efforts. Employers who fail to establish a management loss control committee as required, can be subject to a stop work order, requiring the cessation of all business operations.

Purchase of Insurance Requirement - (H.3591, Rep. Koczera)

This bill would require the DIA to file with the House and Senate Committees on Ways & Means, and the Committee on Commerce and Labor a review of all transfers between

budget subsidiary accounts in the prior fiscal year. This bill would also require the DIA Commissioner to provide the Secretary of the Commonwealth with a notice explaining the duties, responsibilities, and liabilities of each corporation to purchase and provide workers' compensation insurance coverage.

Average Weekly Wage - Attorney's Fees - (S.53, Sen. Lynch, Connolly, and Shannon)

Section 1 of this bill addresses injured employees who return to work (without a lump sum settlement) and receive wages which are less than the pre-injury wages. This bill would apply the prior average weekly wage to any subsequent period of incapacity, whether or not such incapacity was the result of a new injury or subsequent injury as set forth in §35B. Section 2 of this bill would eliminate consideration of the last best offer in awarding attorney's fees when the insurer files for discontinuance of benefits or refuses initial payment. Currently, the claimants attorney is only entitled to payment if the administrative judge accepts the offer of the claimant or the amount submitted by the conciliator.

Scar Based Disfigurement - (S.71, Sen. Lynch)

This bill would eliminate the requirement that scar based disfigurement appear on the face, neck or hands to be compensable. This would require compensation for all disfigurement, whether or not scar based, regardless of its location on the body. Section 36(k) was amended by chapter 398 to limit payments for purely scar based disfigurement by requiring benefits only when the disfigurement is on the face, neck, or hands.

Employer Fines - Increase - (S.1840, Sen. Lynch)

This bill was written by the Advisory Council with the assistance of a panel of insurance experts. The bill seeks to curtail abuses of employers who fail to carry workers' compensation insurance by increasing the fines and penalties imposed on violating employers. Senate 1840 would require that violators pay a fine equal to three times the amount of premium which was avoided. In addition, the bill would require employers to pay a \$5,000 criminal penalty in severe cases and reimburse the DIA Trust Fund when an employee is injured and requires trust fund benefits. The bill would also allow companies to sue violators under the Unfair and Deceptive Business Practices Act (ch. 93A) when losing a competitive bid as a result of premium avoidance. Finally, it would require the Division of Industrial Accidents to conduct an education campaign to inform the entire employer community of the insurance requirement and the new fines.

Bills with an “Extension Order” For Further Consideration

Increase Benefits - (H.1441, Rep. Cabral)

This bill would increase wage benefits for injured workers under sections 34 and 35 by restoring the amount to 2/3 of average weekly wage and the duration to 260 weeks for §34 (currently 156) and 600 weeks for §35 (currently 260 or 520 for serious injuries).

Total Incapacity (§34) - Increase Benefits - (H.3006, Rep. Kennedy)

This bill would increase the weekly compensation for total incapacity (§34) benefits. Compensation would increase from the current 60% to 2/3 of average weekly wage.

Partial Incapacity (§35) Increase Benefits, Limit Durations - (H.3008, Rep. Kennedy)

This bill would increase temporary total benefits to 2/3 of average weekly wage. It would eliminate the requirement that benefits not exceed 75% of §34 benefits and combined earnings and benefits not to exceed two times the state average weekly wage. It also amends the maximum duration from 260 weeks to 520 weeks.

Attorney's Fees - Agreements to Pay Benefits - (S.56, Sen. Lynch)

Section 1 of this bill would allow attorneys to collect fees for advancing an employee's rights under section 75A (preferential hiring of injured workers) and 75B (protections against handicap discrimination), in addition to any attorney's fees owed under section 13A. Section 2 of this bill adds two new subsections to section 19. It would allow any administrative judge, administrative law judge or conciliator to approve any agreement to pay benefits authorized by §19. In addition, it would allow an agreement to include a pay without prejudice clause.

SECTION
- 1 -

OVERVIEW

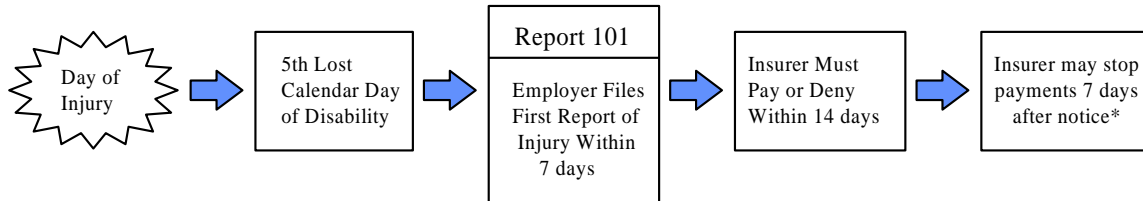
Provisions to Resolve Disputes.....19

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PROVISIONS TO RESOLVE DISPUTES

Figure 1: Schedule of Events

Schedule of Events:



*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.

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.

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.² When the insurer pays a claim, it may do so without accepting liability for a period of 180 days. 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.³ 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.

After a conference order is issued or the pay without prejudice period expires, the insurer may not stop payment without an order from an AJ. 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.

² 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.

³ The pay without prejudice period may be extended up to one year under special circumstances. The DIA must be notified seven days in advance.

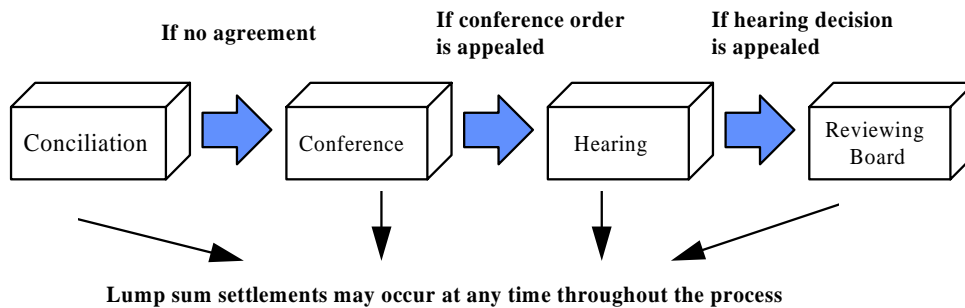
Dispute Resolution Process

Requests for adjudication may be filed either by an employee seeking benefits, or an insurer seeking modification or discontinuance of benefits following the payment without prejudice period.

Figure 2: Dispute Resolution Process

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.



A dispute not resolved at conciliation will then be referred to a conference where it is assigned to an AJ who retains the case throughout the process if possible. The insurer must 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 AJ may require injury and hospital records. This order may be appealed to a hearing within 14 days.

At the hearing, the AJ 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 AJ 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 ALJ's will hear the case.

At the reviewing board, a panel of three ALJ's will review the evidence presented at the hearing and may ask for oral arguments from both sides. They can reverse the AJ'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 AJ 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.

Lump Sum Settlements

A case can be resolved at any point during the DIA's three step dispute resolution period by settlement or by the decision of an administrative judge (AJ) or administrative law judge (ALJ).

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.

AJ's 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. AJ's and ALJ's must determine whether settlements are 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.

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 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

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. These benefits include weekly 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. The statute dictates that the maximum benefit be set at 100% of the State Average Weekly Wage (SAWW), and that a minimum benefit of at least 20% of the SAWW.⁴

In addition, the insurer is required to furnish 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.

Below is a list of the SAWW's since 1992 and the maximum (SAWW) and minimum benefit levels for §34 and §34A claims:

Table 1: Indemnity Benefits

<u>Effective Date</u>	<u>Maximum Benefit</u>	<u>Minimum Benefit</u>
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
10/1/96	\$631.03	\$126.21
10/1/97	\$665.55	\$131.11

Source: DIA Circular Letter No. 289 (October 1, 1997)

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

⁴ 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, 1997, the SAWW is \$665.55.

(\$665.55), while the minimum is 20% of the SAWW (\$133.11) if claims involve injuries occurring on or after October 1, 1997. 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 (\$665.55), while the minimum is 20% of the SAWW (\$133.11) if claims involve injuries that occurred on or after October 1, 1997. 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 G.L.152 §13A(10). As of October 1, 1997 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 **\$822.06** plus necessary expenses. If the employee's attorney fails to appear at a scheduled conciliation, the amount paid is **\$411.03**.

(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 **\$1,174.41**. 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 \$ **587.21**.

(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 **\$587.21** plus necessary expenses. This fee can be reduced to **\$293.61** 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 **\$822.06** 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 **\$411.03** 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 **\$4,110.30** 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 **\$1,174.41**. 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.

SECTION

- 2 -

WORKPLACE INJURY & CLAIMS STATISTICS

<i>Occupational Injuries and Illnesses.....</i>	<i>27</i>
<i>Case Characteristics.....</i>	<i>29</i>

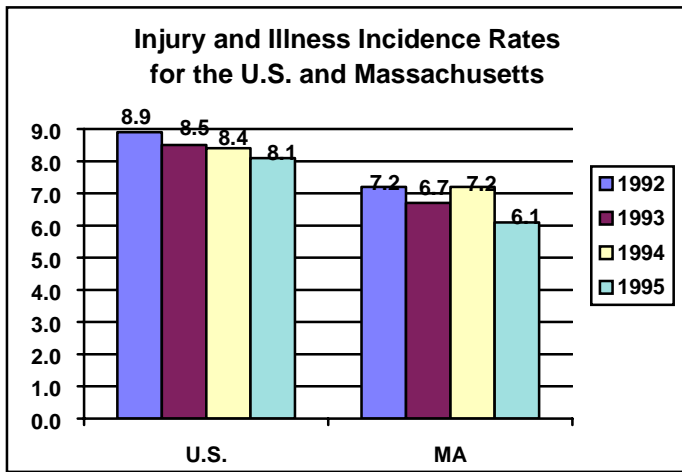
OCCUPATIONAL INJURIES AND ILLNESSES

Every year the Massachusetts Department of Labor & Workforce Development in cooperation with the U.S. Department of Labor, Bureau of Labor Statistics, conducts an *Annual Survey of Occupational Injuries and Illnesses* in Massachusetts. This study surveys 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 1995.

The initial results of the 1995 annual survey were released in March of 1997. In 1995 the Commonwealth averaged 2,537,800 workers in the private sector workforce. Of these workers, 127,100 experienced some sort of job-related injury or illness. This means that for every 100 full-time workers, 6.1 were injured in 1995 (incidence rate). For the fourth year in a row, Massachusetts ranks the lowest incident rate among all New England states and well below the national average of 8.1. Out of the 127,100 cases, 64,200 were serious enough to keep workers from their jobs for at least a day (or required restricted work activity). For the third year in a row, Massachusetts displayed the lowest overall rate of workplace injuries in New England with an incidence rate of 7.2. This makes the Commonwealth the only New England state to remain below the national average for four consecutive years.

	1995	1994	1993	1992
U.S.	8.1	8.4	8.5	8.9
MA	6.1	7.2	6.7	7.2
CT	8.0	8.5	9.0	9.0
ME	9.7	10.5	10.7	10.8
RI	8.5	8.5	7.9	8.5
VT	no data	9.3	9.3	9.1
NH	no data	no data	no data	no data

Figure 3: Injury and Illness Incidence Rates



Source: Labor & Industry News - March '97

Table 2: Injury Incidence Rates by Industry

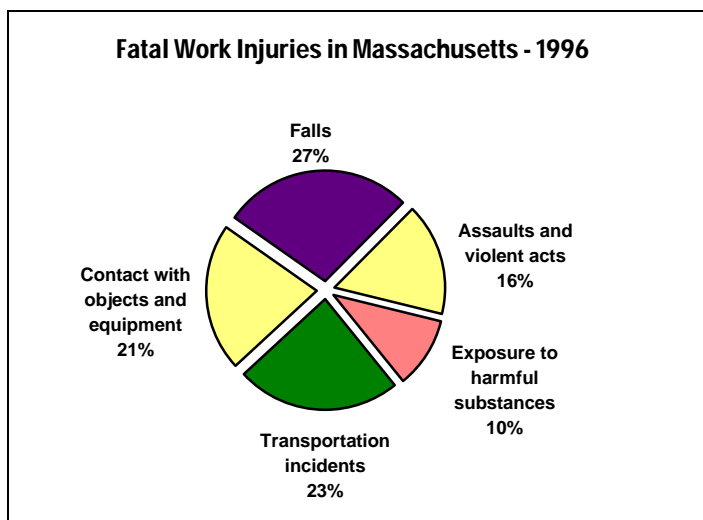
Industry Division (Massachusetts)	1992	1993	1994
Private Industry	7.2	6.7	7.2
Agriculture, forestry, and fishing	10.1	9.2	10.9
Construction	11.9	10.5	11.2
Manufacturing	7.3	7.3	8.1
• Durable goods	6.6	6.8	7.3
• Nondurable goods	8.6	8.4	9.4
Transportation and public utilities	8.3	9.0	9.3
Wholesale and retail trade	7.9	7.6	7.5
• Wholesale trade	6.3	7.1	7.5
• Retail trade	8.7	7.9	7.6
Finance, insurance, real estate	5.9	2.1	2.3
Services	6.3	6.1	6.8

The survey also categorized incidence rates according to Massachusetts industry. The construction industry clearly had the highest overall incidence rate in 1994 with 11.2 injuries for every 100 full time workers. Finance, insurance and real estate had the lowest incidence rates, with 2.3 injuries per 100 workers.

Source: Labor and Industry News, May 10, 1996

Fatal Work Injuries

Fatal work injuries in Massachusetts 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 1996 a total of 62 fatal work injuries occurred in Massachusetts. This calculates to be only 1% of the 6,112 fatal work injuries nationally.

Figure 4: Distribution of Fatal Occupational Injuries by Event in Massachusetts

Falls were the leading cause of workplace deaths in Massachusetts at 27% of the total cases in 1996. Nationally, the leading cause of workplace death results from transportation incidents (42%). Massachusetts' deviation from the national average is most likely reflective of the heavy presence of the construction industry in the economy.

Source: Bureau of Labor Statistics, *News* 8/7/97

CASE CHARACTERISTICS

The following tables and statistics illustrate trends, by injury type⁵ in claims, average claim cost, distribution of losses, and frequency for the five most recent years of available data. This data is derived from insurance claims paid by commercial insurers writing policies in the state and does not include data from self insured employers or self insurance groups (SIGs). 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. Each year of the data is developed to the fifth report so the years can be compared equally.

The number of claims for all injury types have been declining for the last five years. This corresponds with data from the DIA indicating a major decline in its case load. The average claim cost has risen steadily over a five year trend. In the 1988/89 policy year, 78% of the losses were paid in indemnity (wage replacement) benefits, while 22% paid for medical benefits. A shift occurred by the 1992/93 policy year to 68% for indemnity benefits and 32% medical.

Case Data By Injury Type

Table 3: Claim Counts

<i>Composite Policy Year</i>	<i>Fatal</i>	<i>Permanent Total</i>	<i>Permanent Partial</i>	<i>Temporary Total</i>	<i>Medical Only</i>
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

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

<i>Composite Policy Year</i>	<i>Fatal</i>	<i>Permanent Total</i>	<i>Permanent Partial</i>	<i>Temporary Total</i>	<i>Medical Only</i>
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

⁵ It is important to note that the WCRB claim categories do not correspond to specific sections of the workers' compensation act. For example, the permanent total category includes predominantly section 34A benefits, but may also include benefits under section 30 and section 36.

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

SECTION

- 3 -

DISPUTE RESOLUTION

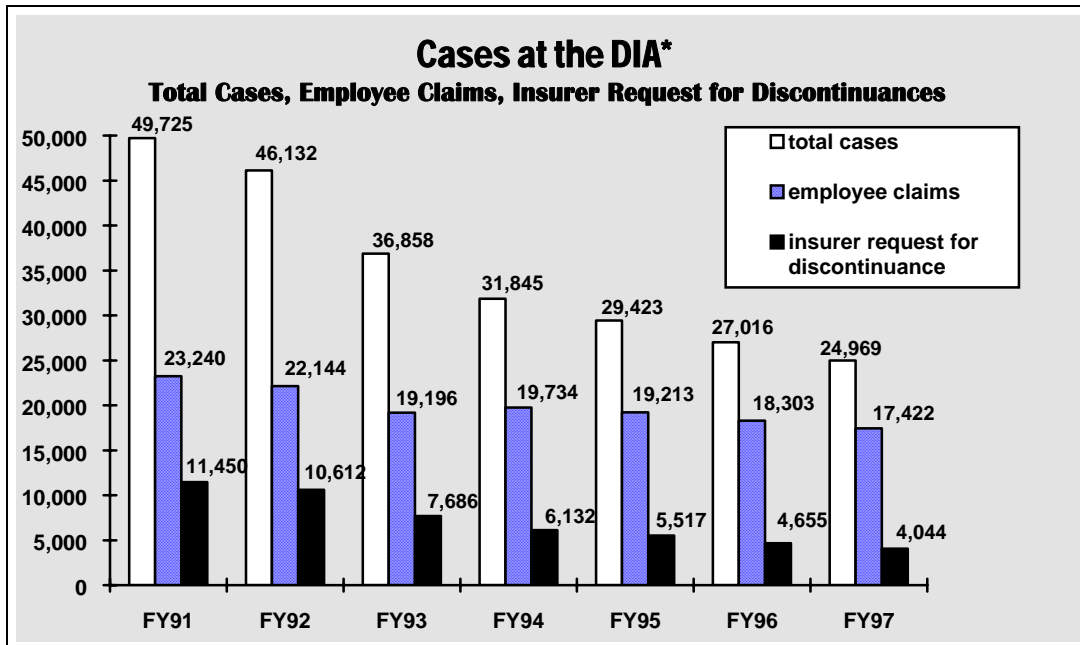
<i>Cases at the DIA.....</i>	<i>35</i>
<i>Administrative Judges.....</i>	<i>36</i>
<i>Conciliation.....</i>	<i>38</i>
<i>Conference.....</i>	<i>42</i>
<i>Hearings.....</i>	<i>45</i>
<i>Case Time Frames.....</i>	<i>48</i>
<i>Reviewing Board.....</i>	<i>53</i>
<i>Lump Sum Settlements.....</i>	<i>56</i>
<i>Impartial Medical Examinations.....</i>	<i>58</i>

DIA CASELOAD

Cases originate at the DIA when any of the following are filed: an employee's "claim" for benefits, an insurer's "complaint" for reduction of benefits, a third party claim, or request for approval of a lump sum settlement.

As demonstrated in Figure 5, there has been a significant decline in cases (50%) at the DIA since implementation of the 1991 reform act. For the fifth straight year, "total cases" have continued to decline, decreasing by 7.5% in FY'97. Employee's claims, which account for 70% of the total cases, declined 4.8% in FY'97 to 17,422 and have decreased 25% since 1991. Most noticeably, insurer requests for discontinuances declined 13.1% in FY'97 and has declined by 65% since 1991.⁶

Figure 5: Total Cases



Source: DIA report 28

***Note:** Total Cases include employee claims, insurer request for discontinuance, lump sum request, third party claims, and section 37/37A requests.

⁶ DIA report 28: Statistics for sections of the law being claimed (indicates cases that are received at the DIA for litigation).

ADMINISTRATIVE JUDGES

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. At the close of FY'97 there were 25 administrative judges (AJ's) in Boston and the regions presiding over the conference and hearing stages of dispute resolution. Of these, 21 serve six year terms, and four were appointed for one year re-call terms. The statute provides for the appointment of 21 AJ's, but allows the governor to recall AJ's whose terms have expired for one year terms.

The Senior Judge may refuse to assign new to AJ's with an inordinate number of hearing decisions outstanding. 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.

The Senior Judge typically will take an AJ off-line near the end of a term until reappointment is made. 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.

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). [see Appendix K for members]

When a judicial position becomes available, the nominating panel convenes to review applications for appointment and reappointment. 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 ALJ's 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.

Advisory Council Review

The Advisory Council reviews and rates those candidates approved by the Nominating Panel. Once Council members receive all information on the candidates, they are invited for an interview before Council. On the affirmative vote of at least seven voting members, the Advisory Council may rate any candidate either "qualified," "highly qualified," or "unqualified." The Council may wish to take "no position" on a candidate if consensus cannot be reached. Once a rating has been issued, it is then sent to the Governor.

For a list of the appointment and expiration dates of the 25 administrative judges and the 6 administrative law judges, see appendix D.

Scheduling Cycle

In FY'97 the 25 Administrative Judges at the Division of Industrial Accidents worked in 12 week scheduling cycles (this cycle was reduced from 13 weeks as the result of decreasing caseloads). The first three weeks of the cycle are devoted to conferences, the next two weeks are for continuances and writing, the next five weeks are devoted to hearings, and the final two weeks are set aside for continuances and writing..

Week 1	Conferences
Week 2	Conferences
Week 3	Conferences
Week 4	Continuances
Week 5	Writing
Week 6	Hearings
Week 7	Hearings
Week 8	Hearings
Week 9	Hearings
Week 10	Hearings
Week 11	Continuances
Week 12	Writing

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 substantiating the positions of both sides of 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

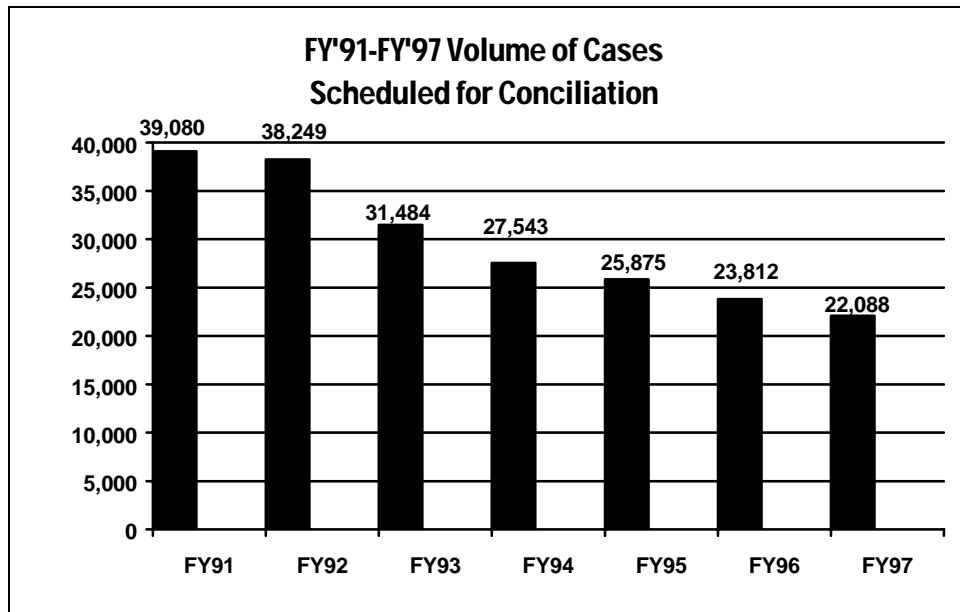
Conciliations are scheduled automatically by computer at the Office of Claims Administration (OCA). Attendance of both the insurer and the employee is required. The employer may attend, as well as other interested parties with permission of the parties. All relevant issues (including causal relationship, disability, medical condition, etc.) are reviewed at the meeting.

When liability is not an issue but modification or discontinuance of benefits is sought, both parties are required to submit written settlement offers. 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 reviewed at conciliation is indicative of the total volume of disputed claims because nearly every case to be adjudicated must first go through conciliation. The case load at conciliation peaked in 1991 at 39,080 cases. After the 1991 reforms, the volume has decreased every year to the current low of 22,088 cases in fiscal year 1997 (43% less than 1991 levels).

Figure 6: Volume of Cases Scheduled for Conciliation

Source: DIA report 17

Figure 6 indicates the number of conciliations scheduled in FY'97. The volume of cases scheduled for conciliation decreased by 7.2% in FY'97. Out of the 22,088 conciliations scheduled in FY'97, 18,757 conciliations actually occurred.⁷

Conciliation Outcomes

Cases Referred to Conference - Conciliation outcomes may be divided into two major categories: "referred to conference," or "resolved." In FY'97, 56% of the 22,088 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%.⁸

As in previous years, a small percentage (2%) 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.

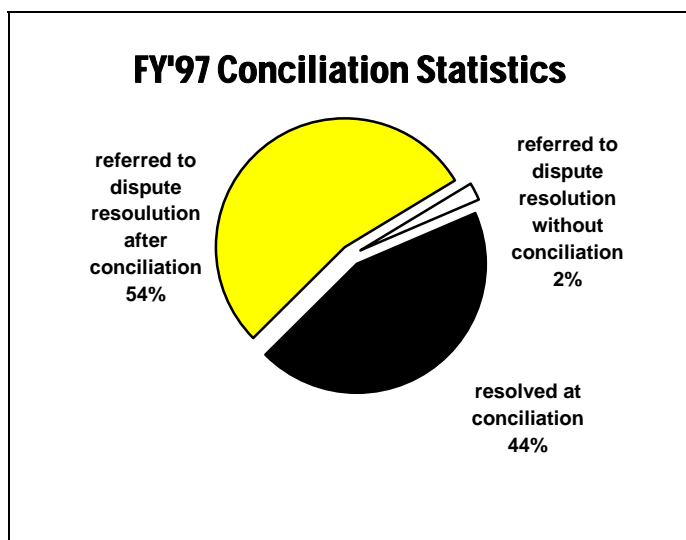
Resolved Cases - The remaining 44% of conciliation cases in FY'97 are considered to be resolved (that is they were not referred on to conference). Numbers for FY'97 are similar to previous years (FY'96 - 45%, FY'95 - 47%, FY'94 - 45%, FY'93 - 46%, FY'92 - 49%, FY'91 - 48%). While the case load has decreased since the 1991 reforms, the percentage of cases resolved at conciliation has remained around 50%. Cases may be

⁷ This figure accounts for those cases withdrawn or adjusted prior to the actual conciliation. "Referred to conference" (11,989), "conciliated - adjusted" (3,670), "conciliated- pay without prejudice" (86), "withdrawn at conciliation" (2,093), "lump sum approved as complete" (454), "referred to lump sum" (465) = 18,757

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

withdrawn or rescheduled when information is deficient or the procedure is not followed properly, thereby removing incomplete cases from proceeding to conference.

Figure 7: Fiscal Year 1997, Conciliation Statistics



Source: DIA report 17

Conciliation Outcomes FY'97 and FY'96	Number of Cases		Percentage	
	FY'97	FY'96	FY'97	FY'96
Referred to Dispute Resolution	12,420	13,069	56.2%	54.8%
Withdrawn	4,058	4,628	18.3%	19.4%
Adjusted Prior to Conciliation	792	878	3.5%	3.6%
Lump Sum	1,062	985	4.8%	4.1%
Conciliated-Adjusted	3,670	4,122	16.6%	17.3%
Conciliated-Pay Without Prejudice	86	130	0.3%	0.5%
Totals	22,088	23,812	100%	100%

Source: DIA Report 17

Resolved cases- conciliated

Cases may be “conciliated” in two ways. 38% 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 exactly the same as last year’s percentage of “conciliated-adjusted” cases.

Cases may also be “conciliated - pay without prejudice” (1% of resolved cases in both FY'97 and FY'96) 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, 38% were rescheduled in FY'97. This is an increase from the 37% in FY'96, 35% rescheduled in FY'95, 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.

⁹ DIA report 16

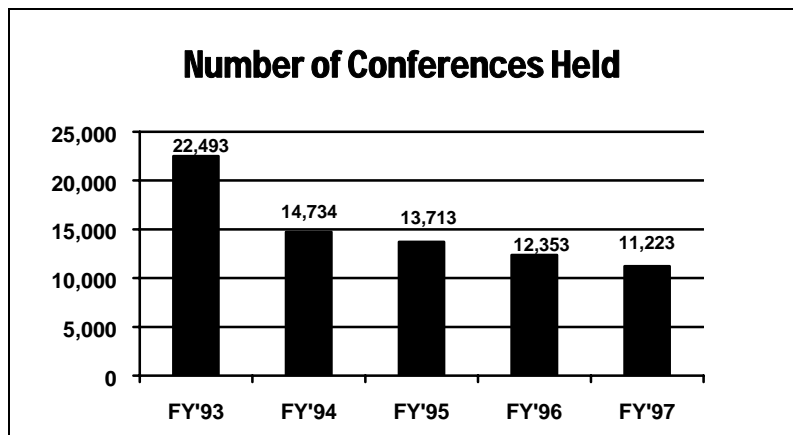
CONFERENCE

Each case referred to a conference is assigned an administrative judge who must retain the case throughout the entire process if possible. The conference is intended to compile the evidence and to identify the issues in dispute. The administrative judge may require injury and medical records as well as statements from witnesses. In FY'97, conference orders were issued on average within 6 days of the close of the conference. The judge's conference order may be appealed within 14 days to a hearing.

Volume of Conferences

The number of conferences held in FY'97, decreased by 9.1% (12,353 in FY'96 to 11,223 in FY'97¹⁰). Historically, the number of conferences held has represented approximately half of the cases scheduled for conciliation. FY'97 numbers are in this range, whereas in FY'93 the volume of conferences (22,493) was well above 50% of conciliations, as the backlog of cases began to be resolved.

Figure 8: Fiscal Years 1993-1997, Conferences Held



Source: DIA Report 45B

Conference Outcomes

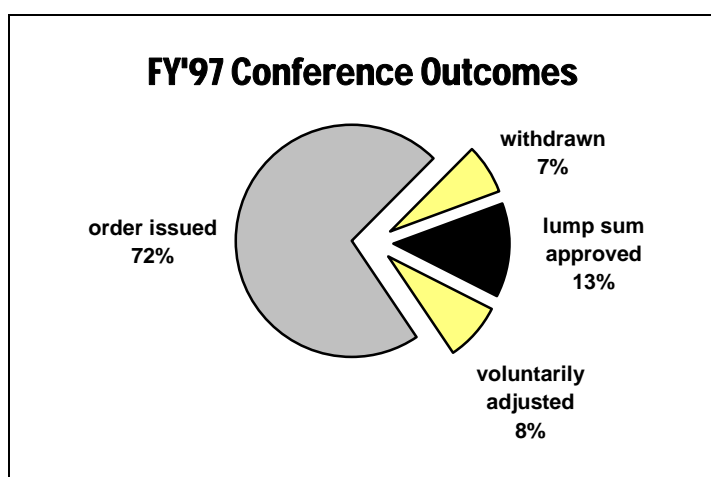
When a case is withdrawn, directed to lump sum conference, or voluntarily adjusted, it may never actually reach the conference as it could be settled before review by the administrative judge. A case may be withdrawn at or before the conference either by the moving party or by the administrative judge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

¹⁰ 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 11,223 conferences which took place and were completed in the year.

In a majority of conferences (72% in FY'97) the administrative judge will issue an order to modify, terminate or begin indemnity medical benefits. This is a slightly higher percentage than the last fiscal year. In fiscal year 1997, 84.2% of conference orders were appealed, a slight increase from 83.8% in FY'96.

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 a retired 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 by the presiding AJ rather than scheduling a separate meeting. Lump sum settlements approved comprised a slightly lower percentage of the dispositions in FY'97 (13.3%) than in FY'96 (14.3%).

Figure 9: Fiscal Year 1997, Conference Outcomes



Source: DIA report 45B

Figure 10: Fiscal Years 1997 and 1996, Conference Outcomes

Conference Outcomes FY'97 and FY'96	Number of Cases		Percentage	
	FY'97	FY'96	FY'97	FY'96
Withdrawn	794	891	6.6%	6.7%
Lump Sum Settlement Approved	1,600	1,900	13.3%	14.3%
Voluntarily Adjusted	994	1,126	8.3%	8.5%
Order Issued	8,597	9,272	71.6%	69.8%
Other	30	100	0.2%	0.8%
Total	12,015	13,289	100%	100%

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

Conference Queue

The Senior judge has explained that a conference queue of between 1,500 and 2,000 cases can be scheduled within the 12 week scheduling cycle.¹¹ A queue much

¹¹ In FY 1998, another week of hearings was added to the scheduling cycle, making it weeks.

lower than 1,500 will not provide enough cases for the judges to hear and a queue higher than 2,000 will require changes in scheduling and assignment of cases

The conference queue remained relatively stable throughout FY'97, ending 123 cases above the start of the year (2,129 on 7/2/96 and 2,252 on 6/25/97). The queue fluctuated throughout the year, responding to the scheduling cycle of the judges. The queue reached a high of 2,826 on 6/11/97 and a low of 862 on 10/30/96.

Figure 11: Conference and Hearing Queues; Fiscal Years 1991 -1997

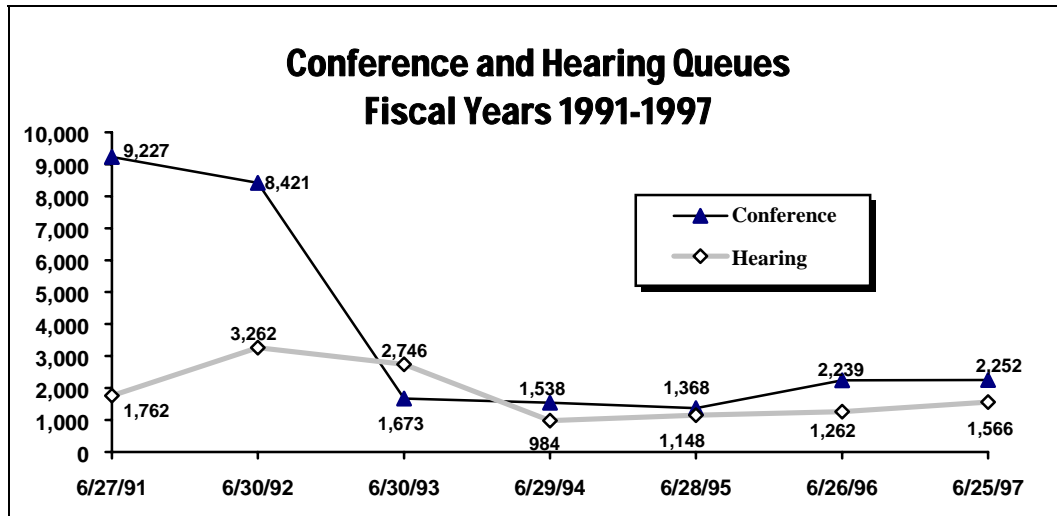
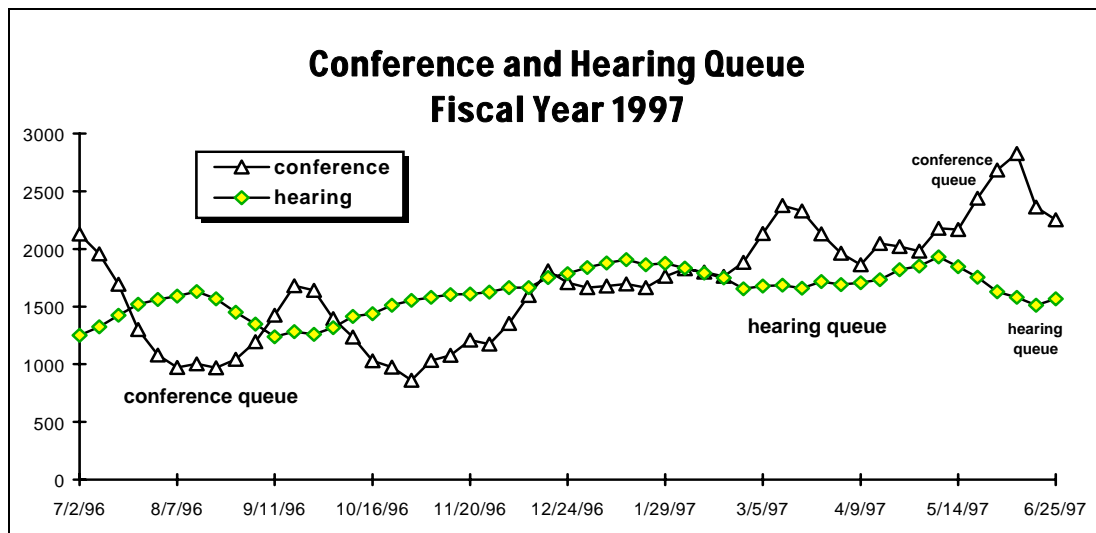


Figure 12: Conference and Hearing Queue; Fiscal Year 1997



Source: DIA report 404

HEARINGS

According to the workers' compensation act, the administrative judge that presided over the conference must 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'97, the average time from the beginning of a hearing to the issuance of the decision was 193 days.¹² This is 15 days longer than the average of 178 days last fiscal year. 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 25 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 hearing queues may arise for individual judges with high appeal rates.

Hearing Queue

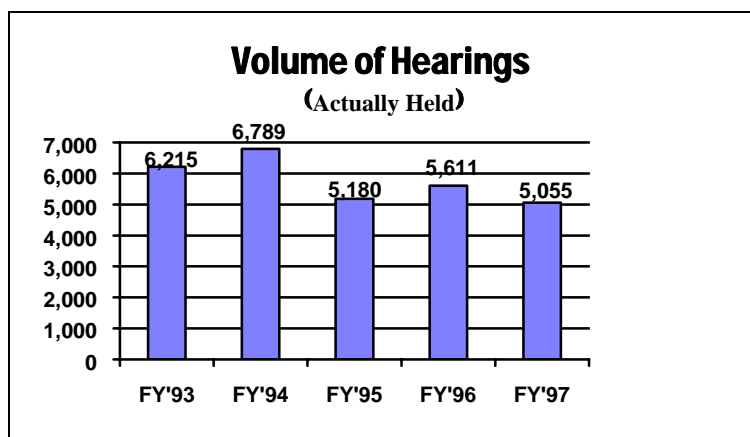
It is difficult to compare the hearing queue with the conference queue because of differences in the two proceedings. Hearings must be scheduled with the same judge who presided over the conference, whereas conferences are scheduled according to availability (when "judge ownership" is not yet a factor). Since hearings are also more time consuming than conferences it takes more time to handle a hearing queue than a conference queue. Fiscal year 1997 began with a conference queue of 1,251 and ended at 1,566. In the last seven 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'97 4,697 cases were appealed to the hearing stage of dispute resolution (55% of the 8,597 conference orders) but approximately 5,055 hearings were held.¹³

¹² DIA report 591. Senior Judge Jennings disputes this figure. According to his statistics, the day the hearing begins through the day the hearing decision is issued is an average of 101.5 days. At the time of this printing, this large discrepancy is being investigated.

¹³ Dispositions included: "Voluntarily Adjusted," "Referred to Lump Sum," "Decision Filed," "Lump sum Approved/Recommended," and "Administrative Withdrawal."

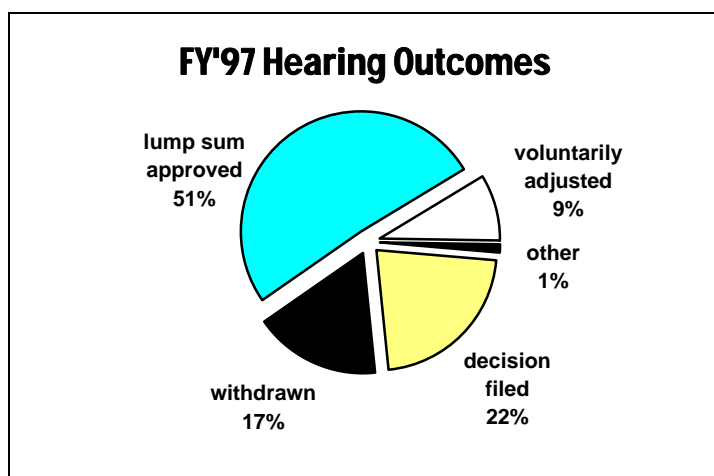
Figure 13: Fiscal Years 1993-1997, Volume of Hearings

Source: DIA Report 346

The number of hearings “actually held” decreased by 10% in FY'97 to its current level of 5,055 cases. Last year this number increased by 8% to 5,611 cases.

Hearing Outcomes

The number of hearing dispositions entered in FY'97 totaled 6,210, decreasing slightly from last fiscal year's total of 7,051 dispositions.¹⁴ “Lump sums” consists of half of all the cases while “decision filed” accounts for only 22%, virtually the opposite of the situation at conference.

Figure 14: Fiscal Year 1997, Hearing Outcomes

Source: DIA Report 346

¹⁴ There is usually a greater number of dispositions than the actual number of hearings because some cases have more than one disposition, others are withdrawn before the hearing, and others are from prior years.

Figure 15: Fiscal Years 1997 and 1996, Hearing Outcomes

Hearing Outcomes FY'97 and FY'96	Number of Cases		Percentage	
	FY'97	FY'96	FY'97	FY'96
Withdrawn	1,030	1,282	17.0%	18.7%
Lump Sum Settlement Approved	3,060	3,198	50.6%	46.7%
Voluntarily Adjusted	545	649	9.0%	9.5%
Decision Filed	1,343	1,469	22.2%	21.5%
Other	74	244	1.2%	3.6%
Total	6,052	6,842	100%	100%

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'97, 3,060 lump sum settlements were approved by the judge at hearing. 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.

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 Division of Industrial Accidents' dispute resolution process. In 1991 when the Division 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.

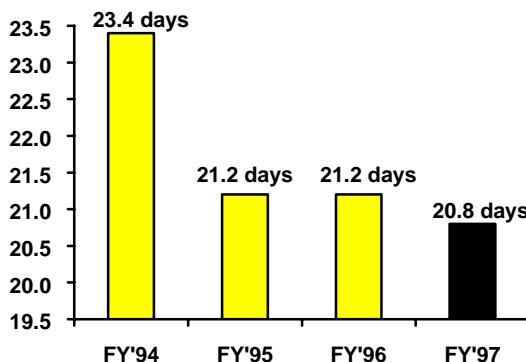
Since 1993 the DIA has been able to eliminate its backlog of cases. This was achieved by adding more judges to the DIA's division of dispute resolution, appointing a Senior Judge to manage the caseloads and assignments of the judges, utilizing management techniques to improve the functioning of the division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

The following case time frame statistics are taken from Diameter Report #491.

Case Time Frames Guide

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 Division of Industrial Accidents, a conciliation is automatically scheduled.

Claim to Conciliation



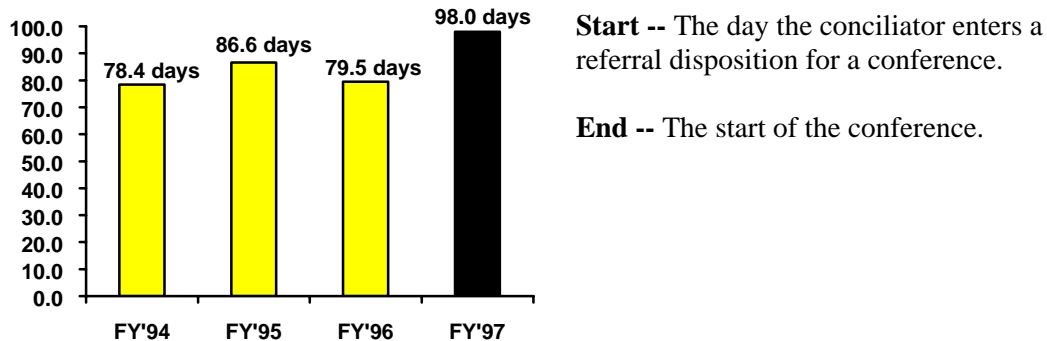
Start -- The day the Division receives the employee's claim for benefits, measured by the time stamp on the correspondence when the Division receives it (if there is no time stamp, the date that it is entered is used, however most claims have the date stamped).

End -- The day the conciliation starts.

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.¹⁵

Conciliation to 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 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.

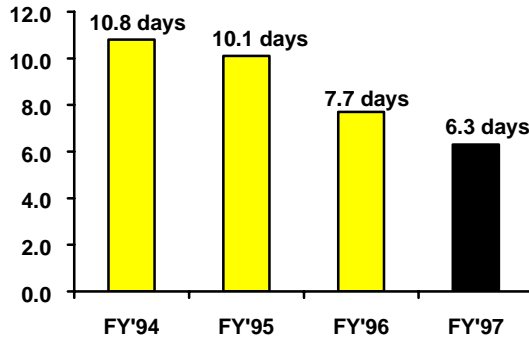
Scheduled Conference (Conference Start) to Conference Order - At the conclusion of the conference, the administrative judge must issue a determination in the form of a conference order. The conference order is a short written document requiring an administrative judge's initial impression of compensability 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

¹⁵ 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".

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

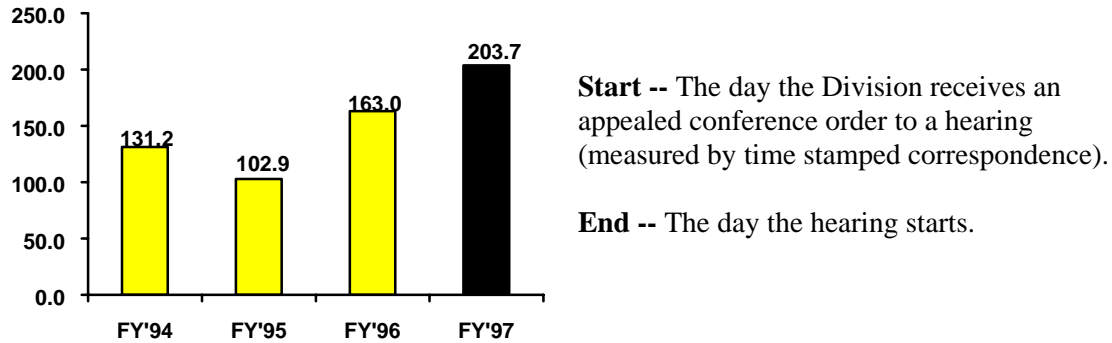


Start -- The first actual conference that takes place. If the scheduled conference is rescheduled, the start date will be the rescheduled conference.

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.

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.

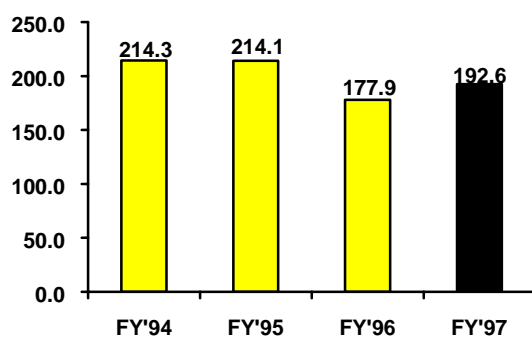
Appeal of Conference Order to Hearing

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.

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 and/or compensability.

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'97 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 11: Regional Time Frames

FY '97	Claim to Conciliation	Conciliation to Conference	Conference scheduled (start) to Order	Appeal to Hearing receipt to Hearing	Hearing scheduled (start) to Hearing decision
<i>Boston</i>	20.7 days	103.8 days	6.4 days	201.0 days	200.3 days
<i>Fall River</i>	20.7 days	81.6 days	9.7 days	196.0 days	174.6 days
<i>Lawrence</i>	21.6 days	110.7 days	7.4 days	197.5 days	205.4 days
<i>Springfield</i>	20.6 days	93.1 days	2.4 days	210.1 days	146.9 days
<i>Worcester</i>	20.6 days	90.7 days	4.6 days	217.9 days	209.5 days
<i>Statewide</i>	20.8 days	98.0 days	6.3 days	203.7 days	192.6 days

REVIEWING BOARD

The Reviewing Board consists of six administrative law judges (ALJ's) whose primary function is to review appeals of hearing decisions. While appeals are heard by a panel of three ALJ's, initial pre-transcript conferences are held by individual ALJ's. The administrative law judges also work independently to perform three other statutory duties: 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 identify and narrow the issues, to determine if oral argument is necessary and to decide if producing a transcript is necessary. 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 if needed.

Cases that are not withdrawn or settled ultimately proceed to a panel of three ALJ's. 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 vast majority of cases are remanded for further findings of fact and/or review of conclusions of law. The panel may, however, 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'97	529 cases
FY'96	506 cases
FY'95	695 cases
FY'94	657 cases
FY'93	412 cases
FY'92	493 cases

The number of hearing decisions appealed to the Reviewing Board in FY'97 was 529. This is a slight increase from last year (506). Previous totals have included: 695 (FY'95), 657 (FY'94), 412 (FY'93), and 493 (FY'92).

The Reviewing Board resolved 565 cases in FY'97 (some from the prior year) compared to 772 in the previous fiscal year.

Table 23: Appeals Resolved by Reviewing Board, FY'97

Disposition of Cases, FY'97	Number of Cases
Full Panel:	368
Lump Sum Conferences:	99
Withdrawals/Dismissals for Failing to File Briefs:	98
Total # of Appeals Resolved:	565

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 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'97, 14 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'97, administrative law judges heard 65 §15 petitions on a rotating basis, much lower than the 967 petitions heard last fiscal 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 1997 was 13.

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 AJ's) will decide if it is in the best interest of the employee to settle.

Table 24: Lump Sum Conference Statistics

<i>Fiscal Year</i>	<i>Total lump sum conferences scheduled</i>	<i>Lump sum settlements approved</i>
FY'97	9,293	8,770 (94.4%)
FY'96	10,047	9,633 (95.9%)
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 49% 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'97, only 3 lump sum settlements were disapproved in the whole fiscal year. The remainder of the scheduled lump sum conferences without an "approved" disposition were either withdrawn or rescheduled.

There are four dispositions that indicate a lump sum settlement for conciliations, conferences, and 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 protect 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 the table below.

Table 25: Lump Sum Settlements Pursued, FY'97

<i>Meeting FY'97</i>	<i>Lump Sum Pursued¹⁶</i>	<i>Percentage of Total Cases Scheduled</i>
Conciliation	1,062	4.8%
Conference	1,794	14.6%
Hearing	3,218	51.8%

Source: see previous sections on conciliation, conference and hearing

¹⁶ 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 parties must agree on the selection of an impartial physician. If the parties cannot agree, the AJ must appoint one. An insurer may also request an impartial examination if there is a delay in the conference order.¹⁷ Furthermore, any party may request an impartial exam to assess the reasonableness or necessity of a particular course of medical treatment, with the impartial physician's opinion binding the parties until a subsequent proceeding. Should an employee fail to attend the impartial medical examination they risk the suspension of benefits.¹⁸

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

¹⁷ M.G.L. c.152, § 8(4)

¹⁸ §45 of M.G.L. c.152.

examinations are determined by the Commissioner and set by regulation by the Commonwealth's Executive Office of Administration & Finance.

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'97, \$1,735,705¹⁹ was collected in filing fees.

As of 7/1/97, there were 510 physicians²⁰ on the roster consisting of 36 specialties. This is a slight decrease from the 531 physicians as of 7/1/96.

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'97 the impartial unit scheduled 6,784 examinations. Of these, 4,605 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 Division and to each party within 21 calendar days after completion of the examination. The number of exams scheduled in FY'96 was 7,465, and 5,734 were conducted in the year.

Waivers of Impartial Exam Fees

In 1995, the Supreme Judicial Court ruled that the Division of Industrial Accidents must waive the filing fee for indigent claimants appealing an administrative judge's benefit-denial order. As a result of this decision, the D.I.A. has implemented procedures and standards for processing waiver requests and providing financial relief for the section 11A fee.

¹⁹ This figure does not include "interest" or "miscellaneous" revenue (\$75,015.00)

²⁰ Including contracts pending renewal.

The Waiver Process - A workers' compensation claimant who wishes to have the impartial examination fee waived must complete the form "Affidavit of Indigence and Request for Waiver of §11A (2) Fees" (Form 136). This document must be completed before 10 calendar days following the appeal of a conference order.

It is within the discretion of the Commissioner to accept or deny a claimant's request for a waiver based on documentation supporting the claimant's assertion of indigency as established in 452 CMR 1.02. If the Commissioner denies a waiver request it must be supported by findings and reasons in a Notice of Denial report. Within 10 days of receipt of the Notice of Denial report a party can request a reconsideration. The Commissioner can deny this request without a hearing if past documentation does not support the definition of "indigent" set out in 452 CMR 1.02, or if the request is inconsistent or incomplete. If a claimant is granted a waiver and prevails at a hearing, the insurer must reimburse the Division for any fees waived.

Definition of Indigency -

An indigent party is:

- a) one who receives one of the following types of public assistance: Aid to Families with Dependent Children (AFDC), Emergency Aid to Elderly Disabled and Children (EAEDC), poverty related veteran benefits, food stamps, refugee resettlement benefits, Medicaid, or Supplemental Security Income (SSI) or
- b) one whose annual income after taxes is 125% of the current federal poverty threshold (established by the U.S. Department of Health and Human Services) as referred to in M.G.L. c.261 §27A(b). Furthermore, a party may be determined indigent based on the consideration of available funds relative to the party's basic living costs.

Size of Family Unit	Amount
1	\$9,675
2	\$12,950
3	\$16,225
4	\$19,500
5	\$22,775
6	\$26,050
7	\$29,325
8	\$32,600

For family units with more than eight members, add \$3,275 for each additional member in the family. The poverty guidelines are updated annually by the U.S. Department of Health and Human Services.

SECTION

- 4 -

DIA ADMINISTRATION

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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 1997, the Office of Claims Administration received 42,510 First Report of Injury Forms, 50 more than FY'96 (42,460). The number of claims, discontinuances and third party claims decreased to 24,757, 18.4% less than the previous year (30,361). The total number of referrals to conciliation for the fiscal year was 22,056, 7.6% less than FY'96 (23,866).

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 referred to a collection agency.

In fiscal year 1997, \$363,968 was collected in fines, a decrease from the \$377,109 collected in FY'96.

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 1997, Claims

Administration received six in house referrals. Outside referrals are directly reported to the Insurance Fraud Bureau or the Attorney General's Office. Claim Administration assists the Insurance Fraud Bureau investigators on copies of suspected workers' compensation files and receives status update letters.

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.

OFFICE OF EDUCATION AND VOC. 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.

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 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 previous 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.²¹

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 vocational rehabilitation provider.

²¹ G.L. ch. 152 secs. 30 E-H. 452 C.M.R. 4.00

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.

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'97 the Office of Education and Vocational Rehabilitation consisted of 7 disability analysts, 12 rehabilitation review officers, and 5 clerks.

OEVR certified 88 vocational rehabilitation providers in FY'97 to develop and implement the individual written rehabilitation plan (IWRP). The number of approved providers may continue to decrease in the future for reasons relating to trends in claims filing and increased use by insurers of providers who offer multiple services relating to workers' compensation services.

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 12: Utilization of Voc. Rehab. Services, FY'92 - FY'97

Fiscal Year	Referral to OEVR	Mandatory/ Inform. Meetings	Referrals to Insurer for VR	IWRPs approved	Return to work	% RTW after plan development
FY'97	3,266	2,455/292	1,094	690	320	46%
FY'96	3,347	2,653/119	1,185	727	364	50%
FY'95	3,219	2,833	1,370	811	391	48%
FY'94	3,756	3,190	1,706	948	470	50%
FY'93	4,494	3,882	2,253	1,078	554	51%
FY'92	6,014	3,367	2,106	1,010	583	58%

Source: DIA - OEVR

Trust Fund Payment of Vocational Rehabilitation

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 finance the rehabilitation services.

The amount expended by the trust fund for insurer denials has decreased substantially from FY'92 levels. Insurers are increasingly providing vocational rehabilitation on a voluntary basis, without an OEVR mandate.

Table 13: Private Trust Fund Expenditures for §30H Voc. Rehab Services

Fiscal Year	Expenditures
FY'96	8,700
FY'95	8,826
FY'94	10,970
FY'93	37,146
FY'92	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. The DIA collected no money from insurers for voc. rehab (pursuant to §30H) in FY'97. In FY'96, 8,000 was collected and in FY'95, \$54,215 was collected in reimbursements.

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.”²² 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 proposals yearly to notify the general public that these grants are available. Grants are awarded on a competitive basis according to scope and content of proposals.

See appendix F for a list of proposals recommended for funding in FY'98.

²² G.L. ch. 23E, 3(6)

OFFICE OF INSURANCE

The Office of Insurance issues self insurance licenses, monitors all self insured employers, 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.²³ To be self insured, employers must 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 any losses that may occur.²⁴ 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 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, 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'97, five new licenses were issued to bring the total number to 206 licensed companies covering a total of 417 Subsidiaries. Each self insurance license provides approval for a parent company and its subsidiaries to self insure. This amounts to approximately \$305 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).²⁵

²³ 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.

²⁴ G.L. 452 C.M.R. 5:00

²⁵ The Commonwealth of Massachusetts does not fall under the category 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 (G.L. ch.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 facilitates the filing and investigation of claims 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 the 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. In FY '97, an estimated 5,900 inquiries were made to the Insurance Register.

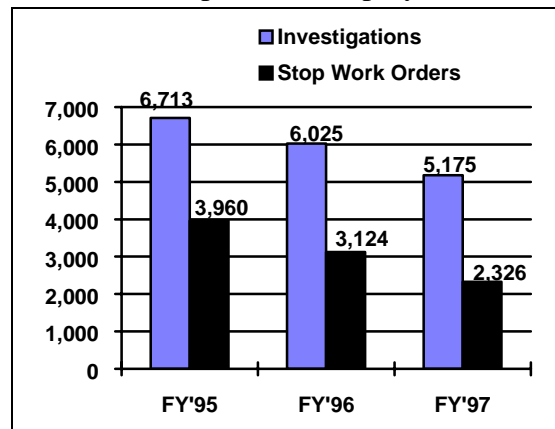
The Insurance Unit is also responsible for handling insurance complaints. Complaints are often registered by telephone and the unit will provide the party with the necessary information to handle the case. During the year, 540 complaints were handled by the office.

OFFICE OF INVESTIGATIONS

In Massachusetts, employers are required to provide for payment of workers' compensation benefits either through the purchase of insurance, through membership in a self insurance group, or through licensing as a self insurer (G.L. Ch. 152, §25A). The Office of Investigations of the Division of Industrial Accidents is charged with enforcing this mandate by investigating employers and imposing penalties for violations established by the legislature at G.L. Ch. 152, §25C.

The Office has access to the Workers' Compensation Rating and Inspection Bureau (WCRIB) database 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 appearing on this database is investigated for insurance coverage or alternative forms of financing (self-insurance, self-insurance group, reciprocal exchange). The WCRIB database documents only those employers that have or had a commercial insurance policy, and therefore is only one method of identifying uninsured employers in the state. Also, calls and letters are received from the general public that provide tips and suggestions of companies which may be lacking appropriate insurance. Furthermore, license and permit audits often uncover fraudulent employers who fail to provide adequate coverage.

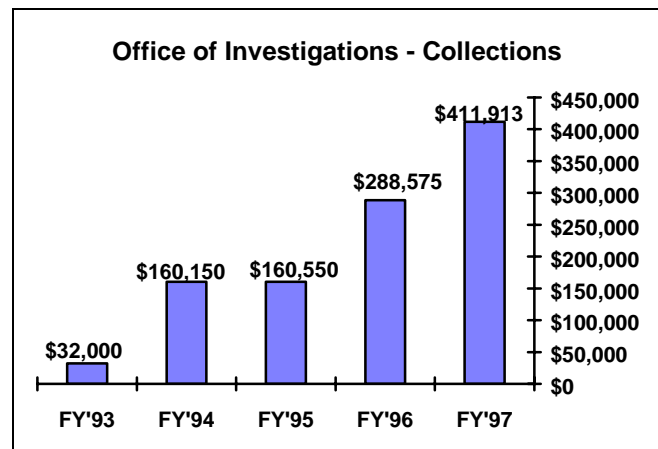
Stop Work Orders - The Office of Investigations, as required by the statute, will issue a "Stop Work Order" to any business with one or more full or part time employees that fails to provide proof of workers' compensation coverage upon demand. Such an order requires that all business operations cease and becomes effective immediately upon service. An employer may appeal the stop work order and remain open, however. In FY'97, 2,326 stop work orders were issued as a result of 5,175 investigations conducted²⁶. The number of stop work orders issued in FY'97 was 41% less than FY'95 levels. Also decreasing are the number of investigations conducted (5,175 in FY'97), down 23% from FY'95 levels.



²⁶ "Office of Investigations - Monthly Report - June, 1997," (July 2, 1997).

Fines and Penalties - Fines resulting from a stop work order begin at \$100.00 per day, starting the day the stop work order is issued, and continue until proof of coverage to the DIA is obtained. An employer who believes the issuance of the stop work order was unwarranted has ten days to file an appeal. A hearing must take place within 14 days, during which time the stop work order will not be in effect. The stop work order and penalty will be rescinded if the employer can prove it had workers' compensation insurance during the disputed time. If at the conclusion of the hearing, the Division finds the employer had not obtained adequate insurance coverage, the employer must pay a fine of \$250.00 a day beginning from the original issuance of the stop work order, continuing until insurance is obtained (G.L. ch.152 §25C). Any employee affected by a stop work order must be paid for the first ten days lost, and that period shall be considered "time worked."

In addition to established fines, an employer lacking insurance coverage may be subject to punishment by a fine not to exceed \$1,500, or by imprisonment for up to one year, or both. If the employer continues to fail to provide insurance, additional fines and imprisonment may be imposed. The Commissioner or designee can file criminal complaints against employers (including the president and treasurer of a corporation personally) who violate any aspect of Section 25C. The amount collected in FY'97 was \$411,913.



Licenses and Permits - The statute requires that local or state licensing boards obtain proof of insurance prior to issuing or renewing a license or permit (i.e. building permits, liquor licenses).

Public Contracts - Section 25C states that neither the Commonwealth nor any of its political subdivisions should enter into any contract for public work if a particular business fails to comply with any of the insurance requirements of Chapter 152. Companies involved in any local, state or other public sector funded projects can be barred from all public funded projects for a three year period for failure to carry workers' compensation insurance.

Losing a Competitive Bid - Any business that loses a competitive bid for a contract may bring an action for damages against another business that is awarded the contract because of cost advantages achieved by not securing workers' compensation insurance or deliberate misclassification of employees. If a violation is established, the person bringing on the suit shall recover, as liquidated damages, 10% of the total amount bid of the contract, or \$15,000, whichever is less (G.L.ch.152, §25C (9)).

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 whose employers did not obtain insurance, and to reimburse insurers for certain payments under sections 26, 34B, 35C, 37, 37A, and 30H. The DIA has established a department known as the Trust Fund to process requests for benefits, administer claims, and respond to claims filed before the division of dispute resolution. In FY'97, the Trust Fund had a Deputy Director and a manager to oversee the unit, as well as 5 attorneys, 2 accountants, 3 claims adjusters, 4 investigators, 3 clerks, a paralegal, and 2 registered nurses to administer the fund. These employees work in conjunction with the General Counsel and five attorneys from the Office of Legal Counsel to administer the fund.²⁷

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 DIA'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 Division's records.²⁸

In FY'97, \$4,655,470 was paid to uninsured claimants. 298 claims were filed, and 86 claims were accepted.

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

In an effort to encourage employers to hire previously injured workers, the legislature established a Second Injury Fund to offset any financial disincentives associated with the employment of injured workers.

Section 37 requires insurers to pay benefits 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"²⁹, insurers become eligible to receive reimbursement from the DIA's trust fund for 75% of compensation paid after the first 104 weeks of payment. Employers are entitled to an adjustment to their experience modification factors as a result of these reimbursements.

²⁷ 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.

²⁸ 452 C.M.R. 3.00

²⁹ 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.

Section 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 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 have ever been filed.)

At the close of fiscal year 1997, 903 claims for benefits under these sections were pending all of which pertain to §37. The Trust Fund paid \$659,801 in quarterly payments on 42 claims and settled 374 cases for \$15,818,899.

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) must 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 a maximum of 104 weeks. 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 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.

In FY'97, \$21,329 was paid for rehabilitation services on 7 cases (See OEVR).

Latency Claims (Section 35C)

Section 35C states that when there is at least a five year difference between the date of injury and the date of benefit eligibility, benefits' paid will be based upon levels in effect on the date of eligibility. The trust fund will reimburse the insurer or self-insurer for supplemental benefits due to cost of living adjustments.

In FY'97, \$927,940 was paid as latency claims and 73 claims were filed.

Cost of Living Adjustments (section 34B)

Section 34B provides supplemental benefits for persons receiving death benefits under section 31 and permanent and total incapacity benefits under section 34A, whose date of personal injury was at least 24 months prior to the review date. The supplemental benefit is 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 after October 1, 1986, insurers will be reimbursed for any increase that exceeds 5%.

COLA payments for FY'97 totaled \$1,792,184 for the public trust fund and \$11,506,346 for the private fund.

OFFICE OF HEALTH POLICY

The DIA is charged with ensuring that adequate and necessary health care services are provided to the state's injured workers. Specifically the statute directs the commissioner to monitor health care providers for appropriateness of care, necessary and effective treatment, the proper costs of services, and the quality of treatment. The statute directs the commissioner to appoint medical consultants to the Medical Consulting Consortium (MCC), as well as members of the Health Care Services Board (see Appendix J for current members).

Commissioner Campbell created the 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 also is the liaison to the Medical Consultant Consortium (MCC) a group of medical consultants to advise the Commissioner on health matters. In fiscal year 1997, the Commissioner also created the Office of the Health Care Services Board and appointed an executive director.

Utilization Review

According to the Division's regulations (452 C.M.R. 6.00), utilization review is a system for reviewing the "appropriate and efficient allocation of health care services" to determine whether those services should be paid 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 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.

In fiscal year 1997, the Division withdrew proposed revisions to the Utilization Review and Quality Assessment regulations (452 CMR 6.00). The new regulations

would have specified the credentials necessary to be approved as a utilization review agents. Moreover, they would have required electronic submission of all claims data in a format to be prescribed by the DIA. The revisions were withdrawn in light of Executive Order 384 which mandated that all regulations be reviewed for necessity, redundancy, and to ensure the least intrusive measures are required.

Medical Utilization Trending and Tracking System

The commissioner is required to implement within the Division a quality control system regarding delivery of health care services to injured workers. The statute states that the DIA should “monitor the medical and surgical treatment provided to injured employees and the services of other health care providers, and monitor hospital utilization as it relates to the treatment of injured employees. The monitoring shall include determinations concerning the appropriateness of the service, whether treatment is necessary and effective, the proper costs of services, and the quality of treatment.”³⁰

According to the regulations promulgated in furtherance of this directive (452 C.M.R. 6.07), the DIA intends to 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, 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.

For the past five years, the DIA has been implementing a program to gather billing data from insurers and utilization review agents to monitor trends in costs as well as patterns of treatment of injured workers in Massachusetts. This data will be used to identify providers who over or under-utilize medical procedures, and to revise treatment guidelines. The agency contends its regulatory authority extends to reporting requirements, despite rescission of its proposed regulations requiring submission of data.

Implementation of this program involves an enormous data gathering process. The Division has 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 Division does not intend to buy equipment, but rather contract with a vendor to collect data. The Center for Health Economics Research, of Waltham, Massachusetts, has been hired to conduct the project. In fiscal year 1997, approximately \$500,000 was allocated for this project.

Health Care Services Board

The DIA’s Health Care Services Board (HCSB) is a voluntary committee of health care providers, as well as employer and employee representatives (see Appendix J

³⁰ G.L. ch. 152, sec. 13.

for current members). The HCSB is charged with reviewing and investigating complaints against providers, developing appointment criteria for the impartial physicians roster, and developing written treatment guidelines used for utilization review.

Complaints Against Providers - The 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 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 - The HCSB is also required to develop eligibility criteria to select and maintain a roster of qualified impartial physicians to conduct medical examinations pursuant to §8(4) and §11A. (*See section DIA - Impartial Unit*). The 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) roster and the §11(A) roster differ pursuant to G.L. ch. 152.

Treatment Guidelines - Under section 13 of Chapter 152, the commissioner is required to ensure that adequate and necessary health care services are provided to injured workers by utilizing treatment guidelines developed by the HCSB, including appropriate parameters for treating injured workers. An advisory group was appointed to develop treatment guidelines.

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

THE REGIONAL OFFICES

The Division of Industrial Accidents has offices in Boston, Lawrence, Worcester, Fall River, and Springfield. Headquarters are located in Boston, and 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 Divisions 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 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 DIA, 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.

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 has moved to expanded and enhanced office space within the last six years.

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
Louis Connolly, Manager

Springfield

436 Dwight Street, Room 105
Springfield, MA 01103
413/784-1133
Marc Joyce, Manager

Worcester

44 Front Street
Worcester, MA 01608
508/753-2072
Bill Taupier, Manager

SECTION

- 5 -

DIA FUNDING

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DIA FUNDING

To ensure that the Division of Industrial Accidents has adequate funds, the legislature required the employers of Massachusetts, both public and private, to pay assessments covering the expenses of operating the agency and for the payment of trust fund benefits. 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 will yield revenues sufficient to pay the obligations of the workers' compensation trust funds and the operating costs of the DIA. This assessment rate multiplied by the employer's standard premium is the DIA assessment, and is paid as part of an employer's insurance premium.³¹

The assessment rate for private sector employers in 1998 is 4.021% of standard premium. This is a 5% decrease from the 1997 rate of 4.226%.

The Trust Funds - The DIA must make payments to uninsured injured employees and employees denied vocational rehabilitation services by their insurers. In addition, it must reimburse insurers for benefits for second and latent injuries, injuries involving veterans, and for specified cost of living adjustments.³²

These obligations are paid out of the trust funds.³³ One account is reserved for payments to private sector employers (the private trust fund); the other is for payments to public sector employers (the public trust fund).

The Special Fund - The DIA's operating expenses are paid from a Special Fund, funded entirely by assessments charged to private sector employers. Operating expenses must be appropriated by the legislature each year through the General Appropriations Act.

Chapter 23E of the Massachusetts General Laws directs the Advisory Council to review the DIA's operating budget as well as the Workers' Compensation Trust Fund budgets. With the affirmative vote of seven members, the Council may submit an alternative budget to the Director of Labor and Workforce Development.

³¹ 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. 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).

³² G.L. Ch. 152, § 65(2) (1996).

³³ Each year the DIA creates a budget for the private and public trust funds, collects assessments, and disburse funds as obligations arise-- without appropriation from the legislature.

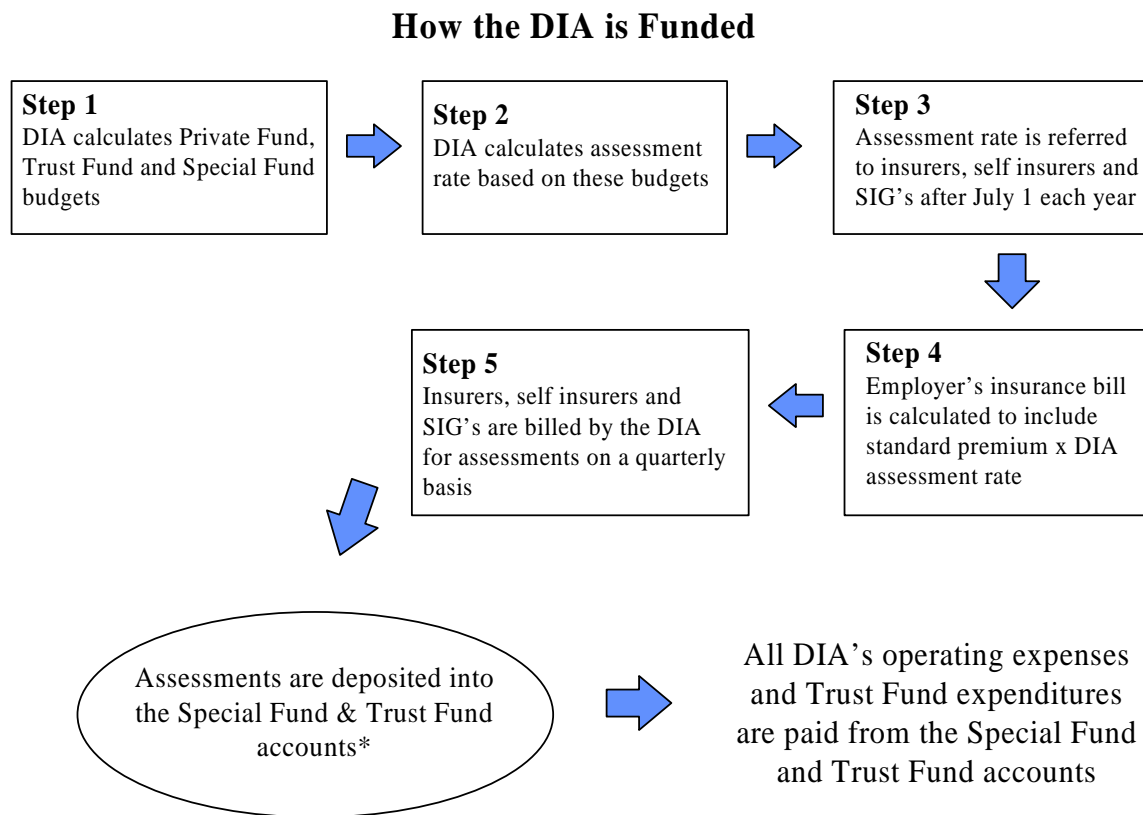
The Funding Process

At the beginning of each fiscal year, the DIA estimates the amount of money needed to maintain its operations in 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), and submitted for legislative action.

In May and June, the DIA, with the assistance of consulting actuaries, estimates future expenses and determines assessments necessary to fund the special fund and the trust funds. The budgets and the corresponding assessments must be submitted to the Director of Labor and Workforce Development by July 1 of each year.

By July, the legislature appropriates the DIA's operating expenses. At that time, insurance carriers are notified of the assessment rates paid quarterly directly to the DIA. Collected assessments are deposited into the DIA's accounts which are managed by the Commonwealth's Treasurer.

Figure 14: DIA Funding Process

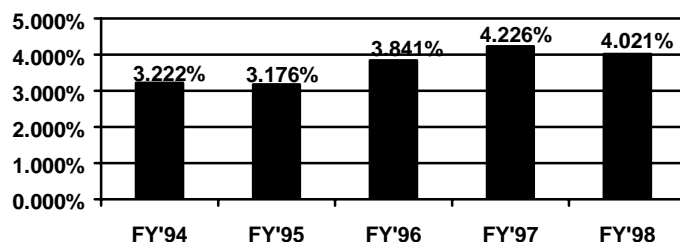


*Note: Maintained by the State Treasurer.

PRIVATE EMPLOYER ASSESSMENTS

On June 26, 1997, Tillinghast released its analysis of the DIA FY'98 assessment rates as mandated under G.L. ch.152, section 65. Specifically, the report detailed the estimated amount required by the special fund and trust funds for FY'98, beginning July 1, 1997. Included in the report are the assessment rates to be applied to public and private employer insurance premiums. The private employer assessment rate has been calculated to be **4.021%** of standard premium, a decrease of 4.8% from last year (4.226%). The following breaks down the process of the assessment rate calculation for private employers.

History of Private Employer Assessment Rates



1. FY'98 EXPENDITURES: \$59.9M

The first step in the assessment process is the calculation of the expected FY'98 expenditures. Private employers are assessed for the sum of the Private Trust Fund budget and the Special Fund budgets.

PRIVATE TRUST FUND BUDGET	Projected FY'98 Expenditures (6/26/97)	FY'97 Expenditures (estimated on 3/31/97)
Section 37 (2nd Injuries)	\$15,442,500	\$17,618,051
Uninsured Employers	\$5,625,000	\$5,267,000
Section 30H (Rehabilitation)	\$0	\$30,000
Section 35C (Latency)	\$973,500	\$988,000
Section 34B (COLA's)	\$12,744,688	\$14,161,000
Defense of the Fund	\$2,100,000	\$2,379,000
TOTAL	\$36,885,688	\$40,443,051

<i>SPECIAL FUND BUDGET</i>	Projected FY'98 Expenditures	FY'97 Expenditures (estimated on 3/31/97)
TOTAL	\$23,000,000	\$20,000,000

<i>PRIVATE EMPLOYER EXPENDITURES</i>	Projected FY'98 Expenditures	FY'97 Expenditures (estimated on 3/31/97)
TOTAL	\$59,885,688	\$60,443,051

2. PROJECTED FY'98 INCOME: \$7.1M

Any income derived by the funds is used to offset assessments. An amount is projected for the collection of fees and fines for deposit in the Special Fund, reimbursements from uninsured employers for deposit in the Private Trust Fund, and an amount estimated for interest earned on the Private Fund and the Special Fund balances.

FY'98 Fines and Fees (Special Fund) = \$4,800,000

FY'98 Income Due to Reimbursements = \$1,650,000

Estimated Investment Income (FY'97) = \$608,443 (Private Fund: \$175,093/Special Fund: 433,350)

Total Projected FY'98 Income: \$7,058,443

3. ADJUSTMENTS TO FUND BUDGETS: \$7.2M (Private Fund)

According to G.L. ch.152, §65(4)(c), the amount assessed employers for any fund must be reduced by a certain percentage of moneys held over from the previous year. Any amount greater than 35% of FY'96 expenditures in a particular fund must be used to reduce amounts assessed for that fund in FY'98. The balance of the Special Fund at the end of FY'97 will have a surplus which exceeds 35% of FY'96 disbursements. Therefore the assessment was calculated with a \$7.5 million reduction to the Special Fund Budget. The Private Trust Fund budget was not reduced because the year end balance was not great enough.

<i>SPECIAL FUND:</i>	<u>FY'97 Estimated Year End Balance</u> \$14,445,000	<u>35% of FY'96 Expenditures</u> \$7,274,962	<u>Amount of Reduction Required</u> \$7,170,038
<i>PRIVATE TRUST FUND:</i>	<u>FY'97 Estimated Year End Balance</u> \$5,836,443	<u>35% of FY'96 Expenditures</u> \$14,852,860	<u>Amount of Reduction Required</u> \$0

4. CONVERSION TO RATIO:

Expenditures, income, and any balance adjustment, must be converted to a ratio. This is calculated by dividing each of the above by the assessment base which represents losses paid in FY'96. For the Private Fund, the assessment base is \$674.4M.

<i>Private Expenditure Ratio:</i>	8.879%	(\$59.9 million/\$674.4 million)
<i>Projected Income Ratio:</i>	1.046%	(\$7.1 million/\$674.4 million)
<i>Balance Adjustment Ratio:</i>	1.063%	(\$7.2 million/\$674.4 million)

5. CALCULATION OF THE ASSESSMENT RATIO: 6.769%

After the projected expenditures, income and balance adjustments are converted to ratios, the last two items are subtracted from the expected expenditure ratio to calculate an assessment ratio.

Projected expenditures - Projected income - Balance adjustment = Assessment Ratio			
8.879%	1.046%	1.063%	6.769%

6. CALCULATION OF THE ASSESSMENT RATE: 4.021%

Since the assessment ratio is relative to paid losses, the ratio must be converted into a rate that is relative to projected premiums. This is done by multiplying the assessment ratio by an assessment base factor which represents a ratio of losses to premiums (based on information provided by the WCRIBM). The 1998 assessment base factor is .594.

Assessment Ratio x Assessment Base Factor = Assessment Rate		
6.769%	.594	4.021%

PUBLIC EMPLOYER ASSESSMENTS

On June 26, 1997, Tillinghast released its analysis of the DIA FY'98 assessment rates as mandated under G.L. ch.152, section 65. Specifically, the report detailed the estimated amount required by the special fund and trust funds for FY'98, beginning July 1, 1997. Included in the report are the assessment rates to be applied to public and private employer insurance premiums. The public employer assessment rate has been calculated to be **11.844%** of standard premium.

The following breaks down the process of the assessment rate calculation for public employers.

1. FY'98 EXPENDITURES: \$4.6M

The first step in the assessment process is the calculation of the expected FY'98 expenditures. Public employers are not assessed for the Special Fund budget.

PUBLIC TRUST FUND BUDGET	Projected FY'98 Expenditures (6/26/97)	Actual FY'97 Expenditures (estimated on 6/30/97)
Section 37 (2nd Injuries)	\$307,500	\$363,027
Uninsured Employers	\$0	\$0
Section 30H (Rehabilitation)	\$0	\$0
Section 35C (Latency)	\$16,500	\$0
Section 34B (COLA's)	\$4,276,286	\$1,745,630
TOTAL	\$4,600,286	\$2,108,657

Note: Cost associated with defense of the Public Trust Fund are not charged to public employers.

2. ANTICIPATED INVESTMENT INCOME OFFSET: \$13,869

Calculated at 3% of FY'97 year end balance of \$462,309.

3. ADJUSTMENTS TO PUBLIC FUND BUDGET: \$0

According to G.L. ch.152, §65(4)(c), the amount assessed employers for any fund must be reduced by a certain percentage of moneys held over from the previous year. Any amount greater than 35% of FY'96 expenditures in a particular fund must be used to reduce amounts assessed for that fund in FY'98. The FY'97 Public Fund year-end balance does not approach the amount for a reduction.

PUBLIC TRUST	FY'97 Estimated	35% of FY'96	Amount of
---------------------	------------------------	---------------------	------------------

FUND:	<u>Year End Balance</u>	<u>Expenditures</u>	<u>Reduction Required</u>
	\$462,309	\$693,977	\$0

4. CONVERSION TO RATIO:

Expenditures, income, and any balance adjustment, must be converted to a ratio. This is calculated by dividing each of the above by the assessment base which represents losses paid in FY'96. For the Public Fund, the assessment base is \$23M.

Public Expenditure Ratio:	20%	(\$4.6 million/\$23 million)
Projected Income Ratio:	0.06%	(\$13,869/\$23 million)
Balance Adjustment Ratio:	0%	(\$0/\$23 million)

5. CALCULATION OF THE ASSESSMENT RATIO: 19.94%

After the projected expenditures, income and balance adjustments are converted to ratios, the last two items are subtracted from the expected expenditure ratio to calculate an assessment ratio.

Projected expenditures -	Projected income -	Balance adjustment =	Assessment Ratio
20%	0.06%	0%	19.94%

6. CALCULATION OF THE ASSESSMENT RATE: 11.844%

Since the assessment ratio is relative to paid losses, the ratio must be converted into a rate that is relative to projected premiums. This is done by multiplying the assessment ratio by an assessment base factor which represents a ratio of losses to premiums (based on information provided by the WCRIBM). The 1998 assessment base factor is .594.

Assessment Ratio x	Assessment Base Factor =	Assessment Rate
19.94%	.594	11.844%

THE DIA OPERATING BUDGET

Legislative Appropriations, FY 1998

The Division of Industrial Accidents initially requested a budget of \$19,713,633 for fiscal year 1998. In House 1, the Governor's recommendation for the DIA's budget was \$17,000,000, a reduction of \$2,713,633 from the Division's request. The House of

Representatives approved a budget of \$17,000,000 and the Senate approved appropriations totaling \$18,441,665. The final conference committee resolution appropriated \$18,441,665.

DIA Request	\$19,713,633
Governor's Recommendation	\$17,000,000
Full House	\$17,000,000
Full Senate	\$18,441,665
Conference Committee	\$18,441,665

General Appropriations Act

The Governor vetoed two DIA accounts contained in the Conference Committee budget reducing the overall DIA budget by \$1,014,978. The two accounts affected by the Governor's vetoes were for the operation and administrative expenses (reduced by \$864,978), and the payroll expenses of the division's "justices" (reduced by \$150,000). Both accounts were restored to their original House 1 amounts. This year's appropriation of \$17,426,687 is 8% less than last year's appropriation amount of \$19,017,209.

How the Governor's Vetoes Affected the DIA Budget

Account #	Purpose	Conference Committee Budget	Governor's Reduction	General Appropriations Act
7002-0500	Operation and administrative expenses of the DIA.....	\$15,137,144	VETOED - \$864,978	\$14,272,166
7002-0501	AA subsidiary payroll expenses of the Office of the Commissioner.....	\$292,120	UNCHANGED \$0	\$292,120
7002-0502	AA subsidiary payroll expenses of the division's "justices".....	\$3,012,401	VETOED - \$150,000	\$2,862,401
TOTALS		<u>\$18,441,665</u>	<u>- \$1,014,978</u>	<u>\$17,426,687</u>

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

FY'92: \$14.6 million

FY'96: \$17.8 million

FY'93: \$15.7 million

FY'97: \$19.0 million

FY'94: \$17.2 million

FY'98: \$17.4 million

FY'95: \$17.5 million

*Figure 16: Special Fund Expenditures, FY'97***Special Fund Expenditures, FY'97**

SUB	Budgeted	Expended	Balance
AA	\$12,756,966	\$12,675,241	\$81,725
BB	137,711	101,326	36,385
CC	77,475	47,214	30,261
DD	341,251	317,538	23,713
EE	855,976	795,282	60,694
GG	1,522,311	1,341,036	181,275
HH	1,396,752	1,009,863	386,889
JJ	1,068,197	799,171	269,026
KK	618,840	590,679	28,161
LL	280,575	232,893	47,683
TOTAL	\$19,056,054	\$17,910,243*	\$1,145,812

***Note:** Expended total does not include \$3,661,402 for fringe benefits, \$526,447 for indirect costs, and \$26,899 for FY'96 adjustment. The total including these costs is \$22,124,993.

Budget Subsidiaries

Subsidiary AA: Regular Employee Compensation

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 for defined time periods, incurred when 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/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 Division. 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.

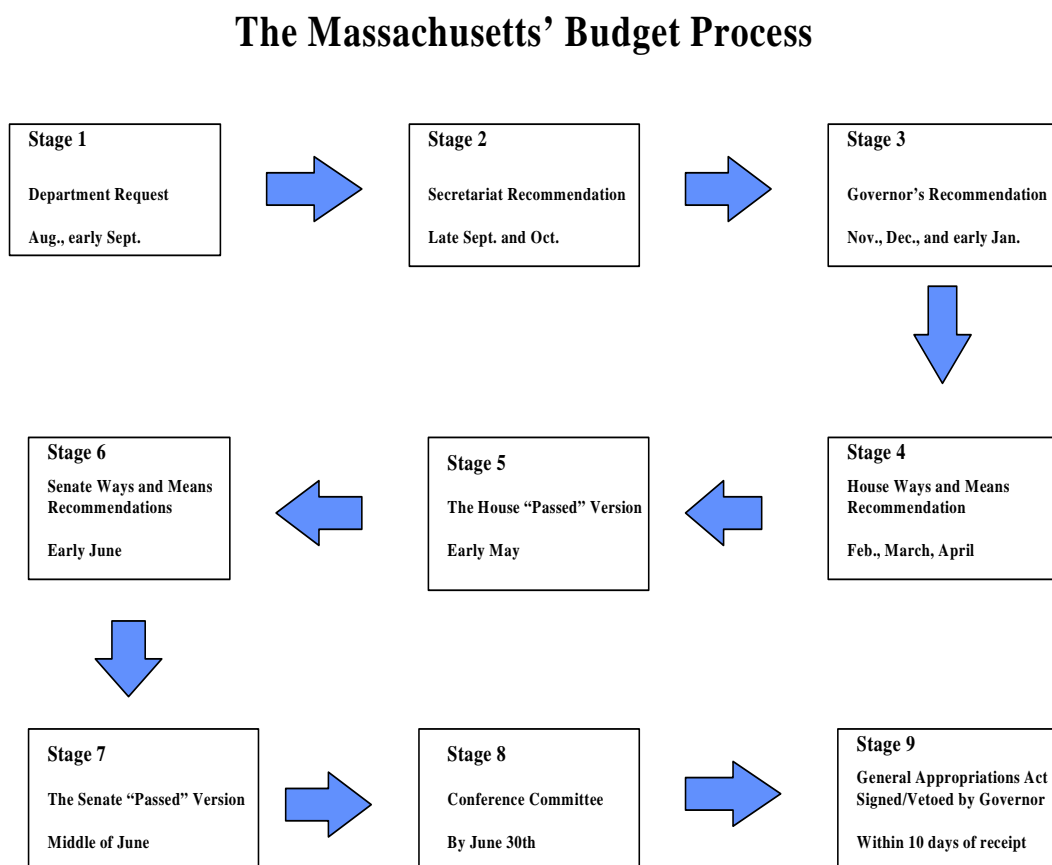
Subsidiary LL: Equipment Lease-Purchase, Lease and Rental, Maintenance and Repair

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.

The Budget Process

The operating budget of the DIA must be appropriated by the legislature even though employer assessments fund the agency. The Division, therefore, must submit to the budget process in the same manner as most other government agencies. It is helpful to view this process in nine distinct phases.³⁴ The following is a brief description of the process.

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

Figure 15: Budget Process**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 September and October

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: November, December, and 1st weeks of January

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: February, 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 days 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.

SECTION

- 6 -

INSURANCE COVERAGE

<i>Mandatory Insurance Coverage.....</i>	<i>99</i>
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MANDATORY INSURANCE COVERAGE

Every private employer in the Commonwealth of Massachusetts is required to maintain workers' compensation insurance. Coverage may consist of purchasing a commercial insurance policy, membership in a self insurance group, participation in a reciprocal insurance exchange,³⁵ or maintaining a license as a self insured employer. 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 insurance is not required. Seamen, some professional athletes, and unincorporated sole proprietors are exempt.

The requirements of the workers' compensation act (G.L. Chapter 152) are elective for all municipalities, counties, towns, and school districts. All Commonwealth of Massachusetts employees are covered under the act as well as most other public employers. Other public employee groups, such as police, fire, and some teacher groups, have special provisions for occupational injuries that are separate from the workers' compensation act.

The Commonwealth of Massachusetts funds workers' compensation claims directly from the General Fund. The agency which administers claims for workers' compensation by state employees is the Public Employee Retirement Administration Commission (PERAC), 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.³⁶

The Office of Investigations at the Division 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 coverage, the DIA's trust fund will pay the claim. In most cases, the DIA will seek repayment from the uninsured company.

³⁵ 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.

³⁶ For more information of the coverage of public employees see Report to the Legislature on Public Employees, Massachusetts Workers' Compensation Advisory Council, 1989

COMMERCIAL INSURANCE

The most common method of obtaining workers' compensation coverage is by purchasing a commercial insurance policy. In exchange for payment of an annual premium based on rates approved each year by the Commissioner of Insurance.

Premium

The manual premium of a company is based on the employer's payroll multiplied by a classification rate assigned to that particular business (roofing, plumbing, service, etc.). The premium is then adjusted by an experience modification factor to determine 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.

The insurance company will administer all workers' compensation claims and pay all medical, indemnity (weekly compensation), rehabilitation, and supplemental benefits due under the workers' compensation act.

The Classification System

Workers' compensation insurance rates are calculated and charged to employers according to categories of industries called classifications. Each classification details the business functions of a particular industry. Every employer purchasing workers' compensation insurance is assigned a basic classification determined by its overall business function. Standard exception classifications may then be assigned for low risk tasks performed within most companies (i.e. clerical work).

Classifications were developed on the theory that the nature, extent and likelihood of certain injuries are common to any given industry. Each classification groups together employers that have a similar exposure to injuries so that overall costs of workers' compensation can be distributed equitably among employers. Without a classification system, employers in low risk industries would be forced to subsidize high risk employers through higher insurance costs. Classifications must also be comprised of enough employers to provide a meaningful statistical base for the development of rates.

Regulation of Classifications - Classifications in Massachusetts are established by the Workers' Compensation Rating & Inspection Bureau (WCRB) and submitted to the Commissioner of Insurance for approval. A hearing is conducted by the Commissioner to determine whether classifications and rates are not excessive, inadequate or unfairly discriminatory and that they fall within a range of reasonableness (Ch. 152, §53A). The classifications submitted by the WCRB were at one time based on the uniform classifications set by the National Commission on Compensation Insurance (NCCI) used in 34 states.

Basic Classifications - Each business in the Commonwealth is assigned one “basic” classification that best describes the business of the employer, not the work performed by separate employees. Once a basic classification has been selected, it becomes the company’s “governing” classification, the basis for determination of premium.

5188	N/A-TX
PHRASEOLOGY AUTOMATIC SPRINKLER INSTALLATION & DRIVERS	
CROSS-REF. <i>Sprinkler Installation & Drivers</i> - applies to automatic sprinklers intended for fire extinguishing purposes. Lawn sprinkler installation to be separately rated as Code 5183.	
SCOPE This all-inclusive classification covers the shop and sprinkler systems. Code 5188 also contemplates the installation of automatic fire extinguisher systems which use dry chemicals. The shop prepares the various sizes of pipe by cutting and threading according to specifications and also gets together the fittings, such as heads, couplings, valves, hangers, regulators and alarms so that everything will fit at the job site. Incidental cutting or threading may be performed at the job site if difficulty arises in the running of sprinkler lines through walls and floors. The majority of the piping is done at ceiling level which requires extensive work on staging.	

1996 NCCI “Scopes of Basic Manual Classifications”

Although most companies are assigned one governing classification, the following conditions require more than one basic classification to be used:

- the basic classification specifically states certain operations to be separately rated;
- the company is engaged in construction or erection operations, farm operations, repair operations, or operates a mercantile business, under which certain conditions allow for additional classifications to be assigned; or
- the company operates more than one business in a state.

Standard Exception Classifications - In addition to the 600 “basic” classification codes that exist in Massachusetts, there are four “standard exception classifications” for those occupations which are common to virtually every business and pose lesser risk of worker injury. Employees who fall within the definition of a standard exception classification are not generally included in the basic classification. These low cost standard exception classifications are: Clerical Office Employees (Code 8810), Drafting Employees (Code 8810), Drivers, Chauffeurs and Their Helpers (Code 7380), and Sales-persons, Collectors or Messengers-Outside (Code 8742).

General Inclusions and Exclusions - Sometimes certain operations within a company appear to be a separate business. Most are included, however, within the scope of the governing classification. These operations are called *general inclusions* and are:

- Employee cafeteria operations;
- Manufacture of packing containers;
- Hospital or medical facilities for employees;
- Printing departments; and
- Maintenance or repair work.

Some operations of a business are so unusual that they are separately classified. These operations are called *general exclusions* and are usually classified separately. General exclusions are:

- Aircraft operation - operations involved with flying and ground crews;
- New construction or alterations;
- Stevedoring, including tallying and checking incidental to stevedoring;
- Sawmill operations; and
- Employer-operated day care service.

Manual Rate - Every classification has a corresponding manual rate that is representative of losses sustained in the past three years. An employers' base rate is based on manual rate per \$100 of payroll, for each governing and standard exception classification.

<u>Class Code</u>	<u>Governing Classification</u>	<u>Manual Rate</u>	<u>Payroll</u>	<u>Base Rate</u>
5188	Automatic Sprinkler Installation & Drivers	\$2.50	\$200,000	\$5,000
<u>Class Code</u>	<u>Standard Exception</u>	<u>Manual Rate</u>	<u>Payroll</u>	<u>Base Rate</u>
8810	Clerical Employees	\$.25	\$50,000	\$125

Appealing a Classification - When a new company applies for insurance, the broker or agent chooses a classification which is audited by the insurance carrier at the end of the policy year. If the carrier determines the employer was misclassified, the employer would be charged additional premium for the correct class. The WCRB is responsible for determining the proper classification for every employer in Massachusetts. If an employer disagrees with the classification they have been placed in or believes a separate classification should be created, there is an appeal process made available by Ch.152, §52D. The first step of the process is to file a formal appeal with the WCRB's Governing Committee (for those insured in the Voluntary Market) or the Residual Market Committee (for those insured in the Assigned Risk Pool). The WCRB will send an auditor to the worksite and proceed to make a ruling on the classification in question. If reclassification is denied, an appeal can be taken to the Commissioner of Insurance. A hearing officer will then be selected by the Commissioner to conduct an evidentiary hearing on the classification issue.

Construction Industry - In the construction industry alone, there are over 67 different classifications for each distinct kind of construction or erection operation. Often multiple classifications must be assigned to large general contractors who use different trades during the many phases of construction projects. Separate payrolls must be maintained for separate classifications or else a construction company can be assigned to the highest rated classification that applies to the job or location where the operation is performed.

Workers' Compensation Insurance Manual

Prior to April 1996, Massachusetts consumers, agents, and carriers utilized the Basic Manual for Workers' Compensation & Employer Liability Insurance of the National Council on Compensation Insurance (NCCI) to determine the classification of insureds as well as terms of policies, premium calculation, credits and deductibles. However, as of April of 1996, a new version of the manual was published by NCCI designed to be used in states with competitive rating. As Massachusetts is an administered pricing state (e.g., the Commissioner of Insurance must approve all rates), the NCCI manual no longer applied to Massachusetts risks.

The Workers' Compensation Rating and Inspection Bureau (WCRIB) created a Massachusetts specific manual as the result of this. The manual was submitted to the Commissioner of Insurance for approval in November, 1996. At a Division of Insurance Hearing in December, 1996, the proposed manual was opposed by human service groups who believed the new manual would require a change in their classifications, resulting in higher premiums.

In January of 1997, Commissioner Ruthardt approved the rules portion of the manual that sets forth the specifications for workers' compensation insurance policies. Part-2 of the manual, dealing with classifications, remained unapproved so that discussions could occur between the WCRIB and interested parties. In May, another manual was submitted. On June 13, 1997, the Division of Insurance held another hearing on revisions to Part-2 of the manual. Although agents and contractors praised the revisions, the State Rating Bureau (SRB) has remained opposed to the manual. The SRB believes that changes made to the manual could cause the reclassification of risks and effect premiums. Therefore, actuarial data is needed to provide support to establish that the classifications under the new manual will not produce premiums that are excessive, inadequate, or unfairly discriminatory, or fall outside a range of reasonableness in violation of M.G.L. ch. 152, §53A.

According to the WCRIB³⁷, it proposes to make four types of revisions to the manual.

(1) Addition or Deletion of Standard Exception Classifications

The WCRIB added or deleted the words "& Drivers", "& Clerical", "& Salespersons" or "All Employees" to various classifications. The prior manual contained many inconsistencies regarding the inclusion of standard exception classifications and special employment. This revision was made to correct errors that have occurred in previous manuals where phrases such as "& Drivers" may have been left out. The WCRIB maintains that this revision is a housekeeping matter to correct errors that occurred during reprints of prior manuals.

The WCRIB has assessed the impact of these changes with regard to potential changes to premium for employers who may be affected by the addition of "drivers" to

³⁷ Sworn testimony of Roy S. Stewart, President, WCRIBM, filed with Commissioner of Insurance with supporting documents.

their classification. It was determined that 9 classes would experience premium increases, affecting as many as 19 policies.

(2) Classification Codes for Industries not Referenced in Prior Manuals

Using existing classification codes, the WCRIB added new phraseology to describe those businesses not described by a classification in the prior manual. Occasionally a company will not clearly fall within the wording of any existing classification and the WCRIB must choose the classification that “most closely describes the business” (NCCI, Rule IV D 3). By adding this more inclusive phraseology, the revision would help eliminate confusion and inconsistencies involved with the classification assignment process.

(3) Insertion of Language More Clearly Defining Scopes of Existing Classifications

The purpose of this revision is to more clearly define the scopes of the operations under the existing classification codes. This language is intended to describe such things as raw materials used, processes involved with the nature of the business being classified. This additional clarification of the language will further simplify the classification assignment process.

(4) Insertion of Cross References to Classifications for Separately Rated Operations

In previous manuals, certain classification phraseologies (and their respective footnotes) required that certain operations be separately classified. However, these footnotes failed to indicate what the separate classification code should be. This revision will eliminate inconsistencies by indicating what the separate classification codes should be.

The WCRIB contends that no employer will experience a dramatic increase in premiums as a result of the changes in the manual. If any reclassification were to occur, it would not be because the manual redefines the classes used. Any reclassification will result either because the business itself has evolved and the present class no longer accurately reflects the nature of the operation, or because the risk was misclassified originally.

Division of Insurance Decision - In October, 1997, the Division of Insurance issued a decision and order regarding the Massachusetts-Specific Workers' Compensation Insurance Manual proposed by the WCRIB in November, 1996. Commissioner Ruthardt declined to approve the proposed changes to the classification section of the manual.

The decision stated that the both the statute and regulation "specify that manuals which classify risks are considered to be rate filings." Because the WCRIB failed to justify its recommendations and satisfy statutory requirements for a rate filing, the Division could not approve it. Presiding Officer Jean F. Farrington directed the WCRIB to address issues raised during the hearings and submit evidence that would substantiate each change it proposes to the classification section of the manual.

Below is a time-line of the events leading up to this decision.

Time-Line of Insurance Manual

<i>April, 1996</i>	NCCI drafts a new version of existing manual designed to be used in states specifically with competitive rating. Massachusetts, therefore can no longer use the NCCI manual.
<i>November 20, 1996</i>	WCRIB submits a Massachusetts-Specific W/C Insurance Manual.
<i>December 4, 1996</i>	DOI holds informational hearing on WCRIB's submission of new W/C Insurance Manual. Employers object to changes in classifications section.
<i>December 31, 1996</i>	DOI approves the rules portion of the manual but disapproves section dealing with classifications.
<i>May 19, 1997</i>	WCRIB submits a new revised W/C Insurance Manual. Identifies all changes to classifications, and provides examples of how some classes would be affected by the changes.
<i>June 13, 1997</i>	DOI holds a public hearing on revisions made to the classification section of the manual. State Rating Bureau objects.
<i>July 11, 1997</i>	State Rating Bureau files advisory filing urging the hearing's officer to disallow the proposed changes without more information and justification.
<i>October, 1997</i>	DOI disapproves changes to classification section of the manual.

All Risk Adjustment Program

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.

Deductible Policies

Available since 1991, deductible policies can provide the advantages of a retrospective policy and self insurance. 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. A typical policy with a \$5,000 per claim deductible will experience a 10.6% reduction in premium. In policy year 1996, large deductible credits were provided in amounts approximating 82% of premium.

PER CLAIM DEDUCTIBLE³⁸ <i>Effective January 1, 1993</i>	
Medical and Indemnity Deductible Amount	Premium Reduction Percentage
\$500	3.0%
\$1,000	4.2%
\$2,000	6.2%
\$2,500	7.1%
\$5,000	10.6%

MASSACHUSETTS BENEFITS CLAIM AND AGGREGATE DEDUCTIBLE PROGRAM³⁹			
Estimated Annual Standard Premium	Claim Deductible Amount	Aggregate Deductible Amount	Premium Reduction Percentage
0 to \$75,000	\$2,500	\$10,000	7.0%
\$75,001 to \$100,000	\$2,500	\$10,000	6.5%
\$100,001 to \$125,000	\$2,500	\$10,000	5.9%
\$125,001 to \$150,000	\$2,500	\$10,000	5.4%
\$150,001 to \$200,000	\$2,500	\$10,000	4.5%
over \$200,000	\$2,500	5% of Estimated Annual Standard Premium	4.3%

Retrospective Rating Plans

Retrospective rating is an insurance rating system that bases premium on an 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 should not be confused with "experience rating." Both adjust premium based on an employer's loss history. Experience rating, however,

³⁸ WCRIBM Circular Letter 1760, Sept. 13, 1996.

³⁹ WCRIBM Circular Letter 1760, Sept. 13, 1996.

adjusts premiums at the start of the policy period (to predict future losses), whereas retrospective rating adjusts premiums at the end of the policy period to reflect losses that actually occurred.

Although retrospective premiums are determined by a complex formula, they are generally based on three factors: losses the employer incurs during a policy period; expenses that are related to the losses incurred; and basic premium. Incurred losses have historically included both medical and indemnity losses, interest on judgments, and expenses incurred in third-party recoveries.⁴⁰ 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. Premium is calculated by adding basic premium to 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.⁴¹

Eligibility for a retrospective rating plan is based upon a minimum 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 \$75,000.⁴² Although these eligibility standards exclude 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 losses, retrospective plans reward those businesses that maintain effective loss control programs. If losses are low, the insured will pay less than standard premium.

Nevertheless, under these two plans there is significant uncertainty regarding what the final premium will amount to since companies cannot predict the volume or severity of workplace accidents.

In 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 have enhanced the competitive market by allowing employers a greater choice in insurance options.

Premium Discounting

Insurance companies that provide workers' compensation coverage must factor in the various expenses of servicing policies to determine appropriate premium levels. However, a problem occurs when pricing premiums for large policies; as the premium increases, the proportion required to pay expenses decreases. In an effort to compensate for these differences, insurance companies must provide a premium discount to large

⁴⁰ "Retrospective Rating," *Risk Financing*, Supplement No. 46, May 1995: III.D.7.

⁴¹ Richard Carris, "The Mathematics of Retros," *CPCU Journal*, Vol. 46, No. 1, March 1993: 38-39.

⁴² "Retrospective Rating Plans," *Fire Casualty & Surety Bulletins*, Sept. 1994.

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 they are paying over \$10,000 in premiums.

TYPE "A" COMPANIES			TYPE "B" COMPANIES		
Layer of Standard Premium		Percent of Premium Discount	Layer of Standard Premium		Percent of Premium Discount
First	10,000	0.0%	First	10,000	0.0%
Next	190,000	9.1%	Next	190,000	5.1%
Next	1,550,000	11.3%	Next	1,550,000	6.5%
Over	1,750,000	12.3%	Over	1,750,000	7.5%

WCRI BM, A General Revision of Workers' Comp. Insurance Rates and Rating Values, pg. 590 (Aug. 14, 1995).

Dividend Plans

Offered as a means of reducing an employers insurance costs, dividend plans can provide the policy-owner with a partial return on a previously paid premium. This payment from the insurer takes into account investment income, expenses, and the insured's overall loss-experience in a given year. The dividend is usually paid to the policy owner directly or by applying it to future premiums due. Regardless of how the payment is issued, dividends are non-taxable since they are considered a return of premium.⁴³

Dividend plans may seem attractive to policy holders, but sometimes promise more than can be delivered. Insurer's are not legally bound to pay what they may have estimated a policy holder's return to be. Moreover, many insurers 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.⁴⁴

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. A captive allows non-insurance organizations to create and run their own insurance company to insure the risks of their shareholders.⁴⁵ Although captives are conceptually similar to self insurance, they are subject to the same governmental regulations applying to any insurance company.

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.⁴⁶ In fact, a company that wants to form it's own captive

⁴³ "Risk Management-Life, Health, and Income Exposures," Life Insurance, Part 4: 406.

⁴⁴ "Thinking About the Work Comp Crisis," Merritt Risk Management Review, December 1991: 3.

⁴⁵ The Captive Insurance Manual, NILS Publishing Co., vol. 1, 1995 revision: 3.

⁴⁶ "Combined WC/EB Captives-Challenge With A Pay-Off," The Journal of Workers Compensation, September 26, 1994: 38.

must be willing to invest the standard benchmark of about a million dollars in capital. The 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. Group captives do not involve the same expenses and burdens since the risks and costs are spread among its 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 its insurance program by allowing it to bypass the uncertainty of hard and soft insurance markets that can lead to unpredictable premium rates.⁴⁷

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.⁴⁸

Captive insurance is not an option for every company. Often a company must invest a large portion of its assets when forming a 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 of a captive, 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.⁴⁹

The recent growth of captives in the United States has enhanced and diversified the insurance market. In 1995, captives represented over one-third of commercial line business in the U.S. and take in over \$60 billion in premium volume annually.⁵⁰ In fact, captives are now considered to be the second most common choice in the alternative market next to self-insurance.⁵¹ Vermont has clearly set the pace in the captive industry as a result from a flexible regulatory environment, lower premium taxes, and a quality

⁴⁷ "When to Form a Captive," Risk Management, November 1, 1994: 73-74.

⁴⁸ Ibid.

⁴⁹ "Captive Plan Designed To Cut Workers' Comp. Costs," National Underwriter, November 28, 1994: 12.

⁵⁰ "Captive Market Matures: Growth Ahead?," Risk Management, August 1, 1995: 14.

⁵¹ Ibid.

infrastructure.⁵² Success in other states will solely depend upon the ability of governments to provide adequate incentives for captive formation.

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.

⁵² "When to Form a Captive," Risk Management, November 1, 1994: 73-74.

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). This occurs when a carrier determines that the cost of providing insurance to a particular company is greater than the premiums they can collect. 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 substantial portion of the market 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 1995, 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.

If the overall losses exceed the allowable premium approved each year (revenues), 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, called the residual market load. 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.⁵³

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 policy year 1995 the burden was -3.0%, meaning that the pool had a net operating gain that year.⁵⁴

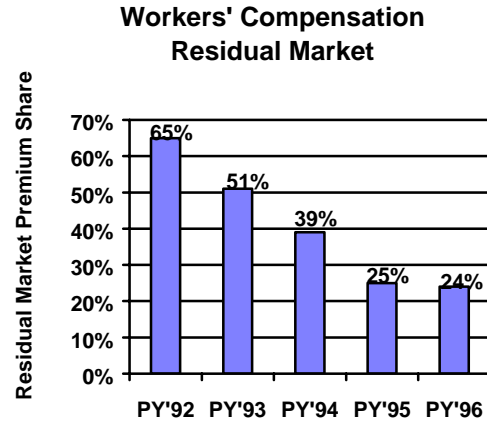
Loss ratios have also continued to decline. The residual market loss ratio measures the amount of losses and expenses to the premiums written (roughly money out divided by money in). A loss ratio greater than 100% indicates that losses are greater than revenues (premiums). In policy year 1996, the estimated loss ratio was 70%, significantly down from a high of 168% in 1987.⁵⁵

⁵³ 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.

⁵⁴ WCRB Special Bulletin No. 13-97, (Nov. 7, 1997).

⁵⁵ WCRB Special Bulletin No. 13-97, (Nov. 7, 1997).

In 1992, 64.7% of every premium dollar was written in the residual market. Since that time the residual market has been declining. For policy year 1996, the residual market was at or below 15% of total premium and preliminary figures for policy year 1997 are at 11%, indicating a much healthier and improved insurance system.⁵⁶



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.

⁵⁶ WCRB Special Bulletin No. 12-97 (Oct. 24, 1997).

SELF INSURANCE & GROUP SELF INSURANCE

Self insurance and self insurance groups (SIGs) became an extremely popular device to control rising workers' compensation costs in the late 1980's and early 1990's. Much of the cost savings derived from avoidance of residual market loads incorporated in commercial insurance premiums to pay for the large assigned risk pool. Since 1993, insurance rates have decreased dramatically making self insurance and membership in self-insurance groups far less attractive. In recent years employers have reassessed cost savings associated with these programs and many have turned to commercial insurance plans, most noticeably large deductible policies and retrospective rating plans.

The Division of Industrial Accidents strictly regulates self insured employers through its annual licensing procedures. 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 (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.⁵⁷ 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 insurance⁵⁸ evaluates employers every year to determine their continued eligibility and set a new bond amount.

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, a SIG must have "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."⁵⁹

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 October 1, 1997, there were 31 SIGs in the state. SIGs have very stringent reporting procedures, but it is difficult to determine how

⁵⁷ 452 C.M.R. 5:00: Code of Massachusetts Regulations concerning insurers and self insurers

⁵⁸ See section on *DIA - Office of Insurance* for fiscal year 1997 statistics on self insurance.

⁵⁹ Division of Insurance regulations -- 211 C.M.R. 67.02

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.

Companies who join self insurance groups rely heavily on the solvency and safety records of fellow members, since the insurance risks are spread amongst the group. If one of the employers in a group declares bankruptcy or suffers a catastrophic accident, the whole group must absorb the losses. In addition, all members share joint and several liability for losses incurred.

WORKERS' COMPENSATION RATES

The Massachusetts workers' compensation system relies on the private insurance market as the source of funding for mandatory no-fault coverage of workplace injuries. A healthy insurance market is therefore essential not only to individual carriers, but to employers and employees as well. On May 1, 1996, the insurance market improved dramatically with a third rate reduction in as many years. The residual market also improved considerably in the year.

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 60 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" (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.

Rates for 1996 and 1997

On April 30, 1996, the commissioner of insurance approved an agreement on workers' compensation insurance rates effective May 1, 1996, at levels on average 12.2% less than those for 1995. This marked the third rate reduction in as many years. These rates were effective for years 1996 and 1997.⁶⁰

Table 14: Average Rate Changes for General Classifications

Effective: May 1, 1996	Manufacturing	Contracting	Office and Clerical	Goods and Services	Misc.
Avg. Rate Change	-15.7%	-10.3%	-10.7%	-12.5%	-9.0%
Maximum Increase	-5.6%	-0.3%	-0.6%	-2.4%	1.1%
Maximum Decrease	-27.5%	-24.8%	-25.0%	-25.9%	-24.1%

⁶⁰ In August 1997, the WCRB submitted a rate filing request for an average rate decrease of 11.1% (an average decrease of 12.2% for voluntary market risks and an average decrease of 3.5% for residual market risks). These rates are proposed to become effective January 1, 1998.

INSURANCE FRAUD BUREAU

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 (G.L. ch. 338) and further amended in 1991 to include workers' compensation.⁶¹ 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 1996 annual report documents the progress of the Bureau since its inception.

The Investigative Process

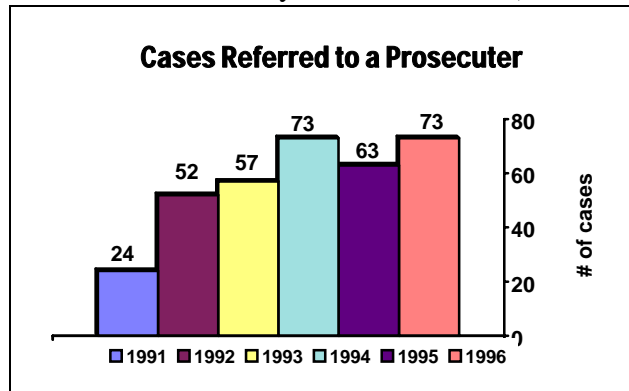
Referrals - Cases of suspected fraud for all types of insurance are referred to the IFB either through an insurance carrier or through a toll-free hotline (1-800-32FRAUD). For 1996, 1,083 cases were referred to the IFB. This is a decrease of 47.4% from 1995 levels. As in other years, the majority of referrals come from insurance carriers (which in FY'96 represented 1,025 referrals). This is a decline of 11.4% from 1995 in which insurance carriers referred 1,158 cases.

Evaluation - Once a referral is received by the IFB, an investigative staff must evaluate each case within 20 working days. During this time, 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'96, however, the IFB's backlog of referrals pending an evaluation reduced by 39% (pending referrals from December 31, 1996 versus 1995).

Assigned Cases - Once resources become available, a referral is assigned to an investigator and officially becomes a "case." In 1996 a total of 436 new cases were assigned to investigators.

⁶¹ G.L. St. 1990, ch. 338 as amended by St. 1991, ch. 398, Section 9

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 1996, a total of 73 cases were referred to a prosecutor. This is an increase of 16% over 1995 levels. This total includes a continued increase in the percentage of workers' compensation cases referred for prosecution.



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 investigate the following types of workers' compensation fraud:

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'96 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.

Web Site - The Insurance Fraud Bureau has its own Internet web site which can be found at: <http://www.ifb.org>. The site is designed to inform the public on the activities and accomplishments of the IFB. The site also allows the general public to submit anonymous tips on suspected insurance fraud.

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

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APPENDIX A

Advisory Council Members

Voting Members:

Edmund C. Corcoran, Jr., (Chair), Manager, Disability Program/WC, Raytheon,
125 Spring Street, Lexington, MA 02173 Tel: 860-3811 FAX: 860-2408
William H. Carnes, (Vice Chair), Teamsters Union, Local 25, 544 Main Street,
Boston, MA 02129-1113 Tel: 241-8831 FAX: 242-4284
Edward Sullivan, Jr., SEIU-Local 254, 11 Beacon Street, Boston, MA 02108
Tel: 367-7360 FAX 367-7372
Jeanne-Marie Boylan, Boston Sand and Gravel Company, 169 Portland Street,
Boston, MA 02114 Tel: 227-9000 FAX 523-7947
Robert Banks, J.A.C. Ironworkers - Local 7, 195 Old Colony Avenue, South
Boston, MA 02127 Tel: 268-0707 FAX: 268-7878
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 01749 Tel: (508) 562-3495 FAX: (508) 562-9461
John J. Perry, Teamsters, Local 82, 3330 Dorchester Street, South Boston, MA 02127
Tel: 269-6868 FAX: 269-6914
Lawrence Morrisroe, Carpenters' Union, 10 Dry Dock Avenue, Boston, MA 02210,
Tel: 350-0017 FAX: 330-1684
Joseph Tamulis, T Equipment Corp., 170 Granite Avenue, Dorchester, MA 02124-5431
Tel: (617) 282-7610 FAX: 265-5568

Non-Voting Members:

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
Angelo Buonopane, Director, Department of Labor & Workforce Development,
Suite 1402-14th Floor, McCormack Building, One Ashburton Place, Boston,
MA 02108 Tel: 727-6573 FAX: 727-1090
David A. Tibbetts, Director, Department of Economic Affairs, One Ashburton Place,
Boston, MA 02108 Tel: 727-3206

Staff:

Matthew A. Chafe, *Executive Director*
Andrew Burton, *Research Analyst*
Ann Helgran, *Paralegal*

APPENDIX B

Terms of Advisory Council Members

Voting Members

Term Exp. Date

Edward Sullivan, Jr.	(labor)	6/25/01
Antonio Frias, Sr.	(business)	6/25/01
Robert Banks	(labor)	6/25/00
Edmund Corcoran	(self insurer)(chair-expires '98)	6/25/99
Lawrence Morrisroe	(labor)	6/25/99
Joseph Tamulis	(small business)	6/25/98
John J. Perry	(labor)	6/25/98
Jeanne-Marie Boylan	(business)	7/01/99
William Carnes	(labor)	6/25/97
John Gould	(business)	6/25/95

Non-Voting Members

Amy Vercillo	(rehab)	6/25/95
J. Bruce Cochrane	(insurance)	6/25/97
Alan S. Pierce	(bar)	6/25/98
Angelo Buonopane Director, Department of Labor & Workforce Development One Ashburton Place Boston, MA 02108		Ex-Officio
David A. Tibbertts Director, Economic Affairs One Ashburton Place Boston, MA 02108		Ex-Officio

APPENDIX C

AGENDA

Fiscal Year 1997

July 10, 1996

DIA Update
DIA Employer Assessments
Construction Industry Insurance Classifications and Rates
DIA Fiscal Year 1997 Budget
Government Reorganization Plan
Action Items
Minutes - June 12, 1996

August 7, 1996

Legislation
DIA Update
Workers' Compensation Insurance Classifications
Contract for Rate Filing Analysis
Action Items
Minutes - July 10, 1996
Executive Director Update

September 11, 1996

DIA Update
Contract for Rate Filing Analysis
Stop Work Orders
Budget Subcommittee
Action Items - Minutes - August 7, 1996
Executive Director Update

October 9, 1997

DIA Update
Vendor Presentations for Rate Filing Analysis - Ernst & Young; Watson Wyatt;
Coopers & Lybrand; Tillinghast
Judicial Appointments
Steve Sharek; Dino Theodore; Elaine Noble
Action Items
Minutes -September 11, 1997

November 13, 1996

DIA Update
Commerce & Labor Committee Oversight Hearing
Annual Report: Dispute Resolution System
Action Items
 Minutes - October 9, 1996
Executive Director Update

December 11, 1996

DIA Update
Budget Subcommittee Update
Division of Insurance Hearings
DIA Hearing
Action Items
 Minutes - November 13, 1996
Executive Director Update
 Draft Fiscal Year 1996 Annual Report

January 8, 1997

DIA Update
Action Items
 Minutes - December 11, 1996
DIA Budget Subcommittee Update
Annual Report - Concerns & Recommendations
Division of Insurance - Workers' Compensation Manual
Executive Director Update

February 12, 1997

DIA Update
 Stop Work Orders
 Budgetary Matters
Action Items
 Minutes - January 8, 1997
FY' 98 DIA Budget
Employer Fines Meeting Update
Workers' Compensation Legislation
Executive Director Update

March 12, 1997

DIA Update
DIA Budget
Employer Fines Meeting Update
Workers' Compensation Legislation
Action Items
 Minutes - February 12, 1996
Executive Director Update

April 7, 1997

Legislation

April 9, 1997

DIA Update
DIA Budget
Employer Fines Meeting Update
Workers' Compensation Legislation
Action Items
 Minutes - February 12, 1996
Executive Director Update

May 14, 1997

DIA Update
Action Items
 Minutes - March 12, 1997
 Minutes - April 9, 1997
Commerce & Labor Committee Hearing
Executive Director Update
 A. Rate Filing Analysis

June 11, 1997

DIA Update
Action Items
 Minutes - May 14, 1997
Insurance Manual - Roy Stewart, President WCRIB
DIA Employer Assessments
Wage Benefit Study
Executive Director Update

APPENDIX D

Roster of Judicial Expiration Dates

<u>NAME</u>	<u>AFFILIATION</u>	<u>EXPIRATION DATE</u>
1. Carolynn Fischel	Unenrolled	5/28/98
2. Frederic E. Levine	Unenrolled	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. John Bradford (Resigned - 10/31/97)		
3. Martine Carroll	Unenrolled	1/31/00
4. David Chivers	Republican	5/28/98
5. Karen Corcoran	Democrat	7/06/00
6. William Constantino	Republican	5/26/01
7. Janet Cox	Unenrolled	5/21/98
8. Richard Heffernan	Democrat	9/04/03
9. John Harris	Republican	5/28/98
10. Emogene Johnson	Unenrolled	7/29/00
11. James LaMothe, Jr.	Republican	1/31/03
12. William Long	Democrat	8/03/00
13. Douglas McDonald	Democrat	7/06/00
14. John McLaughlin	Republican	5/28/98
15. Theodore Merlo	Republican	5/28/98
16. Bridget Murphy	Republican	7/27/00
17. Daniel O'Shea	Republican	5/21/98
18. James St. Amand	Democrat	5/14/98
19. Diane Solomon	Unenrolled	8/10/00
20. Stephen Sumner	Unenrolled	7/05/02
21. Jo'Anne Thompson	Republican	9/18/98

INDUSTRIAL ACCIDENT BOARD ONE YEAR TERMS

1. Joellen D'Esti	Unenrolled	7/17/98
2. Fred Taub	Democrat	7/01/98
3. Richard Tirrell	Democrat	7/01/98

RETIRED/PART-TIME TERM EXPIRATIONS

1. William Pickett	Democrat	2/05/98
2. Nicholas Vergardos	Democrat	2/05/98

APPENDIX E

Massachusetts Bar Association Survey of Department of Industrial Accidents Judicial Performance

By statute, the senior judge of the Massachusetts Department of Industrial Accidents must periodically evaluate the performance of DIA judges.

The Massachusetts Bar Association and its Civil Litigation Section's Workers' Compensation Committee believe attorney input is vital to properly assess judicial performance. Therefore, the association's Board of Delegates voted in 1995 to authorize the committee to conduct a survey of the bar to evaluate DIA judicial performance.

Many DIA judges and attorneys were instrumental in developing the survey over a two-year period. Particular attention was paid to the formulation of the survey questions. Procedures were adopted to ensure the anonymity of the individual attorney respondents. Considerable effort went into developing a list of workers' compensation practitioners from across the commonwealth. The list was comprised of employees' counsel, insurers' counsel and lawyers who represent both parties at the DIA. Approximately 500 surveys were distributed and 178 responses returned.

Surveys were distributed in early December 1996. The results were tabulated in early February 1997 by MBA staff.

The MBA thanks those who participated in this inaugural endeavor. It is hoped that the Governor's Council, the DIA Nominating Panel and all other interested parties will seriously consider the survey results in the renomination process.

February 13, 1997

RESPONSE BY NUMBER	Does the Judge demonstrate a basic knowledge of workers' compensation law and procedure?		Does the Judge exhibit appropriate judicial demeanor?		Is the Judge punctual?		Are the Judge's hearing decisions supported by adequate subsidiary findings based on the evidence?		Does the Judge understand and correctly apply the rules of evidence at hearing?		Does the Judge avoid excessive bias in the administration of justice?	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
D. Bean	110	12	114	7	103	13	85	23	93	12	94	18
J. Bradford	75	26	100	1	102	1	69	29	58	37	92	8
K. Capeless	58	22	63	21	73	9	41	18	45	22	52	20
M. Carroll	107	4	108	2	99	3	93	13	94	11	92	18
D. Chivers	55	1	54	1	54	1	45	7	48	4	41	13
D. Constantino	49	16	55	11	63	2	37	12	37	14	46	13
J. Cox	90	2	87	1	64	23	77	2	80	3	70	16
J. D'Esiti	96	17	85	27	99	11	74	23	79	19	85	17
F. Gromelski	60	18	54	24	69	9	46	17	45	22	59	14
J. Harris	42	29	82	15	94	2	46	37	58	29	40	53
R. Heffernan	112	4	112	2	111	2	105	5	105	2	103	5
E. Johnson	95	6	95	4	90	7	78	13	79	13	72	20
J. Lamothe	103	4	98	6	100	3	93	5	95	4	96	6
F. Levine	104	3	103	3	104	1	94	5	95	4	90	11
W. Long	73	12	81	5	83	2	60	11	65	8	71	9
D. MacDonald	83	3	83	2	83	1	71	2	73	3	78	3
J. McKenna	87	20	95	9	96	9	68	32	80	20	61	41
J. McLaughlin	94	0	91	3	90	2	79	5	85	1	86	4

	Does the Judge demonstrate a basic knowledge of workers' compensation law and procedure?		Does the Judge exhibit appropriate judicial demeanor?		Is the Judge punctual?		Are the Judge's hearing decisions supported by adequate subsidiary findings based on the evidence?		Does the Judge understand and correctly apply the rules of evidence at hearing?		Does the Judge avoid excessive bias in the administration of justice?	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
T. Merio	97	21	40	77	111	5	69	36	76	32	67	45
B. Murphy	44	4	44	4	47	1	39	5	39	5	37	8
D. O'Shea	112	0	111	1	111	0	106	1	106	2	107	2
D. Solomon	111	5	85	30	19	95	81	21	94	14	85	25
J. St. Amand	51	7	49	10	51	7	42	11	44	12	46	14
S. Sumner	84	4	86	4	84	2	71	9	80	7	69	16
F. Taub	116	3	111	4	114	1	96	9	101	7	83	32
J. Thompson	52	45	77	22	73	25	36	46	33	57	66	26
R. Tirrell	108	4	104	7	105	4	97	11	102	6	98	8
	Does the Judge demonstrate a basic knowledge of workers' compensation law and procedure?		Does the Judge exhibit appropriate judicial demeanor?		Is the Judge punctual?		Do the Judges decisions adequately address issues raised on appeal?		Does the Judge write decisions in a clear and well reasoned manner?		Does the Judge avoid excessive bias in the administration of justice?	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
C. Fischel	120	8	114	6	110	2	106	8	102	7	88	28
S. Holmes-Wilson	77	7	81	3	80	3	72	7	69	8	73	8
E. Kirby	54	11	66	4	68	0	54	8	47	12	68	0
S. Maze-Rothstein	89	15	87	20	97	8	85	14	74	22	78	26
W. McCarthy	129	0	127	2	124	0	117	4	114	5	111	13
S. Smith	76	13	81	10	85	1	65	20	65	18	69	20

Results by Percentages	Does the Judge demonstrate a basic knowledge of workers' compensation law and procedure?		Does the Judge exhibit appropriate judicial demeanor?		Is the Judge impartial?		Are the Judge's hearing decisions supported by adequate subsidiary findings based on the evidence?		Does the Judge understand and correctly apply the rules of evidence at hearing?		Does the Judge avoid excessive bias in the administration of justice?	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
D. Bean	90%	10%	94%	6%	89%	11%	79%	21%	89%	11%	84%	16%
J. Bradford	74%	26%	99%	1%	99%	1%	70%	30%	61%	39%	92%	8%
K. Capeless	73%	27%	75%	25%	89%	11%	70%	30%	67%	33%	72%	28%
M. Carroll	96%	4%	98%	2%	97%	3%	88%	12%	90%	10%	84%	16%
D. Chivers	98%	2%	98%	2%	98%	2%	87%	13%	92%	8%	76%	24%
D. Constantino	75%	25%	83%	17%	97%	3%	76%	24%	73%	27%	78%	22%
J. Cox	98%	2%	99%	1%	74%	26%	98%	2%	96%	4%	81%	19%
J. D'Esti	85%	15%	76%	24%	90%	10%	76%	24%	81%	19%	83%	17%
F. Gromelaki	77%	23%	69%	31%	89%	11%	73%	27%	67%	33%	81%	19%
J. Harris	59%	41%	85%	15%	98%	2%	55%	45%	67%	33%	43%	57%
R. Heffernan	97%	3%	98%	2%	98%	2%	96%	4%	98%	2%	95%	5%
E. Johnson	94%	6%	96%	4%	93%	7%	86%	14%	86%	14%	78%	22%
J. Lamothe	96%	4%	94%	6%	97%	3%	95%	5%	96%	4%	94%	6%
F. Levine	97%	3%	97%	3%	99%	1%	95%	5%	96%	4%	89%	11%
W. Long	86%	14%	94%	6%	98%	2%	85%	15%	89%	11%	89%	11%
D. MacDonald	97%	3%	98%	2%	99%	1%	97%	3%	96%	4%	96%	4%
J. McKenna	81%	19%	91%	9%	91%	9%	68%	32%	80%	20%	60%	40%
J. McLaughlin	100%	0%	97%	3%	98%	2%	94%	6%	99%	1%	96%	4%

	Does the Judge demonstrate a basic knowledge of workers' compensation law and procedure?		Does the Judge exhibit appropriate judicial demeanor?		Is the Judge punctual?		Are the Judge's hearing decisions supported by adequate subsidiary findings based on the evidence?		Does the Judge understand and correctly apply the rules of evidence at hearing?		Does the Judge avoid excessive bias in the administration of justice?	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
T. Merlo	82%	18%	34%	66%	96%	4%	66%	34%	70%	30%	60%	40%
B. Murphy	92%	8%	92%	8%	98%	2%	89%	11%	89%	11%	82%	18%
D. O'Shea	100%	0%	99%	1%	100%	0%	99%	1%	98%	2%	98%	2%
D. Solomon	96%	4%	74%	26%	17%	83%	79%	21%	87%	13%	77%	23%
J. St. Amand	88%	12%	83%	17%	88%	12%	79%	21%	79%	21%	77%	23%
S. Sumner	96%	4%	96%	4%	98%	2%	89%	11%	92%	8%	81%	19%
F. Taub	98%	2%	97%	3%	99%	1%	91%	9%	94%	6%	72%	28%
J. Thompson	54%	46%	78%	22%	75%	25%	44%	56%	37%	63%	72%	28%
R. Tirrell	96%	4%	94%	6%	96%	4%	90%	10%	94%	6%	93%	7%
	Does the Judge demonstrate a basic knowledge of workers' compensation law and procedure?		Does the Judge exhibit appropriate judicial demeanor?		Is the Judge punctual?		Do the Judges decisions adequately address issues raised on appeal?		Does the Judge write decisions in a clear and well reasoned manner?		Does the Judge avoid excessive bias in the administration of justice?	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
C. Fischel	94%	6%	95%	5%	98%	2%	93%	7%	94%	6%	76%	24%
S. Holmes-Wilson	92%	8%	96%	4%	96%	4%	91%	9%	90%	10%	90%	10%
E. Kirby	83%	17%	94%	6%	100%	0%	87%	13%	80%	20%	100%	0%
S. Maze-Rothstein	86%	14%	81%	19%	92%	8%	86%	14%	77%	23%	75%	25%
W. McCarthy	100%	0%	98%	2%	100%	0%	97%	3%	96%	4%	90%	10%
S. Smith	85%	15%	89%	11%	99%	1%	77%	23%	78%	22%	78%	22%

APPENDIX F

FY'98 Office of Safety Proposals Recommended for Funding

1. Western MassCOSH
458 Bridge Street, Springfield, MA 01103
(413) 731-0760
Title: Protecting Workers' Health: A Training Program on Confined spaces for Employees of Northampton & Greenfield
Program Administrator: Philip Korman
Total Funds Requested: \$20,355.47 **Approved:** \$20,355.47
2. Automatic Rolls of New England
31 Southbridge Street, Auburn, MA 01501
(508) 798-8858
Title: Cumulative Trauma & Musculoskeletal Injury Prevention Program
Program Administrator: William Carlson
Total Funds Requested: \$4,280.00 **Approved:** \$4,280.00
3. Braintree Hospital Rehabilitation Network
100 Baystate Drive, Braintree, MA 02118
(617) 356-0520
Title: Work Injury Prevention Prog. for Musculoskeletal & Repet. Motion Disorders
Program Administrator: Mary Riley
Total Funds Requested: \$11,757.00 **Approved:** \$11,757.92
4. Massachusetts Construction Safety Congress
256 Freeport Street, Boston, MA 02122
(617) 426-3551
Title: OSHA-Approved Safety Training for Construction Apprentices and Journeymen
Program Administrator: Joseph Dart
Total Funds Requested: \$29,968.00 **Approved:** \$29,839.00
5. Department of Public Health - Occupational Health Surveillance Program
250 Washington Street, Boston, MA 02108
(617) 624-5625
Title: Occupational Health & Safety Training for Restaurant Workers
Program Administrator: Robin Dewey
Total Funds Requested: \$29,098.0 **Approved:** \$29,098.02

6. Massachusetts Interlocal Insurance Association
60 Temple Place, Boston, MA 02111
(617) 426-7272
Title: An Ergonomic Training Program for Prevention of Musculoskeletal injuries
and Back Pain
Program Administrator: Jeffrey Sienna
Total Funds Requested: \$28,592.50 **Approved:** \$28,292.50
7. Morton Hospital & Medical Center
88 Washington Street, Taunton, MA 02780
(508) 824-0243
Title: FY98 RFR Injury Prevention Program
Program Administrator: Kathleen Hickey
Total Funds Requested: \$14,066.00 **Approved:** \$ 9,416.50
8. Gentex Optics, Inc.
P.O. Box 307, West Main Branch, Dudley, MA 01571
(508) 943-3860
Title: Cumulative Trauma, Musculoskeletal Injury Prevention & JSA Training
Program Administrator: John Stapler
Total Funds Requested: \$8,706.00 **Approved:** \$8706.00
9. KomTek
40 Rockdale Street, Worcester, MA 01606
(508) 853-4500
Title: Accident Investigation/Hazard Assessment Training Program
Program Administrator: Deborah Emmons
Total Funds Requested: \$8,666.50 **Approved:** \$8,666.50
10. Boston Plasterers & Cement Masons
7 Frederika Street, Dorchester, MA 02124
(617) 825-7472
Title: PROJECT CASH
Program Administrator: David McCabe
Total Funds Requested: \$29,355.38 **Approved:** \$29,355.38
11. Helpline - c/o Brockton Area Multi Service, Inc.
500 Belmont Street, Suite 230, Brockton, MA 02401
(508) 584-4357
Title: Occupational Health & Safety Training for Brockton Young Workers
Program Administrator: Elaine Reiser
Total Funds Requested: \$29,500.20 **Approved:** \$29,830.20

12. JATC for the Electrical Contracting Industry of Greater Boston
194 Freeport Street, Dorchester, MA 02122
(617) 436-0980
Title: Local 103, IBEW Health & Safety Steward Training Program
Program Administrator: Philip Mason
Total Funds Requested: \$29,750.00 **Approved:** \$29,744.00
13. WorkRight, Inc.
66 Carol Road, Needham, MA 02192
(617) 444-9638
Title: "Ergonomic Training for Manufacturers of Medical-Surgical Instruments and Devices"
Program Administrator: Bette Hoffman
Total Funds Requested: \$27,013.50 **Approved:** \$26,950.00
14. Operating Engineers
One Engineers Way, Canton, MA 02021
(617) 821-0306
Title: Crane Safety
Program Administrator: William Mooney
Total Funds Requested: \$26,111.36 **Approved:** \$26,111.36
15. UAW Local 2322
56 Main Street, Northampton, MA 01060-3129
(413) 584-4905
Title: Working Together: Health & Safety Training for UAW Local 2322 & Six other Umass Amherst Unions
Program Administrator: Jenny Hein
Total Funds Requested: \$11,745.84 **Approved:** \$11,745.00
16. Asbestos Workers Local #43
1053 Burts Pit Road, Northampton, MA 01060-3630
(413) 584-0028
Title: Preventing Asbestos and Fiberglass-Related Disease & Confined Space Injuries for Building Trades Workers in Western Mass
Program Administrator: Robert Starr
Total Funds Requested: \$19,872.20 **Approved:** \$19,863.20
17. Independent Laundry Workers Local 66L
697 Broadway, Somerville, MA 02144
(617) 628-8770
Title: Health & Safety Training for Laundry Workers
Program Administrator: Eduardo Lebron
Total Funds Requested: \$30,000.00 **Approved:** \$26,500.00

18. Dept. of Mental Retardation
160 No. Washington Street, Boston, MA 02114
(617) 727-5608
Title: Take a Step Back: The Roots of Violence in Services & Possible Alternatives
Program Administrator: Eddie Sanabria
Total Funds Requested: \$26,309.00 **Approved:** \$26,309.00
19. Advanced Therapeutic Resources
157 Elm Street, Amesbury, MA 01913
(508) 388-6775
Title: Ergonomics & Safety Training for the Prevention of Musculoskeletal Injuries
Program Administrator: Julie Cicalis
Total Funds Requested: \$25,315.00 **Approved:** \$25,315.00
20. Yankee Candle Company
Route 5, P.O. Box 110, South Deerfield, MA 01373
(413) 665-8306
Title: Occupational Safety & Health & Education Program
Program Administrator: Kenneth Bergeron
Total Funds Requested: \$29,850.00 **Approved:** \$19,500.00
21. Chadwick's of Boston
35 United Drive, West Bridgewater, MA 02379-1021
(508) 583-8110
Title: Taking the Next Step Toward Injury Prevention CTD & Back Injury Awareness Training
Program Administrator: Thomas Minichiello
Total Funds Requested: \$29,980.00 **Approved:** \$ 23,980.00
22. City of Worcester
City Hall, Room #109, 455 Main Street, Worcester, MA 01608
(508) 799-1031
Title: Cumulative Trauma & Musculoskeletal Injury Prevention Program
Program Administrator: Lori Favata
Total Funds Requested: \$11,327.00 **Approved:** \$11,327.00
23. Eaton Corporation
108 Cherry Hill Drive, Beverly, MA 01915
(508) 921-0750
Title: Progressing the Safety Process Through the Development of an Ergonomic Team & Musculoskeletal Injury Prevention Training
Program Administrator: Paula KeJong
Total Funds Requested: \$28,363.00 **Approved:** \$24,163.00

24. Quabaug Corporation
18 School Street
N. Brookfield, MA 01535
(508) 867-7731
Title: Occupational Safety & Health Education and Training Program
Program Administrator: Patti Coffill
Total Funds Requested: \$27,450.00 **Approved:** \$8,025.00
25. Workers Education Program, Inc.
30 Winter Street - 9th Floor, Boston, MA 02108
(617) 422-0173
Title: CTD Prevention Program
Program Administrator: Harneen Chernow
Total Funds Requested: \$15,130.00 **Approved:** \$10,816.25
26. Presmet Corporation
112 Harding Street, Worcester, MA 01604
(508) 792-6400
Title: Occupational Safety and Health Training and Education Program
Program Administrator: Kevin Smith
Total Funds Requested: \$29,475.00 **Approved:** \$19,950.00
27. Grieco Bros., Inc.
50 Island Street, Lawrence, MA 01840
(508) 686-9802
Title: Occupational Safety and Health Training and Education Program
Program Administrator: Charlene Maginnis
Total Funds Requested: \$28,725.00 **Approved:** \$22,125.00
28. ResourceNet International
613 Main Street, Wilmington, MA 01887
(508) 988-7284
Title: Safety is No Accident: Safe Behavior Training at ResourceNet International
Program Administrator: Demetria Scott
Total Funds Requested: \$29,925.00 **Approved:** \$28,425.00
29. Benn Safety Management and Training
45 Pullen Avenue, Pawtucket, RI 02861
(401) 724-4007
Title: Lockout/Tagout Training for Wastewater Treatment Personnel
Program Administrator: William Gordon
Total Funds Requested: \$29,705.81 **Approved:** \$28,405.81

30. FLEXcon Company, Inc.
FLEXcon Industrial Park - Spencer, MA 01562-2642
(508) 885-8200
Title: Occupational Safety & Health Education and Training Program
Program Administrator: Catherine Benjamin
Total Funds Requested: \$29,475.00 **Approved:** \$18,750.00
31. M/A Com, Inc.
1011 Pawtucket Blvd., Lowell, MA 01853
(508) 442-4464
Title: Preventing Cumulative Trauma Disorder thru Continuous Improvement
Program Administrator: Marie Dziadosz
Total Funds Requested: \$29,869.00 **Approved:** \$22,419.00
32. MassCOSH
555 Amory Street, Jamaica Plain, MA 02130
(617) 524-6686
Title: Preventing Workplace Injury from Violence in City of Quincy Employees
Program Administrator: Laurie Sheridan
Total Funds Requested: \$30,000.00 **Approved:** \$24,035.00
33. Royal Institutional Services, Inc.
520 Columbia Street, Somerville, MA 02143
(617) 629-4100
Title: Occupational Safety & Health Training and Education Program
Program Administrator: Nathan Benjamin
Total Funds Requested: \$21,675.00 **Approved:** \$17,025.00
34. Sisters of Providence Health Systems
1223 Main Street, Holyoke, MA 01040
(413) 539-2635
Title: Occupational Safety and Health Education and Training Program
Program Administrator: Deborah LaVoie
Total Funds Requested: \$29,565.00 **Approved:** \$19,950.00
35. WorkSafe
206 Wareham Street - Suite 213, Middleboro, MA 02346
Title: Ergonomic Training and Injury Prevention
Program Administrator: Marilyn Zurwaski
Total Funds Requested: \$26,366.00 **Approved:** \$29,982

36. Workwise, Inc.
10 Penobscot Road, Natick, MA 01760
(508) 653-4635
Title: Ergonomics & Safety Training for the Prevention of Upper
Extremity CTD's & Back Injury
Program Administrator: Gay Geiger Hughes
Total Funds Requested: \$8,142.00 **Approved:** \$5,317.00
37. C&K Components, Inc.
15 Riverdale Avenue, Newton, MA 02158
(617) 926-6400
Title: Ergonomic Training and Education
Program Administrator: Stephen O'Neil
Total Funds Requested: \$15,175.00 **Approved:** \$15,175.00
38. Occupational Health & Safety Solutions, Inc.
91 Main Boulevard, Shrewsbury, MA 01545
(508) 842-3464
Title: Prevention of Acute and Chronic Musculoskeletal Disorders
Program Administrator: Gail Army
Total Funds Requested: \$20,740.00 **Approved:** \$20,740.00
39. Neles-Jamesbury
640 Lincoln Street, Worcester, MA 01615
(508) 852-0200
Title: Occupational Safety & Health Education and Training Program
Program Administrator: Kenneth Tumas
Total Funds Requested: \$29,550.00 **Approved:** \$11,325.00
40. Motorola I.S.G.
20 Cabot Boulevard, Mansfield, MA 02048
(508) 261-4000
Title: Prevention of Musculoskeletal Disorder in Office Workers
Program Administrator: Barbara Mundy
Total Funds Requested: \$29,440.00 **Approved:** \$22,345.00

APPENDIX G

WORKERS' COMPENSATION LEGISLATION

Before the Joint Committee on Commerce & Labor

1997-1998 Legislative Session

Employer Fines - (H.5039 - *Lees*)

This bill would amend § 25C (2) regarding fines for failing to secure workers' compensation insurance. It would add provisions allowing the DIA Commissioner to reduce employer fines to an amount no lower than \$250 following a hearing in which there is a finding that:

- (a) the fine would have a severe negative impact on the cash flow or financial stability of the business;
- (b) weekends and holidays interrupted the employer's ability to secure coverage in a more timely fashion;
- (c) the business was unable to secure voluntary coverage thus delaying their application to the Massachusetts Workers' Compensation Assigned Risk Pool for coverage; or
- (d) the amount of annual premium for worker's compensation coverage is less than the amount of fines imposed by the DIA under the stop work order.

Section 2 of the bill, would amend § 75A, which requires employers to give preference in hiring to injured employees applying for re-employment. This bill would relieve the rehiring requirement if the injured employee has been employed by another employer for more than six months since the date of injury. Section 3 of the bill would amend § 1 (4). It would make the coverage of corporate officers elective.

Employer Fines S.52 - (*Lynch*)

This bill would increase the fines for employers who fail to obtain workers' compensation insurance. The bill would:

- increase the fines from the current \$100.00 per day to \$200.00 per day, per employee;
 - create a civil penalty for employers in the construction industry who lack insurance, charging \$500.00 per day, per employee, for each day the employer was without insurance (counting the date of service of the stop work order as the first day and date of payment of the penalty with the proof of insurance or self-insurance as the final day);
 - increase the fine from \$250.00 per day to \$500.00 per day, per employee, when an employer appeals a stop work order and is found, after a hearing, that coverage was lacking;
 - create a civil penalty of \$1,000 per day, per employee, for employers doing business in the construction industry who appeal a stop work order and are found that coverage was lacking. This penalty would account for each day that the employer was without insurance (counting the date of service of the stop work order as the first day and date of payment of the penalty with the proof of insurance or self-insurance as the final day);
- cap the maximum punishment by fine from the current \$1,500.00 to \$10,000.00.

Stop Work Orders - New Corporations (H. 1872 - *Kulik*)

This bill would amend §25C to require the DIA to give a three day notice to any business it intends to investigate. This bill would create a new section, §25V, which would require the DIA to notify all persons filing articles of incorporation with the Secretary of State's Office of their responsibilities to obtain workers' compensation.

Tax Information for Fraud Investigation (H.3585 - *Honan*)

This bill would amend Ch. 62C of the General Laws, which provides administrative procedures relative to state taxation. Section 21(a) prohibits the Department of Revenue from disclosing taxpayer information contained on any person's tax return or tax document to anyone but the taxpayer, except for criminal prosecution in certain enumerated instances. Section 21(b) provides the exceptions to this prohibition. This bill would require the DOR to disclose tax information to the Commissioner of the DIA or any state, county or municipal official, for the purpose ascertaining or confirming the existence of fraud, abuse or improper payment of benefits.

Fraudulent Activities - Modification of Benefits (H.3965 - *Dempsey*)

This bill would add a new subsection 8B, which would give the Division of Industrial Accidents the authority to initiate investigations and proceedings to alter the payments of benefits received by employees suspected of engaging in fraudulent activities.

Def. of Employee - Exemption of Sole Proprietors & Partnerships (S.22 - *Amorello*, H.445 *Miceli*, H.3594 - *Koczera*, H.3010 - *Resor*) These bills would amend the definition of employee, giving a sole proprietor or a partnership the option of being considered an employee, thereby making workers' compensation coverage elective.

Def. of Employee - Exemption of Sole Shareholders (S.74 - *Murray*)

This bill would amend the definition of employee by exempting the sole shareholder of a corporation or an officer who is a sole shareholder from the requirements of obtaining workers' compensation insurance.

Def. of Employee - Exemption of Corporate Officers (H.1079 - *Stanley*, H.1645 - *Lepper*)

These bills are similar to S. 41 and S. 72 filed last legislative session. These bills would amend the definition of employee by making workers' compensation coverage elective for corporate officers regardless of their duties. This proposal would especially effect small, family run businesses where the owners typically are the only workers.

Definition of Employer - Exemption of Volunteers (H.883 - *Walrath*)

This bill would exempt from the act any director, officer or trustee of a nonprofit entity (as defined by the IRS code), provided they receive no compensation except reimbursement for out of pocket expenses.

Def. of Employer - Exemption of Employee Owned Companies (H.3003 - *Casey*)

This bill would amend the definition of an "employer" by excluding businesses which are fifty percent or more employee owned, and with less than four employees.

Definitions - Contractors & Sub-Contractors (H.644 - *Hynes*) [Refile]

This bill (filed last legislative session as H. 1793 and H. 1794) would exempt residential contractors from the requirement of providing workers' compensation insurance for certain

subcontractors. H. 644 would exclude from the definition of employee any subcontractor who enters into a contract with a residential contractor provided that the general 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.

Employee Leasing Companies - Exclusive Remedy (H.881 - *Kaufman*)

This bill would amend §14A which allows the Commissioner of Insurance to regulate the terms of workers' compensation policies for employee leasing companies. The bill would extend the exclusive remedy doctrine to both the leasing company and the client company, as well as the provisions of the employer's liability provisions of a workers' compensation policy, in any given controversy.

Creation of a Residential Home Contractor Classification (H.645 - *Hynes*) [Refile]

H. 645 would establish a new classification of risks and premiums for residential home contractors whose premium rate would be capped at 40% of the 1995 classification rate.

Exemption of Out of State Employers (S.20 - *Amorello*)

This bill would create a new section (25V) and that would exempt an out of state employer from the Massachusetts workers' compensation laws when its employees work in Massachusetts temporarily. The exemption would only apply if: the employer is not a resident of Mass. and was not contracted here; the employer does not have a permanent place of business in-state; or the employee has not worked in-state for more than 5 consecutive days, 10 days in a 30-day period or 30 days in a 360-day period. The workers' compensation laws of the resident state would govern any work related injuries in Massachusetts.

Insurance Requirement - Exemption of Agricultural Employers (S.29 - *Brewer*)

This bill would amend §25B by exempting from the insurance requirement agricultural or horticultural employers with a gross annual payroll below \$100,000.

Study of Occupational Safety & Health of Public Employees (H.640 - *Businger*)

This bill would authorize the Joint Committee on Commerce & Labor to conduct a study on the occupational safety and health of public employees. Such a study would include an examination of safety standards, health hazards, the prevention of industrial accidents, enforcement mechanisms, etc.

Insurance Discounts for Drug Free Workplace Programs (S.59 - *Magnani, Stasik, Murray, Thompson, Stefanini, and Tarr*) This bill would require that employers who implement a drug-free workplace program receive a 5% discount on workers' compensation premium. Employers would have to comply with the standards and procedures set forth in the legislation and all applicable rules adopted by the DIA.

Medical Insurance for Injured Workers (S.30 - *Brewer on behalf of MA AFL-CIO*) [Refile]

This bill would require any employer that provides accident, health and life insurance coverage or makes contributions to an employee welfare fund, 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. This legislation conflicts with a U.S. Supreme Court case, District of Columbia v. Greater Washington Board of Trade, 113 S.Ct.580 (1992). The Supreme Court declared that an identical piece of legislation enacted in Washington, D.C. was unconstitutional. According to

the Supreme Court the legislation in question impermissibly sought to regulate health benefits that "relate to" ERISA covered benefits, and therefore were preempted by federal law.

Benefits for Specific Injuries - Scar Based Disfigurement (S.51 - *Lynch*, H.3765 - *Cabral*)

[Refile]

These bills would eliminate the requirement that scar based disfigurement appear on the face, neck or hands to be compensable. This would require compensation for all disfigurement, whether or not scar based, regardless of its location on the body. Section 36(k) was amended by chapter 398 to limit payments for purely scar based disfigurement by requiring benefits only when the disfigurement is on the face, neck, or hands.

Durable Medical Equipment (S.97 - *Travaglini*, S.98 - *Travaglini*)

Senator Robert Travaglini filed these bills in the last legislative session as an outside section to the 1997 budget. They apply to providers of durable medical equipment. These bills would accomplish the following:

- Providers of durable medical equipment would be considered a "provider" for all purposes of ch. 152.
- If a treating physician of an injured employee prescribes and determines a treatment to be medically necessary, no insurer, self insurer, third party claims administrator or utilization review agent could deny or refuse reimbursement for their costs, unless:
 - 1) the provider is given the same rights of appeal as any physician provider or injured employee with respect to claims denial or refusal of any adverse utilization review determination; and
 - 2) the utilization review agent, insurer, self-insurer or third party administrator discloses to the physician, injured employee or provider of medical equipment the standards used for the denial.
- A durable medical equipment provider would have a private right of action to enforce this provision and other applicable sections under chapter 152. Any violation of this provision would be deemed an unfair method of competition as defined by chapter 176D and an unfair practice as defined in ch. 93A.

Voluntary Payment of Benefits - Pay Without Prejudice (H.654 - *Koczera*, S.70 - *Morrissey*)

H. 654 and S.70 are identical. These bills would amend section 19 of the act. This section addresses agreements between an insurer and a claimant to voluntarily pay benefits. Unless payment begins within 14 days of receipt of the first report of injury or an employee's complaint, all agreements to make payments must be in writing and approved by the DIA. This applies to voluntary payment of weekly indemnity benefits as well as lump sum agreements which are further regulated by §48. Section 7 of the statute explicitly states that the decision to pay or deny a claim for benefits must be made by the insurer within fourteen days, under penalty of law. Section 8 of the act states that if an insurer begins payment within this time frame, it has 180 days to unilaterally cease making payments. The pay without prejudice period does not apply when an insurer denies a claim and later voluntarily agrees to pay, or where an insurer makes a late decision to pay benefits. This "pay without prejudice" period is one feature of the 1991 reforms credited with encouraging prompt payment of claims and reducing disputed claims at the agency. Currently, the DIA will not approve a §19 agreement that contains a pay without prejudice clause on the basis that such an agreement violates the prompt payment mandates of

sections 7 and 8. These bills seek to allow insurers who do not make prompt payment within 14 days to have the benefit of the pay without prejudice period should the insurer agree to make future payments.

New Section - Insurance Coverage of Domestic Employees (S.19 - *Amorello*)

This bill would add a new section (25V) to Ch.152. It would require all insurance companies that provide comprehensive personal liability, tenant's or homeowner's insurance to also provide "workers' compensation insurance" covering domestic employees.

Impartial Examinations (S.54 - *Lynch*)

This bill is substantively identical to H. 1072 filed last year. It would create a new section 9C to allow an AJ or ALJ to appoint an impartial physician to examine and report on a claimant's condition prior to a conference or hearing. [Currently, under section 8(4), an impartial physician can be requested at the conference stage only at the request of the insurer after the 180 day pay without prejudice period has expired.] This bill also replaces language for section 11A impartial exams. It would remove the Ch. 398 requirement that an impartial exam be conducted whenever "a dispute over medical issues is the subject of a conference order." Under this bill, appointment of an impartial physician would be at the discretion of the AJ or ALJ. It also requires that the report indicate whether employment is the predominant contributing cause for mental or emotional disability. This bill would expand the role of the impartial physician by requiring that the physician make a determination about causation, whether or not the determination can be made with a reasonable degree of medical certainty. Moreover, the causation standard would change from whether the work-related injury was the "major or predominant contributing cause" of the disability to whether the work-related injury was "probably caused or was contributing cause" of the disability. The standard would therefore be eased. The report from section 9C must be entered into evidence at the hearing, and the current requirement that it be treated as prima facie evidence is eliminated. This means that the impartial report must not be the only medical evidence presented to the AJ, but that medical evidence from the employee's treating physician and insurer reports may be entered as well. The fee for any deposition would be paid by the deposing party, however, if the decision of the AJ is in favor of the employee, the cost of the deposition would be added to the amount awarded to the employee.

Impartial Medical Examinations (H.3009 - *Kennedy*)

This bill would amend section 11A, dealing with the impartial medical examination process. Additional medical evidence could be presented along with the impartial report at hearing. This bill would also create a new section 8B governing the content of the report and the conditions of the exam. It would require that the report state whether the workplace injury was a "contributing cause" of the disabling condition, whether the injury claimed is "mental or emotional in nature," and whether "any disabling mental or emotional condition has as its significant or predominant contributing cause, an event or series of events within the employment."

Comprehensive (S.53 - *Lynch, Connolly*)

Section 1 of this bill addresses injured employees who return to work Shannon (without a lump sum settlement) and receive wages which are less than the pre-injury wages. This bill would apply the prior average weekly wage to any subsequent period of incapacity, whether or not such incapacity was the result of a new injury or subsequent injury as set forth in §35B. Section 2 of this bill would eliminate consideration of the last best offer in awarding attorney's fees when the insurer files for discontinuance of benefits or refuses initial payment. Currently, the claimants

attorney is only entitled to payment if the administrative judge accepts the offer of the claimant or the amount submitted by the conciliator.

Pilot Program on Limited Provider Networks (S.91 - *Tarr*)

This bill would authorize the Commissioner of the Department of Labor and Industries to develop a pilot program designed to evaluate the potential of limited provider networks to control costs and maintain quality care. Participation would include no more than 20 small employers and should be representative of small employers across the Commonwealth. An open and competitive process must be used in selecting an insurance carrier to run the program.

Creating a Workers' Compensation Insurance Fund (H.1449 - *Tolman, MA AFL-CIO*)

This bill would create a non-profit independent public corporation to provide workers' compensation insurance as an alternative to insurance secured through the private market, and also to serve as the carrier of last resort.

Insurance Rates - Competitive Rating (H.2238 - *Bosley*)

This bill would require a system of competitive rating of workers' compensation insurance rates. Insurance carriers would competitively price insurance coverage, rather than have the Commissioner of Insurance approve a uniform set of rates required for all carriers. This bill was extensively studied by the Council in the Fall of 1996, when a lengthy report was prepared by J.H. Albert and submitted to the Legislature. The Council endorsed the proposal, with some suggestions and cautionary remarks. This bill is identical to the original bill filed by Rep. Bosley. The original, however, was replaced with a version which incorporated concerns of the Council and the State Rating Bureau.

Total Incapacity, Partial Incapacity - Increase Benefits (H.1441 - *Cabral, MA AFL-CIO*)

This refile bill would increase wage benefits for injured workers under sections 34 and 35 by restoring the amount to 2/3 of average weekly wage and the duration to 260 weeks for §34 (currently 156) and 600 weeks for §35 (currently 260 or 520 for serious injuries).

Total Incapacity - Increase Benefits (H.3006 - *Kennedy*)

This bill would increase the weekly compensation for total incapacity (§34) benefits. Compensation would increase from the current 60% to 2/3 of average weekly wage.

Partial Incapacity - Increase Benefits & Limiting Durations (H.3008 - *Kennedy*)

This bill would increase temporary total benefits to 2/3 of average weekly wage. It would eliminate the requirement that benefits not exceed 75% of §34 benefits and combined earnings and benefits not to exceed two times the state average weekly wage. It also amends the maximum duration from 260 weeks to 520 weeks.

Medical Services (S.90 - *Tarr*)

Section 1 would amend §30 by eliminating the requirement that the employee report to a physician within a preferred provider arrangement (PPA) for his/her first scheduled appointment. Section 2 would amend §30 by requiring the Commissioner to promote the "efficient coordination by the insurer of said health care services as well as other services provided by the insurer." §30 states that medical services provided must be presumed adequate and reasonable when they comport with the medical treatment guidelines. Section 3 would amend §30 would require that this presumption apply whether an appeal is made to the insurer (i.e., through the

utilization review process) or whether an appeal is filed with the DIA. Section 4 would amend §30 by allowing employees within a PPA to switch doctors within a medical specialty once.

Comprehensive Bill (H.1649 - Stanley)

1. Ch. 23E, § 6 Expedited procedures for Fraudulent Activity

This section would amend the procedure for expedited conferences for claims alleging illegal discontinuance of compensation, fraudulent behavior, catastrophic injuries or medical emergencies. It would require that these claims be referred to conference within seven days.

2. Ch. 152 §1 (1) Definition of Average Weekly Wages

This section would exclude overtime pay from the calculation of average weekly wage.

3. New Section §1 (5a) Definition of Experience Modified Insured

This section would create a definition of experience modified insured to mean (for the purposes of lump sum agreements under §48 (1)) "any employer eligible for an experience rated plan in the Commonwealth."

4. §1 (7A) Definition of Personal Injury

This section amends the standard by which an injury that combines with a pre-existing condition is determined to be compensable. The current statute reads "the resultant condition shall be compensable only to the extent such compensable injury or disease remains a major but not necessarily predominant cause of disability or need for treatment." This bill would amend it to read "the resultant condition shall be compensable only to the extent such compensable injury or disease is and remains the predominant contributing cause of disability or need for treatment. A contributing cause shall be determined to be the predominant cause if it is the largest single cause and is also larger than all other causes taken in combination.

5. §8 (2) (c) When Insurers may modify or discontinue payments

This section alters when an employer must resume payments of benefits after they have been discontinued because of a return to work. The bill requires resumption of benefits only after the employee informs by certified letter and medical evidence demonstrating that a changed or worsening medical condition renders him incapable of performing such work. (The current provision requires that the employee inform the insurer and employer that the resulting disability renders him incapable of performing such work.)

6. §8 (2) Termination/Modification of Payments

This section brings the terms by which an employer can terminate an employee that has returned to work (and therefor trigger reinstated benefits) in line with the handicap discrimination legislation.

7. New Clause §8 (2) (n) Termination/Modification of Payments

This section would create another means by which an insurer may motion for modification of benefits "based upon evidence of fraudulent actions or behavior."

8. §8 (2) Termination/Modification of Payments

For the purposes of §8 (2) (d) this section would create the presumption that termination of an injured employee within 180 days of returning to work was for the reason that the employee was physically or mentally incapable of performing the essential functions of the job with or without accommodation. This appears to bring the employer's right to terminate in line with handicap discrimination laws. The presumption could be rebutted if termination was for cause or other bona fide personnel reasons.

9. §8 (4) Impartial Medical Exam

This bill would alter the circumstances under which an insurer could request an impartial examination after starting payment of benefits. The bill would allow an insurer to request an impartial exam anytime after accepting liability or being assigned liability by an AJ or ALJ. (Presently an insurer may request an impartial exam no sooner than 60 days after requesting a

discontinuance conference but before a conference order has been issued.) Under the bill, the insurer could suspend all or part of the payment of benefits if the report contained "evidence of the ability to perform the essential functions of a job consistent with the employee's education, skills, and experience." The medical report would constitute prima facie evidence at a subsequent proceeding, as is contained in §11A.

Failure of an employee to report to an impartial exam or to submit requested medical reports to the examiner would constitute sufficient cause for suspension of benefits.

10. § 10 New Paragraph

This section would create an expedited process whereby no conciliation or conference would be held for a claim for section 34 (temporary total) benefits involving occupational disease, stress, cardio-vascular deficits, cerebral vascular deficits, asbestosis, cancer or by reason of the serious and willful misconduct of the employer (§28), permanent and total incapacity (§34A0 and or when death occurs before full payment of benefits (§36A). These types of claims would proceed immediately to hearing. All impartial medical examinations and medical depositions would be conducted prior to the hearing. The hearing would be required to occur within 180 days of the filing of the claim.

11. §11 Hearings

This section would amend §11, dealing with hearings. It would require that all discovery, including medical depositions, take place before the hearing commences. Each party would be required to submit a draft decision outlining the factual and legal basis for the decision within seven days of the close of the hearing.

12. §11A Impartial Medical Exams

This section would amend §11A by requiring the Senior Judge to appoint an impartial examiner from the roster (currently agreed to by the parties or by the AJ) within seven days of an appeal of a conference order (currently 10 days).

13. §11B Procedure for Hearing

This section would require that no post-hearing discovery could occur, and that all medical depositions occur prior to the scheduled hearing date.

14. §13 (3) Health Care Services Board

This section would add a representative of occupational health nurses to the makeup of the Health Care Services Board.

15. §13 (4) New Section

This section would prohibit physicians treating workers' compensation claimants from referring them to a clinical laboratory for diagnostic nuclear medicine, radiation oncology, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services if the physician or his/her immediate family has a financial interest in the entity.

16. §20 Hospital Records as Evidence

This section would strike the requirement that original copies of hospital records be submitted when being introduced into evidence at DIA proceedings.

17. §20 Adequate and Reasonable Health Care Services

This would amend the circumstances under which an injured employee could choose his or her treating physician. The employee could still choose a treating physician and switch once. Unless the insurer had a preferred provider arrangement (pursuant to §30 or 8 (1)), in which case the employee would be required to choose one from the network.

18. §30H Vocational Rehabilitation Services

This section would amend the vocational rehabilitation requirement. An employer would satisfy the voc/rehab obligation if the rehab plan was consistent with a functional capacity evaluation from a treating physician and the employer guarantees the position for 12 months.

19. §35D Computation of Weekly Wage Earning Capacity

The section amends the computation of earning capacity by requiring it to be computed by an administrative judge.

20. §35D (2) Earning Capacity

This section would amend the computation of earning capacity by allowing as prima facie evidence the written offer of the employee's job at the time of injury consistent with a functional capacity evaluation from either the treating physician, an impartial physician under §8 (4) or a company physician.

21. §35D(3) Earning Capacity

This section would amend the computation of earnings capacity by allowing as prima facie evidence the written report of a suitable available job consistent with a functional capacity evaluation from a treating physician an impartial physician under §8 (4) or a company physician.

22. §48 Lump Sum Agreements

This section would amend the manner by which lump sum agreements are reviewed by the DIA. A conciliator would be required to review all agreements for completeness unless the employee is not represented by counsel or where the parties seek determination by an AJ or ALJ on an amount to discharge a lien. In such cases an AJ or ALJ would be required to approve the agreement as being in the claimant's best interest. The section would eliminate the requirement that an agreement contain no bars on employment with any employer. It removes the \$10,000 fine against employers seeking to obtain illegal releases, as well as the right of an employee to reopen the claim when the settlement violates these provisions. The section also removes the provisions nullifying agreements regarding any future legal actions whether or not related to workers' compensation. It removes the presumption that the employee is physically incapable of refusing to work for one month for every \$1,500 amount in the settlement.

23. §75A Preference of Injured Employees for Rehiring

This section would provide preferential rehiring rights only for injured employees who have not settled cases pursuant to a lump sum agreement under §48.

24. §75B Qualified Handicapped Persons

This section would amend §75B to allow employers the right to secure the resignation of an injured employee as part of lump sum agreement under §48.

Comprehensive Bill (S.33 - *Creedon*)

1. Definitions (§1 (1)) - Average Weekly Wage

Section 1 would amend the definition of average weekly wage by requiring that the average weekly wage for §35 claimants who have returned to work and suffered reinjury, must be calculated using the wage the claimant was earning at the time of the original injury.

2. Benefits (§35) - Maximum Amount

Section 2 would amend §35 by eliminating the requirement that partial disability benefits not exceed 75% of §34 benefits.

3. Benefits (§35B) - Subsequent Injury

Section 3 would amend §35B to require that an injured employee who returns to work for at least 2 months and suffers another injury, will receive benefits at the rate currently in place, whether or not the new injury is a recurrence of the former injury. Section 3 would allow the employee to opt out of this section if it would subject him/her to a lower rate of compensation.

4. Procedure (§7A) - Employee Unable

Section 4 would amend §7A to state that when an employee is killed or becomes mentally unable to testify as the result of a workplace injury, a presumption is created that the claim complies with all procedural requirements and the injury was not the result of a willful. Section 4 of the bill would require that the incapacity to testify be determined to be "the result of the injury" rather than "causally related" as it currently reads.

5. Conciliation §10(6) - Last Best Offer

Section 5 would repeal subsection 6 of §10 which requires that each party submit written offers stating the amount of benefits believed to be owed in cases involving a request for additional compensation or to modify/discontinue benefits.

6. Conference (10B) - Last Best Offer

Section 6 would amend §19A (2(b)) by repealing the requirement that the administrative judge at conference implement one of the offers rendered at conciliation. It would require that the insurer submit an offer two days before the conference to the claimant. Unless the offer is accepted, the insurer would not be required to pay a referral fee under §13A.

7. Attorney's Fees (§13A) - Last Best Offer

Section 7 would amend §13A dealing with attorney's fees. This bill would remove all reference to the last best offer submissions.

8. Fraudulent Conduct (§14) - Duty to Reveal Knowledge of Fraud

Section 8 would amend §14 dealing with fraudulent actions by stating in subsection 3 that a person who knowingly makes a false or misleading statement or conceals knowledge of any event affecting the payment of benefits will be punished by five years imprisonment, *if they were required by law to reveal the matter*. Presumably, this is to ensure the protection of privileged information (e.g., information protected by the attorney-client privilege).

Rate of Reimbursement for Health Care Services (S.55 - Lynch)

Section 1 deletes the current language in section 13 and replaces it with simpler language stating that the Rate Setting Commission (now called Division of Health Care Finance & Policy) must establish the maximum reimbursement rates for hospitalization and all other health care services, and that no insurer may be held liable for any charge greater than those established rates. The bill would eliminate the ability for insurers and medical providers to negotiate rates. It would remove the "regardless of setting" provision thereby allowing hospitals to set rates higher than non-hospital facilities. It would remove the requirement that providers sign bills with their license numbers, and the removal of the adherence to federal "safe harbor" regulations. Further, all provisions regarding treatment protocols, utilization review and the establishment of the Health Care Services' Board would be deleted.

Health Care Services - PPA's and UR Guidelines - Section 2 creates a new section 30. The bill would eliminate authorization for preferred provider arrangements (PPA's) as well as all language pertaining to utilization review guidelines.

Partial Incapacity (§35) - Increase Benefits - Section 3 would amend section 35 (partial incapacity benefits) by eliminating the maximum rate of benefits (75% of §34 benefits). It would eliminate the duration of §35 benefits as well.

Lump Sum Settlements (H.2051 - Donovan)

This bill would amend §48 by requiring that a carrier's waiver of reimbursement under §15 could not be considered future weekly benefits. It would also remove the necessity that an employer that is an experience modified insured approve a lump sum settlement.

Lump Sum Settlements - Conciliator Approval (H.653 - Koczera, S.71 - Morrissey)

Both H. 653 and S. 71 are identical and seek to amend §48 of the act which pertains to lump sum settlements. This bill would elevate the role of the conciliator to approve lump sum settlements "as being in the claimant's best interest." Currently, the statute provides that conciliators may "approve as complete" lump sum settlements, a much lower standard. Roughly 300 lump sum settlements are reviewed by conciliators each year, compared to 10,000 that are reviewed by

ALJs. This higher standard ensures stricter review of the terms of the settlement, and should encourage early settlement.

Lump Sum Agreements - Review Board Approval (S.93 - *Tisei*)

This bill would amend Section 48 by requiring that proposed lump sum agreements be submitted for approval to the Review Board. The Review Board would insure that the lump sum agreement document is accurate and in conformity with factual representations made by the parties in all prior proceedings. The agreement would be approved only if the proposed payment is found by the Review Board to be in "direct correlation to a known and expected term of disability, and to a known and expected degree of loss in earnings capacity resulting from the subject of injury." The bill also creates a procedure whereby lump sums made prior to enactment of this bill can be reexamined. The agreement could be "reformed to correct any inequities in payments, if so found, with an accompanying order for an additional payment." If additional payments are merited, the Review Board could order them.

Lump Sum Settlements - Limitations on Agreements (H.3598 - *Larkin*)

This bill would limit when a lump sum agreement can discharge an employee's right to payment of future benefits. No lump sum agreement should be entered into or approved unless: (1) the employee has returned to work for at least 6 months, earning at least 75% of his/her pre-injury wage; (2) survivor benefits are claimed under §31; (3) the employee is determined by an AJ to be permanently and totally disabled; (4) or the employee becomes a domiciliary of another state.

Make the Conciliation Process Optional (H.3395 - *Sullivan*)

This bill would require the DIA to notify all parties when a claim or complaint is received. It would make conciliation optional, at the discretion of the filing party. Section 36 benefit claims or medical-only claims would have to be conciliated.

Attorney's Fees (S.56 - *Lynch*)

Section 1 of this bill would allow attorneys to collect fees for advancing an employee's rights under section 75A (preferential hiring of injured workers) and 75B (protections against handicap discrimination), in addition to any attorney's fees owed under section 13A.

Agreements to Pay Benefits (§19) - Section 2 of this bill adds two new subsections to section 19. It would allow any administrative judge, administrative law judge or conciliator to approve any agreement to pay benefits authorized by §19. In addition, it would allow an agreement to include a pay without prejudice clause. (See discussion regarding H. 654 on page 7 of other packet.)

Removal of AJ's & ALJ's - Code of Judicial Conduct (H.3763 - *Cabral*) [Refile]

This bill would require the Senior Judge, the AJ's and the ALJ's to be subject to the Code of Judicial Conduct as promulgated by the SJC.

Special Fund & Trust Fund Budgets - Reducing Year End Balances (H.3588 - *Koczera*)

Section 1 of this bill would amend §65(4) to require that the Advisory Council vote and record its support or opposition to any proposed trust fund budget. Section 2 would amend how much money the DIA can carry forward each year from year-end balances. Currently, only 35% of a prior years expenditures can be brought forward in a new fiscal year. Any balance exceeding 35% of the prior year's expenditures must be used to reduce the employers special fund assessment. This bill, as it is written, would make it in nearly impossible to reduce year end balances because it would require reductions only when the balance exceeds a prior year's expenditures. To ensure that balances are reduced to a greater extent than current practice, a

lower amount than 35% of expenditures ought to be the threshold. The bill should be amended to read some percent less than 35%.

Special Fund & Trust Fund Assessments - Reporting of DIA Transfers (H.3591 - *Koczera*)

This bill would require the DIA to file with the House and Senate Committees on Ways & Means, and the Committee on Commerce and Labor a review of all transfers between budget subsidiary accounts in the prior fiscal year. This bill would also require the DIA Commissioner to provide the Secretary of the Commonwealth with a notice explaining the duties, responsibilities, and liabilities of each corporation to purchase and provide workers' compensation insurance coverage.

Right of Action for School Employees Not Covered by WC (H.2626 - *Swan*)

Certain municipalities, municipal boards, and school districts are not covered by the workers' compensation act because they did not elect coverage when workers' compensation was first enacted. Section 67 allows employees of uninsured employers to file actions for damages against employers involving work related injuries. This bill would specifically allow school employees to file such actions if the school district was not covered by the workers' compensation act.

Comprehensive Bill (H.3770 - *Dempsey, AIM*) [Refile]

§1 - This section expedites the dispute resolution process for employees who file claims for illegal discontinuances, discontinuances based on fraud, and for medical emergencies. Such claims would by-pass conciliation and be assigned to an administrative judge for a conference to be held within seven days.

§2 - This section requires DIA judges to conform to the state Code of Judicial Conduct. The Commissioner would establish a process for handling complaints by the public against judges.

§3 - This section excludes overtime from the calculation of the average weekly wage.

§4 - The 1991 reform requires an insurer to obtain the employer's consent to lump sum settlements. The law covers employers who are "experienced modified insureds". Although that term was not defined by the statute, it has been restrictively applied to limit the number of employers whose consent must be obtained prior to settlement. Section 4 defines an "experienced modified insured" employer as any employer eligible for an experienced rated plan.

§5 - This section amends the standard used to determine compensability when a subsequent injury aggravates an underlying injury or condition. Under current law, whether a subsequent injury is compensable will depend upon whether the underlying condition is work-related or non-work related. This section applies the same standard regardless of the nature of the prior condition. The section also limits compensation in situations where the aggravating injury has a minor impact by requiring that any aggravating injury be the predominant contributing cause of the present disability.

§6 - This section permits the automatic resumption of compensation when an employee who returns to work subsequently leaves within twenty-eight days, if the employee presents current medical documentation of a worsened or changed condition which prevents performance of job duties.

§7 - This section conforms statutory language relating to suitable job offers to the terminology used in the Americans with Disabilities Act.

§8 - This section permits an insurer to terminate or suspend benefits based on evidence of fraudulent activity or behavior. An employee whose benefits have been terminated pursuant to this section would be entitled to an expedited claims process under section 1 of this legislation.

§9 - This section reduces the current time period for presuming disability when an employee is terminated from benefits from one year to six months, and provides that the presumption shall be rebutted if the discharge was for bona fide personnel actions, including reductions in force.

§10 - This section allows an insurer who accepts liability either voluntarily or involuntarily to request the assignment by the Senior Judge of an impartial physician. If the impartial exam supports a work capability the insurer may file a complaint for modification and suspend benefits. This section should result in significant savings since, under current law, there is a waiting period before the exam may be requested. This change will strengthen the value of the impartial medical report. This section also eliminates the penalty on insurers who suspend benefits in reliance on the report of an impartial physician selected from the roster. Instead of a penalty, an insurer would be required to pay interest at 5% to the employee if benefits are reinstated by the judge. Finally, the section requires direct payments to the impartial physician by the insurer in section 8(4) cases.

§11 - This section requires complex or serious claims which do not lend themselves to resolution at conciliation, and which depend on the use of evidence not allowed at conference, to proceed directly to a hearing within 180 days. Claims involving occupational disease, stress, heart, lung, or cancer cases, and intentional injury would be subject to the expedited process. This change represents savings since it will reduce the time period for final resolution of the issues.

§12 - This section requires all medical testimony to be taken in person or by deposition prior to a hearing and eliminates post-hearing discovery. The section also requires the parties to prepare draft decisions. Since it now takes as much as six months to complete medical depositions after lay testimony has concluded, this provision should result in significant time and cost savings.

§13 - This section contains a technical correction necessary to permit impartial exams in 8(4) cases.

§14 - See section 12.

§15 This section would add an Occupational Health Nurse to the makeup of the HCSB.

§16 - This section prohibits physicians from referring claimants to health care services facilities in which the physician or physician's family has a financial interest. Exemptions are permitted in cases of emergency or where there is no alternative facility within a reasonable distance.

§17 - This section conforms Massachusetts to the practice in 49 states by providing that employees are responsible for paying their own attorney's fees. Fees would be capped at twenty percent of cash award to an employee, not to exceed an upper limit of \$4,000. The section creates exceptions where the employee is covered by an arbitration agreement or elects to obtain legal services from the DIA.

§18 - This section creates a legal assistance pilot program whereby the DIA would create an Office of Legal Assistance to provide legal counseling to injured workers free of charge as an alternative to private counsel.

§19 - This section expands the existing definition of a "fraudulent workers' compensation insurance act" to include certain false billing practices by health care providers if done with an intent to defraud. Prohibited practices would include unbundling, upcoding, exploding, and duplicating.

§20 - This section allows certified copies to be substituted for original hospital records at a hearing.

§21 - This section would allow an offer of a modified job consistent with a functional capacity evaluation and guaranteed for twelve months to satisfy all obligations to provide vocational rehabilitation.

§22 - This section requires employees to use an insurer provided or agreed to physician while receiving benefits during the 180 day pay without prejudice period.

§23 - This section requires the amount of an earning capacity to be consistent with a bona fide modified job offer.

§24-§25 - This section allows a functional capacity evaluation performed by a treating physician, impartial physician or company physician to support the determination of an earning capacity when an employee receives a written offer of his or her former job.

§26 - This section coordinates the receipt of workers' compensation, Social Security, and retirement benefits by requiring reductions in weekly benefit amounts where the employee is receiving federal old age benefits or payments under an employee benefits plan.

§27 - This section permits employers and employees to agree to terminate the employment relationship when a lump sum includes future wage losses; in addition, the settlement may specify that the employee will not seek re-employment with the employer for a designated period of time.

§28 - This section creates an exception to preferential rehiring in cases where liability has been redeemed by a lump sum settlement. Finally, the section amends the presumption of disability to conform with the terminology of the ADA.

§29 - This section would amend §75B to allow an employer to secure a resignation as part of a lump sum settlement.

Exemption of Corporate Officers (H.3968 - *Lepper*)

This bill is similar to H.1079 which exempts corporate officers from the requirement of obtaining workers' compensation insurance. The bill differs from H.1079 by adding the conditions that there can be no more than two who are the only employees. Furthermore the bill requires the officers to file written notice with the DIA.

Exemption of Volunteers of Charitable and Non-Profit Organizations (H.3969 - *Murray*)

This bill would make the requirement of obtaining workers' compensation insurance elective for volunteers of charitable and non-profit organizations. This legislation was enacted in the last legislative session.

Lump Sum Settlements - Approval (H.3764 - *Cabral*)

This bill (similar to H. 2051) would remove the necessity that an employer that is an experience modified insured approve a lump sum settlement.

Impartial Physicians - Appointment (H.3971 - *Owens-Hicks*)

Section 1 of this bill would amend section 11A by not allowing an impartial physician to be appointed when the report of both the treating physician and the insurer's physician agree with respect to "diagnosis and etiology." (Etiology is the branch of medicine that deals with the causes of disease.) Section 2 would limit the number of times an impartial medical examiner can be appointed to five times in any one month. It would further require that an insurer could not recommend the same examiner for more than a "majority of cases." Section 3 would make any impartial medical examiner subject to the penalties provided in ch. 152, sec. 14 §3 (anti-fraud provisions) if they knowingly produced a false or inaccurate report to benefit the insurer.

Insurance Rates - Competitive Rating (H.3773 - *Koczera*)

This bill (identical to last years "substitute-bill" which incorporated the Advisory Council's concerns) would require a system of competitive rating of workers' compensation insurance rates. The bill would take into account the concerns of the Council as expressed in our report.

Health Care Workers Infected by HIV on the Job - (H.2678 - *Stefanini*)

This bill is aimed at protecting health care workers who are exposed to the HIV virus while on the job by requiring the Department of Public Health to adopt the Occupational Safety and Health Administration (OSHA) Bloodborne Disease Standard¹ to cover all health care workers' who provide services in Massachusetts.

Enhanced Workers' Compensation Benefits for Infected Employees - This section adds new sections to both Chapters 32 and 152 respectively, requiring employers to pay HIV infected employees a supplement to their workers' compensation benefits of an amount equal to the difference between the workers' compensation amount and the workers' average weekly wage. The employer would also be required to provide a minimum of \$500,000 of special disability insurance and a life insurance policy equal to twice the workers' most recent annual salary to any health care worker exposed to the virus.

Health Care Workers Infected by HIV or HBV on the Job (H.3075 - *Kennedy*)

This bill would protect health care workers who are exposed to either the HIV virus or the hepatitis-B virus (HBV) while on the job. This bill creates a health care workers disability board to determine whether infected health care workers are able to perform their regular duties without posing a danger to public health, and to determine the degree of disability. The bill would require the Department of Public Health to adopt the Occupational Safety and Health Administration (OSHA) Bloodborne Disease Standard to cover all health care workers' who provide services in Massachusetts. Disability or death of a health care worker infected within the course of employment can apply for and receive benefits in accordance with the workers' compensation laws.

Comprehensive Bill - (H.3967 - *Kennedy*)

1. **§11A(1) Impartial Physician Criteria**

Section 1 of this bill would require an Impartial Selection Subcommittee (created in Section 13 later in this bill) to establish the criteria for being named and remaining on the impartial physician roster. Currently the Department's Health Care Services Board establishes this criteria.

2. **§11A(2) Impartial Medical Exams -- Assignment of Doctor**

Section 2 of this bill would require the Senior Judge to provide both parties a list of three potential impartial physicians; each party could remove one name from the list. If both parties chose the same name, the Senior Judge would assign that physician. Currently, if both parties can not agree upon an impartial physician, the administrative judge must appoint one.

3. **§11A(2) Impartial Medical Exams -- Prima Facie Weight**

Section 3 of this bill would require the Senior Judge to provide medical information (i.e. medical histories, reports, and records) and an accurate job description to the impartial medical examiner. It would eliminate the standard requiring that the impartial report constitute "prima facie evidence" and can only be rebutted when additional testimony is required due to the complexity of the medical issues involved or the inadequacy of the report. This bill would require the report to constitute a rebuttable presumption and would allow the impartial's determination to be overcome by "clear and convincing countervailing evidence to the contrary."

4. **§11A(2) Impartial Medical Exams -- Medical Reports & Depositions**

This bill would amend the impartial medical exam provisions allowing additional medical reports or depositions "by right to any party by the administrative judge's own initiative or upon motion by a party." The bill maintains the requirement that additional testimony at the hearing be allowed when the AJ finds the testimony is required due to the complexity of issues or

¹ Published December 2, 1991.

inadequacy of the report. Finally, it gives each party "the right" to engage a "physician" to appear or be deposed for the purpose of rebutting the impartial report.

5. §13(3) HCSB -- Creation of an Impartial Selection Committee

Section 5 of this bill creates an Impartial Selection Committee of the Health Care Services Board to be responsible for reviewing and approving the criteria for selecting and updating the roster of impartial physicians. Representatives of business and labor would be required to serve on this subcommittee. Currently the Health Care Services Board serves this function.

6. §34 Total Incapacity Benefits -- Increasing Benefits

This bill would increase the weekly compensation for total incapacity (§34) benefits. Compensation would increase from the current 60% to 2/3 of average weekly wage. The current duration would remain.

7. §35 Permanent and Total Incapacity -- Increasing Benefits

Section 7 of this bill would increase the weekly compensation for permanent and total incapacity (§35) benefits. Compensation would increase from the current 60% to 2/3 of average weekly wage.

8. §48(1) Experience Modification Employers - Lump Sum Denial

Section 8 of this bill would require experience modified insured employers who deny a lump sum agreement to employees, to submit a written explanation for the denial to the administrative judge. If the administrative judge determines the reason to be frivolous, the administrative judge may approve the lump sum.

9. §48(4) Presumption Employee is Incapable of Returning to Work

Section 9 of this bill would delete the presumption that an employee is physically incapable of returning to work whenever a lump sum agreement has been perfected. This bill would also delete the time-period for this presumption (1 month for each \$1,500 included in the settlement). It also deletes the provision that no re-employment rights shall inure during the period of presumption.

Drug Testing of Employees (H.3778 - Menard, AIM)

This bill creates a new chapter (149A) providing specific standards under which an employer may test employees and prospective employees for substance abuse. An employer would be allowed to test under the following circumstances:

(1) *Where the employer has reason to suspect that the employee's job performance is being or has been affected by the use of a drug;*

(2) *To prevent a health or safety risk to the employee, to fellow employees or to the public health;*

(3) *To maintain productivity, quality of services, or security;*

(4) ***Following an accident;***

(5) *Where the employee is participating in a drug related employee assistance program or rehabilitation program and for one year after completion of such program;*

(6) *Where the test is conducted pursuant to the requirements of federal or state law or regulations; or*

(7) *As part of a drug-free workplace program to deter and detect the use, possession or sale of controlled substances.*

If a drug test is confirmed to be positive, the employer may sanction the employee with a variety of punishments, including, but not limited to, suspension or termination. This proposed legislation creates a course of action for employees who believe they have been wrongly accused by the employer of their alleged violation.

Workplace Safety Programs (H.3589 - Koczera)

This bill would create within the DIA an office of safety, training and injury prevention, responsible for the implementation and enforcement of safety programs for employers of the Commonwealth. Employers with ten or more employees would be required to prepare a written safety program and establish a management loss control committee to carry out workplace safety programs that encourage injured employees to return to work and educate employees on workplace safety. This bill would require the Commissioner of the Division of Industrial Accidents to develop a list of the ten lowest experience modification employers for each policy year in an effort to recognize employers for their safety efforts. Employers who fail to establish a management loss control committee as required, can be subject to a stop work order, requiring the cessation of all business operations.

Scar Based Disfigurement (S.71 - Lynch)

This bill would eliminate the requirement that scar based disfigurement appear on the face, neck, or hands to be compensable. This would require compensation for all disfigurement, whether or not scar based, regardless of its location on the body. Section 36(k) was amended by chapter 398 to limit payments for purely scar based disfigurement by requiring benefits only when the disfigurement is on the face, neck, or hands.

Employer Fines - Increase (S.1840 - Lynch)

This bill was written by the Advisory Council with the assistance of a panel of insurance experts. The bill seeks to curtail abuses of employers who fail to carry workers' compensation insurance by increasing the fines and penalties imposed on violating compensation insurance by increasing the fines and penalties imposed on violating employers. Senate 1840 would require that violators pay a fine equal to three times the amount of premium which was avoided. In addition, the bill would require employers to pay a \$5,000 criminal penalty in severe cases and reimburse the DIA Trust Fund when an employee is injured and requires trust fund benefits. The bill would also allow companies to sue violators under the Unfair and Deceptive Business Practices Act (ch. 93A) when losing a competitive bid as a result of premium avoidance. Finally, it would require the Department of Industrial Accidents to conduct an education campaign to inform the entire employer community of the insurance requirement and the new fines.

APPENDIX H

Joint Committee on Commerce & Labor - FY'97

Senator Stephen F. Lynch (Chair)
State House - Room 312-D
Boston, MA 02133-1053
(617) 722-1150

Senator David P. Magnani
State House - Room 413-A
Boston, MA 02133-1053
(617) 722-1640

Senator Dianne Wilkerson
State House - Room 312-C
Boston, MA 02133-1053
(617) 722-1673

Senator Marc R. Pacheco
State House - Room 413-B
Boston, MA 02133-1053
(617) 722-1551

Senator Robert A. Bernstein
State House - Room 218
Boston, MA 02133-1053
(617) 722-1544

Senator Robert L. Hedlund
State House - Room 413-E
Boston, MA 02133-1053
(617) 722-1646

Rep. Robert M. Koczera (Chair)
State House - Room 43
Boston, MA 02133-1053
(617) 722-2030

Representative Michael J. Rodrigues
State House - Room 43
Boston, MA 02133-1053
(617) 722-2030

Representative Janet W. O'Brien
State House - Room 477
Boston, MA 02133-1053
(617) 722-2070

Representative William Greene, Jr.
State House - Room 236
Boston, MA 02133-1053
(617) 722-2430

Representative Vincent A. Pedone
State House - Room 540
Boston, MA 02133-1053
(617) 722-2090

Representative Brian Knuuttila
State House - Room 443
Boston, MA 02133-1053
(617) 722-2460

Representative Stephen P. LeDuc
State House - Room 38
Boston, MA 02133-1053
(617) 722-2470

Representative Charles A. Murphy
State House - Room 236
Boston, MA 02133-1053
(617) 722-2430

Representative Thomas J. O'Brien
State House - Room 33
Boston, MA 02133-1053
(617) 722-2060

Representative Bradley H. Jones, Jr.
State House - Room 443
Boston, MA 02133-1053
(617) 722-2460

Representative Cele Hahn
State House - Room 540
Boston, MA 02133-1053

APPENDIX I

The Governor's Council

Room 184, State House
Boston, MA 02133
(617) 727-2756

The Massachusetts Governor's Council, also known as the Executive Council, is comprised of eight individuals elected from districts, and the Lt. Governor who serves ex officio. The eight councillors are elected from their respective districts every two years. Each councillor is paid \$15,000 annually plus certain expenses.

The Council generally meets at noon on Wednesdays in its State House Chamber, next to the Governor's Office, to act on such issues as payments from the state treasury, criminal pardons and commutations, and approval of gubernatorial appointments; such as judges, notaries, and justices of the peace.

The Governor's Council is responsible for approving all Administrative Judge and Administrative Law Judges at the Department of Industrial Accidents.

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Bus: (508) 998-1322

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Cynthia S. Creem
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Christopher A. Iannella
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Edward M. O'Brien
10 Dragon Circle
Easthampton, MA 01027
Bus: (413) 527-4600

APPENDIX J

Health Care Services Board

Patricia Crane

Vice-President Development and Public Affairs
Lowell General Hospital 295 Barnam Street
Lowell, MA 01854

Hospital Administrative Representative

Henry W. DiCarlo

Director, Loss Prevention
Stride Rite Corporation
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Cambridge, MA 02142

Employers Representative

Jefferson H. Dickey, M.D.

25 Maple Street
Florence, MA 01060

Physician Representative

William F. Fishbaugh Jr., MD

Director, Sports Medicine, Occup. Health
Braintree Hospital Rehabilitation Network
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Braintree, MA 02184

Physician Representative

Dean Hashimoto, MD, JD

Boston College School of Law
885 Center Street
Newton, MA 02159

Physician Representative

Peter A. Hyatt, DC

227 East Street
Methuen, MA 01844

Chiropractic Representative

Catherine Lane, RPT

Boston Center for Physical & Sports Medicine
653 Summer Street
Boston, MA 02210

Physical Therapy Representative

Charles E. Lutton, MD, PhD

P.O.Box 428
Ashland, MA 01721

Physician Representative

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

Chair/Ex-Officio Member

William P. Ryan
International Union of Operating Engineers, Local 4
120 Mt. Hope Street
Roslindale, MA 02131

Employee Representative

Jonathan Schaffer, MD
Department of Orthopedic Surgery
Brigham & Women's Hospital
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Boston, MA 02115

Physician Representative

Willie Stephens, DDS
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Dentist Representative

Harriet G. Tolpin, Ph.D.
Simmons College
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Public Representative

Bernard S. Yudowitz, M.D., J.D.
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Physician Representative

Robert Davis, Executive Director

Sarah Gibson, Esq., Counsel

Donna Ward, HCSB Staff

Hella Dalton, HCSB Staff

APPENDIX K

Industrial Accident Nominating Panel - FY'97

Mr. James C. Cronin, Esq.

Raytheon
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Fax: 860-2408

Mr. Paul Johnson

* (Laurie Wallach)
Chief Legal Counsel
State House - Room 271
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Office: 727-2065
Fax: 727-8290

Mr. Gino Maggi, President

Inter-all Corporation
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Fax: 727-1090

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Fax: 227-2010

Mr. David Tibbetts, Director
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Brenda Miller, Asst.

Mr. Louis Mandarini

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below)
V.A. Office: 232-9500 x4836
Fax: 724-0113

Joseph W. Jennings, III

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

APPENDIX L

Medical Consultant Consortium

(as of 12/30/97)

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APPENDIX M

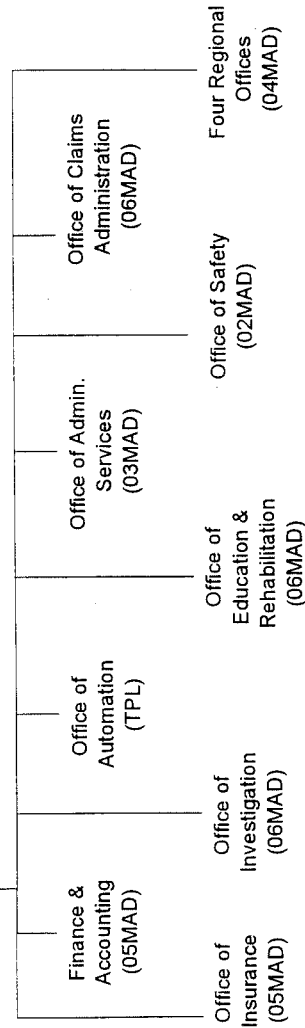
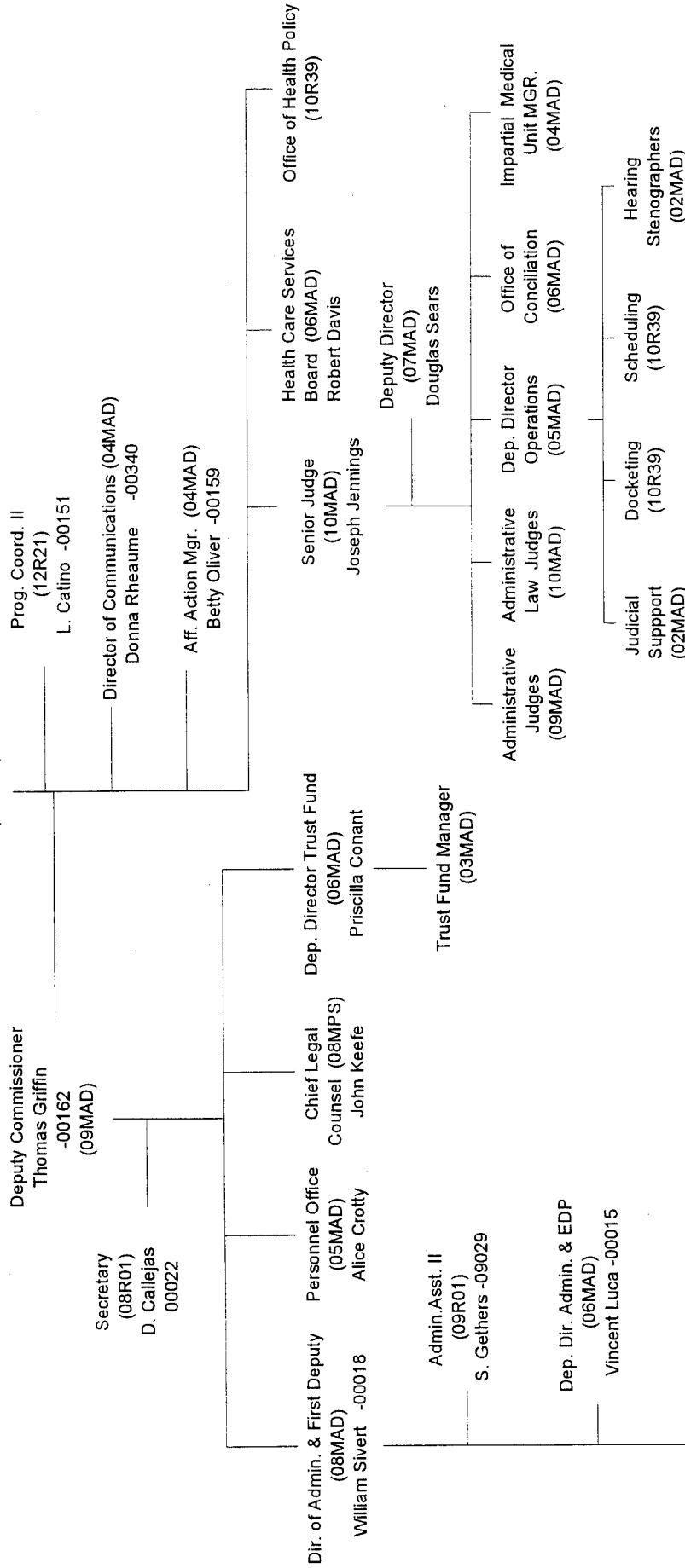
FISCAL YEAR 1997

**DEPARTMENT OF INDUSTRIAL ACCIDENTS
ORGANIZATIONAL CHART**

Friday, May 2, 1997

COMMISSIONER

James J. Campbell -00003
(10MAD)



OFFICE OF ADMINISTRATION AND EDP

1st Dep. Director of
Admin. (07MAD)
William Siver -00018

Dep. Director
Admin. & EDP
(06MAD)
Vincent Luca -00015

Budget Director
(05MAD)

Ed Cure -X0021

1. Accountant V
(14R01)

J. Endres -00149

1. Accountant IV
(12R01)

D. Arnold -09063

1. Business MGT.
Specialist (12R01)
D. Lentini -00142

2. Accountant III's
(10R01)

B. Kelly -00148
D. Cavanaugh -00130

5. Accountant II's
(08R01)

C. Marcial -00108

J. Poteau -00146

R. Ponnudurai -00147

C. Emerho -00002

S. Whittle -09055

1. Admin. Asst. I
(07R02)
J. Casal -00188

1. Admin. Secretary I
(15V01)
J. Scott -00157

Contract Specialist
(06R02)

E. Granberry 00183

J. Haynes -00131

Automation Manager
(16R01) TPL
Joseph Constantine -00207

APPLICATIONS/OPERATIONS

PROGRAMMING/NETWORKING

1. EDP Analyst III's
(TPL)
C. Collins -00206

1. EDP Systems Supervisor
(17V06)

C. Ryan -09007

1. Asst MGR Computer
Operations (11R22)
D. Moran -00173

1. Electronic Computer
Operator (17V06)
F. Nazaire -00174

1. EDP Programmer V
(TPL)
B. Leary -00125

2. EDP Programmer IV
(TPL)

K. Healy -00204
T. Barrett -00205

2. EDP Analyst III
(TPL)
H. Kupets I -00197
M. Drury -00126

ADMINISTRATIVE SERVICES

Administrative
Services Manager
(03MAD)
Jean Phalan -09013

3. Clerk Vs
(15V05)

H. Lilley -00290

S. Mohan -00114

R. Fuytes -00064

2. Clerk
III's/Principal
Clerk (11V01)
J. Cashman -00111
J. McCormack

PUBLIC INFORMATION

1. Info. Officer III
(11R01)
E. Butts -00001

3 Program Coord. I's
(10R38)

L. Gilgan -00115

T. Rashid -00117

-00118

1. Clerk IV (13V02)
K. McNeil -00285

1. EDP III (12V04)
B. Salamone -00110

OFFICE OF CLAIMS ADMINISTRATION

Director (06MAD)
James Hayes -00017
(Acting)

Appeals Review Examiner
(14R01)
F. Sena -00331

Admin. Assistant II (09R01)
P. Donoghue - 00153

ParaLegal (10R39)
P. Downey -00124

EDP III (12V04)
D. Sammut -00113

PROCESSING UNIT

Processing Manager
(03MAD)
Janine Senatore -09018

RECORD ROOM

1. Admin. Asst. II
(09R01)
A. Arroyo -00027

1 Head Clerk/CkIV (13V02)
D. Pesantes -00191

1 EDP III (12V04)
A. Ivers -00236

9 Clerk III's/Principal Clerk
(11V01)
W. Lewis -00180
L. Payton -00182
F. Wallace -00269
J. Carota -00181
M. Ivery -00178
H. McGlothlin -00143
M. Albert -00138
R. Chen -09040
J. Pimental -00120

1 Typist II/Clerk II (09V07)
G. Webb -00141

2. EDP II (10V04)
* -00193
J. Silva -09050

DATA ENTRY

1. Admin. Asst. II
(09R01)
B. Peake -00150

1 Admin. Asst. I (07R02)
D. Keefe -00132

8 EDP III's (12V04)
I. McGuire -00079
H. Reddick -00198
A. Luo -09048
E. Campbell -00135
R. Cookson -09052
M. Catalano -00074
S. Steed -00199
I. Rivera -00192

PROCESSING UNIT

1. Admin. Assistant II
(09R01)
E. Lydston -00154

4 Clerk III's/Principal Clerk
(11V01)
K. Kilburn -00179
I. Fuytes -00195
J. Durrette -00116
S. Dillon -00267

OFFICE OF EDUCATION AND REHABILITATION

Director (06MAD)
Stephen Linsky -00161

Administrative Assistant II
(09R01)
B. Mahn -00152

1. Clerk V (15V05)
M. Dean -00268

2. Clerk III/Principal Clerk
(11V01)
J. Hampton -00112
N. Dileo -00177

1. Clerk IV/Head Clerk
(13V03)
M. Adrien -00223

1. EDP II (10V04)
D. Atherton -00085

Disability Analyst Supervisor
(10R35)
L. Hamlin -00145

2. Disability Analysts (08R17)
L. Magarian -00186
R. Porte -00184

Vocational Rehab.
Counselor IV
(21940)
R. Demetrio -09017

4. Vocational
Rehab. Counselor III
(19058)
T. Rogg -00272
K. Consoil -00273
G. Lopes -00275
M. Moltrup -09061

OFFICE OF INSURANCE

Director (05MAD)
Richard Lundregan -00281

Administrative Assistant I
(07R02)
N. Fisher -00280

Self Insurance Adminsitrator
(03MAD)
Frank Janas -00327

1. Research Analyst II
(10R20)
M. Owen -00245

1. Clerk V (15V05)
T. Finneran -00194

1. Clerk III/Principal Clerk
(11V01)
A. Powers -09044

1. Steno II/Sr. Clerk
(10V12)
S. Fisher -00133

1. EDP II (10V04)
B. Cheatum -09049

OFFICE OF INVESTIGATIONS

Investigation Manager
(06MAD)
James O'Dea -09016

Research Analyst I
(09R18)
P. Allosso -00244

Administrative Assistant II
(09R01)
J. Parziale -00332

Administrative Secretary
(15V01)
L. Battista -00216

Chief Investigator (20V01)
J. Zimini -00020

9. Investigators (18V07)
J. Iandolo -00063
G. Fleming -00059
D. Edehri -00055
M. Moschella -00056
E. Faretta -00060
W. Taupier -00061
S. Riley -00057
R. Danforth -00282
J. Beauregard -00058

OFFICE OF PERSONNEL

Director (05MAD)
Alice Crotty -00016

1. Personnel Officer I
(11R31)

M. Pesantes -00155

1. Program Coordinator I
(10R38)

M. Guerin -09037

1. ClerkIV (15V05)

P. Beard -09038

OFFICE OF SAFETY

Director (02MPM)
James Hayes -00237

1. Industrial Safety &
Health Inspector III
(23Y10)

T. Carroll -00235

1. Clerk III/Principal Clerk
(11V01)
N. Reyes -X0016

DIA REGIONAL

FALL RIVER OFFICE

Manager (04MPM)
Henry Mastey -00240

1. Administrative Assistant I (07R02)
M. Quintal -00226

4. Administrative Judges (09MAD)

J. McLaughlin -00166
J. Cox -00164
W. Long -09025
J. Bradford -00004

1. Review Examiner II (14R10)
S. Sharek -00262

2. Review Examiner I (12R14)
Y. Viera-Cardoza -00250
J. Feliz -00252

2. Voc. Rehab. Counselor III
(19058)
A. Gonsales -00276
U. Maranhas -00279

1. Disability Analyst (08R17)
P. Dowd -09057

4. Administrative Sec. (15V01)
L. Baptiste -00025
F. Moniz -00232
D. Tripp -00218
D. Briggs -00221

3. Hearing Stenographers (17V09)
B. Gomes -00046
J. Doherty -09002
T. Parker -00040

1. Clerk III/Principal Clerk (11V01)
M. Pacheco -09041

1. EDP III (12V04)
J. Jones -00202

LAWRENCE OFFICE

Manager (04MPM)
L. Connolly -00238

1. Administrative Assistant I
(07R02)
* -00228

2. Administrative Judges (09MAD)

R. Heffernan -X0004
J. LaMothe -00010

1. Review Examiner II (14R10)
P. Whelton -00254

1. Review Examiner I (12R14)
G. Ramirez -00246

1. Voc. Rehab. Counselor III
(19058)
I. Gerrish -00271

1. Disability Analyst (08R17)
* -00187

2. Administrative Sec. (15V01)
M. Leard -00311
B. Ciancetta -00308

2. Hearing Stenographers (17V09)
G. Signorelli -00031
T. O'Keefe -00315

1. EDP III (12V04)
J. Chapman -00200

SPRINGFIELD OFFICE

Manager (04MPM)
Marc Joyce -00239

1. Administrative Assistant I
(07R02)
M. Sullivan -00029

3. Administrative Judges (09MAD)

J. St. Amand -00007
B. Murphy -09024
D. Chivers -00168

2. Review Examiner II's (14R10)
N. Hicks -00257
T. Sullivan -00261

1. Voc. Rehab. Counselor
IV(21940)
E. Bajgier -09060

1. Voc. Rehab. Counselor III
(19058)
R. Fitzgerald -00274

1. Disability Analyst (08R17)
G. Urbina -09059

3. Administrative Sec. (15V01)
G. Gosselin -00028
M. Woodfine -00224
J. Holve -09028

3. Hearing Stenographers (17V05)
N. Whitley -00047
M. Allen -00050
L. King -00037 (part-time)

1. Clerk III/Principal Clerk (11V01)
C. Callahan -X0015

1. EDP III (12V04)
L. Beaudry -00080

WORCESTER OFFICE

Manager (04MPM)
Leonard Gabrila -00241

1. Administrative Assistant I
(07R02)
C. Rafferty -00225

4. Administrative Judges (09MAD)

T. Merlo -00012
F. Gromelski -00014
J. Constantino -00006
S. Sumner -00011

3. Review Examiner I (12R14)
D. Candia -00249
J. Brunelle -00251
W. Trybulski -00248

2. Voc. Rehab. Counselor III
(19058)
K. Fleming -00270
D. Thibault -00277

1. Disability Analyst (08R17)
L. Chenevert -09058

4. Administrative Sec. (15V01)
P. O'Melia -X0009
D. Miller -X0013
D. Layton -09031
P. Vincequere -09035

3. Hearing Stenographers (17V09)
B. Pike -00042
T. Valis -00034
C. Nalesnik -00035

1. Clerk III/Principal Clerk (11V01)
* -09043

1. EDP III (12V04)
T. Sweeney -00201

TRUST FUND

Deputy Director (06MAD)
Priscilla Conant -09017
(Acting)

Manager (03MAD)
K. Bullock -09000

Administrative Assistant II
(09R01)
M. J. Henderson -09005

SUPPORT STAFF

1. Clerk V (15V05)
K. Cunningham -09012

2. Clerk IV/Head Clerk
(13V02)
* -09009
J. Lentini -09001

2. Accountant II's
(08R01)
B. Tisei -09006
N. Tsapatsaris -09007

5. Counsel II's (17R01)
P. Benitez-Perales -09010
P. Ingrahm -09011
D. Andronico -09020
T. Finn -00022
M. Kelly -00023

1. Paralegal (10R39)
A. Fortes -09021

4. Investigators (18V07)
T. Vincequere -09015
M. Keefe -09013
J. Primeau -09014
* -09016

2. Registered Nurse III
(03A16)
D. DiBella -09003
T. Clemente -09004

3. Claims Adjusters
(08R03)
K. Magnotta -09002
T. Allison -09018
R. Andronico -09019

LEGAL COUNSEL

Chief Legal Counsel
(08MPS)
John Keefe -00021

4. Counsel II (17R01)
J. Labadini -00328
C. Calliotte -09019
D. Theodore -00087
T. Sternberg -09015

1. Paralegal (10R39)
* -00086

1. Adm. Secretary
(15V01)
A. Frederick -09051

OFFICE OF HEALTH POLICY

Commissioner
(10R39)

James J. Campbell -00003

|

1. Paralegal (10R39)
D. Ward 09045

|

3. Research Analyst II
(10R20)
F. Clarke - 00189
P. Blackburn -00343
* -00344

|

1. Disability Analyst I
(08R17)
S. Shea - 00185

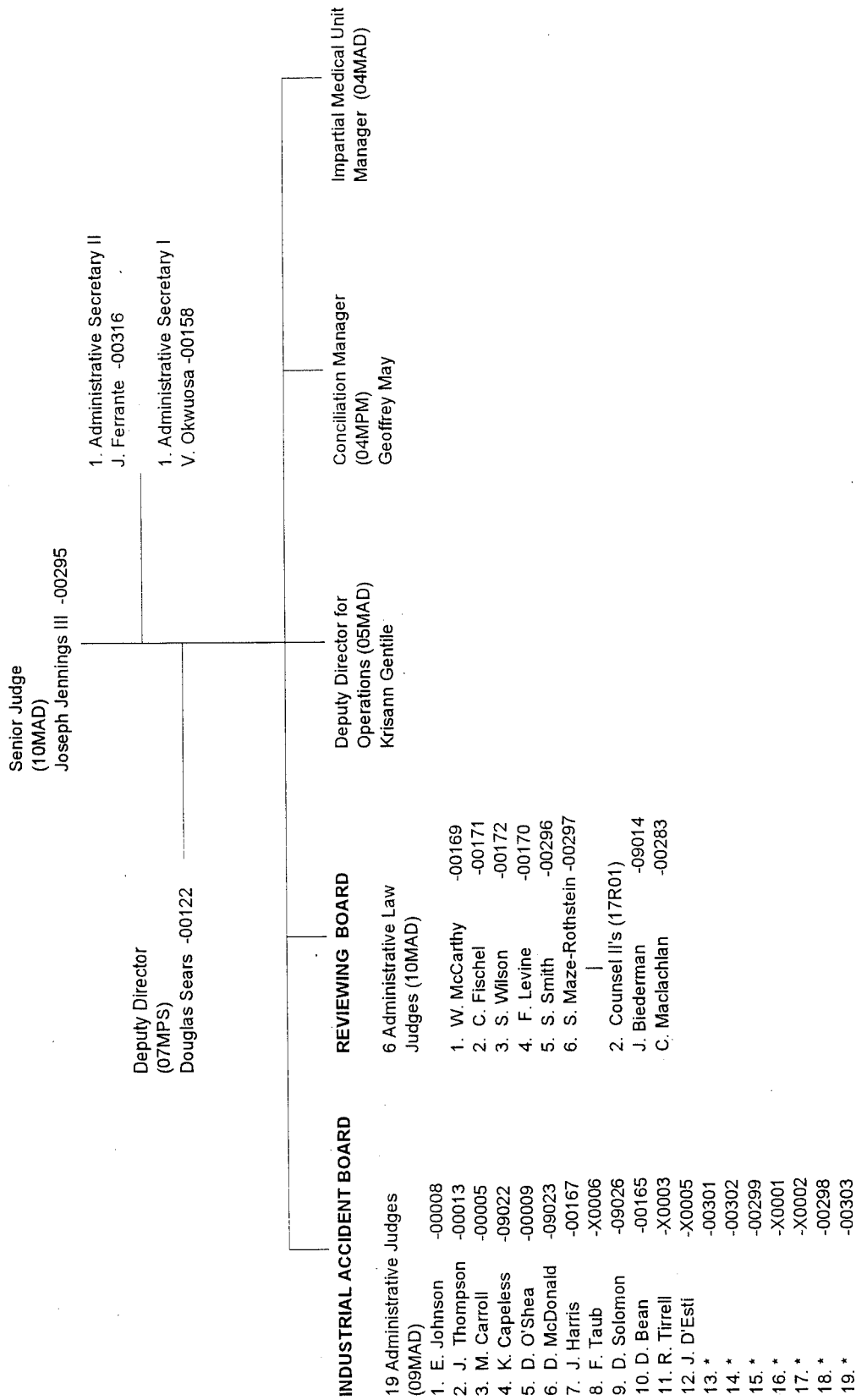
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1. Program Coordinator I
(10R38)
* - 00109

|

4. Admin. Secretary I
(15V01)
V. Doctor - 00212
E. Lauzon -00215
R. Callhan -00305
L. Rogers -00227

DIVISION OF DISPUTE RESOLUTION



DIVISION OF DISPUTE RESOLUTION CONT

Deputy Director for
Operations (05MAD)
KrisAnn Gentile -09020

JUDICIAL SUPPORT	REVIEWING BOARD SECRETARIES (CON'T)	DOCKETING UNIT	SCHEDULING UNIT	HEARING STENOGRAPHERS
Manager (02MAD) Deborah Pierre -09021 12 Administrative Secretaries (15V01) 1. N. Nunes -00213 2. J. Samuel -00220 3. J. Marshall -00310 4. E. Flanagan -00304 5. D. Urphart -09034 6. T. Thompson -00219 7. W. Ferebee -00306 8. C. Long -00211 9. L. Jones -00234 10. * -00156 11. E. Hausman -00209 12. M. Browne -00026 5. Floating Administrative Secretaries (15V01) 1. P. Brown -00230 2. C. Corcoran -00329 3. J. Cruickshank -00214 4. S. McQuarrie -00119 5. V. Faiella -00231	Manager (02MAD) Con't 7. Administrative Secretaries (15V01) 1. M. Crosby -09033 2. H. Houlder -00233 3. A. Tainter -00229 4. K. Ivers -00307 5. C. Shidler -09030 6. L. Kuntamukkala -00309 7. R. Callahan -00305	1. Paralegal (10R39) M. Fitzpatrick -09046 2. Clerk I/V/Head Clerk (13V02) T. Courage -00222 M. Bernal -09036 1. Clerk III/Principal Clerk (11V01) P. Lando -00136	1. Paralegal (10R39) M. Flaherty -09047 2. Clerk I/V/Head Clerk (13V02) A. Porfido -00210 J. Dapsys -09027 1. EDP III (12V04) L. Soto -00121	Manager (02MAD) Nancy Ramella -00038 20. Hearing Stenographers (17V09) A. Lagere -00036 M. LaRose -00043 K. DeGregorio -00049 L. Verrochi -00030 M. Flaherty -00048 B. O'Brien -00044 L. Person -00039 P. Phelan -00041 D. Washington -00045 L. Sutera -00052 L. Brown -00053 D. Golden -00054 P. Foley -00051 P. Nelson -00037 P. Finelli -00313 C. Marquis -00314 J. Luongo -00032 S. Hayes -00312 S. Gillea -00128 M. Jones -00129

DIVISION OF DISPUTE RESOLUTION CON'T

SENIOR JUDGE

CONCILIATION UNIT

Conciliation Manager (06MPPM)
Geoffrey May -00242

IMPARTIAL MEDICAL UNIT

Impartial Unit Manager
(04MAD)
Kathleen White -00326

SUPPORT STAFF

1. Administrative Asst. II
(09R01)
S. Perez -00203

1. Clerk IV/Head Clerk (13V02)
M. Bell -09039

1. Steno II/Senior Clerk
(10V12)
K. Wallace -00134

CONCILIATORS

8. Review Examiner II
(14R10)
S. Conte -00256
K. Walsh -00258
N. Mann -00259
J. Runkal -00260
C. Rubbico -00255
L. Delaney -00263
C. Casella -00265
* -00264

2. Review Examiner I
(12R14)
S. DeMarco -00253
C. Burns -00247

1. Accountant II (08R01)
E. Ruiz -00317

1. Accountant I (07R02)
C. Bynoe -00330

1. Administrative Assistant I
(07R02)
P. DeBonis -00321

8. Clerk V's (15V05)
D. French -00318
E. Smith -00319
D. Weaver -00320
* -00322

M. Sheppard -00323
L. Fitzpatrick -00324
V. Blanchard -00325
J. Keogh -00190

ADVISORY COUNSEL

Executive Director (06MAD)
Matthew Chafe -00160

1. Research Analyst II (10R20)
A. Burton -09064

1. Paralegal (10R39)
A. Helgran -00243

OFFICE OF HEALTH CARE SERVICES BOARD

Commissioner (10MAD)
James J. Campbell

|

Executive Director (06MAD)
Robert Davis -00341

|

1. Research Analyst II
(10R20)

-00342

|

1. Admin. Secretary I
(15V01)

H. Dalton

-X0010

(DIA) POSITIONS FILLED 314 VACANCIES 19 TOTAL 333

(T F) POSITIONS FILLED 20 VACANCIES 03 TOTAL 23

APPENDIX N

COLLECTIONS AND EXPENDITURES REPORT

<i>SPECIAL FUND</i>	<i>FY'97</i>	<i>FY'96</i>	<i>FY'95</i>	<i>FY'94</i>	<i>FY'93</i>
<u>COLLECTIONS</u>					
INTEREST	945,546	998,971	585,191	365,817	217,797
ASSESSMENT	14,518,007	16,915,362	21,084,055	17,537,534	13,743,804
LESS RET. CHECKS	0	26,640	44	0	88,274
ADJUSTMENTS		0	3,241		
LESS REFUNDS	12,825	67,265	10,354	98,514	9,022
SUB-TOTAL	14,505,182	16,821,457	21,070,416	17,439,020	13,646,508
FILING FEES	3,974,703	3,970,484	3,281,447	4,744,199	3,483,110
COLLECTION FEE	33,414	16,205	10,354		
LESS RET. CHECKS	3,228	80,608	2,566	4,447	4,743
LESS REFUNDS	3,721	4,579	3,014	5,192	2,131
SUB-TOTAL	3,934,340	3,869,092	3,805,513	4,734,560	3,476,236
1ST REPORT FINES	391,801	377,109	665,226	402,442	85,707
LESS COLLECTION FEE	24,033	12,072	9,218		
LESS RET. CHECKS	1,900	700	1,200	300	0
LESS REFUNDS	600	500	1,500	2,200	0
SUB-TOTAL	365,268	363,837	653,308	399,942	85,707
STOP WORK ORDERS	432,640	292,175			
LESS REFUNDS	225				
LESS BAD CHECKS	11,322	3,600			
COLLECTION FEE	9,180	2,460			
SUB-TOTAL	411,913	286,115			
LATE ASSESS. FINES	50,350	97,865	25,701	33,822	21,970
STOP WORK ORDERS		see above	370,271	166,600	see Private Fund
SEC. 7 & 14 FINES	5,018	5,118	10,400	0	6,000
MISCELLANEOUS	19,681	22,899	12,876	7,867	880
SUB-TOTAL	75,049	125,882	419,248	208,289	28,850
TOTAL COLLECTIONS	20,237,298	22,465,354	26,533,676	23,147,628	17,455,098
BALANCE BRGT FWD	13,724,400	12,044,652	6,015,882	3,035,890	2,621,052
TOTAL	33,961,698	34,510,006	32,549,558	26,183,518	20,076,150
LESS EXPENDITURES	22,124,993	20,785,606	20,504,906	20,167,636	17,040,260
BALANCE	11,836,705	13,724,400	12,044,652	6,015,882	3,035,890
<u>EXPENDITURES</u>					
SALARIES	12,675,242	11,966,331	11,432,627	10,984,604	9,797,077
FRINGE BENEFITS	3,661,402	3,703,858	3,613,307	3,513,989	2,666,838
INDIRECT COSTS	526,447	498,563	501,841	578,985	613,250
NON-PERSONNEL COSTS	5,235,003	4,613,724	4,954,835	5,093,478	3,957,815
FY'96 ADJUSTMENT	26,899				
PRIOR YEAR DEFICIENCY		3,130			
SUB-TOTAL	22,124,993	20,785,606	20,502,616	20,171,056	17,034,980
misc.			2,290	-3,420	5,280
TOTAL EXPENDITURES	22,124,993	20,785,606	20,504,906	20,167,636	17,040,260

COLLECTIONS AND EXPENDITURES REPORT

<i>PUBLIC TRUST</i>	<i>FY'97</i>	<i>FY'96</i>	<i>FY'95</i>	<i>FY'94</i>	<i>FY'93</i>
<u>COLLECTIONS</u>					
INTEREST	0	0	0	53,222	98,627
SECTION 30H	0	0	4,192	0	0
ASSESSMENTS	2,493,610	2,064,334	1,419,799	819,613	1,632,650
REFUNDS	7,834	46,712	9,024	93	205
TOTAL ASSESSMENTS	2,485,776	2,017,622	1,410,775	819,520	1,632,445
TOTAL COLLECTIONS	2,485,776	2,017,622	1,414,967	872,742	1,731,072
BALANCE BRGT FWD	202,743	167,910	285,328	2,291,964	3,056,655
TOTAL	2,688,519	2,185,532	1,700,295	3,164,706	4,787,727
LESS EXPENDITURES	2,273,075	1,982,790	1,532,385	2,879,379	2,495,761
BALANCE	415,444	202,742	167,910	285,327	2,291,966
<u>EXPENDITURES</u>					
RR COLAS	1,910,048	1,779,911	1,514,040	2,621,503	2,464,967
OEVR sec 30H		0	0	0	0
RR SEC. 37	363,027	142,513	18,345	254,676	30,794
RR LATENCY CLAIMS	0	0	0	3,200	0
RR REHAB	0	366			
SHELBY CLAIMS		60,000			
MM IME SEC 37	0	0			
TOTAL EXPENDITURES	2,273,075	1,982,790	1,532,385	2,879,379	2,495,761

<i>PRIVATE TRUST</i>	<i>FY'97</i>	<i>FY'96</i>	<i>FY'95</i>	<i>FY'94</i>	<i>FY'93</i>
<u>COLLECTIONS</u>					
INTEREST	626,082	1,390,938	620,028	354,842	187,259
ASSESSMENTS	38,664,243	33,891,287	30,147,213	28,974,039	25,187,627
LESS RET. CHECKS	0	6,956	2,129	0	143,490
ADJUSTMENTS		0	92,088		
LESS REFUNDS	30,513	151,983	5,285	160,718	23,843
SUB-TOTAL	38,633,730	33,732,348	30,047,711	28,813,321	25,020,294
REIMBURSEMENTS	1,673,509	1,346,814	1,129,709	1,029,263	572,170
PLUS ADJUSTMENTS		0	95,899		
LESS COLLECTION FEE	1,739	74,462	23,739		
LESS ADJUST. COLL. FEE			3,810		
RET. CHECK	18,109	5,588	4,772	200	1,818
REFUNDS	6,414	1,548			
SUB-TOTAL	1,647,247	1,265,216	1,193,287	1,029,063	570,352
STOP WORK ORDER *			0	0	31,150
LESS RET. CHECKS			0	0	0
SUB-TOTAL			Special Fund*	Special Fund*	*31,150
MISC.	0	18,989			
SEC. 30 H	0	8,000	54,215	41,842	16,833
TOTAL COLLECTIONS	40,907,059	36,415,491	31,915,241	30,239,068	25,825,888
BALANCE BRGT FWD	6,567,009	12,588,262	12,363,485	7,588,112	3,652,610
TOTAL	47,474,068	49,003,753	44,278,726	37,827,180	29,478,498
LESS EXPENDITURES	39,579,060	42,436,743	31,690,464	25,463,695	21,890,386
BALANCE	7,895,008	6,567,010	12,588,262	12,363,485	7,588,112

COLLECTIONS AND EXPENDITURES REPORT

EXPENDITURES	FY'97	FY'96	FY'95	FY'94	FY'93
RR SEC. 34	710,675	1,445,378	2,646,319	2,591,989	2,783,111
RR SEC. 35	699,467	828,384	750,064	795,556	714,888
RR LUMP SUM	1,180,308	2,112,194	1,575,454	1,373,464	1,146,409
RR SEC. 36 *	73,236	342,590	182,747	484,297	490,492
RR SEC. 31	106,268	93,383	69,115	109,928	106,862
RR SEC. 34, PERM. TOTAL	125,571	32,234			
RR COLA ADJ	113,192	100,838	123,267	12,459	11,160
RR EE MEDICAL REIMB.	48,911	49,961	64,091	29,158	18,832
RR EE TRAVEL	194	980	2,682	5,627	8,618
RR EE MISC. EXPENSE	0	669	32,638		
RR EE BOOKS & SUPPLIES	0	210	176	0	122
RR FUNERAL EXPENSES	0	4,000	480	8,000	4,000
RR VETERANS SERVICES	0	0	1,522	4,690	1,711
RR LEGAL FEES	364,741	725,505	499,328	716,184	599,323
RR LEGAL EXPENSES	44,299	66,294	44,002	72,862	35,292
RR LEGAL MISC. / OTHER	8,489				
RR MEDICAL EXPENSES	953	4,899	1,463,797	1,797,948	1,854,762
RR REHAB SERVICES	11,804	16,031	47,893	5,172	6,954
RR REHAB. SERV. TRAVEL	398	613	1,319	323	
RR LABOR MARKET STUDY	20,076	26,142			
RR REHAB (OLD)	1,190				
RR MEDICAL	1,087,517	1,479,997			
RR MEDICAL RECORDS	1,992	315			
RR WELFARE LIENS	54,545	342,996	0	209,069	61,741
SUB-TOTAL RR	4,653,826	7,673,613	7,504,894	8,216,726	7,844,277
KK EQUIPMENT	0	20,995			
MM TUITION	1,644	6,403	940	2,828	22,490
SUB-TOTAL CLAIMANTS	4,655,470	7,701,011	7,505,834	8,219,554	7,866,767
<u>INSURERS</u>					
RR COLAS	13,701,773	11,844,247	12,741,936	10,924,588	11,325,195
RR SHELBY CLAIMS	1,844,665	6,723,487			
RR LATENCY SEC. 35	927,940	702,996	749,166	4,768,138	246,407
RR LEGAL FEE SEC. 35	165,445	163,488	113,783		
RR LEGAL EXP. SEC. 35	0	1,770			
RR SEC. 37	16,479,884	13,260,236	8,487,924	699,185	1,896,753
SUB-TOTAL INSURERS	33,119,707	32,696,224	22,092,809	16,391,911	13,468,355
TOTAL LEGAL	37,775,177	40,397,235	29,598,643	24,611,465	21,335,122
<u>OEVR</u>					
MM IME CORP.	0	280	450		
MM TUITION	12,055	0	2,500	9,440	20,596
RR REHAB-30H	8,564	363	6,018	1,530	13,795
RR TRAVEL REHAB	308	0	114		
RR EE TRAVEL	0	0	0	0	2,458
RR EE BOOKS & SUPPLIES	402	0	194	0	297
SUB-TOTAL OEVR	21,329	643	9,276	10,970	37,146
TOTAL BENEFITS	37,796,506	40,397,878	29,607,919	24,622,435	21,372,268

COLLECTION AND EXPENDITURE REPORT

EXP.-DEFENSE OF THE FUND	FY'97	FY'96	FY'95	FY'94	FY'93
AA PERSONELL	744,871	579,854	495,141	306,588	196,223
AA OVERTIME	765	15,598			
SUB-TOTAL	745,636	595,452	495,141	306,588	196,223
DD FRINGE	211,276	180,849	151,436	100,412	61,810
DD UNIVERSAL HEALTH	640	650	624	155	112
DD MEDICARE	9,008	8,006	5,984	4,197	2,728
DD UNEMPLOYMENT	2,237	2,354			
SUB-TOTAL	223,161	191,859	158,044	104,764	64,650
BB TRAVEL	10,657	7,013	7,926	834	
BB TRAINING/TUITION	1,325	4,690	1,035	110	
BB PETTY CASH	50				
SUB-TOTAL	12,032	11,703	8,961	944	
CC CONSULTANT	7,972	7,290			
EE MV RENTALS	57	800	69	542	
EE ADVERTISING	430	482	0	355	
EE BOOKS/SUPPLIES	20,586	59,868	364,826	2,914	
EE PETTY CASH REIMB.		59	25		
EE IMPARTIAL APPEALS	16,900	19,580	19,125	10,575	
EE CENTRAL REPRO.	0	500	1,240		
EE OMIS CHARGEBACK	6,681	9,713	3,999		
EE CONF. INCIDENTALS		54			
EE CELLULAR PHONES	829	1,083	2,454		
EE PETTY CASH	15				
SUB-TOTAL	45,498	92,139	391,738	14,386	
HH CONSULTANTS	276,030	598,532	358,301	191,494	
SUB-TOTAL	276,030	598,532	358,301	191,494	
JJ OPERATIONAL SERV.	386,539	457,853	244,357	48,309	
SUB-TOTAL	386,539	457,853	244,357	48,309	
KK EQUIPMENT	26,054	16,060	221,438	19,270	
LL ACTION TRANS., INC		620			
LL PRAXIS	6,396				
LL XEROX	4,730				
LL MOBIL COMM	39	24			
SUB-TOTAL	37,219	16,704	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	0	10,600	2,800	11,000	
RR BEARAK REPORTS	48,467	54,809	15,348		
RR SECTION 50 INTEREST	0	1,924			
SUB-TOTAL	48,467	67,333	204,565	155,505	257,244
TOTAL DEFENSE OF FUND	1,782,554	2,038,865	2,082,545	841,260	518,117
TOTAL EXPENDITURES	39,579,060	42,436,743	31,690,464	25,463,695	21,890,385

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

APPENDIX O

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 below are advocacy groups 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 & approval of the Governor's Council, an elected body of 8 members that meets once a week.

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 is 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.

Massachusetts Rehabilitation Commission

59 Temple Place, Boston, MA 02108 (Boston District)

617-482-1780

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)

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.

The Rate Setting Commission and the Division of Insurance are also State Agencies.

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

600 Washington Street, Boston, MA 02111

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:

- 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.

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, NW, 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.