THE STATE OF THE MASSACHUSETTS WORKERS' COMPENSATION SYSTEM

FISCAL YEAR 2003 ANNUAL REPORT

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

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February 20, 2004

His Excellency Mitt Romney
Governor of Massachusetts
State House – Room 360
Boston, MA 02133

Dear Governor Romney:

On behalf of the Massachusetts Workers' Compensation Advisory Council, I am pleased to present you with our Fiscal Year 2003 Annual Report: The State of the Massachusetts Workers' Compensation System.

The Advisory Council's Annual Report illustrates a detailed analysis of the workers' compensation system in Massachusetts. The report provides summaries in areas such as the workers' compensation insurance market, legislative initiatives, occupational illness and injury statistics, and the operations of the Division of Industrial Accidents (DIA). The Advisory Council also identifies specific areas of concern and offers conclusive recommendations to enhance the workers' compensation system. Finally, the report recognizes significant achievements within the DIA and other related organizations that play a role in improving the system.

We appreciate your consideration of the Advisory Council's analysis of the workers' compensation system as outlined in this Annual Report and thank you for your interest in our policy positions, concerns, and recommendations.

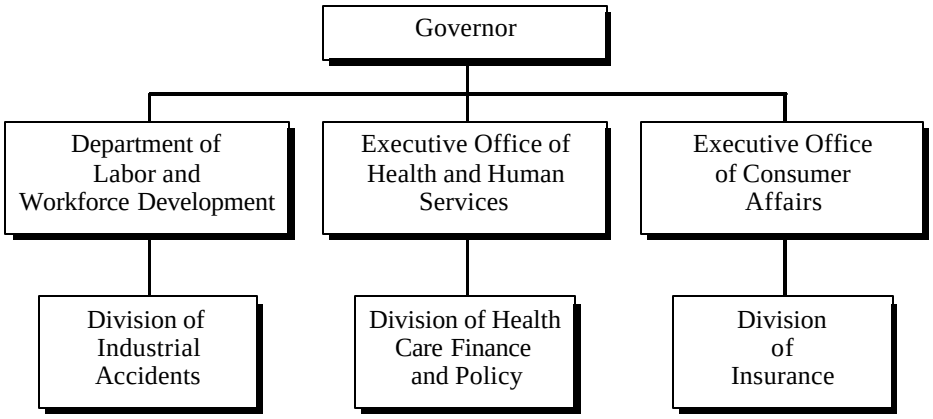
We look forward to working with you in the future and continuing our mission to improve services to injured workers, employers, and all participants in the Commonwealth's workers' compensation system.

Very truly yours,

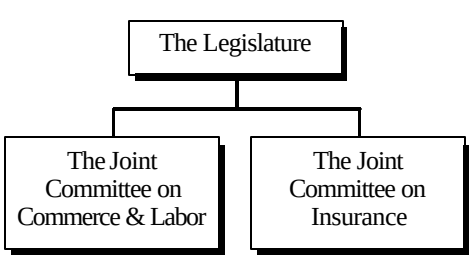
Andrew S. Burton
Executive Director

Government Regulation of Workers' Compensation

Administrative



Legislative



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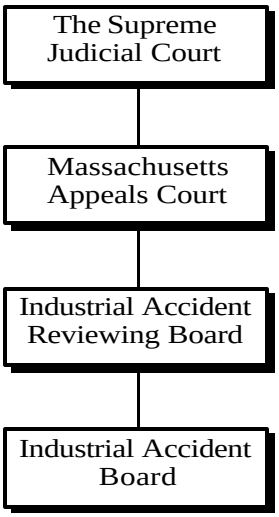
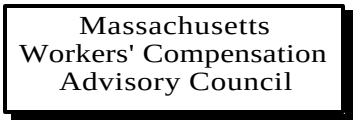


Oversight



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

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INTRODUCTION

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 functions are 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 (DIA) and the state of the Massachusetts workers' compensation system. In addition, members are required to review the annual operating budget of the DIA, and submit an independent recommendation when necessary. The Council also reviews the insurance rate filing and participates 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 the Department of Labor & Workforce Development and the Director of the Department of Economic Development serve as ex-officio members.

The employee and employer representatives comprise the voting members of the Council, and cannot take action without at least seven affirmative votes. The Council's chair and vice-chair 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 (M.G.L., c.30A, §11(a)).

Advisory Council Studies

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 office of the Advisory Council, 600 Washington Street, 6th Floor, Boston, Massachusetts (617) 727-4900 ext. 378.

For further information about the Massachusetts Workers' Compensation Advisory Council, visit our web page at: **http://www.mass.gov/wcac/**.

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FISCAL YEAR 2003 IN REVIEW

During fiscal year 2003, the Division of Industrial Accidents (DIA) experienced a slight decrease in the number of workers' compensation cases filed. Since the enactment of the Workers' Compensation Reform Act of 1991, the number of cases filed at the DIA has decreased by 60%. Employee claims, which account for 73% of the total cases filed, increased slightly by 208 cases in the fiscal year but have decreased by 38% since fiscal year 1991. Insurers requests for discontinuance, which account for 15% of the total cases, decreased slightly by 192 cases in fiscal year 2003 and have decreased by 74% since the 1991 Reform Act.

The stability of the workers' compensation insurance market was questioned throughout fiscal year 2003. Although there is a common goal to have both affordable and stable rates, many of the system's constituents voiced frustration over an unpredictable market. On March 1, 2003, the Workers' Compensation Rating & Inspection Bureau of Massachusetts (WCRIBM) submitted a rate filing on behalf of insurers seeking an increase of 10.8% (later revised to 8.6%) on average rates. However, the State Rating Bureau's filing sharply contrasted with the WCRIBM's filing as a decrease of 9.9% was proposed. In an unusual measure, the Attorney General's Office became a party in the rate process and asked the Commissioner of Insurance to reduce average rates by 21.4%. Although the Commissioner would eventually order a 4% rate reduction, the disparity in rate filings reinforced the perception that workers' compensation rates in Massachusetts are both unpredictable and based on an imperfect science.

On July 1, 2002, the Advisory Council sent a letter to the Joint Committee on Commerce & Labor stating the Council's inability to reach a consensus on Senate Bill 2358. This bill would require the Division of Health Care Finance & Policy to set rates for physician and hospital services paid for under c.152 at a "usual and customary" fee. Although the Council has expressed concern with the adequacy of these current rates, it was agreed that that the language of "usual and customary" is too broad based and ill defined. The Council's letter encouraged the Commerce & Labor Committee to conduct an independent cost-analysis that would offer a clearly defined mechanism for rate-setting detailing the benefits of such a change.

During the 2001-2002 Legislative Session, only one bill regarding the workers' compensation system was passed into law. On July 25, 2002, the Governor signed House Bill 4348 that makes workers' compensation coverage elective for directors and officers who own at least 25% of the stock of a corporation and allows sole proprietors and partners to purchase coverage. Immediately following its passage, House Vice Chairman Rodrigues invited all affected parties to a meeting to discuss the regulation of the new law. In October of 2002, the DIA held two public hearings to receive comments on the proposed regulations. Finally, on October 23, 2002, the Commissioner of Insurance approved a proposal by the Workers' Compensation Rating & Inspection Bureau to determine the appropriate premium charged to sole proprietors and partners who elect coverage.

On August 14, 2002, the Advisory Council voted to endorse their support for a proposed increase to the Impartial Physician Fee Schedule. A letter of endorsement was sent to the Executive Office for Administration & Finance (EOAF) stating the current fee was both inadequate and outdated, as exhibited by the steady decline of physicians on the Impartial Physician Roster. Concern was also expressed with the significant decrease in the number of doctors in certain medical specialties. On August 26, 2002, the EOAF notified the Legislature of its intention to increase the fee from $350 to $450. On October 3, 2002, the EOAF held a public hearing on the proposed fee. The new fee schedule went into effect on November 1, 2002.

On October 9, 2002, the DIA presented the Advisory Council with a detailed proposal on Phase II of the database conversion project (Oracle). The fiscal year 2003 budget included a provision that allowed the release of sufficient funds from the Special Reserve Account upon the affirmative vote of the Advisory Council. After the budget was signed by the Governor, the Advisory Council voted to immediately release funds totaling $2,200,000 to support Phase II of the conversion. The Advisory Council formed a subcommittee to monitor each step of the project and was provided progress updates at each Advisory Council meeting.

On November 20, 2002, the Advisory Council's legislative subcommittee met with Representative Koczera (House Chairman of the Commerce & Labor Committee) to propose legislation regarding Industrial Accident Board Appointments. As a result of this meeting, Representative Koczera filed House Bill 2924. This bill would attempt to stagger judicial terms "naturally" by making the appointment of new Administrative Judges (AJ's) for six-year terms, rather than the current practice of being appointed to fill the remaining time-period of a vacant term. This bill would also create a system of judicial performance review in which the Senior Judge would be required to review the performance of newly appointed Administrative Judges after their first two years of service.

On January 12, 2003, the Advisory Council testified at a public hearing held by the Office of Commerce & Labor to express concern on how the DIA's line-item is treated during the Commonwealth's budget process. It was explained that no tax dollars are used to fund the DIA or any of its activities, as the Special Fund is used to reimburse the Commonwealth's General Fund for 100% of its budgeted appropriation. This opportunity to educate state policy makers on the unique funding mechanism of the DIA continued in February when members of the Council's budget subcommittee met with representatives from the Executive Office of Administration and Finance.

On January 23, 2003, the Massachusetts Young Worker Initiative Task Force held a briefing at the State House on their newly released report, titled "*Protecting Young Workers in Massachusetts.*" The task force is a workplace advocacy group comprised of representatives from youth, community, health organizations, schools, employers, unions, and parents. Specifically, the report provided state lawmakers with a blueprint to ensure positive and safe work experiences for youth workers. The task force developed a series of recommendations that would permit parents of injured teens to seek civil remedies and would encourage workplaces and public schools to provide additional safety training.

On February 13, 2003, three leading business associations (The Massachusetts Taxpayers Foundation, Associated Industries in Massachusetts, and the Greater Boston Chamber of Commerce) released a report detailing the high costs of conducting business in Massachusetts. The report, titled "*Fragile Progress: Reigning in Massachusetts' High Business Costs,*" compared five business costs (health care, electricity, unemployment insurance, workers' compensation, and taxes) with those in competing states. The report touts workers' compensation as the Commonwealth's "greatest business cost success story." The report recommends that success of the 1991 Reform Act be preserved by urging that no changes be made to the system without clear and convincing evidence. The report further recommends that any proposed modifications to the workers' compensation system be "subject to an independent and thorough cost/benefit analysis."

On March 6, 2003, the Advisory Council's budget subcommittee met with members of the DIA to carefully review the Governor's Fiscal Year 2004 Budget Recommendations (House 1) along with the Fiscal Year 2003 Spending Projections. On March 12, 2003, the subcommittee recommended that that the Advisory Council endorse the DIA's line-item of $18,772,922 contained in House 1. The subcommittee voiced concern over the use of overtime-pay within the DIA. Secondly, there was concern that the Governor's Budget did not stipulate any specific funds for the Safety Grant Program. Finally, there was concern over an outside section within the Governor's Budget that allowed the Advisory Council to release funds to pay for the agency's computer conversion project.

On June 30, 2003, Governor Romney signed the fiscal year 2004 General Appropriations Act that allocated the DIA an $18,698,357 operating budget. The final appropriation was only $74,565 less than the Governor's Recommendation (House 1) which was endorsed by the Advisory Council in April. Provisions contained within the DIA’s appropriation required that "not less than" $800,000 be expended for occupational safety grants and that a judge be assigned to hear cases in Berkshire County "not less than once a month."

CONCERNS & RECOMMENDATIONS

The Advisory Council is mandated by M.G.L. c.23E, §17 to include in its annual report "an evaluation of the operations of the [DIA] along with recommendations for improving the workers' compensation system." In an effort to enhance the workers' compensation system, the Council has identified the following areas of concern and offers its recommendations to address them.

Enforcement of the WC Insurance Mandate

For the past eight years, the Advisory Council has examined various approaches in deterring employers from violating the workers' compensation mandate. Council members have agreed that the stop work order and fine provisions, which were established in 1987, are not sufficiently punitive to deter employers from violating the mandate to obtain workers' compensation insurance coverage. A flat fine of $100 per day may be a sufficient penalty to a low-risk business with few employees, but as the risk of a business increases and more workers are employed, the fine becomes both smaller in severity and less of a deterrent.

A related concern of the Advisory Council is the magnitude of Trust Fund Claims. When an employee is injured at work, and it is discovered that the employer failed to provide coverage, the employee may obtain benefits through the DIA's Trust Fund. The Trust Fund was created in the statute as a protective measure to pay for the benefits of injured employees of uninsured employers. The Trust Fund is financed through assessments paid by the vast majority of employers who purchase insurance. In fiscal year 2003, approximately $4,108,222 was paid to uninsured claimants.

TRUST FUND PAYMENTS TO UNINSURED CLAIMANTS	
Fiscal Year 2003:	$4,108,222
Fiscal Year 2002:	$4,579,380
Fiscal Year 2001:	$3,302,809
Fiscal Year 2000:	$3,390,180
Fiscal Year 1999:	$3,132,378

In 1997 the Advisory Council worked with members of the Joint Committee on Commerce & Labor to develop legislation that would reinforce the stop work order process by creating a fine structure based on the amount of premium an uninsured business avoided. Therefore, employers who have avoided higher premiums (higher risk to the Trust Fund) would be subject to a larger fine than employers who eluded smaller amounts. Although this bill has been "favorably-rated" in past legislative sessions, the Legislature has been unable enact it. The Advisory Council recommends that the "employer fines" legislation be refiled and addressed in the 2003 - 2004 Legislative Session. The passage of this bill would force fraudulent employers to purchase workers' compensation insurance while helping to alleviate multiple claims against the Trust Fund.

Due to past legislative inactivity, the Advisory Council was pleased to see that the DIA undertook a pilot project that made internal changes within the Office of Investigations to enhance their investigative techniques. As a result of the pilot project, the Office of

Investigations has expanded the use of research in the early stages of an investigation and has increased their available resources for referrals [see page 69, *Office of Investigations*]. By focusing on the quality of investigations, the DIA will enhance the likelihood that penalties will be recovered and help alleviate the competitive disadvantage faced by the vast majority of employers who purchase workers' compensation policies.

Due to the infancy of these investigative changes, it is too early to determine if more employers will be encouraged to purchase workers' compensation insurance. Perhaps the greatest indicator of success will come from analyzing the volume of claims on the Workers' Compensation Trust Fund in future years. The Advisory Council will continue to support the DIA's efforts in strengthening the stop work order process internally and encourages the agency to further promote the mandatory requirement of workers' compensation insurance to employers of the Commonwealth.

Although the Advisory Council is encouraged by recent internal changes made within the Office of Investigations, it is clear that any complete solution requires legislative activity. The Advisory Council has endorsed **Senate Bill 1705** which would require the mandatory debarment or suspension of contractors and subcontractors from engaging in any of the Commonwealth's public sector projects for not carrying workers' compensation insurance or other serious offenses.[1] The Advisory Council recommends that the Legislature pass Senate Bill 1705, filed by Senator Steven A. Tolman, in an effort to level the playing field for honest contractors who are at a competitive disadvantage when bidding on public sector projects. Currently, Senate Bill 1705 is before the Joint Committee on State Administration.

Finally, the Council has voted to endorse the concept of **House Bill 2205**, filed by Representative Martin J. Walsh. This bill would provide a vehicle for both private citizens and insurers to bring forth a civil action against employers who fail to pay workers' compensation premiums as mandated by Chapter 152. On suits brought forth by private citizens, the majority of the damages would be deposited into the DIA's Special Fund to pay for the agency's operating expenses. Insurance carriers would be able to recover the full amount of the award in situations where they obtain court approval to replace the private citizens in the lawsuit. The Advisory Council is only supporting this bill in concept due to the fact that additional changes are expected to be made. The Council welcomes the opportunity to work with the Legislature in the refinement of this bill.

Annual Survey of Occupational Injuries and Illnesses

Since 1992, the Division of Occupational Safety (DOS) has been in a partnership with the U.S. Department of Labor, Bureau of Labor Statistics (BLS), in an effort to collect injury and illness data in a uniform format. In Massachusetts alone, surveys are collected from over 5,800 employers (200,000 nationwide) in an effort to represent the total private economy. Once data has been collected and correlated, these statistics are published in a

[1] Current law allows state regulators the option to debar contractors for the following serious offenses: conviction for bribery, theft, forgery, destroying business records, receiving stolen property or rigging bids. Debarment may also be issued if a contractor is found to have violated any of the following statutes: anti-trust, campaign contribution, employment discrimination, hours of labor, prevailing wages, overtime pay, equal pay, child labor or workers' compensation.

report known as the *Annual Survey of Occupational Injuries and Illnesses* [see page 29, *Occupational Injuries and Illnesses*]. Funding for the annual survey is split 50/50 between state government (DOS) and the federal government (BLS).

The survey's data is calculated into incidence rates that measure the frequency of injuries. Specifically, the survey examines the frequency of non-fatal injuries and illnesses that occurred in the private sector workforce for every 100 full-time workers. Each year the level of incidence rates can be influenced by changes in the economic climate, working conditions, an employer's emphasis on safety and training, and the number of hours that employees work. In the past, both insurers and employers have found the data useful in assessing safety and injury trends. The Office of Safety has also expressed interest in utilizing the survey to identify high-risk industries that could be targeted for the DIA's Safety Grant Program.

In November of 2003, the Director of the Department of Occupational Safety met with members of the Advisory Council to explain how deep cuts in the fiscal year 2004 budget forced Massachusetts to withdraw its participation in the annual survey. Next year when the survey analyzes 2003 data, the Bureau of Labor & Statistics will begin classifying occupations using the North American Industry Classification System, rather than the Standard Industrial Classification System. This change to the classification system accentuates the importance that Massachusetts participates with other states in next year's first benchmark year of the survey.

Although the annual survey falls outside of the statutory mandate for DOS, the benefits of having comparable statewide injury data, which can be analyzed by industry, region, or injury type, far outweigh the cost of the program. The Advisory Council strongly recommends that the Legislature restore the $110,000 in funding to the Division of Occupational Safety's line-item in the fiscal year 2005 budget so that the Commonwealth can resume participation in the annual survey in this important benchmark year.

Industrial Accident Board Appointments/Performance Review

In fiscal year 1998, the DIA experienced delays in both conferences and hearings due to the expiration of a large number of judicial terms. During that fiscal year, nine of twenty-four administrative judge (AJ) terms expired, as did all six administrative law judge (ALJ) terms. With as many as nine AJ's and all six ALJ's expiring in 2004, the Advisory Council believes that future delays to the system can be prevented if **House Bill 2924** can be immediately passed.

In an effort to improve on previously filed legislation, the Advisory Council formed a subcommittee in the fall of 2002 and met with Representative Robert Koczera, a committed sponsor of past judicial term staggering legislation. As a result of these discussions, House Bill 2924 was filed, creating a new approach to stagger judicial terms as positions are vacated. If passed, the new law would make the initial appointment of all new Administrative Judges for 6-year terms, regardless of whether or not they were appointed to fill a vacancy. Currently, the statute provides that any judge appointed to fill a vacancy, occurring prior to the expiration of a term, must be appointed for the unexpired portion of that term.

The focus of this legislation is clearly on Administrative Judges, rather than Administrative Law Judges (ALJ's), due to their unique circumstances in which they are taken off-line as their term expiration date approaches. This is not a problem for ALJ's, who have the ability to continue fulfilling their statutory duties until reappointment or until a successor has taken their place.

House Bill 2924 also creates a system of judicial performance review. The Senior Judge would be required to review the performance of new AJ's after two years of service. If the performance review supports the continuation of a term, the AJ would continue to serve the remainder of the 6-year term. However, in the event the performance review recommends against the continuation of a term, the performance review would be submitted to the Governor for appropriate removal action if deemed necessary.

Council members strongly believe that the poor performance of even one Administrative Judge can have an adverse effect on all participants in the workers' compensation system. The Advisory Council recommends the immediate passage of House Bill 2924 as sponsored by Representative Robert Koczera, Representative William Greene, and Senator Marc Pacheco. The enactment of this bill would more efficiently disperse future judicial appointments and allow the workers' compensation system to function without delays for injured workers, employers, and insurers.

Code of Judicial Conduct Legislation

The Advisory Council continues to support the need for a uniform code of judicial conduct for DIA administrative judges (AJ's) and administrative law judges (ALJ's). During the 2003 - 2004 Legislation Session, Representative Anthony Cabral filed **House Bill 2380**, subjecting the Senior Judge, the AJ's, and the ALJ's to the judicial code of conduct as set forth by the Supreme Judicial Court (SJC).

The Advisory Council recommends the passage of House Bill 2380 with the stipulation that this legislation be amended by substituting the American Bar Association's (ABA's) Model Code of Judicial Conduct for State Administrative Law Judges, in lieu of the current language as set forth by the SJC. Although both codes exhibit similar ethics, the ABA code will most appropriately serve DIA judges, as they are technically not members of the constitutional judiciary, but rather the executive branch of government. The passage of this bill would enhance the authority that both AJ's and ALJ's exercise over the fate of injured employees and employers, helping to ensure the fair administration of justice.

Scar Based Disfigurement Legislation

The Council also endorses **House Bill 2382**, filed by Representative Anthony Cabral, which would eliminate the requirement that scar-based disfigurement appear on the face, neck or hands to be conpensable. If passed, this legislation would rightfully compensate workers for all disfigurement, whether or not scar-based, regardless of its location on the body, subject to a $15,000 maximum benefit. During fiscal year 2000 the Advisory Council asked the actuarial firm Tillinghast - Towers Perrin to estimate the impact on workers' compensation costs if scarring awards were restored to their pre-chapter 398 levels. Although Tillinghast was unable to quantify the impact of such a proposed

revision due to incomplete data, it was suggested that such a change would have a "relatively minimal impact on system costs."

DIA Building Security - Boston and Regional Offices

The Advisory Council recognizes the need for enhanced security at the DIA and it's four regional offices. During fiscal year 2003, the DIA created a subcommittee to address internal security-weaknesses. Subcommittee Members agreed that the DIA needed a qualified security consultant to evaluate the vulnerabilities of the agency. As a result of this recommendation, the DIA has drafted a Request for Responses (RFR) which will be issued in the future. After a security consultant identifies the scope and cost, the DIA will need to secure funding to implement the proposed changes.

The Advisory Council is in full agreement that the Legislature should appropriate the necessary funding within the DIA's fiscal year 2005 line-item to pay for enhanced security measures for both the Boston and regional offices. The Advisory Council also encourages the DIA to reinstate the requirement that employees wear the photo-identification badges so that the maximum amount of security can be provided to employees of the DIA and the general public under existing budgetary constraints.

Office of Safety Training Grants

The Office of Safety is responsible for establishing and supervising programs that entail the education and training of employees and employers in the recognition, avoidance, and prevention of unsafe or unhealthy working conditions. To fulfill this mandate, the DIA awards grants to qualified applicants, based on a competitive selection process.

For the past fifteen years, the Office of Safety has been providing grants under the "Occupational Safety and Health Education and Training Program." Historically, the Safety Grant Program has been funded with an annual budget of $800,000 and allots up to $30,000 in grants for each proposal. In fiscal year 2003, the DIA received 62 proposals and funded 34 grants training over 29,079 employees. Clearly, this program has been a valuable success. By focusing on the pre-injury stages of workers' compensation, safety grants have saved the Commonwealth's employers thousands of dollars.

The Advisory Council applauds the efforts made by the Office of Safety in providing education and training to employees on a variety of workplace safety issues. The Council recommends that the Safety Grant program receive "not less than $800,000" in the fiscal year 2005 budget, thereby allowing for more employees and employers to be educated, while attaining the ultimate goal of creating safer workplaces. Council members are also in agreement that the DIA should attempt to measure the cost-savings to employers generated by this program. If cost-savings can be identified, this will help create support within the Legislature for future efforts to increase funding.

Oracle Conversion - Continued Advancement

In the fall of 2000, Oracle Corporation proposed a new computer application to replace the DIA's antiquated scheduling system, known as "Diameter."[2] The proposed application would modernize the agency's database, streamline data entry and maintenance, and would provide new tools to both the agency and the public (i.e. online submission of various DIA forms).

Before the new computer system could be built, the Advisory Council entered into a unique partnership with the DIA to ensure that adequate funding was available to lay the foundation for the agency's move to e-government. Throughout the project's two phases, Council members were well informed on the project's accomplishments and setbacks. Clearly, this cooperation and open communication between the DIA and the Advisory Council displays how state government can provide cost-effective and efficient services.

As Phase II of the project comes to a close, the Advisory Council fully recognizes the potential in cost-savings that this state-of-the-art database will provide to the workers' compensation system in Massachusetts. Oracle has estimated that the annual savings to both insurers and the agency could exceed $1 million from online form submissions. These savings will be passed on to the employers of the Commonwealth by favorably impacting the assessment rates. We encourage the DIA to remain committed to protecting this investment in technology. Special attention should be placed on the maintenance of both the software and hardware that is utilized by the system. The Advisory Council encourages the DIA to explore future expansion possibilities (i.e. additional online forms, waiting room kiosks, etc.) as the needs of its users grow.

The Advisory Council appreciates the efforts of the DIA for taking the initiative to implement this conversion. Ultimately, our common goal is to promote technological expansion to enhance workers' compensation services that will assist injured workers, employers, insurers, attorneys, vocational rehabilitation providers, and the medical community. After witnessing the initial benefits that this state-of-the-art system is already providing, it appears to be both time and money well spent.

DIA Funding

The Advisory Council continues to express concern about how the DIA's line-item is treated during the Commonwealth's budget process. Too often a misconception is made that the DIA is a tax-funded agency and that reducing its funding (in across the board cuts) will help alleviate budget shortfalls in Massachusetts. This is entirely untrue.

The DIA administers three separate budgets that are funded solely by assessments on employer's workers' compensation policies, fines for various infractions against the Workers' Compensation Act, and fees collected by the agency. The three funds are made up of the Special Fund, the Private Trust Fund, and the Public Trust Fund. The Special Fund is used to pay for the operation of the agency. The Trust Funds were established so

[2] The DIA has utilized Diameter since 1987 as a scheduling and database system. Although reports were generated from this system, data was not developed fully to produce understandable and reliable statistics. Diameter was written in Unify programming language and was based on outdated technology that made maintenance difficult.

the DIA could make payments to uninsured-injured employees and those 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. One account is reserved for payments to private sector employees, while the other account is reserved for public sector employees.

During the fiscal year 2002 budget process, the Legislature's Conference Committee on the budget reduced the DIA's line-item by over $1 million dollars from all previous proposed amounts (DIA Request, House 1, House Ways & Means, Senate Ways & Means, and the Governor's Recovery Budget). By treating the DIA's account as a tax-funded agency rather than an assessment-funded agency, the Legislature is jeopardizing the overall efficiency and effectiveness of the DIA in assisting injured workers as they maneuver through the Workers' Compensation System.

The Advisory Council would like all parties involved in the state budget process to recognize that the DIA is funded by an assessment on employers which is based on an amount to adequately fund the DIA. There are no tax dollars used to fund this agency or any of its activities, as the DIA's special fund is used to reimburse the Commonwealth's General Fund for 100% of its budgeted appropriation.

Office of Education and Vocational Rehabilitation

The Office of Education and Vocational Rehabilitation (OEVR) determines eligibility and oversees the vocational rehabilitation process administered to workers' compensation recipients. For the past five years both the Advisory Council and the Joint Committee on Commerce & Labor have expressed concern with vocational rehabilitation system and has recommended that OEVR take a more aggressive approach to promptly initiate services and increase suitable work returns of injured workers.

The Advisory Council established a subcommittee in fiscal year 2000 to address these concerns and conjointly worked to remedy and enhance this process. During fiscal year 2003, ongoing meetings were conducted among the Advisory Council subcommittee members, the DIA Administration, and the Director of OEVR. Since subcommittee work began in 2000, OEVR has experienced substantial progress in delivering services to injured workers. As a result of the subcommittee's recommendations, a working dialogue was initiated with OEVR and the Department of Labor & Workforce Development to integrate career centers into the vocational rehabilitation process. Furthermore, referrals are expected to reach OEVR in a more timely fashion with the recent completion of the Oracle conversion project.

Although OEVR has made vast improvements, many injured workers are still not evaluated in a timely manner. Furthermore, inconsistencies still exist among the regional offices with how determinations and vocational programs are processed. The Advisory Council will continue to support the efforts of the vocational rehabilitation subcommittee in their endeavor to improve OEVR and its delivery of services to injured workers. The Advisory Council plans to formally submit a report to the Joint Committee on Commerce & Labor outlining the accomplishments and improvements to OEVR.

LEGISLATION

As the first half of the 2003-2004 Legislative Session comes to a close, approximately thirty-six bills have been filed by the House and Senate seeking to amend the workers' compensation system (see Appendix C). The vast majority of bills concerning workers' compensation matters are referred to the Joint Committee on Commerce & Labor. Once legislation is referred to the committee, a public hearing is held on the bills. For a list of members of the Joint Committee on Commerce & Labor, see Appendix D.

Commerce & Labor Hearing

On July 24, 2003, the Joint Committee on Commerce & Labor held a hearing on all workers' compensation legislation before the committee. Representatives from the Advisory Council appeared before the committee to testify on four bills that had been previously endorsed by the Advisory Council.

At the Commerce & Labor hearing, the Council expressed support for **House Bill 2924**, filed by Representative Koczera, which would "naturally" stagger judicial terms at the DIA by making the initial appointment of all Administrative Judges for 6-year terms.

The Council also supported (with a stipulation that it be amended) **House Bill 2380**, filed by Representative Cabral, which would subject the Senior Judge, the Administrative Judges, and the Administrative Law Judges to a judicial code of conduct. The Advisory Council offered an amendment to this legislation that would substitute the American Bar Association's Model Code of Judicial Conduct for State Administrative Law Judges, in lieu of the current language as set forth by the Supreme Judicial Court.

The Council also expressed support for **House Bill 2382**, filed by Representative Cabral, which would eliminate the requirement that scar-based disfigurement appear on the face, neck or hands to be compensable.

Finally, the Advisory Council endorsed the concept of **House Bill 2205**, filed by Representative Walsh. This bill would provide a vehicle for both private citizens and insurers to bring forth a civil action against employers who illegally fail to pay workers' compensation premiums as mandated by Chapter 152.

See Appendix H for the Advisory Council's written testimony at this hearing.

Legislation Endorsed by the Advisory Council

Of the thirty-six bills filed in the 2003-2004 Legislative Session, five bills have been endorsed by the Advisory Council (four bills before the Joint Committee on Commerce & Labor and one bill before the Joint Committee on State Administration). The affirmative vote of at least seven voting members must occur in order for a bill to be endorsed by the Advisory Council.

SENATE BILL 1705
Filed By: Sen. Steven A. Tolman
Type of Bill: NEW
Endorsed by Advisory Council: YES
Laws Affected: Debarment or Suspension of Contractors (c.29, §29F)

Senate Bill 1705 would amend M.G.L. c.29, §29F, which allows the Commonwealth the optional power of debarring or suspending contractors and subcontractors from engaging in any of the Commonwealth's public sector projects for not carrying workers' compensation insurance or other serious offenses.[3] This proposed legislation would amend Section 29F by replacing the word "may" to "shall," effectively making the debarment or suspension of violators mandatory. This bill was filed by Senator Steven A. Tolman and the Massachusetts Building Trades Council in an effort to level the playing field for contractors who are at a competitive disadvantage when bidding on public sector projects because they complied by the law, securing workers' compensation insurance, when their competitors did not.

HOUSE BILL 2205
Filed By: Rep. Martin J. Walsh
Type of Bill: NEW
Endorsed by Advisory Council: YES (in concept)
Laws Affected: Private Right of Action to Recover WC Coverage Payments (c.152, §25C)

This new bill would allow up to 10 people to bring a civil action against an employer to recover amounts which should have been paid in securing proper workers' compensation insurance as mandated by Chapter 152. Such a person seeking civil action could petition either the Attorney General's Office, the Commissioner of Insurance, or a superior court to hold a "probable cause hearing." At the hearing, it shall be *prima facie* evidence that such probable cause exists if it is shown that:

- an employee was paid any portion of wages in cash with no deductions or taxes withheld;
- no accompanying pay slip showing the wage payment and deductions as required by law;
- an individual was misclassified as an independent contractor when actually an employee;
- wages were not timely paid;
- the employer failed to withhold from the employee's wages all related state taxes; or
- employees have not been properly reported on certified payroll records as required by law.

If the decision shows that probable cause exists, the person who brought the petition shall serve a copy of the decision to any insurer that was entitled to collect amounts not paid and the persons shall simultaneously state any intention to file suit under this section. Any persons who prevail in an action shall be entitled to recover 25% of the amounts unlawfully not paid or $25,000, whichever is less.

[3] Current law allows state regulators the option to debar contractors for the following serious offenses: conviction for bribery, theft, forgery, destroying business records, receiving stolen property or rigging bids. Debarment may also be issued if a contractor is found to have violated any of the following statutes: anti-trust, campaign contribution, employment discrimination, hours of labor, prevailing wages, overtime pay, equal pay, child labor or workers' compensation.

HOUSE BILL 2380
Filed By: Rep. Antonio Cabral
Type of Bill: Refile
Endorsed by Advisory Council: YES (with ABA language amended)
Laws Affected: Code of Judicial Conduct - Senior Judge, AJ's, and ALJ's (c.23F, §8)

This refiled bill (previously H.2648) would require the Senior Judge, the Administrative Judges and Administrative Law Judge's to be subject to the Code of Judicial Conduct as promulgated by the Supreme Judicial Court. A previous version of this bill was endorsed by the Advisory Council in the Fiscal Year 2002 Annual Report.

HOUSE BILL 2382
Filed By: Rep. Antonio Cabral
Type of Bill: Refile
Endorsed by Advisory Council: YES
Laws Affected: Benefits for Specific Injuries (c.152, §36(k)) - Scar-Based Disfigurement

This refiled bill (previously H.2649) 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.

NOTE: In July of 2002, the Advisory Council sent a letter to Representative Greene and Senator Pacheco stating that the "Council continues to be receptive to amending Section 36(k) to allow compensation for scar-based disfigurement regardless of its location on the body." However, in reference to Senate Bill 2358, the Council noted that they could not reach a consensus on a SAWW multiplier to determine a maximum benefit "until a thorough cost-analysis can be conducted." House Bill 2382 would not affect the $15,000 maximum benefit for scar-based disfigurement currently in the statute.

HOUSE BILL 2924
Filed By: Rep. Robert M. Koczera
Type of Bill: NEW
Endorsed by Advisory Council: YES
Laws Affected: Judicial Appointments - Judicial Performance Review (c.23E, §4)

Section 1 of this new bill, endorsed by the Advisory Council, would attempt to stagger judicial terms "naturally" by clarifying that newly appointed Administrative Judges (AJ's) be appointed to new six-year terms, rather than the current practice of being appointed to fill the remaining time-period of a vacant term. In theory, the current law could create a situation in which a newly appointed Judge would only be appointed to serve a 1-year term, if the slot they were filling was vacated after 5-years.

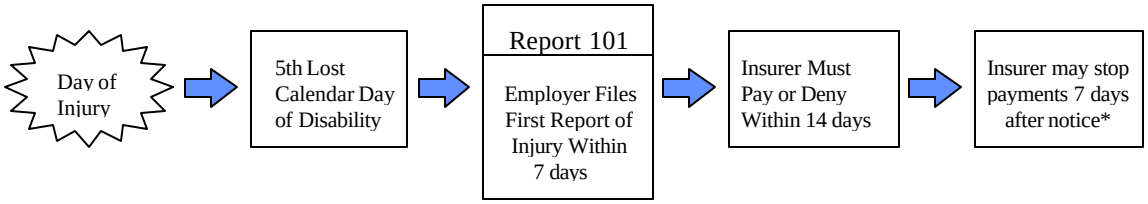
Section 2 of this proposed legislation would require the Senior Judge to review the performance of newly appointed Administrative Judges after their first 2-years of service. If the performance review supports the continuation of their term, the AJ may continue to serve the remainder of their term. However, if the performance review recommends against a continuation of their term, the performance review would be submitted to the Governor for appropriate action.

SECTION
- 1 -
OVERVIEW

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, they may be subject to a fine.

The insurer then has 14 days, upon receipt of an employer's first injury report, to either pay the claim or to notify the DIA, the employer, and the employee of refusal to pay.[4] When the insurer pays a claim, they 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.[5] 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.

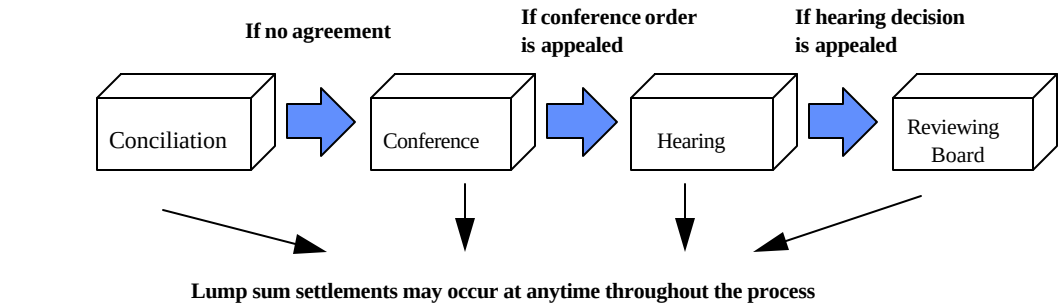
[4] If there is no notification or payment has not begun, the insurer is subject to a fine of $200 after 14 days, $2,000 after 60 days, and $10,000 after 90 days.

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

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. The AJ may require both injury and hospital records. A conference 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 review the evidence presented at the hearing. The ALJ's may request 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 process 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 or hearing level of dispute resolution, 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 they 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 M.G.L. c.251, §12 and §13. 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 continue 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; and 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.[6] 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. In October 2002, for the first time since 1940, the SAWW experienced a decrease (- $8.37) from the previous year. As of October 2003, the SAWW has experienced a $1.89 increase from last year.

Table 1: Indemnity Benefits

Effective Date	Maximum Benefit	Minimum Benefit
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
10/1/98	$699.91	$131.98
10/1/99	$749.69	$149.93
10/1/00	$830.89	$166.18
10/1/01	$890.94	$178.19
10/1/02	$882.57	$176.51
10/1/03	**$884.46**	**$176.89**

Source: DIA Circular Letter No. 310 - Table III (October 1, 2003)

[6] The Statewide Average Weekly Wage (SAWW) is determined under M.G.L. c.151A, §29(2) & promulgated by the Director the Division of Employment and Training. As of October 1, 2003, the SAWW is $884.46.

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 (**$884.46**), while the minimum is 20% of the SAWW (**$176.89**), if claims involve injuries occurring on or after October 1, 2003. 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 (**$884.46**), while the minimum is 20% of the SAWW (**$176.89**), if claims involve injuries that occurred on or after October 1, 2003. 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 (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). However, children under 18 years old may continue to receive payments even if the maximum has been reached. Burial expenses may not exceed $4,000.

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 a lump sum). If the old injury was settled with a lump sum, then the employee will be compensated only if the new claim can be determined to be a new injury.

Attorney's Fees

The dollar amounts specified for attorney's fees are listed in M.G.L. c.152, §13A(10). As of October 1, 2003, 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 **$893.39** plus necessary expenses. If the employee's attorney fails to appear at a scheduled conciliation, the amount paid is **$446.69**.

(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 **$1,276.27**. 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 **$638.13**.

(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 **$638.13** plus necessary expenses. This fee can be reduced to **$319.07** 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 **$893.39** 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 **$446.69** 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 **$4,466.95** 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 **$1,276.27**. 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 & CLAIM STATISTICS

OCCUPATIONAL INJURIES AND ILLNESSES

Since 1992, the Division of Occupational Safety (DOS) has been in a partnership with the U.S. Department of Labor, Bureau of Labor Statistics (BLS), in an effort to collect injury and illness data in a uniform format. In Massachusetts alone, surveys are collected from over 5,800 employers (200,000 nationwide) in an effort to represent the total private economy. Once data has been collected and correlated, these statistics are published in a document known as the *Annual Survey of Occupational Injuries and Illnesses*. Funding for the annual survey is split 50/50 between state government (DOS) and the federal government (BLS). Due to budget cuts affecting the Division of Occupational Safety in fiscal year 2004, this could be the last year (2001 data) Massachusetts participates in the survey.

Injury and Illness Incidence Rates

Incidence rates are calculated to measure the frequency of injuries. Specifically, the study examines the frequency of non-fatal injuries and illnesses 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) for every 100 full-time workers. Each year the level of incidence rates can be influenced by changes in the economic climate, working conditions, an employer's emphasis on safety and training, and the number of hours that employees work. In 2001, Massachusetts had a population of 6,379,304 people with a workforce of 3,276,105 workers.

The following table exhibits a regional view of the injury and illness incident rates per 100 full-time workers since 1996. The table visibly demonstrates the downward trend in incidence rates both nationally and within Massachusetts. In 2001, Massachusetts had an incident rate of 5.1 work-related injuries or illnesses (resulting in lost work-time) for every 100 full-time workers in private industry. For the tenth year in a row, Massachusetts ranks the lowest for incident rates among all New England states and is well below the national average of 5.7. Furthermore, this makes the Commonwealth the only New England state to remain below the national average for ten consecutive years.

Table 2: Injury and Illness Incidence Rates - U.S. and New England 1996-2001 (Private Industry)

Region	*2001*	*2000*	*1999*	*1998*	*1997*	*1996*
United States……	5.7	6.1	6.3	6.7	7.1	7.4
Massachusetts…..	5.1	5.5	5.8	5.7	5.7	6.1
Connecticut……..	6.3	6.7	6.8	7.1	6.6	8.0
Maine……...	8.7	9.0	9.3	9.2	8.7	8.9
Rhode Island……	6.8	no data	7.0	6.7	7.8	7.1
Vermont……...	7.0	6.9	7.6	6.9	6.7	no data
New Hampshire...	no data	no data	no data	no data	no data	no data

Source: Bureau of Labor Statistics - Boston Office.

Incidence Rates by Industry

The survey also has the ability to categorize incidence rates by industry. In Massachusetts, the construction industry had the highest overall incidence rate in 2001, with 9 injuries for every 100 full-time workers. Finance, insurance and real estate had the lowest incidence rates, with 1.4 injuries per 100 workers.

Table 3: Nonfatal Injury & Illness Incidence Rates by Industry - Massachusetts 1996-2001

MASSACHUSETTS (Industry Division)	**2001**	**2000**	**1999**	**1998**	**1997**	**1996**
Private Industry:	**5.1**	**5.5**	**5.8**	**5.7**	**5.7**	**6.1**
Agriculture, forestry, and fishing:	8.1	7.7	11.6	10.8	10.7	7.6
Construction:	9.0	9.4	9.5	9.0	10.3	10.8
Manufacturing:	5.4	6.0	6.3	6.6	7.1	7.3
▪ Durable goods:	4.7	5.7	5.7	6.0	N/A	N/A
▪ Non-durable goods:	6.8	6.5	7.2	7.5	N/A	N/A
Transportation & public utilities:	8.2	8.2	8.1	9.3	8.9	9.0
Wholesale and retail trade:	5.6	6.9	6.6	5.9	5.6	6.4
▪ Wholesale trade:	5.4	7.6	6.1	6.2	N/A	N/A
▪ Retail trade:	5.7	6.6	6.8	5.8	N/A	N/A
Finance, insurance, real estate:	1.4	1.4	1.7	1.9	2.2	1.4
Services:	4.4	4.5	5.0	4.9	5.6	5.4

Source: Bureau of Labor Statistics - Boston.

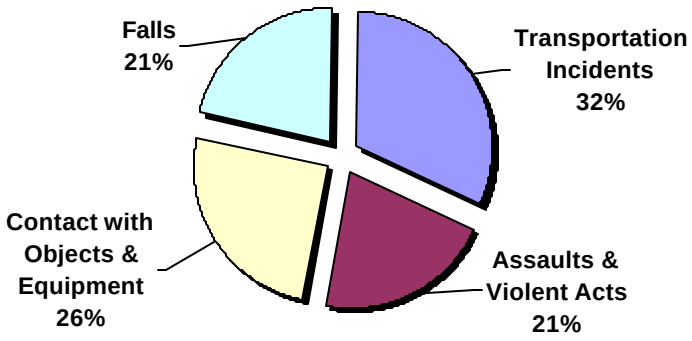
Fatal Work Injuries

Fatal work injuries are calculated nationally each year by the U.S. Department of Labor, Bureau of Labor Statistics. The program, known as the *Census of Fatal Occupational Injuries*, tracks data from various states and federal administrative sources including death certificates, workers' compensation reports and claims, reports to various regulatory agencies, and medical examiner reports. Much like the *Annual Survey of Occupational Injuries and Illnesses*, this census is a federal/state cooperative venture in which costs are split equally. The collection of data in 2002 marks the 11th year that all 50 states (and the District of Columbia) have participated in this survey.

In 2002, a total of 5,524 work-related fatalities were recorded nationally by the program, representing a 6.6% decline from figures in 2001 (5,915 fatalities in 2001). The decrease in fatalities nationally, mirrors the trend in Massachusetts in which work-related fatalities decreased by 15% in 2002 (46 fatalities in 2002 / 54 fatalities in 2001). The number of fatalities in Massachusetts calculates to be less than 1% of the 5,524 fatalities nationally in 2002.

In 2002, transportation incidents were the leading cause of workplace deaths in Massachusetts, accounting for 32% of the total cases. Nationally, transportation incidents are also the leading cause of on-the-job fatalities, accounting for 43% of the fatal work injuries in 2002.

Figure 3: Distribution of Fatal Occupational Injuries by Event - Massachusetts 2002



Source: Bureau of Labor Statistics, News - USDL-03-488

Figure 4: Fatal Occupational Injuries by State and Event or Exposure, 2002 (Northeast Region)

State of Injury	Total Fatalities		Event or Exposure (percent of state total for 2002)					
	2001	2002	Transportation Incidents	Assaults & Violent Acts	Contact with Objects & Equipment	Falls	Exposure to Harmful Substances	Fires & Explosions
U.S. Total……..	5,915	5,524	43%	15%	16%	13%	10%	3%
Northeast……..	724	708	38%	19%	16%	15%	8%	4%
Massachusetts….	54	46	30%	20%	24%	20%	--	--
Connecticut…….	41	39	46%	18%	13%	--	--	--
Maine……..	23	30	83%	--	--	--	--	--
New Hampshire..	9	19	47%	--	26%	--	--	--
New Jersey…….	129	129	36%	22%	10%	16%	11%	5%
New York……..	220	238	30%	24%	17%	19%	7%	4%
Pennsylvania…...	225	188	41%	12%	18%	13%	11%	4%
Rhode Island…...	17	8	--	62%	--	--	--	--
Vermont……..	6	11	--	--	--	--	--	--

Source: Bureau of Labor Statistics, News - USDL-03-488

CASE CHARACTERISTICS

The following tables and statistics illustrate trends, by "injury kind" in claims, average claim cost, and frequency for the five most recent years of available data. [7] This data is derived from insurance claims paid by commercial insurers writing policies in Massachusetts and does not include data from self insured employers or self insurance groups (SIGs). Insurance data is not considered reliable until several years after the policy year in which the claims occurred. For this reason, the most recent year comprising of reliable data is the 2000/2001 policy year. Each year of the data is developed to the fifth report, so the years can be compared equally.

Case Data By Injury Type

Table 4: Developed Claim Counts (Including Large Deductibles)

Composite Policy Year	*Injury Kind 1 Fatal*	*Injury Kind 2 Permanent Total*	*Injury Kinds 3&4 Partial Disability*	*Injury Kind 5 Temporary Total*	*Injury Kind 6 Medical Only*
1996/1997	42	52	5,918	23,953	74,003
1997/1998	44	78	6,748	24,644	77,703
1998/1999	37	156	6,943	24,414	76,823
1999/2000	21	76	6,931	25,668	77,538
2000/2001	34	33	6,165	24,710	74,713

Source: WCRIBM, schedule Z data by injury type (developed to 5th report) from Section V-D Exhibit 2-3.

Table 5: Average Claim Costs - "Indemnity + Medical" (Including Large Deductibles)

Composite Policy Year	*Injury Kind 1 Fatal*	*Injury Kind 2 Permanent Total*	*Injury Kinds 3&4 Partial Disability*	*Injury Kind 5 Temporary Total*	*Injury Kind 6 Medical Only*
1996/1997	231,135	450,067	46,032	7,164	358.19
1997/1998	227,535	462,805	46,165	8,273	382.16
1998/1999	303,952	711,294	45,618	9,655	402.80
1999/2000	413,905	797,536	47,997	11,997	431.51
2000/2001	733,048	713,251	55,332	14,320	467.78

Source: WCRIBM, schedule Z data by injury type (developed to 5th report) from Section V-D Exhibit 1-3.

[7] It is important to note that the WCRIBM claim categories ("injury kind") 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 6: Average Claim Costs - Indemnity (Including Large Deductibles)

Composite Policy Year	Injury Kind 1 Fatal	Injury Kind 2 Permanent Total	Injury Kinds 3&4 Partial Disability	Injury Kind 5 Temporary Total
1996/1997	229,119	315,318	33,460	4,504
1997/1998	222,124	294,297	33,640	5,377
1998/1999	231,774	335,092	33,093	6,345
1999/2000	385,162	356,777	34,554	7,966
2000/2001	724,641	260,455	40,992	9,860

Source: WCRIBM, schedule Z data by injury type (developed to 5th report) from Section V-D Exhibit 1-3.

Table 7: Average Claim Costs - Medical (Including Large Deductibles)

Composite Policy Year	Injury Kind 1 Fatal	Injury Kind 2 Permanent Total	Injury Kinds 3&4 Partial Disability	Injury Kind 5 Temporary Total	Injury Kind 6 Medical Only
1996/1997	2,016	134,749	12,571	2,660	358.19
1997/1998	5,412	168,508	12,525	2,897	382.16
1998/1999	72,178	376,202	12,526	3,310	402.80
1999/2000	28,744	440,760	13,443	4,032	431.51
2000/2001	8,407	452,796	14,340	4,460	467.78

Source: WCRIBM, schedule Z data by injury type (developed to 5th report) from Section V-D Exhibit 1-3.

Claim Frequency

Based on Developed Payroll and Developed Claim Counts
Unadjusted for Class Mix Changes

Table 8: Claim Frequency (Number of Claims per Million Worker-Weeks)

Composite Policy Year	Injury Kind 1 Fatal	Injury Kind 2 Permanent Total	Injury Kinds 3&4 Partial Disability	Injury Kind 5 Temporary Total	Injury Kind 6 Medical Only
1996/1997	0.477	0.591	67.26	272.25	841.12
1997/1998	0.493	0.877	75.85	277.01	873.41
1998/1999	0.412	1.739	77.25	271.64	854.75
1999/2000	0.222	0.786	72.07	266.88	806.20
2000/2001	0.335	0.321	60.20	241.32	729.64

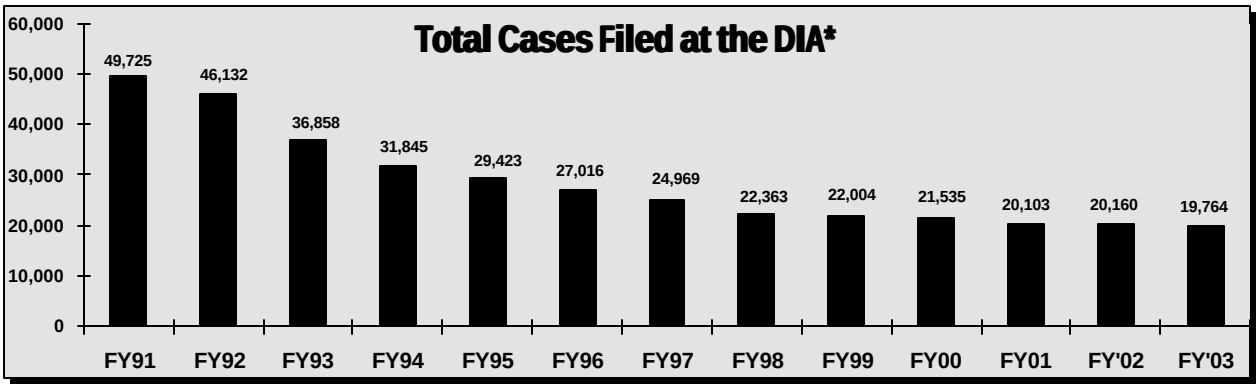
Source: WCRIBM, schedule Z data by injury type (developed to 5th report) from Section V-D Exhibit 1-4.

SECTION
- 3 -
DISPUTE RESOLUTION

CASES FILED AT THE DIA

Cases originate at the DIA when any of the following are filed: *an employee's claim for benefits, an insurer's complaint for termination or modification of benefits, a third party claim, a request for approval of a lump sum settlement, or a section 37/37A request*. As demonstrated in Figure 5, there has been a significant decline (-60%) in the DIA caseload since the implementation of the 1991 Reform Act. However, this trend of decreases appears to be ending as the graph below indicates that the level of cases filed has been similar for the last three years.

Figure 5: Total Cases Filed at the DIA, FY'91 - FY'03



Source: CMS Report 28

Employee claims, which account for 73% of the total cases filed at the DIA, increased slightly by 208 cases in FY'03. In 1991, employee claims reached an all time high of 23,240 cases filed. Employee claims have decreased by 38% since 1991. Insurers requests for discontinuance, which account for 15% of the total cases, decreased slightly by 192 cases in FY'03. Since the 1991 Reform Act, these requests for discontinuance have decreased by 74%.

Table 9: Breakdown of Total Cases Filed at the DIA, Fiscal Year 2003 and Fiscal Year 2002

Total Cases Filed at the DIA FY'03 and FY'02	Number of Cases		Percentage	
	FY'03	FY'02	FY'03	FY'02
Employee Claims	14,442	14,234	73.1%	70.6%
Insurers Discontinuance Request	2,954	3,146	15.0%	15.6%
Lump Sum Conference Request	1,658	1,934	8.4%	9.6%
Third Party Claims	429	598	2.2%	3.0%
Section 37/37A Request	281	201	1.4%	1.0%
TOTALS:	**19,764**	**20,160**	**100%**	**100%**

Source: CMS Report 28

CONCILIATION

The first stage of the dispute resolution process is known as the conciliation. The main objective of the conciliation is to remove cases that can be resolved without formal adjudication from the dispute resolution system. 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. Although conciliators may encourage the parties to work out a settlement, they have no authority to order the parties to resolve their differences. Approximately 40% of the cases that proceed through conciliation are "resolved" as a result of this process and exit the dispute resolution system. Such resolved cases take on a broad range of dispositions including withdrawals, lump sum settlements, and conciliated cases. The remaining 60% of cases are referred from conciliation to a conference.

The Conciliation Process

Conciliations are scheduled automatically by computer through Data Processing. Attendance of both the insurer and the employee is required. The employer may attend, as well as other interested parties, with the permission of all 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, the conciliator must record the last offer made by them, or record a zero. In an effort to promote compromise, the last, best offer should indicate what each party believes the appropriate compensation rate should be.

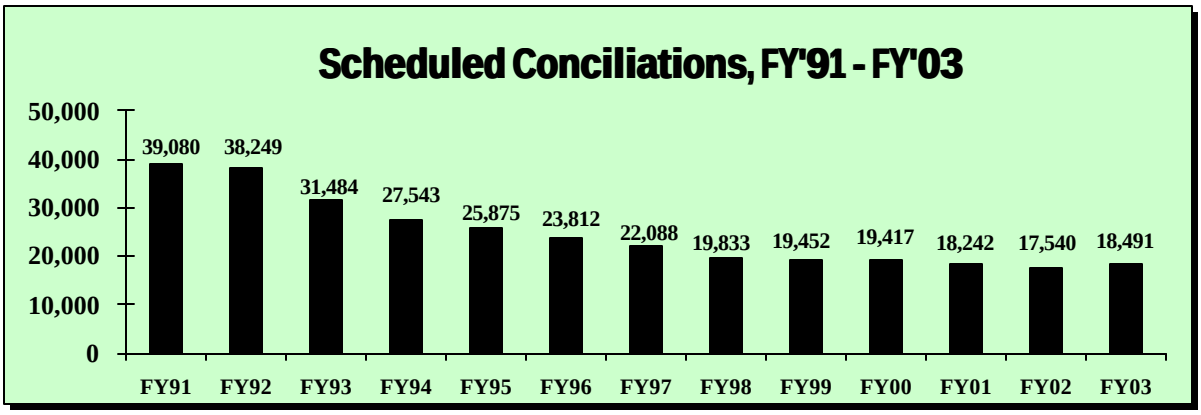
A conciliator's recommendation is written into the case file and the disposition is recorded in the DIA's Case Management System (CMS).

Volume of Scheduled Conciliations

The number of cases reviewed at conciliation is indicative of the total volume of disputed claims, as nearly every case to be adjudicated must first go through conciliation. The caseload of scheduled conciliations peaked in 1991 at 39,080 cases. For the past five years, the volume of scheduled conciliations has remained comparatively level. In FY'03, there were 18,491 cases scheduled for conciliation, which represents a 53% decrease since the Workers' Compensation Reform Act of 1991.

Figure 6 displays the number of cases scheduled for conciliation at the DIA beginning in fiscal year 1991. In fiscal year 2003, the volume of cases scheduled for conciliation increased slightly (951 cases) from last fiscal year. It is important to note that many cases scheduled for a conciliation may never actually appear before a conciliator as cases can be withdrawn or adjusted prior to scheduled meeting.

Figure 6: Volume of Cases Scheduled for Conciliation, FY'91-FY'03

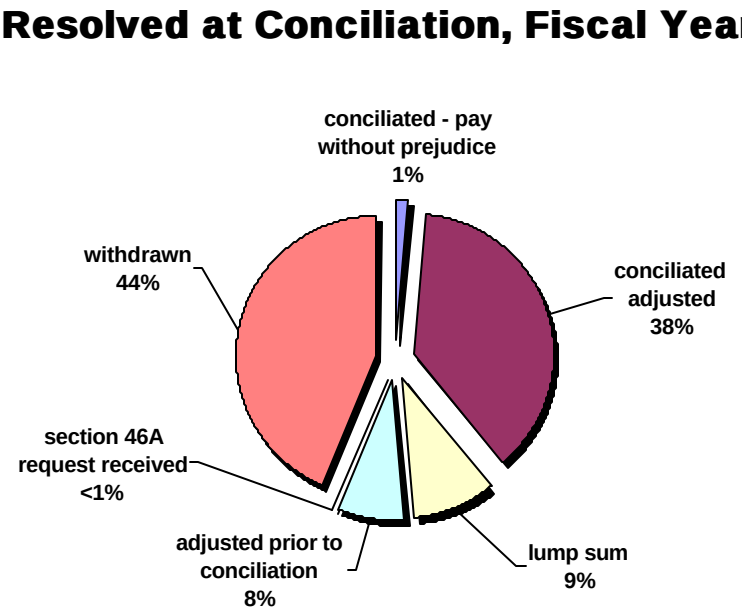


Source: CMS Report 17

Resolved at Conciliation

Disputed cases that are scheduled for a conciliation can be divided into two distinct outcomes: "referred to conference," or "resolved." In FY'03, 7,647 cases were resolved (they were not referred on to a conference) and exited the dispute resolution system. Historically, 40% of the cases that are scheduled for a conciliation are resolved while the remaining 60% of cases are referred to conference, the next stage of dispute resolution. As in previous years, a small percentage of the cases scheduled for conciliation are referred to conference without conciliation taking place. This occurs when the respondent (or party that is not putting forth the case) does not appear for the conciliation.

Figure 7: Pie-Chart Detailing Cases Resolved at Conciliation, Fiscal Year 2003



Source: CMS Report 17

Table 10: Resolved at Conciliation, Fiscal Year 2003 and Fiscal Year 2002

Resolved at Conciliation FY'03 and FY'02	Number of Cases		Percentage	
	FY'03	FY'02	FY'03	FY'02
Conciliated - Pay Without Prejudice	103	99	1.3%	1.4%
Conciliated Adjusted	2,896	2,975	37.9%	41.9%
Lump Sum	713	721	9.3%	10.1%
Adjusted Prior to Conciliation	601	612	7.8%	8.6%
Section 46A Request Received[8]	1	N/A	<1%	N/A
Withdrawn	3,333	2,699	43.6%	38.0%
TOTALS:	**7,647**	**7,106**	**100%**	**100%**

Source: CMS Report 17

As displayed in *Table 10*, cases may be conciliated by two methods. Approximately 38% of the resolved cases were "conciliated-adjusted," meaning an agreement was reached at conciliation between the parties to initiate, modify, or terminate the compensation. Secondly, cases may be "conciliated - pay without prejudice" (1% of resolved cases in both FY'03 and FY'02), meaning the pay without prejudice period has been extended and the insurer may discontinue compensation without DIA or claimant approval.

The table also indicates that the most prevalent method a case can exit the dispute resolution system at conciliation is through a withdrawal. A case can be withdrawn under various methods. Either before or during the conciliation, the moving party may choose to withdraw the case. A case can also be withdrawn by the agency if the parties either fail to show up for a conciliation or provide the required information.

A case may also be resolved at conciliation utilizing a lump sum settlement. Conciliators are empowered by law to approve lump sum sums "as complete" but cannot make a determination that the lump sum is in the claimants "best interest." At conciliation, lump sum settlements only account for 9% of the resolved cases at this level of dispute resolution. The percentage of resolved cases that result in a lump sum increase dramatically at both conference and hearing stages.

[8] In fiscal year 2003, the DIA began tracking the "Section 46A Request Received" disposition. Due to the fact that the tracking of this statistic began late in the fiscal year, it is likely that more than one of these request were received during this time period.

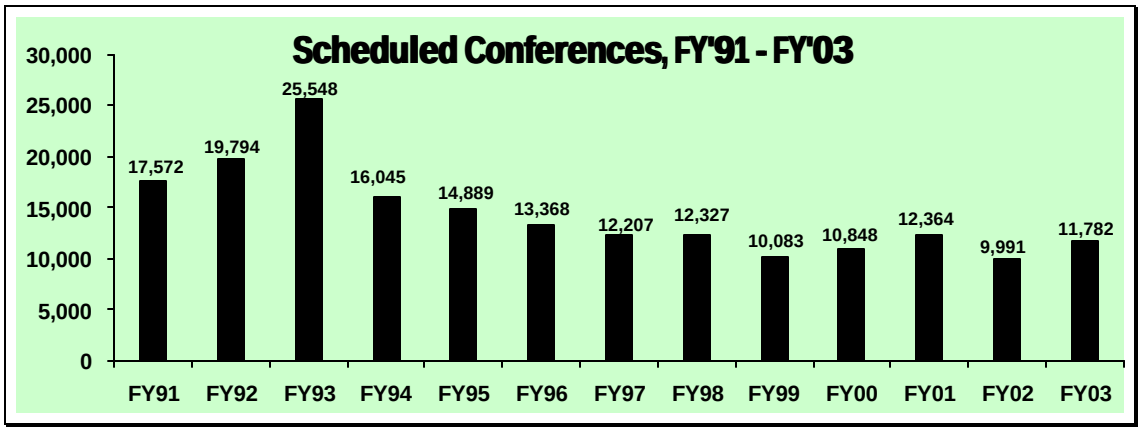
CONFERENCE

The second stage of the dispute resolution process is known as the conference. Each case referred to a conference is assigned an administrative judge (AJ) who must retain the case throughout the entire process if possible. The intent of the conference is 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. Although the conference is an informal proceeding, the administrative judge will issue a binding order shortly after the conference has concluded. This conference order is subject to appeal by the parties. The conference order is a short, written document requiring an administrative judge's initial impression of compensability, based upon 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 thus providing incentives to pursue settlements or devise return to work arrangements. About 85% of all conference orders in a given fiscal year are appealed to the hearing level of dispute resolution. In the remaining 15% of conference orders, the parties either accept the order or otherwise voluntarily adjust, withdraw or settle the matter.

Volume of Scheduled Conferences

Conferences are scheduled by the Scheduling Unit at the DIA. This occurs after a conciliation has taken place and was unsuccessful at bringing the parties together into reaching an agreement on the disputed issues. The number of conferences scheduled in FY'03 increased by 18% (9,991 in FY'02 to 11,782 in FY'03) from last fiscal year.[9] Each year, the number of conferences scheduled is greater than the number of conferences that will actually take place before an administrative judge since many cases are withdrawn or resolved before ever reaching a conference.

Figure 8: Scheduled Conferences, FY'91 - FY'03

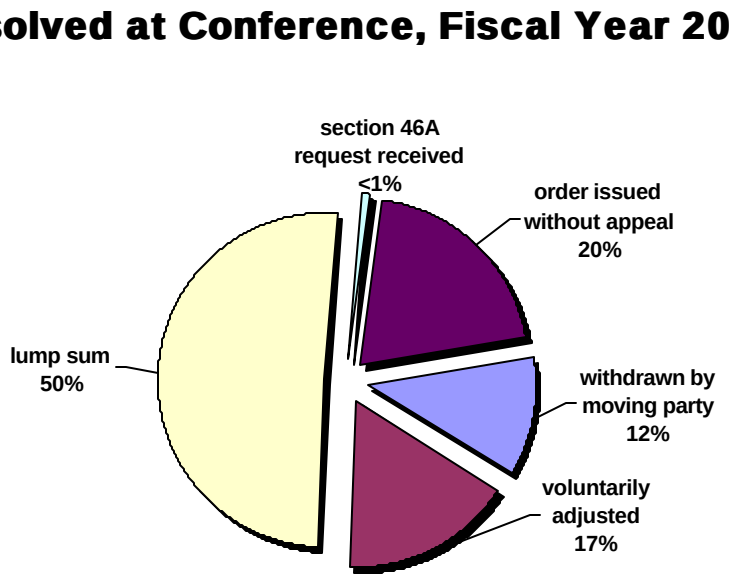


Source: CMS Report 45AB (Conference Statistics - For Scheduled Dates)

Cases Resolved at Conference

Each year, thousands of disputed cases are resolved at the conference level of the dispute resolution process and will not be forwarded to a hearing. In fiscal year 2003, 5,926 cases were resolved at the conference level and exited the dispute resolution system. Although a case may be resolved at the conference level, this does not necessarily mean that the parties appeared before an administrative judge. Often a case may be withdrawn before a scheduled conference takes place either by the moving party or by the administrative judge. Furthermore, when a case is directed to a lump sum conference or is voluntarily adjusted, it may never actually reach the scheduled conference. *Figure 9* and *Table 11* display the various methods a disputed case can be resolved at conference.

Figure 9: Pie-Chart Detailing Cases Resolved at Conference, Fiscal Year 2003



Source: CMS Reports 434, 319AB, 476A, 431

Table 11: Cases Resolved at Conference, Fiscal Year 2003 and Fiscal Year 2002

Resolved at Conference FY'03 and FY'02	Number of Cases		Percentage	
	FY'03	FY'02	FY'03	FY'02
Withdrawn by Moving Party	703	583	11.9%	11.2%
Voluntarily Adjusted	995	915	16.8%	17.6%
Lump Sum	3,005	2,732	50.7%	58.3%
Section 46A Request Received	4	N/A	<1%	N/A
Order Issued Without Appeal	1,219	961	20.6%	18.5%
Total	**5,926**	**5,191**	**100%**	**100%**

Source: CMS Reports 434, 319AB, 476A, 431

[9] In an effort to avoid duplication, the number of "scheduled conferences" does not include cases that were "rescheduled for a conference." In FY'03, 1,186 cases were "rescheduled for a conference."

As displayed in *Table 11*, there are various methods by which a disputed case can be resolved at the conference level. First, the moving party may decide to withdraw the case completely from the system. In fiscal year 2003, 703 cases (12% of resolved cases at conference) exited the system in this manner.

Second, the parties may agree to have the case voluntarily adjusted. This occurs at the conference when a compromise on any part of the case (benefit level, benefit duration, etc.) can be reached among the parties. In fiscal year 2003, 995 cases (17% of resolved cases at conference) were voluntarily adjusted.

The most prevalent method in which a case exits the system at the conference level is through a lump sum settlement. Lump sum settlements may be approved either at a conference or a separate lump sum conference. The procedure is the same for both meetings. In some instances, the presiding AJ will hear the lump sum, while in others, an assigned ALJ will hear the case on a lump sum list. Most lump sum settlements are approved directly at the conference or the hearing level by the presiding AJ, rather than scheduling a separate meeting. In fiscal year 2003, 3,005 cases (51% of resolved cases at conference) exited the system through a lump sum.

Another method in which a case could exit the system is if a "Section 46A Request" is filed when there is an outstanding lien on a case that has been deemed compensable. A "Section 46A Request" occurs in conjunction with a lump sum settlement. The case is required to appear before an administrative law judge (ALJ) to determine if reimbursement is owed out of the proceeds of the award. In fiscal year 2003, only 4 of these request have been documented.[10]

Finally, the most obvious method in which a case can exit the system at the conference level is when the presiding administrative judge issues a conference order and it is not appealed by any of the parties to the hearing level. In fiscal year 2003, 1,219 conference orders (21% of resolved cases at conference) were issued by administrative judges, not resulting in an appeal. However, the vast majority of conference orders are appealed to the hearing stage of dispute resolution. In fiscal year 2003, 7,899 conference orders (85% of all conference orders) were appealed to a hearing. [11]

Table 12: Conference Orders, FY'03 - FY'00

Conference Orders FY'03 - FY'00	Total Orders	Appealed	Without Appeal
Fiscal Year 2003	**7,899**	6,680 (84.6%)	1,219 (15.4%)
Fiscal Year 2002	**6,802**	5,841 (85.9%)	961 (14.1%)
Fiscal Year 2001	**8,486**	7,361 (86.7%)	1,125 (13.2%)
Fiscal Year 2000	**7,570**	6,516 (86.1%)	1,054 (13.9%)

Source: CMS Reports 319AB, "Appealed Conference Order Statistics."

[10] In fiscal year 2003, the DIA began tracking the "Section 46A Request Received" disposition. Due to the fact that the tracking of this statistic began late in the fiscal year, it is likely that more than four of these request were received during this time period.

[11] CMS Report 319AB, "Appealed Conference Order Statistics."

Conference Queue

The Senior Judge has explained that, depending on the number of available judges, a conference queue of between 1,500 and 2,000 cases can effectively be scheduled during the judges' regular cycles. If the queue increased beyond 2,000 cases, adjustments in scheduling and assignments would need to occur.

As Figure 11 shows below, the conference queue decreased significantly in FY'03 due to a scheduling cycle that focused on decreasing the backlog of conferences. In FY'03 the conference queue ended 1,262 cases below the start of the year (1,747 on 7/2/02 and 485 on 6/25/03). The conference queue reached a high of 2,448 on 12/18/02 and a low of 331 on 6/18/03.

Figure 10: Conference and Hearing Queues; Fiscal Years 1991 - 2003

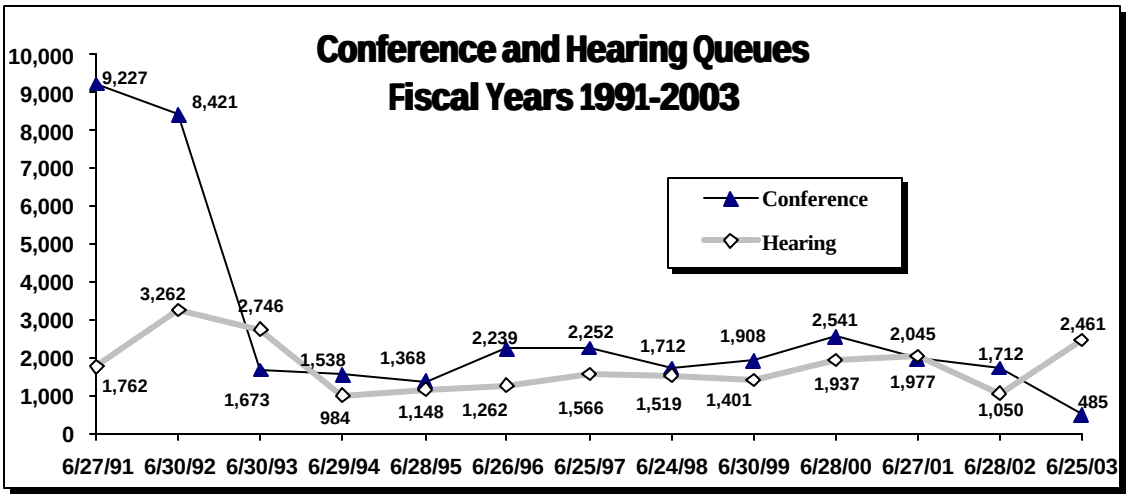
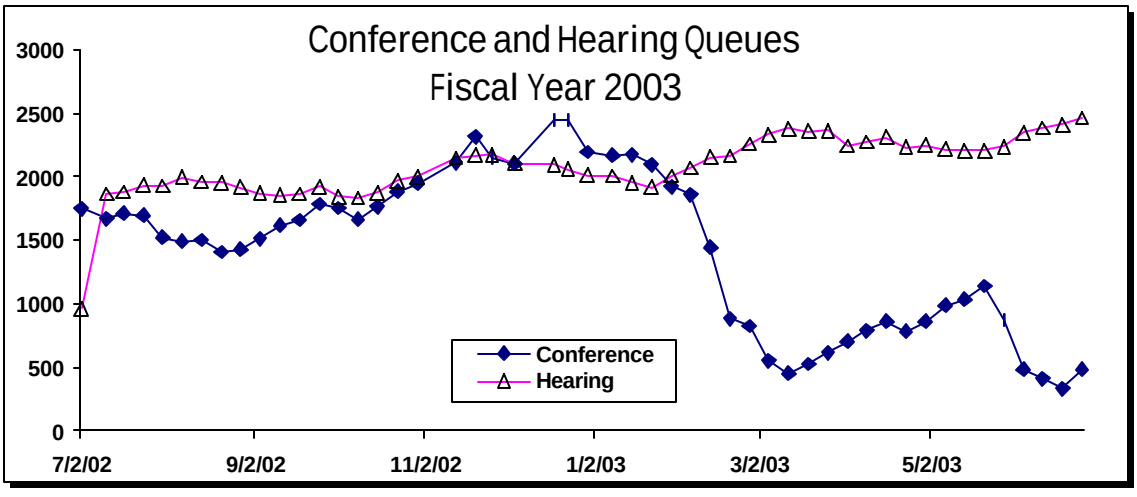


Figure 11: Conference and Hearing Queue; Fiscal Year 2003



Source: CMS Report 404

HEARINGS

The third stage of the dispute resolution process is known as the hearing. According to the Workers' Compensation Act, an administrative judge that presides over a conference must review the dispute at the hearing, unless scheduling becomes "impractical." The procedure is formal and a verbatim transcript of the proceedings is recorded. Written documents are presented and witnesses are examined and cross-examined, in accordance with the Massachusetts Rules of Evidence. If the parties are disputing medical issues, an impartial physician will be selected from a DIA roster before the hearing takes place so that an Impartial Medical Examination (IME) of the injured employee can occur. At the hearing, the impartial physician's report is the only medical evidence that can be presented 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 in the report. 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 forwarded to the Reviewing Board.

Hearing Queue

Much like conferences, hearings are scheduled by the Scheduling Unit at the DIA. This occurs after a conference has taken place and the judge's order has been appealed by any party. The scheduling of hearings is more difficult than conferences because the hearing must be assigned to the judge who heard the case at the conference level. 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 difficulty in evenly distributing cases, since hearing queues may occur for individual judges with high appeal rates.

It is difficult to compare the hearing queue with the conference queue because of the 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 2003 began with a hearing queue of 958 and ended at 2,461. In the last twelve years, the hearing queue has been as low as 409 cases in September 1989 and as high as 4,046 in November 1992.

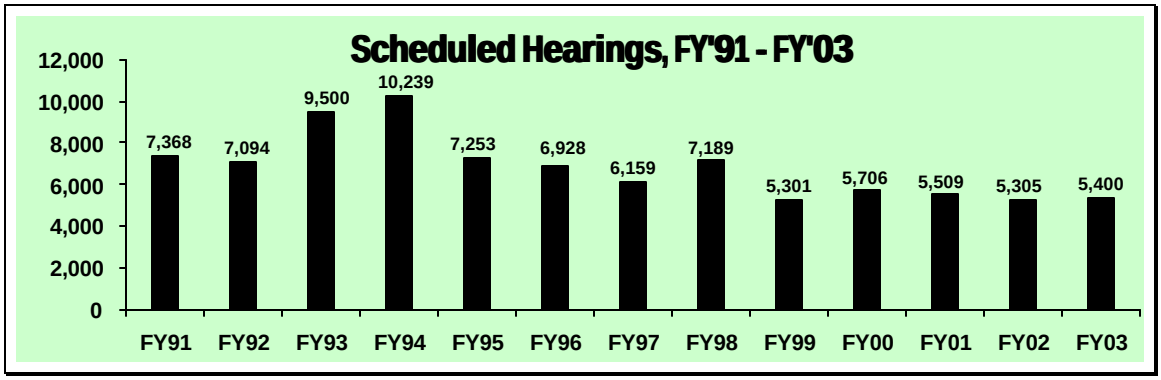
Volume of Scheduled Hearings

The number of hearings scheduled in FY'03 increased by only 95 cases (5,305 in FY'02 to 5,400 in FY'03) from last fiscal year since the schedule focused on drawing down the conference queue.[12] Each year, the number of hearings scheduled is greater than the number of hearings that will actually take place before an administrative judge since

[12] In an effort to avoid duplication, the number of "scheduled hearings" does not include cases that were "rescheduled for a hearing." In FY'03, 1,644 cases were "rescheduled for a hearing."

many cases are withdrawn or resolved before ever reaching a hearing. The following chart shows how the number of "scheduled hearings" has remained relatively stable over the past four fiscal years.

Figure 12: Scheduled Hearings, FY'91 - FY'03

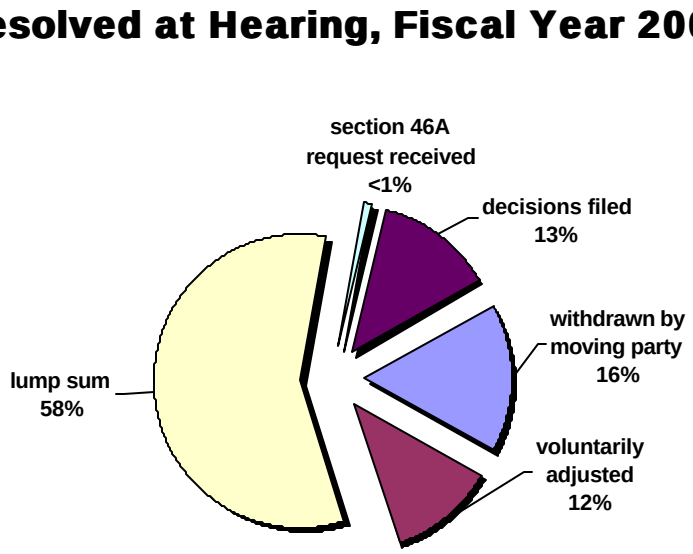


Source: CMS Report 46 (Hearing Statistics - For Scheduled Dates)

Cases Resolved at Hearing

In fiscal year 2003, 4,922 cases were resolved at the hearing level. It is important to note that a case resolved at the hearing level does not necessarily exit the system as the parties have 30 days from the date of the decision to appeal a case to the reviewing board. Much like conferences, a case resolved at the hearing level does not mean that the case made it to the actual hearing as it may be withdrawn, voluntarily adjusted or a lump sum could occur prior to the proceeding. The following pie-chart and statistical table shows the various methods by which a disputed case can be resolved at hearing.

Figure 13: Pie-Chart Detailing Cases Resolved at Hearing, Fiscal Year 2003



Source: CMS Report 431

Table 13: Cases Resolved at Hearing, Fiscal Year 2003 and Fiscal Year 2002

Resolved at Hearing FY'03 and FY'02	Number of Cases		Percentage	
	FY'03	FY'02	FY'03	FY'02
Withdrawn by Moving Party	811	769	16.5%	15.7%
Voluntarily Adjusted	587	566	11.9%	11.6%
Lump Sum	2,868	2,855	58.3%	58.4%
Section 46A Request Received	13	N/A	<1%	N/A
Decisions Filed	643	698	13.1%	14.3%
Total	**4,922**	**4,888**	**100%**	**100%**

Source: CMS Report 431

As displayed in *Table 13*, there are various methods by which a disputed case can be resolved at the hearing level. First, the moving party may decide to withdraw the case completely from the system. In fiscal year 2003, 811 cases (16% of resolved cases at hearing) exited the system in this manner.

Second, the parties may agree to have the case voluntarily adjusted. This occurs at the hearing when a compromise on any part of the case (benefit level, benefit duration, etc.) can be reached among the parties. In fiscal year 2003, 587 cases (12% of resolved cases at hearing) were voluntarily adjusted.

Much like at the conference level, the most prevalent method by which a case exits the system at the hearing is through a lump sum settlement. Lump sum settlements may be approved either at a hearing or at a separate lump sum conference. The procedure is the same for both meetings. Most lump sum settlements are approved directly at the conference or the hearing level by the presiding AJ, rather than scheduling a separate meeting. In fiscal year 2003, 2,868 cases (58% of resolved cases at hearing) exited the system through a lump sum.

Another method in which a case could exit the system is if a "Section 46A Request" is filed when there is an outstanding lien on a case that has been deemed compensable. A "Section 46A Request" occurs in conjunction with a lump sum settlement. The case is required to appear before an administrative law judge (ALJ) to determine if reimbursement is owed out of the proceeds of the award. In fiscal year 2003, only 13 of these request have been documented at the hearing level.[13]

Finally, the most obvious method by which a case can exit the system at the hearing level is when the presiding administrative judge issues a hearing decision. In fiscal year 2003, 643 hearing decisions (13% of resolved cases at hearing) were filed by administrative judges.

[13] In fiscal year 2003, the DIA began tracking the "Section 46A Request Received" disposition. Due to the fact that the tracking of this statistic began late in the fiscal year, it is likely that more than 13 of these request were received during this time period.

REVIEWING BOARD

The fourth and final possible stage of dispute resolution at the DIA is known as the reviewing board. The reviewing board consists of six administrative law judges (ALJ's) whose primary function is to review the appeals from 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).

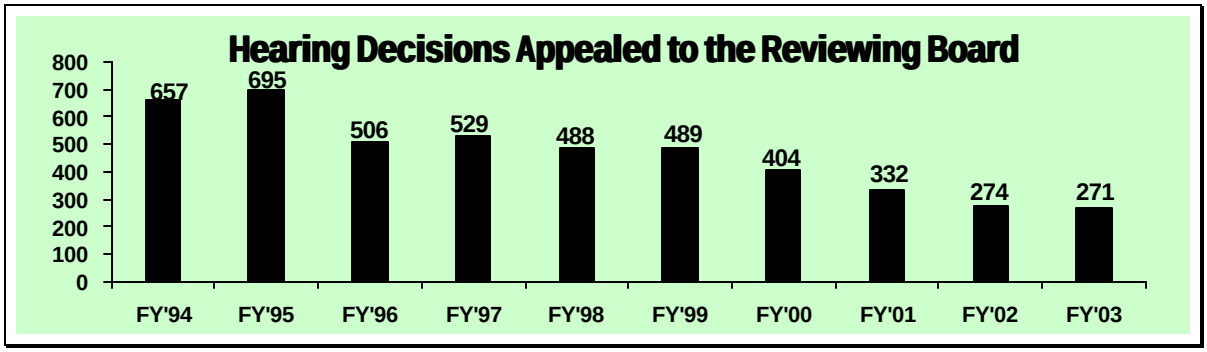
Volume of Hearing Decisions Appealed to the Reviewing Board

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, based on indigence, 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 following this first meeting. After the pre-transcript conference, the parties are entitled to a verbatim transcript of the appealed hearing.

Ultimately, cases that are not withdrawn or settled 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. However, the panel may reverse the administrative judge's decision, only when it determines that the decision was beyond the AJ's scope of authority, arbitrary or capricious, or contrary to law. The panel is not a fact-finding body, although it may recommit a case to an AJ for further findings of fact. The number of hearing decisions appealed to the Reviewing Board in fiscal year 2003 was 271.

Figure 14: Hearing Decisions Appealed to the Reviewing Board, FY'94 - FY'03



Source: CMS Report 46 (Hearing Statistics - For Scheduled Dates)

The Reviewing Board resolved 311 cases in FY'03 (some from the prior year) compared to 334 in the previous fiscal year.

Figure 15: Appeals Resolved at the Reviewing Board, Fiscal Year 2003

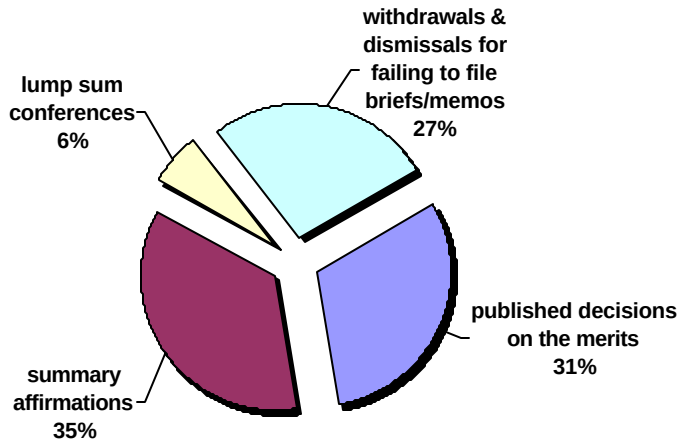


Table 14: Appeals Resolved at the Reviewing Board, Fiscal Year 2003

Appeals Resolved at the Reviewing Board, FY'03	*Number of Cases*
Published Decision on the Merits (Full Panel):	96 (30.9%)
Summary Affirmations (After Full Panel Deliberation):	110 (35.4%)
Lump Sum Conferences:	20 (6.4%)
Withdrawals/Dismissals for Failing to File Briefs/Memos:	85 (27.3%)
Total Number of Appeals Resolved by the Reviewing Board:	**311 (100%)**

Source: DIA Reviewing Board

Lump Sum Conferences

The purpose of the lump sum 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.

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 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 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'03, administrative law judges heard 1,042 section 15 petitions on a rotating basis.

Compromise and Discharge of Liens (§46A)

Administrative law judges are also responsible to determine the fair and reasonable amount to be paid out of lump sum settlements to discharge liens under M.G.L. c.152, §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 Transitional Assistance 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 Transitional Assistance 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 lien-holder 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 fiscal year 2003 was 59.

ADMINISTRATIVE JUDGES

DIA administrative judges (AJs) and administrative law judges (ALJs) are appointed by the Governor, with the advice and consent of the Governor's Council. Candidates for the positions are first screened by the Industrial Accidents Nominating Panel [see Appendix D for members] and then rated by the Advisory Council. M.G.L. c.23E allows for the appointment of 21 administrative judges, 6 administrative law judges, and as many former judges to be recalled as the Governor deems necessary.

As one management tool to maintain a productive staff, the Senior Judge may stop assigning new cases to any judge with an inordinate number of hearing decisions unwritten. Intended as a sanction, it provides a judge who has fallen behind with the opportunity to catch up. This could become problematic if a large queue of new cases were to develop. The administrative practice of taking a judge off-line is relatively rare and occurs for limited amounts of time.

The Senior Judge may 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.

Appointment Process

Nominating Panel - The nominating panel is comprised of thirteen members which include: the Governor's Chief Legal Counsel, the Director of Labor and Workforce Development, the Director of Economic Development, the DIA Commissioner, the DIA Senior Judge, and eight members appointed by the Governor (two from business, two from labor, a health care provider, a lawyer who represents claimants in workers' compensation matters, a lawyer who represents employers or insurers in workers' compensation matters, and a lawyer who does not practice workers' compensation law).

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 the understanding of anatomy and physiology. In addition, an AJ must have a minimum of a college degree or four years of writing experience and an ALJ must be a Massachusetts attorney (or formerly served as an AJ). Consideration for reappointment includes review of a judge's written decisions, as well as the Senior Judge's evaluation of the applicant'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. Candidates then meet with Council members for a formal interview. On the affirmative vote of at least seven voting members, the Advisory Council may rate any candidate either "qualified," "highly qualified," or "unqualified." This rating is then forwarded to the Governor for review. In instances when the Advisory Council was unable to reach a consensus on a candidate's qualification, a letter has been forwarded to the Governor stating that "no position" has been taken.

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 will decide if it is in the best interest of the employee to settle.

Table 15: Lump Sum Conference Statistics, FY'03-FY'91

Fiscal Year	*Total lump sum conferences scheduled*	*Lump sum settlements approved*
FY'03	**7,887**	**7,738 (95.7%)**
FY'02	8,135	7,738 (95.1%)
FY'01	8,111	7,801 (96.2%)
FY'00	8,297	7,940 (95.7%)
FY'99	7,900	7,563 (95.7%)
FY'98	9,579	9,158 (95.6%)
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: CMS Report 86: Lump Sum Conference Statistics for Scheduled Dates

The number of lump sum conferences scheduled has declined by 60% since FY'91. In FY'03, only 10 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 an assigned ALJ. Conciliators and administrative judges may refer cases to lump sum conferences to determine if settlement is in the best interest of the employee. 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 the agreement "as complete." Most attorneys want their client's settlement reviewed and determined by a judge to be in their "best interest."

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 16: Lump Sum Settlements Pursued at Each Level of Dispute Resolution

Fiscal Year 2003	*Lump Sum Pursued*[14]	*% Total Cases Resolved (at each level of dispute)*
Conciliation	713	9.3%
Conference	3,005	50.7%
Hearing	2,868	58.3%

Source: See Previous Sections on Conciliations, Conferences, and Hearings.

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

IMPARTIAL MEDICAL EXAMINATIONS

The impartial medical examination has become a significant component of the dispute resolution process, since it was created by the Reform Act of 1991. 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.[15] 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.[16]

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. Each party must receive the impartial report at least 7 days prior to the start of a hearing.

Impartial Unit

The Impartial Unit, within the DIA's 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.

[15] M.G.L. c.152, §8(4).
[16] M.G.L. c.152, §45.

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

The following details the DIA's fee schedule:

Table 17: Fee Schedule - Impartial Medical Examinations

$450	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
$125	Supplemental medical report
$100	When worker fails to keep appointment (maximum of 2)
$100	For cancellation less than 24 hours before exam

Source: DIA Medical Unit
Note: Fee Schedule is subject to increase.

The deposing party is responsible for paying the impartial examiner for services and the report. Should the employee prevail at hearing, the insurer must pay the employee the cost of the deposition. In FY'03, approximately $1,977,200 was collected in filing fees.

As of 6/30/03, there were 215 physicians on the roster consisting of 27 specialties. [17] 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'03 the impartial unit scheduled 7,151 examinations. Of these, 4,521 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). [18] 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'02 was 7,267 and 4,437 were conducted in that year.

Impartial Exam Fee Waiver for Indigent Claimants

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 DIA has implemented procedures and standards for processing waiver requests and providing financial relief for the section 11A fee.

[17] Including contracts pending renewal.
[18] Additional reports may be entered upon FY'03 closure.

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.

An indigent party is defined as:

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.

Table 18: Indigency Requirements, 2003

Size of Family Unit	Amount*
1	$8,980
2	$12,120
3	$15,260
4	$18,400
5	$21,540
6	$24,680
7	$27,820
8	$30,960

For family units with more than eight members, add $3,140 for each additional member in the family. The poverty guidelines are updated annually by the U.S. Department of Health and Human Services.

SOURCE: *Federal Register*, Vol. 68, No. 26, February 7, 2003, pp. 6456-6458.
*48 Contiguous States and D.C.

SECTION
- 4 -
DIA ADMINISTRATION

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, as well as for ensuring that claims forms are processed in a timely and accurate manner. Quality control is a priority of the office and it is essential to ensure that each case is recorded in a systematic and uniform method.

The OCA consists of the processing unit, the data entry unit, the record room and the first report compliance office. The Manager of Claims Administration is responsible for the oversight of responses to all subpoena requests, certified mail and file copy requests, as well as 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, including all electronic filings that come into the OCA.[19] The OCA then reviews each form, ensuring they are complete and accurate. Any incomplete or inaccurate forms are returned to the sender. All other forms are forwarded to the data entry unit.

The data entry operators enter all forms and transactions into the DIA's Oracle 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, as well as to ensure 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 Oracle case tracking system.

In fiscal year 2003, the Office of Claims Administration received 36,641 First Report of Injury Forms, 170 less than FY'02 (36,471). The number of claims, discontinuances and third party claims received by the office decreased by 900 to 20,420. The total number of referrals to conciliation for the fiscal year was 17,826, which was slightly less than last year's referrals (18,020).

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 of Injury Form in the allotted time. Fines are $100, and are doubled if referred to a collection agency.

[19] Online filing submissions of the First Report of Injury (Form 101) became effective at the DIA in April of 2003.

In fiscal year 2003, $173,152 was collected in fines, a substantial decrease from the $340,200 collected in FY'02.[20]

The office is also responsible for maintaining a database on cases discovered by the DIA, where there may be suspicion of fraud. In fiscal year 2003, the Office of Claims Administration received twelve in-house referrals (telephone calls, anonymous letters or within DIA units via CMS). Outside referrals are directly reported to the Insurance Fraud Bureau or the Attorney General's Office. Claims Administration assists the Insurance Fraud Bureau investigators on copies of suspected workers' compensation files, and receives status update letters. A total of 45 such inquiries were processed during FY'03.

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 and Boston offices 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, located in Dorchester, where they are stored for 80 years.

[20] A CMS Program glitch from May 2002 to October 2002 prevented monthly First Report fines to be generated. This problem was corrected in November of 2002 and 700 bills were generated from the backlog.

OFFICE OF EDUCATION AND VOC. REHAB

The Office of Education and Vocational Rehabilitation (OEVR) oversees the rehabilitation of disabled workers' compensation recipients with the ultimate goal of successfully returning them to employment.

While OEVR seeks to encourage the voluntary development of rehabilitation services, it has the authority to mandate services for injured workers determined to be suitable for rehabilitation. Vocational rehabilitation (VR) is defined by the act as "non-medical services reasonably necessary at a reasonable cost to restore a disabled employee to suitable employment as near as possible to pre-injury earnings. Such services may include vocational evaluation, counseling, education, workplace modification, and retraining, including on-the-job training for alternative employment with the same employer, and job placement assistance."[21]

A claimant is eligible for vocational rehabilitation services when injury results in a functional limitation prohibiting a return to previous employment, or when the limitation is permanent or will last an indefinite period of time. Liability must be established in every case and the claimant must be receiving benefits.

Vocational Rehabilitation Specialist

Each year, OEVR approves vocational rehabilitation specialists to develop and implement the individual written rehabilitation plans (IWRP). The standards and qualifications for a certified provider are found in the regulations, 452 C.M.R. 4.03. Any state vocational rehabilitation agency, employment agency, insurer, self-insurer, or private vocational rehabilitation agency may qualify to perform these services.

Credentials must include at least a master's degree, rehabilitation certification, or a minimum of 10 years of experience. A list of the providers is available from the OEVR. In FY'03, OEVR approved 60 VR providers. It is the responsibility of the provider to submit progress reports on a regular basis, so that the RRO can have a clear understanding on the progress a case. Progress reports must include the following:

1. Status of vocational activity;
2. Status of IWRP development (including explanation if IWRP has not been completed within 90 days);
3. If client is retraining, copy of grades received from each marking period and other supportive data (such as attendance);
4. Summary of all vocational testing used to help develop an employment goal and a vocational goal; and
5. The name of the OEVR Rehabilitation Review Officer.

[21] M.G.L. c.152, §1(12).

Determination of Suitability

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, and through referrals from 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.[22]

Once prospective candidates have been identified, an initial mandatory meeting between the injured worker and the Rehabilitation Review Officer is scheduled for the purpose of determining whether or not an injured worker is suitable for VR services. During this meeting, the RRO obtains basic case information from the client, explains the VR process (including suitability, employment objectives in order of priority, client rights, and OEVR's role in the process) and answers any questions the client may have. The failure of an employee to attend the mandatory meeting can result in the discontinuance of benefits until the employee complies.

Once a "mandatory meeting" has concluded, it is the duty of the RRO to issue a decision on the appropriateness of the client for vocational rehabilitation services. This is done through a Determination of Suitability (DOS) Form. Suitability is determined by a number of factors including: medical stability, substantial functional limitations, feasibility and cost-effectiveness of services, and liability must be established. If a client is deemed "suitable," the RRO will write to the insurer and request VR services for the injured worker. The insurer must then choose any OEVR-approved provider so that an Individual Written Rehabilitation Program (IWRP) can be developed. The insurer must also submit to OEVR any pertinent medical records within 10 days. If a client is deemed "unsuitable," the insurer can refer the client again after six months has elapsed.

At any point during the OEVR process after an injured worker has been found suitable for VR services, a RRO can schedule a "team meeting" to resolve issues of disagreement among any of the represented parties. All parties are invited and encouraged to attend team meetings. At the conclusion of the meeting, if parties are still in disagreement, the RRO can refer the matter back to the parties with recommendations and an action plan. All team meetings are summarized in writing.

Individual Written Rehabilitation Program (IWRP)

After an employment goal and vocational goal has been established for the injured worker, an Individual Written Rehabilitation Program (IWRP) can be written. The IWRP is written by the vocational provider and includes the client's vocational goal, the services the client will receive to obtain that goal, an explanation why the specific goal and services were selected, and the signatures necessary to implement it. A vocational rehabilitation program funded voluntarily by the insurer has no limit of length, however OEVR-funded programs are limited to 52 calendar weeks for pre-12/23/91 injuries and

[22] M.G.L. c.152, §30 E-H. 452 C.M.R. 4.00

104 calendar weeks for post-12/23/91 injuries. The IWRP should follow OEVR's priority of employment goals:

1. Return to work with same employer, same job modified;
2. Return to work with same employer, different job;
3. Return to work with different employer, similar job;
4. Return to work with different employer, different job; and
5. Retraining.

In order for an IWRP to be successful, it needs to be developed jointly with the client and the employer. An IWRP with the specific employment goal of permanent, modified work must include:

1. a complete job description of the modified position (including the physical requirements of the position);
2. a letter from the employer that the job is being offered on a permanently modified basis; and
3. a statement that the client's treating physician has had the opportunity to review and comment on the job description for the proposed modified job.

Before any vocational rehabilitation activity begins, the IWRP must be approved by OEVR. Vocational Rehabilitation is successful when the injured worker completes a VR program and is employed for 60 days. A "Closure Form" must then be signed by the provider and sent to the appropriate RRO. Closures should meet the following criteria:

1. all parties should understand the reasons for case closure;
2. the client is told of the possible impact on future VR rights;
3. the case is discussed with the RRO;
4. a complete closure form is submitted by the provider to OEVR; and
5. the form should contain new job title, DOT code, employer name and address, client wage, and the other required information.

Lump Sum Settlements

An employee obtaining vocational rehabilitation services 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. Nevertheless, OEVR will consent to a lump sum settlement if the insurer agrees to continue to provide rehabilitation benefits.

Utilization of Vocational Rehabilitation

In fiscal year 2003, OEVR was headed by a Director and staffed by 11 Rehabilitation Review Officers, 3 Disability Analysts, and 4 Clerks. Out of the 2,494 cases referred to OEVR in FY'03, 92% proceeded to a "mandatory meeting" for a determination of suitability for vocational rehabilitation services. The remaining 8% exited the system for reasons that include the non-establishment of liability or that the employee was not on compensation. Of those cases which received a "mandatory meeting," 39% were referred to the insurer/self-insurer with a request to initiate vocational rehabilitation services by an OEVR certified provider. In FY'03, there was a 37% success ratio of injured workers who completed plans and returned to work.

Table 19: Utilization of Voc. Rehab. Services, FY'92 - FY'03

Fiscal Year	*Referrals to OEVR*	*Mandatory/ Inform. Meetings*	*Referrals to Insurer for VR*	*IWRPs approved*	*Return to work*	*% RTW after plan development*
FY'03	**2,494**	**2,287/43**	**886**	**507**	**187**	**37%**
FY'02	2,743	2,348/23	842	501	214	43%
FY'01	2,895	2,421/132	915	483	253	52%
FY'00	2,782	2,245/227	911	514	318	62.5%
FY'99	2,939	2,236/227	951	546	341	62.5%
FY'98	3,011	2,422/236	1,040	603	371	61.5%

Source: DIA - OEVR

Trust Fund Payment of Vocational Rehabilitation

If an insurer refuses to pay for vocational rehabilitation services while OEVR determines that the employee is suitable for services, the office may utilize moneys from the Trust Fund to finance the rehabilitation services. Fiscal year 2003encumbrances of the Trust Fund totaled $25,052.50 for vocational rehabilitation services. 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.

OFFICE OF SAFETY

The function of the Office of Safety is to promote programs that reduce work related injury and illnesses in Massachusetts. The statute requires the Office of Safety to establish and supervise 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."[23] In pursuit of this objective, the office administers the *Occupational Safety and Health Education and Training Program*.

Safety Grant Program

The DIA's Office of Safety awards grants for programs which provide workplace safety training for employees and/or employers of industries operating within the Commonwealth and whose entire staff is covered under the Massachusetts Workers' Compensation Law (M.G.L. c.152).

The overall objective of the education and training programs is to reduce work related injuries and illnesses. The Office of Safety supervises the programs that are established which consist of:

A. Identifying, evaluating, and controlling safety and health hazards in the workplace;

B. Fostering activities by employees/employers to prevent workplace accidents and injuries;

C. Making employees/employers aware of all federal and state health and safety standards, statutes, rules and regulations that apply, including those that mandate training and education in the workplace;

D. Referring employees/employers to the appropriate agency for abatement procedures for safety and health related issues;

E. Targeting preventive educational programs for specifically identified audiences with significant occupational health and/or safety problems;

F. Encouraging awareness and compliance with federal and/or state occupational safety and health standards and regulations;

G. Promoting understanding among employee and employer groups of the importance of ongoing safety health education and training programs and help to begin such efforts;

H. Encouraging labor/management cooperation in the area of occupational safety and health; and

I. Encouraging collaborations between various groups, organizations, educational or health institutions to devise innovative, preventive methods for addressing occupational health and safety issues.

[23] M.G.L. c.23E, §3(6).

During the past fifteen fiscal years, the Massachusetts Division of Industrial Accidents (DIA) has issued its RFR for the Office of Safety's "Occupational Safety and Health Education and Training Program." To date, the Division has funded a total of 523 preventive training programs targeting a wide variety of workers and industries within the Commonwealth. To date, the safety programs have trained over 200,000 people.

The Office of Safety publishes an RFR annually to notify the general public that grants are available. The program has an annual budget of $800,000. In FY'03, proposals could be submitted up to a maximum of $30,000. In FY'03, 972 announcement letters were mailed to various industries throughout the state. As a result of these announcement letters and the advertisements published in the regional newspapers, the Office of Safety issues over 368 RFR's annually. Of the 368 RFR's issued, the DIA received 62 requests for funding (proposals). Of these, approximately 51% received funding.

A uniform criteria to competitively evaluate all proposals received is developed by a Proposal Selection Committee, appointed by the Commissioner. The Committee recommends a list of qualified applicants for funding. Upon approval of this list by the Commissioner, contracts are awarded. In FY'03, the Office of Safety was able to fund a total of 34 grants in FY'03 that resulted in the training of 29,079 employees throughout the Commonwealth (see Appendix K for a list of proposals recommended for funding in FY'04). Over 98% of the participants rated the program they attended as "excellent" or "good."

Frank S. Janas Training Center

In October of 2000, the DIA dedicated a new safety training center in memory of the late Frank Janas at the Lawrence Regional Office. Mr. Janas was a beloved DIA employee who worked in the Office of Insurance for seven years. The training center is a valuable tool for both private employers and government agencies that would like to conduct safety-related training or seminars. The conference training center holds 90 auditorium style seats, has valuable conference amenities (wide-screen TV/VCR, Apollo projector, podium, computer hookups, etc.), and is handicap accessible.

Frank Janas Training Center Contact:
Thomas Carroll
Division of Industrial Accidents
160 Winthrop Avenue
Lawrence, MA 01840
617-727-4900 x279
email: tomc@dia.state.ma.us

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.[24] To be self insured, employers must have enough capital to cover the expenses associated with self insurance. However, many smaller and medium-sized companies have also been approved to self insure. The Office of Insurance evaluates employers every year to determine their eligibility for self insurance 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.[25] 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 reinsurance varies from $100,000, 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'03, two (2) new licenses were issued to bring the total number of "parent-licensed" companies to 143, covering a total of 445 subsidiaries. Each self insurance license provides approval for a parent company and its subsidiaries to self insure. This amounts to approximately $224.9 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 (MTA), the Massachusetts Port Authority, and the Massachusetts Water Resource Authority (MWRA).[26]

[24] 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.

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

[26] 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, however, the state does not pay insurance premiums or post a bond for its liabilities (M.G.L. c.152, §25B).

Insurance Unit

The Insurance Unit maintains a record of the workers' compensation insurer for every employer in the state. This record, known as the insurer register, dates back to the 1920's and facilitates the filing and investigation of claims after many years.

In the past, the insurance register had a record keeping system, which 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 mailed in a form and the notecard was changed manually.

Through legislative action, the Workers' Compensation Rating and Inspection Bureau (WCRIBM) 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'03, an estimated 5,779 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.

OFFICE OF INVESTIGATIONS

In Massachusetts, employers with one or more employees are required to have a valid workers' compensation policy at all times. Employers can meet this statutory requirement by purchasing a commercial insurance policy, gaining membership in a self insurance group, or licensing as a self insurer (M.G.L. c.152, §25A). The Office of Investigations is charged with enforcing this mandate by investigating whether employers are maintaining insurance policies and by imposing penalties when violations are uncovered. When an employer fails to carry a workers' compensation policy and an injury occurs at their workplace, the claim is paid from the DIA's Workers' Compensation Trust Fund (funded entirely by the employers who purchase workers' compensation policies). In fiscal year 2003, the Office of Investigations had ten investigators on staff.

Referrals to the Office of Investigations

The Office of Investigations has access to the Workers' Compensation Rating and Inspection Bureau (WCRIBM) database on all policies written by commercial carriers in the state. From this database, it can be determined which employers have either canceled or failed to renew their insurance policies. Employers on this database are investigated for insurance coverage or alternative forms of financing (self-insurance, self-insurance group, reciprocal exchange).

The Office of Investigations also works with other state agencies for referrals. Both the Division of Employment & Training and the Secretary of State's Office have been utilized in the past. During the fiscal year, the DIA had discussions with the Department of Revenue, the Office of Consumer Affairs and Business Regulation, the Division of Professional Licensure, the Division of Occupational Safety, and the Registry of Motor Vehicles, in an effort to expand upon the available databases and to develop better enforcement tools.

Another type of referral the Office of Investigations utilizes is through anonymous calls and letters received from the general public. These tips have historically played a crucial role in identifying which companies may be without insurance.

Referrals can also come to the Office of Investigations internally within the DIA. Whenever a Section 65 claim (an injury occurs at an uninsured business) is entered into the system, the Office of Investigations will be notified by the Office of Insurance that a particular company is without insurance.

Stop Work Orders

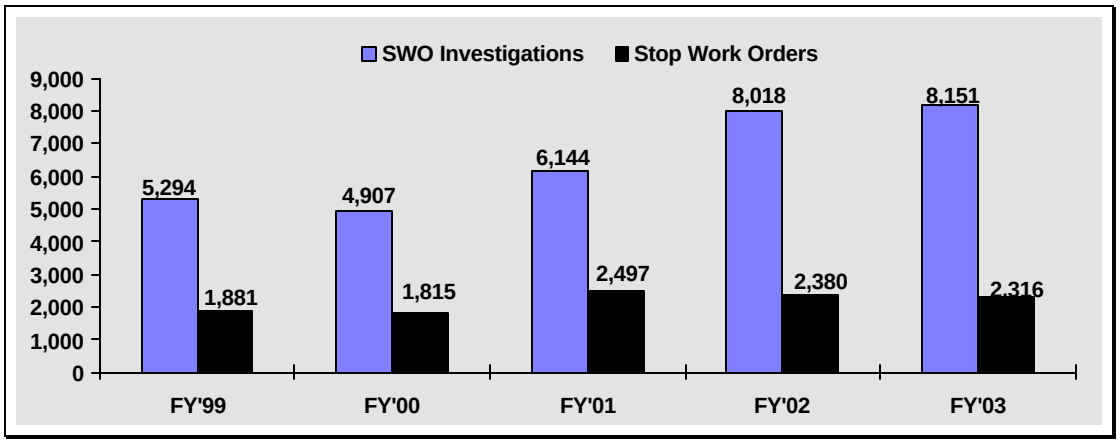
Once a referral has been thoroughly investigated "in-house" (using various investigative tools such as established databases, internet, etc.) and the investigator has information that a business exists, a compliance letter is mailed to the suspected employer requesting they provide proof of workers' compensation insurance. If the business fails to respond to this letter or is unable to display proof of coverage, the investigator assigned to that case will make a visit to the worksite. During this visit, a business that is unable to

provide proof of coverage upon demand will be issued a "stop work order." Such an order requires that all business operations cease and becomes effective immediately upon service. However, if an employer chooses to appeal the stop work order, they have the right to remain open until the case is resolved.

Fines resulting from a stop work order begin at $100.00 per day, starting the day the stop work order is issued, and continuing until proof of coverage and payment of the fine is received by the DIA. 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. This fine begins accruing from the original issuance of the stop work order, continuing until insurance is obtained (M.G.L. c.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 a criminal court proceeding with a possible 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) that violate any aspect of Section 25C.

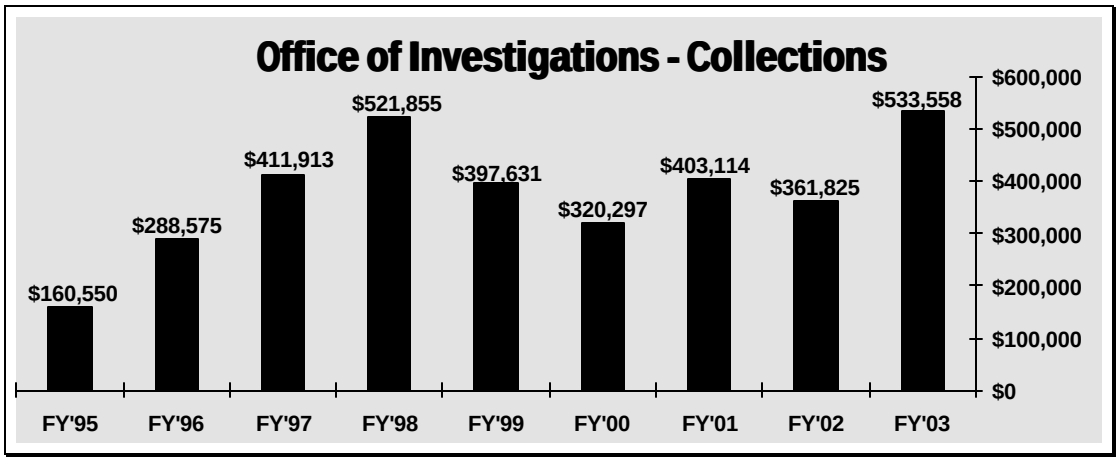
Figure 16: MA SWO's & Investigations



Source: Office of Investigations

In fiscal year 2003, 2,316 stop work orders were issued as a result of 8,151 investigations conducted. Of the 2,316 stop work orders issued, 2,302 (99%) were issued to "small" companies (1-10 employees), 14 were issued to "medium" companies (11-75 employees) and none were issued to "large" companies (76+ employees).

Figure 17: Office of Investigations - Collections



Source: Office of Investigations

In fiscal year 2003, the Office of Investigations collected $533,558 in fines from employers who violated the workers' compensation insurance mandate.

Stop Work Order Pilot Program

In fiscal year 2003, the Office of Investigations implemented a pilot program to enhance the stop work order investigation process. The pilot program was developed in an effort to make investigations more targeted, focused, and research driven. The DIA believes that by placing more attention on the quality of investigations, it will increase the likelihood of collecting fines from violating employers.

Under the new system, referrals received by the Office of Investigations will be assigned to an individual investigator who will first conduct "in-house" research utilizing all available databases. By conducting this research before traveling to particular worksites, investigators will be able to close cases where an insurance policy has been discovered or when there is substantial evidence that a company has ceased operations.

Another aspect of the pilot program was to allow companies more flexibility among payment options for fines. The Office of Investigations has recently installed hardware that allows companies to pay stop work order fines using credit card payment. The initial feedback from this payment option has been overwhelmingly positive, as many companies have utilized this feature.

The DIA has explained on numerous occasions that there will be an initial drop in both the number of stop work orders issued and the amount of collections received under the new system. Due to the program's infancy, it may be too early to determine whether changes made to the investigation process will ultimately encourage more employers to purchase workers' compensation insurance. However, perhaps the greatest indicator of success will come from analyzing the volume of claims on the Workers' Compensation Trust Fund in future years to come.

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 their Division of Dispute Resolution.

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, stating 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.[27] In FY'03, $4,108,222 was paid to uninsured claimants, 222 claims were filed, and 345 claims for benefits were paid.

Second Injury Fund 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," insurers become eligible to receive reimbursement from the DIA's trust fund for up to 75% of compensation paid after the first 104 weeks of payment. [28] Employers are entitled to an adjustment to their experience modification factors as a result of these reimbursements.

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

[27] 452 C.M.R. 3.00

[28] An employee is considered to suffer a second injury when an on the job accident or illness occurs that 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" due to the combined effects of the preexisting impairment and the subsequent injury than the disability as a result of the subsequent injury by itself.

mental condition, resulting from the service of that fellow employee in the armed forces. (A negligible number of these claims have been filed.)

At the close of fiscal year 2003, 255 §37 claims were paid and 255 were settled. The total amount paid in settlements in FY'03 was $16,781,186.

Vocational Rehabilitation (Section 30H)

Section 30H provides that if an insurer and an employee fail to agree on a vocational rehabilitation program, 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'03, $24,892 was paid for rehabilitation services and the DIA collected $3,630 from insurers. During FY'03, 6 claims for benefits were filed and 11 claims for benefits were paid out.

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 (for section's 31, 34, 35A or 35), benefits' paid will be based upon levels in effect on the date of eligibility. This same date of eligibility rather than the date of injury is also used to compute supplemental benefits known as COLA (Cost of Living Adjustments) for employees subject to this section. In FY'03, approximately $1,189,898 was paid as latency claims and there were 100 claims 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'03 totaled $2,106,371 for the Public Trust Fund and $17,809,263 for the Private Fund.

OFFICE OF HEALTH POLICY

The Office of Health Policy (OHP), within the Division of Industrial Accidents, was created in July of 1993 by the Commissioner pursuant to the promulgation of M.G.L. c.152, §5, §13, and §30. The statute authorizes the Department of Health Policy to approve and monitor workers' compensation utilization review (UR) programs in the Commonwealth to ensure compliance with the requirements of 452 CMR 6.00 et seq.

During fiscal year 2003, the Office of Health Policy was staffed by five employees: an Executive Director (Registered Nurse), a UR Coordinator (Registered Nurse), a Clinical Coordinator (Registered Nurse), an EDP Programmer, and a Program Coordinator.

Utilization Review

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. This review of medical care is conducted before, during, or following treatment to an injured worker. The utilization review and quality assessment regulations mandate that all insurers conduct UR on all health care services provided to injured workers that have been delivered on or after October 1, 1993, regardless of the date the employee is injured. UR agents must use the treatment guidelines endorsed by the Health Care Services Board and adopted by the DIA for the specific conditions to which these guidelines apply. All medical care relating to workplace injuries must be reviewed under established guidelines and review criteria.

In Massachusetts, UR agents are required to use licensed health care professionals to conduct utilization review. Care and treatment can be approved by a licensed or registered nurse using established guidelines and review criteria. Care that cannot be approved must be reviewed by a licensed health care practitioner in the same school as the provider prescribing the care or treatment for the injured employee. All decisions regarding care and treatment (and the basis for the decision) must be disclosed in writing to the injured employee and the ordering practitioner within specific timeframes. Any decision, by any licensed reviewer cannot be arbitrary and will be based on established guidelines. For care that cannot be approved, the UR agent must inform the injured employee and the ordering practitioner of their rights and procedure to appeal the decision to the UR agent. After the exhaustion of this process, the injured worker and practitioner have additional rights to appeal the determination of the UR agent to the DIA or file a claim for payment to the DIA in accordance with 452 CMR 1.07.

The OHP conducts investigations on all complaints received. Violations are recorded and forwarded to the Commissioner for due process. The OHP tracks the nature and pattern of these complaints and takes this information into account when reviewing policy and procedures of UR agents.

To ensure the regulatory compliance with UR regulations, the OHP:

- Reviews new applications from UR agents seeking approval to conduct UR for workers' compensation in Massachusetts. The OHP UR Coordinator provides consultation as requested throughout the application process to ensure all systems, policies and procedures comply with the DIA's rules, regulations and standards.
- Conducts system wide Quality Assessment Audits annually from UR agents. The OHP UR Coordinator supports and assists the UR agent throughout the following alternating process to remain in compliance with the DIA's regulations and requirements:

  Application Review - Conducted every two years, the Application Review examines demographic information, changes in operations, and policy procedures.

  Medical Record Review Audits - A sample of the agent's medical records are reviewed to monitor the quality of care provided to inured workers and to ensure the agent's compliance with the DIA's rules and regulations.

  On-Site Reviews - Upon a mutually agreed date, this review is conducted for the purpose of confirming that the organization is operating in a manner consistent with 452 CMR 6.0 *et seq*.
- Audits the applications of Preferred Provider Arrangements and processes them according to 452 CMR 6.03.

Outreach and Support to UR Agents

The OHP provides outreach and support to UR agents in an effort to assist them in providing the highest quality of service to injured workers. Each year, the OHP hosts a meeting with UR agents to provide updates on common issues and to share new information. Agents are encouraged to provide input for agenda items. As necessary, the agency's UR Coordinator will schedule meetings and phone consultations with any UR agent having difficulty complying to the DIA's regulations. The OHP also provides in-service training to employees of UR agents upon request.

Health Care Services Board

Pursuant to M.G.L. c.152 §13, the Health Care Services Board ("HCSB") is a medical advisory body of 14 members specified by statute and appointed by the commissioner. The HCSB met throughout fiscal year 2003, discharged its statutory responsibilities with regularity, and continued to assist the commissioner and the DIA with the implementation of multiple medical initiatives stemming from the Governor's workers' compensation reforms of 1991.

During fiscal year 2003, one member left the HCSB and two members were appointed. The HCSB managed its affairs with its Chair appointed by the commissioner, legal counsel and administrative staff.

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. The HCSB continues to receive, investigate and resolve complaints against health care practitioners providing medical services to injured workers under the workers' compensation statute. In fiscal year 2003, the HCSB received 4 such complaints.

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 M.G.L. c.152, §8(4) and §11A. The HCSB reviewed the impartial criteria for appointment to the DIA's impartial physician rosters last modified in fiscal year 1997 and revised the impartial criteria in fiscal year 2003. The HCSB also continued to work with the Senior Judge in the recruitment of physicians and health care practitioners throughout fiscal year 2003.

Treatment Guidelines - Under §13 of c.152, the Commissioner is required to ensure that adequate and necessary health care services are provided to injured workers by utilizing treatment guidelines developed by the HCSB, including appropriate parameters for treating injured workers. In addition to an annual review and endorsement of the existing 28 medical treatment guidelines adopted by the DIA, the HCSB continued to work on medical guidelines for pain management while reviewing its existing guidelines.

Compensation Review System (CRS)

As part of the 1991 Workers' Compensation Reform Act, the statute mandated that the DIA "monitor the medical and surgical treatment provided to injured employees and the services of other health care providers, and monitor hospital utilization as it relates to the treatment of injured employees. The monitoring shall include determinations concerning the appropriateness of the service, whether treatment is necessary and effective, the proper costs of services, and the quality of treatment" (M.G.L. c.152, §13).

In order to fulfill this legislative mandate, the OHP set out to create a Compensation Review System (CRS). The goals of CRS are to provide standardized, comparable data for the improvement of programs, policies, and services relative to injured workers in Massachusetts, review compliance with HCSB Treatment Guidelines, review patterns of care, and review utilization of medical services and trends in medical care. In addition, CRS will aid in controlling costs by detecting over-utilization and improper utilization of treatments. This will be accomplished by collecting data from insurers, self-insurers and third party administrators (TPA) and comparing this data to the treatment guidelines. During 2003, the OHP focused on claims related to Treatment Guidelines #20 & #21 for back injuries. In 2004, data collection will continue to be related to back injuries and include treatment guidelines for chronic back injuries and pain.

On January 1st, 2003, the OHP started receiving and compiling data from insurers, self-insurers and Third Party Administrators (TPA's) from across the state. The OHP recorded a 98% compliance rate for data submission from these entities for the first, second and third quarters. Throughout the fiscal year, the OHP sent out memorandums,

held several regional meetings, and communicated with insurers, self-insurers and TPA's to provide assistance and support with the reporting requirements.

Currently, the OHP is merging the submitted data into a database for review. The data will be used to analyze the utilization of medical treatment for work-related injuries and to compare utilization to the Treatment Guidelines promulgated by the HCSB. The OHP is optimistic that CRS will be a valuable tool to secure the best medical care for the injured worker at the lowest possible cost.

DIA 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. The offices are 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 Oracle case scheduling system.

Cases are assigned to administrative judges by the Oracle 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. Therefore, the costs of operating each office is 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 MA General Laws, MA court reporters, and DIA reports.

The following are addresses for the regional offices:

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

Lawrence
160 Winthrop Avenue
Lawrence, MA 01840
(978) 683-6420
Dan DeMille, Manager

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

Worcester
8 Austin Street
Worcester, MA 01608
(508) 753-2072
Jonathan Ruda, Manager

SECTION
- 5 -
DIA FUNDING

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). There are no tax dollars used to fund the Division of Industrial Accidents or any of its activities.

Table 20: Funding Mechanisms for the Division of Industrial Accidents

Assessments - A charge levied against all companies in Massachusetts on their workers' compensation policy;
Referral Fees - A fee paid by the insurer when a case cannot be resolved at the Conciliation level and is referred to Dispute Resolution for adjudication. The current referral fee is $574.90 as of October 1, 2003. This fee is 65% of the current State Average Weekly Wage, which is $884.46. (This figure changes every October 1st);
Fines - There are three types of fines. First, a Stop Work Order Fine is issued to a company without insurance, and it accumulates until they obtain a policy. Second, a Late First Report Fine is issued to a company if the injury is not reported within the specified time. This amount is $100. Third, a 5% fine is charged when assessments are paid later than 30 days of billing.

Source: Division of Industrial Accidents' Website: www.mass.gov/dia/

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.[29] The assessment rate for private sector employers in FY'04 is 3.670% of standard premium. This is an 18% increase from the FY'03 rate of 4.488%.

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. The DIA reimburses the General Fund the full amount of its budget appropriations plus fringe benefits and indirect costs from the assessments, fines, and fees collected. Payments are made quarterly. 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.

The Trust Funds - The Trust Fund was established so the DIA can 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

[29] 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.

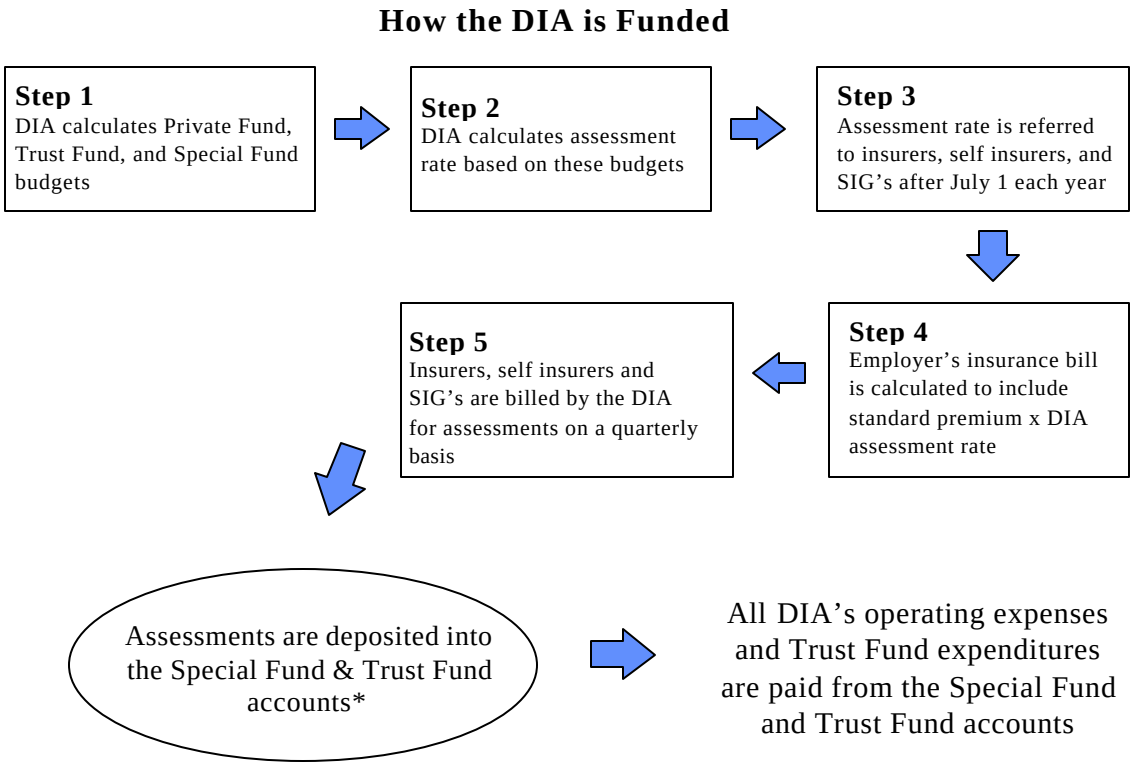
injuries, injuries involving veterans, and for specified cost of living adjustments.[30] These obligations are paid out of the trust funds. One account is reserved for payments to private sector employers (the private trust fund); the other is for payments to public sector employers (the public trust fund).

The 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 uses consulting actuaries to estimate future expenses and determine the assessments necessary to fund the special fund and the trust fund. The budgets and the corresponding assessments must be submitted to the Director of Labor and Workforce Development by July 1st annually. 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 18: DIA Funding Process



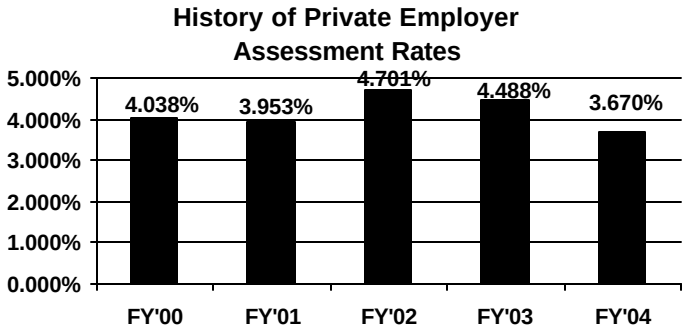
*Note: Maintained by the State Treasurer.

[30] M.G.L. c.152, §65(2).

PRIVATE EMPLOYER ASSESSMENTS

On June 26, 2003, Tillinghast - Towers Perrin released a revised analysis of the DIA's FY'04 assessment rates as mandated under M.G.L. c.152, section 65. Specifically, the report detailed the estimated amount required by the special fund and trust funds for FY'04, beginning July 1, 2003. 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 **3.670%** of standard premium, a decrease by about 18% from last year (4.488%).

Figure 19: History of Private Employer Assessment Rates



The public employer assessment rate has been calculated to be **45.043%** of standard premium, an increase of 13% from last year's assessment (39.851%).

Overview of Assessment Rate Calculations

Tillinghast - Towers Perrin uses the following six steps in determining the assessment rates for both private and public employers:

1. Project the Fiscal Year 2004 Expenditures;
2. Project the Fiscal Year 2004 Income (excluding assessments);
3. Estimate Balance Adjustments;
4. Convert Above Items to Ratios by comparing them to the Assessment Base;
5. Calculate the Assessment Ratio by Subtracting the Projected Income and Balance Adjustment Ratios from the Projected Expenditure Ratio; and
6. Calculate the Assessment Rate by multiplying the Assessment Ratio by the Assessment Base Factor.

1. FISCAL YEAR 2004 PROJECTED EXPENDITURES: $72.7M

The first step in the assessment process is the calculation of the expected FY'04 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'04 Expenditures (6/13/03)
Section 37 (2nd Injuries)	$21,670,000
Uninsured Employers	$ 4,000,000
Section 30H (Rehabilitation)	$ 9,500
Section 35C (Latency)	$ 1,557,500
Section 34B (COLA's)	$18,656,432
Defense of the Fund	$ 4,000,000
Total:	**$49,893,432**

SPECIAL FUND BUDGET	Projected FY'04 Expenditures (6/13/03)
Total:	**$22,769,322**

PRIV. EMPLOY. EXPENDITURES	Projected FY'04 Expenditures (6/13/03)
Total:	**$72,662,754**

2. PROJECTED FISCAL YEAR 2004 INCOME: $6.5M

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'04 Fines and Fees (Special Fund) = $5,350,000
FY'04 Income Due to Reimbursements = $ 700,000
Estimated Investment Income (FY'03) = $ 415,392 (Private Fund: $201,241/Special Fund: $214,151)

Total Projected FY'04 Income: $6,465,392

3. ADJUSTMENTS TO FUND BUDGETS: $6.1M

According to M.G.L. c.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'02 expenditures in a particular fund must be used to reduce amounts assessed for that fund in FY'04. The balances of both Special Fund and Private Trust Fund at the end of FY'03 will have a surplus exceeding 35% of FY'02 disbursements. Therefore, the assessment was calculated with a $6 million reduction to the Special Fund Budget, and no reduction to the Private Trust Fund Budget.

SPECIAL FUND:	**FY'03 Estimated Year End Balance**	**35% of FY'02 Expenditures**	**Amount of Reduction Required**
	$14,276,757	$8,222,391	$6,054,366

PRIVATE TRUST FUND:	**FY'03 Estimated Year End Balance**	**35% of FY'01 Expenditures**	**Amount of Reduction Required**
	$13,416,038	$15,061,943	$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 first three steps by the assessment base, which represents losses paid during Calendar Year 2002. For the Private Fund, the assessment base is $755.3M.

Private Expenditure Ratio:	9.620%	($72.7 million/$755.3 million)
Projected Income Ratio:	0.856%	($ 6.5 million/$755.3 million)
Balance Adjustment Ratio:	1.486%	($ 6.1 million/$755.3 million)

5. CALCULATION OF THE ASSESSMENT RATIO: 7.963%

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**
9.620%	0.856%	0.801%	**7.963%**

6. CALCULATION OF THE ASSESSMENT RATE: 3.670%

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 2004 assessment base factor is .461.

Assessment Ratio x	Assessment Base Factor =	**Assessment Rate**
7.963%	.461	**3.670%**

DIA OPERATING BUDGET

Legislative Appropriations, Fiscal Year 2004

The Division of Industrial Accidents initially requested a budget of $18,382,631 for fiscal year 2004. In House 1, the Governor's recommendation for the DIA's budget was $18,772,922 ($390,291 more than the DIA's original request). The House of Representatives approved a budget of $17,862,495 and the Senate approved appropriations totaling $18,548,357. The final conference committee resolution appropriated $18,698,357 to the DIA, $315,726 more than the agency's original request.

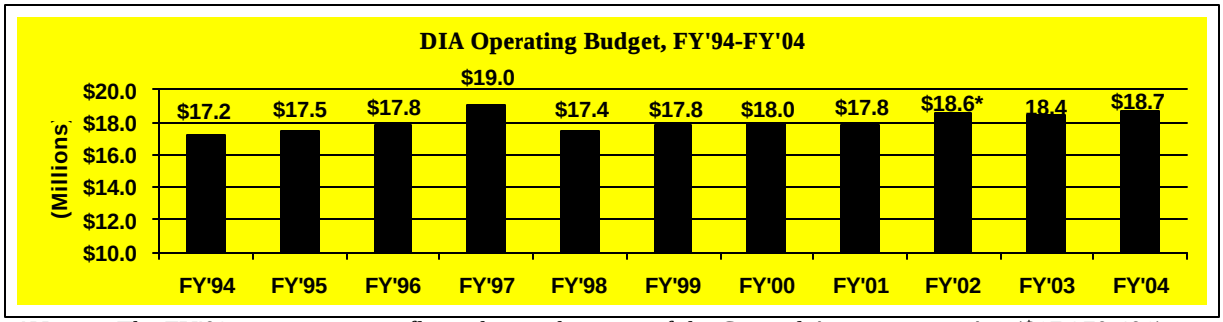
Table 21: Legislative Budget Process for DIA Line-Item, Fiscal Year 2003 - Fiscal Year 2004

Fiscal Year 2003 Budget Process		Fiscal Year 2004 Budget Process	
DIA Request	$18,642,473	DIA Request	$18,382,631
Governor's Rec.	$18,573,319	Governor's Rec.	$18,772,922
Full House	$18,532,631	Full House	$17,862,495
Full Senate	$18,597,548	Full Senate	$18,548,357
Conference Committee	$18,532,631	Conference Committee	$18,698,357
*Gen. Appropriations Act	$18,382,631	Gen. Appropriations Act	$18,698,357

***Includes $150,000 Veto**

General Appropriations Act

On June 30, 2003, Governor Romney signed the FY'04 General Appropriations Act which allocated the DIA an $18,698,357 operating budget. The FY'04 appropriation is only $74,565 less than the Governor's Recommendation (House 1) which was endorsed by the Advisory Council in April. This appropriation represents a 1.7% increase from last year's final appropriation. Provisions contained within the DIA's appropriation require that "not less than" $800,000 be expended for occupational safety grants and that a judge be assigned to hear cases in Berkshire County "not less than once a month." Furthermore, the allocation allows for the Advisory Council to release sufficient funds from the Special Reserve Account to pay for expenses "to continue expansion of the conversion of the agency's computer system from unify to oracle." The budget designates that "not more than" $150,000 be expended towards electronic arbitration.



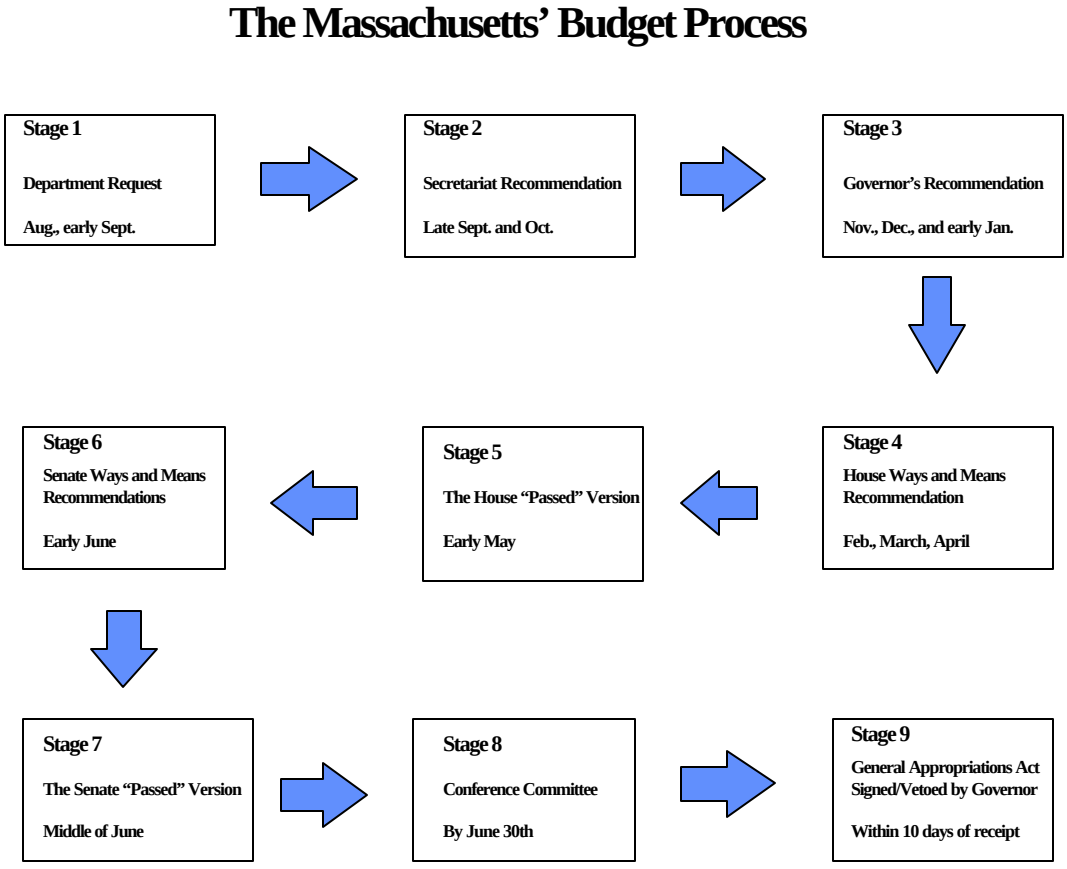
***Note:** The FY'02 appropriation reflects the combination of the General Appropriation Act ($17,270,401) and the Supplemental Budget figures ($1,327,147).

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.[31]

The following is a brief description of the process:

Figure 20: The Massachusetts' Budget Process



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

STAGE #1: Department Request

Time Frame: August and Early September

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

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, and 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. Typically 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 that both the House and Senate must ratify. 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 both 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

MANDATORY INSURANCE COVERAGE

Every private sector employer in the Commonwealth is required to maintain workers' compensation insurance.[32] Coverage may consist of purchasing a commercial insurance policy, membership in a self-insurance group, participation in a reciprocal insurance exchange, or maintaining a license as a self-insured employer. [33]

All Commonwealth of Massachusetts employees are covered under the Workers' Compensation Act, with claims paid directly from the General Fund. The Executive Office of Administration & Finance, Human Resources Division administers workers' compensation claims, with individual agencies paying a yearly "charge-back" based on losses paid in the prior year. This charge-back comes directly from each agency's operating budget.

When enacted in 1911, the Workers' Compensation Act was elective for counties, cities, towns, and school districts. The majority of municipal employees are covered, with only a few communities having never adopted coverage for certain employee groups. Municipalities attain insurance coverage in a manner identical to private employers (commercial insurance, self-insurance, or membership in a self-insurance group). [34]

The Office of Investigations at the DIA monitors employers in the state to ensure no employer operates without insurance. The office may issue fines and close any business operating without coverage.[35] If an employee is injured while working for a company without coverage, a claim may be filed with the DIA's trust fund.[36]

Exemption of Corporate Officers

On July 25, 2002, a new law went into effect that made the requirement of obtaining workers' compensation insurance elective for corporate officers (or the director of a corporation) who own 25% of the issued and outstanding stock of that corporation. Said corporate officer must provide the Commissioner of the DIA with a written waiver of their rights should they choose to opt-out from the workers' compensation system.[37] The policies and procedures surrounding the exemption of a corporate officer or director are governed by 452 CMR 8.06 et.seq. The new law also amended the definition of an employee by giving a sole-proprietor or a partnership the ability to be considered an "employee" so they can obtain coverage under a workers' compensation insurance policy.

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[32] 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.

[33] 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.

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

[35] See section covering Office of Investigations.

[36] See section covering Trust Fund.

[37] Form 153 - "Affidavit of Exemption for Certain Corporate Officers."

COMMERCIAL INSURANCE

Purchasing a commercial insurance policy is the most common method of complying with the workers' compensation mandate. These policies are governed by the provisions of M.G.L. c.152, and are regulated by the Division of Insurance (DOI). The Workers' Compensation Rating & Inspection Bureau of Massachusetts (WCRIBM) has delegated authority to determine standard policy terms, classifications, and manual rates, in addition to maintaining statistics on behalf of the Commissioner of Insurance.

While commercial insurance policies are available that provide for varying degrees of risk retention (such as small and large deductibles), the most common type is first dollar coverage, whereby all losses are paid from the first dollar incurred for medical care and indemnity payments. A variety of pricing mechanisms are also available (including retrospective rating and dividend plans), with the most common being guaranteed cost. In exchange for payment of an annual premium based on rates approved each year by the Commissioner of Insurance, an employer is guaranteed that work related injuries and illnesses will be paid in full by the insurer.

The WCRIBM's Massachusetts Workers' Compensation and Employers Liability Insurance Manual sets forth the methods to determine the classification of insureds as well as terms of policies, premium calculation, credits and deductibles.

The Insurance Market

The commercial insurance market is the primary source of funding for workers' compensation benefits in Massachusetts. A healthy insurance market, therefore, is essential to the welfare of both employees and employers.

Commercial insurance carriers are regulated by the DOI, which provides licensing, monitors solvency, determines rates, approves the terms of policies, and adjudicates unfair claims handling practices. In FY'03, the DOI approved a total of 4 new licenses to carriers to write workers' compensation insurance in Massachusetts.[38] During this same time period, one insurer withdrew their workers' compensation license.

In Massachusetts, workers' compensation insurance rates are determined through an administered pricing system.[39] Insurance rates are proposed by the Workers' Compensation Rating and Inspection Bureau of Massachusetts (WCRIBM) on behalf of the insurance industry, and set by the Commissioner of Insurance. The WCRIBM submits to the Commissioner a classification of risks and premiums, referred to as the rate filing, which is reviewed by the State Rating Bureau. By law, a rate filing must be

[38] Of these 4 new licenses, one was already licensed in the state but added workers' compensation designations to their policies.

[39] In the United States, workers' compensation insurance rates are regulated one of three ways: through administered pricing, competitive rating, or a monopolistic state fund. Administered pricing involves strict regulation of rates by the state. Competitive rating allows carriers to set rates individually, usually based on market-wide losses developed by a rating organization and approved by the state. Monopolistic state funds require that workers' compensation insurance be purchased exclusively through a program run by the state. Some states have competitive state funds that allow employers to purchase insurance from either a private carrier or the state.

submitted at least every two years, and no classifications or premiums may take effect until approved by the Commissioner.[40]

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."[41]

On Friday, August 29, 2003, Insurance Commissioner Julianne Bowler issued a rate decision, which reduced average rates for workers' compensation insurance by **4%** from 2001-2002 rate levels. This rate reduction became effective for policies taking effect on or after September 1, 2003. The only rate increase since 1994 occurred in 2001 when the Insurance Commissioner allowed a 1 percent increase.

The table to the right illustrates the fluctuations in workers' compensation insurance rates since 1987 and how this would effect a company's premium, assuming a their premium was $100 in 1987 (with all other factors remaining the same - experience rating, discounts, etc.).

Table 22: Impact of Rate Changes, 1987 - 2003

YEAR	Percent Change from Previous Year's Rate	Assuming a Manual Rate of $100 in 1987
1987	No Change	$100.00
1988	+ 19.9%	$119.90
1989	+ 14.2%	$136.93
1990	+ 26.2%	$172.81
1991	+ 11.3%	$192.34
1992	No Change	$192.34
1993	+ 6.24%	$204.34
1994	- 10.2%	$183.50
1995	- 16.5%	$153.22
1996	- 12.2%	$134.53
1997	No Change	$134.53
1998	- 21.1%	$106.15
1999	- 20.3%	$84.60
2000	No Change	$84.60
2001	+ 1%	$85.44
2002	No Change	$85.44
2003	**- 4%**	**$82.03**

Source: Division of Insurance WC Rate Decisions

Deviations & Schedule Credits

The Workers' Compensation Act allows individual carriers to seek permission from the Commissioner to use a percentage decrease from approved rates within certain classifications.[42] These percentage decreases are called "downward deviations." Schedule credits are also used in Massachusetts as a tool for competitive pricing, by allowing insurers to reward policyholders for good experience. These discounting techniques have become an important part of the Massachusetts insurance market. While open competition is not permitted, the use of deviations (and other alternatively priced policies) has encouraged carriers to compete for business on the basis of pricing.

In Massachusetts, approximately 48 insurers are currently offering deviations or scheduled credits to their customers. These discounts (some as high as 35%) will remain in effect until the next rate filing.

[40] If the Commissioner takes no action on a rate filing within six months, the rates are then deemed to be approved. If the Commissioner disapproves the rates, 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.

[41] M.G.L. c.152, §53A(2).

[42] M.G.L. c.152, §53A(9).

The Classification System

Workers' compensation insurance rates are calculated and charged to employers, according to industry categories called classifications. Every employer purchasing workers' compensation insurance is assigned a basic classification determined by the nature of its operations. 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 which distributes the overall costs of workers' compensation equitably among employers. Without a classification system, employers in low risk industries would be forced to subsidize high-risk employers through higher insurance costs.

Regulation of Classifications - Classifications in Massachusetts are established by the Workers' Compensation Rating & Inspection Bureau (WCRIBM) subject to approval by the Commissioner of Insurance. Hearings are conducted at the Division of Insurance to determine whether classifications and rates are not excessive, inadequate or unfairly discriminatory and that they fall within a "range of reasonableness."[43]

Basic Classifications - Each business in the Commonwealth is assigned one "basic" classification that best describes the business of the employer. Once a basic classification has been selected, it becomes the company's "governing" classification, the basis for determination of premium.

Although most companies are assigned one governing classification, the following conditions determine when more than one basic classification should 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 4 "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).

[43] M.G.L. c.152, §53A.

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 by the industry. An employers' base rate is based on manual rate per $100 of payroll, for each governing and standard exception classification.

Class Code	Governing Classification	Manual Rate	Payroll	Base Rate
5188	Automatic Sprinkler Installation & Drivers	$2.50	$200,000	$5,000

Class Code	Standard Exception	Manual Rate	Payroll	Base Rate
8810	Clerical Employees	$.25	$50,000	$125

Appealing a Classification - When a new company applies for insurance, the broker or agent assigns 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 is charged additional premium or receives a credit for the correct class. The WCRIBM is responsible for determining the proper classification for all insureds in Massachusetts. If an employer disagrees with its assigned classification, or believes a separate classification should be created, there is an appeal process made available by M.G.L. c.152, §52D. A formal appeal must be held with the WCRIBM's Governing Committee (for those insured in the Voluntary Market) or the Residual Market Committee (for those insured in the Assigned Risk Pool). The WCRIBM 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 made 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 the various types of construction or erection operations. 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. The Massachusetts Construction Classification Premium Adjustment Program is a program that provides for a manual premium credit ranging from 5% to 25%, depending on average hourly wages paid to employees. Because a disparity exists between high and low wage construction employers (largely determined by the existence of a collective bargaining agreement), this program is designed to offset the higher premiums associated with larger payrolls and equalize workers' compensation costs.

Premium Calculation

Premiums charged to employers in Massachusetts are dependent on several factors that are designed to measure each company's exposure to loss. Premium is based on uniform rates that are developed for each classification and modified according to the attributes of each employer. In return for payment of premiums, 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 following is an overview of the premium calculation process.

Manual Premium - The first step in the premium calculation process is determination of manual premium. The manual premium is reflective of both the industry (manual rate) and size (payroll) of a company. The manual premium is calculated by multiplying the employer's manual rate by its annual payroll per $100.

Manual Premium = (Manual Rate x Payroll)/100

An employer's manual rate is assigned according to its classification. As explained in the prior section, every classification has a corresponding manual rate that reflects the industry's exposure to loss.

Once a corresponding manual rate has been established, exposure to loss for the particular employer must then be considered. In Massachusetts, this is determined by payroll. Payroll is a factor of an employers wage rate, the number of employees employed, and the number of hours worked. All other factors being equal, a firm with a large payroll has a greater exposure to loss than a firm with a smaller payroll. Furthermore, since indemnity benefits are calculated as a percentage of wages earned, payroll also reflects severity of potential loss.

Standard Premium - Once a manual premium has been determined, it is then multiplied by an experience modification factor to determine the standard premium.

Standard Premium = Manual Premium x Experience Modification Factor

Experience rating is a system of comparing the claims history of each employer against the average claims experience of all employers within the same classification. An experience modification factor is calculated, which provides either a premium reduction (credit) or a premium increase (debit) to an insured's premium. For example, a modification of .75 results in a 25% credit or savings to the premium, while a modification of 1.10 produces a 10% debit or additional charge to the premium. When a modification of 1.00 (unity) is applied, no change to premium results.

The experience modification factor is determined on an annual basis, which is based on an insured's losses for the last three completed years. For instance, two similar employers may have a manual rate of $25 per $100 of payroll, but the safety conscious employer (with fewer past claims) may have an experience modification factor of .80, thus adjusting his rate to $20 per $100 of payroll. The other employer, who is not as safety conscious, may have an experience modification factor of 1.20, which adjusts the company's rate to $30 per $100 of payroll.

All Risk Adjustment Program - In January 1990, the WCRIBM instituted the All Risk Adjustment Program (ARAP), calculated in addition to the experience modification factor. Its original purpose was 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.

Premium Discounting

Insurance companies that provide workers' compensation coverage must factor in the various expenses involved with servicing insureds 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, insurers must provide a premium discount to large 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.

Table 23: Percent of Premium Discount for Type A & B Companies

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%

Source: WCRIBM, A General Revision of Workers' Comp. Insurance Rates and Rating Values, pg. 590 (8/14/95).

Deductible Policies

Since 1991, deductible policies can provide the advantages of a retrospective policy and self-insurance. Employers are responsible for paying from the first dollar incurred up to the deductible limit, either on a per claim basis or on an aggregate basis for claims in the policy year. The insurer pays all benefits and then seeks reimbursement from the employer up to the amount of the deductible.

Table 24: Premium Reduction % Per Claim Deductible

PER CLAIM DEDUCTIBLE[44] *Effective May 1, 1996*	
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%

Source: WCRIBM

Table 25: Massachusetts Benefits Claim and Aggregate Deductible Program

MASSACHUSETTS BENEFITS CLAIM AND AGGREGATE DEDUCTIBLE PROGRAM[45]			
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%

Source: WCRIBM, A General Revision of Workers' Comp. Insurance Rates & Rating Values (8/14/95).

Retrospective Rating Plans

Retrospective rating bases premium on an insured's actual losses calculated at the conclusion of the policy period. Therefore, the insured has greater control over its insurance costs by monitoring and controlling its own losses. Retrospective rating should not be confused with "experience rating." Both adjust premium based on an employer's loss history. Experience rating, however, 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.

The Formula - 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 medical and indemnity losses, interest on judgments, and expenses incurred in third-party recoveries.[46] A basic premium is necessary to defray the expenses that do not vary with losses and to provide the insurance company with a

[44] Massachusetts Workers' Compensation and Employer's Liability Insurance.
[45] Massachusetts Workers' Compensation and Employer's Liability Insurance.
[46] "Retrospective Rating," Risk Financing, Supplement No. 46, May 1995: III.D.7.

profit. To control the cost of the premium in extreme cases, the policies state that the premium cannot be less than a specific minimum and cannot exceed a stated maximum.

Eligibility Requirements - Eligibility for a retrospective rating plan is based upon a minimum standard premium. Eligibility for a one-year plan is an estimated standard premium of at least $25,000 per year, and for a three-year plan the estimated standard premium must be at least $75,000.[47] 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 smaller employers are purchasing retrospective plans to lower premiums by controlling company losses.

Benefits and Disadvantages - Under the right circumstances, retrospective rating can benefit both the insurer and the policyholder. The policyholder benefits by paying a smaller premium at the beginning of the policy year. Because premium is determined by losses, retrospective plans reward those businesses that maintain effective loss control programs. If losses are low, the insured will pay less than standard premium. However, there is a significant uncertainty regarding the final premium amount, since it is impossible to be precise in predicting the volume or severity of workplace accidents. An unexpected claim towards the end of a policy period can be detrimental to a company, if funds have not been set aside for the retro premium. Furthermore, there is little incentive for the insurance company to limit settlement costs, when they are able to recover payments made on claims brought against the policyholder.

Dividend Plans

Offered as another 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 insured 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.[48] 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.[49]

[47] Workers' Compensation: Exposures, Coverage, Claims, Levick, Dwight E. Standard Publishing Corp., page 11-4.
[48] "Risk Management-Life, Health, and Income Exposures," Life Insurance, Part 4: 406.
[49] "Thinking About the Work Comp Crisis," Merrit Risk Management Review, December 1991: 3.

ASSIGNED RISK POOL

Any employer rejected for workers' compensation insurance can obtain coverage through the residual market, known as the Assigned Risk Pool. Administered by the Workers' Compensation Rating and Inspection Bureau (WCRIBM), the Assigned Risk Pool is the "insurer of last resort" and is required by law to provide coverage when an employer is rejected by at least two carriers within five business days. Very small employers and companies in high-risk classifications or having poor experience ratings often cannot obtain insurance in the voluntary market. This occurs when a carrier determines that the cost of providing insurance to a particular company is greater than the premium it can collect.

The estimated ultimate residual market share for the 12-months ending August, 2003 is 14%.[50] Although this percentage has trended upward since 1999, it remains far below the 64.7% of workers' compensation premium share that was in the residual market during the 1992 policy year.

Employers insured through the pool pay standard premium, and are not offered premium discounts, dividend plans, etc. The Commissioner of Insurance chooses the carriers that will administer the policies, called "servicing carriers." These carriers are paid a commission for servicing the policies, and are subject to performance standards and a paid loss incentive program. These programs are designed to provide servicing carriers with incentives to provide loss control services to those insured.

Residual Market Loads - Every insurance carrier licensed to write workers' compensation policies is required to be a member of the Assigned Risk Pool. Members are collectively responsible for underwriting pool policies, for bearing the risk of all losses, and are entitled to any profits generated. When the pool operates at a deficit, the members are subject to an assessment. Assessments are calculated in direct proportion to the amount of premium written in the voluntary market. This is called the Residual Market Load.

The Residual Market Load is incorporated into rates, and was a significant factor for employers to search out alternative risk financing options. Self insurance and self-insurance groups are not subject to residual market assessments. The Residual Market Load is incorporated into manual rates. 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. 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). The estimated (as of 9/02) residual market burden for Policy Year 2001 is 88.8% with a resulting residual market burden of 2.4%.[51]

[50] WCRIBM Special Bulletin No. 11-03 (November 12, 2003).
[51] WCRIBM Special Bulletin No. 04-03 (April 23, 2003).

ALTERNATIVE RISK FINANCING METHODS

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

Self Insurance

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.[52] 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 its own claims or engage the services of a law firm or a third party administrator (TPA) to handle claims administration. The office of insurance evaluates employers every year to determine their continued eligibility and set a new bond amount.

Figure 21: Self Insurance in MA - Premium Dollars

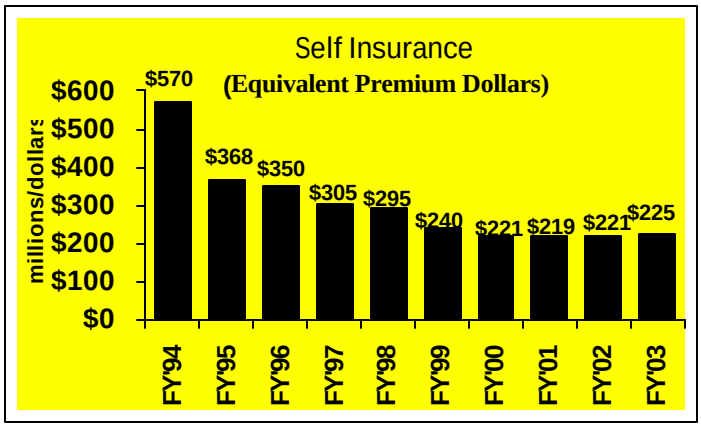


Table 26: Total Self-insured licenses in Massachusetts

	New Licenses	Total Licenses	Companies Covered
FY'03	2	143	445
FY'02	2	139	478
FY'01	3	151	419
FY'00	5	173	437
FY'99	6	174	464
FY'98	5	186	503
FY'97	5	206	417
FY'96	5	226	734
FY'95	11	227	734
FY'94	23	224	688

Source: DIA Office of Insurance

[52] 452 C.M.R. 5.00: Code of Massachusetts Regulations concerning insurers and self insurers.

Self Insurance Groups

Companies in related industries may join forces to form a self insurance group (SIG). Regulated by the Division of Insurance, SIGs may include public employers, non-profit groups, and private employers in the same industry or trade association.[53]

As part of the workers' compensation reform package of 1985, SIGs were permitted in Massachusetts to provide an alternative to coverage in the assigned risk pool. Since that time, membership has been a popular alternative to commercial insurance because of the ability for members to manage their own claims. In addition, SIGs are generally able to reduce administrative costs from a fully insured plan. These savings result from reduced or eliminated commissions, premium taxes, etc.

Table 27: Membership in W/C SIGs as of Jan. 1st

Membership in Workers' Compensation Self-Insurance Groups as of Jan. 1st

Year	Number of Groups	Number of Members
1991	8	N/A
1992	21	N/A
1993	28	N/A
1994	27	2,300
1995	31	2,550
1996	32	2,700
1997	30	2,830
1998	26	2,880
1999	25	2,821
2000	24	Unavailable
2001	25	Unavailable
2002	25	3,000
2003	24	3,456

Source: Division of Insurance

Members of a self insurance group are assigned a classification and are charged manual rates approved by the Commissioner of Insurance for commercial insurance policies. Premium is calculated in the same manner, with manual rates adjusted by an experience modification factor and the All Risk Adjustment Program (ARAP).[54] Cost savings arise through dividends returned to members and deviated rates.

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.

The first group was approved in 1987. After a few years of modest interest, eight SIGs were formed in 1991 and 21 in 1992. As of January 1, 2003, there were 24 SIGs in the Commonwealth.

[53] 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. (Div. of Insurance Regulations, 211 CMR 67.02).

[54] 211 CMR 67.09.

INSURANCE FRAUD BUREAU

The Insurance Fraud Bureau (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. [55] It was created in 1990 to investigate auto insurance fraud and expanded in 1991 to include workers' compensation fraud.[56] While its mission statement is to include all lines of insurance, the focus is on automobile and workers' compensation insurance.

IFB Funding

The IFB receives half of its annually budgeted operating revenues from the Automobile Insurers Bureau (AIB) and half from the Workers' Compensation Rating and Inspection Bureau (WCRIB). In 2002, each of these bureaus contributed a total of $2,736,070 to fund the IFB. The 2002 operating expenses for the IFB totaled $5,555,455, a $320,341 increase over 2001 expense levels. Due to actual operating expenses being less than what was budgeted for, the IFB returned the net surplus of $166,507 back to the AIB and WCRIB in early 2003.

The Investigative Process

Referrals - Cases of suspected fraud for all types of insurance are generally referred to the IFB, either through an insurance carrier or through a toll-free hotline, which can be reached at: 800-32-FRAUD. In calendar year 2002, the IFB received 300 referrals regarding workers' compensation fraud.[57] Of these referrals, 87 (29%) were accepted for investigation.

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 has historically existed in investigations at this initial stage.

Assigned Cases - Once resources become available, a referral is assigned to an investigator and officially becomes a "case." In calendar year 2002, a total of 77 "new" cases were assigned to investigators dealing with workers' compensation fraud and 114 cases were investigated during the year.

[55] 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.

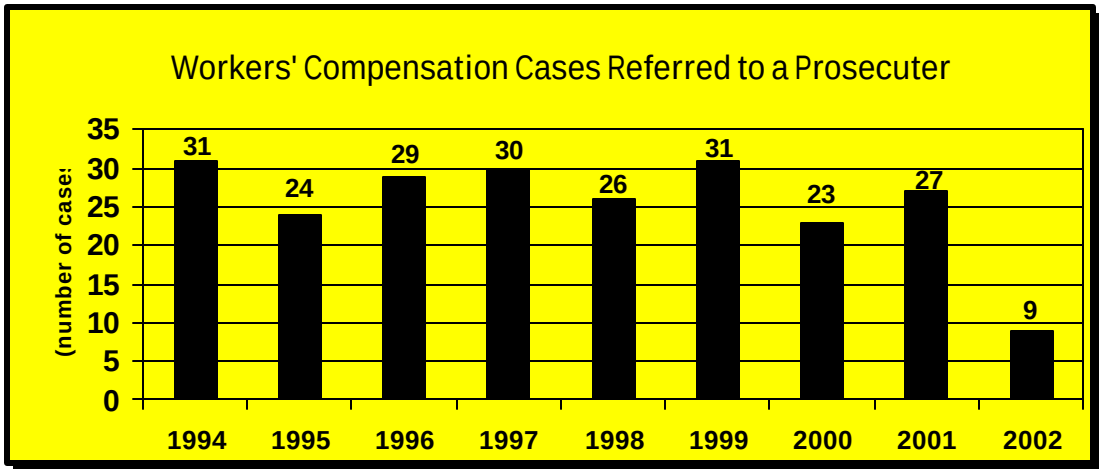
[56] M.G.L. St. 1990, c.338 as amended by St. 1991, c.398, §9

[57] Solicited referrals are included in this number.

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 calendar year 2002, a total of 19 cases were referred to a prosecutor dealing with workers' compensation fraud.

Figure 22: Workers' Compensation Cases Referred to a Prosecutor



Source: 2002 Insurance Fraud Bureau Annual Report

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:

> *Claimants with duplicate identities who worked while receiving workers' compensation benefits or who earned income from one or more employers and failed to disclose it; cases where subjects participated in physical activities wholly inconsistent with the disability claimed or whose injuries were fraudulently attributed to the workplace; premium evasion cases; phony death claims; and staged falls.*

While fraud continues to be a major concern for everyone involved in workers' compensation, the IFB and the Attorney General's Office continue to make great strides 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, to those who consider defrauding the workers' compensation system, that fraud will not be tolerated.

LIST OF APPENDICES

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EVELYN N. FLANAGAN, Program Coordinator
ANN M. HELGRAN, Paralegal

APPENDIX B

Agenda - Fiscal Year 2003

July 10, 2002
DIA Update
Impartial Medical Rates
- Council Member Tom Jones

Vocational Rehabilitation
- Council Member Carol Falcone

Action Items
- Minutes - June, 2002

Executive Director Update
Miscellaneous

August 14, 2002
DIA Update
Action Items
- Minutes - July, 2002

Executive Director Update
Miscellaneous

September 11, 2002
DIA Update
Vocational Rehabilitation Subcommittee Update
- Council Member Carol Falcone

Action Items
- Minutes - August, 2002

Executive Director Update
Miscellaneous

October 9, 2002
DIA Update
Oracle – Phase II
Action Items
- Procurement for Actuarial Consulting Services (Draft)
- Minutes - August, 2002
- Minutes - September, 2002

Budget Subcommittee Update
Executive Director Update
Miscellaneous

November 13, 2002
DIA Update
Oracle Conversion – Phase II
RFR Discussion
- Mercer Risk, Finance & Insurance Consulting

Action Items
- Minutes - October, 2002

Executive Director Update
Miscellaneous

December 18, 2002
DIA Update
Action Items
- Minutes - November, 2002

Executive Director Update
Miscellaneous

January 8, 2003
DIA Update
Insurance Rate Filing - Bidder Presentations
- Mercer Risk, Finance & Insurance Consulting - Scott J. Lefkowitz
- Tillinghast - Towers Perrin - Ann M. Conway

Fiscal Year 2002 Annual Report - Final Draft
Action Items
- Minutes - November, 2002
- Minutes - December, 2002

February 12, 2003
DIA Update
Compensation Review System (CRS)
- Catherine Farnam, Director of Office of Health Policy

Action Items
- Minutes - January, 2003

Executive Director Update
Miscellaneous

March 12, 2003
DIA Update
Budget Subcommittee Update & Discussion
Action Items
- Minutes - February, 2003

Executive Director Update
Miscellaneous

April 9, 2003
DIA Update
Actuarial Review of Rate Filing
- Ann Conway, Tillinghast Towers-Perrin

OEVR Subcommittee Update
- Council Member Carol Falcone

Action Items
- Minutes - March, 2003

Executive Director Update

May 14, 2003
Actuarial Review of Rate Filing - SRB & Attorney General
- Ann Conway & Mr. Bardis, Tillinghast Towers-Perrin

Action Items
- Minutes - April, 2003

Miscellaneous
Judicial Interviews - Executive Session

May 22, 2003

Actuarial Review of Rate Filing - SRB & Attorney General

- Ann Conway & Manolis Bardis, Tillinghast Towers-Perrin

Judicial Interviews - Executive Session

June 11, 2003

Judicial Interview – Executive Session

- John T. Walsh

DIA Update

Action Items

- Minutes - May 14, 2003
- Minutes - May 22, 2003

Workers' Compensation Legislation Discussion

Executive Director Update

Miscellaneous

APPENDIX C

Joint Committee on Commerce & Labor - FY'03

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Senator Susan C. Tucker
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Rep. Michel J. Rodrigues (Chair)
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Senator Brian P. Lees
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Representative Jennifer M. Callahan
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Representative Mark A. Howland
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Representative Michael F. Rush
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Representative Lewis G. Evangelidis
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Representative Paul J. Loscocco
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APPENDIX D

Industrial Accident Nominating Panel

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APPENDIX E

The Governor's Council

Room 184, State House
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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 councilors are elected from their respective districts every two years. Each councilor 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 Judges and Administrative Law Judges at the Division of Industrial Accidents.

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APPENDIX F

Health Care Services Board

Current Members (2003):

Dean M. Hashimoto, MD, JD (Chair)	*Ex-Officio Member*
Henry W. DiCarlo, MM (Vice-Chair)	*Employers' Representative*
David S. Babin, MD	*Physician Representative*
Robert A. Gundersen	*Hospital Administrative Representative*
Peter A. Hyatt, DC	*Chiropractic Representative*
Robert P. Naperstek, MD	*Physician Representative*
Barbara C. Mackey, MS, APRN	*Public Representative*
L. Christine Oliver, MD	*Physician Representative*
Cynthia M. Page, PT	*Physical Therapist Representative*
Janet D. Pearl, MD, MSC	*Physician Representative*
Nancy Lessin	*Employee Representative*
Bernard S. Yudowitz, MD, JD	*Physician Representative*

Staff:

Catherine R. Farnam, RN, MS, CS	*Executive Director*
Judith A. Atkinson, Esq.	*Counsel*
Hella Dalton	*Research Analyst*

All members can be reached c/o:

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Health Care Services Board
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Fax: (617) 348-2176

APPENDIX G

Roster of Judicial Expiration Dates

INDUSTRIAL ACCIDENT REVIEWING BOARD - SIX YEAR TERMS

1.	Martine Carroll	Unenrolled	05/28/04
2.	Frederick Levine	Unenrolled	05/28/04
3.	Susan Maze-Rothstein	Democrat	06/10/04
4.	William McCarthy	Democrat	05/21/04
5.	Patricia Costigan	Unenrolled	06/03/04
6.	<VACANT>	<N/A>	05/28/04

INDUSTRIAL ACCIDENT BOARD - SIX YEAR TERMS

1.	Douglas Bean	Republican	06/26/05
2.	Michael Chadinha	Republican	05/28/04
3.	David Chivers	Republican	05/21/04
4.	William Constantino	Republican	06/13/07
5.	Lynn Brendemuehl	Unenrolled	07/06/06
6.	<VACANT>	<N/A>	05/21/04
7.	John Harris	Republican	05/28/04
8.	Richard Heffernan	Democrat	09/04/09
9.	John Preston	Republican	07/29/06
10.	James LaMothe	Republican	01/31/09
11.	Roger Lewenberg	Republican	06/26/04
12.	Fred Taub	Democrat	08/03/06
13.	Douglas McDonald	Democrat	07/06/06
14.	Bridget Murphy	Republican	07/27/06
15.	Maureen McManus	Republican	05/28/04
16.	Herbert Dike	Republican	07/05/08
17.	Dianne Solomon	Unenrolled	08/10/06
18.	<VACANT>	<N/A>	05/28/04
19.	Omar Hernandez	Democrat	12/29/05
20.	Richard Tirrell	Democrat	05/14/04
21.	Charles E. Walker, Jr.	Unenrolled	09/18/04

INDUSTRIAL ACCIDENT BOARD - ONE YEAR TERMS

1.	Leo Purcell	Democrat	09/09/04

APPENDIX H

Testimony:
Workers' Compensation Advisory Council

Joint Committee on Commerce & Labor Hearing
State House – Gardner Auditorium
July 24, 2003

Good morning. My name is Tom Jones and I am testifying in my capacity as Chairman of the Massachusetts Workers' Compensation Advisory Council. When I am not volunteering my time for the Council, I serve as the Vice President and Counsel of the Employer's Resource Group for Associated Industries of Massachusetts. I am also joined by Andrew Burton who serves as our Executive Director.

The Advisory Council is a Governor-appointed Board comprised of leaders from business and labor, as well as representatives from the legal, medical, insurance and vocational rehabilitation communities. Each month, Council Members come together to discuss a variety of workers' compensation issues with the ultimate goal of identifying problems and developing solutions. When the affirmative vote of at least seven members can be reached between business and labor, these positions are reflected in our recommendations.

It has been twelve years since the enactment of the Workers' Compensation Reform Act of 1991 and the Massachusetts Workers' Compensation System continues to benefit. However, the Advisory Council believes that the passage of certain bills would further complement the system for injured workers, employers and insurers.

The Council supports **House Bill 2924**, filed by Representative Koczera, which would "naturally" stagger judicial terms at the DIA by making the initial appointment of all Administrative Judges (AJ's) for six-year terms. Currently, the statute provides that any judge appointed to fill a vacancy, occurring prior to the expiration of a term, must be appointed for the unexpired portion of that term. With as many as nine AJ's and all six ALJ's terms expiring next year, the Advisory Council believes future delays to the system can be prevented with the passage of this bill. This proposed legislation also creates a system of performance review for newly appointed Administrative Judges. The Senior Judge would be required to conduct a performance review after two years into an AJ's initial term. Only in the event that a performance review recommended against the continuation of a term would it be forwarded to the Governor for appropriate removal action if deemed necessary.

The Council also endorses **House Bill 2380**, filed by Representative Cabral, which would subject the Senior Judge, the Administrative Judges, and the Administrative Law Judges to a judicial code of conduct. We would like to offer an amendment to this legislation that would substitute the American Bar Association's (ABA's) Model Code of Judicial Conduct for State Administrative Law Judges, in lieu of the current language as set forth by the Supreme Judicial Court (SJC). Although both codes exhibit similar ethics, the ABA code will most appropriately serve DIA judges, as they are technically not members of the constitutional

judiciary, but rather the executive branch of government. The Council believes that the DIA's 6-year appointed administrative judges should not be bound to the same code of ethics as judicial life appointees. The passage of this bill will enhance the authority that administrative judges exercise over the fate of injured employees and employers, helping to ensure the fair administration of justice.

The Council also endorses **House Bill 2382**, filed by Representative Cabral, which would eliminate the requirement that scar-based disfigurement appear on the face, neck or hands to be compensable. If passed, this legislation would rightfully compensate workers for all disfigurement, whether or not scar-based, regardless of its location on the body, subject to a $15,000 maximum benefit. In 2000, the Advisory Council asked the actuarial firm Tillinghast - Towers Perrin to estimate the impact on workers' compensation costs of restoring scarring awards to their pre-chapter 398 level. Although Tillinghast was unable to quantify the impact of such a proposed revision due to incomplete data, they suggested that it would have a "relatively minimal impact on system costs."

Finally, the Council has voted to endorse the concept of **House Bill 2205**, filed by Representative Walsh. This bill would provide a vehicle for both private citizens and insurers to bring forth a civil action against employers who illegally fail to pay workers' compensation premiums as mandated by Chapter 152. On suits brought forth by private citizens, the majority of the damages would be deposited into the DIA's Special Fund to pay for the agency's operating expenses. Insurance carriers would be able to recover the full amount of the award in situations where they obtain court approval to replace the private citizens in the lawsuit. The Advisory Council believes that the concept of this legislation will help alleviate the competitive disadvantage faced by the vast majority of honest employers who purchase workers' compensation policies, when their competitors may not. The Advisory Council is only supporting this bill in concept due to the fact that additional changes are expected to be made. We welcome the opportunity to work with the legislature in the refinement of this bill.

On behalf of the Advisory Council, I would like to thank the Joint Committee on Commerce & Labor for holding this hearing and allowing us the opportunity to share our recommendations. However, it is important to note that the Advisory Council reserves the right to remove any endorsement on a specific bill if altered or attached to other legislation not supported by the Council. Any effort to amend the workers' compensation system must be carefully scrutinized to ensure that changes to the statute will build upon the successful aspects of the system, benefiting both injured workers and employers.

Thank you for the consideration of our recommendations.

We will be happy to answer any questions.

APPENDIX I

Testimony:
Workers' Compensation Advisory Council

Office of Commerce & Labor
State House – Gardner Auditorium
February 12, 2003

Good morning. My name is Tom Jones, Chair of the Massachusetts Workers' Compensation Advisory Council. I am joined by William Carnes, Vice Chair of the Council. I am also joined by Andrew Burton who serves as our Executive Director. Mr. Carnes is the Vice President and Business Agent of Local 25 of the Teamsters Union and represents the interests of labor on the Council. I am the Vice President and Counsel of the Employer's Resource Group for Associated Industries of Massachusetts and represent the interests of business on the Council.

The Advisory Council is a volunteer board comprised of leaders from labor and business, as well as representatives from the legal, medical, insurance and vocational rehabilitation communities. Each month, Council Members come together to discuss a variety of workers' compensation issues with the ultimate goal of reaching a consensus. When compromise can be reached between labor and business, these positions are reflected in our recommendations.

We are here today to describe the Division of Industrial Accidents and express our concerns regarding how the DIA's line-item is treated during the Commonwealth's budget process. A common misconception made is that the DIA is a tax-funded agency and that reducing its funding, specifically across the board cuts, will help alleviate budget shortfalls in Massachusetts. This is entirely untrue.

As exhibited in the attached chart, the DIA administers three separate budgets, which are funded solely by assessments on workers' compensation policies, fines for various infractions against the Workers' Compensation Act, and fees. The three funds are made up of the Special Fund, the Private Trust Fund, and the Public Trust Fund. The Special Fund is used to pay for the operation of the agency. The Trust Funds were established so the DIA can make payments to uninsured-injured employees and employees denied vocational rehabilitation services by their insurers. In addition, the Trust Fund is required to reimburse insurers for benefits for injuries involving veterans, second injuries, and for specified cost of living adjustments. One account is reserved for payments to private sector employees, while the other account is for payments to public sector employees.

During the fiscal year 2002 budget process, the Legislature's Budget Conference Committee reduced the DIA's line-item by over $1.0 million as a result of an across the board cut from all previous amounts proposed. Although the Governor later restored this funding in a supplemental budget, the overall efficiency and effectiveness of the DIA in

assisting injured workers was jeopardized when the DIA's account was apparently misconstrued and treated as a tax-funded agency rather than a totally assessment-funded organization.

In the Workers' Compensation Reform Act of 1985, the Commonwealth's employer community agreed to be assessed to pay for the DIA to ensure that it would always have adequate funding to fulfill its mandate. As part of that agreement, the law also established the Workers' Compensation Advisory Council as an oversight board to monitor and evaluate the DIA's operating budget and performance. The Advisory Council remains committed in monitoring the fiscal year 2004 budget process to ensure the DIA can provide effective services to injured workers and to all employers. Any effort to increase or decrease the DIA's funding will be carefully scrutinized to ensure that the agency will have adequate funding to fulfill its statutory mandate.

In closing, the Advisory Council would like all parties involved in the state budget process to recognize that the DIA is funded by an assessment on employers which is based on an amount determined to be adequate for the operation of the DIA. There are **no tax dollars** used to fund this agency or any of its activities, as the DIA's Special Fund is used to reimburse the Commonwealth's General Fund for 100% of its budgeted appropriation.

On behalf of the Advisory Council, I would like to thank the Office of Commerce & Labor for holding this hearing and allowing us the opportunity to share our recommendations. We will be happy to answer any questions.

APPENDIX J

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

Massachusetts Workers' Compensation Advisory Council
600 Washington Street, Boston, MA 02111
Phone: *617-727-4900 x378* Web Page: *http://www.state.ma.gov/wcac/*
The Advisory Council is a labor-management committee appointed by the Governor to monitor, make recommendations, give testimony, and report on all aspects of the workers' compensation system, except the adjudication of particular claims or complaints, and to improve the workers' compensation system in the Commonwealth.

Division of Industrial Accidents (DIA)
600 Washington Street, Boston, MA 02111 (Boston Office)
Phone: *617-727-4900* Info: *800-323-3249 x470* Web Page: *http://www.state.ma.gov/dia/*
The Division of Industrial Accidents administers the Commonwealth's workers' compensation system. The DIA provides prompt and rational compensation to victims of occupational injuries and illness, and oversees that medical treatment to injured workers is provided in a timely manner while balancing the needs of employers to contain workers' compensation insurance costs.

Joint Committee on Commerce and Labor
State House, Room 43, Boston, MA 02133
Phone: *617-722-2030* Web Page: *http://www.state.ma.gov/legis/comm/j12.htm*
The Commerce and Labor Committee consists of elected state representatives and senators. It is their duty to consider all matters concerning commercial, industrial and mercantile establishments, industrial development, consumer protection, and discrimination with respect to employment, labor laws and other such matters.

Office of the Governor
State House, Room 360, Boston, MA 02133
Phone: *617-727-7238* Web Page: *http://www.state.ma.gov/gov*
The Governor appoints the Director of Labor, the Director of Economic Development, the Commissioner of the DIA, Administrative Judges and Administrative Law Judges of the DIA, as well as the members of the Workers' Compensation Advisory Council.

Governor's Council
State House, Room 184, Boston, MA 02133
Phone: *617-727-2795* Web Page: *http://www.state.ma.gov/gov/govco.htm*
The Massachusetts Governor's Council, also known as the Executive Council, is composed of eight individuals elected from districts, and the Lt. Governor who serves ex officio. The eight councilors are elected from their respective districts every two years. The Council generally meets at noon every Wednesdays in its State House Chamber, next to the Governor's Office, to act upon 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. All DIA judges are appointed by the Governor subject to the consent & approval of the Governor's Council.

Department of Labor and Workforce Development
One Ashburton Place, Boston, MA 02108
Phone: *617-727-6573* Web Page: *http://www.state.ma.gov/dlwd/*
The Department of Labor and Workforce Development 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 Division of Industrial Accidents in one of five departments that fall under the Department of Labor and Workforce Development. The Director of Labor is an ex-officio member of the Workers' Compensation Advisory Council.

Massachusetts Rehabilitation Commission
59 Temple Place, Boston, MA 02111
Phone: *617-482-1780* Web Page: *http://www.state.ma.gov/mrc/*
The mission of the MRC is to provide comprehensive services with and for persons with disabilities toward the goal of employment and independence. In cooperation with other public and private human service organizations, the MRC promotes its ultimate vision of equality, empowerment and productive independence of individuals with disabilities.

Department of Business and Technology
One Ashburton Place, Boston, MA 02108
Phone: *617-727-8380* Web Page: *http://www.state.ma.gov/dbt/*
The Department of Economic Development and its offices and divisions seek to promote job creation and long-term economic growth in Massachusetts. It seeks to attract new businesses to the state, help existing businesses expand, assist emerging firms in obtaining the human, financial, and technological resources necessary to prosper and grow, and provide assistance and training to the unemployed and underemployed. The Director of Economic Development is an ex-officio member of the Workers' Compensation Advisory Council.

Office of the Attorney General
One Ashburton Place, Boston, MA 02108
Phone: *617-727-2200* Web Page: *http://www.state.ago.state.ma.gov/*
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.

Insurance

Division of Insurance (DOI)
One South Station, 5th floor, Boston, MA 02110
Phone: *617-521-7794* Web Page: *http://www.state.ma.us/doi/*
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
Phone: *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
Phone: *617-727-4900 x409*
Issues stop work orders and fines employers without workers' compensation insurance.

The Workers' Compensation Rating and Inspection Bureau of Massachusetts (WCRIB)
101 Arch Street, 5th floor, Boston, MA 02110
Phone: *617-439-9030* Web Page: *www.wcribm.org*
Private non profit body funded by insurers;

- Licensed rating organization for workers' compensation; WCRIB submits workers' compensation insurance rates, rating plans, and forms for approval (rates are subject to approval by the Commissioner of Insurance);
- WCRIB 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
Phone: *407-997-1000* Web Page: *http://www.ncci.com/index.html*
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 WCRIB;
- Determines residual market loss reserves.
- In 34 other states, NCCI is the organization that files for insurance rates or loss costs (in Massachusetts, it is the WCRIB that files for rate changes);
- NCCI also administers various state funds where the state acts as an insurance carrier for workers' compensation.

Medical

Division of Health Care Finance and Policy
2 Boylston Street, Boston, MA 02116
Phone: *617-451-5340* Web Page: *http://www.state.ma.gov/dhcfp/*
The Division of Health Care Finance and Policy (formerly the Rate Setting Commission) sets reimbursement rates for medical services in workers' compensation.

DIA - The Health Care Services Board
Phone: *617-727-4900 x578* Web Page: *http://www.state.ma.gov/dia/hcsb*
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
Phone: *781-893-4610 / 800-322-2303* Web Page: *http://www.massmed.org/*
Private, non-profit professional association represents the Massachusetts physician community.

Massachusetts Hospital Association
5 New England Executive Park, Burlington, MA 01803
Phone: *781-272-8000* Web Page: *http://www.mhalink.org*
The Massachusetts Hospital Association (MHA) is a voluntary, non-profit organization comprised of hospitals and health systems, related organizations, and other members with a common interest in promoting the health of the people of the Commonwealth.

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

Massachusetts Chiropractic Society
76 Woodland Street, Methuen, MA 01844-4295
Phone: *978-682-8242 / 800-442-6155* Web Page: *http://www.masschiro.org*
The Massachusetts Chiropractic Society a non-profit membership service organization representing the chiropractic profession in Massachusetts. The Society's principle function is to maintain the standards in education, ethics, and professional competency necessary to meet the requirements of the profession and the expectations of the general public.

American Physical Therapy Association of Massachusetts
14 Beacon Street, Suite 719, Boston, MA 02108
Phone: *617-523-4285* National Chapter: 800-999-2782 Web Page: *http://aptaofmass.org*
The American Physical Therapy Association of Massachusetts Inc., with more than 2200 members, is a component of the American Physical Therapy Association. APTA's goal is to foster advancement in physical therapy practice, education, and research.

American Occupational Therapy Association
4270 Montgomery Lane, P.O. Box 31220, Bethesda, MD 20824-1220
Phone: *301-652-2682* Web Page: *http://www.nih.gov/nia/related/aoaresrc/dir/45.htm*
The American Occupational Therapy Association (AOTA) supports the professional community for occupational therapists and develops and preserves the viability and relevance of the profession. The organization serves the interests of its members, represents the profession to the public, and promotes access to occupational therapy services.

Public Policy/ Research

Workers' Compensation Research Institute (WCRI)
955 Massachusetts Avenue, Cambridge, MA 02139
Phone: *617-661-9274* Web Page: *http://www.wcrinet.org*
WCRI is a nonpartisan, non-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
Phone: *617-262-1180* Web Page: *http://www.aimnet.org*
The Associated Industries of Massachusetts is a dues-supported, non-profit, nonpartisan employers' association dedicated to improving the Commonwealth's economic climate.

Massachusetts AFL-CIO
8 Beacon Street, Boston, MA 02108
Phone: *617-227-8260* Web Page: *http://www.massaflcio.org*
Umbrella organization represents its member local offices of unions in Massachusetts.

International Association of Industrial Accident Boards and Commissions (IAIABC)
1201 Wakarusa, C-3, Lawrence, KA 66049
Phone: *904-252-2915* Web Page: *http://www.iaiabc.org*
The International Association of Industrial Accident Boards and Commissions serves the needs of the workers compensation system through promoting efficient and farsighted regulation and administration of the law.

Fraud

Insurance Fraud Bureau of Massachusetts (IFB)
101 Arch Street, Boston, MA 02110
Phone: *617-439-0439* (*1-800-32FRAUD*) Web Page: *http://www.ifb.org*
The Insurance Fraud Bureau of Massachusetts is a multifaceted investigative agency dedicated to the systematic elimination of fraudulent insurance transactions. Authorized by an Act of the Massachusetts Legislature and signed into law in 1990, the Insurance Fraud Bureau undertakes cases for investigation and preparation for criminal prosecution. The Bureau is wholly funded by the insurance industry in Massachusetts.

Safety

Office of the Attorney General - Business and Labor Protection Bureau
Fair Labor and Business Practices Division, 200 Portland Street, Boston, MA 02114
Phone: *617-727-3477* Web Page: *http://www.ago.state.ma.gov/ago5.htm*
The Business and Labor Protection Bureau investigates and prosecutes violations of child labor laws and work-related injuries to minors, grants workplace procedure waivers, inspects workplace safety on construction sites, industrial sites and in the manufacturing industry. They also prosecute egregious cases of violations of industrial workplace safety and may shut down a job site in cases of imminent danger to the safety of employees or the public.

DIA - Office of Safety
Phone: *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)).

Massachusetts Coalition of Occupational Safety and Health (MassCOSH)
555 Armory Street
Boston, MA 02130
Phone: *617-825-7233* Web Page: *http://www.masscosh.org*

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 MA Chapter (West Boylston) 508-835-2333
- *Massachusetts Safety Council* (Braintree) (Serves Eastern MA) 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.

Legal

Massachusetts Bar Association
Workers' Compensation Committee
20 West Street, Boston, MA
Phone: *617-542-3602* Web Site: *http://www.massbar.org*
The Massachusetts Bar Association is the statewide voluntary professional association for all lawyers, in all types of practice, in all areas of law.

Massachusetts Academy of Trial Attorneys
15 Broad Street, Suite 415, Boston, MA 02109
Phone: *617-248-5858* Web Site: *http://www.massacademy.com*
Private, non-profit professional association represents 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
Phone: *202-219-7491* Web Site: *http://www.dol.gov*
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).

Occupational Safety and Health Administration (OSHA)
200 Constitution Avenue, N.W.,
Washington, D.C. 20210
Regional Office: 133 Portland Street
Boston, MA 02114
Phone: *617-565-7164* Web Site: *http://www.osha.org*

National Institute for Occupational Safety and Health (NIOSH)
944 Chestnut Ridge Road,
Morgantown, WV 26505-2888
Phone: *800-356-4674* Web Site: *http://www.cdc.gov/niosh/homepage.html*
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
Phone: *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, N.W.,
Washington, D.C. 20062-2000
Phone: *202-659-6000* Web Site: *http://www.uschamber.com*
Publishes an analysis of state workers' compensation statutes.

APPENDIX K

Office of Safety Proposals
Recommended for Funding - FY 2004

1. Caritas Good Samaritan Occupational Health Services
   75 Stockwell Drive
   Avon, MA 02322
   (508) 427-3900
   Title: Occupational Safety and Health Training and Education Program
   Category of Applicant: Non-profit
   Target Population: Employees/Supervisors/Employers
   Geographic Target: Statewide
   Program Administrator: Kathleen Pacheco
   Total Funds Requested: $28,116.80 **Approved:** $28,116.80

2. Asbestos Workers, Local #43
   1053 Burts Pit Road
   Northampton, MA 01060-3630
   (413) 584-0028
   Title: Preventing Asbestos Related Disease for Building Trades Workers in Western, MA
   Category of Applicant: Labor Organization/Federation
   Target Population: Employees
   Geographic Target: Worcester/Lawrence/Springfield
   Program Administrator: Robert Starr
   Total Funds Requested: $19,330.64 **Approved:** $19,330.64

3. Hebrew Rehabilitation Center for the Aged
   12 Centre Street
   Boston, MA 02131
   (617) 363-8475
   Title: Ergonomic Training Program
   Category of Applicant: Private Employer
   Target Population: Employees/Employers/Supervisors
   Geographic Target: Boston
   Program Administrator: Maria Parasirakis
   Total Funds Requested: $30,000.00 **Approved:** $30,000.00

4. Pioneer Valley Central Labor Council
   640 Page Blvd.
   Springfield, MA 01104
   (413) 732-7970
   Title: Keep Safe: Health and Safety on the Job
   Category of Applicant: Labor Organization
   Target Population: Employees
   Geographic Target: Springfield
   Program Administrator: Irene Kimball
   Total Funds Requested: $13,723.26 **Approved:** $13,723.26

5. Genzyme Corporation
11 Pleasant Street Connector
Framingham, MA 01701-9322
(508) 270-2356
Title: Ergonomic Training to Prevent Work Related Musculo-skeletal Injuries
Category of Applicant: Private Employer
Target Population: Employees/Employers/Supervisors
Geographic Target: Fall River, Boston
Program Administrator: Linda Devlin
Total Funds Requested: $30,000.00 **Approved:** $30,000.00

6. Electrical JATC
187 Industrial Avenue
Springfield, MA 01104
(413) 737-2253
Title: Safety Issues for Electricians
Category of Applicant: Labor Organization
Target Population: Employees
Geographic Target: Springfield
Program Administrator: Ron Grise
Total Funds Requested: $29,596.50 **Approved:** $29,596.50

7. Acushnett Company
333 Bridge Street
Fairhaven, MA 02719
(508) 979-2358
Title: Ergonomic Training to Prevent Musculo-Skeletal Injuries
Category of Applicant: Private Employer
Target Population: Employees/Safety Committee
Geographic Target: Fall River
Program Administrator: Kathleen Kellerman
Total Funds Requested: $28,759.50 **Approved:** $28,759.00

8. North Andover Fire Department
124 Main Street
North Andover, MA 01845
(978) 688-9590
Title: Chemical Awareness & CPR for North Andover School Custodians
Category of Applicant: Public Employer
Target Population: Employees/Supervisors
Geographic Target: Lawrence
Program Administrator: William Dolan
Total Funds Requested: $5,631.64 **Approved:** $6,416.16

9. Intercity Homemaker Service, Inc.
33 Dartmouth Street
Malden, MA 02148
(781) 321-6300, ext. 149
Title: Ergonomic Training for Musculo-skeletal Disorders
Category of Applicant: Private Employer
Target Population: Employees/Supervisors
Geographic Target: Boston
Program Administrator: Annamaria Georgopoulos
Total Funds Requested: $15,675.00 **Approved:** $15,675.00

10. Quadrant Health Strategies, Inc.
34 Salem Street
Wilmington, MA 01887
(978) 988-8832
Title: Ergonomic Training to Prevent Musculoskeletal Injuries
Category of Applicant: Private Employer
Target Population: Employees/Employer
Geographic Target: Fall River
Program Administrator: Rena Hannaford
Total Funds Requested: $29,643.00 **Approved:** $29,462.50

11. Advanced Therapeutic Resources
100 Main Street, Suite 16
Amesbury, MA 01913
(508) 388-6775
Title: Improving Safety Awareness at Seven Different Companies
Category of Applicant: Private Employer
Target Population: Employees/Supervisors
Geographic Target: Boston
Program Administrator: Trish Going
Total Funds Requested: $30,000.00 **Approved:** $30,000.00

12. Henry Lee Willis Community Center, Inc.
119 Forest Street
Worcester, MA 01609
(508) 799-0702
Title: A Program to Reduce Injuries and Lost Workdays Due to Resident Aggression
Category of Applicant: Private Employer
Target Population: Employees/Employers
Geographic Target: Statewide
Program Administrator: Carlton Watson
Total Funds Requested: $29,704.00 **Approved:** $29,704.00

13. Franklin Regional Council of Governments
425 Main Street
Greenfield, MA 01301
(413) 774-3167
Title: Preventing Occupational Injury & Building Safety Awareness in Franklin County Towns and Schools
Category of Applicant: Public Employer
Target Population: Employees/Supervisors/Employers
Geographic Target: Springfield
Program Administrator: Lisa White
Total Funds Requested: $25,480.25 **Approved:** $25,480.25

14. Haemonetics Corporation
400 Wood Road
Braintree, MA 02184
(781) 848-7100
Title: Implementation of Ergonomics and Injury Preventation at Haemonetics
Category of Applicant: Private Employer
Target Population: Employees/Supervisors
Geographic Target: Boston
Program Administrator: Mitch Campbell
Total Funds Requested: $19,350.00 **Approved:** $19,350.00

15. MA Bay Self-Insurance Group, Inc.
12 Gill Street, Suite 5500
Woburn, MA 01888-4043
(781) 938-0900
Title: Preventation of Musculo-skeletal Disorders through Ergonomic Training
Category of Applicant: Non-profit
Target Population: Employees/Supervisors
Geographic Target: Statewide
Program Administrator: Kathleen Meloon
Total Funds Requested: $21,225.00 **Approved:** $21,225.00

16. Operating Engineers, Local 98
2 Center Square
E. Longmeadow, MA 01028
(413) 525-4221
Title: Homeland Security Health and Safety Awareness Program
Category of Applicant: Joint Labor Management Committee
Target Population: Employees
Geographic Target: Springfield
Program Administrator: Michael J. Florio
Total Funds Requested: $28,454.16 **Approved:** $28,454.16

17. Acushnett Rubber dba Precix, Inc.
744 Belleville Street
New Bedford, MA 02745
(508) 998-4095
Title: Ergonomic Training to Prevent Musculo-Skeletal Injuries, First-Aid, CPR
Category of Applicant: Private Employer
Target Population: Employees/Supervisors/Safety Team
Geographic Target: Fall River
Program Administrator: Lou Cabot
Total Funds Requested: $30,000.00 **Approved:** $30,000.00

18. Envirobusiness, Inc.
701 Concord Avenue
Cambridge, MA 02138
(617) 868-4321
Title: Ergonomics and Bloodborne Pathogens Safety Training Program
Category of Applicant: Private Employer
Target Population: Employees
Geographic Target: Statewide
Program Administrator: Kevin McManus
Total Funds Requested: $29,157.00 **Approved:** $29,157.00

19. Mt. Wachusett Community College
444 Green Street
Gardner, MA 01440-1000
(978) 632-6600
Title: Computer based Safety Training and Stress Management Program
Category of Applicant: Public Employer
Target Population: Employees/Supervisor
Geographic Target: Worcester
Program Administrator: Diane Greb
Total Funds Requested: $18,000.00 **Approved:** $18,000.00

20. Minuteman Tech High School
758 Marrett Road
Lexington, MA 02173
(781) 861-6500, ext. 348
Title: Occupational Safety and Health Education and Training
Category of Applicant: Public Employer
Target Population: Employees/Supervisors
Geographic Target: Boston
Program Administrator: Carol Zanin
Total Funds Requested: $29,950.00 **Approved:** $29,950.00

21. Mass Compliance, LLC
P.O. Box 609
West Falmouth, MA 02574
(978) 857-9552
Title: Hazwopper Training for Three Private Companies
Category of Applicant: Private Employer
Target Population: Employees/Employers/Supervisors
Geographic Target: Statewide
Program Administrator: Beth Comeau DiPietro
Total Funds Requested: $29,719.10 **Approved:** $29,719.10

22. The Mitre Corporation
202 Burlington Road
Bedford, MA 01730
(781) 271-3028
Title: Ergonomic Training to Prevent Musculo-skeletal Injuries
Category of Applicant: Non-profit
Target Population: Employees/Supervisors/Safety Committee
Geographic Target: Boston
Program Administrator: Joyce Barth
Total Funds Requested: $24,565.50 **Approved:** $24,565.50

23. City of Worcester, City Hall
455 Main Street
Worcester, MA 01608
(508) 799-1185
Title: Tips on the Prevention of Workplace Back Injuries/Sprains and Strains
Category of Applicant: Non-profit/Public Employer
Target Population: Employees
Geographic Target: Worcester
Program Administrator: Lisa Carmody
Total Funds Requested: $10,363.00 **Approved:** $10,363.00

24. Labor-Management Construction Alliance
256 Freeport Street
Boston, MA 02122
(617) 436-4159
Title: Workplace Hazard Education for Construction Workers
Category of Applicant: Non-profit
Target Population: Employees
Geographic Target: Statewide
Program Administrator: Mary Vogel
Total Funds Requested: $29,953.00 **Approved:** $29,953.00

25. Brunetta Associates
15 Houston Street
Methuen, MA 01844
(978) 688-8745
Title: Occupational Safety and Health Education and Training Program
Category of Applicant: Private Employer
Target Population: Employees/Employers/Supervisors
Geographic Target: Statewide
Program Administrator: Anthony Brunetta
Total Funds Requested: $29,972.50 **Approved:** $29,972.50

26. Printing Industries of New England
8 Crystal Pond Road
Southborough, MA 01772
(508) 404-4100
Title: Lockout/Tagout Training for the Printing Industries
Category of Applicant: Non-profit Employer
Target Population: Employees/Employers/Supervisors
Geographic Target: Statewide
Program Administrator: Mark Flannery
Total Funds Requested: $19,546.00 **Approved:** $19,546.00

27. MKS
6 Shattuck Road
Andover, MA 01810
(978) 975-2350
Title: OSHA Outreach Training
Category of Applicant: Public Employer
Target Population: Employees/Employers/Supervisors
Geographic Target: Lawrence
Program Administrator: Daniel Shea
Total Funds Requested: $29,125.00 **Approved:** $29,125.00

28. Office of the Attorney General
One Ashburton Place
Boston, MA 02108-1698
(617) 727-5768 ext. 2031
Title: Occupational Safety and Health Education and Training Program
Category of Applicant: Public Employer
Target Population: Employees/Employers/Supervisors
Geographic Target: Statewide
Program Administrator: Joseph Shea
Total Funds Requested: $18,850.50 **Approved:** $18,850.50

29. Western MassCOSH
640 Page Boulevard
Springfield, MA 01104
(413) 731-0760
Title: Training to Protect the Health and Safety of Employees in the City of Chicopee, MA
Category of Applicant: Non Profit
Target Population: Employees/Supervisors
Geographic Target: Springfield
Program Administrator: Aaron Wilson
Total Funds Requested: $2,275.00 **Approved:** $2,275.00

30. Family Services of Fall River Home Assistance Program
151 Rock Street
Fall River, MA 02720
(508) 678-7542
Title: Health and Safety Training
Category of Applicant: Private Employer
Target Population: Employees/Supervisors
Geographic Target: Fall River
Program Administrator Susan Potvin
Total Funds Requested: $29,969.50 **Approved:** $29,969.50

31. Boston Carpenters Apprenticeship & Training
385 Market Street
Brighton, MA 02135
(617) 782-4314
Title: Occupational Safety and Health Training Program
Category of Applicant: Labor/Management
Target Population: Employees/Supervisors/Employer
Geographic Target: Statewide
Program Administrator: Benjamin Tilton
Total Funds Requested: $29,730.60 **Approved:** **$**29,730.60

32. Bridgewater State College
Boyden Hall
Office of Environmental Safety
Bridgewater, MA 02325
(508) 531-2751
Title: Slips, Trips, Falls and Lifting/Back Repetitive Motion Injuries Prevention Program
Category of Applicant: Public Employer
Target Population: Employees/Employers
Geographic Target: Bridgewater
Program Administrator: Patricia Delaney
Total Funds Requested: $26,253.64 **Approved:** $26,253.64

33. Sargent and Associates
23 Chelmsford Street
Chelmsford, MA 01824
(978) 256-7459
Title: Ergonomics Training for EMT's, Paramedics, and Wheelchair Van Operators
Category of Applicant: Private Employer
Target Population: Employees/Supervisors/Employers
Geographic Target: Lawrence
Program Administrator: William Russell
Total Funds Requested: $15,306.00 **Approved:** $15,306.00

34. Compliance Integration
12 Williams Street
Beverly, MA 01915
(978) 821-4714
Title: Occupational Safety and Health Training
Category of Applicant: Private Employer
Target Population: Employees/Supervisors/Employer
Geographic Target: Lawrence
Program Administrator: Cindy Keegan
Total Funds Requested: $23,150.00 **Approved:** $14,049.89

APPENDIX L

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. Includes contracted faculty; contracted advisory board/commission members; seasonal; student interns, etc. (These employees are generally not eligible for benefits.)

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 charge-back; universal health insurance payments, etc.

Subsidiary EE: Administrative Expenses

Expenses associated with divisional operations. Includes office and administrative supplies; printing expenses and supplies; micrographic supplies; central reprographic charge-back; 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.

APPENDIX M

COLLECTIONS AND EXPENDITURES REPORT - FISCAL YEAR 2003

SPECIAL FUND	FY'03	FY'02	FY'01	FY'00	FY'99
COLLECTIONS					
INTEREST	**209,426**	**342,449**	**932,637**	**959,382**	**808,450**
ASSESSMENT	23,213,608	16,031,304	14,427,829	16,363,865	16,154,391
LESS RET. CHECKS	0	(2,789)	(9,320)	0	(2,032)
LESS REFUNDS	(20,171)	(258,971)	(332,081)	(6,666)	(35,059)
SUB-TOTAL	**23,193,437**	**15,769,544**	**14,086,428**	**16,357,199**	**16,117,300**
FILING FEES	5,264,175	4,254,978	4,431,724	4,102,258	3,840,649
COLLECTION FEE	(21,944)	(23,705)	(18,778)	(16,073)	(20,873)
LESS RET. CHECKS	(6,610)	(2,739)	(1,027)	(2,044)	(1,486)
LESS REFUNDS	(7,480)	(7,325)	(7,368)	(9,319)	(3,784)
SUB-TOTAL	**5,228,141**	**4,221,209**	**4,404,551**	**4,074,822**	**3,814,506**
1ST REPORT FINES	179,750	333,515	378,050	378,310	321,593
LESS COLLECTION FEE	(5,798)	(12,460)	(13,100)	(14,550)	(14,111)
LESS RET. CHECKS	0	(1,640)	(500)	(500)	(200)
LESS REFUNDS	(200)	(700)	(200)	(1,100)	(100)
SUB-TOTAL	**173,752**	**318,715**	**364,250**	**362,160**	**307,182**
STOP WORK ORDERS	637,426	393,340	465,961	392,343	480,995
LESS REFUNDS	(1,750)	(423)	0	(1,100)	(100)
LESS BAD CHECKS	(29,962)	(5,250)	(12,208)	(18,130)	(10,233)
COLLECTION FEE	(72,156)	(25,842)	(50,639)	(52,816)	(73,031)
SUB-TOTAL	**533,558**	**361,825**	**403,114**	**320,297**	**397,631**
LATE ASSESS. FINES	19,574	28,124	36,661	24,611	40,698
SEC. 7 & 14 FINES	5,700	0		7,912	(13,600)
MISCELLANEOUS	43,800	56,120	43,472	42,526	31,765
SUB-TOTAL	**69,074**	**84,244**	**80,133**	**75,049**	**58,863**
TOTAL COLLECTIONS	**29,407,388**	**21,097,986**	**20,271,113**	**22,148,909**	**21,503,932**
BALANCE BRGT FWD	7,638,265	10,065,860	12,725,215	11,785,359	10,915,459
TOTAL	**37,045,653**	**31,163,846**	**32,996,328**	**33,934,268**	**32,419,391**
LESS EXPENDITURES	(22,316,917)	(23,525,582)	(22,930,468)	(21,209,053)	(20,634,032)
BALANCE	**14,728,736**	**7,638,264**	**10,065,860**	**12,725,215**	**11,785,359**
EXPENDITURES					
ORACLE START-UP	936,853	2,731,097			
ORACLE SOFTWARE			408,754		
UNISYS CORP.			23,264		
ORACLE CONSULTANTS			825,000		
SUN MICROSYSTEMS			4,264		
TOTAL	**936,853**	**2,731,097**	**1,261,282**		
REPAYMENT					
SALARIES	13,788,158	13,644,820	13,158,744	13,003,221	12,607,469
FRINGE BENEFITS	2,969,507	2,965,931	3,798,264	3,104,485	3,016,856
INDIRECT COSTS	405,376	285,004	332,090	466,539	410,052
NON-PERSONNEL COSTS	4,171,404	3,872,690	4,348,884	4,584,213	4,599,654
IP INDIRECT-EX	45,619	29,528	31,204	50,595	
ADJUSTMENT		(3,488)			
TOTAL REPAYMENT	**21,380,064**	**20,794,485**	**21,669,186**	**21,209,053**	**20,634,031**

COLLECTIONS AND EXPENDITURES REPORT - FISCAL YEAR 2003

PUBLIC TRUST	***FY'03***	***FY'02***	***FY'01***	***FY'00***	***FY'99***
COLLECTIONS					
INTEREST	**2,924**	**5,376**	**21,904**	**3,135**	**6,322**
ASSESSMENTS	2,094,687	3,376,503	3,103,066	1,981,649	2,422,464
REFUNDS	0	(39,494)			
BD CHECKS		0	0	0	0
TOTAL ASSESSMENTS	**2,094,687**	**3,337,009**	**3,103,066**	**1,981,649**	**2,422,464**
TOTAL COLLECTIONS	**2,097,611**	**3,342,385**	**3,124,970**	**1,984,784**	**2,428,786**
BALANCE BRGT FWD	37,945	56,716	25,572	15,984	3,078
TOTAL	**2,135,556**	**3,399,101**	**3,150,542**	**2,000,768**	**2,431,864**
LESS EXPENDITURES	(2,122,546)	(3,361,156)	(3,093,826)	(1,975,196)	(2,415,880)
BALANCE	**13,010**	**37,945**	**56,716**	**25,572**	**15,984**
EXPENDITURES					
RR COLAS	2,106,371	3,249,773	3,023,919	1,758,754	1,986,675
RR SEC. 37	16,175	111,383	69,907	182,203	329,406
RR SEC. 19 COLA	0	0	0	34,239	99,799
RR REHAB			0	0	0
SHELBY CLAIMS					
MM IME SEC 37			0	0	0
TOTAL EXPENDITURES	**2,122,546**	**3,361,156**	**3,093,826**	**1,975,196**	**2,415,880**

PRIVATE TRUST	***FY'03***	***FY'02***	***FY'01***	***FY'00***	***FY'99***
COLLECTIONS					
INTEREST	**266,311**	**511,003**	**1,246,983**	**1,077,109**	**684,536**
ASSESSMENTS	41,155,377	41,651,141	39,778,971	40,602,911	45,753,726
LESS RET. CHECKS	0	(6,533)	(60,437)	0	(99,739)
LESS REFUNDS	(45,402)	(820,175)	(994,294)	(209)	0
SUB-TOTAL	**41,109,975**	**40,824,433**	**38,724,240**	**40,602,702**	**45,653,987**
REIMBURSEMENTS	698,536	922,936	547,085	1,015,647	1,535,973
LESS COLLECTION FEE	(220)	(783)	(1,005)	(1,554)	(68,582)
RET. CHECK	(1,000)	(5,290)	(6,193)	(5,978)	(68,163)
REFUNDS	(15,000)	(519)	(588)	(325)	0
SUB-TOTAL	**682,316**	**916,344**	**539,299**	**1,007,790**	**1,399,228**
SEC. 31-J. FERNANDEZ			**8,068**		
SEC. 30 H	**3,630**	**3,471**	**0**	**8,846**	**5,583**
TOTAL COLLECTIONS	**42,062,232**	**42,255,251**	**40,518,590**	**42,696,447**	**47,743,334**
BALANCE BRGT FWD	22,394,085	23,172,956	18,724,712	18,952,485	10,405,623
TOTAL	**64,456,317**	**65,428,207**	**59,243,302**	**61,648,932**	**58,148,957**
LESS EXPENDITURES	(48,152,196)	(43,034,125)	(36,070,345)	(42,924,220)	(39,196,473)
BALANCE	**16,304,121**	**22,394,082**	**23,172,957**	**18,724,712**	**18,952,484**

COLLECTION AND EXPENDITURE REPORT - FISCAL YEAR 2003

EXPENDITURES	***FY'03***	***FY'02***	***FY'01***	***FY'00***	***FY'99***
RR SEC. 34	696,301	496,677	732,945	616,463	512,980
RR SEC. 35	243,633	291,047	297,577	391,977	499,521
RR LUMP SUM	749,968	1,462,143	699,231	585,288	605,388
RR SEC. 36	184,359	184,054	39,953	110,339	402,173
RR SEC. 31	69,226	71,502	281,105	79,231	89,077
RR SEC. 34, PERM. TOTAL	311,716	305,627	265,364	261,656	186,699
RR SEC.31-J. FERNANDEZ			8,068		
RR COLA ADJ	175,618	167,841	137,101	158,367	118,130
RR EE MEDICAL	38,453	48,593	44,634	59,453	46,298
RR EE TRAVEL	84	0	0	87	443
RR EE MISC. EXPENSE	550	0	0	0	235
RR EE BOOKS & SUPPLIES	0	0	0	0	0
RR BURIAL BENEFITS	1,969	4,000	0	0	0
RR VETERAN LIENS	0	0	0	0	0
RR LEGAL FEES	296,840	408,008	256,360	276,535	259,326
RR LEGAL EXPENSES		23,815	22,777	23,372	17,636
RR LEGAL MISC. / OTHER		6,384	2,141	2,222	2,000
RR MEDICAL EXPENSES		23,000	109	2,724	0
RR VOC. REHAB SERVICES	6,927	4,442	4,837	14,955	10,168
RR REHAB. SERV. TRAVEL	0	64	98	356	393
RR LABOR MARKET STUDY	7,000	7,000	11,093	12,569	8,400
RR REHAB (PRIOR YEAR)	406	6	2,925	1,323	0
RR MEDICAL	994,132	1,199,572	406,235	592,679	528,946
RR MEDICAL RECORDS		567	1,853	1,262	1,402
RR WELFARE LIENS	0	93,728	88,403	26,357	0
SUB-TOTAL RR	**3,777,182**	**4,798,070**	**3,302,809**	**3,217,215**	**3,289,215**
MM TUITION	**2,085**	**1,140**	**0**	**0**	**335**
SUB-TOTAL CLAIMANTS	**3,779,267**	**4,799,210**	**3,302,809**	**3,217,215**	**3,289,550**
INSURERS					
RR COLAS	17,809,263	15,835,070	15,325,146	11,837,661	13,875,293
RR SEC. 19 COLA LUMP SUM	1,021,639	1,203,306	1,026,126	648,587	583,460
RR SHELBY CLAIMS	0	0	86,033	85,000	0
RR LATENCY SEC. 35	1,377,046	1,173,347	950,567	798,983	504,805
RR LEGAL FEE SEC. 35	266,943	186,357	172,111	142,010	96,598
RR LEGAL EXP. SEC. 35		1,800	860	3,933	3,483
RR SEC. 37	19,863,605	16,719,602	12,782,757	23,959,801	19,043,385
SUB-TOTAL INSURERS	**40,338,496**	**35,119,482**	**30,343,600**	**37,475,975**	**34,107,024**
TOTAL LEGAL	**44,117,763**	**39,918,692**	**33,646,409**	**40,693,190**	**37,396,574**
OEVR					
JJ IME CORP.	0	0	0	0	0
MM TUITION	16,848	15,448	7,728	7,070	1,780
RR REHAB-30H	4,879	12,989	5,528	1,143	5,089
RR TRAVEL REHAB	151	0	112	65	219
RR EE TRAVEL	1,226	2,620	810	0	3,618
RR EE BOOKS & SUPPLIES	1,788	1,742	354	0	931
SUB-TOTAL OEVR	**24,892**	**32,799**	**14,532**	**8,278**	**11,637**
TOTAL PRIVATE TRUST	**48,152,196**	**43,034,125**	**36,070,345**	**42,924,220**	**37,408,211**

COLLECTION AND EXPENDITURE REPORT - FISCAL YEAR 2003

EXPENDITURES DEFENSE OF THE FUND	*FY'03*	*FY'02*	*FY'01*	*FY'00*	*FY'99*
AA PERSONNEL	1,569,972	1,405,120	1,147,577	1,058,255	1,011,619
AA OVERTIME	2,386	0	0	0	0
SUB-TOTAL	**1,572,358**	**1,405,120**	**1,147,577**	**1,058,255**	**1,011,619**
DD FRINGE	338,370	303,759	328,866	253,881	241,439
DD UNIVERSAL HEALTH	304	8,079	0	555	0
DD MEDICARE	10,956	293	0	15,829	0
DD UNEMPLOYMENT	2,060	1,260	2,295	2,116	2,023
DD BOND	0	310	62		
DD WORKERS' COMP CHRG.	335	19,234	1,321	6,529	
SUB-TOTAL	**352,025**	**332,935**	**332,544**	**278,910**	**243,462**
BB TRAVEL	7,384	7,252	9,322	10,261	10,778
BB TRAINING/TUITION	2,200	3,009	6,186	0	1,419
BB EMPLOYEE REIMBURS	55	0	156	91	116
BB PRIDE & PERFOMANCE	201	0	390		
BB PETTY CASH					
BB MANAGER TRAINING		1,000			
SUB-TOTAL	**9,840**	**11,261**	**16,054**	**10,352**	**12,313**
CC LAW CLERKS		**0**	**12,128**	**4,440**	
EE RENTAL/MV CHRG-BACK	2,173	1,703	0	231	262
EE DEST. OLD RECORDS	5,293				
EE ADVERTISING	54	0	0	0	0
EE BOOKS/SUPPLIES	32,881	36,887	28,971	5,069	5,885
EE IMPARTIAL APPEALS	11,650	5,600	5,950	12,650	8,550
EE CENTRAL REPRO.	0	222	0	0	0
EE OMIS CHARGEBACK		6,648	0	2,219	0
EE SEC. 37 INTEREST	0	0	46,344		
EE VERIZON WIRELESS	4,904				
EE BELL ATLANTIC	2,700				
EE NEW ENG. TEL.	2,830				
EE MOBILE PHONES		3,712	1,448	998	899
EE AT&T			5,695	0	40
EE TELEPHONE & FAX	2,224	4,577	0	7,269	11,701
EE POSTAGE	23,375	3,039	13,000	10,000	9,400
EE MCI TELEPHONE			1,242	1,594	1,099
EE QUEST COMM.	0	810			
EE STATE BOOK STORE	264				
EE REFRESHMENTS	0	594			
EE ITT COMPUTER SERV.	10,341	0	0	2,225	
EE WATER	864	1,367			
EE INDIRECT COSTS	89,017	42,493	39,296	51,937	36,900
SUB-TOTAL	**188,570**	**107,652**	**141,946**	**94,192**	**74,736**
HH CONSULTANTS	1,449,826	798,586	400,493	475,574	130,008
SUB-TOTAL	**1,449,826**	**798,586**	**400,493**	**475,574**	**130,008**
JJ OPERATIONAL SERV.	76,237	87,584	106,575	106,069	100,972
SUB-TOTAL	**76,237**	**87,584**	**106,575**	**106,069**	**100,972**

(CONTINUED ON NEXT PAGE)

COLLECTIONS AND EXPENDITURES REPORT - FISCAL YEAR 2003

EXPENDITURES DEFENSE OF THE FUND	***FY'03***	***FY'02***	***FY'01***	***FY'00***	***FY'99***
GG BOSTON LEASE	322,676	293,687	146,846	146,846	146,846
GG ELECTRICITY	2,859	5,432	3,300	1,675	1,915
SUB-TOTAL	**325,535**	**299,119**	**150,146**	**148,521**	**148,761**
KK EQUIPMENT	294	3,036	63,010	7,681	31,288
SUB-TOTAL	**294**	**3,036**	**63,010**	**7,681**	**31,288**
LL PRAXIS		0	0	8,116	10,757
LL PAGE NETWORK		0	52	13	26
LL XEROX	3,024	4,524	4,448	0	6,739
LL MOBIL COMM					
LL ORACLE	8,891	0	0	5,063	
LL SIMPLEX	0	0	0	0	0
LL FAIRCHILD	2,153	2,870	2,929	1,311	1,217
LL PITNEY BOWES	101	912	681		
LL IKON	493	778	976		
LL SUN	0	6,853	7,829		
LL RETROFIT	3,514	4,037	5,652		
LL COMMAIR	348				
LL CAM OFFICE SERV	74				
LL PYRAMID	16,164	16,164	16,164	16,564	16,164
LL CONGRESS ALARM	94	140			
LL RICOH	0	63			
SUB-TOTAL	**34,856**	**36,341**	**38,731**	**31,067**	**34,903**
RR PENALTIES SEC. 8	0	1,000	200	0	200
SUB-TOTAL	**0**	**1,000**			
TT				7,859	
SUB-TOTAL				**7,859**	
TOTAL DEFENSE OF FUND	**4,009,541**	**3,082,634**	**2,409,404**	**2,222,752**	**1,788,262**
TOTAL EXPENDITURES	**52,161,737**	**46,116,759**	**38,479,749**	**45,146,972**	**39,196,473**

APPENDIX N

Workers' Compensation Legislation

Before the Joint Committee on Commerce & Labor
2003-2004 Legislative Session

HOUSE BILLS:

HOUSE BILL 297
Filed By: Rep. Thomas P. Kennedy
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: WC Rates (c.118G, §7), Provider Complaints to HCSB (c.152 §13), Medical Report Fees (§30A) DIA Review - Insurer Claims Procedures (§13) Disciplinary Measures (§13)

Section 1 of this refiled bill (formerly H.2282 and S.101) would amend c.118G mandating that rates for physician and hospital services paid for under Chapter 152, set by the Division of Health Care Finance & Policy, be comparable to rates paid by commercial carriers. In addition, rates would be established that fully cover administrative costs associated with services to patients covered under c.152 when these costs exceed those covered under commercial health insurance policies.

Section 2 of this bill would amend c.152, §13 by requiring that the Health Care Services Board hear complaints by physicians regarding insurers and report the findings to the Division of Insurance.

Section 3 and 4 of this bill would amend c.152, §30A by requiring an insurer to pay the fee for medical reports within 14 days upon receipt. The insurer would also be subject to the same civil fines for failing to pay for reports as physicians are subject to for failing to make reports.

Section 5 of this bill would amend c.152, §13 by requiring the Division of Industrial Accidents to review the claims procedures of workers' compensation insurers including "duplicative and excessive documentation of service requests, standards for utilization review, use of non-physician reviewers, and the prompt payment of claims." The DIA would also be required to review the disposition of all complaints against insurers brought before the Health Care Services Board.

Section 6 of this bill would amend c.152, §13 by allowing the Commissioner of the Division of Industrial Accidents to discipline an insurer if it is determined that the insurer has violated any part of Chapter 152 or rule adopted under this chapter.

HOUSE BILL 305
Filed By: Rep. Patricia A. Walrath
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Exemption of Non-Profit Entities (c.152, §1)

This refiled bill (formerly H.3674) would amend the word "employer" as not including: "nonprofit entities, as defined by the Internal Revenue Code, that are staffed by volunteers, board members, directors, and paid employees." This would make the requirement of obtaining workers' compensation insurance elective for said employers. Current law only exempts non-profit entities that are exclusively staffed by volunteers.

HOUSE BILL 498
Filed By: Rep. Martin J. Walsh, AFL-CIO
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Comprehensive Bill (c.152, §1(7A), §13, §14, §30, §34, §35, §36, §46A)

Section 1 of this refiled bill (formerly H.777) would amend Section 1(7A) by allowing administrative judges to consider the employee's pre-injury employment when determining predominant cause of disability.

Section 2 would amend Section 13 setting the medical payment rate at no less than 80% of the usual and customary fee for any such health care service.

Section 3 would clarify Section 14(1) providing penalties against an insurer who refuses to pay medical benefits without reasonable grounds.

Section 4 would amend Section 30 allowing an emergency conference before an administrative judge to determine if an injured worker is entitled to medical treatment.

Sections 5 and 6 would amend Section 30 by limiting utilization review to five of "the most common industrial injury or illnesses." This change would limit the utilization review process to the most frequent care given to injured workers. Failure for an insurance company to comply with utilization review time guidelines would result in said treatments to "be deemed approved."

Section 7 would increase wage benefits for injured workers under §34 by restoring the amount to 2/3 of an employee's average weekly wage.

Section 8 would amend Section 35 by adding additional circumstances under which an administrative judge may extend the number of weeks under §35 (partial disability) benefits. These additional conditions are that the injured worker has returned to employment pursuant to an Individual Written Rehabilitation Plan under Section 30(H), has been found unsuitable for vocational rehabilitation by the OEVR, has returned to work at less than their pre-injury AWW, or has a permanent partial incapacity.

Section 9 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.

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Section 10 would amend Section 46A by requiring an injured workers general health insurance carrier (if they have one) to cover all medical expenses of the injured worker until the workers' compensation insurer is ordered to pay a disputed claim. Currently, there is no language requiring a health insurance provider to cover these costs.

HOUSE BILL 670
Filed By: Rep. Eugene L. O'Flaherty
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Attorney's Fees (c.152, §13A(10)), Agreements to Pay Benefits (§19), Temporary Total Disability (§34), Permanent and Total Incapacity (§34A)

Section 1 of this refiled bill (formerly S.66) would allow attorneys to collect fees for advancing an employee's rights under §75A (preferential hiring of injured workers) and §75B (protection against handicap discrimination), in addition to any attorney's fees owed under §13A.

Section 2 of this bill adds two new subsections to §19. It would allow any administrative judge, administrative law judge or conciliator to approve any agreement to pay benefits authorized by §19. It would also allow an agreement to include a pay without prejudice clause.

Section 3 of this bill would amend §34 and require the insurer to pay the injured employee 60% of his average weekly wage (AWW) before the injury, but not more or less than the maximum or minimum weekly compensation rate, if the injury is considered total. If the AWW were found to be less than the minimum weekly compensation rate, it would then be increased to equal the AWW.

Section 4 of this bill would amend §34A and require the insurer to pay the injured employee two-thirds of his AWW before the injury, but not more or less that the maximum or minimum weekly compensation rate if the injury is considered permanent and total. If the AWW were found to be less than the minimum weekly compensation rate, it would then be increased to equal the AWW.

HOUSE BILL 671
Filed By: Rep. Eugene L. O'Flaherty
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Definition of Average Weekly Wage (c.152, §1(1)), Return to Work - Attorney Fees (§13A(4)), Eliminate Consideration of Offers at Conciliation (§13A(4))

Section 1 of this refiled bill (formerly S.77) addresses injured employees who return to work (without a lump sum settlement) and receive wages that 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.

HOUSE BILL 672
Filed By: Rep. Eugene L. O'Flaherty
Type of Bill: Refile (Partial)
Endorsed by Advisory Council: No
Laws Affected: Rate of Reimbursement - Health Care Services (c.152, §13), PPA's (§30)

Section 1 of this refiled bill (formerly S.79) deletes the current language in §13 and replaces it with simpler language. This legislation states 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. This proposed legislation 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 HCSB would be deleted.

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.

HOUSE BILL 673
Filed By: Rep. Eugene L. O'Flaherty
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Appointment of Impartial Physicians (c.152, §9C), Impartial Exams (§11A).

Section 1 of this refiled bill (formerly S.78) 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 §8(4), an impartial physician can be requested at the conference stage only at the request of the insurer after pay without prejudice period has expired.]

This bill also replaces language for §11A on impartial exams. It would remove the c.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 §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 deposing party would pay the fee for any deposition. 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.

HOUSE BILL 1241
Filed By: Rep. Martin J. Walsh
Type of Bill: NEW
Endorsed by Advisory Council: No
Laws Affected: Scar-Based Disfigurement (c.152, §36(k)), Burial Expenses (§33), Extension of Partial Incapacity Benefits (§35).

Section 1 of this new 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. Under this bill, compensation could not exceed the average weekly wage in the Commonwealth (at time of injury) multiplied by 29. Currently, the statute states that scar-based disfigurement compensation cannot exceed $15,000.

Section 2 would require an insurer to pay for burial expenses when a worker has died, not to exceed eight thousand dollars. Currently, the statute requires the insurer to pay reasonable expenses of burial, not to exceed four thousand dollars.

Section 3 would amend Section 35 by adding additional select circumstances under which an administrative judge may extend the number of weeks under §35 (partial disability) benefits. These additional conditions are that the injured worker has returned to employment pursuant to an Individual Written Rehabilitation Plan, has been found unsuitable for vocational rehabilitation, has returned to employment at less than his pre-injury average weekly wage, or has a permanent partial incapacity.

HOUSE BILL 1243
Filed By: Rep. Martin J. Walsh
Type of Bill: NEW
Endorsed by Advisory Council: No
Laws Affected: Federal Occupational Safety & Health Standards - Protecting State Employees

This new bill would require the Department of Labor & Workforce Development and the Division of Industrial [Occupational] Safety to apply the Federal Occupational Safety and Health Standards (OSHA) as minimum standards to protect workers employed at any state workplace.

HOUSE BILL 1808
Filed By: Rep. Shirley Owens-Hicks
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Impartial Physician - Appointment (c.152, §11A)

Section 1 of this refiled bill (previously H.3251) would amend §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 5 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 §14(3) (anti-fraud provisions) if they knowingly produce false or inaccurate reports to benefit the insurer.

HOUSE BILL 2197
Filed By: Rep. Anthony Petruccelli
Type of Bill: NEW
Endorsed by Advisory Council: No
Laws Affected: Scar-Based Disfigurement (c.152, §36(k)), Burial Expenses (§33), Temporary Total Benefits - Increase (§34).

Section 1 of this new 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. Under this bill, compensation could not exceed the average weekly wage in the Commonwealth (at time of injury) multiplied by 29. Currently, the statute states that scar-based disfigurement compensation cannot exceed $15,000.

Section 2 would require an insurer to pay for burial expenses when a worker has died, not to exceed eight thousand dollars. Currently, the statute requires the insurer to pay reasonable expenses of burial, not to exceed four thousand dollars.

Section 3 would increase wage benefits for injured workers under §34 (Temporary Total) by restoring the benefit to 2/3 of average weekly wage (currently 60% of AWW). This bill would also extend the amount of time an injured worker could collect benefits under §34 by deleting the 156-week maximum that compensation is due under this section.

HOUSE BILL 2198
Filed By: Rep. Michael J. Rodrigues
Type of Bill: NEW
Endorsed by Advisory Council: No
Laws Affected: Corporate Officers/Directors - Waiver of Rights (c.152, §1(4))

This new bill would clarify the "waiver of rights," as outlined in Form 153, that corporate officers or directors can exercise if they own at least 25% of the corporation's stock. Language in this bill would bar a corporate officer or director "any right created by statute, at common law, or under the law of any other jurisdiction for himself, his spouse, children, parents and any other member of his family or next of kin" against his employer or insurer for any damage or loss that is a result of injury.

Last year House Bill 4348 was signed into law allowing certain corporate officers or directors to exempt themselves from workers' compensation insurance coverage. A corporate officer who owns no less than 25% of issued and outstanding stock of said corporation are allowed to exercise this exemption by completing an affidavit (Form 153) and submitting it to the Department of Industrial Accidents.

HOUSE BILL 2205
Filed By: Rep. Martin J. Walsh
Type of Bill: NEW
Endorsed by Advisory Council: Supporting in "Concept"
Laws Affected: Private Right of Action to Recover WC Coverage Payments (c.152, §25C)

This new bill would allow up to 10 people to bring a civil action against an employer to recover amounts which should have been paid in securing proper workers' compensation insurance as mandated by Chapter 152. Such a person seeking civil action could petition either the Attorney General's Office, the Commissioner of Insurance, or a superior court to hold a "probable cause hearing." At the hearing, it shall be *prima facie* evidence that such probable cause exists if it is shown that:

- an employee was paid any portion of wages in cash with no deductions or taxes withheld;
- no accompanying pay slip showing the wage payment and deductions as required by law;
- an individual was misclassified as an independent contractor when actually an employee;
- wages were not timely paid;
- the employer failed to withhold from the employee's wages all related state taxes; or
- employees have not been properly reported on certified payroll records as required by law.

If the decision shows that probable cause exists, the person who brought the petition shall serve a copy of the decision to any insurer that was entitled to collect amounts not paid and the persons shall simultaneously state any intention to file suit under this section. Any persons who prevail in an action shall be entitled to recover 25% of the amounts unlawfully not paid or $25,000, whichever is less.

HOUSE BILL 2380
Filed By: Rep. Antonio Cabral
Type of Bill: Refile
Endorsed by Advisory Council: YES (with ABA language)*
Laws Affected: Code of Judicial Conduct - Senior Judge, AJ's, and ALJ's (c.23F, §8)

This refiled bill (previously H.2648) would require the Senior Judge, the Administrative Judges and Administrative Law Judges to be subject to the Code of Judicial Conduct as promulgated by the Supreme Judicial Court. A previous version of this bill was endorsed by the Advisory Council in the Fiscal Year 2002 Annual Report.

***Note:** The Council previously supported House Bill 2648, which was refiled and modified during the 2001-2002 Legislative Session by Representative Antonio Cabral. The changes made to this bill reflect a technical amendment proposed by the Council that utilizes the American Bar Association's (ABA's) Model Code of Judicial Conduct for State Administrative Law Judges. Although the ABA's code only addresses conduct for ALJ's, the Council has recommended that this code also be applied to AJ's.

HOUSE BILL 2381
Filed By: Rep. Antonio Cabral
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Lump Sum Settlements (c.152, §48) - Approval

This refiled bill (previously H.2650) would require the insurer to notify an employer, with an experience modified policy, of any lump sum agreement, allowing the employer to attend any proceeding in which a lump sum is being presented for approval before their employee. Currently, insurance companies are not required to notify the employer of lump sum activity.

HOUSE BILL 2382
Filed By: Rep. Antonio Cabral
Type of Bill: Refile
Endorsed by Advisory Council: Yes*
Laws Affected: Benefits for Specific Injuries (c.152, §36(k)) - Scar-Based Disfigurement

This refiled bill (previously H.2649) 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.

*NOTE: In July of 2002, the Advisory Council sent a letter to Representative Greene and Senator Pacheco stating that the "Council continues to be receptive to amending Section 36(k) to allow compensation for scar-based disfigurement regardless of its location on the body." However, in reference to Senate Bill 2358, the Council noted that they could not reach a consensus on a SAWW multiplier to determine a maximum benefit "until a thorough cost-analysis can be conducted." House Bill 2382 would not affect the $15,000 maximum benefit for scar-based disfigurement currently in the statute.

HOUSE BILL 2388
Filed By: Rep. Peter J. Larkin
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Lump Sum Settlements (c.152, §48) - Limits on Agreements

This refiled bill (previously H.3246) would limit when a lump sum agreement can discharge an employee's right to payment of future benefits. Under this proposed legislation, no lump sum agreement could 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 the AJ to be permanently and totally disabled;
4. or the employee becomes a domiciliary of another state.

HOUSE BILL 2924
Filed By: Rep. Robert M. Koczera
Type of Bill: NEW
Endorsed by Advisory Council: YES
Laws Affected: Judicial Appointments - Judicial Performance Review (c.23E, §4)

Section 1 of this new bill, endorsed by the Advisory Council, would attempt to stagger judicial terms "naturally" by clarifying that newly appointed Administrative Judges (AJ's) be appointed to new six-year terms, rather than the current practice of being appointed to fill the remaining time-period of a vacant term. In theory, the current law could create a situation in which a newly appointed Judge would only be appointed to serve a 1-year term, if the slot they were filling was vacated after 5-years.

Section 2 of this proposed legislation would require the Senior Judge to review the performance of newly appointed Administrative Judges after their first 2-years of service. If the performance review supports the continuation of their term, the AJ may continue to serve the remainder of their term. However, if the performance review recommends against a continuation of their term, the performance review would be submitted to the Governor for appropriate action.

HOUSE BILL 2930
Filed By: Rep. Robert P. Spellane
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Serious and Willful Misconduct (c.152, §27) - Intoxication, Unlawful Use of a Controlled Substance

This refiled bill (previously H.2854) would amend §27 by barring workers' compensation benefits to employees who are injured while intoxicated or while using an illegal controlled substance as defined in §1 of Chapter 94C. Currently, §27 bars workers' compensation benefits to employees injured as a result of "serious and willful misconduct."

HOUSE BILL 3293
Filed By: Rep. Peter J. Larkin
Type of Bill: Similar
Endorsed by Advisory Council: No
Laws Affected: Insurance Rates - Loss Cost - Competition (c.152, §53A)

This bill (similar to H.2115) would create a system of competitive rating for determining workers' compensation insurance rates. Like the current law, insurers would submit all their loss data to the designated rating organization and would adhere to the uniform classification system. The rating organization would develop a "loss cost" for each classification (e.g. roofers, clerical workers).

- "loss costs" are the historical aggregate data and loss adjustment expenses, developed and trended for each classification;
- the "loss cost" is expressed as a dollar amount per $100 of Payroll;
- Example: The loss cost for a "roofer" might be $6.00 and for a "clerical worker" $.90.

Each carrier would develop its own "loss cost multiplier (LCM)." This factor takes into account the carriers expenses other than LAE, such as overhead, acquisition, marketing, profit, etc. LCM's will be multiplied by the loss cost to get the rate per $100 or payroll.

RATE = LOSS COST x LCM

- Example: If the loss cost for a roofer is $6 and the carrier's LCM for roofers is 1.4 then the rate will be $6 x 1.4 or $8.40 per $100 of payroll. If the loss cost for a clerical worker was $.90 and the LCM for clerical workers was .90, the rate will be $.90 x .90 or $.81 per $100 of payroll.

This new system of insurance pricing would apply to all new or renewed workers' compensation policies.

HOUSE BILL 3482
Filed By: Rep. John H. Rogers
Type of Bill: NEW
Endorsed by Advisory Council: No
Laws Affected: Workers' Compensation Reinsurance Pool (c.152, §65C)

This new bill would require the Workers' Compensation Rating & Inspection Bureau of Massachusetts (WCRB) or its servicing carriers to assign no less than 20% of the total written premium in the Reinsurance Pool (Residual Market) to third party claims administrators (TPA's) located in Massachusetts. Said TPA's can have no common ownership with any insurer writing workers' compensation within the Commonwealth.

SENATE BILLS:

SENATE BILL 28
Filed By: Senator Robert A. Antonioni
Type of Bill: New Legislation
Endorsed by Advisory Council: No
Laws Affected: Continuation of Temporary Total Benefits (c.152, §34)

This new legislation would extend the benefits for injuries compensable under section 34 (temporary total) assuming there has been no discontinuance or modification order of an administrative judge. Currently, §34 benefits are equal to 60% of the injured worker's average weekly wage and are limited in duration to 156 weeks. Senate 28 would allow an injured worker to receive additional benefits upon the exhaustion of their section 34 benefits. This additional compensation would be equal to 45% of their average weekly wage "pursuant to section 35." The maximum benefits period for §35 injuries is 260 weeks, but may be extended to 520 weeks.

SENATE BILL 29
Filed By: Senator Robert A. Antonioni
Type of Bill: New Legislation
Endorsed by Advisory Council: No
Laws Affected: Workers' Compensation Dependency Benefits (c.152, §35A)

This new legislation would amend §35A, which provides additional compensation to injured workers who have dependents. Currently, §35A provides additional compensation of $6 per/week to injured workers who have persons dependent upon them for injuries occurring under §34, §34A, and §35. No weekly payments under this section can be greater than $150 per week when combined with the compensation due under §34, §34A, and §35. Senate 29 would provide injured workers additional compensation of $15 per/week to injured workers who had persons dependent upon them. This bill would also cap weekly payments at $300 when combined with the compensation due under §34, §34A, and §35.

SENATE BILL 40
Filed By: Senator Robert S. Creedon, Jr.
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Comprehensive Bill (c.152, §1, §10, §7A, §10A, §13A, §14, §34, §35, §35B)

1. Definitions (§1(1)) - Average Weekly Wage
Section 1 of this refiled bill (formerly S.42) 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 re-injury, must be calculated using the wage the claimant was earning at the time of the original injury.

2. Conciliation (§10(6)) - Last Best Offer
Section 2 would repeal §10(6) 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.

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SENATE 40 CONTINUED

3. Presumptions (§7A) – Employee Unable to Testify
Section 3 would amend §7A by stating that when an employee dies, 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 intention of the employee to injure or kill himself.

4. Conference (10A(2)) - Last Best Offer
Section 4 would amend §10A(2) 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.

5. Attorney's Fees (§13A) – Last Best Offer
Section 5 would amend §13A dealing with attorney's fees. This bill would remove all reference to the last best offer submissions.

6. Fraudulent Conduct (§14) - Duty to Reveal Knowledge of Fraud
Section 6 would amend §14 dealing with fraudulent actions. This section states 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).

7. Total Incapacity (§34) – Percent Allowed for Total Injury
Section 7 of this bill would amend §34 and require the insurer to pay the injured employee 60% of his average weekly wage (AWW) before the injury, but not more or less than the maximum or minimum weekly compensation rate, if the injury is considered total. If the AWW is found to be less than the minimum weekly compensation rate, it would then be increased to equal the AWW.

8. Benefits (§35) - Maximum Amount
Section 8 would amend §35 by eliminating the requirement that partial disability benefits cannot exceed 75% of §34 benefits.

9. Benefits (§35B) - Subsequent Injury
Section 9 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 allows the employee to opt out of this section if it would subject them to a lower rate of compensation.

10. Benefits (§35) - Extension of Benefits
Section 10 would allow the extension of §35 benefits from 260 to 520 weeks if a judge finds, or an insurer agrees, that the injured worker is "incapable of earning at least ninety percent of the average weekly wage before the injury after having been deemed unsuitable for vocational rehabilitation services by the Office of Education and Vocational Rehabilitation under section 30G or, having been deemed suitable for vocational rehabilitation services by said office completed an appropriate rehabilitation program pursuant to section 30G."

SENATE BILL 47
Filed By: Senator John A. Hart, Jr.
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Attorney's Fees (c.152, §13A(10)), Agreements to Pay Benefits (§19), Temporary Total Disability (§34), Permanent and Total Incapacity (§34A)

Section 1 of this refiled bill (formerly S.66 and identical to H.670 filed in this session) would allow attorneys to collect fees for advancing an employee's rights under §75A (preferential hiring of injured workers) and §75B (protections against handicap discrimination), in addition to any attorney's fees owed under §13A.

Section 2 of this bill adds two new subsections to §19. It would allow any administrative judge, administrative law judge or conciliator to approve any agreement to pay benefits authorized by §19. It would also allow an agreement to include a pay without prejudice clause.

Section 3 of this bill would amend §34 and require the insurer to pay the injured employee 60% of his average weekly wage (AWW) before the injury, but not more or less than the maximum or minimum weekly compensation rate, if the injury is considered total. If the AWW were found to be less than the minimum weekly compensation rate, it would then be increased to equal the AWW.

Section 4 of this bill would amend §34A and require the insurer to pay the injured employee two-thirds of his AWW before the injury, but not more or less that the maximum or minimum weekly compensation rate if the injury is considered permanent and total. If the AWW were found to be less than the minimum weekly compensation rate, it would then be increased to equal the AWW.

SENATE BILL 49
Filed By: Senator John A. Hart, Jr.
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Benefits for Scar-Based Disfigurement (c.152, §36)

This refile bill (formerly S.74) would eliminate the requirement that scar-based disfigurement appear on the face, neck or hands to be compensable. Compensation would be required 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.

SENATE BILL 51
Filed By: Senator John A. Hart, Jr.
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Definition of Average Weekly Wage (c.152, §1(1)), Eliminate Consideration of Last Best Offer in Awarding Attorney's Fees (§13A(4))

Section 1 of this refiled bill (formerly S.77) addresses injured employees who return to work (without a lump sum settlement) and receive wages that 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 claimant's attorney is only entitled to payment if the administrative judge accepts the offer of the claimant or the amount submitted by the conciliator.

SENATE BILL 52
Filed By: Senator John A. Hart, Jr.
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Rate of Reimbursement - Health Care Services (c.152, §13), PPA's (§30),

Section 1 of this refiled bill (formerly S.79) deletes the current language in §13 and replaces it with simpler language. It states 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. This proposed legislation 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.

Sections 2 and 3 would eliminate authorization for preferred provider arrangements (PPA's) as well as all language pertaining to utilization review guidelines. Section 35 (partial incapacity benefits) would also be amended by eliminating the maximum rate of benefits (75% of §34 benefits). It would eliminate the duration of §35 benefits as well.

SENATE BILL 60
Filed By: Senator Brian P. Lees
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Definition of Employee (c.152, §1(4)), Elective Coverage - Corporate Officers

This refiled bill (formerly S.56) would make coverage elective for corporate officers and employees who are immediate family members, who are also sole executive officers. A mistake was made in the drafting of this legislation as several sentences were left out.

SENATE BILL 61
Filed By: Senator Brian P. Lees
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Employer Fines Reduction (c.152, §25C), Preferential Hiring (§75A), Employee Definition - Elective Coverage of Corporate Officers (§1(4))

Section 1 of this refiled bill (formerly S.57) 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.

SENATE BILL 72
Filed By: Senator Brian P. Lees
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Employee Leasing Companies - Exclusive Remedy (c.152, §15)

This refiled bill (formerly H.1138 in the 1999-2000 session and identical to S.88 filed in this session) would amend §15 by barring an action at law for damages for personal injuries or wrongful death by an employee towards an employee leasing company and its client company, if each are in compliance with the requirements of Chapter 152. Currently, §15 only provides protection to "the insured person employing such employee and liable for payment of the compensation provided by this chapter for the employee's personal injury or wrongful death and said insured person's employees."

SENATE BILL 76
Filed By: Senator Thomas M. McGee
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Comprehensive Bill (c.152, §1, §6, §7, §8, §13A, §28, §29, §30, §31, §33, §34, §34A, §34B, §35, §35D, §35E, §36, §50)

This refiled bill (formerly H.2284) seeks to amend many aspects of Chapter 152.

Section 1 of this bill would amend the definition of "Average Weekly Wage" by specifying that if an injured employee is employed by more than one *employer*, the total earnings from the several *employers* should be considered in determining average weekly wage. Currently the law is more specific in stating that if the injured employee is employed by more than *one insured employer or self-insurer* rather than "employer" as proposed by this legislation. Section 1 of this bill also states that weeks in which an employee received less than *four hours* in wages is considered lost time for determining average weekly wage. Currently, the law considers lost time as weeks when an employee receives *less than five dollars in wages*.

Section 2 of this bill would amend §1(7A) regarding the definition of "Personal Injury" in dealing with mental or emotional disabilities. Currently, "Personal Injuries" include mental or emotional disabilities only where the *predominant contributing cause* of such disability is an event or series of events occurring within any employment. This bill would replace "the predominant contributing cause" with "a significant contributing cause."

Section 3 of this bill would substantially increase the fines for employers who violate the provisions of §6 with regard to the reporting of the notice of injury to the DIA, the employee, or insurer. Currently, if an employer violates this provision three or more times they are required to pay a fine of $100 for each violation. This bill would eliminate the necessity that a violation occurs three or more times before a penalty is issued. Fines would be issued as follows: $100 for first violation; Subsequent violations within a year are increased $100 for each subsequent violation; If an employer fails to make notice to the DIA, employee, and insurer, it must pay additional penalty to the DIA of $1,000 into the Special Fund and $1,000 to the employee; If an employer fails to make notice to the DIA, employee, and insurer within 90 days, an additional penalty of $10,000 will be assessed.

Section 4 would amend §7(2) by increasing the penalty placed on insurers who fail to begin payment of weekly benefits or notify parties of refusal to pay benefits within 14 days of receipt of the employer's First Report of Injury. This bill would require the insurer to pay the employee an amount of $200 or their compensation rate (whichever is higher). If the insurer still fails to begin payments or make such notification within 60 days, they must pay a penalty of $1,000 to both the Special Fund and to the employee.

Section 5 and 6 of this bill would amend §8 by decreasing the "pay without prejudice" period to 90 days. Currently, when an insurer pays a claim, it may do so without accepting liability for a period of 180 days. This pay without prejudice period establishes a window where the insurer may refuse a claim and stop payments at its will. Up to 180 days, the insurer can unilaterally terminate or modify any claim as long as it specifies the grounds and factual basis for so doing. The purpose of the pay without prejudice period is to encourage the insurer to begin payments to the employee instead of outright denying the claim.

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SENATE 76 CONTINUED

Section 7 of this bill would allow the pay without prejudice period to be extended upon agreement by the parties in 90-day increments not to exceed one year. Currently, pay without prejudice extensions are not required to be set at 90-day increments.

Section 8 of this bill would amend §13A(5). This section assesses an insurer a penalty of $3,500 (plus necessary expenses) whenever an insurer files a complaint or contests a claim for benefits and then later accepts the claim or withdraws the complaint within 5 days. This section of the proposed legislation would increase the number to 10 days.

Section 9 of this bill would amend §28, paragraph 1, which address injuries caused by serious and willful misconduct of the employer. This section of the proposed legislation would further define "willful misconduct" as a "knowing and willful violation of the Federal and/or State O.S.H.A. standards." Currently, if an employee is injured by serious and willful misconduct by the employer, they will receive double compensation for their injuries.

Section 10 of this bill would amend §29 dealing with the required period of incapacitation. Current law states that no compensation pursuant to §34 and §35 shall be paid for any injury which does not incapacitate the employee from earning full wages for a period of 5 or more calendar days. If incapacity extends for a period of 21 days or more, compensation is paid from the date of the onset of the incapacity. This bill decreases this 21-day period to *5 days or more*.

Section 11 of this bill would amend §30, which requires the insurer to furnish medical and hospital services, and medicines if needed. Except for the first appointment, the injured worker may select a treating physician and may switch to another such professional *once.* This bill would allow the injured worker the option of switching physicians *twice*.

Section 12 would amend §31 covering death benefits for dependents. Current law provides the widow or widower, that remains unmarried, 2/3 of the average weekly wage (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) of the deceased employee. This bill would increase the minimum amount a widower is entitled, to $200 per week and $12 more a week for each child of the deceased employee.

Section 13 would amend §33 regarding burial expenses for deceased employees. Currently, the insurer is required to pay reasonable expenses for burial, not exceeding $4,000. This bill would increase the amount the insurer is required to pay for burial expenses not to exceed $6,000.

Section 14 would increase the weekly compensation for total incapacity (§34) benefits. Compensation would increase from the current 60% to 2/3 of average weekly wage. Duration would increase from the current 156 weeks to 208 weeks.

Section 15 would amend §34A pertaining to permanent and total incapacity. When the incapacity for work resulting from the injury is both permanent and total, an insurer is required to pay an injured employee a weekly compensation equal to 2/3 of their average weekly wage before injury, but not more than the maximum weekly compensation rate nor less than the minimum compensation rate. Current law requires that this payment be made "following payment of compensation in §34 and §35." This section of H.2854 would delete this requirement.

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SENATE 76 CONTINUED

Sections 16 and 17 would amend §34B pertaining to supplemental benefits for §31 or §34A. This bill would expand supplemental benefits to include both §34 and §35.

Section 18 would amend §35 pertaining to partial incapacity benefits, by raising the wage benefits for injured workers to *2/3* AWW of the difference between their AWW before the injury and the weekly wage they are capable of earning after the injury, *but not more than the maximum weekly compensation rate*. Currently for §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.

Section 19 would amend the duration allowed for §35 benefits. Currently, the maximum benefit period for partial disability is 260 weeks, but may be extended to 520 weeks. This bill would increase the maximum benefit period to 442 weeks and could be extended at "the discretion of an administrative judge."

Section 20 would amend §35A, which provides additional compensation to injured workers who have dependents. Currently, §35A provides additional compensation of $6 per/week to injured workers who have persons dependent upon them for injuries occurring under §34, §34A, and §35. No weekly payments under this section can be greater than $150 per week when combined with the compensation due under §34, §34A, and §35. This section of Senate 76 would provide injured workers additional compensation of $12 per/week to injured workers who had persons dependent upon them. This bill would also cap weekly payments at $250 when combined with the compensation due under §34, §34A, and §35.

Section 21 of this bill would amend §35D(5) and require that implementation of this section be subject to §8. Employment would be defined as a job that the employee is physically and mentally capable of performing, as long as it relates to the employee’s work experience, education, or training either before or after the injury.

Section 22 of this bill would amend §35E. It would require that any person receiving old age benefits pursuant to federal social security law or receiving pension benefits paid by an employer should not be entitled to benefits under §35. This is unless the employee can establish that they would have remained active in the labor market.

Section 23 of this bill would amend§36(k). It would require that for bodily disfigurement, compensation will not exceed $20,000 and will be payable in addition to other sums outlined in this legislation.

Section 24 of this bill would amend §50. Payments required by order that are not made within 60 days of being claimed by employee, dependent or other party would accrue interest at a rate of 12% per year. If sums include weekly payments, then interest will accrue on each unpaid weekly payment.

SENATE BILL 88
Filed By: Senator Michael W. Morrissey
Type of Bill: Refile
Endorsed by Advisory Council: No
Laws Affected: Employee Leasing Companies - Exclusive Remedy (c.152, §15)

This refiled bill (formerly H.1138 in the 1999-2000 session and identical to S.72 filed in this session) would amend §15 by barring an action at law for damages for personal injuries or wrongful death by an employee towards an employee leasing company and its client company, if each are in compliance with the requirements of Chapter 152. Currently, §15 only provides protection to "the insured person employing such employee and liable for payment of the compensation provided by this chapter for the employee's personal injury or wrongful death and said insured person's employees."

SENATE BILL 101
Filed By: Senator Marc R. Pacheco
Type of Bill: Refile
Endorsed by Advisory Council: No - Senate Bill 2358 was discussed in detail at the 6/12/02 AC meeting but members were unable to reach a consensus. A letter was sent to Commerce & Labor stating concern with the adequacy of the current rates.
Laws Affected: Reimbursement Rates for Physician and Hospital Services (c.118G, §7), Scar-Based Disfigurement (c.152, §36)

Section 1 of this refiled bill (formerly S.2358) would amend c.118G, §7 by adding a new paragraph requiring the Division of Health Care Finance & Policy (DHCFP) to set rates for physician and hospital services paid for under c.152 at a "usual and customary fee" for any such health care service. Current language requires the Division to set these rates, which are determined by a regulatory process that promulgates in fee schedules (114.3 CMR 40.00) and other formats that ensure a public process. Rates are currently negotiable among the insurer, employer, and the health care service provider (c.152, §13).

Section 2 of this bill would eliminate the requirement that scar-based disfigurement appear on the face, neck or hands to be compensable. Senate Bill 101 would require compensation for all disfigurement, whether or not scar-based, regardless of its location on the body. The proposed legislation further states that payments for these type of injuries could not exceed the average weekly wage in the Commonwealth (at date of injury) multiplied by 29 [$882.57 (SAWW) x 29 = $25,594.53 (maximum benefit)]. Current language in the statute limits payments for scar-based disfigurement from exceeding $15,000.

SENATE BILL 107
Filed By: Senator Charles E. Shannon, Jr.
Type of Bill: New Legislation
Endorsed by Advisory Council: No
Laws Affected: Employee Financial Assistance Fund (c.10, §67), Return to Work Disagreement - Independent Physician (§45)

Section 1 of this new legislation would create an "Employee Financial Assistant Fund" that would be credited pursuant to §45. Monies expended from this fund would only be for purposes of §45. Under section 45, benefits of an employee may be suspended unilaterally for the refusal to submit to an examination by a physician of the employer or insurer's choice.

Section 2 of this bill would add a new paragraph to §45 allowing an employer to require (at their own expense) an examination of an employee, by a physician selected by the employer, if the employee's physician has previously reported in writing that employee is able to return to work. If the employer's physician disagrees with the employee's physician, the employee and the employer must agree to abide by the results of a third examination by an independent physician. Section 2 would also require each employer in the Commonwealth to annually pay 1% of their annual gross payroll into the "Employee Financial Assistant Fund" created above in Chapter 10. Each employee in the Commonwealth may pay into this fund no more than 1% of their annual gross wage. An employee who contributes to this fund is eligible to receive financial assistance from the fund in accordance with regulations promulgated by the Commissioner.

SENATE BILL 123
Filed By: Senator Steven A. Tolman
Type of Bill: New Legislation
Endorsed by Advisory Council: No
Laws Affected: Benefits for State Social Workers Resulting From Acts of Violence (c.30, §58)

This new legislation would compensate state employees who receive bodily injuries resulting from acts of violence by children in their custody or parents of said children. If eligible for workers' compensation benefits, these injured state employees would receive the difference between the weekly cash benefits entitled under Chapter 152 and their regular salary. The affected employee's absence would not be charged against their available sick leave credits. Current law allows this benefit to state employees who receive bodily injuries resulting from acts of violence from patients or prisoners only.