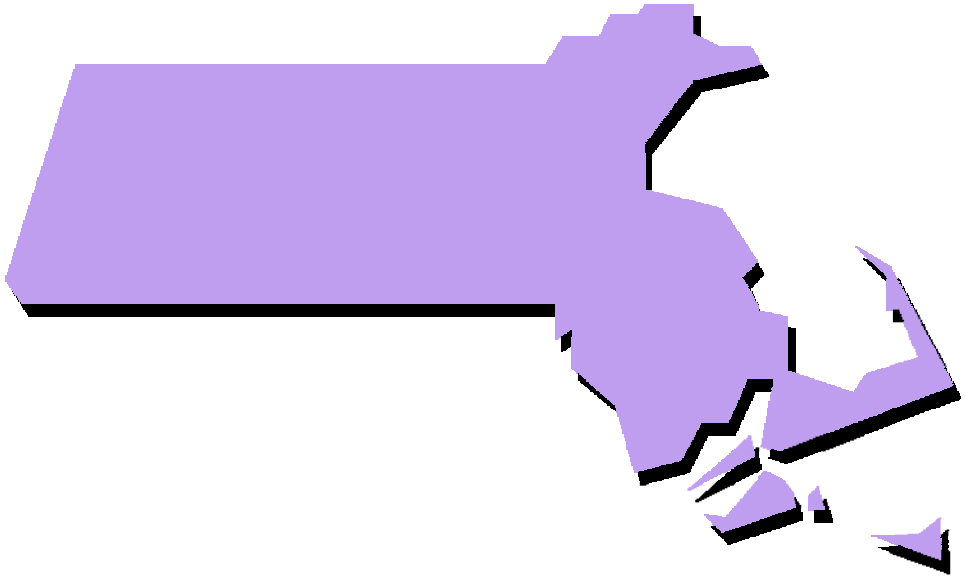
COMMONWEALTH OF MASSACHUSETTS

FISCAL YEAR 2010 ANNUAL REPORT

THE STATE OF THE MASSACHUSETTS WORKERS' COMPENSATION SYSTEM



MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

JANUARY 2011

THE STATE OF THE MASSACHUSETTS WORKERS' COMPENSATION SYSTEM

FISCAL YEAR 2010 ANNUAL REPORT

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

1 CONGRESS STREET, SUITE 100
BOSTON, MASSACHUSETTS 02114-2017
(617) 727-4900, EXT. 378
WWW.MASS.GOV/WCAC/

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

MICKEY LONG
CHAIR

EDMUND C. CORCORAN, JR.
VICE-CHAIR

ANDREW S. BURTON
EXECUTIVE DIRECTOR

January 12, 2011

His Excellency Deval L. Patrick
Governor of Massachusetts
State House – Room 280
Boston, MA 02133

Dear Governor Patrick:

On behalf of the Massachusetts Workers' Compensation Advisory Council, I am pleased to present you with our Fiscal Year 2010 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 eight 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.

It is important to note that this report and its recommendations are a product of the commitment and contributions made by council members who volunteer their time 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.

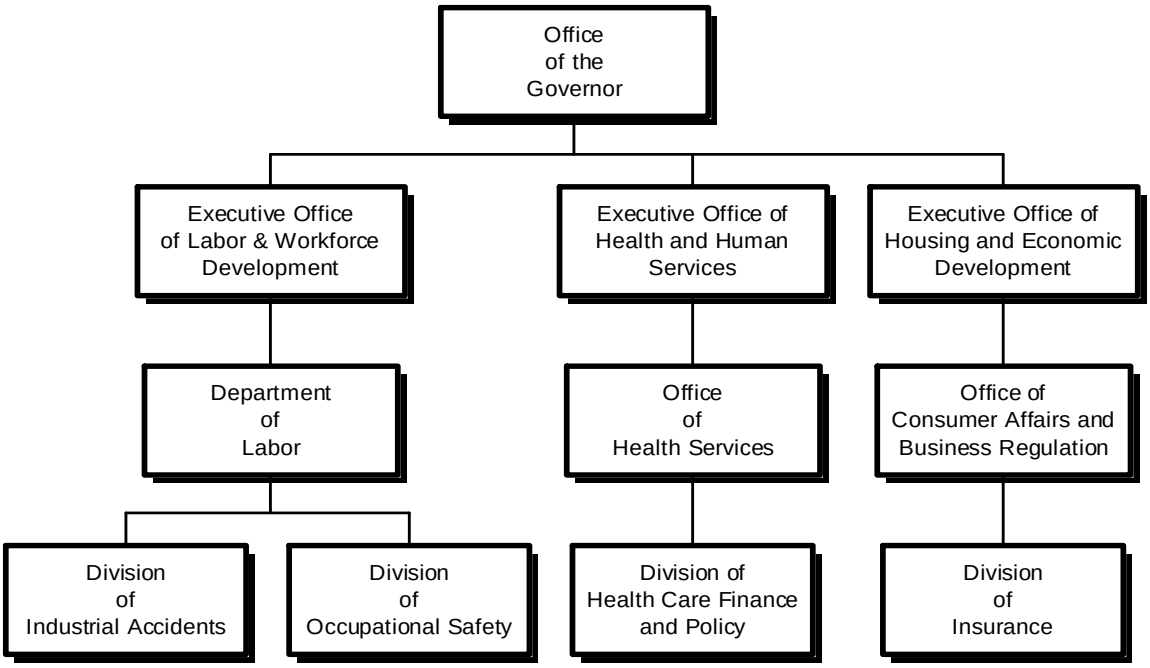
The Advisory Council hopes that this report will serve to highlight the successes of the past year and offer guidance to policymakers looking to improve the system. We look forward to working with you in the future and continuing our shared mission to improve services to injured workers, employers, and all participants in the Commonwealth's workers' compensation system.

Very truly yours,

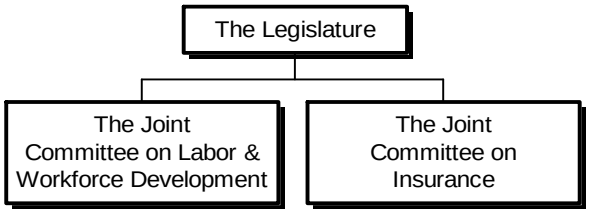
Andrew S. Burton
Executive Director

Government Regulation of Workers' Compensation

Executive Branch



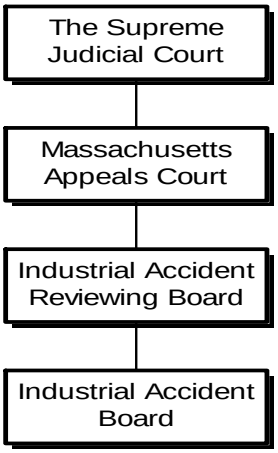
Legislative Branch



Oversight

Massachusetts Workers' Compensation Advisory Council

Appeals Process



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

TABLE OF CONTENTS

SECTION 1: INTRODUCTION

SECTION 2: OVERVIEW

SECTION 3: WORKPLACE INJURY AND FATALITY STATISTICS

SECTION 4: DISPUTE RESOLUTION

SECTION 5: DIA ADMINISTRATION

SECTION 6: DIA FUNDING

SECTION 7: INSURANCE COVERAGE

TABLES AND FIGURES

SECTION
- 1 -

INTRODUCTION

ADVISORY COUNCIL

The Massachusetts Workers' Compensation Advisory Council was created by the Massachusetts General Court on December 10, 1985, with the passage of chapter 572 of the Acts of 1985. The function of the Council is to monitor, recommend, give testimony, and report on all aspects of the workers' compensation system, except the adjudication of particular claims or complaints. The Council also conducts studies on various aspects of the workers' compensation system and reports its findings to key legislative and administrative officials (see Appendix A for complete list of Members).

Pursuant to the Act, the Advisory Council is mandated to issue an annual report evaluating the operations of the Department 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 (see Appendix B for a list of formal studies).

The Advisory Council is comprised of 16 members that are appointed by the Governor for five-year terms. The membership consists of: 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 and the Director of the Department of Economic Development serve as ex-officio members.

The voting members of the Council are comprised of the employee and employer representatives 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 Department of Industrial Accidents, 1 Congress Street, Suite 100, 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, 1 Congress Street, Suite 100, 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/**.

FISCAL YEAR 2010 IN REVIEW

During fiscal year 2010, the workers' compensation system in Massachusetts continued to experience changes that were influenced by outside economic factors, reduced caseloads, new regulations, proposed legislation, administrative initiatives, a rate stipulation, a landmark court decision, and the introduction of several online services. Below, we outline some of the fiscal year's highlights.

Fiscal year 2010 marked another year of significant caseload reductions in all areas of dispute resolution at the Department of Industrial Accidents (DIA). During the fiscal year, decreases were recorded in employee claims (-8.7%), conciliations (-8%), conferences (-19%), and hearings (-12%). With a decreased volume in caseloads, the DIA was able to maintain extremely low conference and hearing queues, ensuring that injured workers and insurers received an efficient and timely administration of justice.

On July 8, 2009, the DIA held a public hearing on proposed amendments to 452 CMR 6.00: "Utilization Review (UR) and Quality Assessment." Included in the proposed changes to the UR regulations was the creation of an application fee for both in-state and out-of-state UR agents, fines for non-compliance with regulations and policies, and removing the mandate requiring insurers to undertake UR for treatments and services requested during the 12-week period immediately following the date of injury. The proposed regulations went into effect on August 21, 2009.

On August 4, 2009, the Workers Compensation Research Institute (WCRI) reported that medical payments per workers' compensation claim in Massachusetts were the lowest of 14-studied states, despite steady increases since 2001. The study, *CompScope™ Medical Benchmarks for Massachusetts, 9th Edition,* reported that a key driver of the lower medical payments was the lower prices paid for nonsurgical services. Although Massachusetts has the lowest fee schedule in the nation, the study found that prices paid for surgeries were higher in the Commonwealth compared to other study states. This is due to the fact that employers and insurers in Massachusetts often negotiated surgery prices higher than what the fee schedule dictated, particularly for orthopedic surgeries. The WCRI is an independent, not-for-profit research organization that studies the workers' compensation benefit delivery systems nationwide.

On September 15, 2009, the DIA and the Workers' Compensation Rating & Inspection Bureau of Massachusetts launched an online Proof of Coverage (POC) application that allows the public to verify whether a business has a valid workers' compensation policy. In addition to verifying workers' compensation coverage in the voluntary market and the assigned risk pool, the POC application also provides links to coverage databases for both self insured employers and self insurance groups. The development of the POC application was fully supported by the Advisory Council and is a prime example of how a public/private partnership can work together to fight fraud.

On September 30, 2009, the Joint Committee on Labor & Workforce Development held a public hearing on all legislation related to workers' compensation. At this hearing,

representatives from the Advisory Council testified in support of eight workers' compensation bills. Among the bills supported by the Advisory Council was legislation creating a workers' compensation private right of action (H.1870 and S.2375), increasing both civil and criminal penalties against uninsured employers (H.17 and S.729), restoring scar-based disfigurement benefits (S.681), increasing the maximum burial allowance (H.1865), creating penalties for employers who fail to timely report injuries (H.1863), and instituting civil fines against employers who fail to notify their employees of workers' compensation coverage (H.1839).

In October of 2009, Governor Deval Patrick used his Section 9C budgetary powers to reduce statewide spending. Specifically, the DIA's fiscal year 2010 line-item was reduced by $789,719. The Governor explained that the reductions were necessary due to a $600 million shortfall in projected General Fund revenues. As a result of the 9C cuts, the DIA joined other state agencies by instituting a furlough program directed toward managers and union employees. In response to the mid-year reductions, the Advisory Council forwarded a letter to the Governor explaining the DIA's unique, self sustaining, employer funded system, in which no General Fund dollars are used to support the agency's activities.

On November 1, 2009, Risk and Insurance magazine released the results of a study comparing each state's workers' compensation rankings. The study, performed by Peter Rousmaniere, attempted to compare each state's lost time frequency, duration of disability, benefit generosity, and insurance costs. Massachusetts ranked on top with the best workers' compensation system among the 50 states, due in part to very low insurance costs, high wage replacement benefits, and a very low medical fee schedule. In contrast to Massachusetts, the state of Montana ranked dead last with some of the highest insurance costs and employee benefits.

On December 9, 2009, the Advisory Council was presented with an overview of a digital recording pilot project that was being tested in DIA courtrooms. The agency undertook this project to determine whether stenographic services could be enhanced and streamlined. It was explained to Advisory Council members that the transcription process would still be conducted by DIA-employed stenographers and that transcription time-frames would not be lengthened. To date, the agency has not taken any further steps to implement digital recording in the courtrooms.

On December 11, 2009, the Massachusetts Supreme Judicial Court (SJC) affirmed a decision of the DIA's Industrial Accident Review Board which awarded workers' compensation benefits to a teacher, serving as a volunteer chaperone, who was injured while skiing on a high school field trip (Karen Sikorski's Case). In its unanimous decision, the SJC agreed that a teacher who acts as a chaperone to students participating in a school-sponsored activity "is acting in the course of her employment" and is not engaged in "recreational" activity within the meaning of the state's workers' compensation law.

On December 17, 2009, the DIA offered a new service to insurance companies and self-insured employers, allowing for online filing and payment of quarterly assessments. All insurance companies in Massachusetts that are licensed to write workers' compensation insurance must report and remit all collected assessments to the DIA on a quarterly basis. The new technology works in conjunction with online Automated Clearing House debit and credit functions. The online service, which began as a voluntary program, became mandatory on September 30, 2010.

On December 22, 2009, the Workers' Compensation Rating and Inspection Bureau of Massachusetts introduced an online Classification Request Form, allowing the public to request an employer's workers' compensation classification codes and the percentage of payroll associated with each classification code for the current and prior two policy years. Upon submitting a request, classification information is returned to the requester, free of charge, within 2-3 business days. The new online form was the result of a recommendation made by the Advisory Council's Employee Misclassification Subcommittee. The subcommittee was created in September of 2009 to address the problem of premium evasion fraud in Massachusetts.

On January 13, 2010, the Advisory Council was presented with an overview of the Trust Fund's reimbursement procedures for Cost of Living Adjustments (COLAs). COLA reimbursements, established as part of the 1985 Reform Act, reimburse insurers for cost of living increases paid to spouses receiving death benefits or employees receiving permanent and total incapacity benefits. Reimbursements are for 100% of the COLA paid for claims with injury-dates occurring prior to 10/1/86. For injury-dates after 10/1/86, insurers can only be reimbursed for COLA amounts that exceed 5% of the State Average Weekly Wage (SAWW). The DIA experienced a recent spike in COLA expenditures in FY'09 due to a backlog of cases that grew during FY'07 and FY'08.

In February of 2010, the Advisory Council endorsed the Governor's Fiscal Year 2011 Budget Recommendation of $20,047,378 for the operations of the DIA. In light of the difficult and uncertain economic times, the Advisory Council also recommended that the DIA give careful consideration and judgment on all expenses associated with moving or renovating the Boston office. Additionally, the Advisory Council expressed concern over four outside sections that could have negatively impacted the operations of the DIA

On February 10, 2010, the Advisory Council was presented with an overview of a newly revised Safety Grant Program. Under the changes, the grant application was streamlined and can be submitted and administered entirely online. In addition to a more user friendly application process, contract language was strengthened, oversight increased, and year-end reports can better measure the types of injuries that occur before and after safety training. Each year the Office of Safety awards approximately $800,000 in safety grants to Massachusetts' employers to help fund programs which provide workplace safety training. In fiscal year 2010, the Office of Safety funded a total of 66 grants which resulted in the training of over 12,425 employees.

In March of 2010, the Advisory Council met twice in Executive Session to review the qualifications of sixteen DIA judicial applicants seeking either appointment or

reappointment to the position of Administrative Judge or Administrative Law Judge. Upon the vote of at least seven voting members, the Advisory Council may rate any candidate as either "qualified," "highly qualified," or "unqualified." At the conclusion of the interviews, the Advisory Council forwarded all sixteen judicial recommendations to the Governor's Chief Legal Counsel for review.

On April 14, 2010, the Division of Occupational Safety (DOS) presented Council members with an overview of the Annual Survey of Occupational Injuries and Illnesses. The survey, which measures the frequency of injuries in Massachusetts, was not conducted in 2009 due to a lack of funding in the FY'10 line-item for DOS. It was noted to Council members that funding amounts proposed thus far in the FY'11 budget process would once again prevent Massachusetts from participating in the survey. Council Members suggested that DOS reach out to the Workers' Compensation Rating & Inspection Bureau to see if there would be any interest in fostering a public/private partnership to share funding of the survey.

On April 28, 2010, Workers' Memorial Day was observed in Massachusetts to honor those workers killed and injured on the job. Coinciding with Workers' Memorial Day was the release of a statewide occupational fatality report sponsored by the Massachusetts AFL-CIO, the Massachusetts Coalition for Occupational Safety and Health, and the Western Massachusetts Coalition for Occupational Safety and Health. The report, "*Dying for Work in Massachusetts: Loss of Life and Limb in Massachusetts Workplaces*," highlights the fact that many workplace deaths are preventable with a proper emphasis on safety. In 2009, 59 workers in Massachusetts died on the job.

On May 12, 2010, the Insurance Commissioner of Massachusetts signed a rate stipulation which reduced average rates for workers' compensation insurance by 2.4% from 2008-2009 rate levels. The stipulation, which will save the Commonwealth's employer community an estimated $22.5 million, was based on an agreement reached between the State Rating Bureau, the Workers' Compensation Rating & Inspection Bureau, and the Attorney General's Office. This decrease marks the tenth time workers' compensation rates have decreased since 1991.

On June 9, 2010, the Division of Insurance presented Council members with an overview of the regulatory and financial controls that are in place in Massachusetts to protect the financial solvency of Self Insurance Groups (SIGs). This issue came to light in April of 2010 when the New York Supreme Court ruled that the state was unconstitutionally taxing healthy SIGs to cover $450 million in unfunded liabilities caused by the insolvency of one Third Party Administrator (TPA). The TPA, CRM Holdings, entered into financial trouble when they allegedly offered their members artificially low rates by under-reserving losses. Unlike New York, members of SIGs in Massachusetts are only financially responsible for their own members and not the liabilities of other SIGs. In 2010, there were 22 SIGs operating in Massachusetts, representing 5,381 employers.

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 further improve the workers' compensation system, the Council has identified the following areas of concern and offers these recommendations to address them.

1. DIA Employer Funding

The Department of Industrial Accidents (DIA) is just one of only a handful of agencies in Massachusetts with no financial impact on the state's General Fund. In fact, the DIA receives 100% of its funding from either assessments placed on the state's employer community or from the collection of filing fees and fines (for violations of Chapter 152). During this unprecedented fiscal crisis, which has been characterized by General Fund revenue shortfalls and "across the board" cuts, it is critically important for policymakers to understand the source of the DIA's funding and why the taxpayer model did not work.

Prior to becoming an employer-funded agency in 1985, the DIA was consistently underfunded by the legislature. During the late 1970s and early 1980s, the neglect in adequate funding led to an extremely understaffed agency with costly dispute resolution delays. It was not uncommon for an injured worker to wait months, if not years, for a decision on their workers' compensation benefits. The agency was so financially strapped that at one point in 1983, the DIA ran out of money for stamps, requiring insurers and law firms to pick up their own mail - mail which contained judicial orders with 10-day appeal deadlines! One practicing attorney dubbed the DIA, "the most neglected orphan in the judicial system in the Commonwealth."

In November of 1983, Governor Michael Dukakis appointed industry experts to a Governor's Task Force on Workers' Compensation to identify systematic problems and determine where reform was necessary. After months of public hearings and detailed research into the operations of other state workers' compensation systems, the Task Force identified funding shortfalls as one of the root causes for delays at the DIA. To address this problem, the Task Force recommended a funding structure that would be independent of the tax revenue supported General Fund. In 1985, the Legislature agreed and adopted the recommendation, transferring the agency's cost burden from the state's General Fund to the Commonwealth's employer community.

The move to an independently funded system transformed the agency almost immediately. With the DIA's operating budget increasing from $5.9M in fiscal year 1986 to $12.4M in fiscal year 1989, the agency now had greater resources to increase staffing levels. In fact, just three years following the reform, the DIA was able to add 189 positions, increasing the total workforce by 167%. Although funding changes introduced by the 1985 Reform Act have proven, for the most part, to be successful in

freeing the DIA from General Fund budget constraints, the independent funding structure has recently been tested.

Upon signing the 2010 General Appropriations Act, Governor Deval Patrick reduced the DIA's Special Fund line-item by $202,534 from all previous proposed amounts. The Governor stated in his Veto Explanation that the line-item was reduced, "by an amount not recommended in light of available [General Fund] revenues." In October of 2009, the Governor used his Section 9C powers and proposed further reductions which decreased the DIA's fiscal year 2010 line-item by $789,719. The Governor stated that the reductions were necessary due to a $600 million statewide shortfall in projected General Fund revenues. As a result of the combined decreases of nearly one million dollars, the DIA participated in a statewide furlough program affecting both management and union employees.

During the fiscal year 2011 budget process, numerous amendments and outside sections were introduced by policymakers to permit the transfer of agency funds and to consolidate shared services within each Secretariat. Although these are well intended budget management and cost saving measures for like-funded agencies, the proposals did not take into account those state agencies funded by independent sources. When the FY'11 General Appropriations Act was signed in July of 2010, it contained an outside section (Outside Section #138) allowing the Secretary of Administration and Finance to transfer the unexpended balance of any agency's fund, trust fund or separate account to the General Fund. The possible transfer of these funds jeopardizes the $25 million contained in the DIA's collective account balances at the close of fiscal year 2010.

The workers' compensation system in Massachusetts has come a long way since 1985 when employer costs were out of control and dispute resolution delays were widespread. Today, the Commonwealth's workforce is rewarded by a system that delivers timely benefits, provides the highest quality of healthcare, assists the injured worker with returning to employment, and promotes safety and health in the workplace. Much of the present system's success can be attributed to the DIA's independent funding structure which has allowed the agency to retain appropriate staffing levels to provide efficient and effective services.

In order to maintain the present vitality of 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, based on an amount to adequately fund the operations of the DIA. With no reliance on state tax dollars, a shortage in General Fund revenues should have no impact on the agency's budget. Moreover, mid-year reductions and account transfers are especially unfair to employers in Massachusetts who are consequently over-assessed for the DIA's budget without any immediate financial recourse. No system can properly function if it is not adequately funded, staffed, and managed. The Advisory Council remains committed to monitoring future budget cycles and educating policymakers to ensure the DIA can provide effective services to injured workers and employers.

2. Statutory Number of DIA Judges

During the fiscal year 2011 budget process, several attempts were made by policymakers to amend the state budget with language that would allow the Governor to appoint fewer than the statutorily authorized number of Administrative Judges (AJs) and Administrative Law Judges (ALJs). With significant declines in DIA caseloads over the last two decades, a reduction in judicial staffing, on the surface, seems to make sense. However, when looking more closely at the current case timeframes and at the characteristics of modern claims, proposed reductions to judicial staffing levels may be without merit. To begin, one only has to look at where the agency once was, and where it is today.

In 1985, the workers' compensation system was facing a growing backlog of claims, lengthy dispute resolution delays, and skyrocketing workers' compensation insurance premiums. To address these problems, the legislature passed a law creating temporary recall judge positions, which allowed the Governor to appoint former judges to serve for a short defined period of time. Depending on the need, recall judges could have their terms extended. During the late 1980s and early 1990s, the legislature also increased the statutory number of AJs from 16 to 21 and the number of ALJs from four to six. To further manage the backlog of cases, the 1991 Reform Act called for the additional appointment of six AJs to serve for three-year terms, with 1-year recall rights. By the end of 1993, 32 AJs were actively hearing cases at the DIA in an effort to bring dispute resolution delays under control.

Today, the workers' compensation system bears no resemblance to the broken system of nearly 20 years ago. With just 21 AJs covering four regional offices, backlogs no longer remain and the volume of annually scheduled hearings has consistently remained around 5,500 cases since 1999. The average timeframe for a case to appear before a judge following a conciliation is four to ten weeks (a far cry from the 12 to 18 months it took in years past). However, even with these incredible gains, the current timeframes are still not in compliance with Section 10A of the Workers' Compensation Act, which requires a conference to occur within 28 days of the agency receiving a case.

Furthermore, today's cases are much more time consuming and complex than at any other point in the 100-year history of the state's workers' compensation system. It is not uncommon for a case to have multiple parties and witnesses debating the medical and scientific evidence surrounding a latent occupational disease caused by the exposure to a chemical over 30 years ago. Even the simplest of lines connecting an employee to an employer have become blurred with the increased use of independent contractors and temporary employment agencies.

At the Advisory Council's meeting in February of 2010, the DIA provided council members with a formal report on the impact fewer judges would have on the dispute resolution system. The report, written by a sitting ALJ, concluded that reducing judicial personnel would, "result in an expansion of the time between the filing of claims and complaints, and their ultimate resolution." The report noted that fewer judges would especially have a negative effect on cases in the regional offices when parties have a

conflict with a particular judge. The report further concluded that the financial losses associated with delays would not be offset by the minimal reduction to an employer's annual assessment.

The DIA's dispute resolution system is currently operating very efficiently, in large part, because the agency has a full complement of highly qualified judges. Council members strongly believe that during periods of economic uncertainty and reduced caseloads, a comprehensive review of the agency's entire operations is merited, rather than a narrow focus on one unit. Any reduction in the number of judges will naturally increase the workload of the remaining judges and could cause delays for injured workers in having their cases reviewed. Increasing the amount of time it takes to litigate a case costs all workers' compensation participants money. If it is determined upon review that a reduction in judges would not have a negative impact on the efficiency of services presently afforded to injured workers, employers and insurers, the Advisory Council urges that personnel decisions be determined by judicial performance and not based upon the timing of the reappointment schedule.

3. Measuring Occupational Injuries and Illnesses

Since 1992, the Division of Occupational Safety (DOS) has partnered with the U.S. Department of Labor, Bureau of Labor Statistics (BLS), in an effort to collect injury and illness data in a uniform manner. Each year, surveys are collected from approximately 280,000 private and public sector establishments. The collected data, which comes from mandatory safety logs kept by employers, is then compiled into a report known as the "*Annual Survey of Occupational Injuries and Illnesses (SOII)*." Specifically, the report identifies both the number and rate of nonfatal injuries and illnesses by calculating incidence rates for every 100 full-time workers.

The survey's results have proven to be useful for all types of organizations. Liberty Mutual, the state's largest direct writer of workers' compensation insurance, uses the data to calculate a *Workplace Safety Index* to determine the most disabling injuries. Such rankings have resulted in targeted research and development for better non-slip floor surfaces and improved ladder safety. In the healthcare industry, SOII data on workplace violence has demonstrated a need for better prevention efforts. In 2006, scaffolding injury data was used by OSHA to develop stronger safety standards following a deadly scaffolding collapse at Emerson College. The DIA's Office of Safety has also utilized the survey results to identify high-risk industries that can be targeted for their annual Safety Grant Program.

For survey year 2008 (the most recent year for SOII data), the survey was expanded into the public sector, which includes nearly 19 million state and local government workers. In states where public employers subscribe to OSHA-designated plans, participation in the survey is mandatory. However, because public sector workers in Massachusetts are not covered by OSHA protections, survey participation would have been optional for public employers. To address this, Governor Deval Patrick signed Executive Order #511

in April of 2009, requiring that all state agencies comply with the survey's injury and illness reporting requirements. Although the executive order sent a strong message that workplace safety is a priority of the administration, future funding for the survey remains in doubt.

During the last eight budget cycles, DOS has struggled to receive the necessary funds to cover the survey's administrative costs (approximately $75,000). Because funding for the survey is split evenly between state and federal government, the state can lose out on federal matching funds when unable to meet its financial obligations. Twice during the last decade, the Commonwealth has been left with a gaping hole in workplace injury and illness data. Last year, Massachusetts was the only state in the nation that did not participate in the survey due to insufficient funding.

Council members believe that the benefits of having comparable statewide injury data far outweigh the modest cost of its collection and correlation. In fact, devoting resources towards safety awareness has traditionally offered a strong return on investment as evidenced by a reduction of injuries, reduced business costs, and most importantly, a more productive and healthy workforce. The Advisory Council recommends that the state provide DOS with the necessary funding to ensure that Massachusetts receives federal matching funds to continue its participation in this beneficial survey. Council members also believe that alternative funding mechanisms should be explored to provide a long-term funding solution. The Advisory Council encourages DOS to explore both private and public financial assistance, such as reaching out to the insurance community or utilizing funds from the DIA's Safety Grant program.

4. The Second Injury Fund

The Massachusetts Second Injury Fund (SIF) was created in 1919 to encourage employers to hire seriously disabled workers who had suffered from catastrophic injuries resulting in the loss of one hand, one foot, or one eye. Under this system, the Commonwealth would provide financial assistance to an insurance company if the previously disabled worker suffered a subsequent injury that resulted in the loss of the other hand, the other foot, or the other eye. This reimbursement to the insurer would benefit the employer by offsetting the total costs associated with the second injury. While the SIF statute has evolved over the last 90 years, becoming more expansive in the types of injuries that are eligible for reimbursement, two major objectives have remained:

1. Encouraging employers to hire and retain workers who have preexisting conditions; and
2. Providing economic relief to employers who hire workers with preexisting conditions that sustain a subsequent workplace injury.

In May of 2008, the Advisory Council formed a Second Injury Fund Subcommittee to better understand how SIFs operate both nationally and within Massachusetts. The

main goal of the subcommittee was to evaluate the effectiveness of SIFs in promoting the employment and retention of employees with prior disabilities. The subcommittee met throughout the summer to examine the SIF caseload within Massachusetts, the Americans with Disabilities Act, experience rating, recent SIF case law, and national trends.

SIF Caseload within Massachusetts - The DIA's Trust Fund administers all SIF reimbursements in Massachusetts. The Trust Fund has an annual budget of approximately $47 million, in which nearly half of the expenditures are primarily attributed to SIF expenses. Just ten years ago, SIF expenses accounted for only one-third of the Trust Fund's annual budget. Although the number of SIF settlements has decreased over the last decade, the average cost per claim has steadily increased by nearly 50%, in part due to rising medical costs and claim severity. In fiscal year 2010, the Trust Fund disbursed $22,877,654 for SIF reimbursements and made payments on 277 claims. The administration of SIF claims is complicated by the fact that the Trust Fund continues to receive claims from three distinct statutory time periods, known as the "Old Act," "Mid Act," and "New Act" (see page 82 for a complete description of the three statutory time periods).

Americans with Disabilities Act - To determine whether the Massachusetts SIF effectively promotes the employment and retention of employees with prior disabilities, the Advisory Council examined current laws which share similar goals. The Americans with Disabilities Act (ADA) is a federal anti-discrimination statute designed to remove the barriers that prevent qualified individuals with disabilities from enjoying the same employment opportunities available to those without disabilities. Enacted in 1990, the ADA applies only to employers with 15 or more employees. With over half a million small businesses operating in Massachusetts at any given time, many employees would not be protected by the discrimination provisions of the ADA. In this regard, the SIF provides broader coverage than the ADA.

Experience Rating - SIF reimbursements are specifically designed to help employers bear the additional cost associated with hiring workers with prior disabilities. In order for this financial assistance to work, the reimbursements collected by insurance carriers must be timely reported to the designated rating bureau so that the employer can have their experience modification factor revised to reflect the lower claim costs. Unfortunately, many SIF claims are processed too late (not within the 3-year experience period) to have any effect on an employer's experience modification factor. This is the case with "Mid-Act" (1985-1991) and "Old-Act" (1973-1985) claims which presently represent approximately 22% of all the claims received by the Trust Fund. To be eligible for experience rating in Massachusetts, an employer must have a premium of at least $11,000 during the last two years. Although only 20% of Massachusetts employers are experience rated, this accounts for approximately 80% of the total premium volume.

Recent SIF Case Law - On April 16, 2008, the Massachusetts Supreme Judicial Court (SJC) issued a decision on the Kim Oakes's Case/Steven Alves's Case. The issue before the SJC was whether the lower courts erred in finding that the "Mid Act" Section 37 claims (filed between 12/10/85 thru 12/23/91) were not subject to a statute of limitations. In both cases, the SJC affirmed the decision of the lower courts that "Mid-Act" Second Injury Fund petitions are not subject to a statute of limitations. The Advisory Council has been informed that this decision could jeopardize the Trust Fund's ability to make accurate predictions regarding the level of future assessments that will be necessary to keep the SIF solvent. From FY'07 through FY'10, there were over 350 pre-1991 cases filed with the Trust Fund.

National Trends - Since the early 1990s, at least twenty jurisdictions in the United States have either eliminated or have begun to phase out their SIFs. To understand why states are electing to close their SIFs, the Advisory Council closely examined the last six states that have passed legislation to abolish their funds (New York, South Carolina, Arkansas, Georgia, West Virginia, and South Dakota). The primary reason for SIF closure was either due to fund insolvency issues (NY, AR, GA, WV) or the fund not serving its intended purpose (SC, SD). In Massachusetts, where assessments are collected annually from employers based on the needs of the Trust Fund, SIF insolvency has not been an issue but should be monitored closely.

For over 90 years, the SIF in Massachusetts has attempted to promote the hiring and retention of workers with prior disabilities with varying degrees of success. However, in its present structure, the SIF often fails to benefit either employers or employees due to the stale nature of claims that are submitted many years after the second injuries occurred. The Massachusetts SIF needs to be repaired so that the objectives of the fund directly benefit the two parties with the most at stake - previously disabled workers and the businesses that employ them. In order to accomplish this goal, focus should be placed on "Mid-Act" and "Old-Act" claims where reimbursements can no longer be converted into premium adjustments.

The Advisory Council is recommending that during the 2011-2012 Legislative Session, legislation is filed and passed to phase out Section 37 Second Injury Fund reimbursements for all new and arising cases eligible for reimbursement with injuries occurring before December 23, 1991, so called "Mid Act" and "Old Act" claims. Council members believe that such legislation should become effective 180 days after enactment to allow insurers adequate time to review and submit remaining caseloads. The Advisory Council is further recommending the preservation of the Second Injury Fund in Massachusetts for all claims arising on or after December 23, 1991, so called "New Act" claims. It is important to note that passage of such legislation will not impact the amount of benefits received by injured workers in any way. Instead, the Commonwealth's employer community will be protected from having to fund stale SIF claims without the possibility for future premium savings.

5. Employer Fraud - Misclassification & Uninsured Employers

Employers who intentionally misclassify their employees or operate without workers' compensation insurance altogether, cost honest business owners and taxpayers millions of dollars annually. By some estimates, the "underground economy" in the United States accounts for up to $1 trillion per year in unreported cash holdings and contributes to over $100 billion in lost revenue annually. Recent studies have estimated that there are between 126,000 to 248,000 misclassified workers in Massachusetts, with approximately 13% of the Commonwealth's employers misclassifying some of their workers. With future uncertainty of the economic climate, it is likely these statistics will only rise as more employers turn to fraud to reduce their workers' compensation costs.

When an employer makes a decision to engage in workers' compensation fraud, the result is an unfair and burdensome cost to compliant employers in the form of higher premiums. This shift in costs is especially detrimental to small businesses and high risk industries such as construction, where the margin of profit is already small. Beyond creating an unlevel playing field for competitors, employer fraud unnecessarily jeopardizes the health of the workers they employ. Without a valid insurance policy, employers have fewer incentives to develop workplace safety programs because there is no tool in place to assess a financial penalty for poor injury experience.

During the last three years, Massachusetts has made great strides at curbing employer fraud. In March of 2008, Governor Deval Patrick issued Executive Order #499 establishing a Joint Enforcement Task Force on the Underground Economy and Employee Misclassification. The Task Force is charged with coordinating the efforts among multiple state agencies to increase compliance with existing labor, licensing, and tax laws. With active collaboration and information sharing among its 17-member agencies, the Task Force uses its collective strength to uproot the underground economy.

Last year, the DIA and the Workers' Compensation Rating & Inspection Bureau of Massachusetts (WCRIB) formed a public/private partnership to develop an online Proof of Coverage (POC) tool. Launched in September of 2009, the POC tool allows the public to verify whether a particular business has a current workers' compensation insurance policy. In December of 2009, a complimentary online premium fraud tool was added to the POC, allowing the public to request an employer's workers' compensation classification codes and the percentage of payroll associated with each code for the current and prior two policy years.

In August of 2010, Governor Deval Patrick signed into law Senate Bill 2375, an Advisory Council supported bill, creating a workers' compensation private right of action. The new law creates a vehicle for private citizens and insurers to file a civil action against employers who illegally fail to carry workers' compensation insurance or misclassify their workers for the purpose of avoiding premiums. On suits brought forth by private citizens, the majority of damages are deposited into the DIA's Trust Fund to help off-set benefit payments made to injured workers of uninsured employers.

While Massachusetts has taken a step in the right direction in confronting employer fraud, the Advisory Council believes that more attention still needs to be placed on outdated penalty statutes and fine-tuning current fraud tools. Although there is no "silver bullet" that will force every employer to adequately insure their employees, the Advisory Council believes that the following collective recommendations will be instrumental in curtailing employer fraud.

5.1 Increase Stop Work Order Fines & Expand DIA Investigative Powers - When the DIA's Office of Investigations learns that an employer is operating without workers' compensation insurance, an investigator is sent to the worksite to issue a "stop work order" (SWO). Such an order requires that all business operations cease immediately upon service. Fines resulting from a SWO begin at $100 per day, starting the day of issuance and continuing until insurance is secured and penalties are paid. Employers who believe the issuance of a SWO is unwarranted may appeal the order and remain open. However, if the SWO is upheld following an appeal hearing, an employer will be fined $250 for each day it was without coverage. Although this fine structure may have served as a sufficient penalty when it was introduced in 1987, it is no more than a slap on the wrist to dishonest employers in today's highly competitive business environment.

During the 2009-2010 Legislative Session, House Bill 17 was filed on behalf of the Executive Office of Labor & Workforce Development. This new legislation would increase the daily SWO fines levied against uninsured employers to $250 per day. In cases when a stop work order is appealed, the daily stop work order fines would double to $500 per day. In addition to increasing the civil penalties, the legislation would allow DIA to inspect business records during investigations to ensure that employers who do have workers' compensation insurance are not misclassifying their employees. The DIA would be required to share information with the agencies of the Joint Task Force on the Underground Economy if potential signs of employee misclassification are present.

The Advisory Council believes that the current civil penalties for stop work orders, which have not been updated in over 23 years, are grossly insufficient and no longer serve as a deterrent against uninsured employers. Furthermore, the Advisory Council recognizes that the current statute is vague in regards to DIA enforcement powers involving misclassification fraud. Allowing investigators to inspect employment records will help ensure that employers are properly classifying their workforce. The Advisory Council is recommending that House Bill 17 be refiled and passed during the 2011-2012 Legislative Session.

5.2 Increase Criminal Penalties - In Massachusetts, criminal prosecutions against uninsured employers are reserved for the most extreme and flagrant cases of employer fraud. Much like the current civil fines, criminal penalties are greatly outdated. Created in 1986, criminal penalties are capped at $1,500 and/or up to one year in state prison. During the 2009-2010 Legislative Session, Senator Susan Tucker filed Senate Bill 729, which would significantly increase the severity of criminal penalties that can be levied against uninsured employers. On criminal convictions, the bill would allow a judge assess fines up to $10,000 and/or impose sentencing for up to 5 years in state prison.

Perhaps the most notable example of a case ripe for criminal prosecution comes from the 2003 Station Night Club Fire in Rhode Island that took the lives of 100 people, four of whom were club employees. Beyond not having the required workers' compensation insurance, a subsequent investigation found that club owners were engaged in a range of illegal business practices that included paying bartenders under the table, violating fire and building codes, and allowing overcrowding beyond the license capacity. Fortunately, Rhode Island's laws contained tough criminal penalties that fined the Night Club owners over a million dollars for failing to carry workers' compensation insurance.

Established nearly 25 years ago, the present fine structure in Massachusetts is outdated and insufficient. The Advisory Council is recommending that Senate Bill 729 be refiled and passed during the 2011-2012 Legislative Session. Council members believe that this legislation sends a strong message to uninsured businesses in the Commonwealth that workers' compensation employer fraud is a serious violation of the law and will be met with serious consequences.

5.3 Remove Address Requirement on the Proof of Coverage Tool - When Massachusetts joined 42 other states by launching an online Proof of Coverage (POC) tool, it became much harder for uninsured employers to hide in the Commonwealth. The POC tool is an online search engine that enables the public to verify workers' compensation coverage for businesses operating within Massachusetts. The website, located within the DIA's homepage (www.mass.gov/dia), also provides separate internet links to verify businesses that are self insured or members of a self insurance group. By allowing the public to both directly verify coverage and report workplace fraud (via an online referral form), a natural fraud deterrent has been created.

Since its introduction in September of 2009, the POC tool has been deemed an overwhelming success. In addition to enhancing the referral process, the fraud detection tool has increased the quality of daily tips received by the Office of Investigations. Now that the POC tool has been in operation for over a year, it is time to take a closer look at how the search engine can be improved.

In its present structure, it is very difficult to find policy information when the exact location of an employer is unknown. Many businesses have multiple locations, some of which may not be listed on the workers' compensation policy. Furthermore, an employer's workers' compensation policy may be listed under their home address and not at the true location of the business. Sometimes the location of a business is just unknown, which is often the case when homeowners hire contractors for short term projects. Because the POC tool requires the user to include either the "city or town" or "zip code" fields, misleading search results could appear.

The Advisory Council is recommending that the DIA, in partnership with the WCRIB, remove the address requirement from the POC search fields. Presently, no other states with online coverage tools mandatorily require the user to input the address listed on the insurance policy. Council members believe that removing this requirement will greatly improve the accuracy of the search results when the location of an employer is unknown.

6. Employee Benefits

The principle foundation to any healthy workers' compensation system is the establishment of a benefit structure that fairly and adequately compensates workers who are injured or killed on the job. Periodically, benefit structures must be reevaluated and adjusted to ensure payments reflect the overall economic conditions. For the past six years, the Advisory Council has identified two specific benefits that need to be addressed.

6.1 Restore Scar-Based Disfigurement Benefits - In September of 2009, the Advisory Council testified before the Joint Committee on Labor & Workforce Development advocating for the passage of Senate Bill 681, filed by Senator John Hart, Jr. This bill would provide compensation for scar-based disfigurement appearing on any part of the body, subject to a $15,000 maximum benefit. The eligibility criteria for this benefit was last modified nearly 20 years ago by the 1991 Reform Act, which limited compensation for disfigurement to the face, neck or hands and created a $15,000 maximum benefit.

In June of 2000, the Advisory Council contracted with the actuarial firm Tillinghast - Towers Perrin to estimate the cost-impact of restoring scarring awards to their pre-1991 levels. Unfortunately, the contracted actuaries were unable to quantify the impact of such a proposed revision due to incomplete data, though it was suggested that such a change would have a "relatively minimal impact on system costs."

During fiscal year 2007, the Advisory Council contracted with Deloitte Consulting to conduct a similar scar-based disfigurement study. Specifically, the Advisory Council directed the actuary to measure the cost impact for six proposed amendment scenarios accounting for historical claim trends and changes in claim frequency and severity. After conducting interviews with representatives from both the DIA and the WCRIB, it was determined that the available statistical data was not refined to the required level of detail in either organization's databases.

Although scar-based disfigurement legislation has failed to become a law during the past three legislative sessions, the Advisory Council remains committed with its support in restoring this benefit to the injured worker. The Advisory Council is recommending that Senate Bill 681 be refiled and passed during the 2011-2012 Legislative Session. Advisory Council members strongly believe that the location of scarring on the body is irrelevant and that compensation, with a $15,000 maximum benefit, should be provided to workers who suffer these traumatic, and at times, horrific injuries.

6.2 Increase the Maximum Burial Allowance - Although the majority of workers' compensation benefits are linked to the State Average Weekly Wage (SAWW), there continues to be certain benefits that are not tied to an index, and therefore not adjusted on an annual basis. One such benefit is the maximum burial allowance for the dependents of deceased workers. In Massachusetts, when an employee has been killed on the job, the workers' compensation statute requires the insurer to "pay the reasonable expenses of burial, not exceeding four thousand dollars" [M.G.L. c.152, §33].

This amount has not been adjusted since 1991. In 2009, a total of 59 work-related fatalities were recorded in Massachusetts.

In October of 2010, the National Funeral Directors Association released the results from their biennial Member General Price List Survey. In 2009, the median adult casketed funeral cost (with vault) in New England was $7,703. It is important to note that these costs do not include cemetery monument costs or miscellaneous cash advance charges such as flowers and obituaries. Nationally, the median cost of a funeral (without a vault) rose by 75% between 1991 ($3,742) and 2009 ($6,560). During this same time period, the SAWW rose by 112%. In this regard, the SAWW may not be a reliable index to tie to the price of funerals.

State mandated burial allowances vary considerably in the U.S., ranging from a high of $15,000 in Rhode Island and Minnesota to a low of $2,000 in Mississippi. With such a large range, it is important that Massachusetts look to the most available data in determining an appropriate maximum benefit. The Advisory Council is recommending that House Bill 1865 be refiled and passed during the 2011-2012 Legislative Session. This bill would increase the maximum amount an insurer is obligated to pay for burial expenses from $4,000 to $8,000. Council members believe that the passage of this legislation will ensure there is sufficient compensation available to the families of those workers killed on the job so that they may be honored with a respectful burial.

7. Employer Responsibilities

In addition to providing indemnity and medical benefits to injured employees, workers' compensation insurance also protects employers from personal injury lawsuits. With these protections, comes a wide range of employer responsibilities. Although the penalties for violating these responsibilities are often negligible, their effect can have great implications on the speed in which a claim is processed. The Advisory Council believes that there is a need to legislatively address two basic employer responsibilities that are far too often disregarded.

7.1 Create Civil Fines for Employers who Fail to Notify Employees of Coverage - In Massachusetts, employers are required by law to provide written notice to new employees that they have obtained workers' compensation insurance. In addition, the statute requires an employer to provide notice to all employees when an insurance policy is cancelled or expired [M.G.L. c.152, §22]. Presently, the statute does not specify any civil penalties for employers who fail to provide such notices to employees. The posting of insurance information is vital towards educating workers that there is a remedy should they experience an occupational injury. Often times, employees do not know of their workplace rights or protections, resulting in compensable injuries that go unreported.

The Advisory Council is recommending that House Bill 1839 be refiled and passed during the 2011-2012 Legislative Session. This legislation, previously filed by Representative

Pam Richardson, would create civil fines for employers who fail to properly notify their employees under §22 of the Workers' Compensation Act. Under the provisions of this bill, employers would be fined not less than $50, nor more than $100 per day, for failing to provide written notice of coverage or cancellation.

7.2 Strengthen Injury Reporting Compliance - The second employer responsibility requiring attention involves the timely reporting of injuries. Under Massachusetts law, all employers must report to the DIA any workplace fatality or injury that incapacitates an employee from earning full or partial wages for a period of five or more calendar days [M.G.L. c.152, §6]. This report, known as the "Employer's First Report of Injury or Fatality - Form 101" (FRI), can be submitted by mail or online and is due within seven days from the fifth calendar day of disability (not including Sundays or legal holidays).

The DIA's Office of Claims is responsible for ensuring that employers are timely reporting workplace injuries. Failure to file, or timely file, a FRI three or more times within any year is punishable by a fine of $100 for each violation. Each failure to pay a fine within 30 days is considered a separate violation. Massachusetts is the only state in the nation that allows an employer to have two violations in any year before fines are assessed. In fiscal year 2010, the DIA collected $116,542 in fines stemming from late or unreported injuries, representing over a 50% decrease from the prior year. From the 30,443 FRIs processed in the fiscal year, only 29% were filed online.

During the first half of the 2009-2010 Legislative Session, Representative David Torrisi filed House Bill 1863 on behalf of the Advisory Council, which would remove the flat fine of $100 and create the following escalating fine structure based on the tardiness of each violation:

- 1 - 30 calendar days late: $250
- 31 - 90 calendar days late: $500
- More than 90 calendar days late: $2,500

The timely reporting of injuries is to the advantage of all parties in the workers' compensation system. Studies have shown that the sooner claim management begins, the faster the claim is resolved with minimal conflicts. This equates to savings for the employer and prompt benefit payments to the injured worker. The Advisory Council is recommending that House Bill 1863 be refiled and passed during the 2011-2012 Legislative Session. With today's technology, in which employers have an instantaneous ability to submit FRIs online, there is no justification for waiving the fines on the first two violations in any year. Moreover, an escalating fine structure provides a more equitable penalty for employers.

8. Medical Fee Schedule Task Force

The Division of Health Care Finance and Policy (DHCFP) regulates the rates of payment (fee schedule) for hospitals and health care providers rendering services covered by insurers under the Workers' Compensation Act. The fee schedule is subject to a regulatory proceeding ensuring a public process through which rate setting is established. Although rate negotiation is common in certain specialties (particularly for orthopedic surgeries), the rates set by the DHCFP are the only amount that an insurer is required to pay. While medical costs are rising in Massachusetts, the overall payments for health related services are comparatively low to other states. However, even with the lowest fee schedule in the country, Massachusetts continues to achieve a very high rate of satisfaction with medical outcomes among those treated.

The Difficulties of Rate Setting - There is no question that the rate setting process is an imperfect science. If rates are set too low, injured workers could be denied proper access to quality medical care. Conversely, if rates are set too high, the fee schedule does not meet its goal as a cost containment tool. The DHCFP has experienced past difficulties with obtaining reliable data to make accurate rate decisions, largely because many insurance companies are often reluctant to share their medical claim information. Furthermore, there is evidence that many of the rates that physicians charge vary substantially for the same procedure. This inconsistency in fees, combined with a lack of medical data, underscores the difficulties that DHCFP experiences when attempting to set an equitable rate.

The Rhode Island Model - Following a host of reforms during the late 1980s and early 1990s, Rhode Island created a Fee Schedule Task Force in 1992. The Task Force consists of a diverse group of representatives from the state's Department of Labor & Training, Beacon Mutual Insurance, self insured employers, the Medical Advisory Board, Blue Cross/Blue Shield, third party administrators, the Rhode Island Medical Society, and the Hospital Association of Rhode Island. As a representative body of the Rhode Island workers' compensation system, the Task Force provides all parties with a forum to continually fine-tune the fee schedule and expand codes when necessary. Since its inception, the Task Force has achieved many accomplishments, including the clean-up of excess CPT codes that did not correspond with workers' compensation claims, the creation of state-specific CPT codes, the establishment of rules to ensure the fee schedule could not be manipulated to benefit one party, and the implementation of annual cost of living increases for all CPT codes.

Recent Amendments to the Fee Schedule - In February of 2009, the DHCFP held two public hearings relative to proposed increases to the fee schedule to more closely reflect the negotiated amounts already being paid by insurers and employers. At the public hearings, the Advisory Council recommended that the DIA and the DHCFP work together to form a Massachusetts Medical Fee Schedule Task Force, similar to the one create in Rhode Island. A total of fifteen organizations testified at the hearing showing

overwhelming support for the proposed increases. The Advisory Council applauds the DHCFP for addressing the workers' compensation medical fee schedule in 2009. The fee schedule, which had not been adjusted in nearly five years, is now closer to the actual costs of healthcare services rendered in certain fields. However, the recent amendments to the fee schedule only serve as a "band-aid" to the much larger problem of maintaining updated and accurate rates.

The Advisory Council is impressed with how various interests were able to come together in Rhode Island to produce and maintain a fee schedule that accurately reflects the costs incurred by health care providers. In Massachusetts, where medical providers receive the lowest payments in the nation yet face the second highest practice expenses associated with providing medical care to injured workers, an effective vehicle is needed to better coordinate dialogue between the medical community, insurance companies, and the DHCFP. The Advisory Council is again recommending that the DIA and the DHCFP work together in establishing a Medical Fee Schedule Task Force to provide a mechanism that can promptly react when areas of the fee schedule become unrepresentative of system costs. An unreasonable fee schedule could ultimately lead to higher costs and poor treatment patterns.

LEGISLATION

During the 2009-2010 Legislative Session, approximately 50 bills were filed by the House and Senate seeking to amend the workers' compensation system (see Appendix M for a complete list of legislation). The vast majority of bills concerning workers' compensation matters are referred to the Joint Committee on Labor & Workforce Development (JCLWD). For a complete list of JCLWD members, see Appendix C.

Legislation Endorsed by the Advisory Council

Each year, the Advisory Council reviews proposed workers' compensation legislation before the JCLWD. When the affirmative vote of at least seven members can be reached between business and labor, these positions are reflected in the Advisory Council's recommendations. During the 2009-2010 Legislative Session, the Advisory Council voted to support the passage of the following bills addressing employer fraud, employee benefits, and employer responsibilities:

LEGISLATION ENDORSED BY THE ADVISORY COUNCIL

House Bill 1870 (Walsh), **Senate Bill 682** (Hart), **Senate Bill 2375** - Private Right of Action

House Bill 17 (EOLWD) - Stop Work Order Fines/DIA Investigative Powers

Senate Bill 729 (Tucker) - Increasing Criminal Penalties

Senate Bill 681 (Hart) - Scar-Based Disfigurement Benefits

House Bill 1865 (Torrisi) - Increasing the Maximum Burial Allowance

House Bill 1863 (Torrisi) - Penalties for Failing to Timely Report Injuries

House Bill 1839 (Richardson) - Civil Fines for Failing to Notify Employees of Coverage

Public Hearing on Workers' Compensation Legislation

On September 30, 2009, the JCLWD held a public hearing on all filed workers' compensation legislation. At this hearing, representatives from the Advisory Council appeared before the committee and testified in support of eight bills that were endorsed by the Advisory Council (see Appendix H for Advisory Council testimony).

Following a public hearing, a legislative committee will convene in Executive Session to review public testimony and discuss the merits of each bill before making their recommendations to the full membership of the House or Senate. When a committee deems a bill to be "favorably rated," it is the first essential step for a bill to become a law. Bills that are reported out favorably are then sent on to the relevant committees for further review. During the 2009-2010 Legislative Session, the JCLWD "favorably rated" the following ten bills affecting the workers' compensation system:

LEGISLATION "FAVORABLY RATED" BY THE JCLWD

House Bill 1821 (Mariano) and **Senate Bill 686** (Hart) - Widow's Benefits

House Bill 1839 (Richardson) - Civil Fines for Failing to Notify Employees of Coverage*

House Bill 1846 (Rodrigues) - WC Payroll Audits - Requirements and Penalties

House Bill 1863 (Torrisi) - Penalties for Failing to Timely Report Injuries*

House Bill 1865 (Torrisi) - Increasing the Maximum Burial Allowance*

House Bill 1870 (Walsh) and **Senate Bill 682** (Hart) - Private Right of Action*

Senate Bill 681 (Hart) - Scar-Based Disfigurement Benefits*

Senate Bill 729 (Tucker) - Increasing Criminal Penalties*

* Endorsed by the Massachusetts Workers' Compensation Advisory Council

Legislation Enacted

Of the fifty workers' compensation bills before the Joint Committee on Labor and Workforce Development, only one bill was signed into law during the 2009-2010 Legislative Session. On August 9, 2010, Governor Deval Patrick signed into law **Senate Bill 2375** creating a workers' compensation private right of action.[1] This legislation, endorsed by the Advisory Council, was originally filed by Representative Martin Walsh (House Bill 1870) and Senator John Hart, Jr. (Senate Bill 682). These two identical bills, which eventually became Senate Bill 2375, created a vehicle for private citizens and insurers to bring forth a civil action against employers who illegally fail to carry workers' compensation insurance or misclassify their workers for the purpose of avoiding premiums. On suits brought forth by private citizens, the majority of the damages are deposited into the DIA's Trust Fund to help off-set payments made to injured workers of uninsured employers.

Also of note, was the passage floor finishing legislation, originally appearing before the Joint Committee on Public Safety and Homeland Security. On July 2, 2010, Governor Deval Patrick signed into law **House Bill 4565** banning the commercial use and sale of a highly flammable wood floor finishing product.[2] Specifically, the new law targets lacquer sealer - a wood floor finishing product that can burst into flames at the slightest trigger. The legislation was jointly supported by Representative Martin Walsh and Senator Patricia Jehlen in response to a recommendation made by a Floor Finishing Task Force organized by the Massachusetts Coalition for Occupational Safety and Health (MassCOSH).

[1] The Private Right of Action law can be found in Chapter 285 of the Acts of 2010.
[2] The Floor Finishing law can be found in Chapter 154 of the Acts of 2010.

SECTION - 2 -

OVERVIEW

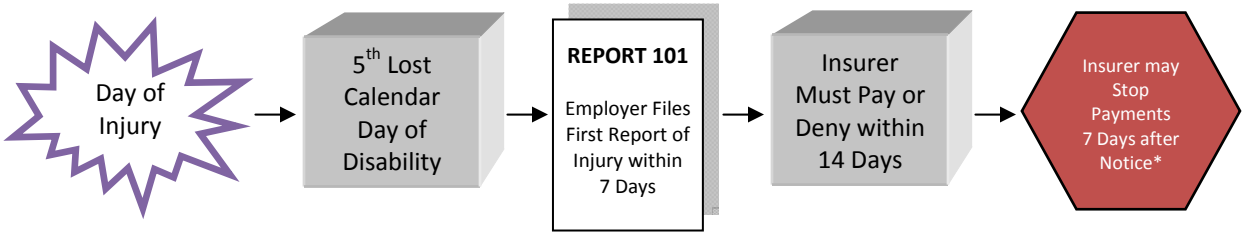
PROVISIONS TO RESOLVE DISPUTES

Workers' Compensation Claims

When an employee is disabled or incapable of earning full wages for five or more calendar days, or dies, as the result of a work-related injury or disease, the employer must file a First Report of Injury. This form must be sent to the Office of Claims Administration at the DIA, the insurer, and the employee within seven days of notice of the injury.[3] Failure to file, or timely file, a First Report of Injury three or more times within any year is punishable by a fine of $100 for each violation. In addition to state mandated reporting guidelines, employers must also comply with federal injury recordkeeping and reporting requirements administered by the Occupational Safety and Health Administration (OSHA).

The insurer then has 14 days upon receipt of the employer's First Report of Injury to either pay the claim or to notify the DIA, the employer, and the employee of their 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 known as the "pay without prejudice period." This period establishes a window where the insurer may refuse a claim and stop payments at 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.

Figure 1: Schedule of Events



*NOTE: The insurer may stop payments unilaterally (with 7 days notice) only if the case remains within the 180 day "pay without prejudice period," and the insurer has not assigned or accepted liability for the case. Otherwise, the insurer must file a "complaint" and go through the dispute resolution process.

[3] The First Report of Injury can be submitted to the DIA by mail or through online submission.

[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.

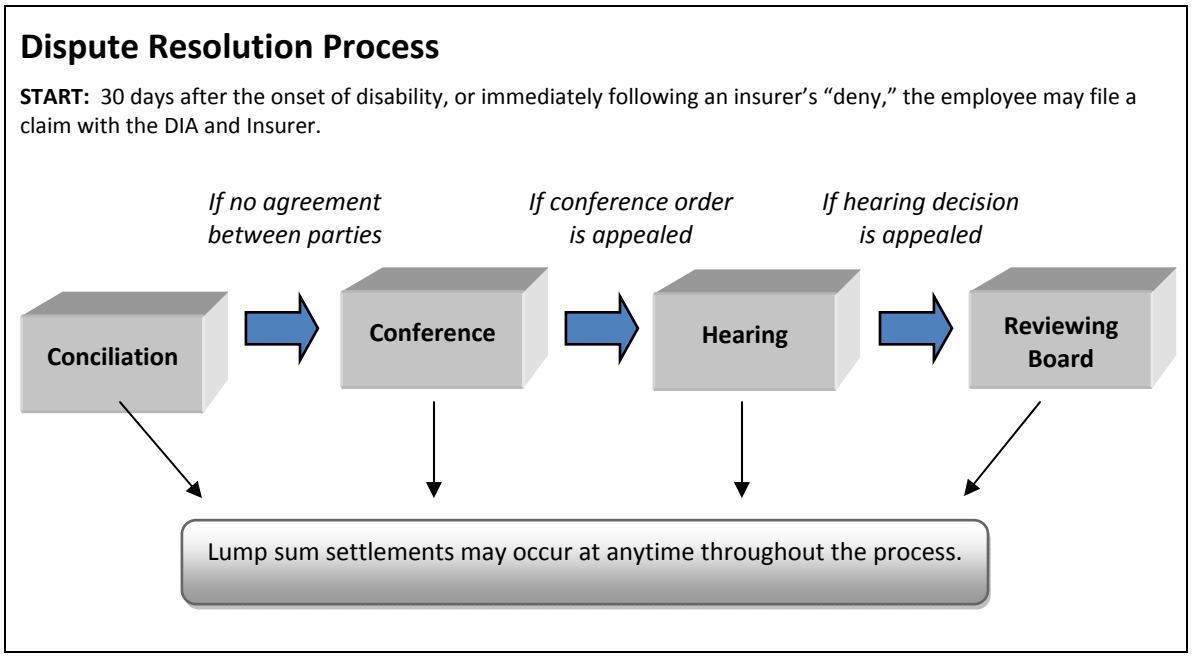
[5] The insurer does not need permission from the DIA to terminate or reduce benefits during the 180 day "pay without prejudice" period if said change is based on actual income of the employee or if it gives the employee and the DIA at least seven days written notice of its intent to stop or modify benefits and contest any claim filed. The employee can contest discontinuance by filing a claim with the DIA. The pay without prejudice period may be extended up to one year under special circumstances.

After a conference order is issued or the pay without prejudice period expires, the insurer may not stop payment without an order from an Administrative Judge (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 a referral to the division of dispute resolution.

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 from the filing date of such order.

At 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 proceeding 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. Any party may appeal a hearing decision within 30 days.

This time limit for appeals may be extended up to one year for reasonable cause. A fee of 30% of the state average weekly wage must accompany the appeal. The claim will then proceed to the reviewing board, where a panel of Administrative Law Judge's (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 costs 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 either a voluntary settlement agreed to by the parties or by the decision of an AJ or 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 ALJ will decide if a lump sum settlement is in the best interest of the parties.

At the conference or hearing level of dispute resolution, the AJ 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.

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, and §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, as well as any medicines if needed. The insurer must also pay for vocational rehabilitation services if the employee is determined to be suitable for such services by the DIA.

Below is a list of the SAWW since 1995 along with the maximum (SAWW) and minimum benefit levels for §34 and §34A claims. In October of 2010, the SAWW decreased for only the third time in 72 years.

Table 1: Minimum and Maximum Benefit Levels - §34 Claims and §34A Claims

Effective Date (Effective Oct 1st)	Maximum Benefit (100% of SAWW)	Minimum Benefit (20% of SAWW)
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
10/1/04	$918.78	$183.76
10/1/05	$958.58	$191.72
10/1/06	$1,000.43	$200.09
10/1/07	$1,043.54	$208.71
10/1/08	$1,093.27	$218.65
10/1/09	$1,094.70	$218.94
10/1/10	**$1,088.06**	**$217.61**

Source: DIA Circular Letter No. 336 - Table I (October 6, 2010)

[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, 2010, the SAWW is $1,088.06.

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 ($1,088.06), while the minimum is 20% of the SAWW ($217.61), if claims involve injuries occurring on or after October 1, 2010. 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 benefit period is 260 weeks for partial disability, but may be extended to 520 weeks.

Permanent and Total Incapacity (§34A) - Payments will equal 66.67% of the AWW following the exhaustion of temporary (§34) and partial (§35) payments. The maximum weekly compensation rate is 100% of the state average weekly wage ($1,088.06), while the minimum is 20% of the SAWW ($217.61), if claims involve injuries that occurred on or after October 1, 2010. 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.

Permanent Loss of Function and Disfigurement Benefits (§36) - An employee who has a work-related injury or illness that results in a permanent loss of a specific bodily function or receives scarring on the face, neck or hands, will receive a one-time payment. This benefit is paid in addition to other payments; for example medical bills, lost wages, etc. The amount paid depends on the location and severity of the disfigurement or function lost.

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, 2010, 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 **$1,042.82** plus necessary expenses. If the employee's attorney fails to appear at a scheduled conciliation, the amount paid is **$520.89**.

(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 **$1,488.30**. 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 **$743.26**.

(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 **$743.26** plus necessary expenses. This fee can be reduced to **$372.08** 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 **$1,042.82** 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 **$520.89** 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 **$5,209.00** 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 **$1,488.30**. 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
- 3 -

WORKPLACE INJURY AND FATALITY STATISTICS

OCCUPATIONAL INJURIES AND ILLNESSES

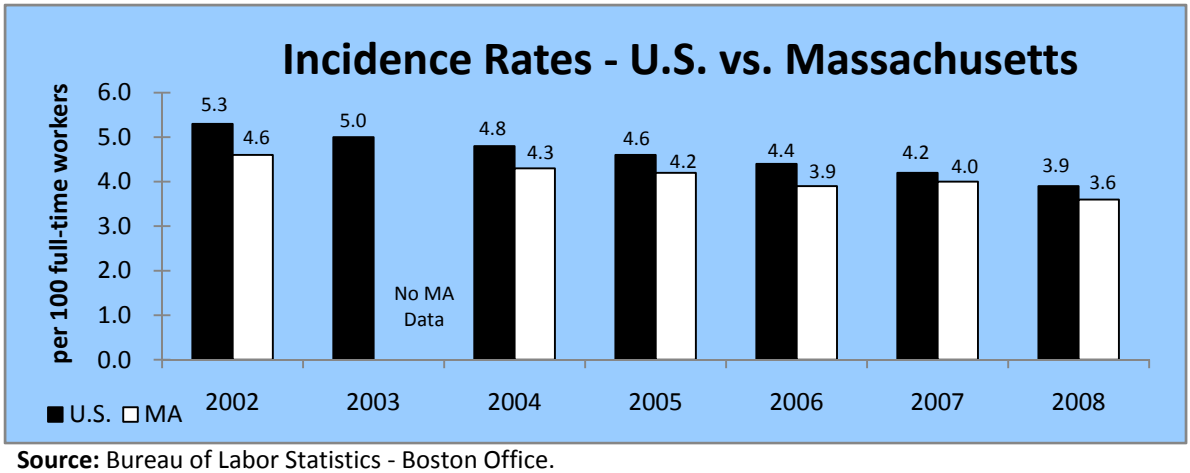
Since 1992, the Massachusetts Division of Occupational Safety (DOS) has been in a partnership with the U.S. Department of Labor, Bureau of Labor Statistics (BLS), in an effort to collect injury and illness data in a uniform format. Throughout the country, surveys are collected from a sample of private industry establishments in an effort to represent the total private economy. Each year 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 (DOS) and federal (BLS) government.

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 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 the number of hours that employees work. In 2008, Massachusetts had a population of 6,497,967 people with an estimated private sector workforce of 2,850,000 workers.

During 2008, the private sector workforce in the U.S. experienced approximately 3.7 million non-fatal injuries and illnesses, resulting in an incidence rate of 3.9 cases per 100 full-time workers. In Massachusetts alone, there were 82,600 non-fatal occupational injuries and illnesses, resulting in an incidence rate of 3.6 cases per 100 full time workers. Of the 82,600 workplace injuries and illnesses in Massachusetts during 2008, roughly 37,900 (46%) did not result in lost workdays, while approximately 33,300 (40%) involved days away from work, job transfer, or restrictions. The graph below shows how occupational injury and illness rates have steadily declined at both the national level and within Massachusetts from 2002 to 2008. The graph also displays how incidence rates in Massachusetts have consistently remained lower than national rates.

Figure 3: Incidence Rates - U.S. vs. Massachusetts, 2002 - 2008



Source: Bureau of Labor Statistics - Boston Office.

Incidence Rates by Region

The following table exhibits a regional breakout of the injury and illness incident rates per 100 full-time workers since 2002. Historically, Massachusetts has led all other New England states with the lowest incident rate of work-related injuries or illnesses (resulting in lost work-time).

Table 2: Injury and Illness Incidence Rates - U.S. and New England 2002-2008 (Private Industry)

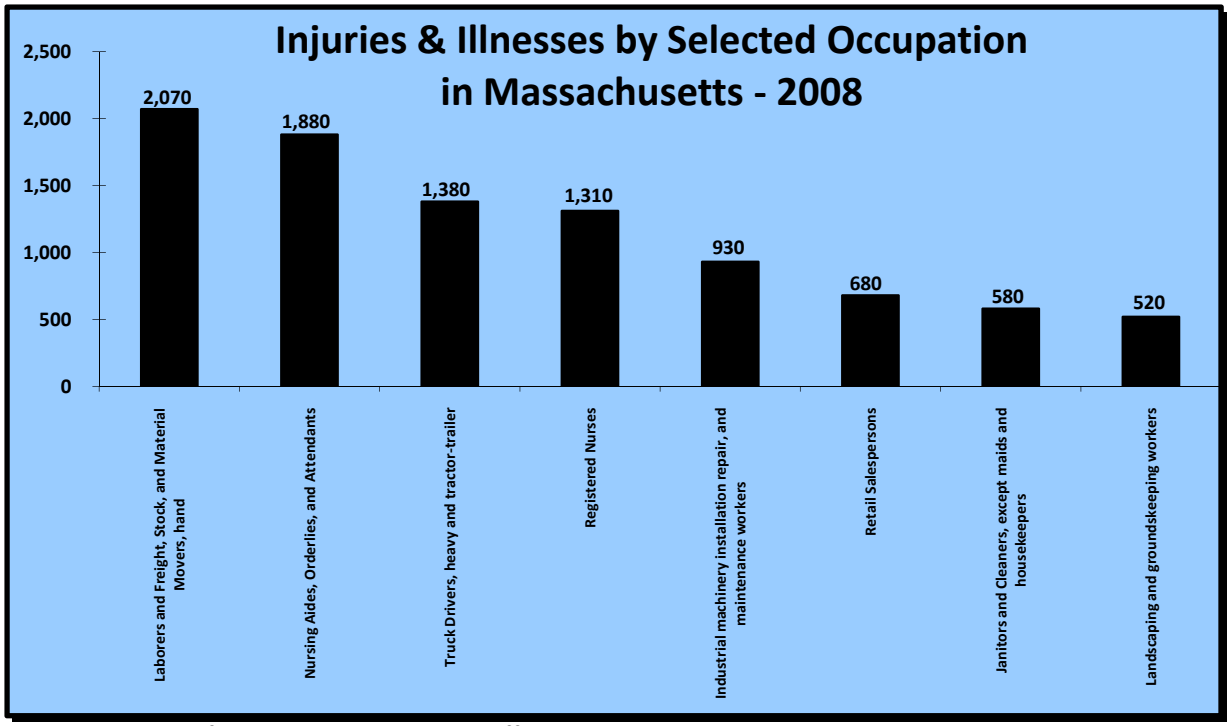
Region	2008	2007	2006	2005	2004	2003	2002
United States……	3.9	4.2	4.4	4.6	4.8	5.0	5.3
Massachusetts…..	3.6	4.0	3.9	4.2	4.3	no data	4.6
Connecticut……..	4.6	4.8	4.8	5.0	4.8	5.1	5.4
Maine……..	6.0	6.4	7.0	7.2	6.9	7.7	8.1
Rhode Island……	no data	5.1	5.2	5.5	5.2	5.4	5.3
Vermont……..	5.5	5.9	5.5	6.2	5.8	5.2	6.7
New Hampshire...	no data	no data	no data	no data	no data	no data	no data

Source: Bureau of Labor Statistics - Boston Office.

Injuries & Illnesses by Occupation

The survey also has the ability to categorize the number of injuries and illnesses by occupation in Massachusetts. In 2008, laborers (non-construction) and nursing aides, orderlies and attendants had the highest number of injuries and illnesses involving days away from work in Massachusetts.

Figure 4: Nonfatal Injuries & Illnesses with Days Away from Work by Selected Occupation in MA - 2008



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 "agriculture, forestry, and fishing" industry had the highest overall incidence rate in 2008, with 9.3 injuries for every 100 full-time workers. This industry represented a small fraction of the total private sector employees in 2008. The "financial activities" sector, which employed 7.8% of the private sector workforce, had the lowest incidence rate, with 0.9 injuries per 100 workers. As a whole, the goods-producing industries in Massachusetts, which employed about 15% of the private sector workforce, had a higher incidence rate (3.9) than service-producing industries (3.5), which employed the remaining 85% of the private sector workforce in 2008.

Table 3: Nonfatal Injury & Illness Incidence Rates by Industry - Massachusetts 2002-2008

MASSACHUSETTS (Selected Industry Division)	2008	2007	2006	2005	2004	2003	2002
Private Industry:	**3.6**	**4.0**	**3.9**	**4.2**	**4.3**	**no data**	**4.6**
Construction:	4.8	6.1	6.4	6.5	6.9	no data	6.8
Trade, Transportation & Utilities:	4.3	5.1	4.8	5.4	5.2	no data	7.4
Retail trade:	4.3	5.5	4.7	5.2	4.7	no data	5.3
Agriculture, forestry, and fishing:	9.3	5.4	5.9	5.0	4.5	no data	7.8
Wholesale trade:	3.2	2.9	4.0	4.5	4.2	no data	5.5
Manufacturing:	3.5	3.8	4.1	4.2	4.5	no data	5.3
Financial Activities:	0.9	1.3	0.9	1.2	1.2	no data	1.1

Source: Bureau of Labor Statistics - Boston Office.

OCCUPATIONAL FATALITIES

Fatal work injuries are calculated nationally each year by the U.S. Department of Labor, Bureau of Labor Statistics. The program, known as the *National 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 2009, a total of 4,340 work-related fatalities were recorded nationally by the program, representing a 17% decrease from the revised total of 5,214 fatalities in 2008. The national rate of fatal work injuries in 2009 was 3.3 per 100,000 workers, down from the rate of 3.7 per 100,000 workers in 2008. The overall fatal work injury rate for the U.S. in 2009 was at its lowest level since the fatality census was first conducted in 1992.

Workplace Fatalities in Massachusetts

In 2009, Massachusetts experienced 59 workplace fatalities, 9 fewer fatalities than recorded in 2008. The leading cause of workplace death in Massachusetts came from transportation incidents (20) and contact with objects and equipment (12) in which 32 workers were killed. Nationally, transportation incidents were the leading cause of on-the-job fatalities, accounting for 39% of the fatal work injuries in 2009. Following transportation incidents and contact with objects and equipment, Massachusetts workers were killed by falls (11), assaults and violent acts (9), and exposure to harmful substances or environments (7).

Figure 5: Fatal Occupational Injuries by State and Event or Exposure, 2009 (Northeast Region)

State of Fatality	Total Fatalities		Event or Exposure (state total for 2009)					
	2008 (Revised)	2009	Transportation Incidents	Assaults & Violent Acts	Contact with Objects & Equipment	Falls	Exposure to Harmful Substances	Fires & Explosions
U.S. Total.....	5,214	4,340	1,682	788	734	617	390	113
Massachusetts....	68	59	20	9	12	11	7	--
Connecticut.....	28	34	9	13	3	7	--	--
Maine.....	24	16	10	--	--	--	--	--
New Hampshire..	7	6	3	--	--	--	--	--
Rhode Island.....	6	7	--	--	4	--	--	--
Vermont.....	10	12	7	--	--	--	--	--

Source: Bureau of Labor Statistics, News-USDL-10-1142

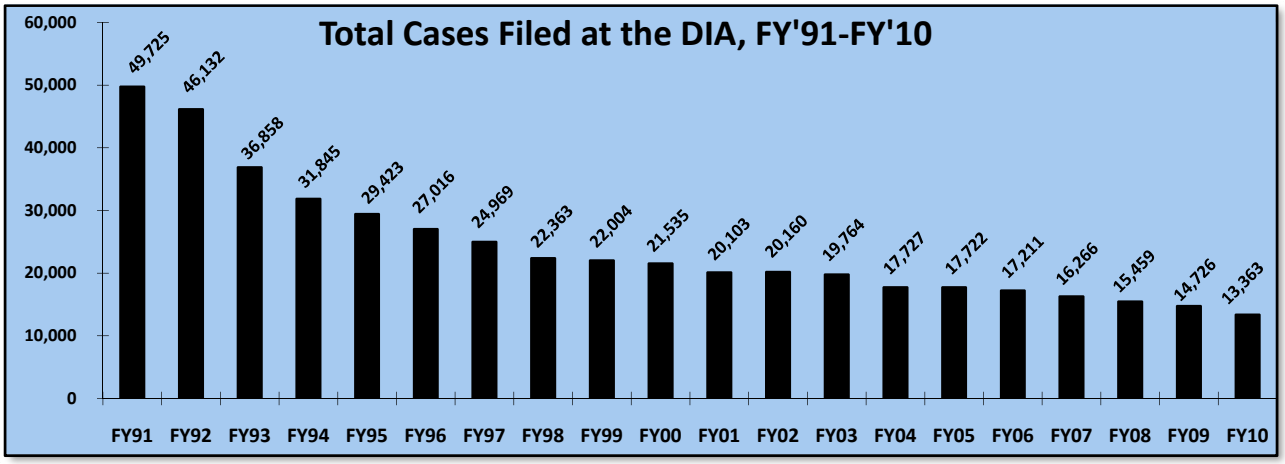
SECTION
- 4 -

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 6, there has been a significant decline (-73%) in the DIA caseload since the implementation of the 1991 Reform Act. In FY'10, the total number of cases filed at the DIA was 13,363, a decrease of 9% from the previous fiscal year.

Figure 6: Total Cases Filed at the DIA, FY'91 - FY'10



Source: CMS Report 28

Employee claims, which account for 77% of the total cases filed at the DIA, decreased by 970 cases (-8.7%) in FY'10. In 1991, employee claims reached an all time high of 23,240 cases filed. Employee claims have decreased by 56% since 1991. Insurers request for discontinuance or modification of benefits account for 16% of the total cases and decreased by 185 cases in FY'10. Since the 1991 Reform Act, these requests by insurers to discontinue or modify benefits have decreased by 81%.

Table 4: Breakdown of Total Cases Filed at the DIA, Fiscal Year 2010 and Fiscal Year 2009

Total Cases Filed at the DIA FY'10 and FY'09	*Number of Cases*		*Percentage*	
	FY'10	**FY'09**	**FY'10**	**FY'09**
Employee Claims	10,241	11,211	76.6%	76.1%
Insurer's Request for Discontinuance	2,139	2,324	16.0%	15.8%
Lump Sum Conference Request	545	594	4.1%	4.0%
Third Party Claims	159	283	1.2%	1.9%
Section 37/37A Request	279	314	2.1%	2.1%
TOTALS:	**13,363**	**14,726**	**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 45% of the cases that are scheduled for 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 55% of cases are referred from conciliation to a conference to be heard before an Administrative Judge.

The Conciliation Process

Conciliations are scheduled automatically by computer through the Data Processing Unit. 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 this meeting.

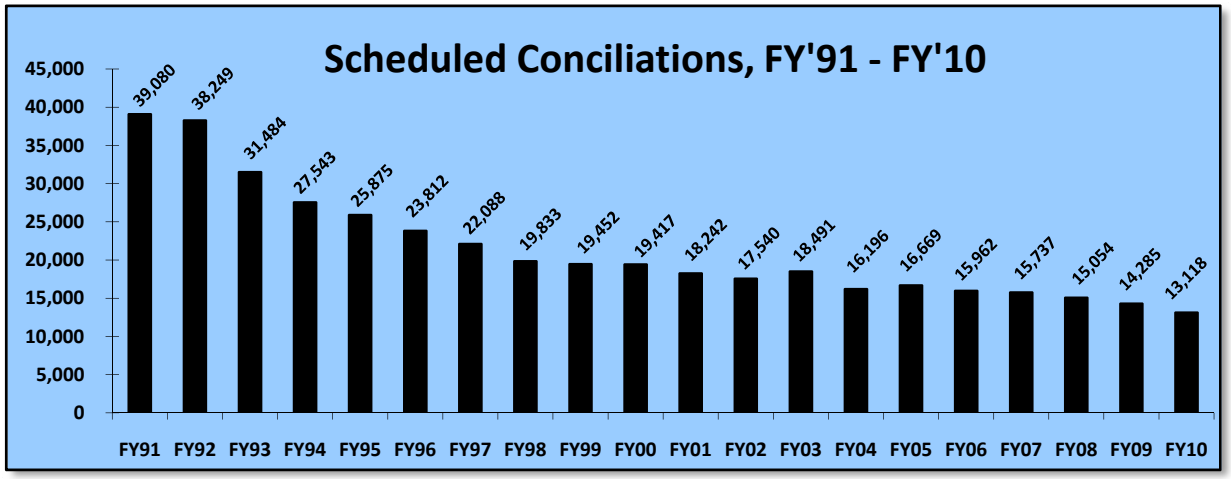
When liability is not an issue but modification or discontinuance of benefits is sought, both parties are required to submit written settlement offers. If the employee fails to file, the conciliator must record either the last offer made by the employee or the maximum compensation rate. If the insurer fails to file, the conciliator must record the last offer made 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.

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. In FY'10, there were 13,118 cases scheduled for conciliation, which represents a 66% decrease since the Workers' Compensation Reform Act of 1991.

Figure 7 displays the number of cases scheduled for conciliation at the DIA beginning in fiscal year 1991. In fiscal year 2010, the volume of cases scheduled for conciliation decreased by 8% (1,167 fewer cases) from the previous year. It is important to note that many cases scheduled for conciliation may never actually appear before a conciliator as cases can be withdrawn or adjusted prior to the scheduled meeting.

Figure 7: Volume of Cases Scheduled for Conciliation, FY'91-FY'10

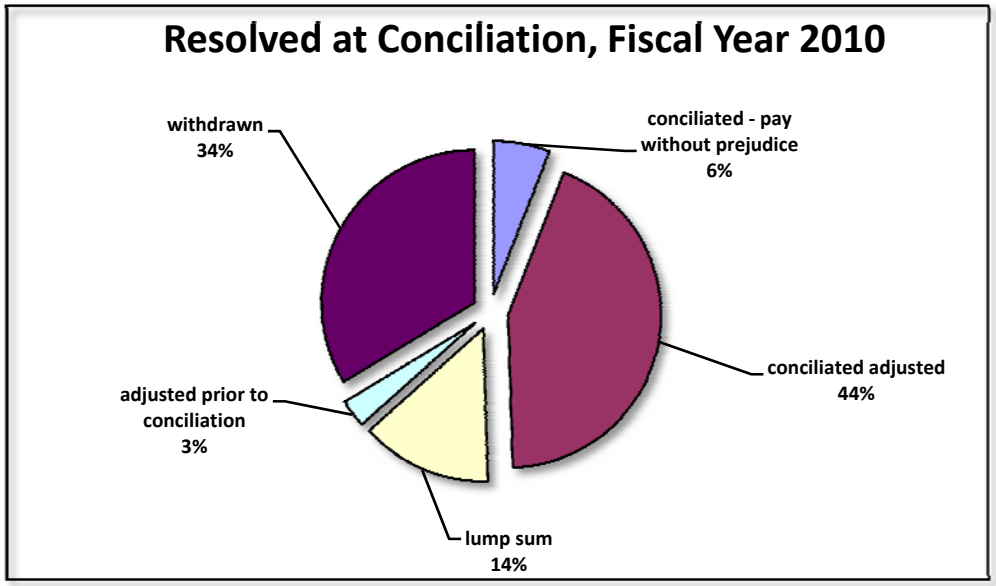


Source: CMS Report 17

Resolved at Conciliation

Disputed cases that are scheduled for conciliation can be divided into two distinct outcomes: "referred to conference," or "resolved." In FY'10, 5,942 cases were resolved (they were not referred on to a conference) and exited the dispute resolution system. Approximately 45% of cases that are scheduled for conciliation are resolved while the remaining 55% 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 a conciliation taking place. This occurs when the respondent (the party not putting forth the case) does not appear for the conciliation.

Figure 8: Pie-Chart Detailing Cases Resolved at Conciliation, Fiscal Year 2010



Source: CMS Report 17

Table 5: Resolved at Conciliation, Fiscal Year 2010 and Fiscal Year 2009

Resolved at Conciliation FY'10 and FY'09	*Number of Cases*		*Percentage*	
	FY'10	**FY'09**	**FY'10**	**FY'09**
Conciliated - Pay Without Prejudice	351	343	5.9%	5.3%
Conciliated Adjusted	2,640	2,818	44.4%	43.6%
Lump Sum	806	937	13.6%	14.5%
Adjusted Prior to Conciliation	154	171	2.6%	2.6%
Withdrawn	1,991	2,196	33.5%	34.0%
TOTALS:	**5,942**	**6,465**	**100%**	**100%**

Source: CMS Report 17

As displayed in Table 5, cases may be conciliated by two methods. Approximately 44% 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" (6% of resolved cases in FY'10), 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 second most prevalent method a case can exit the dispute resolution system at conciliation is through a withdrawal (1,991 cases in FY'10). 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 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 agreements "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 14% 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 the conference stage and the hearing stage.

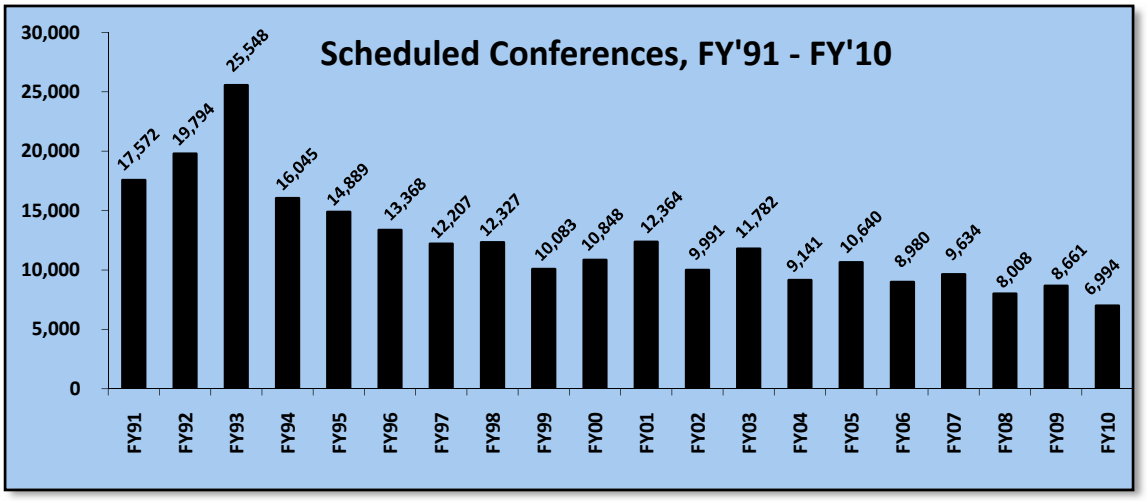
CONFERENCE

The second stage of the dispute resolution process is known as the conference. Each case referred to a conference is assigned to 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 AJ may require injury and medical records as well as statements from witnesses. Although the conference is an informal proceeding, the AJ will issue a binding order (subject to appeal) shortly after the conference has concluded. The conference order is a short, written document requiring an AJ's initial impression of compensability, based upon a summary presentation of facts and legal issues. 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. Approximately 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 may accept the order or otherwise voluntarily adjust, withdraw or settle the matter.

Volume of Scheduled Conferences

Conferences are scheduled by the Central Scheduling Unit at the DIA. This occurs after a conciliation has taken place and was unsuccessful at bringing the parties together to reach an agreement on the disputed issues. The number of conferences scheduled in FY'10 decreased by 19% (8,661 in FY'09 to 6,994 in FY'10) from last fiscal year.[7] 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 9: Scheduled Conferences, FY'91 - FY'10



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

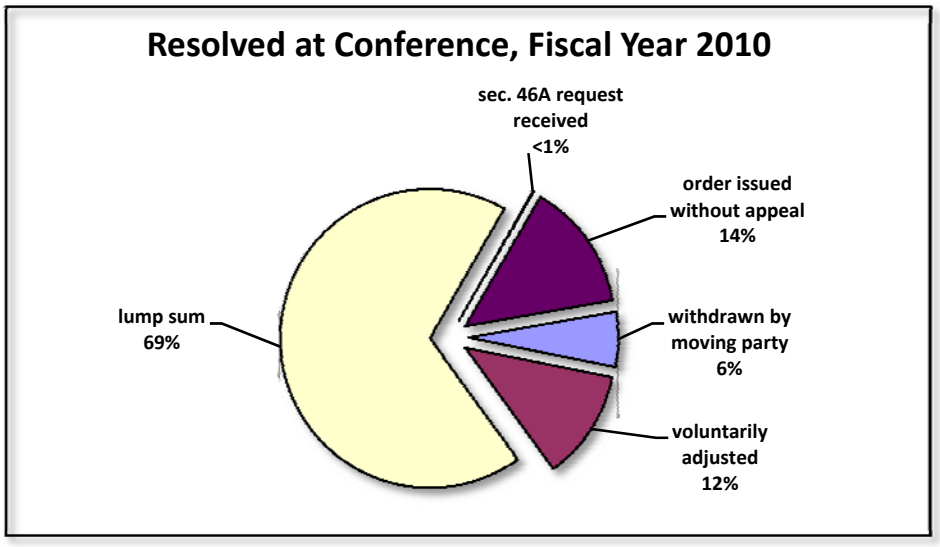
[7] In an effort to avoid duplication, the number of "scheduled conferences" does not include cases that were "rescheduled for a conference." In FY'10, 1,664 cases were "rescheduled for a conference."

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 2010, 5,491 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 10 and Table 6 display the various methods a disputed case can be resolved at conference.

Figure 10: Pie-Chart Detailing Cases Resolved at Conference, Fiscal Year 2010



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

Table 6: Cases Resolved at Conference, Fiscal Year 2010 and Fiscal Year 2009

Resolved at Conference FY'10 and FY'09	*Number of Cases*		*Percentage*	
	FY'10	**FY'09**	**FY'10**	**FY'09**
Withdrawn by Moving Party	306	401	5.6%	6.6%
Voluntarily Adjusted	640	789	11.7%	13.1%
Lump Sum	3,803	4,008	69.3%	66.3%
Section 46A Request Received	1	7	<1%	<1%
Order Issued Without Appeal	741	836	13.5%	13.8%
Total	**5,491**	**6,041**	**100%**	**100%**

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

As displayed in *Table 6* 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 2010, 306 cases (6% 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 2010, 640 cases (12% 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 2010, 3,803 cases (69% 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 2010, only 1 of these requests has been documented.

Finally, a case can exit the system at the conference level when the presiding AJ issues a conference order and it is not appealed by any of the parties to the hearing level. In fiscal year 2010, 741 conference orders (15% of all conference orders) were issued by AJs, not resulting in an appeal. However, the vast majority of conference orders are appealed to the hearing stage of dispute resolution. In fiscal year 2010, 4,892 conference orders (85% of all conference orders) were appealed to a hearing.

Table 7: Conference Orders, FY'10 - FY'01

Conference Orders FY'10 - FY'01	Total Orders	Appealed	Without Appeal
Fiscal Year 2010	**4,892**	4,151 (84.9%)	741 (15.1%)
Fiscal Year 2009	**6,081**	5,245 (86.3%)	836 (13.7%)
Fiscal Year 2007	**7,048**	6,149 (87.2%)	899 (12.8%)
Fiscal Year 2006	**6,591**	5,768 (87.5%)	823 (12.5%)
Fiscal Year 2005	**7,494**	6,457 (86.2%)	1,037 (13.8%)
Fiscal Year 2004	**6,448**	5,609 (87.0%)	839 (13.0%)
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%)

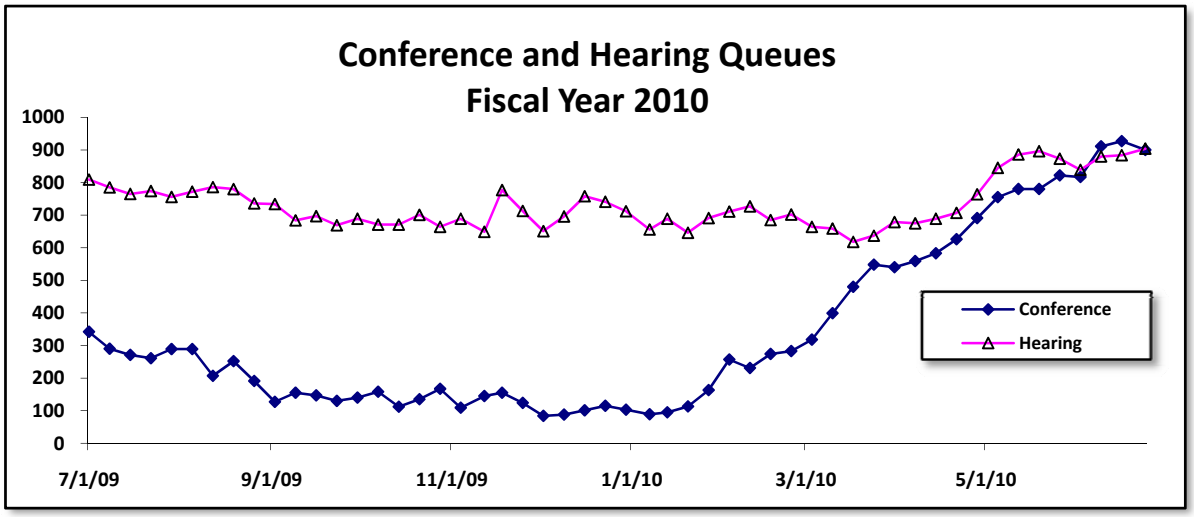
Source: CMS Reports 319AB, "Appealed Conference Order Statistics."

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 an AJ's normal cycle. If the queue increases beyond 2,000 cases, adjustments in scheduling and assignments would need to occur.

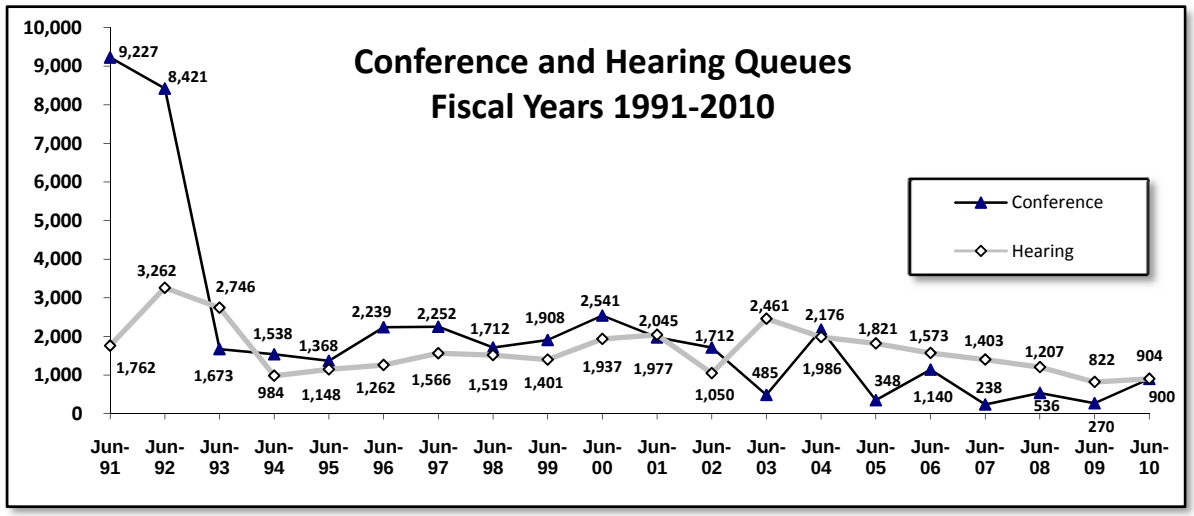
As presented in *Figure 11*, the conference queue during fiscal year 2010 remained well below the benchmark of 1,500 cases, thereby allowing cases to be efficiently scheduled. In FY'10 the conference queue ended 558 cases higher than the start of the year (342 on 7/1/09 and 900 on 6/24/10). The conference queue reached a high of 927 on 6/16/10 and a low of 84 on 12/2/09.

Figure 11: Conference and Hearing Queues; Fiscal Year 2010



Source: CMS Report 404

Figure 12: Conference and Hearing Queue; Fiscal Years 1991-2010



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 (AJ) that presides over a conference must review the dispute at the hearing level, 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 IME report is the only medical evidence that can be presented unless the AJ 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 time may be extended up to 1-year for reasonable cause. Appealing parties must pay a fee of 30% of the state average weekly wage. The claim is then forwarded to the Reviewing Board.

Hearing Queue

Much like conferences, hearings are scheduled by the Central 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 because 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 2010 began with a hearing queue of 809 cases and increased to 904 cases by the end of the fiscal year. Since 1991, the hearing queue has been as low as 618 cases (March '10) and as high as 4,046 (Nov. '92).

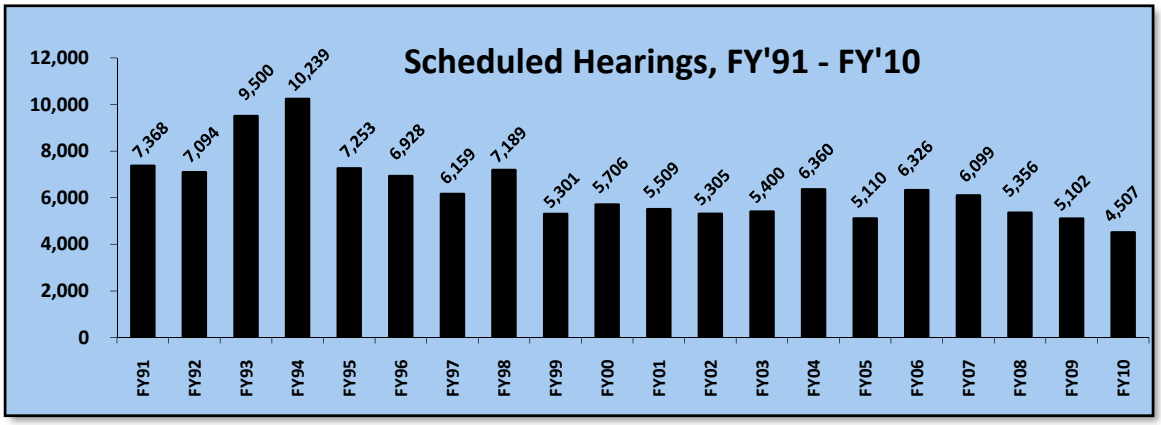
Volume of Scheduled Hearings

The number of hearings scheduled in FY'10 decreased by 595 cases (5,102 in FY'09 to 4,507 in FY'10) from last fiscal year.[8] Each year, the number of hearings scheduled is greater than the number of hearings that will actually take place before an Administrative Judge since many cases are withdrawn or resolved before ever reaching

[8] In an effort to avoid duplication, the number of "scheduled hearings" does not include cases that were "rescheduled for a hearing." In FY'10, 3,293 cases were "rescheduled for a hearing."

a hearing. The figure below shows that the number of "scheduled hearings" in fiscal year 2010 decreased by 12% from the previous fiscal year.

Figure 13: Scheduled Hearings, FY'91 - FY'10



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

Cases Resolved at Hearing

In fiscal year 2010, 4,185 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 decision date 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 14: Pie-Chart Detailing Cases Resolved at Hearing, Fiscal Year 2010

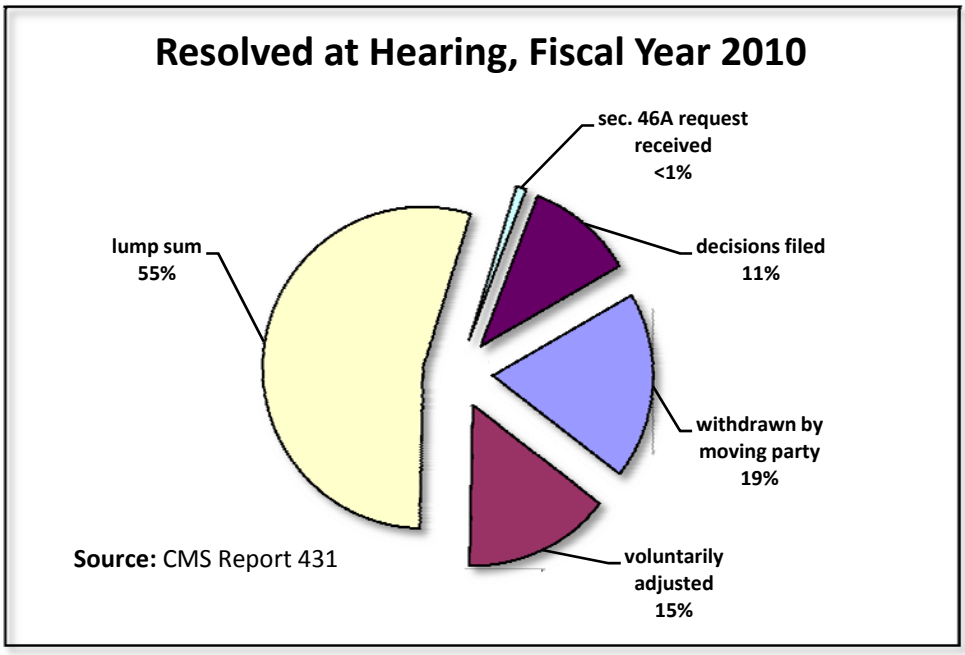


Table 8: Cases Resolved at Hearing, Fiscal Year 2010 and Fiscal Year 2009

Resolved at Hearing FY'10 and FY'09	*Number of Cases*		*Percentage*	
	FY'10	**FY'09**	**FY'10**	**FY'09**
Withdrawn by Moving Party	774	849	18.5%	17.2%
Voluntarily Adjusted	625	665	14.9%	13.5%
Lump Sum	2,317	2,838	55.4%	57.6%
Section 46A Request Received	15	11	<1%	<1%
Decisions Filed	454	560	10.8%	11.4%
Total	**4,185**	**4,923**	**100%**	**100%**

Source: CMS Report 431

As displayed in Table 8 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 2010, 774 cases (19% 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 2010, 625 cases (15% 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 level 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 2010, 2,317 cases (55% of resolved cases at hearing) exited the system through a lump sum settlement.

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 2010, only 15 of these requests have been documented at the hearing level.

Finally, a case can exit the system at the hearing level when the presiding Administrative Judge issues a hearing decision. In fiscal year 2010, 454 hearing decisions (11% of resolved cases at hearing) were filed by Administrative Judges.

REVIEWING BOARD

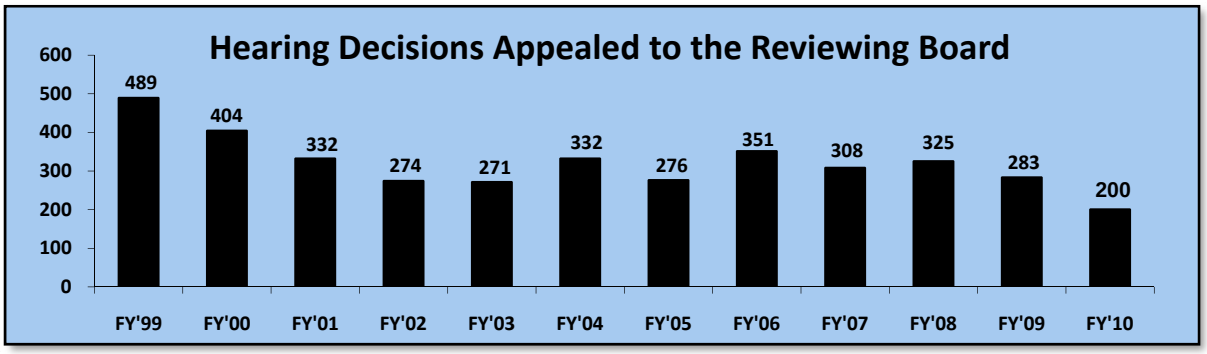
The fourth and final stage of dispute resolution at the DIA is known as the reviewing board. The reviewing board consists of six Administrative Law Judges (ALJ's) whose primary function is to review the appeals from hearing decisions. While appeals are heard by a panel of three ALJ's, initial pre-transcript 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 decision date. 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 required 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 25% to 30% of the cases are withdrawn or settled following this first meeting. After the pre-transcript conference takes place, the parties are entitled to a verbatim transcript from 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 2010 was 200.

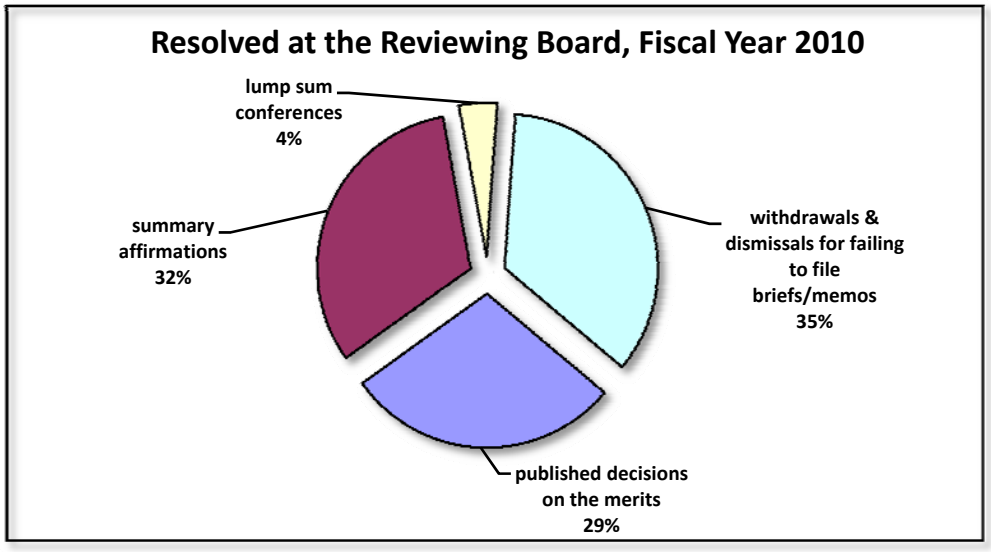
Figure 15: Hearing Decisions Appealed to the Reviewing Board, FY'99 - FY'10



Source: DIA Reviewing Board

In fiscal year 2010, the Reviewing Board resolved 255 cases (some from the prior year), representing a 9.3% decrease from cases resolved in fiscal year 2009 (281 cases).

Figure 16: Appeals Resolved at the Reviewing Board, Fiscal Year 2010



Source: DIA Reviewing Board

Table 9: Appeals Resolved at the Reviewing Board, Fiscal Year 2010

Appeals Resolved at the Reviewing Board, FY'10	*Number of Cases*
Published Decision on the Merits (Full Panel):	73 (28.6%)
Summary Affirmations (After Full Panel Deliberation):	82 (32.2%)
Lump Sum Conferences:	10 (3.9%)
Withdrawals/Dismissals for Failing to File Briefs/Memos:	90 (35.3%)
Total Number of Appeals Resolved by the Reviewing Board:	**255 (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 a lump sum conference at the request of the parties or the parties may request a lump sum conference directly. The number of lump sum conferences scheduled in 2010 was 971.

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. However, the accident 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'10, Administrative Law Judges heard 1,184 Section 15 petitions on a rotating basis.

Compromise and Discharge of Liens (§46A)

Administrative Law Judges are also responsible for determining 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 (DTA) 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 DTA 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 that were heard in fiscal year 2010 was 39.

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 or hearing 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 whereby an Administrative Law Judge will decide if it is in the best interest of the employee to settle.

Table 10: Lump Sum Conference Statistics, FY'10-FY'91

Fiscal Year	*Total lump sum conferences scheduled*	*Lump sum settlements approved*
FY'10	**6,344**	**5,866 (92.5%)**
FY'09	6,897	6,480 (94.0%)
FY'07	7,532	6,901 (91.6%)
FY'06	7,416	6,830 (92.1%)
FY'05	7,575	6,923 (91.4%)
FY'04	8,442	7,754 (91.9%)
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 68% since FY'91. In FY'10, only 7 lump sum settlements were disapproved. 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 occurred at either conciliation, conference, or hearing:

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 lump sum settlements, however, 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. In this situation, the parties would fill out a form to request a lump sum conference 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 settlements have historically become increasingly prevalent at the later stages of the dispute resolution process.

Table 11: Lump Sum Settlements Pursued at Each Level of Dispute Resolution - FY'10

Fiscal Year 2010	*Lump Sum Pursued*[9]	*% Total Cases Resolved (at each level of dispute)*
Conciliation	806	13.6%
Conference	3,803	69.3%
Hearing	2,317	55.4%

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

[9] 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.[10] 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.[11]

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

[10] M.G.L. c.152, §8(4).
[11] M.G.L. c.152, §45.

collect filing fees, schedule examinations, and to ensure that medical reports are promptly filed and that physicians are compensated after the report is received.

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

The following table details the DIA's fee schedule:

Table 12: 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

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'10, approximately $1,545,691 was collected in filing fees.

As of 6/30/10, there were 251 physicians on the roster consisting of 27 specialties.[12] 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'10 the impartial unit scheduled 5,002 examinations. Of these, 3,783 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).[13] Medical reports are required to be submitted to the DIA and to each party within 21 calendar days after completion of the examination. Last year (FY'09), the impartial unit scheduled 5,239 examinations. Of these, 3,971 exams were actually conducted in the fiscal year.

Impartial Exam Fee Waiver for Indigent Claimants

In 1995, the Supreme Judicial Court ruled that the Department 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

[12] Including contracts pending renewal.
[13] Additional reports may be entered upon FY'09 closure.

and standards for processing waiver requests and providing financial relief for the Section 11A fee.

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

It is within the discretion of the DIA 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 ten 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 DIA 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 13: DIA Indigency Requirements, 2010

2010 HHS Poverty Guidelines	
Size of Family Unit	**Amount***
1	$10,830
2	$14,570
3	$18,310
4	$22,050
5	$25,790
6	$29,530
7	$33,270
8	$37,010

For family units with more than eight members, add $3,740 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. 75, No. 148, August 3, 2010, pp. 45628-45629.
*48 Contiguous States and the District of Columbia.

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 (see Appendix E for a list of Governor's Council members). Candidates for the positions are first screened by the Industrial Accidents Nominating Panel 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 (see Appendix G for a roster of judicial expiration dates).

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. This provides a judge who has fallen behind with the opportunity to catch up. The administrative practice of taking a judge off-line is relatively rare and occurs for a limited time period. However, the Senior Judge may take an AJ off-line near the end of a term until reappointment or a replacement is made. This enables the off-line 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 as designated by statute (see Appendix D for a list of Industrial Accident Nominating Panel members). When a judicial position becomes available, the Nominating Panel convenes to review applications for appointment and reappointment. The panel considers an applicant's skills in fact finding and 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 - Upon the completion of the Nominating Panel's review, recommended applicants are forwarded to the Advisory Council. The Advisory Council will review these candidates either through a formal interview or by a "paper review." On the affirmative vote of at least seven voting members, the Advisory Council may rate any candidate as either "qualified," "highly qualified," or "unqualified." This rating must then be forwarded to the Governor's Chief Legal Counsel within one week from the time a candidate's name was transmitted to the Council from the Nominating Panel (see Appendix J for Advisory Council guidelines for reviewing judicial candidates).

SECTION
- 5 -

DIA ADMINISTRATION

OFFICE OF CLAIMS ADMINISTRATION

The Office of Claims Administration (OCA) is the "starting point" for all documents within the Department of Industrial Accidents (DIA). Every workers' compensation case is established from filings received from employers, insurance companies, attorneys and third party providers under the provisions of M.G.L. c.152. Quality control is a top priority of the office to ensure that each case is properly recorded in a systematic and uniform method.

Claims Processing

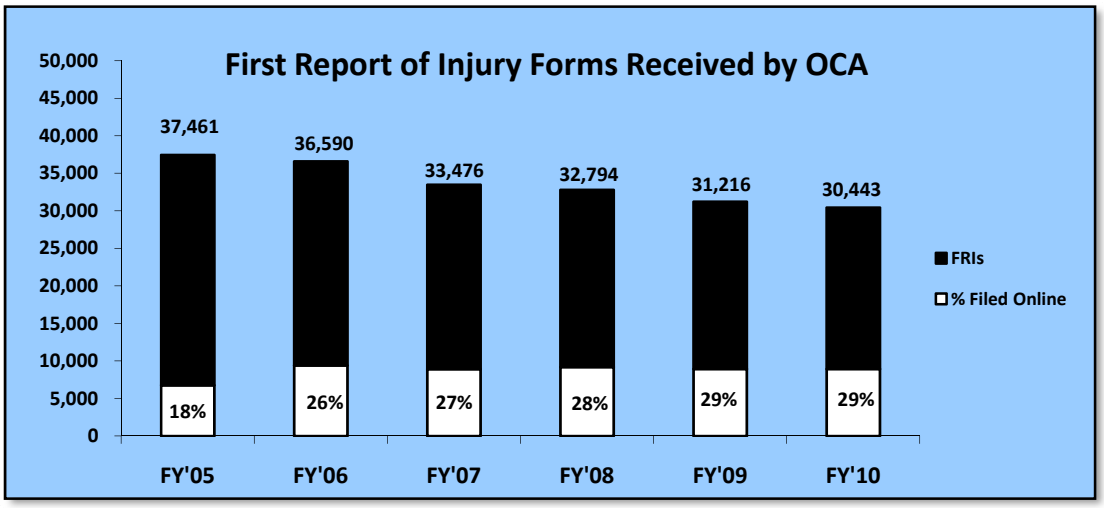
During the last two fiscal years, the OCA has streamlined the claims process by introducing electronic online filings in conjunction with the agency's Document Management System (DMS). These technological advancements have greatly reduced the DIA's reliance on paper documents, thereby reducing costs to the agency and its users. With the inception of new technology, the role of the OCAs staff has changed dramatically, resulting in the absorption of four internal units into one.

The OCA has four primary functions centered upon receiving, entering, storing, and retrieving information. The first function consists of receiving lost time reports, insurance forms, claims, appearances, and liens. Once this information is received, it must be entered into the Case Management System (CMS) database. The growing use of the agency's electronic online filing system has increased both the speed and accuracy of entered information. In fact, the online filing system will automatically reject any forms submitted that are incomplete or inaccurate. Since September 21, 2008, the OCA has used a quality-control process that creates a barcode cover-sheet for every document stored in DMS. This barcode system eases the ability to view and reproduce the records of an entire case file for both internal and external users.

While quality control measures may slow down the process, they are necessary for accurate and complete record keeping. Forms and online filings are entered in the queue in order of priority, with the need for scheduling at dispute resolution as the main objective. All conciliations are scheduled upon entry of a claim through CMS. Information entered into CMS automatically generates violation notices, schedules conciliations and other judicial proceedings, and produces statistical reports. The DIA and other agencies use this data to facilitate various administrative and law enforcement functions.

In FY'10, the OCA received 30,443 First Report of Injury Forms (FRIs), a decrease of 4.8% from FY'09 (31,216). Approximately 29% (8,934) of all FRIs were filed online during FY'10, the same percentage as last fiscal year. In FY'10 the number of claims, discontinuances and third party claims received by the OCA was 13,841, a 12.8% decrease from the 15,873 received in FY'09 (prior to review and CMS processing). The total number of referrals to conciliation for FY'10 was 12,940, which represents a decrease of 6.3% from FY'09 (13,806).

Figure 17: First Report of Injury Forms Received by the Office of Claims Administration



Source: DIA - Office of Claims Administration

Information Storage

OCAs' Record Room has historically served as the "central repository" for all files relative to the DIA. However, due to space constraints, the OCA contracted with an offsite storage facility in FY'09 to store 9,000 boxes of files. Around this same time, DMS was implemented and the reliance upon DIA paper files came to an end. Presently, the small percent of paper files that remain are in the process of being scanned into DMS.

The DIA continues to maintain a document retention cycle of 40 years (28 of these years at the state archive). Manual file procedures are kept strictly in accordance with the State Record Center (SRC) regulations. When a request is made to the SRC, the corresponding paper file is scanned and returned to the OCA.

Keeper of Records

OCA serves as Keeper of Records (KOR) and responds to all written requests for records in compliance with the Massachusetts Public Records Law [M.G.L. c.66]. All documents are not considered public records. In accordance to M.G.L. c.4, §7(26), records considered exempt in whole, or in part, shall be withheld. If you are not a party to the workers' compensation case, then a signed authorization for the release of records from either the claimant or a court order is required. A letter of receipt will be forwarded from the KOR which will include the status of the file and its location. The trend in public record requests continues to rise and grow unabated.

In addition to processing subpoenas and public records requests, the KOR answers investigative and pre-employment screening inquiries. The KOR also assists past and present claimants in obtaining copies of files or documents relevant to social security, disability, and retirement benefits. A fee is charged to all requestors for copies, labor and research. Inquiries are also submitted by the Insurance Fraud Bureau, the Attorney

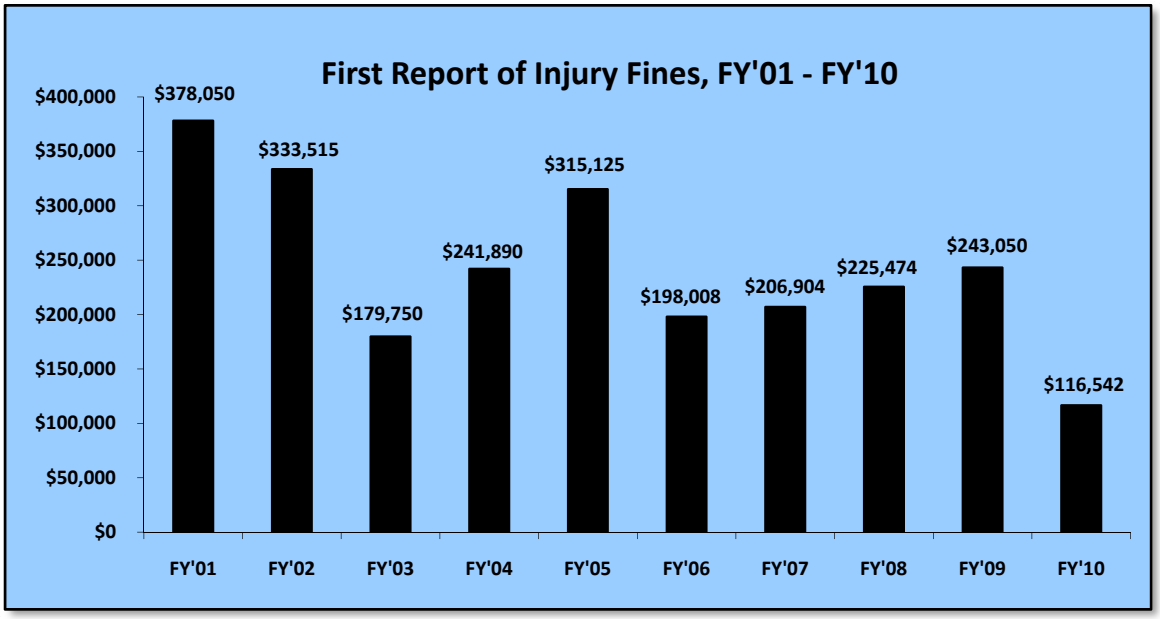
General's Office, the Social Security Administration and other government entities. Occasionally, a KOR representative is summoned to appear in court to testify on behalf of the DIA on documents relating to a workers' compensation case.

First Report Compliance

In Massachusetts, all employers must file an *Employer's First Report of Injury or Fatality* (Form 101), within seven calendar days of receiving notice of any injury alleged to have arisen out of and in the course of employment that incapacitates an employee from earning full wages for a period of five calendar days. Failure to file this report or filing of the report late is a violation under M.G.L. c.152, §6. If such violation occurs three or more times within any year, a fine of $100 for each such violation will be sent to the employer. Each failure to pay a fine within thirty calendar days of receipt of a bill from the DIA is considered a separate violation whereby Demand Notices are generated. These notices range from $200 - $500 and are under the jurisdiction of DIA's Office of Revenue.

In fiscal year 2010, the OCA collected $116,542 in FRI fines, a decrease of $126,508 from the $243,050 collected in FY'09. The office is also responsible for maintaining a database on cases identified by the DIA where there may be potential fraud. In fiscal year 2010, the OCA received 12 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. Each year, the OCA assists investigators from the Insurance Fraud Bureau by providing them with workers' compensation case-files on suspected fraudulent claims. A total of 21 such inquiries were processed during FY'10.

Figure 18: First Report of Injury Fines, FY'01-FY'10



Source: Collection & Expenditure Reports, FY'01-FY'10

OFFICE OF EDUCATION & VOCATIONAL REHABILITATION

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 Workers' Compensation 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. It shall also mean reasonably necessary related expenses."[14]

A claimant is eligible for vocational rehabilitation services when an 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. All Request for Response (RFR) information, including application forms, are now available through the DIA website [www.mass.gov/dia/].

Credentials for a vocational rehabilitation specialist must include at least a master's degree, rehabilitation certification, or a minimum of ten years of experience. A list of certified providers can be obtained directly from OEVR or from the department's website. In FY'10, OEVR approved 49 VR providers. It is the responsibility of each provider to submit progress reports on a regular basis so that OEVR's Rehabilitation Review Officers (RROs) can have a clear understanding of each case's progress. Progress reports must include the following:

[14] M.G.L. c.152, §1(12)

1. Status of vocational activity;
2. Status of IWRP development (including explanation if the 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.

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.[15] Through the use of new technology, such as the automatic scheduling system, OEVR has made significant progress in identifying disabled workers for mandatory meetings early on in the claims process.

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 may 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 an OEVR-approved provider so that an IRWP can be developed. The insurer must also submit to OEVR any pertinent medical records within ten 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, the 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

[15] M.G.L. c.152, §30 (E-H); 452 C.M.R. §4.00

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 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 of 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 time. However, OEVR-mandated IWRP's are limited to 52 calendar weeks for pre-12/23/91 injuries and 104 calendar weeks for post-12/23/91 injuries.[16] 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;
5. Retraining; and
6. Any recommendation for a workplace accommodation or a mechanical appliance to support the employee's return to work.

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;

[16] M.G.L. c.152, §19.

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 if successfully rehabilitated.

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. As a result, 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

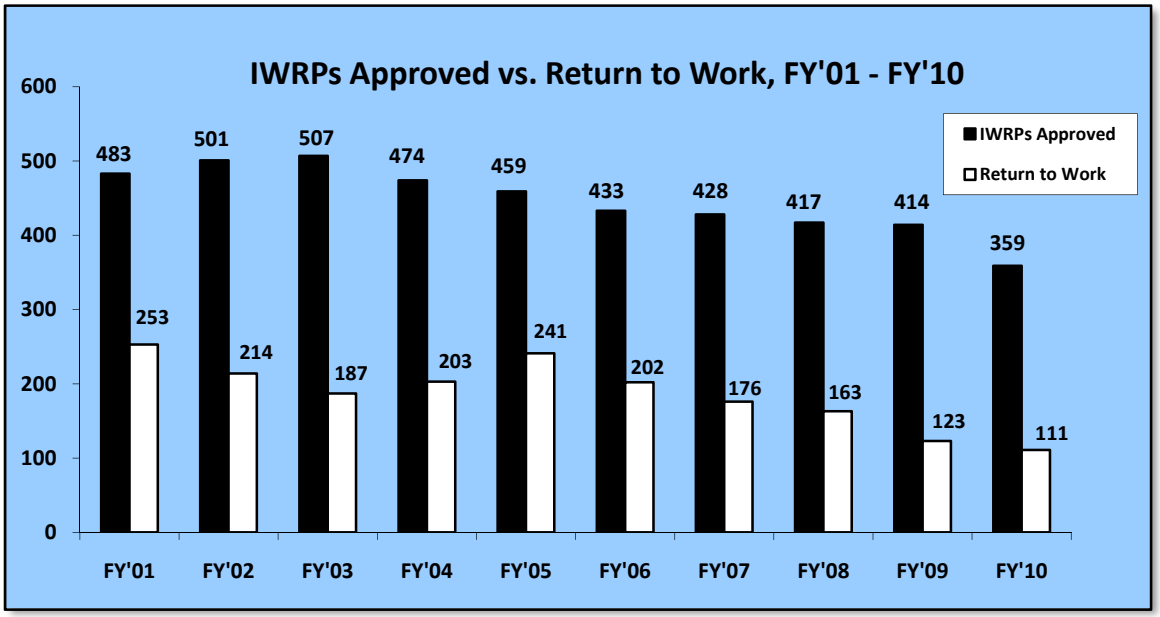
In FY'10, OEVR was headed by a Director and staffed by 7 Rehabilitation Review Officers, 1 Program Coordinator, and 3 Clerks. During the fiscal year, referrals to OEVR increased by 8%. This increase is possibly attributed to the poor economic conditions whereby more individuals were requesting assistance in finding employment. Out of the 2,818 cases referred to OEVR in FY'10, 67% (1,893) proceeded to a "mandatory meeting" for a determination of suitability for vocational rehabilitation services. The remaining 33% exited the system for reasons that include the non-establishment of liability or the employee was not on compensation. Of those cases that received a "mandatory meeting," 31% (593) were referred to the insurer/self-insurer with a request to initiate vocational rehabilitation services by an OEVR certified provider. In FY'10, there was a 31% success ratio of injured workers who completed plans and returned to work.

Table 14: Utilization of Vocational Rehabilitation Services, FY'05 - FY'10

Fiscal Year	*Referrals to OEVR*	*Mandatory/ Inform. Meetings*	*Referrals to Insurer for VR*	*IWRPs approved*	*Return to work*	*% RTW after plan development*
FY'10	**2,818**	**1,893/51**	**593**	**359**	**111**	**31%**
FY'09	2,611	2,150/62	642	414	123	30%
FY'08	2,828	2,281/69	647	417	163	39%
FY'07	2,839	2,292/46	705	428	176	41%
FY'06	2,932	2,315/40	747	433	202	47%
FY'05	3,418	2,744/19	763	459	241	53%

Source: DIA – OEVR

Figure 19: Comparison of IWRPs Approved vs. Return to Work, FY'01-FY'10



Source: DIA - Office of Education and Vocational Rehabilitation

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 monies from the Workers' Compensation Trust Fund to finance the rehabilitation services. In fiscal year 2010, the Trust Fund paid $10,825 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 Office of Safety is responsible for establishing and supervising the Safety Grant Program for the education and training of employees and employers in the recognition, avoidance and prevention of unsafe or unhealthy working conditions. On an annual basis, safety training grants are awarded to qualified applicants based upon a competitive selection process initiated by a grant application. The Office of Safety also advises employees and employers of safety issues surrounding the work environment and maintains a comprehensive safety DVD library on a variety of safety topics.

Since 1991, the Office of Safety has annually administered a grant program entitled "Workplace Safety Training & Education Grant Program." To date, the DIA has funded hundreds of preventive training programs which have benefitted and educated workers and employers throughout the Commonwealth.

The Safety Grant Program

Each fiscal year the DIA's Office of Safety awards approximately $800,000 in safety grants to pay for programs which provide workplace safety training for employees and/or employers for industries and organizations 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 program is to reduce work related injuries and illnesses by:

- Targeting preventive educational programs for specifically identified audiences with significant occupational health and/or safety problems;
- Fostering activities by employees/employers to prevent workplace accidents, injuries, and illnesses;
- Encouraging a proactive approach toward identifying, evaluating, and addressing safety and health hazards in the workplace;
- Collaborating with state agencies, businesses, and other organizations to increase access to safety training - specifically for non English speaking workers and young workers entering the workforce for the first time;
- Continuing efforts to ensure Safety Grants are distributed more evenly throughout the Commonwealth by increasing regional public outreach;
- Encouraging labor/management cooperation in the area of occupational safety and health prevention programs; and,
- Encouraging collaborations between various groups, organizations, educational or health institutions to devise innovative preventive methods for addressing safety.

Grant Applications

Each fiscal year the Office of Safety publishes a grant application to notify the general public that safety grants are available for funding in the upcoming fiscal year. Language contained in the DIA's line-item in the FY'11 General Appropriations Act did not indicate a specific allocation amount for the agency to make available for the Safety Grant Program. However, the agency has set aside $800,000 in funding for Fiscal Year 2011 safety grants. During the fiscal year, the Office of Safety participated in regional informational workshops and over 500 announcement letters were emailed to various industries and organizations throughout the Commonwealth. As a result of this notification and a comprehensive regional outreach program, the Office of Safety received more than 70 grant applications in FY'10 for potential FY'11 funding.

The criteria to objectively evaluate all proposals received are developed by an Evaluation Committee, appointed by the Commissioner. Following review, the Committee recommends a list of suitable applicants for funding. Upon approval of this list by the Commissioner, and completion of contractual paperwork, grants are then awarded. In fiscal year 2011, the Office of Safety will award $742,013 in safety grant funding to 66 organizations, training nearly 15,000 employees (see Appendix K for a list of safety grant proposals recommended for funding in FY'11).

Health and Safety Committee

The Office of Safety is also responsible for administering the DIA's Health and Safety Committee. On April 27, 2009, Governor Deval Patrick signed Executive Order #511 establishing a Massachusetts Employee Safety and Health Advisory Committee. In addition to the Advisory Committee, the Executive Order required all Executive Branch agencies to maintain detailed records concerning occupational injuries, illnesses and death. The Executive Order also required each agency to develop a joint labor-management health and safety committee to survey safety and health hazards and to make recommendations on improving workplace safety.

In fiscal year 2010, the Office of Safety organized a joint labor-management Health and Safety Committee which included representation from the DIA's regional offices and the various collective bargaining units. In September of 2010, the Health and Safety Committee held their first meeting to formalize building-emergency evacuation plans. The committee plans to continually meet on a monthly basis. The Director of the Office of Safety also serves on the Massachusetts Employee Safety and Health Advisory Committee.

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.[17] To be self insured, employers must have enough capital to cover the expenses associated with self insurance (i.e. bond, reinsurance, and a TPA). However, many smaller and medium-sized companies have also been approved to self insure. The Office of Insurance evaluates employers annually to determine their eligibility for self insurance and to establish new bond amounts.

Any business seeking self insurance status must first provide the Office of Insurance the company's most current annual report, a description of the business, and credit rating from at least two of the following companies: Dun & Bradstreet, Moody's or Standard & Poor's. If a company is granted self insurance status, the Office of Insurance will mail them a self insurance application to complete.

For an employer to qualify to self insure, it must post a surety bond or negotiable securities to cover any losses that may occur. The amount of deposit varies for every company depending on their previous reported losses and predicted future losses. The average bond or security deposit 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 company, and the attaching point of reinsurance.

Employers who are self insured must purchase catastrophe reinsurance of at least $500,000. Smaller self insured companies are required to 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. Each self insurance license provides approval for a parent company and its subsidiaries to self insure.

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 Human Resources Division (HRD), has similar responsibilities to an insurer, however, the state does not pay insurance premiums or post bond for its liabilities.

[17] C.M.R. 5.00: Code of Massachusetts Regulations concerning insurers and self insurers. These regulations may be waived by the Commissioner of the DIA for employers that have strong safety records and can produce the necessary bond to cover for all incurred losses.

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).

In FY'10, one new license was issued, bringing the total number of "parent-licensed" companies at 100, covering a total of 371 subsidiaries. Each self insurance license provides approval for a parent company and its subsidiaries to self insure. This amounts to approximately $294,788,102 in equivalent premium dollars. A complete list of self insured employers and their subsidiaries is available for public viewing on the DIA's website.

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 1930's and facilitates the filing and investigation of claims after many years. Any injured worker may contact this office directly to obtain the insurance information of an employer.[18]

In the past, the insurance register had a record keeping system which consisted of information manually recorded on 3x5 note cards (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 note card was changed manually.

Through legislative action, the Workers' Compensation Rating and Inspection Bureau (WCRIB) became the official repository of insurance policy coverage in 1991. The DIA was provided with computer access to this database, which includes policy information from 1986 to present. Information prior to 1986 must be researched through the files at the DIA, now stored on microfilm. In FY'10, an estimated 2,560 inquiries were made to the Insurance Register.

[18] The Insurance Unit can be contacted directly at 617-727-4900 x408. The Unit also maintains a website that is accessible through the DIA's homepage at: www.mass.gov/dia/.

OFFICE OF INVESTIGATIONS

In Massachusetts, every employer with one or more employees is required to have a valid workers' compensation policy at all times.[19] 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 an insurance 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).

Referrals to the Office of Investigations

The Office of Investigations has access to the Workers' Compensation Rating and Inspection Bureau (WCRIB) database on all policies written by commercial carriers in the state. From this database, it can be determined which employers have 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, and reciprocal exchange).

In September 2009, the Office of Investigations began accepting online referrals from the public. The online referral form went live in conjunction with the launching of the Massachusetts Proof of Coverage Application that allows the public to verify whether a particular business has a current workers' compensation insurance policy.

Another type of referral the Office of Investigations receives is through anonymous calls (1-877-MASSAFE) and letters received from the general public. In May 2008, the Office of Investigations also began managing a new fraud hotline developed by the Joint Task Force on the Underground Economy and Employee Misclassification (1-877-96-LABOR). Anonymous phone 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 is immediately notified by the Office of Insurance that a particular company is without insurance.

Compliance Checks

Referrals received by the Office of Investigations are assigned to an individual investigator who conducts comprehensive "in-house" research utilizing all available databases. This initial research, known as a "compliance check," allows the investigator to close a case where an insurance policy has been discovered or when there is

[19] A law passed in 2002 allows officers of corporations who own at least 25% of the stock of the corporation to exempt themselves from coverage.

substantial evidence that a company has ceased operations. In FY'10, the Office of Investigations conducted a total of 47,415 "compliance checks." Once a referral has been thoroughly reviewed "in-house" and it is probable that an employer is in violation of the statute, the DIA will conduct a "field investigation" at the worksite.

Field Investigations & Stop Work Orders

During a "field investigation" to a worksite, an investigative team will request that the business provide proof of workers' compensation insurance coverage. In FY'10, the Office of Investigations conducted 7,142 "field investigations." If a business fails to provide proof of coverage, a "stop work order" (SWO) is immediately issued. Such an order requires that all business operations cease and the SWO becomes effective immediately upon service. However, if an employer chooses to appeal the SWO, the business may remain open until the case is decided. In FY'10, the DIA issued a total of 3,102 SWOs. Of the 3,102 SWOs issued, 3,025 (97.5%) were issued to "small" employers (1-10 employees), 73 (2.3%) were issued to "medium" employers (11-75 employees), and 4 (<1%) were issued to large employers (75+ employees). The Office of Investigations estimates that 8,943 new employees became covered in FY'10 as a result of each employer who purchased workers' compensation insurance after receiving a SWO.

The table below depicts the vital statistics for the Office of Investigations during the last five years. It is important to note that "compliance investigations" and "field investigations" were redefined by the Office of Investigations in April of 2008. As a result, there is no comparable data available for these fields prior to FY'09.

Table 15: Office of Investigations - Vital Statistics, FY'06-FY'10

Fiscal Year	Compliance Checks	Field Investigations	SWOs Issued	SWO Fines Collected	New Employees Covered due to SWOs
FY2010	47,415	7,142	3,102	$1,608,652	8,943
FY2009	32,505	8,171	3,316	$1,369,954	9,527
FY2008	n/a	n/a	1,126	$533,972	3,136
FY2007	n/a	n/a	389	$389,867	*not tracked*
FY2006	n/a	n/a	227	$246,657	*not tracked*

Source: Office of Investigations / Collection and Expenditure Reports

Stop Work Order Fines and Debarment

Fines resulting from a SWO are $100 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 SWO was unwarranted, has ten days to file an appeal. A hearing must take place within 14 days, during which time the SWO will not be in effect. The SWO and penalty will be rescinded by the hearing officer if the employer can prove it had workers' compensation insurance at the time of

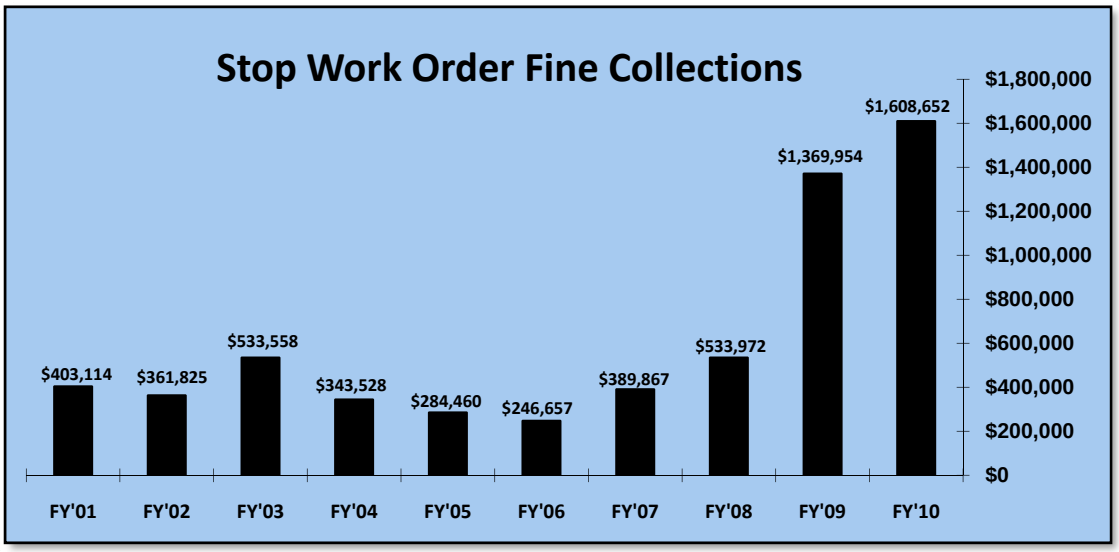
issuance. If at the conclusion of the hearing the DIA hearing officer finds the employer had not obtained adequate insurance coverage, the employer must pay a fine of $250 a day. Any employee affected by a SWO must be paid for the first ten days lost and that period shall be considered "time worked."

Following a determination that an employer has been operating without workers' compensation insurance, the business is immediately placed on the DIA's Debarment List. Once on the debarment list, a business is prevented from bidding or participating in any state or municipal funded contracts for a period of three years. The DIA maintains a list of debarred businesses on their website. During fiscal year 2010, 3,102 additional employers were placed on the debarment list.

In addition to established fines and debarment, 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) for violations of Section 25C.

In fiscal year 2010, the Office of Investigations collected $1,608,652 in fines from employers who violated the workers' compensation insurance mandate. In an effort to make paying SWO fines much easier, the DIA is now allowing the payment of fines online with debit cards, credit cards, money orders or certified checks.

Figure 20: Office of Investigations – SWO Fine Collections, FY'01 - FY'10



Source: Collection & Expenditure Reports, FY'01-FY'10

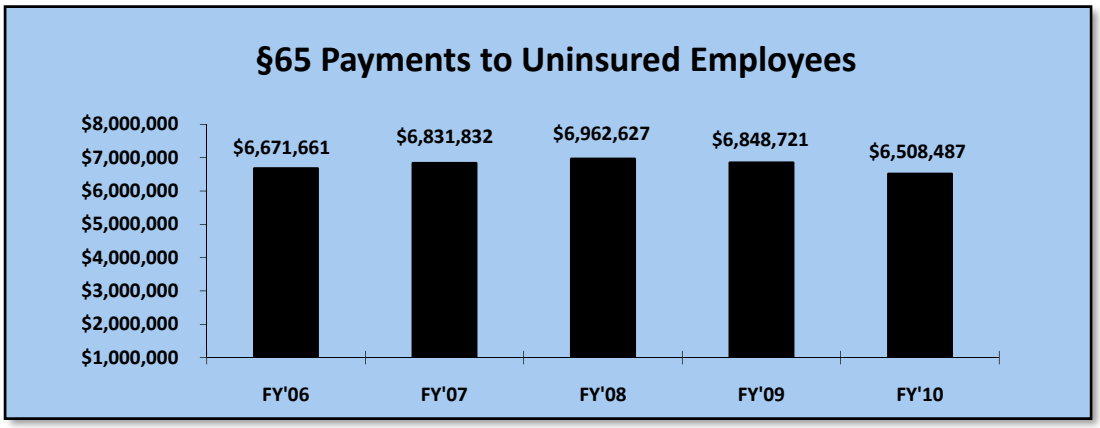
WORKERS' COMPENSATION TRUST FUND

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 Workers' Compensation Trust Fund (WCTF), to process requests for benefits, administer claims, and respond to claims filed before the Division of Dispute Resolution.

Uninsured Employers (Section 65)

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 agency's records.[20] In FY'10, $6,508,487 was paid to uninsured claimants, 142 claims were filed, and 547 claims for benefits paid. The DIA aggressively goes after uninsured employers to recoup monies paid out from the Trust Fund. During fiscal year 2010, the DIA recovered from employers and third parties before the Board and courts of commonwealth the amount of $713,360.

Figure 21: §65 Payments to Uninsured Employees



Source: Collections & Expenditures Reports, FY'06 - FY'10

Second Injury Fund Claims (Sections 37, 37A, and 26)

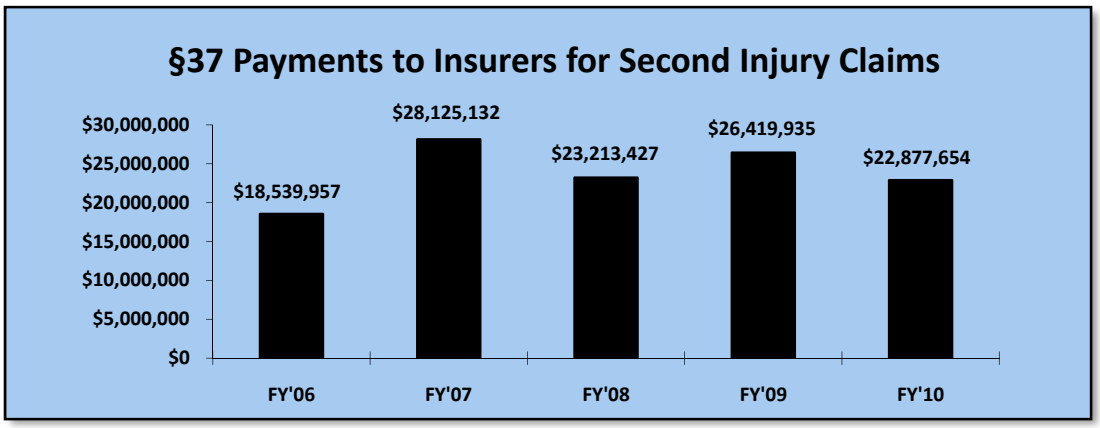
In an effort to encourage employers to hire previously injured workers, the Legislature established a Second Injury Fund to offset any financial disincentives associated with the employment of injured workers. Section 37 allows insurers to be reimbursed by the Trust Fund when compensation is being paid as the result of a combination of a prior

[20] 452 C.M.R. 3.00

impairment and a second injury. When the injury is determined to be a "second injury," insurers become eligible to receive reimbursement from the DIA's WCTF for up to 75% of compensation paid after the first 104 weeks of payment. [21] Employers may be entitled to an adjustment to their experience modification factors as a result of these reimbursements.

At the close of fiscal year 2010, 277 §37 claims were paid and settled (seven fewer than in FY'09). The total amount of §37 payments in FY'10 was $22,877,654 (includes quarterly payments under §37 and interest).

Figure 22: §37 Payments to Insurers for Second Injury Claims



Source: Collections & Expenditures Reports, FY'06 - FY'10

The administration of second injury claims is complicated by the fact that the Trust Fund continues to receive claims from three distinct statutory time periods, known as the "Old Act," "Mid Act," and "New Act." The following page provides a brief outline of the distinct characteristics of each of the three time periods.

Section 37A was enacted to encourage the employment of servicemen returning from World War II. The Legislature created a fund to reimburse insurers for benefits paid for an injury aggravated or prolonged by a military injury. Insurers are entitled to reimbursement for up to fifty percent of the payments for the first 104 weeks of compensation and up to one hundred percent for any amount thereafter.

Section 26 provides for the direct payment of benefits to workers injured by the activities of fellow workers, where those activities are traceable solely and directly to a physical or mental condition, resulting from the service of that fellow employee in the armed forces. (A negligible number of these claims have been filed.)

[21] 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.

"Old Act" - 1973 thru 1985

- The Legislature greatly expanded SIF reimbursements to include any "known physical impairment which is due to any previous accident, disease or any congenital condition and is, or is likely to be, a hindrance or obstacle to his employment..."
- The Attorney General was responsible for defending claims against the SIF.
- Employer knowledge of pre-existing physical impairment was not required for reimbursement.
- Reimbursement was not to exceed 50% of all compensation subsequent to that paid for the first 104 weeks of disability.
- Allowed the Chairman of the IAB to proportionally assess all insurers if the SIF was unable to financially sustain itself.
- Did not contain a statute of limitations.

"Mid Act" - 1985 thru 1991

- An insurer could obtain SIF reimbursement for §31 (death benefits), §32 (dependent benefits), §33 (burial expenses), §34 (temporary total), §35 (partial), §36 (scarring), §34A (permanent and total), §36A (death before full payment of compensation and brain damage injuries), and §30 (medical benefits).
- Provided reimbursement in an "amount equal to" 75% of compensation paid after the first 104 weeks of disability.
- Must have medical records existing prior to second injury to establish employer knowledge of impairment.
- Funded by assessments added directly to an employer's WC premium rate.
- Did not contain a statute of limitations.

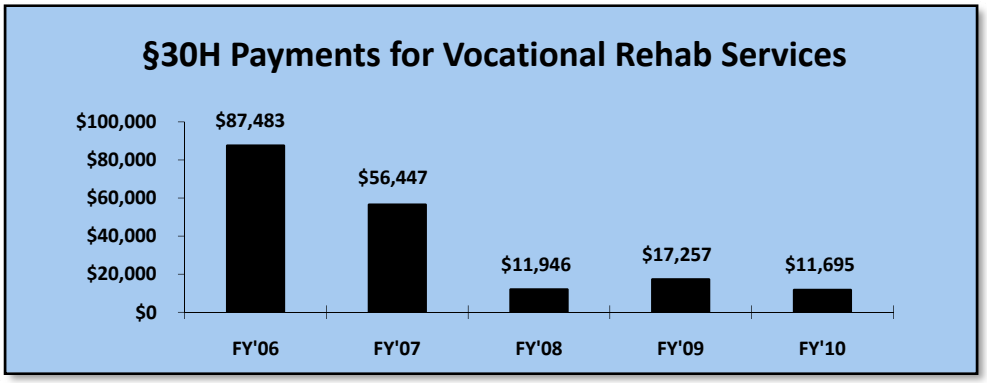
"New Act" - 1991 thru Present

- The Legislature substantially curtailed the type and amount of benefits that are reimbursable and shifted responsibility of defending the Trust Fund from the Attorney General to the Office of Legal Counsel within the DIA.
- Provided reimbursement in an "amount not to exceed" 75% of compensation paid after the first 104 weeks of disability.
- SIF Reimbursement was restricted to benefits paid for §34A (permanent and total) and for §§ 31, 32, and 33 (death cases).
- Created a 2-year statute of limitations based on when the petition was filed.
- New requirement that the employer must have personal knowledge of impairment, and that such knowledge be established by the employer within 30 days of the date of employment.

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 of the program, with that amount being paid into the Trust Fund by the insurer. In FY'10, no new cases were accepted for §30H benefits and the Trust Fund paid $11,695 for vocational rehabilitation services on existing cases.

Figure 23: §30H Payments for Vocational Rehabilitation Services



Source: Collections & Expenditures Reports, FY'06 - FY'10

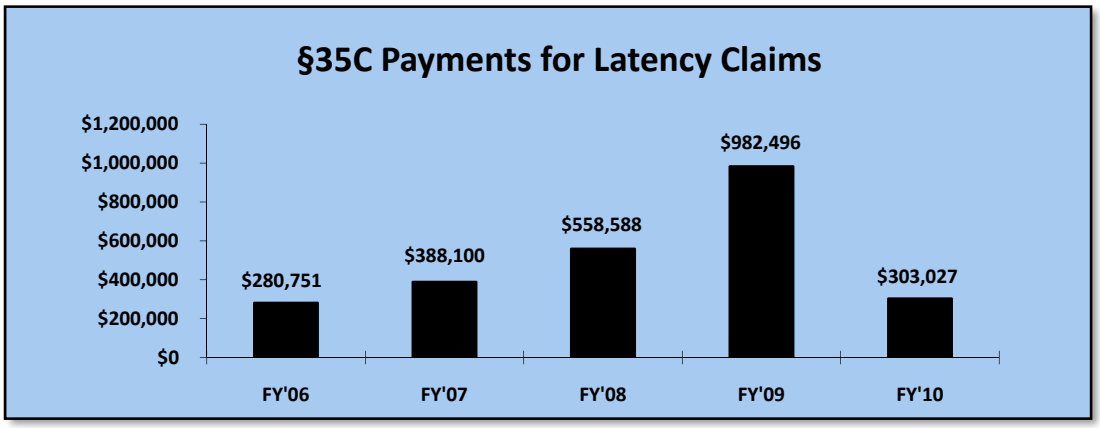
Latency Claims (Section 35C)

Because some occupational diseases and illnesses might not show up until many years after initial exposure, the Legislature added §35C to the Workers' Compensation Act in 1985:

> *"[w]here there is a difference of five years or more between the date of injury and the initial date on which an injured worker or his survivor first became eligible for benefits under sections 31, 34, 34A, or 35, the applicable benefits shall be those in effect on the date of eligibility for benefits."*

Some examples of latent medical conditions are asbestosis, hepatitis C and chemical exposures causing certain forms of cancer. The purpose of §35C is to make an employee or surviving spouse whole by adjusting the compensation to what would be presumed to be the higher wages at the date of disability or death rather than the likelihood of a lower wage at the date of exposure. The Trust Fund is required to reimburse the insurer the difference between the wage at the time of exposure and the wage on the date of disability or death. In FY'10, the Trust Fund paid out $303,027 for latency claims.

Figure 24: §35C Payments for Latency Claims

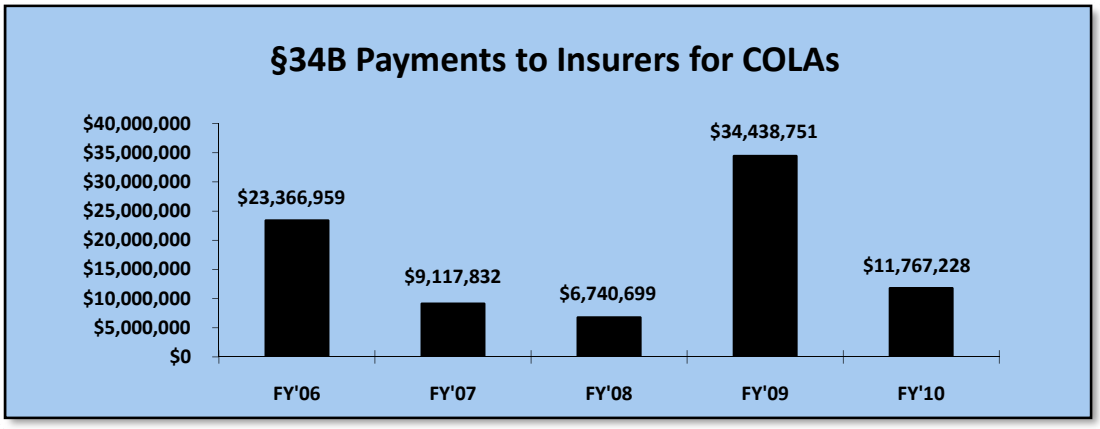


Source: Collections & Expenditures Reports, FY'06 - FY'10

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 base 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 all supplemental benefits paid on all claims with dates of injury occurring prior to 10/1/86. For injury dates after 10/1/86, insurers can only be reimbursed for amounts paid that exceed 5% of the State Average Weekly Wage (SAWW). It is important to note that after December 23, 1991, the change in AWW (as it pertains to COLA) was capped at 5% and therefore extinguishes COLA reimbursements for injuries occurring thereafter. COLA payments for FY'10 totaled $11,767,228 for the Private Trust Fund.

Figure 25: §34B Payments to Insurers for Cost of Living Adjustments



Source: Collections & Expenditures Reports, FY'06 - FY'10

OFFICE OF HEALTH POLICY

The Office of Health Policy (OHP) 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 Office 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 2010, the Office of Health Policy was staffed by four employees: an Executive Director (Nurse/Attorney), a UR Coordinator (Registered Nurse), a Program Analyst, and a Research Analyst.

Utilization Review

Utilization review is a system for reviewing proposed medical treatment/procedures in order to determine whether or not the services are appropriate, reasonable, and necessary. 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 after 12 weeks from date of injury. The insurer may choose to undertake utilization review at any time during the 12 week period immediately following the date of injury. However, the insurer is mandated to undertake utilization review before denying any request for medical services during this initial 12 week period. 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 treatment guidelines.

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 medical professional using established treatment guidelines. Care that cannot be approved must be reviewed by a licensed health care practitioner in the same school as the practitioner prescribing the care or treatment for the injured employee. All decisions regarding care and treatment must be disclosed in writing to the injured employee and the ordering practitioner within specific timeframes. The determination letter must specify the treatment guideline consulted to render the determination and the clinical rationale. All decisions by licensed reviewers must 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 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. During fiscal year 2010, 10 complaints were received and responded to by the Executive Director of the OHP. 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 compliance with UR regulations, the OHP:

- Reviews applications from UR Agents seeking approval to conduct UR for Massachusetts workers' compensation recipients. The OHP UR Coordinator provides assistance as requested throughout the application process to ensure that each application includes information documenting the UR Agent's knowledge and agreement to comply with state and DIA rules, regulations, policies and procedures. UR Agents are required submit a new application every two years. If the UR Agent has any material change to the program within the two year period, the DIA must be notified within 30 days.
- Conducts Quality Assessment Audits annually for UR Agents. The OHP UR Coordinator supports and assists the UR Agent throughout the following alternating process to ensure compliance with regulations and requirements:

  Case Record Audits - A sample of the agent's case records are reviewed to monitor the quality of care provided to injured 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 6.00 *et seq*. and in accordance with the policies and procedures set forth in the UR application.
- Ensures that applications of Preferred Provide Arrangements identify the approved UR Agent who will conduct the utilization reviews. Pursuant to 452 CMR 6.03, the OHP may require the PPA to survey affected employees to determine the employees' understanding of their rights when participating in the PPA arrangement.

Outreach and Support to UR Agents

The OHP provides outreach and support to UR Agents in an effort to assist them in offering the highest quality of service to injured workers. The OHP is providing educational sessions to all UR Agents at the time of onsite audits. As necessary, the agency's UR Coordinator schedules meetings and telephone consultations with any UR Agent having difficulty complying with the DIA's regulations.

Health Care Services Board

Pursuant to M.G.L. c.152 §13, the Health Care Services Board ("HCSB") is a medical advisory body consisting of 14 members specified by statute and appointed by the Commissioner (see Appendix F for a list of HCSB members). The HCSB met throughout fiscal year 2010, 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 Workers' Compensation Reform Act of 1991.

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. In fiscal year 2010, the HCSB received 3 such complaints. Upon a finding of a pattern of abuse by a particular provider, the HCSB is required to refer its findings to the appropriate board of registration. The HCSB continues to receive, investigate and resolve complaints against health care practitioners providing medical services to injured workers.

IME Roster Criteria - The HCSB is also required to develop eligibility criteria for the DIA 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 continued to work with the Senior Judge in the recruitment of physicians and health care practitioners throughout fiscal year 2010.

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 fiscal year 2010, the HCSB developed and endorsed a *"General Acupuncture Protocol"* that was added to the Massachusetts Treatment Guidelines. During the fiscal year, revisions were also made to the specific acupuncture sections of Treatment Guidelines 1, 2 and 14. In addition to an annual review and endorsement of the existing 28 medical treatment guidelines adopted by the DIA, the HCSB is currently working on updating the Chronic Pain Guideline.

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, as well as review compliance with HCSB Treatment Guidelines, review patterns of care, and review utilization of medical services and trends in medical care. In addition, CRS was designed to aid in controlling costs by detecting over-utilization and improper utilization of treatments. The OHP originally collected medical billing data from insurers, self-insurers and third party administrators. In fiscal year 2009, the OHP suspended the collection of all CRS data. The OHP continues to review prior collected data to assist the HCSB in developing treatment guidelines and updating existing guidelines.

OFFICE OF ASSESSMENTS & COMPLIANCE

In 2005, the DIA created the Office of Assessments & Compliance to verify the accuracy of the assessments that are collected by the agency. Each year, the DIA determines an assessment rate that will yield revenues sufficient to pay the obligations of the Workers' Compensation Trust Fund as well as the operating costs for the DIA.[22] 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.

The DIA uses the Workers' Compensation Rating and Inspection Bureau of Massachusetts (WCRIB) to communicate the annual assessment rate change, via circular letter, which is issued in July. The assessment rate changes are applied to policies, effective July 1st of that year, until notification of new rates are issued the following year. All insurance companies in Massachusetts that are licensed to write workers' compensation insurance must report and remit all collected assessments to the DIA on a quarterly basis.[23] Prior to the creation of the Office of Assessments & Compliance, the DIA had completely relied upon insurance carriers to self-report and pay the appropriate amounts collected from employers.

Definition of "Standard Premium"

In the past, there has been confusion in the insurance industry regarding the definition of "standard premium." Confusion was eliminated in 1997 when Circular Letter 1778 was issued by the WCRIB. The circular letter clearly stated that the assessment should be applied to premiums prior to the effect of any company deviations. As used in c.152, §65 and 452 CMR 7.00, standard premium is defined as "direct written premium equal to the product of payroll by class code and currently applicable manual rates multiplied by any applicable experience modification factor."

Assessment Audit - Phase I

In 1999, the DIA utilized the services of three accounting firms to ensure that accurate and complete assessments were collected from policyholders and then properly remitted to the DIA. The initial reviews were designed to cover a two-year period spanning from July 1, 1996 to June 30, 1998 and included insurance carriers licensed to write workers' compensation in Massachusetts. Upon the completion of Phase I by the CPA firms in August of 2007, the DIA had collected a total of $7.6 million from insurance carriers as a result of underpaid assessment amounts. The cost of conducting the Assessment Audit in Phase I totaled $1.9 million. This represents a DIA retention rate of 75%. In addition to the $7.6M collected as a result of CPA reviews, the DIA also

[22] Regulated by M.G.L. c.152, §65(4).

[23] Quarterly assessment reports are due no later than 40 days after the end of the calendar quarter being reported. The quarterly assessment forms are mailed to each insurance company the first week in January, April, July and October.

collected $1.9 million from conducting internal reviews, resulting in a grand total of $9.5 million collected in Phase I of the project.

Assessment Audit - Phase II

Phase II of the assessment reviews was initiated in FY'06 and continued through FY'10. In Phase II, the focus was on assessments calculated and remitted during a 5-year review period from January 1, 1999 to December 31, 2003. The insurance companies reviewed as part of Phase II include both companies currently licensed to write workers' compensation insurance in Massachusetts, as well as companies that no longer write new business in Massachusetts, but did so during the applicable review time period. Phase II encompassed a selection of companies that range from single insurance carriers to multi-company insurance groups. The DIA's clarification of the definition of standard premium has effectively decreased confusion in the insurance industry regarding assessment calculation, thus resulting in the increased accuracy of assessment payment by insurance companies on a quarterly basis.

In FY'10, the Department of Industrial Accidents collected $121,121 from companies under assessment review in Phase II. The audit expense associated with the reviews for FY'10 was 28%, thereby representing a DIA retention rate of 72%. The DIA anticipates that Phase II reviews will be completed in December of 2010.

Assessment Audit - Phase III

In FY'08, Phase III of the assessment reviews began and continued through FY'10. Phase III focuses on assessments calculated and remitted during a 4-year review period between January 1, 2004 and December 31, 2007. In FY'10, a total of 3 CPA firms were assisting the DIA with the audit reviews of approximately 25 companies licensed to write workers' compensation in Massachusetts.

Presently, Phase III reviews are nearly complete and notifications have been sent to each company regarding the audit findings. Both Phase II and Phase III audits took much longer than expected due to the size and complexity of the selected companies under review. The DIA anticipates that Phase III reviews will be completed in December of 2010.

Assessment Audit - Phase IV and Phase V

The DIA plans to continue the assessment audit process with at least two additional phases. Phase IV and Phase V will help bring existing audits current and will include additional companies that have not been reviewed. The DIA is presently in the process of selecting companies for Phase IV and Phase V.

The following table details the assessments that have been remitted to the DIA on a fiscal year basis from the result of CPA reviews.

Table 16: Assessment Recovery Project - Collections by Fiscal Year

Assessment Recovery Project Fiscal Year 2000 – Fiscal Year 2010		
Fiscal Year	***Amount Collected***	***Cumulative Amount***
Fiscal Year 2000	$158,704	$158,704
Fiscal Year 2001	$67,793	$226,497
Fiscal Year 2002	$1,106,377	$1,332,874
Fiscal Year 2003	$1,539,935	$2,872,809
Fiscal Year 2004	$223,939	$3,096,748
Fiscal Year 2005	$4,537,865	$7,634,613
Fiscal Year 2006	$1,847,086	$9,481,699
Fiscal Year 2007	$92,685*	$9,574,384
Fiscal Year 2008	$1,064,992	$10,639,376
Fiscal Year 2009	$44,421	$10,683,797
Fiscal Year 2010	$121,121	$10,804,918

Source: DIA Office of Assessments & Compliance

* The Office of Assessments & Compliance collected an additional $4,045,202 from insurance companies during FY'07 by instituting improvements in the quarterly assessment collection process.

Online Payment of Assessments

Since the beginning of 2010, the DIA has offered insurance companies the capability to securely file and pay assessments online, moving the DIA closer to a paperless environment. On September 30, 2010, the online filing of assessment payments was made mandatory for all insurance companies. Currently, all insurers are utilizing the website to file and pay assessments using Automated Clearing House (ACH) debit or credit. The online filing works in conjunction with the DIA's OnBase System for storing and retrieving documents.

DIA REGIONAL OFFICES

The Department of Industrial Accidents has its main headquarters in Boston and is served by four regional offices in Lawrence, Worcester, Fall River, and Springfield.

The Senior Judge and the managers of the conciliation, stenography, judicial support 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, clerks, and data entry 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 and hearing rooms in which 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 Case Management System (CMS).

Cases are assigned to Administrative Judges by CMS 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 with the exception of the Springfield office, which is located in a building owned by the Commonwealth. The managers are 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 cost of operating each office is managed by each regional manager.

Resources of the Offices

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 that are networked to the Boston office. Also available to each region is online access to the Massachusetts General Laws and DIA case information for attorneys with registered user accounts.

The following are addresses for the DIA headquarters and four regional offices:

Boston, MA
1 Congress Street, Suite 100
Boston, MA 02114-2017
(617) 727-4900

Fall River, MA
1 Father DeValles Boulevard
Fall River, MA 02723
(508) 676-3406
Henry Mastey, Manager

Lawrence, MA
345 Merrimack St., Bldg. 1, Suite 230
Lawrence, MA 01843
(978) 683-6420

Worcester, MA
340 Main Street
Worcester, MA 01609
(508) 753-2072
Walter Weekes, Manager

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

SECTION
- 6 -

DIA FUNDING

DIA FUNDING

Leading up to the 1985 Reform Act, the Department of Industrial Accidents had been experiencing funding shortfalls which led to costly delays in the Dispute Resolution System. To ensure the DIA had adequate funding, the Legislature in 1985 transferred the agency's cost burden from the State's General Fund to the Commonwealth's employer community via assessments collected by workers' compensation insurance carriers. 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 Department of Industrial Accidents or any of its activities.

Figure 26: Funding Sources for the Department of Industrial Accidents

Funding Sources for the DIA

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 $707.24 as of October 1, 2010. This fee is 65% of the current State Average Weekly Wage (SAWW), which is now $1,088.06. (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 workers' compensation insurance, and it accumulates until they obtain a policy and the fine is paid. Second, a Late First Report Fine of $100 is issued to a company if the injury is not reported within the specified time. Third, a 5% fine is charged when assessments are paid later than 30 days of billing.

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

The Assessment Rate

Each year, the DIA determines an assessment rate that will yield revenues sufficient to pay the obligations of the Workers' Compensation Trust Fund and the operating costs for 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.[24] The assessment rate for private sector employers in FY'11 is 6.813% of standard premium. This represents a 5.7% decrease from the FY'10 assessment rate of 7.222%.

The Special Fund - The DIA's operating expenses are paid from a Special Fund, which is funded entirely by assessments charged to private sector employers. Although the Special Fund budget is subject to the general appropriations process, 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. These

[24] For employers that are self insured or are members of self insured groups, an "imputed" premium is determined, whereby the WCRIB 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 cannot seek reimbursement for benefits paid under sections 34B, 35C, 37, 30H, 26, and 37A. Separate opt out assessment rates are determined.

payments are made quarterly to the State Treasurer's Office. 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.

The Trust Fund - 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, the Trust Fund must reimburse insurers for benefits for second and latent injuries, injuries involving veterans, and for specified cost of living adjustments.[25] One account is reserved for payments to private sector employers (Private Trust Fund); the other is for payments to public sector employers (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.

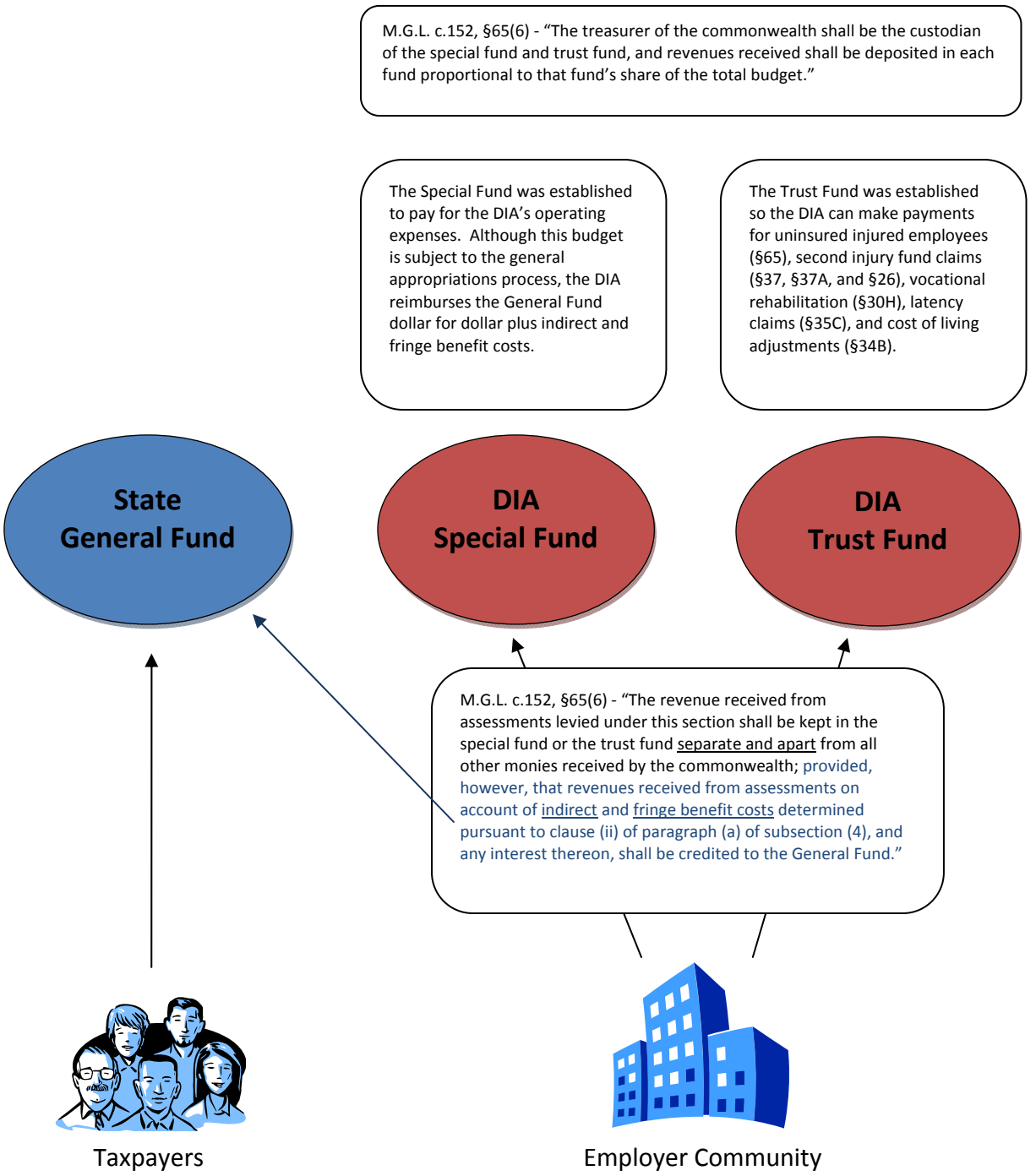
In May and June, the DIA uses consulting actuaries to estimate future expenses and determine the assessments necessary to fund the Special Fund and the Trust Fund. The budgets and the corresponding assessments must be submitted to the Director of Labor by July 1st annually. Historically, the Legislature appropriates the DIA's operating expenses before July 1st. 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.

If the DIA is unable to meet its spending obligations due to insufficient revenue, the Commissioner may levy additional assessments on the employer community. Any additional assessment is subject to the approval of the Director of Labor and can be reviewed by the Workers' Compensation Advisory Council. The Advisory Council may submit its own estimate of the necessary additional assessment to the Director of Labor for consideration.

At the close of a fiscal year, all balances (in either the Special Fund or the Trust Fund) remain in their respective accounts and do not revert to the State's General Fund. If the balance of any account exceeds 35% of the previous year's disbursements from that fund, the budget for that fund (for the purpose of calculating the assessment rate) must be reduced by that part of the balance in excess of 35% of the previous year's disbursements. It is believed that the Legislature created this "35% Rule" to ensure the agency had sufficient funding in the event of an emergency or unforeseen circumstance.

[25] M.G.L. c.152, §65(2).

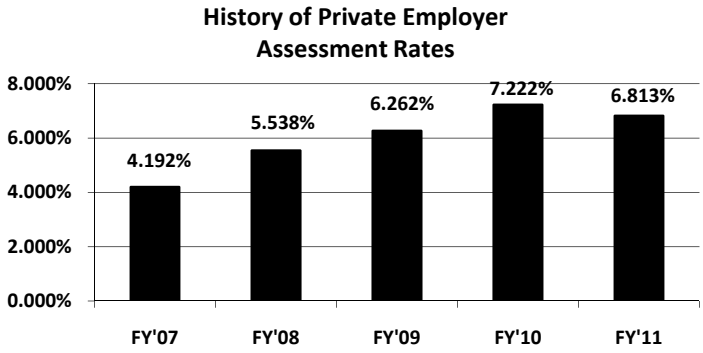
Figure 27: The DIA's Unique Funding Process



IMPORTANT: Year End Balances within the Special Fund and Trust Fund **DO NOT** revert to the State's General Fund. These balances remain within their respective accounts and are only used to offset future assessments when the balance of a particular fund exceeds 35% of the previous year's disbursements.

PRIVATE EMPLOYER ASSESSMENTS

Figure 28: History of Private Employer Assessment Rates



On June 24, 2010, Deloitte Consulting released an analysis of the DIA's FY'11 assessment rates as mandated under M.G.L. c.152, section 65 (4) & (5). Specifically, the report details the estimated amount required by the Special Fund and Trust Fund for FY'11, beginning July 1, 2010. Included in the report are the assessment rates to be applied to private employer insurance premiums. The private employer assessment rate has been calculated to be 6.813% of standard premium, a decrease of 5.7% from last year's private assessment (7.222%). It is important to note that the Public Fund has no remaining municipalities thereby resulting in a FY'11 public assessment rate of 0%.

The decrease to the private employer assessment rate is a result of several factors. First, the DIA has reduced their combined projected expenditures for the Private Trust Fund and Special Fund budgets by $4.4M (see Step #1). Second, the estimated FY'10 year-end balance in the Special Fund exceeded 35% of the previous year's expenditures resulting in a $1.8M offset to the Special Fund budget (see Step #3). Finally, Deloitte's estimate of net written premium for Calendar Year 2011 was relatively stable at $834M (see Step #6).

Overview of Assessment Rate Calculations

Deloitte Consulting uses the following six steps in determining the assessment rates for both private and public employers:

1. Project the Fiscal Year 2011 Expenditures;
2. Project the Fiscal Year 2011 Income (excluding assessments);
3. Estimate Fiscal Year 2011 Balance Adjustments, if any;
4. Convert Above Items to Ratios by comparing them to the Assessment Base ('09 Paid Losses);
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 2011 PROJECTED EXPENDITURES: $82.2M

The first step in the assessment process is the calculation of the expected FY'11 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'11 Expenditures (06/10)	+/- FY'10 Projected Expenditures (06/09)
Section 37 (2nd Injuries)	$24,990,440	- $2,758,177
Uninsured Employers	$ 9,130,552	+ $ 179,231
Section 30H (Rehabilitation)	$ 4,537	- $ 21,855
Section 35C (Latency)	$ 500,000	- $1,228,971
Section 34B (COLA's)	$16,747,170	- $ 824,143
Defense of the Fund	$ 5,914,685	+ $ 914,685
Total:	**$57,287,384**	**- $3,739,230**

SPECIAL FUND BUDGET	Projected FY'11 Expenditures (06/10)	+/- FY'10 Projected Expenditures (06/09)
Total:	**$24,910,480**	**- $648,022**

PRIV. EMPLOY. EXPENDITURES	Projected FY'11 Expenditures (06/10)	+/- FY'10 Projected Expenditures (06/09)
Total:	**$82,197,863**	**- $4,387,252**

2. PROJECTED FISCAL YEAR 2011 INCOME: $6.8M

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'11 Fines and Fees (Special Fund) =	$6,115,322	
FY'11 Income Due to Reimbursements =	$ 625,307	
Estimated Investment Income (FY'10) =	$ 45,239	(Private Fund: $24,166/Special Fund: $21,073)
Total Projected FY'11 Income:	**$6,785,868**	

3. ADJUSTMENTS TO FUND BUDGETS: $1.8M (Special Fund) / $0 (Private Trust Fund)

In accordance with 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'09 expenditures in a particular fund must be used to reduce amounts assessed for that fund in FY'11. The balance of the Special Fund at the end of FY'10 will have a surplus exceeding 35% of FY'09 disbursements. Therefore, the assessment was calculated with a $1.8M reduction to the Special Fund Budget.

SPECIAL FUND:	**FY'10 Estimated Year End Balance**	**35% of FY'09 Expenditures**	**Amount of Reduction Required**
	$10,023,561	$8,250,190	$1,773,371

PRIVATE TRUST FUND:	**FY'10 Estimated Year End Balance**	**35% of FY'09 Expenditures**	**Amount of Reduction Required**
	$11,495,085	$25,848,801	$0

4. CONVERSION TO RATIOS:

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 paid losses during Calendar Year 2009. For the Private Fund, the assessment base is $711,180,529.

Private Expenditure Ratio:	11.558%	($82.2 million/$711.2 million)
Projected Income Ratio:	0.954%	($6.8 million/$711.2 million)
Balance Adjustment Ratio:	0.249%	($1.8 million/$711.2 million)

5. CALCULATION OF THE ASSESSMENT RATIO: 10.354%

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**
11.558%	0.954%	0.249%	**10.354%**

6. CALCULATION OF THE ASSESSMENT RATE: 6.813%

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. M.G.L. c.152, §65(5) requires the WCRIB to compute this ratio and submit it to the DIA for review and approval. Since 2004, the DIA has adjusted the assessment base factor provided by the WCRIB to reflect standard premium (WCRIB projects net premium) and to account for historical differences in the WCRIB estimates relative to actual premium levels. This year, the WCRIB provided an assessment base factor of .642 to the DIA based on a projected $949.6M in net written premiums for Calendar Year 2011. After making adjustments to reflect standard premium, rates, and projections in wage and employment levels, the DIA used an assessment base factor of .658 based on a projected $834M of net written premiums for Calendar Year 2011.

Assessment Ratio	x Assessment Base Factor	= **Assessment Rate**
10.354%	.658	**6.813%**

DIA OPERATING BUDGET

Legislative Appropriations, Fiscal Year 2011

The Department of Industrial Accidents initially submitted a request to the Executive Office for Administration & Finance for a budget of $20,047,378 for fiscal year 2011. On January 27, 2010, Governor Deval Patrick released his Fiscal Year 2011 Budget Recommendations (House 2) and appropriated $20,047,378 to the DIA's line-item. After extensive review by the Advisory Council's Budget Subcommittee, the Advisory Council endorsed the Governor's House 2 Budget Recommendation, stating that it "would fairly and adequately fund the operations of the DIA." The Massachusetts House of Representatives agreed with the Governor and the Advisory Council and appropriated $20,047,378 in their respective budgets for the DIA. However, both the Senate and the Conference Committee reduced this appropriation by $140,834.

Fiscal Year 2011 General Appropriations Act

On June 30, 2010, Governor Patrick signed the FY'11 General Appropriations Act, which allocated the DIA a **$19,906,544** operating budget. This final appropriation represents a 3% decrease from last year's General Appropriations Act. The line-item did not specify an amount for the DIA to allocate towards the Safety Grant Program as has been the practice in past budgets.

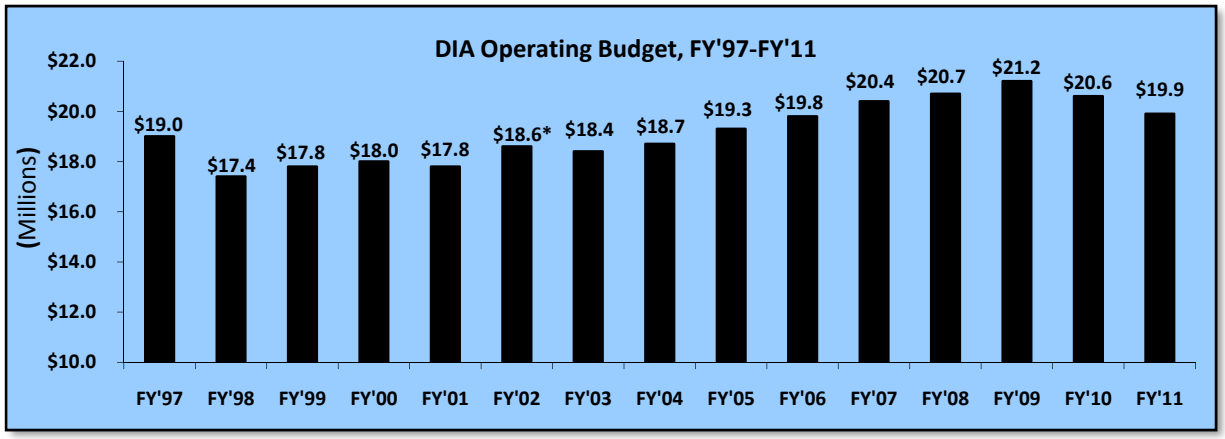
Included in the FY'11 General Appropriations Act was **Outside Section #138** that provides a financial mechanism for the Secretary of Administration and Finance to transfer the unexpended balance of any agency's fund, trust fund or other separate account to the General Fund. Since 1985, the DIA has been funded entirely by assessments on employers in the Commonwealth. Each year, the DIA's year-end account balances are used to offset these assessments, thereby reducing the overall cost of workers' compensation insurance. Throughout the FY'11 budget process, the Advisory Council repeatedly expressed concern regarding the inclusion of this language in a final budget.

Table 17: Legislative Budget Process for DIA Line-Item, Fiscal Year 2010 - Fiscal Year 2011

Fiscal Year 2010 Budget Process		Fiscal Year 2011 Budget Process	
DIA Request	$21,196,452	DIA Request	$20,047,378
Governor's Rec.	$20,758,502	Governor's Rec.	$20,047,378*
Full House	$20,758,502	Full House	$20,047,378
Full Senate	$20,758,502	Full Senate	$19,906,544
Conference Committee	$20,758,502	Conference Committee	$19,906,544
Gen. Appropriations Act	**$20,555,968**	**Gen. Appropriations Act**	**$19,906,544**
9C Spending Cuts	(- $789,719)		

* Budget endorsed by the Advisory Council on February 10, 2010.

Figure 29: DIA Operating Budget, FY'97 - FY'11



***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 is appropriated by the Legislature even though employer assessments fund the agency. The Division, therefore, must abide by the budget process in the same manner as most other tax funded government agencies. It is helpful to view this process in nine distinct phases.[26]

The following is a brief description of the Massachusetts Budget Process:

Figure 30: Overview of the Massachusetts' Budget Process

STAGE #1: Department Request **Time Frame:** Between July and October
Each agency prepares a budget for the next fiscal year and a spending plan for the current fiscal year. Agency requests are submitted to the Executive Office for Administration & Finance (A&F).

STAGE #2: Governor's Recommendation (House 1) **Time Frame:** November, December, and first 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.

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

STAGE #3: 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 #4: 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.

STAGE #5: Senate Ways and Means Committee Recommendations

Time Frame: Early June

The House version of the budget 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 #6: 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 #7: 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 General Appropriation Act is being finished.)

STAGE #8: General Appropriations Act

Time Frame: Within ten days of receipt

The Governor has ten calendar days to decide their 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.

STAGE #9: Section 9C Spending Cuts

Time Frame: At any time during a Fiscal Year

Although the Budget Process is now complete, the Governor can announce 9C cuts (M.G.L. c.29, section 9C) at any time it is determined that revenue is likely to be insufficient to pay for all authorized spending. The Governor can only use 9C powers to cut funding in sections of the government that are under his control (Executive Branch Agencies). The Governor is not authorized to cut local aid, the courts, the legislature, or other constitutional offices.

SECTION
- 7 -

INSURANCE COVERAGE

MANDATORY INSURANCE COVERAGE

Every private sector employer in the Commonwealth is required to maintain workers' compensation insurance.[27] 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. [28]

All Commonwealth of Massachusetts employees are covered under the Workers' Compensation Act, with claims paid directly from the General Fund. The Human Resources Division within the Executive Office of Administration & Finance administers workers' compensation claims for state agencies. On an annual basis, each individual agency pays 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).

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.[29] If an employee is injured while working for a company without coverage, a claim may be filed with the DIA's Trust Fund.[30]

Exemption of Corporate Officers

In 2002, a new law was passed that made the requirement of obtaining workers' compensation insurance elective for corporate officers (or the director of a corporation) who own at least 25% of the issued and outstanding stock of that corporation. A corporate officer must provide the DIA with a written waiver of their rights should they choose to opt-out from the workers' compensation system.[31] 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.

[27] 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.

[28] 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.

[29] See page 74 covering the Office of Investigations.

[30] See page 77 covering the Workers' Compensation Trust Fund.

[31] 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 (WCRIB) has delegated authority to determine standard policy terms, classifications, and manual rates, in addition to maintaining statistical data 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 WCRIB's Massachusetts Workers' Compensation and Employers Liability Insurance Manual sets forth the methods to determine the classification of insured's as well as terms of policies, premium calculations, 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'10, the DOI approved a total of 12 new licenses to carriers to write workers' compensation insurance in Massachusetts. In addition, four existing licenses were amended to include workers' compensation. During the same period, three insurance carriers gave up their license to write workers' compensation insurance.

In Massachusetts, workers' compensation insurance rates are determined through an administered pricing system.[32] Insurance rates are proposed by the Workers' Compensation Rating and Inspection Bureau of Massachusetts (WCRIB) on behalf of the

[32] 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.

insurance industry, and set by the Commissioner of Insurance. The WCRIB 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 submitted at least every two years, and no classifications or premiums may take effect until approved by the Commissioner.[33]

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" (see Appendix I for Advisory Council testimony).[34]

On Wednesday, May 12, 2010, Insurance Commissioner Joseph G. Murphy signed a rate stipulation which reduced average rates for workers' compensation insurance by 2.4% from 2008-2009 rate levels. This decrease will save Massachusetts employers an estimated $22.5 million in workers' compensation premiums. The stipulation was based on an agreement reached between the State Rating Bureau, the Workers' Compensation Rating & Inspection Bureau (WCRIB), and the Attorney General's Office. On March 1, 2010, the WCRIB had originally proposed a 4.5% rate increase to average workers' compensation rates. The rate reduction became effective for policies taking effect on or after September 1, 2010. Under the stipulation, the new rates will only remain in effect for one year. This rate decrease marks the tenth time workers' compensation rates have decreased since 1991.

Table 18: Impact of Rate Changes, 1991-2010

YEAR	Percent Change from Previous Year's Rate	Assuming a Manual Rate of $100 in 1991
1991	+ 11.3%	$100.00
1992	No Change	$100.00
1993	+ 6.24%	$106.24
1994	- 10.2%	$95.40
1995	- 16.5%	$79.66
1996	- 12.2%	$69.94
1997	No Change	$69.94
1998	- 21.1%	$55.18
1999	-20.3%	$43.98
2000	No Change	$43.98
2001	+ 1%	$44.42
2002	No Change	$44.42
2003	- 4%	$42.64
2004	No Change	$42.64
2005	-3%	$41.36
2006	No Change	$41.36
2007	-16.9%	$34.37
2008	-1%	$34.03
2009	No Change	$34.03
2010	**-2.4%**	**$33.21**

Source: Division of Insurance WC Rate Decisions

The table to the right illustrates the fluctuations in workers' compensation insurance rates since 1991 and how each year's rate would effect a company's premium, assuming their premium was $100 in 1991 (with all other factors remaining the same - experience rating, discounts, etc.).

[33] 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.

[34] M.G.L. c.152, §53A(2).

Deviations & Scheduled 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.[35] These percentage decreases are called "downward deviations." Scheduled 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 calendar year 2009, approximately 50 carrier groups submitted downward deviation filings, with over 20 individual companies offering discounts of at least 20% to their customers.[36]

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 (WCRIB) 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."[37]

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.

[35] M.G.L. c.152, §53A(9).
[36] Division of Insurance 2009 Annual Report.
[37] M.G.L. c.152, §53A.

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 four "standard exception classifications" for those occupations, which are common to virtually every business and pose a decreased risk to worker injury. Employees who fall within the definition of a standard exception classification are not generally included in the basic classification. These low cost standard exception classifications are: Clerical Office Employees (Code 8810), Drafting Employees (Code 8810), Drivers, Chauffeurs and their Helpers (Code 7380), and Sales-persons, Collectors or Messengers-Outside (Code 8742).

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

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

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

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

Manual Rate - Every classification has a corresponding manual rate that is representative of losses sustained 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	$4.13	$200,000	$8,260

Class Code	Standard Exception	Manual Rate	Payroll	Base Rate
8810	Clerical Employees	$.09	$50,000	$45

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 or their employees were misclassified, the employer is charged additional premium or receives a credit for the correct class. The WCRIB is responsible for determining the proper classification for all insured 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 WCRIB's Governing Committee (for those insured in the Voluntary Market) or the Residual Market Committee (for those insured in the Assigned Risk Pool). The WCRIB 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 the company's 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 of 1990, the WCRIB instituted the All Risk Adjustment Program (ARAP), calculated in addition to the experience modification factor. The ARAP surcharges experience rated risks, both voluntary and assigned, with a record of losses greater than expected under the Experience Rating Plan. The purpose of this program is to provide a revised pricing mechanism for experience rated risks to share in the underwriting losses they generate. The WCRIB will calculate the ARAP adjustment and identify it as a separate factor on the experience rating calculation sheet.

For ratings effective before September 1, 2007 and after, the ARAP factor, expressed as a debit percentage, can range from 1.00 (unity) to a maximum surcharge of 1.49. For ratings effective September 1, 2007 and after, the maximum ARAP surcharge factor decreased from 1.49 to 1.25. Prior to January 1, 2008, the ARAP factor was applied to the policy's Standard Premium less a Massachusetts Benefits Deductible Program credit or a Massachusetts Benefits Claim and Aggregate Deductible Program credit, if applicable. Effective January 1, 2008, the ARAP factor is applied to the policy's standard premium (the deductible credit was moved inside of Standard Premium effective January 1, 2008).

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, problems can occur when pricing premiums for large policies because 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 19: Percent of Premium Discount for Type A & B Companies in Massachusetts

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: WCRIB Website [www.wcribma.org], Premium Discount Table.

Deductible Policies

Table 20: Premium Reduction % per Claim Deductible

PER CLAIM DEDUCTIBLE[38] *Effective September 1, 2005*	
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: WCRIB

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 21: Massachusetts Benefits Claim and Aggregate Deductible Program

MASSACHUSETTS BENEFITS CLAIM AND AGGREGATE DEDUCTIBLE PROGRAM[39] *Effective September 1, 2005*			
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: WCRIB

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

[38] Massachusetts Workers' Compensation and Employer's Liability Insurance Manual.
[39] Massachusetts Workers' Compensation and Employer's Liability Insurance Manual.

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.[40] A basic premium is necessary to defray the expenses that do not vary with losses and to provide the insurance company with a 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.[41] 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 employer's insurance costs, dividend plans can provide the policy-owner with a partial return on a previously paid premium. This

[40] "Retrospective Rating," Risk Financing, Supplement No. 46, May 1995: III.D.7.
[41] Workers' Compensation: Exposures, Coverage, Claims, Levick, Dwight E. Standard Publishing Corp., page 11-4.

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.[42] 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.[43]

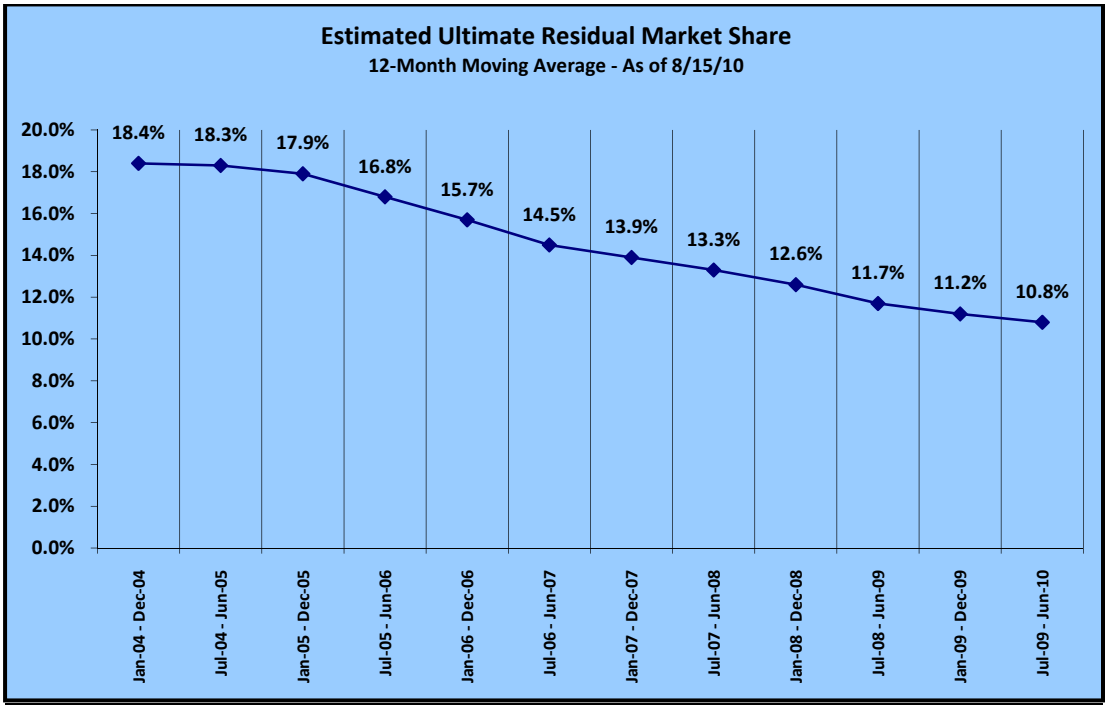
[42] "Risk Management-Life, Health, and Income Exposures," Life Insurance, Part 4: 406.
[43] "Thinking About the Work Comp Crisis," Merrit Risk Management Review, December 1991: 3.

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 (WCRIB), 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 June, 2010 is 10.8%. During the last six years this percentage has trended downward from 18.4%. Today the residual market remains far below the 1992 policy year level of 64.7%.

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." The servicing carriers are paid a commission for servicing these 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.

Figure 31: Estimated Ultimate Residual Market Share (Massachusetts) - 12 Month Average



Source: WCRIB Special Bulletin No. 10-10 (August 24, 2010).

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 can be 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. 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 the first quarter of 2010) residual market loss ratio for Policy Year 2009 is 67.0%.

Residual Market Burden - The Residual Market Burden is a measure of the pool-related costs that pool members incur when writing assessable voluntary business. For example, a positive burden of 10% indicates that an insurer will incur ten dollars of pool related obligations for every one hundred dollars of voluntary assessable premium written. By comparison, a burden of -5% indicates that a pool member will earn a profit of five dollars for every one hundred dollars of voluntary assessable premium written. For Policy Year 2008, the estimated Residual Market Burden (as of the first quarter of 2010) was 1.06%, assuming a Loss Ratio of 67.0%.[44]

[44] WCRIB Special Bulletin No. 09-10 (August 3, 2010).

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. Many employers now turn to traditional commercial insurance plans, most noticeably large deductible policies and retrospective rating plans.

Self Insurance

The DIA strictly regulates self insured employers through its annual licensing procedures (see page 75 covering the Office of Insurance). For an employer to qualify to self insure, it must post a surety bond or negotiable securities to cover any 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 or security deposit 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.[45] 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 to set bond amounts.

Table 22: Vital Statistics on Self Insurance in Massachusetts, FY'01 - FY'10

Fiscal Year	New Licenses	Total Licenses	Companies Covered	Equivalent Premium Dollars
FY'10	1	100	371	$295M
FY'09	0	112	373	$276M
FY'08	1	108	401	$264M
FY'07	2	116	400	$292M
FY'06	2	114	434	$277M
FY'05	2	129	409	$262M
FY'04	1	129	380	$245M
FY'03	2	143	445	$225M
FY'02	2	139	478	$221M
FY'01	3	151	419	$219M

[45] 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.[46]

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.

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).[47] 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, 2010, Massachusetts had 22 active SIGs with 5,381 members.

Table 23: 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
2004	24	3,768
2005	25	4,472
2006	25	4,696
2007	25	5,086
2008	24	5,453
2009	24	5,553
2010	22	5,381

Source: Division of Insurance

[46] 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).

[47] 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. [48] The IFB was created in 1990 to investigate auto insurance fraud and expanded in 1991 to include workers' compensation fraud.[49] While its mission statement is to include all lines of insurance, the focus is on automobile and workers' compensation insurance.

In 2009, the IFB's Workers' Compensation Fraud Team was made up of a Deputy Chief and six investigators dedicated to workers' compensation fraud (with an emphasis on premium fraud matters). During the year, the IFB continued its partnership with the Joint Enforcement Task Force on the Underground Economy and Employee Misclassification and was responsible for a significant portion of their investigations.

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 2009, each of these bureaus separately contributed a total of $4,153,765 to fund the IFB. The 2009 operating expenses for the IFB totaled $8,475,018, which was very similar to 2008 operating expenses ($8,446,385).

The Investigative Process

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 primarily 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 in which the subject staged an on-the-job accident;*
- *Cases where subjects participated in physical activities wholly inconsistent with the disability claimed or whose injuries were fraudulently attributed to the workplace;*
- *Premium evasion fraud and phony death claims.*

[48] 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.

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

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 2009, the IFB received 333 referrals regarding workers' compensation fraud. Workers' compensation fraud referrals only represent 8.5% of all IFB referrals. The vast majority of referrals (77.6%) received by IFB are for automobile insurance fraud (3,051 in calendar year 2009). Workers' compensation cases are fewer in count because automobile policies vastly outnumber workers' compensation policies. However, the dollar amounts for workers' compensation fraud perpetrated is significantly higher per case, particularly for premium evasion cases which can be in the millions of dollars in losses.

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." After an investigator has completed their work on a case, it is referred to a prosecutor (primarily the Massachusetts Attorney General's Office), transferred to another agency, or closed due to lack of evidence.

Indictments & Convictions

In 2009, there were 14 individuals charged (either through indictments or complaints issued) involving workers' compensation fraud as a result of the work of the Insurance Fraud Bureau. Much like the cases referred to the Insurance Fraud Bureau, the vast majority of indictments or complaints issued are for cases involving automobile insurance fraud (232 individuals charged in 2009).

In calendar year 2009 there were 5 convictions for workers' compensation fraud (47 convictions for automobile insurance fraud) and 5 cases were continued without a finding. During the year, $297,252 in restitution was ordered from cases of workers' compensation fraud.

JOINT TASK FORCE ON THE UNDERGROUND ECONOMY

Established in March of 2008 by Executive Order #499, the Joint Enforcement Task Force on the Underground Economy and Employee Misclassification ("Task Force") is charged with coordinating the investigative efforts among multiple state agencies to eliminate workplace fraud and employee misclassification. The Task Force is chaired by the Director of Labor and includes 17-member agencies and a partnership with the Insurance Fraud Bureau of Massachusetts.

Central to the Task Force mission is helping honest businesses to compete on a level playing field and ensuring that workers receive the benefits and protections due to them under the law. In addition, the Task Force also benefits consumers and taxpayers by helping to ensure that purchased goods are properly licensed and regulated and that lost tax revenues are recovered.

In October of 2010, the Task Force released an annual report, detailing the results of the second full year of operation. In this report, the Task Force stated that its member agencies had collectively recovered $6,489,549, an increase of over 350% from first year efforts ($1,439,024). From April 1, 2009 through March 31, 2010, the Task Force received 413 complaints through its referral phone line and online referral form. The Task Force also receives hundreds of complaints made directly to its member agencies. In investigating these complaints, Task Force member agencies conducted over 5,000 compliance cross-checks.

Joint Task Force - Member Agencies

Executive Office of Labor and Workforce Development
- Department of Labor
- Department of Industrial Accidents
- Division of Apprentice Training
- Division of Career Services
- Division of Occupational Safety
- Division of Unemployment Assistance

Executive Office of Administration and Finance
- Division of Capital Asset Management
- Department of Revenue
- Supplier Diversity Office

Executive Office of Health and Human Services
- Massachusetts Office of Refugees and Immigrants

Executive Office of Housing and Economic Development
- Department of Housing and Community Development
- Division of Professional Licensure
- Office of Small Business & Entrepreneurship
- State Office of Women and Minority Owned Businesses

Executive Office of Public Safety and Security
- Department of Public Safety

Office of the Attorney General
- Fair Labor Division

Office of the Treasurer
- Alcoholic Beverages Control Commission

Based on the review and investigation of Task Force referrals, the Department of Industrial Accidents issued 12 stop orders for lack of workers' compensation coverage. As a result, the DIA recovered $5,300 in fines and 37 employees received workers' compensation coverage (see page 77 for more detailed statistics on the Office of Investigations).

Information Sharing Legislation Enacted

During the 2009-2010 Legislative Session, legislation was enacted that will greatly improve joint enforcement capabilities by allowing the Department of Revenue to share worker classification information from tax filings with other Task Force agencies. The Task Force expects this new law to assist the investigative sub-team in developing potential targets. The passage of this legislation was made possible by the collaborative efforts of the Executive Office of Labor and Workforce Development, the Executive Office of Administration and Finance, the Executive Office of Housing and Economic Development, and Department of Revenue.

Multi-State and Federal Cooperative Efforts

In addition to inter-agency collaboration within Massachusetts, the Task Force has worked closely with federal agencies and other state task forces to share new ideas and to open potential avenues for multi-state enforcement initiatives.

In October of 2009, the Massachusetts Task Force, and the New York State Department of Labor, Joint Enforcement Task Force on Employee Misclassification, co-sponsored the first Northeastern States Regional Summit on the Underground Economy and Employee Misclassification. This summit convened nearly 80 state labor directors and senior officials representing nine states, from Maryland to Maine and points in between, to discuss best practices, potential pitfalls and successful strategies central to investigating/enforcing state labor, licensing and tax laws, as well as an array of state perspectives around successful data sharing to strengthen enforcement.

In May of 2010, the U.S. Department of Labor (DOL) hosted an employee misclassification conference with more than a dozen other states with similar Task Forces to Massachusetts. The conference served as an exchange of ideas and allowed the DOL to inform the states of the federal government's growing focus on the area of employee misclassification. The Task Force anticipates that in the coming years, the Federal Government will play a larger role in multi-state enforcement and funding efforts.

Future Initiatives

As the Task Force enters into its third year of operation, a number of new initiatives are currently being undertaken:

1. the establishment of an advisory council consisting of a steering committee and five regional advisory groups to guide the Task Force's efforts;

2. the commissioning of a research study to show the current depth and scope of employee misclassification and underground economy in Massachusetts;
3. the implementation of fraud detection technology to assist targeted enforcement by member agencies
4. the reorganization of the Task Force's Investigative Sub-Team to streamline the investigative process;
5. the building of an education and outreach plan to further inform workers, businesses, and municipal decision makers about the work of the Task Force and the state's employer compliance standards; and,
6. the development of a Task Force informational handout and new Task Force website.

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

LIST OF APPENDICES

APPENDIX A – Advisory Council Members, FY'10

ADVISORY COUNCIL MEMBERS – FY'10

BUSINESS	*LABOR*
EDMUND C. CORCORAN, JR. Raytheon Company 235 Wyman Street Waltham, MA 02451-1219 Tel: **(781) 768-5115** FAX: (781) 768-5126	**MICKEY LONG** AFL-CIO 193 Old Colony Avenue, P.O. Box E-1 Boston, MA 02127 Tel: **(617) 269-0229** FAX: (617) 269-0567
DAVID P. POWELL AGC of Massachusetts, Inc. 888 Worcester Street, Suite 40 Wellesley, MA 02482 Tel: **(781) 235-2680 x 16** FAX: (781) 235-6020	**WILLIAM T. CORLEY** IBEW Local 103 256 Freeport Street Dorchester, MA 02122 Tel: **(617) 268-4200** FAX: (617) 268-0330
ANTONIO FRIAS S & F Concrete Contractors, Inc. 166 Central Street, P.O. Box 427 Hudson, MA 01749-0427 Tel: **(978) 562-3495** FAX: (978) 562-9461	**JOHN A. PULGINI** Pulgini & Norton, LLP 10 Forbes Road West, Suite 240 Braintree, MA 02184 Tel: **(781) 843-2200** FAX: (781) 843-4900
JOHN REGAN Associated Industries of Massachusetts 222 Berkeley Street, P.O. Box 763 Boston, MA 02117-0763 Tel: **(617)262-1180** FAX: (617) 536-6785	**STEPHEN JOYCE** The Carpenters Center 750 Dorchester Avenue Boston, MA 02125-1132 Tel: **(617) 268-3400** FAX: (617) 268-6656
TERI A. MCHUGH Boyle, Morrissey & Campo, P.C. 695 Atlantic Avenue Boston, MA 02111 Tel: **(617) 451-2000** FAX: (617) 451-5775	**STEPHEN P. FALVEY** The Carpenters Center 750 Dorchester Avenue Boston, MA 02125-1132 Tel: **(617) 307-5132** FAX: (978) 685-7373
EX-OFFICIO	***EX-OFFICIO***
GEORGE NOEL Director, Department of Labor One Ashburton Place, Suite 2112 Boston, MA 02108 Tel: **(617) 626-7100** FAX: (617) 727-9725	**GREG BIALECKI** Secretary, Department of Business Development One Ashburton Place, Suite 2101 Boston, MA 02108 Tel: **(617) 727-8380** FAX: (617) 727-4426

CLAIMANT'S BAR	*INSURANCE*	*MEDICAL PROVIDER*
BERNARD J. MULHOLLAND Ford, Mulholland & Moran 288 North Main St., P.O. Box 4499 Brockton, MA 02303 Tel: **(508) 586-5353** FAX: (508) 588-8855	**PETER A. COOK, SR.** Cook & Co. Insurance Agency, Inc. 1025 Plain Street – P.O. Box 1068 Marshfield, MA 02050 Tel: **(781) 837-7300 x 611** FAX: (781) 837-5668	**DENNIS M. HINES** South Shore Hospital 55 Fogg Road So. Weymouth, MA 02190 Tel: **(781) 340-8590** FAX: (781) 340-8146

STAFF	
ANDREW S. BURTON, EXECUTIVE DIRECTOR	***EVELYN N. FLANAGAN, SPECIAL PROJECTS COORDINATOR***

APPENDIX B – Advisory Council Studies, 1989-2010

- Actuarial Analysis of the Insurance Rate Filing as Submitted by the Workers' Compensation Rating & Inspection Bureau of Massachusetts, KPMG (2005).
- Analysis of September 2003 Workers' Compensation Rating and Inspection Bureau of Massachusetts Rate Filing, Tillinghast - Towers Perrin, (2003).
- Analysis of September 2001 Workers' Compensation Rating and Inspection Bureau of Massachusetts Rate Filing, Tillinghast - Towers Perrin, (2001).
- Addendum to the 1997 Tillinghast Analysis of Proposed Changes to Section 34 and 35 of Chapter 152 of the Massachusetts General Laws, Tillinghast, (2000).
- Analysis of the Workers' Compensation Rating and Inspection Bureau (WCRIBM) and State Rating Bureau (SRB) Rate Filings, Tillinghast - Towers Perrin, (1999).
- Analysis of Proposed Changes to Section 34 and 35 of Chapter 152 of the Massachusetts General Laws, Tillinghast - Towers Perrin, (1997).
- Review of WC Ratemaking Concepts and WCRIBM 8/14/97 Filing, Ernst & Young LLP, (1997).
- Competitive Rating of Workers' Compensation in Massachusetts, J.H. Albert, (1995).
- Study of Workers' Compensation Insurance Rate Methodology, The Wyatt Company, (1994).
- Study of Workers' Compensation Wage Replacement Rates, Tillinghast; Professor Peter Kozel, (1994).
- Analysis of the Massachusetts Department of Industrial Accidents' Dispute Resolution System, Endispute, Inc., B.D.O. Seidman, (1991).
- Report to the Legislature on Occupational Disease, Massachusetts Workers' Compensation Advisory Council, (1990).
- Report to the Legislature on the Mark-up System for Case Scheduling, Massachusetts Workers' Compensation Advisory Council, (1990).
- Medical Access Study, Lynch-Ryan, The Boylston Group, (1990).
- The Analysis of Friction Costs Associated with the Massachusetts' Workers' Compensation System, Vols. 1-3, Milliman & Robertson, John Lewis, (1990).
- Report to the Legislature on Public Employees, Massachusetts Workers' Compensation Advisory Council, (1989).
- Report to the Legislature on Competitive Rating, Massachusetts Workers' Compensation Advisory Council, (1989).
- Report on Competitive Rating, Tillinghast, (1989).
- Assessment of the Department of Industrial Accidents & Workers' Compensation System, Peat Marwick Main, (1989).

APPENDIX C - Joint Committee on Labor & Workforce Development, FY'10

Senator Thomas M. McGee (Chair)
State House - Room 112
Boston, MA 02133-1053
(617) 722-1350

Senator Karen E. Spilka (Vice-Chair)
State House - Room 511-C
Boston, MA 02133-1053
(617) 722-1120

Senator Stephen J. Buoniconti
State House - Room 309
Boston, MA 02133-1053
(617) 722-1578

Senator Robert A. O'Leary
State House - Room 511-B
Boston, MA 02133-1053
(617) 722-1485

Senator Joan M. Menard
State House – Room 216
Boston, MA 02133-1053
(617) 722-1280

Senator Robert L. Hedlund
State House - Room 313-C
Boston, MA 02133-1053
(617) 722-1646

Rep. Cheryl A. Coakley-Rivera (Chair)
State House – Room 39
Boston, MA 02133-1053
(617) 722-2014

Rep. Robert L. Rice, Jr. (Vice-Chair)
State House - Room 39
Boston, MA 02133-1053
(617) 722-2425

Representative John H. Rogers
State House - Room 162
Boston, MA 02133-1053
(617) 722-2380

Representative John P. Fresolo
State House - Room 156
Boston, MA 02133-1053
(617) 722-2380

Representative Michael F. Rush
State House - Room 544
Boston, MA 02133-1053
(617) 722-2080

Representative Paul McMurtry
State House - Room 443
Boston, MA 02133-1053
(617) 722-2230

Representative Sean Garballey
State House – Room 134
Boston, MA 02133-1053
(617) 722-2220

Representative James Arciero
State House - Room 34
Boston, MA 02133-1053
(617) 722-2460

Rep. Anne-Margaret Ferrante
State House - Room 26
Boston, MA 02133-1053
(617) 722-2263

Representative Todd M. Smola
State House - Room 156
Boston, MA 02133-1053
(617) 722-2220

Representative Karyn E. Polito
State House - Room 167
Boston, MA 02133-1053
(617) 722-2080

APPENDIX D – Industrial Accident Nominating Panel

Paul V. Buckley, Commissioner (Chair)
Division of Industrial Accidents
1 Congress Street, Suite 100
Boston, MA 02114
Tel: 617-727-4900 x356
Email: pbuckley@dia.state.ma.us

Joseph Bonfiglio, Bus. Mgr. & Sec. Treasurer
Massachusetts Laborers' District Council
7 Laborers' Way
Hopkinton, MA 01748
Tel: 508-435-4164
Email: jbonfiglio@masslaborers.org

Joanne Goldstein, Secretary
Executive Office of Labor & Workforce Dev.
1 Ashburton Place, Suite 2122
Boston, MA 02108
Tel: 617-626-7100
Email: nancy.snyder@state.ma.us

Dennis Hines
11 Black Pond Hill Road
Norwell, MA 02061
Tel: 781-659-7608
Email: dennis_hines@sshosp.org

Michael A. Torrisi
Torrisi & Torrisi, L.L.C.
555 Turnpike Street, Suite 44
North Andover, MA 01845
Tel: 978-683-4440
Email: torrisilaw@yahoo.com

William Cowan, Gov. Chief Legal Counsel
State House, Room 271
Boston, MA 02133
Tel: 617-725-4030
Email: william.cowan@state.ma.us

Jeffrey E. Poindexter
Bulkley, Richardson and Gelinas
1500 Main Street - P.O. Box 15507
Springfield, MA 01115
Tel: 413-781-2820
Email: jpoindexter@bulkley.com

William McCarthy, Senior Judge
Division of Industrial Accidents
1 Congress Street, Suite 100
Boston, MA 02114
Tel: 617-727-4900 x340
Email: martinec@dia.state.ma.us

Stephen Marley
Director of Human Resources
Harvard University
Cambridge, MA 02138
Tel: 617-384-5503
Email: steve_marley@harvard.edu

Bob Bower
Mass. AFL-CIO
389 Main Street, Suite 101
Malden, MA 02148
Tel: 781-324-8230
Email: bbower@massaflcio.org

Vincent M. Tentindo
C3 Shipway Place
Boston, MA 02129
Tel: 617-242-9600
Email: vmt@tkcklaw.com

George Ramirez, General Counsel
Housing & Economic Development
1 Ashburton Place, Suite 2101
Boston, MA 02108
Tel: 617-788-3695
Email: george.ramirez@state.ma.us

Donald F. Baldini
10 Hawthorne Street
Winchester, MA 01890
Tel: 617-574-5867
Email: donald.baldini@libertymutual.com

APPENDIX E – The Governor's Council

Room 184, State House
Boston, MA 02133
(617) 725-4015

The Massachusetts Governor's Council, also known as the Executive Council, is comprised of eight individuals elected from their respective districts every two years. Each councilor is paid $15,000 annually plus certain expenses. The Lieutenant Governor serves as an Ex-Officio Member.

The Council generally meets at noon on Wednesdays in the 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 Department of Industrial Accidents.

Carol A. Fiola - District 1
307 Archer Street
Fall River, MA 02720
GC: (617) 725-4015 x 1
Res: (508) 674-9200
Fax: (508) 674-9201
Email: carolfiola@aol.com

Kelly A. Timilty - District 2
52 Murray Hill Road
Roslindale, MA 02131
GC: (617) 725-4015 x 2
Res: (617) 325-6569
Email: kellytimiltygc2@aol.com

Marilyn M. Petitto Devaney - District 3
98 Westminster Avenue
Watertown, MA 02472
GC: (617) 725-4015 x 3
Res: (617) 923-0778
Fax: (617) 727-6610

Christopher A. Iannella - District 4
263 Pond Street
Boston, MA 02130
GC: (617) 725-4015 x 4
Bus: (617) 227-1538
Fax: (617) 742-1424

Mary-Ellen Manning - District 5
P.O Box 4444
Salem, MA 01970
GC: (617) 725-4015 x 5
Bus: (978) 740-1090
Fax: (617) 727-6610
Email: maryellenmanning@earthlink.net

Michael J. Callahan - District 6
500 Salem Street
Medford, MA 02155
GC: (617) 725-4015 x 6
Res: (781) 393-9890

Thomas J. Foley - District 7
27 Ridgewood Road
Worcester, MA 01606-2506
GC: (617) 725-4015 x 7
Email: tjfoley512@charter.net

Thomas T. Merrigan - District 8
23 Plum Tree Lane
Greenfield, MA 01301-9687
GC: (617) 725-4015 x 8
Bus. (413) 774-5300
Fax. (413) 773-3388
Email: merrigan@valinet.com

APPENDIX F – Health Care Services Board, 2010

1 Congress Street, Suite 100
Boston, MA 02114
(617) 727-4900 x310

Current Members (2010):

Dean M. Hashimoto, MD, JD (Chair)	*Ex-Officio Member*
Henry W. DiCarlo, MM (Vice-Chair)	*Employer Representative*
David S. Babin, MD	*Physician Representative*
Marco Volpe, PT, DPT, OCS	*Physical Therapist Representative*
Peter A. Hyatt, DC	*Chiropractic Representative*
Robert P. Naperstek, MD	*Physician Representative*
Barbara C. Mackey, MS, APRN	*Public Representative*
David C. Deitz, MD, Ph.D.	*Physician Representative*
Cynthia M. Page, PT, MHP	*Hospital Administrative Representative*
Janet D. Pearl, MD, MSc	*Physician Representative*
Nancy Lessin	*Employee Representative*
Julius J. Baronas, DDS, MAGD	*Dentist Representative*
Richard P. Zimon, MD, FACP	*Physician Representative*

Staff:

Diane Neelon, RN, BS, JD	*Executive Director*
Judith A. Atkinson, Esq.	*Counsel*
Hella Dalton	*Research Analyst*

APPENDIX G – Roster of Judicial Expiration Dates

INDUSTRIAL ACCIDENT REVIEWING BOARD - SIX YEAR TERMS

1.	William McCarthy	Democrat	05/21/10
2.	Bernard Fabricant	Unenrolled	09/21/16
3.	Mark Horan	Democrat	09/21/16
4.	Frederick Levine	Unenrolled	09/21/16
5.	Patricia Costigan	Unenrolled	06/03/10
6.	Catherine W. Koziol	Democrat	08/18/14

INDUSTRIAL ACCIDENT BOARD - SIX YEAR TERMS

1.	Douglas Bean	Republican	06/26/11
2.	Michael Chadinha	Republican	05/28/10
3.	Christina Poulter	Democrat	10/12/16
4.	Cheryl A. Jacques	Democrat	03/26/14
5.	Lynn Brendemuehl	Unenrolled	07/06/12
6.	David Sullivan	Democrat	09/21/16
7.	Steven Rose	Republican	05/28/10
8.	Richard Heffernan	Democrat	07/22/15
9.	John Preston	Republican	07/29/12
10.	Paul F. Benoit	Unenrolled	08/18/14
11.	Roger Lewenberg	Republican	09/21/16
12.	Fred Taub	Democrat	08/03/12
13.	Douglas McDonald	Democrat	07/06/12
14.	Bridget Murphy	Republican	07/27/12
15.	Maureen McManus	Republican	09/21/16
16.	Emily J. Novick	Unenrolled	08/18/14
17.	Dianne Solomon	Unenrolled	08/10/12
18.	Dennis Maher	Democrat	09/15/14
19.	Omar Hernandez	Democrat	12/29/11
20.	Richard Tirrell	Democrat	05/14/10
21.	Kalina Vendetti	Democrat	09/22/16

APPENDIX H – WCAC Testimony: JCLWD Legislative Hearing, 9/30/09

Joint Committee on Labor & Workforce Development
State House – Hearing Room A-2
September 30, 2009

Good morning. My name is Andrew Burton and I serve as the Executive Director of the Massachusetts Workers' Compensation Advisory Council. Today, I am joined by Advisory Council Chairman Mickey Long, who is an AFL-CIO attorney and represents the interests of labor. I am also joined by Council Member John Regan, who is the Vice President for Government Affairs at AIM and who represents the interests of business.

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 volunteer their time 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. The Advisory Council has reviewed the proposed workers' compensation legislation before your committee and has identified employer fraud, employee benefits, and employer responsibilities, as the three most important areas in the system in need of improvements.

Employer Fraud

First, the Advisory Council supports the passage of **House Bill 1870**, filed by Representative Martin Walsh and **Senate Bill 682**, filed by Senator John Hart, Jr. These identical bills would provide a vehicle for both private citizens and insurers to bring forth a civil action against employers who illegally fail to carry workers' compensation insurance or misclassify their workers for the purpose of avoiding premiums. On suits brought forth by private citizens, the majority of the damages would be deposited into the DIA's Trust Fund to help off-set payments made to injured workers of uninsured employers. In fiscal year 2008 alone, the Trust Fund paid nearly $7 million in workers' compensation benefits to uninsured claimants. The Advisory Council believes that the passage of this legislation will help alleviate the competitive disadvantage faced by the vast majority of honest employers who purchase workers' compensation policies and properly classify their employees.

Secondly, the Advisory Council supports **House Bill 17**, filed on behalf of the Executive Office of Labor & Workforce Development. This new legislation would increase the daily stop work order fines levied against uninsured employers to $250 per day (presently $100). In cases when a stop work order is appealed, the daily stop work order fines would increase to $500 per day (presently $250). The current civil penalties for stop work orders, which have not been updated in 22 years, are grossly insufficient and no longer serve as a deterrent against uninsured employers. In addition to increasing the civil penalties, this legislation more clearly defines the DIA investigative powers to ensure that business records can be

inspected during compliance investigations. In cases where an investigator uncovers potential employee misclassification, this legislation will require the DIA to share information with the agencies of the Joint Task Force on the Underground Economy.

Finally, the Advisory Council supports **Senate Bill 729**, filed by Senator Susan Tucker. This refiled legislation would significantly increase the severity of criminal penalties for employers who fail to provide mandatory workers' compensation insurance for their employees. On criminal convictions, this bill would allow a judge to impose sentencing for up to 5 years in state prison and/or fines up to $10,000. Established in 1987, the present fine structure is outdated and insufficient, capping criminal penalties at $1,500 or up to one year in prison. In Massachusetts, criminal prosecutions against uninsured employers are reserved for the most extreme and flagrant cases. The Advisory Council believes this legislation sends a strong message to uninsured businesses in the Commonwealth that workers' compensation employer fraud is a serious violation of the law and will be met with serious consequences.

Employee Benefits

For the past three legislative sessions, the Advisory Council has identified the need to update and adjust certain employee benefits. First, the Advisory Council supports the passage of **Senate Bill 681**, filed by Senator John Hart, Jr. This bill would rightfully provide compensation for scar-based disfigurement appearing on any part of the body, subject to a $15,000 maximum benefit. The eligibility criteria for this benefit was last modified by the 1991 Reform Act, which limited compensation for disfigurement to only the face, neck or hands. Advisory Council members strongly believe that the location of scarring on the body is irrelevant and that compensation, with the $15,000 maximum benefit, should be provided to workers who suffer these traumatic, and at times, horrific injuries.

The Advisory Council also supports **House Bill 1865**, filed by Representative David Torrisi. This bill would require an insurer to pay for burial expenses when a worker has been killed on the job, not to exceed eight thousand dollars. The current burial allowance of $4,000 has not been increased in 18 years and is well below the national average. In 2006, the National Funeral Directors Association reported that the average adult casketed funeral cost in New England was $7,407. This figure does not include cemetery, monument, or marker costs or miscellaneous charges for flowers and obituaries. The Advisory Council believes that the Commonwealth has an obligation to ensure there is sufficient compensation available to the families of those workers killed on the job so that they may be honored with a respectful burial.

Employer Responsibilities

The Advisory Council also believes that there is a need to legislatively address some basic employer responsibilities that are far too often disregarded. The first involves the requirement that employers provide written notice to new employees that they have obtained workers' compensation insurance. The current law also requires an employer to

provide notice to all employees when an insurance policy is cancelled or expired. The Advisory Council supports **House Bill 1839**, filed by Representative Pam Richardson, which would create civil fines for this section of the law (c.152, §22). Under the provisions of this bill, employers would be fined not less than $50, nor more than $100 per day, for failing to provide written notice of coverage or cancellation. Often times, employees do not know of their rights or workplace protections, resulting in compensable injuries that go unreported.

The second employer responsibility that needs to be addressed involves the timely reporting of injuries. Under the current law, Massachusetts employers are given one week to report any workplace fatality or injury that incapacitates an employee from earning full or partial wages for a period of five or more calendar days. The Advisory Council supports **House Bill 1863**, filed by Representative David Torrisi, which would remove the flat fine of $100 and create an escalating fine structure based on the tardiness of each violation.

- 1 - 30 calendar days late: **$250**
- 31 - 90 calendar days late: **$500**
- More than 90 calendar days late: **$2,500**

Finally, the bill would remove the current fine waiving provision on the first two late violations in any year. Massachusetts is the only state in the country with such a fine waiving provision. In today's business environment in which employers have an instantaneous ability to report injuries online, there is no justification for waiving fines on the first two violations in any year.

Throughout this legislative session, the Advisory Council will continue to review workers' compensation legislation to ensure that any changes to the statute will build upon the successful aspects of the system, benefiting both injured workers and employers. Should you have any questions, members of the Advisory Council and staff are available as a resource to meet with any Committee Members to discuss the workers' compensation system. On behalf of the Advisory Council, I would like to thank the Joint Committee on Labor & Workforce Development for holding this hearing and allowing us the opportunity to share our recommendations.

APPENDIX I – WCAC Testimony: DOI Insurance Rate Hearing, 4/30/10

APRIL 30, 2010

WORKERS' COMPENSATION RATE HEARING
DOCKET NO. R2010-01

STATEMENT OF THE MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

Good morning. My name is Andrew Burton and I serve as the Executive Director for the Massachusetts Workers' Compensation Advisory Council. The Advisory Council is a labor-management council that monitors and makes recommendations on all aspects of the workers' compensation system in the Commonwealth. The Council members are appointed by the Governor and are comprised of leaders from business and labor, as well as representatives from the legal, medical, insurance, and vocational rehabilitation communities.

At our last meeting, the Advisory Council was presented with a brief overview of the rate filing by WCRIB Chief Actuary, Robert McCarthy. Council members learned that during the last three filings, the Bureau has adopted a prescriptive approach to simplify the rate-making process in an attempt to eliminate actuarial judgment in reaching an unbiased indication. This effort has clearly brought the parties closer together as reflected in the attached chart that depicts the narrowing of the gap between past filings and each ultimate rate decision. The Advisory Council is optimistic that the use of consistent methodologies over time will result in rates that are both stable and predictable for consumers.

Although the Advisory Council's involvement in the rate hearing process is limited by statute, we are empowered to gather loss data from "any insurance company or rating organization" and to "present a written statement and oral testimony relating to any issues which may arise during the course of the hearing" [M.G.L. c.152, §53A(6)]. In light of this year's modest request for a 4.5% increase to average rates, coupled with the fact that no new methodologies were introduced to the core rate-setting issues, the Advisory Council will refrain from obtaining a consultant to perform an actuarial analysis of the rate filing. However, if there is any way we can be of assistance to the Commissioner of Insurance in resolving any issues pertaining to the filing, we respectfully request that you contact us.

In closing, the Council recognizes the importance of adequate rates and their impact on employer costs, accessibility of coverage in the voluntary market, and safety in the workplace. Adequate rates are essential to all participants in the workers' compensation system since they provide the foundation for stable and competitive insurance markets.

On behalf of the Advisory Council, I thank you for the opportunity to present testimony and I look forward to providing you with any assistance at your request.

APPENDIX J – WCAC Guidelines for Reviewing Judicial Candidates

(Last Revised in August, 2004)

As the Massachusetts Workers' Compensation Advisory Council is charged with reviewing the qualifications of candidates for the position of administrative judge and administrative law judge at the Division of Industrial Accidents, the following guidelines are adopted to assist the Council in evaluating and rating candidates.

A. Information Distribution: Any information regarding a candidate, compiled by the Industrial Accident Nominating Panel, that is transmitted to the Advisory Council will be mailed, faxed, or delivered to the Advisory Council members. In the event this information cannot be provided to the Advisory Council members before an interview takes place, it will be provided at the interview.

B. Paper Review - Sitting Judges: Sitting Judges, seeking reappointment or appointment to a new position, who receive a favorable recommendation from the Senior Judge, will not be required to formally interview before the Council. The Advisory Council will vote on the qualifications of these Judges by reviewing any information provided by the Industrial Accident Nominating Panel. However, the Chair may, in his discretion or upon a vote of the majority of the Council members, require a sitting Judge to appear before the Council for an interview.

C. Paper Review - Nomination Pool Candidates: Any candidate who is currently serving in the Nomination Pool and reapplies for a judgeship will not be required to formally interview before the Council. The Advisory Council will vote on the qualifications of these candidates by reviewing any information provided by the Industrial Accident Nominating Panel. However, the Chair may, in his discretion or upon a vote of the majority of the Council members, require a Nomination Pool candidate to appear before the Council for an interview.

D. Interview Notification to Candidates: All other candidates not mentioned in (B) or (C), will be formally interviewed by the Advisory Council. Said candidates will be notified by the Executive Director by telephone regarding the date, time, and location of the interviews.

E. Advisory Council Interviews: The Council will convene in Executive Session for the interview process. Each candidate must be prompt for their scheduled interview time. Each candidate will be allotted no more than 15 minutes for their interview. Council members will use nameplates for identification purposes and will forego introducing themselves to each candidate. The Chair will ask the candidates to briefly introduce themselves, state their qualifications, and their reasons for seeking the position. Upon recognition of the Chair, both voting and non-voting members may ask questions of the candidates. Council members will use discretion in limiting questioning to the most pertinent concerns.

F. Voting Procedure: Upon determining a candidate's qualifications, pursuant to section 9 of chapter 23E, council members shall make a clear distinction of those candidates who have never served on the Industrial Accident Board, from those who are Sitting Judges, seeking reappointment or appointment to a new position. In conjunction with the Advisory Council's findings, it shall be noted that the judicial ratings of new candidates cannot and should not be compared to the judicial ratings of Sitting Judges.

Upon the completion of all interviews for each meeting, the Chair will ask for a motion on each candidate in the order in which they were interviewed. The Chair will first recognize only motions that rate the candidate as either "Qualified" or "Unqualified." If a motion for "Unqualified" passes, the Chair may recognize a "Motion to Reconsider" or shall move to the next candidate. If a motion for "Qualified" passes, a Council member may motion that the candidate be rated "Highly Qualified." A candidate must receive 7 affirmative votes for any motion to pass.

G. Proxy Votes: Voting by proxy is permitted. The Executive Director will contact each voting member prior to the interviews to obtain a proxy in the event said member is unable to attend. Voting members may direct their proxy how to vote on any candidate.

H. Transmission of Findings: After each meeting, the Chair shall address letters in alphabetical order to the Governor's Chief Legal Counsel advising him/her of the findings of the Council regarding each candidate. Each letter shall state that the qualifications of the candidate were reviewed, that an interview was conducted if necessary, and shall state the rating of the Council. In the event information was lacking on a particular candidate, this will be stated in the letter. In the event Council members could not agree as to "Qualified," "Unqualified," or "Highly Qualified" for any candidate, then the letter shall state that the Council could not reach a consensus on the qualifications for that candidate.

I. Request for Additional Time: In circumstances where the Advisory Council believes it has "good cause" to request additional time to review the candidates, beyond the one week time limit allotted in Executive Order No. 456, the Chair may contact the Governor's Chief Legal Counsel stating such reasons. The Chair will contact the Governor's Chief Legal Counsel by letter, phone, or fax, depending upon the urgency of the request.

APPENDIX K – Safety Grant Proposals Recommended for Funding, FY'11

RECOMMENDED FOR FUNDING

Boston Carpenters
750 Dorchester Avenue
Boston, MA 02125
Category of Applicant: Trade Association
Geographic Target: Metro Boston
Program Administrator: Christine Riley
Total Funds Approved: $24,999.60

Eastern MA Carpenters
350 Fordham Road
Suite 201
Wilmington, MA 01887
Category of Applicant: Trade Association
Geographic Target: Metro North
Program Administrator: Thomas Iacobucci
Total Funds Approved: $24,974.69

Medical Training Associates
P.O. Box 4
Rockport, MA 01966
Category of Applicant: Private Employer
Geographic Target: Northeastern MA
Program Administrator: Craig Morrill
Total Funds Approved: $24,900.00

New England Carpenters
13 Holman Road
Millbury, MA 01527
Category of Applicant: Trade Association
Geographic Target: Metro West
Program Administrator: Bertrand Rousseua
Total Funds Approved: $24,866.34

JATC of Greater Boston
194 Freeport Street
Dorchester, MA 02122
Category of Applicant: Trade Association
Geographic Target: Metro Boston
Program Administrator: Leo Purcell
Total Funds Approved: $23,473.15

Children's Hospital
300 Longwood Avenue
Boston, MA 02115
Category of Applicant: Private Employer
Geographic Target: Boston Region
Program Administrator: Howard Brightman
Total Funds Approved: $23,005.00

Town of North Attleboro
43 South Washington Street
North Attleboro, MA 02760
Category of Applicant: Public Employer
Geographic Target: Southeastern MA
Program Administrator: Joanne Cathcart
Total Funds Approved: $22,881.31

IBEW 223 JATC
P.O. Box 1238
Lakeville, MA 02347
Category of Applicant: Trade Association
Geographic Target: Southeastern MA
Program Administrator: Robert Revil
Total Funds Approved: $22,708.61

Teamsters Local 25
544 Main Street
Boston, MA 02129
Category of Applicant: Trade Association
Geographic Target: Boston Region
Program Administrator: Steven Sullivan
Total Funds Approved: $22,124.92

IBEW 223 JATC
P.O. Box 1238
Lakeville, MA 02347
Category of Applicant: Trade Association
Geographic Target: Southeastern MA
Program Administrator: Robert Revil
Total Funds Approved: $21,184.93

City of Lowell
375 Merrimac Street
Lowell, MA 01852
Category of Applicant: Public Employer
Geographic Target: Northeastern MA
Program Administrator: Karen Gagnon
Total Funds Approved: $21,135.72

Alternatives
50 Douglas Road
Whitinsville, MA 01588
Category of Applicant: Private Employer
Geographic Target: Western MA
Program Administrator: P. Ingersol-Mahoney
Total Funds Approved: $19,868.00

Dend Corp Home Instead Senior Care
1645 Falmouth Road, Bldg. C
Centerville, MA 02632
Category of Applicant: Private Employer
Geographic Target: South Shore
Program Administrator: Colleen Berman
Total Funds Approved: $18,686.48

Builders Association of Central MA
51 Pullman Street
Worcester, MA 01606
Category of Applicant: Trade Association
Geographic Target: Western MA
Program Administrator: Patricia Chalifoux
Total Funds Approved: $17,272.50

Plumbers Local 12
1240 Mass. Avenue
Boston, MA 02125
Category of Applicant: Trade Association
Geographic Target: Metro Boston
Program Administrator: Richard Carter
Total Funds Approved: $16,003.56

IBEW 223 JATC
P.O. Box 1238
Lakeville, MA 02347
Category of Applicant: Trade Association
Geographic Target: Southeastern MA
Program Administrator: Robert Revil
Total Funds Approved: $14,964.83

Central MA Convention Center
30 Elm Street
Worcester, MA 01609
Category of Applicant: Private Employer
Geographic Target: Central MA
Program Administrator: Donna McCabe
Total Funds Approved: $19,987.60

New Bedford Public Schools
455 County Street
New Bedford, MA 02740
Category of Applicant: Public Employer
Geographic Target: Southeastern MA
Program Administrator: Andrew O'Leary
Total Funds Approved: $18,725.00

MAC Company LLC Home Instead Sr. Care
231 Sutton Street
North Andover, MA 01845
Category of Applicant: Private Employer
Geographic Target: Northeastern MA
Program Administrator: Martha Cashins
Total Funds Approved: $17,761.50

Lawrence Training School
88 Franklin Street
Lawrence, MA 01841
Category of Applicant: Trade Association
Geographic Target: Northeastern MA
Program Administrator: Maria Alcantara
Total Funds Approved: $16,262.93

Home Bldrs & Remodelers Assoc. of Cape Cod
9 New Venture Drive #7
South Dennis, MA 02660
Category of Applicant: Trade Association
Geographic Target: South Shore
Program Administrator: Suzie Roettig
Total Funds Approved: $15,300.00

Sheet Metal Workers
1181 Adams Street
Dorchester, MA 02124
Category of Applicant: Labor Organization
Geographic Target: Boston Region
Program Administrator: John Healy
Total Funds Approved: $14,040.95

Sullivan Tire Co. Inc.
41 Accord Park Drive
Norwell, MA 02061
Category of Applicant: Private Employer
Geographic Target: South Shore
Program Administrator: Anne M. Lustwerk
Total Funds Approved: $13,735.06

Cape Abilities
895 Mary Dunn Road
Hyannis, MA 02601
Category of Applicant: Non-profit Org.
Geographic Target: South Shore
Program Administrator: Patricia Janiak
Total Funds Approved: $12,381.75

Worcester JATC
51 Union Street
Worcester, MA 01608
Category of Applicant: Trade Association
Geographic Target: Central MA
Program Administrator: David Delagorgendiere
Total Funds Approved: $10,624.88

Security Construction Services Inc.
59 Apsley Street
Hudson, MA 01749
Category of Applicant: Private Employer
Geographic Target: Central MA
Program Administrator: Janet Ceddia
Total Funds Approved: $10,139.32

The Arc of Northern Bristol County
141 Park Street
Attleboro, MA 02703
Category of Applicant: Non-profit Org.
Geographic Target: Southwest
Program Administrator: Patricia Kirby
Total Funds Approved: $9,641.77

Mass Pile Drivers
750 Dorchester Avenue
Boston, MA 02125
Category of Applicant: Trade Association
Geographic Target: Boston
Program Administrator: David Borrus
Total Funds Approved: $8,926.00

St. Marys Women & Childrens Center
90 Cushings Avenue
Dorchester, MA 02124
Category of Applicant: Non-profit Org.
Geographic Target: Boston Region
Program Administrator: Elie St. Brice
Total Funds Approved: $13,018.77

MassCOSH
42 Charles Street
Dorchester, MA 0222
Category of Applicant: Non-profit Org.
Geographic Target: Boston Region
Program Administrator: Marcy Goldstein-Gelb
Total Funds Approved: $12,198.00

Judge Rotenberg Education Center
240 Turnpike Street
Canton, MA 02021
Category of Applicant: Non-profit Org.
Geographic Target: Central MA
Program Administrator: Cherie Boisvert
Total Funds Approved: $10,4

Cape Cod Child Development Program Inc.
83 Pearl Street
Hyannis, MA 02601
Category of Applicant: Non-profit Org
Geographic Target: South Shore
Program Administrator: Mary Pat Messmer
Total Funds Approved: $9,770.38

Catania Hospitality Group
141 Falmouth Road
Hyannis, MA 02601
Category of Applicant: Private Employer
Geographic Target: South Shore
Program Administrator: Sally Bowles
Total Funds Approved: $9,073.60

BAMSI
10 Christy's Drive
Brockton, MA 02301
Category of Applicant: Non-profit Org.
Geographic Target: Southeastern MA
Program Administrator: Vanessa Tierney
Total Funds Approved: $8,827.50

Tewksbury Public Schools
139 Pleasant Street
Tewksbury, MA 01876
Category of Applicant: Public Employer
Geographic Target: Northeastern MA
Program Administrator: Loreen Bradley
Total Funds Approved: $8,704.82

Mark Meacham, Inc.
253 A Worcester Road
Charlton, MA 01507
Category of Applicant: Private Employer
Geographic Target: Western MA
Program Administrator: Sue Meacham
Total Funds Approved: $8,430.79

SunWind LLC
P.O. Box 700
Brewster, MA 02631
Category of Applicant: Private Employer
Geographic Target: South Shore
Program Administrator: Timothy Holmes
Total Funds Approved: $8,319.25

Lawrence Pumps
371 Market Street
Lawrence, MA 01843
Category of Applicant: Private Employer
Geographic Target: Northeastern MA
Program Administrator: Janet Grogan
Total Funds Approved: $7,917.19

Rehabilitative Resources
1 Picker Road, P.O. Box 368
Sturbridge, MA 01566
Category of Applicant: Non-profit Org.
Geographic Target: Western MA
Program Administrator: Bonita Keefe-Layden
Total Funds Approved: $7,778.09

Sprinkler Fitters Local 550
46 Rockland Street
Boston, MA 02131
Category of Applicant: Trade Association
Geographic Target: Boston Region
Program Administrator: Robyn Gelbwachs
Total Funds Approved: $7,425.73

Hub Pen
1525 Washington Street
Braintree, MA 02184
Category of Applicant: Private Employer
Geographic Target: South Shore
Program Administrator: Laurie Hoffman
Total Funds Approved: $8,602.02

Community Teamwork Inc.
167 Dutton Street
Lowell, MA 01852
Category of Applicant: Non-profit Org.
Geographic Target: Northeastern MA
Program Administrator: Julie Salois
Total Funds Approved: $8,346.00

JSC Transportation
224 Calvary Street
Waltham, MA 02453
Category of Applicant: Private Employer
Geographic Target: Metro Boston
Program Administrator: Susan Downs
Total Funds Approved: $8,184.97

City of Peabody
24 Lowell Street
Peabody, MA 01960
Category of Applicant: Public Employer
Geographic Target: Northeastern MA
Program Administrator: Heidi Henson
Total Funds Approved: $7,820.00

N East Retail Lumber Association
585 Greenbush Road
Rensselaer, NY 12144
Category of Applicant: Non-profit Org.
Geographic Target: Statewide
Program Administrator: Tom Lindberg
Total Funds Approved: $7,704.00

FIBA Technologies, Inc.
1535 Grafton Road, P.O. Box 350
Millbury, MA 01527
Category of Applicant: Private Employer
Geographic Target: Western Massachusetts
Program Administrator: Carl Gordon
Total Funds Approved: $6,851.00

Robert B. Our Company
P.O. Box 1539
Harwich, MA 02645
Category of Applicant: Private Employer
Geographic Target: South Shore
Program Administrator: Abigail Our
Total Funds Approved: $5,882.00

Sencorp
400 Kidds Hill Road
Hyannis, MA 02601
Category of Applicant: Private Employer
Geographic Target: South Shore
Program Administrator: Dennis Babineau
Total Funds Approved: $5,022.15

TACO, Inc. HVAC
583 Bedford Street
Fall River, MA 02720
Category of Applicant: Private Employer
Geographic Target: Southwest
Program Administrator: David Grof
Total Funds Approved: $4,754.01

Hillview Montessori School
75 Foundation Avenue
Haverhill, MA 01835
Category of Applicant: Public Employer
Geographic Target: Northeast
Program Administrator: Andrea Kwiatkowski
Total Funds Approved: $4,529.24

Hockomock YMCA
300 Elmwood Street
North Attleboro, MA 02760
Category of Applicant: Non-profit Org.
Geographic Target: Southwest
Program Administrator: John Metcalf
Total Funds Approved: $4,304.61

Henry Lee Willis Community Center
119 Forest Street
Worcester, MA 01609
Category of Applicant: Non-profit Org.
Geographic Target: Western MA
Program Administrator: Opal Stone
Total Funds Approved: $3,210.00

Ze-Gen
1380 Soldiers Field Road
Boston, MA 02035
Category of Applicant: Private Employer
Geographic Target: Metro Boston
Program Administrator: Gideon Gradman
Total Funds Approved: $5,697.75

Advocates Inc.
One Clarks Hill Drive, Suite 305
Framingham, MA 01702
Category of Applicant: Non-profit Org.
Geographic Target: Metro West
Program Administrator: Javier Cruz
Total Funds Approved: $4,815.00

Harrison Global Transportation
224 Calvary Street
Waltham, MA 02453
Category of Applicant: Private Employer
Geographic Target: Metro West
Program Administrator: Bret Tyson
Total Funds Approved: $4,702.12

North Central Human Services
31 Lake Street
Gardner, MA 01440
Category of Applicant: Non-profit Org.
Geographic Target: Western Massachusetts
Program Administrator: Elizabeth Foss
Total Funds Approved: $4,439.95

City of Attleboro
City Hall, 77 Park Street
Attleboro, MA 02703
Category of Applicant: Public Employer
Geographic Target: Southwest
Program Administrator: Diane Morris
Total Funds Approved: $4,226.00

FOCO, Inc. Le Limo Service
224B Cherry Street
Shrewsbury, MA 01545
Category of Applicant: Private Employer
Geographic Target: Western MA
Program Administrator: Jennifer Brugliera
Total Funds Approved: $3,104.87

Trident Environmental Group
62 LaCombe Street
Marlborough, MA 01752
Category of Applicant: Private Employer
Geographic Target: Metro West
Program Administrator: Garrett Quinn
Total Funds Approved: $2,950.00

City of Cambridge
147 Hampshire Street
Cambridge, MA 02139
Category of Applicant: Public Employer
Geographic Target: Boston Region
Program Administrator: Catherine Mitrano
Total Funds Approved: $2,374.00

Brockton Day Nursery
243 Crescent Street
Brockton, MA 02302
Category of Applicant: Public Employer
Geographic Target: Southeastern MA
Program Administrator: Patricia Plummer-Wilson
Total Funds Approved: $2,018.77

Shorey Manufacturing
P.O. Box 1539
Harwich, MA 02645
Category of Applicant: Private Employer
Geographic Target: South Shore
Program Administrator: Abigail Our
Total Funds Approved: $1,605.00

Town of Mansfield
10 Plymouth Street
Mansfield, MA 02048
Category of Applicant: Public Employer
Geographic Target: Southeastern MA
Program Administrator: Donald Tebeau
Total Funds Approved: $2,801.65

Crane & Company, Inc.
54 South Street
Dalton, MA 01226
Category of Applicant: Private Employer
Geographic Target: Berkshire/Western MA
Program Administrator: Robert Dionne
Total Funds Approved: $2,287.12

Markman Children's Program
505 North Main Street
Attleboro, MA 02702
Category of Applicant: Non-profit Org.
Geographic Target: Southwestern MA
Program Administrator: Diane Bardsley
Total Funds Approved: $1,861.80

Bass River Inc.
437 Essex Street
Beverly, MA 01915
Category of Applicant: Non-profit Org.
Geographic Target: North Shore
Program Administrator: Larry Lusignan
Total Funds Approved: $1,419.09

APPENDIX L – Collections & Expenditures Report, FY'10 - FY'06

COLLECTIONS AND EXPENDITURES REPORT, FISCAL YEAR 2010 - FISCAL YEAR 2006

SPECIAL FUND	*FY'10*	*FY'09*	*FY'08*	*FY'07*	*FY'06*
COLLECTIONS					
INTEREST	**11,498**	**107,609**	**432,041**	**785,884**	**670,515**
ASSESSMENTS	20,269,416	20,458,701	17,245,272	15,301,449	18,005,869
LESS RET. CHECKS	(17,388)	(94,125)	(4,615)	0	(10,806)
LESS REFUNDS	(57,793)	(336,026)	(119,948)	(457)	0
SUB-TOTAL	**20,194,235**	**20,028,550**	**17,120,709**	**15,300,992**	**17,995,063**
REFERRAL FEES	3,993,493	4,786,125	4,068,091	4,362,429	4,162,760
COLLECTION FEE	0	0	(422)	(15,534)	(17,889)
LESS RET. CHECKS	(711)	(3,998)	(10,134)	(10,536)	(4,497)
LESS REFUNDS	(115,277)	(654,402)	(10,422)	(3,094)	(7,129)
SUB-TOTAL	**3,877,505**	**4,127,725**	**4,047,093**	**4,333,265**	**4,133,245**
1ST REPORT FINES	116,542	243,050	225,474	206,904	198,008
LESS COLLECTION FEE	0	0	0	(7,368)	(11,077)
LESS RET. CHECKS	(100)	(1,200)	(500)	(2,700)	0
LESS REFUNDS	(91,511)	(6,780)	(500)	(700)	0
SUB-TOTAL	**24,931**	**235,070**	**224,474**	**196,136**	**186,931**
STOP WORK ORDERS	1,645,564	1,381,180	535,396	391,328	250,299
LESS REFUNDS	(33,516)	0	(200)	0	(3,537)
EDS FEE	(48)	(21)	0	(71)	(105)
LESS BAD CHECKS	(3,348)	(11,200)	0	(300)	0
MERCHANT FEE	0	(5)	(1,224)	(1,091)	0
SUB-TOTAL	**1,608,652**	**1,369,954**	**533,972**	**389,867**	**246,657**
LATE ASSESS. FINES	45,498	74,673	26,942	20,400	28,050
MISCELLANEOUS	81,526	29,848	29,817	37,044	32,945
ADJUSTMENT	0	6,939			
SUB-TOTAL	**127,024**	**111,460**	**56,759**	**57,444**	**60,995**
TOTAL SPECIAL FUND COLLECTIONS	**25,843,845**	**25,980,368**	**22,415,048**	**21,063,588**	**23,293,406**
BALANCE BRGT FWD	4,878,605	2,470,245	5,634,120	9,201,123	9,148,914
TOTAL	**30,722,450**	**28,450,613**	**28,049,168**	**30,264,710**	**32,442,320**
LESS EXPENDITURES	(22,770,315)	(23,572,008)	(25,602,577)	(24,630,590)	(23,250,818)
ADJUSTMENT	0	0	0		9,621
BALANCE	**7,952,135**	**4,878,605**	**2,446,591**	**5,634,121**	**9,201,123**
EXPENDITURES					
TOTAL COMPUTER	**2,786**	**37**	**414,431**	**1,020,176**	**438,890**
REPAYMENT - SALARIES	13,791,029	14,298,709	14,284,592	13,698,054	13,535,090
FRINGE BENEFITS	3,611,928	3,490,000	5,161,232	4,227,282	3,614,974
INDIRECT COSTS	742,764	365,987	265,292	255,506	230,155
NON-PERSONNEL COSTS	4,575,218	5,385,628	5,176,399	5,418,795	5,428,939
OTHER INDIRECT COSTS	24	0	3,312	9,534	0
IP INDIRECT-EXPENSE	46,566	31,647	0	1,243	0
ADJUSTMENT FRINGE Q.1	0	0	297,319	0	2,770
TOTAL REPAYMENT	**22,767,529**	**23,571,971**	**25,188,146**	**23,610,414**	**22,811,928**
TOT. SPECIAL FUND EXPENDITURES	**22,770,315**	**23,572,008**	**25,602,577**	**24,630,590**	**23,250,818**

COLLECTIONS AND EXPENDITURES REPORT, FISCAL YEAR 2010 - FISCAL YEAR 2006

PUBLIC TRUST FUND	*FY'10*	*FY'09*	*FY'08*	*FY'07*	*FY'06*
COLLECTIONS					
INTEREST	**884**	**4,039**	**8,466**	**9,718**	**7,324**
ASSESSMENTS	339	457	142,598	39,415	62,936
LESS FUNDS TRANSFERRED	(339)	(45)	(109,108)		
TOTAL ASSESSMENTS	**0**	**412**	**33,490**	**39,415**	**62,936**
TOTAL PUBLIC TRUST COLLECTIONS	**884**	**4,451**	**41,956**	**49,133**	**70,260**
BALANCE BRGT FWD	846,303	841,852	799,896	750,763	680,503
TOTAL	**847,187**	**846,303**	**841,852**	**799,896**	**750,763**
LESS EXPENDITURES	(440,476)	0	0	0	0
BALANCE	**406,711**	**846,303**	**841,852**	**799,896**	**750,763**
EXPENDITURES					
RR COLAS	440,476	0	0	0	0
RR SEC. 37	0	0	0	0	0
RR SEC. 19 COLA	0	0	0	0	0
TOT. PUBLIC TRUST EXPENDITURES	**440,476**	**0**	**0**	**0**	**0**

PRIVATE TRUST FUND	*FY'10*	*FY'09*	*FY'08*	*FY'07*	*FY'06*
COLLECTIONS					
INTEREST	**28,012**	**128,052**	**268,411**	**308,118**	**232,217**
ASSESSMENTS	55,076,303	55,002,085	50,338,430	53,365,665	46,686,859
LESS RET. CHECKS	(24,085)	(282,474)	0	(2,500)	(2,584)
LESS REFUNDS	(67,776)	(980,934)	(87,852)	(196)	0
SUB-TOTAL	**54,984,442**	**53,738,678**	**50,250,578**	**53,362,969**	**46,684,275**
REIMBURSEMENTS	717,782	1,401,891	1,289,675	1,205,800	1,444,681
RET. CHECK	(3,603)	(11,496)	(1,569)	(28,053)	(1,161)
REFUNDS	(819)	(1,877)	(1,070)	(10,282)	0
SUB-TOTAL	**713,360**	**1,388,518**	**1,287,036**	**1,167,465**	**1,443,520**
SEC. 30 H	**0**	**25,924**	**0**	**3,393**	**728**
OTHER TRUST FUND	**0**	**87,378**	**238,385**		
TOT. PRIVATE TRUST COLLECTIONS	**55,725,814**	**55,368,550**	**52,044,410**	**54,841,945**	**48,360,740**
BALANCE BRGT FWD	7,667,309	26,153,119	15,282,709	8,934,528	13,618,318
TOTAL	**63,393,123**	**81,521,669**	**67,327,119**	**63,776,473**	**61,979,058**
LESS EXPENDITURES	(46,834,827)	(73,853,717)	(41,174,001)	(48,493,764)	(53,044,529)
ADJUSTMENT	0	0	0		1,500
BALANCE	**16,558,296**	**7,667,952**	**26,153,118**	**15,282,709**	**8,936,029**

COLLECTIONS AND EXPENDITURES REPORT, FISCAL YEAR 2010 - FISCAL YEAR 2006

PRIVATE TRUST FUND	***FY'10***	***FY'09***	***FY'08***	***FY'07***	***FY'06***
CLAIMANTS - EXPENDITURES					
RR SEC. 34	1,414,491	1,209,059	1,320,000	1,248,883	1,183,723
RR SEC. 35	379,035	428,448	449,319	474,278	465,122
RR LUMP SUM	1,043,946	1,345,645	1,570,455	1,242,755	1,635,402
RR SEC. 36	180,802	220,957	502,719	176,065	119,966
RR SEC. 31	98,761	163,090	131,075	78,508	91,434
RR SEC. 34, PERM. TOTAL	620,747	436,661	376,980	356,338	306,009
RR COLA ADJ	227,594	269,725	331,026	275,751	154,612
RR EE MEDICAL	24,846	22,527	56,400	75,111	98,387
RR EE TRAVEL	5,219	3,500	2,059	6,045	3,500
RR EE MISC. EXPENSE	709	632	15,726	0	637
RR BURIAL BENEFITS	4,000	4,000	0	4,575	0
RR LEGAL FEES	604,005	618,683	672,952	606,698	643,260
RR VOC. REHAB SERVICES	8,168	10,666	11,874	9,956	6,236
RR REHAB (PRIOR YEAR)	0	0	504	63	397
RR MEDICAL	1,891,511	2,108,479	1,515,100	2,272,265	1,941,114
SUB-TOTAL CLAIMANT PAYMENTS	**6,503,834**	**6,842,072**	**6,956,189**	**6,827,291**	**6,649,799**
MM TUITION	**4,653**	**6,649**	**6,438**	**4,541**	**21,862**
TOTAL CLAIMANTS	**6,508,487**	**6,848,721**	**6,962,627**	**6,831,832**	**6,671,661**
INSURERS - EXPENDITURES					
RR COLAS	11,081,676	33,566,021	5,751,523	8,032,750	21,914,829
RR SEC. 19 COLA LUMP SUM	685,552	872,730	989,176	1,085,082	1,452,130
RR LATENCY SEC. 35C	303,027	982,496	558,588	388,100	280,751
RR SEC. 37	15,765,761	20,116,257	16,990,276	19,389,653	7,543,763
RR SEC. 37 QUARTERLY	6,999,945	5,998,937	6,138,343	8,537,194	10,996,194
RR SEC. 37 INTEREST	111,948	304,741	84,808	198,285	0
TOTAL PAYMENT TO INSURERS	**34,947,909**	**61,841,182**	**30,512,714**	**37,631,064**	**42,187,667**
OEVR - EXPENDITURES					
MM TUITION	7,938	7,427	3,893	40,070	63,834
RR PRIOR YEAR REHAB	0	0	0	0	0
RR REHAB-30H	148	3,814	4,189	7,708	12,022
RR HEALTHSOUTH HLDS	0	0	0	0	780
RR FCE REIMBURSEMENT	0	0	0	0	625
RR CRAWFORD & CO.	0	0	0	0	462
EE OTHER	0	463	182	896	
RR EE TRAVEL	2,070	4,000	1,942	2,282	2,886
RR EE BOOKS & SUPPLIES	1,539	1,553	1,740	5,491	6,874
SUB-TOTAL OEVR EXP.	**11,695**	**17,257**	**11,946**	**56,447**	**87,483**

COLLECTIONS AND EXPENDITURES REPORT, FISCAL YEAR 2010 - FISCAL YEAR 2006

PRIVATE TRUST FUND	***FY'10***	***FY'09***	***FY'08***	***FY'07***	***FY'06***
DEFENSE - EXPENDITURES					
AA PAYROLL - SALARY	2,955,695	2,837,630	1,611,214	1,661,496	1,833,394
AA OVERTIME COSTS	0	0	362	26,798	11,803
AA SICK LEAVE BUY BACK	0	0	0	293	0
SUB-TOTAL	**2,955,695**	**2,837,630**	**1,611,576**	**1,688,587**	**1,845,197**
BB TRAVEL	44,308	0	18,877	23,291	18,578
BB CONFERENCE TRAINING	1,860	2,015	81	1,074	437
BB EE REIMBURSEMENT	16	47,071	0	23	448
BB EMPLOYEE REIMBURS	5,333	5,976	5,265	1,774	1,696
SUB-TOTAL	**51,517**	**55,062**	**24,223**	**26,162**	**21,159**
CONTRACTED STUDENT INTERNS	7,290	9,010	5,803		
SUB-TOTAL	**7,290**	**9,010**	**5,803**		
DD FRINGE	821,784	732,511	632,427	542,343	493,193
DD UNIVERSAL HEALTH INS.	0	0	0	0	269
DD MEDICARE TAX	0	0	0	0	9,653
DD UNEMPLOYMENT INS.	0	0	0	0	1,914
DD BOND	2,093	0	445	0	356
DD WC CHARGEBACK	44,072	16,556	57,571	18,842	39,141
DD HEALTH SERVICES CORP	0	2,092	1,935		
SUB-TOTAL	**867,949**	**751,159**	**692,378**	**561,185**	**544,526**
EE RENTAL/MV CHRG-BACK	1,134	3,402	3,629	3,629	3,629
EE DEST. OLD RECORDS	7,201	7,052	6,912	5,875	5,786
EE ADVERTISING	0	713	365	990	474
EE BOOKS/SUPPLIES	27,127	27,241	20,138	29,220	28,400
EE IMPARTIAL APPEALS	13,950	17,188	13,050	13,950	20,375
EE CENTRAL REPRO.	2,615	2,686	2,821	1,170	0
EE POSTAGE	9,910	12,796	0	3,317	14,101
EE WATER	974	1,251	1,087		0
EE TRAINING / TUITION	0	0	0	(50)	12,190
EE JUDGEMENT (E54)	0	0	0	0	0
EE TEMP USE SPACE	2,245	0	4,415	0	815
EE PRINTING	1,345	4,635	149	83	
EE CONFERENCE, INCIDEN.	0	2,820	0	3,795	
EE MCKENZIE	0	0	0	93,983	
EE INDIRECT COSTS	94,063	82,829	35,696	44,578	39,875
EE POSTAGE CHRG-BACK	2,211	2,742	3,177		
EE FIA CREDIT CARDS	0	0	1,852		
EE MEMBERSHIPS	0	0	1,350		
SUB-TOTAL	**162,775**	**165,355**	**94,641**	**200,540**	**125,645**
MED SUP/TOILETRIES & PERSONL	937				
SUB-TOTAL	**937**				
GG BOSTON LEASE	626,923	620,826	647,011	507,823	495,209
GG ELECTRICITY - BOSTON	20,970	26,792	33,994	13,409	9,084
GG FUEL FOR VEHICLES	0	63			
SUB-TOTAL	**647,893**	**647,681**	**681,005**	**521,232**	**504,293**

(CONTINUED ON NEXT PAGE)

COLLECTIONS AND EXPENDITURES REPORT, FISCAL YEAR 2010 - FISCAL YEAR 2006

PRIVATE TRUST FUND	*FY'10*	*FY'09*	*FY'08*	*FY'07*	*FY'06*
HH CONSULTANTS	238,027	197,310	150,143	422,850	412,422
SUB-TOTAL	**238,027**	**197,310**	**150,143**	**422,850**	**412,422**
JJ OPERATIONAL SERV.	167,589	144,383	186,493	391,137	438,802
SUB-TOTAL	**167,589**	**144,383**	**186,493**	**391,137**	**438,802**
KK EQUIPMENT	31,564	6,649	18,914	1,650	1,225
SUB-TOTAL	**31,564**	**6,649**	**18,914**	**1,650**	**1,225**
LL CBE HOLDINGS	3,028	35,791	12,711	4,536	29,017
LL XEROX	124	424	1,113	0	1,685
LL ORACLE	18,705	17,607	23,583	13,692	16,538
LL ASAP SOFTWARE EXPRS	0	22,963	18,489	0	10,593
LL SIMPLEX TIME RECORDER	213	424	245	0	0
LL SHARED TECHNOLOGY	0	0	0	0	1,883
LL PITNEY BOWES	1,150	1,439	1,419	1,272	1,331
LL IKON	498	608	784	0	0
LL SUN MICROSYSTEMS	0	4,982	4,467	3,601	4,748
LL RETROFIT	2,811	6,086	3,829	2,527	2,837
LL MILLENNIUM MECHAN	1,027	1,395	992	0	191
LL FIRE EQUIPMENT	0	225	183	0	168
LL JEWEL PROTECTIVE SYSTEMS	0	0	0	0	125
LL ENTERPRISE RENT-A-CAR	46,952	27,113	4,979	3,808	3,639
LL OFFICE EQUIPMENT	0	0	0	0	204
LL CAM OFFICE SERVICES	60	222	222		
LL NTIRETY	0	0	0	3,371	11,556
LL RONCO COMM & ELEC	0	0	0	21,233	6,865
LL MMARS ACCT SYST	33,540	2,672	2,652	1,872	1,499
LL KEANE	0	0	2,603	0	874
LL KFORCE	0	0	0	0	2,340
LL COMPUTER EQUIPMENT	0	0	0	0	1,239
LL TSG HEALTHCARE RESR	0	0	0	0	18,763
LL DELL MARKETING	33,847	85,670	32,865	43,038	35,996
LL QWEST COMM.	360	356	332	376	27
LL ITT COMPUTER SERV.	2,941	22,439	23,460	16,327	17,918
LL VERIZON SERVICES	4,839	37,964	23,296	17,918	18,808
LL AMS IMAGINING	23,403	30,692	0	116	0
LL TELEPHONE LEASE	0	1,188	4,754	4,753	3,692
LL NEXTELL	0	0	2,500	2,702	6,353
LL EGI BUSINESS TRUST	0	0	17,434	18,826	
LL EMC CORP.	0	0	1,500		
LL PEOPLESERVE	0	0	6,306		
LL PAUL DAUBITZ	0	0	1,648		
LL OVERTURE PARTNERS	0	0	3,900		
LL LANTEL COM	166	1,276	3,494		
LL CITY LIGHTS ELEC	0	0	2,543		
LL GATEWAY COMPANIES	0	0	1,825		
LL STENOGRAPHER CORP	0	0	434		

(CONTINUED ON NEXT PAGE)

COLLECTIONS AND EXPENDITURES REPORT, FISCAL YEAR 2010 - FISCAL YEAR 2006

PRIVATE TRUST FUND	*FY'10*	*FY'09*	*FY'08*	*FY'07*	*FY'06*
LL EOS APPROACH	2,188	1,439	1,523		
LL ULTRAGUARD PROTECT	65	156	156		
LL EASTON CONSULTING	0	4,000			
LL ATLANTIC ASSOCIATES	21,295	7,963			
LL COMM-TRACT	0	440			
LL PAETEC COMM	8,562	7,500			
LL GRAYBAR ELECTRIC	0	600			
LL GOVT CONNECTION	6,543	1,430			
LL INTEGRATED PARTNERS	2,370	6,944	2,450		
LL RALCO ELECTRIC	258				
LL BCM CONTROLS	50				
LL INTEGRATED ELEC SVCS	450				
LL CELLO PARTNERSHIP	19,415				
LL DIGITAL RESOURCES	640				
SUB-TOTAL	**235,500**	**332,008**	**208,691**	**159,968**	**198,889**
NN NON-MAJOR INFRA MAIN	0	0	0	725	0
NN DOC DESTRUCTION	0	0	2,847	385	0
NN PASEK EQUIPMENT	0	43			
NN ACCENT BANNER	0	117			
NN KILLEN ELECTRIC SVC	0	150			
SUB-TOTAL	**0**	**310**	**2,847**	**1,110**	**0**
RR PENALTIES SEC. 8	0	0	10,000	0	5,560
SUB-TOTAL	**0**	**0**	**10,000**	**0**	**5,560**
TOTAL DEFENSE EXPENDITURES	**5,366,736**	**5,146,557**	**3,686,714**	**3,974,421**	**4,097,718**
TOTAL PRIV. TRUST EXPENDITURES	**46,834,827**	**73,853,717**	**41,174,001**	**48,493,764**	**53,044,529**

DIA - INCOME SUMMARY

INCOME SUMMARY	*FY'10*	*FY'09*	*FY'08*	*FY'07*	*FY'06*
Total Assessments (All 3 Funds)	75,178,677	73,767,640	67,404,777	68,703,376	64,742,274
Total Filing Fees	3,877,505	4,127,725	4,047,093	4,333,265	4,133,245
Total First Report Fines	24,931	235,070	224,474	196,136	186,931
Total SWOs	1,608,652	1,369,954	533,972	389,867	246,657
Total Misc. Fines	81,526	29,848	29,817	37,044	32,945
Total 5% Fines (Late Assess.)	45,498	74,673	26,942	20,400	28,050
Total Reimbursements	713,360	1,388,518	1,287,036	1,167,465	1,443,520
Total 30H	0	25,924	0	3,393	728
Total Other Trust Fund	0	87,378			
Yr. Adj. for Refunds to TF	0	6,939	238,385	0	0
Total Interest	40,394	239,700	708,918	1,103,720	910,056
TOTAL INCOME	**81,570,543**	**81,353,369**	**74,501,414**	**75,954,666**	**71,724,406**

APPENDIX M – Workers' Compensation Legislation, 2009-2010 Session

H.17*	NEW	Stop Work Orders - Strengthening Enforcement
H.1796	*Refile*	Election to Receive WC Benefits or Pension - MBTA
H.1800	*Refile*	Workers' Compensation Dependency Benefits - Increase
H.1801	*Refile*	Extension of Temporary Total Benefits
H.1805	*Refile*	Workers' Compensation - Comprehensive
H.1811	*Refile*	Serious and Willful Misconduct – Intoxication
H.1812	*Refile*	Safe Workplaces for Employees of the Commonwealth
H.1821	*Refile*	Widow's Benefits
H.1822	NEW	Waiver of Right of Action for Injuries
H.1825	*Refile*	Attorney Fees - Agreements to Pay Benefits - Temp. Total - Perm. Total
H.1826	*Refile*	Appointment of Impartial Physicians - Impartial Exams
H.1827	*Refile*	Average Weekly Wage - Attorney Fees - Last Best Offer
H.1828	*Refile*	Average Weekly Wage - Attorney Fees - Last Best Offer
H.1834	NEW	Permanent and Partial Incapacity
H.1835	*Refile*	Partial Incapacity - Removes Ability to Extend Benefit
H.1836	NEW	Referral at Conciliation - Conference Heard on Same Date
H.1838	NEW	Online Proof of Coverage Tool
H.1839*	NEW	Notice by Insured to New Employees – Fines
H.1843	*Refile*	Third Party Lawsuits - Protecting Employee Leasing Companies
H.1846	*Refile*	Workers' Compensation Payroll Audits - Requirements & Penalties
H.1853	*Refile*	Insurance Rates - Loss Cost – Competition
H.1863*	NEW	Penalties for Failing to Timely Report Injuries
H.1864	*Refile*	Insurance Rates - Loss Cost – Competition
H.1865*	*Refile*	Burial Expenses
H.1866	NEW	Invalid Workers' Compensation Certificate - Criminal Offense
H.1868	*Refile*	Scar-Based Disfigurement - Burial Expenses - Extension of Partial Disability
H.1870*	*Similar*	Private Right of Action to Recover WC Un-Paid Premiums
H.1871	*Refile*	Safe Workplaces for Employees of the Commonwealth
H.1872	*Refile*	Termination or Modification of Payments - Impartial Medical Exams
H.1873	*Refile*	Rate of Payment by Insurers for Health Care Services
H.1877	*Refile*	Private Right of Action to Recover WC Coverage Payments
H.2549	*Refile*	Benefits for State Social Workers Resulting from Acts of Violence
H.2989	*Similar*	Public Records Exemption - Information within First Report of Injury
H.3693	NEW	Impartial Medical Examinations - Recording/Videotaping
H.3694	*Refile*	Workers' Compensation Insurance Premiums – Placeholder
S.681*	*Refile*	Scar-Based Disfigurement
S.682*	*Similar*	Private Right of Action to Recover WC Un-Paid Premiums
S.686	*Refile*	Widow's Benefits
S.694	*Refile*	Workers' Compensation – Comprehensive
S.695	*Refile*	Benefits for Members of the Armed Services or National Guard
S.703	*Refile*	Authority for AJs to Determine Fraudulent Acts by Parties
S.704	*Refile*	Definition of "Proceeding" for the Purpose of Fraudulent Acts
S.705	*Refile*	Definition of "Proceeding" for the Purposes of Chapter 152
S.716	NEW	Workers' Compensation – Comprehensive
S.718	*Refile*	Workers' Compensation – Comprehensive
S.728	*Refile*	Falsifying or Forging WC Certificates and Declarations
S.729*	*Refile*	Increasing Criminal Penalties for Failing to Provide WC Insurance
S.2011	*Refile*	Benefits for Members of the Armed Services or National Guard
S.2375*	*Substitute*	Private Right of Action to Recover Amounts Not Paid under Chapter 152

* Endorsed by the Workers' Compensation Advisory Council

HOUSE BILLS:

HOUSE BILL 17
Filed By: Executive Office of Labor and Workforce Development
Type of Bill: NEW
Endorsed by Advisory Council: YES
Laws Affected: Stop Work Orders - Strengthening Enforcement (c.152, §25C)

This new legislation would increase the daily stop work order fines levied against uninsured employers to $250 (presently $100). In cases when a stop work order is appealed, and at the conclusion of a hearing the DIA finds the employer not in compliance with the insurance mandate, the daily stop work order fines would increase to $500 (presently $250). Established in 1987, the present stop work order fine structure has not been adjusted in 22 years.

In addition to increasing the stop work order fines, this bill would clarify the investigative powers of the DIA in determining whether or not an employer has met the requirements of Chapter 152. The more clearly defined powers would ensure that DIA investigators can enter and inspect any place of business or job site at a reasonable time, make observations regarding the number of workers and their activities, and require the production of appropriate business records for examination and copy.

Finally, this new legislation would allow DIA investigators to make referrals to the Joint Task Force on the Underground Economy (or any other appropriate agency) if during the course of an investigation it is found that the employer is:

- materially understating or concealing payroll;
- materially misrepresenting or concealing employee duties so as to avoid proper classification for premium calculations; or
- materially misrepresenting or concealing information pertinent to the computation and application of an experience modification factor.

HOUSE BILL 1796
Filed By: Representative Brian S. Dempsey
Type of Bill: Refile (H.3460)
Endorsed by Advisory Council: No
Laws Affected: Election to Receive WC Benefits or Pension - MBTA (c.152, §73)

This bill would prevent any present or former MBTA employee from simultaneously collecting benefits due from a workplace injury and receiving payment from a pension (by reason of same injury). Section 73 of Chapter 152 specifically prohibits the collection of "dual benefits" for all Commonwealth employees including, the Massachusetts Turnpike Authority, the Massachusetts Port Authority, the Blue Hills Regional School system, the Greater Lawrence Sanitary District, the Minuteman Regional Vocational Technical School District, the Massachusetts Water Resources Authority or any police officer of the Massachusetts Bay Transportation Authority. Due to ambiguous wording, it is unclear whether or not this bill replaces the first sentence of §73 or adds an additional sentence.

HOUSE BILL 1800
Filed By: Representative Lewis G. Evangelidis
Type of Bill: Refile (H.3796)
Endorsed by Advisory Council: No
Laws Affected: Workers' Compensation Dependency Benefits - Increase (c.152, §35A)

This refiled bill 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. House 1800 would provide injured workers additional compensation of $15 per/week for each person wholly dependent upon them. This bill would also cap weekly payments at $300 when combined with the compensation due under §34, §34A, and §35.

The amount of $6 per dependent per week has not increased since a 1959 amendment to the Act. The current cap of $150 per week has not been increased since 1979.

HOUSE BILL 1801
Filed By: Representative Lewis G. Evangelidis
Type of Bill: Refile (H.3795)
Endorsed by Advisory Council: No
Laws Affected: Extension of Temporary Total Benefits (c.152, §34)

This refiled bill 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. House 1801 would allow an injured worker to receive additional benefits upon the exhaustion of their §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.

HOUSE BILL 1805
Filed By: Representative Sean Garballey
Type of Bill: Refile (H.1861)
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 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.

CONTINUED ON NEXT PAGE

HOUSE BILL 1805 CONTINUED

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 (AWW).

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 bill would require compensation for all disfigurement, whether or not scar-based, regardless of its location on the body. Section 36(k) was amended by the 1991 Reform Act to limit payments for purely scar-based disfigurement by requiring benefits only when the disfigurement is on the face, neck, or hands.

Section 10 would amend Section 46A by requiring an injured worker's 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 1811
Filed By: Representative Bradley H. Jones and Representative George N. Peterson, Jr.
Type of Bill: Refile (H.1796)
Endorsed by Advisory Council: No
Laws Affected: Serious and Willful Misconduct (c.152, §27) - Intoxication, Unlawful Use of a Controlled Substance

This refiled bill would amend §27 and deny workers' compensation benefits to employees who are injured while intoxicated or unlawfully using a 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," but does not elaborate specifically what constitutes "serious and willful misconduct." This bill would not bar compensation to dependents if the injury resulted in death.

HOUSE BILL 1812
Filed By: Representative Bradley H. Jones and Representative George N. Peterson, Jr.
Type of Bill: Refile (H.3797)
Endorsed by Advisory Council: No
Laws Affected: Safe Workplaces for Employees of the Commonwealth (c.149, §40A)

This refiled bill seeks to apply the federal safety standards that apply to the private workforce to public sector employees and its political subdivisions. A majority of states already apply OSHA standards to their state and municipal employees.

HOUSE BILL 1821
Filed By: Representative Ronald Mariano
Type of Bill: Refile (H.1816 and S.1061) / Identical to S.686 (this session)
Endorsed by Advisory Council: No, Unable to Reach a Consensus in 2008
Laws Affected: Widow's Benefits (c.152, §35C, §32, §31)

This refiled bill would significantly alter the definition of the "average weekly wage" exclusively for Section 35C cases (latency claims). Under this bill, the surviving dependent of a worker that had died from an occupational illness or disease would receive compensation based upon the earnings of the last full time employment, regardless of whether that worker was earning wages at the time of death. According to the SJC's decision in the *McDonough's Case*, the widow of an employee who died as a result of past asbestos exposure was not entitled to receive compensation under Section 35C since the deceased had voluntarily retired in 1991 and was not receiving wages on the date of his death. Section 35C clearly states that "[w]hen there is a difference of five years or more between the date of injury and the initial date [of] eligib[ility] for benefits under section thirty-one...the applicable benefits shall be those in effect on the first date of eligibility for benefits."

Last legislative session, the Advisory Council was asked by the House Committee on Ways and Means to provide guidance on this bill. The Advisory Council discussed the bill at the April 9, 2008 Advisory Council meeting and was unable to reach a consensus in either support or opposition to the proposed legislation. The Advisory Council has been informed by the DIA that the passage of this bill could financially jeopardize the Workers' Compensation Trust Fund, which makes reimbursement payments to insurers for latency injuries.

HOUSE BILL 1822
Filed By: Representative Allen J. McCarthy
Type of Bill: NEW
Endorsed by Advisory Council: No
Laws Affected: Waiver of Right of Action for Injuries (c.152, §24, §68, and c.229 §2)

This new legislation would significantly alter the exclusivity provisions under §24 of the Workers' Compensation Act. In cases when there are no dependents of an employee who has died from an occupational injury, and that employee has not given notice to the employer to preserve his/her right of action at common law under §24, this bill would permit the next of kin to bring a tort claim against the employer.

CONTINUED ON NEXT PAGE

HOUSE BILL 1822 CONTINUED

Under §24, employees are deemed to have waived their right to bring an action against their employer for a compensable injury, unless they notify their employer (at the time of hire) that they did not want to waive their common law rights. Prior to 1985, §24 barred tort claims on employees only. In response to *Ferriter v. Daniel O'Connell's Sons*, 381 Mass. 507 (1980), which recognized a loss of consortium claim against an employer brought by an employee's wife, the Legislature amended §24 to extend the exclusivity provision to bar tort and statutory claims brought by family members of an employee injured or killed in a work-related accident.

House Bill 1822 appears to have been filed in response to the 2008 SJC Decision, *Taciana Ribeiro SAAB & another v. Massachusetts CVS Pharmacy, LLC*. In this case, a deceased employee's parents were barred from bringing a wrongful death claim against the employer. The parents argued that exclusivity provisions under §24 should not be applied to them because there were no dependents in which to receive compensation from §31 death benefits. In its decision, the SJC found that because the injuries were compensable, the deceased worker's parents were barred from maintaining any action against their son's employer.

HOUSE BILL 1825
Filed By: Representative Eugene L. O'Flaherty
Type of Bill: Refile (H.1825)
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 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. In Massachusetts, the attorney fees specified in §13A are the only fees payable for any services provided to employees.

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

Section 3 of this bill attempts to amend §34 benefits for injuries that are total. However, due to mistakes in drafting, the proposed language is unclear.

Section 4 of this bill would attempt to amend §34A benefits for injuries that are both permanent and total. This section would remove the minimum weekly compensation rate for injuries under §34A, thereby reducing an employee's benefit to their Average Weekly Wage. This section of the bill also has ambiguous language.

HOUSE BILL 1826
Filed By: Representative Eugene L. O'Flaherty
Type of Bill: Refile (H.1826)
Endorsed by Advisory Council: No
Laws Affected: Appointment of Impartial Physicians (c.152, §9C), Impartial Exams (§11A).

Section 1 of this refiled bill 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 the 180-day pay without prejudice period has expired.]

Section 2 of this bill 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 also 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 1827
Filed By: Representative Eugene L. O'Flaherty
Type of Bill: Refile (H.1827) / Identical to H.1828 (this session)
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 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.

HOUSE BILL 1828
Filed By: Representative Eugene L. O'Flaherty
Type of Bill: Refile (H.1827) / Identical to H.1827 (this session)
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 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.

HOUSE BILL 1834
Filed By: Representative Robert L. Rice, Jr.
Type of Bill: NEW
Endorsed by Advisory Council: No
Laws Affected: Permanent and Partial Incapacity (c.152, §35F)

This new legislation would create a new Permanent and Partial Incapacity Benefit (§35F) for eligible claimants that have exhausted the Partial Incapacity Benefit (§35). When incapacity for work resulting from the injury is both permanent and partial, an eligible claimant could receive the following benefits under the proposed §35F:

- Weekly compensation equal to 2/3 of the difference between his/her average weekly wage before the injury and the weekly wage he/she is capable of earning after the injury, but no more than 75% of what such employee would receive if he or she were eligible for Total Incapacity Benefits (§34).
- An insurer could reduce the amount paid to the employee under this section to the amount at which the employee's combined weekly earnings and benefits are equal to two times the average weekly wage in the commonwealth at the time of such reduction.
- There would be no limit on duration for this benefit.

Currently, Partial Incapacity Benefits are handled under §35 regardless of whether they are temporary or permanent. The duration of §35 benefits may be doubled (from 260 weeks to 520 weeks) for certain types of injuries that may be deemed long-term or permanent.

HOUSE BILL 1835
Filed By: Representative Robert L. Rice, Jr.
Type of Bill: NEW
Endorsed by Advisory Council: No
Laws Affected: Partial Incapacity - Removes Ability to Extend Benefit (c.152, §35)

This new legislation would remove the provision in §35 (Partial Incapacity Benefit) that allows for the extension of benefits from 260 weeks to 520 weeks for certain types of injuries that may be deemed long-term or permanent. Currently, under §35, an insurer or Administrative Judge may extend the §35 benefit to 520 weeks for certain permanent conditions, which include:

- the permanent loss of 75% or more of any bodily function or sense listed in §36(1)(a), (b), (e), (f), (g), or (h);
- a permanently life-threatening physical condition; and
- a permanently disabling occupational disease, if it is physical in both nature and cause.

It is important to note that Representative Robert L. Rice, Jr. has filed additional legislation (see House Bill 1834) which would create a new Permanent and Partial Incapacity Benefit (§35F) for eligible claimants that have exhausted the Partial Incapacity Benefit (§35).

HOUSE BILL 1836
Filed By: Representative Robert L. Rice, Jr.
Type of Bill: NEW
Endorsed by Advisory Council: No
Laws Affected: Referral at Conciliation - Conference Heard on Same Date (c.152, §10(4))

This new legislation would add a new subsection to §10(4) that would require unresolved cases at conciliation to be referred for a conference to be heard on the same day the conciliation was held. The parties, by agreement, would be able to request a continuance of this conference date. Currently under §10A, the administrative judge "shall require the parties to appear before him for a conference within twenty-eight days of receipt of the case by the division of the dispute resolution."

HOUSE BILL 1838
Filed By: Representative Pam Richardson
Type of Bill: NEW
Endorsed by Advisory Council: No
Laws Affected: Online Proof of Coverage Tool (c.152, §22A)

This new legislation would require the Department of Industrial Accidents (DIA) to publish on their website a listing of all companies required to be covered by workers' compensation insurance. For each company, the listing would be required to include:

- whether or not coverage is in effect;

CONTINUED ON NEXT PAGE

HOUSE BILL 1838 CONTINUED

- the effective dates of the policy;
- the holder or carrier of the policy; and
- all industry codes associated with the policy.

House Bill 1838 also requires the Workers' Compensation Rating & Inspection Bureau (WCRIB) to furnish the DIA with all relevant policy information in accordance with the online proof of coverage tool.

In February of 2009, the DIA and the WCRIB agreed to work together to build an online proof of coverage application that will display all of the information required in this bill, with the exception of all industry codes associated with each policy. Work will begin on this project in June of 2009.

HOUSE BILL 1839
Filed By: Representative Pam Richardson
Type of Bill: NEW
Endorsed by Advisory Council: YES
Laws Affected: Notice by Insured to New Employees - Fines (c.152, §22)

This new legislation would create fines against employers for violations of §22. This section of the law requires employers to give written notice to new employees that they have provided for them workers' compensation insurance. Fines also would be created for employers that fail to notify all of their employees of policy termination or expiration, either on or before the day the policy expires. Under the provisions of this bill, employers would be fined not less than $50 nor more than $100 per day for failing to provide written notice of coverage or cancellation.

HOUSE BILL 1843
Filed By: Representative Michael J. Rodrigues
Type of Bill: Refile (H.1069)
Endorsed by Advisory Council: No
Laws Affected: Third Party Lawsuits (§15) - Protecting Employee Leasing Companies (§14A)

Section 1 of this refiled bill would clarify that an injured worker is barred from filing a third party lawsuit against an insured Employee Leasing Company or its client company if both are in compliance with Chapter 152. Currently, under §15, injured employees may sue third parties if a compensable injury was "caused under circumstances creating a legal liability in some person other than the insured to pay damages." A Superior Court Case has held that a client company was not protected by the exclusive remedy provision from a leased employee who brought a suit against them [*Margolis v. Charles Precourt & Sons, Inc.* - 6/7/99].

Section 2 of this bill would require the Commissioner of Insurance to establish regulations requiring Employee Leasing Companies to be the workers' compensation policyholder of employees leased to client companies. This section of the bill is unnecessary as the Commissioner of Insurance has already established regulations requiring Employee Leasing Companies to insure its employees leased to other entities [211 CMR 111.00].

HOUSE BILL 1846
Filed By: Representative Michael J. Rodrigues
Type of Bill: Refile (H.5027)
Endorsed by Advisory Council: No
Laws Affected: Workers' Compensation Payroll Audits - Requirements & Penalties (§25V)

Section 1 of this refiled bill would create criminal penalties for employers who knowingly submit an application for insurance coverage that contains false, misleading or incomplete information for the purpose of avoiding or reducing insurance premiums. All insurance applications would be required to contain a sworn statement by the employer attesting to the accuracy of the submitted information. Under this bill, employers convicted of criminal offenses would be subject to minimum mandatory fines, imprisonment or both. The minimum criminal fine would be $1,000 with a maximum fine of $10,000. The maximum imprisonment sentence in a state prison would be 5 years. An offender could also be imprisoned in jail for not less than 6 months but not more than 2.5 years.

Section 2 of this bill would require the Division of Insurance to establish by rule the minimum requirements for payroll verification audits and employee classifications. Annual onsite audits would be required for all experience rated employers in the construction class. For all other employers, audits would be conducted biennially.

Section 3 of this bill would require employers to annually submit to their carrier a copy of any quarterly contribution reports required by the Division of Unemployment Assistance. In addition, employers would be required to submit an annual self-audit supported by annual contribution reports.

Section 4 of this bill requires employers to make available all records necessary for the payroll verification audits and to allow the auditor to make a physical inspection of the worksites. The penalty for failing to provide reasonable access to records would be three times the most recent estimated annual premium, payable to the insurer. This section would also make it a violation of Chapter 93A (regulating business practices for consumer protection) for employers that understate or conceal payroll, knowingly misrepresent or conceal employee duties so as to avoid proper classification for premium calculations, or misrepresent or conceal information pertinent to the computation and application of an experience rating modification factor.

Section 5 would require an employer to indemnify an insurer for all workers' compensation benefits paid to an employee who suffers a compensable injury, but was not reported as earning wages on the last quarterly contribution report filed with the Division of Unemployment Assistance before the accident. Failure to indemnify the insurer within 21 days after demand would be grounds for the insurer to immediately cancel coverage.

HOUSE BILL 1853
Filed By: Rep. John W. Scibak
Type of Bill: Refile (H.4590) / Identical to H.1864 (this session)
Endorsed by Advisory Council: No
Laws Affected: Insurance Rates – Loss Cost - Competition (c.152, §53A)

This refiled bill would change how workers' compensation rates are determined in Massachusetts. Currently, the Commonwealth uses a system of "Administered Pricing" in which the Commissioner of Insurance makes the final determination in establishing workers' compensation rates per job classification.

Under House Bill 1853, workers' compensation insurance rates would be determined under a "Loss-Cost System." Similar to the current law, insurers would submit all their loss data to a designated rating organization (WCRIB) and would adhere to a uniform classification system. Instead of a rate hearing, the Commissioner of Insurance would hold a loss-cost hearing in which the WCRIB would submit a loss cost filing for each classification (e.g. roofers, clerical workers). "Loss Costs" are the historical aggregate data and loss adjustment expenses (LAE), developed and trended for each classification and is expressed as a dollar amount per $100 of payroll. For example, the loss cost for a "roofer" might be $6.00 and for a "clerical worker" $.90.

Following the Commissioner's approval of a loss-cost filing, each carrier would submit to the State Rating Bureau a “loss cost multiplier (LCM)" filing. This LCM takes into account the carriers expenses other than LAE, such as overhead, acquisition, marketing, profit, etc. Upon approval of this filing, LCM's would be multiplied by the loss cost to determine the final rate.

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.]

The Advisory Council's involvement in the rate process would remain limited in scope, allowing for the presentation of written and oral testimony relating to any issues which may arise during the course of the hearing. A safety mechanism has been included in this legislation which would allow the Commissioner of Insurance to hold a "Market Competition Hearing" if the market were deemed unhealthy or non-competitive. In this event the Commissioner would have the authority to revert the market to a temporary system of administered pricing.

HOUSE BILL 1863
Filed By: Representative David M. Torrisi
Type of Bill: NEW
Endorsed by Advisory Council: YES
Laws Affected: Penalties for Failing to Timely Report Injuries (c.152, §6)

This new legislation, filed on behalf of the Workers' Compensation Advisory Council, would strengthen the penalties against employers that fail to timely report injuries. Currently under §6, all employers must report to the DIA any workplace fatality or injury that

CONTINUED ON NEXT PAGE

HOUSE BILL 1863 CONTINUED

incapacitates an employee from earning full or partial wages for a period of five or more calendar days. This report, known as the "*Employer's First Report of Injury or Fatality - Form 101*" (FRI), can be submitted on paper or online and is due within seven days from the fifth calendar day of disability (not including Sundays or legal holidays). Failure to file, or timely file, a FRI three or more times within any year is punishable by a fine of $100 for each violation. Each failure to pay a fine within 30 days is considered a separate violation.

House Bill 1863 would amend §6 and remove the fine waiving provision on the first two FRI violations in any year. In addition, this bill would create the following escalating fine structure based on tardiness of each FRI violation:

- 1 - 30 calendar days late: $250
- 31 - 90 calendar days late: $500
- More than 90 calendar days late: $2,500

Finally, this bill would increase the penalty for the late payment of fines from $100 to $250 for each 30 calendar days late.

HOUSE BILL 1864
Filed By: Rep. David M. Torrisi
Type of Bill: Refile (H.4590) / Identical to H.1853 (this session)
Endorsed by Advisory Council: No
Laws Affected: Insurance Rates – Loss Cost - Competition (c.152, §53A)

This refiled bill would change how workers' compensation rates are determined in Massachusetts. Currently, the Commonwealth uses a system of "Administered Pricing" in which the Commissioner of Insurance makes the final determination in establishing workers' compensation rates per job classification.

Under House Bill 1864, workers' compensation insurance rates would be determined under a "Loss-Cost System." Similar to the current law, insurers would submit all their loss data to a designated rating organization (WCRIB) and would adhere to a uniform classification system. Instead of a rate hearing, the Commissioner of Insurance would hold a loss-cost hearing in which the WCRIB would submit a loss cost filing for each classification (e.g. roofers, clerical workers). "Loss Costs" are the historical aggregate data and loss adjustment expenses (LAE), developed and trended for each classification and is expressed as a dollar amount per $100 of payroll. For example, the loss cost for a "roofer" might be $6.00 and for a "clerical worker" $.90.

Following the Commissioner's approval of a loss-cost filing, each carrier would submit to the State Rating Bureau a “loss cost multiplier (LCM)" filing. This LCM takes into account the carriers expenses other than LAE, such as overhead, acquisition, marketing, profit, etc. Upon approval of this filing, LCM's would be multiplied by the loss cost to determine the final rate.

CONTINUED ON NEXT PAGE

HOUSE BILL 1864 CONTINUED

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.]

The Advisory Council's involvement in the rate process would remain limited in scope, allowing for the presentation of written and oral testimony relating to any issues which may arise during the course of the hearing.

A safety mechanism has been included in this legislation which would allow the Commissioner of Insurance to hold a "Market Competition Hearing" if the market were deemed unhealthy or non-competitive. In this event the Commissioner would have the authority to revert the market to a temporary system of administered pricing.

HOUSE BILL 1865
Filed By: Representative David M. Torrisi
Type of Bill: Refile (H.4170)
Endorsed by Advisory Council: YES
Laws Affected: Burial Expenses (§33)

This refiled bill 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. In 2006, the average adult casketed funeral cost (with vault) in New England was $7,407. It is important to note that these costs do not include cemetery monument or marker costs or miscellaneous cash advance charges such as flowers or obituaries.

HOUSE BILL 1866
Filed By: Representative Cleon H. Turner
Type of Bill: NEW
Endorsed by Advisory Council: No
Laws Affected: Invalid Workers' Compensation Certificate - Criminal Offense

This new legislation would make it a criminal offense for an employer to falsely assert they have an active workers' compensation policy or display a certificate of insurance when such certificate is invalid or has been cancelled, revoked, or otherwise terminated. Under this bill, employers convicted of criminal offenses would be subject to minimum mandatory fines, imprisonment or both. The minimum criminal fine would be $1,000. The maximum imprisonment sentence would be 2.5 years in a jail or house of correction. In addition to said criminal penalties, a convicted employer would be held personally liable for any loss or damages to anyone who has relied on such false assertion or invalid certificate. This bill fails to identify what section of law is being addressed and will need to be amended for clarification.

HOUSE BILL 1868
Filed By: Representative Martin J. Walsh
Type of Bill: Refile (H.1862)
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 refiled 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 the 1991 Reform Act 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 ($1,093.27 x 29 = $31,704.83). 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 from 260 weeks to 520 weeks. 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 1870
Filed By: Representative Martin J. Walsh
Type of Bill: Similar (S.1066) / Identical to S.682 (this session)
Endorsed by Advisory Council: YES
Laws Affected: Private Right of Action to Recover WC Un-Paid Premiums (c.152, §25C)

This bill would allow "any 3 persons" to bring a civil action against an employer to recover amounts which should have been paid pursuant to Chapter 152 to cover their workers. At least 90 days prior to filing a civil action, the persons who intend to bring a civil action would be required to serve a copy of the complaint to the suspected employer and any insurer that was entitled to collect amounts not paid. Once a civil action has been filed, any insurer that failed to file a complaint or seek arbitration would be prohibited from attempting to recover or collect any amounts, unless the insurer receives voluntary and written approval from the plaintiffs.

A court may dismiss the action if the plaintiffs cannot show probability that at least one of the following facts exists:

- The employer failed to withhold state and local taxes from an employee's pay;
- An individual performing services for an employer was misclassified as an independent contractor whereas the individual was in fact an employee of the employer;

CONTINUED ON NEXT PAGE

HOUSE BILL 1870 CONTINUED

- An individual performing services for an employer was neither classified as an independent contractor nor listed on payroll records as required by M.G.L. c.151, §15;
- An individual performing public works construction under M.G.L. c.149, §27 was not listed on the §27B certified payroll records;
- An employee was terminated after suffering an on the job injury;
- An employee was told by the employer or the employer's agent not to disclose that an on the job injury occurred to either a physician, hospital or other health care provider; or
- The employer was recently cited, prosecuted or debarred for misclassification of employees under M.G.L. c.149, §148B.

When the plaintiffs prevail in court they shall collectively be entitled up to $25,000 (or 25% of the amounts unlawfully not paid - whichever is less) plus cost of reasonable attorney fees, as well as additional amounts from the defendant(s) as liquidated damages. The remainder of damages would be deposited into the DIA's Workers' Compensation Trust Fund, unless the insurer had been substituted as the plaintiff.

HOUSE BILL 1871
Filed By: Representative Martin J. Walsh
Type of Bill: Refile (H.1866)
Endorsed by Advisory Council: No
Laws Affected: Safe Workplaces for Employees of the Commonwealth (c.149, §40)

This legislation would require the Division of Occupational Safety (DOS) to apply federal occupational and health standards to public sector employees (state, city/town, and county) and its independent authorities. Under this legislation, DOS would be given the authority to conduct investigations and the power to establish regulations and corrective action where it has found a violation. This proposed legislation would not apply to the fire services of the Commonwealth, its independent authorities or other political subdivisions.

HOUSE BILL 1872
Filed By: Representative Martin J. Walsh
Type of Bill: Refile (H.1865)
Endorsed by Advisory Council: No
Laws Affected: Termination or Modification of Payments (c.152, §8) - Impartial Medical Exams (c.152, §11A)

Section 1 of this bill would amend an insurer's right to modify or terminate the payment of benefits. Under current law, an insurer paying benefits can only modify or discontinue payments under specific circumstances. One of these circumstances is when the insurer has possession of a medical report from either the treating or impartial medical examiner indicating that the employee is capable of returning to the job held at the time of injury or another suitable job. House Bill 1872 would eliminate the "impartial medical examiner report" from these specific circumstances.

CONTINUED ON NEXT PAGE

HOUSE BILL 1872 CONTINUED

Section 2 of this bill would amend §8(4) involving the insurer's right to request an Impartial Medical Exam (IME) when the dispute is over medical issues. Under current law, when an insurer requests an IME, the Senior Judge is responsible for appointing an impartial physician.

House Bill 1872 would require the Administrative Judge, to which the case has been assigned, to appoint the impartial physician. This section of the bill would also diminish the weight given to the IME report thereby allowing the parties to submit other medical evidence at a hearing.

Section 3 of this bill would amend §11A involving the necessity to obtain an IME when a conference order is appealed. Under current law, the parties may agree upon an impartial physician, or the Senior Judge will assign one. This bill requires the Administrative Judge to appoint the impartial physician. This section of the bill would also diminish the weight given to the IME report thereby allowing the parties to submit other medical evidence at a hearing. Under current law, once a case is brought before an Administrative Judge at a hearing, the impartial physician's report and deposition are 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 Reform Act was designed to solve the problem of "dueling doctors," which frequently resulted in the submission of conflicting evidence by employees and insurers.

HOUSE BILL 1873
Filed By: Representative Martin J. Walsh
Type of Bill: Refile (H.1864)
Endorsed by Advisory Council: No
Laws Affected: Rate of Payment by Insurers for Health Care Services (c.152, §13)

This refiled bill would empower Administrative Judges to determine the rate of payment for health care services "if the insurer, employer and health care service provider cannot agree or if equity of justice requires a rate other than so provided."

Currently, the Division of Health Care Finance and Policy (DHCFP) is responsible for regulating the rates of payment (fee schedule) for hospitals and health care providers rendering services covered by insurers under the Workers' Compensation Act. The fee schedule is subject to a regulatory proceeding ensuring a public process through which rate setting is established. Although rate negotiation is common, the rates that are set by the DHCFP are the only amount that an insurer is required to pay.

HOUSE BILL 1877
Filed By: Representative Martin J. Walsh
Type of Bill: Refile (H.1857)
Endorsed by Advisory Council: No (WCAC endorsed S.1066 in 2007-2008)
Laws Affected: Private Right of Action to Recover WC Coverage Payments (c.152, §25C)

House Bill 1877 would allow "any 10 persons" to bring a civil action, on behalf and in the name of the "Workers' Compensation Trust Fund," against an employer to recover amounts which should have been paid in securing proper workers' compensation insurance. Such persons seeking a civil action must first petition either the Commissioner of Insurance, the Attorney General's Office 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
- The employees have not been properly reported on certified payroll records as required by law.

After a decision that probable cause exists, the persons who intend to bring a civil action would be required to serve a copy of the decision to any insurer that was entitled to collect amounts not paid. At least 90 days after such service, the plaintiff may file a civil action. Once a civil action has been filed, any insurer that failed to file a complaint or seek arbitration would be prohibited from attempting to recover or collect any amounts, unless the insurer receives voluntary and written approval from the plaintiffs. When the plaintiffs prevail in court they shall collectively be entitled up to $25,000 (or 25% of the amounts unlawfully not paid - whichever is less) plus cost of reasonable attorney fees, as well as additional amounts from the defendant(s) as liquidated damages. The remainder of damages would be deposited into the DIA's Workers' Compensation Trust Fund, unless the insurer had been substituted as the plaintiff.

HOUSE BILL 2549
Filed By: Representative James J. O'Day
Type of Bill: Refile (S.1103)
Endorsed by Advisory Council: No
Laws Affected: Benefits for State Social Workers Resulting from Acts of Violence (c.30, §58)

This refiled bill would compensate state employees who receive bodily injuries resulting from acts of violence by children in their caseload 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.

HOUSE BILL 2989
Filed By: Representative John P. Fresolo
Type of Bill: Similar (H.3195)
Endorsed by Advisory Council: No
Laws Affected: Public Records Exemption - Information within First Report of Injury (c.4, §7)

This bill would exempt from the Public Records Law specific information contained within the First Report of Injury (Form 101). Information protected would include: the name, age, sex, and occupation of any injured employee, and the date, nature, circumstances and cause of injury. In June of 2006, the Advisory Council formed a subcommittee to address the solicitation practices of a select group of law firms who were using the Massachusetts Public Records Law to obtain the names and addresses of employees who have been injured on the job ("Form 101 - First Report of Injury"). Several years ago, a public records lawsuit was filed against the DIA when the agency redacted the names and addresses on Form 101 public record requests.

HOUSE BILL 3693
Filed By: William C. Galvin
Type of Bill: New
Endorsed by Advisory Council: No
Laws Affected: Impartial Medical Examinations - Recording/Videotaping (c.152, §11A(2))

This new legislation would provide the claimant with the right to record or videotape the Impartial Medical Examination at their own expense. Such recording could be introduced as evidence at the hearing. The DIA would be required to advise claimants of these rights. Under current law, the impartial physician's report and deposition are 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 by the report.

HOUSE BILL 3694
Filed By: Representative Michael J. Rodrigues
Type of Bill: Refile (H.1839) / see H.1846 (this session)
Endorsed by Advisory Council: No
Laws Affected: Workers' Compensation Insurance Premiums

This exact bill was filed in the 2007-2008 Legislative Session to serve as a "placeholder" for future legislation that would create a "true up" provision concerning workers' compensation insurance premiums. In the fall of 2008, House Bill 5027 was filed which created a payroll verification audit process to ensure that employers were not falsifying insurance applications for the purpose of avoiding or reducing premiums. House Bill 5027 was refiled in the 2009-2010 Legislative Session as House Bill 1846.

SENATE BILLS:

SENATE BILL 681
Filed By: Senator John A. Hart
Type of Bill: Refile (S.1060)
Endorsed by Advisory Council: YES
Laws Affected: Scar-Based Disfigurement (c.152, §36(k))

This refiled bill 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. This bill would not affect the $15,000 maximum benefit for scar-based disfigurement currently in the statute. In 1991, section 36(k) was amended by the 1991 Reform Act to limit payments for purely scar-based disfigurement by requiring benefits only when the disfigurement is on the face, neck, or hands.

SENATE BILL 682
Filed By: Senator John A. Hart, Jr.
Type of Bill: Similar (S.1066) / Identical to H.1870 (this session)
Endorsed by Advisory Council: YES
Laws Affected: Private Right of Action to Recover WC Un-Paid Premiums (c.152, §25C)

This bill would allow "any 3 persons" to bring a civil action against an employer to recover amounts which should have been paid pursuant to Chapter 152 to cover their workers. At least 90 days prior to filing a civil action, the persons who intend to bring a civil action would be required to serve a copy of the complaint to the suspected employer and any insurer that was entitled to collect amounts not paid. Once a civil action has been filed, any insurer that failed to file a complaint or seek arbitration would be prohibited from attempting to recover or collect any amounts, unless the insurer receives voluntary and written approval from the plaintiffs.

A court may dismiss the action if the plaintiffs cannot show probability that at least one of the following facts exists:

- The employer failed to withhold state and local taxes from an employee's pay;
- An individual performing services for an employer was misclassified as an independent contractor whereas the individual was in fact an employee of the employer;
- An individual performing services for an employer was neither classified as an independent contractor nor listed on payroll records as required by M.G.L. c.151, §15;
- An individual performing public works construction under M.G.L. c.149, §27 was not listed on the §27B certified payroll records;
- An employee was terminated after suffering an on the job injury;
- An employee was told by the employer or the employer's agent not to disclose that an on the job injury occurred to either a physician, hospital or other health care provider; or
- The employer was recently cited, prosecuted or debarred for misclassification of employees under M.G.L. c.149, §148B.

CONTINUED ON NEXT PAGE

SENATE BILL 682 CONTINUED

When the plaintiffs prevail in court they shall collectively be entitled up to $25,000 (or 25% of the amounts unlawfully not paid - whichever is less) plus cost of reasonable attorney fees, as well as additional amounts from the defendant(s) as liquidated damages. The remainder of damages would be deposited into the DIA's Workers' Compensation Trust Fund, unless the insurer had been substituted as the plaintiff.

SENATE BILL 686
Filed By: Senator John A. Hart
Type of Bill: Refile (H.1816 and S.1061) / Identical to H.1821 (this session)
Endorsed by Advisory Council: No, Unable to Reach a Consensus in 2008
Laws Affected: Widow's Benefits (c.152, §35C, §32, §31)

This refiled bill would significantly alter the definition of the "average weekly wage" exclusively for Section 35C cases (latency claims). Under this bill, the surviving dependent of a worker that had died from an occupational illness or disease would receive compensation based upon the earnings of the last full time employment, regardless of whether that worker was earning wages at the time of death. According to the SJC's decision in the *McDonough's Case*, the widow of an employee who died as a result of past asbestos exposure was not entitled to receive compensation under Section 35C since the deceased had voluntarily retired in 1991 and was not receiving wages on the date of his death. Section 35C clearly states that "[w]hen there is a difference of five years or more between the date of injury and the initial date [of] eligib[ility] for benefits under section thirty-one...the applicable benefits shall be those in effect on the first date of eligibility for benefits."

Last legislative session, the Advisory Council was asked by the House Committee on Ways and Means to provide guidance on this bill. The Advisory Council discussed the bill at the April 9, 2008 Advisory Council meeting and was unable to reach a consensus in either support or opposition to the proposed legislation. The Advisory Council has been informed by the DIA that the passage of this bill could financially jeopardize the Workers' Compensation Trust Fund, which makes reimbursement payments to insurers for latency injuries.

SENATE BILL 694
Filed By: Senator Thomas M. McGee
Type of Bill: Refile (S.1076)
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 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*

CONTINUED ON NEXT PAGE

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 employer fails to make notice to the DIA, employee, and insurer, it must pay an additional penalty to the DIA of $1,000 into the Special Fund and $1,000 to the employee;
If 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 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.

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

CONTINUED ON NEXT PAGE

SENATE BILL 694 CONTINUED

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 addresses 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 the 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 of burial, not exceeding $4,000. This bill would increase the amount the insurer is required to pay for burial expenses to not 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 their average weekly wage. The 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 S.694 would delete this requirement.

Sections 16 and 17 would amend §34B pertaining to supplemental benefits for §31 or §34A.

CONTINUED ON NEXT PAGE

SENATE BILL 694 CONTINUED

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, under §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 durations allowed for §35 benefits. Currently, the maximum benefit period for partial disability is 260 weeks, but may be extended to 520 weeks. This bill increases the maximum benefit period to 442 weeks and could be extended at "the discretion of an AJ."

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 694 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) regarding the computation of a weekly wage. This section would disallow an employee's compensation rate to be decreased in any proceeding on the fact that an employee had enrolled or is participating in a vocational rehabilitation program, <u>whether or not</u> it is paid for by the insurer or the department.

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 695
Filed By: Senator Thomas M. McGee
Type of Bill: Refile (S.1079) / Identical to S.2011 (this session)
Endorsed by Advisory Council: No
Laws Affected: Benefits for Members of the Armed Services or National Guard (c.1, §7A)

This refiled bill would provide workers' compensation benefits to employees who previously sustained an emotional or physical injury in the U.S. Armed Forces or National Guard and subsequently receive a workplace injury which combines with, or is aggravated or prolonged by their injury in the military, "regardless of the extent to which the services related disability contributes." Current law requires that when an on-the-job injury or disease combines with a pre-existing condition (not compensable under Chapter 152), the resulting condition is only compensable to the extent such on-the-job injury or disease remains a major but not necessarily predominant cause of disability or need for treatment.

SENATE BILL 703
Filed By: Senator Michael W. Morrissey
Type of Bill: Refile (S.1082)
Endorsed by Advisory Council: No
Laws Affected: Authority for AJs to Determine Fraudulent Acts by Parties (c.152, §14)

This refiled bill would give an administrative judge the authority to determine whether a party defrauded or attempted to defraud another party. According to this legislation, the defrauding party would be assessed the whole costs of the proceedings, including attorney fees and a penalty (SAWW x 6) to the aggrieved party. Any employee, who received payments for compensation from a fraudulent claim, would be required to reimburse the insurer or self-insurer.

SENATE BILL 704
Filed By: Senator Michael W. Morrissey
Type of Bill: Refile (S.1081)
Endorsed by Advisory Council: No
Laws Affected: Definition of "Proceeding" for the Purpose of Fraudulent Acts (c.152, §14(2))

This refiled bill would define the word "proceeding" as used in Chapter 152, section 14(2). Under the proposed definition, a proceeding would include all actions by a party (including attorneys and medical experts acting on behalf of a party), at any time during and after the filing of a claim. Section 14(2) specifies the costs and penalties for illegal or fraudulent conduct at any 'proceeding.' Minimum penalties under this section include an amount not less than the average weekly wage multiplied by six ($1,093.27 x 6 = $6,559.62).

SENATE BILL 705
Filed By: Senator Michael W. Morrissey
Type of Bill: Refile (S.1080)
Endorsed by Advisory Council: No
Laws Affected: Definition of "Proceeding" for Purposes of Chapter 152 (c.152, §1)

This refiled bill would define the word "proceeding" as used in Chapter 152. Under the proposed definition, a proceeding would include conciliations, conferences, hearings and presentations to appellate courts. The definition would also include any actions by a party (including attorneys and medical experts acting on behalf of a party), at any time during and after the filing of a claim.

SENATE BILL 716
Filed By: Senator Bruce Tarr
Type of Bill: NEW
Endorsed by Advisory Council: No
Laws Affected: Actions Not Based on Reasonable Grounds (c.152, §14), Recordings at Hearings (c.152, §11), Modification or Discontinuation of Benefits (c.152, §8), Adequate and Reasonable Health Care Services (c.152, §30).

Section 1 of this new legislation clarifies what types of insurer practices should be considered as actions "not based on reasonable grounds." Under this bill, any insurer, who more than once in a five year period, contests the total and permanent disability of an employee, after a decision has been fully adjudicated in favor of the employee, must produce evidence of either:

- improvement in the condition of the employee;
- evidence that the employee has been working or otherwise behaving in a manner inconsistent with a total and permanent disability; or
- evidence of a significant advancement in medical science that has a substantial likelihood of affecting the total and permanent disability of the employee.

The failure by an insurer to produce evidence of one of the above shall be considered "an action not based on reasonable grounds," and would be subject to the penalties of §14.

Section 2 of Senate Bill 716 contains an error and does not properly clarify what section of the law should be addressed.

Section 3 of this legislation would require all hearings to be recorded by tape or video and copies or transcriptions made available to any party at a reasonable cost.

Section 4 of this legislation would remove clause (d) from c.152, §8, which allows an insurer to modify or discontinue benefit payments when the insurer has either a medical report that indicates the employee is capable of returning to work or modified work, or a written report from the employer indicating a suitable job is available.

Section 5 of Senate Bill 716 would prohibit an insurer from participating in the medical judgments of any utilization review process, except to provide necessary information at the request of utilization review agents.

SENATE BILL 718
Filed By: Senator James E. Timilty / Representative Kevin G. Honan
Type of Bill: Refile (S.1099)
Endorsed by Advisory Council: No
Laws Affected: Withholding Taxes on Wages (c.62B), Employment & Training (c.151A), Workers' Compensation Penalties (c.152 §25C)

This refiled legislation would institute penalties on employers who fail to withhold taxes on wages or pay into the Unemployment Compensation Fund. This bill also directly affects the Department of Industrial Accidents in regards to the Stop Work Order penalty provisions used against uninsured employers. The following is a brief summary of each section that directly affects the Department of Industrial Accidents.

Section 3 of this bill would replace §25C(1) with new language that would effect how stop work orders are calculated. Under this proposed language a stop work order would be calculated using the "first date of the employer's non-compliance" as the first day the $100/day penalty accrues. The present law starts the stop work order fine on the "date of service of the stop work order." This section would substantially increase the penalties issued to uninsured employers in virtually every case.

Section 4 of this bill would amend §25C(2), by creating a definitive time-frame on the appeal process for employers who appeal the imposition of a stop work order or civil penalty. The present statute only requires the DIA to grant a hearing within 14 days of receiving an appeal. Once an appeal is granted, there is presently no timeframe for a hearing to be scheduled or for a decision to be issued. This amended section would require the DIA to schedule a hearing on any appeal within 7 days of the filing of the appeal. This section would also require the DIA to issue a decision on any appeal within seven days of the date of the hearing. This section contains contradicting wording as written and may need to be rewritten.

Section 5 of this bill would amend §25C(4), in line 68, by clarifying the rate of payment an employer is required to pay their employees during the first 10 days that a stop work order has been in effect. This amended language would clarify that employees receive their "regular rate of pay, but in no event less than the minimum wage as required by state or federal wage and hour laws, whichever is higher."

Section 6 of this bill would amend §25C(5), in line 74, by requiring that the DIA deposit all monies collected from criminal convictions against uninsured employers into the Commonwealth's General Fund. Presently these penalties are deposited into the DIA's Trust Fund (75%) and the DIA's Special Fund (25%). The criminal penalties collected are used to offset employer assessments in subsequent years.

Section 7 of this bill would amend §25C(5), by increasing the maximum criminal penalties against uninsured employers from $1,500 to $305,000. There seems to be an error in the way this section is worded. To remain consistent with previous sections of this bill, it is likely the authors intended the maximum criminal penalty to be $3,500.

Section 8 of this bill would replace §25C(6), placing the burden on uninsured employers (who

CONTINUED ON NEXT PAGE

SENATE BILL 718 CONTINUED

have received a stop work order) to notify state or local licensing agencies of their stop work order when seeking such licenses or permits. Failure to provide such notification would void any issued license or permit.

Section 9 of this bill would replace §25C(7), placing the burden on uninsured employers (who have received a stop work order) to notify the Commonwealth or its subdivisions of their stop work order when seeking state contracts. Failure to provide such notification would void any state contract.

Section 10 of this bill would amend §25C(8), by requiring outstanding liens or judgments owed to the DIA to be considered a tax due to the Commonwealth, which may be collected through the procedures provided for by chapter 62C ("Administrative Provisions Relative to State Taxation").

Section 11 of this bill would amend §25C(9)(b), by eliminating the maximum award of $15,000 due to any person who wins a civil action against a competing employer who has won a competitive bid due to cost advantages achieved by deliberately misclassifying employees. This section would make the maximum award 10% of the total amount bid on the contract.

Section 12 of this bill would amend §25C(9)(e), by only allowing the prevailing plaintiff to collect monies for reasonable attorney fees and costs in actions brought by losing bidders. The present statute allows either party that prevails to collect monies for reasonable attorney fees.

Section 13 of this bill would add five additional subsections after §25C(10). The purpose of the first subsection (11) is unclear due to ambiguous wording. The second subsection (12) allows the DIA to issue a stop work order to an insured employer who hires additional workers but fails to properly report their wages in compliance with Chapter 62E. The third subsection (13) gives the Secretary of Labor and the DIA Commissioner powers to subpoena any employer's payroll and business records for the purpose of determining compliance to Chapter 152. Said employers would have 7 days to provide these records. The fourth subsection (14) requires inter-agency cooperation between the Department of Industrial Accidents and the Department of Revenue in providing immediate access to employer reports and notices submitted in accordance with Chapter 62E(2) with respect to hired employees or entering into agreements with contractors for the performance of services. The fifth subsection (15) requires the DIA to report any employer who fails to comply with Chapter 152 to the Department of Revenue and the Attorney General's Office for additional enforcement action.

SENATE BILL 728
Filed By: Senator Susan C. Tucker
Type of Bill: Refile (S.1112)
Endorsed by Advisory Council: No
Laws Affected: Falsifying or Forging WC Certificates & Declarations (c.267, §1)

Chapter 267, section 1, sets the punishment for any person who intends to injure or defraud by falsifying or forging specific public and legal documents. Senate Bill 728 would add two new documents to this list: "certificate of insurance" and "insurance declarations page." The current penalty for falsifying or forging documents is imprisonment in state prison for not more than ten years or jail for not more than two years.

SENATE BILL 729
Filed By: Senator Susan C. Tucker
Type of Bill: Refile (S.1111)
Endorsed by Advisory Council: YES
Laws Affected: Increasing Criminal Penalties for Failing to Provide WC Insurance (c.152, §25C)

This refiled bill would increase the severity of criminal penalties for employers who fail to provide workers' compensation coverage for their employees. Under this bill, employers convicted of criminal offenses, would be subject to minimum mandatory fines, imprisonment, or both. The maximum imprisonment sentence would be 5 years in state prison with a minimum imprisonment in the house of correction for not less than 6 months nor more than 2.5 years. The maximum criminal fine would increase to $10,000 with a minimum fine of $1,000. Current law limits criminal penalties at no more than $1,500 or by imprisonment for not more than 1 year, or both.

SENATE BILL 2011
Filed By: Senator Michael W. Morrissey
Type of Bill: Refile (S.1079) / Identical to S.695 (this session)
Endorsed by Advisory Council: No
Laws Affected: Benefits for Members of the Armed Services or National Guard (c.1, §7A)

This refiled bill would provide workers' compensation benefits to employees who previously sustained an emotional or physical injury in the U.S. Armed Forces or National Guard and subsequently receive a workplace injury which combines with, or is aggravated or prolonged by their injury in the military, "regardless of the extent to which the services related disability contributes." Current law requires that when an on-the-job injury or disease combines with a pre-existing condition (not compensable under Chapter 152), the resulting condition is only compensable to the extent such on-the-job injury or disease remains a major but not necessarily predominant cause of disability or need for treatment.

SENATE BILL 2375
Filed By: Senate Ways & Means
Type of Bill: Substitute Bill for Senate 682
Endorsed by Advisory Council: YES
Laws Affected: Private Right of Action to Recover Amounts not Paid (c.152, §25C)

On April 12, 2010, the Senate Ways & Means Committee substituted Senate Bill 2375 for Senate Bill 682. This legislation, which was signed into law by Governor Deval Patrick on August 9, 2010, would allow "any 3 persons" to bring a civil action against an employer to recover amounts which should have been paid by the employer pursuant to Chapter 152. At least 90 days prior to filing a civil action, the "three persons" are required to provide notice to the employer (and any insurer entitled to collect amounts no paid) regarding what might become the substance of the complaint and include a statement of intent to file suit. Once a civil action has been filed, any insurer that failed to file a complaint or seek arbitration is prohibited from attempting to recover or collect any amounts sought, unless the insurer obtains the voluntary and written approval from the plaintiffs.

Plaintiffs must prove a violation of Chapter 152 by a preponderance of the evidence. If the plaintiffs prevail in court, they are collectively entitled to recover 25% of the amount not paid or $25,000 (whichever is less), plus costs and reasonable attorney s' fees. The plaintiffs can recover an addition amount from the employer as compensatory and liquidated damages which shall be equal to 25% of the amount not paid or $25,000 (whichever is less). Any amounts recovered by the plaintiffs (with limited exceptions) will be deposited into the DIA's Workers' Compensation Trust Fund, unless the insurer has been substituted as the plaintiff.

Any actions filed under this new law can only be filed 90 days following the expiration of an affected workers' compensation policy (if such policy existed) and must be commenced within 6 years after the cause of action accrues. The bill exempts insurance contracts in effect on the effective date of this Act.

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL
1 Congress Street, Suite 100
Boston, MA 02114-2017
Phone: 617.727.4900 x378 • Fax: 617.727.1288
www.mass.gov/wcac