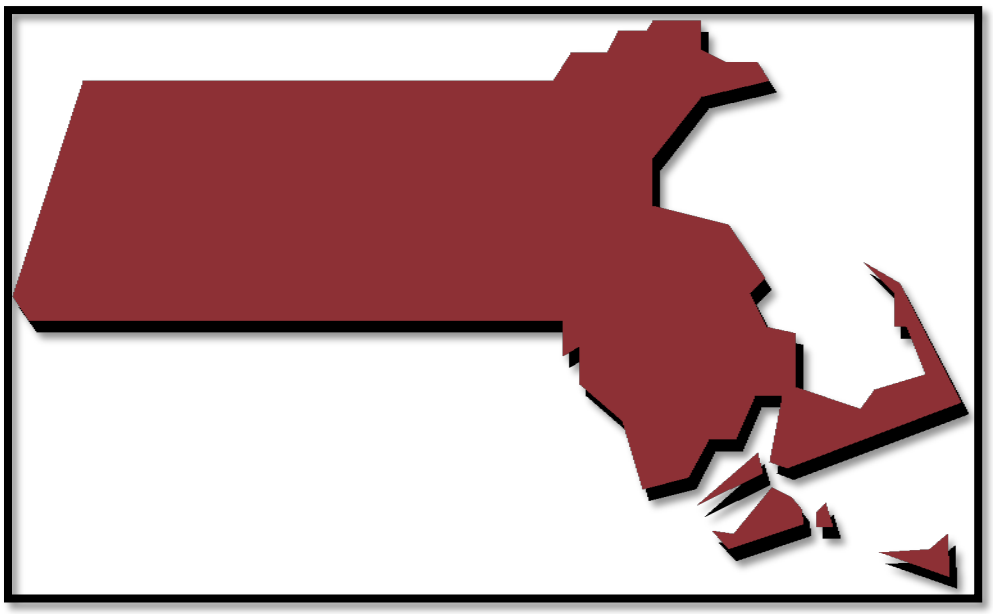
COMMONWEALTH OF MASSACHUSETTS

FISCAL YEAR 2011 ANNUAL REPORT

THE STATE OF THE MASSACHUSETTS WORKERS' COMPENSATION SYSTEM



MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

JANUARY 2012

THE STATE OF THE MASSACHUSETTS WORKERS' COMPENSATION SYSTEM

FISCAL YEAR 2011 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

WILLIAM S. MONNIN-BROWDER
EXECUTIVE DIRECTOR

January 11, 2012

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 the Council's Fiscal Year 2011 Annual Report: The State of the Massachusetts Workers' Compensation System.

The Advisory Council's Annual Report provides a detailed analysis of the workers' compensation system in Massachusetts. It includes an overview and discussion of the operations of the Department of Industrial Accidents (DIA), summaries of legislative initiatives and current statistics related to occupational illness and injury. The Advisory Council also identifies seven specific areas of concern and offers recommendations to enhance the workers' compensation system. Finally, the report recognizes significant achievements by the DIA and other related agencies and organizations in improving the system.

This report and its recommendations are a product of the commitment and contributions made by council members who volunteer their time to analyze a variety of workers' compensation issues with the ultimate goal of identifying problems and developing solutions. An affirmative vote of at least seven members of the Council is necessary for the Council to adopt a position or otherwise take action.

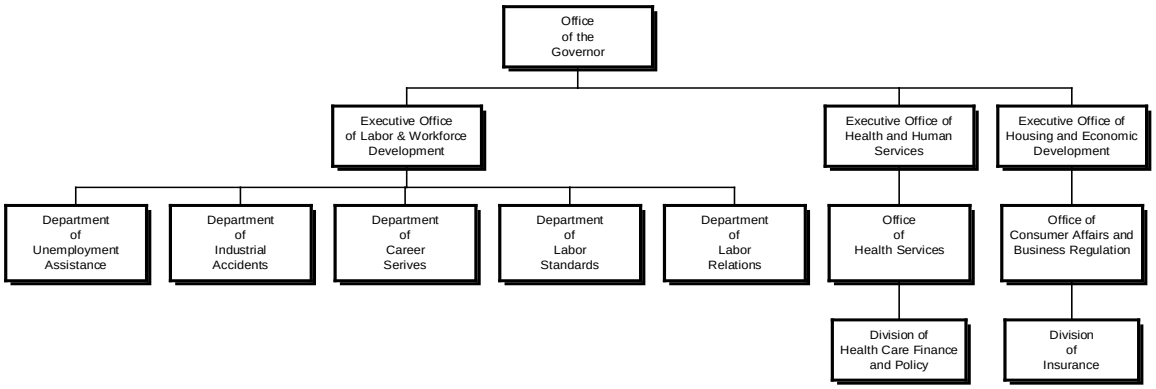
The Advisory Council hopes that this report will serve to highlight the successes of the past year and offer guidance to policymakers looking to improve the system. We look forward to working with you in the future and continuing our shared mission to improve services to injured workers, employers and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

Very truly yours,

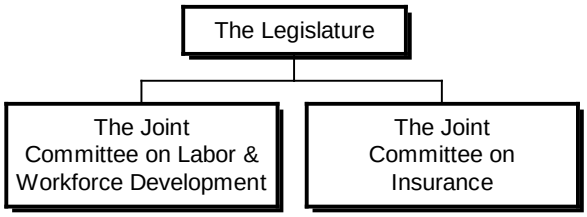
William S. Monnin-Browder
Executive Director

Government Regulation of Workers' Compensation

Executive Branch



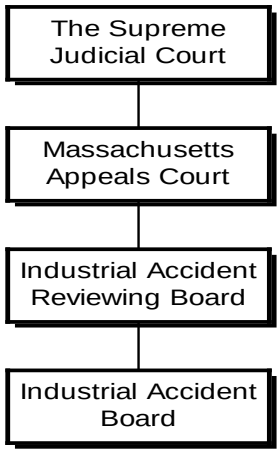
Legislative Branch



Oversight

Massachusetts Workers' Compensation Advisory Council

Appeals Process



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

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ADVISORY COUNCIL

This year marks the 100th anniversary of the Workers' Compensation Act. In 1911, the Massachusetts Legislature passed "An Act relative to payments to employees for personal injuries received in the course of their employment and to the prevention of such injuries," establishing the workers' compensation system in Massachusetts. Since its inception, the objectives of the system have been to promote workplace safety, ensure that workers injured on the job receive sufficient medical care and compensation, and facilitate a prompt return to work. To address efficiency problems that arose in the 1970s and 1980s, two major reforms were passed, the first in 1985 and the second in 1991. As a result of these reforms, the system became more responsive to the issues of caring for injured workers, while providing employers and insurers with the mechanisms to control system costs.

As part of the 1985 reform, the Massachusetts Workers' Compensation Advisory Council (WCAC) was created.[1] The Council is comprised of 16 members who are appointed by the Governor for five-year terms. The membership consists of ten voting members, including five employee representatives (each of whom is a member of a duly recognized and independent employee organization) and five employer representatives (representing manufacturing classifications, small businesses, contracting classifications, and self-insured businesses); and six non-voting members, including one representative of the workers' compensation claimant's bar, one representative of the insurance industry, one representative of medical providers, one representative of vocational rehabilitation providers, the Secretary of Labor and Workforce Development (ex-officio), and the Secretary of Housing and Economic Development (ex-officio) (see Appendix A for complete list of current WCAC members).

The Council's mandate 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 B for a list of WCAC studies). Pursuant to the Act, the Advisory Council must issue an annual report evaluating the operations of the Department of Industrial Accidents (DIA) and the condition 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. An affirmative vote of at least seven members of the Council is necessary for the Council to adopt a position or otherwise take action.

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,

[1] An Act Relative to Workers' Compensation can be found in Chapter 572 of the Acts of 1985.

Boston, Massachusetts. Meetings are open to the general public pursuant to the Commonwealth's open meeting laws.

Advisory Council Studies

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

FISCAL YEAR 2011 IN REVIEW

During fiscal year 2011, the workers' compensation system in Massachusetts continued to experience changes that were influenced by outside economic factors, reduced caseloads, new laws and regulations, 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.

FY'11 marked another year of caseload reductions in three separate areas of dispute resolution at the Department of Industrial Accidents. During the fiscal year, decreases were recorded in employee claims (-2%), conciliations (-3%), and hearings (-9%), while conferences increased slightly (5%). With a decreased volume in caseloads at hearing, the DIA was able to maintain extremely low hearing queues, ensuring that injured workers and insurers received efficient and timely administration of justice.

On July 2, 2010, Governor Deval Patrick signed into law House Bill 4565, which bans the commercial use and sale of highly flammable wood floor finishing products.[2] Specifically, the new law targets lacquer sealer—a wood floor finishing product that can burst into flames at the slightest trigger. The Massachusetts Coalition for Occupational Safety and Health (MassCOSH) brought this issue to the attention of the Advisory Council after a string of deadly house fires in 2004 and 2005. MassCOSH spearheaded a Task Force comprised of labor, industry, and safety representatives, as well as members of the Vietnamese community to develop the legislation, which prohibits the use and sale of floor finishing products that ignite at temperatures less than 100 degrees.

On July 15, 2010, Attorney General Martha Coakley entered into a multi-million dollar agreement with Pittsburgh-based FedEx Ground for allegedly misclassifying drivers as independent contractors, which led to the underpayment of payroll taxes, workers' compensation premiums, and unemployment insurance contributions. The Attorney General's Office signed a settlement agreement with FedEx Ground recovering over $3 million, $442,000 of which has been earmarked for the DIA.

In early 2010, the DIA announced that they had signed a new lease, and would be relocating their Boston Regional Office in July, 2010 from 600 Washington Street, Boston, MA 02111 to 1 Congress Street, Boston, MA 02114. In order to expedite this transition with as little interruption as possible, the IT network (CMS and DMS) was shut down for several days. The DIA was closed to the public from Thursday, July 15, 2010 until Monday, July 19, 2010, and no cases were heard for the three days of the move. The DIA was back up and running and hearing cases in Boston and in the regions by Tuesday, July 20.

[2] An Act Relative to Floor Finishing Products can be found in Chapter 154 of the Acts of 2010.

On August 9, 2010, Governor Deval Patrick signed into law Senate Bill 2375, which creates a workers' compensation private right of action.[3] This legislation, endorsed by the Advisory Council, created a vehicle for private citizens and insurers to bring 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 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.

On September 1, 2010, *Risk and Insurance* magazine published an article, "Close Second Injury Funds,"[4] by Peter Rousmaniere, an expert in the field of workers' compensation, recommending the closure of Second Injury Funds (SIFs) in Massachusetts and New York. Rousmaniere argues that the SIF no longer serves its intended purpose, which is to encourage employers to hire workers with prior work related disabilities. The SIF is funded by an assessment charge on the employers' workers' compensation premium. One of the problems with SIFs is that all employers are required to contribute to the fund, yet only employers that are experience rated receive the adjustment. A related issue is that there is no mechanism in place to ensure that the employer is aware of the potential adjustment benefits that the employer is entitled to receive.

On September 8, 2010, the Office of Safety presented the Council with an overview of the revamped Safety Grant Program. Revisions to the program included streamlining the grant application, which allows the grant to be submitted and administered entirely online. Additionally, under the revised program, state agencies and vendors who train state employees will be ineligible to receive funds. The changes were made to increase accountability, broaden the reach of the program, and enhance the oversight of the grant, thereby enabling the DIA to track the progress of the trainings from beginning to end. Each year, the Office of Safety awards approximately $800,000 in safety grants to Massachusetts' employers to help fund programs that provide workplace safety training. In FY'11, the Office of Safety funded a total of 61 grants which resulted in the training of over 8,000 employees.

On October 28, 2010, the DIA issued an amended Circular Letter No. 335 easing the paperwork requirements for out-of-state contractors. The amendment followed the issuance of the original Circular Letter on August 26, 2010, which was to be utilized by businesses domiciled in other states but operating in Massachusetts. The insurance industry had two major concerns. First, the original form included a 10-day advanced notice of cancellation and insurers had no formal procedure in place for this type of scenario. Second, there was concern that the signature line contained language that could subject the insurer to perjury charges. The DIA agreed to remove both items from the form and reissued the amended Circular Letter on October 28, 2010.

On December 8, 2010, Advisory Council members voted to approve a three-part recommendation developed by the Professional Employers Organization (PEO)/Proof of

[3] An Act Further Regulating Workers' Compensation Insurance (also known as the "Private Right of Action Law") can be found in Chapter 285 of the Acts of 2010.

[4] Peter Rousmaniere, "Close Second Injury Funds," *Risk and Insurance*, September 1, 2010.

Coverage (POC) Subcommittee. The recommendation addressed the concern brought to the attention of the Advisory Council by the National Association of Professional Employer Organizations (NAPEO) during the August 11, 2010 Advisory Council Meeting. NAPEO explained that when performing a search in the POC tool, all the names of every client company appears within the search results. The three-part recommendation included the prevention of disclosure of the client list on the POC tool, a request that the Office of Investigations perform testing on the POC tool to determine whether client-companies are consistently being named on policies, and that the DIA partner with the Workers' Compensation Rating and Inspection Bureau (WCRIB) to remove the mandatory requirement that a user enter an employer's location into the POC search field for results.

On December 10, 2010, the Workers Compensation Research Institute (WCRI), an independent not-for-profit research organization that studies the workers' compensation benefit delivery systems nationwide, reported that medical payments per workers' compensation claim in Massachusetts were the lowest of the states they studied in 2007 for claims with 12 months experience and more than seven days of lost time. The study, *CompScope™ Medical Benchmarks for Massachusetts, 10th Edition,* studied 15 states injury claims between 2002-2007, collectively representing more than 50 percent of the nation's workers' compensation benefit payments, to analyze how the state systems compared to others and how they changed over time. The study showed that growth in medical costs per claim slowed after 2005, following several years of rapid growth. Several factors led to the lower cost per claim in Massachusetts in 2007, including lower payments to both hospital and nonhospital providers. Medical costs per claim in Massachusetts were 45 percent lower than in the typical study state in 2007.[5]

On December 17, 2010, American International Group, Inc. (AIG) entered into a 50-state settlement agreement requiring AIG to pay state insurance regulators $100 million in fines and additional assessments for their past role in underreporting workers' compensation premiums. AIG was also required to pay an additional $46.5 million to 26 states for back premium taxes and assessments which should have been paid had the company been properly reporting insurance premiums. The examination further found that AIG was in non-compliance with ratings, forms, and financial reporting laws. The settlement agreement was the result of a two-year multistate workers' compensation market conduct examination that determined AIG had wrongfully reported $2.1 billion worth of workers' compensation premiums as general or commercial automobile liability premiums between 1985 and 1996. Massachusetts is scheduled to receive $3.4 million in fines and penalties from the settlement, which will be deposited in the state's General Fund.

In December of 2010, the Commonwealth's Secretary of Labor and Workforce Development announced the continued expansion of the Bureau of Labor Statistics (BLS) Annual Survey of Occupational Injuries and Illnesses to include public sector employees through a cooperative agreement. During the last eight budget cycles, the

[5] Workers' Compensation Research Institute, *CompScope™ Medical Benchmarks for Massachusetts* (10th ed. 2010).

Division of Occupational Safety, which is now part of the Department of Labor Standards, has struggled to receive the necessary funds to cover the survey's administrative costs (approximately $75,000). In its Fiscal Year 2010 Annual Report, the Advisory Council voiced concern regarding the state not providing the necessary funding for the survey. At that time, the Advisory Council recommended that the state appropriate the essential funds to ensure that Massachusetts receives federal matching funds to continue its participation in this survey. The Advisory Council is pleased to see that the survey will continue with the expansion of public sector employees.

On January 19, 2011, members of the Massachusetts Bar Association met with the Advisory Council members to discuss the possible partial funding for a survey regarding the 28 Administrative Judges (AJs) and the Administrative Law Judges (ALJs) who oversee workers' compensation cases. The survey would evaluate judges on factors such as their knowledge of workers' compensation laws and procedures; knowledge of the rules of evidence; judicial demeanor and temperament; punctuality; timeliness of filing hearing decisions; and whether a judge exhibits bias toward claimants.

On Wednesday, January 26, 2011, Governor Deval Patrick released his FY'12 Budget Recommendation (House 1). The total amount appropriated for the operating expenses of the DIA was $19,106,544. The House 1 recommendation was $800,000 less than the final appropriation allocated to the DIA in FY'11 (representing a 4% decrease). In conjunction with the release of the House 1 Budget, Governor Patrick proposed Article 87, a Reorganization Plan to streamline the Executive Office of Labor and Workforce Development (EOLWD). Under the proposed plan, the Department of Labor and the Department of Workforce Development would be eliminated and their functions would be performed by EOLWD. All five EOLWD agencies, including the DIA, would report directly to the Secretary.

On February 8, 2011, the DIA distributed a formal report to the Advisory Council members regarding the impact fewer judges would have on the dispute resolution system. The report was conducted after the Advisory Council voiced concern relative to the appointment process of the AJs and ALJs. 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."

On February 16, 2011, Circular Letter No. 337 was released by the DIA. According to the Circular Letter, the DIA would institute a new contract with its Impartial Medical Examiners, pursuant to M.G.L. c. 152, §11A. For the first time since 1986, the contract increases the fees for conducting the deposition of an Impartial Medical Examiner. The new fee structure increases the amount paid to the Impartial Medical Examiner for a deposition lasting up to two hours from $500 to $700, with an additional $150 when the deposition exceeds two hours. The new fee schedule took effect on July 1, 2011.

On February 22, 2011, the Massachusetts Court of Appeals sided with the DIA in an ongoing public records lawsuit. In its decision *Georgiou v. Commissioner of the*

Department of Industrial Accidents,[6] the appellate court upheld a lower court's determination that the name and address of injured employees reported to the DIA are within the privacy exemption of "public records," and therefore are not subject to public disclosure. From the 1990s to 2003, a select group of attorneys requested and received monthly printouts from the DIA listing names and addresses contained within the First Report of Injury (FRI). The printouts were used by the law firms to directly mail information about their services to the injured worker.

On March 3, 2011, the Fiscal Year 2012 Budget Subcommittee met to review Governor Deval Patrick's House 1 Budget Recommendation. The Budget Subcommittee expressed concern over Section 160 of Governor Patrick's proposed Article 87 Reorganization Plan (H.39), which requires the DIA and the Department of Labor Relations to transfer employees, proceedings, rules and regulations, property, and legal obligations to EOLWD. The members of the Advisory Council explained that the funding structure for the DIA is unique in that employer assessments, not state funds, pay for its operations. Another issue of concern was Outside Section 17, which would have enabled the Governor to appoint fewer than the number of DIA judges currently authorized by statute and the effect this reduction would have on the DIA's operations. At that time, the Subcommittee chose not to forward any recommendations to the full Advisory Council. The Subcommittee agreed to continue monitoring the FY'12 budget process and reserved its right to make future recommendations.

On March 11, 2011, the House and the Senate enacted House Bill 39, *"*An Act Reorganizing the Executive Office of Labor and Workforce Development."[7] Article 87 of the Massachusetts Constitution authorizes the Governor to file reorganization plans for the purpose of "transferring, abolishing, consolidating or coordinating the whole or any part of any agency, or the functions, within the executive department." The plan took effect 60 calendar days following the date it was filed by the Governor.

On April 12, 2011, Joseph G. Murphy, the Insurance Commissioner of Massachusetts, signed a rate stipulation that holds workers' compensation rates at their current levels until at least September of 2012. The stipulation will save the Commonwealth's employer community an estimated $65 million in proposed increases. The stipulation was based on an agreement reached between the WCRIB, the Division of Insurance's State Rating Bureau and the Attorney General's Office.

On April 28, 2011, Workers' Memorial Day was observed in Massachusetts to honor those workers killed or injured on the job. Coinciding with Workers' Memorial Day was the release of a statewide occupational fatality report sponsored by the Massachusetts AFL-CIO, MassCOSH and Western Massachusetts Coalition for Occupational Safety and Health (Western MassCOSH). 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 2010, 51 workers in Massachusetts died on the job.

[6] Georigiou v. Comm'r of the Dep't of Indus. Accidents, 78 Mass. App. Ct. 1128 (2011).
[7] Chapter 3 of the Acts of 2011.

On May 19, 2011, the Joint Committee on Labor and Workforce Development held a public hearing on legislation related to workers' compensation. At the hearing, a representative from the Advisory Council testified in support of seven workers' compensation bills. The bills supported by the Advisory Council included legislation instituting civil fines against employers who fail to notify their employees of workers' compensation coverage (H.542), creating penalties for employers who fail to timely report injuries (H.1405), increasing the maximum burial allowance (H.1406), establishing premium avoidance fines that charge uninsured employers 3-times the premium for the entire period it operated without insurance (H.2308), increasing criminal penalties against uninsured employers (S.915 and S.938), and restoring scar-based disfigurement benefits (S.927).

On June 3, 2011, the Workers' Compensation Selection Subcommittee identified eight candidates to be interviewed for the recently vacated WCAC Executive Director position. The subcommittee suggested that a series of questions be forwarded to each applicant in advance, instructing the candidates to provide a written response to one of the questions. This request was made to assist Advisory Council members in reviewing a sample of the applicant's writing. After interviewing the candidates and much deliberation, the Council met in Executive Session and recommended the name of one candidate to be forwarded to the Secretary of the EOLWD.

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 Funding

The DIA became an employer-funded agency in 1985. 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). The DIA's budget, therefore, has no financial impact on the state's General Fund. Nevertheless, policymakers often misidentify the DIA's budget as being drawn on the General Fund. 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-funded 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 failure of policymakers to provide adequate funding to the DIA 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 that could have 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 through assessments.

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 its 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 continues to be tested.

The Advisory Council remains concerned that, during the Commonwealth's budget process, the DIA's account continues to be treated as a tax-funded agency rather than an assessment-funded agency. This common misconception that the DIA is a tax-funded agency leads policymakers to believe that by reducing the DIA's funding, it will help alleviate budget shortfalls in Massachusetts. The DIA's Special Fund line-item in the Fiscal Year 2012 General Appropriations Act (GAA), as signed by Governor Deval Patrick, was $800,000 less than the amount appropriated in the Fiscal Year 2011 GAA.

In conjunction with the FY'12 budget recommendation, Governor Patrick proposed an Article 87 Reorganization Plan (House Bill 39) to streamline the Executive Office of Labor and Workforce Development, which was later approved by the Legislature. While the plan is a well-intended budget management and cost saving measure for tax-funded agencies, Council members expressed concern regarding the potential impact of financial shared services on the DIA. Specifically, given the DIA's status as an employer-funded agency, the Council is concerned with how costs associated with DIA operations at the Secretariat level will be charged back to the agency.

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 injured workers 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 provide efficient and effective services by retaining appropriate staffing levels.

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 ascertained to adequately fund the operations of the DIA. DIA funding maintains no reliance on state tax dollars; therefore, 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 FY'12 budget process, attempts were made by policymakers to amend the General Laws with language that would allow the Governor to appoint fewer than the

number of Administrative Judges (AJs) and Administrative Law Judges (ALJs) presently authorized by statute. The primary objective of workers' compensation is to provide an effective delivery system to all parties with the prompt adjudication of claims. The proposed reduction in the number of DIA judges threatens access to the swift adjudication for all parties involved and the long term impact could be particularly alarming. At first glance, with the DIA caseloads having significantly declined over the last two decades, a reduction in judicial staffing appears to make sense. However, a more careful look at the current case timeframes and the complex characteristics of modern claims indicates that proposed reductions to judicial staffing levels may be without merit and could have adverse effects on the system. A comprehensive look at the development of the agency is necessary before any decisions concerning changes to system should be made.

In 1985, the workers' compensation system was facing a growing backlog of claims, lengthy dispute resolution delays, and escalating workers' compensation insurance premiums. In order to rectify these problems, the legislature passed a law creating a temporary recall of 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. In an effort to bring dispute resolution delays under control and 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 one-year recall rights. By the end of 1993, 32 AJs were actively hearing cases at the DIA.

Currently, the workers' compensation system runs both effectively and efficiently, having no resemblance to the broken system of nearly 20 years ago. Since 1999, with just 21 AJs covering five offices, the volume of annually scheduled hearings have remained at approximately 5,500 with backlogs no longer existing. The average timeframe for a case to appear before a judge following the conciliation is approximately 8 to 12 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.

During 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 performance.

3. 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, the statute's 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 $52 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 FY'11, the Trust Fund disbursed $22,299,988 for SIF reimbursements and made payments on 271 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 84 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*.[8] The issue before the SJC was whether the lower courts erred in finding that the "Mid Act" Section 37 claims (filed between December 10, 1985 and December 23, 1991) 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

[8] Kim Oakes's Case, 451 Mass. 190 (2008); Steven Alves's Case, 451 Mass. 171 (2008).

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'11, there were over 351 pre-1991 cases filed with the Trust Fund.

National Trends - Since the early 1990s, at least 20 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 be 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.

4. Employer Fraud - Misclassification & Uninsured Employers

Employer fraud has a negative impact on honest employers, as well as the public sector. Employers obtain an unfair advantage over competitors when they intentionally misclassify their employees or operate without workers' compensation insurance altogether, costing 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 five years, Massachusetts has made great strides at curbing employer fraud. In March of 2008, Governor Deval Patrick issued Executive Order No. 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. On September 19, 2011 the United States Department of Labor and several state agencies joined together to attack this growing problem by signing a Memo of Understanding (MOU) pledging to work together to address the misclassification of employees.

In August of 2011, 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 steps 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.

4.1 Increase Stop Work Order Fines – 3x Premium Avoided - 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. Pursuant to M.G.L. c. 152, 25(c), 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.

The Advisory Council recommends that the legislature pass House Bill 2308, filed by Representative Tom Sannicandro on behalf of the Advisory Council. On employers caught operating without workers' compensation insurance, this bill would replace the present flat fine of $100 per day with a premium avoidance fine of 3-times the premium the violating employer would have paid in the assigned risk pool for the entire period it operated without insurance. If the period is seven days or less, the fine imposed would total $250 for each day the employer lacked insurance. The proposed legislation also deletes the provision requiring that a higher fine be charged to employers who appeal a stop work order to an administrative hearing.

It has been 24 years since civil penalties for operating without insurance were last updated. The current flat-fine levied against uninsured employers is not sufficiently punitive to deter employers from violating the mandate to obtain workers' compensation coverage. Accordingly, over the last five years, the DIA's Trust Fund has paid out in excess of $33 million in benefits to injured workers' of uninsured employers. Massachusetts needs to make some changes if it wants the system to operate more efficiently. Currently, at least 15 other states are utilizing some form of premium avoidance fine on employers operating without workers' compensation insurance. The proposed legislation bases the fine on a "sliding scale" so that employers who have avoided greater amounts of premiums would be subject to a larger fine than employers that have avoided smaller amounts of premium. The purpose of the bill is to curtail the abuse by dishonest employers who fail to carry mandatory workers' compensation insurance for their employees.

4.2 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. Established in 1987, criminal penalties are capped at $1,500 and up to one year imprisonment. During the 2011-2012 Legislative Session, three identical bills supported by the Advisory Council were re-filed (Senate Bill 915 filed by Katherine Clark, Senate Bill 938 filed by Senator Thomas M. McGee and House Bill 468 filed by Representative Ronald Mariano). This re-filed legislation would significantly increase the severity of criminal penalties that can be levied against uninsured employers. On criminal convictions, the bill would allow a judge to assess fines up to $10,000 and five years imprisonment.

Created nearly 25 years ago, the present fine structure in Massachusetts is outdated and insufficient. The Advisory Council continues to support legislation to increase the severity of criminal penalties for uninsured employers. 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.

4.3 Pursue Civil Actions In and Out of State to Recover Monies Paid by the Trust Fund on Uninsured Claims - 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 DIA, then, pursues uninsured employers to recoup monies paid out from the Trust Fund. Recognizing the significant impact of these uninsured claims on the Trust Fund, the Council urges continued vigilance by the DIA in pursuing these uninsured employers, both in and out of state.

4.4 Increase Public Awareness - The DIA has active investigation and civil litigation units that pursue employers who fail to provide their employees with workers' compensation coverage. In addition to continuing these efforts, the Council recommends that the DIA pursue public awareness strategies to ensure that anyone who employs people in Massachusetts is aware that: (1) they are required to provide workers' compensation coverage to their employees and (2) if they fail to provide that coverage, they will be subject to penalties.

5. Employee Benefits

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

5.1 Restore Scar-Based Disfigurement Benefits - On May 19, 2011, the Advisory Council testified before the Joint Committee on Labor and Workforce Development advocating for the passage of Senate Bill 927 filed by Senator John Hart, Jr. Under the 1991 Reform Act, scar-based disfigurement benefits are limited to only disfigurement appearing on the face, neck and hands. Senate Bill 927 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, to obtain an estimate of the cost-impact of restoring scar-based disfigurement benefits awards to their pre-1991 levels, the Advisory Council contracted with the actuarial firm Tillinghast - Towers Perrin. 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 FY'07, 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 Workers'

Compensation Rating and Insurance Bureau of Massachusetts (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 previous legislative sessions, the Advisory Council remains committed in its support of restoring this benefit to the injured worker. The Advisory Council is recommending that Senate Bill 927 be 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.

5.2 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. The maximum burial allowance for the dependents of deceased workers is one such benefit. 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."[9] This amount has not been adjusted since 1991. In 2010, a total of 51 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 of costs, it is important that Massachusetts look to the most pertinent available data in determining an appropriate maximum benefit. The Advisory Council is recommending that House Bill 1406, filed by Representative David Torrisi, be 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.

[9] M.G.L. c.152, §33.

6. Employer Responsibilities

Workers' compensation insurance does more than provide indemnity and medical benefits to injured employees; it also protects employers from personal injury lawsuits. A wide range of employer responsibilities come with these protections. Although the penalties for violating these responsibilities are often negligible, their effect can have great implications on the speed with 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.

6.1 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 expires.[10] 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. Oftentimes, employees do not know of their workplace rights or protections, which results in compensable injuries going unreported.

The Advisory Council is recommending that House Bill 542, filed by Representative Tom Sannicandro, be passed during the 2011-2012 Legislative Session. This legislation 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.

6.2 Strengthen Injury Reporting Compliance - The timely reporting of injuries is another employer responsibility that requires attention. 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.[11] 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 FY'11, the DIA collected $133,926 in fines stemming from late or unreported injuries, representing a 15% increase from the prior year. From the 30,820 FRIs processed in the fiscal year, only 31% were filed online.

[10] M.G.L. c.152, §22.
[11] M.G.L. c.152, §6.

The Advisory Council continues to support House Bill 1405, filed by Representative David Torrisi 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. This equates to savings for the employer and prompt benefit payments to the injured worker. The Advisory Council is recommending that House Bill 1405 be 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.

7. Medical Fee Schedule Task Force

The Division of Health Care Finance and Policy's (DHCFPs) mandate is to establish public 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 determined. 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 system. 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 - In 1992, following a host of reforms during the late 1980s and early 1990s, Rhode Island created a Fee Schedule Task Force consisting of a diverse group of representatives from the state's Department of Labor and 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. The Task Force offers a forum to continually enhance the fee schedule and expand codes when necessary. The Task Force has achieved many accomplishments since its inception, 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 created in Rhode Island. A total of 15 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 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 2011-2012 Legislative Session, approximately 28 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 and Workforce Development (JCLWD) (see Appendix C for a complete list of JCLWD members).

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 2011-2012 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 2308 (Rep. Sannicandro) - Stop Work Order Fines/DIA Investigative Powers

House Bill 468 (Rep. Mariano), **Senate Bill 915** (Sen. Clark) and **Senate Bill 988** (Sen. McGee) - Increasing Criminal Penalties

Senate Bill 927 (Sen. Hart) - Scar-Based Disfigurement Benefits

House Bill 1406 (Rep. Torrisi) - Increasing the Maximum Burial Allowance

House Bill 1405 (Rep. Torrisi) - Penalties for Failing to Timely Report Injuries

House Bill 542 (Rep. Sannicandro) - Civil Fines for Failing to Notify Employees of Coverage

House Bill 2308 (Rep. Sannicandro) - Stop Work Order Fine/3x Premium Avoidance

Public Hearing on Workers' Compensation Legislation

On May 19, 2011, the JCLWD held a public hearing on legislation related to workers' compensation. At this hearing, a representative from the Advisory Council testified in support of seven workers' compensation bills that were endorsed by the Advisory Council (see Appendix H for Advisory Council testimony).

Next, the JCLWD will review the merits of each bill and make 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 various relevant committees for further review. As of the halfway point of the 2011-2012 Legislative Session, the JCLWD has reported out one piece of legislation supported by the Advisory Council. House Bill

1406, filed by Representative David Torrisi, was reported favorably and referred to the House Committee on Ways and Means.

SECTION - 2 -

OVERVIEW

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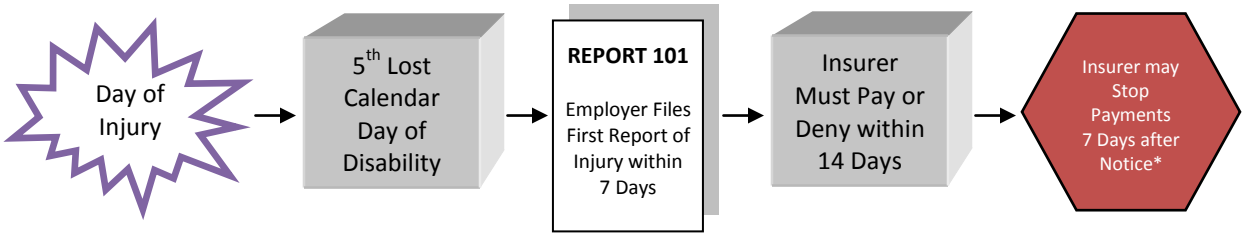
PROVISIONS TO RESOLVE DISPUTES

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 (FRI). 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.[12] Failure to file, or timely file, an FRI 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.

The insurer then has 14 days upon receipt of the employer's FRI to either pay the claim or to notify the DIA, the employer, and the employee of their refusal to pay.[13] 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.[14] 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.

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

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

[13] 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.

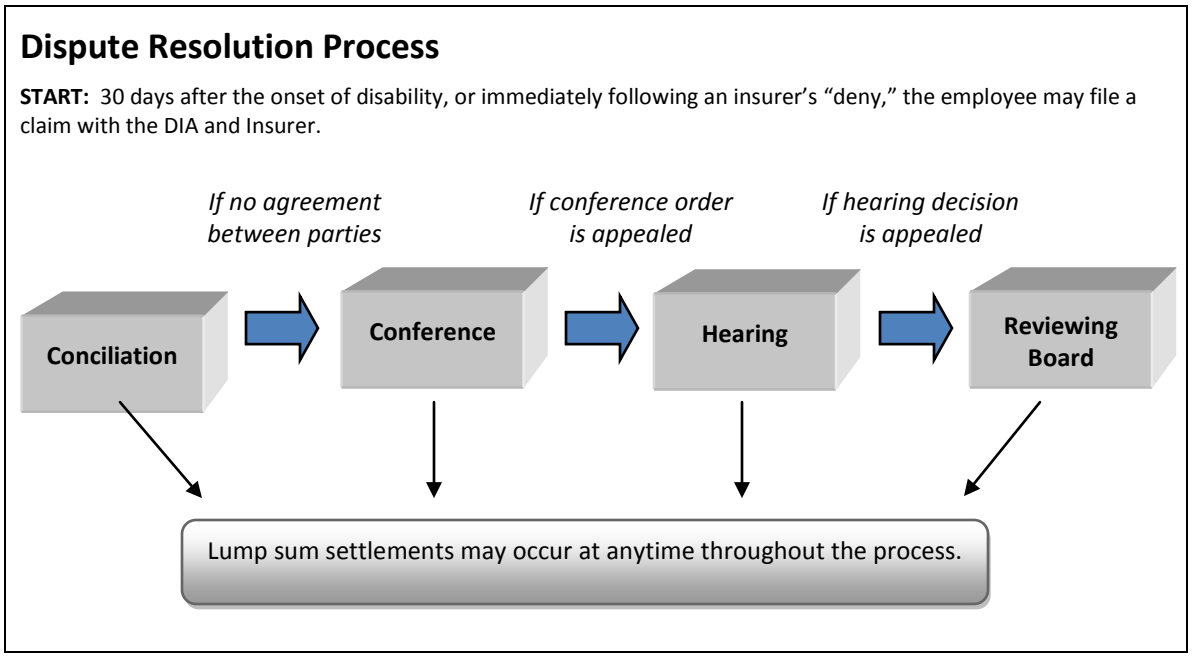
[14] The insurer does not need permission from the DIA to terminate or reduce benefits during the 180 day "pay without prejudice" period if said change is based on actual income of the employee or if it gives the employee and the DIA at least seven days written notice of its intent to stop or modify 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.

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 Judges (ALJs) will hear the case.

At the reviewing board, a panel of three ALJs review the evidence presented at the hearing. The ALJs 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 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 employee.

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. AJs and ALJs 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 is 100% of the State Average Weekly Wage (SAWW) and that the minimum benefit is 20% of the SAWW.[15] 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 maximum and minimum benefit levels for §34 and §34A claims since 1995. In October of 2011, the SAWW increased to $1,135.92, a 4.4% ($47.76) increase from the previous year.

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
10/1/11	**$1,135.82**	**$227.16**

Source: DIA Circular Letter No. 339 - Table I (October 3, 2011)

[15] SAWW is determined under M.G.L. c.151A, §29(2) and promulgated by the Commissioner of Unemployment Assistance.

Indemnity and Supplemental Benefits

The following are the various forms of indemnity and supplemental benefits employees may receive depending on their AWW, SAWW, and their degree of disability:

Temporary Total Disability (§34) - Compensation will be 60% of the employee's AWW before injury, while remaining above the minimum and below the maximum payments that are set for each form of compensation. For claims involving injuries occurring on or after October 1, 2011, the maximum weekly compensation rate is $1,135.82 (100% of the SAWW) and the minimum rate is $227.16 (20% of the SAWW). The limit for temporary benefits is 156 weeks.

Partial Disability (§35) - Compensation is 60% of the difference between the employee's AWW before the injury and the weekly wage earning capacity after the injury. This amount cannot exceed 75% of temporary benefits under §34 if they were to receive those benefits. The maximum 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 employee's AWW following the exhaustion of temporary (§34) and partial (§35) payments. For claims involving injuries occurring on or after October 1, 2011, the maximum weekly compensation rate is $1,135.82 (100% of the SAWW) and the minimum rate is $227.16 (20% of the SAWW). The payments must be adjusted each year for cost of living allowances (COLA).

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 SAWW 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 SAWW plus any 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. Pursuant to subsection 10 of that section, the dollar amounts specified in subsections (1) through (6), inclusive, shall be changed October 1st of each year to reflect adjustments to the SAWW. Below is a summary of the current 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 **$1,062.34** plus necessary expenses. If the employee's attorney fails to appear at a scheduled conciliation, the amount paid is **$531.17**.

(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 **$1,517.62**. The AJ 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 **$758.81**.

(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 **$757.90** plus necessary expenses. This fee can be reduced to **$378.95** 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 AJ 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 **$1,062.34** 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 **$531.17** 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 **$5,311.62** plus necessary expenses. An AJ 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 AJ 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 **$1,517.62**. An AJ 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.....**39**

Occupational Fatalities.....**42**

OCCUPATIONAL INJURIES AND ILLNESSES

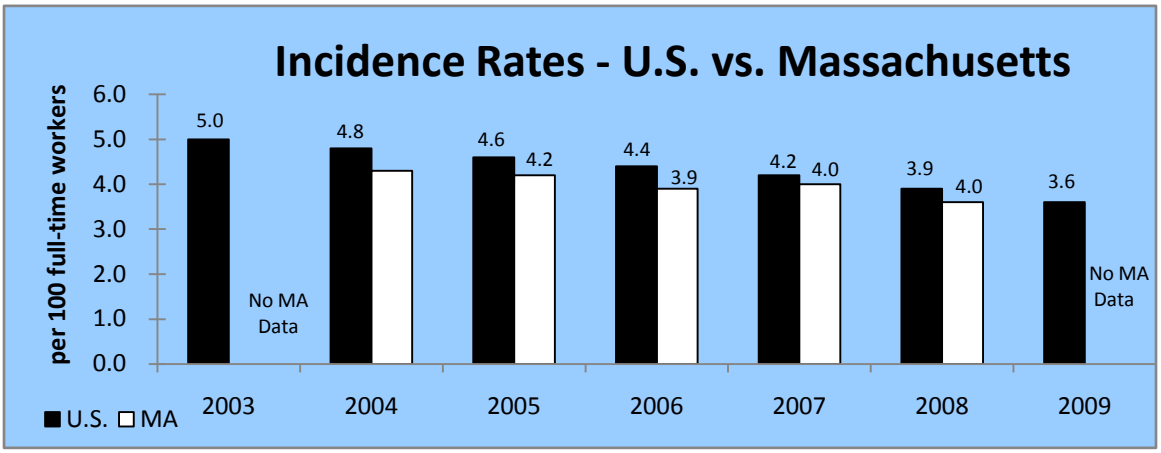
Since 1992, the Massachusetts Department of Labor Standards, formally the Division of Occupational Safety, has been in a partnership with the U.S. Department of Labor, Bureau of Labor Statistics (BLS), in an effort to collect injury and illness data in a uniform format. Throughout the country, surveys 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 and federal 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 2009, Massachusetts had a population of 6,547,629 people with an estimated private sector workforce of 3,228,000 workers.

During 2009, the private sector workforce in the U.S. experienced approximately 3.3 million non-fatal injuries and illnesses, resulting in an incidence rate of 3.6 cases per 100 full-time workers. The graph below shows how occupational injury and illness rates have steadily declined at both the national level and within Massachusetts from 2003 to 2009. The graph also displays how incidence rates in Massachusetts have consistently remained lower than national rates.

Figure 3: Incidence Rates - U.S. vs. Massachusetts, 2003 - 2009



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 2003-2009 (Private Industry)

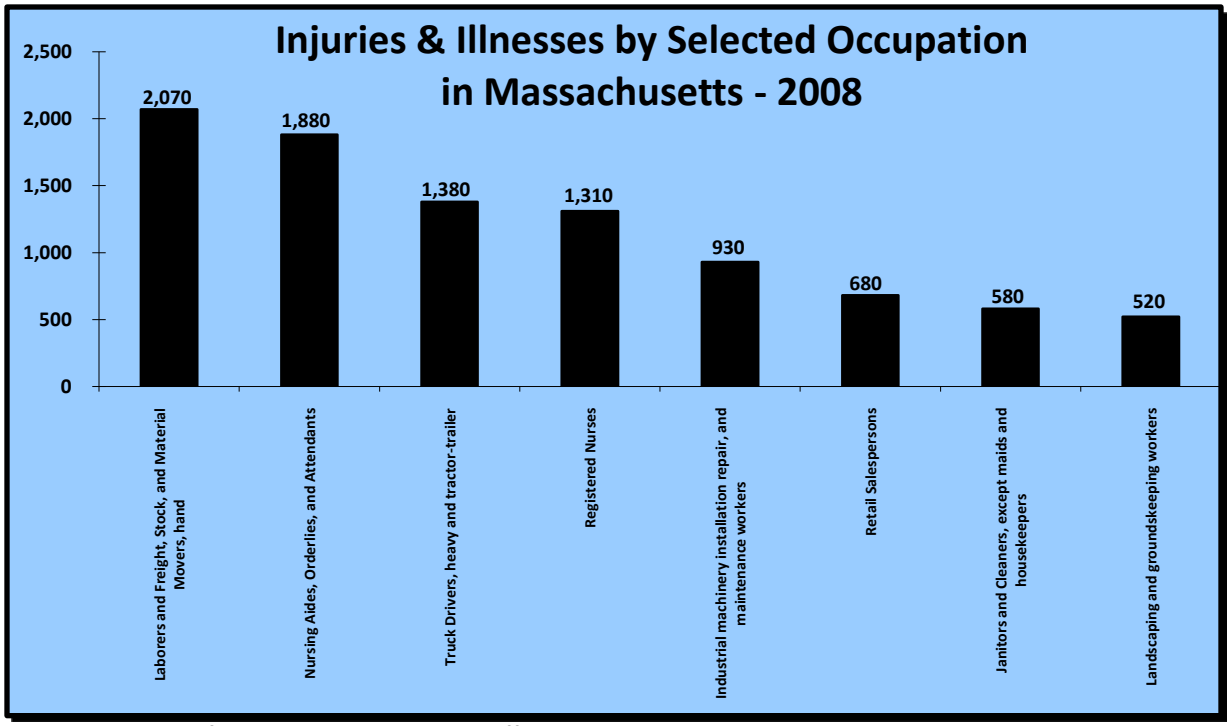
Region	2009	2008	2007	2006	2005	2004	2003
United States……	3.6	3.9	4.2	4.4	4.6	4.8	5.0
Massachusetts…..	no data	3.6	4.0	3.9	4.2	4.3	no data
Connecticut……..	4.2	4.6	4.8	4.8	5.0	4.8	5.1
Maine……..	5.6	6.0	6.4	7.0	7.2	6.9	7.7
Rhode Island……	no data	no data	5.1	5.2	5.5	5.2	5.4
Vermont……..	5.2	5.5	5.9	5.5	6.2	5.8	5.2
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 2003-2009

MASSACHUSETTS (Selected Industry Division)	2009	2008	2007	2006	2005	2004	2003
Private Industry:	**no data**	**3.6**	**4.0**	**3.9**	**4.2**	**4.3**	**no data**
Construction:	no data	4.8	6.1	6.4	6.5	6.9	no data
Trade, Transportation & Utilities:	no data	4.3	5.1	4.8	5.4	5.2	no data
Retail trade:	no data	4.3	5.5	4.7	5.2	4.7	no data
Agriculture, forestry, and fishing:	no data	9.3	5.4	5.9	5.0	4.5	no data
Wholesale trade:	no data	3.2	2.9	4.0	4.5	4.2	no data
Manufacturing:	no data	3.5	3.8	4.1	4.2	4.5	no data
Financial Activities:	no data	0.9	1.3	0.9	1.2	1.2	no data

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 2010, a total of 4,547 work-related fatalities were recorded nationally by the program, representing a <1% decrease from the revised total of 4,551 fatalities in 2009. The national rate of fatal work injuries in 2010 was 3.5 per 100,000 workers, the same as the final rate for 2009. The overall fatal work injury rate for the U.S. in 2010 was at its lowest level since the fatality census was first conducted in 1992.

Workplace Fatalities in Massachusetts

In 2010, Massachusetts experienced 51 workplace fatalities, 13 fewer fatalities than recorded in 2009. The leading cause of workplace death in Massachusetts came from falls (15) and transportation incidents (14) in which 29 workers were killed. Nationally, transportation incidents were the leading cause of on-the-job fatalities, accounting for 40% of the fatal work injuries in 2010. Following falls and transportation incidents, Massachusetts workers were killed by assaults and violent acts (12), exposure to harmful substances or environments (5) and contact with objects and equipment (4).

Figure 5: Fatal Occupational Injuries by State and Event or Exposure, 2010 (Northeast Region)

State of Fatality	Total Fatalities		Event or Exposure (state total for 2010)					
	2009 (Revised)	2010 (Prelim.)	Transportation Incidents	Assaults & Violent Acts	Contact with Objects & Equipment	Falls	Exposure to Harmful Substances	Fires & Explosions
U.S. Total.....	4,551	4,547	1,766	808	732	635	409	107
Massachusetts....	64	51	14	12	4	15	5	--
Connecticut.....	34	49	11	17	3	5	4	8
Maine.....	16	19	12	--	3	3	--	--
New Hampshire..	6	5	--	--	--	--	--	--
Rhode Island.....	7	9	--	4	--	--	--	--
Vermont.....	12	13	7	--	3	--	--	--

Source: Bureau of Labor Statistics, News-USDL-11-1247

SECTION
- 4 -

DISPUTE RESOLUTION

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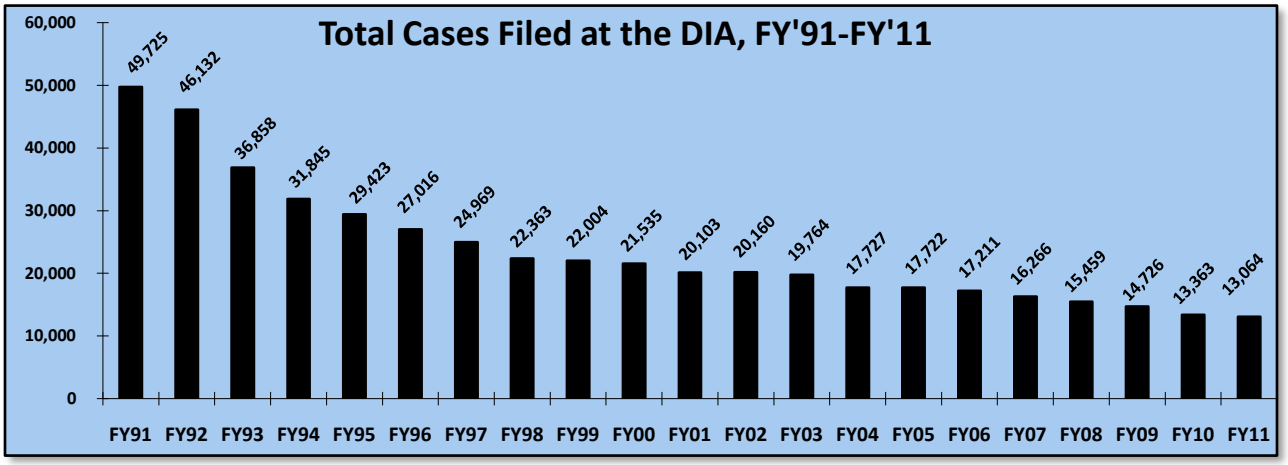
CASES FILED AT THE DIA

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 (-74%) in the DIA caseload since the implementation of the 1991 Reform Act. In FY'11, the total number of cases filed at the DIA was 13,064, a decrease of 2.2% from the previous fiscal year.

Figure 6: Total Cases Filed at the DIA, FY'91 - FY'11



Source: CMS Report 28

Employee claims, which account for 79% of the total cases filed at the DIA, decreased by 55 cases (-.5%) in FY'11. 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 15% of the total cases and decreased by 148 cases in FY'11. Since the 1991 Reform Act, these requests by insurers to discontinue or modify benefits have decreased by 83%.

Table 4: Breakdown of Total Cases Filed at the DIA, Fiscal Year 2011 and Fiscal Year 2010

Total Cases Filed at the DIA FY'11 and FY'10	*Number of Cases*		*Percentage*	
	FY'11	**FY'10**	**FY'11**	**FY'10**
Employee Claims	10,296	10,241	78.8%	76.6%
Insurer's Request for Discontinuance	1,991	2,139	15.2%	16.0%
Lump Sum Conference Request	402	545	3.1%	4.1%
Third Party Claims	104	159	<1%	1.2%
Section 37/37A Request	271	279	2.1%	2.1%
TOTALS:	**13,064**	**13,363**	**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 44% 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 56% 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.

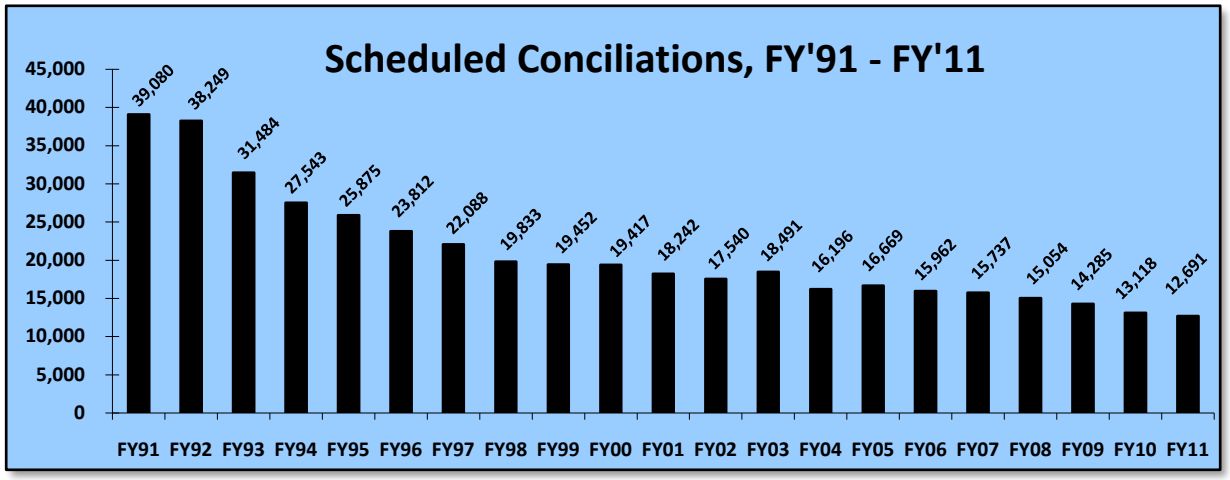
When liability is not an issue but modification or discontinuance of benefits is sought, both parties are required to submit written settlement offers. If the employee fails to file, the conciliator must record either the last offer made by the employee or the maximum compensation rate. If the insurer 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'11, there were 12,691 cases scheduled for conciliation, which represents a 68% decrease since the Workers' Compensation Reform Act of 1991.

Figure 7 displays the number of cases scheduled for conciliation at the DIA beginning in FY'91. In FY'11, the volume of cases scheduled for conciliation decreased by 3% (427 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'11

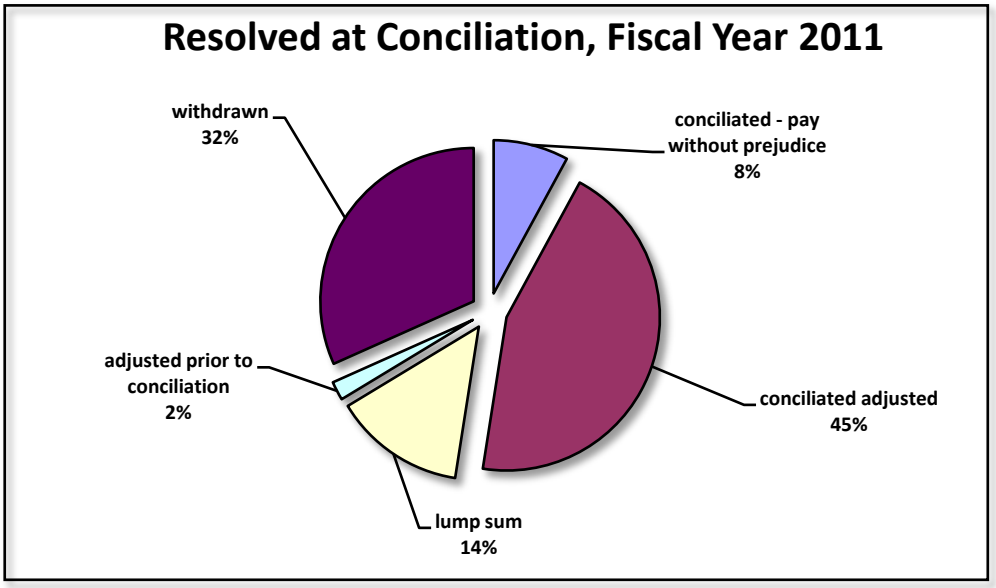


Source: CMS Report 17

Resolved at Conciliation

Disputed cases that are scheduled for conciliation can be divided into two distinct outcomes: "referred to conference" or "resolved." In FY'11, 5,632 cases were resolved (they were not referred on to a conference) and exited the dispute resolution system. Approximately 44% of cases that are scheduled for conciliation are resolved while the remaining 56% 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: Chart Detailing Cases Resolved at Conciliation, Fiscal Year 2011



Source: CMS Report 17

Table 5: Resolved at Conciliation, Fiscal Year 2011 and Fiscal Year 2010

Resolved at Conciliation FY'11 and FY'10	*Number of Cases*		*Percentage*	
	FY'11	**FY'10**	**FY'11**	**FY'10**
Conciliated - Pay Without Prejudice	425	351	7.5%	5.9%
Conciliated Adjusted	2,509	2,640	44.5%	44.4%
Lump Sum	765	806	13.6%	13.6%
Adjusted Prior to Conciliation	125	154	2.2%	2.6%
Withdrawn	1,808	1,991	32.1%	33.5%
TOTALS:	**5,632**	**5,942**	**100%**	**100%**

Source: CMS Report 17

As displayed in

Table 5, cases may be conciliated by two methods. Approximately 45% 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" (8% of resolved cases in FY'11), 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 (1,808 cases in FY'11). 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." Lump sum settlements only account for 14% of the resolved cases at the conciliation level of dispute resolution. The percentage of resolved cases that result in a lump sum increases dramatically at both the conference stage and the hearing stage.

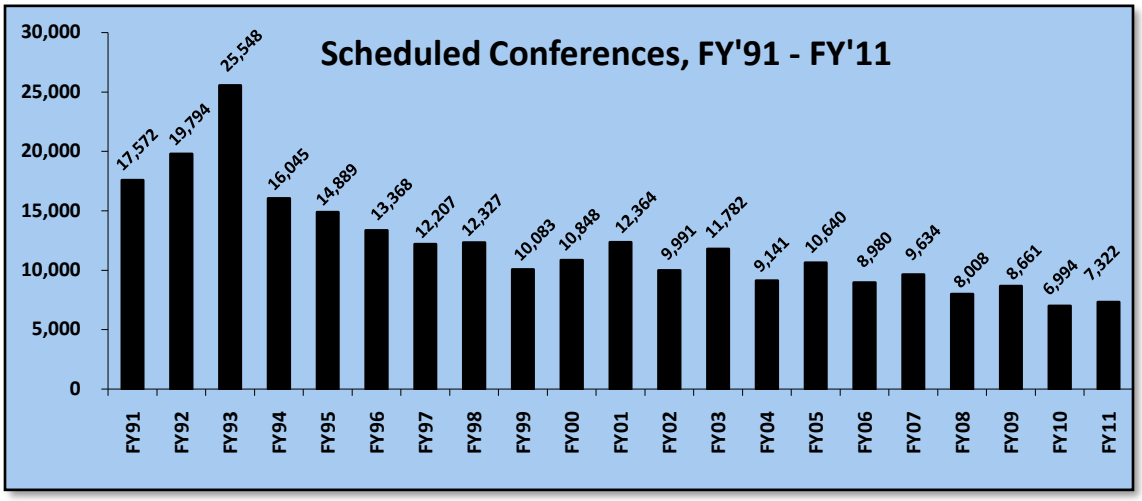
CONFERENCE

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 87% of all conference orders in a given fiscal year are appealed to the hearing level of dispute resolution. In the remaining 13% 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 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'11 increased by 5% from last fiscal year (6,994 in FY'10 to 7,322 in FY'11).[16] Each year, the number of conferences scheduled is greater than the number of conferences that will actually take place before an AJ since many cases are withdrawn or resolved before ever reaching a conference.

Figure 9: Scheduled Conferences, FY'91 - FY'11



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

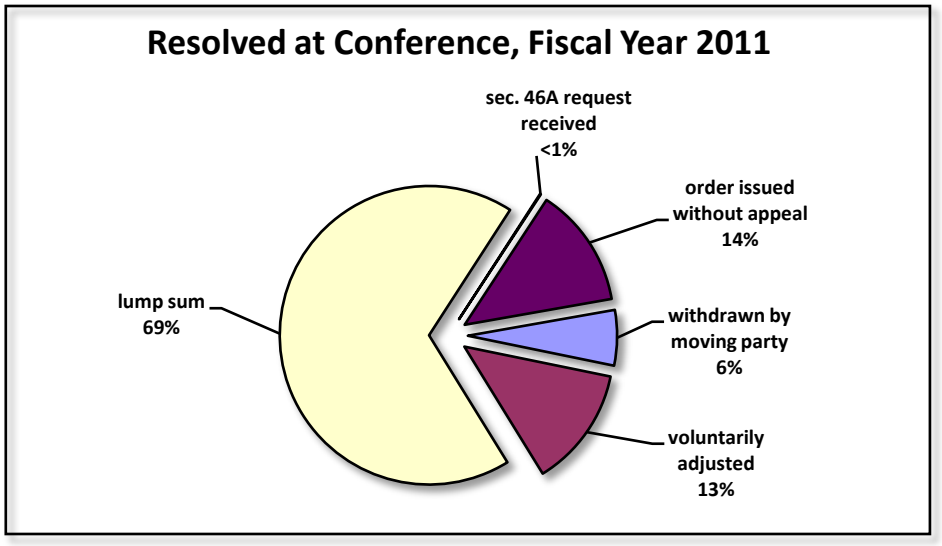
[16] In an effort to avoid duplication, the number of "scheduled conferences" does not include cases that were "rescheduled for a conference." In FY'11, 2,381 cases were "rescheduled for a conference."

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 FY'11, 5,446 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 AJ. Often a case may be withdrawn before a scheduled conference takes place either by the moving party or by the AJ. 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: Chart Detailing Cases Resolved at Conference, Fiscal Year 2011



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

Table 6: Cases Resolved at Conference, Fiscal Year 2011 and Fiscal Year 2010

Resolved at Conference FY'11 and FY'10	*Number of Cases*		*Percentage*	
	FY'11	**FY'10**	**FY'11**	**FY'10**
Withdrawn by Moving Party	335	306	6.2%	5.6%
Voluntarily Adjusted	700	640	12.9%	11.7%
Lump Sum	3706	3,803	68.0%	69.3%
Section 46A Request Received	3	1	<1%	<1%
Order Issued Without Appeal	702	741	12.9%	13.5%
Total	**5,446**	**5,491**	**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 FY'11, 335 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 FY'11, 700 cases (13% 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 Administrative Law Judge (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 FY'11, 3,706 cases (68% 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 ALJ to determine if reimbursement is owed out of the proceeds of the award. In FY'11, only three of these requests were 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 FY'11, 713 conference orders (14% 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 FY'11, 4,939 conference orders (86% of all conference orders) were appealed to a hearing.

Table 7: Conference Orders, FY'11 - FY'01

Conference Orders FY'11 - FY'10	Total Orders	Appealed	Without Appeal
Fiscal Year 2011	**4,939**	4,226 (85.6%)	713 (14.4%)
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%)

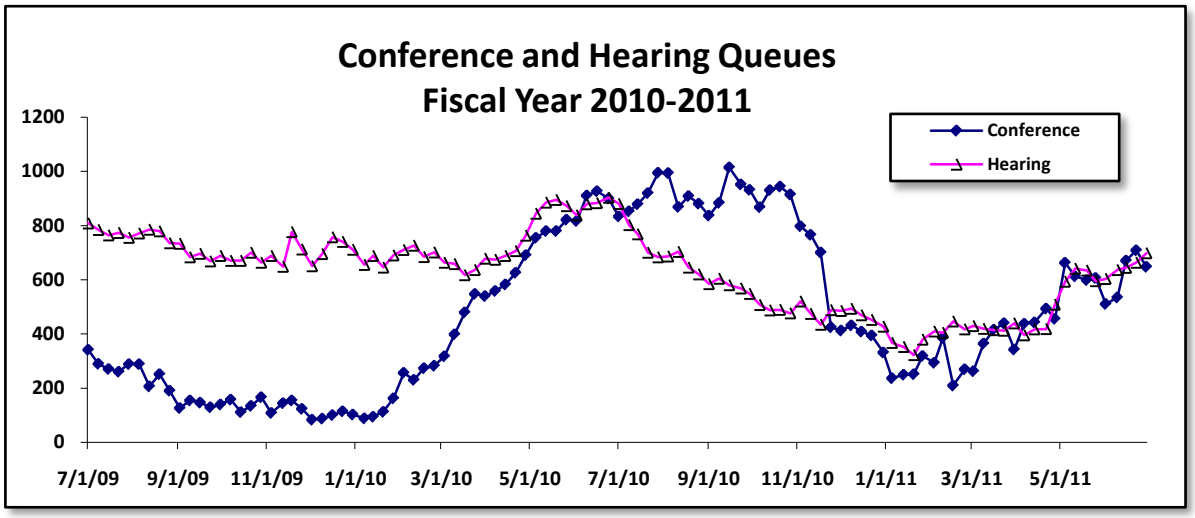
Source: CMS Reports 319AB, "Appealed Conference Order Statistics."

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.

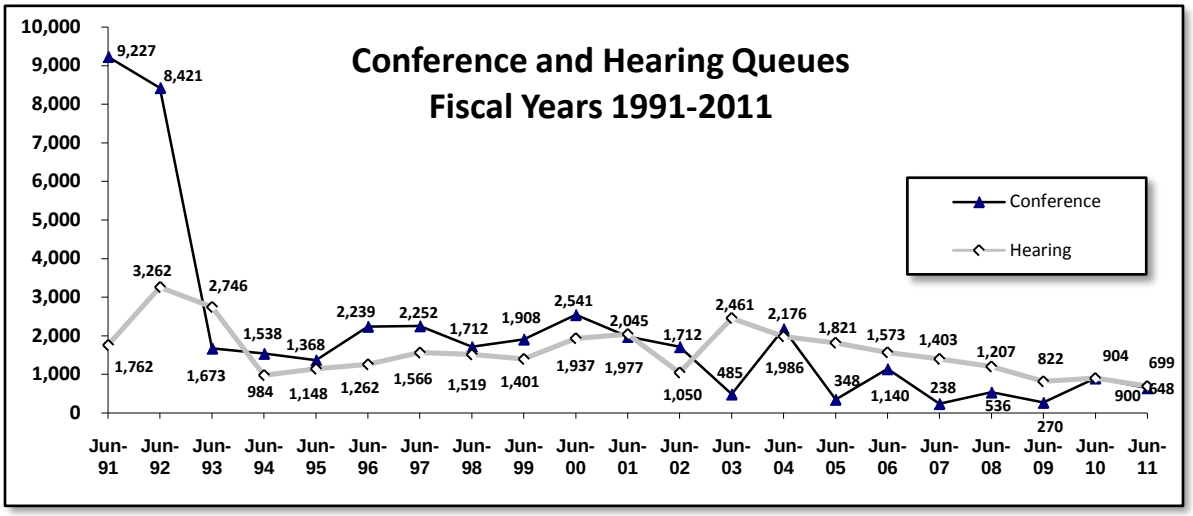
As presented in Figure 11, the conference queue during FY'11 remained well below the benchmark of 1,500 cases, thereby allowing cases to be efficiently scheduled. In FY'11 the conference queue ended 186 cases higher than the start of the year (834 on July 1, 2010 and 648 on June 29, 2011. The conference queue reached a high of 1,015 on September 15, 2010 and a low of 210 on February 16, 2011.

Figure 11: Conference and Hearing Queues; Fiscal Year 2010-2011



Source: CMS Report 404

Figure 12: Conference and Hearing Queue; Fiscal Years 1991-2011



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 one 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. FY'11 began with a hearing queue of 881 cases and decreased to 699 cases by the end of the fiscal year. Since 1991, the hearing queue has been as low as 323 cases (January 2011) and as high as 4,046 (November 1992).

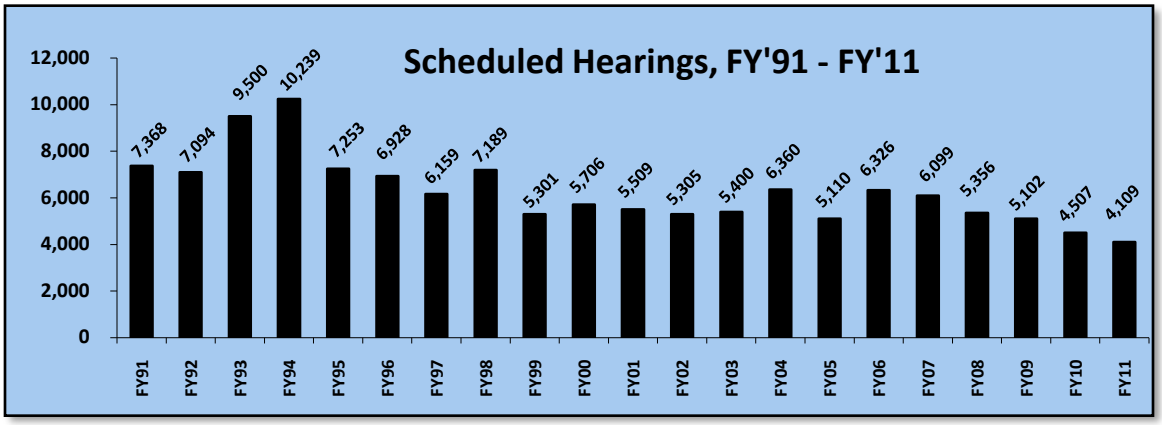
Volume of Scheduled Hearings

The number of hearings scheduled in FY'11 decreased by 398 cases from last fiscal year (4,507 in FY'10 to 4,109 in FY'11).[17] Each year, the number of hearings scheduled is greater than the number of hearings that will actually take place before an AJ since many cases are withdrawn or resolved before ever reaching a hearing. The figure below

[17] In an effort to avoid duplication, the number of "scheduled hearings" does not include cases that were "rescheduled for a hearing." In FY'11, 3,411 cases were "rescheduled for a hearing."

shows that the number "scheduled hearings" in FY'11 decreased by 9% from the previous fiscal year.

Figure 13: Scheduled Hearings, FY'91 - FY'11



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

Cases Resolved at Hearing

In FY'11, 3,666 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 settlement could occur prior to the proceeding. The following chart and statistical table shows the various methods by which a disputed case can be resolved at hearing.

Figure 14: Chart Detailing Cases Resolved at Hearing, Fiscal Year 2011

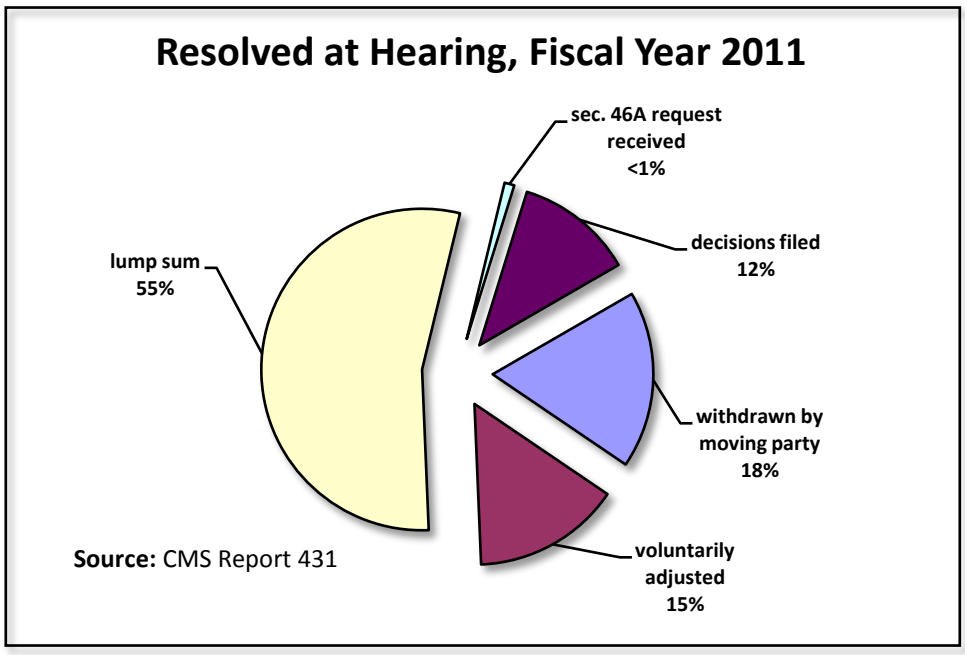


Table 8: Cases Resolved at Hearing, Fiscal Year 2011 and Fiscal Year 2010

Resolved at Hearing FY'11 and FY'10	*Number of Cases*		*Percentage*	
	FY'11	**FY'10**	**FY'11**	**FY'10**
Withdrawn by Moving Party	667	774	18.2%	18.5%
Voluntarily Adjusted	532	625	14.5%	14.9%
Lump Sum	2,006	2,317	54.7%	55.4%
Section 46A Request Received	10	15	<1%	<1%
Decisions Filed	451	454	12.3%	10.8%
Total	**3,666**	**4,185**	**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 FY'11, 667 cases (18% 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 FY'11, 532 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 FY'11, 2,006 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 to determine if reimbursement is owed out of the proceeds of the award. In FY'11, only ten of these requests have been documented at the hearing level.

Finally, a case can exit the system at the hearing level when the presiding AJ issues a hearing decision. In FY'11, 451 hearing decisions (12% of resolved cases at hearing) were filed by AJs.

REVIEWING BOARD

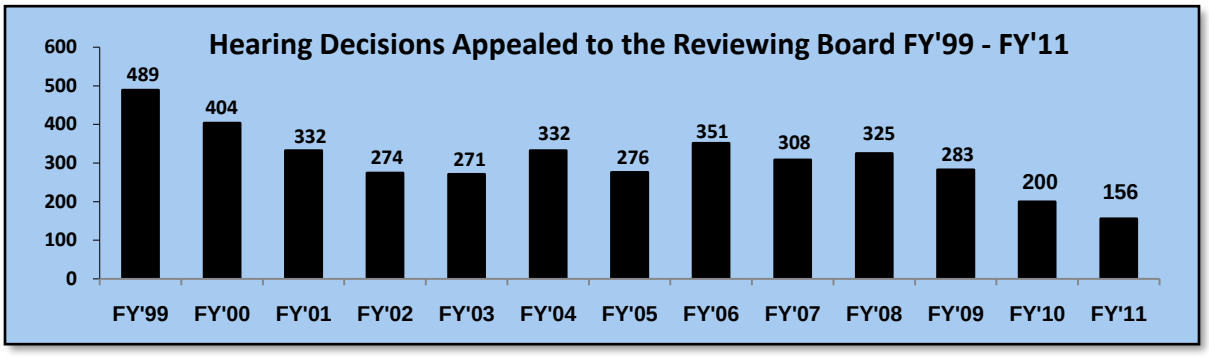
The fourth and final stage of dispute resolution at the DIA is known as the reviewing board. The reviewing board consists of six Administrative Law Judges (ALJs) whose primary function is to review the appeals from hearing decisions. While appeals are heard by a panel of three ALJs, initial pre-transcript conferences are held by individual ALJs. The ALJs also work independently to perform three other 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 ALJs. The panel reviews the evidence presented at the hearing, as well as any findings of law made by the Administrative Judge (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 AJ'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 FY'11 was 156.

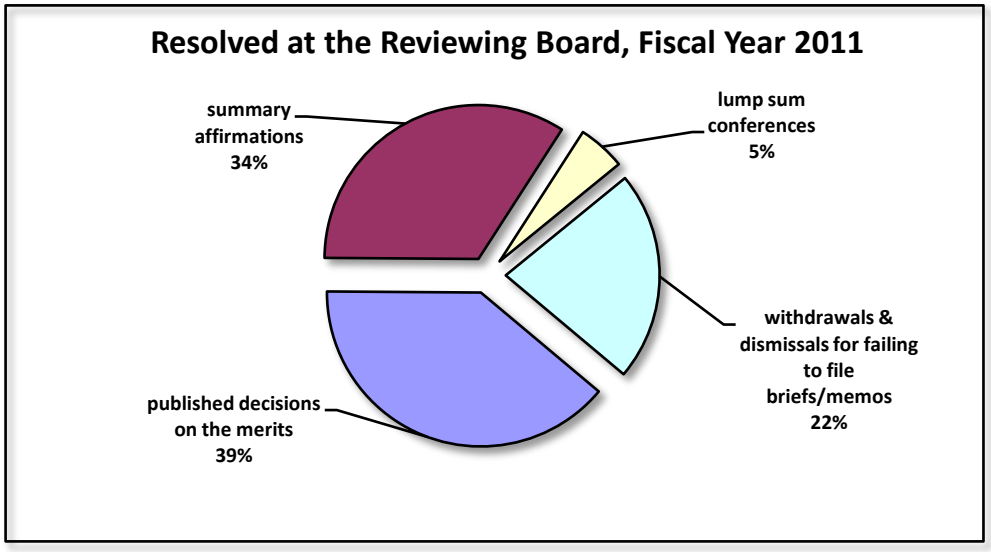
Figure 15: Hearing Decisions Appealed to the Reviewing Board, FY'99 - FY'11



Source: DIA Reviewing Board

In FY'11, the Reviewing Board resolved 228 cases (some from the prior year), representing a 10.6% decrease from cases resolved in FY'10 (255 cases).

Figure 16: Appeals Resolved at the Reviewing Board, Fiscal Year 2011



Source: DIA Reviewing Board

Table 9: Appeals Resolved at the Reviewing Board, Fiscal Year 2011

Appeals Resolved at the Reviewing Board, Fiscal Year 2011	*Number of Cases*
Published Decision on the Merits (Full Panel):	89 (39.0%)
Summary Affirmations (After Full Panel Deliberation):	78 (34.2%)
Lump Sum Conferences:	12 (5.3%)
Withdrawals/Dismissals for Failing to File Briefs/Memos:	49 (21.5%)
Total Number of Appeals Resolved by the Reviewing Board:	**228 (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 AJs 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 FY'11 was 619.

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'11, ALJs heard 1,177 Section 15 petitions on a rotating basis.

Compromise and Discharge of Liens (§46A)

ALJs 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 FY'11 was 18.

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 (AJ) may approve lump sum settlements at conference or hearing just as an Administrative Law Judge (ALJ) does at a lump sum conference. At the request of the parties, conciliators and AJs may also refer the case to a separate lump sum conference whereby an ALJ will decide if it is in the best interest of the employee to settle.

Table 10: Lump Sum Conference Statistics, FY'11-FY'91

Fiscal Year	*Total lump sum conferences scheduled*	*Lump sum settlements approved*
FY'11	**6,168**	**5,496 (89.1%)**
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 69% since FY'91. In FY'11, only four 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 - AJs 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 AJs 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'11

Fiscal Year 2011	*Lump Sum Pursued*[18]	*% Total Cases Resolved (at each level of dispute)*
Conciliation	756	13.6%
Conference	3,706	68.0%
Hearing	2,006	54.7%

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

[18] 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 (AJ) 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.[19] 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.[20]

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 seven 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

[19] M.G.L. c.152, §8(4).
[20] 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 Director and set by regulation through the Commonwealth's Executive Office of Administration and Finance.

The following table details the DIA's fee schedule:

Table 12: Fee Schedule - Impartial Medical Examinations

$450	Impartial medical examination and report
$700	For deposition lasting up to 2 hours
$150	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'11, approximately $1,560,963 was collected in filing fees.

As of June 30, 2011, there were 230 physicians on the roster consisting of 33 specialties.[21] 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'11 the impartial unit scheduled 3,398 examinations. Of these, 3,358 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).[22] 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'10, the impartial unit scheduled 5,002 examinations. Of these, 3,783 exams were actually conducted in the fiscal year.

Impartial Exam Fee Waiver for Indigent Claimants

In 1995, the Supreme Judicial Court ruled that the DIA must waive the filing fee for indigent claimants appealing an AJ's benefit-denial order. As a result of this decision, the DIA has implemented procedures and standards for processing waiver requests and providing financial relief from the Section 11A fee.

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

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

It is within the discretion of the DIA Director to accept or deny a claimant's request for a waiver, based on documentation supporting the claimant's assertion of indigency. If the Director 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 reconsideration. The Director can deny this request without a hearing if past documentation does not support the definition of "indigent" 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, 2011

2011 HHS Poverty Guidelines	
Size of Family Unit	**Amount***
1	$10,890
2	$14,710
3	$18,530
4	$22,350
5	$26,170
6	$29,990
7	$33,810
8	$37,820

For family units with more than eight members, add $3,820 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. 76, No. 13, January 20, 2011, pp. 3637-3638.
*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 13 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

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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

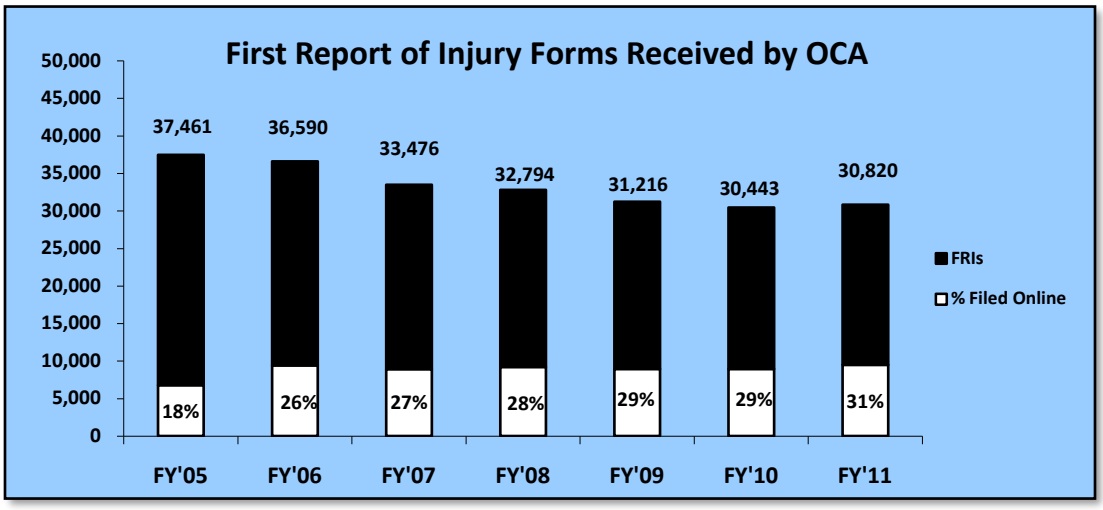
During the last two fiscal years, the OCA has streamlined the claims process by introducing electronic online filings in conjunction with the agency's Document Management System (DMS). These technological advancements have greatly reduced the DIA's reliance on paper documents, thereby reducing costs to the agency and its users. With the inception of new technology, the role of the OCA's 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'11, the OCA received 30,820 First Report of Injury Forms (FRIs), an increase of 1.2% from FY'10 (30,443). Approximately 31% (9,482) of all FRIs were filed online during FY'11, a slight increase from FY'10. In FY'11 the number of claims, discontinuances and third party claims received by the OCA was 14,725, a 6.4% increase from the 13,841 received in FY'10 (prior to review and CMS processing). The total number of referrals to conciliation for FY'11 was 12,589 (includes 2,900 online filings or 34%), which represents a decrease of 2.7% from FY'10 (12,940).

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



Source: DIA - Office of Claims Administration

Information Storage

OCA's 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. All documents are not considered public records. In accordance with 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 number of public records requests received by the DIA continues to trend upward.

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

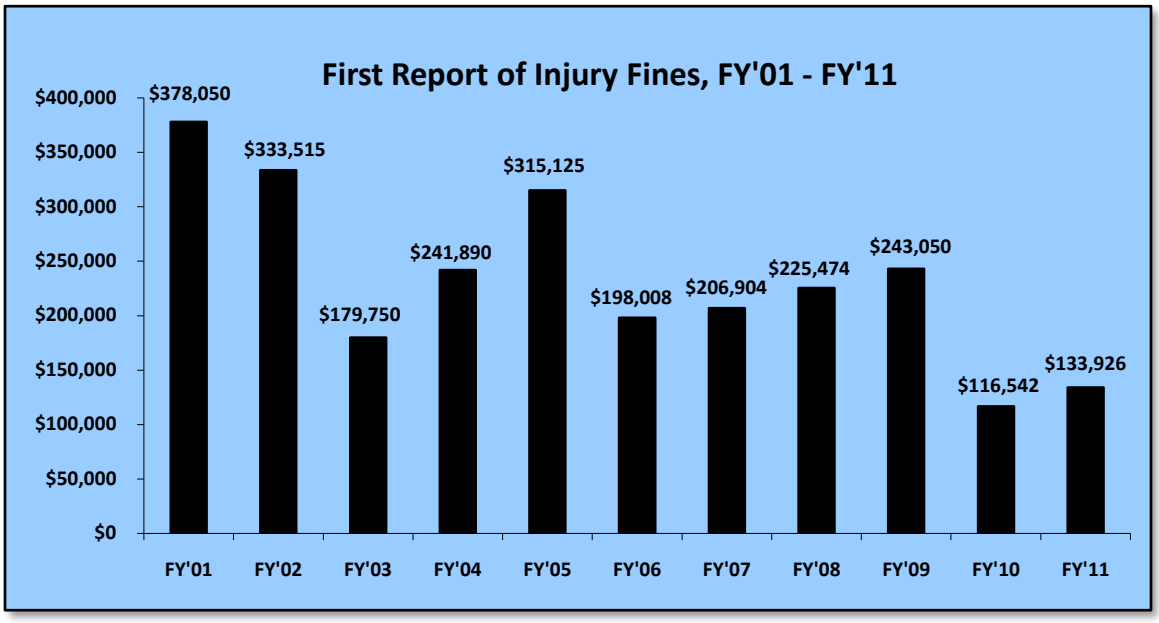
General's Office, the Social Security Administration and other government entities. Occasionally, a KOR representative is summoned to appear in court to testify on behalf of the DIA on documents relating to a workers' compensation case.

First Report Compliance

In Massachusetts, all employers must file an *Employer's First Report of Injury or Fatality* (Form 101) (FRI), 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 30 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 to $500 and are under the jurisdiction of DIA's Office of Revenue.

In FY'11, the OCA collected $133,926 in FRI fines, an increase of $17,384 over the $116,542 collected in FY'10. The office is also responsible for maintaining a database on cases identified by the DIA where there may be potential fraud. In FY'11, the OCA received 26 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 51 such inquiries were processed during FY'11.

Figure 18: First Report of Injury Fines, FY'01-FY'11



Source: Collections & Expenditures Report, FY'07 - FY'11 (see Appendix L for the complete report).

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."[23]

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 CMR §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, is 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'11, OEVR approved 47 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:

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);

[23] M.G.L. c.152, §1(12)

4. Summary of all vocational testing used to help develop an employment goal and a vocational goal; and
5. The name of the OEVR RRO.

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.[24] 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 RRO 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 VR services. This is done through a Determination of Suitability 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 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

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

[24] M.G.L. c.152, §30 (E-H); 452 CMR §4.00

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 VR program funded voluntarily by the insurer has no limit of time. However, OEVR-mandated IWRP's are limited to 52 calendar weeks for pre-December 23, 1991 injuries and 104 calendar weeks for post-December 23, 1991 injuries.[25] 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 VR activity begins, the IWRP must be approved by OEVR. VR is successful when the injured worker completes a VR program and is employed for 60 days. A "Closure Form" must then be signed by the provider and sent to the appropriate RRO. Closures should meet the following criteria:

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

[25] M.G.L. c.152, §19.

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

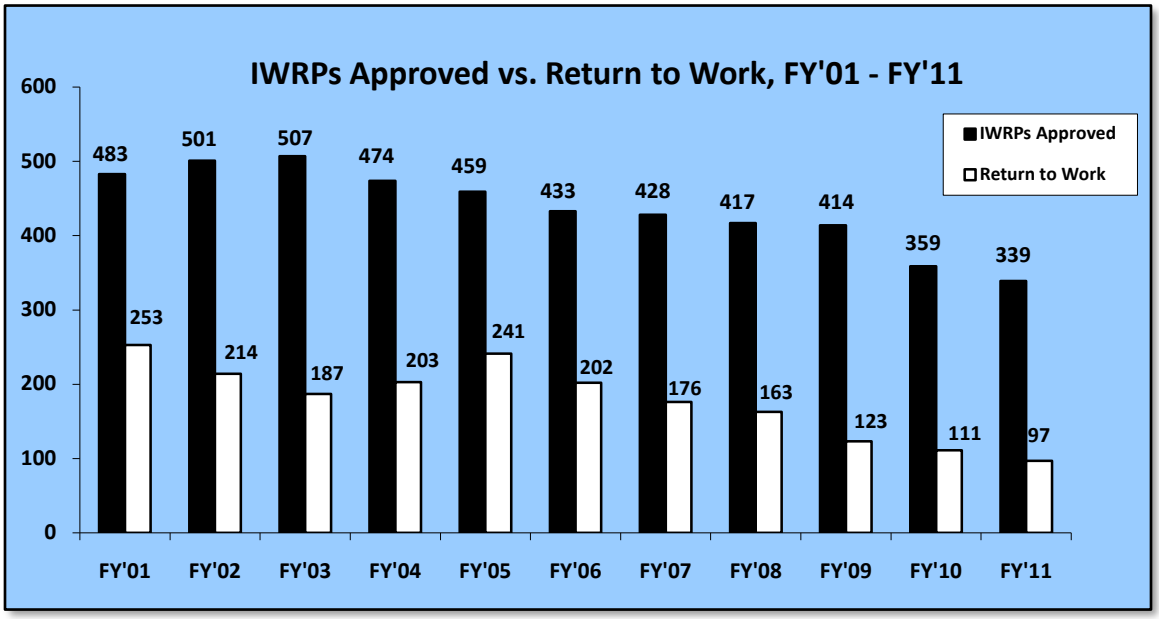
In FY'11, OEVR was headed by a Director and staffed by seven RROs, one Program Coordinator, and three Clerks. During the fiscal year, referrals to OEVR decreased by 16%. Out of the 2,362 cases referred to OEVR in FY'11, 70% (1,665) proceeded to a "mandatory meeting" for a determination of suitability for vocational rehabilitation services. The remaining 30% 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," 29% (481) were referred to the insurer/self-insurer with a request to initiate vocational rehabilitation services by an OEVR certified provider. In FY'11, there was a 29% success ratio of injured workers who completed plans and returned to work.

Table 14: Utilization of Vocational Rehabilitation Services, FY'05 - FY'11

Fiscal Year	*Referrals to OEVR*	*Mandatory/ Inform. Meetings*	*Referrals to Insurer for VR*	*IWRPs approved*	*Return to work*	*% RTW after plan development*
FY'11	**2,362**	**1,665/10**	**481**	**339**	**97**	**29%**
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'11



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 FY'11, the Trust Fund paid $6,097.52 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. 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 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

The DIA Office of Safety administers and manages the "Workplace Safety Training and Education Grant Program." The goal of the program is to promote safe and healthy conditions in the workplace through training, education and other preventative programs for employees and employers of industries and organizations operating within the Commonwealth covered by the Massachusetts Workers' Compensation Law, (M.G.L. Ch. 152). The grant program has an annual budget of $800,000 and proposals can be submitted to a maximum of $25,000.

This fiscal year, the Office of Safety participated in regional informational workshops and over 800 announcement letters were emailed to various industries and organizations through the Commonwealth. The grant application was also published to notify the general public that safety training grants are available. As a result of this outreach, the Office of Safety received over 75 grant applications in FY'11.

The criteria to objectively evaluate all proposals received are developed by an Evaluation Committee appointed by the Director of the Department of Industrial Accidents. Following review, the Committee recommends a list of suitable applicants for funding; upon approval of this list by the Director, contracts are awarded (see Appendix K for a list of safety grant proposals recommended for funding in FY'12).

In FY'11, the Office of Safety was able to fund a total of 61 grants, which resulted in the training of about 8000 workers in Massachusetts.

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 creating the committee, the Executive Order required all Executive Branch agencies to maintain detailed records concerning occupational injuries, illnesses and deaths. The Executive Order also required each agency to develop a joint labor-

management health and safety committee to survey safety and health hazards and make recommendations on improving workplace safety.

In FY'10, the Office of Safety organized a joint labor-management Health and Safety Committee that 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.[26] To be self-insured, employers must have enough capital to cover the expenses associated with self insurance (i.e. bond, reinsurance, and a third party administrator (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 with 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 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.

[26] 452 CMR 5.00: Code of Massachusetts Regulations concerning insurers and self-insurers. These regulations may be waived by the Director 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'11, there were no licenses issued, with the total number of "parent-licensed" companies remaining at 100, covering a total of 389 subsidiaries. Each self insurance license provides approval for a parent company and its subsidiaries to self-insure. This amounts to approximately $234,779,577 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 1930s 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.[27]

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'11, an estimated 2,514 inquiries were made to the Insurance Register.

[27] 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.[28] 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.[29] 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 investigative team who conducts comprehensive "in-house" research utilizing all available databases. This initial research, known as a "compliance check," allows the investigators to close a case

[28] 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.

[29] M.G.L. c.152, §25A.

where an insurance policy has been discovered or when there is substantial evidence that a company has ceased operations. In FY'11, the Office of Investigations conducted a total of 52,366 "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'11, the Office of Investigations conducted 5,984 "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'11, the DIA issued a total of 2,567 SWOs. Of the 2,567 SWOs issued, 2,509 (97.7%) were issued to "small" employers (1 to 10 employees), 53 (2.1%) were issued to "medium" employers (11 to 75 employees), and five (<1%) were issued to large employers (75+ employees). The Office of Investigations estimates that 7,384 new employees became covered in FY'11 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'11

Fiscal Year	Compliance Checks	Field Investigations	SWOs Issued	SWO Fines Collected	New Employees Covered due to SWOs
FY2011	52,366	5,984	2,567	$1,836,225	7,384
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 SWO 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

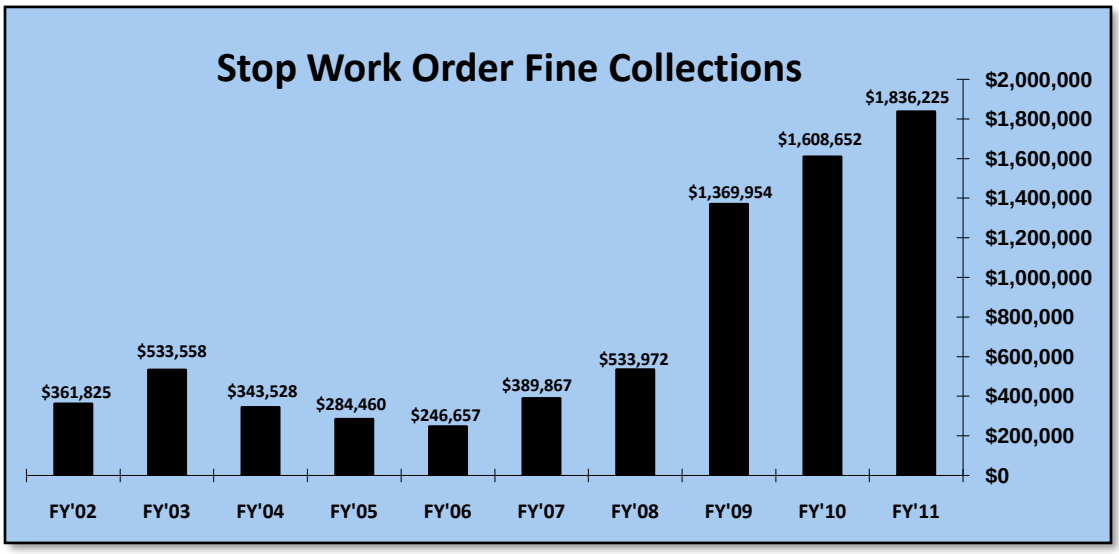
not be in effect. The SWO and penalty will be rescinded by the hearing officer if the employer can prove it had workers' compensation insurance at the time of issuance. If at the conclusion of the hearing the DIA hearing officer finds the employer had not obtained adequate insurance coverage, the employer 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 FY'11, 2,163 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 Director or designee can file criminal complaints against employers (including the President and Treasurer of a corporation) for violations of Section 25C.

In FY'11, the Office of Investigations collected $1,836,225 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'02 - FY'11



Source: Collections & Expenditures Report, FY'07 - FY'11 (see Appendix L for the complete report).

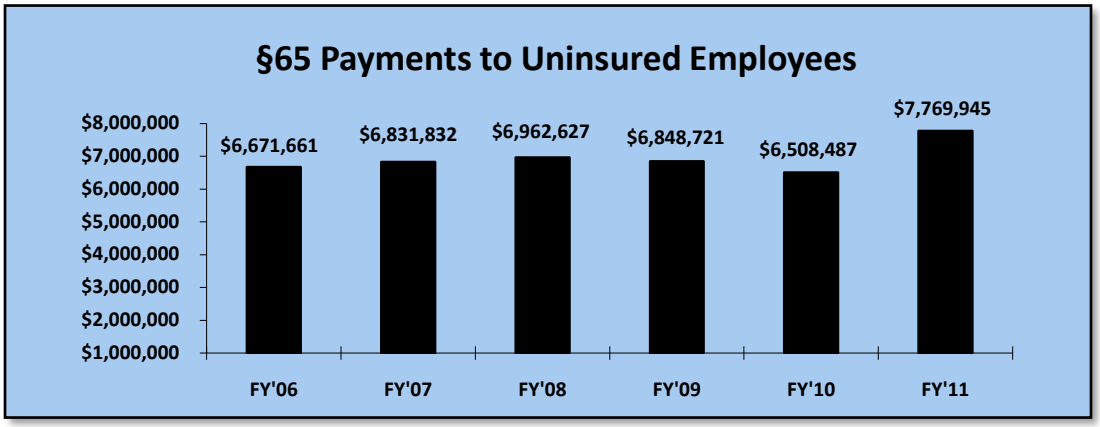
WORKERS' COMPENSATION TRUST FUND

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.[30] In FY'11, $7,769,945 was paid to uninsured claimants, 126 claims were filed, and 602 claims for benefits paid. The DIA aggressively pursues uninsured employers to recoup monies paid out from the Trust Fund. During FY'11, the DIA recovered $1,313,869 from employers and third parties.

Figure 21: §65 Payments to Uninsured Employees



Source: Collections & Expenditures Report, FY'07 - FY'11 (see Appendix L for the complete report).

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

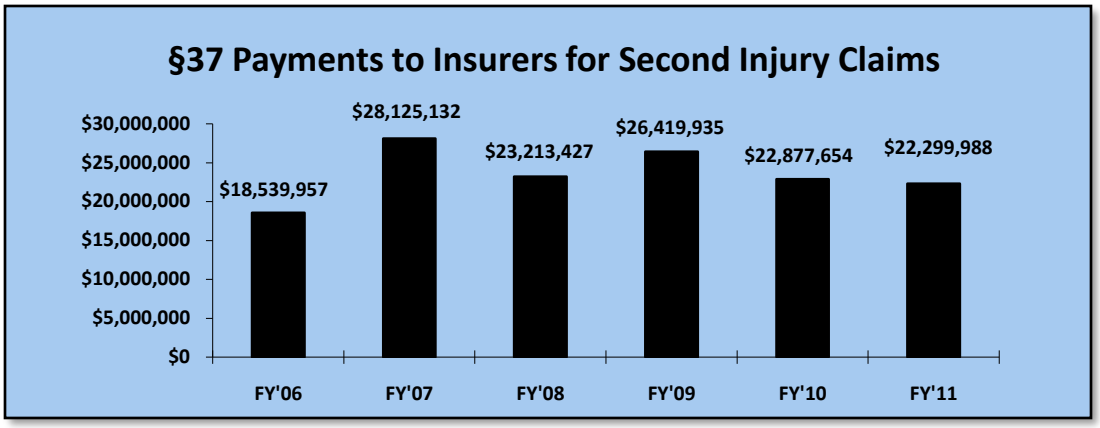
In an effort to encourage employers to hire previously injured workers, the Legislature established a Second Injury Fund (SIF) to offset any financial disincentives associated with the employment of injured workers. Section 37 allows insurers to be reimbursed by the Trust Fund when compensation is being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

[30] 452 CMR 3.00

injury," insurers become eligible to receive reimbursement from the WCTF for up to 75% of compensation paid after the first 104 weeks of payment.[31] Employers may be entitled to an adjustment to their experience modification factors as a result of these reimbursements.

At the close of FY'11, 271 §37 claims were paid and settled (six fewer than in FY'10). The total amount of §37 payments in FY'11 was $22,299,988 (includes quarterly payments under §37 and interest).

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



Source: Collections & Expenditures Report, FY'07 - FY'10 (see Appendix L for the complete report).

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.)

[31] 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 Industrial Accident Board 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.

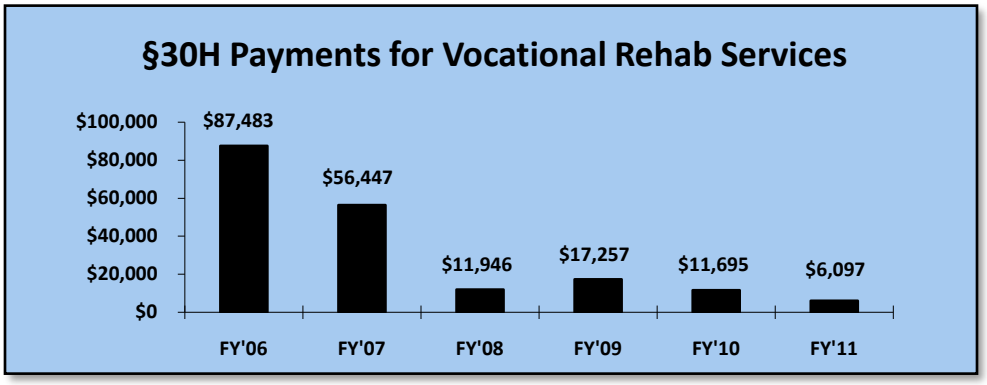
"New Act" - 1991 thru Present

- 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'11, no new cases were accepted for §30H benefits and the Trust Fund paid $6,097 for vocational rehabilitation services on existing cases.

Figure 23: §30H Payments for Vocational Rehabilitation Services



Source: Collections & Expenditures Report, FY'07 - FY'11 (see Appendix L for the complete report).

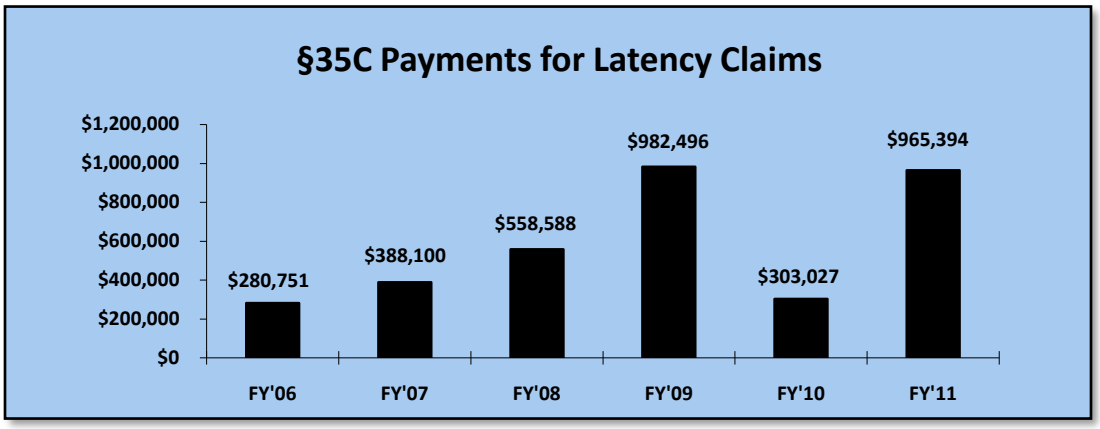
Latency Claims (Section 35C)

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'11, the Trust Fund paid out $965,394 for latency claims.

Figure 24: §35C Payments for Latency Claims

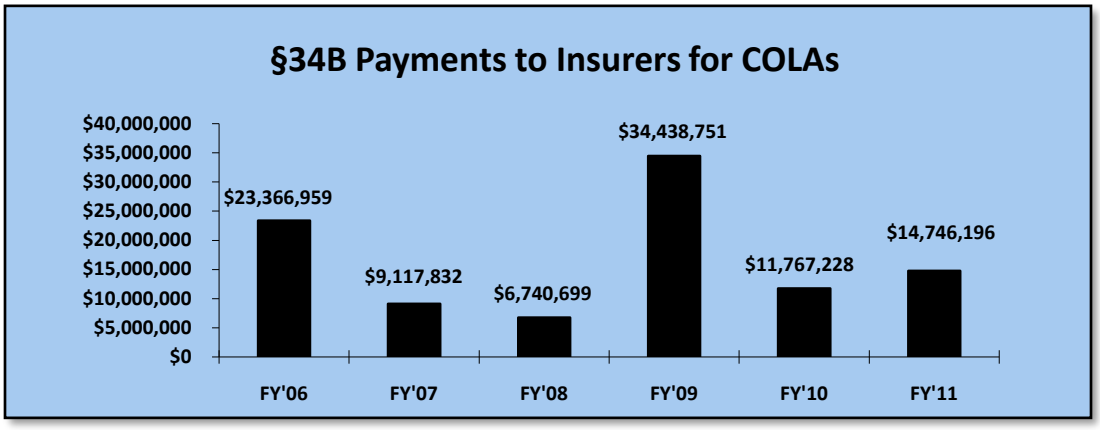


Source: Collections & Expenditures Report, FY'07 - FY'11 (see Appendix L for the complete report).

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 said claimant's 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 October 1, 1986. For injury dates after October 1, 1986, 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'11 totaled $14,746,196 for the Private Trust Fund.

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



Source: Collections & Expenditures Report, FY'07 - FY'11 (see Appendix L for the complete report).

OFFICE OF HEALTH POLICY

The Office of Health Policy (OHP) was created in July of 1993 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 FY'11, 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 UR 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 UR at any time during the 12-week period immediately following the date of injury. However, the insurer is mandated to undertake UR 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 FY'11, 14 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 Director (see Appendix F for a list of HCSB members). The HCSB met throughout FY'11, discharged its statutory responsibilities with regularity, and continued to assist the Director 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 Director, 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 FY'11, the HCSB received three 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 FY'11.

Treatment Guidelines - Under §13 of c.152, the Director is required to ensure that adequate and necessary health care services are provided to injured workers by utilizing treatment guidelines developed by the HCSB, including appropriate parameters for treating injured workers. In FY'11, no new guidelines were added to the Massachusetts Treatment Guidelines.

Compensation Review System

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."[32]

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 FY'09, 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.

[32] M.G.L. c.152, §13.

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.[33] 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.[34] 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 77 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

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

[34] 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'11. 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'11, the DIA collected $1.9 million from companies under assessment review in Phase II. The audit expense associated with the reviews for FY'11 was 28%, thereby representing a DIA retention rate of 72%.

Assessment Audit - Phase III

In FY'08, Phase III of the assessment reviews began and continued through FY'11. Phase III focuses on assessments calculated and remitted during a 4-year review period between January 1, 2004 and December 31, 2007. In FY'11, a total of 3 CPA firms were assisting the DIA with the audit reviews of approximately 34 companies licensed to write workers' compensation policies in Massachusetts.

In FY'11, the DIA collected $2.7 million from companies under assessment review in Phase III. The audit expense associated with the reviews for FY'11 was 16%, thereby representing a DIA retention rate of 84%.

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.

In FY'11, the DIA collected $456,397 from companies under assessment review in Phase IV and Phase V. The audit expense associated with the reviews for FY'11 was 33%, thereby representing a DIA retention rate of 67%.

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 2011		
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
Fiscal Year 2011	$1,919,292	$12,724,210

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 (AJs) 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 AJs 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 Office of Education and Vocational Rehabilitation 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
Brian Dias, Manager

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

Worcester, MA
340 Main Street
Worcester, MA 01609
(508) 753-2072
Vincent Lopes, Manager

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

SECTION - 6 -

DIA FUNDING

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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 DIA 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 $738.28 as of October 1, 2011. This fee is 65% of the current State Average Weekly Wage (SAWW), which is now $1,135.82. (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.[35] The assessment rate for private sector employers in FY'12 is 5.930% of standard premium. This represents a 12.9% decrease from the FY'11 assessment rate of 6.813%.

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

[35] 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 Secretary of the Executive Office of Labor and Workforce Development.

The Trust Fund - The Trust Fund was established so that 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.[36] 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 and submitted for legislative action.

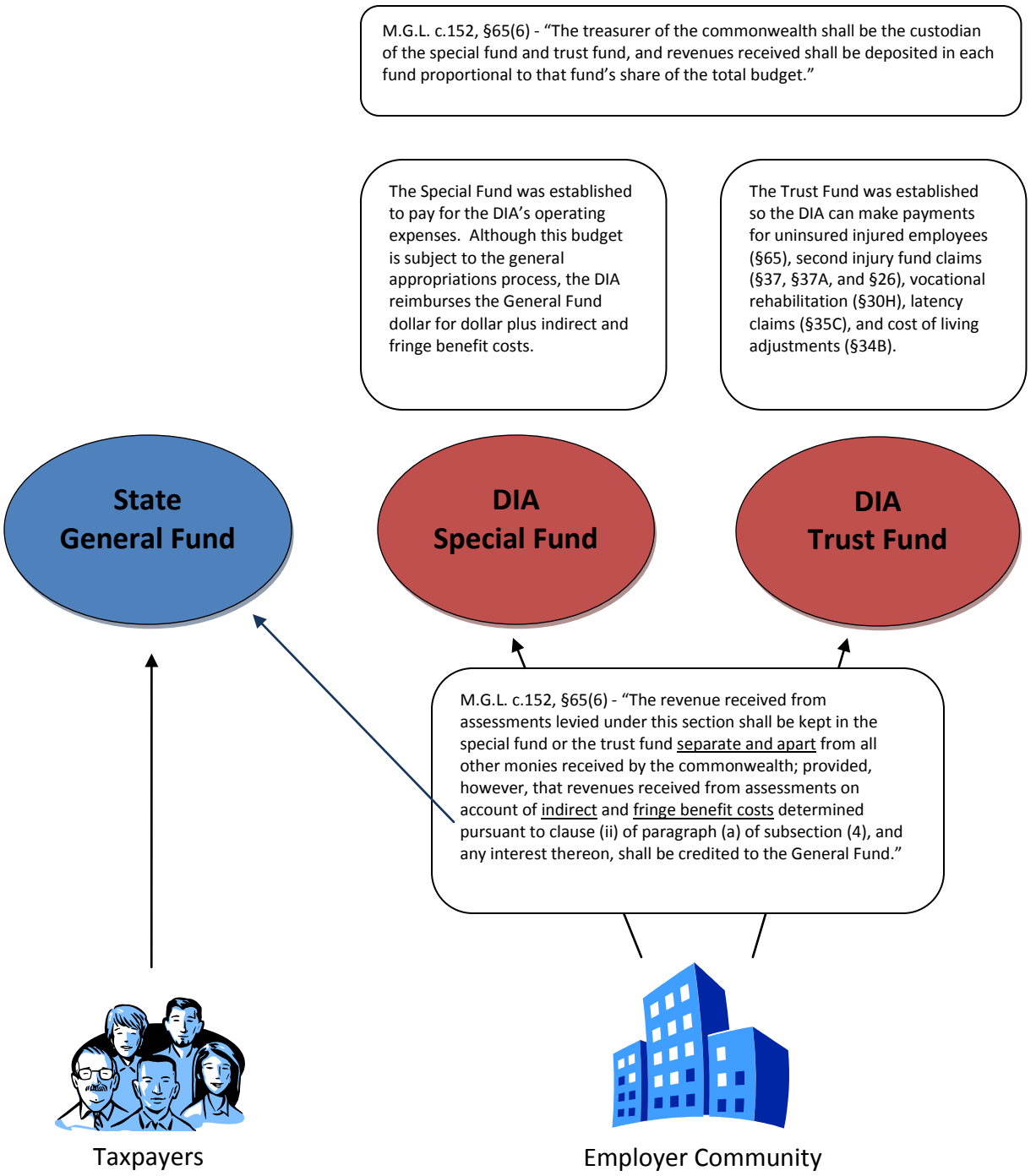
In May and June, the DIA uses consulting actuaries to estimate future expenses and determine the assessments necessary to fund the Special Fund and the Trust Fund. The budgets and the corresponding assessments must be submitted to the Secretary of the Executive Office of Labor and Workforce Development 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 Director may levy additional assessments on the employer community. Any additional assessment is subject to the approval of the Secretary of the Executive Office of Labor and Workforce Development and can be reviewed by the Advisory Council. The Advisory Council may submit its own estimate of the necessary additional assessment to the Secretary of the Executive Office of Labor and Workforce Development 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.

[36] M.G.L. c.152, §65(2).

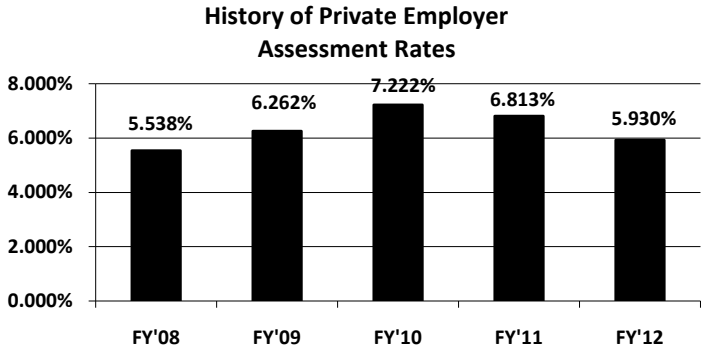
Figure 27: The DIA's Unique Funding Process



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 21, 2011, Deloitte Consulting released an analysis of the DIA's FY'11 assessment rates as mandated under M.G.L. c.152, §65 (4) and (5). Specifically, the report details the estimated amount required by the Special Fund and Trust Fund for FY'12, beginning July 1, 2011. 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 5.930% of standard premium, a decrease of 12.9% from last year's private assessment (6.813%). It is important to note that the Public Fund has no remaining municipalities thereby resulting in a FY'11 public assessment rate of 0%.

FY'12 Private Fund (including Special Fund) expenditures are projected to be $84.2M. This represents a 2.4% increase from the $82.2M FY'11 expenditures projected by Deloitte & Touche in the FY'11 analysis. The increase is primarily driven by a $1.5M increase in estimated Section 35C (Latency) and a $1.5M increase in Section 34B (COLA) payments and a partially offsetting $1.4M decrease in the Special Fund. This memorandum breaks down the assessment rate calculation process for the private employer assessment rate.

OVERVIEW OF ASSESSMENT RATE CALCULATIONS

Deloitte Consulting uses the following six steps in determining the assessment rate for private employers:

1. Project the FY'12 Expenditures;
2. Project the FY'12 Income (excluding assessments);
3. Estimate FY'12 Balance Adjustments, if any;
4. Convert Above Items to Ratios by comparing them to the Assessment Base (2012 selected calendar year 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 2012 PROJECTED EXPENDITURES: $84.1M

The first step in the assessment process is the calculation of the expected FY'12 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'12 Expenditures (06/11)	+/- FY'11 Projected Expenditures (06/10)
Section 37 (2nd Injuries)	$25,279,766	+ $ 289,326
Uninsured Employers	$ 9,113,503	- $ 17,049
Section 30H (Rehabilitation)	$ 0	- $ 4,537
Section 35C (Latency)	$ 2,000,000	+ $1,500,000
Section 34B (COLA's)	$18,212,536	+ $1,465,366
Defense of the Fund	$ 6,053,630	+ $ 138,945
Total:	**$60,659,435**	**+ $3,372,051**

SPECIAL FUND BUDGET	Projected FY'12 Expenditures (06/11)	+/- FY'11 Projected Expenditures (06/10)
Total:	**$23,474,013**	**- $1,436,467**

PRIV. EMPLOY. EXPENDITURES	Projected FY'12 Expenditures (06/11)	+/- FY'11 Projected Expenditures (06/10)
Total:	**$84,133,449**	**+ $1,935,586**

2. PROJECTED FISCAL YEAR 2012 INCOME: $7.3M

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'12 Fines and Fees (Special Fund) =	$5,800,363	
FY'12 Income Due to Reimbursements =	$1,460,454	
Estimated Investment Income (FY'11) =	$ 29,440	(Private Fund: $18,562/Special Fund: $10,878)

Total Projected FY'12 Income: $7,290,257

3. ADJUSTMENTS TO FUND BUDGETS: $4.2M (Special Fund) / $4.4M (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'10 expenditures in a particular fund must be used to reduce amounts assessed for that fund in FY'12. The balance of the Special Fund at the end of FY'11 will have a surplus exceeding 35% of FY'10 disbursements. Therefore, the assessment was calculated with an $8.6M reduction to the Special Fund Budget.

SPECIAL FUND:	**FY'11 Estimated Year End Balance**	**35% of FY'10 Expenditures**	**Amount of Reduction Required**
	$12,178,138	$7,968,635	$4,209,503
PRIVATE TRUST FUND:	**FY'11 Estimated Year End Balance**	**35% of FY'10 Expenditures**	**Amount of Reduction Required**
	$20,779,476	$16,392,189	$4,387,289

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 2010. For the Private Fund, the assessment base is $704,333,836.

Private Expenditure Ratio:	11.945%	($84.1 million/$704.3 million)
Projected Income Ratio:	1.035%	($7.3 million/$704.3 million)
Balance Adjustment Ratio:	1.221%	($8.6 million/$704.3 million)

5. CALCULATION OF THE ASSESSMENT RATIO: 9.689%

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**
11.945%	1.035%	1.221%	**9.689%**

6. CALCULATION OF THE ASSESSMENT RATE: 5.930%

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 .632 to the DIA based on a projected $896.3M in net written premiums for Calendar Year 2012. After making adjustments to reflect standard premium, rates, and projections in wage and employment levels, the DIA used an assessment base factor of .612 based on a projected $963.4M of net written premiums for Calendar Year 2012.

Assessment Ratio	x Assessment Base Factor	= **Assessment Rate**
9.689%	.612	**5.929%**

DIA OPERATING BUDGET

Legislative Appropriations, Fiscal Year 2012

The Department of Industrial Accidents initially submitted a request to the Executive Office for Administration and Finance for a budget of $20,352,668 for FY'12. On January 26, 2011, Governor Deval Patrick released his Fiscal Year 2012 Budget Recommendations (House 1) and appropriated $19,106,544 to the DIA's line-item. On March 3, 2011, after extensive review of the budget recommendation by the Advisory Council's Budget Subcommittee, the subcommittee chose not to forward any recommendation to the full Advisory Council at that time. The subcommittee agreed to continue monitoring the FY'12 budget process and reserved the right to make future recommendations.

Fiscal Year 2012 General Appropriations Act

On July 11, 2011, Governor Patrick signed the FY'12 General Appropriations Act, which allocated the DIA a $19,106,544 operating budget. This final appropriation represents a 4% 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.

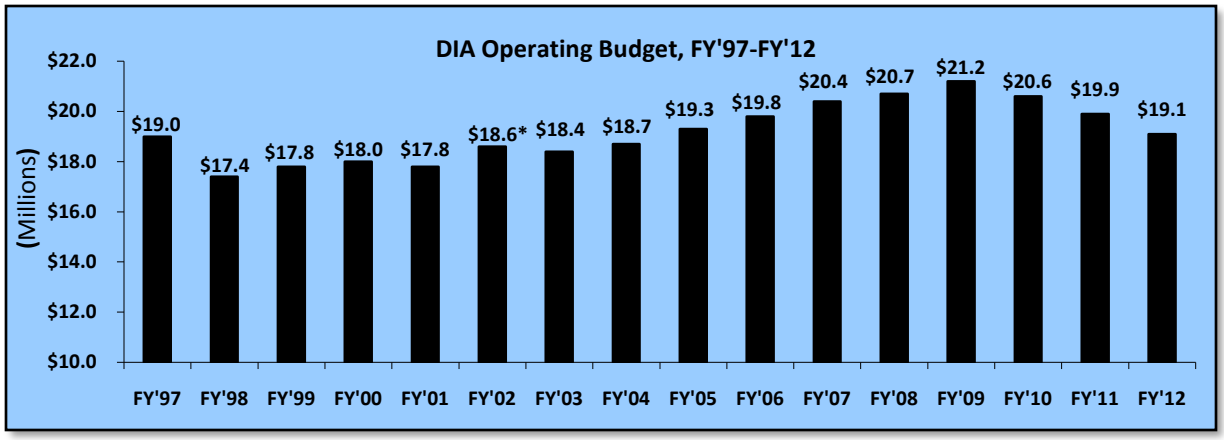
Included in the FY'12 General Appropriations Act was Outside Section #149 that provides a financial mechanism for the Secretary of Administration and Finance to transfer the unexpended balance of any agency's fund, trust fund or other separate account to the General Fund. Since 1985, the DIA has been 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'12 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 7003-0500*, Fiscal Year 2011 - Fiscal Year 2012

Fiscal Year 2011 Budget Process		Fiscal Year 2012 Budget Process	
DIA Request	$20,047,378	DIA Request	$20,352,668
Governor's Rec.	$20,047,378	Governor's Rec.	$19,106,544
Full House	$20,047,378	Full House	$19,106,544
Full Senate	$19,906,544	Full Senate	$19,106,544
Conference Committee	$19,906,544	Conference Committee	$19,106,544
Gen. Appropriations Act	**$19,906,544**	**Gen. Appropriations Act**	**$19,106,544**

* Line-Item changed under Reorganization Plan.

Figure 29: DIA Operating Budget, FY'97 - FY'12



***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 Department, 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.[37] 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 and Finance (A&F).

STAGE #2: Governor's Recommendation **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 the Governor's budget recommendation 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.

[37] "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

The Governor's budget recommendation 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. Typically in April, House Ways and Means presents its version of the budget.

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

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MANDATORY INSURANCE COVERAGE

Every private sector employer in the Commonwealth is required to maintain workers' compensation insurance.[38] 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. [39]

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 and 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.[40] If an employee is injured while working for a company without coverage, a claim may be filed with the DIA's Trust Fund.[41]

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.[42] 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.

[38] 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.

[39] 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.

[40] See page 79 covering the Office of Investigations.

[41] See page 82 covering the Workers' Compensation Trust Fund.

[42] 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'11, the DOI approved a total of ten new licenses to carriers to write workers' compensation insurance in Massachusetts. In addition, five 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.[43] Insurance rates are proposed by the WCRIB on behalf of the insurance industry, and set by the Commissioner of Insurance. The WCRIB submits

[43] 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.

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.[44]

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).[45]

On Tuesday, April 12, 2011, Insurance Commissioner Joseph G. Murphy signed a rate stipulation holding the rates at the current level of 2.4% from 2009-2010 rate levels, saving Massachusetts employers an estimated $65 million in workers' compensation premiums. The stipulation was based on an agreement reached between the State Rating Bureau, the WCRIB, and the Attorney General's Office. The rate became effective for policies taking effect on or after September 1, 2011. Under the stipulation, the rates will only remain in effect for one year. This rate marks the eighth time workers' compensation rates have remained the same since 1991.

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.).

Table 18: Impact of Rate Changes, 1991-2011

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
2011	**No Change**	**$33.21**

Source: Division of Insurance WC Rate Decisions

Deviations & Scheduled Credits

The Workers' Compensation Act allows

[44] 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.

[45] M.G.L. c.152, §53A(2).

individual carriers to seek permission from the Commissioner to use a percentage decrease from approved rates within certain classifications.[46] These percentage decreases are called "downward deviations." In Massachusetts, scheduled credits are also used 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 2010, approximately 50 carrier groups filed and received approval for deviations for at least one of their companies. As a result, about 100 companies offer downward-deviated rates and approximately 30 companies offer deviation or schedule rating credits that are 20% more. It is important to note that not all employers written by these carriers receive the maximum deviation or credit. Reductions may be restricted to certain industrial classes or to policyholders that earn the credits during the policy years by implementing approved cost-containment programs. A list of companies and deviations can be found on the Massachusetts Division of Insurance website.[47]

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 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."[48]

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.

[46] M.G.L. c.152, §53A(9).
[47] http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/mass-div-of-insurance.html
[48] 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 Salespersons, 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 employer's 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[49] *Effective September 1, 2010*	
Medical and Indemnity Deductible Amount	Premium Reduction Percentage
$ 500	1.9%
$1,000	3.1%
$2,000	4.7%
$2,500	5.3%
$5,000	7.8%

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[50] *Effective September 1, 2010*			
Estimated Annual Standard Premium	Claim Deductible Amount	Aggregate Deductible Amount	Premium Reduction Percentage
0 to $75,000	$2,500	$10,000	5.2%
$75,001 to $100,000	$2,500	$10,000	5.2%
$100,001 to 125,000	$2,500	$10,000	5.1%
$125,001 to $150,000	$2,500	$10,000	5.0%
$150,001 to $200,000	$2,500	$10,000	4.8%
over $200,000	$2,500	5% of Estimated Annual Standard Premium	4.6%

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

[49] Massachusetts Workers' Compensation Rating and Inspection Bureau, *Massachusetts Workers' Compensation and Employer's Liability Insurance Manual* (2008).
[50] *Id.*

should not be confused with experience rating. Both adjust premium based on an employer's loss history. Experience rating, however, adjusts premiums at the start of the policy period (to predict future losses), whereas retrospective rating adjusts premiums at the end of the policy period to reflect losses that actually occurred.

The Formula - Although retrospective premiums are determined by a complex formula, they are generally based on three factors: losses the employer incurs during a policy period; expenses that are related to the losses incurred; and basic premium. Incurred losses have historically included medical and indemnity losses, interest on judgments, and expenses incurred in third-party recoveries.[51] 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.[52] 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 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

[51] "Retrospective Rating," *Risk Financing*, Supplement No. 46, May 1995: III.D.7.
[52] Dwight E. Levick & Barbara Grzincic, *Workers' Compensation: Exposures, Coverage, Claims*, 11-4 (1994).

premium.[53] 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.[54]

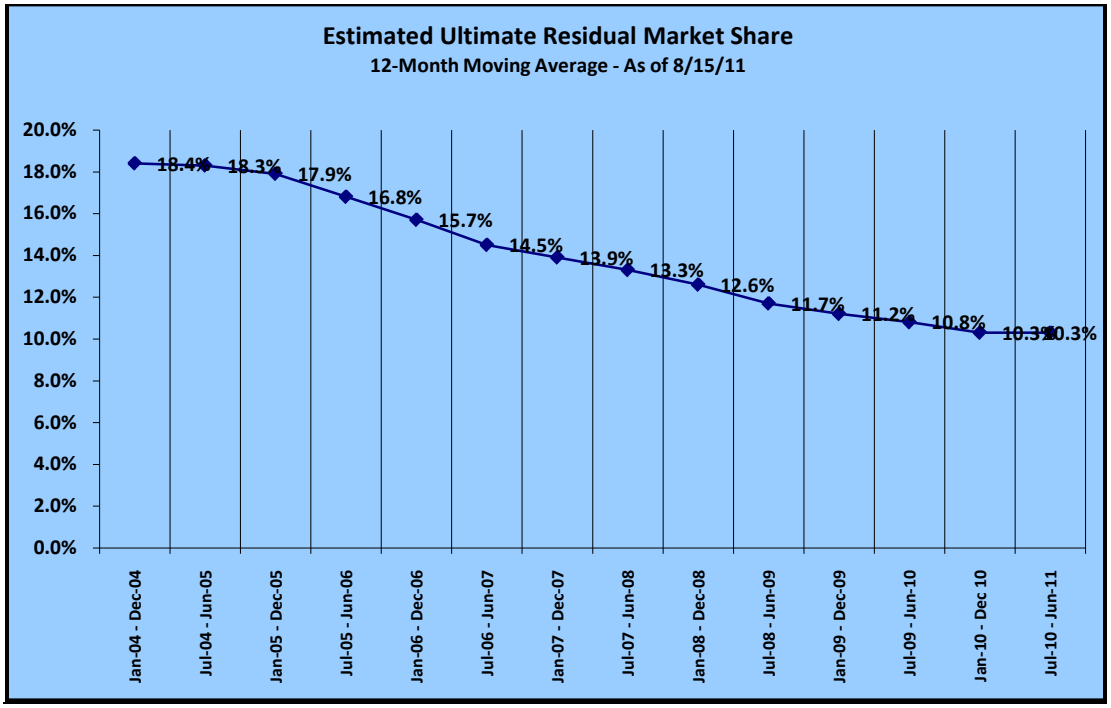
[53] "Risk Management-Life, Health, and Income Exposures," *Life Insurance*, Part 4: 406.
[54] "Thinking about the Work Comp Crisis," *Merritt Risk Management Review*, December 1991: 3.

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, 2011 is 10.3%. During the last seven 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. 09-11 (September 2, 2011).

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 2011) residual market loss ratio for Policy Year 2010 is 70.0%.

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 2010, the estimated Residual Market Burden (as of the first quarter of 2011) was 1546%, assuming a Loss Ratio of 70.0%.[55]

[55] WCRIB Special Bulletin No. 08-11 (August 4, 2011).

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 1980s and early 1990s. 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 77 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 CMR 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.[56] These regulations may be waived by the Director 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'11

Fiscal Year	New Licenses	Total Licenses	Companies Covered	Equivalent Premium Dollars
FY'11	0	100	389	$235M
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

[56] 452 CMR 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.[57]

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).[58] 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, 2011, Massachusetts had 22 active SIGs with 5,581 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
2011	22	5,581

Source: Division of Insurance

[57] 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." 211 CMR 67.02.

[58] 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. [59] The IFB was created in 1990 to investigate auto insurance fraud and expanded in 1991 to include workers' compensation fraud.[60] While its mission statement is to include all lines of insurance, the focus is on automobile and workers' compensation insurance.

In 2010, 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 2010, each of these bureaus separately contributed a total of $4,153,765 to fund the IFB. The 2010 operating expenses for the IFB totaled $8,440,648, which was very similar to 2009 operating expenses ($8,475,018).

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.

[59] 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.

[60] 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 2010, the IFB received 357 referrals regarding workers' compensation fraud. Workers' compensation fraud referrals only represent 9.1% of all IFB referrals. The vast majority of referrals (76.7%) received by IFB are for automobile insurance fraud (3,005 in calendar year 2010). 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 2010, there were 12 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 (213 individuals charged in 2010).

In calendar year 2010 there were 12 convictions for workers' compensation fraud (21 convictions for automobile insurance fraud) and seven cases were continued without a finding. During the year, $490,567 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 includes a number of state agencies and a partnership with the Insurance Fraud Bureau of Massachusetts.

Central to the Task Force's mission is helping honest businesses 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 benefits consumers and taxpayers by helping to ensure that purchased goods are properly licensed and regulated and that lost tax revenues are recovered.

The Task Force will release its 2011 annual report in January 2012. Once released, the report will be posted on the Task Force's website at www.mass.gov/dol/labortaskforce.

Member Agencies

Executive Office of Labor and Workforce Development
- Department of Industrial Accidents
- Department of Labor Standards
- Department 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

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

Massachusetts Commission Against Discrimination

Partner Agency

Insurance Fraud Bureau of Massachusetts

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

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ADVISORY COUNCIL MEMBERS, FY'11

BUSINESS

EDMUND C. CORCORAN, JR.
Raytheon Company
235 Wyman Street
Waltham, MA 02451-1219
Tel: **(781) 768-5115** FAX: (781) 768-5126

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

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 REGAN
Associated Industries of Massachusetts
One Beacon Street, 16th Floor
Boston, MA 02108
Tel: **(617)262-1180** FAX: (617) 536-6785

TERI A. MCHUGH
Boyle, Shaughnessy & Campo, P.C.
695 Atlantic Avenue
Boston, MA 02111
Tel: **(617) 451-2000** FAX: (617) 451-5775

LABOR

MICKEY LONG
AFL-CIO
193 Old Colony Avenue, P.O. Box E-1
Boston, MA 02127
Tel: **(617) 269-0229** FAX: (617) 269-0567

WILLIAM T. CORLEY
IBEW Local 103
256 Freeport Street
Dorchester, MA 02122
Tel: **(617) 268-4200** FAX: (617) 268-0330

JOHN A. PULGINI
Pulgini & Norton, LLP
10 Forbes Road West, Suite 240
Braintree, MA 02184
Tel: **(781) 843-2200** FAX: (781) 843-4900

STEPHEN JOYCE
New England Carpenters Labor Management Program
750 Dorchester Avenue
Boston, MA 02125-1132
Tel: **(617) 268-3400** FAX: (617) 268-6656

STEPHEN P. FALVEY
New England Regional Council of Carpenters
750 Dorchester Avenue
Boston, MA 02125-1132
Tel: **(617) 307-5132** FAX: (978) 685-7373

EX-OFFICIO

JOANNE F. GOLDSTEIN
Secretary, Exec. Office of Labor & Workforce Dev.
One Ashburton Place, Suite 2112
Boston, MA 02108
Tel: **(617) 626-7100** FAX: (617) 727-9725

EX-OFFICIO

GREG BIALECKI
Secretary, Exec. Office of Housing and Economic Dev.
One Ashburton Place, Suite 2101
Boston, MA 02108
Tel: **(617) 727-8380** FAX: (617) 727-4426

CLAIMANT'S BAR

BERNARD J. MULHOLLAND
Ford, Mulholland & Moran, P.C.
288 North Main St., P.O. Box 4499
Brockton, MA 02303
Tel: **(508) 586-5353**
FAX: (508) 588-8855

INSURANCE

TODD R. JOHNSON
T.D. Insurance
One Griffin Brook Drive
Methuen, MA 01844
Tel: **(978) 983-6925**
FAX:

MEDICAL PROVIDER

DENNIS M. HINES
South Shore Hospital
55 Fogg Road
So. Weymouth, MA 02190
Tel: **(781) 340-8590**
FAX: (781) 340-8146

STAFF

WILLIAM S. MONNIN-BROWDER, EXECUTIVE DIRECTOR *EVELYN N. FLANAGAN, SPECIAL PROJECTS COORDINATOR* *CHRISTINA PEURA, LEGAL INTERN*

APPENDIX B – Advisory Council Studies, 1989-2011

- 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, 2011-2012 Session

Senator Daniel A. Wolf (Chair)
State House - Room 511-B
Boston, MA 02133-1053
(617) 722-1350

Sen. Michael J. Rodrigues (Vice-Chair)
State House - Room 215
Boston, MA 02133-1053
(617) 722-1120

Senator Barry R. Finegold
State House - Room 424
Boston, MA 02133-1053
(617) 722-1578

Senator Sal N. DiDomenico
State House - Room 218
Boston, MA 02133-1053
(617) 722-1485

Senator Michael F. Rush
State House – Room 405
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. Lori A. Ehrlich (Vice-Chair)
State House - Room 472
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 Demetrius J. Atsalis
State House - Room 167
Boston, MA 02133-1053
(617) 722-2080

Representative David M. Torrisi
State House - Room 472
Boston, MA 02133-1053
(617) 722-2230

Representative Linda Dean Campbell
State House – Room 174
Boston, MA 02133-1053
(617) 722-2220

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

Representative Denis Andrews
State House - Room B1
Boston, MA 02133-1053
(617) 722-2263

Representative Keiko Orrall
State House - Room 236
Boston, MA 02133-1053
(617) 722-2220

APPENDIX D – Industrial Accident Nominating Panel

Philip Hillman, Director (Chair)
Division of Industrial Accidents
1 Congress Street, Suite 100
Boston, MA 02114
Tel: 617-727-4900 x356
Email: phillman@dia.state.ma.us

Joseph Bonfiglio, Business Manager
MA & Northern NE Laborers' District Council
7 Laborers' Way
Hopkinton, MA 01748
Tel: 508-435-4164/Cell: 617-877-6160
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: Joanne.Goldstein@MassMail.state.ma.us

Dennis Hines
11 Black Pond Hill Road
Norwell, MA 02061
Home: 781-659-7608/Office: 781-624-8590
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

Mark Reilly, Chief Legal Counsel to Governor
State House, Room 271
Boston, MA 02133
Tel: 617-725-4030
Email: mark.a.reilly@state.ma.us

Joseph P. Dusel
Pessolano, Dusel, Murphy & Casartello, P.C.
115 State Street, Fifth Floor
Springfield, MA 01115
Tel: 413-272-6332
Email: attorneys@PDMCPC.com

Omar Hernandez, Senior Judge
Division of Industrial Accidents
1 Congress Street, Suite 100
Boston, MA 02114
Tel: 617-727-4900 x307
Email: omar.hernandez@dia.state.ma.us

Stephen Marley
Director of Human Resources
Harvard University
Cambridge, MA 02138
Tel: 617-495-4586
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
Tentindo, Kendall, Canniff & Keefe, LLP
510 Rutherford Ave.
Boston, MA 02129
Tel: 617-788-3695
Email: vmt@tkcklaw.com

Maureen Flynn, General Counsel
Executive Office Housing & Economic Dev.
1 Ashburton Place, Suite 2101
Boston, MA 02108
Tel: 617-788-3672
Email: maureen.flynn@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.

Charles O. Cipollini – District 1
208 King Street
Fall River, MA 02724
GC: (617) 725-4015 x 1
Res: (508) 674-1093
Fax: (617) 727-6610

Kelly A. Timilty - District 2
52 Murray Hill Road
Roslindale, MA 02131
GC: (617) 725-4015 x 2
Res: (781) 326-2727
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
Email: marilyn.p.devaney@gov.state.ma.us

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

Terrence W. Kennedy - District 6
3 Stafford Road
Lynnfield, MA 01940
GC: (617) 725-4015 x 6
Bus: (617) 387-9809
Email: twklaw@aol.com

Jennie L. Caissie - District 7
53 Fort Hill Road
Oxford, MA 01540
GC: (617) 725-4015 x 7
Bus: (508) 765-0885
Email: jcaissie@caplettelaw.com

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, 2011

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

Current Members (2011):

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.	Omar Hernandez	Democrat	12/29/11
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.	<VACANT	<N/A>	
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.	<VACANT>	<N/A>	
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.	<VACANT>	<N/A>	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.	<VACANT>	<N/A>	
20.	Richard Tirrell	Democrat	05/14/10
21.	Kalina Vendetti	Democrat	09/22/16

APPENDIX H – WCAC Testimony: JCLWD Legislative Hearing, 5/19/2011

Joint Committee on Labor & Workforce Development
State House – Hearing Room A-2
May 19, 2011

Good morning. My name is Stephen Joyce I serve as a Labor Representative of the Massachusetts Workers' Compensation Advisory Council and have been asked to testify on behalf of the Council.

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 **Senate Bill 915,** filed by Senator Katherine Clark, **Senate Bill 938** filed by Senator Thomas M. McGee and **House Bill 468** filed by Representative Ronald Mariano. 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 four 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 927**, 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 1406**, 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 20 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 is new legislation and involves the requirement to provide workers compensation insurance for all employees in the company's workforce. The Advisory Council supports **House Bill 2308**, filed by Representative Tom Sannicandro which addresses the fines and penalties for failure to provide the required workers compensation insurance. Penalties would set at three times the premium would have paid in the assigned risk pool for the entire time it operated without insurance. If this period of time is seven days or less, the fine imposed would total $250 for each day the employer lacked insurance.

Presently, when the DIA's Office of Investigations learns that an employer is operating without insurance, a "stop-work-order" (SWO) is issued and the employer is fined $100 per day, starting the day of issuance and continuing until insurance is secured and penalties are paid. The present flat SWO fines haven't been updated in 23 years. It is important to note that this legislation would not remove the SWO process, but instead, change how the fines are calculated.

The second 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 542**, filed by Representative Tom Sannicandro, 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 third 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 1405**, 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 their 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, 3/30/11

MARCH 30, 2011
WORKERS' COMPENSATION RATE HEARING
DOCKET NO. R2011-01

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.

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 the proposed stipulation announced by the State Rating Bureau, the Attorney General's Office, and the WCRIB, the Advisory Council has refrained 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 Advisory Council is encouraged that the parties were able to reach a timely agreement to keep rates level for another year, which will greatly help employers in Massachusetts during the economic recovery. 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'12

RECOMMENDED FOR FUNDING

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

Mabbett & Associates, Inc.
5 Alfred Circle
Bedford, MA 01730
Category of Applicant: Private Employer
Geographic Target: Statewide
Program Administrator: Todd Dresser
Total Funds Approved: $24,192.70

JATC of Greater Boston
194 Freeport Street
Dorchester, MA 02122
Category of Applicant: Nonprofit
Geographic Target: Boston Region
Program Administrator: Chris Sherlock
Total Funds Approved: $23,733.70

Air Conditioning Contractors
11 Robert Tone Boulevard #234
North Attleboro, MA 02763
Category of Applicant: Trade
Geographic Target: Statewide
Program Administrator: Catherine Flaherty
Total Funds Approved: $23,617.57

Teamsters Local 25
544 Main Street
Boston, MA 02129
Category of Applicant: Labor Organization
Geographic Target: Boston Region
Program Administrator: Steven R. Sullivan
Total Funds Approved: $23,392.87

WNA Chelmsford, Inc.
6 Stuart Road
Chelmsford, MA 03824
Category of Applicant: Private
Geographic Target: Middlesex
Program Administrator: John Demers
Total Funds Approved: $23,112.00

New England Studio Mechanics
10 Tower Office Park, Suite 218
Woburn, MA 01801
Category of Applicant: Labor
Geographic Target: Statewide
Program Administrator: Gregg McCutchen
Total Funds Approved: $23,050.00

Boston Carpenters Apprenticeship & Training
750 Dorchester Avenue
Boston, MA 02125
Category of Applicant: Trade Association
Geographic Target: Statewide
Program Administrator: Eryn McDonald
Total Funds Approved: $22,014.36

New England Carpenters
113 Holman Road
Millbury, MA 01527
Category of Applicant: Trade Association
Geographic Target: Statewide
Program Administrator: Cathy Fenton
Total Funds Approved: $22,008.03

BEST Corporation
33 Harrison Avenue
Boston, MA 02111
Category of Applicant: Nonprofit
Geographic Target: Boston Region
Program Administrator: Mary Cronin
Total Funds Approved: $12,970.32

MASS COSH
42 Charles Street
Dorchester, MA 02122
Category of Applicant: Nonprofit
Geographic Target: Statewide
Program Administrator: Marcy Gelb
Total Funds Approved: $12,642.05

Sprinkler Fitters Local 550
46 Rockland Street
Boston, MA 02132
Category of Applicant: Labor Organization
Geographic Target: Boston Region
Program Administrator: Robin Gelbwachs
Total Funds Approved: $11,801.57

Housing Assistance Corp.
460 Main Street
Hyannis, MA 02601
Category of Applicant: Nonprofit
Geographic Target: Bristol, Plymouth, Nantucket
Program Administrator: Bill O'Neil
Total Funds Approved: $10,966.43

Greater Lowell Tech
250 Pawtucket Boulevard
Tyngsboro, MA 01879
Category of Applicant: Nonprofit
Geographic Target: Middlesex
Program Administrator: John Sheenan
Total Funds Approved: $7,934.00

Builders Association of Central MA
51 Pullman Street
Worcester, MA 01590
Category of Applicant: Labor Organization
Geographic Target: Boston Region
Program Administrator: Patricia Chalifoux
Total Funds Approved: $7,022.51

Tri-County Regional Tech
147 Pond Street
Franklin, MA 02038
Category of Applicant: Municipality
Geographic Target: Statewide
Program Administrator: Peter Dewar
Total Funds Approved: $11,984.00

Town of North Attleboro
43 South Washington Street
North Attleboro, MA 02760
Category of Applicant: Municipality
Geographic Target: Bristol
Program Administrator: Joanne Cathcart
Total Funds Approved: $11,673.70

Plumbers & Pipefitters Local 4
150 Hartwell Street
W. Boylston, MA 01583
Category of Applicant: Labor Organization
Geographic Target: Worcester
Program Administrator: Ray Beaudry
Total Funds Approved: $8,491.20

Cape Cod YMCA
P.O. Box 188
West Barnstable, MA 02668
Category of Applicant: Nonprofit
Geographic Target: Barnstable
Program Administrator: Christine Ezersky
Total Funds Approved: $7,380.64

Hall Keen Management
165 County Road
Plymouth, MA 02360
Category of Applicant: Nonprofit
Geographic Target: Statewid
Program Administrator: Janine Eaton
Total Funds Approved: $5,515.31

City of Cambridge DPW
147 Hampshire Street
Cambridge, MA 02139
Category of Applicant: Municipality
Geographic Target: Middlesex
Program Administrator: Catherine Mitrano
Total Funds Approved: $3,210.00

St. Pierre Manufacturing
317 East Mountain Street
Worcester, MA 01606
Category of Applicant: Private
Geographic Target: Statewide
Program Administrator: Peter St. Pierre
Total Funds Approved: $1,209.10

Riverdale Mills
130 Riverdale Street
Northbridge, MA 01534
Category of Applicant: Private
Geographic Target: Worcester
Program Administrator: Celina Rosa
Total Funds Approved: $1,872.50

APPENDIX L – Collections & Expenditures Report, FY'11 - FY'07

COLLECTIONS AND EXPENDITURES REPORT, FISCAL YEAR 2011 - FISCAL YEAR 2007

SPECIAL FUND	*FY'11*	*FY'10*	*FY'09*	*FY'08*	*FY'07*
COLLECTIONS					
INTEREST	**8,037**	**11,498**	**107,609**	**432,041**	**785,884**
ASSESSMENTS	20,550,569	20,269,416	20,458,701	17,245,272	15,301,449
LESS RET. CHECKS	(154,190)	(17,388)	(94,125)	(4,615)	0
LESS REFUNDS	0	(57,793)	(336,026)	(119,948)	(457)
SUB-TOTAL	**20,396,379**	**20,194,235**	**20,028,550**	**17,120,709**	**15,300,992**
REFERRAL FEES	3,791,090	3,993,493	4,786,125	4,068,091	4,362,429
COLLECTION FEE	0	0	0	(422)	(15,534)
LESS RET. CHECKS	(1,424)	(711)	(3,998)	(10,134)	(10,536)
LESS REFUNDS	(59,433)	(115,277)	(654,402)	(10,422)	(3,094)
SUB-TOTAL	**3,730,233**	**3,877,505**	**4,127,725**	**4,047,093**	**4,333,265**
1ST REPORT FINES	140,905	116,542	243,050	225,474	206,904
LESS COLLECTION FEE	0	0	0	0	(7,368)
LESS RET. CHECKS	(100)	(100)	(1,200)	(500)	(2,700)
LESS REFUNDS	(2,900)	(91,511)	(6,780)	(500)	(700)
SUB-TOTAL	**137,905**	**24,931**	**235,070**	**224,474**	**196,136**
STOP WORK ORDERS	1,844,816	1,645,564	1,381,180	535,396	391,328
LESS REFUNDS	0	(33,516)	0	(200)	0
EDS FEE	(65)	(48)	(21)	0	(71)
LESS BAD CHECKS	(2,200)	(3,348)	(11,200)	0	(300)
MERCHANT FEE	(6,326)	0	(5)	(1,224)	(1,091)
SUB-TOTAL	**1,836,225**	**1,608,652**	**1,369,954**	**533,972**	**389,867**
LATE ASSESS. FINES	268,393	45,498	74,673	26,942	20,400
MISCELLANEOUS	60,864	81,526	29,848	29,817	37,044
ADJUSTMENT	0	0	6,939	**0**	**0**
SUB-TOTAL	**329,257**	**127,024**	**111,460**	**56,759**	**57,444**
TOTAL SPECIAL FUND COLLECTIONS	**26,438,036**	**25,843,845**	**25,980,368**	**22,415,048**	**21,063,588**
BALANCE BRGT FWD	7,952,135	4,878,605	2,470,245	5,634,120	9,201,123
TOTAL	**34,390,171**	**30,722,450**	**28,450,613**	**28,049,168**	**30,264,710**
LESS EXPENDITURES	(22,288,912)	(22,770,315)	(23,572,008)	(25,602,577)	(24,630,590)
ADJUSTMENT	0	0	0	0	0
BALANCE	**12,101,259**	**7,952,135**	**4,878,605**	**2,446,591**	**5,634,121**
EXPENDITURES					
TOTAL COMPUTER	**7,476**	**2,786**	**37**	**414,431**	**1,020,176**
REPAYMENT - SALARIES	13,222,297	13,791,029	14,298,709	14,284,592	13,698,054
FRINGE BENEFITS	4,147,248	3,611,928	3,490,000	5,161,232	4,227,282
INDIRECT COSTS	367,840	742,764	365,987	265,292	255,506
NON-PERSONNEL COSTS	4,428,114	4,575,218	5,385,628	5,176,399	5,418,795
OTHER INDIRECT COSTS	214	24	0	3,312	9,534
IP INDIRECT-EXPENSE	40,254	46,566	31,647	0	1,243
ADJUSTMENT FRINGE	75,469	0	0	297,319	0
TOTAL REPAYMENT	**22,281,436**	**22,767,529**	**23,571,971**	**25,188,146**	**23,610,414**
TOT. SPECIAL FUND EXPENDITURES	**22,288,912**	**22,770,315**	**23,572,008**	**25,602,577**	**24,630,590**

COLLECTIONS AND EXPENDITURES REPORT, FISCAL YEAR 2011 - FISCAL YEAR 2007

PUBLIC TRUST FUND	*FY'11*	*FY'10*	*FY'09*	*FY'08*	*FY'07*
COLLECTIONS					
INTEREST	**618**	**884**	**4,039**	**8,466**	**9,718**
ASSESSMENTS	0	339	457	142,598	39,415
LESS FUNDS TRANSFERRED	0	(339)	(45)	(109,108)	0
TOTAL ASSESSMENTS	**0**	**0**	**412**	**33,490**	**39,415**
TOTAL PUBLIC TRUST COLLECTIONS	**618**	**884**	**4,451**	**41,956**	**49,133**
BALANCE BRGT FWD	406,711	846,303	841,852	799,896	750,763
TOTAL	**407,329**	**847,187**	**846,303**	**841,852**	**799,896**
LESS EXPENDITURES	0	(440,476)	0	0	0
BALANCE	**407,329**	**406,711**	**846,303**	**841,852**	**799,896**
EXPENDITURES					
RR COLAS	0	440,476	0	0	0
RR SEC. 37	0	0	0	0	0
RR SEC. 19 COLA	0	0	0	0	0
TOT. PUBLIC TRUST EXPENDITURES	**0**	**440,476**	**0**	**0**	**0**

PRIVATE TRUST FUND	*FY'11*	*FY'10*	*FY'09*	*FY'08*	*FY'07*
COLLECTIONS					
INTEREST	**19,778**	**28,012**	**128,052**	**268,411**	**308,118**
ASSESSMENTS	61,107,302	55,076,303	55,002,085	50,338,430	53,365,665
LESS RET. CHECKS	(116,286)	(24,085)	(282,474)	0	(2,500)
LESS REFUNDS	(45,686)	(67,776)	(980,934)	(87,852)	(196)
SUB-TOTAL	**60,945,330**	**54,984,442**	**53,738,678**	**50,250,578**	**53,362,969**
REIMBURSEMENTS	1,246,265	717,782	1,401,891	1,289,675	1,205,800
RET. CHECK	(3,075)	(3,603)	(11,496)	(1,569)	(28,053)
REFUNDS	(484)	(819)	(1,877)	(1,070)	(10,282)
SUB-TOTAL	**1,242,706**	**713,360**	**1,388,518**	**1,287,036**	**1,167,465**
SEC. 30 H	**53,358**	**0**	**25,924**	**0**	**3,393**
OTHER TRUST FUND	**0**	**0**	**87,378**	**238,385**	**0**
TOT. PRIVATE TRUST COLLECTIONS	**62,261,172**	**55,725,814**	**55,368,550**	**52,044,410**	**54,841,945**
BALANCE BRGT FWD	16,558,296	7,667,309	26,153,119	15,282,709	8,934,528
TOTAL	**78,819,468**	**63,393,123**	**81,521,669**	**67,327,119**	**63,776,473**
LESS EXPENDITURES	(52,061,907)	(46,834,827)	(73,853,717)	(41,174,001)	(48,493,764)
ADJUSTMENT	0	0	0	0	0
BALANCE	**26,757,561**	**16,558,296**	**7,667,952**	**26,153,118**	**15,282,709**

COLLECTIONS AND EXPENDITURES REPORT, FISCAL YEAR 2011 - FISCAL YEAR 2007

PRIVATE TRUST FUND	*FY'11*	*FY'10*	*FY'09*	*FY'08*	*FY'07*
CLAIMANTS - EXPENDITURES					
RR SEC. 34	1,238,194	1,414,491	1,209,059	1,320,000	1,248,883
RR SEC. 35	538,788	379,035	428,448	449,319	474,278
RR LUMP SUM	1,650,000	1,043,946	1,345,645	1,570,455	1,242,755
RR SEC. 36	446,949	180,802	220,957	502,719	176,065
RR SEC. 31	193,757	98,761	163,090	131,075	78,508
RR SEC. 34, PERM. TOTAL	584,210	620,747	436,661	376,980	356,338
RR COLA ADJ	292,068	227,594	269,725	331,026	275,751
RR EE MEDICAL	26,804	24,846	22,527	56,400	75,111
RR EE TRAVEL	6,500	5,219	3,500	2,059	6,045
RR EE MISC. EXPENSE	500	709	632	15,726	0
RR BURIAL BENEFITS	0	4,000	4,000	0	4,575
RR LEGAL FEES	684,853	604,005	618,683	672,952	606,698
RR VOC. REHAB SERVICES	0	8,168	10,666	11,874	9,956
RR REHAB (PRIOR YEAR)	147	0	0	504	63
RR MEDICAL	2,000,858	1,891,511	2,108,479	1,515,100	2,272,265
EE Books & Supplies	(1,513)	0	0	0	0
Edmond Calandra	450	0	0	0	0
Michael Laira/Solutions	3,007	0	0	0	0
Shattuck Hospital	442	0	0	0	0
SUB-TOTAL CLAIMANT PAYMENTS	**7,666,014**	**6,503,834**	**6,842,072**	**6,956,189**	**6,827,291**
MM TUITION	**2,926**	**4,653**	**6,649**	**6,438**	**4,541**
TOTAL CLAIMANTS	**7,668,940**	**6,508,487**	**6,848,721**	**6,962,627**	**6,831,832**
INSURERS - EXPENDITURES					
RR COLAS	14,746,147	11,081,676	33,566,021	5,751,523	8,032,750
RR SEC. 19 COLA LUMP SUM	886,304	685,552	872,730	989,176	1,085,082
RR LATENCY SEC. 35C	483,743	303,027	982,496	558,588	388,100
RR LATENCY SEC. 35C QUARTERLY	481,651	0	0	0	0
RR SEC. 37	15,688,574	15,765,761	20,116,257	16,990,276	19,389,653
RR SEC. 37 QUARTERLY	6,577,876	6,999,945	5,998,937	6,138,343	8,537,194
RR SEC. 37 INTEREST	33,538	111,948	304,741	84,808	198,285
TOTAL PAYMENT TO INSURERS	**38,897,833**	**34,947,909**	**61,841,182**	**30,512,714**	**37,631,064**
OEVR - EXPENDITURES					
MM TUITION	0	7,938	7,427	3,893	40,070
RR REHAB-30H	0	148	3,814	4,189	7,708
EE OTHER	0	0	463	182	896
RR EE TRAVEL	833	2,070	4,000	1,942	2,282
RR EE BOOKS & SUPPLIES	892	1,539	1,553	1,740	5,491
SUB-TOTAL OEVR EXP.	**1,725**	**11,695**	**17,257**	**11,946**	**56,447**

COLLECTIONS AND EXPENDITURES REPORT, FISCAL YEAR 2011 - FISCAL YEAR 2007

PRIVATE TRUST FUND	*FY'11*	*FY'10*	*FY'09*	*FY'08*	*FY'07*
DEFENSE - EXPENDITURES					
AA PAYROLL - SALARY	2,900,716	2,955,695	2,837,630	1,611,214	1,661,496
AA VACATION-IN-LEU	28,792	0	0	0	0
AA BONUS AND AWARDS	7,500	0	0	0	0
AA OVERTIME COSTS	0	0	0	362	26,798
AA SICK LEAVE BUY BACK	374	0	0	0	293
SUB-TOTAL	**2,937,382**	**2,955,695**	**2,837,630**	**1,611,576**	**1,688,587**
BB TRAVEL	54,674	44,308	0	18,877	23,291
BB CONFERENCE TRAINING	2,305	1,860	2,015	81	1,074
BB EMPLOYEE REIMBURS AP	1,929	0	0	0	0
BB EE REIMBURSEMENT	261	16	47,071	0	23
BB EMPLOYEE REIMBURS	142	5,333	5,976	5,265	1,774
SUB-TOTAL	**59,311**	**51,517**	**55,062**	**24,223**	**26,162**
CONTRACTED STUDENT INTERNS	29,513	7,290	9,010	5,803	**0**
SUB-TOTAL	**29,513**	**7,290**	**9,010**	**5,803**	0
DD FRINGE	979,676	821,784	732,511	632,427	542,343
DD MEDICAL EXPENSES	2,092	0	0	0	0
DD BOND	445	2,093	0	445	0
DD WC CHARGEBACK	14,575	44,072	16,556	57,571	18,842
DD HEALTH SERVICES CORP	0	0	2,092	1,935	0
SUB-TOTAL	**996,788**	**867,949**	**751,159**	**692,378**	**561,185**
EE RENTAL/MV CHRG-BACK	473	1,134	3,402	3,629	3,629
EE DEST. OLD RECORDS	7,201	7,201	7,052	6,912	5,875
EE ADVERTISING	232	0	713	365	990
EE BOOKS/SUPPLIES	25,650	27,127	27,241	20,138	29,220
EE IMPARTIAL APPEALS	14,400	13,950	17,188	13,050	13,950
EE CENTRAL REPRO.	0	2,615	2,686	2,821	1,170
EE POSTAGE	39,750	9,910	12,796	0	3,317
EE WATER	1,814	974	1,251	1,087	0
EE TRAINING / TUITION	0	0	0	0	(50)
EE TEMP USE SPACE	0	2,245	0	4,415	0
EE PRINTING	3,289	1,345	4,635	149	83
EE CONFERENCE, INCIDEN.	7,075	0	2,820	0	3,795
EE MCKENZIE	0	0	0	0	93,983
EE INDIRECT COSTS	92,657	94,063	82,829	35,696	44,578
EE POSTAGE CHRG-BACK	2,182	2,211	2,742	3,177	0
EE FIA CREDIT CARDS	0	0	0	1,852	0
EE MEMBERSHIPS	0	0	0	1,350	0
SUB-TOTAL	**194,723**	**162,775**	**165,355**	**94,641**	**200,540**
MED SUP/TOILETRIES & PERSONL	1,189	937	0	**0**	**0**
SUB-TOTAL	**1,189**	**937**	**0**	**0**	**0**
GG BOSTON LEASE	457,916	626,923	620,826	647,011	507,823
GG ELECTRICITY - BOSTON	1,384	20,970	26,792	33,994	13,409
GG FUEL FOR VEHICLES	0	0	63	**0**	**0**
SUB-TOTAL	**459,300**	**647,893**	**647,681**	**681,005**	**521,232**

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COLLECTIONS AND EXPENDITURES REPORT, FISCAL YEAR 2011 - FISCAL YEAR 2007

PRIVATE TRUST FUND	*FY'11*	*FY'10*	*FY'09*	*FY'08*	*FY'07*
HH CONSULTANTS	128,511	238,027	197,310	150,143	422,850
SUB-TOTAL	**128,511**	**238,027**	**197,310**	**150,143**	**422,850**
JJ OPERATIONAL SERV.	229,083	167,589	144,383	186,493	391,137
SUB-TOTAL	**229,083**	**167,589**	**144,383**	**186,493**	**391,137**
KK EQUIPMENT	172,899	31,564	6,649	18,914	1,650
SUB-TOTAL	**172,899**	**31,564**	**6,649**	**18,914**	**1,650**
LL CBE HOLDINGS	2,319	3,028	35,791	12,711	4,536
LL XEROX	3,574	124	424	1,113	0
LL ORACLE	19,268	18,705	17,607	23,583	13,692
LL ASAP SOFTWARE EXPRS	0	0	22,963	18,489	0
LL SIMPLEX TIME RECORDER	637	213	424	245	0
LL PITNEY BOWES	1,638	1,150	1,439	1,419	1,272
LL IKON	435	498	608	784	0
LL DONNEGAN SYSTEMS	312	0	0	0	0
LL SUN MICROSYSTEMS	0	0	4,982	4,467	3,601
LL RETROFIT	104	2,811	6,086	3,829	2,527
LL MILLENNIUM MECHAN	0	1,027	1,395	992	0
LL FIRE EQUIPMENT	0	0	225	183	0
LL ENTERPRISE RENT-A-CAR	43,703	46,952	27,113	4,979	3,808
LL CAM OFFICE SERVICES	0	60	222	222	0
LL NTIRETY	0	0	0	0	3,371
LL RONCO COMM & ELEC	0	0	0	0	21,233
LL MMARS ACCT SYST	2,685	33,540	2,672	2,652	1,872
LL KEANE	0	0	0	2,603	0
LL DELL MARKETING	58,398	33,847	85,670	32,865	43,038
LL QWEST COMM.	424	360	356	332	376
LL ITT COMPUTER SERV.	32,605	2,941	22,439	23,460	16,327
LL VERIZON SERVICES	25,118	4,839	37,964	23,296	17,918
LL AMS IMAGINING	34,839	23,403	30,692	0	116
LL TELEPHONE LEASE	0	0	1,188	4,754	4,753
LL NEXTELL	0	0	0	2,500	2,702
LL EGI BUSINESS TRUST	0	0	0	17,434	18,826
LL EMC CORP.	0	0	0	1,500	0
LL PEOPLESERVE	0	0	0	6,306	0
LL PAUL DAUBITZ	0	0	0	1,648	0
LL OVERTURE PARTNERS	0	0	0	3,900	0
LL LANTEL COM	388	166	1,276	3,494	0
LL CITY LIGHTS ELEC	0	0	0	2,543	0
LL ULTRAGUARD PROTECT	0	65	156	156	0
LL EASTON CONSULTING	0	0	4,000	0	0
LL ATLANTIC ASSOCIATES	0	21,295	7,963	0	0
LL COMM-TRACT	3,319	0	440	0	0
LL PAETEC COMM	10,781	8,562	7,500	0	0
LL GATEWAY COMPANIES	0	0	0	1,825	0
LL STENOGRAPHER CORP	5,181	0	0	434	0

(CONTINUED ON NEXT PAGE)

COLLECTIONS AND EXPENDITURES REPORT, FISCAL YEAR 2011 - FISCAL YEAR 2007

PRIVATE TRUST FUND	*FY'11*	*FY'10*	*FY'09*	*FY'08*	*FY'07*
LL GRAYBAR ELECTRIC	389	0	600	0	0
LL GOVT CONNECTION	1,085	6,543	1,430	0	0
LL INTEGRATED PARTNERS	10,100	2,370	6,944	2,450	0
LL RALCO ELECTRIC	0	258	0	0	0
LL BCM CONTROLS	0	50	0	0	0
LL HEWLETT PACKARD	48	0	0	0	0
LL CELLO PARTNERSHIP	0	19,415	0	0	0
LL DIGITAL RESOURCES	0	640	0	0	0
SUB-TOTAL	**257,350**	**235,500**	**332,008**	**208,691**	**159,968**
NN WEBSTER CONSTRUCTION	7,127	0	0	0	0
NN CROCKER ELECTRICAL	350	0	0	0	0
NN BELLO PAINTING	1,200	0	0	0	0
NN DUGMORE & DUNCAN	67	0	0	0	0
NN TRIUMVIRATE ENVIRONMENT	388	0	0	0	0
NN SAVE THAT STUFF	134	0	0	0	0
NN EA SPRY	13,588	0	0	0	0
NN EOS APPROACH	2,046	2,188	1,439	1,523	0
NN B&G SERVICES	1,268	0	0	0	0
NN NON-MAJOR INFRA MAIN	0	0	0	0	725
NN DOC DESTRUCTION	0	0	0	2,847	385
NN INTEGRATED ELEC SVCS	1,192	450	0	0	0
NN PASEK EQUIPMENT	0	0	43	0	0
NN ACCENT BANNER	0	0	117	0	**0**
NN KILLEN ELECTRIC SVC	0	0	150	**0**	**0**
SUB-TOTAL	**27,360**	**0**	**310**	**2,847**	**1,110**
RR PENALTIES SEC. 8	0	0	0	10,000	0
SUB-TOTAL	**0**	**0**	**0**	**10,000**	**0**
TOTAL DEFENSE EXPENDITURES	**5,493,490**	**5,366,736**	**5,146,557**	**3,686,714**	**3,974,421**
TOTAL PRIV. TRUST EXPENDITURES	**52,061,907**	**46,834,827**	**73,853,717**	**41,174,001**	**48,493,764**

DIA - INCOME SUMMARY

INCOME SUMMARY	*FY'11*	*FY'10*	*FY'09*	*FY'08*	*FY'07*
Total Assessments (All 3 Funds)	81,341,709	75,178,677	73,767,640	67,404,777	68,703,376
Total Filing Fees	3,730,233	3,877,505	4,127,725	4,047,093	4,333,265
Total First Report Fines	137,905	24,931	235,070	224,474	196,136
Total SWOs	1,836,225	1,608,652	1,369,954	533,972	389,867
Total Misc. Fines	60,864	81,526	29,848	29,817	37,044
Total 5% Fines (Late Assess.)	268,393	45,498	74,673	26,942	20,400
Total Reimbursements	1,242,706	713,360	1,388,518	1,287,036	1,167,465
Total 30H	53,358	0	25,924	0	3,393
Total Other Trust Fund	0	0	87,378	0	0
Yr. Adj. for Refunds to TF	0	0	6,939	238,385	0
Total Interest	28,433	40,394	239,700	708,918	1,103,720
TOTAL INCOME	**88,699,826**	**81,570,543**	**81,353,369**	**74,501,414**	**75,954,666**

APPENDIX M – Workers' Compensation Legislation, 2011-2012 Session

H.39	NEW	Reorganization – Executive Office of Labor & Workforce Development
H.468*	*Similar*	Increasing Criminal Penalties for Failing to Provide WC Insurance
H.532	*Refile*	Workers' Compensation Payroll Audits – Requirements & Penalties
H.536	*Refile*	Exemption of Funeral Home Assistants from WC and Unemployment
H.542*	*Refile*	Notification of Workers' Compensation Coverage or Cancellation
H.549	*Refile*	Extending OSHA Protections to Public Employees
H.593	NEW	Protections for Volunteer Registered Nurses in Disasters & Emergencies
H.1395	*Refile*	Video Recording of Impartial Medical Exams
H.1405*	*Refile*	Penalties for Failing to Timely Report Injuries
H.1406*	*Refile*	Burial Expenses – Increasing Maximum Burial Allowance from $4,000 to $8,000
H.1408	*Refile*	Competitive Determination of WC Insurance Rates (Loss Cost)
H.1664	*Refile*	Presumption of Occupational Disease – Police, Firefighters, EMS
H.2288	*Refile*	Average Weekly Wage for Subsequent Injuries - Attorney Fees
H.2289	*Refile*	Average Weekly Wage for Subsequent Injuries – Attorney Fees
H.2290	*Refile*	Impartial Medical Exams
H.2299	*Refile*	Serious and Willful Misconduct
H.2308*	NEW	Stop Work Order Fines – 3x Premium Avoided
H.2442	*Refile*	Presumption of Occupational Disease – Police, Firefighters, EMS
H.2868	NEW	Scar Based Disfigurement – Separate Benefits for Non-Surgical/Surgical
H.3209	*Refile*	Public Records Exemption – Information within the First Report of Injury
S.127	NEW	Registration Requirements for Professional Employer Organizations (PEOs)
S.915*	*Similar*	Increasing Criminal Penalties for Failing to Provide WC Insurance
S.925	NEW	Affordable Fee Schedule Rates – Coverage Determination
S.927*	*Refile*	Scar-Based Disfigurement
S.938*	*Refile*	Increasing Criminal Penalties for Failing to Provide WC Insurance
S.963	*Refile*	Comprehensive
S.968	*Refile*	Stop Work Orders for Tax & Insurance Fraud – Retroactive Penalties
S.1828	*Refile*	WC Benefits for Members of the Armed Services and National Guard

* Endorsed by the Workers' Compensation Advisory Council.

NOTE: House Bill 2308 was filed by Representative Tom Sannicandro on behalf of the Advisory Council.

HOUSE BILL 39 - Passed Into Law

Subject: Reorganization - Executive Office of Labor & Workforce Development
Primary Sponsor: Governor Deval Patrick
Type of Bill: NEW (Article 87 of the Massachusetts Constitution)
WCAC Position: Monitoring
Statutes Affected: c.152; c.23; c.23E; c.23H; c.149 et al.

This proposed reorganization plan would restructure and streamline the Executive Office of Labor & Workforce Development (EOLWD). Specifically, the bill would eliminate the Department of Labor and the Department of Workforce Development, absorbing their functions within EOLWD. The former Division of Occupational Safety would be renamed the Department of Labor Standards and the Division of Apprenticeship Training will become part of this new department. All remaining EOLWD agencies would report directly to the Secretary of EOLWD.

House Bill 39 also creates uniformity within EOLWD by renaming the "Divisions" as "Departments," all led by a Director. The five departments are: (1) the Department of Industrial Accidents; (2) the Department of Unemployment Assistance; (3) the Department of Career Services; (4) the Department of Labor Relations; and (5) the Department of Labor Standards.

A provision within the reorganization plan allows the Secretary to identify and consolidate "core administrative functions" common to its agencies, including, but not limited to, human resources, financial management, information technology, legal, and procurement and asset management. The Advisory Council has been advised that this section was inserted at the urging of the State Comptroller to maintain consistency among reporting agencies for the Massachusetts Management Accounting & Reporting System (MMARS).

HOUSE BILL 468

Subject: Increasing Criminal Penalties for Failing to Provide WC Insurance
Primary Sponsor: Representative Ronald Mariano (D)
Type of Bill: Similar (S.729 in the 2009-2010 Legislative Session)
WCAC Position: Endorsed by the Advisory Council (2009-2010)
Statutes Affected: c.152, §25C (Stop Work Orders & Penalties)

This legislation (identical to S.915 filed this legislative session) would increase the severity of criminal penalties levied against employers who fail to provide workers' compensation coverage for their employees. Under this bill, employers convicted of a criminal offense, 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 jail 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 to no more than $1,500 or by imprisonment for not more than 1 year, or both.

HOUSE BILL 532

Subject: Workers' Compensation Payroll Audits - Requirements & Penalties
Primary Sponsor: Representative Michael F. Kane (D)
Type of Bill: Refile (H.1846 in the 2009-2010 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §25V (New Section)

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 a criminal offense 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 (Regulation of 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 a demand would be grounds for the insurer to immediately cancel coverage.

HOUSE BILL 536

Subject: Exemption of Funeral Home Assistants from WC and Unemployment
Primary Sponsor: Representative Peter J. Koutoujian (D)
Type of Bill: Refile (H.3916 in the 2009-2010 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §2A (Application of Amendments of Statute); c.151A (Unemployment Insurance); c.111M (Individual Health Coverage)

This refiled bill aims to exempt funeral home assistants, performing specific services, from the employment provisions of Chapter 152 (Workers' Compensation), Chapter 151A (Unemployment Insurance), and Chapter 111M (Individual Health Coverage). The specific services include: (1) parking lot assistants; (2) placement of flowers in respective rooms for decedents services; (3) doorman, greeting visitors indicating which room the family is in; (4) giving directions to church and cemeteries for respective services; (5) rearranging furniture and chairs before and after services; (6) arranging floral tributes in service room and removing for delivery to ceremony; (7) delivering flowers to nursing homes after services; (8) serving as supplemental pallbearers with family members; (9) serving as ushers during church services; (10) assisting elderly and handicap visitors enter and exit for services; and (11) setting out traffic funeral cones at the church where services are to be held.

Prior to the amendments made to the Massachusetts Independent Contractor Law in 2004, various funeral homes utilized the services of independent contractors to perform the above listed jobs. Testimony on this legislation during the 2009-2010 Legislative Session expressed that this menial part-time work was often conducted by retirees to help supplement their income. It was also noted that classifying these workers as employees creates a cost-hardship for many small funeral homes who can't afford to pay the required state-mandated benefits. Testimony by Representative Peter Koutoujian stated that only 17%, of the 600 funeral homes in Massachusetts, conduct more than 40 funerals per year.

HOUSE BILL 542

Subject: Notification of Workers' Compensation Coverage or Cancellation
Primary Sponsor: Representative Tom Sannicandro (D)
Type of Bill: Refile (H.1839 in the 2009-2010 Legislative Session)
WCAC Position: Endorsed by the Advisory Council (2009-2010)
Statutes Affected: c.152, §22 (Notice by Insured to New Employees; Notice of Cessation of Insurance)

This refiled legislation would create fines against employers who fail to provide notice to their new employees that they have secured workers' compensation insurance for them. In addition, the fines would extend to employers who fail to provide their employees notice 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 549

Subject: Extending OSHA Protections to Public Employees
Primary Sponsor: Representative Martin J. Walsh (D)
Type of Bill: Refile (H.1871 in the 2009-2010 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.149, §40 (New Section within Labor & Industries)

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.

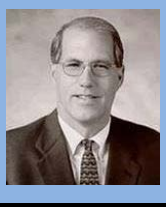
When the Occupational Safety and Health Act (OSHA) passed in 1970, it mandated that private sector workers be covered by OSHA standards and regulations but made it optional for states to adopt these protections for their public employees. Under OSHA, the federal government will pay for 50% of the operating costs associated with a state's plan to cover public employees. Presently, more than 20 states provide public sector workers with OSHA protections. In Massachusetts there are approximately 400,000 employees in the public sector. This legislation gained attention in 2004 following the death of a MassPort electrician who was electrocuted at Logan Airport. A report later issued by DOS documented a number of safety measures (required under OSHA) that could have saved his life.

HOUSE BILL 593

Subject: Protections for Volunteer Registered Nurses in Disasters & Emergencies
Primary Sponsor: Representative Sean Garballey (D)
Type of Bill: NEW
WCAC Position: Monitoring
Statutes Affected: c.112, §C ½ (Immunity of Physician or Nurse); c.152, §§ 69-75 (WC Benefits for State Employees)

This legislation would provide both immunity protections and workers' compensation benefits to registered nurses in Massachusetts who volunteer their services during declared disasters and emergencies. Specifically, this bill would provide volunteer registered nurses with immunity from licensure board discipline and from civil or criminal liability for any harm caused (not amounting to criminal negligence). In addition, the legislation would provide workers' compensation benefits to registered nurses if they are injured, disabled, or killed while volunteering during a declared disaster or emergency. Said registered nurses would be considered an employee of the Commonwealth and be compensated in a like manner as state employees are compensated under Chapter 152.

HOUSE BILL 1395



Subject: Video Recording of Impartial Medical Exams
Primary Sponsor: Representative William C. Galvin (D)
Type of Bill: Refile (H.3693 in the 2009-2010 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §11A(2) (Impartial Medical Examiners)

This refiled 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 1405

Subject: Penalties for Failing to Timely Report Injuries
Primary Sponsor: Representative David M. Torrisi (D)
Type of Bill: Refile (H.1863 in the 2009-2010 Legislative Session)
WCAC Position: Endorsed by the Advisory Council (2009-2010)
Statutes Affected: c.152, §6 (Notice of Injuries)

This refiled legislation 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 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 1405 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-day period a fine payment is late.

HOUSE BILL 1406

Subject: Burial Expenses - Increases Maximum Amount from $4,000 to $8,000
Primary Sponsor: Representative David M. Torrisi (D)
Type of Bill: Refile (H.1865 in the 2009-2010 Legislative Session)
WCAC Position: Endorsed by the Advisory Council (2009-2010)
Statutes Affected: c.152, §33 (Burial Expenses)

This refiled bill would require an insurer to pay for burial expenses when a worker has died as a result of a work related injury, not to exceed eight thousand dollars. 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 charges such as flowers and obituaries. 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.

HOUSE BILL 1408

Subject: Competitive Determination of WC Insurance Rates (Loss Cost)
Primary Sponsor: Representative David M. Torrisi (D)
Type of Bill: Refile (H.1864 in the 2009-2010 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §53A (Classification of Risks and Premiums)

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 1408, 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

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HOUSE BILL 1408 CONTINUED

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.

The American Insurance Association (AIA) supported this legislation during the 2009-2010 Legislative Session. According to AIA's testimony, the proposed 'loss cost' rate making system would be similar to that used in 40 other jurisdictions and all of the other New England States. In February 2008, New York passed legislation establishing a loss cost workers' compensation rating system.

HOUSE BILL 1664

Subject: Presumption of Occupational Disease - Police, Firefighters, EMS
Primary Sponsor: Representative Martin J. Walsh (D)
Type of Bill: Refile (H.2657 in the 2009-2010 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.32 (Retirement Systems & Pensions); c.41 (Officers & Employers of Cities, Towns and Districts); c.152 (Workers' Compensation)

This refiled legislation (identical to H.2442 filed this legislative session) would create a presumption that a contagious disease, contracted by a full-time uniformed member of the police department, fire department, or municipal emergency medical service, was contracted in the line of duty for the purposes of retirement, pension and workers' compensation benefits. Said employees must have served for a minimum of five years and have passed a physical examination prior to impairment that failed to reveal such condition. Under this bill, benefits can be denied if there is a preponderance of the evidence that non-service connected risk factors, accidents, or hazards caused such incapacity. Benefits would be payable as of the date on which the employee last received regular compensation.

HOUSE BILL 2288 & 2289

Subject: AWW for Subsequent Injuries - Attorney Fees
Primary Sponsor: Representative Garrett J. Bradley (D)
Type of Bill: Refile (H.1827 and H.1828 in the 2009-2010 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §1(1) (Definition of "AWW"), §13A(4) (Attorney's Fees)

Section 1 of the these two identical refiled bills addresses injured employees who return to work (without a lump sum settlement) and receive wages that are less than the pre-injury wages as a result from their prior injury. 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 requires that insurers and self-insurers pay the employees counsel attorney fees, in the amount of $700 (plus all necessary expenses), in the event said insurer or self-insurer files a complaint to reduce or eliminate benefits and withdraws said complaint prior to five days before a hearing or otherwise contests a claim, and fails to begin compensation within 21 days when required to pay benefits following a conference. This amount is reduced to $350 in the event said insurer or self-insurer withdraws a complaint within five days of a hearing. This bill also requires the reduction of any attorney fee (payable through this section) by half when the attorney fails to appear to a conciliation without good cause.

HOUSE BILL 2290

Subject: Impartial Medical Exams
Primary Sponsor: Representative Garrett J. Bradley (D)
Type of Bill: Refile (H.1826 in the 2009-2010 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §9C (New Section), §11A(2) (Impartial Medical Exams)

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 only be requested by the insurer at the conference stage following the expiration of the 180-day pay without prejudice period.

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.

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HOUSE BILL 2290 CONTINUED

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 bill also requires that the impartial medical report be entered into evidence at the hearing, but removes the current statutory requirement that it be treated as prima facie evidence. This will allow other medical evidence (employee's treating physician and insurer reports) to be weighed by the Administrative Judge. 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 2299

Subject: Serious and Willful Misconduct - Intoxication & Controlled Substances
Primary Sponsor: Representative Bradley H. Jones, Jr. (R)
Type of Bill: Refile (H.1811 in the 2009-2010 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §27 (Willful Misconduct of Employee)

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 (Controlled Substances Act). 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 2308

Subject: Stop Work Order Fines - 3x Premium Avoided
Primary Sponsor: Representative Tom Sannicandro (D)
Type of Bill: NEW
WCAC Position: Bill Filed on Behalf of the WCAC
Statutes Affected: c.152, §25C (Stop Work Orders & Penalties)

This new legislation, filed on behalf of the Workers' Compensation Advisory Council, would replace the present flat-fine levied against employers caught operating without workers' compensation insurance with a fine based on the amount of premium the employer avoided. Specifically, House Bill 2308 establishes premium avoidance fines that charge uninsured employers 3-times the premium the employer would have paid in the assigned risk pool for the entire period it operated without insurance. If this period is seven days or less, the fine imposed would total $250 for each day the employer lacked insurance. All monies collected would be deposited into the DIA's Private Employer Trust Fund which pays for the workers' compensation benefits to injured workers of uninsured employers.

Presently, when the DIA's Office of Investigations learns that an employer is operating without insurance, a "stop work order" (SWO) is issued and the employer is fined $100 per day, starting the day of issuance and continuing until insurance is secured and penalties are paid. The present flat SWO fines have not been updated in 23 years. It is important to note that this legislation would not remove the SWO process, but instead, change how fines are calculated.

The proposed legislation also deletes a provision requiring that a higher fine be charged to employers who lose on appeal of a SWO at an administrative hearing. This language was proposed to address concerns for potential due process violations with having an increased fine on employers who choose to appeal a SWO.

HOUSE BILL 2442

Subject: Presumption of Occupational Disease - Police, Firefighters, EMS
Primary Sponsor: Representative John P. Fresolo (D)
Type of Bill: Refile (H.2657 in the 2009-2010 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.32 (Retirement Systems & Pensions); c.41 (Officers & Employers of Cities, Towns and Districts); c.152 (Workers' Compensation)

This refiled legislation (identical to H.1664 filed this legislative session) would create a presumption that a contagious disease, contracted by a full-time uniformed member of the police department, fire department, or municipal emergency medical service, was contracted in the line of duty for the purposes of retirement, pension and workers' compensation benefits. Said employees must have served for a minimum of five years and have passed a physical examination prior to impairment that failed to reveal such condition. Under this bill, benefits can be denied if there is a preponderance of the evidence that non-service connected risk factors, accidents, or hazards caused such incapacity. Benefits would be payable as of the date on which the employee last received regular compensation.

HOUSE BILL 2868

Subject: Scar-Based Disfigurement - Separate Benefits for Non-Surgical/Surgical
Primary Sponsor: Representative James Arciero (D)
Type of Bill: NEW
WCAC Position: Monitoring
Statutes Affected: c.152, §36(k) (Specific Injuries)

This new legislation would create two distinct benefit scenarios for bodily disfigurement depending on whether or not disfigurement was caused by a surgical procedure. For non-surgical disfigurement or burns resulting in disfigurement, compensation would be awarded regardless of the location on the body, subject to a $15,000 maximum benefit (this is the present maximum benefit). For surgical scarring, compensation would be awarded only for those scars located on the face, neck or hands, also subject to a $15,000 maximum. In 1991, section 36(K) was amended, requiring that all benefits for scar-based disfigurement be limited to those scars appearing on the face, neck or hands.

HOUSE BILL 3209

Subject: Public Records Exemption - Information within the First Report of Injury
Primary Sponsor: Representative John P. Fresolo (D)
Type of Bill: Refile (H.2989 in the 2009-2010 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.4, §7(26c) (Definition of "Public Records")

This refiled legislation would exempt from the Public Records Law specific information contained within the First Report of Injury Form (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.

Prior to 2003, a select group of law firms in Massachusetts had regularly been requesting and receiving from the DIA a monthly lists of the names and addresses of injured workers contained on the Form 101 filed by employers. These lists were used by the firms to generate information mailings (advertisements) to injured workers. Following the DIA's stoppage of this practice in 2003, the agency was sued. In February of 2011, the Massachusetts Court of Appeals ruled in the DIA's favor in *Georgiou v. Commissioner of the Department of Industrial Accidents,* stating that names and addresses of employees injured on the job are not open to the public due to personal privacy concerns.

SENATE BILL 127

Subject: Registration Requirements for Professional Employer Organizations (PEOs)
Primary Sponsor: Senator Michael J. Rodrigues (D)
Type of Bill: NEW
WCAC Position: Monitoring
Statutes Affected: c.152, §15 (Liability of Person Other than Insured); et al.

This new legislation would regulate the Professional Employer Organization (PEO) industry in Massachusetts by requiring registration with the Massachusetts Office of Consumer Affairs and Business Regulations. PEOs (also known as Employee Leasing Companies) are businesses that form a "co-employer relationship" with existing small businesses to enable them to outsource the management of human resources, employee benefits, payroll and workers' compensation. It is important to note that a PEO is not an employee staffing agency or temporary service provider.

Specifically, Senate Bill 127 would create a regulatory framework for the PEO industry by:

1. Requiring transparency through annual registration of all PEOs;
2. Ensuring that PEOs are financially solvent through annual financial disclosures to ensure that small businesses that partner with PEO's are not harmed;
3. Detailing clear responsibilities of both the PEO and client to ensure consumers are aware of the rights and responsibilities involved in the PEO relationship; and
4. Extending the workers' compensation "exclusive remedy" doctrine to protect both PEOs and their clients when each is in compliance with requirements of Chapter 152.

Language contained in Senate Bill 127 is very similar to language set forth in the "Model Professional Employer Organization Act," developed by the National Association of Professional Employer Organizations (NAPEO). According to NAPEO, 36 states across the country regulate the PEO industry through licensing and/or registration programs.

SENATE BILL 915

Subject: Increasing Criminal Penalties for Failing to Provide WC Insurance
Primary Sponsor: Senator Katherine Clark (D)
Type of Bill: Similar (S.729 in the 2009-2010 Legislative Session)
WCAC Position: Endorsed by the Advisory Council (2009-2010)
Statutes Affected: c.152, §25C (Stop Work Orders & Penalties)

This legislation (identical to H.468 filed this legislative session) would increase the severity of criminal penalties levied against employers who fail to provide workers' compensation coverage for their employees. Under this bill, employers convicted of a criminal offense, 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 jail 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 to no more than $1,500 or by imprisonment for not more than 1 year, or both.

SENATE BILL 925

Subject: Affordable Fee Schedule Rates - Coverage Determinations
Primary Sponsor: Senator James B. Eldridge (D)
Type of Bill: NEW
WCAC Position: Monitoring
Statutes Affected: c.152, §13 (Rate of Payment by Insurers)

This new legislation would require that the rate of payment by insurers for health care services be "sufficient to ensure that the injured can afford all necessary care." Currently, the Division of Health Care Finance & 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. This bill also requires the Commissioner (does not specify DIA or DHCFP) to ensure that compensation and coverage determinations are made in a timely manner.

SENATE BILL 927

Subject: Scar-Based Disfigurement
Primary Sponsor: Senator John A. Hart (D)
Type of Bill: Refile (S.681 in the 2009-2010 Legislative Session)
WCAC Position: Endorsed by the Advisory Council (2009-2010)
Statutes Affected: c.152, §36(k) (Specific Injuries)

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 938

Subject: Increasing Criminal Penalties for Failing to Provide WC Insurance
Primary Sponsor: Senator Thomas M. McGee (D)
Type of Bill: Refile (S.729 in the 2009-2010 Legislative Session)
WCAC Position: Endorsed by the Advisory Council (2009-2010)
Statutes Affected: c.152, §25C (Stop Work Orders & Penalties)

This refiled bill would increase the severity of criminal penalties levied against employers who fail to provide workers' compensation coverage for their employees. Under this bill, employers convicted of a criminal offense, 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 963

Subject: Comprehensive
Primary Sponsor: Senator Bruce E. Tarr (R)
Type of Bill: Refile (S.716 in the 2009-2010 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §14 (Actions Not Based on Reasonable Grounds), §24 (Waiver of Right of Action for Injuries), §11 (Hearings; Evidence; Continuances), §8 (Termination or Modification of Benefits), §30 (Adequate and Reasonable Health Care Services).

Section 1 of this refiled bill 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 963 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 963 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 968

Subject: Stop Work Orders for Tax & Insurance Fraud - Retroactive Penalties
Primary Sponsor: Senator James E. Timility (D)
Type of Bill: Refile (S.718 in the 2009-2010 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.62B (Withholding of Taxes); c.151A (Unemployment Insurance); c.152, §25C (Stop Work Orders & Penalties)

This refiled bill would create a stop work order (SWO) process, similar to the one used by the DIA's Office of Investigations in §25C, for employers that fail to withhold and/or pay taxes or fail to contribute to the Unemployment Compensation Fund. The Department of Revenue would oversee the SWO process for state tax violations and the Executive Office of Labor & Workforce Development would oversee the SWO process for Unemployment Insurance violations. Both SWO processes contain provisions requiring the immediate cessation of all business operations, civil fines of $100 per day for each day of non-compliance, an appeal process, licensing and permit removal, and debarment from state contracts for a 3-year period.

Senate Bill 968 also amends the DIA's present SWO process by changing how the civil penalties are calculated. Upon receiving a SWO, violating employers would be required to pay a retroactive penalty of $100 per day, counting the first date of non-compliance as the first day, and the date of payment of penalty and production of insurance as the final day. Under current law, SWO penalties begin accruing on the date the SWO is issued and cease when the employer has made payment of the penalty and produced evidence of insurance coverage.

SENATE BILL 1828

Subject: WC Benefits for Members of the Armed Services and National Guard
Primary Sponsor: Senator Thomas M. McGee (D)
Type of Bill: Refile (S.695 in the 2009-2010 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §1(7A) (Definition of "Personal Injury")

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.

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