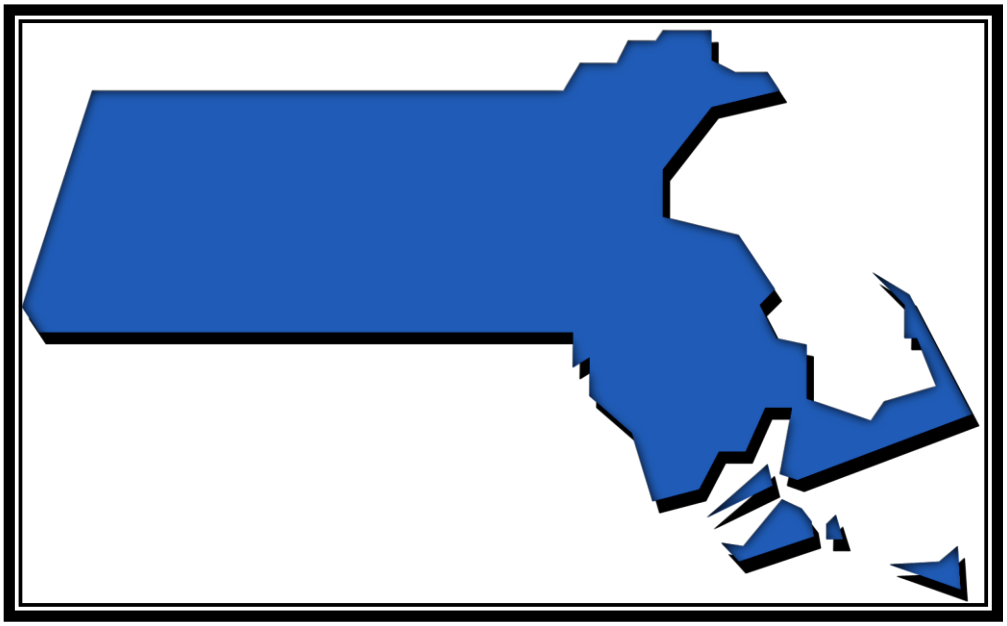
COMMONWEALTH OF MASSACHUSETTS

FISCAL YEAR 2013 ANNUAL REPORT

THE STATE OF THE MASSACHUSETTS WORKERS' COMPENSATION SYSTEM



MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

APRIL 2014

THE STATE OF THE MASSACHUSETTS WORKERS' COMPENSATION SYSTEM

FISCAL YEAR 2013 ANNUAL REPORT

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

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EXECUTIVE DIRECTOR

April 16, 2014

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, we are pleased to present you with the Council's Fiscal Year 2013 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 six specific areas of concern discussed at Council meetings since August 2012 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.

Of particular note this year, the DIA should be commended for its efforts to reduce its assessment rate. As is discussed throughout the report, the workers' compensation system in Massachusetts is funded by an assessment on the workers' compensation insurance premiums paid by employers. For FY'14, the Agency reduced its assessment rate by 21% from the previous fiscal year, down to 3.335% of standard premium. It is the lowest rate since 1995 and the fourth consecutive year where assessment rates have decreased.

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. 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.

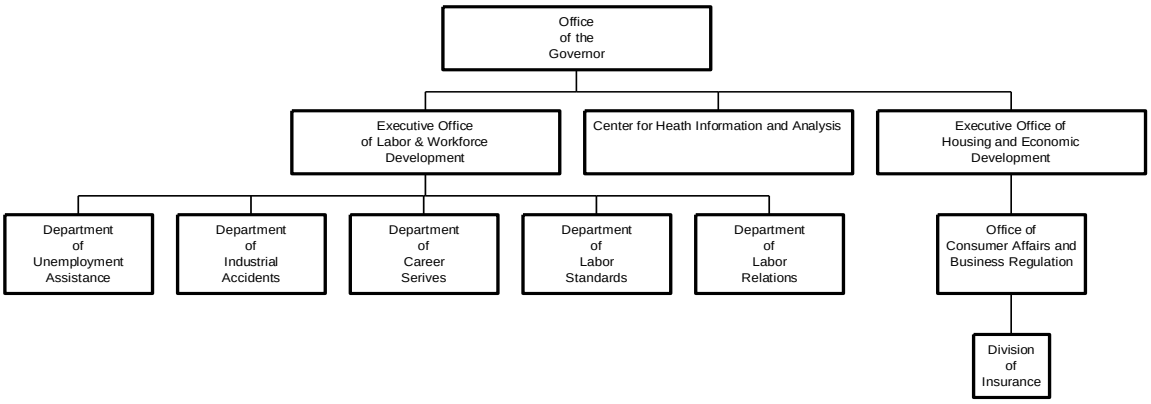
Very truly yours,

Stephen Joyce

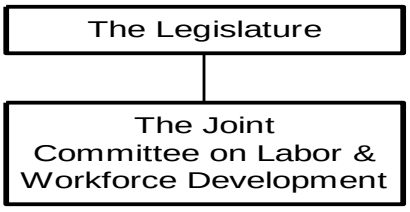
John R. Regan

Government Regulation of Workers' Compensation

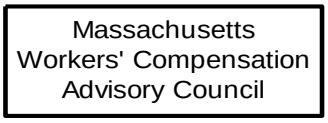
Executive Branch



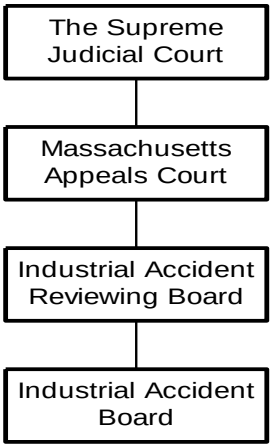
Legislative Branch



Oversight



Appeals Process



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

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INTRODUCTION

ADVISORY COUNCIL

In 1985, the Massachusetts Workers' Compensation Advisory Council (WCAC) was created as part of a significant reform to the workers' compensation system in the Commonwealth.[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 claimants' 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. Pursuant to the Massachusetts Workers' Compensation Act, the Advisory Council must also 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 of its voting members 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, 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. 7443. A list of WCAC studies is included as Appendix B to this report.

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

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

FISCAL YEAR 2013 IN REVIEW

The Massachusetts workers' compensation system continued to experience significant changes in fiscal year (FY) 2013 driven by economic conditions, new laws and regulations, administrative initiatives and other factors. The total number of cases filed at the Department of Industrial Accidents (DIA) decreased 5% in FY'13 from FY'12 (FY'13: 12,799; FY'12: 13,479). Below is an overview of some of the significant developments impacting the workers' compensation system during FY'13.

On July 8, 2012, Governor Deval Patrick signed the FY'13 General Appropriations Act, which allocated $19,114,446 for DIA operating expenses (line item 7003-0500). The amount is $7,902 more than the amount appropriated to DIA in the FY'12 General Appropriations Act ($19,106,544) and $138,627 less than the amount proposed by the Governor in House Bill 2 ($19,253,073).

On August 6, 2012, Governor Deval Patrick signed House Bill 4304, "An Act Establishing a Temporary Workers Right to Know." This legislation strengthens the Commonwealth's ability to regulate staffing and temporary agencies. The bill requires such agencies to provide notice of certain basic information about the job when sending workers on assignments. It also prohibits agencies from charging workers certain fees, like the cost of registering with the staffing agency or for performing a criminal record check. Staffing agencies are also prohibited from charging any fee that would reduce a workers' pay below the minimum wage, and are required to reimburse a worker if it sends the worker to a worksite for the purposes of working and no work is available.

Effective August 8, 2012, the DIA informed all parties that they must use the updated Form 140 (Conference Memorandum), which was streamlined to reflect requirements of DMS to submit certain documents in an electronic format. The streamlined Conference Memorandum coversheet must be signed by counsel and filed with the Administrative Judge at the start of the Conference.

On September 14, 2012, the Office of Health Policy conducted a Chronic Pain Informational Session in Boston. The seminar provided an overview of the problem of prescription drugs being prescribed to injured workers for chronic pain. The seminar also discussed best practices and strategies to deal with the problem, including Massachusetts Treatment Guideline #27: Chronic Pain and the recently enhanced Massachusetts Prescription Monitoring Program.

On October 9, 2012, the DIA issued Circular Letter #342 addressing cost of living adjustments (COLA) payment and reimbursement schedules and requests; maximum and minimum weekly compensation rates; and attorneys' fee schedules. The Circular Letter reports that the Average Weekly Wage, effective October 1, 2012, is $1,173.06. The Average Weekly Wage is used to calculate benefit limits and attorney's fees available under M.G.L. c.152. The DIA subsequently issued two amendments to the COLA table on November 6, 2012 and December 17, 2012.

In October of 2012, WCRI released *CompScope™ Medical Benchmarks for Massachusetts, 13th Edition*, studying injury claims in 16 states, including Massachusetts, between 2010 and 2011. The goal of the study is to analyze how state systems compared to one another and how they changed over time. WCRI reported that employers in Massachusetts paid the lowest average medical cost per claim with more than seven days of lost time among the studied states.[2] The study showed that Massachusetts continued to have lower overall medical payments per claim for both short- and long-term claim maturities for all providers.

In October of 2012, WCRI released another study, *Longer-Term Use of Opioids.* The study found that over a period of two years, the percentage of claims with longer-term use of opioids in Massachusetts fell from 11 percent to 7 percent. Of the study states, Massachusetts was the only state to show such a large decrease. Massachusetts has made several regulatory efforts in recent years to prevent opioid overuse and misuse, including a mandatory education program for physicians that prescribe controlled substances and the enhancement of the state's prescription drug monitoring program.

On December 17, 2012, the DIA held a public hearing on proposed amendments to the regulations pertaining to impartial physicians, including a proposed increase to the impartial medical examination fee schedule. On January 7, 2013, the DIA announced that impartial medical examination fees would increase on January 17, 2013. The new fee schedule increased the fee paid for the impartial exam and report from $450 to $650. The announcement indicated that exam fees submitted on or after January 17, 2013 must reflect the new fee schedule in order for the appeal to be perfected and the examination scheduled. The increase was designed to encourage highly qualified physicians, physicians in highly paid specialties, and physicians in underserved regions to join the impartial physician roster.

On January 17, 2013, the Advisory Council met in Executive Session to review the qualifications of twelve DIA judicial applicants seeking either appointment or reappointment to the position of Administrative Judge or Administrative Law Judge. Upon the vote of at least seven voting members, the Advisory Council may rate any candidate as either "qualified," "highly qualified," or "unqualified." At the conclusion of the interviews, the Advisory Council forwarded its judicial ratings to the Governor's Chief Legal Counsel for review.

On March 26, 2013, the Advisory Council sent a letter to Governor Deval Patrick expressing its opposition to the language included in Outside Section 7 of the Governor's House 1 Budget Proposal that proposed to eliminate the tax exemption for workers' compensation benefits. In 1991, workers' compensation benefit levels for temporary total and partial incapacity were reduced from 2/3rds to 60% of the employee's Average Weekly Wage. At the time the benefit changes were being

[2] Other WCRI studies show that worker outcomes in Massachusetts were better than average than in ten other states studied on metrics such as recovery of health and functioning, access to care, and satisfaction with care. Sharon E. Belton and Te-Chun Liu, *Comparing Outcomes for Injured Workers in Michigan*, Workers' Compensation Research Institute, June 2009.

considered, a key rationale for reducing the benefit levels was to more accurately reflect the take home pay of workers. These benefit reductions were made with the assumption that workers' compensation benefits would not be subject to state or federal taxation. Given this history, the Advisory Council believes that taxing these benefits would be unfair and would further burden injured workers who already receive only a percentage of the wages they earned prior to injury.

April 28, 2013 marked the 25th observance of Workers' Memorial Day. An event was held in Boston on April 25, 2013 honoring workers killed and injured on the job. Coinciding with Workers' Memorial Day was the release of a statewide occupational fatality report sponsored by the Massachusetts AFL-CIO, the Massachusetts Coalition of Occupational Safety and Health, and the Western Massachusetts Coalition for Occupational Safety and Health. The report, *"Dying for Work in Massachusetts: Loss of Life and Limb in Massachusetts Workplaces,"* highlights the fact that many workplace deaths are preventable with a proper emphasis on safety.

On June 6, 2013, the DIA issued Circular Letter #343 addressing the mandatory electronic filing of Form 101 Employers First Report of Injury (FRI). As of January 1, 2014, DIA will cease accepting paper copies of Form 101. Entities can file the forms via Electronic Data Interchange for batch data submissions, secure file transfer for completed PDF forms, or by filing the FRI forms individually via the DIA website using an authorized online account.

On June 28, 2013, the Workers Compensation Rating and Inspection Bureau (WCRIB) issued Circular Letter #2218 outlining the DIA's official assessment rates to be applied to policies effective July 1, 2013. For private employers (insured), the rate was set at 0.034 of standard premium. This is a decrease of 21.2% from the FY'13 private employer assessment rate (0.042).

On October 4, 2013, the DIA issued Circular Letter #344 addressing cost of living adjustments (COLA) payment and reimbursement schedules and requests; maximum and minimum weekly compensation rates; and attorneys' fee schedules. The Circular Letter reports that the Average Weekly Wage, effective October 1, 2013, is $1,181.28. The Average Weekly Wage is used to calculate benefit limits and attorney's fees available under M.G.L. c.152.

CONCERNS & RECOMMENDATIONS

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

1. DIA Funding

CONCERN: SINCE 1985, THE DIA HAS OPERATED AS AN EMPLOYER-FUNDED, RATHER THAN TAX-FUNDED, AGENCY. THE DIA IS FUNDED BY AN ASSESSMENT ON EMPLOYERS AND BY THE COLLECTION OF FINES AND PENALTIES. THE ADVISORY COUNCIL IS CONCERNED THAT IN RECENT YEARS, POLICYMAKERS HAVE TREATED THE DIA AS A TAX-FUNDED AGENCY, REDUCING THE AGENCY'S BUDGET AND IMPOSING MIDYEAR REDUCTIONS AND ACCOUNT TRANSFERS. THE ADVISORY COUNCIL IS CONCERNED THAT THESE ACTIONS NEGATIVELY IMPACT THE DIA'S EFFICIENCY.

RECOMMENDATION: THE ADVISORY COUNCIL RECOMMENDS THAT POLICYMAKERS RECOGNIZE THE DIA'S UNIQUE FUNDING MECHANISM AND ITS PURPOSES. EVEN IN DIFFICULT ECONOMIC TIMES, A SHORTAGE IN GENERAL FUND REVENUES SHOULD HAVE NO IMPACT ON THE AGENCY'S BUDGET.

The DIA receives 100% of its funding from: 1) assessments placed on the state's employer community and 2) the collection of filing fees and fines (for violations of Chapter 152). Prior to becoming an employer-funded agency, the DIA was consistently underfunded by the Legislature. During the late 1970s and early 1980s, the failure of policymakers to provide adequate funding for 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.

In November of 1983, Governor Michael Dukakis appointed industry experts to a Governor's Task Force on Workers' Compensation (Task Force) 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 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 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 (FY) 1986 to $12.4M in fiscal year 1989, the Agency 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 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. 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. Increased Wait Times between the Conciliation and Conference Stages of the Dispute Resolution Process

CONCERN: AT TIMES IN FY'13, THE AVERAGE WAIT TIME BETWEEN THE CONCILIATION AND CONFERENCE STAGES OF THE DISPUTE RESOLUTION PROCESS ROSE AS HIGH AS 16 WEEKS. LONG WAIT TIMES INCREASE COSTS AND ARE A MAJOR BURDEN ON ALL PARTIES.

RECOMMENDATION: THE ADVISORY COUNCIL BELIEVES THAT WAIT TIMES OF 16 WEEKS BETWEEN CONCILIATION AND CONFERENCE ARE TOO LONG AND THAT WAIT TIMES OF EIGHT TO TEN WEEKS ARE MORE CONSISTENT WITH THE GOAL OF THE WORKERS' COMPENSATION SYSTEM TO RESOLVE DISPUTES IN A TIMELY AND EFFICIENT MANNER. THE ADVISORY COUNCIL RECOGNIZES THAT THE DIA HAS TAKEN AND CONTINUES TO UNDERTAKE EFFORTS TO REDUCE THE QUEUE, BUT RECOMMENDS CONTINUED VIGILANCE IN MAINTAINING SHORTER WAIT TIMES.

The primary objective of workers' compensation is to provide an effective delivery system to all parties with the prompt adjudication of claims. Therefore, maintaining an efficient dispute resolution system is a central task of the DIA. The conference is an important step in the dispute resolution process because it is the first opportunity for the parties to appear before a judge. While the purpose of the conference is to compile the evidence and identify issues in dispute, a binding order is issued by the judge shortly after the conference. This order could, among other possibilities, permit insurers to cease paying a questionable claim or require an insurer to pay what appears to be a valid claim. Additionally, the conference can give parties a sense of how the judge might rule at the hearing stage, which can provide an incentive for reaching a settlement or other negotiated resolution.

Given the importance of the conference, the Advisory Council has become concerned as the average wait time between conciliation and conference has risen as high as 16 weeks in recent months. Long wait times are a significant burden on all parties and delay the adjudication of claims. The Advisory Council recommends that DIA endeavor to maintain wait times at the eight to ten week level, which will help ensure the prompt adjudication of claims.

3. Proposed Elimination of the Workers' Compensation Benefit Tax Exemption

CONCERN: THE GOVERNOR'S FY'14 BUDGET PROPOSAL INCLUDED LANGUAGE PROPOSING TO SUBJECT WORKERS' COMPENSATION BENEFITS TO THE STATE INCOME TAX. THE ADVISORY COUNCIL BELIEVES THAT ELIMINATING THE TAX EXEMPTION FOR WORKERS' COMPENSATION BENEFITS WOULD UNDULY IMPACT INJURED WORKERS, AS BENEFITS ARE PAID AT A LEVEL SIGNIFICANTLY LESS THAN THE WORKER'S WAGE PRIOR TO INJURY.

RECOMMENDATION: THE ADVISORY COUNCIL RECOMMENDS THAT THE TAX EXEMPTION UNDER MASSACHUSETTS LAW FOR WORKERS' COMPENSATION BENEFITS BE PRESERVED. THE FINAL FY'14 BUDGET, AS SIGNED BY THE GOVERNOR, DID NOT INCLUDE THE PROPOSED LANGUAGE TO ELIMINATE THIS EXEMPTION.

In 1991, workers' compensation benefit levels for temporary total and partial incapacity were reduced from two-thirds to 60% of the employee's Average Weekly Wage (as defined in the statute). Benefits were also capped at the State Average Weekly Wage, meaning workers who earn above a certain amount receive even less than the 60% of the pre-injury wage generally available under the Workers' Compensation Act. At the time the benefit changes were being considered, a key rationale for reducing the benefit levels was to more accurately reflect the take home pay of workers. These benefit reductions were made with the assumption that workers' compensation benefits would not be subject to state or federal taxation. Given this history, the Advisory Council believes that taxing these benefits would be unfair and further burden injured workers who already receive one of the lowest percentages in the country of the wages they earned prior to injury.

4. Employer Fraud – Misclassfication & Uninsured Employers

CONCERN: EMPLOYERS OBTAIN AN UNFAIR ADVANTAGE OVER COMPETITORS WHEN THEY INTENTIONALLY MISCLASSIFY THEIR EMPLOYEES OR OPERATE WITHOUT WORKERS' COMPENSATION INSURANCE, COSTING HONEST BUSINESS OWNERS AND TAXPAYERS MILLIONS OF DOLLARS ANNUALLY.

RECOMMENDATION #1: THE ADVISORY COUNCIL RECOMMENDS THAT LEGISLATION BE ENACTED TO INCREASE CIVIL PENALTIES FOR EMPLOYERS OPERATING WITHOUT WORKERS' COMPENSATION INSURANCE.

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. One study 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.[3]

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

[3] Françoise Carré and Randall Wilson, *The Social and Economic Costs of Employee Misclassification in Construction*, Labor and Worklife Program, Harvard Law School and Harvard School of Public Health, December 2004.

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.

It has been over 25 years since the civil penalties for operating without insurance were last updated. The current flat-fine levied against uninsured employers is insufficient to deter employers from violating the mandate to obtain workers' compensation coverage. Currently, at least 15 other states are utilizing some form of premium avoidance fine on employers operating without workers' compensation insurance.

The Advisory Council supports legislation (House Bill 1760), currently pending in the Legislature, that proposes to replace the present flat fine of $100 per day with a premium avoidance fine of three 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 bases the fine on a sliding scale so that employers who avoid greater amounts of premiums would be subject to a larger fine than employers that avoid smaller amounts of premium.

RECOMMENDATION #2: THE ADVISORY COUNCIL RECOMMENDS THAT LEGISLATION BE ENACTED TO INCREASE CRIMINAL PENALTIES FOR EMPLOYERS OPERATING WITHOUT WORKERS' COMPENSATION INSURANCE.

Created over 25 years ago, current criminal penalties are outdated and insufficient. The Advisory Council supports legislation (House Bill 1496 and Senate Bills 850 and 871) currently pending in the Legislature that would increase criminal penalties for those failing to provide workers compensation coverage to a fine of up to $10,000 and up to five years imprisonment. Council members believe that increasing the criminal penalties would send a strong message to uninsured businesses in the Commonwealth that workers' compensation employer fraud is a serious violation of the law that will be met with serious consequences.

RECOMMENDATION # 3: THE ADVISORY COUNCIL RECOMMENDS CONTINUED VIGILANCE BY THE DIA IN PURSUING UNINSURED EMPLOYERS TO RECOUP FUNDS PAID BY THE TRUST FUND.

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 can then attempt to recoup those payments from the uninsured employers by pursuing civil actions against them. Every dollar recouped by the Trust Fund reduces the burden on honest employers, who must cover the cost of uninsured claims. By pursuing uninsured employers to seek recoupment, the DIA can help reduce

costs for honest employers, while holding uninsured employers responsible for their failure to secure workers' compensation coverage as required by law.

RECOMMENDATION #4: THE ADVISORY COUNCIL RECOMMENDS THAT THE DIA PURSUE PUBLIC AWARENESS STRATEGIES TO ENSURE THAT ANYONE WHO EMPLOYS PEOPLE IN MASSACHUSETTS IS AWARE OF THEIR OBLIGATIONS UNDER THE WORKERS' COMPENSATION LAW AND PENALTIES FOR FAILING TO SATISFY THOSE OBLIGATIONS.

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

CONCERN: FOR THE PAST SEVEN YEARS, THE ADVISORY COUNCIL HAS IDENTIFIED TWO SPECIFIC EMPLOYEE BENEFITS THAT NEED TO BE ADDRESSED. FIRST, THE ADVISORY COUNCIL IS CONCERNED THAT THE BURIAL ALLOWANCE SET FORTH IN M.G.L. C.152, §33 IS INSUFFICIENT GIVEN CURRENT FUNERAL COSTS. SECOND, THE ADVISORY COUNCIL IS CONCERNED THAT THE LIMITATIONS PLACED ON RECOVERY FOR SCAR-BASED DISFIGUREMENT PERTAINING TO THE LOCATION OF THE SCARRING, AS SET FORTH IN M.G.L. C.152, §36(E), ARE UNFAIR.

RECOMMENDATION #1: THE ADVISORY COUNCIL RECOMMENDS THAT LEGISLATION BE ENACTED TO INCREASE THE MAXIMUM AMOUNT THAT AN INSURER IS OBLIGED TO PAY FOR BURIAL EXPENSES FROM $4,000 TO $8,000.

Although the majority of workers' compensation benefits are linked to the State Average Weekly Wage (SAWW), the maximum burial allowance for the dependents of deceased workers is one benefit not tied to an index, and therefore not adjusted on an annual basis. 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."[4] This amount has not been adjusted since 1991. In 2010, a total of 51 work-related fatalities were recorded in Massachusetts.

The National Funeral Directors Association reports that the median adult casketed funeral cost (with vault) was $8,343. It is important to note that these costs do not include cemetery monument costs or miscellaneous cash advance charges such as flowers and obituaries.

The Advisory Council has voted to support legislation (House Bill 1698 and Senate Bill 866) currently pending in the Legislature that would increase the maximum amount that an insurer is obliged to pay for burial expenses from $4,000 to $8,000. Council members

[4] M.G.L. c.152, §33.

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.

RECOMMENDATION #2: THE ADVISORY COUNCIL RECOMMENDS THAT LEGISLATION BE ENACTED TO REMOVE THE LIMITATION IN EXISTING LAW THAT PROVIDES COMPENSATION FOR SCARRING ONLY WHEN THAT SCARRING IS ON THE HANDS, FACE OR NECK.

Under the 1991 Reform Act, scar-based disfigurement benefits were limited to only disfigurement appearing on the face, neck and hands. In June of 2000, the Advisory Council contracted with the actuarial firm Tillinghast - Towers Perrin to obtain an estimate of the cost-impact of restoring scar-based disfigurement benefits awards to their pre-1991 levels. Unfortunately, the contracted actuaries were unable to quantify the impact of such a proposed revision due to incomplete data, though it was suggested that such a change would have a "relatively minimal impact on system costs."

During 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.

The Advisory Council supports legislation (Senate Bill 861) currently pending in the Legislature that proposes to remove the limitation in existing law that provides compensation for scarring only when that scarring is on the hands, face or neck. Council members believe that the location of scarring on the body is irrelevant and that compensation, with a $15,000 maximum benefit, should be provided to workers who suffer these traumatic, and at times, horrific injuries.

6. Employer Responsibilities

CONCERN: A WIDE RANGE OF EMPLOYER RESPONSIBILITIES COME WITH THE PROTECTIONS AFFORDED BY THE WORKERS' COMPENSATION ACT. ALTHOUGH THE PENALTIES FOR VIOLATING THESE RESPONSIBILITIES ARE OFTEN NEGLIGIBLE, COMPLIANCE WITH THE RESPONSIBILITIES CAN HAVE GREAT IMPLICATIONS ON THE SPEED WITH WHICH A CLAIM IS PROCESSED.

RECOMMENDATION #1: THE ADVISORY COUNCIL RECOMMENDS THAT LEGISLATION BE ENACTED TO 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.[5] 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 supports legislation (House Bill 1761) currently pending in the Legislature that would institute a fine against employers who fail to provide written notice of coverage or cancellation to their employees. The proposed fine is not less than $50, nor more than $100 per day.

RECOMMENDATION #2: THE ADVISORY COUNCIL RECOMMENDS STRENGTHENING INJURY REPORTING COMPLIANCE BY CHANGING THE CURRENT FINE SYSTEM TO AN ESCALATING FINE STRUCTURE THAT VARIES ACCORDING TO THE TARDINESS OF EACH VIOLATION.

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.[6] This report, 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). 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.

The Advisory Council supports legislation (House Bill 1737) currently pending before the Legislature that would remove the flat fine of $100 and create an escalating fine structure based on the tardiness of each violation. The legislation also proposes to fine employers as of the first violation, rather than the third. 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.

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

LEGISLATION

During the 2013-2014 Legislative Session, approximately 32 bills were filed by the House and Senate seeking to alter 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. 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 2013-2014 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 1423 (Rep. Keefe) - Penalties for Contracting when Debarred

House Bill 1496 (Rep. Mariano), **Senate Bill 850** (Sen. Clark) and **Senate Bill 871** (Sen. McGee) - Increasing Criminal Penalties

House Bill 1698 (Rep. Bradley) and **Senate Bill 866** (Sen. Joyce) - Increasing the Maximum Burial Allowance

House Bill 1737 (Rep. Keenan) - Penalties for Failing to Timely Report Injuries

House Bill 1760 (Rep. Sannicandro) - Stop Work Order Fine/3x Premium Avoidance

House Bill 1761 (Rep. Sannicandro) - Civil Fines for Failing to Notify Employees of Coverage

Senate Bill 861 (Sen. Hart) - Scar-Based Disfigurement Benefits

With the exception of House Bills 1423 and 1496, all Advisory Council-supported legislation was referred to the JCLWD for consideration. House Bills 1423 and 1496 were referred to the Joint Committee on the Judiciary.

Public Hearings on Workers' Compensation Legislation

On October 8, 2013, the JCLWD held a public hearing on legislation related to workers' compensation. At this hearing, representatives from the Advisory Council testified in support of eight workers' compensation bills that were endorsed by the Advisory Council (see Appendix I for Advisory Council testimony). On September 4, 2013, the Advisory Council sent a letter in support of House Bills 1423 and 1496 to the Joint Committee on the Judiciary (see Appendix H for a copy of the letter).

Following a hearing, the committee considering the legislation will review the merits of the bill and make a recommendation 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.

SECTION
- 2 -

OVERVIEW

SUMMARY OF BENEFITS

An employee who is injured during the course of their employment is eligible for workers' compensation benefits as set forth in Massachusetts General Laws (M.G.L.) c.152. There are a number of different types of benefits available, which vary depending on the type and severity of the injury.

Certain wage replacement benefits are calculated based on the employee's average weekly wage (AWW) and degree of incapacitation and are subject to minimum and maximum benefit amounts tied to the State Average Weekly Wage (SAWW). In October of 2013, the SAWW increased to $1,181.28, a 0.7% ($8.22) increase from the October 2012 amount ($1,173.06). Table 1 sets forth a list of the maximum and minimum benefit levels for §34 (temporary total incapacity benefits) and §34A (permanent total incapacity benefits) since 1995.

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
10/1/12	$1,173.06	$234.61
10/1/13	**$1,181.28**	**$236.26**

Source: DIA Circular Letter No. 344 – Table III (October 4, 2013)

Benefits available under the Workers' Compensation Act include:

Temporary Total Incapacity (§34) - When incapacity for work resulting from the injury is total, during each week of incapacity, 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, 2013, the maximum weekly compensation rate is $1,181.28 (100% of the SAWW) and the minimum rate is $236.26 (20% of the SAWW). The maximum duration for temporary total incapacity benefits is 156 weeks.

Partial Disability (§35) - When incapacity for work is partial, compensation will be 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) - When incapacity for work resulting from the injury is total and permanent, compensation will equal 2/3rds 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, 2013, the maximum weekly compensation rate is $1,181.28 (100% of the SAWW) and the minimum rate is $236.26 (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 2/3rds 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. Pursuant to M.G.L. c.152, §33, compensable burial expenses may not exceed $4,000.

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.

Medical Benefits (§30) - An injured employee is entitled to adequate and reasonable health care services and medicines, if needed, as well as expenses necessarily incidental to those services.

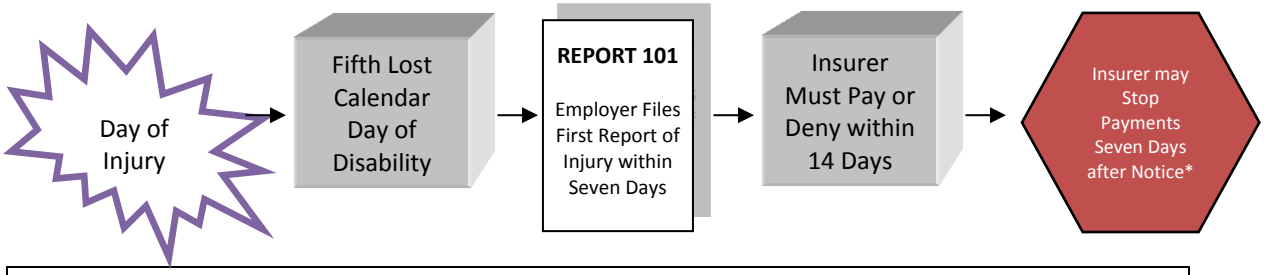
Vocational Rehabilitation Services (§§30E-30H) - An injured employee is also entitled to reasonably necessary vocational rehabilitation services at a reasonable cost if the employee is determined to be suitable for such services by the Department of Industrial Accidents. The purpose of these rehabilitation services is to return the injured worker to suitable employment.

FILING A CLAIM FOR BENEFITS

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 Department of Industrial Accidents (DIA), the insurer, and the employee within seven days of notice of the injury. 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.[7] 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.[8] 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 seven 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 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.

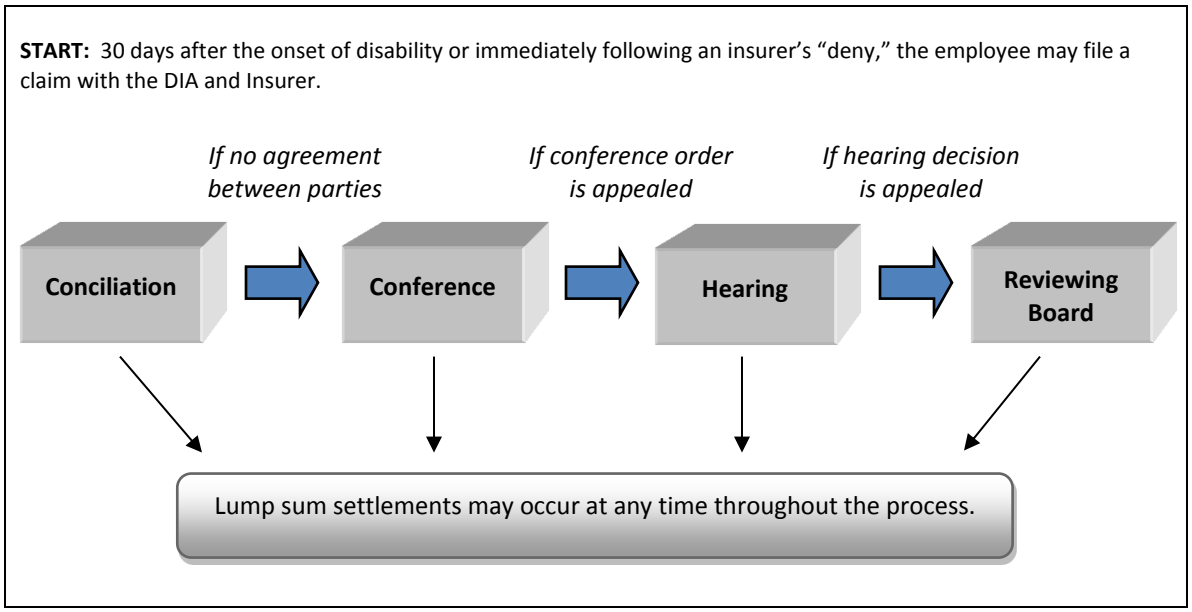
[7] If there is no notification or payment has not begun, the insurer is subject to a fine of $200 after 14 days, $2,000 after 60 days, and $10,000 after 90 days.

[8] 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.

PROVISIONS TO RESOLVE DISPUTES

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

Figure 2: Dispute Resolution Process



The dispute resolution process begins at conciliation, where a conciliator attempts 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 Administrative Judge (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 testimony 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 level, a panel of three ALJs reviews 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 the dispute resolution process, 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.

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 attorney's fee schedule effective October 1, 2013:

(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 **$1,102.38** plus necessary expenses. If the employee's attorney fails to appear at a scheduled conciliation, the amount paid is **$551.19**.

(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 **$1,574.83**. 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 **$787.42**.

(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 **$787.42** plus necessary expenses. This fee can be reduced to **$393.71** 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 **$1,102.38** 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 **$551.19** 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 **$5,511.91** 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 **$1,574.83**. 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

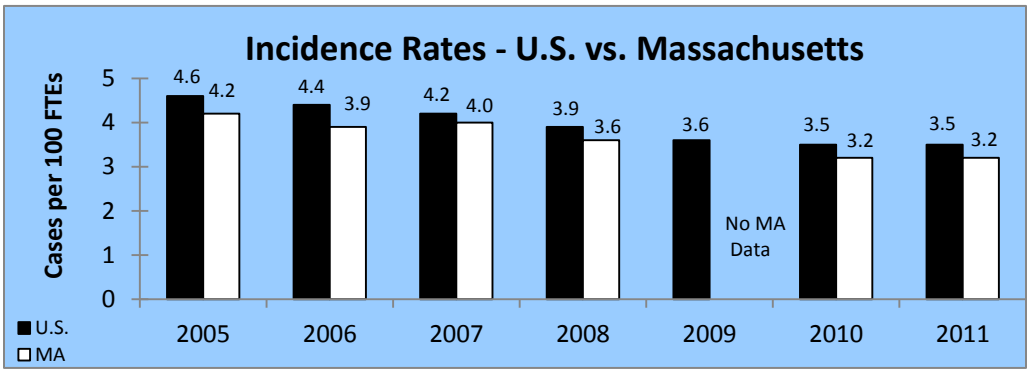
Since 1992, the Massachusetts Department of Labor Standards, formally the Division of Occupational Safety, has been in a partnership with the U.S. Department of Labor, Bureau of Labor Statistics (BLS), in an effort to collect injury and illness data in a uniform format. Throughout the country, surveys 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 the *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 identifies the number of non-fatal injuries and illnesses that occurred in the private sector workforce for every 100 equivalent full-time workers (FTEs). 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 2011, Massachusetts had a population of 6,607,003 people[9] with an estimated private sector workforce of 2,731,100 workers.[10]

During 2011, the private sector workforce in the U.S. experienced approximately 3.0 million non-fatal injuries and illnesses, resulting in an incidence rate of 3.5 cases per 100 FTEs.[11] In Massachusetts alone, there were 70,500 non-fatal occupational injuries and illnesses, resulting in an incidence rate of 3.2 cases per 100 FTEs.[12] The graph below displays how incidence rates in Massachusetts have consistently remained lower than national rates.

Figure 3: Incidence Rates - U.S. vs. Massachusetts, 2005-2011



Source: Bureau of Labor Statistics - Boston Office

[9] U.S. Census Bureau, Quick Facts: Massachusetts (Last updated: January 10, 2013).
[10] Bureau of Labor Statistics, Injury and Illness Rates, Table 6. Incidence rates of nonfatal occupational injuries and illnesses by industry and case types, 2011 (Massachusetts).
[11] Bureau of Labor Statistics, News-USDL-12-2121.
[12] Bureau of Labor Statistics, Injury and Illness Rates, Table 6. Incidence rates of nonfatal occupational injuries and illnesses by industry and case types, 2011 (Massachusetts).

Incidence Rates by Region

The following table exhibits a regional breakout of the injury and illness incidence rates since 2006. Historically, Massachusetts has had the lowest incidence rate of work-related injuries or illnesses (resulting in lost work-time) among all other New England states.

Table 2: Injury and Illness Incidence Rates - U.S. and New England, 2006-2011 (Private Industry)

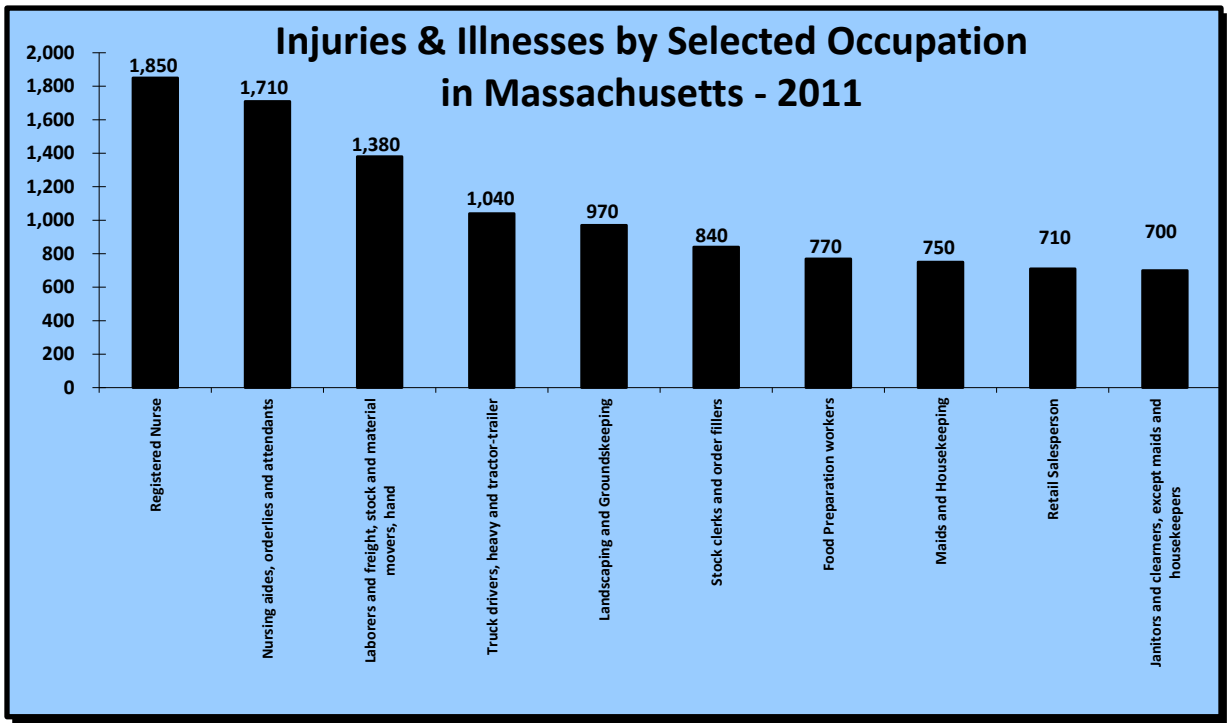
Region	*2011*	*2010*	*2009*	*2008*	*2007*	*2006*
United States	3.5	3.5	3.6	3.9	4.2	4.4
Massachusetts	3.2	3.2	no data	3.6	4.0	3.9
Connecticut	4.5	4.0	4.2	4.6	4.8	4.8
Maine	5.7	5.6	5.6	6.0	6.4	7.0
Rhode Island	no data	no data	no data	no data	5.1	5.2
Vermont	5.0	5.2	5.2	5.5	5.9	5.5
New Hampshire	no data	no data	no data	no data	no data	no data

Source: Bureau of Labor Statistics

Injuries & Illnesses by Occupation

The survey also categorizes the number of injuries and illnesses by occupation in Massachusetts. In 2011, registered nurses had the highest number of injuries and illnesses involving days away from work in Massachusetts among selected occupations.

Figure 4: Nonfatal Injuries & Illnesses with Days Away from Work by Selected Occupation in MA, 2011



Source: Executive Office of Labor and Workforce Development - Department of Labor Standards

Incidence Rates by Industry

The survey also categorizes incidence rates by sector and industry. In Massachusetts, the "education and health service" sector had the highest incidence rate among the ten major industrial sectors identified in the survey in 2011, with 5.0 injuries for every 100 FTEs. This industry group represented (23.4%) of the total private sector employees in 2011. The "financial activities" sector, which employed 7.6% of the private sector workforce, had the lowest incidence rate among the ten sectors, with 0.6 injuries per 100 FTEs. As a whole, the goods-producing industries in Massachusetts, which employed about 13.6% of the private sector workforce, had a higher incidence rate (3.7) than service-providing industries (3.1), which employed the remaining 86.4% of the private sector workforce in 2011.

Table 3: Nonfatal Injury & Illness Incidence Rates by Industry, Massachusetts 2006-2011

MASSACHUSETTS (Major Industry Sector)	**2011**	**2010**	**2009**	**2008**	**2007**	**2006**
Natural resources and mining	3.8	6.1	no data	8.1	4.9	5.2
Construction	4.7	3.9	no data	4.8	6.1	6.4
Manufacturing	3.2	3.4	no data	3.5	3.8	4.1
Trade, transportation, and utilities	3.9	3.8	no data	4.3	5.1	4.8
Information	0.8	1.3	no data	2.2	1.4	1.6
Financial activities	0.6	1.1	no data	0.9	1.3	0.9
Professional and business services	1.5	1.3	no data	1.6	1.7	1.6
Education and health services	5.0	5.0	no data	5.6	5.9	5.7
Leisure and hospitality	4.1	4.0	no data	5.1	5.1	5.5
Other services	2.4	2.9	no data	2.0	2.4	2.7

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 *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 *Survey of Occupational Injuries and Illnesses*, this census is a federal/state cooperative venture.

In 2012, a preliminary total of 4,383 work-related fatalities were recorded nationally by the program, representing an approximately 7% decrease from the revised total of 4,693 fatalities in 2011. The national rate of fatal work injuries in 2012 was 3.2 per 100,000 workers, compared to the final rate of 3.5 for 2011.

Workplace Fatalities in Massachusetts

In 2012, Massachusetts experienced 33 workplace fatalities, 35 less fatalities than recorded in 2011. The leading cause of workplace death in Massachusetts came from transportation incidents, in which 13 workers were killed. Nationally, transportation incidents were the leading cause of on-the-job fatalities, accounting for 41% of the fatal work injuries in 2012. Following transportation incidents, Massachusetts workers were killed by assaults & violent acts (7), falls (7), contact with objects and equipment (5), and exposure to harmful substances or environments (1).

Figure 5: Fatal Occupational Injuries by State and Event or Exposure, 2013 (Northeast Region)

State of Fatality	Total Fatalities		Event or Exposure (State Total for 2012)					
	2011 (Revised)	2012 (Prelim.)	Transportation Incidents	Assaults & Violent Acts	Contact with Objects & Equipment	Falls	Exposure to Harmful Substances	Fires & Explosions
U.S. Total	4,693	4,383	1,789	767	712	668	320	116
Massachusetts	68	33	13	7	5	7	1	–
Connecticut	37	36	9	13	5	7	–	1
Maine	26	19	8	–	4	4	3	–
New Hampshire	9	13	3	–	4	–	–	1
Rhode Island	7	8	3	–	–	–	–	–
Vermont	8	10	3	1	–	–	4	–

Source: Bureau of Labor Statistics, News-USDL-13-1699

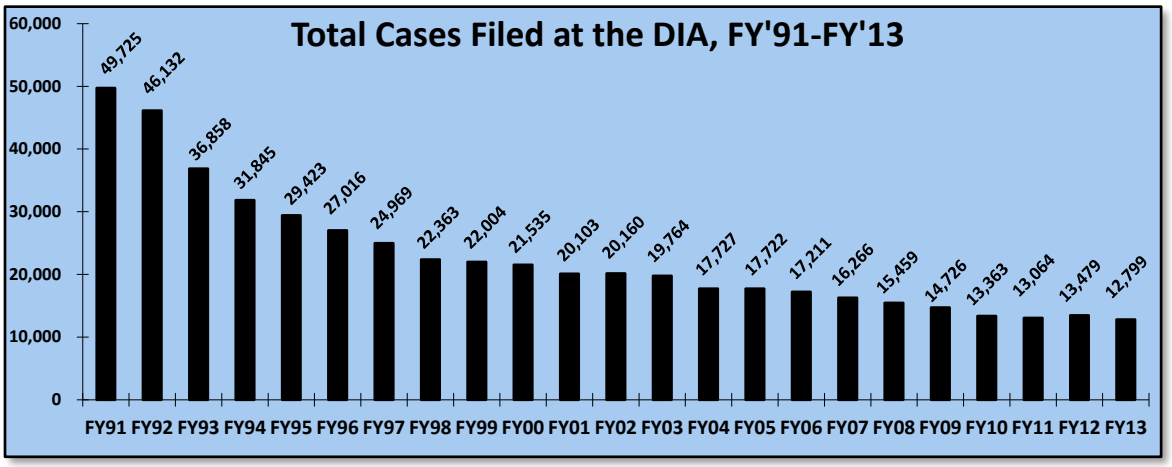
SECTION
- 4 -

DISPUTE RESOLUTION

CASES FILED AT THE DIA

Cases originate at the Department of Industrial Accidents (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'13, the total number of cases filed at the DIA was 12,799, a decrease of 5% from the previous fiscal year.

Figure 6: Total Cases Filed at the DIA, FY'91-FY'13



Source: CMS Report 28

In FY'13, 10,115 employee claims were filed at the DIA, representing 79% of the total cases filed. Employee claims decreased by 403 cases, or 3.8%, from the previous fiscal year. Employee claims have decreased by 56% since 1991, when an all-time high of 23,240 cases were filed. In FY'13, 1,981 insurer's requests for discontinuance or modification of benefits were filed, accounting for 16% of the total cases filed during the fiscal year. These requests for discontinuance decreased by 84 cases, or 4.1%, from the previous fiscal year. Since the 1991 Reform Act, requests by insurers to discontinue or modify benefits have decreased by 83%.

Table 4: Breakdown of Total Cases Filed at the DIA, FY'13 and FY'12

Total Cases Filed at the DIA FY'13 and FY'12	*Number of Cases*		*Percentage*	
	FY'13	**FY'12**	**FY'13**	**FY'12**
Employee Claims	10,115	10,518	79.0%	78.0%
Insurer's Request for Discontinuance	1,981	2,065	15.5%	15.3%
Lump Sum Conference Request	389	493	3.0%	3.7%
Third Party Claims	77	108	<1%	<1%
Section 37/37A Request	237	295	1.9%	2.2%
TOTALS:	**12,799**	**13,479**	**100%**	**100%**

Source: CMS Report 28

CONCILIATION

The first stage of the dispute resolution process is 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 46% 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 encompass a broad range of dispositions including withdrawals, lump sum settlements, and conciliated cases. The remaining 54% 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.

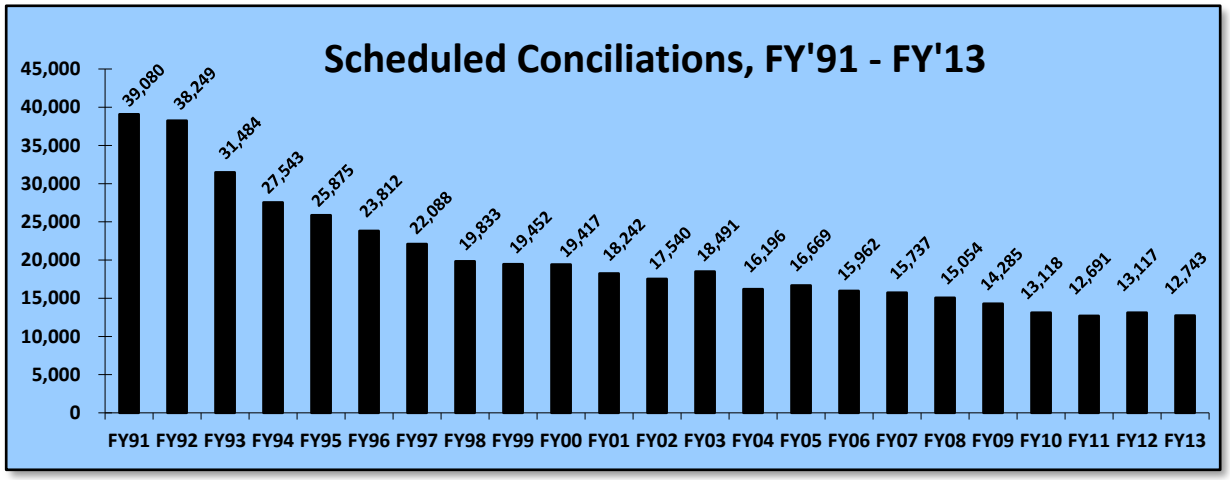
When liability is not an issue, but modification or discontinuance of benefits is sought, both parties are required to submit written settlement offers. If the employee fails to file, the conciliator must record either the last offer made by the employee or the maximum compensation rate. If the insurer 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'13, there were 12,743 cases scheduled for conciliation, which represents a 67% decrease since the 1991 Reform.

Figure 7 displays the number of cases scheduled for conciliation at the DIA beginning in FY'91. In FY'13, the volume of cases scheduled for conciliation decreased by 2.9% (374 cases) from the previous year. It is important to note that many cases scheduled for conciliation 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'13

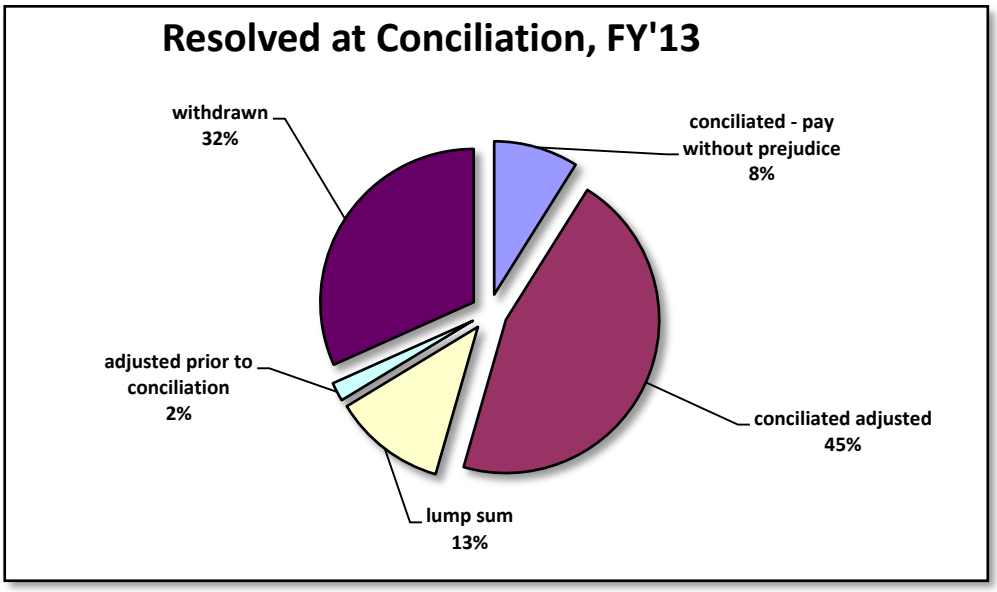


Source: CMS Report 17

Resolved at Conciliation

Disputed cases that are scheduled for conciliation can be divided into two distinct outcomes: "referred to conference" or "resolved." In FY'13, 5,873 cases were resolved, meaning they were not referred on to a conference, and exited the dispute resolution system. The remaining cases were 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 does not appear for the conciliation.

Figure 8: Chart Detailing Cases Resolved at Conciliation, FY'13



Source: CMS Report 17

Table 5: Resolved at Conciliation, FY'13 and FY'12

Resolved at Conciliation FY'13 and FY'12	*Number of Cases*		*Percentage*	
	FY'13	**FY'12**	**FY'13**	**FY'12**
Conciliated - Pay Without Prejudice	455	512	7.7%	8.5%
Conciliated Adjusted	2,614	2,741	44.5%	45.5%
Lump Sum	762	720	13.0%	12.0%
Adjusted Prior to Conciliation	138	125	2.3%	2.1%
Withdrawn	1,904	1,924	32.4%	31.9%
TOTALS:	**5,873**	**6,022**	**100%**	**100%**

Source: CMS Report 17

As displayed in Table 5, cases may be conciliated by two methods. Approximately 45% of the resolved cases in FY'13 were "conciliated adjusted," meaning an agreement was reached at conciliation between the parties to initiate, modify, or terminate the compensation. Secondly, approximately 8% of the resolved cases in FY'13 were "conciliated - pay without prejudice", meaning the pay without prejudice period has been extended and the insurer may discontinue compensation without DIA or claimant approval.

The second most prevalent method a case can exit the dispute resolution system at conciliation is through a withdrawal. Approximately 32% of cases were withdrawn in FY'13. A case can be withdrawn in various ways. 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 through 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 13% 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.

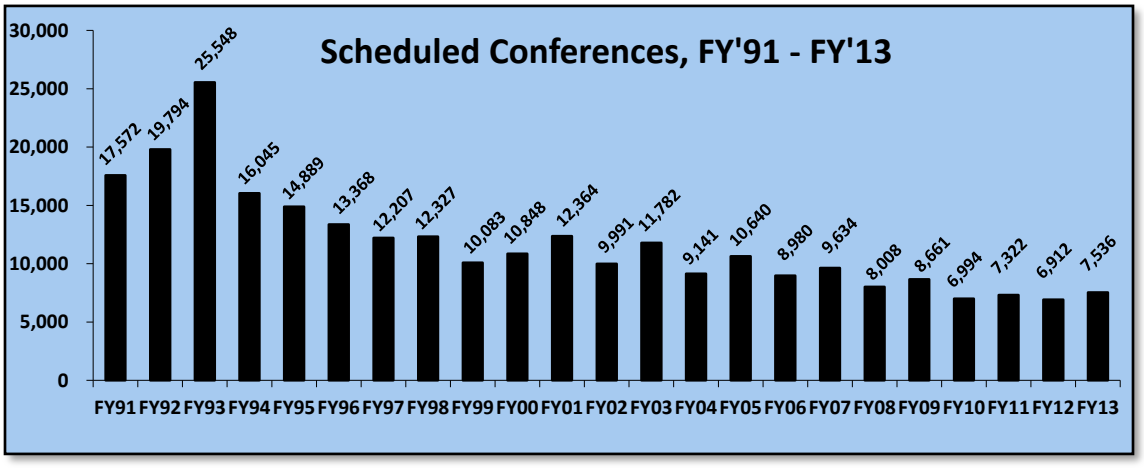
CONFERENCE

The second stage of the dispute resolution process is 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 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 84% of all conference orders in a given fiscal year are appealed to the hearing level of dispute resolution. In the remaining 16% 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'13 increased by 9% from last fiscal year (6,912 in FY'12 to 7,536 in FY'13).[13] Each year, the number of conferences scheduled is greater than the number of conferences that will actually take place before an AJ because many cases are withdrawn or resolved before reaching a conference.

Figure 9: Scheduled Conferences, FY'91-FY'13



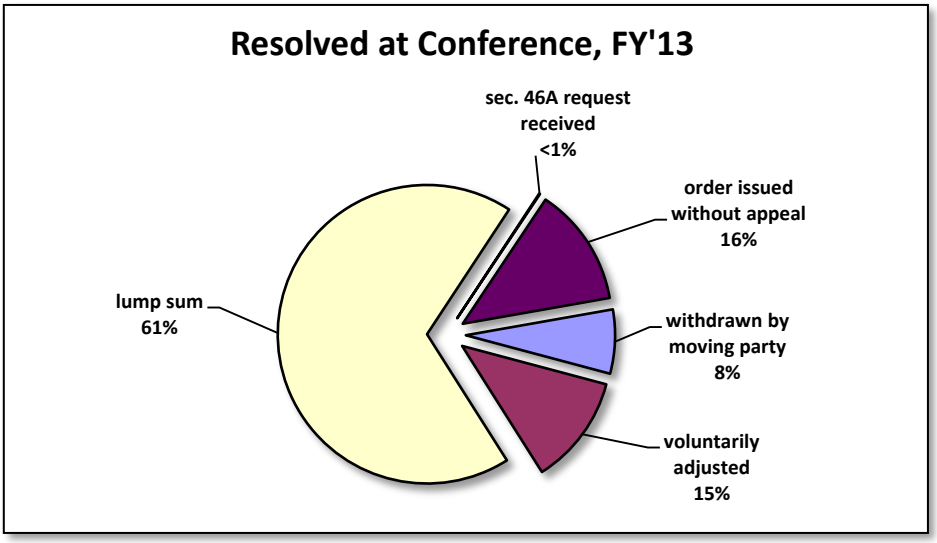
Source: CMS Report 45AB (Conference Statistics - For Scheduled Dates)

[13] In an effort to avoid duplication, the number of "scheduled conferences" does not include cases that were "rescheduled for a conference." In FY'13, 3,080 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'13, 4,952 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, FY'13



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

Table 6: Cases Resolved at Conference, FY'13 and FY'12

Resolved at Conference FY'13 and FY'12	*Number of Cases*		*Percentage*	
	FY'13	**FY'12**	**FY'13**	**FY'12**
Withdrawn by Moving Party	382	363	7.7%	6.6%
Voluntarily Adjusted	761	661	15.4%	12.0%
Lump Sum	3,005	3,792	60.7%	68.7%
Section 46A Request Received	3	6	<1%	<1%
Order Issued Without Appeal	801	701	16.2%	12.7%
Total	**4,952**	**5,523**	**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'13, 382 cases (8% 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'13, 761 cases (15% 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. 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'13, 3,005 cases (61% 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'13, 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'13, 801 conference orders (16% 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'13, 4072 conference orders (84% of all conference orders) were appealed to a hearing.

Table 7: Conference Orders, FY'13-FY'03

Conference Orders FY'13 - FY'03	Total Orders	Appealed	Without Appeal
Fiscal Year 2013	**4,873**	4,072 (83.6%)	801 (16.4%)
Fiscal Year 2012	**4,600**	3,899 (84.8%)	701 (15.2%)
Fiscal Year 2011	**4,928**	4,217 (85.6%)	711 (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%)

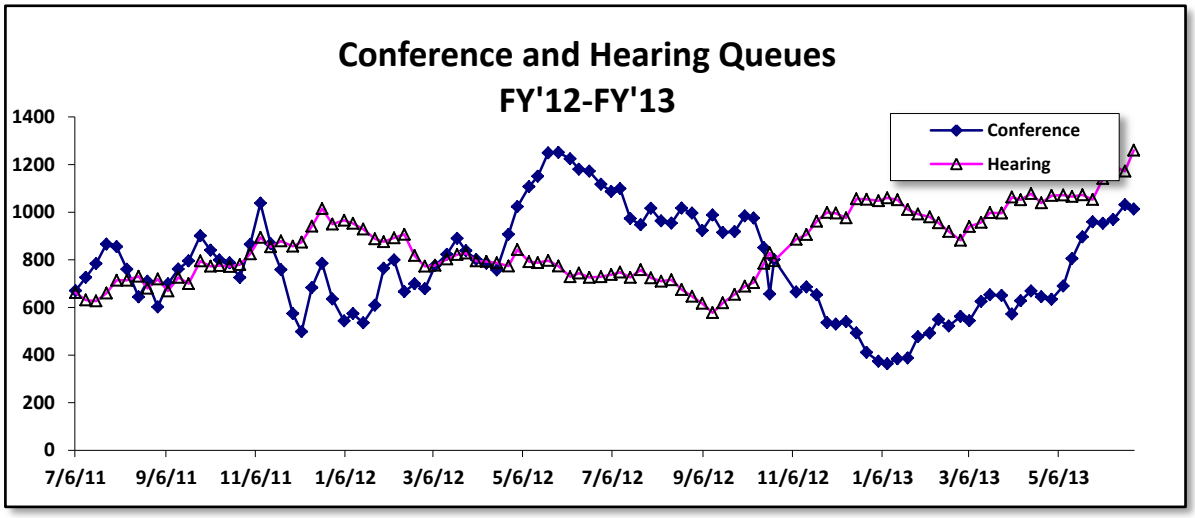
Source: CMS Report 319AB (Appealed Conference Order Statistics)

Conference Queue

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

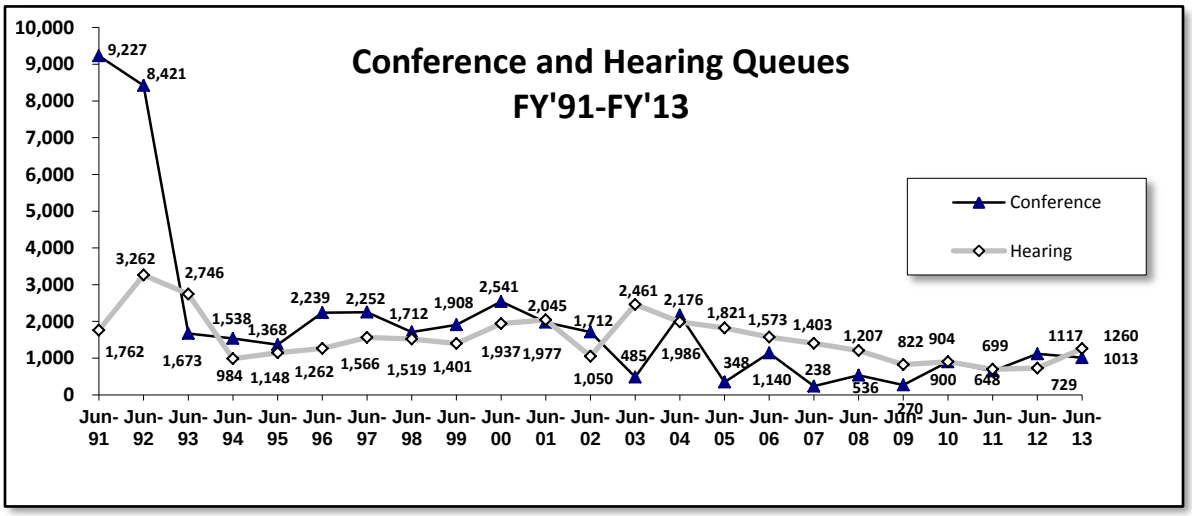
As presented in Figure 11, the conference queue during FY'13 remained below the benchmark of 1,500 cases. In FY'13 the conference queue ended 74 cases below the start of the year (1,087 on July 1, 2012 and 1,013 on June 29, 2013). The conference queue reached a high of 1,099 on July 11, 2012 and a low of 363 on January 9, 2013.

Figure 11: Conference and Hearing Queues, FY'12-FY'13



Source: CMS Report 404

Figure 12: Conference and Hearing Queue, FY'91-FY'13



Source: CMS Report 404

HEARINGS

The third stage of the dispute resolution process is the hearing. Pursuant 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 proceeding 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 because 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 longer 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 work through a hearing queue than a conference queue. FY'13 began with a hearing queue of 738 cases and increased to 1,260 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).

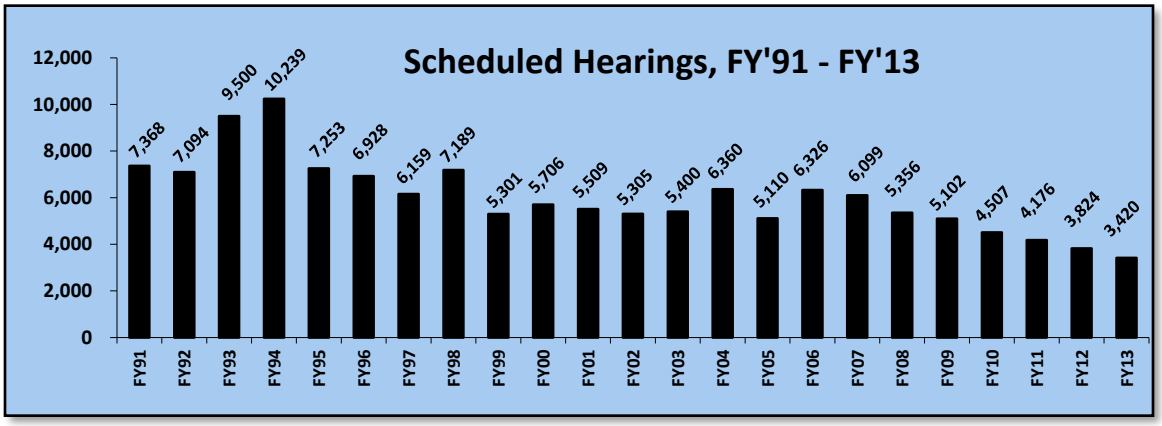
Volume of Scheduled Hearings

The number of hearings scheduled in FY'13 decreased by 404 cases (11%) from last fiscal year (3,824 in FY'12 to 3,420 in FY'13).[14] Each year, the number of hearings scheduled is

[14] In an effort to avoid duplication, the number of "scheduled hearings" does not include cases that were "rescheduled for a hearing." In FY'13, 3,171 cases were "rescheduled for a hearing."

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.

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

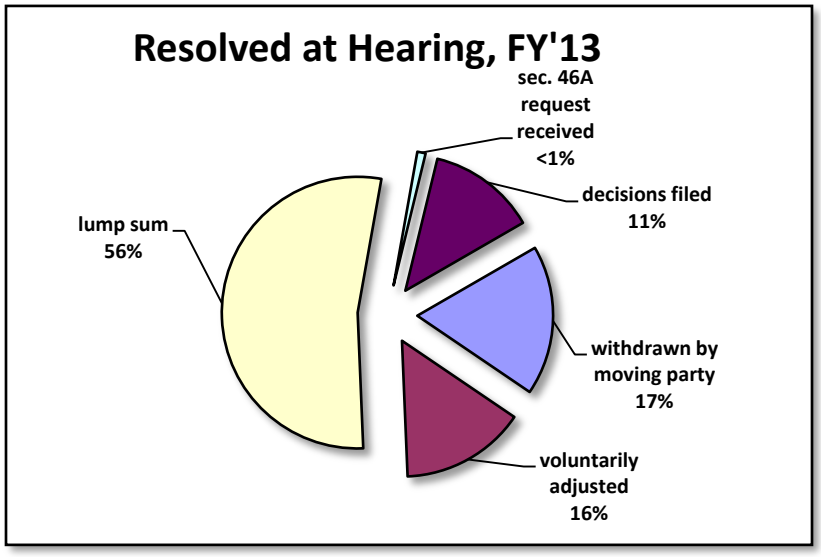


Source: CMS Report 46 (Hearing Statistics - For Scheduled Dates)

Cases Resolved at Hearing

In FY'13, 2,906 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, FY'13



Source: CMS Report 431

Table 8: Cases Resolved at Hearing, FY'13 and FY'12

Resolved at Hearing FY'13 and FY'12	*Number of Cases*		*Percentage*	
	FY'13	**FY'12**	**FY'13**	**FY'12**
Withdrawn by Moving Party	507	611	17.4%	17.7%
Voluntarily Adjusted	451	514	15.5%	14.9%
Lump Sum	1,635	1,869	56.3%	54.0%
Section 46A Request Received	2	12	<1%	<1%
Decisions Filed	311	455	10.7%	13.1%
Total	**2,906**	**3,461**	**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'13, 507 cases (17% 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'13, 451 cases (16% 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'13, 1,635 cases (56% 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'13, only two 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'13, 311 hearing decisions (11% of resolved cases at hearing) were filed by AJs.

REVIEWING BOARD

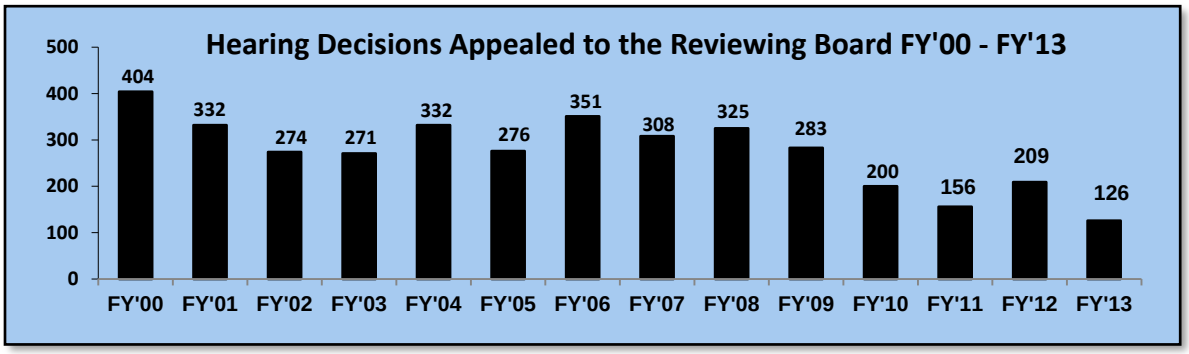
The fourth and final stage of dispute resolution at the DIA occurs when a case proceeds to the Reviewing Board. The Reviewing Board consists of six Administrative Law Judges (ALJs) whose primary function is to review the appeals from hearing decisions. While appeals are heard by a panel of three ALJs, initial pre-transcript conferences are heard 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 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 20% to 25% 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 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'13 was 126.

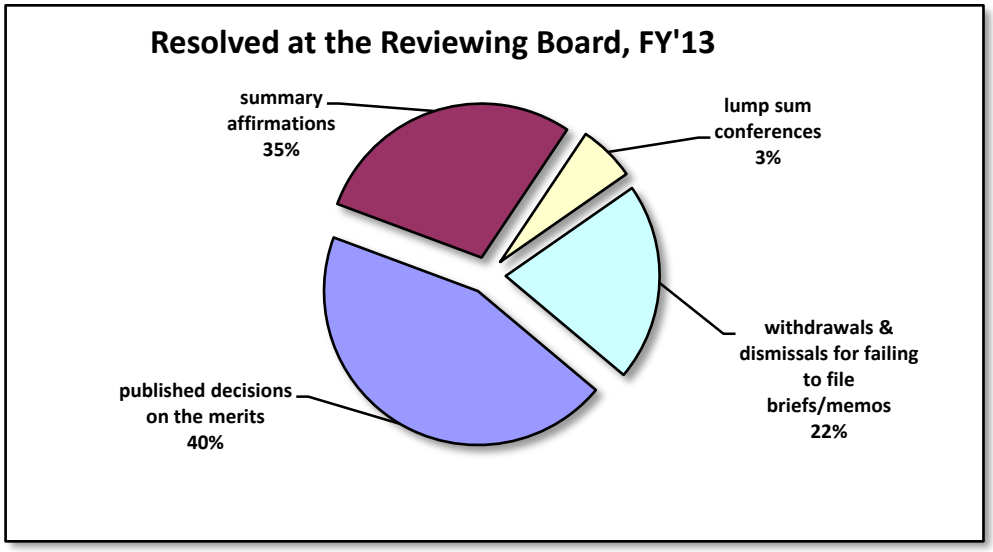
Figure 15: Hearing Decisions Appealed to the Reviewing Board, FY'00-FY'13



Source: DIA Reviewing Board

In FY'13, the Reviewing Board resolved 139 cases (some from the prior year), representing a 14.7% decrease from cases resolved in FY'12 (163 cases).

Figure 16: Appeals Resolved at the Reviewing Board, FY'13



Source: DIA Reviewing Board

Table 9: Appeals Resolved at the Reviewing Board, FY'13

Appeals Resolved at the Reviewing Board, FY'13	*Number of Cases*
Published Decision on the Merits (Full Panel):	56 (40.3%)
Summary Affirmations (After Full Panel Deliberation):	49 (35.3%)
Lump Sum Conferences:	4 (2.9%)
Withdrawals/Dismissals for Failing to File Briefs/Memos:	30 (21.6%)
Total Number of Appeals Resolved by the Reviewing Board:	**139 (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'13 was 814.

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'13, ALJs heard 1,107 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. In FY'13, nine Section 46A conferences were heard.

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'13-FY'91

Fiscal Year	*Total lump sum conferences scheduled*	*Lump sum settlements approved*
FY'13	**6,118**	**5,666 (92.6%)**
FY'12	6,035	5,614 (93.0%)
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'13, only nine 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 M.G.L. c.152, §48, 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 sum 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 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'13

Fiscal Year 2013	*Lump Sum Pursued*[15]	*% Total Cases Resolved (at each level of dispute resolution process)*
Conciliation	762	13.0%
Conference	3,005	60.7%
Hearing	1,635	56.3%

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

[15] "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.[16] 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.[17]

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 collect filing fees, schedule examinations, and to ensure that medical reports are

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

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. The following table details the DIA's fee schedule:

Table 12: Fee Schedule - Impartial Medical Examinations

$650	Impartial medical examination and report
$650	Second Exam, 8(4)
$200	Supplemental Report
$300	Records Review and Report
$150	No Show Fee/Late Cancellation
$750	Deposition Fee (First 2 hours)
$150/hr.	Deposition Fee (2 hours +)

Source: DIA Impartial 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'13, approximately $1,848,350 was collected in Impartial Medical fees.

As of June 30, 2013, there were 147 physicians on the roster consisting of 18 specialties.[18] 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'13, the Impartial Unit scheduled 4,720 examinations, compared to 4,082 in FY'12. Of these, 3,511 exams were actually conducted in the FY'13 (the remainder of the scheduled exams were either canceled due to settlements and withdrawals or took place in the next year). In FY'12, 3,045 examinations were actually conducted in the fiscal year. Medical reports are required to be submitted to the DIA and to each party within 21 calendar days after completion of the examination.

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.

The Waiver Process - A workers' compensation claimant who wishes to have the impartial examination fee waived must complete an *Affidavit of Indigence and Request*

[18] Including contracts pending renewal.

for Waiver of §11A(2) Fees (Form 136). This document must be completed on or 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—see Table 13 below) 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: 2013 HHS Poverty Guidelines

2013 HHS Poverty Guidelines (48 Contiguous States and the District of Columbia)	
Size of Family Unit	**Amount***
1	$11,490
2	$15,510
3	$19,530
4	$23,550
5	$27,570
6	$31,590
7	$35,610
8	$39,630
*For family units with more than eight members, add $4,020 for each additional member in the family.	

Source: *Federal Register*, Vol. 78, No. 16, January 24, 2013, pp. 5182-5183.

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

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. Ensuring that each case is properly recorded in a systematic and uniform method is a top priority for the office.

Claims Processing

Over the last four 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.

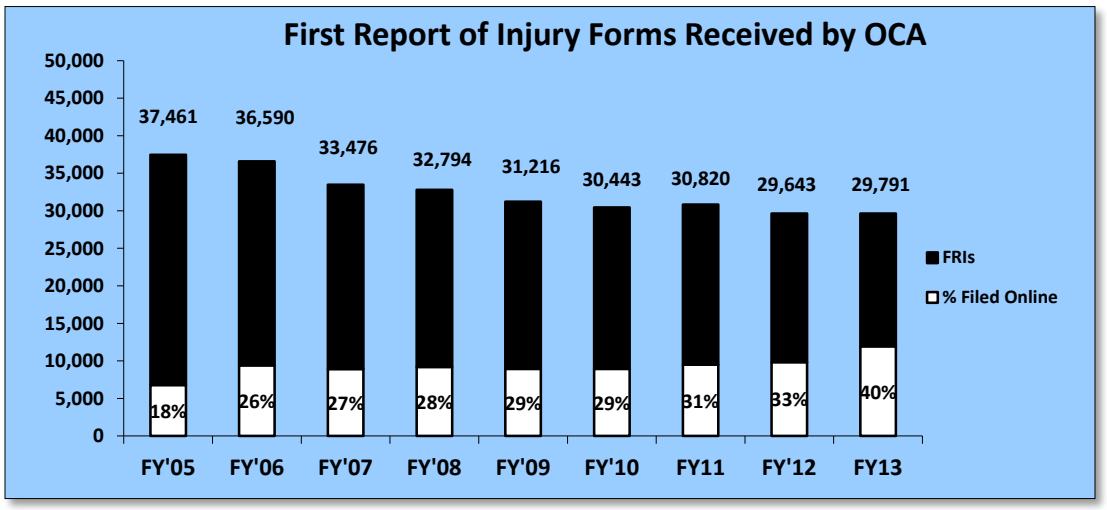
The OCA has four primary functions centered upon receiving, entering, storing, and retrieving information. The first function consists of receiving lost time reports, insurance forms, claims, appearances, and liens. Once this information is received, it must be entered into the Case Management System (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 incomplete or inaccurate submissions. 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'13, the OCA received 29,791 First Report of Injury forms (FRIs), an increase of less than 1% from FY'12 (29,643). Approximately 40% of all FRIs were filed online (8,323 online/3,514 EDI[19]) during FY'13, an increase over the 33% of all FRIs filed online during FY'12. In FY'13 the number of claims, discontinuances and third party claims received by the OCA was 14,125, a 5.4% decrease from the 14,925 received in FY'12 (prior to review and CMS acceptance processing). The total number of referrals to conciliation for FY'13 was 12,174, which represents a decrease of 3.7% from FY'12 (12,646).

[19] EDI, or electronic data interchange, filings began in April 2012.

Figure 17: First Report of Injury Forms Received by the Office of Claims Administration, FY'05-FY'13



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 percentage 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.

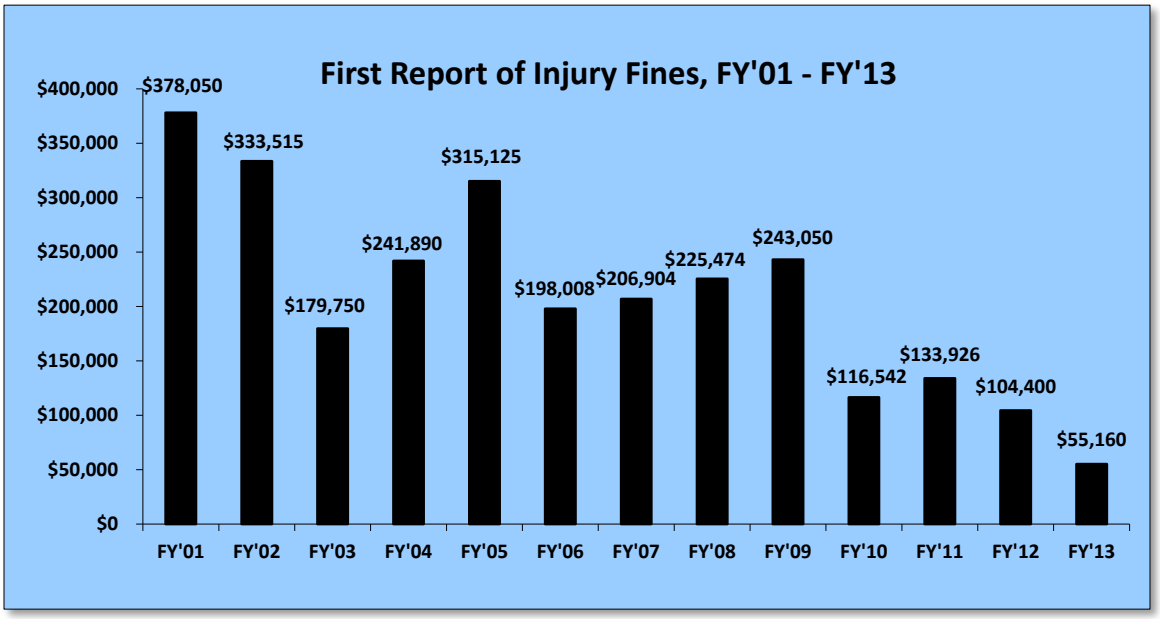
Occasionally, a KOR representative is summoned to appear in court to testify on behalf of the DIA on documents relating to a workers' compensation case.

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'13, the OCA collected $55,160 in FRI fines, a decrease of $49,240 from the $104,400 collected in FY'12. The office is also responsible for maintaining a database on cases identified by the DIA where there may be potential fraud. In FY'13, the OCA received 52 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 55 such inquiries were processed during FY'13.

Figure 18: First Report of Injury Fines, FY'01-FY'13



Source: Collections & Expenditures Report, FY'07 - FY'13 (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. In FY'13, the OEVR was headed by a Director and staffed by six Rehabilitation Review Officers (RROs) and three Clerks. 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."[20]

A claimant is eligible for VR 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 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's website.

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 DIA's website. In FY'13, OEVR approved 41 VR providers. It is the responsibility of each provider to submit progress reports on a regular basis so that OEVR's 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);
4. Summary of all vocational testing used to help develop an employment goal and a vocational goal; and

[20] M.G.L. c.152, §1(12).

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.[21] 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* (DOS) form. Suitability is determined by a number of factors including: medical stability, substantial functional limitations, feasibility and cost-effectiveness of services, and liability must be established. If a client is deemed suitable, the RRO will write to the insurer and request VR services for the injured worker. The insurer must then choose an OEVR-approved provider so that an IWRP 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 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

[21] M.G.L. c.152, §§ 30E - 30H; 452 CMR §4.00 et seq.

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.[22] 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.

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

[22] M.G.L. c.152, §19.

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

During FY'13, referrals to OEVR increased by 5%. 2,672 cases were referred to OEVR in FY'13 and 1,357 "mandatory meetings" were held. Of those cases that received a mandatory meeting, 32% (432) were referred to the insurer/self-insurer with a request to initiate vocational rehabilitation services by an OEVR-certified provider.

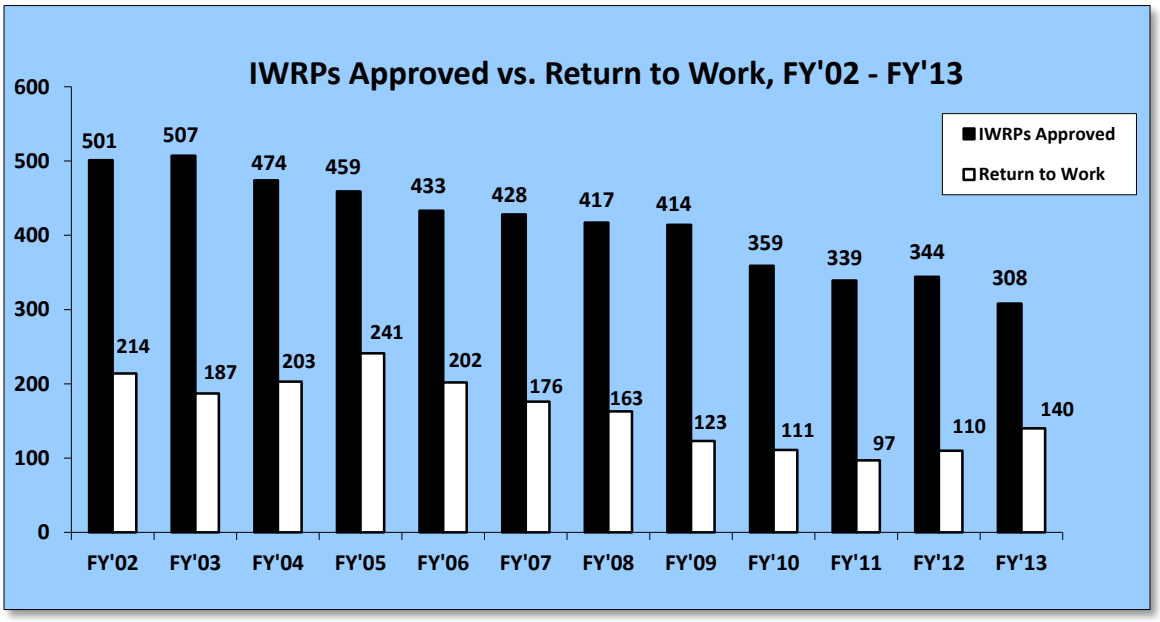
The impact of the economic downturn on the regional and state labor markets continued to hinder the ability of workers to quickly find new employment in FY'13. Despite the challenging economic environment, there was an increase (13%) in the percentage of workers who returned to work within 60 days of plan development and completion. In FY'13, 45% of injured workers returned to work within 60 days of plan completion.

Table 14: Utilization of Vocational Rehabilitation Services, FY'06-FY'13

Fiscal Year	*Referrals to OEVR*	*Mandatory / Inform. Meetings*	*Referrals to Insurer for VR*	*IWRPs approved*	*Return to work*	*% RTW after plan development*
FY'13	**2,672**	**1,357/N/A**	**432**	**308**	**140**	**45%**
FY'12	2,551	1,757/N/A	478	344	110	32%
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%

Source: DIA - Office of Education and Vocational Rehabilitation

Figure 19: Comparison of IWRPs Approved vs. Return to Work, FY'02-FY'13



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'13, the Trust Fund did not pay 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 administering the Workplace Safety Training and Education Grant Program, which provides education and training to employees and employers in the recognition, avoidance and prevention of unsafe or unhealthy working conditions. The safety training grants are awarded to qualified applicants through a competitive selection process. To date, the DIA has funded hundreds of preventive training programs that have benefitted and educated thousands of workers and employers throughout the Commonwealth.

In addition to safety training grants, the Office of Safety provides preventative training advice to employees and employers in addressing potential workplace safety issues. The Office of Safety also maintains a comprehensive safety DVD library, which is accessible to employers and other organizations in the Commonwealth.

The Safety Grant Program

Since 1991, the Office of Safety has administered and managed the safety 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 and covered by the Massachusetts Workers' Compensation Law. Proposals can be submitted up to a maximum of $25,000 per entity, per fiscal year.

The Office of Safety has partnered with the Workforce Training Program, OSHA and other safety professionals providing informational workshops demonstrating the value of preventative safety training and raising awareness to various business groups and organizations throughout the Commonwealth in order to reduce injuries. These successful workshops which include a comprehensive review of the program and the application process are a result of the continued collaboration with business service representatives from regional Career Centers and business development professionals within the community college network.

The Office of Safety continually updates and maintains an extensive database providing information about new initiatives and innovative upgrades to the grant process.

Office of Safety Initiatives

The Massachusetts Youth Employment and Safety Team (YES)

The YES Team, under the leadership of the Department of Public Health (DPH) brings together state and federal agencies concerned with youth employment in Massachusetts. The purpose of the YES Team is to coordinate government efforts to protect and promote the health and safety of young workers in the Commonwealth. The YES Team sponsors a Workplace Health and Safety Poster Contest which challenges youth to use their creativity to speak out with messages and images that promote health and safety at work. For the past two years, the first place poster has been featured on public transportation in Greater Boston, Springfield and Taunton areas.

Massachusetts Occupational Health and Safety Team (MOHST)

The Office of Safety is a member of the Massachusetts Occupational Health and Safety Team, a group of government agencies that share responsibility for protecting worker health and safety.[23] The mission of the team is to reduce work-related injuries and illnesses through the increased coordination of state and federal agency efforts to enforce health, safety and related labor and public health laws, provide training and technical assistance to employers and workers, conduct surveillance of work-related injury/illness and hazards, and mobilize partnerships to address identified health and safety problems and emergency concerns. This year hundreds of roofing and siding contractors, as well as residential construction companies participated in a free seminar focusing on the requirements of OSHA's fall protection standards.

Executive Order 511

Executive Order 511 establishes health and safety committees to promote the development of comprehensive and effective worker health and safety management in all state agencies with the ultimate goal to reduce workplace fatalities, injuries and illnesses. The implementation of Executive Order 511 is progressing with key initiatives that include looking at the full spectrum of hazards affecting employees and creating a comprehensive health and safety "needs list"; identifying needed corrections, with a focus on hazards presenting the greatest risk; and promoting corrections that can occur immediately and evaluating priorities.

[23] Other participants include Department of Labor Standards, the Office of the Attorney General, Department of Public Health, DPH Occupational Health Surveillance Program, OSHA and The Task Force on the Underground Economy and Employee Misclassification.

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. 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 one 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 provide the company with login credentials to complete a self-insurance application online.

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.

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'13, there was one new license issued, with the total number of "parent-licensed" companies decreasing by five to 90, covering a total of 391 subsidiaries. Each self-insurance license provides approval for a parent company and its subsidiaries to self-insure. This amounts to approximately $315,939,197.28 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.[24]

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'13, an estimated 2,681 inquiries were made to the Insurance Register.

[24] The Insurance Unit can be contacted directly at 617-626-5468. The Unit also maintains a website that is accessible through the DIA's homepage.

OFFICE OF INVESTIGATIONS

In Massachusetts, every employer with one or more employees is required to have a valid workers' compensation policy at all times.[25] 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.[26] 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 Workers' Compensation Trust Fund, which is funded entirely by the employers who purchase workers' compensation policies and administered by the DIA.

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.

The Office of Investigations also receives referrals 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 from 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

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

[26] 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'13, the Office of Investigations conducted a total of 84,367 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, an investigative team will request that the business provide proof of workers' compensation insurance coverage. In FY'13, the Office of Investigations conducted 5,790 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'13, the DIA issued a total of 2,337 SWOs. Of the 2,337 SWOs issued 2,280 (97.6%) were issued to small employers (1 to 10 employees), 55 (2.4%) were issued to medium employers (11 to 75 employees), and eight (<1%) were issued to large employers (75+ employees). The Office of Investigations estimates that 6,719 new employees became covered in FY'13 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 eight 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 prior to FY'09.

Table 15: Office of Investigations - Vital Statistics, FY'06-FY'13

Fiscal Year	Compliance Checks	Field Investigations	SWOs Issued	SWO Fines Collected	New Employees Covered due to SWOs
FY2013	84,367	5,790	2,337	$1,351,266	6,719
FY2012	67,640	5,383	2,440	$1,439,180	8,143
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

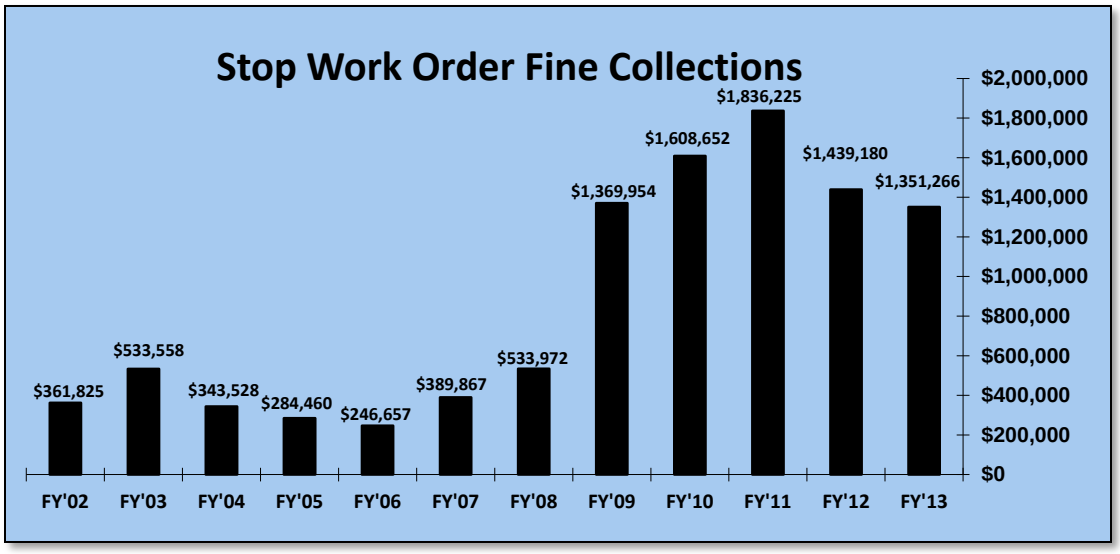
employer who believes the issuance of the SWO was unwarranted has ten days to file an appeal. A hearing must take place within 14 days, during which time the SWO will not be in effect. The SWO and penalty will be rescinded by the hearing officer if the employer can prove it had workers' compensation 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 the Agency's website.

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'13, the Office of Investigations collected $1,351,266 in fines from employers who violated the workers' compensation insurance mandate. In an effort to make paying SWO fines much easier, the DIA now allows fines to be paid online with debit cards, credit cards, money orders or certified checks.

Figure 20: Office of Investigations – SWO Fine Collections, FY'02-FY'13



Source: Collections & Expenditures Report, FY'08 - FY'13 (see *Appendix* L for the complete report).

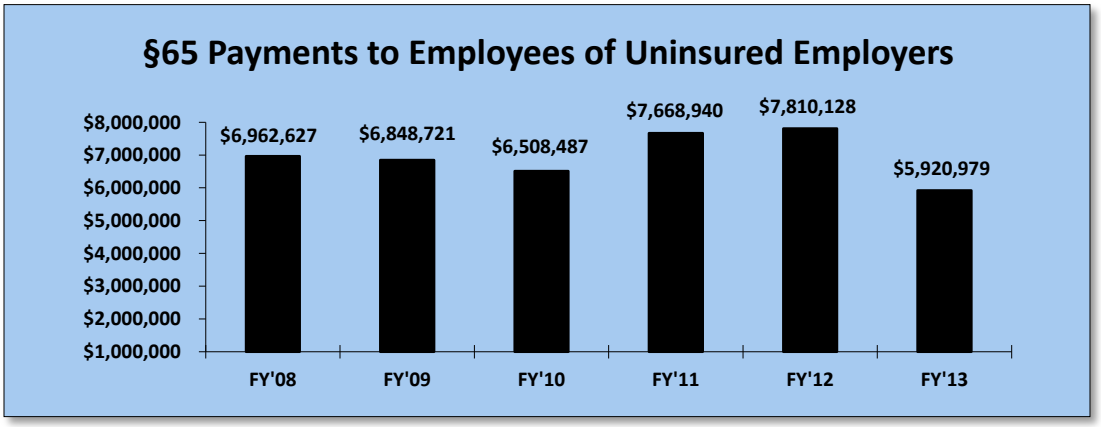
WORKERS' COMPENSATION TRUST FUND

Section 65 of the Workers' Compensation Act establishes a trust fund in the state treasury, known as the Workers' Compensation Trust Fund (Trust Fund), 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 Trust Fund was established to process requests for benefits, administer claims, and respond to claims filed before the Division of Dispute Resolution.

Uninsured Employers (Section 65)

Section 65(2)(e) 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.[27] In FY'13, $5,920,979 was paid to uninsured claimants, 140 claims were filed. 595 claims for benefits were paid during FY'13. The DIA aggressively pursues uninsured employers to recoup monies paid out from the Trust Fund. During FY'13, the DIA recovered $1,368,849 from employers and third parties.

Figure 21: §65 Payments to Employees of Uninsured Employers, FY'08-FY'13



Source: Collections & Expenditures Report, FY'08 - FY'13 (see Appendix L for the complete report).

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

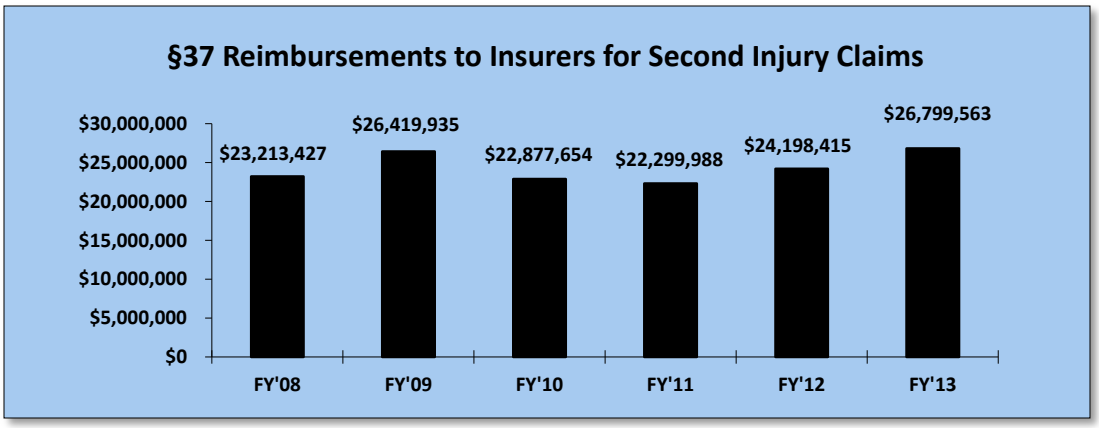
In an effort to encourage employers to hire previously injured workers, the Legislature established a Second Injury Fund (SIF) to offset any financial disincentives associated with the employment of impaired workers. Section 37 allows insurers to be reimbursed by the Trust Fund when compensation is being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

[27] 452 CMR 3.00

injury," insurers become eligible to receive reimbursement from the Trust Fund for up to 75% of compensation paid after the first 104 weeks of payment.[28] Employers may be entitled to an adjustment to their insurance premiums because of experience modification factors occasioned as a result of these reimbursements.

At the close of FY'13, 872 §37 claims were paid. In FY'13, 248 §37 claims were settled. The total amount of §37 payments in FY'13 was $26,799,563 (includes quarterly payments under §37 and interest).

Figure 22: §37 Reimbursements to Insurers for Second Injury Claims, FY'08-FY'13



Source: Collections & Expenditures Report, FY'08 - FY'13 (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.)

[28] An employee is considered to suffer a second injury when an on the job accident or illness occurs that exacerbates a pre-existing impairment. 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.

"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 Chair 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.

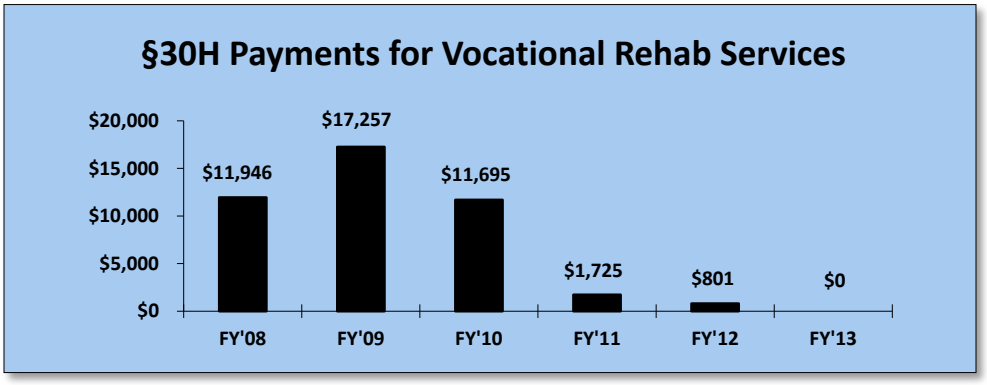
"New Act" - 1991 thru Present

- 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 two-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 or retention.

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 Trust Fund. 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 to the Trust Fund by the insurer. In FY'13, no new cases were accepted for §30H benefits and the Trust Fund did not pay for vocational rehabilitation services on existing cases.

Figure 23: §30H Payments for Vocational Rehabilitation Services, FY'08-FY'13



Source: Collections & Expenditures Report, FY'08 - FY'13 (see Appendix L for the complete report).

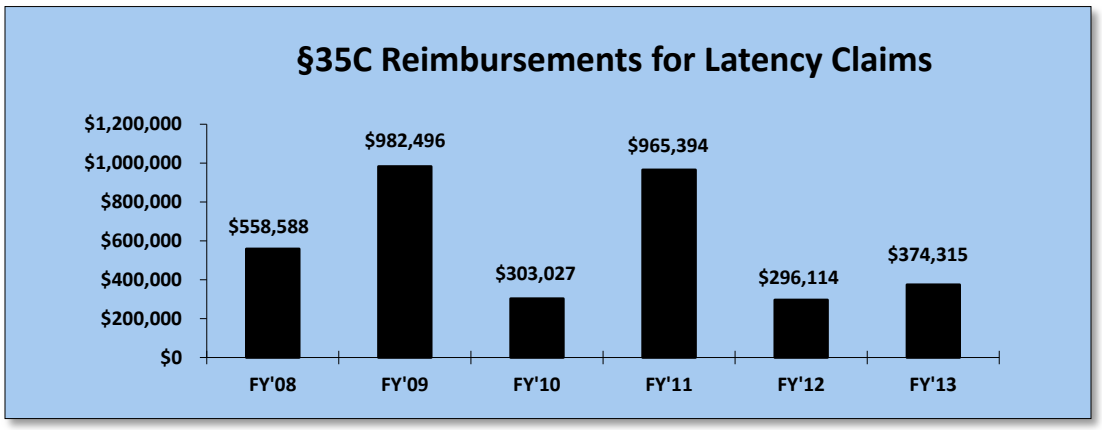
Latency Claims (Section 35C)

Because some occupational diseases and illnesses might not show up until many years after initial injury or 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 injury or 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'13, the Trust Fund paid out $374,314 for latency claims.

Figure 24: §35C Reimbursements for Latency Claims, FY'08-FY'13

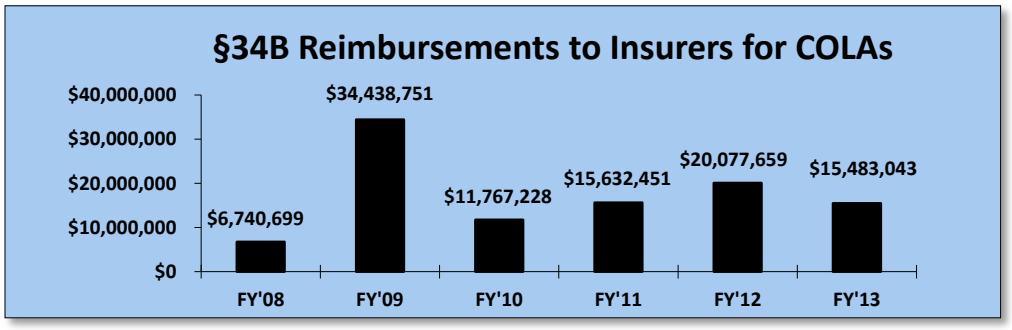


Source: Collections & Expenditures Report, FY'08 - FY'13 (see Appendix L for the complete report).

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 State Average Weekly Wage (SAWW) 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 SAWW. It is important to note that after December 23, 1991, the change in SAWW (as it pertains to COLA) was capped at 5% and therefore extinguishes COLA reimbursements for injuries occurring thereafter. COLA payments for FY'13 totaled $15,483,043.

Figure 25: §34B Reimbursements to Insurers for Cost of Living Adjustments, FY'08-FY'13



Source: Collections & Expenditures Report, FY'08 - FY'13 (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'13, the Office of Health Policy was staffed by three employees: an Executive Director (Nurse/Attorney), a UR Coordinator (Registered Nurse), 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'13, four 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 to 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 Provider Arrangements (PPAs) identify the approved UR Agent who will conduct the utilization reviews. Pursuant to 452 CMR 6.03, the OHP may require the PPA applicant to survey affected employees to determine the employees' understanding of their rights when participating in the PPA.

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 provides 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'13, 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'13, the HCSB received two 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'13.

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.

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."[29]

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.

[29] 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.[30] 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.[31] 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."

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.

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

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

[31] Quarterly assessment reports are due no later than 40 days after the end of the calendar quarter being reported. The quarterly assessment forms are available online the first week in January, April, July and October.

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 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 ranged 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.

Assessment Audit - Phase III and Beyond

In FY'08, Phase III of the assessment reviews began and continued through FY'13. Phase III focuses on assessments calculated and remitted during a 4-year review period between January 1, 2004 and December 31, 2007. In FY'13, a total of two CPA firms assisted the DIA in collecting $231,953 from companies under assessment review. The audit expense associated with the reviews for FY'13 was 22%, thereby representing a DIA retention rate of 78%.

The table on the following page 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, FY'00-FY'13

Assessment Recovery Project Fiscal Year 2000 – Fiscal Year 2013		
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	$2,040,413	$12,845,331
Fiscal Year 2012	$1,502,857**	$14,348,188
Fiscal Year 2013	$231,953***	$14,580,141

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.

** The Office of Assessments & Compliance collected an additional $5M from insurance companies during FY'12 due to underpayments. This amount, which includes late fees, is not included in the chart because it was made outside of the Assessment Recovery Project.

*** The Office of Assessments & Compliance also collected an additional $111,973 in late fees from insurance companies during FY'13.

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 assigned administrative support.

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, 3rd Floor
Fall River, MA 02723
(508) 676-3406
Paul Przystarz, Regional Manager

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

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

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

SECTION
- 6 -

DIA FUNDING

DIA FUNDING

Prior to the 1985 Reform Act, the Department of Industrial Accidents (DIA) experienced funding shortfalls that 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 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 filings) and fines (for violations of the Act). No tax dollars are 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. As of October 1, 2013, the referral fee is $767.83. This fee is 65% of the current State Average Weekly Wage (SAWW), which is now $1,181.28. The SAWW is adjusted annually effective 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 after billing.

Source: DIA's Website

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 (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.[32] The assessment rate for private sector employers in FY'14 is 3.335% of standard premium—the lowest rate since 1995. This represents a 21.2% decrease from the FY'13 assessment rate of 4.234%.

The Special Fund - The DIA's operating expenses are paid from the 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

[32] 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.

benefits and indirect costs from the assessments, fines, and fees collected. These payments are made quarterly to the Treasurer's Office. Chapter 23E of the Massachusetts General Laws directs the Advisory Council to review the DIA's operating and 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 to 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.[33] 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, which is subsequently submitted for legislative action.

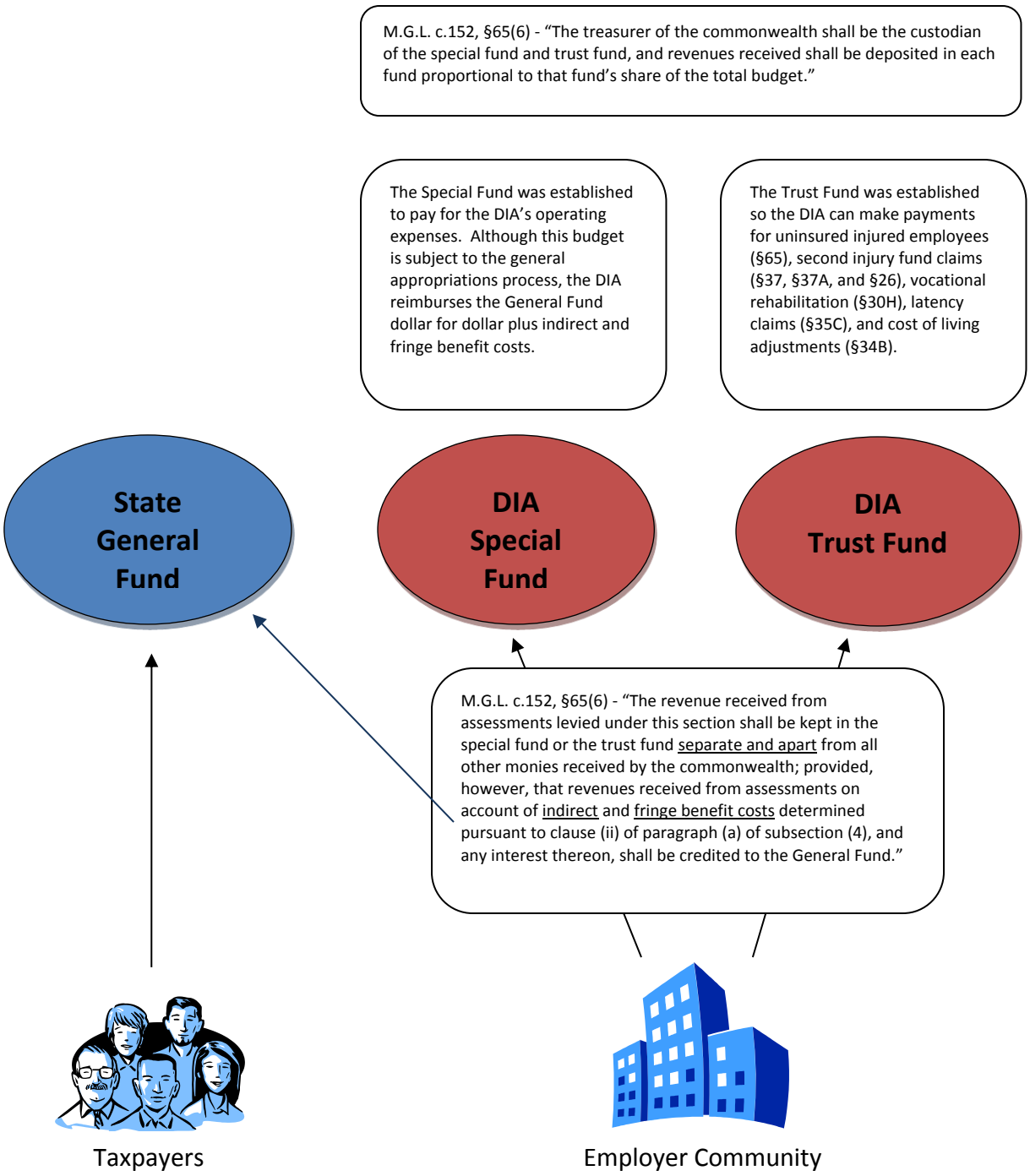
In May and June, the DIA uses consulting actuaries to estimate future expenses and determine the assessments necessary to fund the Special Fund and the Trust Fund. The budgets and the corresponding assessments must be submitted to the Secretary of the Executive Office of Labor and Workforce Development 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, which are 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 (EOLWD) 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 EOLWD 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 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.

[33] M.G.L. c.152, §65(2).

Figure 27: The DIA's Unique Funding Process

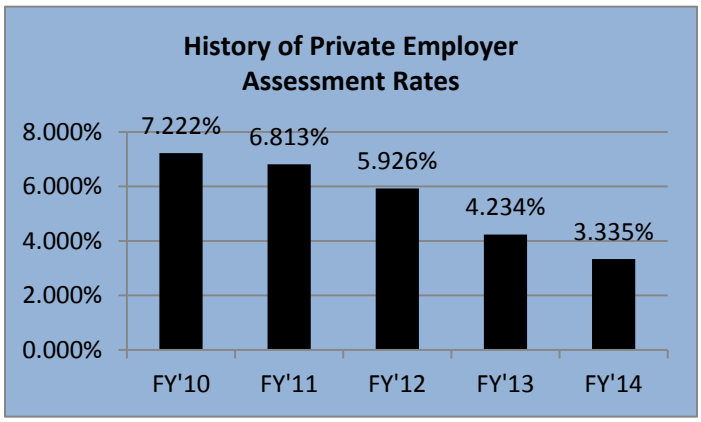


IMPORTANT: Year End Balances within the Special Fund and Trust Fund **DO NOT** revert to the State's General Fund. These balances remain within their respective accounts and are only used to offset future assessments when the balance of a particular fund exceeds 35% of the previous year's disbursements.

PRIVATE EMPLOYER ASSESSMENTS

On June 18, 2013, Deloitte & Touche LLP ("D&T") released an analysis of the DIA's FY'14 assessment rates as mandated by M.G.L. c.152, section 65 (4) & (5). Specifically, the report details the estimated amount required by the Special Fund and Trust Funds for FY'14, beginning July 1, 2013. 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 **3.335%** of standard premium, a decrease of 21.2% from last year's private assessment rate (4.234%). It is important to note that the Public Fund has no remaining municipalities thereby resulting in a FY'14 public assessment rate of 0%.

Figure 28: Private Employer Assessment Rates, FY'10-FY'14



Fiscal year 2014 Private Fund (including Special Fund) expenditures are projected to be $76.8M. This represents a 4.6% decrease from the $80.5M FY'13 expenditures projected by D&T in the FY'13 analysis. The decrease is primarily driven by a $5.3M decrease in estimated Section 34B COLA payments and a $1.5M projected decrease in payments related to uninsured employers. This memorandum breaks down the assessment rate calculation process for the private employer assessment rate.

Overview of the Assessment Rate Calculations

D&T uses the following six steps in determining the assessment rate for private employers:

1. Project FY'14 disbursements;
2. Project FY'14 income (excluding assessments);
3. Estimate FY'14 balance adjustments, if any;
4. Subtract the projected income and balance adjustments from the projected disbursements to calculate the assessment budget;
5. Estimate the premium and loss assessment bases for FY'14; and
6. Calculate the assessment rate, the assessment ratios and the assessment base factors.

1. FISCAL YEAR 2014 PROJECTED DISBURSEMENTS: $76.8M

The first step in the assessment process is the calculation of the expected FY'14 expenditures. Private employers are assessed for the sum of the Private Trust Fund and the Special Fund budgets.

PRIVATE TRUST FUND BUDGET	Projected FY'14 Expenditures (06/13)	+/- FY'13 Projected Expenditures (06/12)
Section 37 (2nd Injuries)	**$26,829,935**	**$3,729,935**
Uninsured Employers	**$7,147,186**	**-$1,502,814**
Section 30H (Rehabilitation)	**$0**	**-$12,500**
Section 35C (Latency)	**$428,000**	**-$247,000**
Section 34B (COLA's)	**$13,124,955**	**-$5,325,045**
Defense of the Fund	**$5,646,737**	**-$524,772**
Total:	**$53,176,813**	**-$3,882,196**

SPECIAL FUND BUDGET	Projected FY'14 Expenditures (06/13)	+/- FY'13 Projected Expenditures (06/12)
Total:	**$23,623,219**	**$202,813**

PRIV. EMPLOY. EXPENDITURES	Projected FY'14 Expenditures (06/13)	+/- FY'13 Projected Expenditures (06/12)
Total:	**$76,800,032**	**-$3,679,383**

2. PROJECTED FISCAL YEAR 2014 INCOME: $7.15M

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.

Fines and Fees (Special Fund) = $5,655,120
Income Due to Reimbursements = $1,481,375
Estimated Interest Income = $17,957 (Private Fund: $12,797/Special Fund: $5,160)

Total Projected FY'14 Income: $7,154,452

3. ADJUSTMENTS TO FUND BUDGETS: $6.2M (Special Fund) / $13.9M (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 monies held over from the previous year. Any amount greater than 35% of FY'13 expenditures in a particular fund must be used to reduce amounts assessed for that fund in FY'14. At the end of FY'13, the balances of the Private and Special Funds will have surpluses exceeding 35% of FY'12 disbursements.

Therefore, the assessment was calculated with a $20.1M reduction to the Private Fund (including Special Fund) budget.

SPECIAL FUND	FY'13 Estimated Year End Balance	35% of FY'12 Expenditures	Amount of Reduction Required
	$13,742,651	$7,580,212	$6,162,439

PRIVATE TRUST FUND	FY'13 Estimated Year End Balance	35% of FY'12 Expenditures	Amount of Reduction Required
	$34,083,827	$20,198,164	$13,885,663

4. CALCULATION OF THE ASSESSMENT BUDGET

The assessment budget is calculated by subtracting the projected income and balance adjustments from the projected disbursements. For the first time this year, D&T was able to allocate the disbursements, income and balance adjustments between the opt-in and opt-out entities based on the loss base for each group.

	Opt-In	Opt-Out	Total
Disbursements	$72,810,017	$3,990,016	**$76,800,033**
Income	$6,394,440	$760,013	**$7,154,453**
Balance Adjustments	$19,007,012	$1,041,090	**$20,048,102**
Total Budget	$47,408,565	$2,188,913	**$49,597,478**
Allocation %	96%	4%	100%

5. CALCULATION OF THE ASSESSMENT BASES

Loss Assessment Base

The FY'14 assessment loss base is $760.7M, comprised of estimated insured, self-insured and group losses. Insured and self-insured entities losses are based on actual loss data from 2005-2012 and the estimated loss assessment base from FY'13. D&T estimated the loss assessment base for self-insured groups based on 2011 and 2012 data.

Premium Assessment Base

The WCRIB provides an estimate of calendar year 2014 net written premium for the insured population, which is then converted to an estimate of the standard premium. This year, the WCRIB estimated 2014 net written premium to be $1,047,782,658. After adjusting the amount to account for rate changes and other factors, the resulting DIA estimated 2014 standard written premium for the insured population is $1.3B.

6. CALCULATION OF THE ASSESSMENT RATES, THE ASSESSMENT RATIOS AND THE ASSESSMENT BASE FACTORS

Assessment Ratio for Private Opt-In Employers

D&T allocated the disbursements, income and balance adjustments between the opt-in and opt-out entities based on the loss base for each group. The assessment ratio calculation takes this allocation into account. The assessment ratio is calculated by dividing the estimated budget by the loss assessment base.

Estimated Budget / Loss Assessment Base = **Assessment Ratio**		
(Private Opt-In)	(Private Opt-In)	(Private Opt-In)
$47,408,565	$662,095,425	7.160%

Assessment Base Factor for Private, Insured Opt-In Employers

The assessment base factor is calculated by dividing the loss assessment base for the segment by the premium assessment base for the segment.

Loss Assessment Base / Premium Assessment Base = Assessment Base Factor		
(Opt-In, Insured)	(Opt-In, Insured)	(Opt-In, Insured)
$585,522,098	$1,256,964,317	46.582%

Assessment Rates for Private, Insured Opt-In Employers

The assessment rate is the product of the assessment ratio and assessment base factor.

Assessment Ratio x Assessment Base Factor = **Assessment Rate**		
0.072 (7.160)	0.466 (.4658)	**3.335% (3.335128)**

DIA OPERATING BUDGET

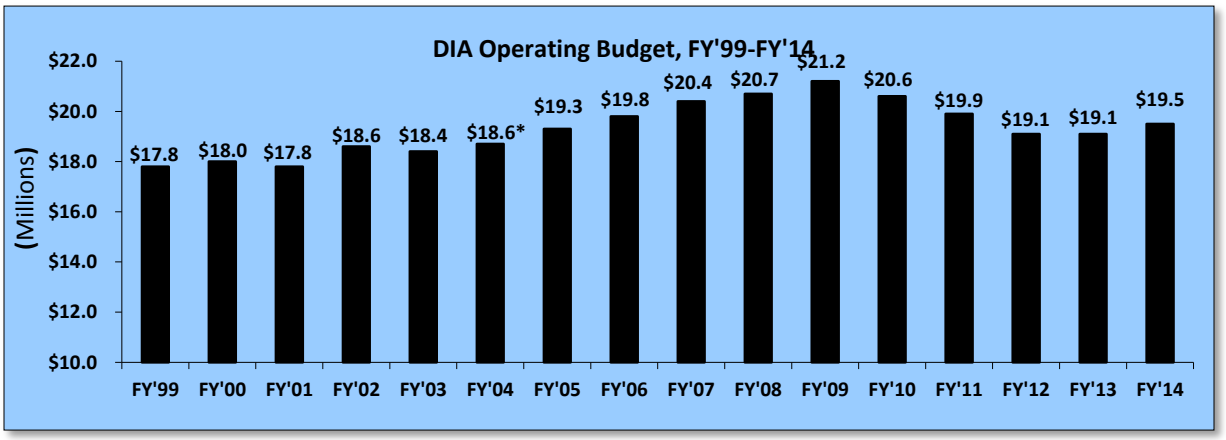
Fiscal Year 2014 General Appropriations Act

On July 12, 2013, Governor Patrick signed the FY'14 General Appropriations Act (FY'14 GAA), which allocated $19,522,205 for DIA operating expenses. This final appropriation represents an increase of $407,759 from last year's General Appropriations Act. Unlike some past years, the line-item did not specify an amount for the DIA to allocate towards the Safety Grant Program. The FY'14 GAA appropriation for the DIA is the amount recommended by the Governor in House Bill 1 ($19,522,205).

Table 17: Budget Process for DIA Line-Item 7003-0500, FY'13-FY'14

Fiscal Year 2013 Budget Process		Fiscal Year 2014 Budget Process	
DIA Request	$19,253,073	DIA Request	$19,522,205
Governor's Rec.	$19,253,073	Governor's Rec.	$19,522,205
Full House	$18,905,037	Full House	$19,442,653
Full Senate	$19,114,446	Full Senate	$19,522,205
Conference Committee	$19,114,446	Conference Committee	$19,522,205
Gen. Appropriations Act	**$19,114,446**	**Gen. Appropriations Act**	**$19,522,205**

Figure 29: DIA Operating Budget, FY'99-FY'14



***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 Agency, therefore, must abide by the budget process in the same manner as most other tax-funded government agencies. 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 budget recommendation must be the first bill submitted to the House of Representatives each calendar year. Typically, 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.
STAGE #3: House Ways and Means Committee Recommendations **Time Frame:** February, March, and April
The Governor's budget recommendation is referred to the House Committee on Ways and Means, 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. The House Committee on Ways and Means typically presents its version of the budget in April.
STAGE #4: The House "Passed" Version **Time Frame:** Early May
After being released by the House Committee on Ways and Means, the full House of Representatives reviews, debates, and offers amendments to the proposed budget. 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 Committee on Ways and Means where hearings are held and testimony is taken. The Senate Committee on Ways and Means typically presents its budget recommendation by early June.
STAGE #6: The Senate "Passed" Version **Time Frame:** Middle of June
After being released by the Senate Committee on Ways and Means, the full Senate reviews, debates, and offers amendments to the proposed budget. Members of the Senate will then vote to approve the new, updated budget.

STAGE #7: Conference Committee

Time Frame: By June 30th

Following approval of the Senate version of the budget, a conference committee is created to resolve differences between the House passed version of the budget and the Senate passed version. Members of this committee include the chair of both the House and Senate Committees on Ways and Means and the 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 his or her position on the budget. During this period, the Governor may both sign the budget and approve it as complete; veto selected line items (reduce to zero), but approve and sign the rest; or partially veto (reduce to a lower number) selected line items and approve and sign the rest. The Legislature has the power to override a Governor's veto by a 2/3 vote in both chambers.

STAGE #9: Section 9C Spending Cuts

Time Frame: At any time during a fiscal year

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

SECTION
- 7 -

INSURANCE COVERAGE

MANDATORY INSURANCE COVERAGE

Every private sector employer in the Commonwealth is required to maintain workers' compensation insurance.[34] This requirement may be satisfied by purchasing a commercial insurance policy, becoming a member in a self-insurance group, or maintaining a license as a self-insured employer.

All Commonwealth of Massachusetts employees are covered under the Workers' Compensation Act, with claims paid 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 charge-back based on losses paid in the prior year. This charge-back comes directly from each agency's operating budget.

Since 1913, Massachusetts cities, towns and other political subdivisions have had the ability to elect to be covered by the Workers' Compensation Act. Most municipal workers are covered by the Act, though some cities and towns have not adopted coverage for all employee groups. Municipalities cover employees in the same manner as employers in the private sector, i.e. through 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. If an employee is injured while working for a company without coverage, a claim may be filed with the Workers' Compensation Trust Fund, which is administered by the DIA.

Exemption of Corporate Officers

In 2002, a law was passed that made the requirement of obtaining workers' compensation insurance elective for corporate officers and directors who own at least 25% of the issued and outstanding stock of the corporation. A corporate officer or director who would like to opt-out from the workers' compensation system must provide the DIA with a written waiver of their rights.[35] The policies and procedures pertaining to the exemption of corporate officers and directors are governed by 452 CMR 8.06. The 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.

[34] 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.

[35] DIA regulations require the waiver to be in the form of an affidavit promulgated by the DIA and known as the *Affidavit of Exemption for Certain Corporate Officers* (Form 153).

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 insureds 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 licenses carriers, monitors solvency, determines rates, approves the terms of policies, and adjudicates unfair claims handling practices. In FY'13, the DOI approved a total of eight new licenses for carriers to write workers' compensation insurance in Massachusetts. In addition, two existing licenses were amended to include workers' compensation. During the same period, four carrier's existing license was amended to delete workers' compensation insurance.

In Massachusetts, workers' compensation insurance rates are determined through an administered pricing system.[36] Insurance rates are proposed by the WCRIB on behalf of the insurance industry, and set by the Commissioner of Insurance. The WCRIB submits

[36] In the United States, workers' compensation insurance rates are regulated in 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.[37]

According to the Workers' Compensation Act, the Commissioner of Insurance (Commissioner) 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."[38]

On August 30, 2012, Insurance Commissioner Joseph G. Murphy released a Decision and Order disapproving the WCRIB's request for an 18.8% increase to workers' compensation rates. As a result, rates will remain at the current levels for now, saving Massachusetts employers an estimated $200 million in projected workers' compensation premium increases, according to the DOI. The WCRIB has the option to submit a new rate filing for review by the DOI.

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, 1991-2013

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
2012	No Change	$33.21
2013	**No Change**	**$33.21**

Source: Division of Insurance WC Rate Decisions

Deviations & Scheduled Credits

The Workers' Compensation Act allows individual carriers to seek permission from the Commissioner to use a percentage decrease from approved rates within certain classifications.[39] These percentage decreases are called downward deviations. In Massachusetts, scheduled credits are also used to reward policyholders with good experience. These

[37] 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.

[38] M.G.L. c.152, §53A(2).

[39] M.G.L. c.152, §53A(9).

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 2012, 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% or more. It is important to note that not all employers whose policies are 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 DOI's website.[40]

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. Hearings are conducted at the DOI to determine whether classifications and rates are "not excessive, inadequate or unfairly discriminatory" and that they fall within a "range of reasonableness."[41]

Basic Classifications - Each business in the Commonwealth is assigned one "basic" classification that best describes the business of the employer. Once a basic classification has been selected, it becomes the company's "governing" classification, the basis for determination of premium. Although most companies are assigned one governing classification, the following conditions determine when more than one basic classification should be used:

- the basic classification specifically states certain operations to be separately rated;

[40] http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/mass-div-of-insurance.html.
[41] M.G.L. c.152, §53A.

- 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 that 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 that 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 filed 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. 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 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.

Employers with construction operations who are eligible for experience rating may be eligible for a premium adjustment under the Massachusetts Construction Classification Premium Adjustment Program. The program provides a manual premium credit ranging from 5% to 25%, depending on average hourly wages paid to employees.

Premium Calculation

The 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, 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 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), which is 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 the 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 Massachusetts, policy holders are entitled to a premium discount if they are paying over $10,000 in premiums. Carriers must elect to use the "Type A" or "Type B" tables to determine the premium discount. Abbreviated versions of the tables are included below.

Table 19: Percent of Premium Discount for Type A & B Carriers in Massachusetts

TYPE A CARRIERS			TYPE B CARRIERS		
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 (abbreviated).

Deductible Policies

Table 20: Premium Reduction % per Claim Deductible

PER CLAIM DEDUCTIBLE[42] *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

Under deductible policies, 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. For agreeing to pay losses up to the deductible amount, employers are entitled to a premium reduction. The DOI has authorized two small deductible programs, one with an aggregate limit and the other without an aggregate limit. Table 20 and Table 21 set

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

forth the deductible amounts for each program and the corresponding premium reduction percentages. To write large deductible policies, insurers must request permission from the DOI.

Table 21: Massachusetts Benefits Claim and Aggregate Deductible Program

MASSACHUSETTS BENEFITS CLAIM AND AGGREGATE DEDUCTIBLE PROGRAM[43] *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 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.[44] 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.[45]

[43] *Id.*
[44] "Retrospective Rating," *Risk Financing*, Supplement No. 46, May 1995: III.D.7.
[45] NCCI, *Retrospective Rating Plan Manual for Workers Compensation and Employers Liability Insurance* (2009 Edition), p. 14.

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

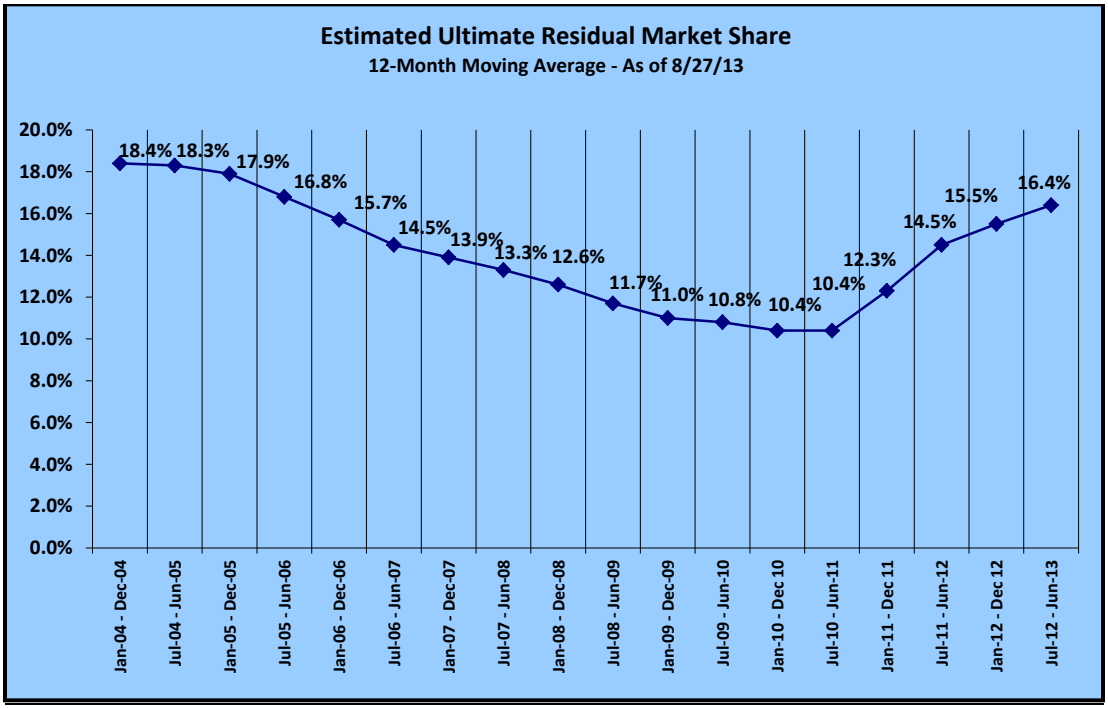
Offered as another means of reducing an employer's insurance costs, dividend plans can provide the policy owner with a partial return on a previously paid premium. This payment from the insurer takes into account investment income, expenses, and the insured's overall loss-experience in a given year.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

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-month period ending June 2013 is 16.4%. The residual market remains far below the 1992 policy year level of 64.7%.

Employers insured through the pool pay a 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. 11-13 (August 27, 2013).

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 manual rates. It can be a significant factor in an employer's decision to seek out alternative risk financing options, as self-insurance and self-insurance groups are not subject to residual market assessments.

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 2013) residual market loss ratio for policy year 2012 is 65.0%.

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 $100 of voluntary assessable premium written. For policy year 2011, the estimated Residual Market Burden (as of the first quarter of 2013) was 0.75, assuming a Loss Ratio of 65.0%.[46]

[46] WCRIB Special Bulletin No. 10-13 (July 29, 2013).

ALTERNATIVE RISK FINANCING METHODS

Self-insurance and self-insurance groups (SIGs) became extremely popular devices to control 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.

Self-Insurance

The DIA strictly regulates self-insured employers through its annual licensing procedures. For an employer to qualify to self-insure, it must post a surety bond or negotiable securities to cover any losses that may occur. 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.[47] 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'02-FY'13

Fiscal Year	New Licenses	Total Licenses	Companies Covered	Equivalent Premium Dollars
FY'13	1	90	391	$315M
FY'12	1	95	463	$234M
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

Source: DIA Office of Insurance

[47] 452 CMR 5.00.

Self-Insurance Groups

Companies in related industries may join together 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.[48]

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 SIG 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).[49] Cost savings arise through dividends returned to members and deviated rates.

Companies who join SIGs 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, 2013, Massachusetts had 22 active SIGs and there were 5,647 members of SIGs.

Table 23: Membership in SIGs as of Jan. 1st, 1991-2013

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
2012	21	5,730
2013	22	5,647

Source: Division of Insurance

[48] According to DOI 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.

[49] 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. The IFB was created in 1990 to investigate auto insurance fraud and expanded in 1991 to include workers' compensation fraud.[50] While its mission statement includes all lines of insurance, the IFB's focus is on automobile and workers' compensation insurance.

In 2012, the IFB's Workers' Compensation Fraud Team was made up of an Investigative Manager plus six dedicated workers' compensation investigators. Additionally, the workers compensation fraud investigations are conducted by some of the Community Insurance Fraud Initiative (CIFI/Task Force) investigators and the provider fraud investigators with the support of three investigative analysts.

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 2012, each of these bureaus contributed $4.3 million to fund the IFB. The 2012 operating expenses for the IFB totaled $8,917,424, which was an increase of $100,880 over the Bureau's 2011 operating expenses ($8,816,544).

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.

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 2012, the IFB received 392 referrals regarding workers' compensation fraud. Workers' compensation fraud referrals only represent 10% of all IFB referrals. The vast majority of referrals (75%) received by IFB

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

are for automobile insurance fraud (3,021 in calendar year 2012). Workers' compensation cases are fewer in number 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 business 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 2012, there were three individuals indicted and/or complaints issued. There were seven individuals convicted. There was a total of $290,181 in restitution ordered for workers' compensation cases.

Additionally, the IFB is an integral part of the Joint Task Force on the Underground Economy and Employee Misclassification and is responsible for a significant portion of their investigations.

JOINT TASK FORCE ON THE UNDERGROUND ECONOMY AND EMPLOYEE MISCLASSIFICATION

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, including the DIA, and has a partnership with the United States Department of Labor and Insurance Fraud Bureau of Massachusetts.

Joint Task Force on the Underground Economy and Employee Misclassification

Members

- Department of Industrial Accidents
- Department of Labor Standards
- Department of Unemployment Assistance
- Fair Labor Division, Massachusetts Attorney General's Office
- Department of Revenue
- Division of Capital Asset Management
- Supplier Diversity Office
- Department of Public Safety
- Massachusetts Office of Refugees and Immigrants
- Division of Banks
- Division of Professional Licensure
- Office of Small Business & Entrepreneurship
- Massachusetts Commission Against Discrimination
- Alcoholic Beverages Control Commission, Massachusetts Treasurer's Office

Other Partners

- 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. In 2012, the Task Force's fourth year of operation, member agencies recovered $21.4 million during a two year period as a result of referrals and cooperative oversight. The Task Force received 237 complaints through its referral phone line (1-877-96-LABOR (877-965-2267)) and online referral system available on the Task Force's website.

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

LIST OF APPENDICES

APPENDIX A – Advisory Council Members, FY'13

ADVISORY COUNCIL MEMBERS, FY'13

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Tel: **(617) 451-2000** FAX: (617) 451-5775

LABOR

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

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

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

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
USI Insurance Services
One Griffin Brook Drive
Methuen, MA 01844
Tel: **(978) 983-6898**
FAX: (978) 688-5340

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*

APPENDIX B – Advisory Council Studies, 1989-2013

- 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, 2013-2014 Session

Senator Daniel A. Wolf (Chair)
State House - Room 511B
Boston, MA 02133-1053
(617) 722-1570

Sen. Michael Barrett (Vice-Chair)
State House - Room 213A
Boston, MA 02133-1053
(617) 722-1572

Senator Barry R. Finegold
State House - Room 416B
Boston, MA 02133-1053
(617) 722-1612

Senator Michael Moore
State House - Room 109B
Boston, MA 02133-1053
(617) 722-1485

Senator Michael F. Rush
State House – Room 504
Boston, MA 02133-1053
(617) 722-1348

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

Rep. Thomas P. Conroy (Chair)
State House – Room 39
Boston, MA 02133-1053
(617) 722-2014

Rep. Lori A. Ehrlich (Vice-Chair)
State House - Room 39
Boston, MA 02133-1053
(617) 722-2014

Representative John H. Rogers
State House - Room 162
Boston, MA 02133-1053
(617) 722-2092

Representative Angelo J. Puppolo, Jr.
State House – Room 236
Boston, MA 02133-1053
(617) 722-2430

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

Representative Kenneth I. Gordon
State House - Room 39
Boston, MA 02133-1053
(617) 722-2014

Representative Mary S. Keefe
State House - Room 473F
Boston, MA 02133-1053
(617) 722-2210

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

Representative Daniel M. Donohue
State House - Room 122
Boston, MA 02133-1053
(617) 722-2006

Representative Keiko M. Orrall
State House - Room 540
Boston, MA 02133-1053
(617) 722-2090

Representative Nicholas A. Boldyga
State House - Room 167
Boston, MA 02133-1053
(617) 722-2810

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 x7356

Omar Hernandez, Senior Judge
Division of Industrial Accidents
1 Congress Street, Suite 100
Boston, MA 02114
Tel: 617-727-4900 x7307

Joseph Bonfiglio, Business Manager
MA & Northern NE Laborers' District Council
7 Laborers' Way
Hopkinton, MA 01748
Tel: 508-435-4164/Cell: 617-877-6160

Stephen Marley
Director of Human Resources
Harvard University
Cambridge, MA 02138
Tel: 617-495-4586

Joanne Goldstein, Secretary
Executive Office of Labor & Workforce Dev.
1 Ashburton Place, Suite 2122
Boston, MA 02108
Tel: 617-626-7100

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

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

Vincent M. Tentindo
Tentindo, Kendall, Canniff & Keefe, LLP
510 Rutherford Ave.
Boston, MA 02129
Tel: 617-788-3695

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

Keeana Saxon, General Counsel
Executive Office of Housing & Economic Dev.
1 Ashburton Place, Suite 2101
Boston, MA 02108
Tel: 617-788-3672

Kate Cook, Chief Legal Counsel to Governor
State House, Room 271
Boston, MA 02133
Tel: 617-725-4030

Donald F. Baldini
10 Hawthorne Street
Winchester, MA 01890
Tel: 617-574-5867

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

Marilyn Lyng O'Connell, Executive Director and Deputy Counsel
Judicial Nominating Commission
State House – Room 54
Boston, MA 02133

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. The Lieutenant Governor serves as an Ex-Officio Member. The Council meets at noon on Wednesdays in the Council Chamber, Room 360, to act on such issues as payments from the state treasury, criminal pardons and commutations, and approval of gubernatorial appointments; such as judges, clerk-magistrates, public administrators, members of the Parole Board, Appellate Tax Board, Industrial Accident Board and Industrial Accident Reviewing Board, notaries and justices of the peace.

Oliver P. Cipollini, Jr. – District 1
20 Biscayne Drive
Marston Mills, MA 02648
GC: (617) 725-4015 x 1

Robert L. Jubinville – District 2
487 Adams Street
Milton, MA 02186
GC: (617) 725-4015 x 2

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

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

Eileen R. Duff - District 5
8 Barberry Heights Road
Gloucester, MA 01930
GC: (617) 725-4015 x 5

Terrence W. Kennedy - District 6
3 Stafford Road
Lynnfield, MA 01940
GC: (617) 725-4015 x 6

Jennie L. Caissie - District 7
53 Fort Hill Road
Oxford, MA 01540
GC: (617) 725-4015 x 7
Fax: (508) 765-0888
Bus: (508) 765-0885

Michael J. Albano - District 8
403 Maple Road
Longmeadow, MA 01106
GC: (617) 725-4015 x 8
Bus. (413) 774-5300
Fax. (413) 773-3388

APPENDIX F – Health Care Services Board, 2013

1 Congress Street, Suite 100
Boston, MA 02114
(617) 727-4900 x7310

Current Members (2013):

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*
John W. Burress, MD, MPH, FACOEM	*Physician Representative*
Elise Pechter, MPH, CIH	*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

(As of August 22, 2013)

INDUSTRIAL ACCIDENT REVIEWING BOARD - SIX YEAR TERMS

1.	Carol Calliotte	Democrat	05/01/19
2.	Bernard Fabricant	Unenrolled	09/21/16
3.	Mark Horan	Democrat	09/21/16
4.	Frederick Levine	Unenrolled	09/21/16
5.	William Harpin	Unenrolled	08/08/18
6.	Catherine W. Koziol	Democrat	08/18/14

INDUSTRIAL ACCIDENT BOARD - SIX YEAR TERMS

1.	Douglas Bean	Republican	06/26/17
2.	Sabina Herlihy	Independent	05/29/19
3.	Christina Poulter	Democrat	10/12/16
4.	Dennis Maher	Democrat	09/15/14
5.	Lynn Brendemuehl	Unenrolled	07/06/18
6.	David Sullivan	Democrat	09/21/16
7.	Steven Rose	Republican	05/28/16
8.	Richard Heffernan	Democrat	07/22/15
9.	John Preston	Republican	07/29/18
10.	Cheryl Jacques	Democrat	03/26/14
11.	Roger Lewenberg	Unenrolled	09/21/16
12.	Fred Taub	Democrat	08/03/18
13.	Douglas McDonald	Unenrolled	07/06/18
14.	Yvonne Vieira-Cardoza	Democrat	06/19/19
15.	Maureen McManus	Republican	09/21/16
16.	VACANT		
17.	Dianne Solomon	Unenrolled	08/10/18
18.	Paul Benoit	Unenrolled	08/18/14
19.	Omar Hernandez	Democrat	12/29/17
20.	Michael Williams	Democrat	08/08/18
21.	Kalina Vendetti	Democrat	08/16/16

APPENDIX H – WCAC Testimony: Letter to Judiciary Committee, 9/4/13

DEVAL L. PATRICK
GOVERNOR

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

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

JOHN R. REGAN
CHAIR

STEPHEN JOYCE
VICE-CHAIR

WILLIAM S. MONNIN-BROWDER
EXECUTIVE DIRECTOR

September 4, 2013

The Honorable Katherine M. Clark
The Honorable Eugene L. O'Flaherty
Joint Committee on Judiciary
State House, Room 136
Boston, MA 02133

RE: Workers' Compensation Advisory Council Support for House Bills 1423 and 1496

Dear Chairwoman Clark and Chairman O'Flaherty:

The Massachusetts Workers' Compensation Advisory Council ("Advisory Council") is a board appointed by the Governor and comprised of business and labor leaders, as well as representatives from the legal, medical, insurance and vocational rehabilitation communities. Each month, Council members volunteer their time to discuss and analyze a variety of workers' compensation issues with the ultimate goal of identifying problems and developing solutions. In order to support legislation, adopt a position or otherwise take action, an affirmative vote of at least seven members between business and labor representatives must be achieved. On May 8, 2013, the members of the Advisory Council carefully reviewed **House Bill 1423**, filed by Representative Mary Keefe and **House Bill 1496**, filed by Majority Leader Ronald Mariano, and voted to **support** both pieces of legislation.

House Bill 1423 would penalize employers, contractors, subcontractors, or any agents thereof, who contract or participate in a contract from which they are barred under the Workers' Compensation Act. Currently, M.G.L. c.152, §25C (10) provides that an employer who fails to provide insurance for their employees will be debarred from bidding or participating in any state or municipal funded contracts for a period of three years. Under this bill, employers who contract or participate in a contract from which they are barred would be penalized for a first offense by a fine of up to $250,000, imprisonment for up to one year, or both. Any subsequent "willful" violation would carry a fine of up to $500,000, imprisonment for up to two years, or both.

House Bill 468 would increase the severity of criminal penalties levied against employers who fail to provide workers' compensation coverage for their employees. Current law limits criminal penalties to imprisonment for not more than one year, a fine of no more than $1,500, or both. This bill would change the criminal penalties to 1) imprisonment in the state prison for not more than 5 years or by imprisonment in a house of correction for not less than 6 months nor more than 2 1/2 years; 2) a fine of not less than $1,000 nor more than $10,000; or 3) both. The Advisory Council believes that this legislation would send 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.

The Advisory Council continues to review workers' compensation legislation and will continue to report any relative findings to your committee. We thank you for allowing us the opportunity to offer our legislative recommendation. We look forward to working with you in order to achieve the necessary changes to continually improve our workers' compensation system.

Sincerely,

John R. Regan

Stephen Joyce

cc: Members of the Joint Committee on the Judiciary
The Honorable Ronald Mariano (House Bill 1496 Sponsor)
The Honorable Mary Keefe (House Bill 1423 Sponsor)
Members of the Massachusetts Workers' Compensation Advisory Council

APPENDIX I – WCAC Testimony: JCLWD Legislative Hearing, 10/8/2013

Testimony of the Workers' Compensation Advisory Council
Joint Committee on Labor & Workforce Development
October 8, 2013

Good morning. My name is William Monnin-Browder and I serve as Executive Director of the Massachusetts Workers' Compensation Advisory Council (Advisory Council). I have been asked to testify today on behalf of the Advisory Council.

The Advisory Council is a board appointed by the Governor and comprised of business and labor leaders, as well as representatives from the legal, medical, insurance and vocational rehabilitation communities. Each month, Council members volunteer their time to discuss and analyze a variety of workers' compensation issues with the ultimate goal of identifying problems and developing solutions. In order to support legislation, adopt a position or otherwise take action, an affirmative vote of at least seven members between business and employee representatives must be achieved.

The Advisory Council has reviewed the proposed workers' compensation legislation before the Joint Committee on Labor and Workforce Development and has identified a number of pieces of legislation that would improve the workers' compensation system in Massachusetts. Advisory Council-supported legislation addresses issues including employer fraud, employee benefits, and employer responsibilities.

Employer Fraud

- **The Advisory Council supports Senate Bills 850 (Senator Clark) and 871 (Senator McGee).**
  These similar bills would increase the severity of criminal penalties for employers who fail to provide mandatory workers' compensation insurance for their employees. Established in 1987, the present fine structure is outdated and insufficient, capping criminal penalties at $1,500 or up to one year in prison. On criminal convictions, this bill would allow a judge to impose sentences of up to five years in state prison and/or fines up to $10,000. The Advisory Council believes this legislation sends a strong message to uninsured businesses in the Commonwealth that workers' compensation fraud is a serious violation of the law and will be met with serious consequences.

Employee Benefits

- **The Advisory Council supports Senate Bill 861 (Senator Hart).**
  This bill would provide compensation for scar-based disfigurement appearing on any part of the body, subject to a $15,000 maximum benefit. Under current law, compensation is only available if the scarring or disfigurement is on the hands, face or neck. Advisory Council members strongly believe that the location of scarring on the body is irrelevant and that compensation, subject to the $15,000 maximum benefit, should be provided to workers who suffer these traumatic, and at times, horrific injuries.

- **The Advisory Council <u>supports</u> Senate Bill 866 (Senator Joyce) and House Bill 1698 (Representative Bradley).**
  This bill would require an insurer to pay for burial expenses when a worker has been killed on the job, not to exceed $8,000. The current burial allowance of $4,000 has not been increased in 20 years and is well below the national median. The National Funeral Directors Association has reported that the median adult casketed funeral cost in 2012 was $8,343. 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.

<u>Employer Responsibilities</u>

- **The Advisory Council <u>supports</u> House Bill 1760 (Representative Sannicandro).**
  This bill would replace the present flat fine levied against employers operating without workers' compensation insurance with a fine based on the amount of premium that the employer avoided. Specifically, the bill would set premium avoidance fines for uninsured employers at three times the premium that 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 be $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 determines 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 the fines associated with it.

- **The Advisory Council <u>supports</u> House Bill 1761 (Representative Sannicandro).**
  Under current law, employers are required to 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. This bill would create civil fines for the failure to provide the required notice. 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.

- **The Advisory Council <u>supports</u> House Bill 1737 (Representative Keenan).**
  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. This bill would replace the flat fine of $100 for employers that fail to report a workplace fatality or injury with 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). The bill would also delete the provision in existing law that triggers fines as of the third violation. Instead, fines would be applied as of the first violation. Massachusetts is the only state in the country with such a fine waiving provision.

Throughout this legislative session, the Advisory Council will continue to review workers' compensation legislation to ensure that any changes to the law 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 are available as a resource to meet with any Committee members to discuss the workers' compensation system in Massachusetts.

On behalf of the Advisory Council, I thank the Joint Committee on Labor & Workforce Development for holding this hearing and allowing the Council this opportunity to share its recommendations.

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 Grants Funded, FY'13

SAFETY GRANTS FUNDED

Signature Health Care
680 Centre Street
Brockton, MA 02302
Category of Applicant: Nonprofit
Geographic Target: Plymouth County
Program Administrator: Jeff Miller
Total Funds Approved: $25,000.00

Medical Training Associates
P.O. Box 4
Rockport, MA 01966
Category of Applicant: Private Provider
Geographic Target: Statewide
Program Administrator: Craig Morrill
Total Funds Approved: $24,975.00

Family Continuity
60 Perseverance Way, 2nd Floor
Hyannis, MA 02601
Category of Applicant: Nonprofit
Geographic Target: Barnstable
Program Administrator: Earl Stuck
Total Funds Approved: $24,664.50

IATSE
New England Studio Mechanics
10 Tower Office Park, Suite 218
Woburn, MA 01801
Category of Applicant: Labor
Geographic Target: Statewide
Program Administrator: Gregg McCutcheon
Total Funds Approved: $23,110.08

Town of North Attleboro
43 South Washington Street
North Attleboro, MA 02760
Category of Applicant: Municipality
Geographic Target: Bristol
Program Administrator: JoAnn Catcart
Total Funds Approved: $21,587.25

New England Carpenters
750 Dorchester Ave.
Boston, MA 02125
Category of Applicant: Labor
Geographic Target: Statewide
Program Administrator: Makita Durant
Total Funds Approved: $24,983.60

JATC of Greater Boston
194 Freeport Street
Dorchester, MA 02122
Category of Applicant: Labor
Geographic Target: Suffolk/Norfolk/Middlesex
Program Administrator: Chris Sherlock
Total Funds Approved: $24,773.92

Mabbett & Associates
5 Alfred Circle
Bedford, MA 01730
Category of Applicant: Labor
Geographic Target: Statewide
Program Administrator: Todd Dresser
Total Funds Approved: $24,215.81

Builders Association of Central MA
51 Pullman Street
Worcester, MA 01606
Category of Applicant: Labor
Geographic Target: Worcester
Program Administrator: Patricia Halifax
Total Funds Approved: $22,163.98

Boston Plasterers and Cement Masons
7 Fredricka Street
Dorchester, MA 0212
Category of Applicant: Labor
Geographic Target: Statewide
Program Administrator: Mary Keohan
Total Funds Approved: $21,206.33

Sheet Metal Workers' LU #17
J.A.T.C.
1181 Adams Street
Dorchester, MA 02124
Category of Applicant: Union
Geographic Target: Suffolk
Program Administrator: Patti Smart
Total Funds Approved: $17,755.21

IBEW 223 JATC
P.O. Box 1238
Lakeville, MA 02347
Category of Applicant: Labor
Geographic Target: Plymouth, Bristol, Barnstable, Nantucket and Dukes
Program Administrator: Bob Revil
Total Funds Approved: $12,007.54

Joseph Abboud Mfg. Corp.
689 Belleville Avenue
New Bedford, MA 02746
Category of Applicant: Private
Geographic Target: Bristol
Program Administrator: Elaine A. Couto
Total Funds Approved: $9,311.14

Seven Hills Foundation
81 Hope Avenue
Worcester, MA 01603
Category of Applicant: Nonprofit
Geographic Target: Statewide
Program Administrator: Beth Early
Total Funds Approved: $8,025.00

Worcester Housing Authority
40 Belmont Street
Worcester, MA 01605
Category of Applicant: Municipality
Geographic Target: Worcester
Program Administrator: Suzanne Chung
Total Funds Approved: $4,987.48

High Point Treatment Center
98 Front Street, 3rd Floor
Bedford, MA 02740
Category of Applicant: Nonprofit
Geographic Target: Bristol/Plymouth
Program Administrator: Anne Zarlengo
Total Funds Approved: $16,673.81

MassCOSH
42 Charles Street
Dorchester, MA 02122
Category of Applicant: Nonprofit
Geographic Target: Suffolk
Program Administrator: Marcy Gelb
Total Funds Approved: $11,053.10

Children's Dental Care
370 Main Street
Stoneham, MA 02180
Category of Applicant: Private
Geographic Target: Middlesex
Program Administrator: Dr. Badrieh Edalatour
Total Funds Approved: $8,624.20

Community Teamwork, Inc.
167 Dutton Street
Lowell, MA 01852
Category of Applicant: Nonprofit
Geographic Target: Middlesex
Program Administrator: Gene Codes
Total Funds Approved: $7,222.50

Greenscape Land Design
100 Revolutionary Drive
E. Taunton, MA 02718
Category of Applicant: Private
Geographic Target: Essex, Bristol, Plymouth
Program Administrator: Karen Sanborn
Total Funds Approved: $2,349.54

Webster Square Day Care Center, Inc.
1048 Main Street
Worcester, MA 01603
Category of Applicant: Private
Geographic Target: Worcester
Program Administrator: Di-Ann
Total Funds Approved: $2,341.10

Combined Energy Systems Inc.
37 Ayer Road, Unit 9
Littleton, MA 01460
Category of Applicant: Private
Geographic Target: Statewide
Program Administrator: Heather McGuirk
Total Funds Approved: $2,252.08

Native Habitat Restoration
19 Cherry Hill
Stockbridge, MA 01262
Category of Applicant: Private
Geographic Target: Berkshire
Program Administrator: Sari Hoy, President
Total Funds Approved: $1,689.50

City of Cambridge, DPW
147 Hampshire Street
Cambridge, MA 02139
Category of Applicant: Municipality
Geographic Target: Middlesex
Program Administrator: Catherine Mitrano
Total Funds Approved: $2,332.60

Cutler Associates, Inc.
43 Harvard Street
Worcester, MA 01609
Category of Applicant: Private
Geographic Target: Worcester
Program Administrator: Andrea Healy
Total Funds Approved: $1,926.00

APPENDIX L – Collections & Expenditures Report, FY'13 - FY'09

COLLECTIONS AND EXPENDITURES REPORT, FISCAL YEAR 2013 - FISCAL YEAR 2009

SPECIAL FUND	*FY'13*	*FY'12*	*FY'11*	*FY'10*	*FY'09*
COLLECTIONS					
INTEREST	**5,740**	**7,275**	**8,037**	**11,498**	**107,609**
ASSESSMENTS	12,941,590	18,289,364	20,550,569	20,269,416	20,458,701
LESS RET. CHECKS	(14,697)	(84,188)	(154,190)	(17,388)	(94,125)
LESS REFUNDS	(8,388)	(75,113)	0	(57,793)	(336,026)
SUB-TOTAL	**12,918,505**	**18,130,063**	**20,396,379**	**20,194,235**	**20,028,550**
REFERRAL FEES	4,049,061	4,073,484	3,791,090	3,993,493	4,786,125
LESS RET. CHECKS	(762)	(1,760)	(1,424)	(711)	(3,998)
LESS REFUNDS	(64,108)	(325,711)	(59,433)	(115,277)	(654,402)
OPERATING TRANSFER	0	(39,347)	0	0	0
SUB-TOTAL	**3,984,191**	**3,706,666**	**3,730,233**	**3,877,505**	**4,127,725**
1ST REPORT FINES	$58,658	118,000	140,905	116,542	243,050
LESS RET. CHECKS	(2,400)	0	(100)	(100)	(1,200)
LESS REFUNDS	(500)	(2,700)	(2,900)	(91,511)	(6,780)
SUB-TOTAL	**55,758**	**115,300**	**137,905**	**24,931**	**235,070**
STOP WORK ORDERS	1,356,053	1,450,641	1,844,816	1,645,564	1,381,180
LESS REFUNDS	(1,200)	(7,900)	0	(33,516)	0
EDS FEE	0	0	(65)	(48)	(21)
LESS BAD CHECKS	(3,300)	(3,200)	(2,200)	(3,348)	(11,200)
MERCHANT FEE	(287)	(361)	(6,326)	0	(5)
SUB-TOTAL	**1,351,266**	**1,439,180**	**1,836,225**	**1,608,652**	**1,369,954**
LATE ASSESS. FINES	111,973	344,349	268,393	45,498	74,673
MISCELLANEOUS	50,689	67,571	60,864	81,526	29,848
ADJUSTMENT	0	0	0	0	6,939
SUB-TOTAL	**162,662**	**411,921**	**329,257**	**127,024**	**111,460**
TOTAL SPECIAL FUND COLLECTIONS	**18,478,122**	**23,810,405**	**26,438,036**	**25,843,845**	**25,980,368**
BALANCE BRGT FWD	14,294,169	12,141,512	7,952,135	4,878,605	2,470,245
TOTAL	**32,772,291**	**35,951,917**	**34,390,171**	**30,722,450**	**28,450,613**
LESS EXPENDITURES	(20,521,034)	(21,657,748)	(22,248,659)	(22,770,315)	(23,572,008)
ADJUSTMENT	1,148	0	0	0	0
BALANCE	**12,252,405**	**14,294,169**	**12,141,512**	**7,952,135**	**4,878,605**
EXPENDITURES					
TOTAL COMPUTER	0	0	**7,691**	**2,786**	**37**
REPAYMENT - SALARIES	12,805,181	13,076,720	13,222,297	13,791,029	14,298,709
FRINGE BENEFITS	3,310,925	4,264,090	4,147,248	3,611,928	3,490,000
INDIRECT COSTS	286,923	477,585	367,840	742,764	365,987
NON-PERSONNEL COSTS	4,118,005	3,800,005	4,428,114	4,575,218	5,385,628
OTHER INDIRECT COSTS	0	0	0	24	0
IP INDIRECT-EXPENSE	0	0	0	46,566	31,647
ADJUSTMENT FRINGE	0	39,347	75,469	0	0
TOTAL REPAYMENT	**20,521,034**	**21,657,748**	**22,164,552**	**22,767,529**	**23,571,971**
TOT. SPECIAL FUND EXPENDITURES	**20,521,034**	**21,657,748**	**22,248,659**	**22,770,315**	**23,572,008**

PUBLIC TRUST FUND	*FY'13*	*FY'12*	*FY'11*	*FY'10*	*FY'09*
COLLECTIONS					
INTEREST	**441**	**559**	**618**	**884**	**4,039**
ASSESSMENTS	0	0	0	339	457
LESS FUNDS TRANSFERRED	0	0	0	(339)	(45)
TOTAL ASSESSMENTS	0	**0**	**0**	**0**	**412**
TOTAL PUBLIC TRUST COLLECTIONS	**441**	**559**	**618**	**884**	**4,451**
BALANCE BRGT FWD	407,887	407,328	406,711	846,303	841,852
TOTAL	**408,328**	**407,887**	**407,329**	**847,187**	**846,303**
LESS EXPENDITURES	**0**	**0**	0	(440,476)	0
BALANCE	**408,328**	**407,887**	**407,329**	**406,711**	**846,303**
EXPENDITURES					
RR COLAS	0	0	0	440,476	0
TOT. PUBLIC TRUST EXPENDITURES	**0**	**0**	**0**	**440,476**	**0**

PRIVATE TRUST FUND	*FY'13*	*FY'12*	*FY'11*	*FY'10*	*FY'09*
COLLECTIONS					
INTEREST	**13,982**	**17,723**	**19,778**	**28,012**	**128,052**
ASSESSMENTS	47,216,893	64,302,080	61,107,302	55,076,303	55,002,085
LESS RET. CHECKS	(8,130)	(301,967)	(116,286)	(24,085)	(282,474)
LESS REFUNDS	(15,651)	(12,414)	(45,686)	(67,776)	(980,934)
SUB-TOTAL	**47,193,112**	**63,987,699**	**60,945,330**	**54,984,442**	**53,738,678**
REIMBURSEMENTS	1,387,682	1,055,230	1,246,265	717,782	1,401,891
RET. CHECK	(18,833)	(8,173)	(3,075)	(3,603)	(11,496)
REFUNDS	0	0	(484)	(819)	(1,877)
SUB-TOTAL	**1,368,849**	**1,047,057**	**1,242,706**	**713,360**	**1,388,518**
SEC. 30 H	**0**	**0**	**53,358**	**0**	**25,924**
OTHER TRUST FUND	**0**	**0**	**0**	**0**	**87,378**
TOT.PRIVATE TRUST COLLECTIONS	**48,575,942**	**65,052,480**	**62,261,172**	**55,725,813**	**55,368,550**
BALANCE BRGT FWD	34,101,000	26,757,561	16,558,295	7,667,309	26,153,119
TOTAL	**82,676,942**	**91,810,041**	**78,819,467**	**63,393,122**	**81,521,669**
LESS EXPENDITURES	(54,077,680)	(57,709,041)	(52,061,906)	(46,834,827)	(73,854,360)
ADJUSTMENT	0	0	0	0	0
BALANCE	**28,599,262**	**34,101,000**	**26,757,561**	**16,558,295**	**7,667,309**

PRIVATE TRUST FUND	*FY'13*	*FY'12*	*FY'11*	*FY'10*	*FY'09*
CLAIMANTS - EXPENDITURES					
RR SEC. 34	1,297,249	1,008,823	1,238,194	1,414,491	1,209,059
RR SEC. 35	344,000	503,908	538,788	379,035	428,448
RR LUMP SUM	1,064,508	2,443,857	1,650,000	1,043,946	1,345,645
RR SEC. 36	108,877	339,108	446,949	180,802	220,957
RR SEC. 31	150,847	225,342	193,757	98,761	163,090
RR SEC. 34, PERM. TOTAL	676,761	711,058	584,210	620,747	436,661
RR COLA ADJ	242,981	229,823	292,068	227,594	269,725
RR EE MEDICAL	22,727	28,584	26,804	24,846	22,527
RR EE TRAVEL	3,500	1,216	6,500	5,219	3,500
RR EE MISC. EXPENSE	222	0	500	709	632
RR BURIAL BENEFITS	0	5,000	0	4,000	4,000
RR LEGAL FEES	506,708	784,787	684,853	604,005	618,683
RR VOC. REHAB SERVICES	5,378	7,602	3,899	8,168	10,666
RR REHAB (PRIOR YEAR)	0	0	147	0	0
RR MEDICAL	1,497,220	1,521,020	2,000,858	1,891,511	2,108,479
EE Books & Supplies	0	0	(1,513)	0	0
SUB-TOTAL CLAIMANT PAYMENTS	**5,920,979**	**7,810,128**	**7,666,014**	**6,503,834**	**6,842,072**
MM TUITION	**0**	**0**	**2,926**	**4,653**	**6,649**
TOTAL CLAIMANTS	**5,920,979**	**7,810,128**	**7,668,940**	**6,508,487**	**6,848,721**
INSURERS - EXPENDITURES					
RR COLAS	14,967,542	19,578,320	14,746,147	11,081,676	33,566,021
RR SEC. 19 COLA LUMP SUM	515,501	499,339	886,304	685,552	872,730
RR LATENCY SEC. 35C	249,478	96,125	483,743	303,027	982,496
RR LATENCY SEC. 35C QUARTERLY	124,836	195,631	481,651	0	0
RR SEC. 37	15,773,208	17,290,467	15,688,574	15,765,761	20,116,257
RR SEC. 37 QUARTERLY	10,999,885	6,907,948	6,577,876	6,999,945	5,998,937
RR SEC. 37 INTEREST	6,470	0	33,538	111,948	304,741
TOTAL PAYMENT TO INSURERS	**42,636,920**	**44,567,830**	**38,897,833**	**34,947,909**	**61,841,182**
OEVR - EXPENDITURES					
MM TUITION	0	0	0	7,938	7,427
RR REHAB-30H	0	801	0	148	3,814
EE OTHER	0	0	0	0	463
RR EE TRAVEL	0	0	833	2,070	4,000
RR EE BOOKS & SUPPLIES	0	0	892	1,539	1,553
SUB-TOTAL OEVR EXP.	**0**	**801**	**1,725**	**11,695**	**17,257**

PRIVATE TRUST FUND	*FY'13*	*FY'12*	*FY'11*	*FY'10*	*FY'09*
DEFENSE - EXPENDITURES					
AA PAYROLL - SALARY	3,195,287	2,906,711	2,900,716	2,955,695	2,837,630
AA VACATION-IN-LEU	1,757	7,279	28,792	0	0
AA BONUS AND AWARDS	0	7	7,500	0	0
AA OVERTIME COSTS	1,620	15,140	0	0	0
AA SICK LEAVE BUY BACK	0	0	374	0	0
SUB-TOTAL	**3,198,664**	**2,929,137**	**2,937,382**	**2,955,695**	**2,837,630**
BB TRAVEL	59,399	55,086	54,674	44,308	0
BB CONFERENCE TRAINING	1,860	1,550	2,305	1,860	2,015
BB EMPLOYEE REIMBURS AP	0	0	1,929	0	0
BB EE REIMBURSEMENT	77	246	261	16	47,071
BB EMPLOYEE REIMBURS	227	242	142	5,333	5,976
SUB-TOTAL	**61,563**	**57,124**	**59,311**	**51,517**	**55,062**
CONTRACTED STUDENT INTERNS	30,151	225	29,513	7,290	9,010
SUB-TOTAL	**30,151**	**225**	**29,513**	**7,290**	**9,010**
DD FRINGE	871,791	1,015,463	979,676	821,784	732,511
DD MEDICAL EXPENSES	0	0	2,092	0	0
DD BOND	0	(445)	445	2,093	0
DD WC CHARGEBACK	0	43,845	14,575	44,072	16,556
DD HEALTH SERVICES CORP	0	2,267	0	0	2,092
SUB-TOTAL	**871,791**	**1,061,130**	**996,788**	**867,949**	**751,159**
EE RENTAL/MV CHRG-BACK	0	0	473	1,134	3,402
EE DEST. OLD RECORDS	6,715	6,840	7,201	7,201	7,052
EE ADVERTISING	0	0	232	0	713
EE BOOKS/SUPPLIES	44,168	41,999	25,650	27,127	27,241
EE IMPARTIAL APPEALS	26,825	15,963	14,400	13,950	17,188
EE CENTRAL REPRO.	999	0	0	2,615	2,686
EE POSTAGE	46,655	27,500	39,750	9,910	12,796
EE WATER	1,421	948	1,814	974	1,251
EE TRAINING / TUITION	298	0	0	0	0
EE TEMP USE SPACE	325	184	0	2,245	0
EE PRINTING	4,870	3,255	3,289	1,345	4,635
EE CONFERENCE, INCIDEN.	3,337	7,422	7,075	0	2,820
EE INDIRECT COSTS	70,012	63,989	92,657	94,063	82,829
EE POSTAGE CHRG-BACK	1,382	2,390	2,182	2,211	2,742
EE MEMBERSHIPS	3,450	625	0	0	0
EE STATE SINGLE AUDIT CHGBK	117	0	0	0	0
SUB-TOTAL	**210,574**	**171,115**	**194,723**	**162,775**	**165,355**
MED SUP/TOILETRIES & PERSONL	71	90	1,189	937	0
SUB-TOTAL	**71**	**90**	**1,189**	**937**	**0**
GG BOSTON LEASE	454,249	475,576	457,916	626,923	620,826
GG ELECTRICITY - BOSTON	0	0	1,384	20,970	26,792
GG FUEL FOR VEHICLES	570	0	0	0	63
SUB-TOTAL	**454,819**	**475,576**	**459,300**	**647,893**	**647,681**
HH CONSULTANTS	169,029	209,757	128,511	238,027	197,310
SUB-TOTAL	**169,029**	**209,757**	**128,511**	**238,027**	**197,310**
JJ OPERATIONAL SERV.	194,367	182,534	229,083	167,589	144,383
SUB-TOTAL	**194,367**	**182,534**	**229,083**	**167,589**	**144,383**

PRIVATE TRUST FUND	*FY'13*	*FY'12*	*FY'11*	*FY'10*	*FY'09*
KK EQUIPMENT	4,951	1,150	172,899	31,564	6,649
SUB-TOTAL	**4,951**	**1,150**	**172,899**	**31,564**	**6,649**
LL AUTOMOBILE RENT/LEASE	42,257	43,027	43,703	46,952	27,113
LL OFFICE EQUIP RENT/LEASE	1,269	983	978	977	1,272
LL PRINT/COPY EQUIP RENT/LEASE	5,392	4,186	3,574	0	0
LL OFFICE EQUIP MAINTENANCE	351	1,396	1,572	727	1,032
LL PRINT/COPY EQUIP MAINT	222	370	472	341	813
SUB-TOTAL	**49,491**	**49,962**	**50,299**	**48,997**	**30,230**
UU TELECOM SERVICES - DATA	21,512	24,366	11,065	15,344	20,774
UU TELECOM SERVICES - VOICE	27,119	13,651	15,527	17,832	19,357
UU SOFTWARE LICENSES	1,223	6,969	5,555	20,672	19,088
UU INFO TECH CHARGEBACK	72,147	26,862	35,290	36,481	25,111
UU INFO TECH PROFESSIONALS	1,563	4,073	10,061	22,535	36,597
UU INFO TECH CABLING	0	122	3,707	166	1,716
UU INFO TECH EQUIP PURCHASE	93,830	57,254	56,894	23,906	125,258
UU IT TELP LEASE-PURCHASE	48	47	0	0	1,188
UU INFO TECH MAINTENANCE	56,663	56,654	68,952	45,529	49,474
SUB-TOTAL	**274,105**	**189,998**	**207,051**	**182,465**	**298,563**
NN NON-MAJOR INFRA MAINT	0	1,845	9,936	1,850	2,086
NN INFRA MAINT TOOLS/SUPPLIES	5	3	0	0	0
NN HAZARDOUS WASTE	0	0	388	0	0
NN NON- HAZARDOUS WASTE	0	1,436	17,036	2,188	1,439
SUB-TOTAL	**5**	**3,284**	**27,360**	**4,038**	**3,525**
RR PENALTIES SEC. 8	200	0	0	0	0
SUB-TOTAL	**200**	0	**0**	**0**	**0**
TOTAL DEFENSE EXPENDITURES	**5,519,780**	**5,331,082**	**5,493,490**	**5,366,736**	**5,146,557**
TOTAL PRIV. TRUST EXPENDITURES	**54,077,680**	**57,709,041**	**52,061,906**	**46,834,827**	**73,853,717**

DIA - INCOME SUMMARY

INCOME SUMMARY	*FY'13*	*FY'12*	*FY'11*	*FY'10*	*FY'09*
Total Assessments (All 3 Funds)	60,111,617	82,117,762	81,341,709	75,178,677	73,767,640
Total Filing Fees	3,984,191	3,706,666	3,730,233	3,877,505	4,127,725
Total First Report Fines	55,758	115,300	137,905	24,931	235,070
Total SWOs	1,351,266	1,439,180	1,836,225	1,608,652	1,369,954
Total Misc. Fines	50,689	67,571	60,864	81,526	29,848
Total 5% Fines (Late Assess.)	111,973	344,349	268,393	45,498	74,673
Total Reimbursements	1,368,849	1,047,057	1,242,706	713,360	1,388,518
Total 30H	0	0	53,358	0	25,924
Total Other Trust Fund	0	0	0	0	87,378
Yr. Adj. for Refunds to TF	0	0	0	0	6,939
Total Interest	20,163	25,557	28,433	40,394	239,700
TOTAL INCOME	**67,054,506**	**88,863,444**	**88,699,826**	**81,570,543**	**81,353,369**

APPENDIX M – Workers' Compensation Legislation, 2013-2014 Session

NUMBERED LIST OF WORKERS' COMPENSATION LEGISLATION

The 188th General Court of the Commonwealth of Massachusetts • Last Updated October 3, 2013

HOUSE BILLS:

SENATE BILLS:

* Bill Endorsed by the Advisory Council

HOUSE BILL 1423

Subject: Workers' Compensation Compliance and Enforcement
Primary Sponsor: Representative Mary S. Keefe (D)
Referred To: Joint Committee on the Judiciary
Previous History: NEW
WCAC Position: Endorsed by the Advisory Council
Statutes Affected: c.152, §25C (Stop Work Orders & Penalties)

This legislation would penalize employers, contractors, subcontractors, or any agents thereof, who contract or participate in a contract from which they are barred under the Workers' Compensation Act. Currently, M.G.L. c.152, §25C(10) provides that an employer who fails to provide insurance for their employees will be debarred from bidding or participating in any state or municipal funded contracts for a period of three years. Under this bill, employers who contract or participate in a contract from which they are barred would be penalized for a first offense by a fine of up to $250,000, imprisonment for up to one year, or both. Any subsequent "willful" violation would carry a fine of up to $500,000, imprisonment for up to two years, or both.

HOUSE BILL 1496

Subject: An Act for Achieving Insurance Responsibility
Primary Sponsor: Representative Ronald Mariano (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.468, S.915 and S.938 in the 2011-2012 Legislative Session)
WCAC Position: Endorsed by the Advisory Council
Statutes Affected: c.152, §25C (Stop Work Orders and 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.

HOUSE BILL 1654

Subject: Criminal Offense for Displaying Invalid Workers' Compensation Certificate
Primary Sponsor: Representative Cleon Turner (D)
Referred To: Joint Committee on Judiciary
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.152

This legislation would impose criminal penalties on employers who falsely assert that they have active workers' compensation insurance or who display an invalid certificate of insurance. The proposed bill would set the penalties at a fine of not less than $1,000, imprisonment in a jail or house of corrections for up to 2½ years, or both. Additionally, the employer who falsely asserted or displayed an invalid certificate would be personally liable for any loss or damage to anyone who relied on the employer's false assertion/display.

HOUSE BILL 1694

Subject: Scar-Based Disfigurement - Separate Benefits for Non-Surgical/Surgical
Primary Sponsor: Representative James Arciero (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.2868 in the 2011-2012 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §36(k) (Specific Injuries)

This refiled legislation would create two distinct benefit scenarios for bodily disfigurement depending on whether or not the 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, §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.

HOUSE BILL 1697

Subject: Impartial Medical Examiners
Primary Sponsor: Representative Garrett J. Bradley (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.2290 in the 2011-2012 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §9C (Appointment of IME Prior to Conference or Hearing), $11A(2) (IMEs)

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 would replace §11A(2) with a new subsection. The subsection would delete a provision in existing law stating that an impartial exam be conducted whenever a dispute over medical issues is the subject of a conference order. Instead, impartial medical examinations would be at the discretion of the AJ or ALJ.

HOUSE BILL 1698

Subject: Burial Expenses – Increase Maximum Amount from $4,000 to $8,000
Primary Sponsor: Representative Garrett J. Bradley (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.1406 in the 2011-2012 Legislative Session)
WCAC Position: Endorsed by the Advisory Council
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, in an amount not to exceed $8,000. 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.

HOUSE BILL 1699

Subject: AWW for Subsequent Injuries – Attorney Fees
Primary Sponsor: Representative Garrett J. Bradley (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.2288 & 2289 in the 2011-2012 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §1(1) (Definition of "AWW"), §13A(4) (Attorney's Fees)

Section 1 of this refiled bill addresses injured employees who return to work (without a lump sum settlement) and receive wages that are less than the pre-injury wages as a result of 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 employee's 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 at conciliation without good cause.

HOUSE BILL 1704

Subject: Workers' Compensation Exclusion for Business Owners
Primary Sponsor: Representative James M. Cantwell (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.152, §1(4) (Affidavit of Exemption)

This bill would require officers or directors of a corporation who own at least 25% of issued and outstanding stock of the corporation who wish to waive their rights under the Workers' Compensation Act to execute a written waiver of their rights under the pains and penalties of perjury. That waiver would be effective when received by the corporation's insurance carrier and the Director of the Department of Industrial Accidents, and remain in effect until written revocation of the waiver by the officer or director. Under current law, the Director of the Department of Industrial Accidents has the authority to promulgate rules and regulations to carry out the purposes of this paragraph. This bill would remove this authority.

HOUSE BILL 1709

Subject: Competitive Determination of WC Insurance Rates (Loss Cost)
Primary Sponsor: Representative Cheryl A. Coakley-Rivera(D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.1408 in the 2011-2012 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 1709, 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 (Massachusetts Workers' Compensation Rating and Insurance Bureau (WCRIB)) and would adhere to a uniform classification system. Instead of a rate hearing, the Commissioner of Insurance would hold a loss cost hearing in which the WCRIB would submit a loss cost filing for each classification (e.g. roofers, clerical workers). "Loss Costs" are the historical aggregate data and loss adjustment expenses (LAE), developed and trended for each classification and is expressed as a dollar amount per $100 of payroll. For example, the loss cost for a "roofer" might be $6.00 and for a "clerical worker" $.90.

Following the Commissioner's approval of a loss-cost filing, each carrier would submit to the Division of Insurance 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 was deemed unhealthy or non-competitive. In this event the Commissioner would have the authority to revert the market to a temporary system of administered pricing.

HOUSE BILL 1713

Subject: Workers' Compensation Entitlement
Primary Sponsor: Representative Stephen L. DiNatale (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.152, §35E (Persons Eligible for Old Age Benefits or Pension)

Under M.G.L. c.152, §35E, a claimant who has reached 65 years old, has been out of the workforce for two years, and is entitled to old age or pension benefits, is not entitled to benefits under §34 (total incapacity benefits) and §35 (partial incapacity benefits). Upon a showing by the employee that "but-for" the injury, he or she would have remained active in the labor market, that employee would still be entitled to §34 and §35 benefits. This bill would add §34A benefits (permanent and total incapacity benefits) to this class of benefits covered by §35E.

HOUSE BILL 1717

Subject: Workers' Compensation Insurance
Primary Sponsor: Representative Michael J. Finn (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.152, §5 (Rules and Regulations)

This bill would add a provision to the Workers' Compensation Act stating that any employer who conducts business in Massachusetts for fewer than 20 days in any given calendar year and who can produce proof of workers' compensation insurance in any other state will be deemed in compliance with the workers' compensation provisions of MA law.

HOUSE BILL 1721

Subject: Video Recording of Impartial Medical Exams
Primary Sponsor: Representative William C. Galvin (D) (By Request)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.1395 in the 2011-2012 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §11A(2) (Impartial Medical Examiners)

This refilled bill 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 1735

Subject: Fairness in Workers' Compensation Benefits
Primary Sponsor: Representative Bradley H. Jones (R)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.2299 of the 2011-2012 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §27 (Willful Misconduct of Employee)

This refiled bill would amend M.G.L. c.152, §27 and deny workers' compensation benefits to employees who are injured while intoxicated or unlawfully using a controlled substance as defined in M.G.L. c. 94C (Controlled Substances Act), § 1. 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 1737

Subject: Penalties for Failing to Timely Report Injuries
Primary Sponsor: Representative John D. Keenan (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.1405 in the 2011-2012 Legislative Session)
WCAC Position: Endorsed by the Advisory Council
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 M.G.L. c.152, §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), 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 1737 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 1748

Subject: Create a Workers' Compensation Classification for Reinforcing Steel
Primary Sponsor: Representative Paul W. Mark (D) (By Request)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.23E, §17A (New Section)

This bill would require the Workers' Compensation Advisory Council to conduct a study on the creation of a workers' compensation classification for reinforcing steel and issue a report with any recommendations for new legislation or regulations.

HOUSE BILL 1760

Subject: Stop Work Order Fines – 3x Premium Avoided
Primary Sponsor: Representative Tom Sannicandro (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.2308 in the 2011-2012 Legislative Session)
WCAC Position: Endorsed by the Advisory Council
Statutes Affected: c.152, 25C (Stop Work Orders & Penalties)

This refiled legislation 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 1760 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 1761

Subject: Notification of Workers' Compensation Coverage or Cancellation
Primary Sponsor: Representative Tom Sannicandro (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.542 in the 2011-2012 Legislative Session)
WCAC Position: Endorsed by the Advisory Council
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 1771

Subject: Incentives for Productive Workers' Compensation Audits
Primary Sponsor: Representative Joseph F. Wagner (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.4357 in the 2011-2012 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §25V (New Section)

This refiled bill would require onsite audits at least annually for all employers in the construction class generating more than the amount of premium required to be experience rated. For all other employers, audits would be required at least biennially. The bill would also require 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. Failure to grant such access would subject the employers to additional premium equal to three times the most recent estimated annual premium, which would be paid to the insurer.

This bill would also make it a violation of M.G.L. c. 93A (Consumer Protection), enforceable only by the Attorney General, for employers to 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.

SENATE BILL 561

Subject: Establishment of Rates of Payment to Medical Providers
Primary Sponsor: Senator Michael J. Rodrigues (D)
Referred To: Joint Committee on Health Care Financing
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.152, §13 (Rate of Payment by Insurer)

This bill would amend M.G.L. c.118, §13C by adding a sentence requiring the secretary, or designated governmental unit to consult with the commissioner of insurance before setting rates for health care services under M.G.L. c.152 in order to certify that a rate increase will not affect employers' WC insurance rates or premiums.

The bill would also amend M.G.L. c.152, §13(1) by adding a provision that allows the insurer, employer and the health care provider to agree to a different rate than that set by the executive office. In addition, any collusion between or among healthcare providers in an effort to obtain higher rates of compensation would be deemed a violation of M.G.L. c.93A.

SENATE BILL 844

Subject: Workers' Compensation Appeals
Primary Sponsor: Senator William N. Brownsberger (D) (By Request)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.152, §13A (Rate of Payment by Insurer)

This bill would add a new provision to M.G.L. c.152, §13A that would require legal services to be provided without expense to claimants appearing before the Appeals Board or any court. The bill would empower the DIA to set eligibility requirements for free legal services.

SENATE BILL 850

Subject: An Act for Achieving Insurance Responsibility
Primary Sponsor: Senator Katherine M. Clark (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.468, S.915 and S.938 in the 2011-2012 Legislative Session)
WCAC Position: Endorsed by the Advisory Council
Statutes Affected: c.152, §25C (Stop Work Orders and 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 860

Subject: Affordable Fee Schedule Rates – Coverage Determinations
Primary Sponsor: Senator James B. Eldridge (D) (By Request)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (S.925 in the 2011-2012 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §13 (Rate of Payment by Insurer)

This refiled 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 Executive Office of Health and Human Services 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 to ensure that compensation and coverage determinations are made in a timely manner.

SENATE BILL 861

Subject: Scar Based Disfigurement
Primary Sponsor: Senator John Hart, Jr. (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (S.927 in the 2011-2012 Legislative Session)
WCAC Position: Endorsed by the Advisory Council
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, §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 866

Subject: Burial Expenses – Increasing Max. Burial Allowances from $4,000 to $8,000
Primary Sponsor: Senator Brian A. Joyce (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.1406 in the 2011-2012 Legislative Session)
WCAC Position: Endorsed by the Advisory Council
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, an amount not to exceed $8,000. 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 2011, a total of 63 work-related fatalities were recorded in Massachusetts.

SENATE BILL 871

Subject: Increasing Criminal Penalties for Failing to Provide WC Insurance
Primary Sponsor: Senator Thomas M. McGee (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.468, S.915 and S.938 in the 2011-2012 Legislative Session)
WCAC Position: Endorsed by the Advisory Council
Statutes Affected: c.152, §25C (Stop Work Orders and 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 885

Subject: Reinstatement of Workers' Compensation Insurance Policy
Primary Sponsor: Senator Michael J. Rodrigues (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.152, §55A (Mid-Term Notice of Cancellation); §63 (Notices)

Section 1 of this bill proposes to amend M.G.L. c.152, §55A (mid-term notice of cancellation) by adding a provision that states "if the reason for cancellation is for non-payment of premium, if the insured pays the amount of premium due on or before the effective date of cancellation, the policy shall be reinstated." This bill provides the employer with an opportunity to submit payment and reinstate WC insurance policy prior to or on the effective date of cancellation when the reason for cancellation is non-payment of premium.

Section 2 of this bill pertains to the timing of notice required for cancellation or termination of an insurance policy. Currently, M.G.L. c.152, §63 states that insurance shall not be cancelled or terminated until 10 days after written notice of cancellation is given to the rating organization. This bill would amend §63 to add a provision stating that if the reason the insurance company wishes to cancel or terminate coverage of an employer is for non-payment of premium, the policy shall be reinstated if the insured pays the premium due on or before the effective date of cancellation.

SENATE BILL 888

Subject: Competitive Determination of WC Insurance Rates (Loss Cost)
Primary Sponsor: Senator Michael J. Rodrigues (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.1408 in the 2011-2012 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §53A (Classification of Risks and Premiums)

This 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 Senate Bill 888, 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 (Massachusetts Workers' Compensation Rating and Insurance Bureau (WCRIB)) and would adhere to a uniform classification system. Instead of a rate hearing, the Commissioner of Insurance would hold a loss-cost hearing in which the WCRIB would submit a loss cost filing for each classification (e.g. roofers, clerical workers). "Loss Costs" are the historical aggregate data and loss adjustment expenses (LAE), developed and trended for each classification and is expressed as a dollar amount per $100 of payroll. For example, the loss cost for a roofer might be $6.00 and for a clerical worker $.90.

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

RATE = LOSS COST x LCM

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

A safety mechanism has been included in this legislation which would allow the Commissioner of Insurance to hold a hearing if the market was 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.

SENATE BILL 894

Subject: Comprehensive
Primary Sponsor: Senator Bruce E. Tarr (R)
Type of Bill: Refile (S.963 in the 2011-2012 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 would clarify 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 the bill would require bills submitted pursuant to adjudication under c.152 to be paid within 30 days unless good cause for delay is shown prior to the end of the 30 day period. Payments made after 30 days without good cause would be required to include interest.

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 this bill 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 898

Subject: Stop Work Orders for Tax & Insurance Fraud – Retroactive Penalties
Primary Sponsor: Senator James E. Timilty (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (S.968 in the 2011-2012 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.62B (Withholding of Taxes); c.151A (Unemployment Insurance); c.152, §25 (Stop Work Orders and 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 898 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 899

Subject: Relative to Workers' Compensation Insurance
Primary Sponsor: Senator James T. Welch (D)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.152, §5 (Rules and Regulations)

This bill would add a provision to the Workers' Compensation Act stating that any employer who conducts business in Massachusetts for fewer than 20 days in any given calendar year and who can

produce proof of workers' compensation insurance in any other state will be deemed in compliance with the workers' compensation provisions of MA law.

SENATE BILL 1739

Subject: WC Benefits for Members of the Armed Services and National Guard
Primary Sponsor: Senator Thomas M. McGee (D)
Referred To: Joint Committee on Veterans and Federal Affairs
Previous History: Similar (H.1828 in the 2011-2012 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 M.G.L. c.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.

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