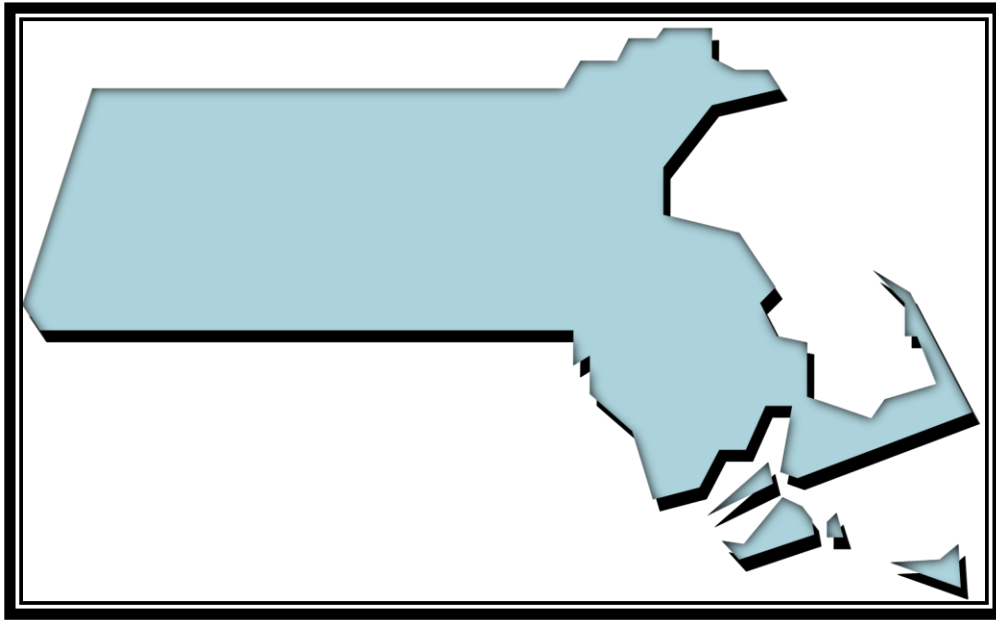


COMMONWEALTH OF MASSACHUSETTS

FISCAL YEAR 2014 ANNUAL REPORT

THE STATE OF THE MASSACHUSETTS
WORKERS' COMPENSATION SYSTEM



MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

April 2015

www.mass.gov/wcac/

FISCAL YEAR 2014 ANNUAL REPORT

THE STATE OF THE MASSACHUSETTS WORKERS' COMPENSATION SYSTEM

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

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- William S. Monnin-Browder (*Executive Director*)
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WILLIAM S. MONNIN-BROWDER
EXECUTIVE DIRECTOR

April 29, 2015

The Honorable Charles D. Baker
Governor of Massachusetts
State House, Room 280
Boston, MA 02133

Dear Governor Baker:

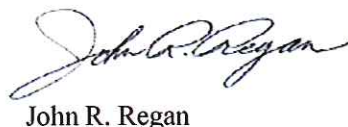
On behalf of the Massachusetts Workers' Compensation Advisory Council, we are pleased to present you with the Council's Fiscal Year 2014 Annual Report: *The State of the Massachusetts Workers' Compensation System*, which the Council approved at its January meeting. The report provides a detailed analysis of the workers' compensation system in Massachusetts, including operations at the Department of Industrial Accidents (DIA). The Advisory Council also identifies concerns with the system and makes recommendations to enhance it. Below are some highlights from the report:

- In FY'14, almost half of claims filed with the DIA were resolved at conciliation, the first stage of the dispute resolution process. The goal of conciliation is to remove claims from the system that do not require formal adjudication, thus promoting efficiency by reducing the number of claims that require conferences and hearings.
- The DIA made case documents more easily accessible to lawyers adjudicating claims at the DIA by installing wireless internet at all offices and introducing a mobile device-friendly application for the Agency's Document Management System.
- The DIA instituted a walk in lump sum program to streamline the way that Administrative Judges consider lump sum settlement requests.
- The Agency continued its vigorous enforcement efforts, in the process ensuring that approximately 6,000 employees not previously covered by their employers received workers' compensation coverage in FY'14. Almost 50,000 employees have received coverage as a result of Stop Work Orders (SWOs) since this statistic began to be tracked in FY'08.
- The DIA streamlined its SWO collections process. 91% of SWO fines are collected within 30 days of the SWO's issuance.
- According to the Oregon Department of Consumer and Business Services, Massachusetts employers in the voluntary market pay, on average, the fourth lowest workers' compensation premium rates in the country.

This report and its recommendations are a product of the commitment and contributions 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.

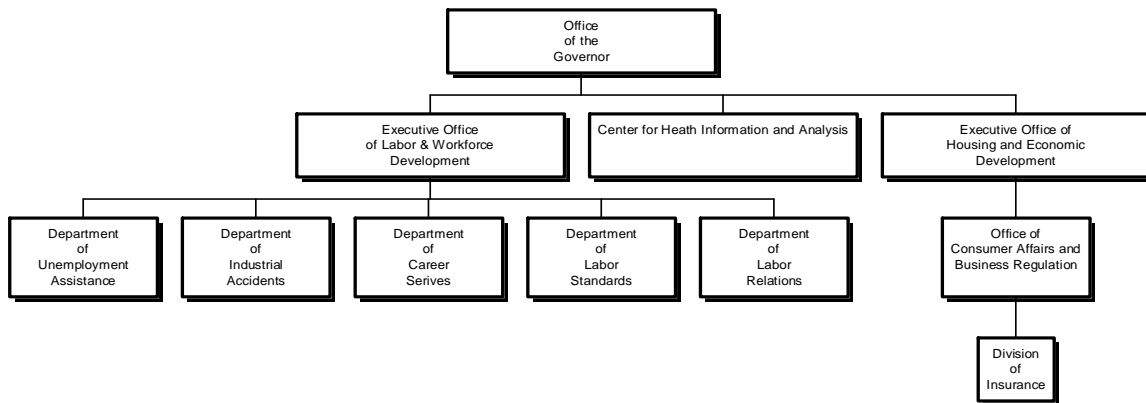
Very truly yours,


Stephen Joyce

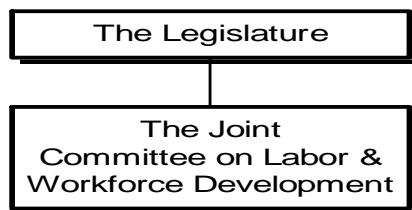

John R. Regan

Government Regulation of Workers' Compensation

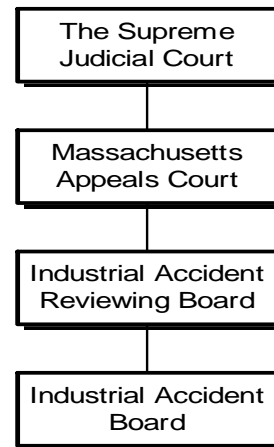
Executive Branch



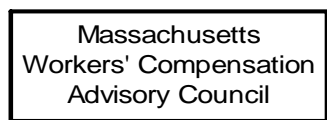
Legislative Branch



Appeals Process



Oversight



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

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SECTION

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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 appointed by the Governor for five-year terms. The membership consists of ten voting members, including five employee representatives and five employer representatives; 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 of 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 2014 IN REVIEW

The Massachusetts workers' compensation system continued to experience significant changes in fiscal year (FY) 2014 driven by economic conditions, administrative initiatives and other factors. Below is an overview of some of the significant developments impacting the Massachusetts workers' compensation system during FY'14.

On July 12, 2013, Governor Deval Patrick signed the FY'14 General Appropriations Act (GAA), which allocated \$19,522,205 for DIA operating expenses (line item 7003-0500). The amount was \$407,759 more than the amount appropriated to DIA in the FY'13 GAA (\$19,114,446) and the same amount proposed by the Governor in House Bill 1.

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 reported that the State Average Weekly Wage (SAWW) effective October 1, 2013 was \$1,181.28. The SAWW is used to calculate benefit limits and attorneys' fees available under the Massachusetts Workers' Compensation Act.

In October 2013, the Workers' Compensation Research Institute (WCRI) released *CompScope™ Medical Benchmarks for Massachusetts, 14th Edition*, studying injury claims in 16 states, including Massachusetts, between 2006 and 2011 (evaluated in 2012). The goal of the study was 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 states studied. The main reason for the lower use of medical services in Massachusetts is likely related to regulations of both prices and utilization of services. 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.

Since January 1, 2014, the DIA has required that all Form 101 First Report of Injury (FRI) forms be filed online. Notice of the change was provided by Circular Letter #343, issued on June 6, 2013. According to the Circular Letter, if a paper FRI is forwarded to the DIA after January 1, 2014, the form will be returned and will need to be re-filed electronically.

On January 8, 2014, the DIA hosted an informational lecture on the emerging applications for robotics in the workplace and in healthcare settings. The lecture touched on the present and the potential applications of robots in the delivery of health care and treatment of injured workers. A number of DIA staff and Advisory Council Members attended the lecture.

On January 30, 2014, the Massachusetts Division of Insurance (DOI) held a public hearing to consider the Workers' Compensation Rating and Inspection Bureau's (WCRIB's) request for a statewide average rate increase of 7.7%, effective January 1, 2014. On March 20, 2014, the DOI reached a settlement with the WCRIB and the Attorney General's Office that calls for a zero percent average rate change, effective April 1, 2014. The DOI reports that businesses across the state will save about \$77 million as a

result of the settlement. As part of the settlement, the parties agreed to modify the classification of certain employer groups to allow more accurate prediction of workers' compensation losses.

On March 24, 2014, the DIA participated in a conference/training entitled "Work Related Injuries – New Challenges & New Solutions." The Senior Judge, as well as Administrative Judges and Administrative Law Judges, participated in the discussion and provided insight from a judges' perspective into these challenges.

On April 1, 2014, an Administrative Bulletin announced that the DIA, in conjunction with the Massachusetts Bar Association (MBA) Workers' Compensation Section, had developed a new process for Walk-in Lump Sum Requests. The process applies to requests in cases that do not have ownership by a single judge. The process also applies to 113 agreements and Section 19 agreements with no judicial ownership. Parties seeking to use the process will be required to report to the Conciliation Unit where a Conciliator will review all requests and documents and determine whether lump sum requests will go forward to the available "Walk-in Lump Sum Judge" on duty for approval.

On April 10, 2014, the MBA's Workers' Compensation Section had an open meeting at the DIA's Lawrence office to discuss medical issues relevant to the practice of workers' compensation law. The meeting featured keynote speaker Dr. Scott Tromanhauser, who focused on clinical outcomes in spine care; operative vs. non-operative alternatives; and fusion surgery outcomes.

April 28, 2014 marked the 26th observance of Workers' Memorial Day. Events were held across the state to honor workers killed and injured on the job. Coinciding with Workers' Memorial Day was the release of a statewide occupational fatality report sponsored by the Massachusetts AFL-CIO, the Massachusetts Coalition for Occupational Safety and Health, and the Western Massachusetts Coalition for Occupational Safety and Health. The report, "Dying for Work in Massachusetts: Loss of Life and Limb in Massachusetts Workplaces," highlights the fact that many workplace deaths are preventable with a proper emphasis on safety.

On May 7, 2014, the DIA announced that all offices would be equipped with wireless internet access beginning Monday, May 12, 2014. Access to wireless internet allows attorneys to access DIA online accounts, e-mail and other internet-based resources available for the practice of workers' compensation law. The DIA also announced that the Document Management System had been modified to improve compatibility with smart phones, iPads, Android tablets and other mobile devices. The DIA also installed wireless printers in all DIA offices, allowing attorneys to print documents from mobile devices.

On June 24, 2014, the DIA announced the creation of a new Section 19 agreement form and the updating of Form 113, Agreement to Pay Compensation. The creation of the new Section 19 form will bring uniformity to the process by requiring relevant information that was often missing prior to its creation. Form 113 was changed to include language, similar to the Form 19, indicating whether or not the agreement closes out the current litigation and, if not, what issues remain in dispute.

On June 26, 2014, Governor Deval Patrick signed Senate Bill 2195, *An Act Restoring the Minimum Wage and Providing Unemployment Insurance Reforms*. While primarily focused on increasing the minimum

wage and reforming unemployment insurance, this legislation also includes a provision increasing the burial allowance under the Workers' Compensation Act from \$4,000 to eight times the State Average Weekly Wage. This legislation will help ensure that sufficient compensation is available to the families of workers killed on the job to provide a respectful burial.

On July 15, 2014, Governor Deval Patrick signed the FY'15 General Appropriations Act (GAA), which allocated \$19,852,999 for DIA operating expenses (line item 7003-0500). The amount is \$330,794 more than the amount appropriated to DIA in the FY'14 GAA (\$19,522,205) and the same amount proposed by the Governor in House Bill 2. The budget also contained, in sections 168 and 169, language that would require insurers seeking to cancel workers' compensation insurance because of nonpayment of premium to issue a renewal policy if the insured pays the amount of premium due on or before the effective date of cancellation.

In August 2014, Governor Deval Patrick appointed two members to the Advisory Council. Frank Ruel, Senior Manager of the Absence Management Program at Raytheon, was appointed to the Council's manufacturer position and Todd Johnson, Senior Vice President and New England Region Technical Resources Director at USI Insurance Services, was appointed to the Council's self-insurer position. Todd previously served on the Advisory Council as the insurer representative. At the Council's September meeting, Chairman Stephen Joyce congratulated Mr. Johnson on his new role and welcomed Mr. Ruel to the Council. Chairman Joyce also thanked outgoing members Edmund Corcoran and Antonio Frias for their years of service to the Advisory Council.

On August 21, 2014, State Auditor Suzanne Bump issued an audit of certain activities of the DIA. The report found that the DIA does not ensure that assessment amounts paid by insurance companies are accurate. The report also found that the DIA performs reviews of self-insurers' liabilities annually, instead of semiannually as required. After the audit, the DIA informed the State Auditor that the Agency had hired two additional auditors to improve its assessment review processes. The DIA also informed the Auditor that legal staff was working to amend M.G.L. c. 152, §25A so that only annual reviews of self-insurers' liabilities would be required.

On October 9, 2014, the DIA issued Circular Letter #345 addressing cost of living adjustment (COLA) payment and reimbursement schedules and requests; maximum and minimum weekly compensation rates; and attorneys' fee schedules. The Circular Letter reports that the SAWW effective October 1, 2014 is \$1,214.99. The SAWW is used to calculate benefit limits and attorneys' fees available under M.G.L. c. 152.

In October 2014, the Oregon Department of Consumer and Business Services released its "2014 Oregon Workers' Compensation Premium Summary" report. The report found that Massachusetts employers in the voluntary market pay, on average, the fourth lowest workers' compensation premium rates in the country. The study found that Massachusetts employers pay rates 37% lower than those in the median state in the study.

CONCERNS AND RECOMMENDATIONS

The Advisory Council is mandated by M.G.L. c.23E, §17 to include in its annual report “an evaluation of the operations of the [Department of Industrial Accidents (DIA)] along with recommendations for improving the workers’ compensation system.” In an effort to further improve the workers’ compensation system, the Council has identified the following areas of concern and offers 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, INCLUDING FY’15, 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 COULD NEGATIVELY IMPACT THE DIA’S EFFICIENCY.

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

The DIA receives 100% of its funding from: 1) assessments paid by the state’s employer community and 2) the collection of filing fees and fines for violations of Chapter 152. The Advisory Council is concerned that during the Commonwealth’s budget process, the DIA continues to be treated as a tax-funded, rather than assessment-funded, agency. In November 2014, Governor Deval Patrick used his powers pursuant M.G.L. c. 29, §9C to reduce net spending levels across the Executive Branch by a total of \$191 million in order to address a projected budgetary shortfall of \$329 million for FY’15. As part of those spending reductions, the DIA’s budget was reduced by 1.5% (\$297,795). The Advisory Council believes that a shortage in General Fund revenue should not cause a reduction in the DIA’s budget, because the Agency is funded by assessments on the employer community, rather than the General Fund.

Prior to becoming an employer-funded agency, the DIA was consistently underfunded by the Legislature. During the 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 injured workers 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 systemic problems and suggest necessary reforms. 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, in the 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 that the DIA can provide effective services to injured workers and employers.

2. Increased Wait Times between Conciliation and Conference

CONCERN: AT TIMES IN FY'14, 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 CLOSER TO EIGHT TO TEN WEEKS ARE MORE CONSISTENT WITH THE WORKERS' COMPENSATION SYSTEM'S GOAL OF RESOLVING DISPUTES IN A TIMELY AND EFFICIENT MANNER. THE ADVISORY COUNCIL RECOMMENDS VIGILANCE ON THE PART OF THE AGENCY TO REDUCE AND MAINTAIN SHORTER WAIT TIMES.

The primary objective of workers' compensation is to provide an effective delivery system to all parties with the prompt adjudication of disputes. 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. The conference can also give parties a sense of how the judge might rule at the hearing stage, which can provide an incentive for reaching a negotiated resolution.

Given the importance of the conference, the Advisory Council is concerned that average wait times between conciliation and conference have 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 recognizes that the DIA has undertaken and continues to undertake efforts to reduce the wait times and recommends that the Agency endeavor to maintain wait times at the eight to ten week level. The Advisory Council continuously monitors the wait times between conciliation and conference and expects to study the issue further in FY'15.

3. Employer Fraud – Misclassification and 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 estimates that there are between 126,000 and 248,000 misclassified workers in Massachusetts, with approximately 13% of the Commonwealth's employers misclassifying some of their workers.

When the DIA's Office of Investigations learns that an employer is operating without workers' compensation insurance, an investigator is sent to the worksite to issue a stop work order (SWO). Such an order requires that all business operations cease immediately upon service. Pursuant to M.G.L. c. 152, 25(c), fines resulting from a SWO begin at \$100 per day, starting the day of issuance and continuing until insurance is secured and penalties are paid. Employers who believe the issuance of a SWO is unwarranted may appeal the order and remain open; however, if the SWO is upheld following an appeal hearing, an employer will be fined \$250 for each day it was without coverage.

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. During the 2013-2014 Legislative Session, the Advisory Council supported legislation (H1760) that proposed 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 premium would be subject to a larger fine than employers who avoid smaller amounts of premium. Currently, at least 15 other states are utilizing some form of premium avoidance fine on employers operating without workers' compensation insurance.

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

Created over 25 years ago, current criminal penalties for failure to provide workers' compensation insurance coverage are outdated and insufficient. During the 2013-2014 Legislative Session, the Advisory Council supported legislation (S871/S850/H1496) that proposed to increase the 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 failing to provide workers' compensation insurance 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 CONTINUED VIGILANCE IN INVESTIGATING AND ISSUING STOP WORK ORDERS TO EMPLOYERS OPERATING WITHOUT WORKERS' COMPENSATION INSURANCE.

By investigating employers and issuing Stop Work Orders to those found to lack workers' compensation insurance as required by law, the Office of Investigations plays an important enforcement role in the Massachusetts workers' compensation system. The Office of Investigations estimates that nearly 50,000 employees across the Commonwealth have become covered by workers' compensation insurance as a result of DIA investigations since the office began tracking the statistic in FY'07. The Advisory Council believes that enforcement is paramount to maintaining the integrity of the Massachusetts workers' compensation system and recommends that the DIA continue to aggressively investigate and pursue employers operating without workers' compensation insurance.

RECOMMENDATION #5: 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.

The Advisory 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.

RECOMMENDATION #6: THE ADVISORY COUNCIL RECOMMENDS THAT LEGISLATION BE ENACTED TO IMPOSE PENALTIES ON CONTRACTORS WHO PARTICIPATE IN PUBLIC WORKS CONTRACTS, DESPITE HAVING BEEN DEBARRED FOR VIOLATING M.G.L. C. 152.

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. The law does not, however, provide for penalties in the event that an employer participates in such a contract, despite their debarment. During the 2013-2014 Legislative Session, the Advisory Council supported legislation (H1423) which sought to impose penalties in such situations (up to a \$250,000 fine or one year imprisonment for a first offense).

4. Employee Benefits

CONCERN: THE ADVISORY COUNCIL IS CONCERNED THAT THE LIMITATIONS PLACED ON RECOVERY FOR SCAR-BASED DISFIGUREMENT, AS SET FORTH IN M.G.L. C. 152, §36(E), ARE UNFAIR AND OUGHT TO BE ADDRESSED.

RECOMMENDATION: ADVISORY 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.

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 benefit awards to their pre-1991 levels. Unfortunately, the contracted actuaries were unable to quantify the impact of the proposed revision due to incomplete data. The actuaries noted that there is an assumption that the collection of such data might be more costly than the amount of benefits paid. To the extent that this is accurate, the actuaries suggest 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 survey, but it was determined that neither the DIA's nor the Workers' Compensation Rating and Insurance Bureau of Massachusetts' (WCRIB's) available statistical data was refined to the level necessary to conduct such a study.

During the 2013-2014 Legislative Session, the Advisory Council supported legislation (S861) that proposed 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 injuries.

5. Employer Responsibilities

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

RECOMMENDATION # 1: THE ADVISORY COUNCIL RECOMMENDS CREATING 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. Presently, the statute does not specify any 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.

During the 2013-2014 Legislative Session, the Advisory Council supported legislation (H1761) 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 FINE SYSTEM.

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. 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.

During the 2013-2014 Legislative Session, the Advisory Council supported legislation (H1737) that proposed to 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 injured workers.

6. Opioid Abuse

CONCERN: ACCORDING TO THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), THE NATION IS CURRENTLY EXPERIENCING AN EPIDEMIC OF PRESCRIPTION PAINKILLER ABUSE. IN JULY OF 2014, THE CDC REPORTED THAT 46 PEOPLE DIE IN THE UNITED STATES EVERY DAY FROM PRESCRIPTION PAINKILLER OVERDOSES. A RECENT STUDY BY THE WORKERS' COMPENSATION RESEARCH INSTITUTE FOUND THAT MASSACHUSETTS PHYSICIANS PRESCRIBE STRONGER NARCOTICS MORE OFTEN THAN THOSE IN THE 16 OTHER STATES STUDIED. WHILE THE SCOPE OF THE PRESCRIPTION DRUG ABUSE PROBLEM EXTENDS BEYOND THE WORKERS' COMPENSATION CONTEXT, IT IS A CRITICAL ISSUE IN THE TREATMENT OF INJURED WORKERS' IN MASSACHUSETTS.

RECOMMENDATION: THE ADVISORY COUNCIL RECOMMENDS THAT POLICYMAKERS AND STAKEHOLDERS CONTINUE TO FOCUS ON THIS ISSUE AND SEEK OUT INNOVATIVE WAYS OF ADDRESSING THE PROBLEM.

In recent years, the issue of opioids in workers' compensation has received a great deal of attention from stakeholders in workers' compensation systems across the country. Studies have shown that high doses of opioids often result in poor outcomes and higher indemnity costs. Prescription opioids can make patients dysfunctional and sleepy, making return to work difficult or impossible. The impacts for individuals and their families can be devastating. In 2011, the CDC observed that more people died from overdoses of prescription drugs than heroin and cocaine combined.

Massachusetts has taken a number of steps to address the issue of prescription drug abuse over the last few years. In 2012, the DIA released a new treatment guideline for chronic pain, which was developed by the Health Care Services Board. The guideline focuses on improving function, not just relieving pain, when treating chronic pain. The guideline also includes new provisions regarding the use of opioids, encouraging the use of patient-physician agreements and drug screening. In 2014, the Department of Public Health promulgated new regulations requiring prescribers to check the Prescription Monitoring Program (PMP) database before prescribing certain narcotic drugs. The PMP allows prescribers to check a patient's prescription history over the last year. The Advisory Council will continue to monitor the impact of opioids in the Massachusetts workers' compensation system.

7. Assessment Audits

CONCERN: ON AUGUST 21, 2014, THE STATE AUDITOR ISSUED AN AUDIT OF CERTAIN DIA FUNCTIONS. AMONG THE AUDIT'S RECOMMENDATIONS WAS THAT THE DIA SHOULD MAKE A NUMBER OF CHANGES IN ITS PROCESSES TO ENSURE THAT ACCURATE ASSESSMENTS ARE BEING COLLECTED.

RECOMMENDATION: THE ADVISORY COUNCIL RECOMMENDS THAT THE DIA CONTINUE TO ADDRESS THE CONCERNS RAISED BY THE STATE AUDITOR AND APPLAUDS THE AGENCY FOR PROMPTLY TAKING STEPS TO DO SO, INCLUDING THE HIRING OF TWO ADDITIONAL INTERNAL AUDITORS TO CONDUCT REVIEWS ON ALL INSURANCE COMPANIES.

The DIA is funded in large part from assessments paid by employers on the basis of their workers' compensation insurance premiums. The assessments must be collected by insurance companies and, in turn, remitted to the DIA. Insurance companies calculate the assessment amount that must be remitted using information provided by the DIA. Recently, the State Auditor released a report indicating that the DIA "does not ensure that assessment amounts paid by insurance companies are accurate." The report observed that the DIA utilizes private accounting firms to conduct reviews of the payments and that the reviews often take place years after the payments were received. The report also noted that, during the period of the audit, it was the policy of the DIA to not review payments from small and medium-sized insurers.

The DIA's response, contained in the audit report, indicated that the Agency has hired two additional internal auditors to conduct reviews on insurance companies. The response indicates that going forward the Internal Audit Unit will continue to audit the top 25% of all insurance companies, which represent 80% of the premium base. On December 10, 2014, the Advisory Council received a report from the Budget Director of the Executive Office of Labor and Workforce Development about changes to the assessment audit process. The Advisory Council will continue to monitor the DIA's audit process.

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 list of members).

Council-Endorsed Legislation

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:

- **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; and
- **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. 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). 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).

Burial Allowance Legislation

The Advisory Council has long been supportive of increasing the burial allowance available under M.G.L. c. 152. Members of the Council expressed concern over the fact that the allowance had not been increased in over 20 years despite significant increases to average funeral costs over that time. On June 26, 2014, Governor Deval Patrick signed Senate Bill 2195, *An Act Restoring the Minimum Wage and Providing Unemployment Insurance Reforms*. The bill included a provision increasing the burial allowance under the Workers' Compensation Act from \$4,000 to eight times the State Average Weekly Wage.

SECTION

-2-

OVERVIEW

SUMMARY OF BENEFITS

An employee who is injured in 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 2014, the SAWW increased to \$1,214.99, a 2.9% (\$33.71) increase from the October 2013 amount (\$1,181.28). 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 AND 34A CLAIMS, 1995-2015

<u>Effective Date</u> (Effective Oct 1 st)	<u>Maximum Benefit</u> (100% of SAWW)	<u>Minimum Benefit</u> (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
10/1/14	\$1,214.99	\$243.00

Source: DIA Circular Letter No. 345 – Table III (October 9, 2014)

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, 2014, the maximum weekly compensation rate is \$1,214.99 (100% of the SAWW) and the minimum rate is \$243.00 (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, 2014, the maximum weekly compensation rate is \$1,214.99 (100% of the SAWW) and the minimum rate is \$243.00 (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. During FY'14, Governor Patrick signed legislation to increase the maximum allowance for compensable burial expenses from \$4,000 to eight times the SAWW.

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.

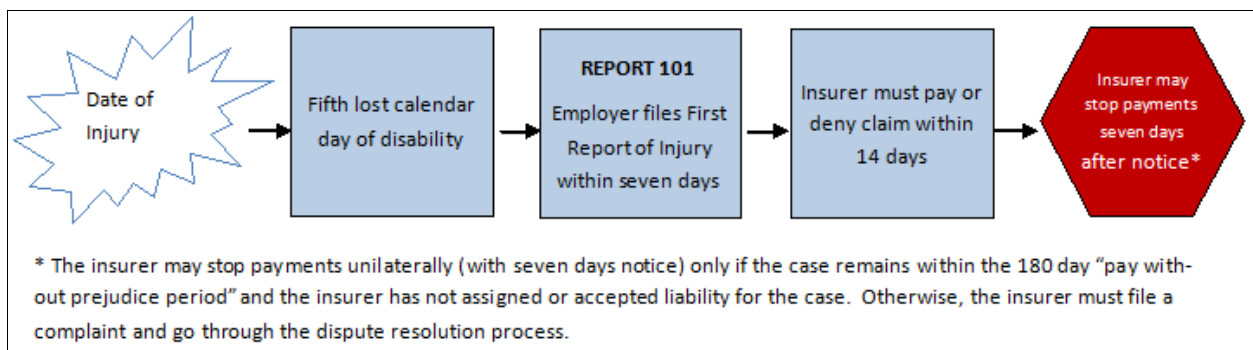
Vocational Rehabilitation Services (§§30E-30H) - An injured employee is also entitled to reasonably necessary vocational rehabilitation services at a reasonable cost if the employee is determined to be suitable for such services by the Department of Industrial Accidents. The purpose of these rehabilitation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

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.² 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.³ The purpose of the pay without prejudice period is to encourage the insurer to begin payments to the employee instead of outright denying the claim.

FIGURE 1: SCHEDULE OF EVENTS



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.

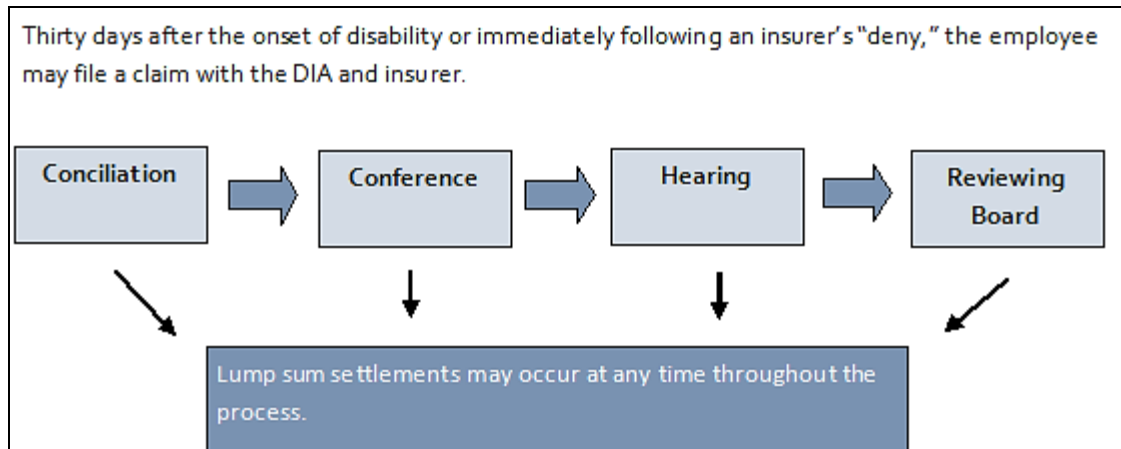
² If there is no notification or payment has not begun, the insurer is subject to a fine of \$200 after 14 days, \$2,000 after 60 days, and \$10,000 after 90 days.

³ The 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 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 Settlement

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 the 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 than 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 to 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.

Attorneys' 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. The following is a summary of the attorney's fee schedule effective October 1, 2014:

- (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 **\$1,117.37** plus necessary expenses. If the employee's attorney fails to appear at a scheduled conciliation, the amount paid is **\$558.68**.
 - (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 **\$1,596.24**. 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 **\$798.12**.
 - (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 **\$798.12** plus necessary expenses. This fee can be reduced to **\$399.06** 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 **\$1,117.37** 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 **\$558.68** 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 **\$5,586.84** 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 **\$1,596.24**. An AJ may increase or decrease this amount based on the complexity of the case and the amount of work an attorney puts in.
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SECTION

-3-

WORKPLACE INJURY AND FATALITY STATISTICS

OCCUPATIONAL INJURIES AND ILLNESSES

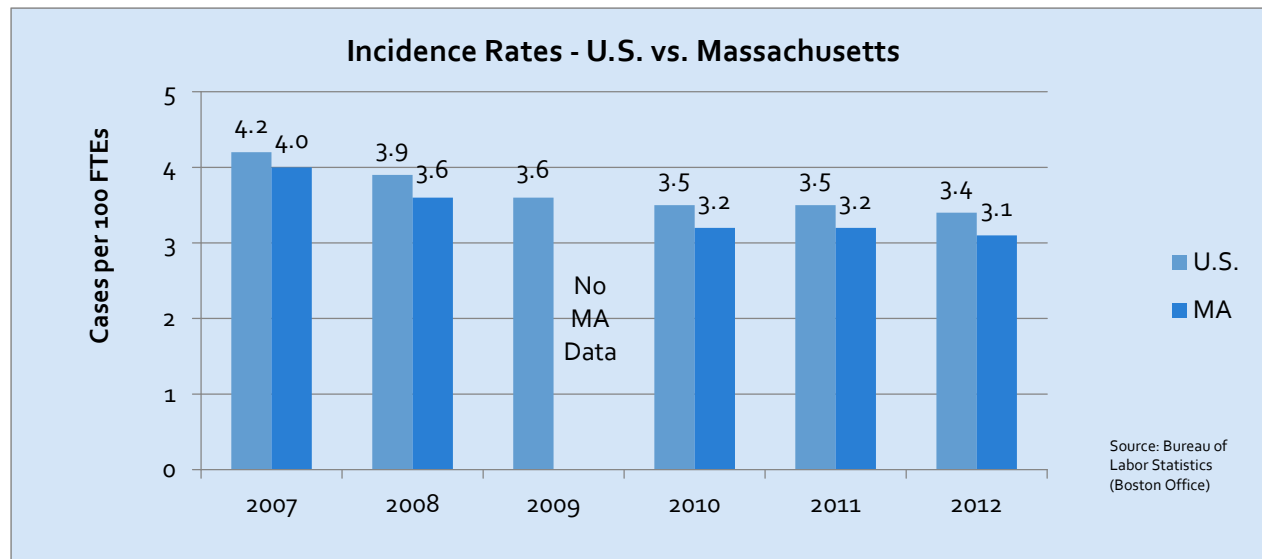
Since 1992, the Massachusetts Department of Labor Standards has been in partnership with the U.S. Department of Labor, Bureau of Labor Statistics (BLS), in an effort to collect injury and illness data in a uniform format. Throughout the country, surveys are collected from a sample of private industry 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 the state and the 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 employees (FTEs). 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.

During 2012, the private sector workforce in the U.S. experienced approximately 3.0 million non-fatal injuries and illnesses, resulting in an incidence rate of 3.4 cases per 100 FTEs.⁴ In Massachusetts, there were 69,700 non-fatal occupational injuries and illnesses, resulting in an incidence rate of 3.1 cases per 100 FTEs.⁵ The graph below displays how incidence rates in Massachusetts have consistently remained lower than national rates.

FIGURE 3: INCIDENCE RATES - U.S. V. MASSACHUSETTS, 2007-2012



⁴ Bureau of Labor Statistics, News-USDL-13-2119.

⁵ Commonwealth of Massachusetts 2012 Occupational Injuries and Illnesses Annual Report. In 2012, Massachusetts had a population of 6,645,301 people with an estimated private sector workforce of 3,202,090 workers. U.S. Census Bureau, Quick Facts: Massachusetts; Bureau of Labor Statistics, May 2012 State Occupational Employment and Wage Estimates (Massachusetts).

Incidence Rates by Region

The following table exhibits a regional breakout of the injury and illness incidence rates since 2007. 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, 2007-2012 (PRIVATE INDUSTRY)

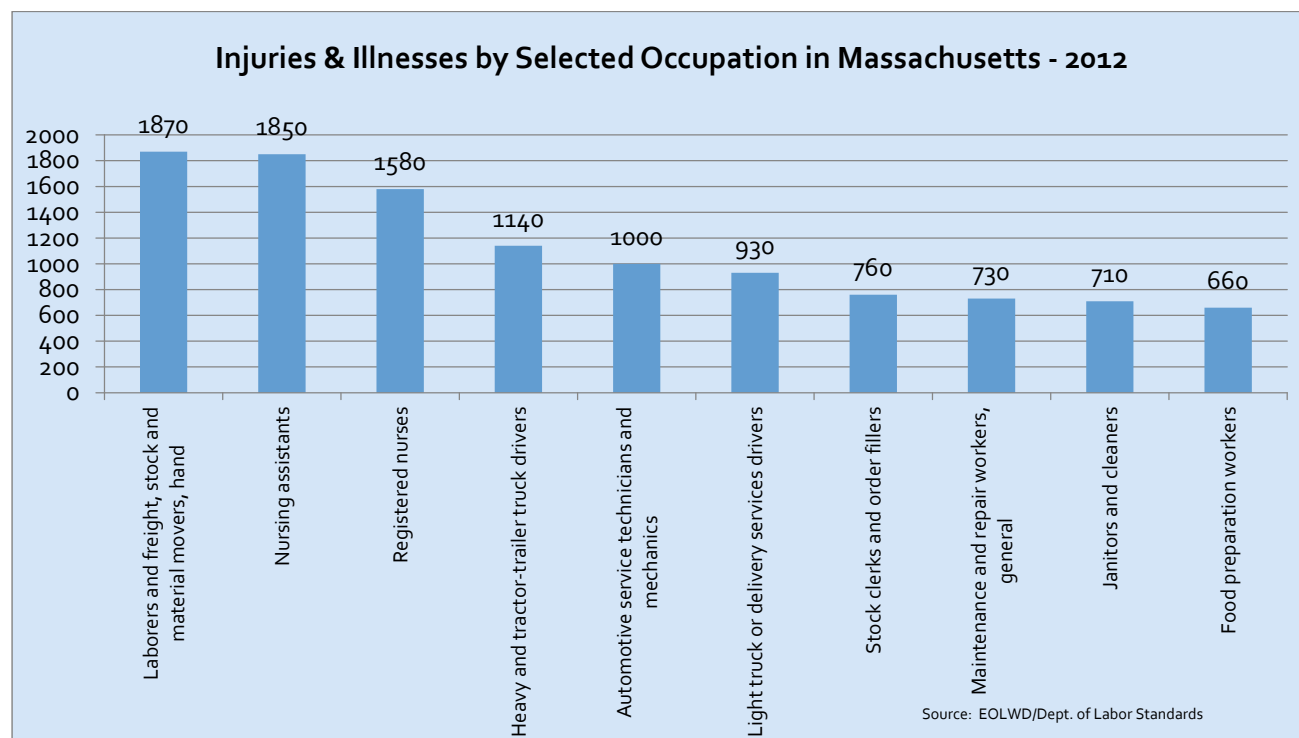
<i>Region</i>	<i>2012</i>	<i>2011</i>	<i>2010</i>	<i>2009</i>	<i>2008</i>	<i>2007</i>
United States	3.4	3.5	3.5	3.6	3.9	4.2
Massachusetts	3.1	3.2	3.2	no data	3.6	4.0
Connecticut	3.9	4.5	4.0	4.2	4.6	4.8
Maine	5.6	5.7	5.6	5.6	6.0	6.4
Rhode Island	no data	no data	no data	no data	no data	5.1
Vermont	5.0	5.0	5.2	5.2	5.5	5.9
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 2012, laborers and freight, stock and material movers, hand had the highest number of injuries and illnesses involving days away from work in Massachusetts among selected occupations.

FIGURE 4: INJURIES & ILLNESSES BY SELECTED OCCUPATION IN MASSACHUSETTS



Incidence Rates by Industry

The survey also categorizes incidence rates by sector and industry. In Massachusetts, the “natural resources and mining” sector had the highest incidence rate among the ten major industrial sectors identified in the 2012 survey.

TABLE 3: NONFATAL INJURY & ILLNESS INCIDENCE RATES BY INDUSTRY, MASSACHUSETTS, 2006-2012

MASSACHUSETTS (Major Industry Sector)	2012	2011	2010	2009	2008	2007	2006
Natural resources and mining	6.9	3.8	6.1	no data	8.1	4.9	5.2
Construction	4.7	4.7	3.9	no data	4.8	6.1	6.4
Manufacturing	3.0	3.2	3.4	no data	3.5	3.8	4.1
Trade, transportation, and utilities	3.8	3.9	3.8	no data	4.3	5.1	4.8
Information	0.9	0.8	1.3	no data	2.2	1.4	1.6
Financial activities	0.7	0.6	1.1	no data	0.9	1.3	0.9
Professional and business services	1.7	1.5	1.3	no data	1.6	1.7	1.6
Education and health services	4.6	5.0	5.0	no data	5.6	5.9	5.7
Leisure and hospitality	4.4	4.1	4.0	no data	5.1	5.1	5.5
Other services	3.3	2.4	2.9	no data	2.0	2.4	2.7

Source: EOLWD

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.

Workplace Fatalities in Massachusetts

In 2013, Massachusetts experienced 55 workplace fatalities, 11 more fatalities than recorded in 2012. The leading cause of workplace death in Massachusetts came from assaults and violent acts, in which 20 workers were killed. Nationally, transportation incidents were the leading cause of on-the-job fatalities, accounting for 40% of the fatal work injuries in 2013. Following assaults and violent acts, Massachusetts workers were killed by transportation incidents (12), falls (11), contact with objects and equipment (6), exposure to harmful substances or environments, (5) and fire and explosions (1).

TABLE 4: FATAL OCCUPATIONAL INJURIES BY STATE, 2014 (NORTHEAST REGION)

State of Fatality	Total Fatalities		Event or Exposure (State Total for 2013)					
	2012 (Revised)	2013 (Prelim.)	Transportation Incidents	Assaults & Violent Acts	Contact with Objects & Equip- ment	Falls	Exposure to Harmful Substances	Fires & Explosions
U.S. Total	4,628	4,405	1,740	753	717	699	330	148
Massachusetts	44	55	12	20	6	11	5	1
Connecticut	36	26	7	7	5	6	—	—
Maine	19	19	6	2	4	4	—	—
New Hampshire	14	14	1	—	6	4	—	1
Rhode Island	8	10	—	—	3	—	—	—
Vermont	11	7	4	—	—	—	—	—

Source: Bureau of Labor Statistics, News-USDL-14-1674

SECTION

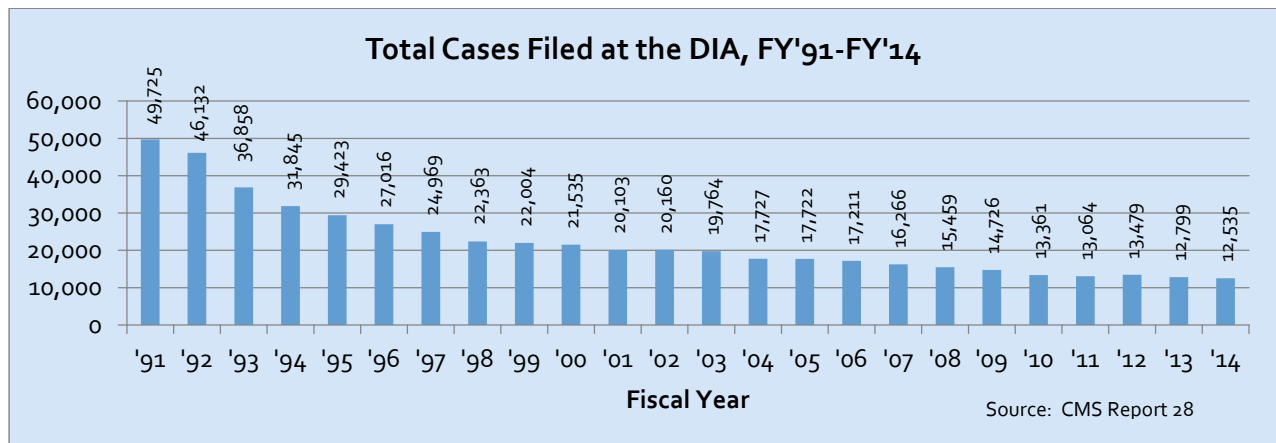
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DISPUTE RESOLUTION

CASES FILED AT THE DIA

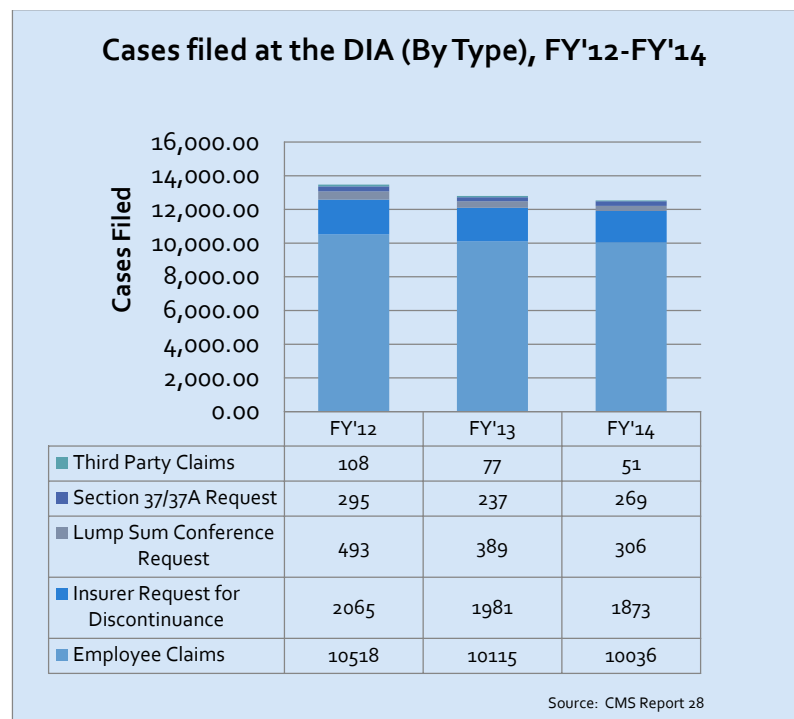
Cases originate at the Department of Industrial Accidents (DIA) when any of the following are filed: an employee's claim for benefits, an insurer's complaint for termination or modification of benefits, a third party claim, a request for approval of a lump sum settlement, or a Section 37/37A request. As demonstrated in Figure 5, there has been a significant decline (75%) in the DIA caseload since the implementation of the 1991 Reform Act. In FY'14, the total number of cases filed at the DIA was 12,535, a decrease of 2% from the previous fiscal year.

FIGURE 5: TOTAL CASES FILED AT THE DIA, FY'91-FY'14



In FY'14, 10,036 employee claims were filed at the DIA, representing 80% of the total cases filed. Employee claims decreased by 79 cases, or less than 1%, from the previous fiscal year. Employee claims have decreased by 57% since 1991, when an all-time high of 23,240 cases were filed. In FY'14 1,873 insurer's request for discontinuance or modification of the benefits were filed, accounting for 15% of the total cases filed during the fiscal year. These requests for discontinuance decreased by 108 cases, or 5.5%, from the previous fiscal year. Since the 1991 Reform Act, requests by insurers to discontinue or modify benefits have decreased by 84%.

FIGURE 6: CASES FILED AT THE DIA (BY TYPE), FY'12-FY'14



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 45% of the cases that are scheduled for conciliation are "resolved" as a result of this process and exit the dispute resolution system. Such resolved cases encompass a broad range of dispositions including withdrawals, lump sum settlements, and conciliated cases. The remaining 55% of cases are referred from conciliation to a conference to be heard before an Administrative Judge.

The Conciliation Process

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

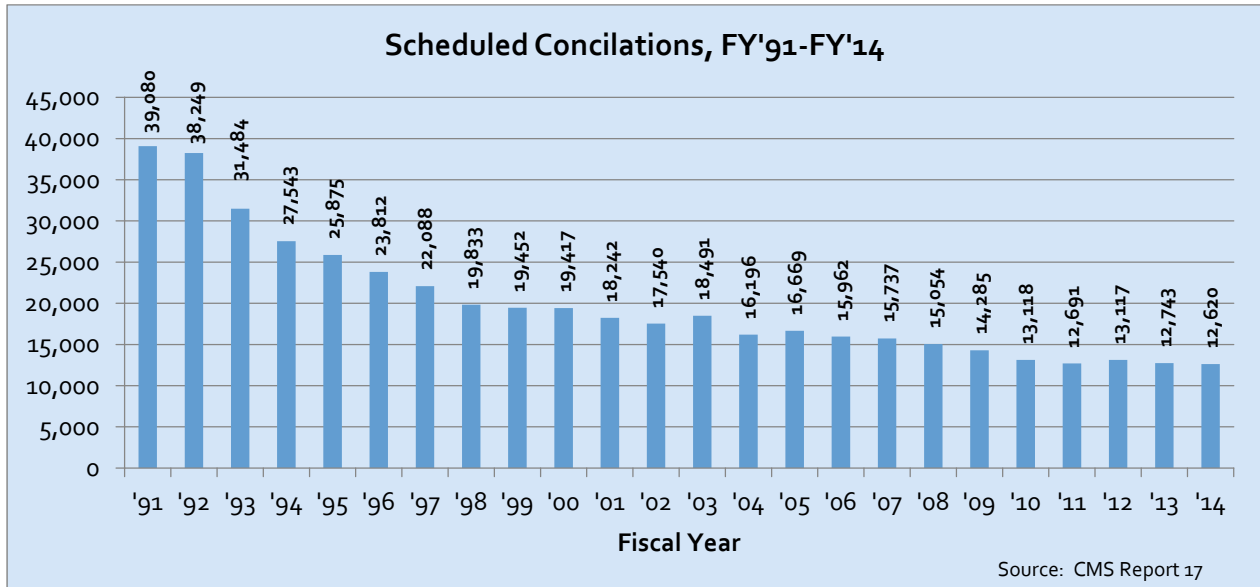
When liability is not an issue, but modification or discontinuance of benefits is sought, both parties are required to submit written settlement offers. If the employee fails to file, the conciliator must record either the last offer made by the employee or the maximum compensation rate. If the insurer fails to file, the conciliator must record the last offer made or record a zero. In an effort to promote compromise, the last best offer should indicate what each party believes to be the appropriate compensation rate.

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'14, there were 12,620 cases scheduled for conciliation, which represents a 68% decrease since the 1991 Reform.

Figure 7 displays the number of cases scheduled for conciliation at the DIA beginning in FY'91. In FY'14, the volume of cases scheduled for conciliation decreased by less than 1% (123 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: SCHEDULED CONCILIATIONS, FY'91-FY'14



Resolved at Conciliation

Disputed cases that are scheduled for conciliation can be divided into two distinct outcomes: “referred to conference” or “resolved.” In FY'14, 5,684 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: RESOLVED AT CONCILIATION (BY RESOLUTION TYPE), FY'14

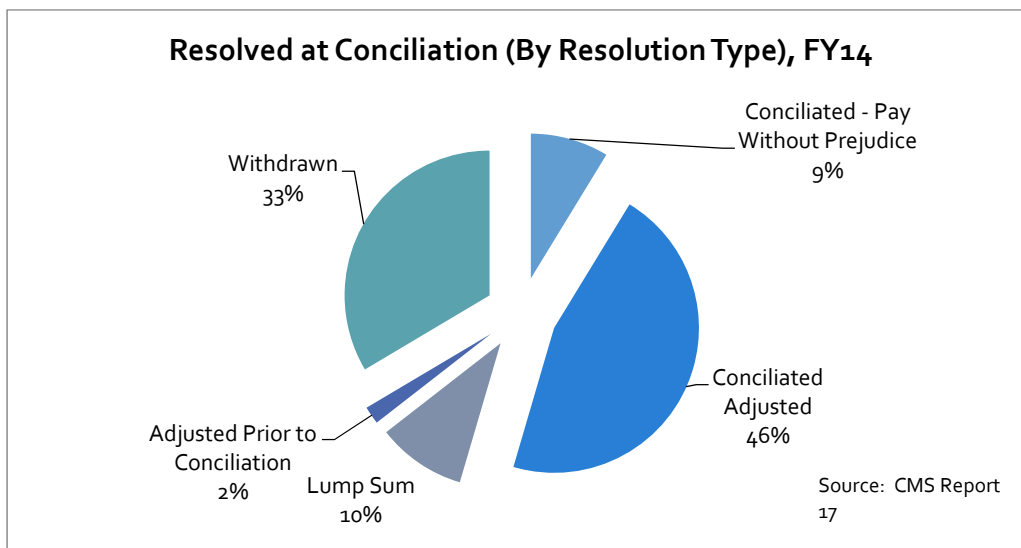


TABLE 5: RESOLVED AT CONCILIATION, FY'14 AND FY'13

Resolved at Conciliation FY'14 and FY'13	Number of Cases		Percentage	
	FY'14	FY'13	FY'14	FY'13
Conciliated - Pay Without Prejudice	496	455	8.7%	7.7%
Conciliated Adjusted	2,604	2,614	45.8%	44.5%
Lump Sum	565	762	9.9%	13.0%
Adjusted Prior to Conciliation	113	138	1.9%	2.3%
Withdrawn	1,906	1,904	33.5%	32.4%
TOTALS:	5,684	5,873	100%	100%

Source: CMS Report 17

As displayed in Table 5, cases may be conciliated by two methods. Approximately 46% of the resolved cases in FY'14 were "conciliated adjusted," meaning an agreement was reached at conciliation between the parties to initiate, modify, or terminate the compensation. Secondly, approximately 9% of the resolved cases in FY'14 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 34% of cases were withdrawn in FY'14. 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 10% 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.

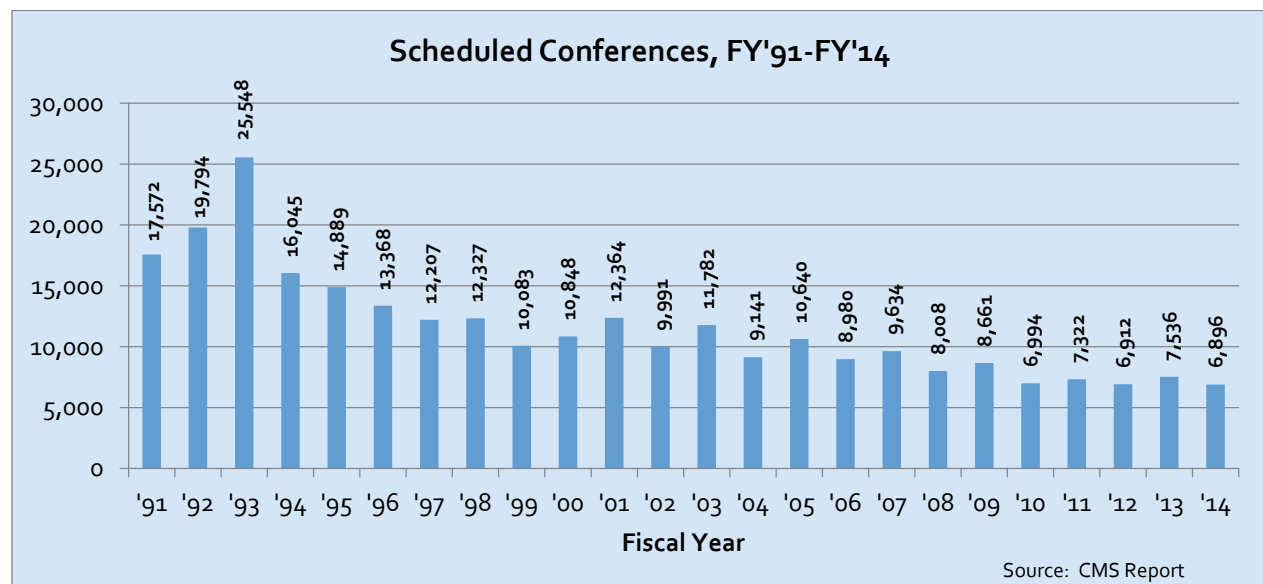
CONFERENCE

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 83% of all conference orders in a given fiscal year are appealed to the hearing level of dispute resolution. In the remaining 17% 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'14 decreased by 8% from last fiscal year (7,536 in FY'13 to 6,896 in FY'14).⁶ 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'14



⁶ In an effort to avoid duplication, the number of "scheduled conferences" does not include cases that were "rescheduled for a conference." In FY'14, 3,251 cases were "rescheduled for a conference."

Cases Resolved at Conferences

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'14, 5,490 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: RESOLVED AT CONFERENCE (BY RESOLUTION TYPE), FY'14

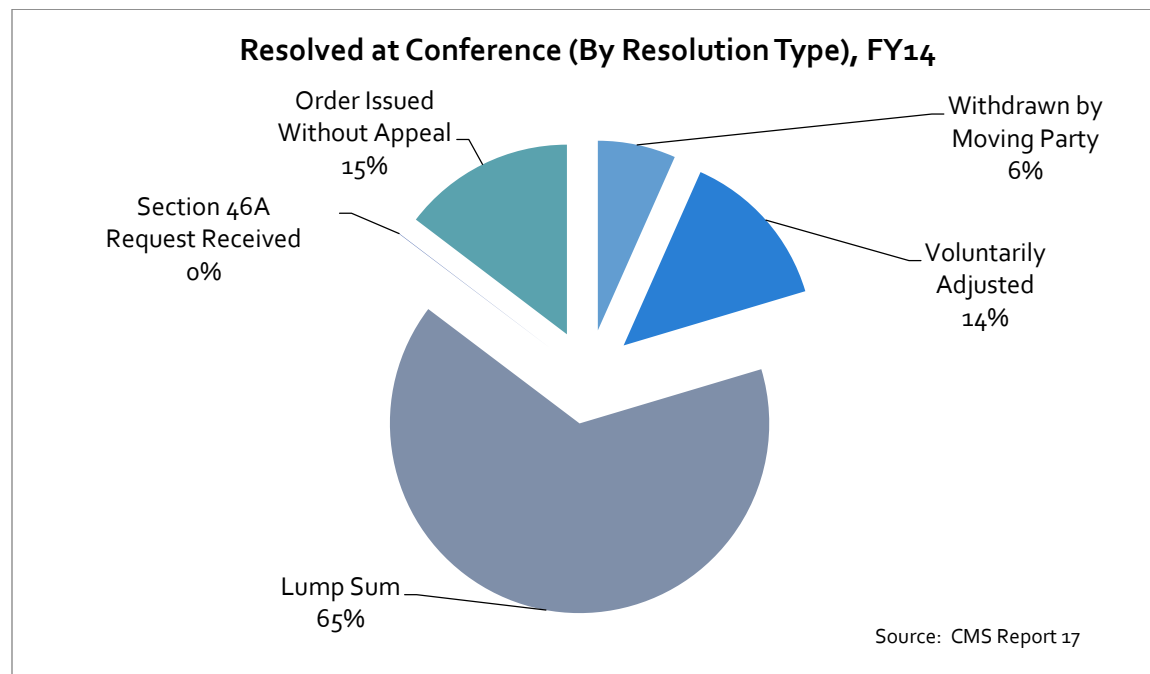


TABLE 6: CASES RESOLVED AT CONFERENCE, FY'14 AND FY'13

Resolved at Conference FY'14 and FY'13	Number of Cases		Percentage	
	FY'14	FY'13	FY'14	FY'13
Withdrawn by Moving Party	365	382	6.6%	7.7%
Voluntarily Adjusted	754	761	13.7%	15.4%
Lump Sum	3,564	3,005	64.9%	60.7%
Section 46A Request Received	2	3	<1%	<1%
Order Issued Without Appeal	805	801	14.7%	16.2%
Total	5,490	4,952	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'14, 365 cases (7% 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'14, 754 cases (14% 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'14, 3,564 cases (65% 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'14, only two 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'14, 805 conference orders (17% 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'14, 3,903 conference orders (83% of all conference orders) were appealed to a hearing.

TABLE 7: CONFERENCE ORDERS, FY'14-FY'03

<i>Conference Orders FY'14 - FY'03</i>	Total Orders	Appealed	Without Appeal
Fiscal Year 2014	4,708	3,903 (82.9%)	805 (17.1%)
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'14 remained below the benchmark of 1,500 cases. In FY'14 the conference queue ended 64 cases below the start of the year (1,068 on July 1, 2013 and 1,004 on June 30, 2014). The conference queue reached a high of 1,102 on June 18, 2013 and a low of 745 on February 19, 2014.

FIGURE 11: CONFERENCE AND HEARING QUEUES, FY'14

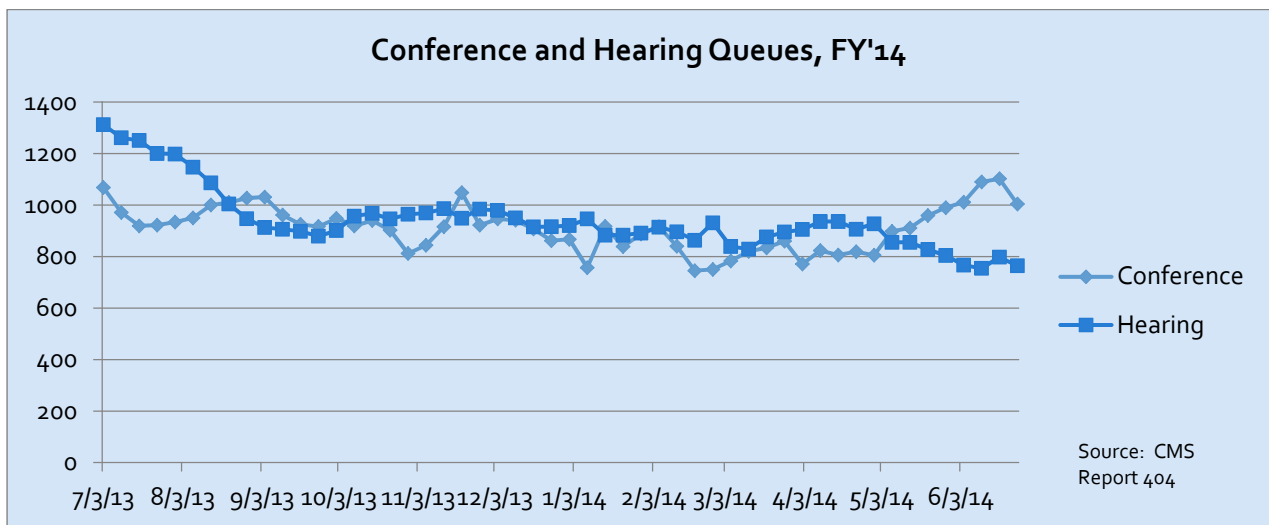
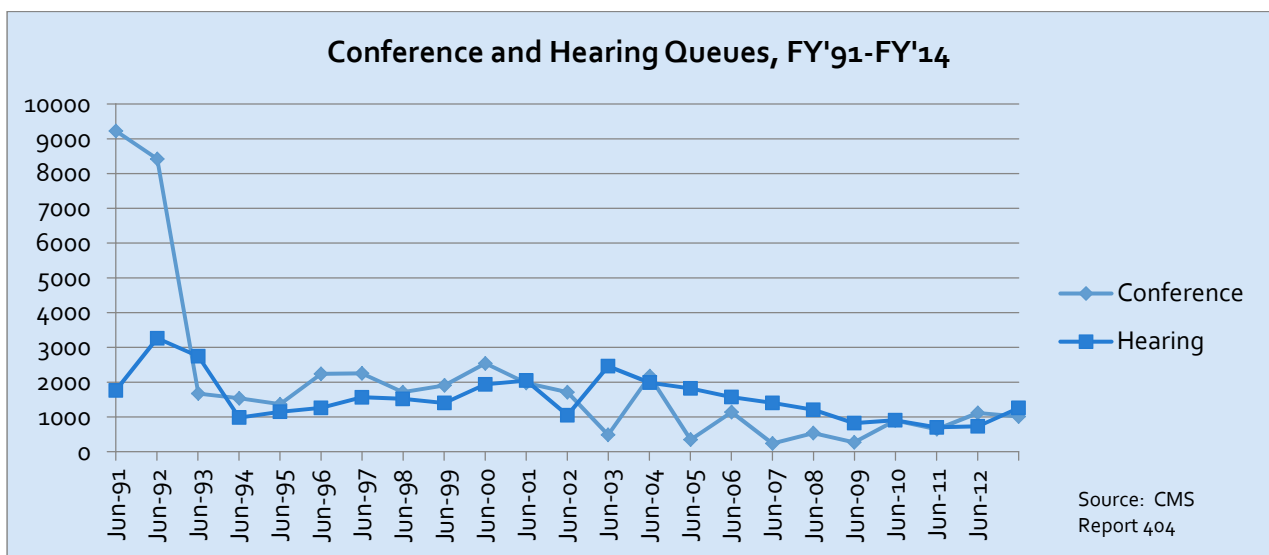


FIGURE 12: CONFERENCE AND HEARING QUEUES, FY'91-FY'14



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.

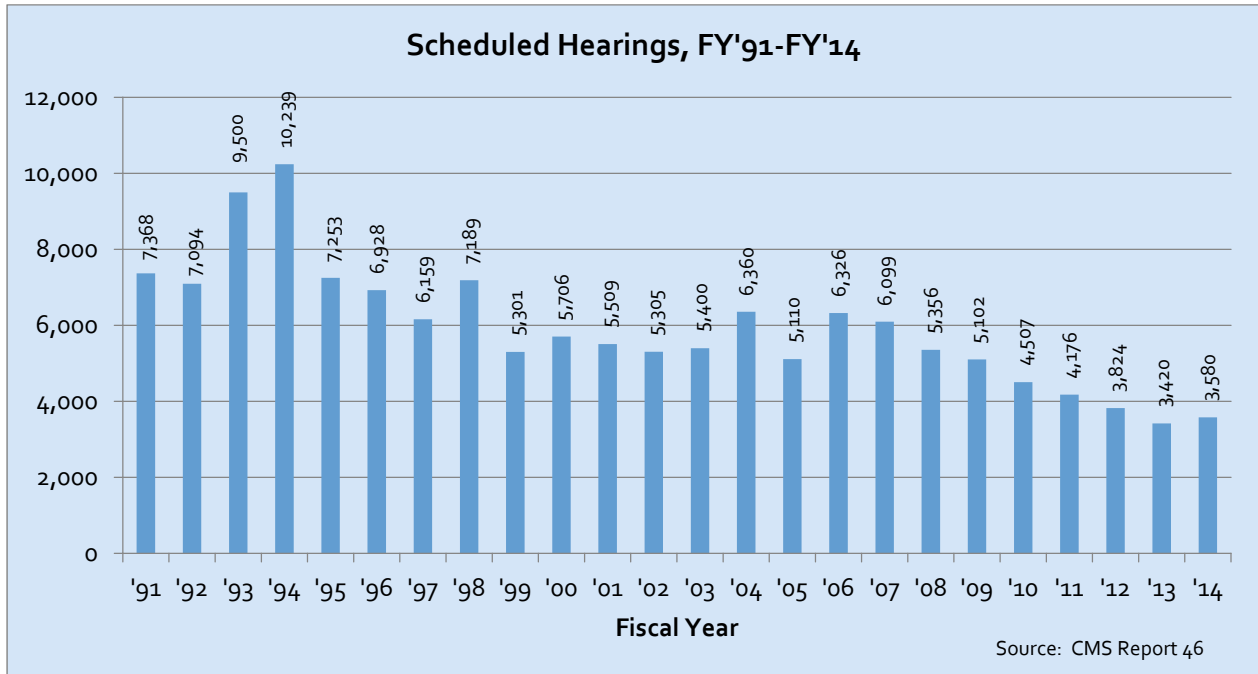
It is difficult to compare the hearing queue with the conference queue because of the differences in the two proceedings. Hearings must be scheduled with the same judge who presided over the conference, whereas conferences are scheduled according to availability (when "judge ownership" is not yet a factor). Since hearings are also more time consuming than conferences, it takes more time to work through a hearing queue than a conference queue. FY'14 began with a hearing queue of 1,312 cases and decreased to 548 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) (see Figure 12).

Volume of Scheduled Hearings

The number of hearings scheduled in FY'14 increased by 160 cases (5%) from last fiscal year (3,420 in FY'13 to 3,580 in FY'14).⁷ Each year, the number of hearings scheduled is greater than the number of hearings that will actually take place before an AJ, because many cases are withdrawn or resolved prior to hearing.

⁷ In an effort to avoid duplication, the number of "scheduled hearings" does not include cases that were "rescheduled for a hearing." In FY'14, 3,999 cases were "rescheduled for a hearing."

FIGURE 13: SCHEDULED HEARINGS, FY'91-FY'14



Cases Resolved at Hearing

In FY'14, 3,129 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 show the various methods by which a disputed case can be resolved at hearing.

FIGURE 14: RESOLVED AT HEARING (BY RESOLUTION TYPE), FY'14

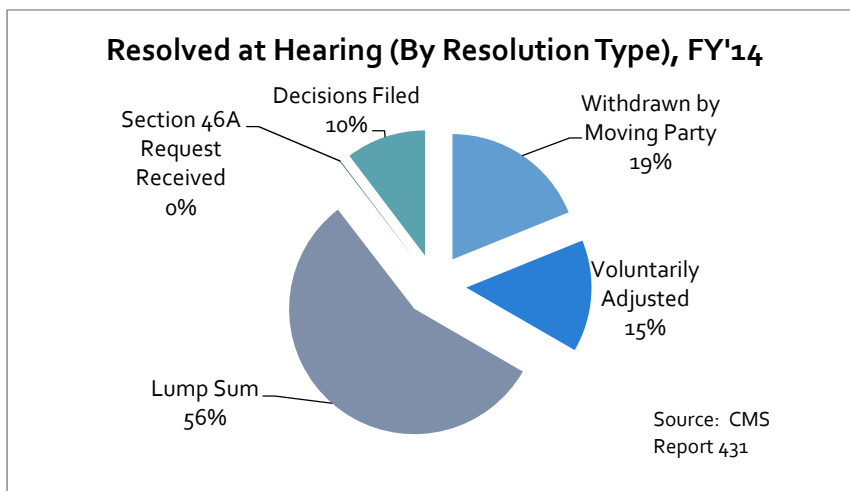


TABLE 8: CASES RESOLVED AT HEARING, FY'14 AND FY'13

Resolved at Hearing FY'14 and FY'13	Number of Cases		Percentage	
	FY'14	FY'13	FY'14	FY'13
Withdrawn by Moving Party	591	507	19.1%	17.4%
Voluntarily Adjusted	452	451	14.4%	15.5%
Lump Sum	1,759	1,635	56.2%	56.3%
Section 46A Request Received	4	2	<1%	<1%
Decisions Filed	323	311	10.3%	10.7%
Total	3,129	2,906	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'14, 591 cases (19% of resolved cases at hearing) exited the system in this manner.

Second, the parties may agree to have the case voluntarily adjusted. This occurs at the hearing when a compromise on any part of the case (benefit level, benefit duration, etc.) can be reached among the parties. In FY'14, 452 cases (14% 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'14, 1,759 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'14, only four 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'14, 323 hearing decisions (10% of resolved cases at hearing) were filed by AJs.

REVIEWING BOARD

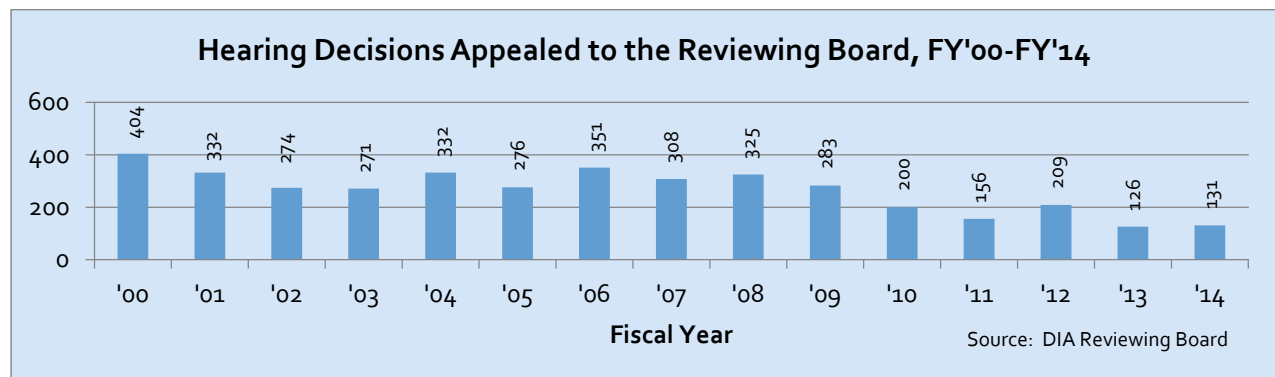
The fourth and final stage of dispute resolution at the DIA occurs when a case proceeds to the Reviewing Board. The Reviewing Board consists of six Administrative Law Judges (ALJs) whose primary function is to review the appeals from hearing decisions. While appeals are heard by a panel of three ALJs, 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'14 was 131.

FIGURE 15: HEARING DECISIONS APPEALED TO THE REVIEWING BOARD, FY'00-FY'14



Appeals Resolved at the Reviewing Board

In FY'14, the Reviewing Board resolved 117 cases (some from the prior year), representing a 15.8% decrease from cases resolved in FY'13 (139 cases).

FIGURE 16: APPEALS RESOLVED AT THE REVIEWING BOARD (BY RESOLUTION TYPE), FY'14

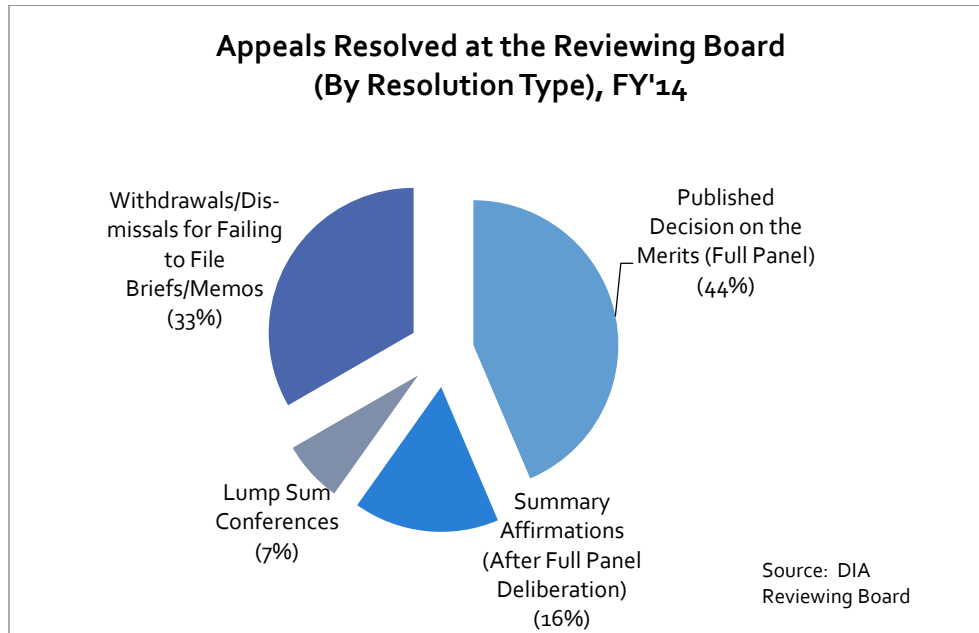


TABLE 9: APPEALS RESOLVED AT THE REVIEWING BOARD, FY'14

<i>Appeals Resolved at the Reviewing Board, FY'14</i>	<i>Number of Cases</i>
Published Decision on the Merits (Full Panel):	51 (43.6%)
Summary Affirmations (After Full Panel Deliberation):	19 (16.2%)
Lump Sum Conferences:	8 (6.8%)
Withdrawals/Dismissals for Failing to File Briefs/Memos:	39 (33.3%)
Total Number of Appeals Resolved by the Reviewing Board:	117 (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'14 was 551.

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'14, ALJs heard 1,255 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'14, 12 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'91-FY'14

<i>Fiscal Year</i>	<i>Total lump sum conferences scheduled</i>	<i>Lump sum settlements approved</i>
FY'14	6,091	5,640 (92.6%)
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'14, 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:

1. **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.
2. **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.
3. **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 the 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."
4. **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'14

Fiscal Year 2014	Lump Sum Pursued ⁸	% Total Cases Resolved (at each level of dispute resolution process)
Conciliation	565	9.9%
Conference	3,564	64.9%
Hearing	1,759	56.2%

Source: See previous sections on conciliations, conferences and hearings.

⁸ "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.⁹ 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.¹⁰

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 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:

⁹ M.G.L. c.152, §8(4).

¹⁰ M.G.L. c. 152, §45.

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: 452 CMR 1.14

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'14, approximately \$2,018,883 was collected in Impartial Medical fees.

As of June 30, 2014, there were 145 physicians on the roster consisting of 27 specialties. 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'14, the Impartial Unit scheduled 4,247 examinations, compared to 4,720 in FY'13. Of these, 2,831 exams were actually conducted in FY'14 (the remainder of the scheduled exams were either canceled due to settlements and withdrawals or took place in the next year). In FY'13, 3,511 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 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: 2014 HHS POVERTY GUIDELINES

2014 HHS Poverty Guidelines (48 Contiguous States and the District of Columbia)	
Size of Family Unit	Amount*
1	\$11,670
2	\$15,730
3	\$19,790
4	\$23,850
5	\$27,910
6	\$31,970
7	\$36,030
8	\$40,090
*For family units with more than eight members, add \$4,060 for each additional member in the family.	

Source: *Federal Register*, Vol. 79, No. 14, January 22, 2014, pp. 3593-3594

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.

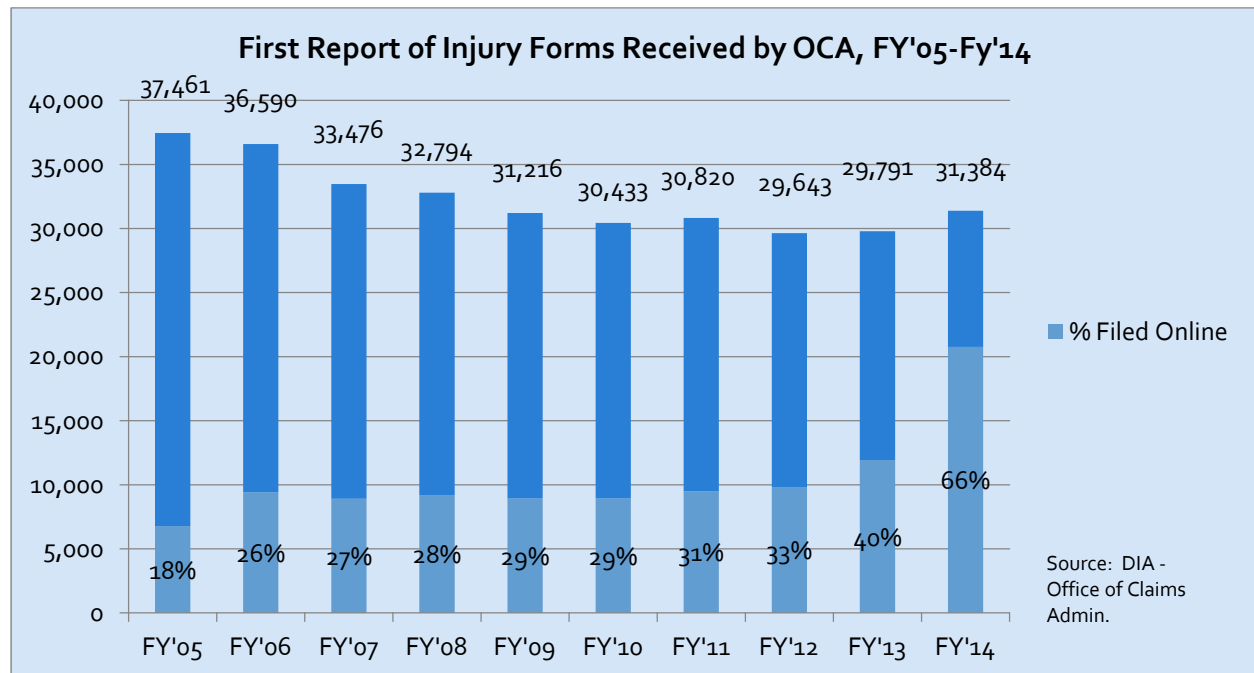
The OCA has four primary functions centered upon receiving, entering, storing, and retrieving information. The first function consists of receiving lost time reports, insurance forms, claims, appearances, and liens. Once this information is received, it must be entered into the Case Management System (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.

As of January 1, 2014, the DIA ceased accepting paper copies of Form 101 Employer's First Report of Injury (FRI). DIA requires electronic submission of all FRI's with options of either an online DIA web account; Electronic Data Interchange (EDI) through their workers' compensation insurers or a secure like transfer.

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'14, the OCA received 31,384 First Report of Injury forms (FRI's), an increase of approximately 5% from FY'13 (29,791). Approximately 66% of all FRI's were filed online (8,871 online/11,883 EDI) during FY'14, an increase over the 75% of all FRI's filed online during FY'13. In FY'14 the number of claims, discontinuances and third party claims received by the OCA was 12,625, an 11% decrease from the 14,125 received in FY'13 (prior to review and CMS acceptance processing). The total number of referrals to conciliation for FY'14 was 11,960, which represents a decrease of 1.8% from FY'13 (12,174).

FIGURE 17: FIRST REPORT OF INJURY FORMS RECEIVED BY THE OFFICE OF CLAIMS ADMINISTRATION, FY'05-FY'14



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.

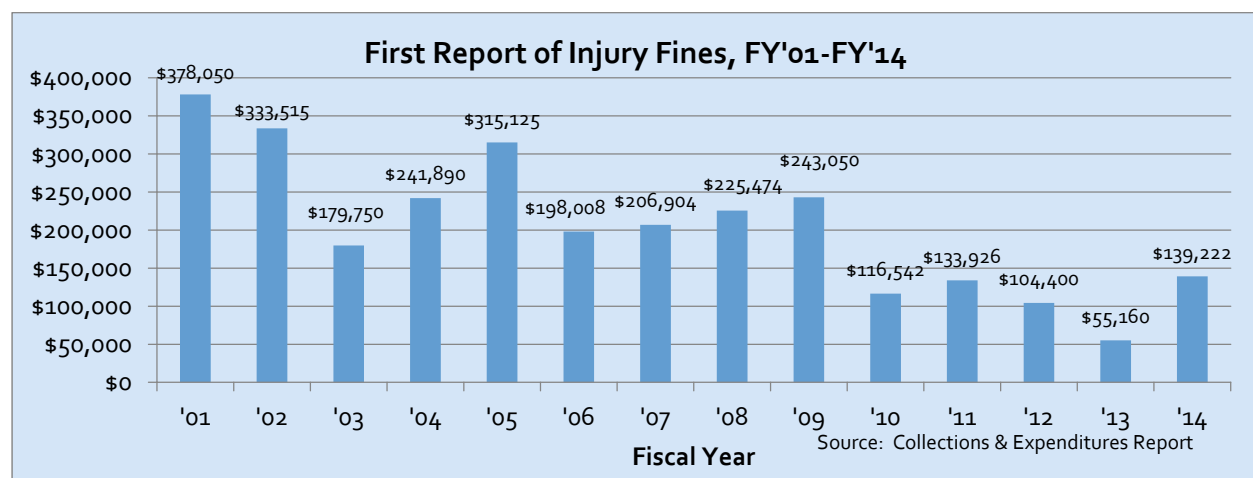
In addition to processing subpoenas and public records requests, the KOR answers investigative and pre-employment screening inquiries. The KOR also assists past and present claimants in obtaining copies of files or documents relevant to social security, disability, and retirement benefits. A fee is charged 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.

FY'14 saw an increase in the number of FRI Violation Bills which resulted in the collections of \$139,222, an increase of \$84,062 from the \$55,160 collected in FY'13. This was a result of the decrease in the number of days allowed for employers/insurers to file FRI's from 25 days to 12 days. The office is also responsible for maintaining a database on cases identified by the DIA where there may be potential fraud. In FY'14, the OCA received 45 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 71 such inquiries were processed during FY'14 and a total number of insurance complaints received were six during FY'14.

FIGURE 18: FIRST REPORT OF INJURY FINES, FY'01-FY'14



OFFICE OF EDUCATION AND 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'14, the OEVR was headed by a Director and staffed by nine 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."¹¹

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'14, OEVR approved 40 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);

¹¹ M.G.L. c.152, §1(12).

3. If client is retraining, copy of grades received from each marking period and other supportive data (such as attendance);
4. Summary of all vocational testing used to help develop an employment goal and a vocational goal; and
5. The name of the OEVR 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.¹² 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.

¹² M.G.L. c. 152, §19.

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 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.¹³ 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 education on how to find employment. As a

¹³ M.G.L. c.152, §19.

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

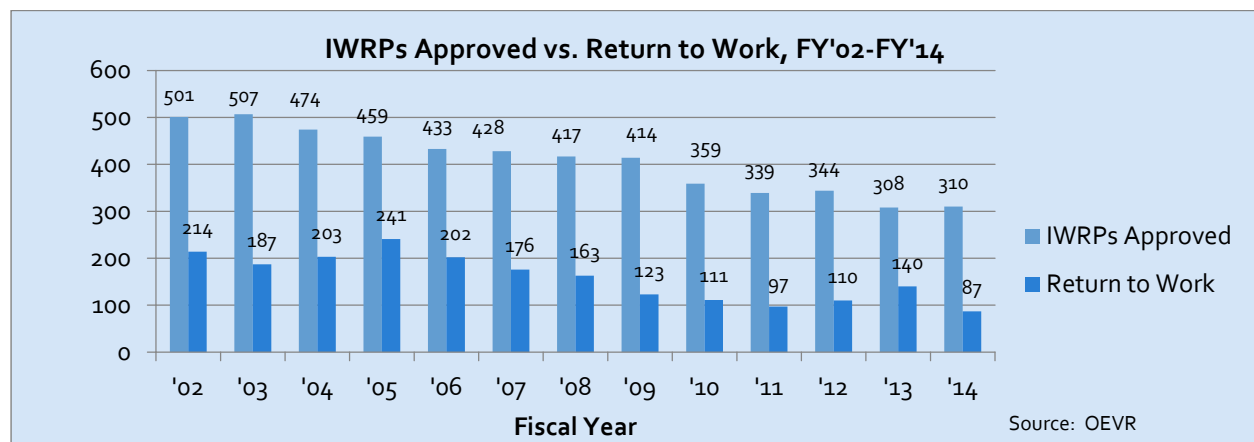
During FY'14, referrals to OEVR increased by 37%. 3,673 cases were referred to OEVR in FY'14 and 2,309 "mandatory meetings" were held. Of those cases that received a mandatory meeting, 23% (533) were referred to the insurer/self-insurer with a request to initiate vocational rehabilitation services by 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'14. In FY'14, 37% of injured workers returned to work within 60 days of plan completion.

TABLE 14: UTILIZATION OF VOCATIONAL REHABILITATION SERVICES, FY'06-FY'14

Fiscal Year	Referrals to OEVR	Mandatory/ Inform. Meetings	Referrals to Insurer for VR	IWRPs approved	Return to work	% RTW after plan development
FY'14	3,673	2,309/N/A	533	310	87	37%
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 Vocation Rehabilitation

FIGURE 19: COMPARISON OF IWRPs APPROVED VS. RETURN TO WORK, FY'02-FY'14



Trust Fund Payment for 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'14, 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 Department of Industrial Accidents (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

The safety grant program is issued under the provisions of M.G.L. c. 23E, § 3, and is managed and administered by the DIA's Office of Safety. The prevention of occupational injury and illness is in everyone's best interest. The goal of the program is to promote safe and healthy conditions in the workplace through training, education, and other preventative programs for the employees and employers covered by the Massachusetts Workers' Compensation Act. The DIA, through the Office of Safety, awards up to \$25,000 to qualifying employers and is the only state agency in the Commonwealth whose primary function is to provide financial assistance for the prevention of occupational injury, illness and death in the workplace.

The Office of Safety makes the grant application available to the general public via their website at www.mass.gov/dia/safety and COMMBUYS, the Commonwealth's newest business access system. The Office of Safety has partnered with the Workforce Training Program, the Department of Labor Standards, 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. These workshops include a comprehensive step-by-step review of the program and the application process. The Office of Safety continually updates and maintains an extensive database, providing information about new initiatives and innovative upgrades to the grant process.

In FY'14 the Office of Safety was able to fund approximately 56 grants which trained nearly 9,000 workers in Massachusetts (see Appendix K).

Office of Safety Initiatives

The Massachusetts Youth Employment and Safety Team (YES Team)

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 MOHST, a group of government agencies that share responsibility for protecting worker health and safety. 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.

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.

Two semi-autonomous public employers are also licensed to self-insure: the Massachusetts Port Authority and the Massachusetts Water Resource Authority.

In FY'14, two new licenses were issued, with the total number of "parent-licensed" companies remaining at 90, covering a total of 513 subsidiaries. Each self-insurance license provides approval for a

parent company and its subsidiaries to self-insure. This amounts to approximately \$330,390,321 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.

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'14, an estimated 2,597 inquiries were made to the Insurance Register.

OFFICE OF INVESTIGATIONS

In Massachusetts, every employer with one or more employees is required to have a valid workers' compensation policy at all times.¹⁴ 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.¹⁵ 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 (WCRI) 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 where an insurance policy has been

¹⁴ Officers and directors of corporations who own at least 25% of stock of the corporation may exempt themselves from coverage.

¹⁵ M.G.L. c.152, §25A.

discovered or when there is substantial evidence that a company has ceased operations. In FY'14, the Office of Investigations conducted a total of 87,064 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 and Stop Work Orders

During a field investigation, an investigative team will request that the business provide proof of workers' compensation insurance coverage. In FY'14, the Office of Investigations conducted 5,785 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'14, the DIA issued a total of 2,150 SWOs. Of the 2,150 SWOs issued 2,094 (97.4%) were issued to small employers (1 to 10 employees), 53 (2.5%) were issued to medium employers (11 to 75 employees), and three (<1%) were issued to large employers (75+ employees). The Office of Investigations estimates that 5,954 new employees became covered in FY'14 as a result of each employer who purchased workers' compensation insurance after receiving a SWO.

The efforts of the Office of Investigations to reduce the number of uninsured employees also benefits employers complying with the workers' compensation law. Uninsured injuries are compensated from the Trust Fund, which is funded by assessments on employers' workers compensation premiums. If the number and severity of uninsured claims decreases, the Trust Fund will need to pay out less, which will result in lower assessment rates.

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'06-14

Fiscal Year	Compliance Checks	Field Investigations	SWOs Issued	SWO Fines Collected	New Employees Covered due to SWOs
FY2014	87,064	5,785	2,150	\$1,430,599	5,954
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	<i>not tracked</i>
FY2006	n/a	n/a	227	\$246,657	<i>not tracked</i>

Source: Office of Investigations/Collection and Expenditure Reports

Stop Work Order Fines and Debarment

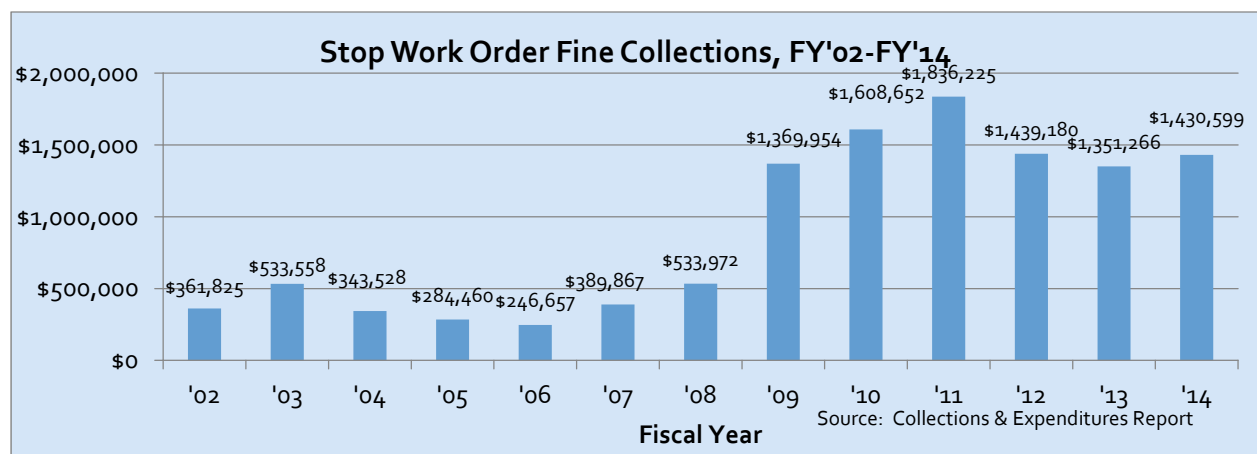
Fines resulting from a SWO are \$100 per day, starting the day the SWO is issued, and continuing until proof of coverage and payment of the fine is received by the DIA. An employer who believes the issuance of the SWO was unwarranted has ten days to file an appeal. A hearing must take place within 14 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 DIA Director or their designee can file criminal complaints against employers (including the President and Treasurer of a corporation) for violations of Section 25C.

In FY'14, the Office of Investigations collected \$1,430,599 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. Over the past five years, approximately 91% of SWO fines have been paid within the first 30 days of SWO issuance.

FIGURE 20: STOP WORK ORDER FINE COLLECTIONS, FY'02-FY'14



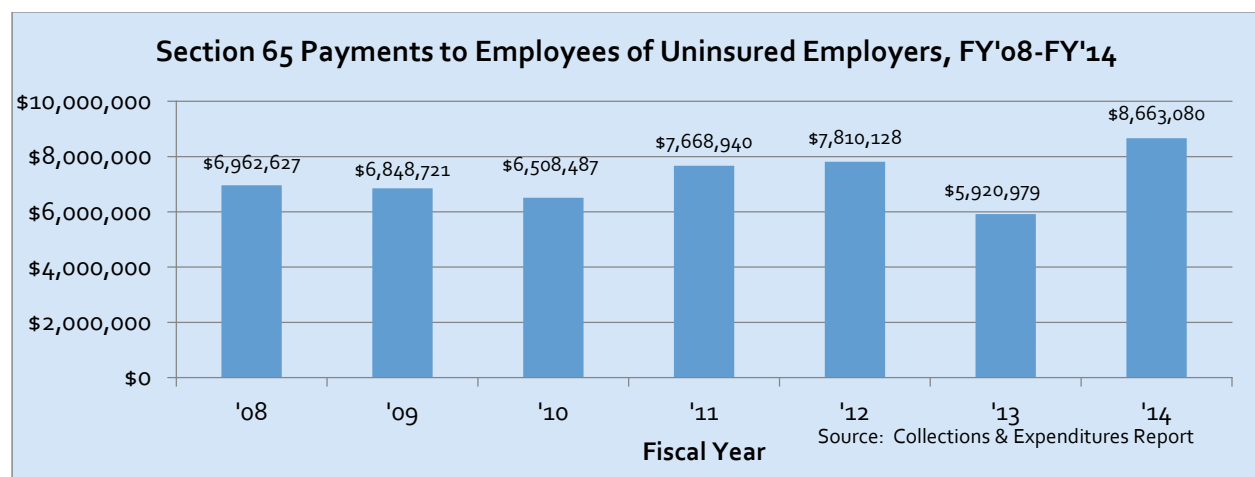
WORKERS' COMPENSATION TRUST FUND

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, and 37A. The Trust Fund also pays for vocational rehabilitation services under certain circumstances pursuant to Section 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.¹⁶ In FY'14, \$8,663,080 was paid to uninsured claimants. 578 claims for benefits were paid during FY'14 and there were 107 new claims filed. The DIA aggressively pursues uninsured employers to recoup monies paid out from the Trust Fund. During FY'14, the DIA recovered \$1,013,557 from employers and third parties.

FIGURE 21: SECTION 65 PAYMENTS TO EMPLOYEES OF UNINSURED EMPLOYERS, FY'08-FY'14



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

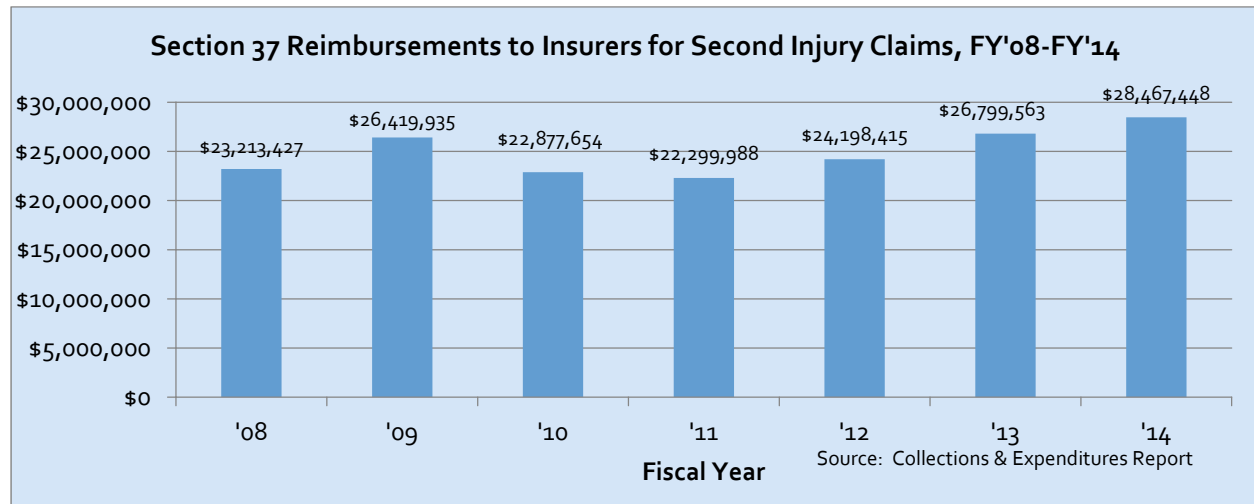
In an effort to encourage employers to hire previously injured workers, the Legislature established a Second Injury Fund (SIF) to offset any financial disincentives associated with the employment of impaired workers. Section 37 allows insurers to be reimbursed by the Trust Fund when compensation is being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

¹⁶ 452 CMR 3.00

determined to be a "second 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.¹⁷ 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'14, 884 §37 claims were paid. In FY'14, 318 §37 claims were settled. The total amount of §37 payments in FY'14 was \$28,467,448 (includes quarterly payments under §37 and interest).

FIGURE 22: SECTION 37 REIMBURSEMENTS TO INSURERS FOR SECOND INJURY CLAIMS, FY'08-FY'14



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."¹⁸ 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.)

¹⁷ 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.

¹⁸ While the chart on the next page indicates that "Old Act" claims are those from the 1973-1986 time period, pursuant to the *Shelby* decision, the Trust Fund only pays "Old Act" SIF claims from December 10, 1985-October 31, 1986. See *Shelby Mutual Insurance Company v. Commonwealth*, 36 Mass. App. Ct. 317.

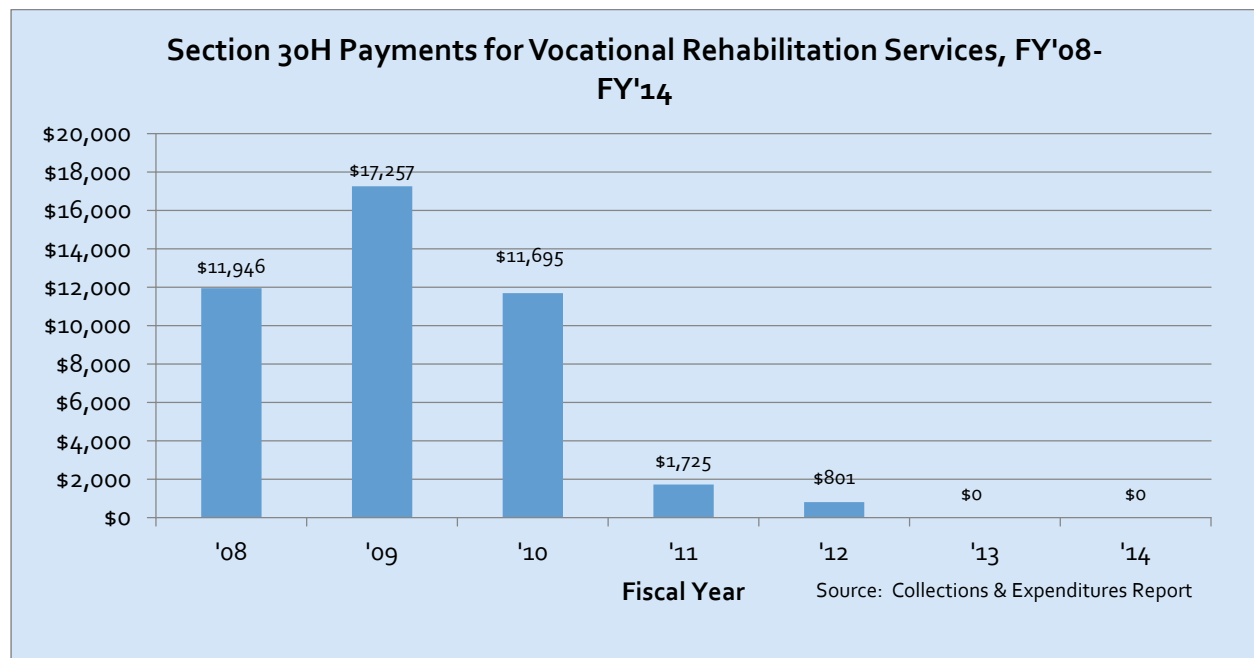
FIGURE 23: SECOND INJURY FUND OVERVIEW

"Old Act" (1973 - 1986)
<ul style="list-style-type: none"> ■ 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" (1986 - 1991)
<ul style="list-style-type: none"> ■ 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 - Present)
<ul style="list-style-type: none"> ■ 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'14, no new cases were accepted for §30H benefits and the Trust Fund did not pay for vocational rehabilitation services on existing cases.

FIGURE 24: SECTION 30H PAYMENTS FOR VOCATIONAL REHABILITATION SERVICES



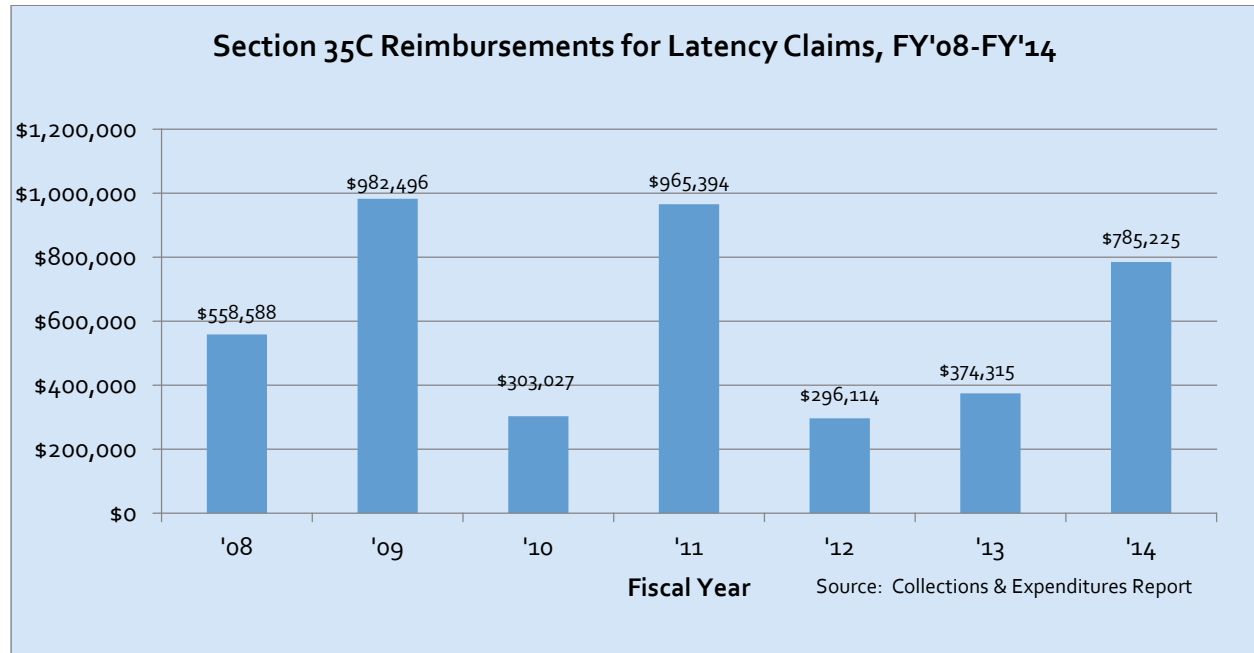
Latency Claims (Section 35C)

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'14, the Trust Fund paid out \$785,255 for latency claims.

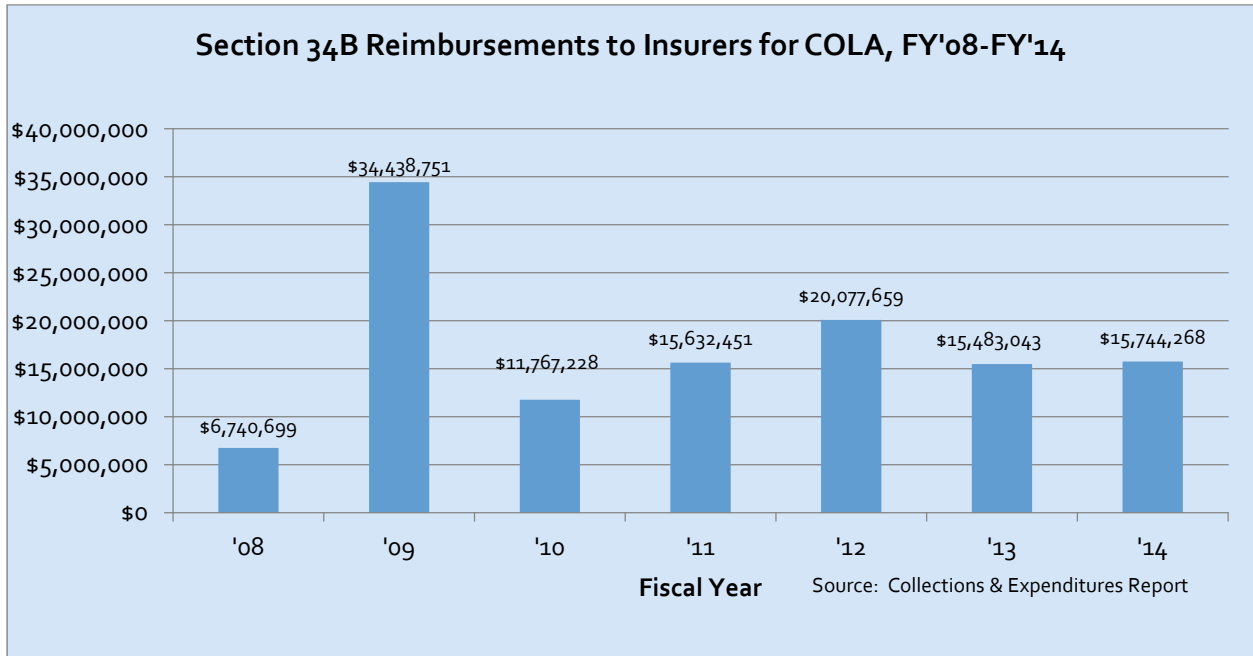
FIGURE 25: SECTION 35C REIMBURSEMENTS FOR LATENCY CLAIMS, FY'08-FY'14



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'14 totaled \$15,744,268.

FIGURE 26: SECTION 34B REIMBURSEMENTS TO INSURERS FOR COLA, FY'o8-FY'14



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) agents who conduct reviews on Massachusetts workers' compensation claims to ensure compliance with the requirements of 452 CMR 6.00 et seq.

During FY'14, 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'14, the Executive Director of the OHP received and responded to eight complaints. 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 an 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'14, 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.

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 discrimination against compensation claimants, over-utilization of procedures, unnecessary surgery or other procedures, and inappropriate treatment of workers' compensation

patients. Upon a finding of a pattern of abuse by a particular provider, the HCSB is required to refer its findings to the appropriate board/agency. In FY'14, the HCSB did not receive any complaints.

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'14.

Treatment Guidelines - Under M.G.L. c.152, §13, the Director of the DIA 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.

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. 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. 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 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'o6 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'o8, Phase III of the assessment reviews began and continued through FY'14. Phase III focuses on assessments calculated and remitted during a 4-year review period between January 1, 2004 and December 31, 2007. In FY'14, a total of two CPA firms assisted the DIA in collecting \$252,797 from companies under assessment review. The audit expense associated with the reviews for FY'14 was 23%, thereby representing a DIA retention rate of 77%.

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: ASSET RECOVERY PROJECT COLLECTIONS, FY'00-FY'14

Assessment Recovery Project Fiscal Year 2000 – Fiscal Year 2014		
<u>Fiscal Year</u>	<u>Amount Collected</u>	<u>Cumulative Amount</u>
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 ¹	\$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 ²	\$14,348,188
Fiscal Year 2013	\$231,953 ³	\$14,580,141
Fiscal Year 2014	\$252,797⁴	\$14,832,938

Source: DIA Office of Assessments & Compliance

¹ 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.

² 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.

³ The Office of Assessments & Compliance also collected an additional \$111,973 in late fees from insurance companies during FY'13.

⁴ The Office of Assessments & Compliance also collected an additional \$17,057 in late fees from insurance companies during FY'14.

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, hearing stenographer, judicial support and vocational rehabilitation units are located in Boston, and each has varying degrees of managerial responsibility for the operations of their respective divisions at the regional offices. Each regional manager works closely with all of the Boston-based managers, including the Senior Judge, to be sure that the public is provided with consistent and reliable service at all times.

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 pre-assigned cases according to availability on the day of the scheduled conciliation, and they report to the conciliation manager located in the Boston office. Hearing stenographers are assigned when needed, and report to the office's regional manager regarding their daily duties. Additionally, they continue to be provided with technical oversight and supervision from the hearing stenographer manager in Boston. 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 that 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 27: FUNDING SOURCES FOR THE DIA

Funding Sources for the DIA	
Assessments:	A charge levied against all companies in Massachusetts on their workers' compensation policies;
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, 2014, the referral fee is \$789.74 (65% of the current State Average Weekly Wage);
Fines:	There are three types of fines: <ol style="list-style-type: none">1. Stop Work Order Fines2. Late First Report Fines3. Late Assessment Fines

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 (Special Fund). 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.¹⁹ The assessment rate for private sector employers in FY'15 is 5.801% of standard premium.

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 plus fringe benefits and indirect costs.

¹⁹ For employers that are self-insured or are members of self-insurance groups, an "imputed" premium is determined, whereby the WCRIB will estimate what the employer's premium would have been had they obtained insurance in the commercial 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 rates are determined.

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.²⁰

Chapter 23E of the Massachusetts General Laws directs the Advisory Council to review the DIA's Special Fund 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 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.

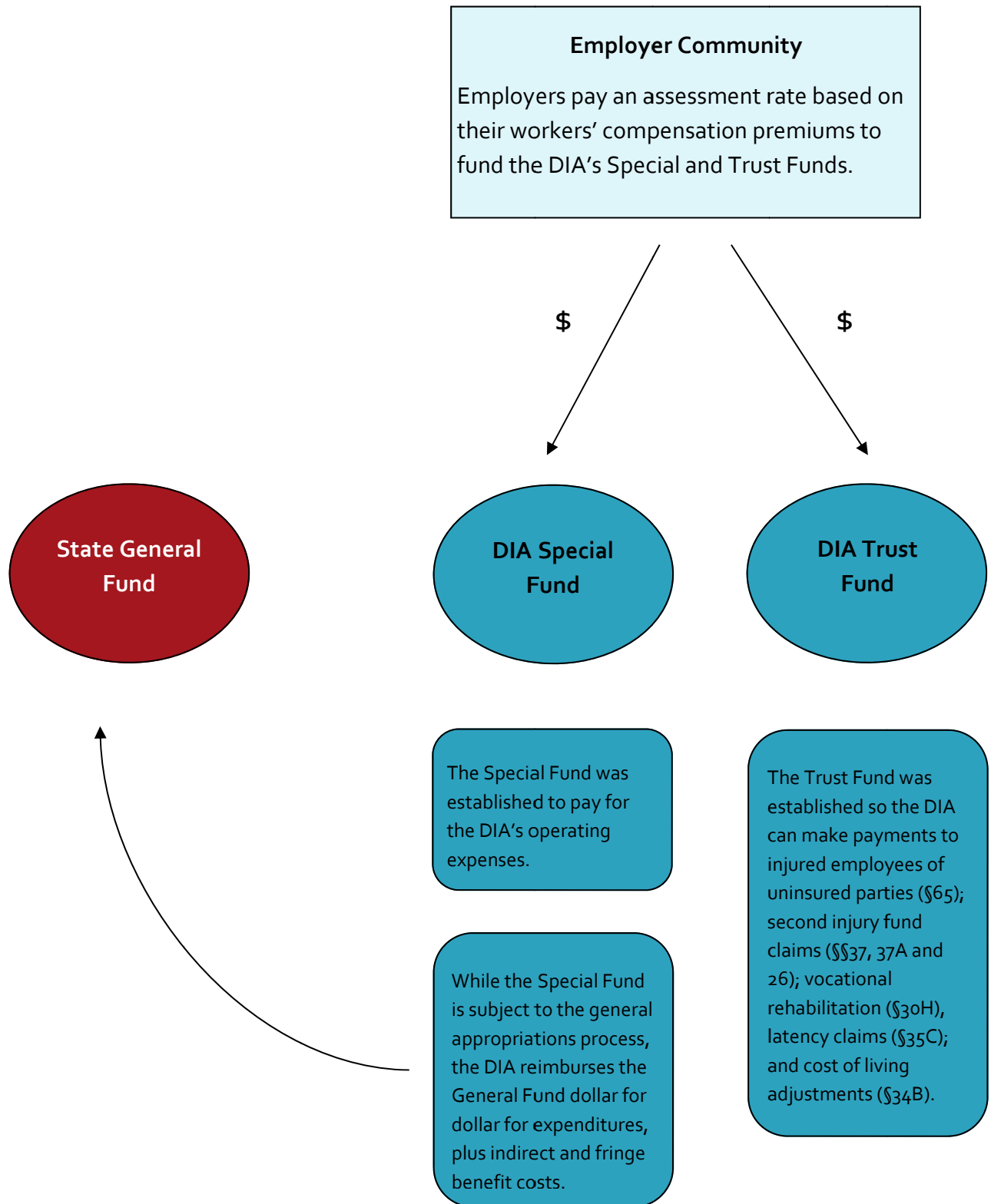
In May and June, the DIA uses consulting actuaries to estimate future expenses and determine the assessments necessary to fund the Special Fund and Trust Fund. This process is discussed in greater detail in the next section of this report. The budgets and corresponding assessments must be submitted to the Secretary of the Executive Office of Labor and Workforce Development (EOLWD) by July 1st annually. Historically, the Legislature appropriates the DIA's operating expenses by July 1st. At that time, insurance carriers are notified of the assessment rates, which are paid quarterly to the DIA directly. 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 approval of the Secretary of 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 the fiscal year, all balances (in either the Special Fund or the Trust Fund) remain in their respective account 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 purposes of calculating the assessment rate) must be reduced by the 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.

²⁰ M.G.L. c. 152, §65(2).

FIGURE 28: THE DIA'S UNIQUE FUNDING PROCESS

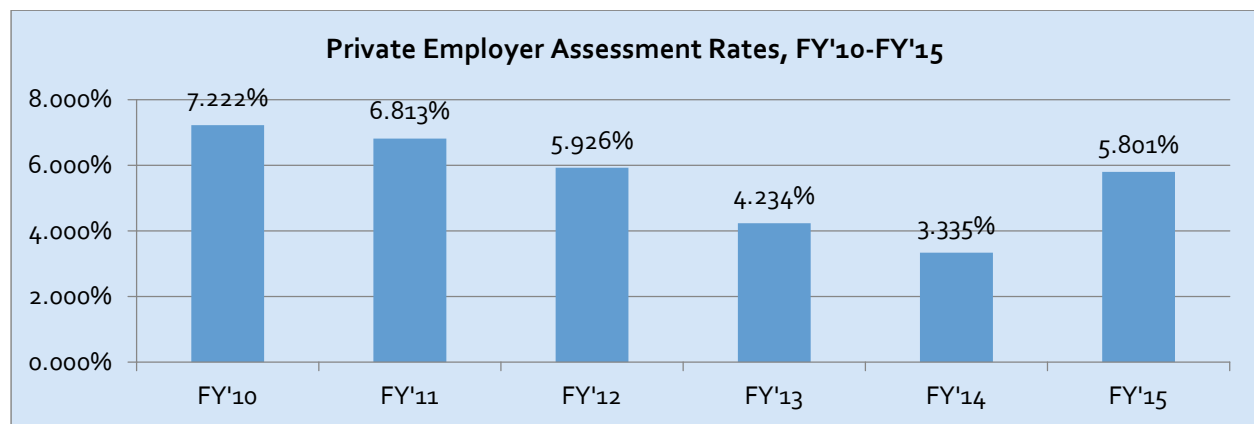


IMPORTANT: Year end balances within the Special Fund and Trust Fund DO NOT revert to the General Fund. These balances remain within their respective accounts and are only used to offset future assessments when the balance of a particular fund exceeds 35% of the previous year's disbursements.

PRIVATE EMPLOYER ASSESSMENTS

On June 26, 2014, Deloitte and Touche LLP (D&T) released an analysis of the DIA's FY'15 assessment rates as mandated by M.G.L. c. 152, § 65(4) and (5). Specifically, the report details the estimated amount required by the Special Fund and Trust Fund for FY'15. Included in the report are the assessment rates to be applied to private employer insurance premiums. For FY'15, the private employer opt-in assessment rate has been calculated to be 5.801% of standard premium. This rate, an increase over the FY'14 assessment rate, is expected to result in a reasonable budget surplus and comes after significant reductions to the rate in previous years. Those rate reductions had the intended effect of reducing the budget surplus below the maximum threshold set by M.G.L. c.152.²¹ The FY'15 rate also reflects a collection lag adjustment, as the new assessment rate is not collected until the second quarter of FY'15. It is important to note that the Public Fund has no remaining municipalities, thereby resulting in a FY'15 public assessment rate of 0%.

FIGURE 29: PRIVATE EMPLOYER ASSESSMENT RATES, FY'10-FY'15



Fiscal Year 2015 Private Fund (including Special Fund) expenditures are projected to be \$80.8M. This represents a 5.2% increase over the \$76.8M FY'14 expenditures projected by D&T in the FY'14 analysis. The increase is primarily driven by a higher projection for COLA payments.

Overview of the FY'15 Assessment Rate Calculation

D&T used the following six steps to determine the assessment rate for private employers:

1. Project FY'15 Disbursements;
2. Project FY'15 income (excluding assessments);
3. Estimate FY'15 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'15; and
6. Calculate the assessment rate, the assessment ratio, and the assessment base factors.

²¹ See previous section for a discussion of the 35% Rule.

1. Fiscal Year 2015 Projected Disbursements: \$80.8M

The first step in the assessment calculation is to determine expected FY'15 expenditures. Private employers are assessed for the sum of the Private Trust Fund and Special Fund budgets.

Private Trust Fund Budget	Projected FY'15 Expenditures	+/- FY'14 Projected Expenditures
Section 37 (2 nd Injuries)	\$27,000,000	\$170,065
Uninsured Employers	\$8,500,000	\$1,352,814
Section 30H (Rehabilitation)	\$0	\$0
Section 35C (Latency)	\$620,000	\$192,000
Section 34B (COLAs)	\$16,000,000	\$2,875,045
Defense of the Fund	\$6,000,000	\$353,263
<i>Total:</i>	\$58,120,000	\$4,943,187

Special Fund Budget	Projected FY'15 Expenditures	+/- FY'14 Projected Expenditures
<i>Total:</i>	\$22,700,000	-\$923,219

Priv. Employ. Expenditures	Projected FY'15 Expenditures	+/- FY'14 Projected Expenditures
<i>Total:</i>	\$80,820,000	\$4,019,968

2. Projected Fiscal Year 2015 Income: \$6.9M

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 Special Fund balances.

Fines and Fees (Special Fund):	\$5,700,000
Income Due to Reimbursements:	\$1,200,000
Estimated Interest Income:	\$9,000 (Private Fund: \$6,000/Special Fund: \$3,000)
<i>Total Projected FY'15 Income:</i>	\$6,909,000

3. Adjustments to Fund Balances: \$2.0M (Special Fund) and -\$2.0M (Private Trust Fund)

In accordance with M.G.L. c. 152, §65(4)(c), the amount assessed to 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'14 expenditures in a particular fund must be used to reduce amounts assessed for that fund in FY'15. At the end of FY'14, the balances of the Private and Special Funds will not have surpluses exceeding 35% of FY'13 disbursements, therefore no adjustments are necessary.

While there was no statutory adjustment to the fund budgets, the DIA requested an offsetting adjustment of \$2,000,000 between the Special Fund and the Private Trust Fund.

Special Fund	FY'14 Estimated Year End Balance	35% of FY'13 Expenditures	Amount of Required Reduction
	\$7,146,915	\$7,181,953	0
Private Trust Fund	FY'14 Estimated Year End Balance	35% of FY'13 Expenditures	Amount of Required Reduction
	\$8,557,849	\$18,927,188	0

4. Calculation of the Assessment Budget

The assessment budget is calculated by subtracting the projected income and balance adjustments from the projected disbursements. Like FY'14, D&T was again 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.

	<u>Opt-In</u>	<u>Opt-Out</u>	<u>Total</u>
Disbursements	\$76,984,719	\$3,835,281	\$80,820,000
Income	\$6,186,274	\$722,726	\$6,909,000
Balance Adjustments	-\$209,895	209,895	\$0
Total Budget	\$71,008,340	\$2,902,660	\$73,911,000
Allocation %	96.1%	3.9%	100%

5. Calculation of the Assessment Bases

Loss Assessment Base

The FY'15 assessment loss base is \$798.4M, composed of estimated insured, self-insured and group losses. Insured and self-insured entities losses are based on actual loss data from 2005-2013. 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 2015 net written premium to be \$1,092,396,850. After adjusting the amount to account for rate changes and other factors, the resulting DIA estimate 2015 standard written premium for the insured population is \$1.2B.

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)
\$63,518,414	\$626,364,117	10.141%

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)
\$626,364,117	\$1,225,047,543	51.130%

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

0.101	0.051	5.185% (pre collection lag adjustment (see below))
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For FY'15, the methodology has been revised to reflect the timing lag between the beginning of FY'15 and the collection of the new assessment rate. For the first quarter of FY'15, the lower FY'14 rate will continue to be the rate collected. Therefore, because the FY'15 rate will be higher than the FY'14 rate, the rate was adjusted upward to account for the lower collection amount during the first quarter of FY'15. Accounting for the timing lag, **5.801%** will be the assessment rate for private, insured opt-in employers.

DIA OPERATING BUDGET

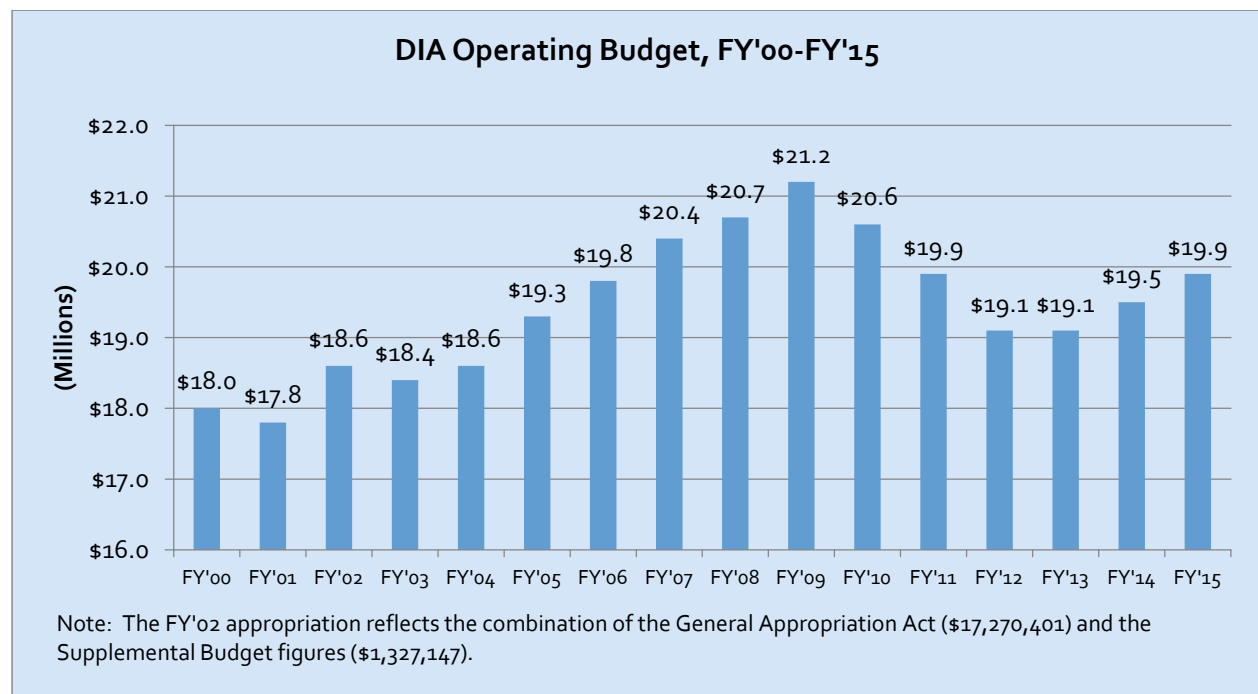
Fiscal Year 2015 General Appropriations Act

On July 15, 2014, Governor Patrick signed the FY'15 General Appropriations Act (GAA), which allocated \$19,852,999 for DIA operating expenses (line item 7003-0500). The amount is \$330,794 more than the amount appropriated to DIA in the FY'14 GAA (\$19,522,205).

TABLE 17: BUDGET PROCESS FOR DIA (LINE-ITEM 7003-0500), FY'14 AND FY'15

Fiscal Year 2015 Budget Process		Fiscal Year 2014 Budget Process	
DIA Request	\$19,852,999	DIA Request	\$19,522,205
Governor's Rec.	\$19,852,999	Governor's Rec.	\$19,522,205
Full House	\$19,347,369	Full House	\$19,442,653
Full Senate	\$19,852,999	Full Senate	\$19,522,205
Conference	\$19,852,999	Conference	\$19,522,205
GAA	\$19,852,999	GAA	\$19,522,205

FIGURE 30: DIA OPERATING BUDGET, FY'00-FY'15



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. Figure 31, below, is a brief description of the Massachusetts budget process.

FIGURE 31: OVERVIEW OF THE MASSACHUSETTS BUDGET PROCESS

Stage 1: Department Request (July-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 of Administration and Finance.
Stage 2: Governor's Recommendation (November-January)	The Governor's budget recommendation must be the first bill submitted to the House of Representatives each calendar year. Typically, the Governor's budget recommendation is released on the fourth Wednesday in January. It must be balanced and include all revenue and expenditure accounts.
Stage 3: House Ways and Means Committee Recommendation (February-April)	The Governor's budget recommendation is referred to the House Committee on Ways and Means (HW&M), where it is analyzed. Public hearings are held. HW&M will then present its version of the budget, usually in April.
Stage 4: House Budget (Early May)	The full House of Representatives reviews, debates and offers amendments to the HW&M version of the budget. The full House votes to pass a new version of the budget, which is then referred to the Senate Committee on Ways and Means (SW&M).
Stage 5: Senate Ways and Means Committee Recommendation (Early June)	SW&M will analyze the House version of the budget and hold hearings and take testimony from interested parties. SW&M will then present its version of the budget, usually by early June.
Stage 6: Senate Budget (June)	After being released by SW&M, the full Senate reviews, debates, and offers amendments to the proposed budget. The full Senate votes to pass a new version of the budget.
Stage 7: Conference Committee (By June 30th)	<p>A conference committee is appointed to resolve differences between the House and Senate passed versions of the budget. A new version of the budget is created, which the House and Senate must each ratify. If one body fails to ratify, the budget will be sent back to the conference committee for more deliberations. Once ratified, the conference committee budget will be signed by the Speaker of the House and Senate President and presented to the Governor for signature.</p> <p>An interim budget can be enacted by the Legislature if the budget is late. Such a budget would allow the government to continue spending while the General Appropriations Act is being finalized.</p>
Stage 7: Governor's Action (By June 30th)	The Governor has 10 days to review the budget and take action to either approve or veto the budget. The Governor may approve or veto the entire budget, veto or reduce specific line items, veto outside sections or submit changes as an amendment to the budget for further consideration by the Legislature. The Legislature may override a Governor's veto by a 2/3 vote in both chambers.
Epilogue: gC Cuts (Any time during the fiscal year)	Even after the budget is completed, the Governor can announce gC cuts (M.G.L. c. 29, §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 gC powers to reduce funding in the Executive Branch.

SECTION

-7-

INSURANCE COVERAGE

MANDATORY INSURANCE COVERAGE

Every private sector employer in the Commonwealth is required to maintain workers' compensation insurance.²² 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.²³ 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.

²² 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.

²³ 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 FY14, the DOI approved a total of four new licenses for carriers to write workers' compensation insurance in Massachusetts. In addition, one existing license was amended to include workers' compensation. During the same period, one carrier's existing license was amended to delete workers' compensation insurance.

In Massachusetts, workers' compensation insurance rates are determined through an administered pricing system.²⁴ Insurance rates are proposed by the WCRIB on behalf of the insurance industry, and set by the Commissioner of Insurance. The WCRIB submits to the Commissioner a classification of risks and premiums, referred to as the rate filing, which is reviewed by the State Rating Bureau. By law, a

²⁴ 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.

rate filing must be submitted at least every two years, and no classifications or premiums may take effect until approved by the Commissioner.²⁵

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."²⁶

On March 20, 2014, Insurance Commissioner Joseph G. Murphy released a Decision and Order disapproving the WCRIB's request for a 7.7% increase to workers' compensation rates. As a result, rates will remain at the current levels for now, saving Massachusetts employers an estimated \$77 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. As part of the settlement, the parties have agreed to modify the classification of certain employer groups to allow for more accurate prediction of workers' compensation losses.

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, 1991-2014

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
2014	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.²⁷ These percentage decreases are called downward deviations. In Massachusetts, scheduled credits are also used to reward policyholders with good experience. These discounting techniques have become an important part of the Massachusetts insurance market. While open competition is not permitted, the use of deviations

²⁵ 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.

²⁶ M.G.L. c.152, §53A(2).

²⁷ M.G.L. c.152, §53A(9).

(and other alternatively priced policies) has encouraged carriers to compete for business on the basis of pricing.

In calendar year 2013, approximately 48 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.²⁸

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 WCRI, 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."

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

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

²⁸ <http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/mass-div-of-insurance.html>.

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.

<u>Class</u> <u>Code</u>	<u>Governing</u> <u>Classification</u>	<u>Manual</u> <u>Rate</u>	<u>Payroll</u>	<u>Base</u> <u>Rate</u>
5188	Automatic Sprinkler Installation & Drivers	\$4.13	\$200,000	\$8,260
<u>Class</u> <u>Code</u>	<u>Governing</u> <u>Classification</u>	<u>Manual</u> <u>Rate</u>	<u>Payroll</u>	<u>Base</u> <u>Rate</u>
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.

$$\text{Manual Premium} = (\text{Manual Rate} \times \text{Payroll}) / 100$$

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.

$$\text{Standard Premium} = \text{Manual Premium} \times \text{Experience Modification Factor}$$

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: PREMIUM DISCOUNT FOR TYPE A & B CARRIERS IN MA

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

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 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 20: PREMIUM REDUCTION % PER CLAIM DEDUCTIBLE

PER CLAIM DEDUCTIBLE ²⁹	
<i>Effective April 1, 2014</i>	
Medical and Indemnity Deductible Amount	Premium Reduction Percentage
\$ 500	2.2%
\$1,000	3.5%
\$2,000	5.3%
\$2,500	6.0%
\$5,000	8.9%

Source: WCRIB

²⁹ Massachusetts Workers' Compensation Rating and Inspection Bureau, Circular Letter #2236 and Circular Letter #2238 dated March 21, 2014.

TABLE 21: MASSACHUSETTS BENEFITS CLAIM AND AGGREGATE DEDUCTIBLE PROGRAM

MASSACHUSETTS BENEFITS CLAIM AND AGGREGATE DEDUCTIBLE PROGRAM ³⁰ <i>Effective April 1, 2014</i>			
Estimated Annual Standard Premium	Claim Deductible Amount	Aggregate Deductible Amount	Premium Reduction Percentage
0 to \$75,000	\$2,500	\$10,000	5.9%
\$75,001 to \$100,000	\$2,500	\$10,000	5.8%
\$100,001 to \$125,000	\$2,500	\$10,000	5.7%
\$125,001 to \$150,000	\$2,500	\$10,000	5.6%
\$150,001 to \$200,000	\$2,500	\$10,000	5.4%
over \$200,000	\$2,500	5% of Estimated Annual Standard Premium	5.0%

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.³¹ 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 \$75,000.³²

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

³⁰ *Id.*

³¹ "Retrospective Rating," *Risk Financing*, Supplement No. 46, May 1995: III.D.7.

³² NCCI, *Retrospective Rating Plan Manual for Workers Compensation and Employers Liability Insurance* (2009 Edition), p. 14.

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

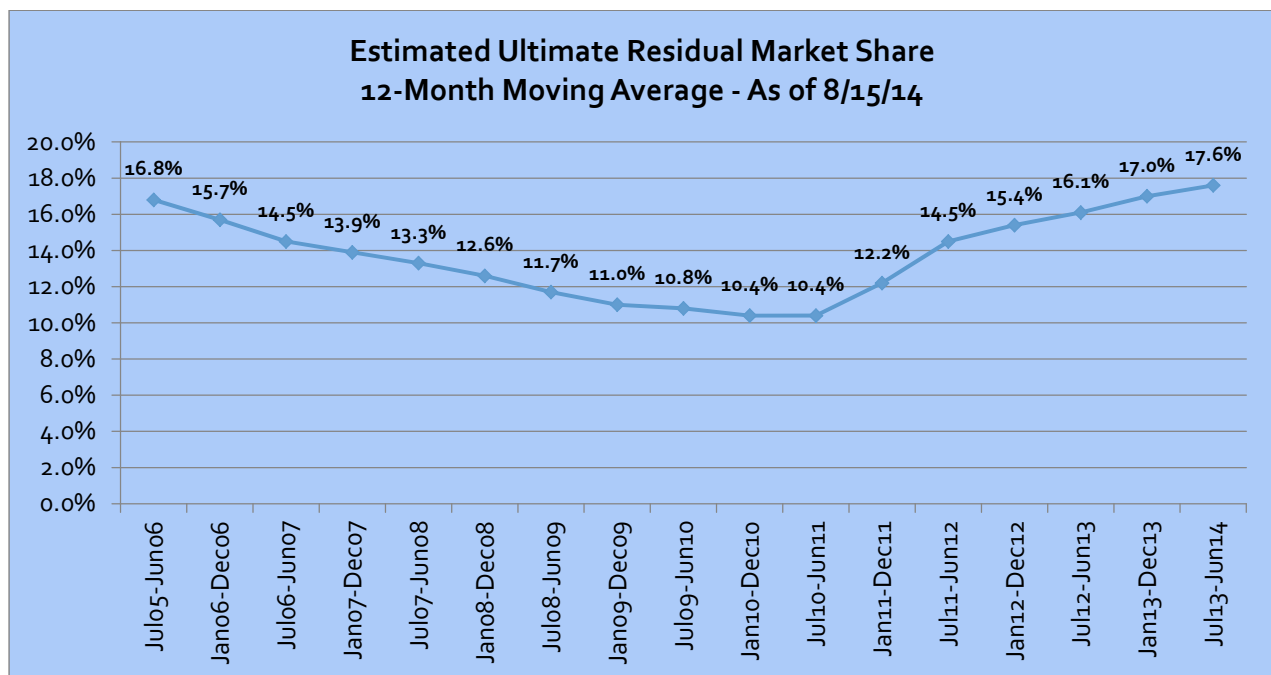
Offered as another means of reducing an employer's insurance costs, dividend plans can provide the policy owner with a partial return on a previously paid premium. This payment from the insurer takes into account investment income, expenses, and the insured's overall loss-experience in a given year. 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 2014 is 17.6%. 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 32: ESTIMATED ULTIMATE RESIDUAL MARKET SHARE - 12 MONTH AVERAGE



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 2014) residual market loss ratio for policy year 2013 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 2012, the estimated Residual Market Burden (as of the first quarter of 2014) was 0.42, assuming a Loss Ratio of 65.0%.³³

³³ WCRIB Special Bulletin No. 7-14 (August 12, 2014).

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.³⁴ 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: STATISTICS ON SELF INSURANCE IN MASSACHUSETTS, FY'02-FY'14

<u>Fiscal Year</u>	<u>New Licenses</u>	<u>Total Licenses</u>	<u>Companies Covered</u>	<u>Equivalent Premium Dollars</u>
FY'14	2	90	513	\$330M
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

³⁴ 452 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.³⁵

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). 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, 2014, Massachusetts had 21 active SIGs and there were 5,802 members of SIGs.

TABLE 23: MEMBERSHIP IN SIGs, 1991-2014

Membership in Workers' Compensation Self Insurance Groups as of Jan. 1 st		
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
2014	21	5,802

Source: Division of Insurance

³⁵ 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.

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. While its mission statement includes all lines of insurance, the IFB's focus is on automobile and workers' compensation insurance.

In 2013, 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 were conducted by some of the Community Insurance Fraud Initiative (CIFI/Task Force) investigators and the provider fraud investigators with the support of four 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 2013, each of these bureaus contributed \$4.4 million to fund the IFB. The 2013 operating expenses for the IFB totaled \$8.8 million, which was an increase of \$200,000 over the Bureau's 2012 operating expenses (\$8.6 million).

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; and
- 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 2013, the IFB received 3,974 referrals; of those 389 were workers' compensation fraud. Workers' compensation fraud referrals only represent 11% of all IFB referrals. The vast majority of referrals (77%) received by IFB are for automobile insurance fraud (3,059 in calendar year 2013). 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. The source of their referrals comes from insurance carriers, DIA, law enforcement agencies and public hotline.

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

There were 172 workers' compensation cases worked on in 2013. 100 of those cases have been closed and/or referred for prosecution. In 2013, there were ten individuals indicted and/or complaints issued. There were two individuals convicted. There was a total of \$47,275 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.

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 2013, the Task Force's fifth year of operation, member agencies recovered \$15.7 million during a one year period as a result of referrals and cooperative oversight. The Task Force received 176 complaints through its referral phone line (1-877-96-LABOR) and online referral system available on the Task Force's website.

On June 26th 2014, Governor Deval Patrick signed into law "An Act Restoring the Minimum Wage and Providing Unemployment Insurance Reforms." In addition to increasing the state's minimum wage, the law also codified the Task Force (effective March 24, 2014), making it a permanent fixture under the Executive Office of Labor and Workforce Development as the Council on the Underground Economy. The law ensures that government agencies work together in a concerted manner to uncover businesses that conceal or misrepresent their employee population to circumvent their employer responsibilities related to business laws and regulatory requirements.

FIGURE 33: MEMBERS OF THE JOINT TASK FORCE

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	
Department of Public Health	
Division of Banks	
Division of Professional Licensure	
Office of Small Business & Entrepreneurship	
Massachusetts Commission Against Discrimination	
Alcoholic Beverages Control Commission, Massachusetts Treasurer's Office	
Corporations Division, Office of the Secretary of the Commonwealth	
Other Partners	
Insurance Fraud Bureau of Massachusetts	

FISCAL YEAR 2014 ANNUAL REPORT

APPENDICES

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SEPTEMBER 4, 2013

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APPENDIX A – Advisory Council Members

Advisory Council Members			
<u>Labor</u>		<u>Business</u>	
Stephen Joyce, Chair N.E. 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 Stephen P. Falvey N.E. Regional Council of Carpenters 750 Dorchester Avenue Boston, MA 02125-1132 Tel: (617) 307-5132 FAX: (978) 685-7373 Mickey Long AFL-CIO 193 Old Colony Avenue, P.O. Box E-1 Boston, MA 02127 Tel: (617) 269-0229 FAX: (617) 269-0567 John A. Pulgini Pulgini & Norton, LLP 10 Forbes Road West, Suite 240 Braintree, MA 02184 Tel: (781) 843-2200 FAX: (781) 843-4900		John Regan, Vice-Chair Associated Industries of Massachusetts (AIM) One Beacon Street, 16th Floor Boston, MA 02108 Tel: (617) 262-1180 FAX: (617) 536-6785 Todd R. Johnson USI Insurance Services LLC 23 Gill Street, Suite 5500 Woburn, MA 01801 Tel: (781) 376-2682 Teri A. McHugh Boyle, Shaughnessy & Campo, P.C. 695 Atlantic Avenue Boston, MA 02111 Tel: (617) 451-2000 FAX: (617) 451-5775 Frank Ruel Raytheon Company 880 Technology Park Drive Billerica, MA 01821 Tel: (978) 436-8249	
<u>Claimant's Bar</u>	<u>Insurance</u>	<u>Voc. Rehab.</u>	<u>Medical Provider</u>
Bernard J. Mulholland Ford, Mulholland & Moran, P.C. 288 North Main St. Brockton, MA 02303 Tel: (508) 586-5353 FAX: (508) 588-8855	Michael Kelley HUB International New England 299 Ballardvale Street Wilmington, MA 01887 Tel: (978) 661-6819	Lisabeth Hosford-Walsh VSR Disability Management 36 Commonwealth Ave. Haverhill, MA 01830 Tel: (978) 994-1899 FAX: (978) 914-6397	Dennis Hines South Shore Hospital 55 Fogg Road So. Weymouth, MA 02190 Tel: (781) 340-8590 FAX: (781) 340-8146
<u>Ex Officio</u>			
Secretary Ronald W. Walker, II Exec. Office of Labor & Workforce Dev. One Ashburton Place, Suite 2112 Boston, MA 02108 Tel: (617) 626-7100 FAX: (617) 727-9725		Secretary Jay Ash Exec. Office of Housing and Economic Dev. One Ashburton Place, Suite 2101 Boston, MA 02108 Tel: (617) 727-8380 FAX: (617) 727-4426	
<u>Staff</u>			
William S. Monnin-Browder, Executive Director		Evelyn N. Flanagan, Special Projects Coordinator	

APPENDIX B – Advisory Council Studies, 1989-2014

- Actuarial Analysis of the Insurance Rate Filing as Submitted by the Workers' Compensation Rating & Inspection Bureau of Massachusetts, KPMG (2005).
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- Addendum to the 1997 Tillinghast Analysis of Proposed Changes to Section 34 and 35 of Chapter 152 of the Massachusetts General Laws, Tillinghast, (2000).
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- 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).
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- 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

Senator Barry R. Finegold

State House - Room 416B
Boston, MA 02133-1053
(617) 722-1612

Senator Michael F. Rush

State House – Room 504
Boston, MA 02133-1053
(617) 722-1348

Rep. Thomas P. Conroy (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 Denise Andrews

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

Representative Mary S. Keefe

State House - Room 473F
Boston, MA 02133-1053
(617) 722-2210

Representative Daniel M. Donohue

State House - Room 122
Boston, MA 02133-1053
(617) 722-2006

Representative Nicholas A. Boydyga

State House - Room 167
Boston, MA 02133-1053
(617) 722-2810

Sen. Michael Barrett (Vice-Chair)

State House - Room 213A
Boston, MA 02133-1053
(617) 722-1572

Senator Michael Moore

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

Senator Robert L. Hedlund

State House - Room 313C
Boston, MA 02133-1053
(617) 722-1646

Rep. Lori A. Ehrlich (Vice-Chair)

State House - Room 39
Boston, MA 02133-1053
(617) 722-2014

Representative Angelo J. Puppolo, Jr.

State House – Room 236
Boston, MA 02133-1053
(617) 722-2430

Representative Kenneth I. Gordon

State House - Room 39
Boston, MA 02133-1053
(617) 722-2014

Representative Wayne A. Matewsky

State House - Room 540
Boston, MA 02133-1053
(617) 722-2090

Representative Keiko M. Orrall

State House - Room 540
Boston, MA 02133-1053
(617) 722-2090

APPENDIX D – Industrial Accident Nominating Panel

George Noel, 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

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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 School of Engineering and Applied
Sciences
20 University Road, SEAS Suite 6th Floor
Cambridge, MA 02138
Tel: 617-495-4586

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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
Tel: 781-624-8590

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

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

Gregory Bialecki, Secretary
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
Joseph P. Dusel, LLC
119 Winsor Street
Ludlow, MA 01056

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

Eileen R. Duff - District 5

8 Barberry Heights Road
Gloucester, MA 01930
GC: (617) 725-4015 x 5

Robert L. Jubinville – District 2

487 Adams Street
Milton, MA 02186
GC: (617) 725-4015 x 2

Terrence W. Kennedy - District 6

3 Stafford Road
Lynnfield, MA 01940
GC: (617) 725-4015 x 6

Marilyn M. Petitto Devaney - District 3

98 Westminster Avenue
Watertown, MA 02472
GC: (617) 725-4015 x 3
Res: (617) 923-0778

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

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

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, 2014

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

Current Members (2013):

Dean M. Hashimoto, MD, JD (Chair)	<i>Ex-Officio Member</i>
Henry W. DiCarlo, MM (Vice-Chair)	<i>Employer Representative</i>
David S. Babin, MD	<i>Physician Representative</i>
Marco Volpe, PT, DPT, OCS	<i>Physical Therapist Representative</i>
Peter A. Hyatt, DC	<i>Chiropractic Representative</i>
John W. Burrell, MD, MPH, FACOEM	<i>Physician Representative</i>
Elise Pechter, MPH, CIH	<i>Public Representative</i>
David C. Deitz, MD, Ph.D.	<i>Physician Representative</i>
Cynthia M. Page, PT, MHP	<i>Hospital Administrative Representative</i>
Janet D. Pearl, MD, MSc	<i>Physician Representative</i>
Nancy Lessin	<i>Employee Representative</i>
Julius J. Baronas, DDS, MAGD	<i>Dentist Representative</i>
Richard P. Zimon, MD, FACP	<i>Physician Representative</i>

Staff:

Diane Neelon, RN, BS, JD	<i>Executive Director</i>
Judith A. Atkinson, Esq.	<i>Counsel</i>
Hella Dalton	<i>Research Analyst</i>

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.

Letter to Chairwoman Katherine M. Clark and Chairman Eugene L. O'Flaherty
September 4, 2013
Page 2

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 supports 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.

Employer Responsibilities

- **The Advisory Council supports 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 supports 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 supports 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'14

SAFETY GRANTS FUNDED

National Lumber Company
1 Maple Street
Mansfield, MA 02048
Category of Applicant: Private
Geographic Target: Statewide
Program Administrator: Joane Cameron
Total Funds Approved: \$25,000.00

Signature Health Care
680 Centre Street
Brockton, MA 02302
Category of Applicant: Nonprofit
Geographic Target: Plymouth
Program Administrator: Jeff Miller
Total Funds Approved: \$24,985.00

IBEW Local 223
111 Rhode Island Road
Lakeville, MA 02347
Category of Applicant: Labor
Geographic Target: Statewide
Program Administrator: Bob Revil
Total Funds Approved: \$24,917.61

Quincy Geneva
320 Blue Hill Ave.
Dorchester, MA 02121
Category of Applicant: Nonprofit
Geographic Target: Suffolk
Program Admin.: Hallie Brisbo/Walter Little
Total Funds Approved: \$24,877.50

ROI Staffing
200 Highland Avenue
Needham, MA 02494
Category of Applicant: Private
Geographic Target: Norfolk
Program Administrator: Greg Kerr
Total Funds Approved: \$24,850.75

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

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

Asbestos Workers Education & Training Fund
Heat and Frost Insulators Local 6
303 Freeport Street
Boston, MA 02122-3513
Category of Applicant: Trade
Geographic Target: Statewide
Program Administrator: Rick Rothwell
Total Funds Approved: \$24,877.50

Children's Dental Care
370 Main Street
Stoneham, MA 02180
Category of Applicant: Private
Geographic Target: Middlesex
Program Admin.: Dr. Badrieh Edalatour
Total Funds Approved: \$24,877.50

Alden Research Laboratory, Inc.
30 Shrewsbury Street
Holden, MA 01520
Category of Applicant: Private
Geographic Target: Worcester
Program Administrator: Kristan Coffey
Total Funds Approved: \$24,798.87

Health Imperatives
942 West Chestnut Street
Brockton, MA 02301
Category of Applicant: Nonprofit
Geographic Target: Plymouth/Hampton
Program Administrator: Tiffany Shelley
Total Funds Approved: \$24,765.00

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: \$24,632.55

Town of Attleboro
43 South Washington Street
North Attleboro, MA 02760
Category of Applicant: Public
Geographic Target: Bristol
Program Administrator: JoAnn Cathcart
Total Funds Approved: \$22,850.00

North Atlantic Corp.
1255 Garr Highway
Somerset, MA 02726
Category of Applicant: Private
Geographic Target: Bristol
Program Administrator: Barbara Laferriere
Total Funds Approved: \$22,100.48

Teamsters Local 25
544 Main Street
Charlestown, MA 02129
Category of Applicant: Trade
Geographic Target: Statewide
Program Administrator: Steve Sullivan
Total Funds Approved: \$21,400.00

Brockton Public Schools
43 Crescent Street
Brockton, MA 02301
Category of Applicant: Municipality
Geographic Target: Plymouth County
Program Administrator: Karen Watkins-Watts
Total Funds Approved: \$19,741.93

National Association of Social Workers
14 Beacon Street, Suite 409
Boston, MA 02108
Category of Applicant: Nonprofit
Geographic Target: Statewide
Program Administrator: Rebekah Gewirtz
Total Funds Approved: \$24,717.00

Solsect Energy Development
89 Hayden Rowe, Suite E
Hopkinton, MA 01748
Category of Applicant: Private
Geographic Target: Middlesex
Program Administrator: Alex Keally
Total Funds Approved: \$24,128.50

Cape Cod Safety Trainers
70 Sparrow Way
South Yarmouth, MA 02664
Category of Applicant: Private
Geographic Target: Barnstable
Program Administrator: Richard Todd
Total Funds Approved: \$22,836.10

Sun Bug Solar LLC
411A Highland Ave., Suite 319
Somerville, MA 02144
Category of Applicant: Private
Geographic Target: Suffolk
Program Administrator: Cheney Brand
Total Funds Approved: \$21,731.70

DCU Center
50 Foster Street
Worcester, MA 01608
Category of Applicant: Private
Geographic Target: Worcester
Program Administrator: Gina Borawski
Total Funds Approved: \$19,966.20

Preservation Housing Management LLC
40 Court Street, Suite 700
Boston, MA 02108
Category of Applicant: Private
Geographic Target: Statewide
Program Administrator: Michael Donovan
Total Funds Approved: \$19,420.00

Family Continuity
60 Perserverance Way, 2nd Floor
Hyannis, MA 02601
Category of Applicant: Nonprofit
Geographic Target: Statewide
Program Administrator: Earl Stuck
Total Funds Approved: \$19,340.25

Sheet Metal Workers
1181 Adams Street
Dorchester, MA 02124
Category of Applicant: Trade
Geographic Target: Statewide
Program Admin.: Patty Smart/John Healy
Total Funds Approved: \$19,315.58

ROCA, Inc.
101 Park Street
Chelsea, MA 02150
Category of Applicant: Nonprofit
Geographic Target: Hampden
Program Administrator: Jake Jacobs
Total Funds Approved: \$17,468.00

South Middlesex Opportunity Counsel (SMOC)
300 Howard Street
Framingham, MA 01702
Category of Applicant: Private
Geographic Target: Franklin
Program Administrator: Lori Chamberlain
Total Funds Approved: \$17,227.00

Hallkeen Management
165 County Road
Plymouth, MA 02367
Category of Applicant: Private
Geographic Target: Statewide
Program Administrator: Janine Eaton
Total Funds Approved: \$17,013.00

Hitec Sensor Solutions
837 Great Road
Littleton, MA 01460
Category of Applicant: Private
Geographic Target: Middlesex
Program Administrator: Karen Mascorito
Total Funds Approved: \$16,463.88

Boston Plasterers
7 Frederika Street
Dorchester, MA 02124
Category of Applicant: Labor
Geographic Target: Statewide
Program Administrator: Mary Keohan
Total Funds Approved: \$13,442.52

Industrial Communications
40 Lone Street
Marshfield, MA 02050
Category of Applicant: Private
Geographic Target: South Shore
Program Administrator: John Doherty
Total Funds Approved: \$12,743.70

WGI
35 Hudson Drive
Southwick, MA 01077
Category of Applicant: Private
Geographic Target: Hampden
Program Administrator: Ann Carzello
Total Funds Approved: \$11,260.00

Foxborough Regional Charter School
131 Central Street
Foxborough, MA 02035
Category of Applicant: Municipality
Geographic Target: Norfolk
Program Administrator: Heidi Berkowitz
Total Funds Approved: \$10,737.75

McGill Hose and Coupling Inc.
41 Benton Drive, P.O. Box 408
East Longmeadow, MA 01028
Category of Applicant: Private
Geographic Target: Hampden

Home Builders and Remodelers of Central MA
51 Pullman Street
Worcester, MA 01606
Category of Applicant: Trade
Geographic Target: Worcester

Program Administrator: Jennifer Gable
Total Funds Approved: \$9,153.85

Imajin That
354 Merrimac Street
Lawrence, MA 01843
Category of Applicant: Private
Geographic Target: Statewide
Program Administrator: Susan Leger Ferraro
Total Funds Approved: \$7,998.25

Heidrea Communications, LLC
1 William Way
Bellingham, MA 02019
Category of Applicant: Private
Geographic Target: Norfolk
Program Administrator: Tina Zagarri
Total Funds Approved: \$7,639.80

F.H. Peterson Machine Corp.
143 South Street
Stoughton, MA 02072
Category of Applicant: Private
Geographic Target: South Shore
Program Administrator: Adam Wainwright
Total Funds Approved: \$6,907.30

Crystal Ice Co. Inc.
178 Front Street
New Bedford, MA 02744
Category of Applicant: Private
Geographic Target: Bristol
Program Administrator: Rob Hicks
Total Funds Approved: \$6,455.31

Southbridge Sheet Metal Works
441 Main St., P.O. Box 517
Southbridge, MA 01566
Category of Applicant: Private
Geographic Target: Worcester
Program Administrator: Angela Brown
Total Funds Approved: \$6,163.20

Worcester Housing Authority
40 Belmont Street
Worcester, MA 01606
Category of Applicant: Municipality
Geographic Target: Worcester

Program Administrator: Patricia Chaiffoux
Total Funds Approved: \$8,560.00

Main Stream Global
60 Island Street, Suite 101W
Lawrence, MA 01840
Category of Applicant: Private
Geographic Target: Essex
Program Administrator: Luis Yopez
Total Funds Approved: \$7,922.28

Conservation Services Group
50 Washington Street
Westborough, MA 01581
Category of Applicant: Private
Geographic Target: Statewide
Program Administrator: Erin Martinez
Total Funds Approved: \$7,610.91

Environmental Integrity Company, LLC
3 Valley Mill Road
Holyoke, MA 01040
Category of Applicant: Private
Geographic Target: Hampden
Program Administrator: Stephen F. Czepiel
Total Funds Approved: \$6,527.00

CBM Industries
470 Constitution Drive
Taunton, MA 02780
Category of Applicant: Private
Geographic Target: Bristol
Program Administrator: Brian Stalters
Total Funds Approved: \$6,345.00

BL Mechanical Inc.
37 Fairbanks Court
Douglas, MA 01516
Category of Applicant: Private
Geographic Target: Worcester
Program Administrator: Richard LeDoux
Total Funds Approved: \$6,052.74

Worcester JATC
242 Mill Street
Worcester, MA 01602
Category of Applicant: Trade
Geographic Target: Worcester

Program Administrator: Suzanne Chung
Total Funds Approved: \$5,992.00

C.M. Cleaning Company
32 Washington Street
Stoughton, MA 02072

Category of Applicant: Private
Geographic Target: Norfolk
Program Administrator: Teresa Moore
Total Funds Approved: \$5,130.65

BayPath Elder Services
33 Boston Post Road
Marlborough, MA 01572

Category of Applicant: Private
Geographic Target: Middlesex
Program Administrator: Terri Falcone
Total Funds Approved: \$4,815.00

New Ecology Inc.
15 Court Street
Boston, MA 02108

Category of Applicant: Private
Geographic Target: Suffolk
Program Administrator: Eric Gardner
Total Funds Approved: \$4,194.00

GAAMHA
208 Coleman Street
Gardner, MA 01440

Category of Applicant: Nonprofit
Geographic Target: Worcester
Program Administrator: Tracy Grant
Total Funds Approved: \$1,125.00

Program Administrator: Robert Fields
Total Funds Approved: \$5,864.24

Automotive Engineering
299 Ballardvale Street, Suite 3
Wilmington, MA 01887

Category of Applicant: Private
Geographic Target: Middlesex
Program Administrator: Jim Castantini
Total Funds Approved: \$4,935.00

Best Corp.
Local 26 Training Center
33 Harrison Ave.
Boston, MA 02111

Category of Applicant: Nonprofit
Geographic Target: Norfolk and Suffolk
Program Administrator: Mary Cronin
Total Funds Approved: \$4,586.44

Ultra Electronics Ocean Systems
115 Bay State Drive
Braintree, MA 02184

Category of Applicant: Private
Geographic Target: Norfolk
Program Administrator: Nancy Snyder
Total Funds Approved: \$2,033.00

APPENDIX L – Collections & Expenditures Report, FY'14 - FY'10

COLLECTIONS AND EXPENDITURES REPORT, FISCAL YEAR 2014 - FISCAL YEAR 2010

<i>SPECIAL FUND</i>	<i>FY'14</i>	<i>FY'13</i>	<i>FY'12</i>	<i>FY'11</i>	<i>FY'10</i>
<u>COLLECTIONS</u>					
INTEREST	5,057	5,740	7,275	8,037	11,498
ASSESSMENTS	11,794,002	12,941,590	18,289,364	20,550,569	20,269,416
LESS RET. CHECKS	(13,054)	(14,697)	(84,188)	(154,190)	(17,388)
LESS REFUNDS	0	(8,388)	(75,113)	0	(57,793)
SUB-TOTAL	11,780,948	12,918,505	18,130,063	20,396,379	20,194,235
REFERRAL FEES	3,644,241	4,049,061	4,073,484	3,791,090	3,993,493
LESS RET. CHECKS	(8,339)	(762)	(1,760)	(1,424)	(711)
LESS REFUNDS	(24,564)	(64,108)	(325,711)	(59,433)	(115,277)
OPERATING TRANSFER	0	0	(39,347)	0	0
SUB-TOTAL	3,611,338	3,984,191	3,706,666	3,730,233	3,877,505
1ST REPORT FINES	140,622	58,658	118,000	140,905	116,542
LESS RET. CHECKS	(500)	(2,400)	0	(100)	(100)
LESS REFUNDS	(900)	(500)	(2,700)	(2,900)	(91,511)
SUB-TOTAL	139,222	55,758	115,300	137,905	24,931
STOP WORK ORDERS	1,467,999	1,356,053	1,450,641	1,844,816	1,645,564
LESS REFUNDS	(33,300)	(1,200)	(7,900)	0	(33,516)
EDS FEE	(1,459)	0	0	(65)	(48)
LESS BAD CHECKS	(2,475)	(3,300)	(3,200)	(2,200)	(3,348)
MERCHANT FEE	(166)	(287)	(361)	(6,326)	0
SUB-TOTAL	1,430,599	1,351,266	1,439,180	1,836,225	1,608,652
LATE ASSESS. FINES	139,446	111,973	344,349	268,393	45,498
MISCELLANEOUS	53,230	50,689	67,571	60,864	81,526
ADJUSTMENT	0	0	0	0	0
SUB-TOTAL	192,676	162,662	411,921	329,257	127,024
TOTAL SPECIAL FUND COLLECTIONS	17,159,840	18,478,122	23,810,405	26,438,036	25,843,845
BALANCE BRGT FWD	12,252,405	14,294,169	12,141,512	7,952,135	4,878,605
TOTAL	29,412,245	32,772,291	35,951,917	34,390,171	30,722,450
LESS EXPENDITURES	(21,877,761)	(20,521,034)	(21,657,748)	(22,248,659)	(22,770,315)
ADJUSTMENT	0	1,148	0	0	0
BALANCE	7,534,484	12,252,405	14,294,169	12,141,512	7,952,135
<u>EXPENDITURES</u>					
TOTAL COMPUTER	0	0	0	7,691	2,786
REPAYMENT - SALARIES	13,516,002	12,805,181	13,076,720	13,222,297	13,791,029
FRINGE BENEFITS	3,530,765	3,310,925	4,264,090	4,147,248	3,611,928
INDIRECT COSTS	389,121	286,923	477,585	367,840	742,764
NON-PERSONNEL COSTS	4,441,873	4,118,005	3,800,005	4,428,114	4,575,218
OTHER INDIRECT COSTS	0	0	0	0	24
IP INDIRECT-EXPENSE	0	0	0	0	46,566
ADJUSTMENT FRINGE	0	0	39,347	75,469	0
TOTAL REPAYMENT	21,877,761	20,521,034	21,657,748	22,164,552	22,767,529
TOT. SPECIAL FUND EXPENDITURES	21,877,761	20,521,034	21,657,748	22,248,659	22,770,315

PUBLIC TRUST FUND	FY'14	FY'13	FY'12	FY'11	FY'10
<u>COLLECTIONS</u>					
INTEREST	388	441	559	618	884
ASSESSMENTS	0	0	0	0	339
LESS FUNDS TRANSFERRED	0	0	0	0	(339)
TOTAL ASSESSMENTS	0	0	0	0	0
TOTAL PUBLIC TRUST COLLECTIONS	388	441	559	618	884
BALANCE BRGT FWD	408,328	407,887	407,328	406,711	846,303
TOTAL	408,716	408,328	407,887	407,329	847,187
LESS EXPENDITURES	0	0	0	0	(440,476)
BALANCE	408,716	408,328	407,887	407,329	406,711
<u>EXPENDITURES</u>					
RR COLAS	0	0	0	0	440,476
TOT. PUBLIC TRUST EXPENDITURES	0	0	0	0	440,476

PRIVATE TRUST FUND	FY'14	FY'13	FY'12	FY'11	FY'10
<u>COLLECTIONS</u>					
INTEREST	12,320	13,982	17,723	19,778	28,012
ASSESSMENTS	38,535,520	47,216,893	64,302,080	61,107,302	55,076,303
LESS RET. CHECKS	(62,943)	(8,130)	(301,967)	(116,286)	(24,085)
LESS REFUNDS	(28,575)	(15,651)	(12,414)	(45,686)	(67,776)
SUB-TOTAL	38,444,002	47,193,112	63,987,699	60,945,330	54,984,442
REIMBURSEMENTS	1,015,107	1,387,682	1,055,230	1,246,265	717,782
RET. CHECK	(1,550)	(18,833)	(8,173)	(3,075)	(3,603)
REFUNDS	0	0	0	(484)	(819)
SUB-TOTAL	1,013,557	1,368,849	1,047,057	1,242,706	713,360
SEC. 30 H	7,259	0	0	53,358	0
OTHER TRUST FUND	0	0	0	0	0
TOT.PRIVATE TRUST COLLECTIONS	39,477,138	48,575,942	65,052,480	62,261,172	55,725,813
BALANCE BRGT FWD	28,599,262	34,101,000	26,757,561	16,558,295	7,667,309
TOTAL	68,076,399	82,676,942	91,810,041	78,819,468	63,393,123
LESS EXPENDITURES	(59,876,592)	(54,077,680)	(57,709,041)	(52,061,907)	(46,834,827)
ADJUSTMENT	0	0	0	0	0
BALANCE	8,199,807	28,599,262	34,101,000	26,757,561	16,558,295

PRIVATE TRUST FUND	FY'14	FY'13	FY'12	FY'11	FY'10
<u>CLAIMANTS - EXPENDITURES</u>					
RR SEC. 34	1,824,561	1,297,249	1,008,823	1,238,194	1,414,491
RR SEC. 35	574,785	344,000	503,908	538,788	379,035
RR LUMP SUM	2,149,430	1,064,508	2,443,857	1,650,000	1,043,946
RR SEC. 36	142,923	108,877	339,108	446,949	180,802
RR SEC. 31	162,689	150,847	225,342	193,757	98,761
RR SEC. 34, PERM. TOTAL	948,058	676,761	711,058	584,210	620,747
RR COLA ADJ	243,368	242,981	229,823	292,068	227,594
RR EE MEDICAL	35,409	22,727	28,584	26,804	24,846
RR EE TRAVEL	8,000	3,500	1,216	6,500	5,219
RR EE MISC. EXPENSE	957	222	0	500	709
RR BURIAL BENEFITS	0	0	5,000	0	4,000
RR LEGAL FEES	868,540	506,708	784,787	684,853	604,005
RR VOC. REHAB SERVICES	3,965	5,378	7,602	3,899	8,168
RR REHAB (PRIOR YEAR)	0	0	0	147	0
RR MEDICAL	1,695,603	1,497,220	1,521,020	2,000,858	1,891,511
EE Books & Supplies	0	0	0	(1,513)	0
SUB-TOTAL CLAIMANT PAYMENTS	8,658,285	5,920,979	7,810,128	7,666,014	6,503,834
MM TUITION	4,795	0	0	2,926	4,653
TOTAL CLAIMANTS	8,663,080	5,920,979	7,810,128	7,668,940	6,508,487
<u>INSURERS - EXPENDITURES</u>					
RR COLAS	15,458,218	14,967,542	19,578,320	14,746,147	11,081,676
RR SEC. 19 COLA LUMP SUM	286,050	515,501	499,339	886,304	685,552
RR LATENCY SEC. 35C	410,002	249,478	96,125	483,743	303,027
RR LATENCY SEC. 35C QUARTERLY	375,253	124,836	195,631	481,651	0
RR SEC. 37	19,717,765	15,773,208	17,290,467	15,688,574	15,765,761
RR SEC. 37 QUARTERLY	8,749,683	6,470	6,907,948	6,577,876	6,999,945
RR SEC. 37 INTEREST	0	10,999,885	0	33,538	111,948
TOTAL PAYMENT TO INSURERS	44,996,971	42,636,920	44,567,830	38,897,833	34,947,909
<u>OEVR - EXPENDITURES</u>					
MM TUITION	0	0	0	0	7,938
RR REHAB-30H	0	0	801	0	148
EE OTHER	0	0	0	0	0
RR EE TRAVEL	0	0	0	833	2,070
RR EE BOOKS & SUPPLIES	0	0	0	892	1,539
SUB-TOTAL OEVR EXP.	0	0	801	1,725	11,695

PRIVATE TRUST FUND		FY'13	FY'12	FY'11	FY'10
<u>DEFENSE - EXPENDITURES</u>					
AA PAYROLL - SALARY	3,667,146	3,195,287	2,906,711	2,900,716	2,955,695
AA VACATION-IN-LEU	1,054	1,757	7,279	28,792	0
AA BONUS AND AWARDS	0	0	7	7,500	0
AA OVERTIME COSTS	696	1,620	15,140	0	0
AA SICK LEAVE BUY BACK	0	0	0	374	0
SUB-TOTAL	3,668,896	3,198,664	2,929,137	2,937,382	2,955,695
BB TRAVEL	51,017	59,399	55,086	54,674	44,308
BB CONFERENCE TRAINING	2,385	1,860	1,550	2,305	1,860
BB EMPLOYEE REIMBURS AP	0	0	0	1,929	0
BB EE REIMBURSEMENT	61	77	246	261	16
BB EMPLOYEE REIMBURS	188	227	242	142	5,333
SUB-TOTAL	53,651	61,563	57,124	59,311	51,517
CONTRACTED STUDENT INTERNS	30,339	30,151	225	29,513	7,290
SUB-TOTAL	30,339	30,151	225	29,513	7,290
DD FRINGE	1,015,522	871,791	1,015,463	979,676	821,784
DD MEDICAL EXPENSES	19	0	0	2,092	0
DD BOND	0	0	(445)	445	2,093
DD WC CHARGEBACK	932	0	43,845	14,575	44,072
DD HEALTH SERVICES CORP	0	0	2,267	0	0
SUB-TOTAL	1,016,472	871,791	1,061,130	996,788	867,949
EE RENTAL/MV CHRG-BACK	0	0	0	473	1,134
EE DEST. OLD RECORDS	0	6,715	6,840	7,201	7,201
EE ADVERTISING	0	0	0	232	0
EE BOOKS/SUPPLIES	45,675	44,168	41,999	25,650	27,127
EE IMPARTIAL APPEALS	18,612	26,825	15,963	14,400	13,950
EE CENTRAL REPRO.	7,950	999	0	0	2,615
EE POSTAGE	25,058	46,655	27,500	39,750	9,910
EE WATER	1,430	1,421	948	1,814	974
EE TRAINING / TUITION	500	298	0	0	0
EE TEMP USE SPACE	176	325	184	0	2,245
EE PRINTING	2,421	4,870	3,255	3,289	1,345
EE CONFERENCE, INCIDEN.	5,464	3,337	7,422	7,075	0
EE INDIRECT COSTS	103,330	70,012	63,989	92,657	94,063
EE POSTAGE CHRG-BACK	2,246	1,382	2,390	2,182	2,211
EE MEMBERSHIPS	1,625	3,450	625	0	0
EE STATE SINGLE AUDIT CHGBK	398	117	0	0	0
SUB-TOTAL	214,884	210,574	171,115	194,723	162,775
FF MED SUP/TOILETRIES & PERSONL	10,027	71	90	1,189	937
FF STATE OFFICE MAINTENANCE	92,586	0	0	0	0
SUB-TOTAL	102,614	71	90	1,189	937
GG BOSTON LEASE	491,459	454,249	475,576	457,916	626,923
GG ELECTRICITY - BOSTON	0	0	0	1,384	20,970
GG FUEL FOR VEHICLES	4	570	0	0	0
SUB-TOTAL	491,463	454,819	475,576	459,300	647,893
HH CONSULTANTS	202,104	169,029	209,757	128,511	238,027
SUB-TOTAL	202,104	169,029	209,757	128,511	238,027

PRIVATE TRUST FUND	FY'14	FY'13	FY'12	FY'11	FY'10
JJ OPERATIONAL SERV.	166,411	194,367	182,534	229,083	167,589
SUB-TOTAL	166,411	194,367	182,534	229,083	167,589
KK EQUIPMENT	8,092	4,951	1,150	172,899	31,564
SUB-TOTAL	8,092	4,951	1,150	172,899	31,564
LL AUTOMOBILE RENT/LEASE	58,710	42,257	43,027	43,703	46,952
LL OFFICE EQUIP RENT/LEASE	1,747	1,269	983	978	977
LL PRINT/COPY EQUIP RENT/LEASE	6,761	5,392	4,186	3,574	0
LL OFFICE EQUIP MAINTENANCE	358	351	1,396	1,572	727
LL PRINT/COPY EQUIP MAINT	410	222	370	472	341
SUB-TOTAL	67,986	49,491	49,962	50,299	48,997
UU TELECOM SERVICES - DATA	27,618	21,512	24,366	11,065	15,344
UU TELECOM SERVICES - VOICE	30,382	27,119	13,651	15,527	17,832
UU SOFTWARE LICENSES	29,199	1,223	6,969	5,555	20,672
UU INFO TECH CHARGEBACK	24,078	72,147	26,862	35,290	36,481
UU INFO TECH PROFESSIONALS	7,278	1,563	4,073	10,061	22,535
UU INFO TECH CABLING	9	0	122	3,707	166
UU INFO TECH EQUIP PURCHASE	38,342	93,830	57,254	56,894	23,906
UU IT Telp LEASE-PURCHASE	0	48	47	0	0
UU INFO TECH MAINTENANCE	34,702	56,663	56,654	68,952	45,529
SUB-TOTAL	191,607	274,105	189,998	207,051	182,465
NN NON-MAJOR INFRA MAINT	723	0	1,845	9,936	1,850
NN INFRA MAINT TOOLS/SUPPLIES	10	5	3	0	0
NN HAZARDOUS WASTE	0	0	0	388	0
NN NON- HAZARDOUS WASTE	1,248	0	1,436	17,036	2,188
SUB-TOTAL	1,982	5	3,284	27,360	4,038
TT LOANS AND SPECIAL PMNTS	40	0	0	0	0
Sub-total	40	0	0	0	0
RR PENALTIES SEC. 8	0	200	0	0	0
SUB-TOTAL	0	200	0	0	0
TOTAL DEFENSE EXPENDITURES	6,216,542	5,519,780	5,331,082	5,493,490	5,366,736
TOTAL PRIV. TRUST EXPENDITURES	59,876,592	54,077,680	57,709,041	52,061,907	46,834,827

DIA - INCOME SUMMARY

INCOME SUMMARY	FY'14	FY'13	FY'12	FY'11	FY'10
Total Assessments (All 3 Funds)	50,224,950	60,111,617	82,117,762	81,341,709	75,178,677
Total Filing Fees	3,611,338	3,984,191	3,706,666	3,730,233	3,877,505
Total First Report Fines	139,222	55,758	115,300	137,905	24,931
Total SWOs	1,430,599	1,351,266	1,439,180	1,836,225	1,608,652
Total Misc. Fines	53,230	50,689	67,571	60,864	81,526
Total 5% Fines (Late Assess.)	139,446	111,973	344,349	268,393	45,498
Total Reimbursements	1,013,557	1,368,849	1,047,057	1,242,706	713,360
Total 30H	7,259	0	0	53,358	0
Total Other Trust Fund	0	0	0	0	0
Yr. Adj. for Refunds to TF	0	0	0	0	0
Total Interest	17,765	20,163	25,557	28,433	40,394
TOTAL INCOME	56,637,366	67,054,506	88,863,444	88,699,826	81,570,543

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

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H.1697	<i>Similar</i>	Impartial Medical Exams.....	2
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* 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 refilled 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 refilled 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.

$$\text{RATE} = \text{LOSS COST} \times \text{LCM}$$

[**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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