Massachusetts Workers' Compensation Advisory Council

FY'16 Annual Report

6/12/17

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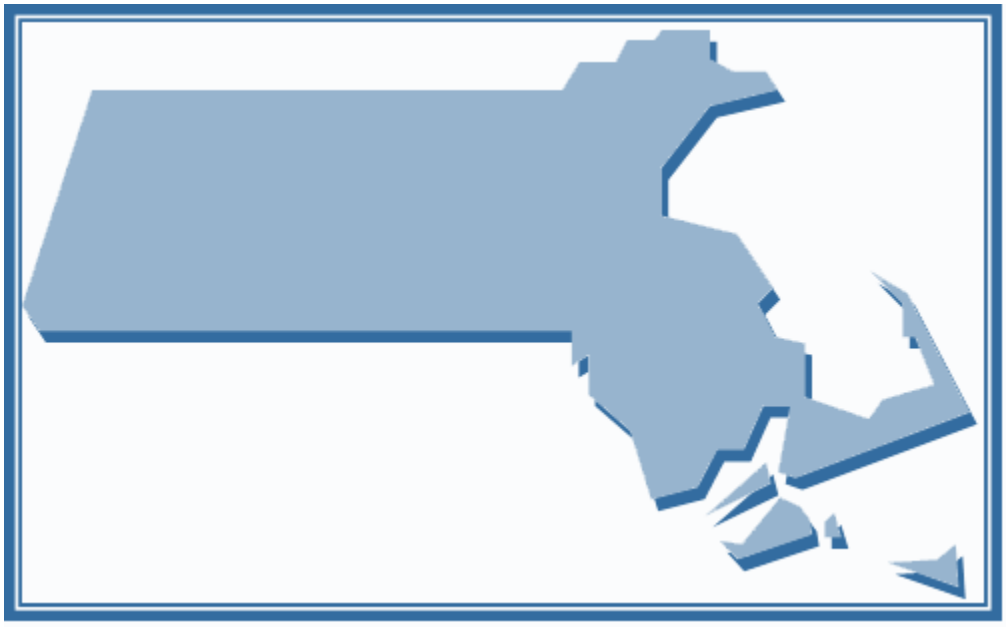
COMMONWEALTH OF MASSACHUSETTS

FISCAL YEAR 2016

ANNUAL REPORT

THE STATE OF THE MASSACHUSETTS

WORKERS' COMPENSATION SYSTEM



MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

JUNE 2017

www.mass.gov/wcac/

FISCAL YEAR 2016 ANNUAL REPORT

THE STATE OF THE MASSACHUSETTS WORKERS' COMPENSATION SYSTEM

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

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***John Regan, Vice-Chair** *(Associated Industries of Massachusetts)*
***Mickey Long** *(AFL - CIO)*
***James Steenbruggen** *(First Electric Motor Service, Inc.)*
***Stephen P. Falvey** *(New England Regional Council of Carpenters)*
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***John A. Pulgini** *(Laborers Union, Local 223)*
***Frank Ruel** *(Raytheon)*

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Ronald L. Walker, II *(Secretary, Executive Office of Labor and Workforce Development)*

STAFF:

Evelyn N. Flanagan *(Acting Executive Director)*

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GOVERNOR
KARYN E. POLITO
LIEUTENANT GOVERNOR

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ACTING EXECUTIVE DIRECTOR

June 12, 2017

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 2016 Annual Report: The State of the Massachusetts Workers' Compensation System. 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.

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.

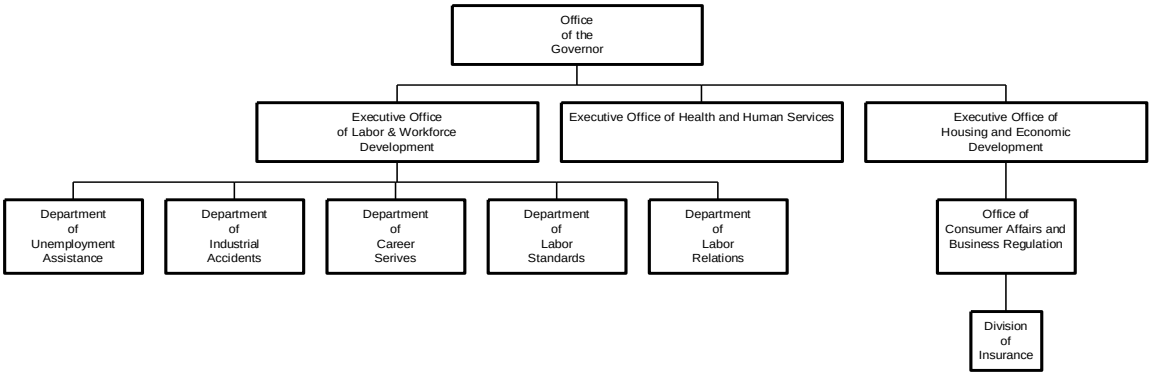
Very truly yours,

Stephen Joyce

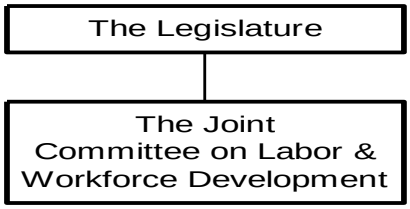
John R. Regan

Government Regulation of Workers' Compensation

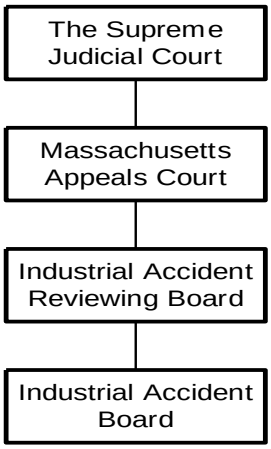
Executive Branch



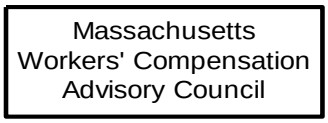
Legislative Branch



Appeals Process



Oversight



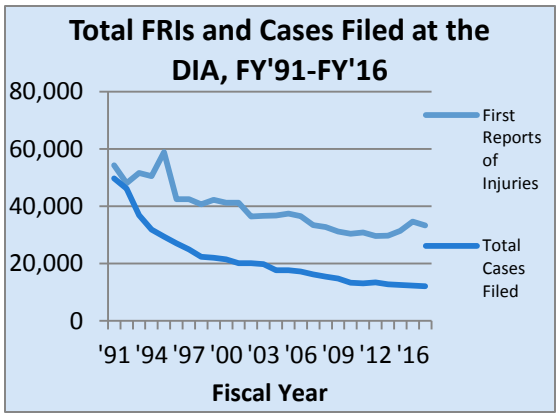
Note: The Advisory Council monitors and reports on all aspects of the workers' compensation system.

KEY FACTS AND FIGURES

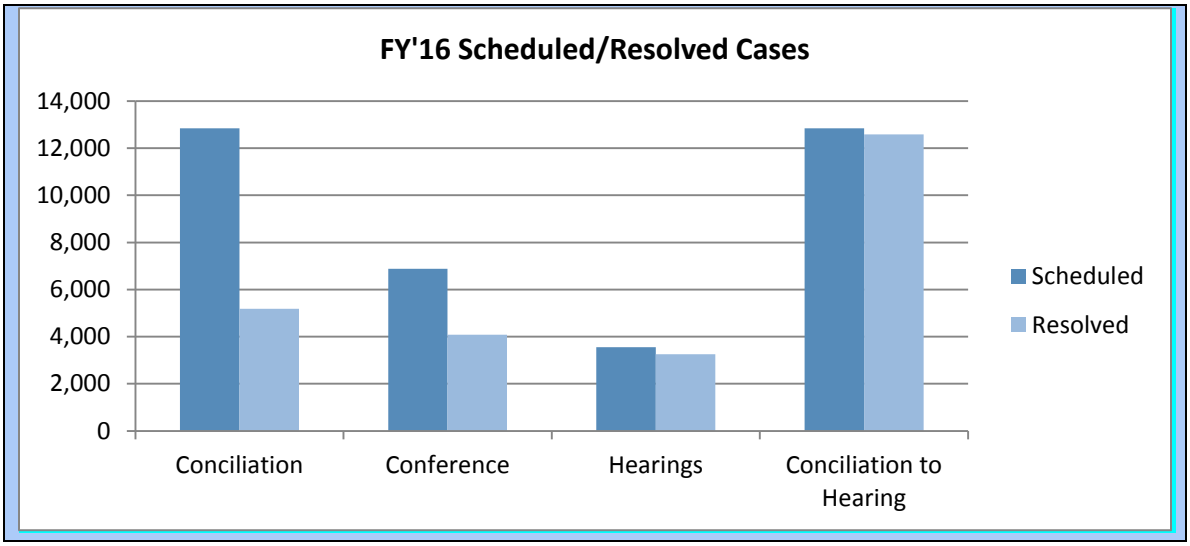
The Massachusetts workers' compensation system as it exists today is, in large part, the product of two significant reforms to the Workers' Compensation Act in 1985 and 1991. Today's system is more efficient and less costly than the period prior to these two important reforms. Below are some of the key facts and figures that define the Massachusetts workers' compensation system in FY'16:

Since 1985, 100% of funding for the Department of Industrial Accidents (DIA) is received from assessments on the employer community and statutory fines/fees. The DIA is not funded by general tax revenue.

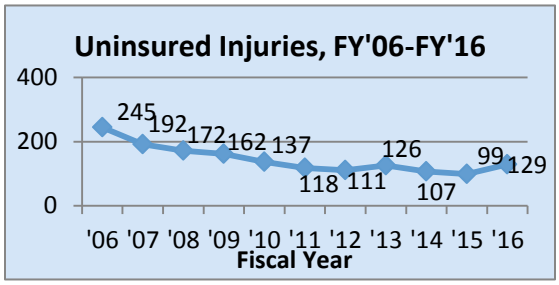
- The number of cases filed with the DIA has decreased 75% since 1991.
- The number of First Reports of Injury (FRIs) filed has **decreased 39%** since 1991.
- In FY'16, there were 129 uninsured injuries reported to the DIA.
- According to the "2016 Oregon Workers' Compensation Premium Summary" report, Massachusetts employers in the voluntary market pay the **eighth lowest workers' compensation premium rates in the country**.



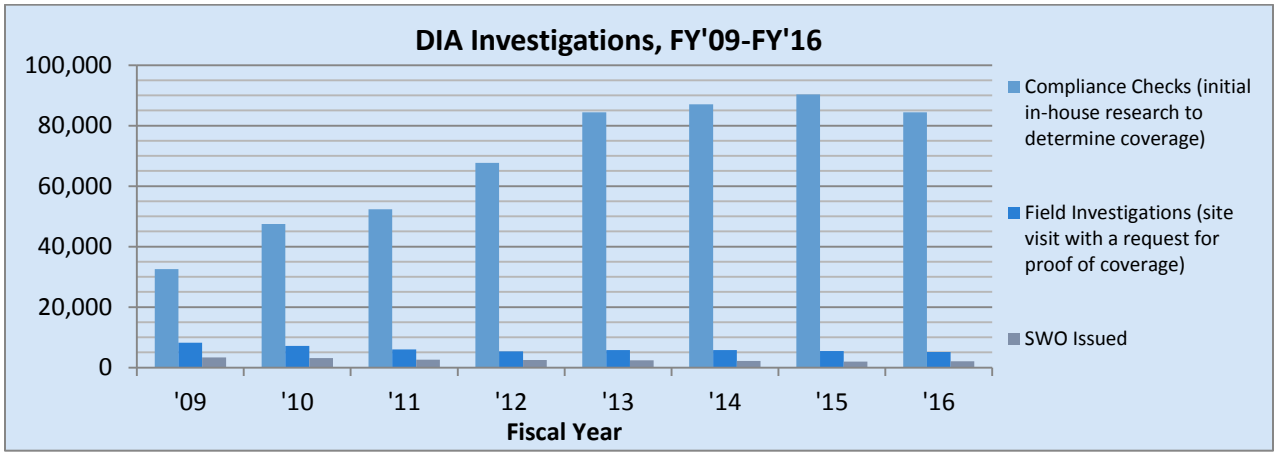
- In FY'16, 12,841 conciliations were scheduled and 5,183 (40%) were resolved; 6,874 conferences were scheduled and 4,078 (59%) were resolved; 3,555 hearings were scheduled and 3,257 (92%) were resolved. **The FY'16 Dispute Resolution system began with 12,841 conciliations scheduled and 12,581 (98%) resolved leaving about 2% of the cases moving forward and waiting for a decision.**



- Since the DIA's Office of Investigation began tracking the statistic in 2008, the Office estimates **over 60,000 new employees have been covered by workers' compensation insurance as a result of DIA investigations**.



- The DIA aggressively pursues uninsured employers to recoup monies paid out from the Trust Fund. During FY'16, **the DIA recouped $1,746,315 from uninsured employers and third parties**.



EXECUTIVE SUMMARY

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. The WCAC is statutorily mandated to report annually on the state of the Massachusetts workers' compensation system. Said report must include an evaluation of the operations of the Department of Industrial Accidents (DIA) along with recommendations for improving the workers' compensation system. The Advisory Council's FY'16 Annual Report contains six sections detailing operations at the DIA, including its dispute resolution process, as well as other aspects of the Massachusetts workers' compensation system. This Executive Summary highlights some of the key developments in FY'16 and identifies important metrics for evaluating the system's success.

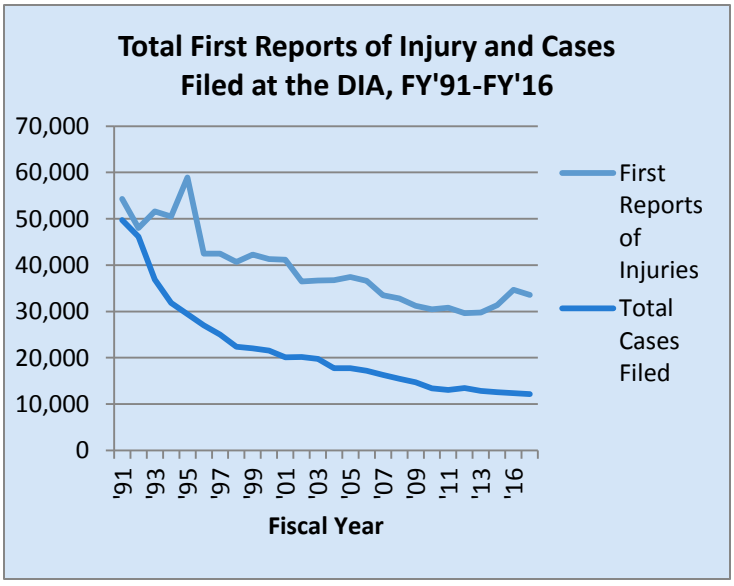
Workplace Injuries and Fatalities

The Massachusetts Department of Labor Standards partners with the U.S. Department of Labor, Bureau of Labor Statistics, to collect injury and illness, as well as fatality, data. The most recent survey found that in calendar year 2014, the private sector workforce in Massachusetts experienced an incidence rate of 2.7 cases per 100 full time equivalent employees (FTEs). The Massachusetts injury and illness rate has consistently remained lower than the national rate, which was 3.2 cases per 100 FTEs in 2014. Massachusetts also has the lowest incidence rate of work-related injuries or illnesses (resulting in lost work-time) among all other New England states.

In 2015, Massachusetts experienced 69 workplace fatalities, an increase of fourteen fatalities from the prior calendar year.

DIA Cases and Claims

A First Report of Injury (FRI) form must be filed with the DIA by the employer when an employee is injured, or alleges an injury, and is unable to earn full wages for five or more calendar days. The form must be filed within seven calendar days (not counting Sundays and legal holidays), from the fifth day of disability. In FY'16, the number of FRIs filed at the DIA increased approximately 4% from the previous fiscal year (FY'16: 34,660; FY'15: 33,353).

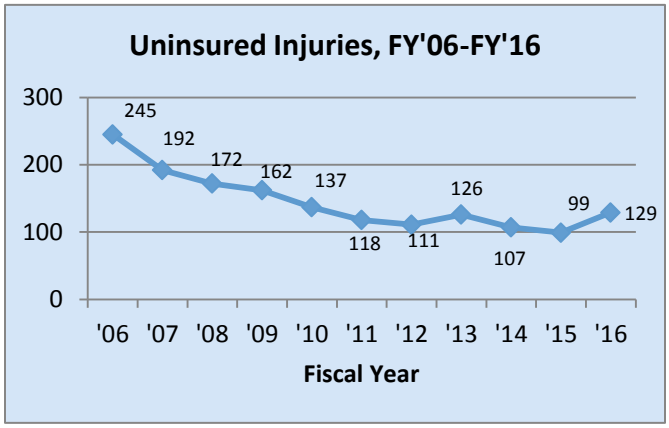


Dispute resolution cases originate at the DIA when any of the following are filed: an employee's claim for benefits, an insurer's complaint for termination or modification of benefits, a third party claim, a request for approval of a lump sum settlement, or a Section 37/37A (Second Injury Fund) request. In FY'16, the number of cases filed with the DIA increased less than 2% from FY'15 (FY'16:

12,342; FY'15: 12,150). As the chart above indicates, the number of cases filed with the DIA has decreased dramatically (75%) since 1991.

Uninsured Injuries

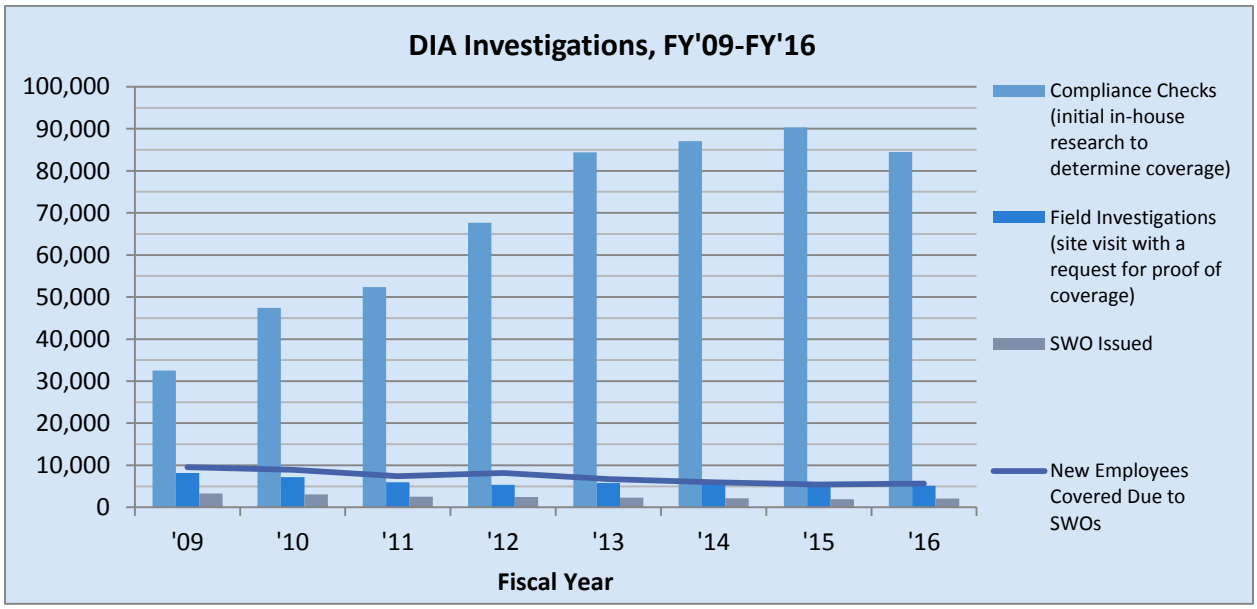
Section 65(2)(e) of the Workers' Compensation Act directs the Trust Fund to pay benefits resulting from approved claims against Massachusetts' employers who are uninsured in violation of the law. In FY'16, there were 129 uninsured injuries filed with the Trust Fund.



The DIA aggressively pursues uninsured employers to recoup monies paid out from the Trust Fund. During FY'16, the DIA recovered $1,746,315 through these recoupment efforts.

Enforcement

The DIA's Office of Investigations is charged with enforcing the workers compensation mandate by investigating whether employers are maintaining insurance policies and by imposing penalties when violations are uncovered. 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 immediately. In FY'16, the DIA issued 2,047 SWOs. The Office of Investigations estimates that almost 5,675 employees became covered by workers' compensation insurance in FY'16 as a result of the DIA's issuance of an SWO. Since the Agency began tracking the statistic in 2008, the Office of Investigations estimates that over 60,000 workers have become covered by workers' compensation insurance as a result of SWOs.



Dispute Resolution

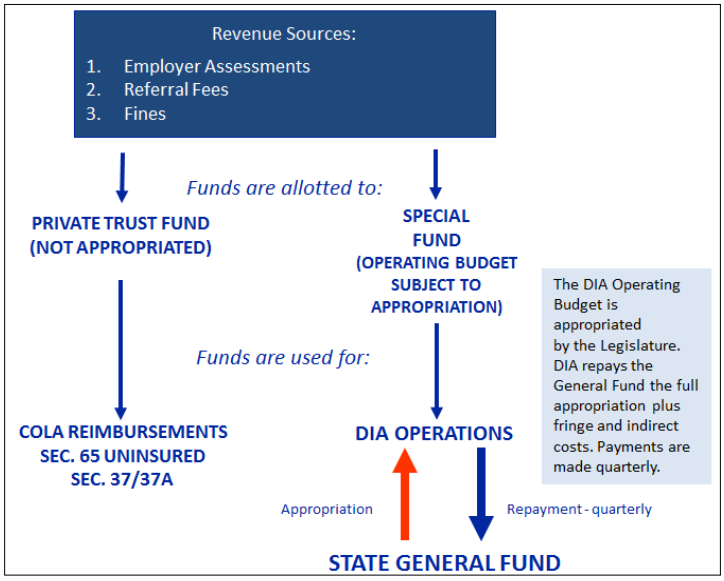
The DIA's dispute resolution process begins when a case is filed. After being filed, a case is scheduled for conciliation. The goal of conciliation is to resolve cases before formal adjudication through the dispute resolution system, thus promoting efficiency by reducing the number of claims that require conferences and hearings. In FY'16, approximately 40% of the claims filed with the DIA were resolved at conciliation. In FY'16, 12,841 conciliations were scheduled and 5,183 cases were resolved.

The next step of the dispute resolution process is the conference. The goal of the conference is to compile the evidence and identify the issues in dispute. In FY'16, 6,874 conferences were scheduled at the DIA, a 3% decrease from the previous year. If the dispute is not resolved following the conference, a hearing will be scheduled. In FY'16, the DIA scheduled 3,555 hearings, a slight decrease over FY'15. Finally, hearing decisions can be appealed to the DIA's Reviewing Board. In FY'16, 137 hearing decisions were appealed to the Reviewing Board.

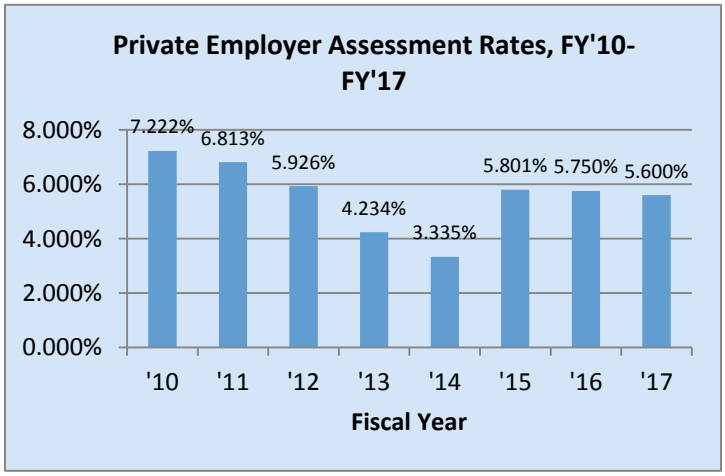
DIA Funding & Assessments

Prior to the 1985 Reform Act, the 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. The DIA is not funded by general tax revenue. The chart to the right sets forth the DIA's funding structure.

DIA Funding Mechanism

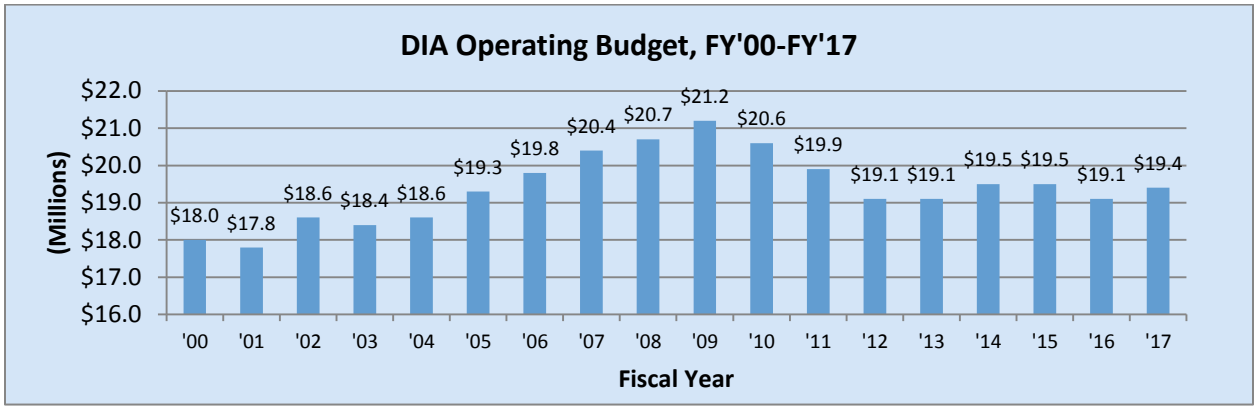


Employers fund the DIA through an assessment on their workers' compensation insurance premiums. For FY'17, the private employer opt-in assessment rate was calculated to be 5.600% of standard premium, a decrease from the FY'16 rate (5.750%).



The operating budget of the DIA is appropriated by the Legislature even though employer assessments fund the Agency. On July 8, 2016, Governor

Charles D. Baker signed the FY'17 General Appropriations Act (GAA), which allocated $19,412,000 for DIA operating expenses (line item 7003-0500). As shown in the chart above, the DIA's operating expenses are appropriated by the General Fund, but the Agency, using funds collected through employer assessments, repays the General Fund the full amount of the appropriation, plus fringe and indirect costs.



Insurance Coverage

In Massachusetts, workers' compensation insurance rates are determined through an administered pricing system. Insurance rates are proposed by the Massachusetts Workers' Compensation Rating and Insurance Bureau (WCRIB) on behalf of the insurance industry and set by the Commissioner of Insurance. On April 20, 2016, Insurance Commissioner Daniel R. Judson approved a 1.5% increase to the average workers' compensation rates for policies taking effect on or after July 1, 2016.

Advisory Council Concerns and Recommendations

The WCAC has identified four areas of concern with the workers' compensation system in the Commonwealth and has offered recommendations to address them.

1. DIA Funding

Since 1985, the DIA has operated as an employer-funded, rather than a 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'16, 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. 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.

2. Late Decisions

Periodically, the Advisory Council is provided with information on administrative judges with hearing decisions outstanding for more than six months. At a time when cases entering the dispute resolution

system have dropped below 13,000, the number of decisions outstanding is troublesome to Council members. The Advisory Council proposes the Senior Judge examine and define appropriate time frames in which to evaluate judicial performance levels. It is the Council's recommendation that those judges who fail to meet the performance levels of their peers be issued appropriate discipline measures, including the process of statutory removal as delineated by M.G.L. c.23E, §8, when necessary.

3. Employer Fraud

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. The Advisory Council recommends continued vigilance by the DIA in investigating, issuing stop work orders to employers operating without workers' compensation insurance and pursuing uninsured employers to recoup funds paid by the Trust Fund. Additionally, 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. Finally, 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.

4. Opioids

According to the Centers for Disease Control and Prevention (CDC), the nation is currently experiencing an epidemic of prescription painkiller abuse. Opioid prescribing continues to fuel the epidemic. Today, at least half of all U.S. opioid overdose deaths involved a prescription opioid. In 2014, more than 14,000 people died from overdoses involving prescription opioids[1]. 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. The Advisory Council recognizes the efforts of policymakers to address the issue. The Advisory Council will continue to monitor legislation filed by the Governor, as well as other efforts, to address the problem of opioids in the Massachusetts workers' compensation system.

Legislation

During FY'15 the Advisory Council voted to support one piece of legislation (House Bill 1427) and oppose four others (House Bill 1684/ Senate Bill 976; House Bill 1686; and House Bill 1726). House Bill 1427, supported by the Advisory Council, 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. Penalties would include a fine of up to $250,000 or one year imprisonment, or both, for a first offense. 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

[1] Centers for Disease Control and Prevention CDC 24/7: Saving Lives, Protecting People – Prescription Opioid Overdoes Data.

funded contracts for a period of three years. On March 9, 2016, the Advisory Council voted in opposition to House Bill 3972 (Rep. DiNatale), An Act allowing insurers the right to deny workers' compensation to a worker who is 65 years or older and out of work for two years, unless a presumption that the individual would be out of the workforce could be overcome. The bill would add §34A permanent and total disability to M.G.L. c.152, §35E. On March 14, 2016, the Advisory Council sent a letter in opposition to House Bill 3972 to the House Committee on Bills in the Third Reading (see Appendix J).

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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.[2] 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.

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

FISCAL YEAR 2016 IN REVIEW

The Massachusetts workers' compensation system continued to experience changes in fiscal year (FY) 2016 driven by economic conditions, administrative initiatives, a rate stipulation and other factors. The total number of cases filed at the Department of Industrial Accidents (DIA) increased slightly (2%) in FY'16 over FY'15 (FY'16: 12,342; FY'15: 12,150). This modest increase is the first increase since FY'12. Below is an overview of some of the highlights which have influenced the Massachusetts workers' compensation system during FY'16:

On April 29, 2015, the DIA issued Circular Letter #348 relative to revising the assessment filing process. That letter was placed on hold to review the process before implementation.

On July 8, 2015, the Advisory Council voted to support House Bill 1427. House Bill 1427 would penalize employers that participate in public contracts when they are debarred. Currently, there is no penalty for doing so. 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.

On July 17, 2015, Governor Charles D. Baker signed the FY'16 General Appropriations Act (GAA), which allocated $19,144,105 for the Department of Industrial Accidents (DIA) operating expenses (line item 7003-0500). The amount was $411,099 less than the amount appropriated to the DIA in the FY'15 GAA ($19,555,204) and $685,895 less than the amount proposed by the Governor in House Bill 1.

On August 12, 2015, the Department of Industrial Accidents announced the tightening of the Stop Work Order (SWO) process. This process provided both in-house and outside collection efforts, including working with a collection agency and writing off uncollectible debt. For the first time in the history of the agency the DIA does not have an overhang and the books are now clean. At the same time, the agency announced that they had expanded their internal audit group to improve its assessment review process. The group's main focus would be to audit insurance companies and self-insurance groups.

In October of 2015, the Department of Industrial Accidents began conducting a series of public comment sessions on its existing regulations, 452 CMR §§1.00-8.07, pursuant to Executive Order 562 issued by Governor Baker to determine whether each section and subsection in the regulation is consistent with state law and to strike out any redundancies. The sessions were scheduled to allow comments by members of the public and interested stakeholders in the Massachusetts workers' compensation system.

On October 5, 2015, the DIA issued Circular Letter #349 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 State Average Weekly Wage (SAWW) effective October 1, 2015 is $1,256.47**.** The SAWW is used to calculate benefit limits and attorneys' fees available under M.G.L. c. 152.

On October 14, 2015, Dr. Simon Talbot, Director of the Upper Extremity Transplant Program at Brigham and Women's Hospital and Assistant Professor at Harvard Medical School gave a presentation on Upper Extremity Transplantation in workers' compensation cases where an injured worker has lost a limb. The implications for the injured workers are clear since industrial accidents are a leading cause of upper extremity amputations and it is possible that in the future transplant will be a treatment option for workers' compensation claimants. For those injured workers who are candidates for a transplant, Dr. Talbot explained the important benefits transplantation had on the major psychological and physical isolation problems faced by amputees after a workplace injury. The upfront cost of a transplant is high compared to prosthetics and although a few of the insurance companies treat some areas of the hand transplant surgeries coverage is not universal.

On October 14, 2015, the Massachusetts Bar Association Continuing Legal Education (MCLE) hosted a seminar to address the overwhelming increase in deaths from opioid addiction. Opioid addiction has reached epidemic proportions for many injured workers with disabling injuries who face addiction issues resulting from the long-term use of narcotic medication. The panel of speakers included attorneys, treating physicians, the Chair of the Governor's Task Force on Opioid Addiction, the Senior Judge of the DIA and members of the Mass Bar's Alternative Mediation Program for Opioid Addiction, which is currently being implemented in several DIA regions.

On October 23, 2015, the Massachusetts DIA participated in a Tri-State educational workers' compensation conference with Rhode Island and New Hampshire. The conference was presented by the Massachusetts Academy of Trial Attorneys, the New Hampshire Association for Justice and the Rhode Island Association for Justice and was held at Patriot Place in Foxboro, Massachusetts. The conference titled "Workers' Comp and Circumstance: Practicing in MA, NH, RI and in Between" was an all-day educational outreach program highlighting the differences in the three states and identifying best practices as well as border issues in each system.

In October of 2015, the Workers' Compensation Research Institute (WCRI) released *CompScope™ Medical Benchmarks for Massachusetts, 16th Edition*, studying injury claims in 16 other states. Claims were analyzed with experience through 2014 for injuries up to and including 2013. The goal of the study was to analyze how state systems compared to one another and how they changed over time. WCRI reported that medical payments for employers in Massachusetts were among the lowest cost per claim with more than seven days of lost time among the 17 states studied. The main reason for the lower use of medical services in Massachusetts is attributed to regulations of both prices and utilization of services.

In November of 2015, the DIA formed a working group regarding Circular Letter #348, which pertains to the assessment collection process. The working group consisted of representatives from the insurance industry, the Workers' Compensation Rating and Inspection Bureau (WCRIB), the Division of insurance (DOI), and the DIA. The purpose of the group is to consider improvements to the assessment reconciliation process. The group made significant progress and reached a consensus on a number of recommendations.

On December 7, 2015, the Supreme Judicial Court denied a petition for further appellate review by The Home Insurance Company (in liquidation) in The Home Insurance Company v. Workers' Compensation Trust Fund. The Trust Fund refused to reimburse Cost of Living Adjustments (COLA) to Home Insurance Company, after entering liquidation, since it was no longer an "insurer" entitled to COLA reimbursement. Insolvent insurers are not entitled to be reimbursed by the Trust Fund because the Trust Fund is a pay as you go system. If a company has gone insolvent, they no longer collect funds from the employers and therefore are not entitled to be reimbursed by the Trust Fund.

On December 9, 2015, Dr. John Buress, Medical Director at Boston Medical Center, Department of Occupational and Environmental Medicine and Assistant Professor of Family Medicine at Boston University Medical School, gave a presentation on health care delivery in the workers' compensation system and the impact of the outdated medical fee schedules detailing the situation facing occupational health doctors. Dr. Buress explained that treating injured workers in Massachusetts is a non-viable business opportunity and that his center was going to be outsourced, which would make it the 22nd occupational health center to close in this state since the impact of the 1991 Reform which locked reimbursement rates in place.

On December 23, 2015, the Workers Compensation Rating and Inspection Bureau of Massachusetts (WCRIB) submitted its rate filing to the Division of Insurance proposing a 6.4% increase with an effective date of July 1, 2016. On January 29, 2016, the Commissioner of Insurance held a hearing and on April 20, 2016, he released his decision of a 1.5% increase to the average rates effective July 1, 2016. The increase of 1.5% was the result of a settlement between the State Rating Bureau, the WCRIB and the Office of the Attorney General.

In January of 2016, the DIA announced that it was continuing its efforts to review opioid use within the context of workers' compensation claims. A committee of stakeholders convened with insurer representatives, employee representatives and Administrative Judges. The group discussed what could be done within the confines of M.G.L. c.152 and developed a pilot Opioid Alternative Treatment Pathway (OATP). The pilot program would be voluntary and would involve only post-lump sum cases where medical treatment is at issue. The new program would allow parties to complete a form with supporting documents to enter the OATP if both parties agreed to do so. The case is then referred to a mediating judge who will bring the parties together to try to develop a treatment plan by assigning a care coordinator to assist the, schedule appointments and identify medical providers. The pilot program was later approved by Governor Baker on October 5, 2016.

On February 10, 2016, Attorney Alan Pierce gave a presentation on the national trends developing in the world of workers' compensation. Workers' compensation very rarely makes national news or gathers national attention because what is happening in one state does not directly affect another state. These national trends concern key issues such as opt-out (company sponsored plans that do not provide equivalent benefits), constitutional challenges (whether the workers' compensation system is satisfying their constitutional mandate), and cost-shifting (use of other health insurance or public resources to cover treatments) and the negative impact it could have on the workers' compensation system.

On March 9, 2016, the Workers' Compensation Advisory Council (WCAC) voted to oppose House Bill 3972 "An Act Relative to Workers' Compensation" which would allow insurers to deny workers' compensation benefits to a worker who is 65 years or older and out of the workforce two years, unless a presumption that the individual would be out of the workforce could be overcome. The Council approved the vote and moved to communicate their opposition to the House Committee on Third Reading (see Appendix J).

On April 13, 2016, the Executive Director of the Advisory Council announced that this would be his last meeting. The Executive Director explained that he had an opportunity to stay in the field and to do some exciting work. The Executive Director thanked everyone for their support during the last 4.5 years.

April 28, 2016, marked the 28th 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.

In May of 2016, the Department of Industrial Accidents introduced its' Opioid/Controlled Substance Protocol. The Protocol is intended to promote the delivery of safe, quality health care to injured workers; ensure patient pain relief and functional improvement; be used in conjunction with other treatment guidelines, not in lieu of other recommended treatment; prevent and reduce the number of complications caused by prescription medication, including addiction; and recommend opioid prescribing practices that promote functional restoration.

In May of 2016, the DIA introduced a revised Chronic Pain Treatment Guideline. Chronic pain represents a specific diagnosis which refers to pain which outlasts the expected duration of the healing time for tissue injury. Chronic pain may be associated with psychosocial problems and thus the treatment should include evidence-based psychological treatment when indicated. This clinical guideline has been created to consistently improve health care services for injured workers by outlining the appropriate evaluation and treatment processes for the management of chronic pain which has been determined to be work related.

During the week of June 5, 2016, the DIA announced that they were seeking applications for the positions of Administrative Judges (AJ) and Administrative Law Judges (ALJ). As of that date, the agency had twelve vacancies through retirements and expiration of six year terms. Qualified candidates had to file applications by the close of business on Monday, July 18, 2016.

On June 30, 2016, the Massachusetts Supreme Judicial Court upheld a previous ruling and debarment penalty imposed on New England Survey Systems, Inc. (NESS) in New England Survey Systems, Inc. vs. Department of Industrial Accidents. NESS argued that it should not be debarred by the DIA from government business because of the placement of a comma in the statute. NESS admits that it failed to

provide insurance but the state is required to prove that NESS's failure was motivated by a desire to avoid high premium rates. The court said that the legislative history added the penalty of debarment for noncompliance in an effort to compel employers to comply with their obligation.

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: NO GENERAL TAXPAYER REVENUE IS USED TO FUND THE DIA.[3] THE AGENCY IS 100% FUNDED BY EMPLOYER ASSESSMENTS, AS WELL AS STATUTORY FEES AND FINES. THE ADVISORY COUNCIL IS CONCERNED THAT IN RECENT YEARS, POLICYMAKERS HAVE TREATED THE DIA AS A TAX-FUNDED AGENCY, REDUCING THE AGENCY'S BUDGET AND IMPOSING MIDYEAR REDUCTIONS AND ACCOUNT TRANSFERS. THE ADVISORY COUNCIL IS CONCERNED THAT THESE ACTIONS 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 is just one of only a handful of agencies in Massachusetts with no financial impact on the state's General Fund. There are **no tax dollars** used to fund this agency or any of its activities. In fact, the DIA receives 100% of its funding from assessments paid by the state's employer community and the collection of filing fees and fines for violations of Chapter 152. Due to this unique, self-sustaining, employer-funded mechanism, General Fund revenues should have no impact on the agency's budget. The Advisory Council is concerned that during the Commonwealth's budget process, including FY'16, the DIA continues to be treated as a tax-funded, rather than assessment-funded, agency. The Advisory Council believes that a shortage in General Fund revenue should not cause a reduction in the DIA's budget or the transfer of accounts as it had been in the past.

The DIA administers three separate budgets, which are funded solely by assessments on workers' compensation policies, fines for various infractions against the Workers' Compensation Act, and fees collected by the agency. The three Funds are made up of the Special Fund, the Private Trust Fund, and the Public Trust Fund. All income received by the DIA is deposited into one of three funds. The Special Fund is used to pay for the operating expenses of the agency. The Special Fund's annual budget is appropriated by the legislature as contained in the General Appropriations Act. The Trust Funds were established so the DIA can make statutory payments to uninsured employees and those denied rehabilitation services by their insurers. In addition, the Trust Funds must reimburse insurers for benefits paid for injuries involving veterans, second injuries, latency claims, and for specified cost of living adjustments.

[3] The DIA's operating expenses are appropriated by the General Fund, but the Agency repays the General Fund the full amount of the appropriation, plus fringe and indirect costs. Therefore, the Agency has no net negative impact on the General Fund.

We note here that in June of 2016, the Secretary of Administration and Finance exercised her authority under G.L. c. 29, §13A to reallocate funds from certain trust fund accounts in order to supplement the state's General Fund. In the course of this reallocation, which encompassed several state funds and agencies, the Public Trust Fund account, with a balance of $409,000, was included in this reallocation in its entirety. It is also pertinent to note that all public self-insured entities that had been contributing to the Public Trust Fund, have opted out of those obligations. There have been no expenditures in the Public Trust Fund since Fiscal Year 2011.

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. The agency was so financially strapped that at one point in 1983, the DIA ran out of money for stamps, requiring insurers and law firms to pick up their own mail – mail which contained judicial orders with 10-day appeal deadlines. One practicing attorney dubbed the DIA, "the most neglected orphan in the judicial system in the Commonwealth."

In November of 1983, Governor Michael Dukakis appointed industry experts to a Governor's Task Force on Workers' Compensation (Task Force) to identify systemic problems and suggest necessary reforms. 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 and in 1985 the Legislature agreed and adopted the recommendation of the Task Force, transferring the Agency's cost burden from the General Fund to the Commonwealth's employer community through assessments. The statute requires all revenue from assessments, be kept in accounts, "separate and apart" from all other monies received by the Commonwealth [M.G.L. c.152, §65(6)].

The move to an independently funded system transformed the Agency almost immediately. 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. Late Hearing Decisions Outstanding

CONCERN: THE ADVISORY COUNCIL IS PERIODICALLY PROVIDED WITH INFORMATION ON ADMINISTRATIVE JUDGES WITH HEARING DECISIONS OUTSTANDING FOR MORE THAN SIX MONTHS. AT A TIME WHEN CASES ENTERING THE DISPUTE RESOLUTION SYSTEM HAVE DROPPED BELOW 13,000, THE ADVISORY COUNCIL IS CONCERNED WITH THE NUMBER OF DECISIONS OUTSTANDING.

RECOMMENDATION: THE ADVISORY COUNCIL RECOMMENDS THAT THE SENIOR JUDGE EXAMINE AND DEFINE APPROPRIATE TIME FRAMES IN WHICH TO EVALUATE PERFORMANCE LEVELS AND THAT THOSE JUDGES WHO FAIL TO MEET THE PERFORMANCE LEVELS OF THEIR PEERS BE ISSUED APPROPRIATE DISCIPLINE MEASURES, INCLUDING THE PROCESS OF STATUTORY REMOVAL AS DELINEATED BY M.G.L. C.23E, §8, WHEN NECESSARY.

The primary objective of workers' compensation is to provide an effective delivery system to all parties with the prompt adjudication of claims. Therefore, maintaining an efficient dispute resolution system is a central task of the DIA. The time between the first hearing and the hearing decision marks the distinct beginning and end points of the most lengthy, complicated and formal stage of the dispute resolution process at the DIA. Many aspects of this time frame are determined by the actions of the parties. According to M.G.L. c.152, §11, a "…decision shall issue within twenty-eight days of the conclusion of the hearing."

On March 1, 2016, the Workers' Compensation Review Board filed a decision in the case of Albert Mancini vs. Suffolk County Sheriff's Department. The case was open for over three years with no decision written. This case brought to light a problem with outstanding decisions for more than six months. As part of the decision written by the Review Board, one judge concurred with the ruling and further found that "…the judge's failure to file a decision over three and one-half years makes it *the* paramount issue in this case, as the harm they have suffered has been caused, or exacerbated, by the judge's failure to honor the letter, and spirit, of the law." However, in Dunphy v. Shaws Supermarket, 9 Mass. Workers' Comp. Rep., 473, 474 n.2 (1995), the court held that "the administration of multitudinous cases often make this ideal unattainable" in response to the statutory timeframe of "no more than twenty-eight days following the close of the testimony."

The DIA Administrative Judges decide complicated and often heavily litigated cases. They must examine complex medical evidence, weigh conflicting testimony, and make credibility determinations in order to issue a decision. Despite that more than three-quarters of all decisions issue within six months, and 95 percent are filed within one year. That means that a very small percentage of cases experience delays beyond that. The Department is continuously working on ways to expedite processes and improve timeliness in all cases.

For historical purposes, in 1997, the average number of outstanding hearing decisions per Administrative Judge was eight. In 2001, the average number of outstanding[4] hearing decisions per Administrative Judge was 9.7. In June 2016, the average number of outstanding hearing decisions per Administrative Judge was two.

[4] A Hearing decision is considered outstanding if not filed within six months of the record close date.

From 1991-1997, 75% of Hearing decisions were written within six months and 94% of Hearing decisions were written within one year. There were 10,872 total decisions filed and six (0.0005%) decisions were filed after 36 months. From 1998-2004, 76% of Hearing decisions were written within six months and 93% of Hearing decisions were written within one year. There were 5,549 total decisions filed and four (0.0007%) decisions were filed after 36 months. From 2005-2010, 77% of Hearing decisions were written within six months and 93% of Hearing decisions were written within one year. There were 3,701 total decisions filed and seven (0.0001%) decisions were filed after 36 months.

From 2011 to June 2016, 76% of Hearing decisions were written within six months and 94% of Hearing decisions were written within one year. From 2011-2014, there were 1,466 total decisions were filed and three (0.002%) decisions were filed after 36 months. From 2015-2016, there were 661 total decisions filed and only one (0.001%) decision was filed after 36 months.

At a time when cases entering the dispute resolution system have dropped below 13,000, the number of decisions outstanding is troublesome to Council members. The Advisory Council proposes the Senior Judge examine and define appropriate time frames in which to evaluate judicial performance levels. It is the Council's recommendation that those judges who fail to meet the performance levels of their peers be issued appropriate discipline measures, including the process of statutory removal as delineated by M.G.L. c.23E, §8, when necessary.

3. Employer Fraud – Misclassification and Uninsured Employers

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

RECOMMENDATION #1: 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 (SWOs) 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 over 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 # 2: 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 #3: THE ADVISORY COUNCIL RECOMMENDS THAT THE DIA PURSUE PUBLIC AWARENESS STRATEGIES TO ENSURE THAT ANYONE WHO EMPLOYS WORKERS 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 #4: 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. The Advisory Council supports legislation (House Bill 1427) which seeks to impose penalties in such situations (up to a $250,000 fine or one year imprisonment for a first offense).

4. 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 14,000 PEOPLE DIED IN THE UNITED STATES FROM PRESCRIPTION PAINKILLER OVERDOSES. 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 impact for individuals and their families can be devastating.

According to the Centers for Disease Control and Prevention (CDC), the nation is currently experiencing an epidemic of prescription painkiller abuse. Opioid prescribing continues to fuel the epidemic. Today, at least half of all U.S. opioid overdose deaths involved a prescription opioid. In 2014, more than 14,000

people died from overdoses involving prescription opioids[5]. 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.

In 2015, Governor Charlie Baker convened an opioid working group to combat the opioid epidemic by addressing prevention, intervention, treatment and recovery. Following up on the group's efforts, the Governor filed legislation in October 2015 to address the crisis. In January of 2016, the DIA announced that it was continuing its efforts to review opioid use within the context of workers' compensation claims. A committee of stakeholders convened with insurer representatives, employee representatives and Administrative Judges. The group discussed what could be done within the confines of M.G.L. c.152 and developed a pilot program called the Opioid Alternative Treatment Pathway (OATP). The pilot program was later approved by Governor Baker on October 5, 2016.

Massachusetts has taken a number of steps to address the issue of prescription drug abuse over the last few years. In March of 2016, Massachusetts became the first state in the U.S. to pass a seven-day limit on opioid prescriptions. In May of 2016, the Department of Industrial Accidents introduced its' Opioid/Controlled Substance Protocol promoting the delivery of safe, quality health care to injured workers; ensure patient pain relief and functional improvement. The Advisory Council will continue to monitor the progress of the Governor's legislation, as well as other efforts to address the problem of opioids in the Massachusetts workers' compensation system

[5] Centers for Disease Control and Prevention CDC 24/7: Saving Lives, Protecting People – Prescription Opioid Overdoes Data.

LEGISLATION

During the 2015-2016 Legislative Session, approximately 30 bills were filed by the House and Senate seeking to alter the workers' compensation system (see Appendix N 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).

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 2015-2016 Legislative Session, the Advisory Council voted to support the passage of House Bill 1427 (Rep. Keefe), An Act Regarding Fair Business Practices in the Commonwealth. 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. On July 30, 2015, the Advisory Council sent a letter in support of House Bill 1427 to the Joint Committee on the Judiciary (see Appendix H).

The Council also voted in opposition to House Bill 1684 (Rep. Bradley)/ Senate Bill 976 (Sen. Eldridge), An Act Increasing Injured Workers' Access to Medical Care and Workers' Compensation Benefits; House Bill 1686 (Rep. Bradley), An Act Relative to Workers Compensation Law Governing Certain Applicable Wages and Fees; and House Bill 1726 (Rep. Bradley), An Act Relative to Fairness in Workers' Compensation Benefits. On July 30, 2015, the Advisory Council sent a letter in opposition to House Bill 1684, Senate Bill 976, House Bill 1686, and House Bill 1726 to the JCLWD (see Appendix I).

On March 9, 2016, the Advisory Council voted in opposition to House Bill 3972 (Rep. DiNatale), An Act allowing insurers the right to deny workers' compensation to a worker who is 65 years or older and out of work for two years, unless a presumption that the individual would be out of the workforce could be overcome. The bill would add §34A permanent and total disability to M.G.L. c.152, §35E. On March 14, 2016, the Advisory Council sent a letter in opposition to House Bill 3972 to the House Committee on Bills in the Third Reading (see Appendix J).

SUMMARY OF BENEFITS

An employee who is injured in the course of their employment is eligible for workers' compensation benefits as set forth in 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 2016, the SAWW increased to $1,291.74, a 2.8% ($35.47) increase from the October 2015 amount ($1,256.47). 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, 1995-2016

Effective Date (Effective Oct 1st)	Maximum Benefit (100% of SAWW)	Minimum Benefit (20% of SAWW)
10/1/95	$604.03	$120.81
10/1/96	$631.03	$126.21
10/1/97	$665.55	$131.11
10/1/98	$699.91	$131.98
10/1/99	$749.69	$149.93
10/1/00	$830.89	$166.18
10/1/01	$890.94	$178.19
10/1/02	$882.57	$176.51
10/1/03	$884.46	$176.89
10/1/04	$918.78	$183.76
10/1/05	$958.58	$191.72
10/1/06	$1,000.43	$200.09
10/1/07	$1,043.54	$208.71
10/1/08	$1,093.27	$218.65
10/1/09	$1,094.70	$218.94
10/1/10	$1,088.06	$217.61
10/1/11	$1,135.82	$227.16
10/1/12	$1,173.06	$234.61
10/1/13	$1,181.28	$236.26
10/1/14	$1,214.99	$243.00
10/1/15	$1,256.47	$251.29
10/1/16	**$1,291.74**	**$258.35**

Source: DIA Circular Letter No. 351 – Table II (October 3, 2016)

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, 2016, the maximum weekly compensation rate is $1,291.74 (100% of the SAWW) and the minimum rate is $258.35 (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 66.67% (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, 2016, the maximum weekly compensation rate is $1,291.74 (100% of the SAWW) and the minimum rate is $258.35 (20% of the SAWW). The payments must be adjusted each year for cost of living allowances (COLA).

Death Benefits for Dependents (§31) - The widow or widower that remains unmarried shall receive 2/3 of the worker's AWW, but not more than the SAWW or less than $110 per week. They shall also receive $6 per week for each child (not to exceed $150 in additional compensation). There are also benefits for other dependents. Benefits paid to all dependents cannot exceed 250 times the SAWW plus any COLA. However, children under 18 years old may continue to receive payments even if the maximum has been reached.

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.

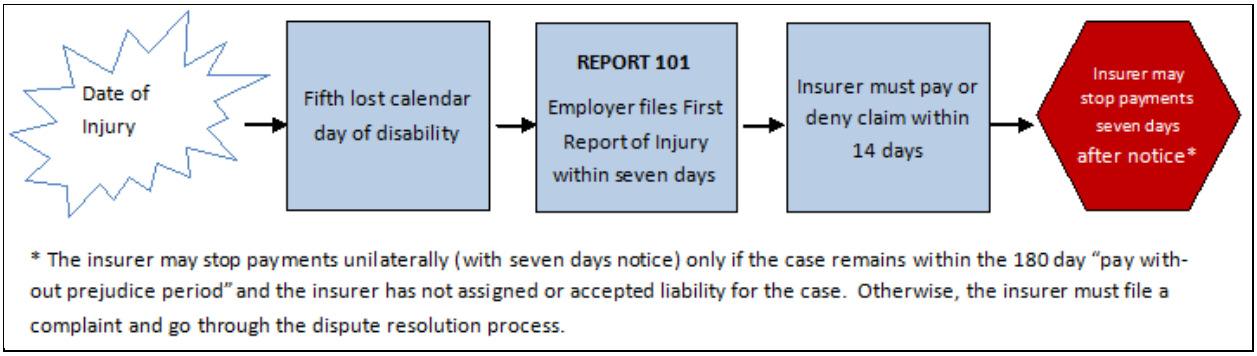
Vocational Rehabilitation Services (§§30E-30H) - An injured employee is also entitled to reasonably necessary vocational rehabilitation services at a reasonable cost if the employee is determined to be suitable for such services by the Department of Industrial Accidents. The purpose of these rehabilitation 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.[6] 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 doing so.[7] 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 and to provide the insurer with additional time to properly investigate the claim.

FIGURE 1: SCHEDULE OF EVENTS



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

After a conference order is issued or the pay without prejudice period expires, the insurer may not stop payment without an order from an Administrative Judge (AJ). In order to terminate benefits, the insurer must file a complaint for modification or termination of benefits, based on an independent 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.

[6] 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.

[7] 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.

SECTION
-2-

WORKPLACE INJURY AND FATALITY STATISTICS

OCCUPATIONAL INJURIES AND ILLNESSES

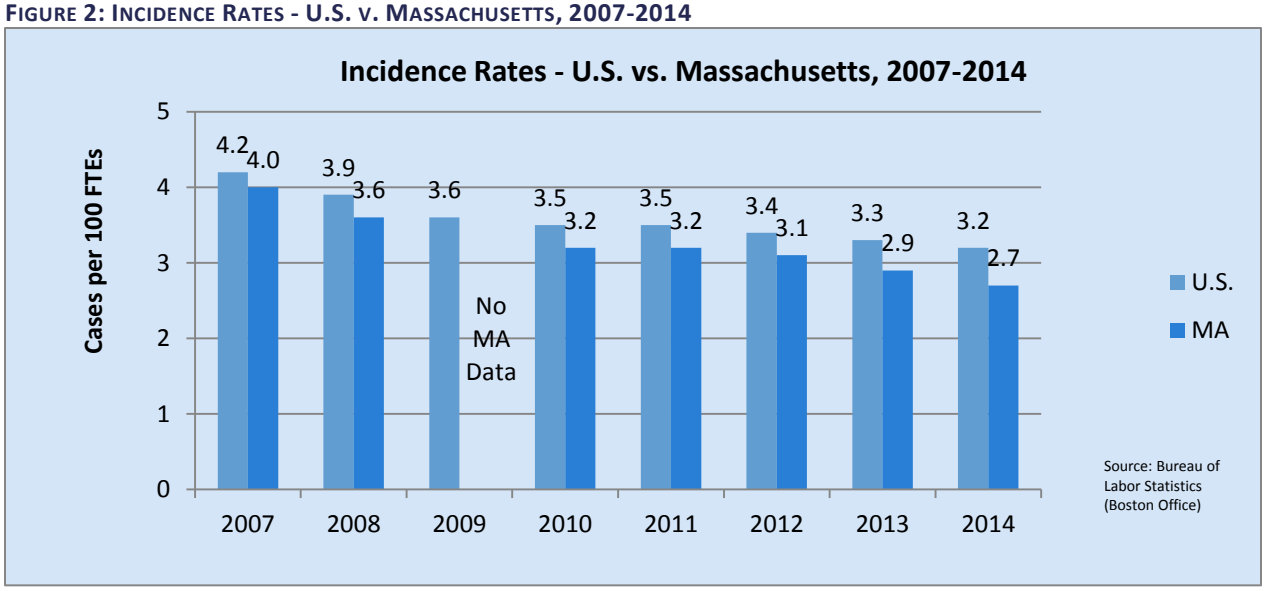
Since 1992, the Massachusetts Department of Labor Standards has been in partnership with the U.S. Department of Labor, Bureau of Labor Statistics (BLS), in an effort to collect injury and illness data in a uniform format. Throughout the country, surveys are collected from a sample of private industry 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 2014, the private sector workforce in the U.S. experienced approximately 3.0 million non-fatal injuries and illnesses, resulting in an incidence rate of 3.2 cases per 100 FTEs.[8] In Massachusetts, there were 62,100 non-fatal occupational injuries and illnesses, resulting in an incidence rate of 2.7 cases per 100 FTEs.[9] The graph below displays how incidence rates in Massachusetts have consistently remained lower than national rates.

FIGURE 2: INCIDENCE RATES - U.S. V. MASSACHUSETTS, 2007-2014



[8] Bureau of Labor Statistics, News-USDL-15-2086.

[9] Commonwealth of Massachusetts 2014 Occupational Injuries and Illnesses Annual Report. In 2014, Massachusetts had a population of 6,745,408 people with an estimated private sector workforce of 3,062,689 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 2008. 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, 2008-2014 (PRIVATE INDUSTRY)

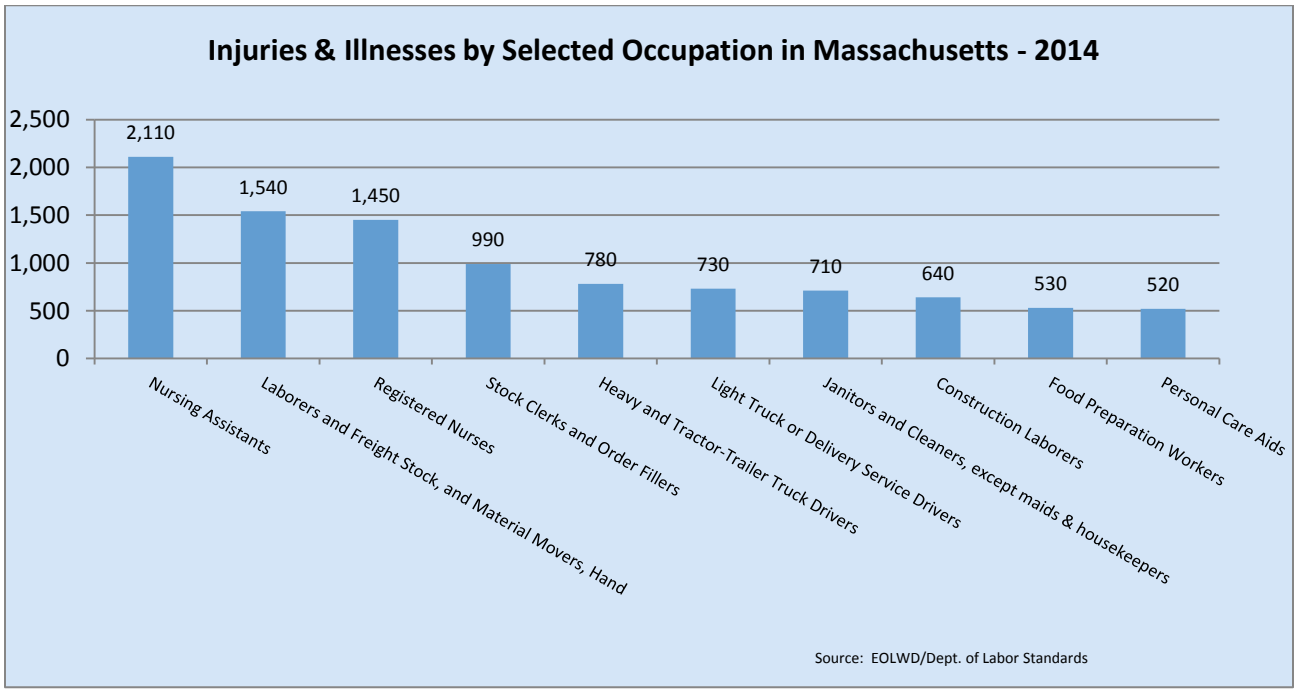
Region	*2014*	*2013*	*2012*	*2011*	*2010*	*2009*	*2008*
United States	3.2	3.3	3.4	3.5	3.5	3.6	3.9
Massachusetts	2.7	2.9	3.1	3.2	3.2	no data	3.6
Connecticut	3.5	3.8	3.9	4.5	4.0	4.2	4.6
Maine	5.3	5.3	5.6	5.7	5.6	5.6	6.0
Rhode Island	no data	no data	no data	no data	no data	no data	no data
Vermont	5.0	5.2	5.0	5.0	5.2	5.2	5.5
New Hampshire	no data	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 2014, Nursing Assistants had the highest number of injuries and illnesses involving days away from work in Massachusetts among selected occupations.

FIGURE 3: 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 2014 survey.

TABLE 3: NONFATAL INJURY & ILLNESS INCIDENCE RATES BY INDUSTRY, MASSACHUSETTS, 2008-2014

MASSACHUSETTS (Major Industry Sector)	2014	2013	2012	2011	2010	2009	2008
Natural resources and mining	4.4	5.2	6.9	3.8	6.1	no data	8.1
Construction	3.3	4.4	4.7	4.7	3.9	no data	4.8
Manufacturing	2.7	2.6	3.0	3.2	3.4	no data	3.5
Service-providing industry	2.7	no data	no data	no data	no data	no data	no data
Trade, transportation, and utilities	3.4	3.4	3.8	3.9	3.8	no data	4.3
Information	0.8	0.9	0.9	0.8	1.3	no data	2.2
Financial activities	0.7	1.4	0.7	0.6	1.1	no data	0.9
Professional and business services	1.1	1.0	1.7	1.5	1.3	no data	1.6
Education and health services	4.3	4.5	4.6	5.0	5.0	no data	5.6
Leisure and hospitality	3.6	3.9	4.4	4.1	4.0	no data	5.1
Other services	1.5	2.2	3.3	2.4	2.9	no data	2.0

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 2015, Massachusetts experienced 69 workplace fatalities, an increase of fourteen fatalities from calendar year 2014. The leading cause of workplace death in Massachusetts came from transportation incidents, in which 26 workers were killed. Nationally, transportation incidents were the leading cause of on-the-job fatalities, accounting for 42% of the fatal work injuries in 2015. Following transportation incidents, Massachusetts workers were killed by falls (17), assaults and violent acts (10), exposure to harmful substances or environments (8), contact with objects and equipment (6), and fire and explosions (2).

TABLE 4: FATAL OCCUPATIONAL INJURIES BY STATE, 2015 (NORTHEAST REGION)

State of Fatality	Total Fatalities		Event or Exposure (State Total for 2015)					
	2014 (Revised)	2015 (Final)*	Transportation Incidents	Assaults & Violent Acts	Contact with Objects & Equipment	Falls	Exposure to Harmful Substances	Fires & Explosions
U.S. Total	4,821	4,836	2,054	703	722	800	424	121
Massachusetts	55	69	26	10	6	17	8	2
Connecticut	35	44	14	10	7	7	6	--
Maine	19	15	5	3	3	--	--	--
New Hampshire	17	18	--	4	4	--	6	--
Rhode Island	10	6	--	--	--	--	--	--
Vermont	10	9	--	1	2	1	3	--

Source: Bureau of Labor Statistics, News-USDL-16-2034

*Important note on future data: Beginning with the 2015 reference year, final data from the Census of Fatal Occupational Injuries (CFOI) was released in December—4 months earlier than in past years. The final 2015 CFOI data was released on December 16, 2016. The December release will be the only release of CFOI data for 2015. A similar schedule will be followed in subsequent years. Preliminary releases, which normally appeared in August or September in past years, will no longer be produced.

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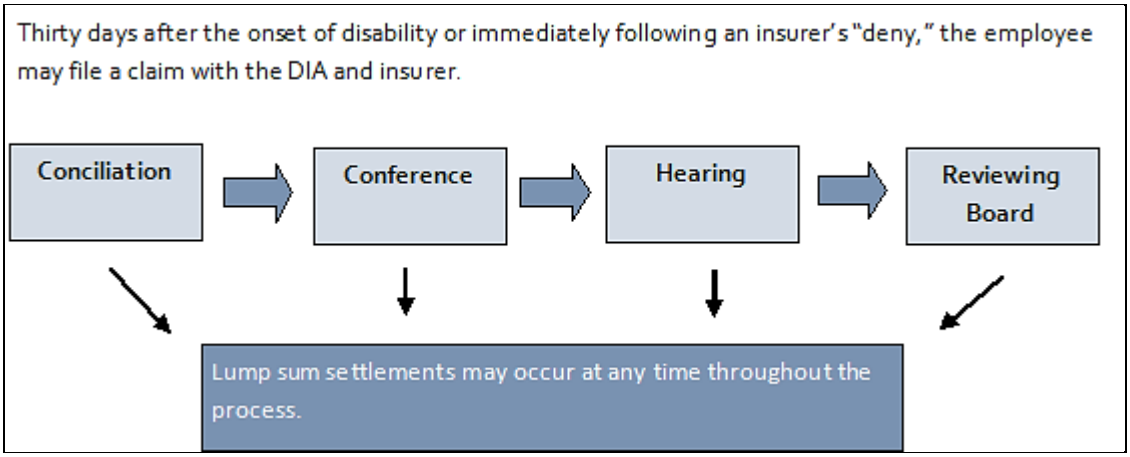
SECTION
-3-

DISPUTE RESOLUTION

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 4: 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 a referral 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 a voluntary settlement agreed to by the parties.

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

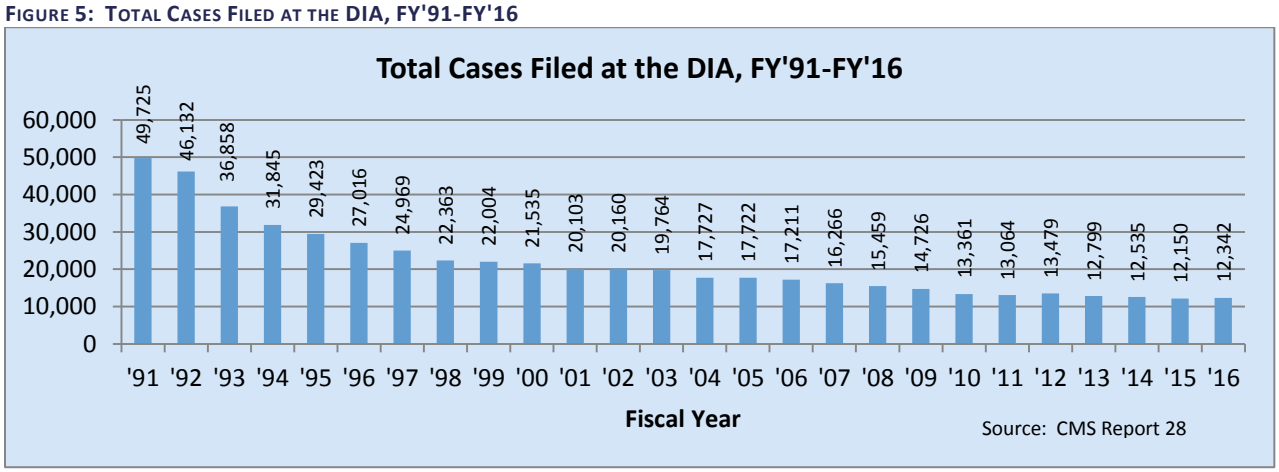
Arbitration & Mediation – At any time prior to five days before a conference, a case may be referred to an independent arbitrator. The arbitrator must make a decision whether to vacate or to modify the compensation pursuant to M.G.L. c.251, §12 and §13. The parties involved may agree to bring the matter 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.

CASES FILED AT THE DIA

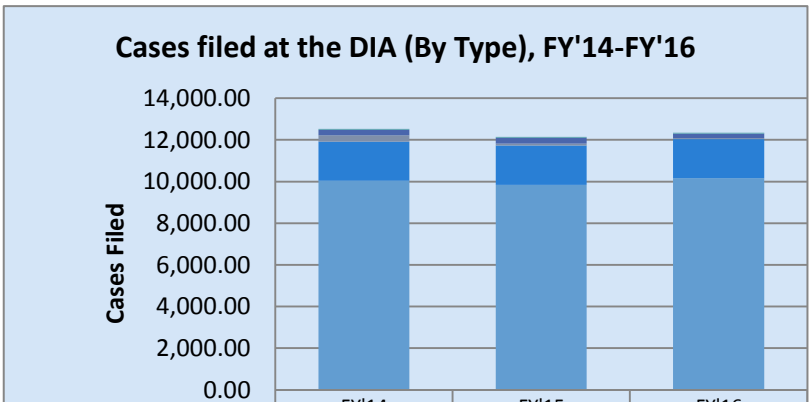
Cases originate at the Department of Industrial Accidents (DIA) when any of the following are filed: an employee's claim for benefits, an insurer's complaint for termination or modification of benefits, a third party claim, a request for approval of a lump sum settlement, or a Section 37/37A request. 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'16, the total number of cases filed at the DIA was 12,342, an increase of nearly 2% from the previous fiscal year.

FIGURE 5: TOTAL CASES FILED AT THE DIA, FY'91-FY'16



In FY'16, 10,170 employee claims were filed at the DIA, representing 82% of the total cases filed. Employee claims increased by 333 cases, or more than 3%, from the previous fiscal year. Employee claims have decreased by 56% since 1991, when an all-time high of 23,240 cases were filed. In FY'16, 1,862 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 38 cases, or less than 2%, 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'14-FY'16



	FY'14	FY'15	FY'16
Third Party Claims	51	57	39
Section 37/37A Request	269	275	214
Lump Sum Conference Request*	306	81	57
Insurer Request for Discontinuance	1873	1900	1862
Employee Claims	10036	9837	10170

* The Division of Dispute Resolution attributes the drop in Lump Sum Conference Requests over the last three fiscal years to the implementation of the Walk-In Lump Sum program discussed in greater detail in the Lump Sum section below.

Source: CMS Report 28

CONCILIATION

The first stage of the dispute resolution process is the conciliation. The main objective of the conciliation is to resolve cases without formal adjudication through the dispute resolution system. At this stage, cases are reviewed for documentation substantiating the positions of both sides of the dispute. Conciliators are empowered to withdraw or reschedule a case until adequate documentation is presented. Although conciliators may encourage the parties to work out a settlement, they have no authority to order the parties to resolve their differences. Approximately 40% of the cases that 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 60% of cases are referred from conciliation to a conference to be heard before an Administrative Judge.

The Conciliation Process

Conciliations are scheduled automatically by the Case Management System (CMS) after a claim, discontinuance request or Sec. 37/37A claim is filed with the Office of Claims Administration (OCA). The Conciliation is scheduled within 14 days of receipt. 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.

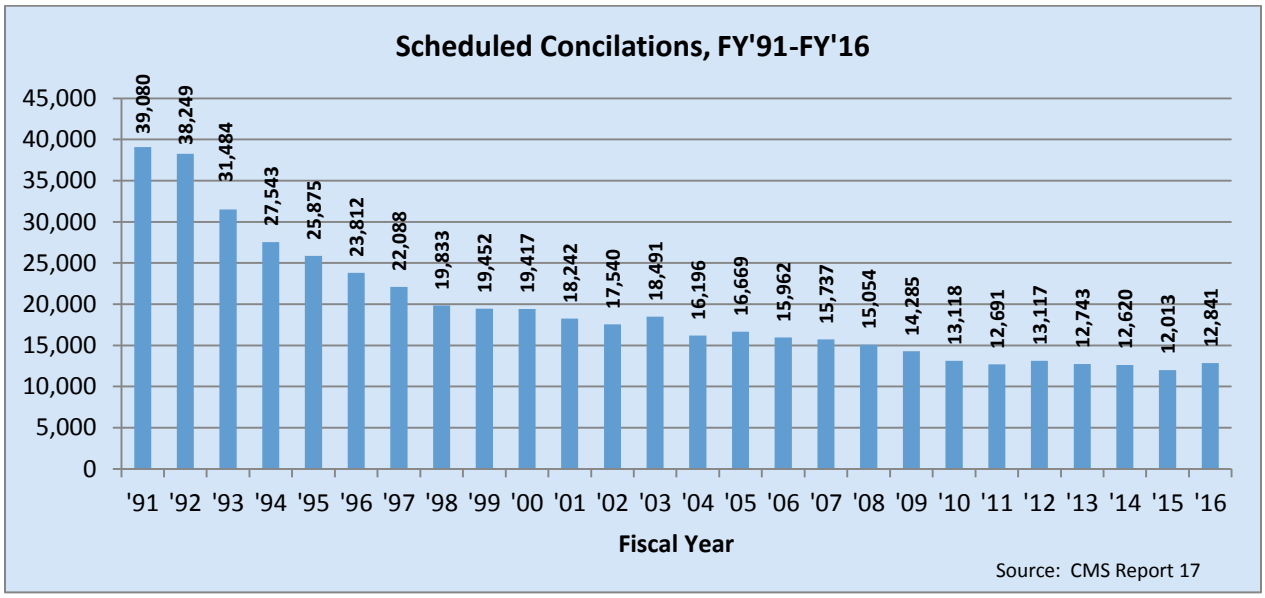
When liability is not an issue, but modification or discontinuance of benefits is sought, both parties are required to submit written settlement offers. If the employee fails to file, the conciliator must record either the last offer made by the employee or the maximum compensation rate. If the insurer 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'16, there were 12,841 cases scheduled for conciliation, which represents a 67% decrease since the 1991 Reform.

Figure 7 displays the number of cases scheduled for conciliation at the DIA beginning in FY'91. In FY'16, the volume of cases scheduled for conciliation increased by 7% (828 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'16



Resolved at Conciliation

Disputed cases that are scheduled for conciliation can be divided into two distinct outcomes: "referred to conference" or "resolved." In FY'16, 5,183 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'16

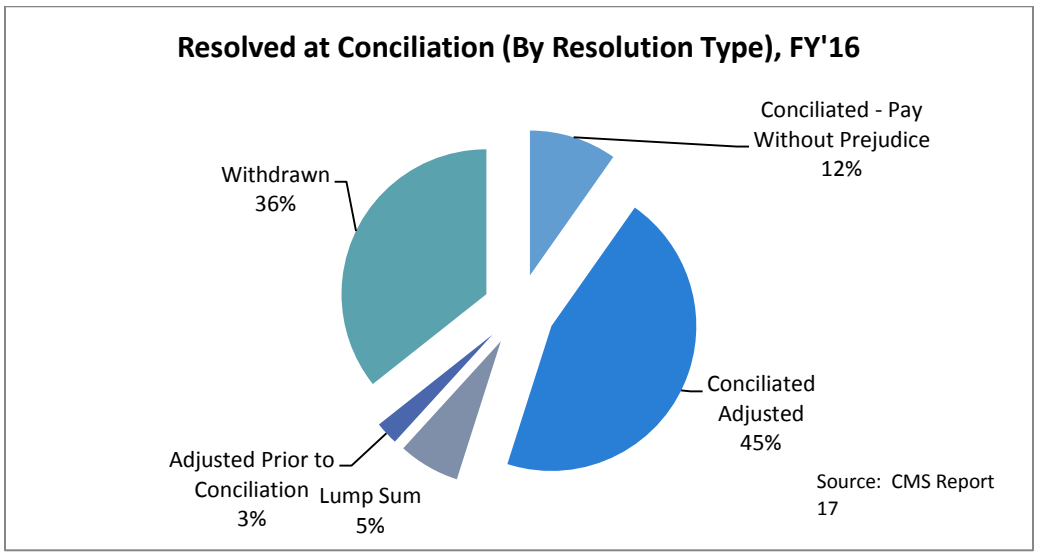


TABLE 5: RESOLVED AT CONCILIATION, FY'16 AND FY'15

Resolved at Conciliation FY'16 and FY'15	*Number of Cases*		*Percentage*	
	FY'16	**FY'15**	**FY'16**	**FY'15**
Conciliated - Pay Without Prejudice	613	523	11.8%	9.8%
Conciliated Adjusted	2,309	2,419	44.5%	45.2%
Lump Sum	235	367	4.5%	6.9%
Adjusted Prior to Conciliation	150	138	2.9%	2.6%
Withdrawn	1,876	1,914	36.2%	35.7%
TOTALS:	**5,183**	**5,361**	**100%**	**100%**

Source: CMS Report 17

As displayed in Table 5, cases may be conciliated by two methods. Approximately 45% of the resolved cases in FY'16 were "conciliated adjusted," meaning an agreement was reached at conciliation between the parties to initiate, modify, or terminate the compensation. Secondly, approximately 12% of the resolved cases in FY'16 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 36% of cases were withdrawn in FY'16. 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 claimant's "best interest." Lump sum settlements only account for 5% of the resolved cases at the conciliation level of dispute resolution.

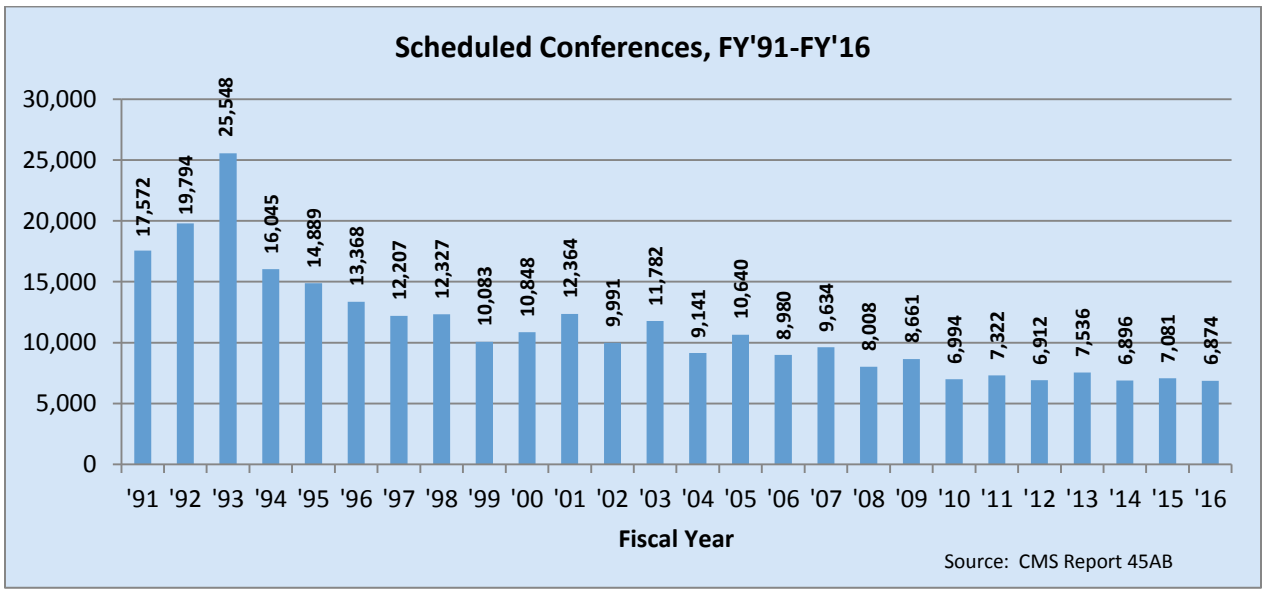
CONFERENCE

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 86% of all conference orders in a given fiscal year are appealed to the hearing level of dispute resolution. In the remaining 14% 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 Impartial 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'16 decreased by 3% from last fiscal year (7,082 in FY'15 to 6,874 in FY'16).[10] 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'16



[10] In an effort to avoid duplication, the number of "scheduled conferences" does not include cases that were "rescheduled for a conference." In FY'16, 4,024 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'16, 4,078 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'16

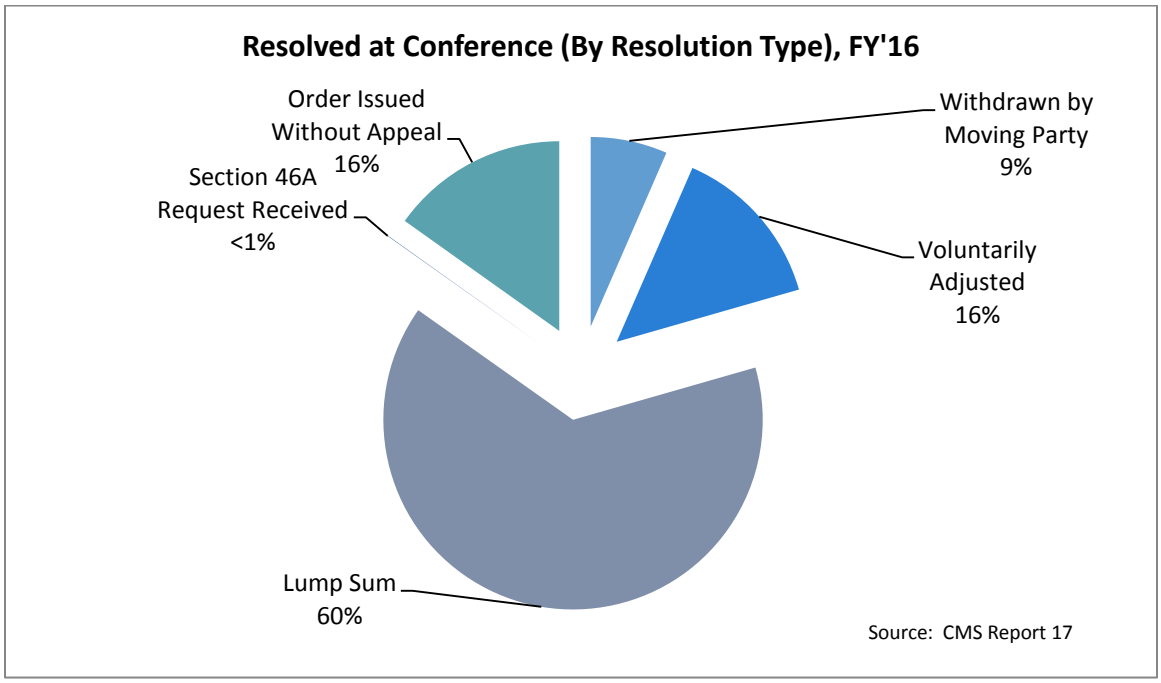


TABLE 6: CASES RESOLVED AT CONFERENCE, FY'16 AND FY'15

Resolved at Conference FY'16 and FY'15	*Number of Cases*		*Percentage*	
	FY'16	**FY'15**	**FY'16**	**FY'15**
Withdrawn by Moving Party	357	322	8.8%	6.5%
Voluntarily Adjusted	647	690	15.9%	14.0%
Lump Sum	2,425	3,163	59.5%	64.2%
Section 46A Request Received	0	2	<1%	<1%
Order Issued Without Appeal	649	746	15.9%	15.2%
Total	**4,078**	**4,923**	**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'16, 357 cases (9% 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'16, 647 cases (16% 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'16, 2,425 cases (60% 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'16, none 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'16, 649 conference orders (16% of all conference orders) were issued by AJs were not appealed. However, the vast majority of conference orders are appealed to the hearing stage of dispute resolution. In FY'16, 3,890 conference orders (86% of all conference orders) were appealed to a hearing.

TABLE 7: CONFERENCE ORDERS, FY'16-FY'03

Conference Orders FY'16 - FY'03	Total Orders	Appealed	Without Appeal
Fiscal Year 2016	**4,539**	3,890 (85.7%)	649 (14.3%)
Fiscal Year 2015	**4,490**	3,744 (83.4%)	746 (16.6%)
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 conference queue during FY'16 remained below the benchmark of 1,500 cases. The conference queue reached its highest point of 908 on September 9, 2015 and the lowest of 276 on September 9, 2015. See Figure 11.

FIGURE 11: CONFERENCE AND HEARING QUEUES, FY'16

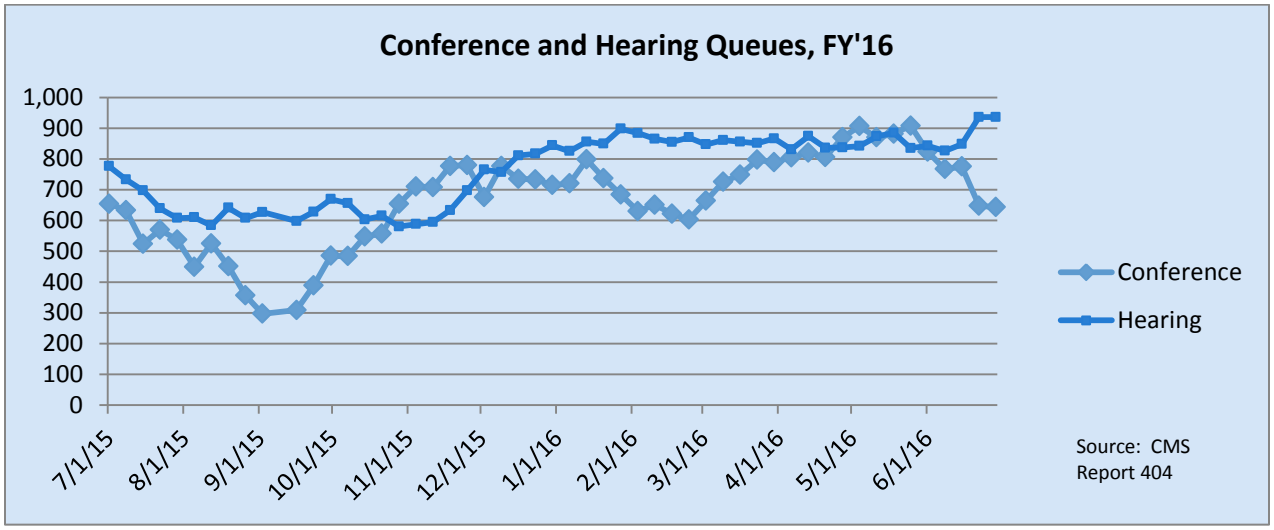
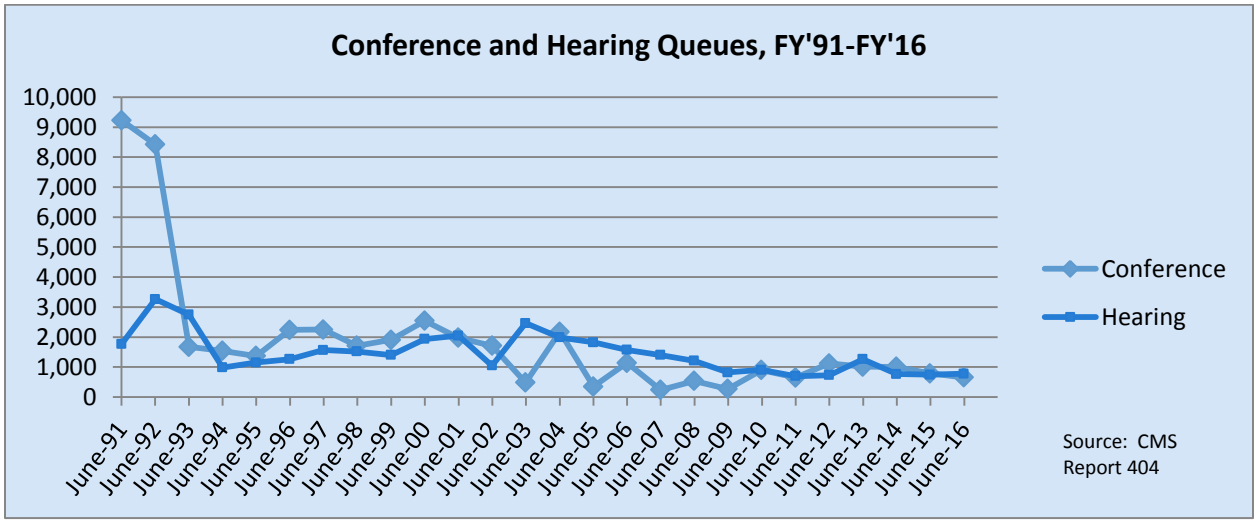


FIGURE 12: CONFERENCE AND HEARING QUEUES, FY'91-FY'16



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 also preside over the hearing, 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 Impartial 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.

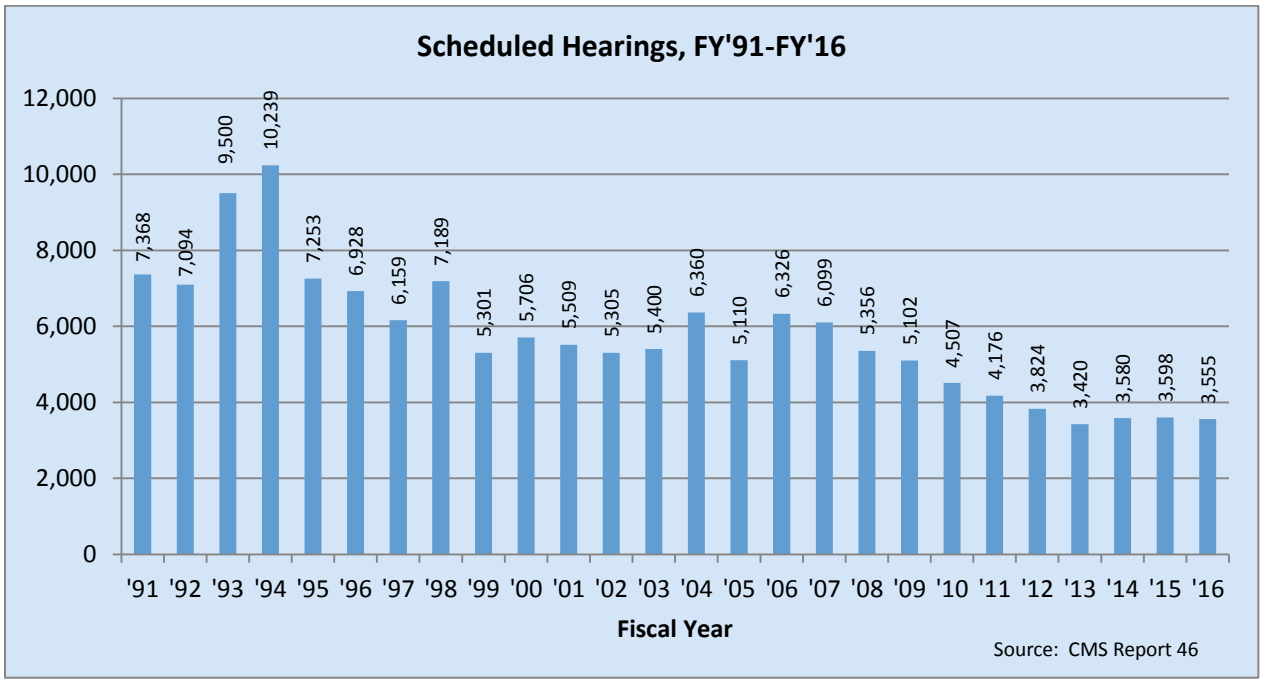
It is difficult to compare the hearing queue with the conference queue because of the differences in the two proceedings. Hearings must be scheduled with the same judge who presided over the conference, whereas conferences are scheduled according to availability (when "judge ownership" is not yet a factor). Since hearings are also more time consuming than conferences, it takes more time to work through a hearing queue than a conference queue. The hearing queue at the beginning of FY'16 was 776 cases. At the end of FY'16, the hearing queue was 936 cases. 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'16 decreased by 43 cases from last fiscal year (3,598 in FY'15 to 3,555 in FY'16).[11] 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.

[11] In an effort to avoid duplication, the number of "scheduled hearings" does not include cases that were "rescheduled for a hearing." In FY'16, 5,068 cases were "rescheduled for a hearing."

FIGURE 13: SCHEDULED HEARINGS, FY'91-FY'16



Cases Resolved at Hearing

In FY'16, 3,257 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'16

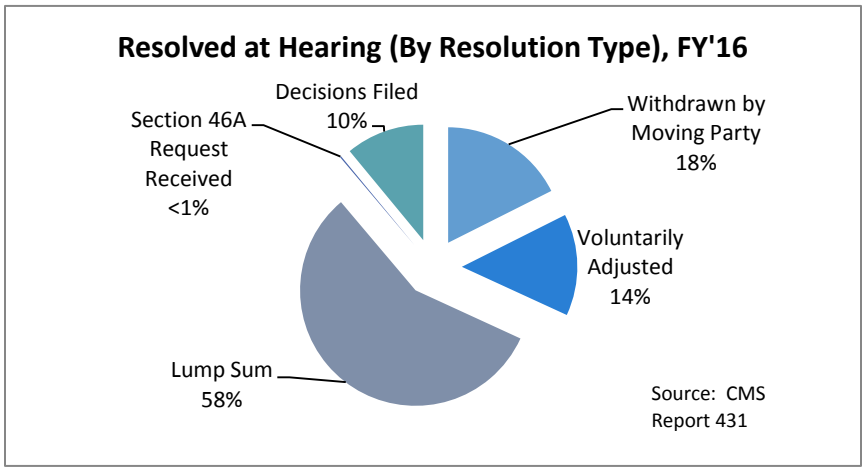


TABLE 8: CASES RESOLVED AT HEARING, FY'16 AND FY'15

Resolved at Hearing FY'16 and FY'15	*Number of Cases*		*Percentage*	
	FY'16	**FY'15**	**FY'16**	**FY'15**
Withdrawn by Moving Party	579	581	17.8%	17.6%
Voluntarily Adjusted	458	471	14.1%	14.3%
Lump Sum	1,900	1,882	58.3%	57.0%
Section 46A Request Received	1	6	<1%	<1%
Decisions Filed	319	363	9.8%	11.0%
Total	**3,257**	**3,303**	**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'16, 579 cases (18% of resolved cases at hearing) exited the system in this manner.

Second, the parties may agree to have the case voluntarily adjusted. This occurs at the hearing when a compromise on any part of the case (benefit level, benefit duration, etc.) can be reached among the parties. In FY'16, 458 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'16, 1,900 cases (58% 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'16, only one of these requests was 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'16, 319 hearing decisions (10% of resolved cases at hearing) were filed by AJs.

REVIEWING BOARD

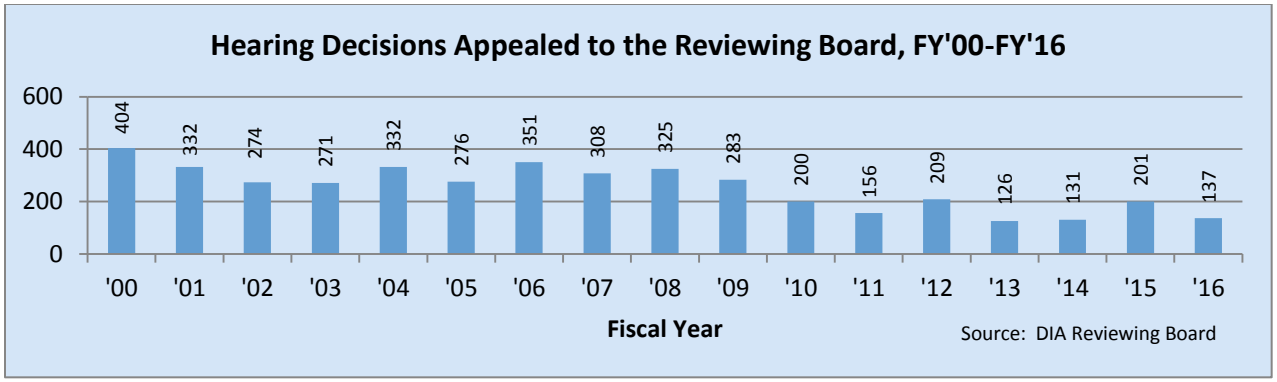
The fourth and final stage of dispute resolution at the DIA occurs when a case proceeds to the Reviewing Board. The Reviewing Board consists of six Administrative Law Judges (ALJs) whose primary function is to review the appeals of hearing decisions. While appeals are heard by a panel of three ALJs, 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'16 was 137.

FIGURE 15: HEARING DECISIONS APPEALED TO THE REVIEWING BOARD, FY'00-FY'16



Appeals Resolved at the Reviewing Board

In FY'16, the Reviewing Board resolved 150 cases (some from the prior year), representing a 22% increase from cases resolved in FY'15 (123 cases).

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

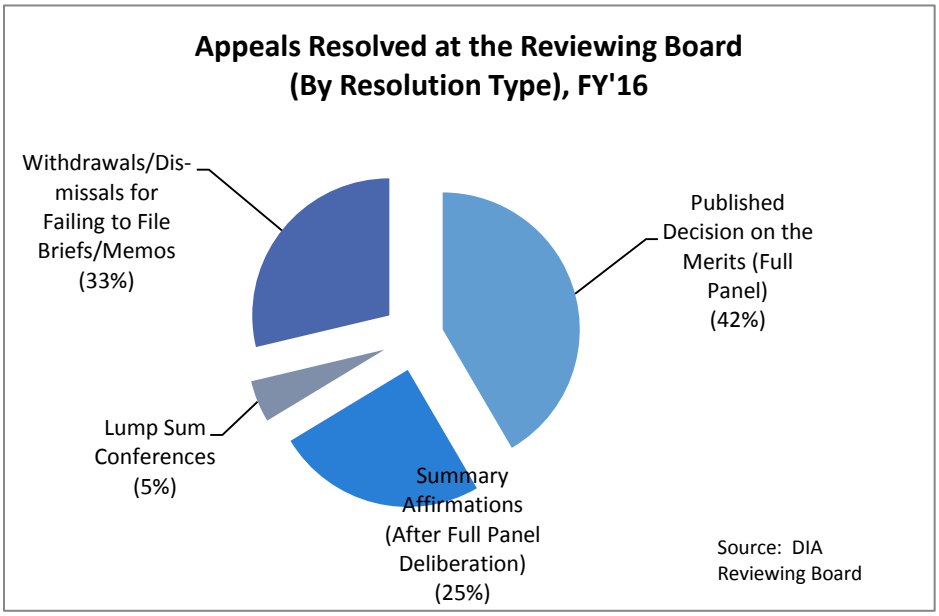


TABLE 9: APPEALS RESOLVED AT THE REVIEWING BOARD, FY'16

Appeals Resolved at the Reviewing Board, FY'16	*Number of Cases*
Published Decision on the Merits (Full Panel):	63 (42.0%)
Summary Affirmations (After Full Panel Deliberation):	37 (24.7%)
Lump Sum Conferences:	7 (4.7%)
Withdrawals/Dismissals for Failing to File Briefs/Memos:	43 (28.7%)
Total Number of Appeals Resolved by the Reviewing Board:	**150 (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'16 was 89.

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'16, ALJs heard 1,230 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'16, 6 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 consent to 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 the insurer has accepted liability for the specific injury and body part.

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'16

Fiscal Year	*Total lump sum conferences scheduled*	*Lump sum settlements approved*
FY'16	**4,409**	**4,187 (95.0%)**
FY'15	5,096	4,834 (94.9%)
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 77.6% since FY'91. In FY'16, four lump sum settlements were disapproved. The remainder of the scheduled lump sum conferences without an "approved" disposition were either withdrawn or rescheduled.

There are four dispositions that indicate a lump sum settlement occurred at either conciliation, conference, or hearing:

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.

TABLE 11: LUMP SUM SETTLEMENTS PURSUED AT EACH LEVEL OF DISPUTE RESOLUTION, FY'16

Fiscal Year 2016	*Lump Sum Pursued*[12]	*% Total Cases Resolved (at each level of dispute resolution process)*
Conciliation	235	4.5%
Conference	2,425	59.5%
Hearing	1,900	58.3%

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

Walk-In Lump Sum Settlements

In the spring of 2014, the DIA implemented a new process for parties seeking approval of a lump sum settlement in situations where there is no judge "ownership" of the matter. Pursuant to the process,

[12] "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.

parties seeking approval of a lump sum report first to the conciliation unit. A conciliator reviews all requests and associated documentation to determine whether the request is ready to go before a judge. If so, the parties will go before the "Walk-In Lump Sum Judge" on duty. In FY'16, 2,438 walk-in lump sums were approved.

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.[13] 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.[14]

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 Scheduling Unit

The Impartial Scheduling 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 Scheduling 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:

[13] M.G.L. c.152,§8(4).
[14] 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 (fee schedule rates effective January 2013).

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'16, approximately $2,213,955 was collected in Impartial Medical fees.

As of June 30, 2016, there were 132 physicians on the roster consisting of 28 specialties. The Impartial Scheduling 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'16, the Impartial Scheduling Unit scheduled 4,330 examinations, compared to 3,931 in FY'15. Of these, 3,120 exams were actually conducted in FY'16 (the remainder of the scheduled exams were either canceled due to settlements and withdrawals or took place in the next year). In FY'15, 3,057 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 indigence. 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: 2016 HHS POVERTY GUIDELINES

2016 HHS Poverty Guidelines (48 Contiguous States and the District of Columbia)	
Size of Family Unit	**Amount***
1	$11,880
2	$16,020
3	$20,160
4	$24,300
5	$28,440
6	$32,580
7	$36,730
8	$40,890
*For family units with more than eight members, add $4,160 for each additional member in the family.	

Source: *Federal Register*, Vol. 81, No. 15, January 25, 2016, pp.4036-4037

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 K for Advisory Council guidelines for reviewing judicial candidates).

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, 2016:

(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 $1,129.48 plus necessary expenses. If the employee's attorney fails to appear at a scheduled conciliation, the amount paid is $564.74.

(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 $1,613.55. 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 $806.78.

(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 $806.78 plus necessary expenses. This fee can be reduced to $403.39 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 $1,129.48 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 $564.74 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 $5,647.43 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 $1,613.55. 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
-4-

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

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.

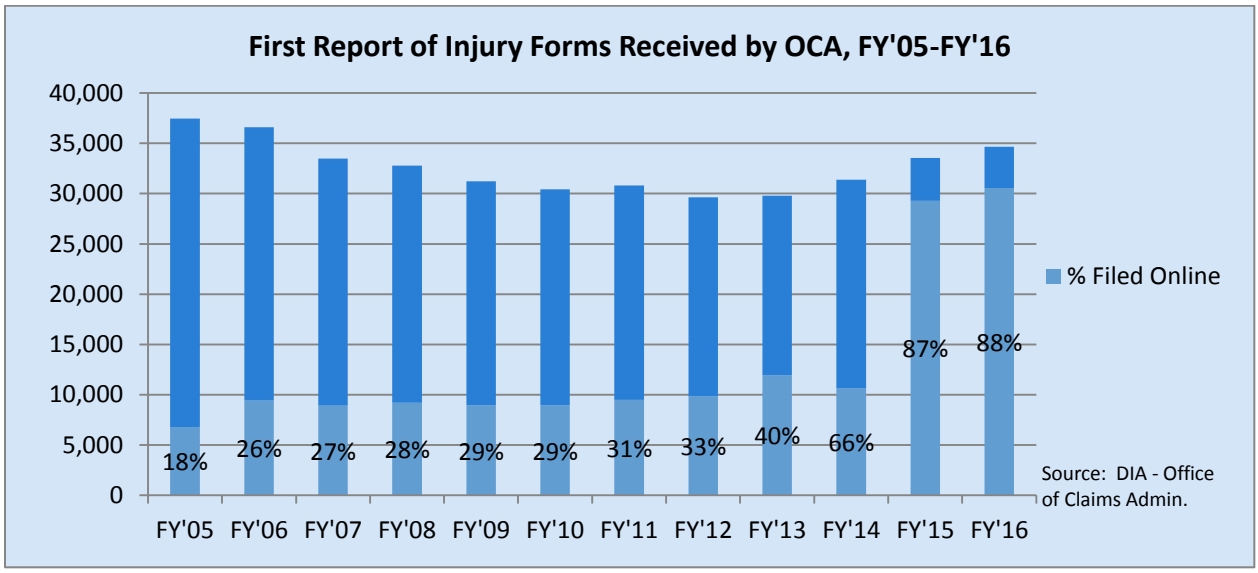
The OCA has four primary functions centered upon receiving, entering, storing, and retrieving information. The first function consists of receiving lost time reports, insurance forms, claims, appearances, and liens. Once this information is received, it must be entered into the Case Management System (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'16, the OCA received 34,660 First Report of Injury forms (FRIs), an increase of approximately 4% from FY'15 (33,353). All FRIs were filed online (6,664 online/23,895 EDI/4,101 Secure File Transfer (SFT)) during FY'16. In FY'16 the number of claims, discontinuances and third party claims received by the OCA was 12,263, an 0.6% increase from the 12,187 received in FY'15 (prior to review and CMS acceptance processing).

FIGURE 17: FIRST REPORT OF INJURY FORMS RECEIVED BY THE OFFICE OF CLAIMS ADMINISTRATION, FY'05-FY'16



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.

The DIA continues to maintain a document retention cycle of 40 years as required by the Records Conservation Board. As of October 2016, all records have been removed from the State Archive at Columbia Point and have been transferred to a privately operated off-site storage facility under a statewide contract. Manual file procedures are kept strictly in accordance with the State Record Center (SRC) regulations. When a request is made to the off-site facility, the corresponding paper file is returned to the OCA and then scanned into the DMS.

Keeper of Records

OCA serves as Keeper of Records (KOR) and responds to all written requests for records in compliance with the Massachusetts Public Records Law (M.G.L. c. 66). All documents are not considered public records. In accordance 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,

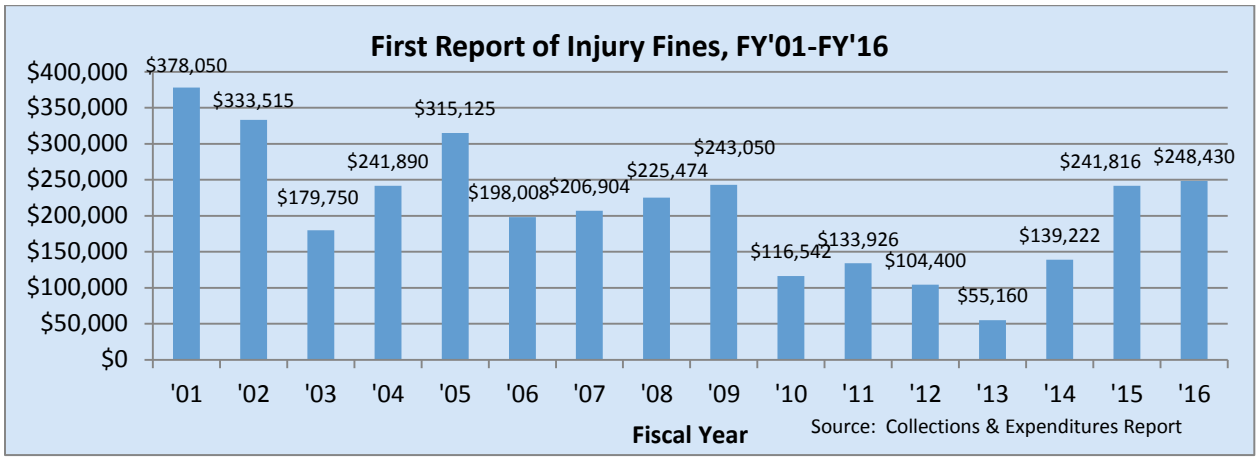
the Attorney General's Office, the Social Security Administration and other government entities. Occasionally, a KOR representative is summoned to appear in court to testify on behalf of the DIA on documents relating to a workers' compensation case.

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'16 saw an increase in the number of FRI violations, which resulted in the collections of $248,430, an increase of $6,614 from the $241,816 collected in FY'15. 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'16, 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 37 such inquiries were processed during FY'16 and a total number of insurance complaints received were 6 during FY'15.

FIGURE 18: FIRST REPORT OF INJURY FINES, FY'01-FY'16



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'16, the OEVR was headed by a Director and staffed by six Rehabilitation Review Officers (RROs) and two 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."[15]

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'16, OEVR approved 31 VR providers. It is the responsibility of each provider to submit progress reports on a regular basis so that OEVR's RROs can have a clear understanding of each case's progress. Progress reports must include the following:

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

[15] M.G.L. c.152, §1(12).

Determination of Suitability

It is the responsibility of OEVR to identify those disabled workers who may benefit from rehabilitation services. OEVR identifies rehabilitation candidates according to injury type after liability has been established, and through referrals from internal DIA sources (including the Office of Claims Administration and the Division of Dispute Resolution), insurers, certified providers, attorneys, hospitals, doctors, employers and injured employees themselves.[16] Through the use of new technology, such as the automatic scheduling system, OEVR has made significant progress in identifying disabled workers for mandatory meetings early on in the claims process.

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

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

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

Individual Written Rehabilitation Program

After an employment goal and vocational goal has been established for the injured worker, an IWRP can be written. The IWRP is written by the vocational provider and includes the client's vocational goal, the services the client will receive to obtain that goal, an explanation of why the specific goal and services were selected, and the 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-

[16] M.G.L. c. 152, §19.

December 23, 1991 injuries and 104 calendar weeks for post-December 23, 1991 injuries.[17] 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 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.

[17] M.G.L. c.152, §19.

Utilization of Vocational Rehabilitation

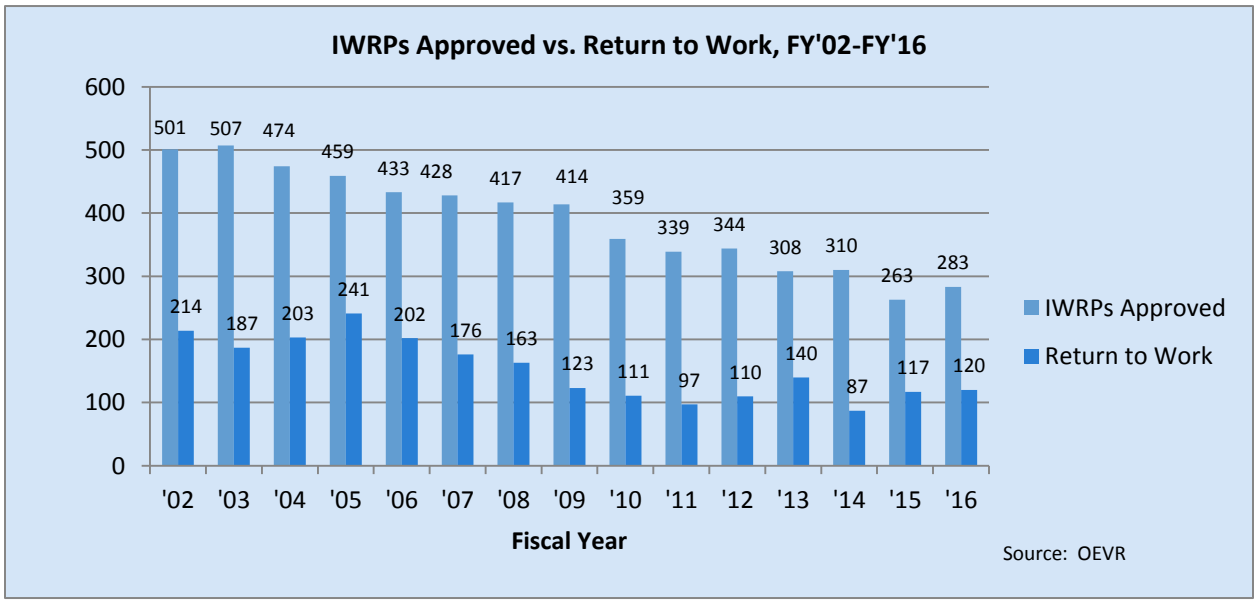
During FY'16, 2,858 cases were referred to OEVR, a decrease of 11% from the previous fiscal year. 1,743 "mandatory meetings" were held and 381 cases were referred to the insurer/self-insurer with a request to initiate vocational rehabilitation services by an OEVR-certified provider. Of the cases that closed in FY'16, 64% of those injured workers who had completed IWRPs returned to work.

TABLE 14: UTILIZATION OF VOCATIONAL REHABILITATION SERVICES, FY'06-FY'16

Fiscal Year	*Referrals to OEVR*	*Mandatory/ Inform. Meetings*	*Referrals to Insurer for VR*	*IWRPs approved*	*Return to work*
FY'16	**2,858**	**1,743/NA**	**381**	**238**	**120**
FY'15	3,228	2,134/N/A	449	263	117
FY'14	3,673	2,309/N/A	533	310	87
FY'13	2,672	1,357/N/A	432	308	140
FY'12	2,551	1,757/N/A	478	344	110
FY'11	2,362	1,665/10	481	339	97
FY'10	2,818	1,893/51	593	359	111
FY'09	2,611	2,150/62	642	414	123
FY'08	2,828	2,281/69	647	417	163
FY'07	2,839	2,292/46	705	428	176
FY'06	2,932	2,315/40	747	433	202

Source: DIA – Office of Education and Vocation Rehabilitation

FIGURE 19: COMPARISON OF IWRPS APPROVED VS. RETURN TO WORK, FY'02-FY'16



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'16, 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 $800,000 in safety grants with a limit of 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 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'16 the Office of Safety was able to fund approximately 49 grants which trained nearly 7,500 workers in Massachusetts (see Appendix L).

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'16, one new license was issued, with the total number of "parent-licensed" companies decreasing to 85, covering a total of 308 subsidiaries. Each self-insurance license provides approval for a parent

company and its subsidiaries to self-insure. This amounts to approximately $264,440,517 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'16, an estimated 2,544 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.[18] 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.[19] The Office of Investigations is charged with enforcing this mandate by investigating whether employers are maintaining insurance policies and by imposing penalties when violations are uncovered. When an employer fails to carry an insurance policy and an injury occurs at their workplace, the claim is paid from the Workers' Compensation Trust Fund, which is funded entirely by the employers who purchase workers' compensation policies and administered by the DIA.

Referrals to the Office of Investigations

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

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

The Office of Investigations also receives referrals through anonymous calls (1-877-MASSAFE) and letters received from the general public. In May 2008, the Office of Investigations also began managing a fraud hotline developed by the Joint Task Force on the Underground Economy and Employee Misclassification (now the Council on the Underground Economy) (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 discovered or when there is substantial evidence that a company has ceased operations. In FY'16, the Office of Investigations conducted a total of 84,443 compliance checks. Once a referral has been

[18] Officers and directors of corporations who own at least 25% of stock of the corporation may exempt themselves from coverage.
[19] M.G.L. c.152, §25A.

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'16, the Office of Investigations conducted 5,115 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'16, the DIA issued a total of 2,047 SWOs. Of the 2,047 SWOs issued 2,001 (97.8%) were issued to small employers (1 to 10 employees), 43 (2.1%) 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 5,675 new employees became covered in FY'16 as a result of each employer who purchased workers' compensation insurance after receiving an 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 nine years. It is important to note that "compliance investigations" and "field investigations" were redefined by the Office of Investigations in April of 2008. As a result, there is no comparable data available prior to FY'09.

TABLE 15: OFFICE OF INVESTIGATIONS - VITAL STATISTICS, FY'06-FY'16

Fiscal Year	Compliance Checks	Field Investigations	SWOs Issued	SWO Fines Collected	New Employees Covered due to SWOs
FY'16	84,443	5,115	2,047	$1,107,030	5,675
FY'15	90,360	5,470	1,928	$1,188,541	5.440
FY'14	87,064	5,785	2,150	$1,430,599	5,954
FY'13	84,367	5,790	2,337	$1,351,266	6,719
FY'12	67,640	5,383	2,440	$1,439,180	8,143
FY'11	52,366	5,984	2,567	$1,836,225	7,384
FY'10	47,415	7,142	3,102	$1,608,652	8,943
FY'09	32,505	8,171	3,316	$1,369,954	9,527
FY'08	n/a	n/a	1,126	$533,972	3,136
FY'07	n/a	n/a	389	$389,867	*not tracked*
FY'06	n/a	n/a	227	$246,657	*not tracked*

Source: Office of Investigations/Collection and Expenditure Reports

Stop Work Order Fines and Debarment

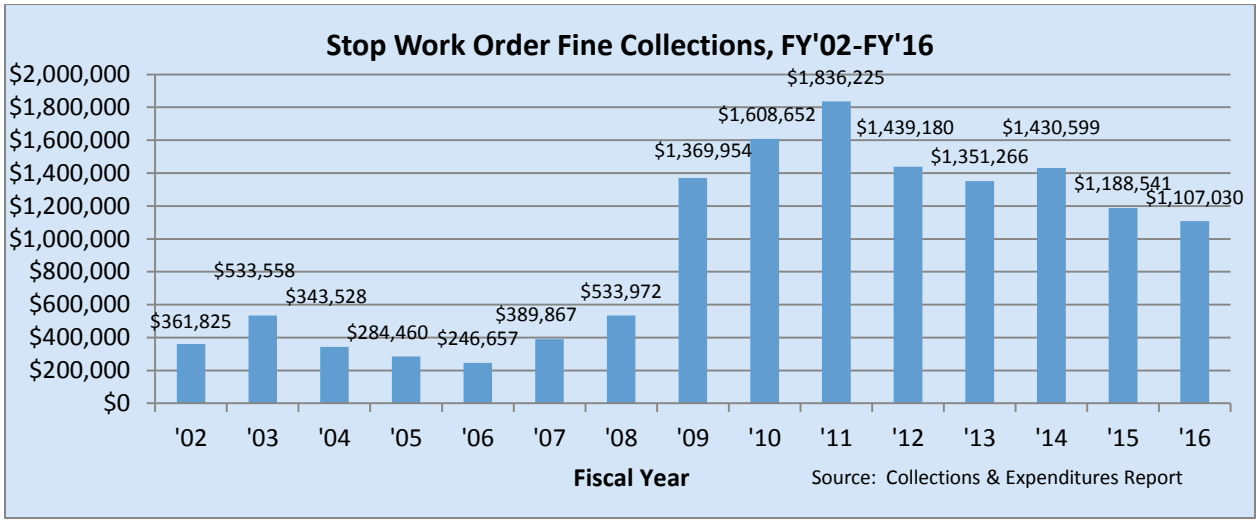
Fines resulting from an SWO are $100 per day, starting the day the SWO is issued, and continuing until proof of coverage and payment of the fine is received by the DIA. An employer who believes the issuance of the SWO was unwarranted has ten days to file an appeal. A hearing must take place within 14 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 an 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'16, the Office of Investigations collected $1,107,030 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 six 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'16



Council on the Underground Economy

The Director of the DIA, or her designee, is a member of the Council on the Underground Economy (CUE). Originally established in March of 2008 by Executive Order #499 as the Joint Enforcement Task Force on the Underground Economy and Employee Misclassification (Task Force), the Task Force was codified into law in March of 2015. The CUE consists of "the secretary of labor and workforce development, or a designee, who shall serve as the chair; the director of the department of unemployment assistance, or a designee; the director of the department of industrial accidents, or a designee; the director of labor standards, or a designee; the commissioner of revenue, or a designee; the chief of the attorney general's fair labor division, or a designee; the commissioner of public safety, or a designee; the director of professional licensure, or a designee; the executive director of the insurance fraud bureau, or a designee; and [eight] persons appointed by the governor who represent government agencies."[20] The CUE is charged with coordinating the investigative efforts among multiple state agencies to eliminate workplace fraud and employee misclassification.

Central to the CUE'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 CUE benefits consumers and taxpayers by helping to ensure that purchased goods are properly licensed and regulated and that lost tax revenues are recovered. The DIA's Office of Investigations plays an active role in the efforts of the CUE.

[20] MGL c.23, §25

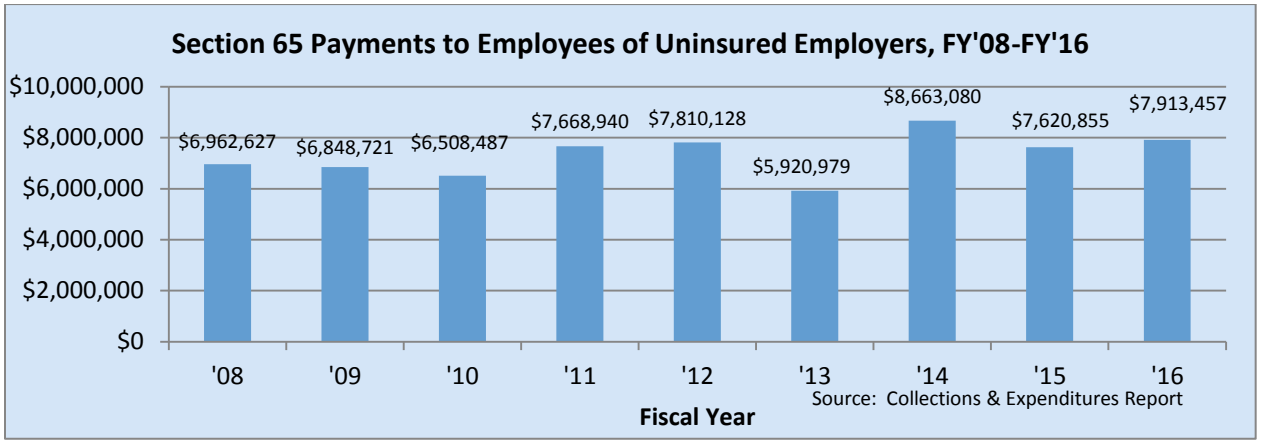
WORKERS' COMPENSATION TRUST FUND

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.[21] In FY'16, $7,088,434 was paid to and on behalf of uninsured claimants. The Trust Fund processed 9,071 payments to claimants and medical providers in 552 cases during FY'16. In FY'16, 138 individuals filed a total of 146 new claims. The DIA aggressively pursues uninsured employers to recoup monies paid out from the Trust Fund. In FY'16, $1,746,315 was collected through recovery efforts.

FIGURE 21: SECTION 65 PAYMENTS TO EMPLOYEES OF UNINSURED EMPLOYERS, FY'08-FY'16



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

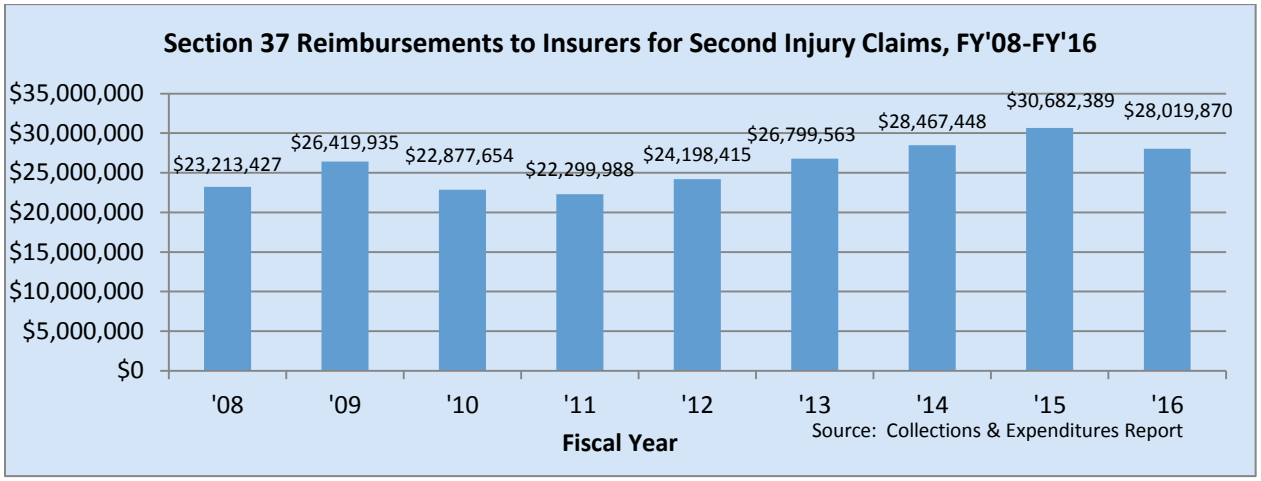
In an effort to encourage employers to hire previously injured workers, the Legislature established a Second Injury Fund (SIF) to offset any financial disincentives associated with the employment of impaired workers. Section 37 allows insurers to be reimbursed by the Trust Fund when compensation is being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

[21] 452 CMR 3.00

Fund for up to 75% of compensation paid after the first 104 weeks of payment.[22] 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'16, 1,834 payments (253 original settlements and 1,581 quarterlies) representing 888 cases were processed as a result of second injury. The total amount paid in all claims in FY'16 was $28,019,870.

FIGURE 22: SECTION 37 REIMBURSEMENTS TO INSURERS FOR SECOND INJURY CLAIMS, FY'08-FY'16



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."[23] 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.)

[22] 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.

[23] 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 (1994).

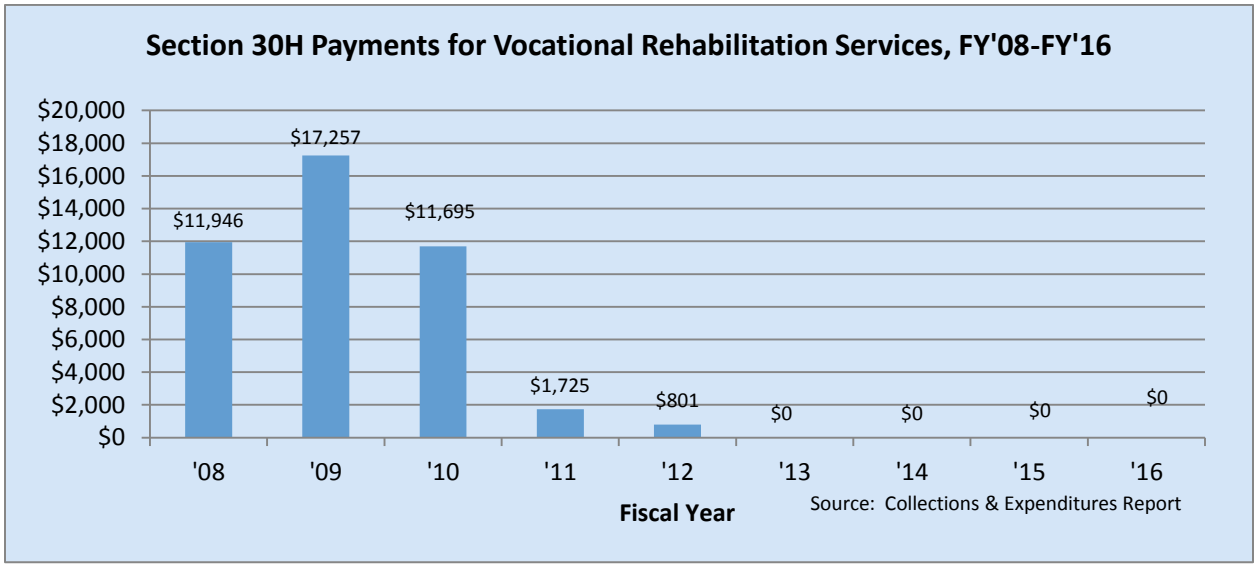
FIGURE 23: SECOND INJURY FUND OVERVIEW

"Old Act" (1973 - 1986)
■ 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)
■ 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)
■ 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'16, 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, FY'08-FY'16



Latency Claims (Section 35C)

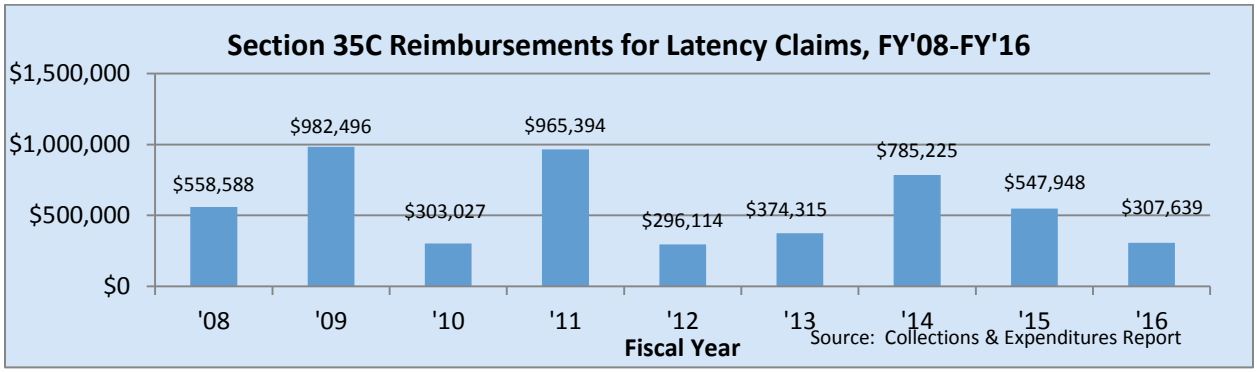
Because some occupational diseases and illnesses might not show up until many years after initial injury or exposure, the Legislature added §35C to the Workers' Compensation Act in 1985:

> "[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'16, the Trust Fund paid out $307,639 for latency claims.

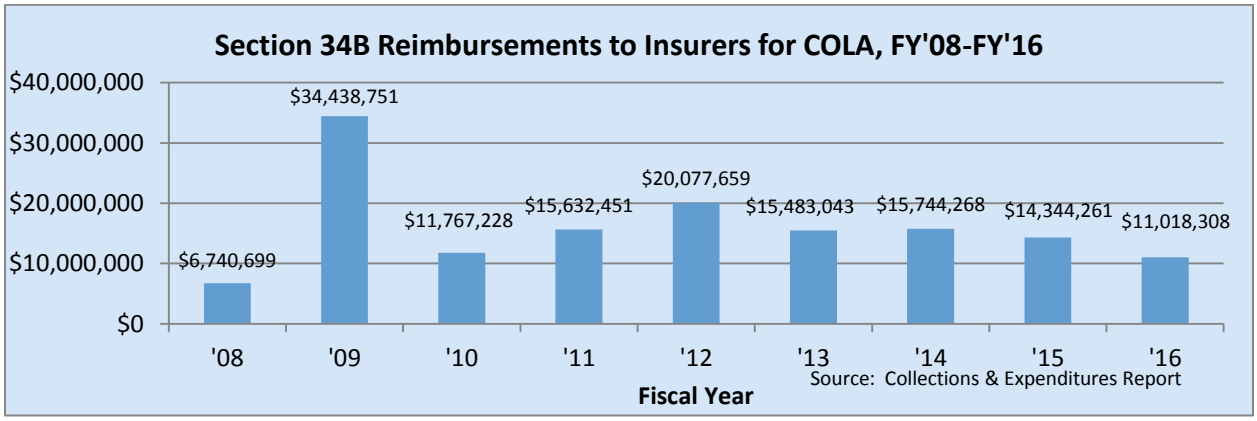
FIGURE 25: SECTION 35C REIMBURSEMENTS FOR LATENCY CLAIMS, FY'08-FY'16



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'16 totaled $0 for the Public Trust Fund and $11,018,308 for the Private Fund. In this context, the term "COLA payments" means reimbursements to insurers for their supplemental cost of living adjustments to injured workers.

FIGURE 26: SECTION 34B REIMBURSEMENTS TO INSURERS FOR COLA, FY'08-FY'16



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'16, 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 and self-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'16, the Executive Director of the OHP received and responded to seven 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 DIA Director (see Appendix F for a list of HCSB members). The HCSB met throughout FY'16, 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'16, the HCSB received four 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.

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. In FY'16, the HCSB created a new Opioid/Controlled Substance Protocol and revised the Chronic Pain Treatment Guideline.

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'06 and continued through FY'11. In Phase II, the focus was on assessments calculated and remitted during a 5-year review period from January 1, 1999 to December 31, 2003. The insurance companies reviewed as part of Phase II include both companies currently licensed to write workers' compensation insurance in Massachusetts, as well as companies that no longer write new business in Massachusetts, but did so during the applicable review time period. Phase II encompassed a selection of companies that ranged from single insurance carriers to multi-company insurance groups. The DIA's clarification of the definition of standard premium has effectively decreased confusion in the insurance industry regarding assessment calculation, thus resulting in the increased accuracy of assessment payment by insurance companies on a quarterly basis.

Assessment Audit - Phase III and Beyond

In FY'08, Phase III of the assessment reviews began and continued through FY'16. DIA auditors are currently auditing the time period between January 1, 2004 and December 31, 2012. In FY'16, as a result of CPA reviews the DIA collected $1,330,854.81 from companies under assessment review.

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'16

Assessment Recovery Project Fiscal Year 2000 – Fiscal Year 2016		
Fiscal Year	***Amount Collected***	***Cumulative Amount***
Fiscal Year 2000	$158,704	$158,704
Fiscal Year 2001	$67,793	$226,497
Fiscal Year 2002	$1,106,377	$1,332,874
Fiscal Year 2003	$1,539,935	$2,872,809
Fiscal Year 2004	$223,939	$3,096,748
Fiscal Year 2005	$4,537,865	$7,634,613
Fiscal Year 2006	$1,847,086	$9,481,699
Fiscal Year 2007	$92,685[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	$252,797[4]	$14,832,938
Fiscal Year 2015	$3,066,350	$17,899,288
Fiscal Year 2016	**$1,330,855[5]**	**$19,230,143**

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.

[5] The Office of Assessments & Compliance also collected an additional amount of $82,994,007 from insurance companies during FY'16.

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, and administrative support staff. 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 owner with the exception of the Springfield office, which is located in a building owned by the Commonwealth. The regional managers are responsible for the day-to-day operations in their respective offices. These managers work with building management to ensure the building is accessible and that the terms of the lease agreements are met.

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 Street, 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

SECTION
-5-

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 is adequately funded, 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, 2016, the referral fee is $839.63 (65% of the current State Average Weekly Wage);
Fines: There are three types of fines:

1. Stop Work Order Fines
2. Late First Report Fines
3. 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.[24] The assessment rate for private sector employers in FY'16 is 5.750% 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.

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

[24] 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.

reimburse insurers for benefits for second and latent injuries, injuries involving veterans and for specified cost of living adjustments.[25]

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 (EOLWD).

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.

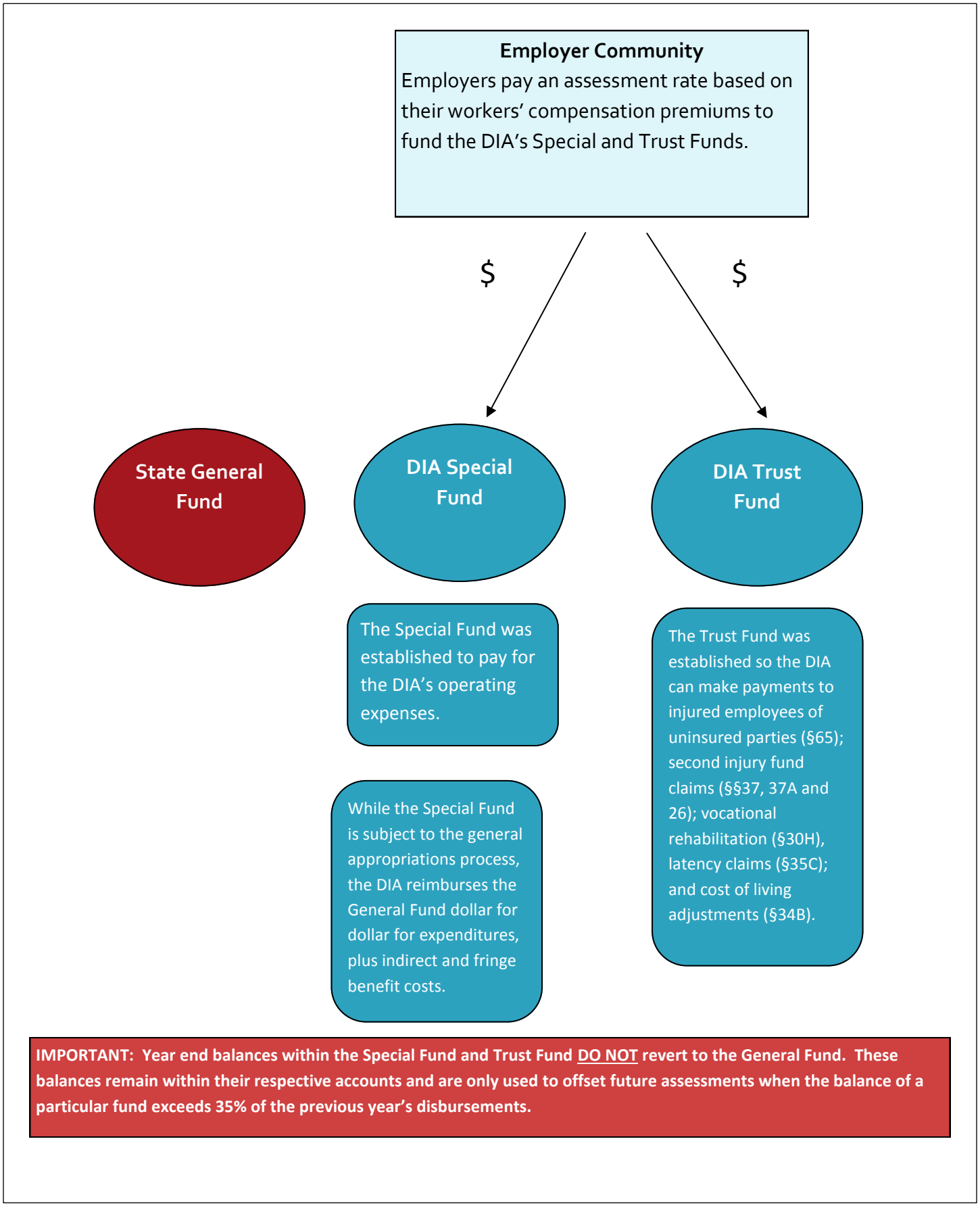
In May and June, the DIA uses consulting actuaries to estimate future expenses and determine the assessments necessary to fund the Special Fund and Trust Fund. This process is discussed in greater detail in the next section of this report. The budgets and corresponding assessments must be submitted to the Secretary of 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. To be clear, the intent is for the DIA to carry an excess balance up to 35% and that if at the end of any given fiscal year the balance exceeds this amount, the Agency must lower its assessment rate to bring the balance down.

[25] M.G.L. c. 152, §65(2).

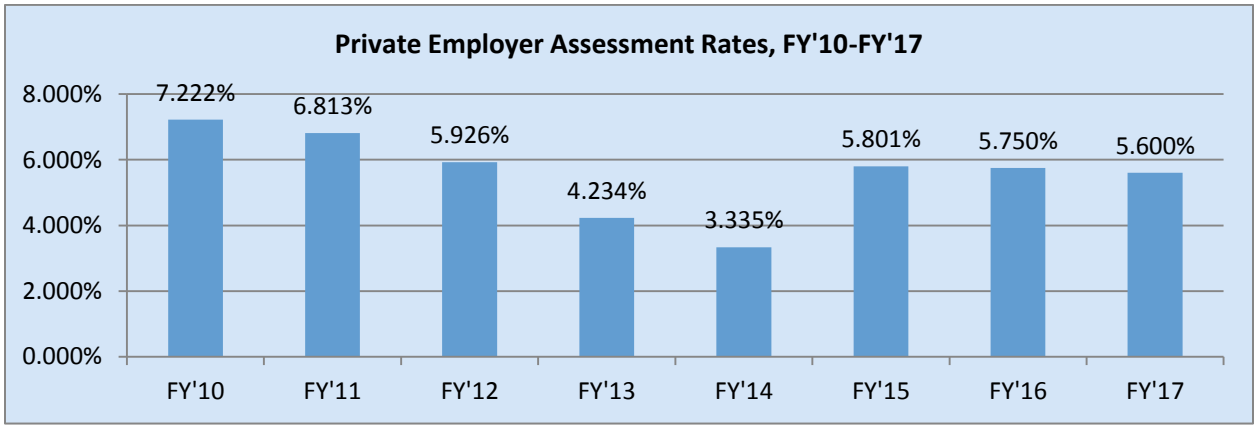
FIGURE 28: THE DIA'S UNIQUE FUNDING PROCESS



PRIVATE EMPLOYER ASSESSMENTS

On June 30, 2016, Deloitte & Touche LLP ("D&T") released an analysis of the DIA's FY'17 assessment rates, calculated pursuant to M.G.L. c.152, § 65 (4) and (5). The report details the estimated amounts required by the Special Fund and Trust Fund for FY'17 operations. Included in the report are the assessment rates to be applied to private employer insurance premiums. For FY'17, the private insured assessment rate has been calculated to be 5.600% of standard premium. The Public Fund has no remaining municipalities, thereby resulting in a FY'17 public assessment rate of 0%.

FIGURE 29: PRIVATE EMPLOYER ASSESSMENT RATES, FY'10-FY'17



Fiscal Year 2017 Private Fund (including Special Fund) expenditures are projected to be $84.4M. This represents a 0.9% decrease over the $85.2M FY'16 expenditures projected by D&T in its FY'16 analysis. The decrease is primarily driven by a $1.0 million (or 6.9%) reduction in the projection for COLA payments when compared to last year and a lower projection for Section 37 payments.

Overview of the FY'17 Assessment Rate Calculation

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

1. Project FY'17 Disbursements;
2. Project FY'17 income (excluding assessments);
3. Estimate FY'17 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'17; and
6. Calculate the assessment rate, the assessment ratios, and the assessment base factors.

1. Fiscal Year 2017 Projected Disbursements: $84.4M

The first step in the assessment calculation is to determine expected FY'17 expenditures. Private employers are assessed for the sum of the Private Trust Fund and Special Fund budgets.

Private Trust Fund Budget	**Projected FY'17 Expenditures**	**+/- FY'16 Projected Expenditures**
Section 37 (2nd Injuries)	$30,000,000	-$373,404
Uninsured Employers	$8,202,000	-$398,000
Section 30H (Rehabilitation)	$0	$0
Section 35C (Latency)	$400,000	-$209,352
Section 34B (COLAs)	$13,800,000	-$1,022,290
Defense of the Fund	$7,629,000	$856,845
Total:	$60,031,000	-$1,146,201

Special Fund Budget	**Projected FY'17 Expenditures**	**+/- FY'16 Projected Expenditures**
Total:	$24,343,000	$306,750

Priv. Employ. Expenditures	**Projected FY'17 Expenditures**	**+/- FY'16 Projected Expenditures**
Total:	$84,374,000	-$839,451

2. Projected Fiscal Year 2017 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): $5,400,000
Income Due to Reimbursements: $1,500,000
Estimated Interest Income: $25,500 (Private Fund: $15,000/Special Fund: $10,500)
Total Projected FY'17 Income: $6,925,500

This represents a 31.0% decrease from the Fiscal 2016 estimated income of $10.0 million due to the inclusion in the prior year of an additional estimated $3 million in income due to premium audits. This year, the DIA informed D&T that less audit insurer premiums than anticipated were realized.

3. Adjustments to Fund Balances: $7.1M

A. 35% Rule Adjustments (M.G.L. c.152, §65(4)(c)): None

M.G.L. c. 152, §65(4)(c) provides that significant overages in the funds balances for the current fiscal year must be used to reduce the subsequent year's rate. Specifically, any amount greater than 35% of FY'16 expenditures in a particular fund must be used to reduce amounts assessed for that fund in FY'17. At the end of FY'16, the balances of the Private and Special Funds will not have surpluses exceeding 35% of FY'15 disbursements, therefore no adjustments are necessary.

Special Fund	FY'16 Estimated Year End Balance	35% of FY'15 Expenditures	Amount of Required Reduction
	$5,469,876	$7,919,170	None

Private Trust Fund	FY'16 Estimated Year End Balance	35% of FY'15 Expenditures	Amount of Required Reduction
	$11,577,672	$20,935,973	None

B. Other Adjustments: $7.1M

According to the DIA, this year their focus is to accomplish the greatest rate reduction that would also minimize the exposure of needing to increase the future rate because of an economic downturn. With this in mind, the DIA requested that D&T include a balance adjustment that would bring the insured employer rate to 5.600%, which requires a balance adjustment of $7.1 million ($5.9 million in the Private Fund and $1.2 million in the Special Fund) in additional collections.

SPECIAL FUND	FY'16 Estimated Year End Balance	Balance Adjustments	FY'17 Estimated Year End Balance
	$5,469,876	$1,155,075	$6,624,951

PRIVATE TRUST FUND	FY'16 Estimated Year End Balance	Balance Adjustments	FY'17 Estimated Year End Balance
	$11,577,672	$5,936,765	$17,514,437

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'16, 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.

	Opt-In	Opt-Out	Total
Disbursements	$79,913,585	$4,460,415	$84,374,000
Income	$6,155,602	$769,898	$6,925,500
Balance Adjustments	-$6,822,364	-$269,476	-$7,091,840
Total Budget	$80,580,347	$3,959,993	$84,540,340
Allocation %	95%	5%	100%

D&T then allocated the assessment budget among the opt-in and opt-out entities based on the loss base. The assessment budget allocated to private insured entities was calculated to be $73,172,190.

5. Calculation of the Assessment Bases

Loss Assessment Base

The FY'17 assessment loss base is $811.8M, composed of estimated insured, self-insured and group losses. Insured and self-insured entities losses are based on actual loss data from 2005-2015. D&T estimated the loss assessment base for self-insured groups based on 2011 and 2012 data. No new data has been provided since Fiscal Year 2014 analysis. The assessment loss base allocated to insured entities was estimated to be $636,122,187.

Premium Assessment Base

The methodology for estimating premium bases for all five groups has changed this year, no longer relying on converting the WCRIB's estimated written premium to standard written premium. This year, D&T calculated the actual premium base implied from collected assessments and assessment rates in prior fiscal years for each group and made a selection based on these prior years. The FY'17 premium base selection for insured entities is $1.298B, compared to $1.203B estimated in D&T's FY'16 analysis.

6. Calculation of the Assessment Rates, the Assessment Ratios and the Assessment Base Factors

Assessment Ratio for Private Insured Entities

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 (Private Insured)	/ Loss Assessment Base (Private Insured)	= Assessment Ratio (Private Insured)
$73,172,190	$636,122,187	11.503%

Assessment Base Factor for Private Insured Entities

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 (Private Insured)	/ Premium Assessment Base (Private Insured)	= Assessment Base Factor (Private Insured)
$636,122,187	$1,298,000,000	49.008%

Assessment Rates for Private Insured Entities

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

Assessment Ratio	x Assessment Base Factor	= Assessment Rate
0.115	0.490	**5.635%** (pre collection lag adjustment (see below))

As in FY'16, the rate calculation methodology reflects the timing lag between the beginning of FY'17 and the collection of the new assessment rate. For the first quarter of FY'17, the higher FY'16 rate will

continue to be the rate collected. Therefore, the rate was adjusted downward to account for the higher collection amount during the first quarter of FY'17. Accounting for the timing lag, 5.600% will be the FY'17 assessment rate for private insured entities.[26]

[26] While this report focuses on the assessment rate calculation for private insured entities, the DIA and D&T use a similar methodology to calculate assessment rates for four other segments: 1) self-insured entities, opt in; 2) self-insured entities, opt out; 3) self-insured groups, opt in; and 4) self-insured groups, opt out. The resulting rates differ because each segment has its own premium base, loss base and assessment ratios.

DIA Operating Budget

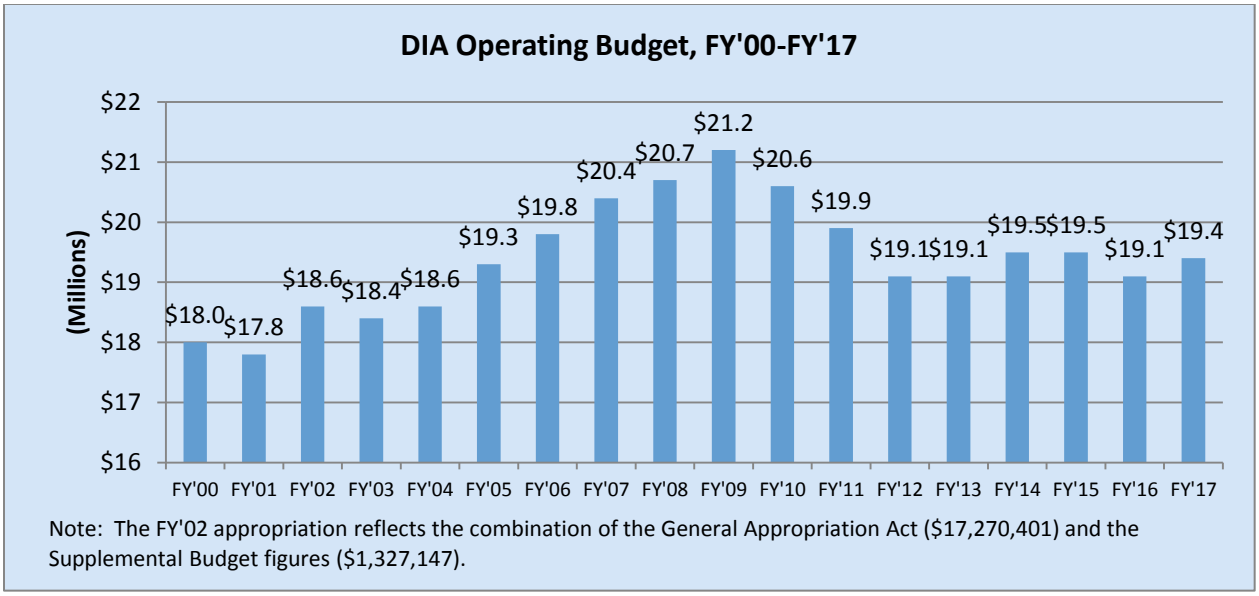
Fiscal Year 2017 General Appropriations Act

On July 8, 2016, Governor Baker signed the FY'17 General Appropriations Act (GAA), which allocated $19,412,000 for DIA operating expenses (line item 7003-0500). The amount is $267,895 more than the amount appropriated to DIA in the FY'16 GAA ($19,144,105).

Table 17: Budget Process for DIA (Line-Item 7003-0500), FY'16 and FY'17

Fiscal Year 2016 Budget Process		Fiscal Year 2017 Budget Process	
DIA Request	$19,830,000	DIA Request	$19,412,000
Governor's Rec.	$19,830,000	Governor's Rec.	$19,412,000
Full House	$19,144,105	Full House	$19,412,000
Full Senate	$19,830,000	Full Senate	$19,412,000
Conference	$19,144,105	Conference	$19,412,000
GAA	$19,144,105	GAA	$19,412,000
9C Budget Reduction	N/A	9C Budget Reduction	N/A
Total	$19,144,105	Total	$19,412,000

Figure 30: DIA Operating Budget, FY'00-FY'17



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

The Budget Process

The operating budget of the DIA is appropriated by the Legislature even though employer assessments fund the Agency. The Agency, therefore, must abide by the budget process in the same manner as most other tax-funded government agencies. 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)**	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. 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.
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: **9C Cuts** **(Any time during the fiscal year)**	Even after the budget is completed, the Governor can announce 9C 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 9C powers to reduce funding in the Executive Branch.

SECTION
-6-

INSURANCE COVERAGE

MANDATORY INSURANCE COVERAGE

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

[27] This mandate includes sole proprietors that are incorporated, domestics and seasonal workers that average over 16 hours of work a week, and family businesses employing family members. There are certain categories of workers for whom insurance is not required. Seamen, some professional athletes, and unincorporated sole proprietors are exempt.

[28] 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 policyholders as well as terms of policies, premium calculations, credits and deductibles.

The Insurance Market

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

Commercial insurance carriers are regulated by the DOI, which licenses carriers, monitors solvency, determines rates, approves the terms of policies, and adjudicates unfair claims handling practices. In FY'16, the DOI approved a total of seven new licenses for carriers to write workers' compensation insurance in Massachusetts. In addition, two existing licenses were amended to include workers' compensation. During the same period, 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.[29] 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

[29] 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.[30]

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."[31]

On April 20, 2016, Insurance Commissioner Daniel R. Judson approved a 1.5% increase to average workers' compensation rates for policies taking effect on or after July 1, 2016. The decision was based on an agreement reached by the State Rating Bureau, the Workers' Compensation Rating & Inspection Bureau (WCRIB), and the Attorney General's Office.

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, 1991-2016

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
2015	No Change	$33.21
2016	**+1.5%**	**$33.71**

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

[30] 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.
[31] M.G.L. c.152, §53A(2).
[32] M.G.L. c.152, §53A(9).

In calendar year 2015, approximately 51 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 22 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.[33]

The Classification System

Workers' compensation insurance rates are calculated and charged to employers according to industry categories called classifications. Every employer purchasing workers' compensation insurance is assigned a basic classification determined by the nature of its operations. Standard exception classifications may then be assigned for low-risk tasks performed within most companies (i.e. clerical work).

Classifications were developed on the theory that the nature, extent and likelihood of certain injuries are common to any given industry. Each classification groups together employers that have a similar exposure to injuries, which distributes the overall costs of workers' compensation equitably among employers. Without a classification system, employers in low-risk industries would be forced to subsidize high-risk employers through higher insurance costs.

Regulation of Classifications - Classifications in Massachusetts are established by the WCRIB, subject to approval by the Commissioner. Hearings are conducted at the DOI to determine whether classifications and rates are "not excessive, inadequate or unfairly discriminatory" and that they fall within a "range of reasonableness."

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

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

Standard Exception Classifications - In addition to the 600 basic classification codes that exist in Massachusetts, there are 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

[33] http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/mass-div-of-insurance.html.

classification. These low cost standard exception classifications are: Clerical Office Employees (Code 8810), Drafting Employees (Code 8810), Drivers, Chauffeurs and their Helpers (Code 7380), and Salespersons, Collectors or Messengers-Outside (Code 8742).

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

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

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

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

Manual Rate - Every classification has a corresponding manual rate that is representative of losses sustained by the industry. An employers' base rate is based on manual rate per $100 of payroll, for each governing and standard exception classification.

Class Code	Governing Classification	Manual Rate	Payroll	Base Rate
5188	Automatic Sprinkler Installation & Drivers	$4.94	$200,000	$9,880

Class Code	Governing Classification	Manual Rate	Payroll	Base Rate
8810	Clerical Employees	$.07	$50,000	$35

Appealing a Classification - When a new company applies for insurance, the broker or agent assigns a classification, which is audited by the insurance carrier at the end of the policy year. If the carrier determines that the employer or their employees were misclassified, the employer is charged additional premium or receives a credit for the correct class. The WCRIB is responsible for determining the proper classification for all insured in Massachusetts. If an employer disagrees with its assigned classification, or believes a separate classification should be created, there is an appeal process made available by M.G.L. c.152, §52D. A formal appeal must be filed with the WCRIB's Governing Committee (for those insured in the Voluntary Market) or the Residual Market Committee (for those insured in the Assigned Risk Pool). The WCRIB will send an auditor to the worksite and proceed to make a ruling on the classification in question. If reclassification is denied, an appeal can be made to the Commissioner. A

hearing officer will then be selected by the Commissioner to conduct an evidentiary hearing on the classification issue.

Construction Industry - In the construction industry alone, there are over 67 different classifications for the various types of construction operations. Often, multiple classifications must be assigned to large general contractors who use different trades during the many phases of construction projects. Separate payrolls must be maintained for separate classifications or else a construction company can be assigned to the highest rated classification that applies to the job or location where the operation is performed.

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

Premium Calculation

The premiums charged to employers in Massachusetts are dependent on several factors that are designed to measure each company's exposure to loss. Premium is based on uniform rates that are developed for each classification and modified according to the attributes of each employer. In return for payment of premiums, the insurance company will administer all workers' compensation claims and pay all medical, indemnity, rehabilitation, and supplemental benefits due under the Workers' Compensation Act. The following is an overview of the premium calculation process.

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

Manual Premium = (Manual Rate x Payroll)/100

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

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

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

Standard Premium = Manual Premium x Experience Modification Factor

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

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

All Risk Adjustment Program - In January of 1990, the WCRIB instituted the All Risk Adjustment Program (ARAP), which is calculated in addition to the experience modification factor. The ARAP surcharges experience-rated risks, both voluntary and assigned, with a record of losses greater than expected under the Experience Rating Plan. The purpose of this program is to provide a revised pricing mechanism for experience-rated risks to share in the underwriting losses they generate. The WCRIB will calculate the ARAP adjustment and identify it as a separate factor on the experience rating calculation sheet.

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

Premium Discounting

Insurance companies that provide workers' compensation coverage must factor in the various expenses involved with servicing insureds to determine appropriate premium levels. However, problems can occur when pricing premiums for large policies because as the premium increases, the proportion required to pay expenses decreases. In an effort to compensate for these differences, insurers must provide a premium discount to large policy holders. The premium discount increases as the size of the policy premium increases, resulting in a premium that better reflects costs. In Massachusetts, policy holders are entitled to a premium discount if they are paying over $10,000 in premiums. Carriers must elect to use the "Type A" or "Type B" tables to determine the premium discount. Abbreviated versions of the tables are included below.

TABLE 19: 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[34] *Effective April 1, 2014*	
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

[34] 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[35] *Effective April 1, 2014*			
Basis for the Aggregate Limit	**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 Basis for the Aggregate Limit	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.[36] 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.[37]

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

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

that maintain effective loss control programs. If losses are low, the insured will pay less than standard premium. However, there is a significant uncertainty regarding the final premium amount, since it is impossible to be precise in predicting the volume or severity of workplace accidents. An unexpected claim towards the end of a policy period can be detrimental to a company, if funds have not been set aside for the retro-premium. Furthermore, there is little incentive for the insurance company to limit settlement costs, when they are able to recover payments made on claims brought against the policyholder.

Dividend Plans

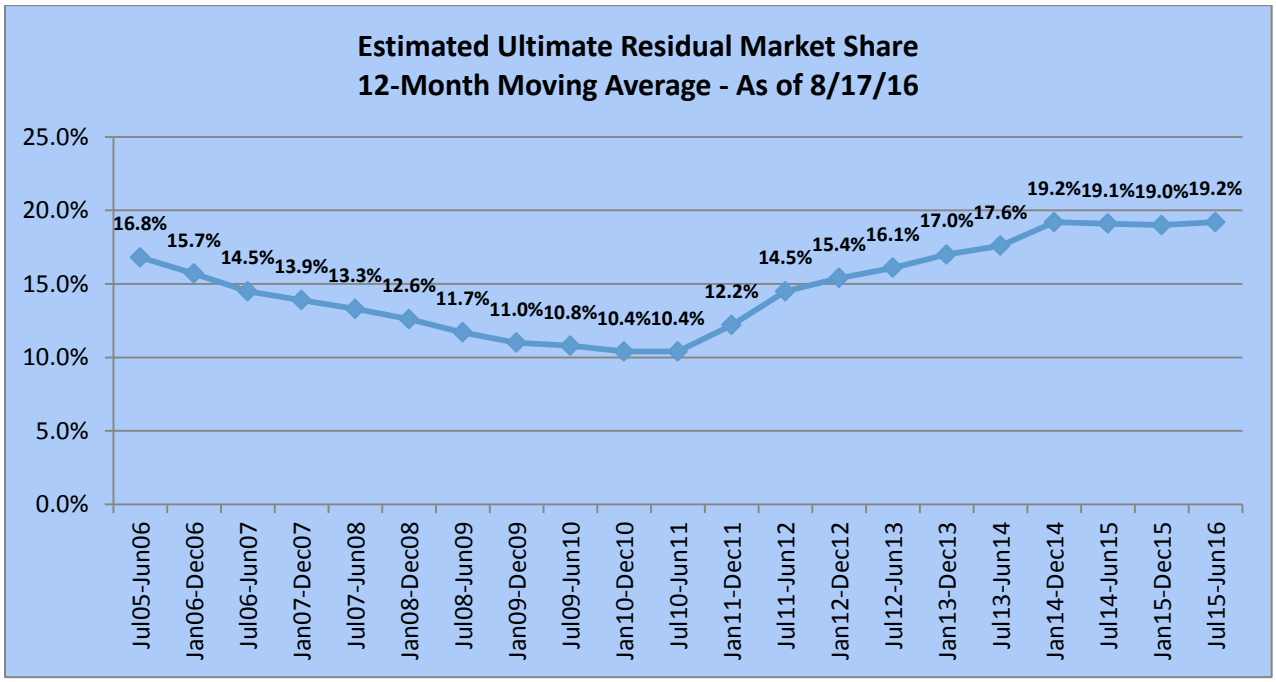
Offered as another means of reducing an employer's insurance costs, dividend plans can provide the policy owner with a partial return on a previously paid premium. This payment from the insurer takes into account investment income, expenses, and the insured's overall loss-experience in a given year.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

ASSIGNED RISK POOL

Any employer rejected for workers' compensation insurance can obtain coverage through the residual market, known as the Assigned Risk Pool. Administered by the Workers' Compensation Rating and Inspection Bureau (WCRIB), the Assigned Risk Pool is the "insurer of last resort" and is required by law to provide coverage when an employer is rejected by at least two carriers within five business days. Very small employers and companies in high-risk classifications or having poor experience ratings often cannot obtain insurance in the voluntary market. This occurs when a carrier determines that the cost of providing insurance to a particular company is greater than the premium it can collect. The estimated ultimate residual market share for the 12-month period ending June 2016 is 19.2%. 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 2016) residual market loss ratio for policy year 2015 is 73.0%.

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 2014, the estimated Residual Market Burden (as of the first quarter of 2016) was 3.62%, assuming a Loss Ratio of 77.0% and an Intermediate VDAC Reapportionment factor of 1.01.[38]

[38] WCRIB Special Bulletin No. 8-16 (July 29, 2016).

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.[39] 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'16

Fiscal Year	New Licenses	Total Licenses	Companies Covered	Equivalent Premium Dollars
FY'16	1	85	308	$264M$
FY'15	0	89	392	$268M
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

[39] 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.[40]

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, 2016, Massachusetts had 25 active SIGs (4 were in runoff) and there were 5,843 members of SIGs.

TABLE 23: MEMBERSHIP IN SIGS, 1991-2016

Membership in Workers' Compensation Self Insurance Groups as of Jan. 1st		
Year	Number of Groups	Number of Members
1991	8	N/A
1992	21	N/A
1993	28	N/A
1994	27	2,300
1995	31	2,550
1996	32	2,700
1997	30	2,830
1998	26	2,880
1999	25	2,821
2000	24	Unavailable
2001	25	Unavailable
2002	25	3,000
2003	24	3,456
2004	24	3,768
2005	25	4,472
2006	25	4,696
2007	25	5,086
2008	24	5,453
2009	24	5,553
2010	22	5,381
2011	22	5,581
2012	21	5,730
2013	22	5,647
2014	21	5,802
2015	21	5,843
2016	25	5,843

Source: Division of Insurance

[40] 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.

As of June 30, 2016, the IFB's Workers' Compensation Fraud Team was made up of an Investigative Manager plus six investigators dedicated to workers' compensation premium evasion and claimant cases. 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 calendar year 2015, each of these bureaus contributed $4.65 million to fund the IFB for a total of $9.3 million, which was an increase of $200,000 over the Bureau's 2014 expenses ($9.1 million). The difference between the budget and actual expenses ($687,915) was refunded back to the AIB and WCRIB (50/50) in 2015.

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 2015, the IFB received 3,658 referrals; of those 296 were workers' compensation fraud. Workers' compensation fraud referrals only represent 8% of all IFB referrals. The vast majority of referrals (75%) received by IFB are for automobile insurance fraud (2,750 in calendar year 2015). 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 101 workers' compensation cases worked on in 2015. 42 of those cases have been closed without prosecution recommended; 10 workers' compensation cases were referred for prosecution. In 2015, there were ten individuals indicted or complaints issued. Restitution ordered in 2015 for workers compensation cases totaled $368,798.

FISCAL YEAR 2016 ANNUAL REPORT

APPENDICES

APPENDIX A – Advisory Council Members, FY'16

<table>
<tr><th colspan="4">Advisory Council Members</th></tr>
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<tr><th colspan="4">Staff</th></tr>
<tr><td colspan="4">Evelyn N. Flanagan, Acting Executive Director</td></tr>
</table>

APPENDIX B – Advisory Council Studies, 1989-2016

- Actuarial Analysis of the Insurance Rate Filing as Submitted by the Workers' Compensation Rating & Inspection Bureau of Massachusetts, KPMG (2005).
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APPENDIX C - Joint Committee on Labor & Workforce Development, 2015-2016 Session

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Representative Keiko M. Orrall
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APPENDIX E – Governor's Council, 2016

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(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.

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Marilyn M. Petitto Devaney - District 3
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APPENDIX F – Health Care Services Board, 2016

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Current Members (2013):

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

Staff:

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

APPENDIX G – Roster of Judicial Expiration Dates

(As of December 30, 2016)

INDUSTRIAL ACCIDENT REVIEWING BOARD - SIX YEAR TERMS

1.	Carol Calliotte	Democrat	05/01/19
2.	Bernard Fabricant	Unenrolled	09/21/22
3.	Martin Long	Democrat	01/04/23
4.			
5.	William Harpin	Unenrolled	08/08/18
6.	Catherine W. Koziol	Democrat	08/18/20

INDUSTRIAL ACCIDENT BOARD - SIX YEAR TERMS

1.	Douglas Bean	Republican	06/26/17
2.	Sabina Herlihy	Independent	05/29/19
3.	Honor Segal	Democrat	01/04/23
4.	Dennis Maher	Democrat	09/15/20
5.	David Braithwaite	Democrat	01/06/21
6.	David Sullivan	Democrat	09/21/16
7.	Steven Rose	Republican	05/28/22
8.	Richard Heffernan	Democrat	09/01/21
9.			
10.	John Barrett	Republican	01/06/21
11.	Roger Lewenberg	Unenrolled	09/21/16
12.			
13.			
14.	Yvonne Vieira-Cardoza	Democrat	06/19/19

15.	Maureen McManus	Republican	09/21/22
16.	Karen Fitzgerald	Democrat	01/06/21
17.	Dianne Solomon	Unenrolled	08/10/18
18.	Paul Benoit	Unenrolled	08/18/20
19.	Omar Hernandez	Democrat	12/29/17
20.	Michael Williams	Democrat	08/08/18
21.	Joseph Spinale	Republican	01/04/23

APPENDIX H – WCAC Letter to Judiciary Committee, 7/30/15

MASSACHUSETTS WORKERS' COMPENSATION
ADVISORY COUNCIL

1 CONGRESS STREET, SUITE 100
BOSTON, MASSACHUSETTS 02114-2017
(617) 727-4900, EXT. 7378
WWW.MASS.GOV/WCAC/

CHARLES D. BAKER
GOVERNOR
KARYN E. POLITO
LIEUTENANT GOVERNOR

STEPHEN JOYCE
CHAIR
JOHN R. REGAN
VICE-CHAIR
WILLIAM S. MONNIN-BROWDER
EXECUTIVE DIRECTOR

July 30, 2015

The Honorable William N. Brownsberger
The Honorable John V. Fernandes
Joint Committee on Judiciary
State House, Room 136
Boston, MA 02133

RE: Workers' Compensation Advisory Council Support for House Bill 1427

Dear Chairman Brownsberger and Chairman Fernandes:

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 July 8, 2015, Advisory Council members carefully reviewed and voted to **support House Bill 1427** filed by Representative Mary Keefe.

House Bill 1427 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. 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. Currently, however, there is not a penalty for contracting or participating in a contract while debarred. This bill would penalize employers who violate §25C(10) with a fine of up to $250,000, imprisonment for up to one year, or both, for a first offense. Any subsequent "willful" violation would carry a fine of up to $500,000, imprisonment for up to two years, or both.

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

Sincerely,

Stephen Joyce

John R. Regan

cc: Members of the Joint Committee on the Judiciary
The Honorable Mary Keefe (House Bill 1427 Sponsor)

APPENDIX I – WCAC Letter to Labor and Workforce Development Committee Hearing, 5/26/2015

MASSACHUSETTS WORKERS' COMPENSATION
ADVISORY COUNCIL

1 CONGRESS STREET, SUITE 100
BOSTON, MASSACHUSETTS 02114-2017
(617) 727-4900, EXT. 7378
WWW.MASS.GOV/WCAC/

CHARLES D. BAKER
GOVERNOR
KARYN E. POLITO
LIEUTENANT GOVERNOR

STEPHEN JOYCE
CHAIR
JOHN R. REGAN
VICE-CHAIR
WILLIAM S. MONNIN-BROWDER
EXECUTIVE DIRECTOR

July 30, 2015

The Honorable Daniel A Wolf
The Honorable John W. Scibak
Joint Committee on Labor and Workforce Development
State House, Room 43
Boston, MA 02133

RE: Workers' Compensation Advisory Council Opposition to House Bills 1684, 1686, 1726 and Senate Bill 976

Dear Chairman Wolf and Chairman Scibak:

As you may be aware, 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 July 8, 2015, Advisory Council members carefully reviewed and voted to **oppose** the following pieces of legislation:

- **House Bill 1684/Senate Bill 976**, An Act Increasing Injured Workers' Access to Medical Care and Workers' Compensation Benefits;
- **House Bill 1686**, An Act Relative to Workers' Compensation Law Governing Certain Applicable Wages and Fees; and
- **House Bill 1726**, An Act Relative to Fairness in Workers' Compensation Benefits.

The Advisory Council believes that Massachusetts has one of the most effective workers' compensation systems in the country and that changes to the system should build upon its successes. At this time, the Advisory Council does not believe that these bills would positively impact the system, and therefore opposes their passage. The Advisory Council will continue to review workers' compensation legislation and report any relevant findings to your committee.

We thank you for allowing us the opportunity to offer this legislative recommendation and look forward to working with you to continually improve our workers' compensation system.

Sincerely,

Stephen Joyce

John R. Regan

cc: Members of the Joint Committee on Labor and Workforce Development

APPENDIX J – WCAC Letter to House Committee on Bills in Third Reading, 3/14/2016

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL
1 CONGRESS STREET, SUITE 100
BOSTON, MASSACHUSETTS 02114-2017
(617) 727-4900, EXT. 7443
WWW.MASS.GOV/WCAC/

CHARLES D. BAKER
GOVERNOR
KARYN E. POLITO
LIEUTENANT GOVERNOR

STEPHEN JOYCE
CHAIR
JOHN R. REGAN
VICE-CHAIR
WILLIAM S. MONNIN-BROWDER
EXECUTIVE DIRECTOR

March 14, 2016

The Honorable Theodore C. Speliotis
House Committee on Bills in the Third Reading
State House, Room 20
Boston, MA 02133

RE: Workers' Compensation Advisory Council Opposition to House Bill 3972

Dear Chairman Speliotis:

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.

At the Advisory Council's March 9, 2016 meeting, members carefully reviewed and unanimously voted to **oppose House Bill 3972, An Act Relative to Workers' Compensation.** As currently written, M.G.L. c. 152, §35E requires an injured worker who is 65 or older and who has been out of the labor force for at least two years and eligible for old age benefits pursuant to the federal social security act or eligible for benefits from a public or private pension which is paid in part or entirely by an employer to prove that he or she would have remained active in the labor market in order to obtain certain workers' compensation benefits. This bill would add M.G.L. c. 152, §34A (permanent and total disability benefits) to the categories of benefits covered by §35E. The Advisory Council believes that this change would be an undue burden on injured workers.

The Advisory Council believes that Massachusetts has one of the most effective workers' compensation systems in the country and that changes to the system should build upon its successes. At this time, the Advisory Council does not believe that this bill would positively impact the system, and therefore opposes its passage.

We thank you for allowing us the opportunity to offer this legislative recommendation and look forward to working with you to continually improve our workers' compensation system. If you have any questions, please do not hesitate to contact us.

Sincerely,

Stephen Joyce

John R. Regan

cc: Members of the Massachusetts House of Representatives

APPENDIX K – 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 L – Safety Grants Funded, FY'16

SAFETY GRANTS FUNDED

New England Carpenters
13 Holman Road
Millbury, MA 01527
Category of Applicant: Trade
Geographic Target: Worcester
Program Administrator: Markita Durant
Total Funds Approved: $25,000.00

New England Studio Mechanics (IATSE)
10 Tower Office Park, Suite 218
Woburn, MA 01801
Category of Applicant: Trade
Geographic Target: Middlesex
Program Administrator: Gregg McCutcheon
Total Funds Approved: $24,984.11

Bills Taxi Service Inc.
1001 Bedford Street
Bridgewater, MA 02324
Category of Applicant: Private
Geographic Target: Plymouth
Program Administrator: Diane Miller
Total Funds Approved: $24,980.00

Home Builders & Remodelers Association
51 Pullman Street
Worcester, MA 01606
Category of Applicant: Non-Profit
Geographic Target: Worcester
Program Administrator: Pat Chalifoux
Total Funds Approved: $24,963.10

Lowell Regional Water Utility
The City of Lowell
815 Pawtucket Blvd.
Lowell, MA 01854
Category of Applicant: Non-Profit
Geographic Target: Lowell
Program Administrator: Steven Duchesne
Total Funds Approved: $24,945.89

Paul Davis Restoration
215 Plain Street
North Attleboro, MA 02760
Category of Applicant: Private
Geographic Target: Bristol
Program Administrator: Cathy DiPilato
Total Funds Approved: $24,888.20

Cape Cod Safety Trainers
70 Sparrow Way
South Yarmouth, MA 02664
Category of Applicant: Private
Geographic Target: Barnstable
Program Admin.: Richard Todd
Total Funds Approved: $24,877.50

Capital Driver Leasing
104 Moody Street
Ludlow, MA 01056
Category of Applicant: Private
Geographic Target: Hampden
Program Admin.: Brenda Sheilds-Dean
Total Funds Approved: $24,868.41

Family Continuity
360 Merrimac Street
Lawrence, MA 01843
Category of Applicant: Non-Profit
Geographic Target: Statewide
Program Admin.: Barbara Wilson/Jo Curtain
Total Funds Approved: $24,824.00

Centerline Communications
95 Ryan Drive
Raynham, MA 02767
Category of Applicant: Private
Geographic Target: Bristol
Program Administrator: Barbara D'Amico
Total Funds Approved: $24,636.75

Bald Builders
6 Merchant St., Suite 1
Sharon, MA 02067
Category of Applicant: Private
Geographic Target: Middlesex
Program Administrator: Joshua Jacoby
Total Funds Approved: $24,610.00

YouthBuild Boston
27 Centre Street
Roxbury, MA 02119
Category of Applicant: Non-Profit
Geographic Target: Suffolk
Program Administrator: Ken Smith or Greg Mumford
Total Funds Approved: $24,396.00

Asbestos Workers
303 Freeport Street
Dorchester, MA 02122
Category of Applicant: Trade
Geographic Target: Suffolk
Program Administrator: Rick Rothwell
Total Funds Approved: $24,182.00

Sheet Metal Workers
1181 Adams Street
Dorchester, MA 02124
Category of Applicant: Trade
Geographic Target: Statewide
Program Administrator: Patty Smart/John Healey
Total Funds Approved: $20,831.18

Oasys Water
407 Brayton Point Road
Somerset, MA 02725
Category of Applicant: Private
Geographic Target: Bristol and Suffolk
Program Administrator: Warren Gaudreau
Total Funds Approved: $19,313.50

Clean Rentals, Inc.
P.O. Box 63100
New Bedford, MA 02746
Category of Applicant: Private
Geographic Target: Bristol
Program Administrator: Ann Bojack
Total Funds Approved: $24,610.00

NASW
14 Beacon Street
Boston, MA 02108
Category of Applicant: Private
Geographic Target: Suffolk
Program Administrator: Michaela Flynn
Total Funds Approved: $24,396.00

North Atlantic Corp.
1255 Grand Army Highway
Somerset, MA 02726
Category of Applicant: Private
Geographic Target: Bristol
Program Administrator: Debra Torres/Barbara Laferriere
Total Funds Approved: $21,346.50

Joseph Botti Co., Inc.
7 Turnpike Street
South Easton, MA 02375
Category of Applicant: Private
Geographic Target: Bristol
Program Administrator: Donna Baker
Total Funds Approved: $20,800.00

Chrystal Ice Co., Inc.
178 Front Street
New Bedford, MA 02740
Category of Applicant: Private
Geographic Target: Bristol
Program Administrator: Robert Hicks
Total Funds Approved: $19,260.00

People Incorporated
4 South Main Street
Fall River, MA 02721
Category of Applicant: Non-Profit
Geographic Target: Bristol
Program Administrator: Megan Scheffer
Total Funds Approved: $18,939.00

Care Dimentions, Inc.
75 Sylvan Street, Suite B 102
Danvers, MA 01923
Category of Applicant: Private
Geographic Target: Essex
Program Administrator: Elizabeth Macomber
Total Funds Approved: $17,120.00

Cold Storage Solutions
310 Kenneth Welch Drive
Lakeville, MA 02347
Category of Applicant: Private
Geographic Target: Plymouth
Program Administrator: Jillian Parenteau
Total Funds Approved: $16,692.00

Baxter Inc.
10 Bayview Street
West Yarmouth, MA 02675
Category of Applicant: Private
Geographic Target: Barnstable
Program Administrator: Jane Baxter
Total Funds Approved: $16,440.55

Riverside
One Cottage Street
Easthampton, MA 01027
Category of Applicant: Non-Profit
Geographic Target: Suffolk
Program Administrator: Charlene Gentes
Total Funds Approved: $14,712.47

Central Metal Finishing Inc.
80 Flagship Drive
North Andover, MA 01845
Category of Applicant: Private
Geographic Target: Essex
Program Admin.: Carol Shibles
Total Funds Approved: $18,447.00

Hollingsworth & Vose
219 Townsend Road
West Groton, MA 01472
Category of Applicant: Private
Geographic Target: Middlesex
Program Administrator: Greg VanFleet
Total Funds Approved: $16,788.30

Boston Plasterers
7 Frederika Street
Dorchester, MA 02124
Category of Applicant: Trade
Geographic Target: Suffolk
Program Administrator: Chris Brousaides
Total Funds Approved: $16,493.79

Worcester JATC
242 Mill Street
Worcester, MA 01602
Category of Applicant: Trade
Geographic Target: Worcester
Program Administrator: Robert Fields
Total Funds Approved: $16,103.50

JGS Lifecare/Jewish Geriatric
770 Converse Street
Longmeadow, MA 01106
Category of Applicant: Private
Geographic Target: Hampden
Program Administrator: Festus Vanjah
Total Funds Approved: $13,979.55

Project Hope
550 Dudley Street
Roxbury, MA 02119
Category of Applicant: Non-Profit
Geographic Target: Suffolk
Program Administrator: Janet Grogan
Total Funds Approved: $13,241.00

Landscaping by J. Michael
853 Plain Street
Marshfield, MA 02050
Category of Applicant: Private
Geographic Target: Plymouth
Program Administrator: J. Michael Lesher
Total Funds Approved: $12,626.00

Busy Bee Party Services, Inc.
91 South Avenue
Whitman, MA 02382
Category of Applicant: Private
Geographic Target: Plymouth
Program Administrator: Jim Coffey
Total Funds Approved: $12,144.50

Town of Paxton/Paxton Municipal Light 578 Pleasant Street
Paxton, MA 01612
Category of Applicant: Municipality
Geographic Target: Worcester
Program Administrator: Jason Lavallee
Total Funds Approved: $10,432.50

Tri State Trucking
411 Hartford Turnpike, P.O.Box 308
Shrewsbury, MA 01545
Category of Applicant: Private
Geographic Target: Worcester
Program Administrator: Joe Bonofiglio
Total Funds Approved: $5,884.87

Vietnam Veterans Workshop, Inc.
17 Court Street
Boston, MA 02108
Category of Applicant: Non-Profit
Geographic Target: Suffolk
Program Administrator: Alexandra Pastore/ Courtney Hunt
Total Funds Approved: $5,136.00

O'Lyn Contractors Inc.
916 Pleasant Street, Unit 4
Norwood, MA 02062
Category of Applicant: Private
Geographic Target: Norfolk
Program Administrator: Richard Dow
Total Funds Approved: $12,840.00

Accutech Packaging
157 Green Street
Foxboro, MA 02035
Category of Applicant: Private
Geographic Target: Norfolk
Program Administrator: Kelly Gagliardi
Total Funds Approved: $12,305.00

NorthEast Arc
64 Holten Street
Danvers, MA 01923
Category of Applicant: Non-Profit
Geographic Target: Essex/Norfolk
Program Administrator: Diane Palocci/Sue McCarthy
Total Funds Approved: $11,490.00

McLane Research Lab
121 Bernard Saint Jean Drive
East Falmouth, MA 02536
Category of Applicant: Private
Geographic Target: Barnstable
Program Administrator: Yuki Honjo
Total Funds Approved: $6,454.77

Tree Technology & Landscape Co., Inc.
6 Spring Brook Road
Foxboro, MA 02035
Category of Applicant: Private
Geographic Target: Norfolk
Program Administrator: Meagon Felix
Total Funds Approved: $5,350.00

MHPI Inc.
70 Bridge Street
Newton, MA 02456
Category of Applicant: Non-Profit
Geographic Target: Suffolk/Barnstable/ Middlesex and Worcester
Program Administrator: Terri Petropoulos
Total Funds Approved: $4,815.00

Boston Education, Skills & Training (BestCorp)
33 Harrison Avenue
Boston, MA 02111
Category of Applicant: Private
Geographic Target: Suffolk
Program Administrator: Mary Cronin
Total Funds Approved: $3,819.90

GAAHMA, Inc.
208 Coleman Street
Gardner, MA 01440
Category of Applicant: Non-Profit
Geographic Target: Worcester
Program Administrator: Tracy Hutchinson
Total Funds Approved: $3,193.00

APPENDIX M – Collections & Expenditures Report, FY'16 - FY'12

COLLECTIONS AND EXPENDITURES REPORT, FISCAL YEAR 2016 - FISCAL YEAR 2012

SPECIAL FUND	***FY'16***	***FY'15***	***FY'14***	***FY'13***	***FY'12***
COLLECTIONS					
INTEREST	**11,243**	**5,316**	**5,057**	**5,740**	**7,275**
ASSESSMENTS	20,662,324	14,677,534	11,794,002	12,941,590	18,289,364
LESS RET. CHECKS	0	0	(13,054)	(14,697)	(84,188)
LESS REFUNDS	(346,009)	(21,280)	0	(8,388)	(75,113)
SUB-TOTAL	**20,316,315**	**14,656,254**	**11,780,948**	**12,918,505**	**18,130,063**
REFERRAL FEES	4,256,506	3,912,134	3,644,241	4,049,061	4,073,484
LESS RET. CHECKS	0	0	(8,339)	(762)	(1,760)
LESS REFUNDS	(76,402)	(136,907)	(24,564)	(64,108)	(325,711)
OPERATING TRANSFER	0	0	0	0	(39,347)
SUB-TOTAL	**4,180,104**	**3,775,227**	**3,611,338**	**3,984,191**	**3,706,666**
1ST REPORT FINES	248,430	252,716	140,622	$58,658	118,000
LESS RET. CHECKS	0	0	(500)	(2,400)	0
LESS REFUNDS	0	(4,662)	(900)	(500)	(2,700)
SUB-TOTAL	**248,430**	**248,054**	**139,222**	**55,758**	**115,300**
STOP WORK ORDERS	1,111,280	1,180,461	1.467,999	1,356,053	1,450,641
LESS REFUNDS	(4,250)	(4,407)	(33,300)	(1,200)	(7,900)
EDS FEE	0	12,487	(1,459)	0	0
LESS BAD CHECKS	0	0	(2,475)	(3,300)	(3,200)
MERCHANT FEE	0	0	(166)	(287)	(361)
SUB-TOTAL	**1,107,030**	**1,188,541**	**1,430,599**	**1,351,266**	**1,439,180**
LATE ASSESS. FINES	101,980	149,304	139,446	111,973	344,349
MISCELLANEOUS	(500)	49,464	53,230	50,689	67,571
ADJUSTMENT	0	0	0	0	0
SUB-TOTAL	**101,480**	**198,768**	**192,676**	**162,662**	**411,921**

TOTAL SPECIAL FUND COLLECTIONS	**25,964,601**	**20,072,160**	**17,159,840**	**18,478,122**	**23,810,405**
BALANCE BRGT FWD	4,980,445	7,534,484	12,252,405	14,294,169	12,141,512
TOTAL	**30,945,046**	**27,606,644**	**29,412,245**	**32,772,291**	**35,951,917**
LESS EXPENDITURES	(23,887,937)	(22,626,201)	(21,877,761)	(20,521,034)	(21,657,748)
ADJUSTMENT	0	0	0	1,148	0
BALANCE	**7,057,109**	**4,980,443**	**7,534,484**	**12,252,405**	**14,294,169**
EXPENDITURES					
TOTAL COMPUTER	**959,520**	**263,116**	0	0	0
REPAYMENT - SALARIES	13,836,825	13,722,012	13,516,002	12,805,181	13,076,720
FRINGE BENEFITS	3,970,076	3,722,851	3,530,765	3,310,925	4,264,090
INDIRECT COSTS	507,811	537,903	389,121	286,923	477,585
NON-PERSONNEL COSTS	4,612,697	4,397,893	4,441,873	4,118,005	3,800,005
OTHER INDIRECT COSTS	1,007	(17,574)	0	0	0
IP INDIRECT-EXPENSE	0	0	0	0	0
ADJUSTMENT FRINGE	0	0	0	0	39,347
TOTAL REPAYMENT	**22,927,410**	**22,363,085**	**21,877,761**	**20,521,034**	**21,657,748**
TOT. SPECIAL FUND EXPENDITURES	**23,887,937**	**22,626,201**	**21,877,761**	**20,521,034**	**21,657,748**

PUBLIC TRUST FUND	*FY'16*	*FY'15*	*FY'14*	*FY'13*	*FY'12*
COLLECTIONS					
INTEREST	**864**	**409**	**388**	**441**	**559**
ASSESSMENTS	0	0	0	0	0
LESS FUNDS TRANSFERRED	0	0	0	0	0
TOTAL ASSESSMENTS	**0**	**0**	0	0	**0**
TOTAL PUBLIC TRUST COLLECTIONS	**864**	**409**	**388**	**441**	**559**
BALANCE BRGT FWD	409,125	408,716	408,328	407,887	407,328
TOTAL	**409,890**	**409,125**	**408,716**	**408,328**	**407,887**
LESS EXPENDITURES	**(409,989)**	**0**	**0**	**0**	**0**
BALANCE	**0**	**409,125**	**408,716**	**408,328**	**407,887**
EXPENDITURES					
RR COLAS	0	0	0	0	0
TOT. PUBLIC TRUST EXPENDITURES	**409,989**	**0**	**0**	**0**	**0**

Note: As stated above, the Secretary of A&F exercised her authority under G.L. c. 29, §13A, to reallocate the entire amount in the Public Trust fund - $409,989.00 - to support the state General Fund.

PRIVATE TRUST FUND	*FY'16*	*FY'15*	*FY'14*	*FY'13*	*FY'12*
COLLECTIONS					
INTEREST	**17,679**	**12,922**	**13,982**	**13,982**	**17,723**
ASSESSMENTS	64,384,880	56,907,836	47,216,893	47,216,893	64,302,080
LESS RET. CHECKS	0	0	(8,130)	(8,130)	(301,967)
LESS REFUNDS	(1,197,886)	(629,833)	(15,651)	(15,651)	(12,414)
SUB-TOTAL	**63,186,994**	**56,278,003**	**47,193,112**	**47,193,112**	**63,987,699**
REIMBURSEMENTS	1,746,315	1,556,069	1,387,682	1,387,682	1,055,230
RET. CHECK	0	0	(18,833)	(18,833)	(8,173)
REFUNDS	0	0	0	0	0
SUB-TOTAL	**1,746,315**	**0**	**1,368,849**	**1,368,849**	**1,047,057**

SEC. 30 H	**0**	**0**	**0**	**0**	**0**
OTHER TRUST FUND	**26,873**	**0**	**0**	**0**	**0**
TOT.PRIVATE TRUST COLLECTIONS	**64,977,861**	**57,846,994**	**48,575,942**	**48,575,942**	**65,052,480**
BALANCE BRGT FWD	6,229,734	8,199,807	34,101,000	34,101,000	26,757,561
TOTAL	**71,207,595**	**66,046,801**	**82,676,942**	**82,676,942**	**91,810,041**
LESS EXPENDITURES	(54,676,967)	(59,817,067)	(54,077,680)	(54,077,680)	(57,709,041)
ADJUSTMENT	0	0	0	0	0
BALANCE	**16,530,627**	**6,229,734**	**28,599,262**	**28,599,262**	**34,101,000**

PRIVATE TRUST FUND	***FY'16***	***FY'15***	***FY'14***	***FY'13***	***FY'12***
CLAIMANTS - EXPENDITURES					
RR SEC. 34	1,108,354	1,120,950	1,824,561	1,297,249	1,008,823
RR SEC. 35	434,169	499,721	574,785	344,000	503,908
RR LUMP SUM	1,844,071	1,801,203	2,149,420	1,064,508	2,443,857
RR SEC. 36	107,669	351,484	142,923	108,877	339,108
RR SEC. 31	245,624	176,642	162,689	150,847	225,342
RR SEC. 34, PERM. TOTAL	925,489	865,685	948,058	676,761	711,058
RR COLA ADJ	866,228	281,448	243,368	242,981	229,823
RR EE MEDICAL	51,727	33,698	35,409	22,727	28,584
RR EE TRAVEL	5,000	9,196	8,,000	3,500	1,216
RR EE MISC. EXPENSE	369	905	957	222	0
RR BURIAL BENEFITS	0	0	0	0	5,000
RR LEGAL FEES	925,689	676,763	868,540	506,708	784,787
RR VOC. REHAB SERVICES	8,482	14,091	3,965	5,378	7,602
RR REHAB (PRIOR YEAR)	0	0	0	0	0
RR MEDICAL	1,384,551	1,789,068	1,695,603	1,497,220	1,521,020
EE Books & Supplies	60	0	0	0	0

SUB-TOTAL CLAIMANT PAYMENTS	**7,907,482**	**7,620,854**	**8,658,285**	**5,920,979**	**7,810,128**
MM TUITION	**5,975**	**0**	**4,795**	**0**	**0**
TOTAL CLAIMANTS	**7,913,457**	**7,620,854**	**8,663,080**	**5,920,979**	**7,810,128**
INSURERS - EXPENDITURES					
RR COLAS	10,679,718	14,073,608	15,458,218	14,967,542	19,578,320
RR SEC. 19 COLA LUMP SUM	338,590	270,653	286,050	515,501	499,339
RR LATENCY SEC. 35C	172,154	436,956	410,002	249,478	96,125
RR LATENCY SEC. 35C QUARTERLY	135,485	110,992	375,253	124,836	195,631
RR SEC. 37	17,626,489	20,682,433	19,717,765	15,773,208	17,290,467
RR SEC. 37 QUARTERLY	10,393,381	9,999,957	8,749,683	10,999,885	6,907,948
RR SEC. 37 INTEREST	0	0	0	6,470	0
TOTAL PAYMENT TO INSURERS	**39,345,817**	**45,574,599**	**44,996,971**	**42,636,920**	**44,567,830**
OEVR - EXPENDITURES					
MM TUITION	942	0	0	0	0
RR REHAB-30H	4	170	0	0	801
EE OTHER	0	0	0	0	0
RR EE TRAVEL	0	0	0	0	0
RR EE BOOKS & SUPPLIES	0	0	0	0	0
SUB-TOTAL OEVR EXP.	**946**	**170**	**0**	**0**	**801**

PRIVATE TRUST FUND	***FY'16***	***FY'15***	***FY'14***	***FY'13***	***FY'12***
DEFENSE - EXPENDITURES					
AA PAYROLL - SALARY	4,285,094	3,878,899	3,667,146	3,195,287	2,906,711
AA STAND-BY PAY	35	0	0	0	0
AA VACATION-IN-LEU	10,678	7,638	1,054	1,757	7,279
AA BONUS AND AWARDS	2,000	0	0	0	7
AA OVERTIME COSTS	1,067	415	696	1,620	15,140

AA SICK LEAVE BUY BACK	1,633	0	0	0	0
SUB-TOTAL	**4,300,506**	**3,886,952**	**3,668,896**	**3,198,664**	**2,929,137**
BB TRAVEL	48,366	44,646	51,017	59,399	55,086
BB CONFERENCE TRAINING	(916)	5,540	2,385	1,860	1,550
BB EE REIMBURSEMENT	22	11	61	77	246
BB EMPLOYEE REIMBURS	652	154	188	227	242
SUB-TOTAL	**48,253**	**50,351**	**53,561**	**61,563**	**57,124**
CONTRACTED STUDENT INTERNS	0	27,773	30,339	30,151	225
SUB-TOTAL	**0**	**27,773**	**30,339**	**30,151**	**225**
DD FRINGE	1,320,920	1,120,020	1,015,522	871,791	1,015,463
DD MEDICAL EXPENSES	0	0	19	0	0
DD BOND	0	0	0	0	(445)
DD WC CHARGEBACK	1,965	1,208	932	0	43,845
DD HEALTH SERVICES CORP	0	0	0	0	2,267
SUB-TOTAL	**1,322,885**	**1,121,228**	**1,016,472**	**871,791**	**1,061,130**
EE DEST. OLD RECORDS	0	6,562	0	6,715	6,840
EE ADVERTISING	431	0	0	0	0
EE BOOKS/SUPPLIES	31,155	30,354	45,675	44,168	41,999
EE IMPARTIAL APPEALS	26,777	13,650	18,612	26,825	15,963
EE CENTRAL REPRO.	0	0	7,950	999	0
EE POSTAGE	1,317	18,055	25,058	46,655	27,500
EE WATER	996	100	1,430	1,421	948
EE TRAINING / TUITION	191	500	500	298	0
EE TEMP USE SPACE	51	0	176	325	184
EE PRINTING	1,551	1,071	2,421	4,870	3,255
EE CONFERENCE, INCIDEN.	6,427	9,924	5,464	3,337	7,422
EE INDIRECT COSTS	157,377	152,069	103,330	70,012	63,989
EE POSTAGE CHRG-BACK	1,394	2,101	2,246	1,382	2,390

EE MEMBERSHIPS	2,558	1,972	1,625	3,450	625
EE STATE SINGLE AUDIT CHGBK	0	0	398	117	0
SUB-TOTAL	**230,222**	**236,357**	**214,884**	**210,574**	**171,115**
FF MED SUP/TOILETRIES & PERSONL	5,267	331	10,027	71	90
FF STATE OFFICE MAINTENANCE	84,209	114,509	92,586	0	0
SUB-TOTAL	**89,476**	**114,840**	**102,614**	**71**	**90**
GG BOSTON LEASE	528,681	494,226	491,459	454,249	475,576
GG FUEL FOR VEHICLES	0	0	4	570	0
SUB-TOTAL	**528,681**	**494,226**	**491,463**	**454,819**	**475,576**
HH CONSULTANTS	234,176	183,669	202,104	169,029	209,757
SUB-TOTAL	**234,176**	**183,669**	**202,104**	**169,029**	**209,757**
JJ OPERATIONAL SERV.	158,940	153,882	166,411	194,367	182,534
SUB-TOTAL	**158,940**	**153,882**	**166,411**	**194,367**	**182,534**
KK EQUIPMENT	1,815	13,027	8,092	4,951	1,150
SUB-TOTAL	**1,815**	**13,027**	**8,092**	**4,951**	**1,150**
LL AUTOMOBILE RENT/LEASE	64,311	51,564	58,710	42,257	43,027
LL OFFICE EQUIP RENT/LEASE	676	911	1,747	1,269	983
LL PRINT/COPY EQUIP RENT/LEASE	17,764	12,139	6,761	5,392	4,186
LL OFFICE EQUIP MAINTENANCE	1,197	1,453	358	351	1,396
LL PRINT/COPY EQUIP MAINT	8	837	410	222	370
SUB-TOTAL	**83,956**	**66,904**	**67,986**	**49,491**	**49,962**
UU TELECOM SERVICES - DATA	28,629	23,858	27,618	21,512	24,366
UU TELECOM SERVICES - VOICE	17,427	17,894	30,382	27,119	13,651
UU SOFTWARE LICENSES	71,932	2,341	29,199	1,223	6,969
UU INFO TECH CHARGEBACK	31,416	30,920	24,078	72,147	26,862
UU INFO TECH PROFESSIONALS	0	2,929	7,278	1,563	4,073
UU INFO TECH CABLING	0	0	9	0	122

UU INFO TECH EQUIP PURCHASE	112,842	138,969	38,342	93,830	57,254
UU IT TELP LEASE-PURCHASE	0	0	0	48	47
UU INFO TECH MAINTENANCE	152,648	50,510	34,702	56,663	56,654
UU INFO TECH CONTRACT SVCS	0	2,570	0	0	0
SUB-TOTAL	**414,894**	**269,991**	**191,607**	**274,105**	**189,998**
NN NON-MAJOR INFRA MAINT	1,525	784	723	0	1,845
NN INFRA MAINT TOOLS/SUPPLIES	0	0	10	5	3
NN NON- HAZARDOUS WASTE	1,417	1,458	1,248	0	1,436
SUB-TOTAL	**2,942**	**2,242**	**1,982**	**5**	**3,284**
TT LOANS AND SPECIAL PMNTS	0	0	40	0	0
SUB-TOTAL	**0**	**0**	**40**	**0**	**0**
RR PENALTIES SEC. 8	0	0	0	200	0
SUB-TOTAL	**0**	**0**	**0**	**200**	0
TOTAL DEFENSE EXPENDITURES	**7,416,747**	**6,621,442**	**6,216,542**	**5,519,780**	**5,331,082**
TOTAL PRIV. TRUST EXPENDITURES	**54,676,967**	**59,817,065**	**59,876,592**	**54,077,680**	**57,709,041**

DIA - INCOME SUMMARY

INCOME SUMMARY	*FY'16*	*FY'15*	*FY'14*	*FY'13*	*FY'12*
Total Assessments (All 3 Funds)	83,503,309	70,934,257	50,224,950	60,111,617	82,117,762
Total Filing Fees	4,180,104	3,775,227	3,611,338	3,984,191	3,706,666
Total First Report Fines	248,430	248,054	139,222	55,758	115,300
Total SWOs	1,107,030	1,188,541	1,430,599	1,351,266	1,439,180
Total Misc. Fines	0	49,464	53,230	50,689	67,571
Total 5% Fines (Late Assess.)	101,980	149,304	139,446	111,973	344,349
Total Reimbursements	1,746,315	1,556,069	1,013,557	1,368,849	1,047,057
Total 30H	0	0	7,29	0	0
Total Other Trust Fund	26,373	0	0	0	0
Yr. Adj. for Refunds to TF	0	0	0	0	0
Total Interest	29,785	18,647	17,765	20,163	25,557
TOTAL INCOME	**90,943,326**	**77,919,563**	**56,637,366**	**67,054,506**	**88,863,444**

APPENDIX N – Workers' Compensation Legislation, 2015-2016 Session

WORKERS' COMPENSATION LEGISLATION

The 189th General Court of the Commonwealth of Massachusetts ●Last Updated: June 9, 2015

HOUSE BILLS:

H4	*New*	Audits of the Special Fund and Trust Fund
H1012	*Similar*	Rates of Payment to Medical Providers; Impact of Rate Changes
H1427	*Similar*	Penalties for Contracting when Debarred
H1684	*New*	Employee Benefits; Dispute Resolution; Trust Fund Responsibilities; Incidental Services
H1685	*New*	Trust Fund; Self-Insurers
H1686	*Similar*	AWW for Subsequent Injuries; Attorney Fees
H1691	*Similar*	Workers' Compensation Exclusion for Business Owners
H1694	*Similar*	Stop Work Order Fines—3x Premium Avoided
H1699	*Similar*	Benefits; Claimants 65 and Over
H1700	*New*	Transparency in Employee Benefits Reporting
H1705	*New*	Workers' Compensation Exclusion for Officers of Non-Profits
H1707	*New*	Scar-Based Disfigurement
H1726	*Similar*	Serious and Willful Misconduct
H1741	*Similar*	Reinforcing Steel Classification Creation Study
H1746	*Similar*	Competitive Determination of WC Insurance Rates (Loss Cost)
H1765	*Similar*	Stop Work Order Fines—3x Premium Avoided
H1766	*Similar*	Notification of Workers' Compensation Coverage or Cancellation
H1774	*Similar*	Workers' Compensation Audits

H1775	*New*	Professional Employee Organizations
H3457	*New*	Third-Party Liens

SENATE BILLS:

S966	*New*	Joint and Several Liability; Shared Civil Legal Responsibility
S968	*New*	Scar-Based Disfigurement
S976	*New*	Employee Benefits; Dispute Resolution; Trust Fund Responsibilities; Incidental Services
S990	*Similar*	Criminal Penalties
S993	*New*	Employee Benefits Reporting
S994	*New*	Workers' Compensation Exclusion for Officers of Non-Profits
S1003	*New*	Professional Employee Organizations
S1011	*Similar*	Adjudication Process
S1018	*Similar*	Stop Work Orders; Retroactive Penalties
S1021	*Similar*	Out-of-State Employers Temporarily in Massachusetts
S1909	*Similar*	WC Benefits for Members of the Armed Services and National Guard

HOUSE BILL 4

Subject: Audits of the Special Fund and Trust Fund
Primary Sponsor: State Auditor Suzanne Bump
Referred To: Joint Committee on State Administration and Regulatory Oversight
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.152, §65 (Trust Fund)

Section 39 of this bill would amend M.G.L. c.152, §65(10) to delete the requirement that the special fund and trust fund be audited biennially. Instead, it would give the Auditor discretion as to how often to audit. It would require such audits to be conducted in accordance with generally accepted government accounting standards.

HOUSE BILL 1012

Subject: Rates of Payment to Medical Providers; Impact of Rate Changes
Primary Sponsor: Representative Paul McMurtry
Referred To: Joint Committee on Health Care Financing
Previous History: Similar to H561 filed during the 2013-2014 Session.
WCAC Position: Monitoring
Statutes Affected: c.118E, §13C (Fee Schedules); c.152, §13(1) (Fee Schedules)

This bill would amend M.G.L. c.118E, §13C by adding a sentence requiring the Secretary of the Executive Office of Health and Human Services (EOHHS), or the designated governmental unit authorized by the Secretary, 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' workers' compensation 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. This bill would also add a provision to §13(1) requiring the Commissioner of Insurance, in consultation with the EOHHS, to certify that a rate increase will not adversely affect employers' workers' compensation insurance premiums.

HOUSE BILL 1427

Subject: Penalties for Contracting when Debarred
Primary Sponsor: Representative Mary S. Keefe
Referred To: Joint Committee on the Judiciary
Previous History: Similar to H1423 filed during the 2013-2014 Session.
WCAC Position: Monitoring
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 1684

Subject: Employee Benefits; Dispute Resolution; Trust Fund Responsibilities; Incidental Services, including Translation and Transportation
Primary Sponsor: Representative Garrett J. Bradley
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Opposed
Statutes Affected: c.23E, §6, c.152 §1 (Definition of "AWW"); c.152, §1(11) (Minimum Weekly Compensation Rate); c.152, §7(1) (Commencement of Payments); c.152, §11E (Interpretation); c.152, §15A (Controversy as to which of two or more insurers is liable), (Trust Fund Liability); c.152, §22 (Notice); c. 152, §30 (Adequate and Reasonable Health Care Service); c.152, §34 (Total Incapacity); and c.152, §65 (Trust Fund)

Section 1: This section would add two new grounds for a motion for expedited conference: (1) a denial based solely on a dispute over the existence of an employment relationship or (2) a dispute limited to the determination of the employee's average weekly wage (AWW) under M.G.L. c. 152.

Section 2: This section would add new provisions to the definition of "average weekly wages" that would require judges to consider all available evidence of wages paid, earned but not paid, or hours worked. Furthermore, in situations where the employee earned less than the wages required to be paid by law, the section would require the AWW calculation to be done as if the employee earned legal wages in compliance with the law.

Section 3: This section would raise the minimum weekly rate of compensation from 20% to 30% of the state average weekly wage (SAWW).

Section 4: This section would require insurers to consider all information provided by both the employer and employee when determining whether to commence payment. The section would also prevent insurers from refusing payment if the employer fails to provide information or participate. In such cases, the insurer would be required to make its determination based on information provided by the employee. The insurer would not waive any defenses if it commences payment on this basis.

Section 5: This section would require the DIA to provide interpretive services throughout the dispute resolution process. Current regulations place the obligation of providing interpreters, in most cases, on the moving party (see 452 CMR 1.09 (4)).

Sections 6, 7 and 8: These sections would provide that in the event that two or more insurers agree that an employee is entitled to compensation, but dispute which insurer should pay, they may mutually agree which one will pay or the trust fund will pay, pending a final decision by the board.

Section 9: This section would expand the employee notice provisions of M.G.L. c. 152, §22. It would require the employer to provide employees with a notice approved by the DIA in English and the employee's preferred language. A notice would also be required to be posted at the workplace. The bill would require employers to inform new employees of their right to obtain the notice in their preferred language. Employers would be required to provide information to employees at the outset of the policy, as well as in the event the policy changes.

Sections 10 and 11: This section would expound on the insurer's responsibility to pay expenses incidental to the provision of health care services, stating that insurer shall furnish such services, which include, but are not limited to interpretation, transportation, and other services necessary to allow the injured employee to obtain effective and timely health care services. It would require the insurer to pay directly for such services at the request of the injured worker or medical provider. It would also provide that transportation services include door-to-door taxi or equivalent services when the injured worker cannot readily obtain other public or private transportation.

Sections 12, 13 and 14: Under existing law, §34 benefits are generally 60% of the employee's AWW, but not more than the statutory maximum (80% of SAWW), unless the employee's AWW is less than the minimum compensation rate (20% of SAWW), in which case benefit is equal to the employee's AWW. This bill would change §34 benefits by creating a tiered system of benefits based on the relationship between the employee's AWW and the SAWW. The bill provides that the employee's weekly benefit amount will be 60% of AWW pre-injury, but not more than statutory maximum, unless the AWW of the employee is: (1) less than the minimum weekly compensation rate, in which case benefits will equal the employee's AWW (Note: Section 3 of this bill would increase the minimum compensation rate from 20% to 30% of the SAWW); (2) less than 50% of the SAWW, but equal to or greater than the minimum weekly compensation rate, in which case compensation will equal 80% of employee's AWW; or (3) less than 70% of the SAWW, but equal to or greater than 50% of the SAWW, in which case compensation rate will be 70% of the employee's AWW.

Sections 15 and 16: These sections would add payments made pursuant to §15A to the list of expenditures that the Trust Fund is permitted to make (Note: See sections 6-8 of this summary for

changes that this bill would make to §15A). These sections would also require the Trust Fund to make payment of weekly benefits and adequate and reasonable health care services within fourteen days of an initial written claim for weekly benefits in cases where the dispute or disputes are limited to (i) the existence of an employment relationship, (ii) a question of which of the multiple insurers, including the Trust Fund, are liable, or (iii) a question of whether the employer is insured. The sections would also require the Trust Fund to recover such payments from any other insurer eventually determined to be liable for such payments or may recover payment from the employee if such benefits and services eventually are denied.

HOUSE BILL 1685

Subject: Trust Fund; Self-insurers
Primary Sponsor: Representative Garrett J. Bradley
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.152, §65(2) (Special Fund; Trust Fund; assessment base; assessment rates; payments; reports; audits),

Section 1: This section would require the Trust Fund to pay approved claims to injured workers against self-insurers whose resources pursuant to §25A (2) (i.e. bond and reinsurance) are insufficient to pay the claims.

Section 2: This section provides that, in cases where it has made payments pursuant to the change set forth in Section 1 of this bill, the Trust Fund will succeed to and be authorized to exercise the rights of the self-insurer or surety company to seek reimbursement under bonds, excess or reinsurance policies, or subrogation. It would also provide that payments made by the Trust Fund are considered payments made by the self-insurer for meeting retention thresholds.

Section 3: This section provides that the bill shall be considered procedural in nature and thus would apply to claims occurring before, on, or after the effective date of the Act.

HOUSE BILL 1686

Subject: AWW for Subsequent Injuries; Attorney Fees
Primary Sponsor: Representative Garrett J. Bradley
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.1699 in the 2013-2014 Legislative Session)
WCAC Position: Opposed
Statutes Affected: c.152, §1(1) (Definition of "AWW"), §13A(4) (Attorney's Fees)

Section 1: This section 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 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: This section would delete §13(A)(4) and replace it with a new paragraph. The new paragraph would require 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 contests a claim for benefits on a form prescribed by the department (other than the initial liability claim), by failing to begin compensation within 21 days of receipt of the claim, when later required to pay benefits following a conference. The attorney's fee would be $350 in the event said insurer or self-insurer withdraws a complaint within five days of a conference. This bill also requires the reduction of any attorney fee (payable through this section) by half when the attorney fails to appear at conciliation and the failure to appear was not beyond the control of the attorney. Finally, this bill would delete a provision in existing paragraph (4) that only one fee shall be paid with respect to any particular written claim under the paragraph.

HOUSE BILL 1691

Subject: Workers' Compensation Exclusion for Business Owners
Primary Sponsor: Representative James M. Cantwell
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H1704 in the 2013-2014 Legislative Session)
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 the paragraph. This bill would remove this authority.

HOUSE BILL 1694

Subject: Stop Work Order Fines – 3x Premium Avoided
Primary Sponsor: Representative Tackey Chan
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.1760 in the 2013-2014 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, 25C (Stop Work Orders & Penalties)

This 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, this bill would establish 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 over twenty 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 1699

Subject: Benefits; Claimants 65 and Over
Primary Sponsor: Representative Stephen L. DiNatale
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H1713 in the 2013-2014 Legislative Session)
WCAC Position: Opposed Redraft (H3972) (note: redraft language was the same as H1699 as originally filed.
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 1700

Subject: Transparency in Employee Benefits Reporting
Primary Sponsor: Representative Carolyn C. Dykema
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.151A, §9, c.152 §6 (Reporting certain contribution to the Unemployment Insurance Program and the Workers' Compensation System)

This bill would require developers working on projects in excess of $250,000 to provide EOLWD with a true attested copy of all payments to the Workers' Compensation system.

HOUSE BILL 1705

Subject: Workers' Compensation Exclusion for Officers of Non-Profits
Primary Sponsor: Representative Michael J. Finn and John V. Fernandes
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.152, §1(4) (Definition of "Employee")

This bill would make workers' compensation elective for officer of a non-profit entity or corporation who is not compensated. Officers seeking to opt out of workers' compensation would be required to submit a notice to the Department of Industrial Accidents.

HOUSE BILL 1707

Subject: Scar-Based Disfigurement
Primary Sponsor: Representative Sean Garballey
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.152, §36(k) (Disfigurement)

Under current law, scarring must be on the hands face or neck in order to be compensable. This bill would eliminate the hand, face or neck limitation and increase and index the maximum benefit from $15,000 to 30 times the SAWW.

HOUSE BILL 1726

Subject: Serious and Willful Misconduct
Primary Sponsor: Representative Bradley H. Jones
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.1735 of the 2013-20142 Legislative Session)
WCAC Position: Opposed
Statutes Affected: c.152, §27 (Willful Misconduct of Employee)

This 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 1741

Subject: Reinforcing Steel Classification Creation Study
Primary Sponsor: Representative Paul W. Mark (By Request)
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H1748 of the 2013-2014 Legislative Session)
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 1746

Subject: Competitive Determination of WC Insurance Rates (Loss Cost)
Primary Sponsor: Representative Paul McMurty
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (S.888 in the 2013-2014 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 this bill, workers' compensation insurance rates would be determined under a "Loss-Cost System." Similar to the current law, insurers would submit all their loss data to a designated rating organization (WCRIB) and would adhere to a uniform classification system. Instead of a rate hearing, the Commissioner of Insurance would hold a loss-cost hearing in which the WCRIB would submit a loss cost filing for each classification (e.g. roofers, clerical workers). "Loss Costs" are the historical aggregate data and loss adjustment expenses (LAE), developed and trended for each classification and is expressed as a dollar amount per $100 of payroll. For example, the loss cost for a roofer might be $6.00 and for a clerical worker $.90.

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

RATE = LOSS COST x LCM

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

This legislation 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.

HOUSE BILL 1765

Subject: Stop Work Order Fines – 3x Premium Avoided
Primary Sponsor: Representative Tom Sannicandro
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.1760 in the 2013-2014 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, 25C (Stop Work Orders & Penalties)

This 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, this bill would establish 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 1766

Subject: Notification of Workers' Compensation Coverage or Cancellation
Primary Sponsor: Representative Tom Sannicandro
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.1761 in the 2013-2014 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §22 (Notice by Insured to New Employees; Notice of Cessation of Insurance)

This legislation would fine 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 1774

Subject: Workers' Compensation Audits
Primary Sponsor: Representative Joseph F. Wagner
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (H.1771 in the 2013-2014 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §25V (New Section)

This 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.

HOUSE BILL 1775

Subject: Recognition and Registration of Professional Employer Organizations
Primary Sponsor: Representative Joseph F. Wagner
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected:

This bill would insert a new section to M.G.L. c. 149 to regulate professional employee organizations (PEOs). With respect to the workers' compensation system, this bill would provide that the responsibility for obtaining workers' compensation insurance would be specifically allocated to either the PEO or client in the contract between them. The bill would also provide that the workers' compensation exclusive remedy would apply to both the PEO and client, regardless of which party has the responsibility for obtaining workers' compensation insurance coverage.

HOUSE BILL 3457

Subject: Workers' Compensation Reimbursement Clarification
Primary Sponsor: Representative Claire D. Cronin
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.152, §15 (Clarify Reimbursement of Workers' Compensation Insurers to Prevent Double Recovery by Injured Worker in Third Party Cases)

M.G.L. c. 152, §15 entitles a workers' compensation insurer to reimbursement in the event that an injured employee recovers damages from a third party. In *Curry v. Great Am. Ins. Co.* (2001), the Massachusetts Appeals Court held that an insurer's lien does not reach settlement proceeds in a third party action that are allocated to pain and suffering and to loss of consortium. This bill would add language to § 15 delineating what settlement proceeds are subject to an insurer's lien. The bill would add the phrase "attributed to damage elements for which compensation was paid" to describe the sum that shall be for the benefit of the insurer. It would add the same phrase to the sentence setting forth what "excess" shall be for the benefit of the injured party.

HOUSE BILL 4071

Subject: Pay without prejudice; conciliations; impartial medical exams
Primary Sponsor: Representative Tackey Chan
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.152, §8 (Termination or Modification of Benefits), §10 (Conciliation), §10A (Dispute Resolution), §10C (Collective Bargaining Agreements), §11A (Impartial Medical Examiners), §13A (Attorney's Fees), §30 (Adequate and Reasonable Health Care Services), §48 (Lump Sum Settlements)

Section 1: This section would add a new §7G to MGL c. 152. The new section would require the claimant's written consent in order for photographs or video of the claimant or the claimant's immediate family to be admissible in evidence or referred to a hearing of any claim for compensation, which is denied by the insurer.

Section 2: This section would change the pay without prejudice provision ("PWOP") of MGL c. 152, §8. Under current law, an insurer may modify or terminate payments within the PWOP subject to a notice provision. This bill would prevent an insurer from modifying or terminating benefits without a court order.

Section 3: This section would delete a provision in §8 allowing insurers to modify or discontinue benefits if an impartial medical examiner has made a report pursuant to §13A which indicates the employee is suitable to return to work. (Section 8 of this bill would delete §13A (see below)).

Section 4: This section would delete a provision in §8 allowing a conciliator to approve an agreement extending the PWOP. (Section 5 of this bill would strike the conciliation portion of the dispute resolution process (see below)).

Section 5: This section would strike the conciliation portion of the dispute resolution process by deleting portions of §10.

Section 6: This section would remove references to conciliation in §10A.

Section 7: This section would remove references to conciliation in §10C.

Section 8: This section would repeal the impartial medical examiner program by striking §11A.

Section 9: This section would remove references to conciliation in §13A.

Section 10: This section would specify that the adequate and reasonable health care services furnished to an injured employee include physical therapy at the injured employee's request.

Section 11: This section would remove references to conciliation in §48.

SENATE BILL 966

Subject: Joint and Several Liability; Shared Civil Responsibility
Primary Sponsor: Senator Sal N. DiDomenico
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.149; c.151; c.151A and c.152

This legislation impacts a number of chapters of the General Laws pertaining to the rights and obligations of employers and employees. With regard to the workers' compensation aspects of the bill, Section 1 would create a new M.G.L. c. 149, § 148D. The section would provide that a "lead company" (as defined in the bill) be subject to joint and several civil liability and share civil legal responsibility for any violations of M.G.L. c. 152 with a "labor contractor" (as defined in the bill) and any subcontractor for all workers whose labor or services are supplied to it by that labor contractor or subcontractor. "Lead company" is defined as a business entity that obtains or is provided workers, directly from a labor contractor or indirectly from a subcontractor, to perform labor or services that have a nexus with the lead company's business activities, operations or purposes. "Labor contractor" is defined as an individual or entity that supplies a lead company with workers to perform labor or services.

SENATE BILL 968

Subject: Scar-Based Disfigurement
Primary Sponsor: Senator Sal N. DiDomenico
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.152, §36(k) (Disfigurement)

Under current law, scarring must be on the hands face or neck in order to be compensable. This bill would eliminate the hand, face or neck limitation and increase and index the maximum benefit from $15,000 to 30 times the SAWW.

SENATE BILL 976

Subject: Employee Benefits; Dispute Resolution; Trust Fund Responsibilities; Incidental Services, including Translation and Transportation
Primary Sponsor: Senator James B. Eldridge
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Opposed
Statutes Affected: c.23E, §6, c.152 §1 (Definition of "AWW"); c.152, §1(11) (Minimum Weekly Compensation Rate); c.152, §7(1) (Commencement of Payments); c.152, §11E (Interpretation); c.152, §15A (Controversy as to which of two or more insurers is liable), (Trust Fund Liability); c.152, §22 (Notice); c. 152, §30 (Adequate and Reasonable Health Care Service); c.152, §34 (Total Incapacity); and c.152, §65 (Trust Fund)

Section 1: This section would add two new grounds for a motion for expedited conference: (1) a denial based solely on a dispute over the existence of an employment relationship or (2) a dispute limited to the determination of the employee's average weekly wage (AWW) under M.G.L. c. 152.

Section 2: This section would add new provisions to the definition of "average weekly wages" that would require judges to consider all available evidence of wages paid, earned but not paid, or hours worked. Furthermore, in situations where the employee earned less than the wages required to be paid by law, the section would require the AWW calculation to be done as if the employee earned legal wages in compliance with the law.

Section 3: This section would raise the minimum weekly rate of compensation from 20% to 30% of the state average weekly wage (SAWW).

Section 4: This section would require insurers to consider all information provided by both the employer and employee when determining whether to commence payment. The section would also prevent insurers from refusing payment if the employer fails to provide information or participate. In such cases, the insurer would be required to make its determination based on information provided by

the employee. The insurer would not waive any defenses if it commences payment on this basis.

Section 5: This section would require the DIA to provide interpretive services throughout the dispute resolution process. Current regulations place the obligation of providing interpreters, in most cases, on the moving party (see 452 CMR 1.09 (4)).

Sections 6, 7 and 8: These sections would provide that in the event that two or more insurers agree that an employee is entitled to compensation, but dispute which insurer should pay, they may mutually agree which one will pay or the trust fund will pay, pending a final decision by the board.

Section 9: This section would expand the employee notice provisions of M.G.L. c. 152, §22. It would require the employer to provide employees with a notice approved by the DIA in English and the employee's preferred language. A notice would also be required to be posted at the workplace. The bill would require employers to inform new employees of their right to obtain the notice in their preferred language. Employers would be required to provide information to employees at the outset of the policy, as well as in the event the policy changes.

Sections 10 and 11: This section would expound on the insurer's responsibility to pay expenses incidental to the provision of health care services, stating that insurer shall furnish such services, which include, but are not limited to interpretation, transportation, and other services necessary to allow the injured employee to obtain effective and timely health care services. It would require the insurer to pay directly for such services at the request of the injured worker or medical provider. It would also provide that transportation services include door-to-door taxi or equivalent services when the injured worker cannot readily obtain other public or private transportation.

Sections 12, 13 and 14: Under existing law, §34 benefits are generally 60% of the employee's AWW, but not more than the statutory maximum (80% of SAWW), unless the employee's AWW is less than the minimum compensation rate (20% of SAWW), in which case benefit is equal to the employee's AWW. This bill would change §34 benefits by creating a tiered system of benefits based on the relationship between the employee's AWW and the SAWW. The bill provides that the employee's weekly benefit amount will be 60% of AWW pre-injury, but not more than statutory maximum, unless the AWW of the employee is: (1) less than the minimum weekly compensation rate, in which case benefits will equal the employee's AWW (Note: Section 3 of this bill would increase the minimum compensation rate from 20% to 30% of the SAWW); (2) less than 50% of the SAWW, but equal to or greater than the minimum weekly compensation rate, in which case compensation will equal 80% of employee's AWW; or (3) less than 70% of the SAWW, but equal to or greater than 50% of the SAWW, in which case compensation rate will be 70% of the employee's AWW.

Sections 15 and 16: These sections would add payments made pursuant to §15A to the list of expenditures that the Trust Fund is permitted to make (Note: See sections 6-8 of this summary for changes that this bill would make to §15A). These sections would also require the Trust Fund to make payment of weekly benefits and adequate and reasonable health care services within fourteen days of an initial written claim for weekly benefits in cases where the dispute or disputes are limited to (i) the existence of an employment relationship, (ii) a question of which of the multiple insurers, including the Trust Fund, are liable, or (iii) a question of whether the employer is insured. The sections would also require the Trust Fund to recover such payments from any other insurer eventually determined to be liable for such payments or may recover payment from the employee if such benefits

and services eventually are denied.

SENATE BILL 990

Subject: Criminal Penalties
Primary Sponsor: Senator Thomas M. McGee
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (S.871 in the 2013-2014 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §25C (Stop Work Orders and Penalties)

This 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 993

Subject: Employee Benefits Reporting
Primary Sponsor: Senator Michael O. Moore
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.151A, §9, c.152 §6 (Reporting certain contribution to the Unemployment Insurance Program and the Workers' Compensation System)

This bill would require developers working on projects in excess of $250,000 to provide EOLWD with a true attested copy of all payments to the Workers' Compensation system.

SENATE BILL 994

Subject: Workers' Compensation Exclusion for Officers of Non-Profits
Primary Sponsor: Senator Michael O. Moore
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected: c.152, §1(4) (Definition of "Employee")

This bill would make workers' compensation elective for officer of a non-profit entity or corporation who is not compensated. Officers seeking to opt out of workers' compensation would be required to submit a written waiver of their rights to the Department of Industrial Accidents.

SENATE BILL 1003

Subject: Recognition and Registration of Professional Employer Organizations
Primary Sponsor: Senator Michael J. Rodrigues
Referred To: Joint Committee on Labor and Workforce Development
Previous History: NEW
WCAC Position: Monitoring
Statutes Affected:

This bill would insert a new section to M.G.L. c. 149 to regulate professional employee organizations (PEOs). With respect to the workers' compensation system, this bill would provide that the responsibility for obtaining workers' compensation insurance would be specifically allocated to either the PEO or client in the contract between them. The bill would also provide that the workers' compensation exclusive remedy would apply to both the PEO and client, regardless of which party has the responsibility for obtaining workers' compensation insurance coverage.

SENATE BILL 1011

Subject: Adjudication Process
Primary Sponsor: Senator Bruce E. Tarr
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Refile (S.894 in the 2013-2014 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 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 1018

Subject: Stop Work Orders; Retroactive Penalties
Primary Sponsor: Senator James E. Timilty
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (S.898 in the 2013-2014 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 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.

This bill would also amend 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 1021

Subject: Out-of-State Employers Temporarily in Massachusetts
Primary Sponsor: Senator James T. Welch
Referred To: Joint Committee on Labor and Workforce Development
Previous History: Similar (S.899 in the 2013-2014 Legislative Session)
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 1909

Subject: WC Benefits for Members of the Armed Services and National Guard
Primary Sponsor: Senator Thomas M. McGee
Referred To: Joint Committee on Veterans and Federal Affairs
Previous History: Similar (H.1739 in the 2013-2014 Legislative Session)
WCAC Position: Monitoring
Statutes Affected: c.152, §1(7A) (Definition of "Personal Injury")

This 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.